NHS
North Hampshire
Clinical Commissioning Group

EQUALITY AND DIVERSITY STRATEGY

2016 – 2020

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Section 1: Purpose and Legal Context

North Hampshire Clinical Commissioning Group is a clinically-led NHS body responsible for the planning and commissioning of health care services for the local population. Our commissioning is about getting the best possible health outcome for the local population by assessing local needs, deciding priorities and strategies and then buying services on behalf of the population.

This strategy sets out how North Hampshire Clinical Commissioning Group will meet its equality duties set out in the Equality Act 2010 Section 149. Our CCG puts the patient at the heart of what we do through effective engagement and involvement of local people in decision making, commissioning healthcare to meet local needs and working in partnership with local people, vulnerable group and hard to reach representatives and forums, local councils and other healthcare providers to improve health outcomes for the nine protected groups, identified under the Equality Act 2010 and hard to reach groups within our community.

The CCG will ensure that all policies, functions and services carried out either by itself or on its behalf will be subjected to an Equality Impact Analysis (EIA) to ascertain any differential impacts on people - specifically with protected characteristics and hard to reach groups within our community or those we employ, in accordance with equality legislation including the Equality Act 2010. Equality Act 2010 (Specific Duties) Regulations 2011; the Health and Social Care Act 2012; the Public Services (Social Value) Act 2012 and the Serious Crime Act 2015.

Through the adoption of the NHS Equality Delivery System 2 (EDS2) assessment tool, the CCG aims to demonstrate to the people we serve how we are meeting our *due regard* duty to the three aims of the Equality Duty, to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not. These are sometimes referred to as the three aims of the general equality duty.

The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Section 2: Our Aims and Vision – the Business Case for Equality and Diversity

2.1 Financial Benefits – Making the best use of resources

The aim is to focus on delivery and the teams in order to make a significant improvement in the coming 5 years, primarily through:

- Maximising the opportunity to protect and improve health for our population with measureable improvements in outcomes
- Continuing to develop integrated care which will require more joint working between commissioners to align the direction of travel and to secure effective care pathways across the whole system using a patient centred approach
- Modernising the local NHS system and targeting services more effectively

2.2 Social Value

Our procurement processes will improve our understanding and support of the wider economic and social benefits to help demonstrate how our work complies with The Public Services (Social Value) Act (2012). The Public Services (Social Value) Act places an obligation on the CCG, as a public authority, to actively consider how a service being procured might improve the economic, social and environmental wellbeing of the relevant area; and how a public authority might secure that improvement through procurement.

2.3 Empowered and Supported Workforce and Visionary Leadership

Within North Hampshire CCG, not only will we be able to meet our targets in relation to recruitment, but we will also be in a position to recruit 'the best' from a wide pool of individuals. We will be able to harness the skills of individuals from diverse backgrounds in service delivery, ensuring continual progress and development.

2.4 Quality Services – Customer (Service Users, Families and Friends) Satisfaction

Increase the confidence of local communities, which in turn will resolve local health related difficulties which may arise. Effective community engagement and consultation also supports organisational changes, particularly cultural changes impacting on how services are managed and delivered. This in turn has a significant benefit not only to local patients and the public, but also staff morale and confidence.

2.5 Local and National Reputation

As an organisation which is aspiring to progress further, embedding diversity throughout the business of the organisation will ensure that we will not only meet our legislative requirements, but also influence outcomes of policy decisions and inspections in a positive way. The flexible approach needed to manage diversity effectively, in terms of responsiveness, managing change and continuous learning from individuals of different backgrounds, will keep the our CCG evolving and better able to meet ever-increasing demands to improve performance in other areas.

Section 3: Local Community and Health Profile

3.1 Overview

NHCCG comprises twenty GP Practices and is responsible for supporting the health needs of a population of 218,556 (up by 5,571 since the 2011 Census population of 212,985, representing an approx. 2.55% increase). The area is a mix of both urban and rural covering Basingstoke, Alton, Hook, Tadley, Odiham and many villages. Our local authority partners are Basingstoke & Deane Borough Council, East Hampshire and Hart District Councils and Hampshire County Council who provide countywide services. Seventy-six per cent of our population live in the Basingstoke and Deane District, 13% in the East Hampshire District and 11% in the West Hart District.

