

Having Clinical Commissioning Group equality strategy

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Part 1: Introduction

Foreword

With the introduction of the Health and Social Care Act, Clinical Commissioning Groups (CCGs) have a responsibility to commission health services that are appropriate, equally accessible and beneficial for our patients, their families and carers.

Access to and outcomes from health services can be affected by various factors including age, ethnic background, gender, whether or not someone is disabled and sexual orientation. There are also factors that will influence how individuals interact with health services; these can include religion and belief, and social and economic factors. These combined factors are widely known as determinants of health and can lead to individuals experiencing health inequalities i.e. poorer health outcomes.

The challenge for our clinical commissioning group is to lead on reducing health inequalities; this can only be done effectively by working in partnership to tackle the wider determinants of health.

Reducing health inequalities and promoting equality should be everyone's business, however we know that demonstrable and sustainable progress in this area can be greatly improved.

The government has specified that clinical commissioning groups, like other public sector organisations, will be subject to the Public Sector Equality Duty (PSED), as laid down in the Equality Act 2010.

The act replaced previous anti-discrimination laws with a single act to make the law simpler and to remove inconsistencies.

The act covers nine protected characteristics (* see page 6) which apply to everyone, so the act protects everyone against unfair treatment.

There will be an increased emphasis on the publication of equality information and the setting of measurable objectives.

This document sets out how we will meet the requirements of the duty, including our equality objectives for 2012 – 2016, and how they will be delivered and evaluated.

Further information on the Equality Act can be found at:

<http://homeoffice.gov.uk/equalities/equality-act/>

Part 1: Introduction

1.0 The Equality Act 2010

From April 2013, clinical commissioning groups will take on legal responsibility for demonstrating compliance with the Equality Act 2010, specifically the Public Sector Equality Duty (PSED).

In so doing, we must have due regard to three aims of the 'general duty' which states we must:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
2. Advance equality of opportunity between people who share a protected characteristic* and those who do not. (*see page 5)
3. Foster good relations between people who share a protected characteristic and those who do not.

To help demonstrate compliance with the general duty, clinical commissioning groups are subject to specific duties, which stipulate specific actions we must take in order to meet the requirements of the Act. The specific duties require clinical commissioning groups to:

- Publish information, at least annually, relating to people who share a protected characteristic who are:
 - Affected by our policies
 - Employees – for organisations with 150 employees or more. (The CCG have fewer employees than this).
- Publish equality objectives at least every four years; objectives should be specific and measureable.

The equality duty means clinical commissioning groups need to be able to demonstrate how we will build consideration of equality into our work; we will need to understand how different groups are affected by our policies and practices, across the protected characteristics.

The guidance on authorisation for clinical commissioning groups comprises six domains and involves a rigorous assessment to look at our arrangements to effectively embed engagement and promote equality. The specific requirements are outlined in Domain 2:

Meaningful engagement with patients, carers and their communities, which requires emerging clinical commissioning groups to:

- Understand our local population including a strategy for promoting choice
- Engage with patients and public including disadvantaged groups
- Use engagement in commissioning decisions
- Collect and share information with patients and the public.

1.1 The protected characteristics

The protected characteristics are specific groups in our population, with whom we have to engage and demonstrate we are promoting equality and eliminating discrimination.

We will work to improve our evidence base across all nine protected characteristics and will more routinely use equality data in order to have due regard in our commissioning decisions.

Protected characteristics

Protected characteristic	Description
Age	Refers to a particular age group; includes younger people; older people; working age population and children.
Disability	A disability is defined as a physical or mental impairment that has a substantial and long-term adverse effect on an individual's ability to carry out normal day to day activity.
Gender reassignment/also known as trans gender	This refers to a person transitioning from one gender to another or a person who expresses themselves as a different gender to the one they were recognised as at birth.
Marriage and civil partnership	Marriage is defined as a 'union between a man and a woman'. Civil partnerships are the legally recognised relationships between same-sex couples. Civil partners and married couples should be treated in the same way.
Pregnancy and maternity	Pregnancy is the condition of being pregnant/expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context; in the non-employment 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 or belief	People that follow a particular religious practice; belief included religious and philosophical beliefs, including lack of belief that generally affects the life choices or the way an individual lives their life.
Sex	Male or female
Sexual orientation	Whether an individual is attracted towards people of their own sex (gay) of the opposite sex (heterosexual) or to both sexes (bisexual)

