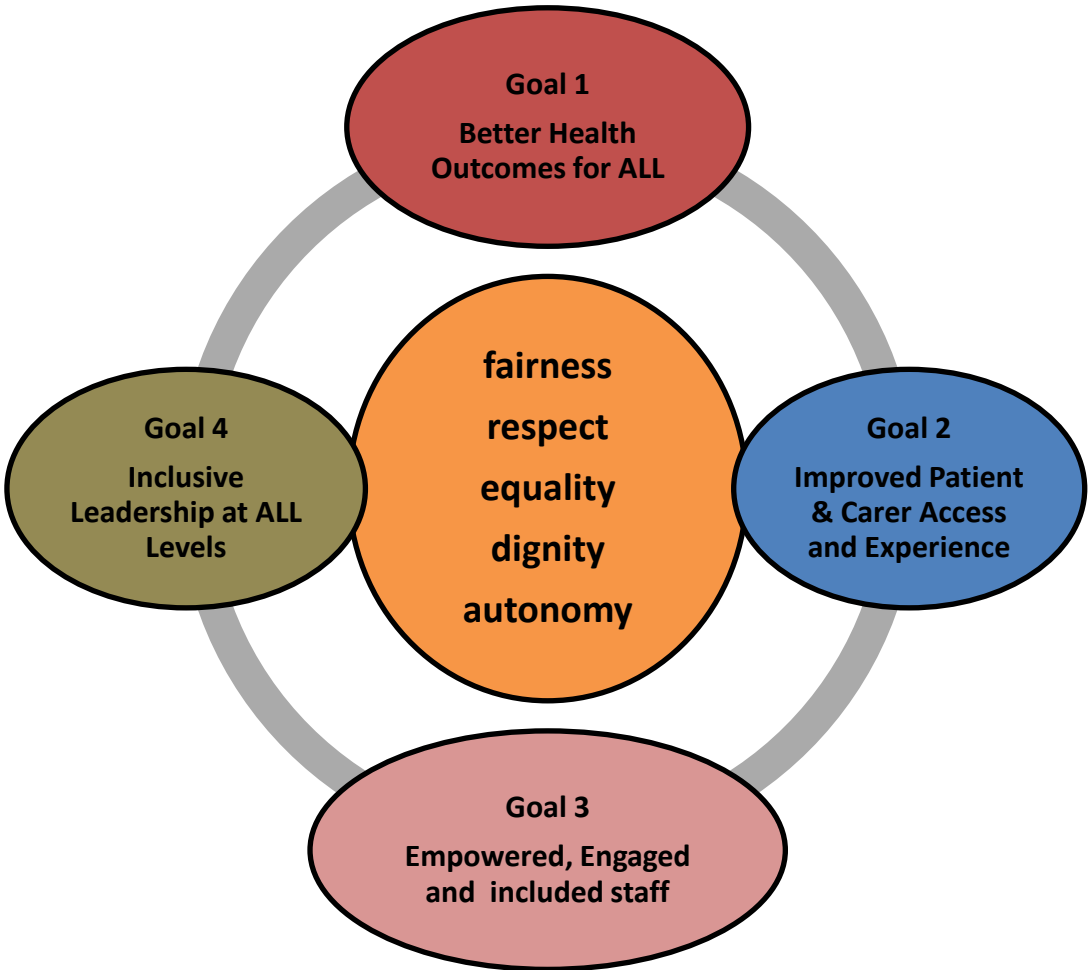
NHS
Wolverhampton
Clinical Commissioning Group

# Equality & Inclusion Annual Report

2014 - 2015

## Wolverhampton Clinical Commissioning Group



## Foreword

Wolverhampton Clinical Commissioning Group (CCG) believes that equality and diversity includes addressing health inequalities and should be embedded into all commissioning activity.

Equality and Diversity are central to our commissioning plans, where everyone has the opportunity to fulfil their potential. Equality is about creating a fairer society and Diversity is about recognising and valuing difference in its broadest sense.

**Wolverhampton Clinical Commissioning Group (WCCG) is fully committed to promoting equality of opportunity, eliminating unlawful and unfair discrimination and valuing diversity.**

Forty nine GP practices in the city are members of the CCG and this provides us with the opportunity to work with our patients to improve services and the overall health of the city. Our GP practice membership will ensure the needs and priorities of our population are clearly identified and addressed by delivering the right care in the right place, at the right time

This annual report sets out how the Clinical Commissioning Group has performed in meeting its legal duties set out in the Equality Act 2010 and the Human Rights Act 1998.

**Dr Dan De Rosa**
CCG Chair

**Dr Helen Hibbs**
Accountable Officer

**Manjeet Garcha**
Chief Nurse

# 1.0 Introduction

This is the Clinical Commissioning Groups (CCG) annual Equality & Inclusion Report which sets out how the CCG has been demonstrating 'due regard' to the public sector equality duty's three aims and will provide evidence for meeting the specific equality duty, which requires all public sector organisations to publish their equality information annually.

**We will commission accessible, high quality health services on the basis of clinical need, tailored appropriately to the different healthcare needs of the various groups in the community we serve;**

## 1.1 What is 'due regard'?

Due regard means that the Clinical Commissioning Group has given advanced consideration to issues of equality and discrimination before making any policy decision that may be affected by them. That is a valuable requirement that is seen as an integral and important part of the mechanisms for ensuring the fulfilment of the aims of anti-discrimination legislation set out in the Equality Act 2010.

## 1.2 A Local Context

Wolverhampton Clinical Commissioning Group is wholly committed to improving the health and wellbeing of its population. The City of Wolverhampton faces significant challenges including difficult indicators for socio-economic status and for deprivation; the significant incidence of long term illness; low overall life expectancy and the differential impact of these factors in different parts of the city. The CCG also faces considerable financial challenges, but we will seek to ensure that every pound spent on healthcare is spent wisely and works efficiently and effectively for the people of Wolverhampton.

Wolverhampton's resident population is approximately 249,500. It is one of the most densely populated places in the country, with nearly 9,000 residents per square mile. The city's population is predicted to grow by 2035 (to 273,000) and its composition will change significantly. By 2020 there will be a growth of between 5% and 10% for 0-39 and 60-79 year olds while the 80 and over population will have increased by nearly 20%. Further into

the future, by 2035, the 80 and over population is forecast to have increased by more than 60%, with lesser increases for 0-39 and 60-79 year olds.

