NHS
Doncaster
Clinical Commissioning Group

# EQUALITY & DIVERSITY STRATEGY

# 2018/19 – 2020/21

Version: 3.1 **FINAL**
Approved: 19th July 2018
Updated: 18 November 2019

# CONTENTS

## 1. Introduction

***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.

***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.

***Our commitment:*** This Strategy sets out our organisational commitment to Equality & Diversity, and ensuring that that it remains central to our commissioning activities and our employment practices.

## 2. The legislative background

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
- Race
- Religion & Belief
- Sexual orientation
- Pregnancy and maternity
- Gender reassignment
- Marriage and civil partnership

As a result of the general nature of the clauses, the responsibility of defining “due regard” has fallen to the Courts. Case law sets out broad principles regarding what public bodies need to do to have “due regard” to the aims set out in the general Public Sector Equality Duties. These are sometimes referred to as the 'Brown principles' (*R. (Brown) v. Secretary of State for Work and Pensions [2008]*).

| | |
|---|---|
| ***KNOWLEDGE*** | Those who have to take decisions must be made aware of their duty to have “due regard” across the protected characteristics. |
| ***CONSCIOUS APPROACH*** | Due regard involves a conscious approach and state of mind and must be considered up-front. |
| ***TIMELINESS*** | A body subject to the duty cannot satisfy the duty by justifying a decision after it has been taken. |
| ***REAL CONSIDERATION*** | The duty must be exercised with real consideration such that it is integrated with the decision making process and can influence the final decision. |
| ***NO DELEGATION*** | The duty remains the responsibility of the CCG at all times and is a continuous duty. |
| ***RECORD KEEPING*** | It is good practice for those exercising public functions to keep an accurate record showing that they had actually considered the general equality duty and pondered relevant questions. |

The **NHS Constitution Principles state** that ‘the NHS provides a comprehensive service, available to all irrespective of age, disability, sex (gender), race, sexual orientation, gender reassignment, religion, belief, pregnancy and maternity or civil partnership status. The service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.’

## 3. Our population – the context in which we operate

Doncaster has a diverse population of over 300,000 patients comprised of many different communities of both place and interest. A community of place is a community of people who are bound together because of where they reside, work, visit or otherwise spend a continuous portion of their time e.g. a neighbourhood. A community of interest is a community of people who share a common interest – this may include the protected characteristics.

As a commissioner we act on behalf of the public, patients and their carers, investing funds on behalf of our communities. In order to make commissioning decisions that reflect the needs, priorities and aspirations of the local population we need to engage with the public and actively seek the views of patients, carers and the wider community. Effective patient and public engagement is therefore a cornerstone of what we are trying to achieve as an organisation, and so we strive to hear voices of people from across communities of interest and place in Doncaster and across the protected characteristics.

We seek information on our population and their healthcare needs to inform our commissioning activity from a variety of sources including the Joint Strategic Needs Assessment, consultation and engagement activities, targeted or specific health assessments, and Census data. 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. We use the statistics collected from the Census to understand the similarities and differences in our populations' characteristics locally, and compare regionally and nationally.

In summary:

- Doncaster is ranked 39 in a list of the most deprived areas in England by the Index of Deprivation 2010.
- 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%).
- In 2011 21.7% (65,535) of Doncaster people reported some form of disability compared to the national average of 17.9%. Of these 33,644 (11.1%) 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.
- 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%.
- Based on Census 2011 data, the proportion of total population in Doncaster classified as 'White British' equates to 91.8%, 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 ethnic group that is the second largest in Doncaster after 'white' is 'white other' which includes 0.4% Irish, 0.2% Gypsy or Irish Traveller, and 2.8% White Other. The 6 largest ethnic groups in Doncaster in order of size are a) White British, b) White Polish, c) Pakistani or British Pakistani, d) Indian or British Indian, e) White and Black Caribbean, f) African.
- 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%.
- 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.
- 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.
- 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.
- 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.
- 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.