Part 2: The national picture

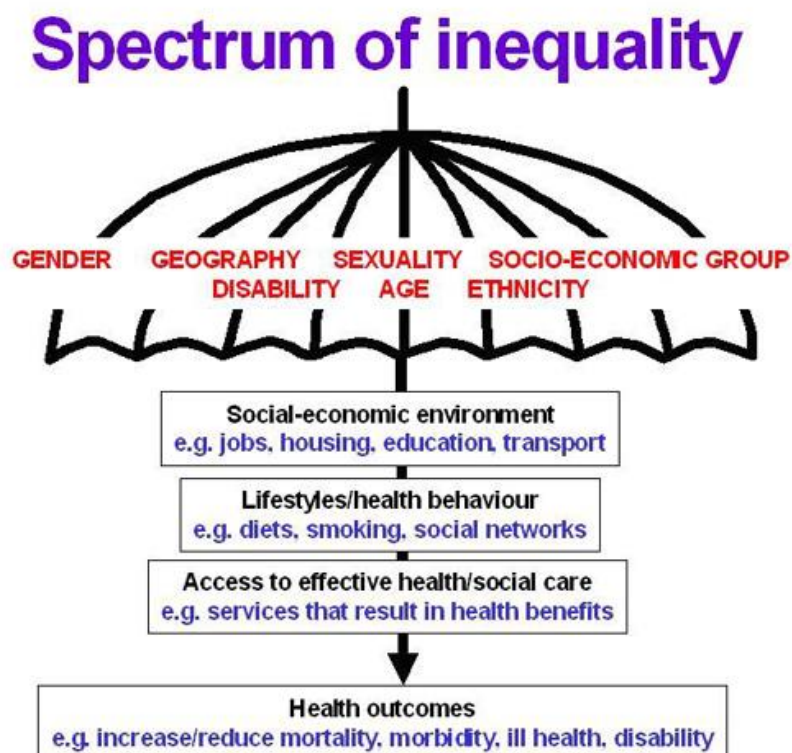
2.0 Health inequalities

The Public Sector Equality Duty encourages public bodies to understand how different people will be affected by their activities so that policies and services are appropriate and accessible to all and, meet different peoples' needs. The wider determinants of health are a major influence on health inequality.

High risk lifestyle choices are strongly correlated to deprivation, most notably seen in increasing smoking levels with increasing deprivation.

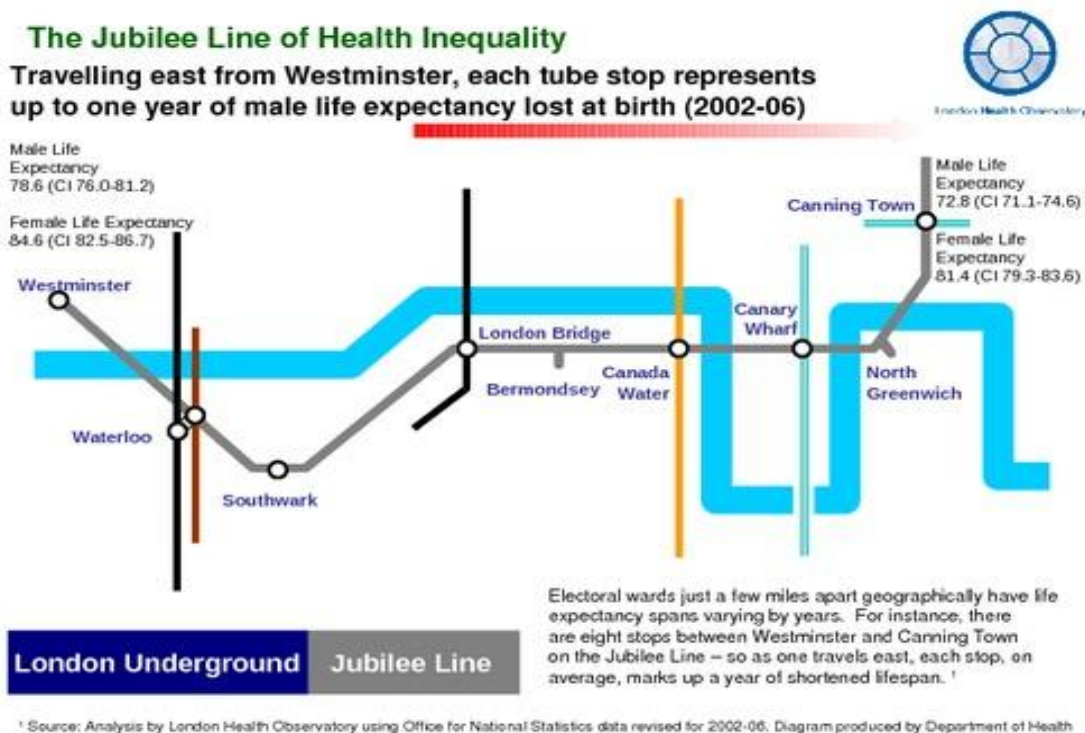
Being a member of certain groups e.g. those with a physical disability or a mental illness, Black, Asian and Minority Ethnic (BAME) groups and the homeless also play a part, due to social marginalisation, poor access to services and likelihood of income deprivation.