Over one third of the population (35.5%) is of black and minority ethnic (BME) origin. The city's Sikh community makes up around 10.5% of the total population, while Black Caribbean communities account for around 5%. The mixed heritage population in the city is relatively small and very young; mixed race children now account for 8% of all children under the age of 15.

There are approximately 800 asylum seekers in the city. It is estimated that at any one time up to 3,000 failed asylum seekers may be in Wolverhampton but it is hard to gauge the exact numbers as they will often not be in contact with statutory services. Wolverhampton has also seen a rise in migrant workers since the expansion of the European Union. Again it is difficult to give a precise view of their impact in the city as many just stay for short periods and are also difficult to track once they arrive in the UK.

Health and well-being and the use of health services are inextricably linked to socio-economic factors and this is seen starkly in Wolverhampton. The health of the people of Wolverhampton is generally worse than the England average. The city is ranked twenty-eighth most deprived out of 354 local authorities. But deprivation is not concentrated in a few areas – almost half of the city's neighbourhoods are amongst the 20% most deprived in the country. The pattern of disadvantage is closely linked to a past history of heavy industry in the centre and east with relative advantage in the west and city edges. This pattern of deprivation has remained persistent over time.

The city also has significant indicators of social deprivation and poor health:

- Life expectancy in Wolverhampton is in the bottom 20% nationally;
- 32% of the population report a limiting long term illness;
- The 4$^{th}$ highest rate of teenage pregnancy in England;
- Rates of obesity amongst middle aged people are above regional averages;
- Early death rates from heart disease, from stroke and from cancer have decreased, but are still above the England average.

- Men from the least deprived areas can expect to live 7.4 years longer than those in the more deprived areas, whilst in women this difference is 5 years.
- The percentage of obese children and the estimated percentage of obese adults are high and the estimated proportions who eat healthily (fruit and vegetables) and are physically active are low.
- Eligibility for free school meals varies by ethnic groups with lower proportions in White and Asian children.

The CCG's Equality and Diversity Policy recognises that our aim is not to treat everyone as though they were the same, but to value the difference between individuals and deal with everyone fairly in that context. That makes it essential that we recognise differences such as:

- Infant mortality is higher for children with mothers born in Pakistan and the Caribbean;
- the prevalence of stroke is much higher among African-Caribbean and South Asian men;
- young Asian women are twice as likely to commit suicide as young white women;
- the incidence of diabetes is 5 times higher among South Asians and 3 times higher among those of Caribbean backgrounds than in the general population;
- people with learning disabilities or long-term mental health problems are 58% more likely to die before the age of 50.

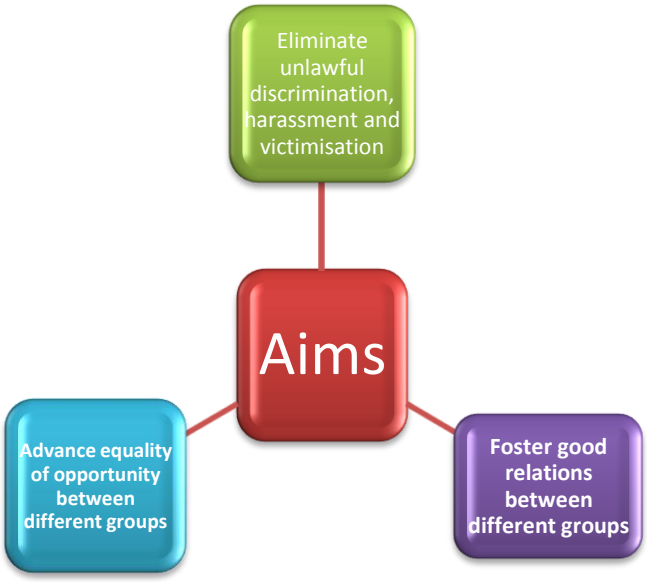
## 1.3 Workforce Profile

Wolverhampton CCG is a small yet dynamic organisation with 68.11 staff working of which 16.11 are part-time. We have robust policies and procedures in place which ensure that all of our staff are treated fairly and with dignity and respect. We are committed to promoting equality of opportunity for all our current and potential employees. We are aware of our legal equality duties as a public sector employer and service commissioner and have equality and diversity training in place for all staff.

Wolverhampton CCG opposes all forms of unlawful and unfair discrimination and will ensure that barriers to accessing services and employment are identified and removed, and that no person is treated less favourably on the grounds of their race, ethnic origin, sex, disability, religion or belief, age, sexual orientation, transgender status, marital or civil partnership status, HIV status, pregnancy or maternity, domestic circumstances, caring responsibilities or any other relevant factor.

## 2.0 Compliance with the Public Sector Equality Duty

The CCG continues to work to show due regard to the aims of the Public Sector General Equality duty as set out in the Equality Act as set out below:




Through the adoption of the NHS Equality Delivery System the CCG aims to demonstrate to the people we serve how we are meeting the three aims of the Equality Duty.

Our vision is for the Right care in the Right place at the Right time for all of our population. Our patients will experience seamless care, integrated around their needs, and they will live longer with an improved quality of life.

### 2.1 Protected characteristics

The general equality duty covers the following protected characteristics: age (including children and young people), disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. People who are considering, undergoing or

have undergone gender reassignment.

Public authorities also need to have due regard to the need to eliminate unlawful discrimination against someone because of their marriage or civil partnership status. This means that the first aim of the general equality duty applies to this characteristic but the other two aims do not. This applies only in relation to work, not to any other part of the Equality Act 2010.

## 2.1 Equality Analysis

CCG commissioners have carried out a range of equality analysis and human rights screening when carrying out their duties to ensure the CCG is paying 'due regard' to the three aims of the Public Sector Equality Duty and the Human rights Act. The following are examples of the assessments undertaken in 2014 to date:

1. **Dementia services**
2. **Urgent and Emergency care**
3. **Dermatology**
4. **Ophthalmology (Eye Care)**
5. **Infertility Policy**

## 2.2 Engagement with local people

Inclusive, accessible and meaningful participation is a core value of the CCG. Our Lay Member for PPI also oversees equality and diversity as part of her portfolio and as such, ensures a methodical approach is taken to enabling maximum participation in the CCG's decision-making.

During 2014 we developed a diverse range of participation opportunities ranging from full and formal public consultations to small and focussed collaboration and co-production initiatives.

