Equality & Diversity in NHS Doncaster CCG

Date updated: **31st January 2016**

1. Introduction

Diversity literally means "difference". There are many things that make us all different such as our age, our education, our past experiences, our health status, our ethnicity, or any disabilities we have. Valuing diversity is about creating a working culture and working practices that recognise, respect, and harness differences for the benefit of those for whom we commission services, for our staff, for our partners and for our organisation.

Equality does not mean treating everyone the same because some people are disadvantaged to begin with through differences like disabilities. Ensuring that everyone has an equal opportunity may mean making different adaptations for different people – like targeting communication campaigns into specific communities in appropriate formats. Equality is therefore not about treating everyone the same, but about treating people according to their needs so that we reduce disadvantage.

Equality and Diversity is central to the work of NHS Doncaster Clinical Commissioning Group (CCG) to ensure that we commission equity of access to services and treatment. The promotion of equality, diversity and human rights is central to the NHS Constitution and other national drivers to reduce health inequalities and increase the health and well-being of the population. We are committed to embedding values of equality and diversity into our commissioning processes, policies and procedures that secure health and social care for our population and into our employment practices.

The Equality Act 2010 brought with it ***Public Sector Equality Duties***. Public bodies are required to declare their compliance with the duties on an annual basis.

Section 149 of the Equality Act outlines the ***general duties*** to have due regard to the following in the exercising of our functions:

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

For the ***specific duty*** we are required to:

- Publish information to demonstrate compliance with the general duty, on the make-up of our workforce, and on those affected by our policies and procedures
- Publish one or more equality objectives covering a four year period

In the context of the Public Sector Equality Duty the ***protected characteristics*** are defined as:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex (male and female)
- Sexual orientation

2. How we meet these duties: a summary

2.1. Our vision

We have two very different roles, one as a commissioner of services reaching out into the community for whom we commissioning services, and one as a corporate body and an employer.

To capture both these roles, we have developed two vision statements in our Equality & Diversity Strategy, an externally-facing vision for our role as a commissioner of services, and an internally-focussed vision for our role as a corporate body and an employer.

- ***Commissioning role:*** To hear a diverse range of Doncaster voices and use equality data to help us to commission effective services that meet identified health needs.

- ***Corporate Body:*** To ensure that we pay due regard to our Public Sector Equality Duties and equal opportunities within employment.

We monitor progress towards this vision through in-year plans and activities which are overseen by our Engagement & Experience Committee, reporting to our Governing Body.

2.2. Our commissioning role

Better information: When planning healthcare services we consider an array of data including performance data, quality data, patient experience data and financial data. We also give due regard to our Equality Duties under the Equality Act 2010 within our strategies/plans and our business cases, undertaking equality analysis of the potential impact of our commissioning plans. Following these analyses, our agreed organisational priorities are captured in our 5 year Strategic Plan and accompanying Delivery Plans. Quality indicators and key performance indicators are attached to the outcomes for each delivery plan area. Relevant equality data is used to help to specify the outcomes, for example reviewing whether services are specifically needed to support particular communities of interest e.g. services for young people, services for disabled people. Doncaster has a diverse population comprised of many different communities of both place and interest. We use a range

of information available to us to help us to better understand the communities for which we commission care and their needs, and this information includes:

- The Data Shine project which seeks to promote and develop the use of large and open datasets amongst the social science community. A key part of this initiative is the visualisation of these data in new and informative ways to inspire new uses and generate insights. The data takes us down to community level across data collected in the 2011 Census.
- Yorkshire and Humber Public Health Observatory (YHPHO) which produces information, data and intelligence on people's health and health care for practitioners, policy makers and the wider community.
- 88 Community Profiles, one for each community in Doncaster. Each profile contains useful information which paints a picture about what a community is like, including its population, educational attainment, crime levels and health issues. This is only a small example of what is contained within each profile and the data included can be useful to inform our understanding of communities in Doncaster.
- The Census which has collected information about the population every 10 years since 1801 (except in 1941). The latest Census in England and Wales took place on 27 March 2011. The statistics collected from the Census are used to understand the similarities and differences in the populations' characteristics locally, regionally and nationally.
- The Joint Strategic Needs Assessment (JSNA) which is a process that identifies the current and future health and wellbeing needs of a local population. Doncaster's JSNA is now part of the work programme of the Health and Wellbeing Board. Joint Strategic Needs Assessment reports are used to identify priorities for action and to inform the writing of local health and wellbeing strategies.
- Health Needs Assessments which we commission through our formal agreement and workplan with the Public Health Team in Doncaster Council to identify the key needs of the population. Needs assessments allow us to obtain an in-depth understanding of the needs of a specific population group for which we are responsible for commissioning healthcare such as the Learning Disability and Autistic Spectrum Disorder Health Needs Assessment and the Children & Young People Needs Assessment.
- Equality analysis is a mandatory field on all coversheets for our Governing Body and its reporting Committees, and is also embedded into our business case process. We undertake separate more in-depth equality analyses where proposed commissioning changes may impact significantly – recent ones have included our breast cancer early detection campaign, mental healthcare, our Children & Young People Mental Health Wellbeing Plan, carer engagement and dementia commissioning.
- Our clinical leaders, who are in direct contact with patients on a daily basis and bring a wealth of insight and patient experience to our commissioning practices.

Health inequalities in commissioning: Our health is determined by our genetics, our lifestyle, the health care we receive, and our wider economic, physical and social environment. Although estimates vary, the wider environment has the largest impact *(Kings Fund, September 2014)*. Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences

have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives. Some differences, such as ethnicity, may be fixed. Others are caused by social or geographical factors (also known as 'health inequities') and can be avoided or mitigated *(National Institute of Health and Care Excellence LGB4, October 2012)*. One of the duties of a CCG under the Health & Social Care Act 2012 is to "have regard to the need to reduce inequalities". Our Constitution confirms that we will do this by contributing to the work of the Doncaster Health and Wellbeing Board through the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy, setting explicit health inequalities targets in our Strategic Plan, and delegating the Delivery & Performance Committee to develop and performance manage delivery plans to reduce health inequalities. As the main local Commissioner of healthcare services in Doncaster, we have clearly outlined in our Strategic Plan our focus on our three underpinning strategic ambitions, our systematic transformational change programmes, and our four key local outcome-based delivery plan priorities. These are therefore also our natural areas of primary focus in identifying and seeking to reduce health inequalities.

Strategic ambitions (the 3C's):	
• Care out of Hospital – the provision of patient centred care outside of a hospital setting, either in a patient's home or based around a primary care community team. • Care of the Frail – in support of an ageing Doncaster population with increased life expectancy where patients can experience multiple medical conditions and an increase in clinical complexity. • Coordinated Care – the provision of integrated care across a whole system that is responsive to patient needs, uses the latest technology to support service delivery, and develops enhanced access to data and information across partner organisations.	
Transformational change programme:	***Outcome-based Delivery Plans:***
• Intermediate Care – design and implementation of a new service model • Primary Care – strategy development based on an extended role for primary care • Community Services – embedding holistic community nursing care and looking at how we can improve specialist nursing services • End of Life Care – delivery of the new community model • Urgent Care – embedding the new service model and supporting the wider health and social care system to integrate working arrangements • Care Homes – focussed on quality improvement, education and market development	1. Cancer – focussed on survival outcomes 2. Children & Younger People's Services – focussed on improved services 3. Dementia – focussed on early diagnosis and support 4. Mental Health – starting with crisis and specialist care and moving on to primary and inpatient services

We have identified health inequalities as a strategic risk on our Governing Body Assurance Framework. We have been taking a 2-fold approach to identifying and tackling health inequalities – engagement with communities of interest and place and undertaking "deep dives" into inequality data in areas as detailed above – starting with cancer, mental health and dementia. We have reported progress on improving our understanding of mental health inequalities to the Inclusion & Fairness Forum, of

which we are a member. Due to the multiple determinants of inequalities, we are now moving beyond the confines of our own organisation and capitalising on the opportunities afforded by the refresh of the Health & Wellbeing Board Strategy to work more in partnership across Doncaster on identifying and addressing health inequalities.