## 4. Our Workforce

NHS Doncaster Clinical Commissioning Group employs over 130 staff that supports our commissioning intentions and is working on management projects or healthcare. The CCG is made up of 41 member practices from across the Doncaster borough.

The CCG has a small Corporate Services Team consisting of a Corporate Governance Team, Engagement and Experience Team and a Patient Experience Team who supports the CCG in ensuring it has fair and inclusive practices in place.

The CCG is committed to holding up to date information about the CCG workforce, in line with Data Protection Legislation, including the reporting of the Workplace Race Equality Standards, and to ensure strategic decisions affecting the workforce are based on accurate reporting data.

The CCG aims to continually collect and monitor data of its workforce to ensure non-discriminatory practice, working with staff and staff side representatives to identify any barriers and eliminate discrimination in the workplace. The CCG has a Colleague Engagement Group that acts as a forum for staff to raise concerns but to also improve working life at the CCG, which includes equality and diversity and staff health and wellbeing.

The CCG has a small workforce of approximately 170 staff (November 2019) which does not include students or training placements, and is therefore not required to publish its workforce data, as in doing so may potentially identify an individual. Regular monitoring and review of staff data is undertaken to promote transparency with the aim of ensuring a diverse and well supported workforce.

CCG employees are supported in their duty to commission high quality services for the population of Doncaster by regular Equality, Diversity and Human Rights training that must be completed at least on an annual basis in line with the Mandatory and Statutory Training Policy. This training is designed to introduce staff to equality and diversity but also to use their diversity and cultural awareness in practice.

## 5. Health Inequalities

### *Definition*

The World Health Organisation defines health inequalities as “differences in health status or in the distribution of health determinants between different population groups"[1]. For example, some people in more deprived areas can have a shorter life expectancy than those who live in less deprived areas. These differences can be due to social, geographical, biological or other factors and can 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

[1] World Health Organisation (2014) Health Impact Assessment Glossary of Terms Used [Online] Available at: http://www.who.int/hia/about/glos/en/index1.html

by social or geographical factors (also known as 'health inequities') and can be avoided or mitigated[2].

### *Why do health inequalities matter?*

In recent years there have been significant improvements in the health of Doncaster people. However, despite this progress, these improvements have not been seen in equal measures across the Borough. There remain significant health inequalities in Doncaster. These inequalities are described in detail in various reports including the Joint Strategic Needs Assessment[3] and the Health and Wellbeing Strategy[4]. Doncaster's Health Profile 2015[5] clearly states that the health of people in Doncaster is varied compared with the England average. Deprivation is higher than average and about 23.8% (13,500) of children live in poverty. Life expectancy for both men and women is lower than the England average - 9.8 years lower for men and 7.0 years lower for women in the most deprived areas of Doncaster than in the least deprived areas.

### *The evidence*

There is clear evidence that reducing health inequalities improves life expectancy and reduces disability across the social gradient. Tackling health inequalities is therefore core to improving access to services, health outcomes, improving the quality of services and the experiences of people. It is also core to the NHS Constitution and the values and purpose of the NHS.[6]

Nationally, the NHS Five Year Forward View sets out the need to address the health and wellbeing gap and prevent any further widening of health inequalities. The NHS Framework of Health Inequalities focuses on a vision of measurable and sustained reductions in health inequalities, where more people can enjoy good health throughout life, wherever they live or whatever their social position.

The need to identify and address health inequalities is also high on the local agenda, featuring in our local Doncaster Health & Wellbeing Strategy (December 2015) which contains a partnership ambition to reduce health inequalities.

### *What leads to health inequalities?*

There are a number of factors which tend to lead to health inequalities. These tend to be grouped into a small number of factors:

- Socio-economic factors e.g. the availability of work, your education, your income, housing and amenities.
- Lifestyle and health-related behaviours e.g. smoking, diet and physical activity.