Underpinning our work is our Participation Framework. This creates a systematic approach to hearing from and speaking to people who represent diverse health needs and

communities. We believe it sets the standard for on-going and meaningful involvement, creating a recognised process for staff, patients and community representatives, and health and social care partners to join forces and work together on commissioning and health improvement.

A full description of this can be found in our Communications and Participation Strategy, which was refreshed in summer 2014. In summary, the framework includes:

- A series of meetings organised to link with the CCG's planning cycle so that a range of commissioning and transformation work can be supported with the views and insights of patients and the public;
- Representatives who sit on two of the CCG's important decision-making committees: Commissioning and Quality & Safety.
- An oversight group (Joint Engagement Assurance Group) that brings senior leads from health, community and social care partners to review our collective participation processes and identify opportunity for joint approaches.
- Patient Partners scheme – a membership of patients from across the city whom we invite to take part in small and large scale participation activities and keep updated through regular communications.

**Examples of our participation**

In addition to our systematic approach above, a diverse range of participation has taken place during 2014.

**Urgent Care Consultation**

A consultation on proposals to redesign the city's urgent and emergency care ran from December 13 to March 14. We received 204 responses to the survey we published. In addition, the city's Equality & Diversity Group were surveyed separately as part of the Equality Impact Assessment. Twenty five organisations responded via Wolverhampton Equality & Diversity Forum. All of the findings were assessed – including the demographic make-up of all respondents – and have informed the delivery of our urgent and emergency care strategy.

The full consultation report, Equality Impact Assessment and final strategy can be found here.

**The Engagement Cycle – Patient Training**

In January 2014 we ran a full-day workshop for both senior commissioning managers and patient representatives on NHS Institute/InHealh Associates' Engagement Cycle. This is the adopted approach for enabling maximum participation in the commissioning cycle at the CCG.

The day, led by David Gilbert, the author of the cycle, enabled delegates to explore the full opportunities available and use some tools to help. The outcome has been the development of a cohort of patients who can be called upon to work closely with the CCG on a range of commissioning and transformation programmes. For staff, the session helped to create a new culture of involving patients in their work.

**Planned Care consultation**

In July to October 2014 we ran a large public consultation on proposals to move some planned care from New Cross Hospital to Cannock Chase Hospital for Wolverhampton patients. Over the period we heard from hundreds of people, having 664 survey responses that helped us to assess the impact of the proposed changes on local people. An Equality Impact Assessment was undertaken, again with the city's Equality and Diversity Forum.

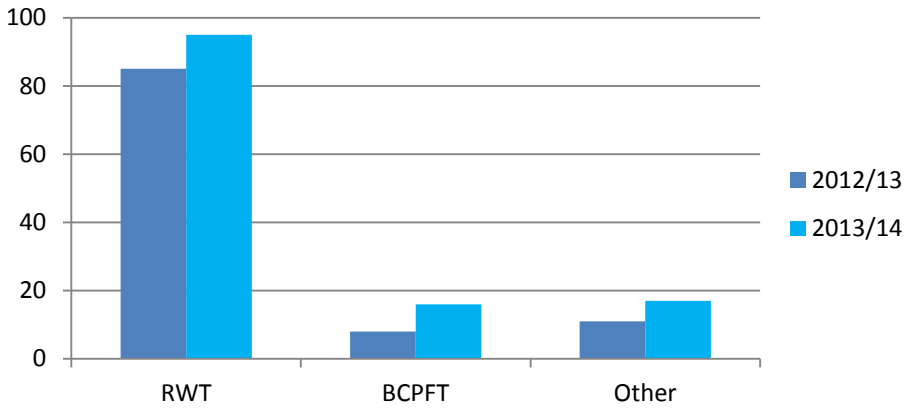
Read more about the consultation.

## 2.3 Patient Experience – Quality matters

**QUALITY MATTERS REVIEW 2012-2014**

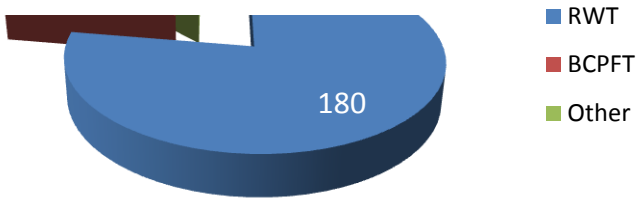
Since the introduction of quality matters in summer 2011 that was initially put in place as an action tracker has developed into a widely used system receiving in excess of 100 queries/concerns each year. The system is used by a range of stakeholders working in conjunction with the CCG.

**Part 1**




**Overall Total Usage – Organisation Type**

Since introduction in summer 2011 there have been 331 issues recorded in Quality Matters. From 331, 93 were closed prior to April 2012. This review focuses on two whole contract years therefore the reporting period is April 2012 to March 2014 and is broken down as follows:-




**RWT** - 180
**BCP**- 24
**Other** - 28

The category shown as 'other' is made up of a series of miscellaneous other categories consisting of the following:-

- General Practitioner
- Primecare (Out of Hours Provider)
- Commissioner (CCG)

Royal Wolverhampton Trust (RWT) has seen the highest number of Quality Matters reported year on year; Black Country Partnerships (BCPFT) has increased with awareness of the Quality Matters process in 2013/14 as has reporting against other providers of care and GP's.