Engaging to support planning and commissioning of healthcare services: Our approach to planning and commissioning healthcare services, advancing equality and tackling health inequalities is influenced not only by what the data tells us, but by listening to, and learning from, patients, carers, and the public. To do this, we need to understand the composition of communities within Doncaster, and, where possible, target our communication and engagement activity to reach communities most affected by our commissioning initiatives. Examples of targeting our approach over the past year have included:

- We have commenced a pilot bringing together and engaging with "Community Ambassadors" who represent our most vulnerable communities of interest in Doncaster including sex workers, the homeless, asylum seekers, the deaf community and the LGBT community. We are using this model to engage with more vulnerable groups on our commissioning priorities such as primary care. We will pilot our approach for approximately a year, and then evaluate.
- We have led the successful development of a Patient Participation Group Network in Doncaster. A Patient Participation Group (PPG) is a group of patients, carers and GP practice staff who meet to discuss practice issues and patient experience to help improve the service. Doncaster has 43 member practices located across Doncaster, the majority of which have established PPGs or are actively engaged with members of their practice through delivering on PPG initiatives. The PPG Network was created as a pilot with the primary aim to unite and consolidate individual PPGs operating across Doncaster; 2 individuals from each PPG are invited to represent their PPG on the Network. The Network provides information, advice, guidance and support to assist PPG representatives to thrive and help them overcome challenges surrounding establishing their PPG, to share PPG learning experiences of what works and perhaps does not work regarding PPG activity, to assist with shifting the strategic focus for PPGs – raising their awareness of NHS Doncaster CCG health priority areas, and to provide an arena and extended opportunities for consultation involving PPG members which influence and shape our commissioning plans and/or intentions. This supports our engagement with geographical communities across Doncaster and will be fundamental to our future public engagement regarding primary care commissioning once we are delegated by NHS England to commission this from April 2016.
- We have developed and led a series of targeted early diagnosis and treatment campaigns:
    - From January 2016, asylum seekers and refugees accessing the Doncaster Conversation Club are now offered full blood screening via the outreach partnership health bus. Mental health outreach group sessions targeting Asylum Seekers & Refugee clients are also delivered by staff from the Talking Shop, Doncaster's single point of access for mental health service provision which is led by Rotherham Doncaster & South Humber NHS Foundation Trust.

    - Distributing translated Cancer awareness information to target some of the faith community attending Doncaster's Mosques.
    - Engagement with and support to Men's Group Doncaster (MG DON), a multi-cultural group of over 60 men in Doncaster. Dementia Friendly training has been delivered, and an introduction made to the Alzheimers Society for further support. The group is receiving referrals from Social Prescribing.
- We have provided Choose Well / Stay Well This Winter information in Doncaster's main alternative language formats and in video format (signing interpreter) and dissemination of the campaign aims to target specific groups.
- We regularly update the content on NHS Doncaster CCG new look, revitalised website and have increasing our internet based activity and extended our reach into groups with a wider interest in the work of the CCG across health & social care. By utilising social media networks available to us, such as Twitter & Facebook, we have managed to generate greater awareness and understanding of areas of our commissioning work through our internet based, communication channels.
- We have developed our communications strategy to ensure more equity within the communications offer / information provision. Our Communications and engagement activity extends itself through the local links established for disseminating information, including articles for local press releases, radio adverts and interviews and creating short video clips in partnership other key stakeholders and organisations to promote local health initiatives and /or national campaigns. 800 surveys for NHS Doncaster CCG have been completed between April 2015 and March 2016.
- We have engaged with Carers to support the development of a Doncaster Carers' Strategy.

Commissioning services: We believe that the biggest impact we can have in tackling identified health inequalities is through our commissioning activities. We commission a range of providers to deliver frontline healthcare to meet the identified needs of our population. We have a variety of contractual mechanisms to assure ourselves of activity, performance, quality and patient experience within commissioned services. As from April 2016, NHS Doncaster CCG will have new commissioning responsibility for commissioning primary medical care services including responsibility for ensuring the quality of service provision. We will be working closely with our member practices to support reduction of health inequalities and unwarranted variation.

Procurement & Contracting: Our Procurement Strategy makes specific reference to the Equality Act 2010. All bidders are required to meet the requirements of the Equality Act 2010 as a pre-qualification criterion; this is then tested during the procurement process and becomes a standard requirement in a resulting contract. Equality and patient experience reports are received as part of contract monitoring. A recent example of where we implemented this approach is within the tendering and procuring process for the new primary care Same Day Health Centre service and GP Out of Hours Service in Doncaster which went live in October 2015.

Partnerships: Tackling health inequalities in Doncaster is a multi-dimensional challenge reaching beyond the boundaries of health. NHS Doncaster CCG is

working in partnership across a range of areas to support compliance with the Equality Act.

The Doncaster Inclusion & Fairness Forum has been set up by the Team Doncaster Strategic Partnership (Team Doncaster) as an independent advisory group to explore and identify ways in which we can make Doncaster a fairer place to live and work. The first meeting was held in May 2015 and the fourth meeting was held in November 2015. Liam Scully, Chief Operating Officer Club Doncaster, is the Independent Chair of the Forum. NHS Doncaster CCG is a key member of the Inclusion & Fairness Forum and represents the CCG and other health partners on the Forum. Team Doncaster asked that the Forum to initially review the following 4 topics:

- Employment
- Mental Health (including children and young people)
- Obesity
- Social Isolation

The Forum's role is to gather evidence to identify inequalities and challenges in relation to these specific topics, collect examples of good practice and hear a range of views of how fairness in Doncaster could be improved, and inform and influence partners to take action and develop a strategic approach to improve fairness in Doncaster. A "Call for Evidence" was initiated to empower stakeholders and the wider public across Doncaster to engage in the work of the Forum. A public Fairness Survey was launched on 6th July and closed on 25th September 2015. Despite a robust online and face-to-face public communication programme led across public sector and third sector partners on the Forum, only a total of 99 responses were received. At its November meeting the Inclusion & Fairness Forum therefore agreed to re-open the consultation and undertake further targeted engagement with under-represented groups. The Forum has benefited from strong partner engagement, resulting in receipt by the Forum of a range of local and national evidence in the four topic areas.

Well North is a collaborative programme which is developing, testing and piloting a set of linked interventions to improve the health of the poorest, fastest, in some of the most deprived areas of the North of England. Well North seeks to make visible previously invisible at-risk people and attempt to solve, rather than manage, their illnesses and anxieties. Specifically, the emergent programmes will seek to reach and engage with people and work with them to identify holistic solutions for them and their families. The programme aims to improve health, bring the health system and economic growth priorities into closer alignment, and build a best practice framework which can be replicated and transplanted. Doncaster is one of the pilot sites for Well North, and Denaby is the chosen pilot area. Over 300 residents were engaged as part of the two week community consultation, and the qualitative information has been thematically analysed from which three key themes have emerged: community spirit, assets, and employment. Community workshops have been held to explore these and work will continue through the Denaby Collaborative and subgroups.

We have continued partnership work with dementia patients and their carers on an initiative to raise awareness of people with dementia and as part of the national strategy to make Doncaster a 'Dementia Friendly Community'.

2.3. Our role as a Corporate Body

Our organisation: We are a small commissioning organisation which grew in December 2015 with the in-housing of Continuing Healthcare eligibility and review services, and we now have around 170 team members. Our organisation is broadly representative of the community which we serve. We try to support our team members to develop an array of cultural competencies to ensure that we pay due regard to equality within our commissioning activities, and this aspiration was recently emphasised in our Organisational Development Strategy.

Corporate Structure: The right corporate systems and processes can help us to embed equality and diversity considerations into the very fabric of our organisation, making it everybody's business to show due regard to our public sector equality duties. Our Experience & Engagement Committee is a formal Committee of our Governing Body and has responsibility for embedding patient experience within commissioning and ensuring that due regard is paid to our public sector equality duties. We have a range of leads championing Equality across the organisation including a Lay Member lead, a clinical lead, an Executive lead and an operational lead. We also have various corporate documents which encapsulate our equality commitment:

- Our "Equality & Diversity Strategy" which was refreshed and approved by our Governing Body in December 2014. The Strategy is available on our website.
- Our use of the Equality Delivery System to develop and publish our Equality Objectives in October 2013. The Equality Delivery System version 2 has been used during 2015/16 to undertake a further self-assessment.
- Publication of equality data annually by the end of January each year (this document).