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[2] National Institute of Health and Care Excellence LGB4, October 2012 https://www.nice.org.uk/advice/lgb4/chapter/introduction
[3] http://www.teamdoncaster.org.uk/Doncaster_Data_Observatory/joint_strategic_needs_assessment.asp
[4] http://www.teamdoncaster.org.uk/Images/Health%20%26%20Wellbeing%20Strategy%202015_Consultation%20v1_tcm33-111125.pdf
[5] http://www.apho.org.uk/resource/browse.aspx?RID=50313
[6] https://www.england.nhs.uk/about/gov/equality-hub/legal-duties/

- Healthcare factors e.g. access to services, understanding of the needs of the population, prevalence of disease.
- Personal factors e.g. age, gender, ethnicity, genetics.

### *Legal duties*

The Health and Social Care Act 2012 introduced legal duties on health inequalities for CCGs. The Act does not define a list of groups impacted by the duties; any group experiencing health inequalities is covered because the duties take a whole population approach. CCGs have duties to:

- Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (section 14T).
- Exercise their functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where they consider that this would improve quality, reduce inequalities in access to those services, or reduce inequalities in the outcomes achieved (section 14Z1).
- Include in an annual commissioning plan an explanation of how they propose to discharge their duty to have regard to the need to reduce inequalities (section 14Z11).
- Include in an annual report an assessment of how effectively they discharged their duty to have regard to the need to reduce inequalities (section 14Z15).

### *The role of the CCG*

Reducing health inequalities is a priority for NHS Doncaster CCG, as highlighted in our partnership working on the Doncaster Health & Wellbeing Board. Not only is it the right thing to do and a legal duty, but in the very challenging financial climate in which we find ourselves in Doncaster, taking action to reduce health inequalities should result in substantial population health gains, reduced healthcare spend and improved health outcomes.[7] There are three main routes through which CCGs can generally have an impact on health inequalities:

- Direct commissioning of services. This includes universal healthcare services that meet the needs of all who need to use the service as well as targeted services that meet the particular needs of specific vulnerable groups such as asylum seekers and refugees, proportionate to their health needs (this is referred to as proportionate universalism).
- Commissioning of primary medical care services e.g. improving quality of primary care by supporting a reduction in unwarranted variation in access and treatment between practices.
- System leadership in respect of the Doncaster Place Plan and the South Yorkshire & Bassetlaw Accountable Care System e.g. taking the lead in coordinating action by all local organisations.

[7] Marmot et al. Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010. February 2010 http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf

## 6. What are we trying to achieve?

We have two very different roles as an organisation, 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.

- ***Commissioning role:*** Hear a diverse range of Doncaster voices and use equality data to help us to commission effective services that meet identified health needs and reduce health inequalities.
- ***Corporate Body:*** Ensure that we pay due regard to our Public Sector Equality Duties and equal opportunities within employment.

## 7. How will we achieve this?

### 7.1. Our commissioning role

To improve health inequalities within our population and be compliant with our duties, we must consistently have regard to the need to reduce inequalities when exercising our functions. There are a number of specific actions which we commit to take in order to identify and address health inequalities:

- ***Leadership:*** Strategic leadership of the health inequalities agenda through our Governing Body, our partnership work through the Doncaster Health & Wellbeing Board, and ensuring all our team members are aware of our duties.

- ***Knowing our local population:*** Understanding the composition, needs, and health inequalities of our population. Using the Joint Strategic Needs Assessment (JSNA) and additional supporting data and evidence to better understand our population, their health needs, and inequalities.

- ***Commissioning:*** Understanding which dimensions of inequality are relevant to our work, and taking account of how inequalities could be reduced using a clear evidence-base. We generally commission services on a universal basis so that they are accessible to all members of society. However we know that not all members of the Doncaster population access universal services fairly, according to their needs. We therefore consider in our commissioning activities whether this universal reach may be better achieved by explicitly targeting specific population groups and commissioning universal services at greater scale and intensity for those who need them the most. We will also consider how services can be commissioned to reduce inequalities and prevent undesirable outcomes e.g. targeting lifestyle factors in health and compliance with treatment, and developing key provider indicators with health inequality outcomes.

