NHS
Barking and Dagenham
Clinical Commissioning Group

# Barking and Dagenham Clinical Commissioning Group equality strategy

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# Part 1: Introduction

**Foreword**

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

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

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

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

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

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

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

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

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

Further information on the Equality Act can be found at:

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

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## 1.0 The Equality Act 2010

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

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

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.

2. Advance equality of opportunity between people who share a protected characteristic* and those who do not. (*see page 6)

3. Foster good relations between people who share a protected characteristic and those who do not.

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

- Publish information, at least annually, relating to people who share a protected characteristic who are:
    - Affected by our policies
    - Employees – for organisations with 150 employees or more. (This does not affect the CCG given employee numbers)

- Publish equality objectives at least every four years; objectives should be specific and measureable.

The equality duty means clinical commissioning groups need to be able to demonstrate how we will build consideration of equality into our work; we will need to understand

how different groups are affected by our policies and practices, across the protected characteristics.

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

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

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

### 1.1 The protected characteristics

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

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

# Protected characteristics

| Protected characteristic | Description |
|---|---|
| Age | Refers to a particular age group; includes younger people; older people; working age population and children. |
| Disability | A disability is defined as a physical or mental impairment that has a substantial and long-term adverse effect on an individual's ability to carry out normal day to day activity. |
| Gender reassignment/also known as trans gender | This refers to a person transitioning from one gender to another or a person who expresses themselvesas a different gender to the one they were recognised as at birth. |
| Marriage and civil partnership | Marriage is defined as a 'union between a man and a woman'. Civil partnerships are the legally recognised relationships between same-sex couples. Civil partners and married couples should be treated in the same way. |
| Pregnancy and maternity | Pregnancy is the condition of being pregnant/expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context; in the non-employment context protection against maternity discrimination is for 26 weeks after giving birth and this includes treating a woman unfavourably because she is breastfeeding. |
| Race | Refers to a group of people defined by their race, colour and nationality (including citizenship), ethnic or national origins. |
| Religion or belief | People that follow a particular religious practice; belief included religious and philosophical beliefs, including lack of belief that generally affects the life choices or the way an individual lives their life. |
| Sex | Male or female |
| Sexual orientation | Whether an individual is attracted towards people of their own sex (gay) of the opposite sex (heterosexual) or to both sexes (bisexual) |