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**Breakdown of Categories**

**Royal Wolverhampton Trust (RWT)**

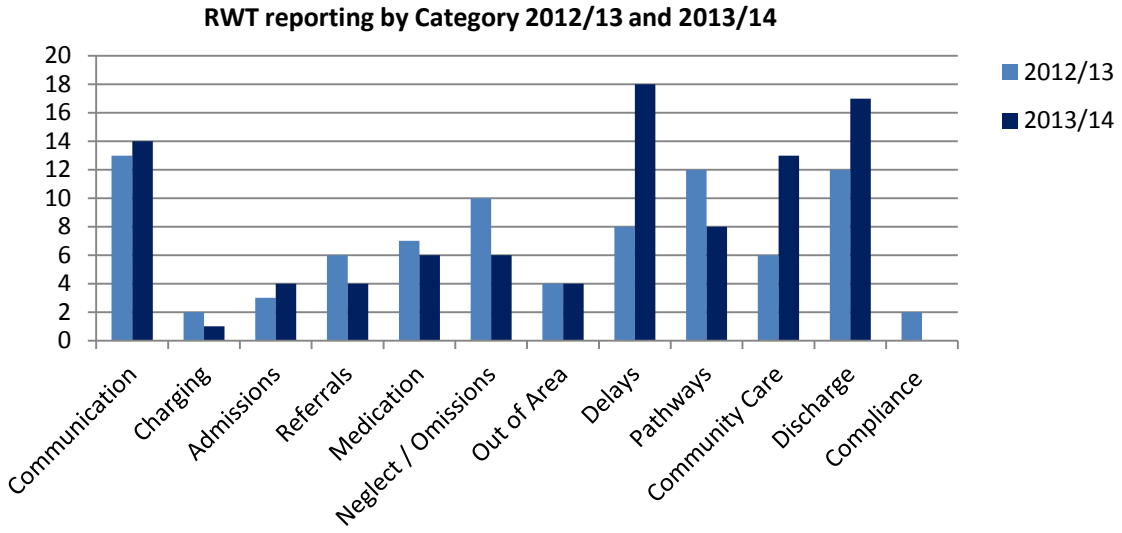
Royal Wolverhampton Trust have experienced the majority of issues/concerns being raised against them in both 2012/13 (85 issues/concerns) and in 2013/14 (95 issues/concerns).

When compared year on year, Delays has seen a significant increase, Delays had not appeared within the 2012/13 top categories shortlist, however following a number of reported issues/concerns in late 2013 and the early quarter of 2014, Delays has become the number 1 reported category. The issues/concerns vary, however the main proportion are due to delays in attending appointments, or delays in receiving letters to appointments / patients lost in the Trusts systems.

Discharge has seen a slight increase from 12 in 2012/13 to 17 in 2013/14, the issues/concerns in 2012/13 mainly regarded handwritten discharge notes. The 2013/14 discharge errors mainly pertain to medications being incorrect, or missed off discharge notes when entered electronically.

Pathways and acts of omission have both decreased within 2013/14, after having higher reporting within 2012/13.

Charging and Compliance remain the two lowest categories of reporting when compared to the previous financial year.



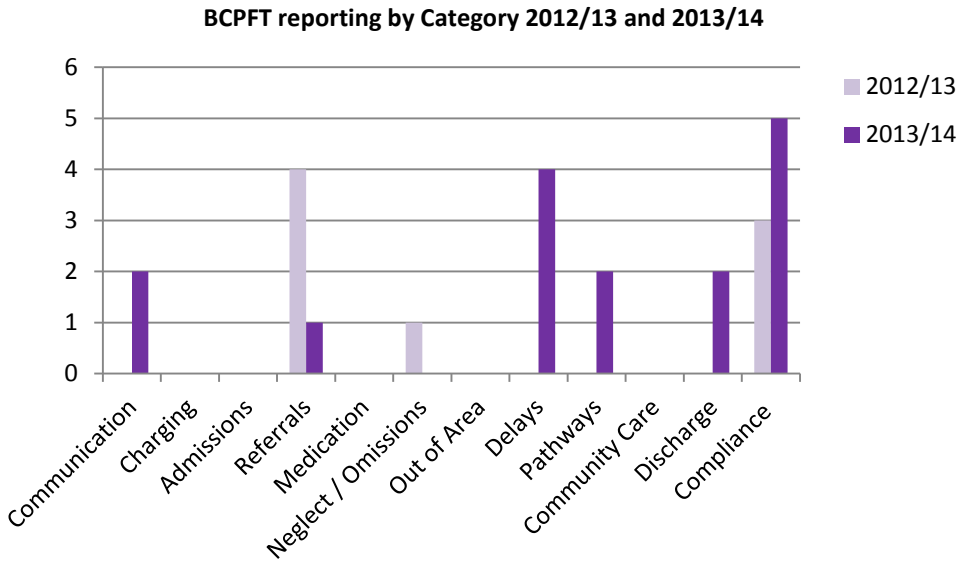

**Black Country Partnership NHS Foundation Trust (BCPFT)**

BCPFT have experienced the lowest number of issues/concerns raised against the Trust in 2013/14 (16) although when compared to 2012/13 (8) the Trust has seen an increase and issues/concerns have doubled.

BCPFT's main are of concern in 2013/14 and their highest reporting category was compliance (5) which has seen a slight increase from 2012/13 (3).

Delays has also seen a large increase, within 2012/13 there were 0 reported, in 2013/14 this has become the second highest reporting category for BCPFT with 4.

Referrals has decreased from 4 in 2012/13 to 1 in 2013/14, and areas such as Charging, Admissions, Medication, Community Care and Out of Area have seen 0 reported in both financial years.




**Other Quality Matters – GP/Commissioner/Other Trusts/Providers.**

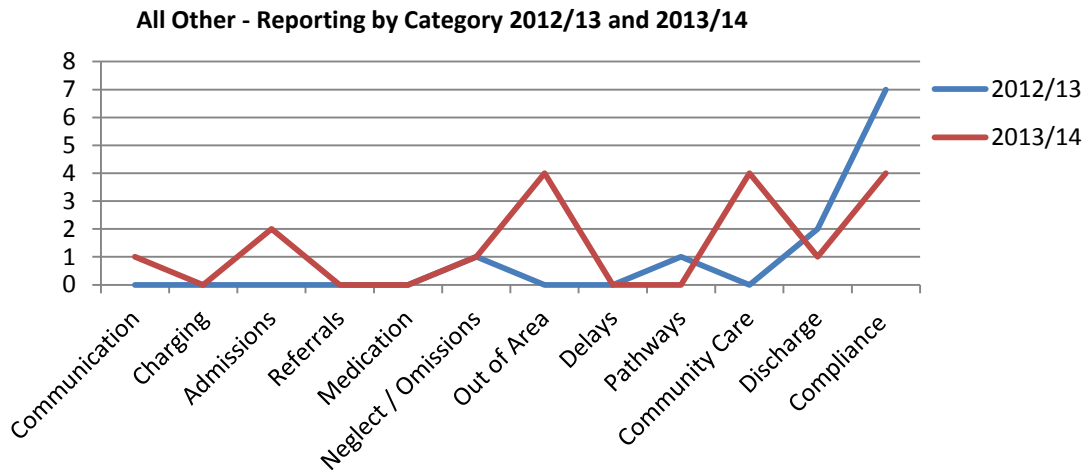
Quality Matters for the other Trusts include General Practitioners, Primecare (Out of Hours Provider), Commissioner (CCG), other associate commissioners and Other NHS Trusts Reporting has increased year on year with awareness and communication with other Trusts and CCG's from 11 in 2012/13, to 17 in 2013/14 and continues to improve.

