NHS
Bath and North East Somerset, Swindon and Wiltshire
Clinical Commissioning Group

Equality, Diversity and Inclusion Strategy

Our strategy describing our commitment to eliminating all forms of discrimination, increasing our awareness and providing equality of opportunity for everyone in Bath and North East Somerset, Swindon and Wiltshire

July 2021

NHS BaNES, Swindon and Wiltshire
Clinical Commissioning Group (BSW CCG)

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Foreword

This document sets out how Bath and North East Somerset, Swindon and Wiltshire (BSW) CCG is developing its plans and approaches to tackling equality, diversity and inclusion in everything we do, whether that is in commissioning services, employing people, developing policies, communicating with or engaging with local people in our work to ensure the right choices and decisions are made.

This document forms part of BSW CCG's commitment to create a positive culture of respect for all individuals, including colleagues, patients, their families and carers as well as community partners. We recognise that we have a journey ahead of us to further develop ourselves and promote better understanding of equality, diversity and bias across our organisation and our successive organisational structures. We want to promote positive practice and value the diversity of all individuals and communities. We know that we need our colleagues and communities to help us with this work and have demonstrated the benefits of this approach over the last year in responding to the COVID-19 pandemic and particularly vaccination of all our communities.

In our commitment to equality, diversity and inclusion, we have a designated Board lead who is responsible for ensuring the Governing Body considers Equality, Diversity and Human Rights, supported by operational Equality Champions within the CCG and we will continue to build on these foundations to support these further developments.

Gill May
Executive Director of Nursing & Quality
Equality & Diversity Lead

Executive Summary

The Bath and North East Somerset, Swindon and Wiltshire (BSW) CCG Equality, Diversity and Inclusion Strategy has been developed in two phases. Firstly, following the merging of our predecessor Clinical Commissioning Groups (CCGs), during our response to the COVID-19 pandemic. And secondly, a year after merging and incorporating the learning locally and globally to refine and better define what we want to achieve. This strategy also further recognises the journey we are taking to form a new Integrated Care System (ICS) known as the BSW Partnership, meaning that we can achieve more as we pool our resources across BSW.

Over the last year, we used our interim strategy to support implementation of the best process, systems and support from each of our predecessor CCGs into BSW CCG. In addition, we have been continuing to learn from other systems and organisations about what good practice really looks like in relation to equality, diversity and inclusion. We have also worked more closely with our colleagues and communities to better define the issues we need to focus on and the actions we need to take. We know that we need to continue to do this more, including building on the learning from the COVID-19 pandemic.

Our whole organisational vision is “Working together to empower people to lead their best life.” As a commissioning organisation, this means that we will work both with our providers and with the people that live here to deliver improved health outcomes for everyone across our population.

This document describes the actions we have already taken and our next steps in relation to the following six areas:

1. ***Leadership and Governance***

   We are compliant with the relevant legislation and guidance on good governance and reporting; we have set up a good infrastructure as we became a new organisation. However, we know that we need our leadership and wider organisation to be more representative of the communities and individuals we serve and to promote greater understanding of life experiences. To support this, a key action is the development of reciprocal mentoring arrangements, facilitating those with different life experiences coming together to learn from each other. As we develop our Integrated Care System and establish new governance arrangements, we intend to bear in mind the need to recruit from a broader base and have more diverse representation in our governance structures.

2. *Impact Assessments*

We routinely assess the impact of service changes as part of our commissioning and governance processes. However, we believe that we can further embed these processes to better understand the impact of changes, and proactively drive improvements in our communities and colleagues where these are most needed. We have templates and forms but will support greater understanding by supporting colleagues to actively consider inequalities in all they do.

3. *Communication and Engagement*

Communications and engagement is a key enabler to tackling inequalities, ensuring our plans and activities are inclusive. We have a small but experienced communications and engagement team that leads campaigns and engagement with our local communities and supports colleagues working at the CCG and across BSW to involve people, including those with protected characteristics and the seldom-heard, in designing services and identifying how we can further reduce health inequalities. The team is already developing more representative engagement via our BSW Citizens' Panel (Our Health, Our Future), a virtual panel of individuals across our communities who complete regular surveys on healthcare topics. Understanding and tackling the impact of COVID-19 on different population groups, including Black, Asian and Minority Ethnic communities, those with learning disabilities, mental health patients, physically disabled people, and vulnerable people remains a key priority for the near future.

4. *Our Workforce*

We are compliant with the relevant legislation and guidance on employment, but we recognise that across the NHS, people with protected characteristics do not always experience the NHS as a good employer. To ensure that we look after our colleagues and give them every opportunity, we have developed our People Strategy and our focus in relation to equality and diversity will be on delivering improved training for all our colleagues on equality, diversity and inclusion, and ensuring that colleagues with protected characteristics have at least equal opportunity in our organisation.

5. *Commissioning and procurement*

As the commissioner and contractor of many services, we ensure that our providers are compliant with relevant legislation in relation to equality, diversity and inclusion. We are ensuring that all healthcare providers provide a completed health inequalities action plan as part of their contracts in 2021/22. However, we recognise that improved use of Impact Assessments and better engagement with our communities can make us even better commissioners of services. A particular focus will be ensuring that all data can and is filtered by protected characteristics and other determinants of equality where this is available and that we take appropriate actions to support equality of access and outcomes in our services. We are also planning some particular actions following learning from Learning Disability Mortality Reviews which are more fully described in the strategy. We will use the Public Health South West – Recovery Framework resources to inform our commissioning and performance of services.

6. Complaints, concerns and compliments

We have already aligned our complaints processes as a single, merged CCG. Our focus now will be on embedding our processes and promoting learning across our wider geography which is more diverse and offers opportunities to collate learning thematically, including using protected characteristics where available.

Our strategy outlines our challenges and opportunities, as well as the actions we have already taken and the things we will continue to focus on in our future as BSW CCG and subsequently BSW Partnership. We recognise that this is part of a longer journey to becoming a mature, inclusion-driven organisation and we will monitor our progress against specific elements of this programme of work and our wider aspirations to be a more inclusive and diverse organisation.

1. Introduction

Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group (BSW CCG) formed on 1st April 2020. We have a population of around 940,000 people and cover a wide geography containing rural and urban, affluent and more deprived areas.

We are committed to eliminating all forms of discrimination and providing equality of opportunity for everyone. We recognise and value the diversity of our communities and believe that equality is pivotal to the commissioning of modern, high quality health services.