# Part 2: The national picture

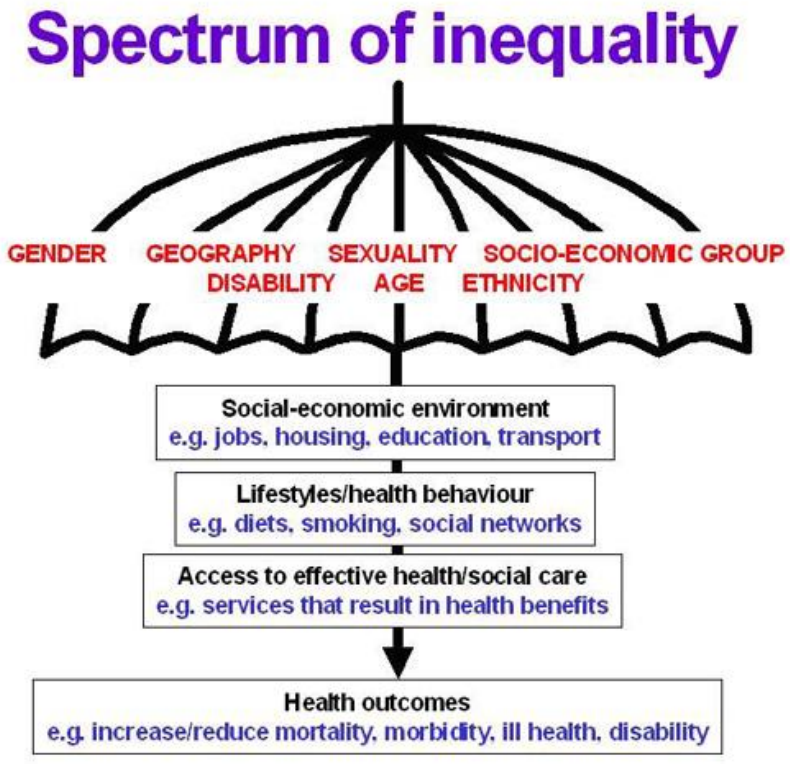
## 2.0 Health inequalities

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

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

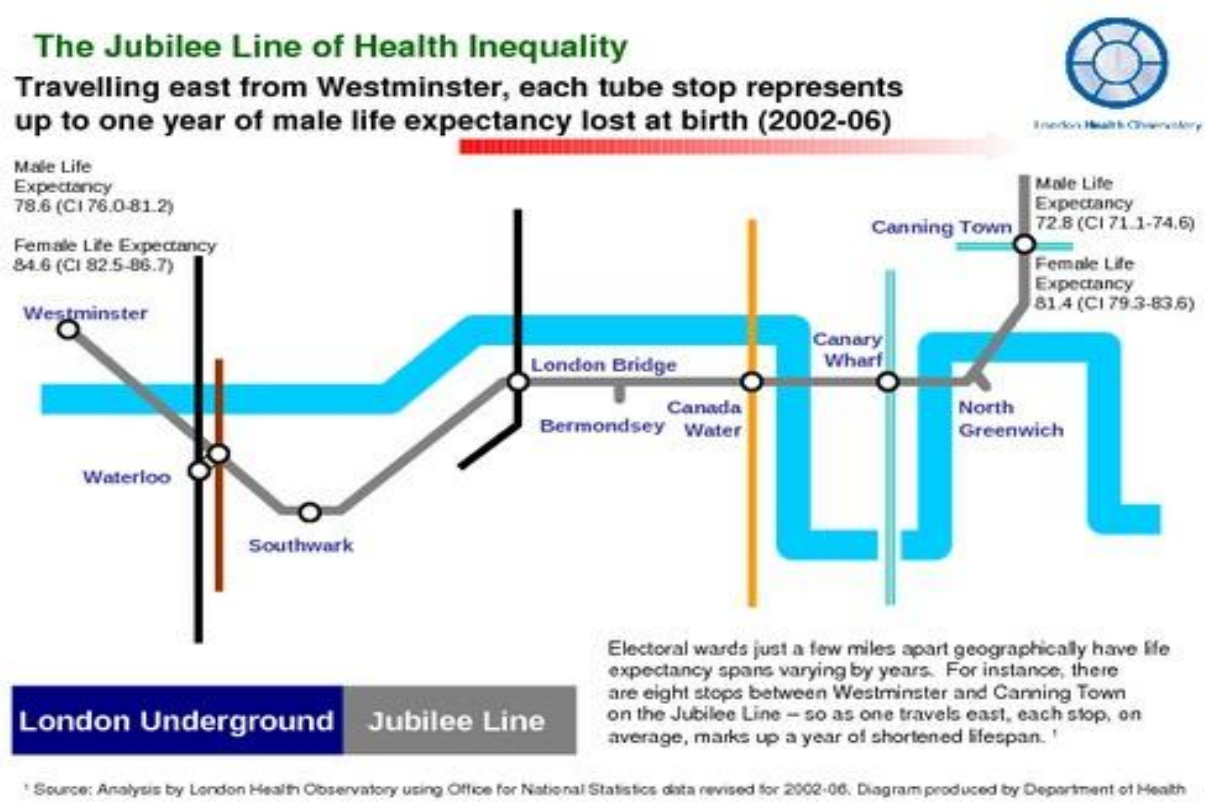
Being a member of certain groups e.g. those with a physical disability or a mental illness, Black, Asian and Minority Ethnic (BAME) groups and the homeless also play a part, due to social marginalisation, poor access to services and likelihood of income deprivation.