Poorer access to local services is associated with economic disadvantage; poorer areas are often served by the poorest quality services. However, there may also be issues of decreased demand from poorer populations, particularly for preventative and well being services.



Health inequalities exist between socioeconomic groups, ethnic groups and between men and women.

Life expectancy and other measures of health can vary strongly between different geographical areas. For example, in London, the life expectancy of the local population falls by one year with each station along the Jubilee Line between Westminster and Canning Town.



2.1 The Marmot Review

The Marmot Review – Fair Society, Health Lives: Strategic Review of Health Inequalities in England post 2010 identified several key messages and states:

“There is a social gradient in health – the lower a person’s social position, the worse his or her health.

Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.

Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.”

2.2 Promoting equality in health

Promoting equality is not about taking away from one group to give to another. In the context of health, it's about ensuring that access to good quality and appropriate services are available to all groups in our population, not just a privileged few.

Different groups should not experience barriers to accessing services or, have less opportunity to live a longer healthier life due to factors beyond their control, specifically the nine protected characteristics.

To truly promote equality in healthcare we have to acknowledge that sometimes things have to be done differently to enable different groups to achieve the same benefits.

2.3 Moving towards equality

Not all inequalities are caused directly by the healthcare system but, the way our health services are structured can contribute to inequalities in access to services and in health outcomes.

Despite the best intentions, inequalities for some groups remain persistent and predictable. We consider this unacceptable and we want to ensure that as commissioners, with leadership from our clinical commissioning group board we have the knowledge and confidence to reduce health inequalities through effectively promoting equality

Part 3: Our local population

3.0 Health profile of Havering

Havering is the third largest London borough, covering some 43 square miles. It is located on the northeast boundary of Greater London.

The current population is estimated to be 236,000 and our CCG has a registered GP population of 243,508.

Our population is older than average for London. An increase of about 5,000 people is expected over the next five years.

The largest population growth will be in those age groups with the greatest need for health and social care – children and the elderly.

Life expectancy is better than the national average with the borough average life expectancy for men at 78.8 years and for women 83.4 years. In the disadvantaged communities, life expectancy for men is reduced by 6.2 years and for women reduced by 4.3 years.

Given our older population, we have large numbers of patients living with long term conditions which reduce their wellbeing and result in significant need for health and social care. This need will grow as the population ages still further. The majority of people over 65 have two or more long term conditions; the majority of people over 75 have three or more. People with long term conditions are most intensive users of health services. They account for 80% of all GP consultations and around 70 per cent of NHS resources are spent on managing term conditions.

Many residents have lifestyles that put them at additional risk of disease, for example, 1 in 5 adults smoke and 1 in 4 are obese.

An increase in healthy living would help offset the increase in need for health and social care as our population ages.

The incidence of communicable disease in Havering is relatively low. However, late diagnosis of HIV is a concern.

Cancers and circulatory diseases remain the big killers although early death rates from cancer, heart disease and stroke have fallen and are now similar to the England average.

Our priorities include improving cancer survival by raising public awareness, reducing injuries caused by falls and promoting bone health and earlier detection of cardio vascular disease through health checks.

3.1 Diversity in Havering

We have used data from the Office for National Statistics and, the 2001 Census to gather local population data for seven of the nine protected characteristics.