The impact of the COVID-19 pandemic has been far-reaching, not least in terms of diversity and inclusion. The pandemic had a catastrophic effect on many people's lives but has had a disproportionate impact on individuals and communities from a Black, Asian or Minority Ethnic background and those with pre-existing health conditions and disabilities (physical and mental health). There is increasing evidence that individuals with any protected characteristic, as well as people experiencing social and economic deprivation, have been more negatively affected by the pandemic and some of the actions that have been taken to tackle it.

The pandemic, alongside other national and international events, has led almost every individual and organisation to consider inclusivity, equality and affirmative action in a new light and this is also true of BSW CCG. We have been alerted to the need to understand which groups of our population are most at risk of contracting COVID-19 and experiencing other inequalities in health access and outcomes. We recognise that some individuals and groups of people are impacted by the issues that drive a range of inequalities not only in direct relation to accessing health care but the impact on their health and wellbeing from wider economic and social determinants.

This strategy is arranged into 6 areas of focus:

1. **Leadership and Governance**: How we will continue to develop our governance structure for equality, diversity and inclusion and ensure that decisions are made based on clear evidence detailing the impact of those decisions on equalities.

2. **Impact Assessments**: Ensure that we complete Equality Impact Assessments (EIAs) to identify potential impacts on and outcomes for patients and do this earlier in our processes. Use the results of EIA as an integral part of our decision making and commissioning processes.

3. **Communication and Engagement**: Ensure that our communications and engagement activities are inclusive and therefore being effective in reaching people from all protected groups, including carers and seldom heard or marginalised communities. Involve people in designing services and identifying

how we can further reduce health inequalities. Work with our statutory and voluntary sector partners on equality issues and to tackle health inequalities.

4. **Our Workforce**: Ensure that our Human Resources policies are fair and transparent, and work in partnership with our colleagues and potential employees to improve their working lives. Ensure all our colleagues have the necessary skills to commission services in line with the Equality Act 2010 but more broadly to have greater understanding of the imperative to combat inequalities.

5. **Commissioning and procurement**: Enhance assurance mechanisms to satisfy ourselves that providers who are delivering services on our behalf are complying with the Equality Act 2010, including accessibility. Monitor the health inequality action plans within healthcare contracts.

6. **Complaints, concerns and compliments:** Monitor complaints, comments and compliments by protected characteristic and understand the themes in complaints.

But more broadly and cutting across these 6 themes, we have a focus on the following elements:

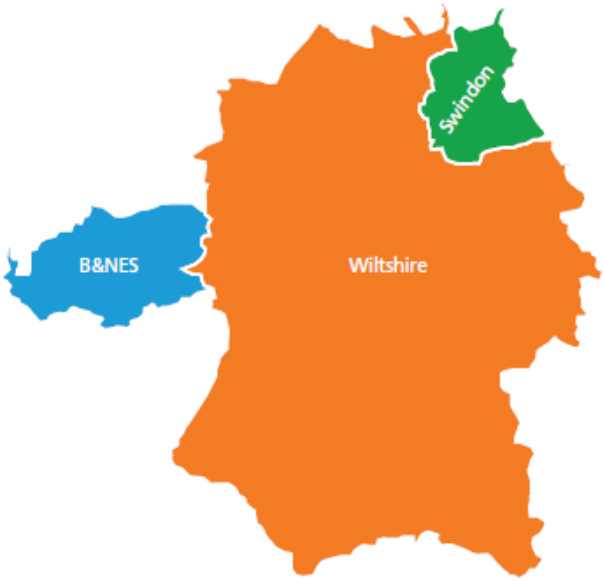
Engagement with colleagues and staff networks is being strengthened and prioritised to enable us to hear and learn from people's lived experience resulting in real change across the NHS.

Representation in decision making will ensure that colleagues with protected characteristics and diverse backgrounds have influence over decisions that affect them. All Board members are expected to lead internal scrutiny and assurance at all levels.

Supporting our colleagues and communities to recover, ensuring there is tailored and ongoing health and wellbeing support during and after the pandemic and bringing back services in a resilient way, learning from the pandemic.

2. BaNES, Swindon and Wiltshire - our population

Bath and North East Somerset, Swindon and Wiltshire (BSW) has a combined population of around 940,000 served by 90 GP practices, three acute hospital trusts, two independent health providers, a mental health provider for adults and a mental health provider for children and young people and an ambulance trust. It has a single Clinical Commissioning Group and is served by three local authorities.



While the area as a whole is less deprived than other parts of England, there are pockets of deprivation sitting alongside more wealthy communities where people do not live as long and are more likely to have health issues.

For example, in some areas of Wiltshire, the gap in life expectancy between the most and least deprived areas is 11.7 years. One of our goals is to reduce this variation in outcomes by working across geographical boundaries and with better collaboration.

In the next five years, we expect our older population to grow considerably. Currently there are 80,000 people aged over 75 in the area, many with multiple long-term illnesses. By 2024 we expect this figure to exceed 100,000. We also expect significant population growth in some areas, for example in Wiltshire there is an on-going programme to relocate army personnel into the authority and across our geography there are a number of large scale housing developments planned or underway.

Cancer, cardiovascular disease and respiratory disease are the main causes of death in BSW, but we know that people in more deprived areas will suffer more from these diseases. A focus for us is to help people to improve their outcomes, or prevent disease, by making healthier choices about smoking, eating and alcohol use.

More detailed information on each of our localities (BaNES, Swindon and Wiltshire) can be found in Appendix 1.

3. BSW CCG's vision, mission, values and key priorities

The recent merging of Bath and North East Somerset, Swindon and Wiltshire CCGs and our increasing collaboration with our stakeholders and providers is part of our journey to form a new Integrated Care System (ICS) known as the BSW Partnership. This means that we can achieve more as we pool our resources across our three localities, including staff, skills, specialisms and finances. We will work even more closely with public health, local authorities (including housing, education and leisure), voluntary and community groups across the whole area. Integrated Care Systems have been shown to deliver the best outcomes for patients and populations.

3.1 Our corporate priorities

Our corporate priorities at the point of merging all influence equality, diversity and inclusion:

1. Reduce inequalities in people's access to care and treatment.
2. Simplify an overly complex system to improve services and make efficiencies.
3. Improve people's journey and experience through care by putting them at the centre of everything we do.
4. Ensure we protect access to specialist treatment.
5. Supporting our communities and citizens to take better ownership of their own health and care.

We know people from our more vulnerable and deprived communities have generally worse health and shorter lives than those in better-off areas, and levels of smoking, obesity, alcohol abuse and mental health issues are higher in these communities. As an Integrated Care System we want to tackle this inequality by formally implementing "health

in all" policies across all health and care partners that specifically help people in disadvantaged or vulnerable communities to access support.