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




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

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



## 2.1 The Marmot Review

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

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

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

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

## 2.2 Promoting equality in health

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

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

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

## 2.3 Moving towards equality

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

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

# Part 3: Our local population

### 3.0 Diversity in Barking and Dagenham

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

### Age

| Age group | Number | Percentage % |
|---|---|---|
| 0 – 4 years | 18,700 | 10.1% |
| 5 - 19 | 39,700 | 21.4% |
| 20 -64 | 108,200 | 58.2% |
| 65 years and over | 19,400 | 10.4% |

Source: Office for National Statistics 2001

7.3% of the population is over 75 years old and 23.4% is aged 15 or under.

Barking and Dagenham has the highest number of preschool children (0 – 4 year olds) in London and, the highest proportion of 5 – 19 year olds of any local authority in England and Wales.

A significant number of local authorities in London saw their older population decrease in percentage terms during the period 2001-2011. Barking & Dagenham had the greatest decrease (-19.5 per cent).

It is expected the older population will decline until at least 2025, then increase again. The rest of England and Wales is experiencing a steady increase in the number of people aged 65 and over.

**Ethnicity**

| Ethnic group | Number | Percentage (%) |
|---|---|---|
| White British | 118,600 | 67.54% |
| White Irish | 2,300 | 1.31% |
| Other White | 8,100 | 4.61% |
| Mixed White and Black Caribbean | 1,900 | 1.08% |
| Mixed White and Black African | 1,000 | .57% |
| Mixed White and Asian | 1,500 | .85% |
| in Other Mixed | 1,300 | .74% |
| Asian or Asian British | 18,800 | 10.71% |
| Indian ethnic group | 6,700 | 3.82% |
| Pakistani | 5,700 | 3.25% |
| Bangladeshi | 3,700 | 2.11% |
| Other Asian | 2,700 | 1.54% |
| Black or Black British | 16,600 | 9.45% |
| Black Caribbean | 4,700 | 2.68% |
| Black African | 10,700 | 6.09% |
| Other Black | 1,300 | .74% |
| Chinese | 3,200 | 1.82% |

Source: Office for National Statistics 2009

## Disability

Figures estimate that in 2010, 7,534 people aged 18 to 64 years in Barking and Dagenham were living with a moderate physical disability and 2,100 adults with a serious physical disability. About 6% (530) people are known to local services through the Council register. By 2015, there will be an extra 272 people aged 18- 64 years with moderate physical disability and 60 with serious physical disability.

Currently, 689 Barking and Dagenham residents are registered as having a learning disability, 678 of whom are aged over 18. However, only 462 people are registered with a learning disability on the GP information system. 86% of adults with learning disability are within working age (18 to 64) but less than 5% of those known by social services have jobs.

A total of 6,330 people in the borough are claiming Incapacity Benefit or Severe Disablement Allowance. The most commonly reported condition is 'mental health and behavioural disorders', 39.5%, followed by diseases of the musculoskeletal system (19.4%).

Finding work is particularly difficult for disabled people. In 2009/10 39.5% of disabled people aged 16 to 64 in Barking and Dagenham were in employment, compared to 45.3% in London.

| | Number | Percentage |
|---|---|---|
| Working age people who are disabled (aged 16-64) (Oct **10-11)** | 23,900 | 20.5% |

Source: Annual population survey Department for Work and Pensions October 2010 – 2011

## Gender

According to the most recent census figures, 52% of the population is female and 48% male, which is consistent with other London boroughs.