Age

Age group	Percentage (%) of Havering population	Number of people
0 – 15 years	19%	44,553
16 – 29 years	17.5%	41,406
30 – 44 years	19.5%	46,106
45 – 64	26.5%	62,574
65 years and over	17.6%	41,498

Disability

17.5% (26,900) of Havering's working age population have identified themselves as being disabled

4% (9,580) are claiming Disability Living Allowance, over 2% (5,350 people) of whom receive Higher Rate Mobility award

Just below 18% (7,435) of older people in Havering are claiming Attendance Allowance, 53% (3,960) of whom receive Higher Rate award

Nearly 4% (5,480) of people are claiming Incapacity Benefits, 77% (4,225) of whom have been Incapacity Benefits claimants for five or more years.

Gender

52% (122,481) are female and 48% are male (113,656). The percentage of women in Havering is slightly above the average for London (50%) and England (51%)

The greater number of females than males in our population may in part be explained by the longer life expectancy of females

Ethnicity

The Borough predominately has a white population and the ethnic minority population is 11.4%. This percentage is well below the London average and slightly below the average for England.

Ethnic group	Percentage (%) of Havering population	Number of people
Asian/Asian British	4.6%	10,800
Black/Black British	4.0%	9,100
Mixed	1.8%	4,100
Chinese	0.6%	1,500
Other non-White	0.5	1,300

The school census reported that nearly 23% of school pupils in Havering were from non-White ethnic groups in 2011, with the most common ethnic group being Black or Black British (9%)

Religion

Religion	Percentage
Christian	7.6%
Hindu	0.77%
Sikh	0.42%
Buddhist	0.18%
Muslim	0.8%
Jewish	0.5%
No Religion	13%
Prefer not to say	8%

Sexual orientation

Figures show 0.1% (170) of people in same-sex couples live in Havering. 0.01% (14) of people in same-sex couples have obtained legal recognition of their relationship in the period from the enforcement of the Civil Partnership Act 2004 to 2009

Pregnancy and maternity

In 2011, the annual birth rate in Havering was 2,700; this is predicted to remain roughly the same by 2026.

The total fertility rate has fluctuated over the years and increased from 1.75% in 2005 to 1.91% in 2010.

The teenage conception rate per 1,000 16 – 18 year olds was 37.6 in 2008.

National census 2011 information has recently been made available and provides more comprehensive information about diversity in Havering. This section will be updated to reflect any relevant changes.

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3.2 What we have done so far

3.2.1 Joint Strategic Needs Assessment (JSNA)

Our joint strategic needs assessment work for 2011/12 was led by a small project team of staff from the council, the Primary Care Trust and our Clinical Commissioning Group. The project team built on the 2010 JSNA refresh; there are two elements to Havering's 11/12 rolling programme of JSNA:

1. JSNA Data. In 2011, Havering's JSNA datasets were made available for the first time on Havering's data intelligence hub www.haveringdata.net. Here a range of data about health and wellbeing in Havering can be accessed by partners, with tables, charts and maps available
2. JSNA chapters. Following the 2010 refresh, there were a number of topics that were chosen to have further in depth needs assessments carried out. These build on the 2010 JSNA refresh and would include looking at areas such as service provision and gaps (which the previous refresh did not consider as it considered a wider range of topics at a higher level). The topics identified were: dementia, obesity, cardiovascular disease, cancer, smoking and breastfeeding.

A demographics update was also included and needs assessment work taking place on domestic violence was incorporated into the JSNA programme. Chapters on keeping people out of hospital, vulnerable children and young people and supporting vulnerable adults and older people are currently in development in phase 2 of the 2011/12 JSNA programme.

A new JSNA data inventory was released in late 2011; this means the future approach to the JSNA will need to be considered by the JSNA project team and Health and Wellbeing Board to ensure that new data and guidance is incorporated in future.

3.2.2 Public Health Report

Our 2010 annual report focused on the subject of cancer.