Our main local providers are Hampshire Hospitals Foundation Trust (HHFT), Southern Health Foundation Trust (SHFT) and South Central Ambulance Service (SCAS). Our main acute provider (HHFT) provides services from Basingstoke, Winchester and Andover and consequently the CCG works in close partnership with West Hampshire CCG to commission these services across the system known as "North and Mid Hampshire".

We recognise the ongoing health inequalities in parts of North Hampshire linked to their protected characteristic or income. Pockets of deprivation exist in South Ham, Popley East and Chineham wards in Basingstoke and parts of Alton East Brooke ward, affecting a substantial number of people who are consequently likely to have poorer health.

We have a large White/British and Christian population, but also have significant numbers of minority ethnic and religious groups, which are increasing. The resident population of the CCG locality is 217,077 people, consisting of 52,530 younger people (aged 0-19) with 42,175 older people (aged 65 and over). By 2021, the largest proportion of population growth is in the number of people aged 65 and over is 22% and 47% for 85 years and over. Due to the population changes, the demand for health and social care services is expected to rise over the next ten years. This group will be at risk of developing chronic diseases.

With the aid of the NHS Equality Delivery System (EDS2) analytical tool and Public Health's Joint Strategic Needs Assessment (JSNA), we understand the different needs of people in different areas based on factors such as the age structure of the population, socio-economic status, ethnicity and access to health services which are all associated with particular health risks. They also allow us to identify areas where we are doing well and those where we need to make improvements in people in order to make a difference in how we commission and deliver healthcare services to the most vulnerable people in our community.

3.2 Age Profile

The age demographic profile of North Hampshire CCG, based on the 2011 census, shows the largest age group are within the 30-64 age range (48.9%), followed by the under 18s group (22.5%). By 2021, it is estimated the highest growth in population will be in the older people group aged 65 and over with the number of the working aged population reducing, indicating a higher level of need and care.

Basingstoke and Deane borough has a higher percentage of children under 15 and middle-aged adults than any other age groups. There are lower percentages of people in their late-teens and early twenties, which reflect the absence of a higher education establishment in the borough. In Hart, the percentage of residents of post- retirement age (65+) has gradually increased over the last ten years. There has been a drop in the percentage of 30-39 ages living in the East Hampshire district and an increase in the percentage of over 65s.

Overall children who are born and live in Hampshire/North Hampshire have good health, life chances and educational attainment. However, there are higher levels of emergency admissions and unplanned hospitalisations for children in North Hampshire and the causes of these injuries need to be investigated to help inform prevention and early intervention initiatives. There is also variation with some groups of children, particularly our vulnerable children, being disadvantaged with poorer health and low educational attainment. We need to better understand the needs of our more vulnerable children to ensure that across the system we commission effective services that improve outcomes for these children.

Adults in Hampshire in general live longer, have good employment and good opportunities to keep healthy. However there is variation with some people having much poorer health and outcomes. The main causes of premature death are cancer, heart disease and respiratory disease. Additionally, in Hart, cancers and digestive disease (including alcohol related disease in women) are of concern.

The ageing population and increased prevalence of chronic diseases require a strong reorientation away from acute and episodic care towards prevention, self-care, more consistent standards of primary care and care that is well co-ordinated and integrated. Nationally, the fastest growth in A&E attendances were from the over 65 group with over 85 age group are 4 times more likely to attend A&E and 8 times more likely to be transported in comparison to younger age groups. There is a need to gain further data on the level of Accident and Emergency department usage and level of emergency admissions which nationally rise with age.