Within 2012/13, Compliance was the highest reported category (7) which has dropped slightly in 2013/14 (4), however also with 4 in 2013/14 are Out of Area issues, and Community Care.

Charging, Referrals, Medication and Delays have not had any issues/concerns in either 2012/13 or 2013/14.

The table below gives a breakdown of figures for both reporting years.

Comparison of Other Quality Matters-

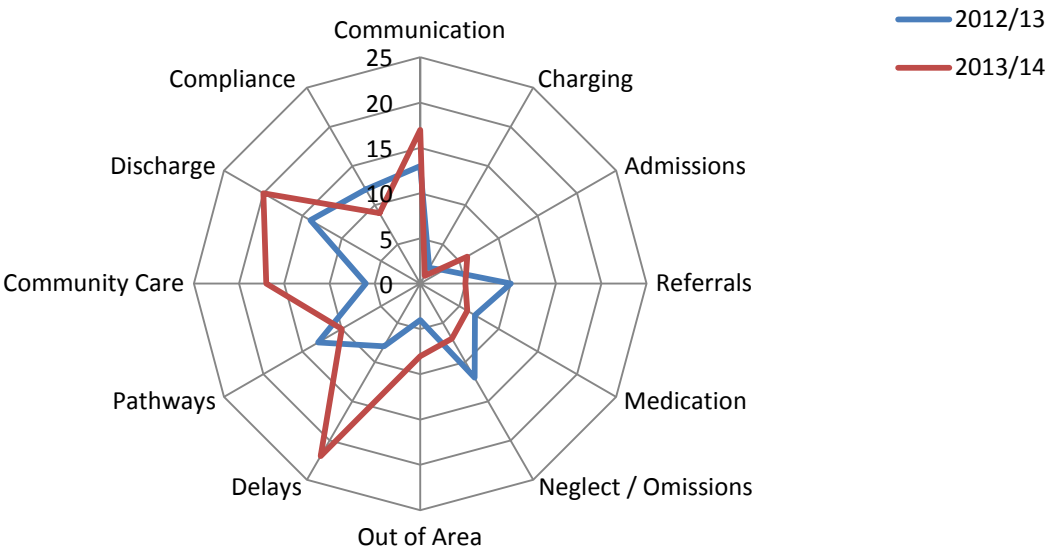



**Categories – All**

When combined, an overall comparison of all Quality Matters in 2012/13 and 2013/14 has seen two categories that stand out against others.Discharge was the highest reporting category in 2012/13 (14) and also received high numbers in 2013/14 (20) reducing slightly to the second highest category in 2013/14.

Delays has seen the largest increase, in 2012/13 when combined delays only received 8 Quality Matters, however in 2013/14 it was the highest reporting category with 22.

Areas including Pathways, Compliance, Charging, Referrals, Medication and Ommissions have all reduced in 2013/14.




Despite some lowered areas when compared year on year, it is clear that Communication has increased alongside Community Care, Out of Area, Admissions and the two highest categories of Discharge and Delays.

**Response Timescales**

In July 2012, The Quality team introduced resolution timescales and discussed these with the Provider Trusts. These were broken down into three manageable timescales, Priority 1 - 28 (working days) Priority 2 -45days, and Priority 3 - 60 days.

In line with the strength and growth of the system, these priorities were amended in September 2013 to create an even better and more effective system. The changes were made base on the Quality Teams performance review and identified that the initial timescales defined in the process were being achieved in good time. The decision to shorten the priorities then took effect.

The new Priorities currently in place are Priority 1 – 18 (working) days, Priority 2, 30 days, and Priority 3, 45 days. Numbers of those allocated timescales since July 2012 (142) are,

| Response Timescales | Total Number Assigned |
|---|---|
| Priority 1 | 100 |
| Priority 2 | 31 |
| Priority 3 | 11 |

The table below gives a breakdown of performance for each provider and priority level.

| | 2012/13 | 2013/14 | |
|---|---|---|---|
| RWT | **3** | 2 | |
| BCPFT | 0 | 2 | *Priority 3* |
| Other | 1 | **3** | |
| | | | |
| RWT | **11** | **14** | |
| BCPFT | 1 | 2 | *Priority 2* |
| Other | 0 | 3 | |
| | | | |
| RWT | **26** | **60** | |
| BCPFT | 0 | 6 | *Priority 1* |
| Other | 0 | 8 | |
| | | | |
| *Total* | 42 | 100 | |

As shown within the above table, the majority of issues/concerns have been resolved in the quickest possible timeframe and a resolution has been agreed with the referring GP, Trust or other source.

There has been an increase in all priorities in 2013/14 with the introduction of the new priority levels when compared to 2012/13.
RWT have had the highest number of Priority 1 and 2 Quality Matters, RWT had the highest number of Priority 3 Matters in 2012/13, and Category ‘Other’ had the highest in 2013/14.

**Reporters of issues/concerns.**

When reviewing the total numbers reported, the original source of each Matter has also been concluded. GP reporting has remained at a fairly equal level in 2013/14 when compared to 2012/13, however the variety of new GP's using the system has increased across a range of different practices by a third.

Within 2013/14, Quality Matters has been well used by other neighbouring CCG's and CSU's which reflects the difference in yearly totals (24) when compared year on year.