- Cancer survival rates in England have improved in recent years. However, they have remained more or less unchanged in Havering which is now in the worst 10% in England with regard to survival one year after diagnosis
Cancer outcomes are generally poorer for:
 - deprived compared with affluent groups
 - in older people compared with younger people
 - in men compared with women
- The relationship between ethnicity and outcomes varies depending on the cancer site and/or risk factor considered.
- There is strong local evidence of inequalities in Havering regarding mortality rates and the prevalence of lifestyle related risk factors

There is a growing evidence base about inequalities in access to and or the performance of preventative and health care services pertinent to cancer and there is evidence of similar trends in Havering.

A recent survey of Havering residents found that people in the disadvantaged communities had lower awareness of cancer screening programmes. However, socio-economically deprived communities are not the only groups affected by cancer related health inequalities.

The picture regarding BAME groups is complex:

- Black people have higher rates of prostate cancer, stomach cancer and multiple myeloma than other ethnic groups.
- Many other non-white ethnic groups have reduced rates of cancer
- Breast cancer survival is worse among black and asian women

Our aim is fewer cases of cancer and if a diagnosis is made, provision of prompt and effective treatment that delivers excellent outcomes and patient experience.

3.2.3 Falls prevention and bone health strategy

Havering has the highest percentage of older people in London, so it is very important that we focus on keeping people active, fit and well into older age. Helping to prevent falls is vital to maintain the health of our elderly population as a fall can result in a fracture, long-term disability and even death. The Havering falls prevention project, led by the public health team, aims to reduce the incidence of falls and encourages better bone health. We are focusing on early intervention and prevention to ensure that those most at risk of falling are supported and can remain in their own homes for longer.

3.2.4 Commissioning strategy plan

The needs of our older and younger populations are very clear and we are already working closely with council colleagues and other partners to ensure that we are able to meet their particular needs and priorities. We understand the real benefits we can bring as clinical commissioners in ensuring we have the right health services in place for our population. Equally we recognise the need to work in collaboration with other Clinical Commissioning Groups to

Havering clinical commissioning group has developed the following priorities for 2012/13- 2014/15:

- **Staying healthy and focusing on preventative health**, including through immunisation, the 'flu campaign and a pulmonary rehabilitation service
- **Improving quality of services and patient experience**, focusing on End of Life services; BHRUT and maternity services; and quality of care and medical attention in community residential settings
- **Managing demand on unplanned services**, including implementation of the Primary Care Redirection Scheme and reviewing GP access
- **Prioritising patient and public engagement**, by setting up a successful patient engagement forum and using the patient experience to inform outcomes

Part 4: Demonstrating compliance with the Public Sector Equality Duty

4.0 How we will comply with the Public Sector Equality Duty

The equality duty is an opportunity for clinical commissioning groups to commission and deliver services that are responsive to the diversity of our local population and deliver improved health outcomes and wellbeing across the nine protected characteristics.

We have developed an action plan to help ensure we can achieve demonstrable change as a result of the public sector equality duty.

Successful delivery of our action plan will be underpinned by the following practical tools for implementation.