Among other initiatives, this will include:

- Helping people with severe mental health problems to access regular health checks.
- Ensuring children with learning disabilities and autism have access to hearing, eyesight and dental services.
- Extending our healthy schools programme.
- Addressing the links between alcohol and mental health.
- Promoting our smoke-free programmes in acute and community settings.
- Ensuring all key organisations delivering health and care across the area use the behaviour change programmes such as "Making Every Contact Count" and "Connect 5".
- Establishing a rough sleeping pathway to address housing and finance issues.
- Promoting healthy living messages in places of work.
- Providing regular meetings between colleagues and their line managers to support physical and mental wellbeing across our organisation.

4. Meeting our duties

The publication of this strategy is a clear expression of our commitment to valuing diversity and embedding equality and Inclusion considerations in the way we deliver our business and make commissioning decisions. We aim to reduce health inequalities by actively identifying and removing barriers or unfair bias to the health and wellbeing of our communities. We will work with our colleagues and communities to better understand some of the ways to achieve this.

We recognise:

- Our legal duties relating to equality, human rights and inclusion – we understand that compliance is not enough and we need to go beyond these to promote cultural changes to ensure equality and inclusion are at the centre of all that we do.
- That our responsibility for discharging the duty cannot be delegated or sub-contracted and that ultimate responsibility for discharging the duty remains with us as commissioners. This means that we must have mechanisms in place to make sure that organisations providing services on our behalf are also meeting the duty.
- That the moral case for equality, diversity and inclusion is fully justified - health inequalities are unacceptable and must be minimised.
- That the *Marmot Review 10 Years On* (2020) estimated that the total annual cost to the NHS associated with inequality is £12.52 billion – this is a strong business case for identifying and addressing barriers to health equality.

Appendix 2 summarises and links to some of the legislation and our obligations and commitments to its adherence, including the Equality Act, Public Sector Equality Duty, Human Rights Act, NHS Constitution, Equality Delivery System (NHS monitoring system), Accessible Information Standard and Learning Disability Mortality Reviews.

We are also aware of our legal duties under the following Acts and are committed to ensuring that we comply with the requirements set out within them

- The Children Act 2004
- The Care Act 2014
- The Children and Families Act 2014
- The Autism Act 2009
- The Public Services - Social Value Act 2012
- Modern Slavery Act 2015

The following sections describe our approach to equality, diversity and inclusion in relation to

1. Leadership and governance,
2. Analysis and assessment of impact,
3. Communications and engagement (including the Accessible Information Standard),
4. Our workforce,
5. Commissioning and Procurement (including specifics on LeDeR) and
6. Complaints, concerns and compliments.

5. Leadership & governance

The CCG's standard of leadership is monitored by NHS England as part of the NHS Oversight indicators. Assessment is made in the following areas:

- Probity and corporate governance
- Staff engagement index
- Progress against the Workforce Race Equality Standard (WRES)
- Effectiveness of working relationships in the local system
- Patient and community engagement

The BSW Governing Body is made up of GPs, lay members, clinical and health professionals from the workforce. We recognise that over time we need to do more to recruit a more diverse Board and ensure that Senior Leaders and Board members have a good understanding of diversity and equality. As our organisation further evolves to become an entity in the Integrated Care System we will prioritise diversity and representativeness in our recruitment.

The core attributes and competencies for all Governing Body members include a requirement to "be committed to ensuring that the organisation values diversity and promotes equality and inclusivity on all aspects of its business." Individual members of the BSW Governing Body will bring different perspectives, drawn from their different professions, roles, backgrounds and experience. Many of the Governing Body members are GPs who work closely with their patient bodies and contribute to the commissioning decisions made by the organisation through the use of this local knowledge. These differing insights into the range of challenges and opportunities facing the CCG will, together, ensure that the CCG takes a balanced view across the whole of its business. The CCG has three lay members on the Governing Body, one with specific responsibility for Patient and Public Involvement.

Equality, diversity and inclusion reporting is presented to the Governing Body and to its appropriate sub-committee(s) regularly and incorporated into reporting, not additional. The Registered Nurse on the Governing Body has an explicit role to take an active leadership role in setting out the vision for equality, diversity and inclusion in the organisation, championing its delivery and continually meeting our legal duties as set within The Equality Act 2010. She is also our Wellbeing Guardian and one of our Freedom to Speak Up Guardians, roles which align closely.

5.1 In leadership and governance, we already:

- Developed the new BSW constitution, governance and accountability mechanisms to enable us to meet our duties and responsibilities, including the delivery of the statutory functions of Equality, Diversity and Human rights. Within these, we clearly articulate our equality objectives for BSW.
- Recruited a Lay Member responsible for Patient and Public Engagement across BSW CCG.
- Identified the Registered Nurse on behalf of the Governing Body to act as the lead for equality, diversity and inclusion alongside the Equality Champions.
- Embedded equality, diversity and inclusion within the CCG Combined Impact Assessment which includes equality, quality and data processing. We also include an assessment of the equality impact for all papers presented to the Governing Body and Committees of the Governing Body.
- Aligned and embedded our equality monitoring systems and processes across BSW CCG as we became a new organisation.
- Developed our BSW CCG People Plan, aligned to our ICS People Plan and the national NHS requirements. The Equality, Diversity and Inclusion Strategy and People Plan are closely aligned with a clear focus on facilitating all of our colleagues to progress and develop in line with their aspirations, treating all our colleagues as system leaders, and enhancing the diversity of our organisation.

5.2 Next steps in leadership and governance:

- Use the BSW Citizen's Panel as an open forum that ensures the public and patients can engage with BSW to continue to develop our Equality, diversity and inclusion priorities. The panel is broadly matched to the composition of our population and all survey data is supplied with perspectives from different localities and people with protected characteristics.
- Widen access to coaching and mentoring across the organisation, asking our Executive and Board members to mentor colleagues, including reciprocal mentoring to support our Executive and Board members to better understand what it is like to walk in the shoes of some of our colleagues and support these colleagues to have a stronger voice. In order to strengthen our approach to this work, we are working with partners across our ICS, giving a breadth of experiences and backgrounds of coaches and mentees.
- Nominated Quality and Equality Leads will link with nominated Equality Champion(s) to ensure the equality and compliance challenge is continually monitored at Board level.

6. Equality Impact Assessments (EIAs)

EIAs allow public authorities including CCGs to identify the impact or effect (either negative or positive) of their policies, procedures, projects, services, and functions on different sections of the population, paying particular regard to the needs of protected groups and other disadvantaged groups.