**Part 2**

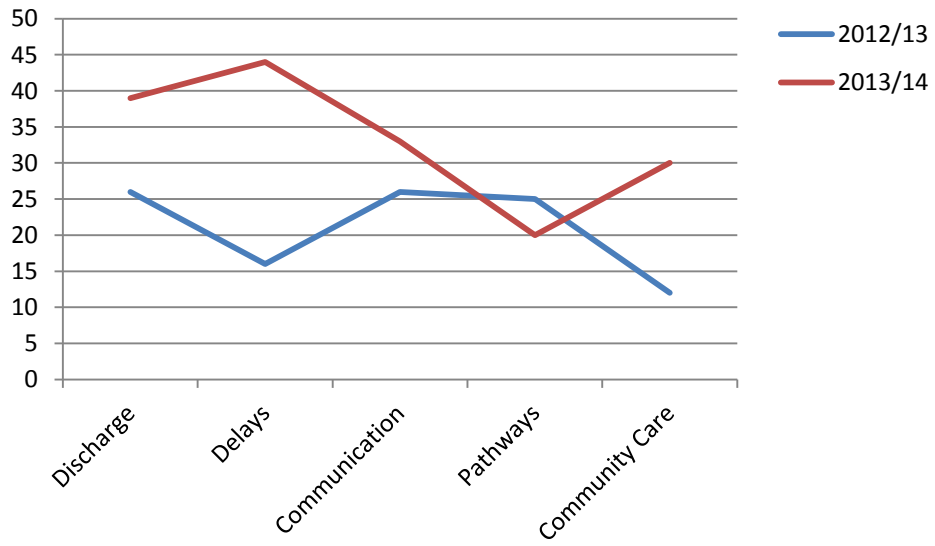
**Trend Analysis**

When comparing all issues/concerns against all providers, the 5 most prevalent types of issues/concerns have been clearly defined.

Across both 2012/13 and 2013/14 a total of 65 issues/concerns relate to discharge. Delays issues/concerns follow with a total of 60, followed by Communication (59). There is then a slight gap to the next nearest categories of Pathways (45) and Community Care (42).

The overall total of the top 5 categories from the possible 12 available, details that overall 271 issues/concerns of the 232 complete total, fall within the top 5 categories.

The table below demonstrates the differences when compared by category year on year.



**Emerging Themes**

Emerging themes have become apparent at certain points since Quality Matters commenced and intervention has occurred within Clinical Quality Review (CQR) Meetings for each Provider Trust. The CQR Meetings are held on a monthly basis and Quality Matters is a standing item on agendas for both BCPFT and RWT. A breakdown summary is produced which gives a monthly, and yearly overview to enable discussions to be held, and where necessary enforce actions against apparent monthly or quarterly trends. This approach has been successful and has enabled in some categories trends to become less apparent when reviewed quarter on quarter.

Where necessary the CCG has led on joint discussions with providers when Quality Matters have combined with other intelligence to ensure that services provided continue to operate successfully. Breakdowns in certain categories are provided to CCG directors to enable local issues/concerns to be factored into higher level concerns.

**Part 3**
**Learning from Quality Matters.**

As part of the closure of an individual Quality Matter, Actions Taken, Lessons Learned and Root Causes are identified for every record. This has enabled the Quality Team to identify success and to re-raise any issues/concerned with Trusts when a previous matter has been closed with a set of actions previously confirmed for that reporting category.

The Quality Team has produced an internal log which details these actions and this has again assisted CCG colleagues such as Contracting, to change service specifications and introduce new performance measures.

For each provider, certain matters have also assisted in changes to process or pathways. BCPFT encountered issues/concerns from GP's within 2013/14 whereby there was a lack of clarity in the services available to a child becoming and adult and an adult with Attention Deficit Disorder (ADD). Following discussions at the CQR for BCPFT, the CCG to meet with

the Joint Commissioner for MH Service to discuss the concerns and clarify the correct pathway for treatment.

As discussions were being held, more GP's raised this very same point and following a number of meetings with both providers and GP's, a series of new actions were created. These included a review of waiting times for adults requiring a diagnosis through the Pathway /Neuropsychiatry Service at the Barberry (Commissioned Provider), and a review of service within BCPFT for adults awaiting a diagnosis of ADD or with a current diagnosis of ADD requiring support and intervention of secondary services. This service would continue to be provided by BCPFT.

The Joint Commissioners established a task and finish group to assist with delivering a new care pathway document which included the identification of gaps and training needs /next steps. The CCG medicines optimisation team were also included to ensure that the prescribing implications / requirements were included.

This is one of a number of examples where the Quality Matters process helped to assist the Trust, the GP's, the CCG and mainly the Patient.

Within the other Provider Trust, RWT, a number of separate GP's were raising high levels of issues/concerns pertaining to District Nursing (DN) and Community Care. The concerns varied slightly but the main focus was on the lack of DN's available to see patients at home with the GP's on a significant amount of the matters, having to visit patients' homes of an evening and weekends where DN provision could not be arranged. Other areas of concerns were with the Walk in centres (WIC) that did not have the capacity to provide dressings to community patients that DN's would not see at home due to policy criteria. This again led to impacts on practice nurses as patients unable to book in for weekend dressings were pointed towards their own GP surgeries or the designated hospital ward at RWT.

Once again following discussions within 2013/14 at the RWT CQR, concerns/issues did not appear to reduce thus leading to more Quality Matters being raised by a number of different GP's. Discussions were then held internally via the CCG Director of Commissioning and meetings were held with the Trust. RWT had previously identified capacity issues in

discussions with the CCG, and therefore high level discussions were held and as part of a wider piece of on-going work, the CCG are now working with RWT to look at the provision of allocated staff and budgets. Since discussions have commenced, significant reporting reductions have been noticed.

Within the top 3 categories, actions identified have been introduced in separate wards and areas rather than Trust wide, however again reporting has dropped in categories towards the end of the 2013/14 financial year.

RWT who have had the highest proportion of the number one overall category (discharge) issues, have previously implemented action plans to reduce errors in discharge. Within 2012/13, the main issue/concern regarded handwritten discharge notes. Quality Matters received high levels of reporting for this issue/concern and actions were introduced Trust wide to ensure that all discharge notes were electronic. This was a positive action and reporting of this type in 2013/14 is very rare.

The issue of Discharge has continued in 2013/14 within this category, however for another reason, thus being incorrect medication noted, errors in dates and missing information in certain areas. Through trend reporting at the CQR, discussions have been held and actions have been identified as part of closures of Quality Matters. These include staff meetings, ward briefings with all staff completing discharge and Trust wide intelligence via newsletters and internal emails at RWT. Due to the large volumes of patients being seen at RWT, the CCG is unlikely to significantly reduce reporting in this category, however is taking as much action as possible to try to reduce and prevent re-occurrence.

**Part 4. Conclusions.**

The exercise has demonstrate how utilisation of Quality Matters has increased since inception in 2012, this was further noticed when the CCG became a legal entity and, coupled with the on-going publicity the process goes from strength to strength.