3.3 Gender Profile

For North Hampshire CCG area, the 2011 census data reflects similar findings as that of our borough and districts within our boundary. In Basingstoke and Deane, its local population is made up of approximately half males and half females. Below the age of 20, the percentage of males in the borough is slightly higher than that of females. Above the age of 65, the percentage of females is slightly higher than that of males. This is similar to Hart and East Hampshire and a similar pattern is found in Hampshire and South East England. In Hart, 4.8% of females described themselves as having a long term health problem or disability which limited their day-to-day activities a lot, compared to 3.7% of males.

Older people in Hampshire generally remain fit and healthy for the majority of their remaining years. However there have been some changes in recent years whereby the length of time people remain in good health has reduced. In Hampshire, in 2011/13, the life expectancy of a man aged 65 years was 19.5 years, the disability free life expectancy was 12.1 years, therefore the number of years a man over the age of 65 years could be expected to have disability or poor health is 7.3 years, which compared to our neighbours is slightly better than average (range 6.0 years to 9.2 years). Similarly, for women living in Hampshire, in 2011/13 the life expectancy at 65 is 21.9 years, with a disability free life expectancy at 65 of 12.4 years and therefore the number of years a woman over 65 years would be expected to have a disability is 9.5 years which compared to our neighbours is about average (range 7.4 years to 11.2 years).

3.4 Disability Profile

The demographic profile of people living with a disability in the North Hampshire CCG area, based on the 2011 census, shows there were 5.6% of residents whose day to day activities were limited a lot, with a further 8% of our population reporting they had some limitations with their day to day activities. This equates to approx. 28,966 residents in 2011 who were living within the North Hampshire CCG boundary who have some level of disability, as defined by the Equality Act, : 'a

physical or mental impairment which has a substantial and long-term adverse effect on your ability to carry out normal day-to-day activities'.

Of Basingstoke and Deane residents, the 2011 census reported approximately one fifth of households had one or more persons with a long-term health problem or disability with, in 2015, an estimated 6,900 Blue (disabled) Badge holders. In East Hampshire 3.7% of the population say they are in bad or very bad health, below the national average of 5.4%. Whilst, according to the 2011 Census, 12% of Hart residents had a long term health problem or disability which limited their day-to-day activities. This is lower than Hampshire (15.8%) and the South East (15.7%). As at May 2015, 2.2% of Hart residents aged 16 and over (2,020) were claiming Disability Living Allowance (DLA). This is lower than Hampshire (3.5%) and the South East (3.8%). In Hart, 22.7% (460) of DLA claimants were aged 65 and over.

3.5 Ethnicity/Race

In North Hampshire CCG area, as at 2011, shows the largest group are White British/Other (93.6%) of which 0.1% were reported as having a White Gypsy or Irish Traveller background. The next largest group were Asian (including those with an Asian British/Other background), followed by those with a Mixed Heritage background (1.6%). Black, African or Caribbean British/Other represented 1.0% of our population with those from Other backgrounds at 0.3%.

The percentage of ethnic minority groups in Basingstoke and Deane Borough almost doubled from 2001-2011. The groups that have seen the highest growth are Asian or Asian-British residents, however a change in definition has added to this growth (Chinese to Asian group). There has been a consistent growth of the Indian community in the borough over recent decades and numbers more than doubled from 2001-2011. More recently, there has been an expansion of Polish and Nepalese communities. The 2011 Census showed that there is variation in the proportion of the population in different ethnic groups by age. For example the White Irish population has a much older age structure than the Mixed population. The majority of Hart residents described themselves as White British. White Other (including Irish, Gypsy or Irish Traveller, and Other White) was the next most common ethnic group followed by Asian or Asian British. BME Residents in East Hampshire account for 7% of the population of the district, up from 4.32% in 2001. The national average in 2011 is 20.2%.