Through the use of EIAs, we have adopted a robust approach that ensures that the impact of decisions which may affect individuals is scrutinised before implementation. We have created a tool that supports assessing the impact of equality, quality and data issues together in a Combined Impact Assessment. This tool allows us to assess the impact of our proposals which in turn enables us to facilitate our services delivering high-quality health care that is fair, accessible to all and meets the needs of our diverse communities.

Almost all functions and activities of the CCG are subject to general or specific equality duties - this means that all strategies, policies, action plans and projects we undertake must be assessed for equality impact including our Human Resources policies and procedures.

6.1 In assessing impact we already:

- Developed a Combined Equality, Quality and Data Impact Assessment template for managers and commissioners to use, supported by our quality leads and this is monitored throughout decision making processes.
- We hold regular quality meetings with each NHS Provider at which relevant equality, diversity and inclusion areas are discussed such as mixed sex accommodation and the underlying essence of care requirements.
- We ensure equality risks are identified, investigated and escalated.
- Our Quality and Performance Assurance Committee (QPAC) and Quality Surveillance Group oversee our EIA process and all proposed changes must have an EIA.
- We have embedded equality as part of our Quality Improvement (QI) programme

6.2 Next steps in assessing impact:

- Nominated BSW Quality and Equality Leads will provide specific coaching on equality and quality impact assessment on a one to one, on the job basis to CCG colleagues responsible for undertaking these assessments. This will help us to deliver our commitment to increase the quality and numbers of impact assessments completed and will ultimately result in quality of service improvements. We plan to use the results of impact assessments policy formulation or service design phase to improve our decision-making and deliver better health outcomes for protected groups.
- We are ensuring that our annual prioritisation process is further driven by equality and quality assessments and analysis of need.

7. Communication and engagement

We want to understand what really matters to local people and demonstrate how everyone's insight and feedback has contributed to planning future health and care services. We are committed to making our communication and engagement work inclusive, ensuring that we make opportunities for a diversity of voices to be heard through the use of modern technologies and communication channels. We will engage and involve local communities and stakeholders from protected and vulnerable groups in the commissioning of services and pathways that will have an impact on them.

Our patient engagement groups in Bath and North East Somerset and Swindon meet regularly and provide an opportunity for the public to feedback and help shape our plans to improve local health and care services. These groups act as a critical friend to the CCG, discussing potential service changes from planning through to delivery. Members are also encouraged to inform and support the CCG's engagement with the wider public, by advising us on different approaches and groups who we should consult with and sharing information and surveys with any other local/community groups they are involved with.

Over the last few years we have engaged with communities on a wide range of projects. During the summer of 2019 for example, as we were thinking about our priorities for the future, we gave people in BSW an opportunity to help shape how health and care services are provided in the future. Over a six week period we invited all local residents to say what they need to live healthier and happier lives as part of a campaign called Our Health, Our Future. We developed a campaign approach that would effectively target young people and included targeted outreach to people with learning disabilities and Black, Asian and Minority Ethnic communities across BSW. Answers were used by health and care providers as part of a forward looking plan which will set out how everyone will be able to access the services and support they need. The plan outlined a local response to priorities laid out in the NHS Long Term Plan which was published in January 2019.

We have set up a virtual forum, known as the Our Health Our Future panel that has a current membership of more than 1,000 people and which participates in online surveys about our work. During COVID-19 we have been recruiting new members to the panel via virtual and face-to-face recruitment events and we have now recruited panel members that are representative of the BSW population. Full reports from each survey are available on our website, and the insights captured from the questionnaires are used to inform future decision making, strategy, service design and service change.

7.1 In communications and engagement we already:

The CCG has an experienced and professional communications and engagement team which continues to work with and involve key stakeholders in areas that require feedback, comment or suggestions for improvement. The ongoing work of the team is in line with the CCG's Communications and Engagement Strategy, published in November 2020. It includes, but is not limited to:

- Overseeing the CCG's Patient and Public Engagement Forums to allow people living in the local area, especially those from minority groups to have their say on healthcare issues.
- Holding regular deep-dive sessions, or in-depth focus groups, that allow key stakeholders to come together with healthcare staff and senior CCG representatives to discuss a specific topic and share their ideas for change, improvement or review.
- Posting thought-provoking and engaging content through the CCG's social media channels that actively encourages a two-way conversation with local people.
- Leading on, but also supporting partner organisations with key campaigns to raise awareness of specific issues, such as winter healthcare and the promoting new or existing services.
- Delivering an Annual General Meeting in which stakeholders can attend to hear the latest CCG updates, put questions to executive directors and take part in discussions that will shape and inform future healthcare services.
- Producing the CCG's Annual Report – and its supplementary patient and public involvement report – to give local people details of the CCG's activities during the past year and its plans for the year ahead.
- Maintaining our engagement log and stakeholder database in line with General Data Protection Regulation (GDPR) guidance to enable us to keep a record of engagement activity and identify and involve relevant stakeholders in our work.
- Sharing information about the work of the CCG via a range of channels including a fortnightly engagement newsletter sent to Forum members and other interested parties.
- Working in partnership with Healthwatch B&NES, Healthwatch Swindon and Healthwatch Wiltshire from our time as standalone CCGs and we are committed to strengthening these relationships to collate insights and understanding of the needs of our population and to support ensuring health and public health messages are tailored to the diversity of cultural needs across our geography.
- Understanding and tackling the wider impact of the pandemic on different population groups, including Black, Asian and Minority Ethnic communities, those with learning disabilities, mental health patients, physically disabled people, and vulnerable people. In March 2021 for example we held an event for people from Black, Asian and Minority Ethnic communities to explore concerns about the COVID vaccine. Over 40 people attended our *Open Doors* event.

7.2 Next steps in communications and engagement:

- Use the BSW Citizens Panel to help us address our priority areas and identify additional local priorities. We will also seek the advice and input from members to design accessible activities and resources that will allow us to engage meaningfully and more widely with different groups and communities and will complement our patient engagement groups.
- Review our patient engagement groups and develop an engagement model for the CCG to ensure there are effective communications at a locality and system-wide level, with a network of supporters, champions and groups so we reach, and have meaningful engagement with, rural communities and seldom-heard groups.
- Scope out and map all the engagement groups, networks, channels available via our partners across BSW so we can share best practice and intelligence, be more effective at reaching seldom-heard groups and avoid duplication.
- Develop a toolkit and training programme to help embed engagement further across the CCG and will also make these tools available to our partners. The toolkit will include guidance on how to involve the public in our work and how our volunteer patient representatives should be supported to fulfil their role with respect to public involvement.
- Continue to strengthen our relationships with the voluntary sector and their involvement in our plans at a system-wide and locality level. We will compliment meetings taking place in each locality with a regular system-wide event.
- Organising and delivering public engagement activities on local and BSW matters that require contribution from the local population, such as collecting views on proposed changes to healthcare services.
- Keeping the BSW website up to date with accurate information that is written in a way that can be read and digested by all people, including those who may have learning disabilities or those for whom English is not a first language.