Learning and development: Our team members need knowledge of the public sector equality duties and the need to consider equality impact during commissioning decisions, which we are achieving through one-to-one support from Communication, Engagement, Experience & Equality team members, through a mandatory e-learning module, and through supplementary face-to-face training for Governing Body members as our key decision makers. In 2015/16 we have rolled out a new type of mandatory video-based training to all staff members looking at cultural competence and unconscious bias, and early evaluation is showing positive feedback from staff on this new thought-provoking training tool. Compliance with mandatory training is monitored through the quarterly Corporate Assurance Report.

Valuing people: Everyone is different, and everyone's individual experience, knowledge and skills bring a unique contribution to our organisation, and we value all contributions equally. Our Equal Opportunities Policy is published on our website as our corporate commitment. Recruitment and selection processes are transparent and include consideration of equality. Policies are in place to support staff in the workplace such as Workplace Wellbeing and Flexible Working. The annual NHS Staff Survey has equality themes and can be analysed by protected characteristic. Each year, the Staff Survey is analysed and an action plan is developed to address issues.

Workforce Race Equality Scheme: We have committed to the Workforce Race Equality Scheme (WRES) which states that from 1 April 2015 all NHS organisations were required to demonstrate how they are addressing race equality issues in a range of staffing areas. The challenge to ensure black and minority ethnic (BME) staff are treated fairly and their talents valued and developed is one that **all** NHS organisations need to meet because:

- Research shows that unfair treatment of BME staff adversely affects the care and treatment of all patients
- Talent is being wasted through unfairness in the appointment, treatment and development of a large section of the NHS workforce
- Precious resources are wasted through the impact of such treatment on the morale, discretionary effort, and other consequences of such treatment
- Research shows that diverse teams and leaderships are more likely to show the innovation, and increase the organisational effectiveness, the NHS needs
- Organisations whose leadership composition bears little relationship to that of the communities served will be less likely to deliver the patient focussed care that is needed

We are tracking WRES metrics, and now that the transfer in of the additional staff on 1st December 2015 is complete, we will refresh our engagement efforts around the WRES.

3. Equality Delivery System & Equality Objectives

3.1. Introduction

The Equality Delivery System (EDS) for the NHS was formally launched in November 2011. Following an evaluation of the implementation of the Equality Delivery System in 2012 and subsequent consultation with a spread of NHS organisations, a refreshed Equality Delivery System known as *EDS2* was launched in November 2013.

The main purpose of the Equality Delivery System was, and remains, to help local NHS organisations, in discussion with local partners including local people, to review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the Equality Delivery System, NHS organisations can also be helped to demonstrate delivery on the public sector Equality Duty (PSED).

3.2. Background

Outcomes: The Equality Delivery system comprises 18 outcomes grouped into four goals as detailed below.

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

Protected Characteristics: Compliance with the Equality Delivery System standards is assessed across the 9 protected characteristics under the Equality Act and can also be readily applied to people from other disadvantaged groups, including people who fall into "Inclusion Health" groups, who experience difficulties in accessing, and benefitting from, the NHS. "Inclusion Health" was defined in a Social Care Task Force and Department of Health publication of 2010. These other disadvantaged groups typically include but are not restricted to:

- People who are homeless
- People who live in poverty
- People who are long-term unemployed
- People in stigmatised occupations (such as women and men involved in prostitution)
- People who misuse drugs
- People with limited family or social networks
- People who are geographically isolated

Grading: Essentially, there is just one factor for NHS organisations to focus on within the Equality Delivery System grading process. For most outcomes the key question is: *How well do people from protected groups fare compared with people overall?* There are four grades – undeveloped, developing, achieving and excelling.

RED	Undeveloped if there is no evidence one way or another for any protected group of how people fare, or evidence is not available. Undeveloped if evidence shows that the majority of people in only two or less protected groups fare well.
AMBER	Developing if evidence shows that the majority of people in three to five protected groups fare well.
GREEN	Achieving if evidence shows that the majority of people in six to eight protected groups fare well.
PURPLE	Excelling if evidence shows that the majority of people in all nine protected groups fare well.

3.3. Use of EDS in NHS Doncaster CCG

We have committed to using the principles of the Equality Delivery System (EDS) within NHS Doncaster CCG, and in 2015/16 we have refreshed our self-assessment against each of the 18 outcomes.

3.4. Results

The sheet overleaf summarise our results from our organisational self-assessment. Further detail is provided in Appendix 1.

Summary EDS Self-Assessment

Goal	Ref	Description	Self-assessed score	Overall score per Goal	Organisation rating
			R A G P	R A G P	R A G P
Goal 1 Better health outcomes	**1.1**	Commissioning, procurement, design and delivery	**A**	**A**	**Amber /Green (see Equality Objectives)**
	1.2	Assessing health needs	**A**		
	1.3	Care pathway transitions	**A**		
	1.4	Patient safety	**A**		
	1.5	Health Promotion	**G**		
Goal 2 Improved patient access and experience	**2.1**	Access to services	**A**	**A G**	
	2.2	Informing, supporting & involving patients in care decisions	**G**		
	2.3	Patient Experience of care	**A**		
	2.4	Complaints	**G**		
Goal 3 A representative and supported workforce	**3.1**	Recruitment and selection	**G**	**G**	
	3.2	Equal pay	**G**		
	3.3	Training & development	**G**		
	3.4	Staff safety	**G**		
	3.5	Flexible working	**G**		
	3.6	Staff experience	**G**		
Goal 4 Inclusive leadership	**4.1**	Board Leadership	**G**	**G**	
	4.2	Identification of equality impact	**G**		
	4.3	Line management	**G**		

4. Equality Objectives

Based on our self assessment against the national Equality Delivery System, our main areas of focus must be where we have identified there is greatest potential for improvement i.e. outcomes one and two where we have assessed ourselves as “developing”. These outcomes focus on better health outcomes and improved patient access and experience respectively.

We believe that our original Equality Objectives remain relevant to these and useful success indicators to measure ourselves against on our journey to our overall equalities vision contained within our Strategy. These are:

- ***Objective 1:*** Make effective use of equality data within the commissioning cycle to prioritise commissioning of services and embed equality within Provider contracts.

- ***Objective 2:*** Ensure appropriate and accessible targeted communication with local communities to empower patients.

Our focus in 2015/16 was primarily on better information (Objective 1) and this will continue as an underpinning theme around health inequalities.

Through the contacts and extended networks we acquired whilst obtaining and providing better information, we were able to identify and deliver patient & public engagement initiatives to better engage with service users, diverse groups across the protected characteristics and those who are seldom heard.

In light of this, in 2016/17 we want to enhance our focus on engagement (Objective 2). This will assist us to continue to develop and build on the work undertaken in the previous year and will also assist us to widen our reach, generating better patient and public involvement within the commissioning cycle. Amongst a range of other engagement methodologies, we will be working with and through our Community Ambassador pilot with communities of interest and our Practice Participation Group (PPG) Network with communities of place,

5. Core data and information

The core data and information we use to inform decisions about our functions is set out in Section 2.2 of this report and summarised in Appendix 2.

Equality data relating to our staffing is set out in Appendix 3.

Our Equality & Diversity Strategy sets out our strategic aims in terms of equality.

Our Engagement & Experience Committee oversees engagement, experience, communication and equality within NHS Doncaster CCG.

This document will be updated annually in January each year.

6. Feeding back to us on equality, and what to do if you think we are not meeting our duties

We wish to hold ourselves accountable to our staff, our partners and members of the public for whom we commission services.