## Religion and belief

Barking and Dagenham is home to a rich and diverse range of faith communities; a majority of the population identify with Christianity

| Religion | Percentage |
|---|---|
| Christian | 68.99 % |
| Buddhist | 0.22 % |
| Hindu | 1.14 % |
| Jewish | 0.33 % |
| Muslim | 4.36 % |
| Sikh | 1.07 % |
| Other Religions | 0.19 % |
| No Religion | 15.3 % |
| People not stating religion | 8.4 % |

Source: 2001 census data

## Sexual Orientation

National estimates of Lesbian Gay Bisexual and Transgender (LGBT) population range from 0.3% to 10% using different measures. The office of National statistics estimates 0.11% same sex couples living in Barking and Dagenham

| | Number | Percentage |
|---|---|---|
| People living in a same-sex couple (aged 16+) | 134 | 0.11% |

**Source: Office for National Statistics 2001**

**Marriage and Civil partnership**

| | Percentage (%) |
|---|---|
| Households of one married couple with no children | 8.97 % |
| Households of one married couple with dependent children | 16.6% |
| Households of one married couple with non-dependent children | 6.22% |

| | Number | Percentage |
|---|---|---|
| Civil Partnerships | 11 | 0.02% |

**Source: Office for National Statistics 2001**

**Pregnancy and Maternity**

Births to Barking and Dagenham women increased by 35% between 2004 and 2010. If the trend since 2001 continues, by 2017 there would be over 5,000 new births each year.

Much of the increase is due to babies being born to women who were born outside the UK but who are now resident in the borough, rather than to women born here. In 2009 nearly 30% of the total numbers of births were to women born in various European countries.

Barking and Dagenham has the highest teenage pregnancy rate in the Outer North East London boroughs, though the trend is downward.

The infant mortality rate is 5.3 per 1,000, higher than other Outer North East London boroughs, as well as London and England levels. Around 20 babies a year will die within the first year of life.

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

## Health profile of Barking and Dagenham

In 2010 the population of the borough was estimated to be just over 182,000 and within Greater London, Barking and Dagenham had the biggest percentage population increase (2.4%) of all London boroughs between 2009 and 2010. The population is expected to continue to rise – although, unusually, the proportion of older people is not.

Life expectancy for men and women has improved over the past 10 years rising from 73 years to 76.3 years for men and from 78.8 years to 80.3 years for women. However life expectancy for men and women in the borough is approximately 1.5 years lower than the UK average.

A 2011 report reviewed health inequalities in London in terms of health outcomes of key indicators. Barking and Dagenham was one of only two London boroughs significantly worse for all indicators which include life expectancy, together with disability adjusted life years, child development, young people not in education, employment or training, and receipt of means tested benefits.

The majority of people over 65 have two or more long term conditions; the majority of people over 75 have three or more long term conditions. People with long term conditions are most intensive users of health services. They account for 80% of all GP consultations and around 70 per cent of NHS resources are spent on managing long term conditions.

About 1 in 5 people over the age of 80 are predicted to suffer from dementia. It's likely there will be an increase in the younger age group, associated with long term heavy drinking and drug use.

Barking and Dagenham is estimated to have the highest prevalence of adult obesity in London, 32% compared to the England average of 24.2%

The Association of Public Health Observatories (APHO) annual health profile 2011, highlighted the following key issues for our borough:

- There is more deprivation, child poverty, childhood obesity, teenage pregnancy and a lower life expectancy than the Outer North East London, London and England averages.
- Areas that are more deprived in the borough have a wider gap in life expectancy at birth between males and females (2005-2009 data).
- Mortality rates are higher than the England averages for all age-all cause mortality, early deaths rates from heart disease and stroke and also cancers.

Based on the health profile, year on year changes show worsening levels of:

- Smoking in pregnancy
- Breast feeding initiation
- Increasing and higher risk drinking
- Healthy eating in adults
- Hospital stays for alcohol related harm
- Excess winter deaths (large increase)

Improvements have been shown in the levels of:

- Physically active children
- Adults who smoke (from 29% to 21%)
- Obese adults
- People diagnosed with diabetes
- Hip fracture in the over 65's (large reduction in hospital admissions)
- Infant deaths

The overall health and health outcomes are not good relative to other parts of the country; our local population is one of the most deprived in the country and life expectancy for both men and women is on average 3 years lower then the England average.

Some of the reasons for this can be attributed to lifestyle issues such as smoking, lack of exercise, obesity and excess alcohol consumption ;there are also significant challenges in the area of health in pregnancy (both of the mother and of the child) and there are the wider determinants of health such as housing, income and education. Barking and Dagenham also faces significant challenges in making sure that employment and educational opportunities are available for all.

For the health of our population to really improve there needs to be a corresponding fall in deprivation, with local people having greater access to resources, decent jobs and educational opportunities. While good health care is important it is not the only factor determining the health of our population.

## 3.2 Work we have done so far

### 3.2.1 Annual Public Health Report 2011

The 2011 Annual Public Health Report focused on the impact of socio-economic circumstances on the health and well being of our local population. Barking and Dagenham was one of the six host boroughs for the Olympics and Paralympics 2012. One of the aspirations of the Olympics is that it will leave behind a legacy of improved health, environment and economic regeneration in the six host boroughs.

The report acknowledges the health challenges facing our local population are large, but the Local Authority, the NHS and other statutory and voluntary sector partners are working together to bring about changes, so that people are healthier, live longer, and are more satisfied with the area they live in.

### 3.2.2 Joint Strategic Needs Assessment 2011

This 2011 was the fourth Joint Strategic Needs Assessment (JSNA) developed by the Barking and Dagenham Partnership. The Partnership was established in 2001 to work together to develop a strategic and co-ordinated approach to delivering services, and improving the quality of life for local people and communities in the borough.
The Partnership brings together the statutory bodies within the borough, as well as representatives of the voluntary and community sector and members of the local community.

The JSNA analyses local health and wellbeing needs, through comprehensive statistics and data. It identifies clear priorities for the new Health and Wellbeing Strategy which has also been developed by the Partnership.

The approach of the JSNA is based on Sir Michael Marmot's independent review into health inequalities in England.
The Marmot report highlighted key policy objectives to:

- Give every child the best start in life;
- Enable all children, young people and adults to maximise their capabilities and have control over their lives;
- Create fair employment and good work for all;
- Ensure a healthy standard of living for all;
- Create and develop healthy and sustainable places and communities;
- Strengthen the role and impact of ill health prevention.

The JSNA shows that there has been much progress in Barking and Dagenham in tackling health inequalities and driving up outcomes. However, substantial inequalities remain and the challenges are many – not least those posed by a rapidly growing population which is placing exceptional strain on already challenged resources and facilities at a time of severe financial constraint.

The JSNA 2011 draws out the important challenges to our residents' health and can be characterised under the following key headings:

- Population growth and changes in our local population.
- Income poverty resulting in reduced wellbeing by numerous mechanisms, including mental health challenges, fuel poverty, decreased access to services and many more.
- High levels of lifestyle risk including smoking, obesity and physical inactivity.
- Continued high death rates from various diseases, especially heart disease, cancer and chronic lung disease, expressed as life expectancy and mortality rates.
- Some single issues that remain problems, for example dementia.

The JSNA demonstrates that far too many local residents are struggling to find work and that there are more people living at or below the poverty line in the borough than both the London and national average. It also highlighted the need for a focus on, and investment in, child health improvement, through tackling the wider determinants of health such as education, housing and poverty.

### 3.2.3 Health and Wellbeing Strategy 2010

A Health and Wellbeing Strategy was published in 2010. The overarching aim of the Strategy is to improve life expectancy for local residents and ensure that they can look forward to the same life span as Londoners living in more affluent areas. The Strategy has ten priorities for action:

1. Reducing the levels of smoking.
2. Increasing participating in physical activity.
3. Promoting healthy eating.
4. Providing a broader range of support for depression.
5. Improving sexual health.
6. Ensuring residents get the benefit of immunisation and screening programmes.
7. Promoting health and well being at work.
8. Reducing levels of harmful drinking.
9. Ensuring the best possible care at end of life.
10. Reducing levels of domestic violence.

The new joint Health and Wellbeing Strategy is the mechanism by which our Health and Wellbeing Board will address the needs identified in our JSNA, setting out agreed priorities for collective action. Through better integration of service planning and service provision, the Council and Clinical Commissioning Group will be able to avoid duplication and increase the efficiency and quality of services for the residents, whilst maximising the use of resources in the current demographic and financial climate.

The Health and Wellbeing Strategy is supported by a detailed delivery plan which provides more specific goals, actions and expected achievements to meet the outcomes. The delivery plan is being developed separately.

The Strategy is due to be refreshed later in 2012, many of the priority areas are likely to remain unchanged, as they present the same challenges to the health of the population as they did in 2010. This strategy will be updated to reflect the 2012 priorities.

# Part 4: Demonstrating compliance with the Public Sector Equality Duty

## 4.0 **How we will comply with the Public Sector Equality Duty**

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

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

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

### 4.1 Equality analysis

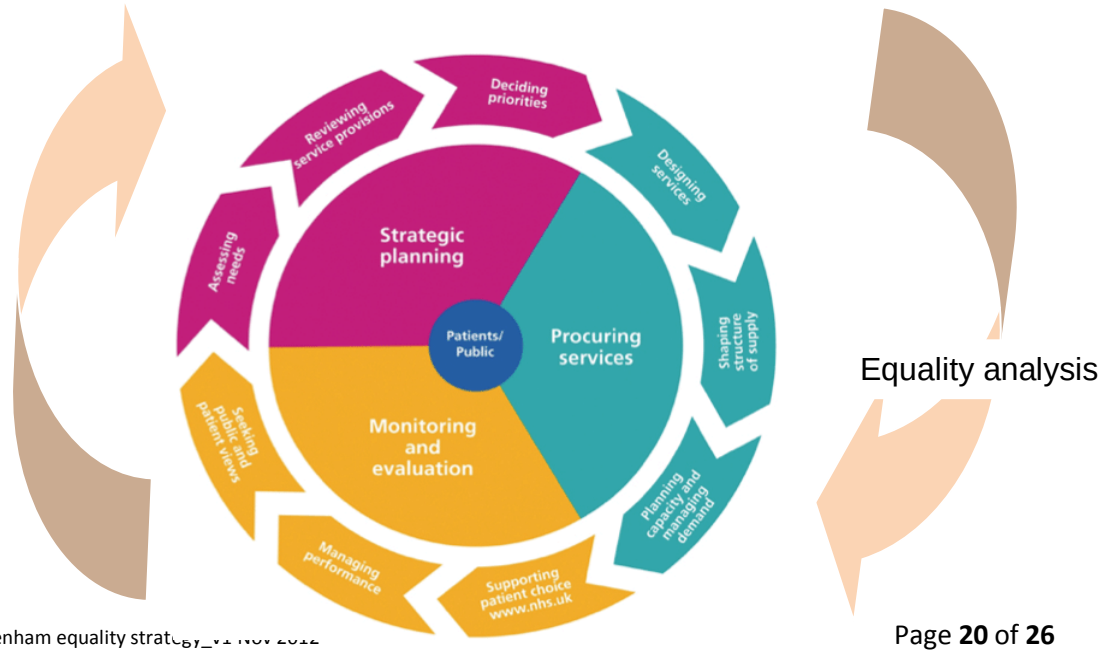
An equality analysis is a tool designed to help identify the potential impact of policies, services and functions on staff, patients, carers, public and stakeholders.

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

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

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

Equality analysis




Equality analysis

## 4.2 **NHS equality delivery system (EDS)**

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

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

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

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

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

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

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

### 4.3 Aligning engagement and equality

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

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

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

### 4.4 Meeting our publication requirements

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

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

# 4.5 Equality action plan

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

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

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

# Part 5: conclusion

## 5.0 Conclusion

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

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