7.3 Accessible Information Standard

Accessible information and communication are central to us delivering our strategic priorities. We cannot achieve this unless we fulfil one of our main responsibilities as a commissioner and report the outcomes of our work so that people have accessible information about the quality of their local health and adult social care. To reach our targeted audiences, we are committed to compliance with accessibility regulations including:

- Publishing information about what we do and distributing it widely.
- Providing information in clear and simple language.
- Setting out clearly, in simple English, what we write.
- Making our website easy to use.
- Making our information available in different formats on request, such as easy-to-read format and in large print.

8. Our CCG workforce

We are committed to working in line with the current employment legislation including meeting the provisions of the Equality Act 2010. The CCG aims to provide a working environment which is free from discrimination, victimisation and harassment on individual and/or institutional basis on the grounds of any of the nine protected characteristics specified in the Equality Act 2010. We know that some colleagues from Black, Asian or Minority Ethnic backgrounds and colleagues with disabilities have experiences in the NHS that do not correspond with our CCG or wider NHS values and we want to change this.

We are committed to ensuring that our colleagues are reflective of the populations we serve from the top down. We believe this will enable us to embed equality, diversity and inclusion into our business and help us to respond more effectively to the needs of our service users and communities. Our responsibilities as an employer are set out in our suite of Human Resources policies and procedures.

We collect information on an annual basis on the CCG's workforce and where possible against the protected characteristics. As the size of the workforce within the individual historical CCGs was relatively small, it was potentially easy to identify colleagues and for this reason, we have not historically published this information. However, this data is now summarised in Appendix 3 which shows that the majority of the workforce is female and has declared an ethnic group of White British.

In the future, we will continue to publish and monitor more detailed information as the BSW collective head count has increased. We also commit to review the BSW Workforce Race Equality Standard (WRES) application and provide assurance that we will advance Black, Asian and Minority Ethnic senior leadership opportunities.

The CCG requires all colleagues to undertake mandatory equality, diversity and inclusion training. Training is provided via an online module which colleagues are required to complete and pass three yearly. We believe that we can offer a more educative and enlightening experience about equality, diversity and inclusion to our colleagues and will seek to find appropriate tools to do this over the coming year; something that has also been requested by some of our colleagues. This will support all of our colleagues to understand their own biases and be able to speak more easily and feel able to challenge equality, diversity and inclusion issues.

Our People Strategy is closely aligned with this Equality, Diversity and Inclusion strategy and has a strong focus on diversity which will also continue to develop over the next few years as we develop into and ICS and with input from our colleagues to support this.

8.1 In relation to our workforce we already:

- We have systems and procedures in place to implement the aims of the general equality duty.
- We aim to have a workplace where discrimination, victimisation and harassment is completely eliminated. In late 2020, the CCG repeated its annual staff survey which seeks to identify areas of good practice as well as factors requiring improvement in leadership, communication, the working environment and employee relations. The questionnaire explicitly asked for responses about bullying and harassment, enabling activities to be planned if any response is required.
- The CCG operates a BSW Colleague Partnership Forum which maintains involvement in staff related policy development and changes affecting the organisation. Following focused work in 2019-20 about organisational change in relation to the merging of our organisation, the group continues to meet monthly.
- The CCG continues to refine its recruitment arrangements to ensure equality of opportunity is provided to applicants to the CCG.
- Policies continue to be developed which support BSW flexible/agile approaches to working to enable colleagues to balance work and life commitments including in regard to caring duties. We recognise that our business needs may have changed during 2020/21 as a result of different ways of working through the pandemic.
- Through the CCG's Learning and Development Policy, opportunities for development are made available to applicants. Targeted groups of colleagues have also received training to assist them in delivering good customer service and therefore reduce the risk of harm to themselves through an enhanced understanding of managing conflict.
- We have co-created an Inclusion Charter with colleagues across the organisation who volunteered to be involved. The Charter closely aligns to our corporate values and behaviours, describing our expectations about the inclusive behaviours in our organisation.

8.2 Next steps in workforce:

- Work locally in partnership with our system partners to improve engagement at every opportunity with perceived "harder to reach groups" and those with one or more protected characteristics as a part of the review of our performance against the Equality Delivery System (EDS) goals and outcomes.
- Periodically review and revise our statutory and mandatory training to ensure that it remains relevant.
- Act on any relevant feedback from subsequent colleague surveys in relation to equality, diversity and inclusion.
- Develop an enhanced equality, diversity and inclusion programme which will raise awareness and understanding and to increase the confidence and capability of our colleagues.

9. Commissioning and Procurement

We recognise that we are ultimately accountable for ensuring that the services we commission are delivered in line with the equality and Human Rights legislation and that both we and our providers comply with the Public Sector Equality Duty. We ensure that all our contracts and Service Level Agreements include clauses and performance measures around our equality and Human Rights duties and responsibilities, e.g. access to services and information in appropriate formats and treating everyone with dignity and respect. Additionally, from 1st April 2021 all healthcare contracts will include a healthcare inequalities action plan.

We understand that we need to work with our partners and providers to improve collection of qualitative and quantitative data to enhance our ability to commission high quality services. Whenever possible we will aim to disaggregate performance data by the nine protected characteristics so that we can monitor the impact of our commissioned services on different groups and take action to make improvements. This includes ensuring that clinical prioritisation takes account of this information and that proactive case finding of waiting lists becomes an embedded part of clinical validation activities within providers.

9.1 In commissioning and procurement we have:

- Introduced specific equality clauses (relating to services and Human Resources) in our contracts with providers.
- Actively considered and developed services that meet the needs of our population, targeting those who currently experience the worst outcomes where possible. For example, we have introduced a cardiac rehabilitation service in one of our localities which proactively tackles health inequalities amongst different communities, to make sure that anyone who needs heart failure or cardiac rehabilitation is supported to do it.
- Included the requirement for a health inequalities action plan in all healthcare contracts; and ensured that there is an identified board level executive responsible for addressing and reducing health inequalities in each provider.
- Worked differently over the last year to support the COVID vaccination programme. We know that working more closely with our communities and providing different means of accessing services (e.g. community venues, a roving bus and canal boat) have all supported better outcomes for our communities.