Success of Quality Matters is in response to continued support from GP colleagues who routinely report clinical quality issues/concerns and also support from colleagues within provider organisations who are committed to working collaboratively with the CCG to improve the quality of care our patients receive.

Once considered by the Quality & Safety Committee this report will be regenerated for specific providers to consider their journey. This will demonstrate at provider level the most prevalent issues/concerns and actions taken to combat problems as well as further work required to improve the quality of care our patients receive.

**Formal Complaints 2014**

| Month | Number | Type | Status |
|---|---|---|---|
| January | 1 + 2 | CHC Process | 2 = carried forward from 2013 (complex complaints closed summer 2014) |
| February | 0 | | |
| March | 0 | | |
| April | 1 | Care Home Inspection | Closed July 14 |
| May | 2 | Out of Hours & Walk In Centre<br>Chiropody | Closed June 14<br>Closed June 14 |
| June | 0 | | |
| July | 0 | | |
| August | 0 | | |
| September | 2 | Learning Disabilities<br>Nursing Home Criteria Change | Closed November 2014<br>Closed November 2014 |
| October | 2 | Raised via MPs<br>Nursing Home Criteria Change<br>Employee Attitude | <br>Closed November 2014<br>Closed November 2014 |
| November | 2 | Procedure of Limited Clinical Value | Closed December 2014<br>Closed December 2014 |
| December | 1 | CHC Process | Ongoing |
| TOTAL | 13 | Lessons Learnt reported to Quality & Safety Committee at time of complaint closure. | 1 carried forward to 2015 |

**Datix Summary – see attached adobe file**

This includes, concerns, compliments, complaints raised that were for other providers etc

**Quality Matters 2014**

| Month | Number |
|---|---|
| January | 10 |
| February | 9 |
| March | 14 |
| April | 14 |
| May | 19 |
| June | 23 |
| July | 13 |
| August | 9 |
| September | 23 |
| October | 15 |
| November | 24 |
| December | 18 |
| TOTAL | 191 |

There were 191 queries raised via GPs regarding care provided by commissioned providers of secondary care. Responses to many of the above incidents were within 18 days and routinely reviewed at the respective Clinical Quality Review Meeting with the provider to ensure learning had taken place and in the event of recurring themes action taken to take a closure look at the collective problem and any further actions that may be required to tackle the problem.

## 3.0 Our Equality Objectives

Our Equality Objectives are set out below. These are supported by the actions set out in the Equality Action Plan (**Appendix 1**) which will be updated each year of the 4 year strategy to ensure continuous development and improvement. In this way, the equality objectives will not be 'static' for four years. They will evolve to stretch the ambition and achievements of the CCG.

1. **To ensure that Leadership and Governance arrangements persist in offering high level assurance of equality.**

2. **Equality approaches are effectively included in key mechanisms of commissioning (such as business case development, procurement, contracting).**

3. **Equality Analysis becomes part of our organisational processes so that projects, policies, strategies, business cases, specifications and contracts have all been developed in consideration of equality, diversity and human rights issues.**

4. **To apply Goals 1 and 2 of the Equality Delivery System to an average of at least three patient pathways for each year of the strategy, and to demonstrate year on year improvements for Goals 3 and 4 (Staff and Leadership)**

5. **To regularly review and update the strategic action plan and equality objectives (on at least an annual basis) to ensure that it is providing appropriate targets for development and improvement.**

6. **To ensure all CCG staff receive basic training to ensure awareness of Equality Act 2010 responsibilities and the NHS Constitution, and that specific training on Equality Analysis and the Equality Delivery System is targeted to all staff who are involved in these processes.**

7. **To ensure that Equality and Diversity forms an ongoing part of our leadership and organisational development programmes**

8. **To ensure that Equality and Diversity approaches are fully included in our engagement of people who use services and in our work with strategic partners and other stakeholders.**

9. **Improve accessibility of information and communication for people from statutorily 'protected groups' and other disadvantaged groups.**

## 4.0 Equality Delivery System (EDS)

Wolverhampton Clinical Commissioning Group adopted the Equality Delivery System (EDS2) as its performance toolkit to support the CCG in demonstrating its compliance with the three aims of the Public Sector General Equality Duty.

**The four EDS goals are:**

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and included staff
4. Inclusive leadership at all levels

**The grades for EDS are as follows:**

**Undeveloped – Red**
**Developing – Amber**
**Achieving – Green**
**Excelling – Purple**

The EDS grading process provides the Clinical Commissioning Group Governing Body with an assurance mechanism for compliance with the Equality Act 2010 and enables local people to co-design the Clinical Commissioning Groups equality objectives to ensure improvements in the experiences of patients, carers, employees and local people.

Wolverhampton CCG has reviewed its original approach to implementing the EDS when selected objectives were chosen to be pursued. However, on reflection, there was concern that this approach would not achieve systematic change speedily enough to have a real impact on patients and other people using services. We have therefore changed the emphasis and have adopted the following approach:

1) Goal 1 and Goal 2 of the EDS will be implemented by applying the corresponding objectives to specific patient pathways. This means that we can consider our commissioning performance in more depth, and test ourselves in partnership with patients, carers and providers. This, we feel, allows for more meaningful change. For the first year of the strategy our focus will be on Urgent Care. We will use the learning outcomes from this pathway approach to inform other pathways for the second, and subsequent years of the strategy.

2) Goal 3 and Goal 4 of the EDS will be implemented by taking a whole organisation approach and ensuring that progress is made in our Human Resources and

Organisational Development strategies, supported by the Central Midlands Commissioning Support Unit (CSU). See **Appendix 1** for update on Action plan where the EDS and Equality Objectives are aligned.