3.6 Gender Reassignment (including Transgender and Transsexual) Profile

Demographic data on residents, who are transgender or are experiencing some form of gender variance, within the North Hampshire CCG population is not available. However, according to the Gender Identity Research and Education Society: The Number of Gender Variant People in the UK - Update 2011[6] highlights: "*Organisations should assume that 1% of their employees and service users may be experiencing some degree of gender variance. At some stage, about 0.2% may undergo transition. The number who have so far sought medical care is likely to be around 0.025%, and about 0.015% are likely to have undergone transition. In any year, the number commencing transition may be around 0.003%.*"

By applying these percentages to the North Hampshire CCG's current population aged 16 and over (as at 2016, 177,861 people), it is estimated that 1,779 people may be experiencing some degree of gender variance, 356 people may undergo transition, 45 may have sought medical care and 27 may have undergone transition. In any year, less than 6 may commence transition.

The barriers which transgender people have described in accessing services with dignity may raise human rights issues and cause distress to them at a vulnerable and sensitive point in their

lives. Transitioning is still high risk for most gender variant people. Gender variant people present for treatment at any age. The median age is 42. Few younger people present for treatment despite the fact that most gender dysphoric adults report experiencing gender variance from a very early age. Social pressure, in the family and at school, inhibits the early revelation of their gender variance. Only 100 or so children and adolescents are referred annually to the UK's sole specialised gender identity service, compared to 1,500 referred to the adult clinics. Nonetheless, presentation for treatment among youngsters is also growing rapidly and has the potential to accelerate if young people feel increasingly able to reveal their gender variance and undertake transition while still young.

3.7 Marriage and Civil Partnership

Civil partners have certain rights in relation to their partner's mental health treatment, under the Mental Health Act 2007. Couples who aren't in a civil partnership do not have these rights. Between 2001 and 2011, there was a slight increase in the percentage of adults who were divorced and a marginal decline in the percentage of residents who were married. Single residents, who have never been in a legal relationship, form an increasing percentage of the adult population. The proportion of households occupied by only one person has increased, whilst the proportion occupied by families has declined slightly. In Hart, 53.2% of the adult population are married, a decline from 56.7% in 2001. Those that are single (never married) account for 27.7% an increase from 25% in 2001. Civil Partnerships account for 0.2% of the Hart population. 18.8% are either separated, divorced or widowed. In East Hampshire 55% of people in East Hampshire are married or in a civil partnership, down from 59.77% in 2001. The national average is 45.9%.

3.8 Pregnancy and Maternity

In the North Hampshire CCG area, the Hospital Episode Stats report there were 2,456 live births for the past year, which shows an approx. 6% increase over the previous reported year. In Basingstoke and Deane, over the last decade, the increase in the number of births in the borough was more than double that of the Hampshire average with the numbers of conceptions to females aged under 18 in the borough in general decline over the same period. More than one in five of all births in the borough in 2014 were to non-UK born mothers. In 2014 there were 1,036 live births from mothers whose usual residence is Hart. This figure remained relatively stable over the five years leading up to 2014 (1,040 live births in 2009). The District's Generalised Fertility Rate (GFR = live births per 1000 women aged 15-44) was 64 in 2014, an increase of 5.4% since 2009. The age of mothers has increased slightly since 2009 with 39% aged 30-34 in 2014 compared to 32 in 2009. The age of mothers in Hart is higher than in Hampshire as a whole.

3.9 Sexual Orientation

Currently, there is no reliable data on the numbers of Lesbian, Gay and Bisexual (LGB) residents within the North Hampshire CCG area. However, the 2013 ONS 'Integrated Household Survey' indicated that 1.6% of the UK adult population identified themselves as LGB. This figure may underestimate the true figure as a further 3.9% stated that they 'Don't know' or refused to answer the question, and another 1.5% provided no response. In the same survey 1.8% of respondents in the South East identified themselves as LGB, 3.9% stated 'Don't know' and 1.5% did not respond. Taking steps to make sure that the needs of our Lesbian, Gay and Bisexual patients are sufficiently addressed leads to better health outcomes and saves the NHS money. Identifying the underlying causes of health problems sooner saves the time and money spent on

misdiagnosis and inappropriate treatment, but more importantly, provides a better health service tailored to meet the needs of this oft overlooked vulnerable group.