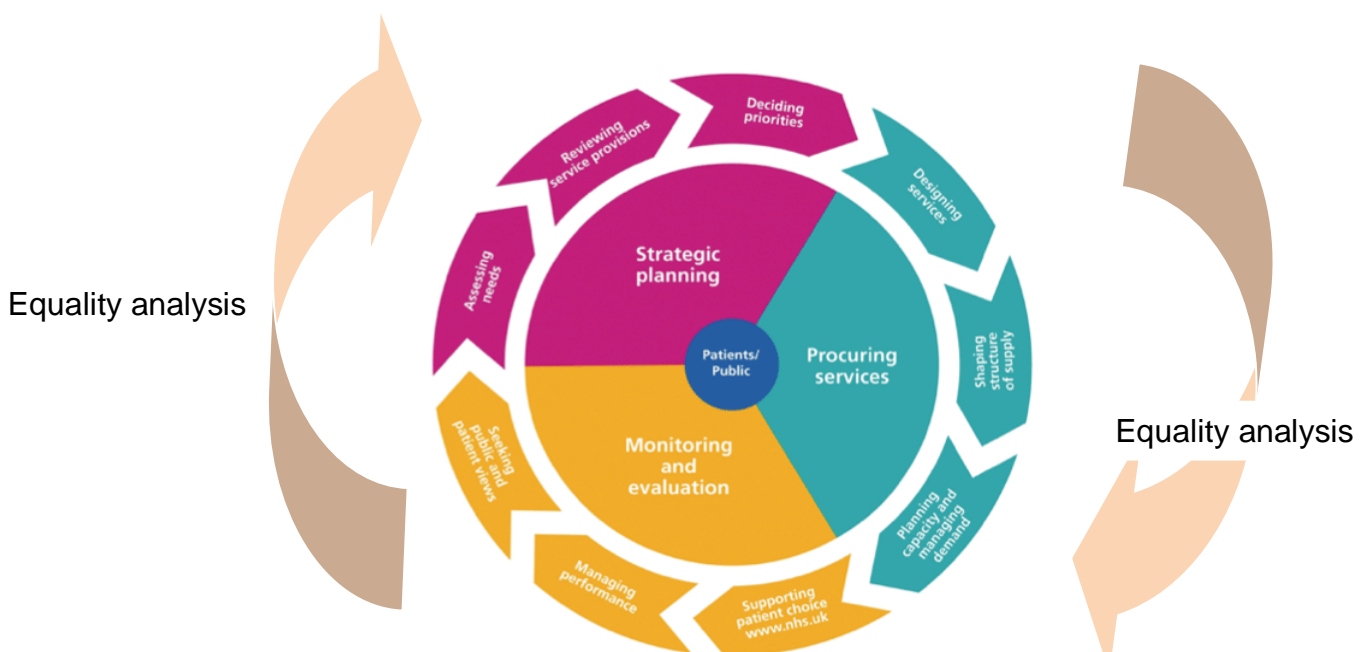
4.1 Equality analysis

An equality analysis is a tool designed to help identify the potential impact of policies, services and functions on staff, patients, carers, public and stakeholders.

Undertaking equality analyses both promotes good practice and provides evidence of compliance with the public sector equality duty.

We have a comprehensive equality analysis toolkit, which in addition to the nine protected characteristics, also includes assessment of social and economic factors and impact on human rights.

The equality analysis has huge potential as a tool for commissioners to tackle health inequality encompassing the wider determinants of health. Currently the process is not always used effectively and we propose that for a more robust and consistent approach the equality analysis process will be used to inform all three stages of the commissioning cycle. The equality analysis template is available to colleagues on the intranet.



4.2 NHS equality delivery system (EDS)

The equality delivery system is an equality outcomes framework specifically designed for the NHS. In September 2011 the PCT board committed to implementing the equality delivery system. This included a governance structure to help ensure our performance on promoting engagement and equality is part of our mainstream governance process.

The equality delivery system for the outer north east London cluster was launched formally in November 2011. The launch event was attended by over 70 individuals comprising patients, public and representatives from local interest groups. The event was used to invite volunteers to become part of the cluster wide equality delivery system working group (EDS WG).

Partnership working is one of the key principles of the equality delivery system framework. Effectively promoting equality and demonstrating improvements cannot be achieved in isolation and, as well as involving our local patients, carers and their families, we are also committed to working in partnership with our statutory partners with colleagues from the local acute trusts and North East London Foundation Trust – including mental health and community services leads also being members of the equality delivery system working group.

The NHS organisations in outer north east London have agreed to a whole system approach to implement the equality delivery system and it was agreed that for the first year the focus would be on learning disability and mental health services. This was proposed because mental health services are applicable to all of the NHS organisations in the cluster which also includes a mental health foundation trust. We also identified mental health as a priority for our clinical commissioning group.

By taking this whole system approach we hope to gather and build upon evidence across the entire NHS pathway: from the commissioning of services, right through to delivery in primary care, acute and community based settings.

We have undertaken our EDS self assessment and are currently consulting with the equality delivery system working group to finalise our baseline grade and develop our equality delivery system objectives. The self assessment is available on request.

We will review the governance arrangements, put in place by the PCT cluster so the work started to date is picked up within our own CCG governance arrangements

4.3 Aligning engagement and equality

Promoting equality and effective community engagement should complement each other. Systematic community engagement is an essential element of partnership working to promote equality.

We cannot properly engage without being proactive about seeking the views of all groups in our community; this in turn will help demonstrate we are promoting equality. Our local residents are an invaluable resource to inform commissioning and to provide feedback from a range of groups and individuals’.

We have a well established engagement forum which meets every eight weeks; we also meet regularly with our Local Involvement Network (LINK). More detail on our approach to community engagement is provided in our clinical commissioning group engagement, experience and communications strategy.