If you have any concerns or feedback (positive or negative) about equality then please contact the Equality & Engagement Officer, Mr Curtis Henry, on 01302 566300 or email curtis.henry@doncasterccg.nhs.uk

If you think we are not meeting our equality duties, and would like to make a complaint please contact the Patient Experience Manager, Mrs Christina Quinn, on 01302 566300 or email christina.quinn@doncasterccg.nhs.uk

Appendix 1: Detailed Equality Delivery System assessment

EDS Outcome 1.1 (EDS Goal 1 – Better health outcomes)

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

Organisational self-assessment	Grade
Commentary: When planning healthcare services we consider an array of data including performance data, quality data, patient experience data and financial data. We also give due regard to our Equality Duties under the Equality Act 2010 within our strategies/plans and our business cases, undertaking equality analysis of the potential impact of our commissioning plans. Following these analyses, our agreed organisational priorities are captured in our 5 year Strategic Plan and accompanying Delivery Plans. Quality indicators and key performance indicators are attached to the outcomes for each delivery plan area. Relevant equality data is used to help to specify the outcomes, for example reviewing whether services are specifically needed to support particular communities of interest e.g. services for young people, services for disabled people. We use a range of information available to us to help us to better understand the communities for which we commission care and their needs, and this information includes the Data Shine project which seeks to promote and develop the use of large and open datasets amongst the social science community, the Yorkshire and Humber Public Health Observatory (YHPHO), 88 Community Profiles (one for each community in Doncaster), Census data, the Joint Strategic Needs Assessment (JSNA) which is a process that identifies the current and future health and wellbeing needs of a local population, Health Needs Assessments, equality analyses, and our clinical leaders who are in direct contact with patients on a daily basis and bring a wealth of insight and patient experience to our commissioning practices. We have identified health inequalities as a strategic risk on our Governing Body Assurance Framework. We have been taking a 2-fold approach to identifying and tackling health inequalities – engagement with communities of interest and place and undertaking "deep dives" into inequality data. Moving forwards, we will be seeking to work in partnership across Doncaster to identify and begin to address the multiple determinants of health inequalities.	**A**
Areas of good practice: • Embedding of equality requirements within the procurement process for the new Urgent Care system which went live in October 2015. • Equality analyses - using a range of data including equality data and patient experience data within commissioning.	
Potential areas for development: • We do not always have information available in all our commissioning areas by the 9 protected characteristics, and this is something on which we are trying to build and remains one of our Equality Objectives. We are working with lead Commissioners to develop our approach within the commissioning process, ensuring local demographic and engagement data available is utilised within the commissioning cycle to determine service requirements and/or service user needs by people specifically represented within protected characteristic groups.	

EDS Outcome 1.2 (EDS Goal 1 – Better health outcomes)
Individual people's health needs are assessed and met in appropriate and effective ways

Organisational self-assessment	Grade
Commentary: We commission personalisation of care through the contracts which we hold with our Providers. As a Commissioner, we require, through our contractual mechanisms, that Providers take account of patients' individual needs and make reasonable adaptations to meet these needs. We seek patient experience data and challenge Providers on the results. We try to meet the needs of individual patients through commissioning a wide range of general services and also commissioning specific services to meet specific needs e.g. single sex accommodation and culturally sensitive services. An example of meeting individualised needs which was a key area of work in 2014/15 and continues in 2015/16 is Individual Placements for personalised care needs where each person's package of care is assessed individually based on their needs and commissioned individually to meet these needs. We commission to meet cultural needs wherever practicable e.g. a choice of carer. Our patients have told us that they want more personalised care closer to home within their communities. We have therefore undertaken a review of Community Nursing Services and moved the model from a more transactional basis to a caseload basis, we have commissioned Woodfield 24 to provide urgent End of Life Care, and we have undertaken a review of Intermediate Care services in readiness for the design of a new model. These models seek to be personalised and culturally sensitive in their delivery.	**A**
Areas of good practice: • A focus on care closer to home within communities in response to patient feedback. • Individual Placements. • Development of a patient experience dashboard to identify themes and trends across the stroke care pathway.	
Potential areas for development: • See Outcome 1.1.	

EDS Outcome 1.3 (EDS Goal 1 – Better health outcomes)

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

Organisational self-assessment	Grade
Commentary: As a Commissioner, we place a requirement upon Providers to work in partnership to ensure seamless care. Service specifications are developed which specify the integrated service to be provided, and large-scale changes are discussed with patients with feedback monitored by protected characteristic. We try to directly target under-represented groups by engaging with their local interest groups within the community, and we have established a Community Ambassador pilot to engage with the most seldom heard groups within Doncaster. Commissioner-led service changes are assessed for equality impact and mitigating actions put in place where possible. We value feedback from patients and proactively engage to try to identify where transitions are not working effectively. In 2015 we have run a pilot to gather patient experience across the Stroke care pathway across multiple organisations, which has evaluated positively and the approach is being rolled out across other areas. We continue to work in partnership with Doncaster Council on the integration of health and social care through the Better Care Fund.	**A**
Areas of good practice: • Collection and analysis of patient experience data across the stroke care pathway.	
Potential areas for development: • We recognise that transition service from children's to adult services can be challenging in some areas, and we are working to smooth the pathways through commissioning practices.	

EDS Outcome 1.4 (EDS Goal 1 – Better health outcomes)

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

Organisational self-assessment	Grade
Commentary: We have a zero tolerance approach to abuse, whether from patients or staff, and staff are encouraged to report all such incidents which are then investigated. A Whistleblowing Policy protects staff who raise concerns. We put patient safety and quality at the heart of commissioning, and our Quality & Safety Committee, which reports directly to our Governing Body, takes reports from our two main Providers of all patient safety incidents, and collates what Keogh called the "smoke detectors" of poor care into a patient safety dashboard to identify areas of risk. The Incident Management Forum monitors Serious Untoward Incidents from Providers and requires staff and patient involvement in the investigation of these. Clinical Quality Review Group meetings are held with our two main Providers where risks and themes are discussed. Quality monitoring includes liaison with the Care Quality Commission and oversight of Quality Accounts, Commissioning for Quality and Innovation measures (CQUINS), Quality Outcome Frameworks, Prescribing, Safeguarding, and Serious Untoward Incidents. There are no current indications in the quality data that any one protected characteristic group is more disadvantaged in terms of quality than patients from a non-characteristic group.	**A**
Areas of good practice: • Quality & Safety Committee identifying the "smoke detectors" of poor care. • Regular meetings with Providers to consider Quality themes and trends. • Identification of equality objectives by CQUINS to address gaps/shortfalls.	
Potential areas for development: • See Outcome 1.1.	

EDS Outcome 1.5 (EDS Goal 1 – Better health outcomes)

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

Organisational self-assessment	Grade
Commentary: As a CCG, we do not have responsibility for commissioning or providing screening, vaccination or health promotion services. However we take our role as the local leader of the NHS very seriously and we aim to undertake health promotion activity linked to our strategic priorities and to the early diagnosis and treatment of conditions in the most appropriate setting. We have continued our 2014/15 campaigns in 2015/16 - concentrating on Cancer and Dementia. Our early cancer diagnosis awareness campaigns have targeted bowel cancer, prostate cancer, lung cancer and breast cancer. We continue working with the Doncaster Rovers Community Foundation to target men as they often present late with symptoms. We recognise a higher rate of prostate cancer diagnosis in Afro Caribbean males, and presentation late and with more aggressive breast cancers in Asian women, and so we have targeted the campaigns into these communities through whatever routes we feel will best engage the underrepresented groups including hairdressers/barbers, and we have distributed translated Cancer awareness information to target some of the faith community attending Doncaster's Mosques. In terms of dementia, we continue working in partnership with Doncaster Council to make Doncaster Dementia Friendly, and we have sought to target the campaign into under-represented groups such as BME communities. We have engaged with Men's Group Doncaster (MG DON), a multi-cultural group of over 60 men in Doncaster, and delivered Dementia Friendly training and introduced the group to the Alzheimers Society for further support; the group is receiving referrals from Social Prescribing. We have provided Choose Well / Stay Well This Winter information in Doncaster's top ten alternative language formats and in video format (signing interpreter) and dissemination of the campaign to specifically targeted groups.	**G**
Areas of good practice: • Targeted early diagnosis and treatment campaigns, including adaptations for language needs and British Sign Language (BSL).	
Potential areas for development: • Further targeting of future campaigns across the protected characteristics. • NHS Doncaster CCG has been approved to take on responsibility for commissioning primary medical care from April 2016, and we will be looking at opportunities afforded by this delegation from NHS England in terms of health promotion.	

EDS Outcome 2.1 (EDS Goal 2 – Improved patient access and experience)

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

<table>
<tr><th>Organisational self-assessment</th><th>Grade</th></tr>
<tr><td>Commentary:

As a Commissioner, access requirements are included in our commissioning contracts. We monitor the performance of our contracts through our Performance Team, with reporting through our Quality & Performance Reports to our Governing Body. We monitor against all the Access targets within the national performance framework and the commitments in the NHS Constitution e.g. 2 week wait for urgent cancer referrals, 18 week wait from referral to first definitive treatment.