- ***Seeking patient experience:*** Through community engagement, gaining knowledge of our local communities' experiences of NHS care and using this to influence future commissioning. We have engagement mechanisms with both

communities of place (geographical communities) and communities of interest (from protected characteristics under the Equality Act 2010 or from more vulnerable groups).

- ***Partnerships:*** Achieving ambitious transformational change with our partners within the Doncaster Place Plan, and wider across the South Yorkshire & Bassetlaw Accountable Care System, and collaboratively with other CCGs. These plans aim to tackle support integration of care and address health inequalities. Working in partnership with Doncaster Council on tackling health inequalities through developing a shared partnership action plan and the membership of the Health Inequalities Forum. Working in partnership with Health Ambassadors through Healthwatch Doncaster to help deliver engagement to hard to reach groups.

- ***Decision-making:*** Considering the impact on inequalities as part of all decision making processes, and keeping a record of such processes. We use equality impact analysis to support key decisions, and include equality impact analysis as standard on coversheets for our decision making meetings.

- ***Monitoring and evaluation:*** Monitoring commissioned services to ensure that identified health inequalities are being addressed, and supporting action to overcome inappropriate variations in outcomes for all people. Many changes to address health inequalities will have a long-term impact on health outcomes, so their effectiveness may not be visible on an annual reporting basis.

### 7.2. Our corporate body role

The right corporate systems and processes can help use as an organisation 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.

- The Governing Body, Senior Management Team, Quality and Patient Safety Committee, Finance, Performance and Contracting and the Primary Care Commissioning Committee all have duty to ensure decisions are made in line with the equality duty as well as having the strategic responsibility for the CCG's performance on equality and diversity.

- We have a range of leads championing Equality across the organisation including a Lay Member lead, two clinical leads, an Executive lead, an operational lead and several staff members from each directorate.

- Our team members need knowledge of the public sector equality duties and the need to consider equality impact during commissioning decisions, which we commit to through one-to-one support from Communication, Engagement,

Experience & Equality team members, through mandatory e-learning, and through supplementary face-to-face training for Governing Body members as our key decision makers.

- To raise awareness with team members by a range of events and communications on key notable dates for raising awareness on the protected characteristics.

- The promotion of equality and diversity will be actively pursued through our Human Resources policies and procedures and our mandatory training programme which will ensure that employees and potential employees are not subject to direct or indirect discrimination.

- We have also committed to the Workforce Race Equality Scheme (WRES) which requires all NHS organisations to demonstrate how they are addressing race equality issues in a range of staffing areas. We published our annual WRES reports on our website.

Through these means, we aim to embed due regard to our public sector equality duties in all our corporate systems and processes.

## 8. Assessing our progress

We have committed to continue to use the national Equality Delivery System to assess our performance against our public sector equality duties. 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

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

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|---|---|
| **UNDEVELOPED** | Undeveloped if there is no evidence one way or another for any protected group of how people fare, or evidence is not available.<br>Undeveloped if evidence shows that the majority of people in only two or less protected groups fare well. |
| **DEVELOPING** | Developing if evidence shows that the majority of people in three to five protected groups fare well. |
| **ACHIEVING** | Achieving if evidence shows that the majority of people in six to eight protected groups fare well. |
| **EXCELLING** | Excelling if evidence shows that the majority of people in all nine protected groups fare well. |

The vision described in this strategy forms the basis of operational delivery plans overseen by the Engagement & Experience Committee, with progress reported to the Governing Body through the Committee minutes.

We aim to keep the public informed of equality & diversity progress via:

- Equality information published by 31st January each year in line with the public sector equality duty.
- The minutes of the Engagement & Experience Committee published through the CCG Governing Body papers.
- CCG website pages.
- Routine engagement activity.