4.4 Meeting our publication requirements

This strategy will be published on our clinical commissioning group website. Alternative formats will be provided upon request.

Our annual publication requirements under the public sector equality duty will be an integral part of our programme for equality delivery system implementation as specified under Objective 1 in our action plan below.

4.5 Equality action plan

What we will do	How we will do it	Who is responsible	Outcome
<p>Implement the Equality Delivery System</p>	<p>Have CCG representation on the EDS working group.</p> <p>Identify additional resources to coordinate the implementation of the Equality Delivery System.</p> <p>Review governance and confirm reporting arrangements.</p>	<p>CCG Chair and Accountable Officer</p>	<p>The EDS will help us demonstrate:</p> <p>How effectively we engage with people representing the nine protected characteristics.</p> <p>How accessible our services are for all groups in our local population.</p> <p>How effectively we work with our provider organisations to help ensure the services we commission are appropriate, effective and equally accessible for our local population.</p> <p>Enable us to identify equality actions and objectives.</p> <p>Demonstrate compliance with the Equality Act 2010 by using the EDS framework to annually publish progress against our equality actions and objectives, across the nine protected characteristics, for our service users and staff.</p> <p>Ensure the CCG board is involved and informed of progress on our performance in promoting and embedding equality.</p>

What we will do	How we will do it	Who is responsible	Outcome
<p>Embed an equality analysis process in our commissioning cycle</p>	<p>Adopt an equality analysis toolkit as part of our formal business planning process.</p> <p>Ensure the equality analysis toolkit is available as part of our programme management documentation.</p> <p>All proposals for new projects and policies will have an equality analysis completed before being considered for approval by the CCG board.</p> <p>All consultation proposals involving service change will include an equality analysis at the beginning of the process.</p> <p>Ensure completed equality analyses are published on our CCG website.</p>	<p>CCG Chair and Accountable Officer</p> <p>CCG Chair and Accountable Officer</p> <p>Project leads</p> <p>Project lead</p> <p>CCG Accountable Officer</p>	<p>We will be able to demonstrate:</p> <p>The needs of our local population have been taken into account in commissioning process.</p> <p>We have considered the impact of our work by the nine protected characteristics, human rights and socioeconomic factors</p> <p>We have identified and, wherever possible, take measures to minimise negative impact of our work on our local population.</p> <p>We can identify good practice and areas where our services are contributing towards promoting equality and reducing health inequalities.</p> <p>We are embedding promoting equality as part of our mainstream business planning process.</p>

What we will do	How we will do it	Who is responsible	Outcome
<p>Improve our processes for data collection and diversity monitoring for both workforce and service users</p>	<p>Practices across our CCG will be encouraged to collect diversity monitoring information across the nine protected characteristics.</p> <p>Adopt HR systems that will allow us to collect diversity monitoring information for our staff</p>	<p>CCG Chair and Accountable Officer</p> <p>All clinical directors</p> <p>All CCG member practices.</p>	<p>Make better use of local population data to help plan and commission future health services.</p> <p>Make better use of our workforce data to help ensure our CCG is a fair and inclusive employer.</p> <p>Establish consistent practice level data on the diversity of our local population.</p>
<p>Proactively manage our contracts to apply the same standards to our providers that we demonstrate ourselves</p>	<p>Contracts will include reference to providers complying with the Equality Act 2010.</p> <p>Providers will have to confirm what arrangements they have in place to demonstrate their services are non-discriminatory.</p>	<p>CCG Chair and Accountable Officer</p> <p>Finance</p> <p>Contracting team</p>	<p>Organisations providing services on our behalf are aware of their responsibilities to comply with equality legislation and are able to demonstrate their services are inclusive and appropriate for our local population.</p>

Part 5: Conclusion

5.0 Conclusion

There is considerable overlap between groups that we target to reduce health inequalities and groups of interest to local statutory agencies. It is in the interest of all agencies to work together to tackle the causes.

Through embedding our proposals to promote equality and community engagement, we will strive to increase residents' confidence in our clinical commissioning group by delivering efficient services integrated with those they receive from other statutory sectors. This should result in, over time, a demonstrable reduction in health inequalities and improved health and well being for all groups in our local community.