Whilst all services are commissioned and provided on a universal basis, health inequalities can also be seen in the way people access services, take up health improvement offers, and the outcomes that follow. When we are commissioning services we therefore try to understand access by protected characteristic as far as the available local data will allow, and we also use national data to understand the national picture (which is likely to be replicated in Doncaster) where the local data may not be available. Services are still commissioned on a universal basis, but with more intense focus in underrepresented areas – an example being the health inequalities demonstrated in the asylum seeker / refugee community. From January 2016, asylum seekers and refugees accessing the Doncaster Conversation Club are now offered full bloods screening via the outreach partnership health bus. Mental health outreach group sessions targeting Asylum Seekers & Refugee clients were also delivered by staff from the Talking Shop, Doncaster's single point of access for mental health service provision which is led by led by Rotherham Doncaster & South Humber NHS Foundation Trust.

We promote choice though a Choice Strategy and we commission for Choice by embedding this within commissioned services contracts.

We engage with our communities to understand their needs and access wants (e.g. care closer to home) and then redesign services and/or procure to meet these needs.</td><td rowspan="3">A</td></tr>
<tr><td>Areas of good practice:

• Choice Strategy.
• Equality analysis.</td></tr>
<tr><td>Potential areas for development:

• As a Commissioner we are largely reliant on our Providers to share patient experience data. For this reason, we are engaging with our patients through our pilot Community Ambassador model and with geographical communities through a Patient Participation Group Network to try to seek direct feedback across our transformational and outcome-based delivery plan areas. We aim to develop these approaches moving forward.</td></tr>
</table>

EDS Outcome 2.2 (EDS Goal 2 – Improved patient access and experience)

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

Organisational self-assessment	Grade
Commentary: We promote choice though our Choice Strategy. We commission for Choice by embedding this in commissioned services contracts. We consult patients if we are planning to commission changes to services. We have a Communication, Engagement & Experience Strategy approved by our Governing Body which captures our strategic vision for communication, engagement & experience. The outcomes the strategy aims to achieve are a) Better Information, b) Engaged Communities, and c) Experience of appropriate and responsive services. We employ different engagement methodologies to best suit each area within our commissioning cycle: • Consultation – on our strategic plans and priorities. • Engagement – on how we specify outcomes, redesign pathways or services and procure services • Validation – of the quality and performance of the services we commission We recognise that there are some groups within any community who may not wish to engage or may need more support to engage with the CCG. We try to address this through a contract with Doncaster CVS for third sector engagement (especially with groups supporting our more seldom heard groups), through targeting our engagement activity, through a pilot bringing together and engaging with "Community Ambassadors" who represent our most vulnerable communities of interest in Doncaster, and through our Patient Participation Group Network. We capture protected characteristic data where people are willing to share this with us so that we can be assured that we are capturing a representative view. We also work closely with Healthwatch Doncaster which provides independent advocacy for the patient voice. We shall implement the new Accessible Information Standard guidelines produced by NHS England in 2016 – the standard ensure that information is provided to all service users and patients in a way they can understand. Alongside this, we are developing our communications and marketing approach when delivering health promotion activities and campaigns to ensure any supporting health promotion material produced is accessible for all.	

Areas of good practice:
 	
• Our range of engagement methodologies.
• Delivery of consultations to determine patient opinion within, for example:
  ○ Dementia Strategy
  ○ Carers Strategy
  ○ Talking Points – our public facing engagements on topics issues which have included a Medicines Waste Campaign, "What is a Good Death" survey, and developing a vision for Care Homes commissioning.	

Potential areas for development: • The engagement activity of the CCG is constantly ongoing. We will need to continue to look for new ways to engage with our communities in a manner and at a time that suits our communities.	

EDS Outcome 2.3 (EDS Goal 2 – Improved patient access and experience)

People report positive experiences of the NHS

Organisational self-assessment	Grade
Commentary: We have a Communication, Engagement & Experience Strategy approved by our Governing Body which captures our strategic vision for communication, engagement & experience. The outcomes the strategy aims to achieve are a) Better Information, b) Engaged Communities, and c) Experience of appropriate and responsive services The Engagement & Experience Committee oversees activity to ensure effective engagement with patients to elicit patient experience, which is fed into our commissioning cycle. We have mapped all our patient experience entry points, developed a patient experience dashboard, and quarterly we identify themes and trends emerging from this. When surveying patients, we seek equality information to ensure we are receiving a representative range of responses across our population. For the first time, we have successfully piloting the collation of patient experience data across an entire care pathway – stroke care – and we are now rolling that approach out to neurology. We have embedded patient experience collation and reporting requirements within our commissioned services contracts, and our Clinical Quality Review Groups for our main contracts receive regular reports. Our Governing Body receives highlight reports. We engage with the engagement/experience governance structures within our main provider trusts. Though requested, equality data from engagements can be limited. Data from our providers tends to include as standard age, disability, race & gender. We recognise that experience of services can vary between protected characteristic groups and, for example, different ethnic groups have different rates and experiences of mental health problems, reflecting their different cultural and socio-economic contexts and access to culturally appropriate treatments. We seek to use this data to influence our commissioning practices.	**A**
Areas of good practice: • Patient Experience Dashboard. • Positive evaluation of the collation of patient experience data across the stroke care pathway.	
Potential areas for development: • We recognise that as a commissioner it is difficult to engage directly with our patients to glean patient experience. We continue to explore multiple methodologies for so doing, including social media, care pathway reviews, online surveying, face-to-face engagement, and patient stories at our Governing Body. We will continue to explore these methodologies and the representativeness of responses.	

EDS Outcome 2.4 (EDS Goal 2 – Improved patient access and experience)

People's complaints about services are handled respectfully and efficiently

Organisational self-assessment	Grade
Commentary: We have an open complaints policy in place which is published on our website and supported by a patient leaflet *Listening, Responding, Improving* which explains the complaints process and responsible organisations for complaints in an accessible format. We have displayed posters featuring people from protected characteristics in our public reception with the aim of encouraging people from protected characteristics to feel able to complain when the care they receive isn't right. Complaints are monitored by protected characteristic where complainants provide this data – it is requested from every complainant. Feedback from patients through the complaints process is taken into consideration for the future commissioning of services and is fed back to Providers as relevant through the Clinical Quality Review Group meetings.	**G**
Areas of good practice: • Posters featuring people from protected characteristics.	
Potential areas for development: • No further areas for development have been identified at this point.	

EDS Outcome 3.1 (EDS Goal 3 – A representative and supported workforce)

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

Organisational self-assessment	Grade
Commentary: Recruitment and selection policies confirm that NHS Doncaster CCG has a fair, open and transparent recruitment process. We recruit via NHS Jobs. All applications request protected characteristic data to monitor application/success rates, but in line with good practice this is not shared with recruiting managers. We offer a guaranteed interview scheme for disabled applicants who meet the core selection criteria for the role. The composition of our workforce is monitored by protected characteristic. We can compare this to the composition of the Doncaster population using Census data on DataShine and this demonstrates broad comparability. We report the composition of our workforce via our quarterly Corporate Assurance Report. We have committed to the Workforce Race Equality Scheme (WRES) which states that from 1 April 2015 all NHS organisations were required to demonstrate how they are addressing race equality issues in a range of staffing areas. We are tracking WRES metrics, and now that the transfer in of the additional staff on 1st December 2015 is complete, we will refresh our engagement efforts around the WRES. Our refreshed Organisational Development Strategy includes an action to ensure our continued cultural competence as an employer, working to identify any potential barriers to employment for equality groups and exploring ways in which we could overcome them.	**G**
Areas of good practice: • Human Resources Policies. • Commitment to the Workforce Race Equality Scheme.	
Potential areas for development: • Implementation of new WRES guidelines in 2016 to support BME staff within workforce recruitment and the workforce.	

EDS Outcome 3.2 (EDS Goal 3 – A representative and supported workforce)

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

Organisational self-assessment	Grade
Commentary: The national Agenda for Change or Very Senior Managers Terms and Conditions are applied to all posts, ensuring equal pay. We have a clear Grading Policy and grading panels consist of both management and staff side representatives. Nationally agreed Agenda for Change profiles are used when undertaking job evaluation. The national terms and conditions handbook is used.	**G**
Areas of good practice: • Application of national Agenda for Change terms and conditions. • Remuneration Committee review of Governing Body remuneration benchmarked to national guidance and local benchmarks.	
Potential areas for development: • No further areas for development have been identified at this point.	