## 9. Equality Objectives

In accordance with the specific public sector equality duty, we are required to publish one or more equality objectives covering a four year period.

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. The wording has been slightly clarified and they read:

- ***Objective 1:*** Utilise information and feedback gleaned from our patients, public and third sector partners to inform and influence the commissioning of healthcare services which are appropriate and responsive to our local population and their needs, ensuring better health outcomes for the Doncaster population by ongoing monitoring and assessment.

- ***Objective 2:*** Ensure appropriate and accessible targeted communication with local communities to raise awareness and understanding of healthcare options.

- ***Objective 3:*** Improved patient access and experience ensuring patient and public engagement at the start of each commissioning cycle as determined by the equality impact analysis, and embedding equality and diversity considerations into the decisions and culture of the CCG.

## 10. Review

This Strategy will be reviewed as a minimum every 3 years.

NHS
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Clinical Commissioning Group

**Equality Analysis Form**

| | | | |
|---|---|---|---|
| **Subject of equality analysis** | Equality and Diversity Strategy | | |
| **Type** | | | **Tick** |
| | **Policy** | | |
| | **Strategy** | | √ |
| | **Business case** | | |
| | **Commissioning service redesign** | | |
| | **Contract / Procurement** | | |
| | **Event / consultation** | | |
| **Owner** | **Name:** | Helen Harris | |
| | **Job Title:** | Head of Corporate Governance | |
| **Date** | 18 November 2019 | | |
| **Assessment Summary** | The aim of this strategy is to promote equality of opportunity, eliminate discrimination and foster good relationships in accordance with the duties of the Equality Act 2010. It sets outs the roles and responsibility of all staff, as well as the protections provided to all staff and the population we commission health services for. This policy sets out the CCG's commitment to delivering our equality objectives and complying with our legal duties. It also clearly sets out the roles and responsibilities of staff with the aim of achieving our equality objectives | | |
| **Stakeholders** | | | **Tick** |
| | **Staff** | | √ |
| | **General public** | | √ |
| | **Service users** | | √ |
| | **Partners** | | √ |
| | **Providers** | | √ |
| | **Other** | | |
| **Data collection and consultation** | Please note that due to the small number of staff employed by the CCG, data with returns small enough to identity individuals cannot be published. However, the data should still be analysed as part of the EIA process, and where it is possible to identify trends or issues, these should be recorded in the EIA.<br><br>Staff and community engagement conducted through Equality Delivery System Engagement. | | |

| Protected characteristic | Positive | Neutral | Negative | Negative: What are the risks?<br>Positive: What are the benefits / opportunities? |
|---|---|---|---|---|
| **Age** | X | | | This policy applies to all regardless of age |
| **Disability** | X | | | This Strategy is not currently available in other formats. The assumption is that all staff will have the correct physical equipment on their desktops to ensure that they will be able to view this document. The CCG website does provide the facility to view documents in larger fonts. |
| **Gender** | x | | | Applies to all regardless of gender |
| **Race** | X | | | Applies to all staff regardless of race/ethnicity. |
| **Religion & Belief** | x | | | Applies to all regardless of religion or belief |
| **Sexual Orientation** | x | | | Applies to all, regardless of sexual orientation |
| **Gender reassignment** | x | | | Applies to all regardless of transgender/gender reassignment |
| **Pregnancy & Maternity** | x | | | Applies to all regardless of pregnancy or maternity |
| **Marriage & Civil Partnership** | x | | | Applies to all regardless of marriage or civil partnership |
| **Social Inclusion / Community** | x | | | Applies to all. |

| Protected characteristic | Positive | Neutral | Negative | Negative: What are the risks?<br>Positive: What are the benefits / opportunities? |
|---|---|---|---|---|
| **Cohesion** | | | | |

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|---|---|
| **Conclusion & Recommendations including any resulting action plan** | None |
| **Review date** | March 2021 |