3.10 Religion/Belief Profile

The demographics for religion or similar/lack of belief shows the North Hampshire CCG area is predominantly Christian at 61.1% of its 2011 census population. The next largest group shows 28.8% had no religion followed by Hindu at 1%; Muslim at 0.8% and Buddhist at 0.5%. In North Hampshire CCG, 0.4% of the North Hampshire CCG reported Other Religion. The Department of Health[9] has highlighted the need to be aware that the regulations on religion or belief extend beyond the more commonly known religions and faiths to include beliefs such as Paganism, humanism, atheism, Shamanism etc. so Other Religion may include some of these beliefs within our Boundary.

The percentage of people in Basingstoke and Deane who describe themselves as Christian has declined slightly and there has been an increase in the percentage of people that stated that their religion was other than Christian. The percentage of residents who stated they had "no religion" almost doubled from 2001-2011. Older residents were more likely to describe themselves as Christian, whilst younger residents were more likely to follow other religions or not have a religion. The highest levels of religions other than Christian recorded within the borough in the 2011 Census were Hindu (1.2%) and Muslim (0.9%). According to the 2011 census, 64% of Hart residents describe themselves as Christian. The second most common religion in Hart was Hindu at 0.8%, which is similar to findings for Hampshire as a whole. 25.8% of respondents stated they had no religion and 7.1% did not state their religion at all. There are fewer Christians in East Hampshire compared to the previous census data but still remains the largest group within that area, with "no religion" at 26% and Islam with just over a third of 1%.

3.11 Carers

In North Hampshire CCG, the proportion of the working aged population is reducing with the number of older people increasing. Although people in Hampshire are living longer and longer in good health this is beginning to change with a fall in healthy life expectancy being seen over the last three years. This change is likely to put pressure on local communities and the caring system (carers) and needs to be factored into the planning of both health and social services.

In Basingstoke and Deane, 1.8% of residents (2,988) in Basingstoke and Deane provided 50 or more hours unpaid care a week at 2011 Census, 34.5% of these residents (1,031) were aged 65 and over. 1.0% of residents (1,697) in Basingstoke and Deane provided 20 to 49 hours unpaid care a week at 2011 Census, 21.0% of these residents (356) were aged 65 and over. 6.3% of residents (10,548) in Basingstoke and Deane provided 1 to 19 hours unpaid care a week at 2011 Census, 16.1% of these residents (1,703) were aged 65 and over. These figures are lower than the national average.

Although 0.47% (440) of Hart residents claim Carer's Allowance as at May 2015 and this figure is lower than for Hampshire as a whole (0.7%), the 2011 Census highlighted 8.9% of all usual residents in households in Hart (7,943) provided unpaid care, 24% of these residents (1,919) were aged 65 and over. This is lower than Hampshire (10.1%) and the South East (9.8%). The census showed that 1.4% of all usual residents in households in Hart (1,282) provided 50 or more hours unpaid care a week, 39% of these (505) were aged 65 and over.

In East Hampshire, 11,613 people provide unpaid car to a family member or friend; 1,424 more than was reported in the previous 2001 census.

3.12 Hard to Reach Groups

There are ongoing health inequalities in parts of North Hampshire linked to their protected characteristic or income. Pockets of deprivation exist in South Ham, Popley East and Chineham wards in Basingstoke and parts of Alton East Brooke ward, affecting a substantial number of people who are consequently likely to have poorer health. Although North Hampshire has a high life expectancy compared to the national average, there is a significant variation in life expectancy between the least and most deprived areas, which has increased over the last decade. In addition, healthy life expectancy is decreasing in North Hampshire, indicating higher levels of need and care. As the demand for care is projected to grow, people are increasingly likely to become providers of care at some point in their lives, with a large percentage suffering from long term health problems or a disability themselves.