EDS Outcome 3.3 (EDS Goal 3 – A representative and supported workforce)

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

Organisational self-assessment	Grade
Commentary: Our team members need knowledge of the public sector equality duties and the need to consider equality impact during commissioning decisions, which we are achieving through one-to-one support from Communication, Engagement, Experience & Equality team members, through a mandatory e-learning module, and through supplementary face-to-face training for Governing Body members as our key decision makers. In 2015/16 we have rolled out a new type of mandatory video-based training to all staff members looking at cultural competence and unconscious bias, and early evaluation is showing positive feedback from staff on this new thought-provoking training tool. Compliance is monitored through the quarterly Corporate Assurance Report. The Engagement & Equalities Officer provides 1:1 challenge and support to individual officers working on areas which may have equality impact. Equality training and awareness includes cultural competence. We have a wider Learning and Development programme which links opportunities to Personal Development Plans developed at Personal Development Reviews. Opportunities are therefore tailored to individual needs identified by each individual and/or their line manager. The Study Leave Policy requires evaluation of each learning and development opportunity. Training and development opportunities are taken up equally across the organisation. Our refreshed Organisational Development Strategy includes an action to develop a portfolio / skills based approach to the leadership of workstreams, giving time to individual and team development within the organisation, providing time for reflection, and developing a more “personalised” or individualised approach to development activities.	**G**
Areas of good practice: • Investment in organisational development. • Personalised approach to development via Personal Development Plans. • Cultural competence and unconscious bias training.	
Potential areas for development: • No further areas for development have been identified at this point.	

EDS Outcome 3.4 (EDS Goal 3 – A representative and supported workforce)

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

<table>
<tr><th>Organisational self-assessment</th><th>Grade</th></tr>
<tr><td>

Commentary:

Everyone is different, and everyone's individual experience, knowledge and skills bring a unique contribution to our organisation, and we value all contributions equally. Our Equal Opportunities Policy is published on our website as our corporate commitment. Recruitment and selection processes are transparent and include consideration of equality. Policies are in place to support staff in the workplace such as Workplace Wellbeing and Flexible Working. The annual NHS Staff Survey has equality themes and can be analysed by protected characteristic. Each year, the Staff Survey is analysed and an action plan is developed to address issues.

Staff are protected through a number of policies including:
- Equal Opportunities Policy
- Grievance Policy
- Disciplinary Policy
- Harassment & Bullying At Work Policy
- Workplace Wellbeing Policy
- Whistleblowing Policy

Fraud training is mandatory. Conflict Resolution training is provided based on a risk assessment for frontline staff.

We have a Colleague Engagement Group which makes suggestions for improvements and responds to concerns raised through the Staff Survey.

The application of both the Grievance Policy and the Disciplinary Policy are monitored by protected characteristic.

</td><td rowspan="3">G</td></tr>
<tr><td>

Areas of good practice:

- Range of Human Resources Policies.
- Continued operation of a Colleague Engagement Group (CEG). The increase staff numbers from December 2015 may better support the organisation with generating greater staff involvement within staff networks/forums – enabling better access to staff feedback across a number of work force issues or concerns, which rely upon capturing responses from our workforce or require staff involvement to shape.
- Utilising results from staff surveys to our influence the direction of travel.

</td></tr>
<tr><td>

Potential areas for development:

- No further areas for development have been identified at this point.

</td></tr>
</table>

EDS Outcome 3.5 (EDS Goal 3 – A representative and supported workforce)

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

<table>
<tr><th>Organisational self-assessment</th><th>Grade</th></tr>
<tr><td>Commentary:

We have a range of employment policies to support staff around the equality agenda, and all have been updated since the inception of the CCG. Policies include:
Flexible Working Policy
Annual Leave Policy
Hours of Work Policy
Management of Work Related Stress Policy
Retirement Policy
Secondment Policy
Study Leave Policy
Workplace Wellbeing Policy
Flexible working options are available for application and are accessed by staff across the organisation. The Flexible Working policy includes options around flexi-time, 9 day fortnights, condensed hours, part time and term-time only contracts.

We continue to participate in and promote the child care voucher scheme.</td><td rowspan="3">G</td></tr>
<tr><td>Areas of good practice:

Range of Human Resources Policies.
Flexible working opportunities.</td></tr>
<tr><td>Potential areas for development:

No further areas for development have been identified at this point.</td></tr>
</table>

EDS Outcome 3.6 (EDS Goal 3 – A representative and supported workforce)

Staff report positive experiences of their membership of the workforce

Organisational self-assessment	Grade
Commentary: Our refreshed Organisational Development Strategy confirms that we want to create an organisational culture such that team members look forward to coming to work. We are all motivated to come to work because we obtain something that we need from work – whether that is the accomplishment of goals, contributing to something bigger, a desire to improve services for the population we serve, personal fulfilment, a desire for challenge, or simply for money. Achieving what we need from work impacts on our morale and motivation and, thus feeds back into our behaviours at work. By supporting team members to achieve their goals at work, we can hopefully together create a fulfilling organisational culture where people look forward to coming to work. NHS Doncaster CCG has a Colleague Engagement Group (CEG) which monitors outcomes from the Staff Survey and recommends actions to improve the workplace for all staff. In recent months the CEG has led the development of Workplace Wellbeing improvements. The Staff Survey from 2014/15 resulted in a full action plan developed by CEG team members which has been monitored. The results of the 2015/16 survey will shortly be reported and again our CEG will again lead the action planning from the results, supported by senior managers. We have invested in Facilities time from 2 Unison team members within the organisation, who engage with other Unison members, attend our Corporate Governance Management Group to feed in the Staff Side perspective, and are consulted on new policies affecting staff. They were supportive of the process to in-house approximately 75 staff from the Yorkshire & Humber Commissioning Support service and support their integration within the workforce from December 2015. We have a regular Staff Brief from the Chief Officer, supported by Senior Management Team members which is open to all staff and provides an opportunity for updates on organisational priorities and a Question & Answer session. Our refreshed Organisational Development Strategy includes an action to have open and honest conversations within the organisation about organisational direction, priorities, and challenges, and give team members opportunities to engage and to influence decisions.	**G**
Areas of good practice: • Colleague Engagement Group. • Staff Survey – action planning by Colleague Engagement Group members.	
Potential areas for development: • The results from the 2015/16 staff survey are currently being evaluated and CEG will again lead the action planning from the results. • We will be supporting our new staff members to integrate into the organisational culture and seeking feedback on ways to enhance their experience.	

EDS Outcome 4.1 (EDS Goal 4 – Inclusive leadership)

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

Organisational self-assessment	Grade
Commentary: The right corporate systems and processes can help us to embed equality and diversity considerations into the very fabric of our organisation, making it everybody's business to show due regard to our public sector equality duties. Our Experience & Engagement Committee is a formal Committee of our Governing Body and has responsibility for embedding patient experience within commissioning and ensuring that due regard is paid to our public sector equality duties. We have a range of leads championing Equality across the organisation including a Lay Member lead, a clinical lead, an Executive lead and an operational lead. We also have various corporate documents which encapsulate our equality commitment: • Our "Equality & Diversity Strategy" which was refreshed and approved by our Governing Body in December 2014. The Strategy is available on our website. • Our use of the Equality Delivery System to develop and publish our Equality Objectives in October 2013. The Equality Delivery System version 2 was published in November 2013 and has been used during 2015/16 to undertake a further self-assessment. • Publication of equality data annually by the end of January each year. We ensure that all Governing Body members are trained in equality & diversity. Health inequalities is a key priority of our Governing Body because we have identified health inequalities as a strategic risk on our Governing Body Assurance Framework with an associated action plan. Tackling health inequalities in Doncaster is a multi-dimensional challenge reaching beyond the boundaries of health, and moving forwards we will be seeking to work in partnership across Doncaster to identify and begin to address the multiple determinants of health inequalities. The Doncaster Inclusion & Fairness Forum has been set up by the Team Doncaster Strategic Partnership (Team Doncaster) as an independent advisory group to explore and identify ways in which we can make Doncaster a fairer place to live and work, and we are a key partner. We are also partnering in the Well North pilot in Denaby which aims to improve health, bring the health system and economic growth priorities into closer alignment and build a best practice framework which can be replicated and transplanted.	**G**
Areas of good practice: • Member of the partnership Inclusion & Fairness Forum. • Well North. • Assurance Framework risk on health inequalities. • Governing Body members are trained in equality & diversity.	
Potential areas for development: • No further areas for development have been identified at this point.	