9.2 Next steps in commissioning and procurement:

- Review the use of NHS EDS 2 across BSW as the framework to help us to gather, analyse and report on equality information against EDS 2 goals and outcomes.
- Review whether specific equality clauses in contracts are working as intended.
- Incorporate equality of performance into performance reports where data is available and continue to work on collating data on protected characteristics where this is not currently available.
- Review the BSW EIA/QIA process as part of our review of our annual planning processes.
- Utilise EIA / QIA outcomes as an integral part of commissioning with the required evaluation actions to be included in final contracts where appropriate.
- Review all procurement processes to ensure that equality is at the heart of every new service.
- Build on the good relationships and working of the last year in relation to COVID to better understand any gaps for our local population groups.

9.3 Learning Disability Mortality Reviews (LeDeR)

The CCG is part of the LeDeR programme (see Appendix 2) which is a national process to report and review the deaths of people with a learning disability (LD). The legacy CCGs forming BSW CCG actively participated in these reviews and this has continued into BSW CCG. The CCG, working with our local authority partners and wider stakeholders have developed the governance of the LeDeR process throughout 2020/21, including strengthening the LeDeR steering group and implementation of a Quality Assurance panel for all LeDeR reviews.

An annual report on our progress and next steps has been developed and is being shared with our Quality and Performance Assurance Committee (QPAC) and Governing Body in May. This describes the significant backlog of reviews that we have undertaken over the last year and our focus on learning from the themes and trends from these reviews which will be reviewed in a dedicated workshop in April 2021.

9.4 Next steps in LeDeR:

The key BSW LeDeR 2021-22 action priorities (aligned to thematic learning from reviews already undertaken) are:

- Continued progression with the improvement to the access and the quality of GP annual health checks.
- A planned review of BSW Hospital/Health Passports.
- Focus on GP diagnosis and LD coding; to meet the health and care needs of individuals.
- To review the impact of respiratory disease and BSW care pathways for those with a learning disability
- Implementation of the The Liberty Protection Safeguards (which were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the Deprivation of Liberty Safeguards (DoLS) system. The Liberty Protection Safeguards will deliver improved outcomes for people who are or who need to be deprived of their liberty. The Liberty Protection Safeguards have been designed to put the rights and wishes of those people at the centre of all decision-making on deprivation of liberty which are planned to come into force in April 2022).

Actions from individual reviews are also followed up as required and some have instigated safeguarding referrals reporting of serious incidents, which have oversight from the quality team.

10. Complaints, concerns and compliments

The CCG is always committed to providing the best possible service. We welcome suggestions and feedback about our services and want to resolve any problems experienced to help make local healthcare services more effective.

The CCG oversees all comments, concerns, compliments and complaints that are received. Complaints and Patient Advice and Liaison Service (PALS) is an impartial service and tries to resolve any concerns or problems that are raised by patients, their families and / or representatives. Complaints and compliments can be made in writing, by email, by telephone or in person. We aim to provide and disseminate this information in accessible formats, via variety of channels, across all groups of people protected under the equalities legislation as and when opportunities arise.

Our Complaints and PALS teams provide updates via the Quality and Performance Assurance Committee and the CCG Governing Body and a Complaints report is also presented to the Quality and Performance Assurance Committee. This report will be developed further to include all BSW complaints and the protected characteristics of the individual where disclosed. This information is also reported as part of the CCG's Annual Report.

10.1 We already:

- Include Patients' Stories as part of the Governing Body meetings in public. These allow individuals to recount their experiences of the delivery of care received as individuals, carers or by family members. This approach ensures that the Governing Body is connected to the communities served by the CCG.

10.2 Next steps in complaints:

- The BSW Governing Body will receive a report on complaints, concerns and compliments at least twice a year. The report will include equality monitoring of access to services and analysis of any equalities trends that have arisen from complaints received or the way they have been handled. The aim is to learn these incidents and improve our service in the future.
- The new, larger CCG is able to draw together complaints and compliments and identify themes in service delivery and protected characteristics across a wider geography. This is beneficial in terms of comparing and learning from experiences.
- We will seek to provide more diverse patient and colleague stories and experiences as examples from which we can all learn. In order to do this, we recognise that we need to build trust amongst our colleagues and patients so that they feel able to share their experiences.

11. Monitoring our progress

A programme plan is in place to monitor progress regularly and this is presented by the Programme Manager to our Senior Leadership Team and members of the Executive Team.

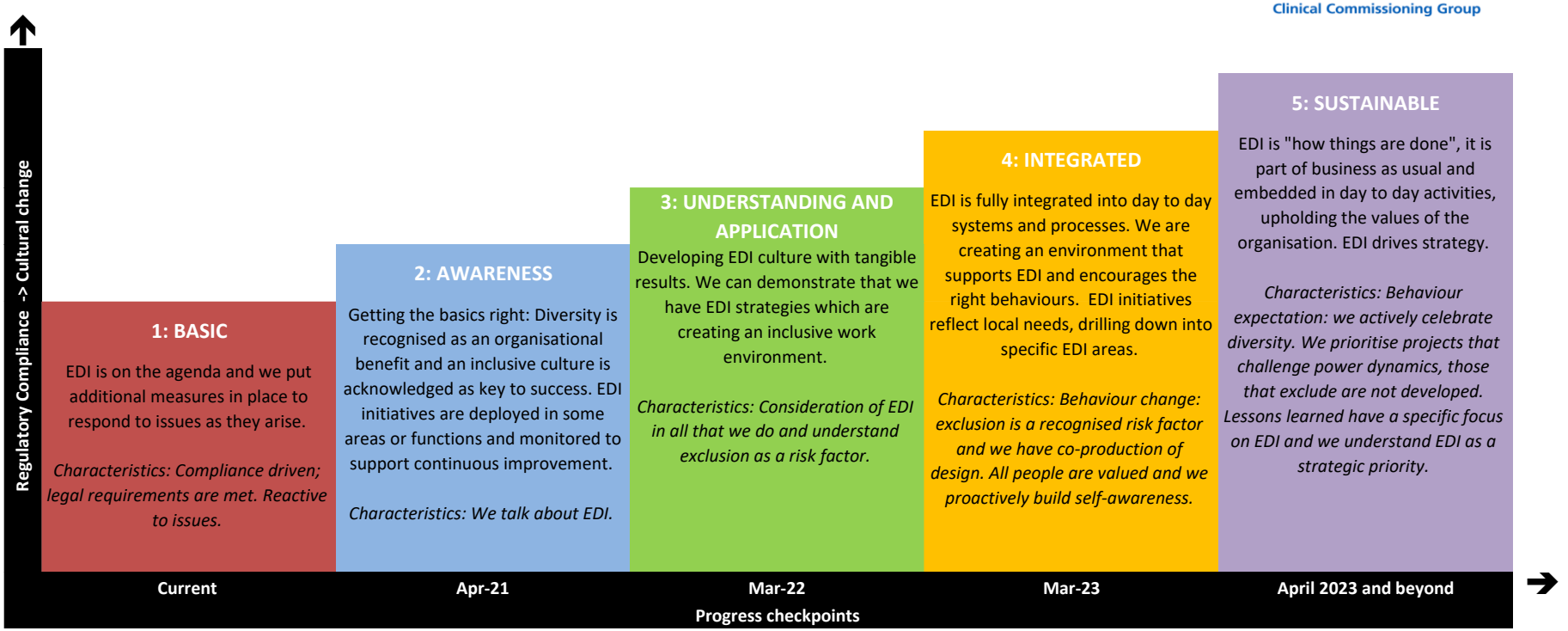
Taking a longer view, we will also continue to monitor our overall ambition to be a more inclusive and diverse organisation. We will do this by plotting our progress on the matrix below using self-assessment informed by our colleagues and stakeholders as well as progress against specific projects which we believe meet the ethos and characteristics of the matrix.