Section 4: Our Progress 2015-2016

In 2015 we began looking more closely at what the Public Sector Equality Duty means for the CCG and ensuring our *due regard* was a beginning and not an end to our approach to equalities. We commenced a programme of activities with CCG services that will enable them to identify (with the assistance of the E&D Lead and Hampshire County Council's Community Development Team) health inequalities at a more local level and take and implement the appropriate action.

There have been two significant changes to the NHS contract last year in regard to embedding equality and diversity with the Equality Delivery System (EDS2) and the NHS Workforce Race Equality Standard being mandated for provider organisations, which involves additional scrutiny of Providers by the CCG.

In summary the CCG has undertaken the following in relation to Equality and Diversity (E&D) in the last year.

- Commissioned a range of initiatives with local providers which aim to meet the diverse health and access needs of the local population by:
  - Improving access to services and introducing specialist services into the community for individual patients;
  - Improved access to diagnostic testing by introducing services into the community to make them speedier and more accessible
  - Extending GP hours and availability to provide a more comprehensive accessible primary care service
  - Upskilling medical practitioners to improve level of primary care and specialist services offered locally
  - Optimising value for money by procuring services aimed at improving the economic, social and environmental wellbeing of the local population.
- The Equality Delivery System (EDS) [original version] summary report was undertaken in January 2015 with objectives identified. As part of embedding equality and diversity within commissioned services and supporting the CCG workforce, the EDS is to be undertaken annually in line with the publication of the CCG's Annual Operating Plan, to ensure E&D remains a key priority within its business objectives.
- The public health profile has been updated to identify the main equality and diversity issues in the local population
- All HR CCG policies were analysed for equality impact on vulnerable groups. A program of reviewing and updating all other CCG policies has been undertaken and analysed for equality impact and should be completed within the 2016-2017 operating year.
- The CCG has identified and is now networking with a range of local public sector and voluntary organisations and forums on E&D to seek their views and ensure health inequalities are identified.
- The CCG identified the need for a Staff Partnership Forum to give staff a voice in how they are supported and how their working environment can be made more empowering. Staff have now made nominations from each of their departments and it is expected the first Staff Partnership Forum will commence by the spring of 2016.
- An online training module has been provided to make staff aware of their duties under the Act, giving practical support to applying this in the workplace and in commissioning services.

- A new appointment, Deputy Chief Nurse, will be recruited to the Quality team with a specific remit for promoting E&D with our patient representatives and the providers we commission from. This is a key role in terms of developing future E&D strategies.

Although our focus over the past year has been working to improve services and access to healthcare, further detailed work is needed, identified through engagement, to improve the health outcomes for LGBT, Gypsies and Travellers, Military Veterans, BME (in particular our Nepalese community), Homeless people, Disabilities and their Carers (Long Term Conditions and Mental Health), Age (Young People below age 24 and Older People aged over 65) and Maternity (mothers and babies).

Section 5: Our Equality Objectives

5.1 Reducing Health Inequalities

- **Ensure the CCG is legally compliant with the Equality Act 2010, Equality Act 2010 (Specific Duties) Regulations 2011; Human Rights 1998; Health and Social Care Act 2012; Serious Crime Act 2015 and Public Services (Social Value) Act 2012**
- **Ensure agreed equality objectives feature in all aspects of the CCG's commissioning services activities**
- **Undertake timely EIAs whenever new projects, proposals or policies, commissioning and strategies are being developed**

5.2 Building Relationships and Partnership Working in the Community

- **Engage with diverse communities and consult with them when undertaking EIAs and other commissioning activities**
- **Work in partnership with local stakeholders and embed a multiagency approach in the delivery of healthcare services**

5.3 Empowering staff and developing talent

- **Create an supportive environment where staff feel empowered**
- **Undertake skills audit and talent management strategy to develop and grow staff from within**

5.4 Embedding Governance and Strategic Leadership

- **Embed effective governance arrangements to ensure equality and diversity is a focus in all that we do and deliver**
- **Develop the leadership and management skills to embed a consistent supportive environment for all staff and diverse workforce**