EDS Outcome 4.2 (EDS Goal 4 – Inclusive leadership)

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

Organisational self-assessment	Grade
Commentary: All Governing Body and Committee papers are accompanied by a coversheet which identifies equality impact and any risk areas. Where appropriate to the level of the activity, a separate Equality Analysis is conducted – recent examples have included our breast cancer early detection campaign, mental healthcare, our Children & Young People Mental Health Wellbeing Plan, carer engagement and dementia commissioning. Equality issues are included within new business cases.	**G**
Areas of good practice: • Governing Body and Committee coversheets. • Equality Analyses.	
Potential areas for development: • There remains the potential to embed equality analysis more consistently across the organisation.	

EDS Outcome 4.3 (EDS Goal 4 – Inclusive leadership)

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

Organisational self-assessment	Grade
Commentary: Equality & Diversity training is mandatory for all employed staff. Understanding is tested through a questionnaire with a required pass rate at the end of the Equality & Diversity module. Compliance is monitored through the quarterly Corporate Assurance Report. The Engagement & Equalities Officer provides 1:1 challenge and support to individual officers working on areas which may have equality impact. Training and awareness includes cultural competence. Human Resources Policies enshrine equal opportunities within the workplace.	**G**
Areas of good practice: • Mandatory e-learning training. • Additional 1:1 support available from Engagement & Equalities Officer.	
Potential areas for development: • We are considering offering an alternative method to the existing e-learning training for key staff.	

Appendix 2: Core data and information

Source	Brief description	Use within organisation
NHS Doncaster CCG Equality Information in the CCG Annual Report	A summary within the CCG Annual Report capturing summary equality activity within the preceding year.	Used to collate a summary of equality activity and identify any emerging themes. Available on our website: www.doncasterccg.nhs.uk
Joint Strategic Needs Assessment (JSNA)	The Joint Strategic Needs Assessment (JSNA) is a process that identifies the current and future health and wellbeing needs of a local population.	Used to identify commissioning priorities and areas of health inequalities to target interventions. Published on the Team Doncaster website under the Data Observatory: http://www.teamdoncaster.org.uk
Community Profiles	There are 88 Community Profiles, one for each community in Doncaster.	Used to identify areas of health inequalities within communities. Published on the Team Doncaster website under the Data Observatory: http://www.teamdoncaster.org.uk
Health Needs Assessments	Health Needs Assessments are commissioned through our agreement with the Public Health Team in Doncaster Council to identify the key needs of the population.	Needs assessments allow us to obtain an in-depth understanding of the needs of a specific population group for which we are responsible for commissioning healthcare. http://www.teamdoncaster.org.uk
Data Shine	The Data Shine project seeks to promote and develop the use of large and open datasets amongst the social science community.	Used to identify areas of health inequalities and target community engagement. The data takes us down to community level across data collected in the 2011 Census. http://datashine.org.uk
Yorkshire & Humber Public Health Observatory	Yorkshire and Humber Public Health Observatory (YHPHO) produces information, data and intelligence on people's health and health care for practitioners, policy makers and the wider community.	Used to identify areas of health inequalities. http://www.yhpho.org.uk/

Source	Brief description	Use within organisation
Census 2011	The Census has collected information about the population every 10 years since 1801 (except in 1941). The latest census in England and Wales took place on 27 March 2011.	The statistics collected from the Census are used to understand the similarities and differences in the populations' characteristics locally, regionally and nationally.
Provider equality data	Data recorded by our Providers on activity by protected characteristics.	The data is recorded by protected characteristic and used to identify themes, support the commissioning process, and to monitor Provider activity. http://www.dbh.nhs.uk/ http://www.rdash.nhs.uk/
Engagement activities and findings	Data on themes emerging from patient and public engagement activity.	Themes and trends arising from engagement are received by the Engagement & Experience Committee.
Workforce Data	Specification included at Appendix 3.	Monitoring of the workforce in terms of representativeness across the protected characteristics. Published within our quarterly Corporate Assurance Report.
Staff Survey	An annual national survey of our staff in terms of satisfaction.	Used to develop an action plan which supports making improvements in the workplace for staff moving forwards.
Complaints	Data on complaints received by NHS Doncaster CCG relating to services that we commission.	The data is recorded by protected characteristic and used to identify themes and support the commissioning process.
Equality Delivery System	A self-assessment of our activity against the national voluntary Equality Delivery System outcomes.	The summary results are included in this report and published in full on our website. The data is used for self-assessment across all standards, and for a deep dive into specific clinical areas.

A picture of Doncaster

Age and Demographics:

The age profile in Doncaster is broadly similar to the national picture with a slightly higher proportion of older people (65+) and slightly lower proportion of working age people (16-64). The number of younger people (0-15) from the 2011 Census was 57,493 (19% of population), working age people (16-64) was 193,768 (64.1%) and older people (65+) was 51,141 (16.9%).

Projecting to 2016, the overall population of Doncaster is predicted to grow by 1% compared to the national prediction of 4%. However in Doncaster the number of older people (65+) is predicted to grow by 9% which is the same as the national predictions. In particular the proportion of people aged over 90 in Doncaster is predicted to grow by 23% which is faster than the national prediction of 20%.

Doncaster is ranked 39 in a list of the most deprived areas in England by the Index of Deprivation 2010.

Carers:

In 2011 11% (33,150) of Doncaster's population provided unpaid care compared to the England average of 10.4%. Of these people 18,773 (6.6%) residents in Doncaster indicated that they provided 1-19 hours of unpaid care a week, 4,994 (1.7%) indicated that they provided 20-49 hours of unpaid care a week and 9,383 (3.2%) indicated that they provided 50 hours or more of unpaid care a week.

Disability:

In Doncaster 21.7% (65,535) of people have some form of disability compared to the national average of 17.9%. Of these 33,644 (11.1%) residents in Doncaster indicated that their day-to-day activities were limited a lot and 31,891 (10.5%) residents indicated that day-to-day activities were limited a little. Doncaster is predicted to have a similar proportion of people with learning disabilities as the national average at 1.85% of the population.

Ethnicity:

Based on Census 2011 data, the proportion of total population in Doncaster classified as 'White British' equates to 91.8% (4.7% less than in 2001), and the national average is 80.45%.Those from Black & Minority Ethnic (BME) backgrounds represent 8.2% of the total population. Young people from BME backgrounds represent 10.2% of the total 0-19 population. The working age population from a

BME background represent 8.8%, and older people from BME backgrounds represent 2.9%.

The proportion of BME population is not as large as the national average however key minority groups do exist in Doncaster. The table below shows the distribution of these groups. The ethnic group that is the second largest in Doncaster is 'white other' which includes 0.4% Irish, 0.2% Gypsy or Irish Traveller, and 2.8% White Other.

White	British	91.8%
	Other	3.4%
Mixed	White & Black Caribbean	0.5%
	White & Black African	0.1%
	White & Asian	0.3%
	Other	0.2%
Asian / Asian British	Indian	0.6%
	Pakistani	0.9%
	Bangladeshi	0%
	Chinese	0.4%
	Other	0.6%
Black / Black British	African	0.4%
	Caribbean	0.3%
	Other	0.1%
Other	Arab	0.1%
	Other	0.3%

Although it appears from the census data that the ethnic group 'Gypsy or Irish Traveller' accounts for only 0.2% of the population, this group is accountable for 587 people, the largest population in South Yorkshire (Barnsley 163, Rotherham 126 and Sheffield 358 people). This is the second largest settlement in the region (42nd in England and Wales). Furthermore local analysis has estimated that the population of this group is closer to 4000 with a number of sites within the borough and also an estimated 900 permanent households.

The working age population for BME groups in Doncaster is 8.8% compared to the National Average of 21.5%.

The older people population for BME groups in Doncaster is 2.9% compared to the national average of 8.4%.

The proportion of people in Doncaster who speak English as their main language is 95.9% compared to the national figure of 92%. Other main languages spoken in Doncaster are Polish 1.6%, Urdu 0.3%, Chinese 0.2% and Punjabi 0.2%.

Gender:

The gender ratio in Doncaster is very similar from birth up until 65+. From the 2011 Census the ratio between the ages 0-17 are Male 50.51% and Female 49.49%.

Between the ages of 18-64 the ratio is Male 50.31% and Female 49.69%. However at 65+ the ratio becomes Male 44.37% and Female 55.63%.

Gender Reassignment:

The 2011 Census did not include a specific question in respect of gender reassignment. It is estimated from national research that 1 in 10,000 are referred to as being transgender or transsexual. This would equate to around 30 residents in Doncaster.