## 4.1 EDS Goal 3 Outcomes; A representative and supported workforce

| Description of Outcome | Rationale | Grading |
|---|---|---|
| 3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades | Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.<br><br>Audit on selection process has been completed on a regular basis throughout the year, with no breaches of recruitment legislation found. | **Achieving** |
| 3.2 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 | 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.<br><br>Job Evaluations are completed independently to ensure a consistent and fair approach. | **Excelling** |
| 3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately | Training and development opportunities are taken up and positively evaluated by all staff.<br><br>Not all staff have had a PDR. A training needs analysis has been completed; however, not all aspects have been delivered yet. | **Developing** |

| | | |
|---|---|---|
| 3.4 Staff are free from abuse, harassment, bullying and violence from both patients and their relatives and colleagues with redress being open and fair to all | When at work, staff are free from abuse, harassment, bullying and violence from any source. | **Developing** |
| 3.5 Flexible working options are made available to staff, consistent with the needs of the service and the way that people lead their lives. (Flexible working may be a reasonable adjustment for disabled members of staff or carers) | Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives.<br><br>Flexible Working Policies are in place with additional guidance documents available to managers to ensure applications under the policy are treated in a fair and consistent approach. Staff also have a right to appeal any decisions. | **Achieving** |
| 3.6 The workforce is supported to remain healthy with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population | A health and wellbeing agenda is being incorporated to focus on the workforce and the wider organisation. A health and well-being group meet regularly that has executive involvement commitment to drive the agenda forward. | **Achieving** |

## 5.0 Performance Monitoring of Providers

The Contract is a mechanism through which the CCG can gain assurance that Equality and Diversity and Human Rights are on top of the providers agenda when planning services for patients and the public. In order to achieve this we have agreed a set of monitoring requirements with our provider organisations which are addressed through monthly contract meetings.

## 6.0 Meeting statutory Human Rights requirements

The Human Rights Act 1998 sets out a range of rights which have implications for the way the CCG buys services and manages their workforce. In practice this means that we must:

- Act compatibly with the rights contained in the Human Rights Act in everything we do
- Recognise that anyone who is a 'victim' under the Human Rights Act can bring a claim against the CCG (in a UK court, tribunal, hearing or complaints procedure)
- Wherever possible existing laws that the CCG as a public body deals with, must be interpreted and applied in a way that fits with the rights in the Human Rights Act 1998.

**Redesign of Services**

When the CCG redesign services and commission new ones we ensure that we consider any potential barriers to accessing the proposed service. This has been enabled through the Programme Office (who coordinates the applications and approval process to develop new services) developing links with the Equality and Diversity Lead to ensure that the processes we have meet the statutory requirements and that we include the philosophy of equality and diversity into the development of all services. This has led to the development of systems and processes that now embed the Equality Impact Analysis Toolkit into the production of the Business Case as well as reconsidering the impact when writing the service specification. The QSC is the governance mechanism where service specification proposals are impact assessed and signed off. This follows through to the tendering and contractual stages. We therefore now always consider the impact on age, disability, gender, race, religion or belief, sexual orientation, gender re-assignment and human rights principles when developing services.

## 7.0 Findings

The evidence set out in this report demonstrates that the Clinical Commissioning Group continues to make good progress towards paying due regard to the way healthcare services are commissioned and delivered.

## 8.0 Summary

To be a trusted and inclusive organisation as set out in our values, we must demonstrate in both our commissioning activities and in the composition of our workforce that we are reflective of the population we serve. Our workforce must be supported and feel confident in their ability to challenge discrimination, advance equal opportunities, foster good relations and safeguard human rights – for each other, and for patients – as required by statute and by the NHS Constitution. We must also work effectively to relay this key message to our service users and stakeholders through effective and inclusive communication.

We will ensure that equality is 'everyone's business' and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions.

**Author:** **Mohammed Ramzan**
Interim Senior Equality and Inclusion Business Partner
**NHS Midlands and Lancashire Commissioning Support Unit**
**Mohammedramzan@nhs.net**

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**Appendix 1 Equality and Diversity Action Plan Update and EDS Outcomes**

| Outcome | Actions | Narrative on Progress | Progress Indicator & risk | Eq Objective (EDS align) |
|---|---|---|---|---|
| CCG staff will be competent and feel assured in completing Equality Analyses for all commissioning activity | Specific training on Equality Analysis | On-going one-to-one support to be extended by holding group drop-in sessions from January 2015. | | 3 |
| Incorporating best practice and ensuring Quality checks | Evaluation of Equality Analysis | Review with staff who have been involved in Equality Analysis to date to test effectiveness of the EA tool and guidance. | | 3 |
| EDS 2 compliance for commissioning of services for people with Learning Disabilities. | The collection and sharing of patient information for people with a learning disability (in support of the Peoples Parliament Health Select Committee work-streams) | Initial meeting with People's Parliament and with Specialist Nurse for Learning Disabilities at RWT. Data mapping exercise to be completed. | | 4 |
| EDS2 compliance | Monitoring progress/nudge actions on 21 recommendations set out in the Urgent Care equality. | Recommendations signed off by CCG, Public Health, Joint Urgent Care and Emergency Board. Health and Wellbeing Board due to sign off on 3rd September 2014 | | 4 |
| EDS2 compliance for specific pathway – language support | Review of Language support and interpretation services commissioned by the CCG | Non-disclosure agreement signed (to ensure declaration of conflict of interest and of confidentiality) | | 9 and 4 |

| | | | | |
|---|---|---|---|---|
| All staff and governing body will be aware of their responsibilities under the Equality Act 2010 and the NHS Constitution and be able to apply this in work practice | Introductory Training to Equality and Diversity.<br><br>Specific training on the Equality and Diversity Policy and EDS2 | E&D and HR group formed by CSU to ensure s.149 compliance in staffing and leadership processes and to track developing requirements of EDS2 and NHS England's Race Equality Standard. | | 6 |

**Appendix 1 Equality and Diversity Action Plan Update and EDS Outcomes**

## EDS Outcomes

| Wolverhampton CCG | |
|---|---|
| **1.1** | Services are commissioned, procured, designed and delivered to meet the health needs of local communities |
| **1.2** | Individual people's health needs are assessed and met in appropriate and effective ways |
| **1.3** | Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed |
| **1.4** | When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse |
| **1.5** | Screening, vaccination and other health promotion services reach and benefit all local communities |
| **2.1** | People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds |
| **2.2** | People are informed and supported to be as involved as they wish to be in decisions about their care |
| **2.3** | People report positive experiences of the NHS |
| **2.4** | People's complaints about services are handled respectfully and efficiently |
| **3.1** | Fair NHS recruitment and selection processes lead to a more representative workforce at all levels |
| **3.2** | 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 |
| **3.3** | Training and development opportunities are taken up and positively evaluated by all staff |
| **3.4** | When at work, staff are free from abuse, harassment, bullying and violence from any source |
| **3.5** | Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives |
| **3.6** | Staff report positive experiences of their membership of the workforce |
| **4.1** | Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations |
| **4.2** | Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are managed |
| **4.3** | Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination |