

## Annual Equality Publication NHS Tameside & Glossop

### Introduction:

Public bodies are required under the new Equality Duties to publish an annual Data Summary Statement on their website by 31 January 2011. This should show how they are meeting their equality duties through their approach to exceeding legal compliance requirements.

The Equality Duty requires public sector organisations and their main contractor partners to segment their data for protected characteristic groups (PCGs) into workforce and service delivery information. This includes for example a protected group breakdown of who we employ by pay bands, who applies and is successful for employment, which patients have declared their protected group profiles by which GP practice, who is taking up which services from protected groups (across service delivery settings), who is satisfied with services when compared to patients from other protected groups, surveys about equality and service satisfaction are anonymous and disaggregated by protected groups.

EPIT (Equality Performance Improvement Toolkit) evidence gathered in 2010 and 2011 has particularly supported this data collection and analysis approach via Goal 2 (follow the webpage links): Develop data to monitor, information to manage and knowledge to act.

We therefore aim to show within this 2011 annual reporting information, what data we have as a primary care trust (NHS Tameside and Glossop), in terms of workforce and patients across each of the local protected characteristic groups. Our approach to monitoring and using that data to improve services is contained within our [Monitoring Report](#) below which can be accessed via our Equality Duties web page.

### Summary of our Equality Duties (part of the Equality Act 2010):

The Equality Act 2010 (the Act) replaced previous anti-discrimination laws with a single Act. It simplified the law, removing inconsistencies and making it easier for people to understand and comply with. It also strengthened the law in important ways, to help tackle discrimination and inequality.

The public sector **Equality Duty** came into force on 5 April 2011. The Equality Duty applies to public bodies and others carrying out public functions. It supports good decision-making by ensuring public bodies consider how different people will be affected by their activities, helping them to deliver policies and services which are efficient and effective; accessible to all; and which meet different people's needs.

The Equality Duty is supported by **specific duties**, set out in regulations which came into force on 10 September 2011. The specific duties require public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty; and to set themselves specific, measurable equality objectives.

Publishing relevant equality information will make public bodies transparent about their decision-making processes, and accountable to their service users. It will give the public the information they need to hold public bodies to account for their performance on equality.

### **What do the specific duties require?**

The specific duties require public bodies to:

- publish information to show their compliance with the Equality Duty, at least annually
- set and publish equality objectives, at least every four years.

All information must be published in a way which makes it easy for people to access it.

As a PCT we have used EPIT for consistent measurement of our status re Equality Outcomes. EPIT is a SHA standard and a comprehensive health equality check. We carried out our second EPIT appraisal in July 2011 (EPIT 2).

This shows we have carried out an analysis which is approved by the SHA and NHS PCT validating organisations across the North West, as a robust equality analysis which has been scrutinised by the Strategic Health Authority in the North West.

### **What did we find?**

The evidence from EPIT Goal 1 is that, in spite of interventions, the diversity of the workforce still doesn't match the demographics of the populations which NHS Tameside and Glossop serve. The EPIT system clearly demonstrates to managers that lack of properly disaggregated data in their organisations means it's difficult to fully comprehend where the gaps lie.

However, the North West workforce information website [eWin](#) provides managers with the tools to analyse their workforce more comprehensively. In addition, resources such as our SHAs [Sexual Orientation Monitoring Workbook](#) (published in July 2011) can help organisations to close gaps in the data. The SHA plans to support North West NHS organisations to continue to address this through the way they conduct the new national [Equality Delivery System](#) and how they attempt to shape the future workforce.

Our EPIT Goal 2 evidence shows that our organisation have made good progress in gathering and analysing data to support our decision-making and planning. NHS Greater Manchester as one of the largest geographical clusters, and our Equality and Diversity Leads Group (working across 10 PCTs) aim to ensure this approach is embedded in the way that the new Clinical Commissioning Groups (CCGs) work. We refer our Commissioners and Business Intelligence colleagues to NHS North West's online evidence library [HELP](#) as one of the tools developed to help organisations find good quality data.

On EPIT Goal 3, the evidence is that our organisation have made good progress in using disaggregated data to inform targeted commissioning plans, and to build novel approaches to public health interventions. The evidence suggests that the benefits of this are increasingly well understood.

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Similarly, on Goal 4, there is evidence that our organisation has strengthening our own governance to assure continued attention to outcomes.

Our aim is to work with our CCG for Tameside and Glossop and NHSGM to transfer our expertise and understanding of these goals, and the working ethos that underpins them, into CCGs and Health and Well Being Boards.

On Goal 5, we can see that our organisation is supporting and strengthening the role of their Equality and Diversity leads and have improved board support and leadership. A key tool to support this goal is the national NHS [Equality and Diversity Leadership Competency Framework](#) which the SHA published in September 2011. The SHA, in partnership with the Department of Health, led a national project to develop this framework.

In addition, NHS NW are continuing to ensure that E&D staff undergo systematic and structured personal development as leaders on this agenda (Institute of Leadership & Management Level 4 in Equality and Diversity).

By the end of 2011, 28 E&D leads from across the North West have undertaken this programme, while another 11 are now embarking on the programme. NHS NW's aim is that two thirds of people responsible for E&D leadership are trained to the ILM 4 standard.

The EPIT two year pilot across all NHS North West organisations has been superseded by EDS in November 2011 as an NHS wide equality performance framework.

### **Equality Delivery System (EDS)**

Designed to:

- Support NHS Commissioners to deliver better outcomes for patients and local communities (with a focus on how we take due regard of protected groups)
- Meet public sector Equality Duty
- Deliver NHS Outcomes Framework

4 Goals, 18 Outcomes

4 grades of achievement annually evidenced by public grading / dashboard of results for all NHS organisations.

### **Organisational Outcomes to be shared with Health & Wellbeing Boards.**

Grading to be carried out by local interest groups (provide 1/2 day training March 2012).

Our NHS Tameside and Glossop plans going forward involved carrying out an early internal Equality Delivery System (EDS) grading. This was completed during December 2011. This informed us about significant gaps in our EDS evidence. Out of the 18 EDS Outcomes we currently have one Outcome still requiring additional evidence to rise above the 'Under-developed' level and we are actively working on this area with our commissioners and providers.

We have very recently launched a new EDS on line Survey for completion by staff, public and patients in January and February 2012. We will use findings of our engagement work with local protected groups to set new Equality Objectives by 6 April 2012.

Our Equality and Diversity Lead will be presenting at an event in London in February 2012 where E&D Leads from across the NHS are attending an EDS Train the Trainer day

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provided by the EDS team. We will be sharing the learning of how our own NHS has taken early steps to implement EDS into our day to day ways of working and how we have arrived at our first internal EDS Grading.

Over the last two years, we have developed a patient representative group – the Consumer Advisory Panel who scrutinise our organisations' key changes for any likely adverse impact on each of the local protected groups. they also make recommendations on how our practice can become more inclusive of taking due regard of the protected groups. Our Chief Operating Officer from Tameside and Glossops' Clinical Commissioning Group (CCG) also attends CAP monthly meetings to keep patient reps apprised of how CCG is developing as an inclusive organisation. Members are encouraged to give Steve Allinson direct feedback at meetings concerning any barriers to inclusion and their suggested solutions. See our 'Engagement with local interest groups report' for more details of CAP work.

At NHS T&G we can link our Clinical Commissioning Group **Plan on a Page** high level **Objectives** (column 1 on left) to our **Transforming lives** right side column by firmly linking these to each of the Equality Delivery System (EDS) 4 Goals:

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

However, we are still following a process of Inclusion involving consulting and engaging with local interest groups representing protected groups, to help us validate / set our new Equality Objectives. We have developed an on line EDS Survey which closes on 29 Feb after 6 weeks. We have events including feedback from local interest groups on 12<sup>th</sup> and 20<sup>th</sup> March. We will also take into account our early EDS internal Grading which has highlighted any significant gaps in EDHR legal compliance and the 4 EDS Goals. On 27 Feb we are training local interest groups on how to carry out an external annual EDS public Grading. Our annual Grading will take place on 19 March, involving local interest groups.

Our early draft Equality Objectives are shown below:

## NHS Tameside & Glossop Equality Objectives 2012 – 2016 **DRAFT COPY**

Equality Objective	Links to EDS	Links to GM Operating Plan (Tameside & Glossop) <b>Transforming Lives</b>	Details of Consultation with Local Interest Groups
<p><b>1. Equality supporting commissioning for complex vulnerable groups</b> Conversation through building our CCG Organisational Development Plan re ‘how CCG can help you as a GP provider to be good commissioners?’</p> <p>Need to specify procedures in place for protected groups when transferring across services.</p> <p><b>Link to data collection at key impact points in primary care. At referral point shared with secondary care.</b></p> <p><b>EDS 1.3</b> Changes across services are discussed with patients, and transitions are made smoothly</p>	<p><b>1. Better health outcomes for all:</b> The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results</p>	<p>1. Focus on reducing avoidable &amp; premature mortality including SHMI: end of life, CVD, COPD, tobacco control, reduce harm from alcohol and improve care for people with dementia.</p>	<p>28 Feb 2012 training local interest groups in how to carry out an annual EDs grading</p> <p>Local interest groups carry out annual EDs grading 19 March 2012.</p> <p>“Involving &amp; Listening to You” (2012) 12<sup>th</sup> March 2012, 1:30am to 3:30am - 2 x 1 hour Staff feedback sessions 20 March 2012, 9.30am to 11.30am Patients &amp; Stakeholder feedback session Venue: NHS Tameside &amp; Glossop, New Century House Boardroom, Denton</p>
<p><b>2. Improving access to organisational key documents &amp; processes such as complaints, for vulnerable groups</b> Our Complaints process to be refined as more accessible for protected groups eg learning disabled patients, visually impaired patients (Easy read version, our website to link into local visually</p>	<p><b>2. Improved patient access and experience:</b> The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience</p>	<p>2. Raising population aspirations about health and health care.</p> <p>5. Ensuring effective engagement of the public and partners in prioritization.</p>	<p>As above</p>

<p>impaired support organisations to explain how information can be accessed in different formats such as Braille where reasonable requests received.)</p> <p><b>EDS 2.4</b> Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently</p>			
<p><b>3. Developing equality products for GP Practices</b> (involving patient representatives from protected groups)</p> <p>Consumer Advisory Panel &amp; other local interest groups to consider &amp; develop what are <b>products</b> that we want <b>GP practices</b> to engage with to evidence good inclusive EDS practice? Example: Headlines, what do I need to do first re recruiting a diverse workforce &amp; embedding reasonable adjustments for staff &amp; patients / carers?</p> <p><b>EDS 3.1</b> 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</p> <p><b>EDS 3.6</b> The workforce is supported to remain healthy, with a focus on addressing major health</p>	<p><b>3. Empowered, engaged and well-supported staff:</b> The NHS should increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' need</p>	<p>3. Focus on choice.</p>	<p>As above</p>

<p>and lifestyle issues that affect individual staff and the wider population</p> <ul style="list-style-type: none"> <li>• Develop a Healthy Workforce policy which is given to all members of staff as part of their induction programme.</li> <li>• Staff are encouraged to raise concerns if they believe that their physical or mental health is being adversely affected within the workplace.</li> <li>• Collect recommendations from staff regarding factors that can be embedded within the organisation to improve the health of its workforce eg all staff to receive a full health check</li> <li>• Make attempts to engage with staff from protected groups and from Staff-side organisations and to follow these recommendations through, to demonstrate that staff are supported to remain healthy with a focus on addressing major health and lifestyle issues</li> </ul>			
<p><b>4. Re-assign E&amp;D Leadership Competencies to current CCG roles re</b></p>	<p><b>4. Inclusive leadership at all levels:</b> NHS organisations should ensure that</p>	<p>4. Continue to build and deliver a quality improvement strategy which is in keeping with</p>	<p>As above</p>

<p><b>NHS T&amp;G.</b></p> <p><b>EDS 4.3</b> The organisation uses the NHS Equality and Diversity Competency Framework to recruit, develop and support strategic leaders to advance equality outcomes</p> <p>Embed these competencies into job descriptions &amp; person specs. Embed into interview questions as a standard approach to demonstrate these E&amp;D leadership competencies – at all job levels.</p> <p>Include vulnerable patient reps in interviewing for all senior roles – develop a process &amp; train up suitable volunteers from protected groups.</p>	<p>equality is everyone’s business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions</p>	<p>recommendations of the Francis Inquiry and prioritises harm free care.</p>	
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**Draft Equality Objectives – may change before 6 April 2012 deadline. We are still consulting on setting these objectives.**

## **Tameside and Glossop**

We have an earlier Equality Strategy 2009-13 which is currently displayed on our website and is subject to update in line with organisational changes.

This approach to 'diversity plus inclusion equals equality of opportunity', is undertaken under unique 'change circumstances' within the NHS. It is therefore inappropriate to make long term strategic plans at this stage. Our focus therefore is on preserving the equality outcomes and plans we already have identified via EPIT and the new EDS scrutiny.

The biggest contribution we can make in the first instance in NHS GM is to embody the best of the accumulated expertise and best practice from all 10 PCTs across the GM Cluster and their 12 provider Trust partners. We use that expertise and influence to shape development of local Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards (HWBBs).

### **Who do Local Protected Groups include?**

What do we mean by protected groups? This includes: age, gender, gender variance (Transgender), disability, race, religion or belief, sexual orientation, marriage and civil partnership, pregnancy maternity and breastfeeding mums, carers\* and military veterans\*.

We have taken a strategic decision to include carers and military veterans in all our scrutiny for inclusion work including our Analysis of the Effects on equality Rolling Programme.

### **Next Steps**

At NHS Tameside and Glossop we are currently promoting completion by public, patients and staff of our **on-line EDS Survey** during February 2012. We are using all of our EDS evidence gathered to begin to set our new Equality Objectives by 6 April 2012.

We are also identifying any significant gaps in terms of protected group data for our patients and workforce and how we intend to address these over the next 4 years. One significant area of data development in 2012 is likely to be through our approach to protected group inclusion within our Joint Strategic Needs Assessment (JSNA) and our approach to Health Needs Assessment through commissioning of protected group data to potentially inform commissioning decisions. This approach refers to locality approaches and Greater Manchester wide initiatives which address health inequalities for vulnerable more marginalised groups.

Patient data has recently been gathered from most of our 43 GP Practices in Tameside and Glossop. We will ensure that individual patient confidentiality is fully maintained where reports by protected groups are provided on our website. We are currently looking at this protected group data from our GP practices and will be displaying summary data in 2012.

Our significant gaps in data collection include a consistent framework to collect individual patient record data by providing the option to patients to declare their details, within primary and secondary care with recommendation for supporting systems across a range of healthcare settings.

Our Monitoring report provides details of our approach to monitoring and reporting in 2012. With the introduction of Clinical Commissioning Groups (CCGs) by April 2013, a significant opportunity is presented to strengthen our approach to a robust data collection and reporting framework. The NHS Outcomes Framework Analysis of the Effects on equality summarises next steps to bring in improvements in linking protected group data collection and analysis to recognising and tackling health inequalities for local protected groups.

See our Equality and Diversity webpage for more detailed documents on meeting our Equality Duties.

Our Equality Duties webpage displays details of the following links to further detailed documents about our approach to data and how this is used for improvements:

- Annual Workforce Report
- Monitoring Report
- Engagement with local interest groups report
  
- EDS (Equality Delivery System) – Summary of Achievements 2012
- EDS internal Grading Report - Jan 2012
- EDS Grading Dashboard – Dec 2011
- EDS on-line Survey for patients and staff – complete now by following the survey link shown
  
- Our organisation’s progress for achieving EDS implementation
  
- EPIT (Equality Performance Improvement Toolkit) Summaries 2010 – see below
  - Goal 1
  - Goal 2
  - Goal 3
  - Goal 4
  - Goal 5
  
- EPIT Summaries 2011 – see below
  - Goal1
  - Goal2
  - Goal3
  - Goal4
  - Goal5
- For NHS Tameside and Glossop’s EDHR performance in 2010 and 2011 using the EPIT process, follow the links for:
  - EPIT consolidated PCT scores - Jan 2010
  - EPIT consolidated Provider partner scores – Q2 2010
  - EPIT consolidated PCT scores - Jan 2011
  - EPIT consolidated Provider partner scores – Q2 2011

Our Strategic Health Authority, NHS North West introduced EPIT as an equality performance tool 2 years ahead of EDS, as a pilot scheme across the North West.

- Joint Strategic Needs Assessment (JSNA) - to follow in 2012
- A breakdown of Equality in the JSNA - to follow in 2012

## Annual Workforce Report: Summary of Findings

Findings are not reported where staff numbers for protected groups are numbers less than ten. This is to ensure data reporting does not lead to any individual members of staff. This detailed data is help by the PCT however and will be used for scrutiny and analysis purposes.

The following significant findings are noted:

- Our BME staff total 4.85% of total workforce. Compared to the local population demographics that we are aware of this figure should be nearer to 7%. However until our re-structure has been completed, it is challenging to begin to identify any significant under-represented protected group. An Analysis of the Effects on equality of our new HR shared Service has been started and now that our Annual Workforce Report is available, we are awaiting a breakdown by staff against pay banding across each of the protected groups. We will then also provide this information for the HR Shared Service team demographic profiles. We are looking for any adverse impacts from these changes, resulting on staff from the protected groups.
- Number of staff attending Training begins to significantly taper off at pay band 8a
- Staff training was received by 45 to 49 year olds in the main
- We have a 3:1 ratio of females to males in our staff make-up. Also a 2:1 ratio of female full to part time staff and 7:1 ratio of male full to part time staff.
- Staff leaving the PCT have resulted in 53% male and 47% who were female. This has resulted in reducing the number of male staff further.
- We have less than 10 disabled staff out of a current workforce of 206. We would expect this to be a 20% or 1 in 5 ratio for disabled staff. Declaration rates by staff are therefore considered significantly low. Reasonable Adjustment training should help to raise awareness of the benefits in declaring any disability or long term health condition through choice.

## Our approach to Hate Crime

We are working with our local statutory partner organisations in delivering a TASP Action Plan. We have targeted all our workforce, GPs and Practice Managers as well as Dental partner organisation leads to attend our Quality and Equality Workshops. Here awareness raising of the prohibited discrimination framework (including all types of Hate Crime) includes our health care responsibilities in recognising all forms of hate crime and supporting alleged victims of potential hate crime (here no incident is too small). Working with local police in reporting incidents is also emphasised in this training workshop. We are developing a Hate Crime policy which will be embedded into all provider partner contracts, once approved following consultation.

Julia Allen, Equality and Diversity Manager 8 February 2012.

Note: This document is subject to sign off by NHS Tameside and Glossop Boards.