1: BASIC	EDI is on the agenda and we put additional measures in place to respond to issues as they arise.
2: AWARENESS	Getting the basics right: Diversity is recognised as an organisational benefit and an inclusive culture is acknowledged as key to success. EDI initiatives are deployed in some areas or functions and monitored to support continuous improvement.
3: UNDERSTANDING AND APPLICATION	Developing EDI culture with tangible results. We can demonstrate that we have EDI strategies which are creating an inclusive work environment.
4: INTEGRATED	EDI is fully integrated into day to day systems and processes. We are creating an environment that supports EDI and encourages the right behaviours. EDI initiatives reflect local needs, drilling down into specific EDI areas.
5: SUSTAINABLE	EDI is "how things are done", it is part of business as usual and embedded in day to day activities, upholding the values of the organisation. EDI drives strategy.

We would currently self-assess our organisation at Level 2: “awareness”, with some features of Level 3: understanding and application

Equality, Diversity and Inclusion (EDI) Maturity Matrix

NHS
Bath and North East Somerset, Swindon and Wiltshire
Clinical Commissioning Group



Adapted from BAE Systems, Solent NHS Trust, Texas A&M Technology Summit (2018).

12. Appendix 1: Our Localities

12.1 Our local Bath and North East Somerset population

Bath and North East Somerset (B&NES) is less ethnically diverse than the UK as a whole with 94.6% of residents defining their ethnicity as being from white groups. 5.4% of the population is from Black, Asian or Minority Ethnic groups, the largest group being Chinese (1.1%). 2.4% of respondents live in households where there is no-one over 16 who has English as their main language.

The local population's age structure is similar to the UK's population however, there is higher number of people aged between 20 - 24 mainly as a result of a high student population. Between 2001 and 2017, the growth in the 20-24 age range accounted for nearly 50% of the area's population growth.

In the last 2011 Census, 16% of BaNES residents reported that their day to day activities were limited through a long term illness or disability and 10% of the population stated that they spent a substantial portion of their time caring for a friend or relative.

- Deprivation within BaNES is substantially less than the England norm;
- Life expectancy for BaNES indicates a slightly better longevity for both males and females;
- Rate of Year 6 children classified overweight is lower; 14% compared to 20% for England;
- Adult obesity rate is lower; 61% in BaNES compared to 65% for England;
- Adult population in BaNES is significantly more physically active; 70% compared to the whole of England that is 57%;
- There is a significantly lower cancer mortality rate per 100,000 for 75 year olds and below in BaNES; 118 per 100,000 population compared to 139 per 100,000 population for England;
- Smoking attributable deaths per 100,000 population is significantly lower in BaNES; 208 compared to 284 per 100,000 population for England.

The 2011 Census identified that residents reported their religion as follows: Christian 56.5%, Muslim 0.7%, Buddhist 0.5%, Hindu 0.3%, Jewish 0.1%, Sikh 0.1%, Other 0.5%, not stated 8.5% and 32.7% reported having no religion.

The Joint Strategic Needs assessment for BaNES estimates that approximately 7% of the population are Lesbian, Gay or Bisexual. The Transgender population is not known, but estimated nationally to be 0.5% to 1%.

12.2 Our local Swindon population

Swindon as a town continues growing and developing at one of the fastest rates in England. Between 2001 and 2011 the last national census data showed that our population expanded by 17% to 210,000. We now have a very diverse community with at least 117 languages being spoken in Swindon schools.

Even though Swindon, the largest town in the area, has around 87% of the population, about 75% of the area of the borough is rural. The rural areas, including the villages of Wroughton, Blunsdon and the market town of Highworth, have also seen an increase in population over the last 10 years due to ongoing housing development.

The 2011 Census highlighted the following:

- Our overall population growth is faster than the average in England
- The growth in the over 75 and over 85 age groups has continued at a faster rate than any other age group (4-5% per annum)
- The proportion of our population with a long-term condition has remained static at 15%
- The proportion of our population from minority groups has nearly doubled in ten years
- The gap in life expectancy between the most and least deprived has decreased
- Life expectancy overall is better than the English average, BUT the potential years of life lost for our female population is amongst the worst in England

Swindon is classified as a prospering town and has benefited from a strong economy with above average growth in our total population. The 2011 census showed an increase in both the 0-9-year olds and working age adult population approaching retirement, but Swindon was below both regional and national averages for those over 60.

The 2011 Census also identified a significant increase in non-White British population to 15% and in those in schools for whom English was not the main language, up to 13%. The Census also identified that residents reported their religion as follows: Christian 57.5%, Muslim 1.7%, Hindu 1.2% and 31% reported having no religion.

In the population of Swindon (aged 16 years or more), it is estimated that 93.4% would self-identify as Heterosexual or straight, 1.2% would self-identify as Lesbian or Gay, 0.8% would self-identify as Bisexual, 0.5% would self-identify as Other, 4% would not provide a response. The Transgender population is not known, but estimated nationally to be 0.5% to 1%.

12.3 Our local Wiltshire population

The population of Wiltshire based on Wiltshire CCG's Joint Strategic Assessment 2018 (JSA) is estimated to be 490,018 – an increase of 4.7% since 2013 with the greatest growth of 7.6% seen in those aged 65 and over.

The 2011 Census identified that 96.6% self-identify as white, the majority being White British. 3.4% of respondents self-identified as being from Black, Asian or Minority Ethnic backgrounds with less than 0.5% in each ethnic group. The 2011 Census also identified that residents reported their religion as follows: Christian 64%, Muslim 0.7%, Buddhist 0.3%, Hindu 0.3%, Jewish 0.1%, Sikh 0.1%, Other 0.5%, not stated 7.7% and 26.5% reported having no religion.