Marriage and Civil Partnership:

The proportion of people over the age of 16 who were married in Doncaster is 46.91% which is similar to the national average of 46.6%. In Doncaster 32.21% of people were single, 0.2% were in a civil partnership, 13.1% were separated/divorced and 7.7% were widows/surviving member of civil partnership.

Pregnancy and Maternity:

Doncaster has a higher proportion of babies born with low birth weight at 9.7% compared to the national average of 7.4%. Teenage conceptions in Doncaster were at a rate of 39.7 per 1000 women, this is above the national rate of 30.0 per 1000 women.

Religion and Belief:

Most of the population of Doncaster in the 2011 Census stated their religion as Christian at 65.9% compared to 59.3% nationally. A further 24.4% stated they had no religion, 2.9% was made up of other religions and 6.9% did not state their religion.

Sexual Orientation:

There is no specific question on the 2011 Census regarding sexual orientation, however in 2010 the Office of National Statistics received responses on their Integrated Housing Survey that suggested that around 1.4% of the population considered themselves as gay, lesbian or bisexual. If this was applied to Doncaster's population this would equate to 4,223 residents.

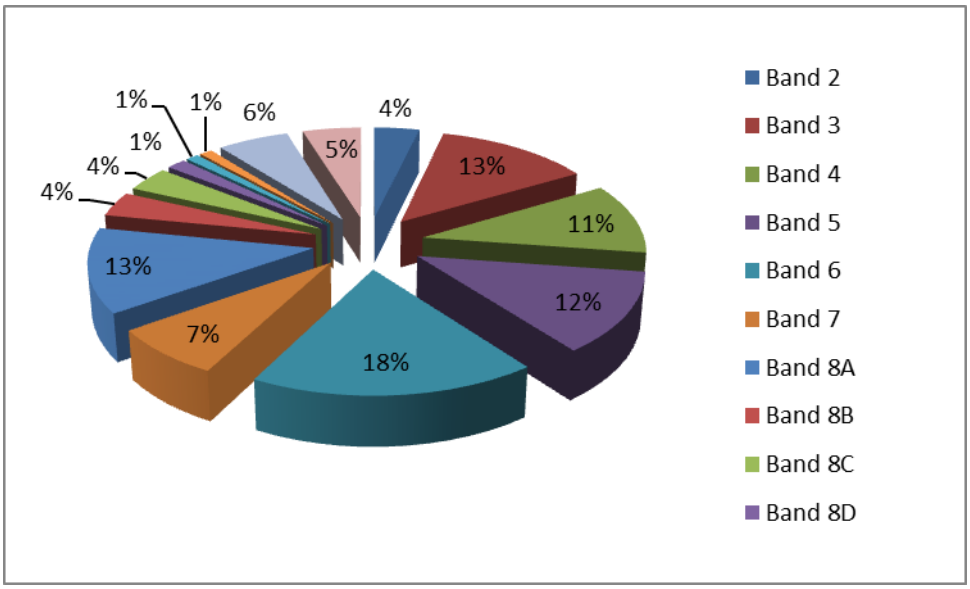
Appendix 3: NHS Doncaster CCG staffing equality data

(as at 31 December 2015)

<table>
<tr><th></th><th colspan="2">Staffing breakdown:</th><th>Count / %</th><th>Doncaster population</th></tr>
<tr><td rowspan="2">Gender</td><td colspan="2">Female</td><td>75%</td><td>50.6%</td></tr>
<tr><td colspan="2">Male</td><td>25%</td><td>49.4%</td></tr>
<tr><td rowspan="12">Age</td><td colspan="2">Under 20</td><td>1%</td><td rowspan="12"><table><tr><td>0 - 19</td><td>24.0%</td></tr><tr><td>20 - 39</td><td>25.2%</td></tr><tr><td>40 - 59</td><td>27.6%</td></tr><tr><td>60 - 79</td><td>18.6%</td></tr><tr><td>80+</td><td>4.5%</td></tr></table></td></tr>
<tr><td colspan="2">20-25</td><td>8%</td></tr>
<tr><td colspan="2">26-30</td><td>9%</td></tr>
<tr><td colspan="2">31-35</td><td>10%</td></tr>
<tr><td colspan="2">36-40</td><td>12%</td></tr>
<tr><td colspan="2">41-45</td><td>16%</td></tr>
<tr><td colspan="2">46-50</td><td>18%</td></tr>
<tr><td colspan="2">51-55</td><td>14%</td></tr>
<tr><td colspan="2">56-60</td><td>9%</td></tr>
<tr><td colspan="2">61-65</td><td>3%</td></tr>
<tr><td colspan="2">66-70</td><td>1%</td></tr>
<tr><td rowspan="20">Ethnicity</td><td rowspan="2">White</td><td>British</td><td>83%</td><td>91.8%</td></tr>
<tr><td>Other</td><td>2%</td><td>3.4%</td></tr>
<tr><td rowspan="4">Mixed</td><td>White & Black Caribbean</td><td rowspan="4">0%</td><td>0.5%</td></tr>
<tr><td>White & Black African</td><td>0.1%</td></tr>
<tr><td>White & Asian</td><td>0.3%</td></tr>
<tr><td>Other</td><td>0.2%</td></tr>
<tr><td rowspan="5">Asian / Asian British</td><td>Indian</td><td rowspan="5">6%</td><td>0.6%</td></tr>
<tr><td>Pakistani</td><td>0.9%</td></tr>
<tr><td>Bangladeshi</td><td>0%</td></tr>
<tr><td>Chinese</td><td>0.4%</td></tr>
<tr><td>Other</td><td>0.6%</td></tr>
<tr><td rowspan="3">Black / Black British</td><td>African</td><td rowspan="3">2%</td><td>0.4%</td></tr>
<tr><td>Caribbean</td><td>0.3%</td></tr>
<tr><td>Other</td><td>0.1%</td></tr>
<tr><td rowspan="2">Other</td><td>Arab</td><td rowspan="2">0%</td><td>0.1%</td></tr>
<tr><td>Other</td><td>0.3%</td></tr>
<tr><td>------</td><td>Prefer not to say</td><td>7%</td><td>Not given as option</td></tr>
<tr><td rowspan="3">Disability</td><td colspan="2">Declared disability</td><td>2%</td><td>21.6%</td></tr>
<tr><td colspan="2">No declared disability</td><td>61%</td><td>------</td></tr>
<tr><td colspan="2">Prefer not to say</td><td>36%</td><td>------</td></tr>
<tr><td rowspan="10">Religion / Belief</td><td colspan="2">No religion / Atheism</td><td>13%</td><td>24.4%</td></tr>
<tr><td colspan="2">Christianity</td><td>60%</td><td>65.9%</td></tr>
<tr><td colspan="2">Buddhism</td><td>1%</td><td>0.2%</td></tr>
<tr><td colspan="2">Hinduism</td><td>1%</td><td>0.3%</td></tr>
<tr><td colspan="2">Judaism</td><td>------</td><td>0.03%</td></tr>
<tr><td colspan="2">Islam</td><td>------</td><td>1.7%</td></tr>
<tr><td colspan="2">Sikhism</td><td>------</td><td>0.4%</td></tr>
<tr><td colspan="2">Any other religion</td><td>5%</td><td>0.3%</td></tr>
<tr><td colspan="2">Prefer not to say</td><td>20%</td><td>24.4%</td></tr>
<tr><td rowspan="7">Sexual orientation</td><td colspan="2">Bisexual</td><td>0%</td><td rowspan="7">Not asked in 2011 Census.</td></tr>
<tr><td colspan="2">Gay man</td><td>0%</td></tr>
<tr><td colspan="2">Gay Woman / Lesbian</td><td>1%</td></tr>
<tr><td colspan="2">Heterosexual</td><td>85%</td></tr>
<tr><td colspan="2">Other</td><td>0%</td></tr>
<tr><td colspan="2">Do not wish to declare</td><td>14%</td></tr>
</table>

	Staffing breakdown:	Count / %	Doncaster population
Pregnancy, maternity and gender reassignment	Due to the small numbers associated with pregnancy/maternity and gender reassignment which may make individuals personally identifiable, these are not included in a public report.	N/A	Not available in 2011 Census data.

Pay Band Profile



By gender the largest proportion of female employees are Band 6. The majority of male employees are on a personal salary/very senior manager salary. 8% of the overall workforce are from a BME background, of that 47% are on Band 8a or equivalent and above.