The following are headline figures for different sections of the community in Wiltshire taken from information published by Wiltshire Council:

- 20% of those registered in Wiltshire are aged 19 or below (23% in England).
- 58% of those registered in Wiltshire are between 20-64 years (60% in England).
- 22% of those registered in Wiltshire are aged over 65 years (17% in England).
- 5% of Wiltshire residents live in some of the most deprived areas nationally. 29% of Wiltshire residents live in some of the least deprived areas nationally.
- There is a 0.8% registered prevalence of Mental Health conditions in Wiltshire, compared to 0.9% for England
- 14.1 people per 1,000 of the population in Wiltshire are receiving carers' allowance, compared to 20 per 1,000 in England.
- There is a near equal split between males and females.
- Wiltshire's minority ethnic population has changed from a largely Asian or Asian British grouping since 2001 to an Eastern European grouping where Polish migrants feature prominently. The number of those classifying themselves as from a 'mixed' background increased by just over 0.5% from 2001-2011 with the Black African population growing significantly over this period also.
- We also know that 2.5% of those aged three and over do not have English as a first language.
- The Integrated Household Survey data collected from January 2012 – December 2012 indicated that 1.1% of those that were surveyed identified themselves as Gay or Lesbian with 0.4% as Bisexual.
- The Gender Identity Research and Education Society, GIRES, estimate (in 2011) that 1% of the population (16+) experience some degree of gender variance, which in Wiltshire (based on 16+ population of 400,680) would equate to approximately 2,404 - 4,007 people.

13. Appendix 2: Links to further information on our statutory duties

13.1 Equality Act (2010)

The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. It provides the basic framework of protection against direct and indirect discrimination, harassment and victimisation. It replaced previous anti-discrimination laws with a single Act, making the law easier to understand and strengthening protection in some situations.
For further information, see UK Legislation: The Equality Act

13.2 Public Sector Equality Duty

The Equality Act contains special provisions for public sector bodies known as the Public Sector Equality Duties (PSED). It means that public bodies have to consider all individuals when carrying out their day-to-day work, including shaping policy, delivering services and in relation to their own employees.

For further information see Public Sector Equality Duty

13.3 Human Rights Act (1998)

Public sector organisations also need to have due regard to the Human Right Act 1998 (HRA). There are five principles of human rights which are: fairness, respect, equality, dignity and autonomy called the FREDA principles which also form part of the NHS Constitution. In commissioning and delivering services which are compatible with the HRA, the CCG commits to undertaking Human Rights based approach in line with PANEL principles: Participation, Accountability, Non-discrimination, Empowerment and Legality.

For further information, see UK Legislation: Human Rights Act.

13.4 The NHS Constitution (2013)

The NHS Constitution sets out rights for patients, public and staff. It outlines NHS commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The NHS Constitution, which was revised in March 2013, contains seven principles that guide the NHS. Many of these demonstrate commitment by the NHS to the requirements of the Equality Act and the Human Rights Act.

For further information, see The NHS Constitution for England

13.5 The NHS Equality Delivery System 2 (2013)

The NHS has a developed a framework for assessing and supporting equality performance called the Equality Delivery System (EDS). The system helps NHS organisations to improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. Based on evaluation of the original 2011 system, a refreshed EDS2 was released in 2013.

For further information, see The Equality Delivery System

13.6 Accessible Information Standard (2016)

From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly funded adult social care were legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. The CCG monitors any gaps in information required via complaints about commissioned providers as an example. The guidance and specification were updated in August 2017.

For further information, see the NHS webpage: Accessible Information Standard

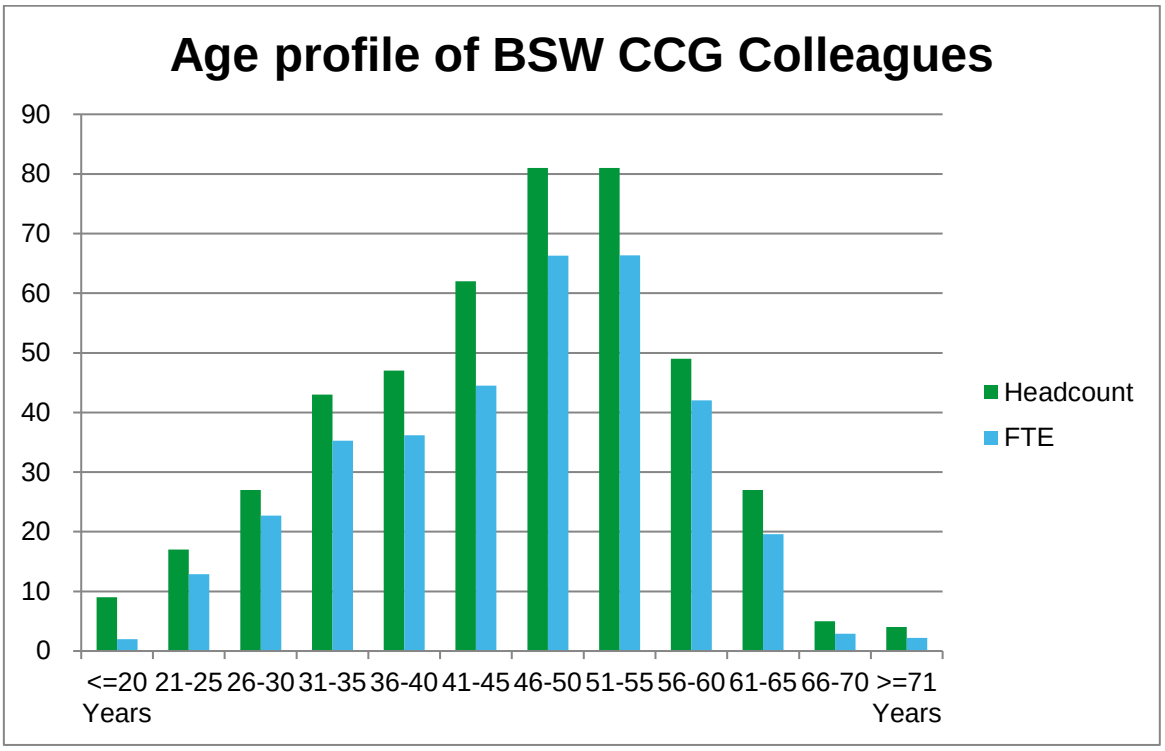
13.7 Learning Disability Mortality Reviews (LeDeR)

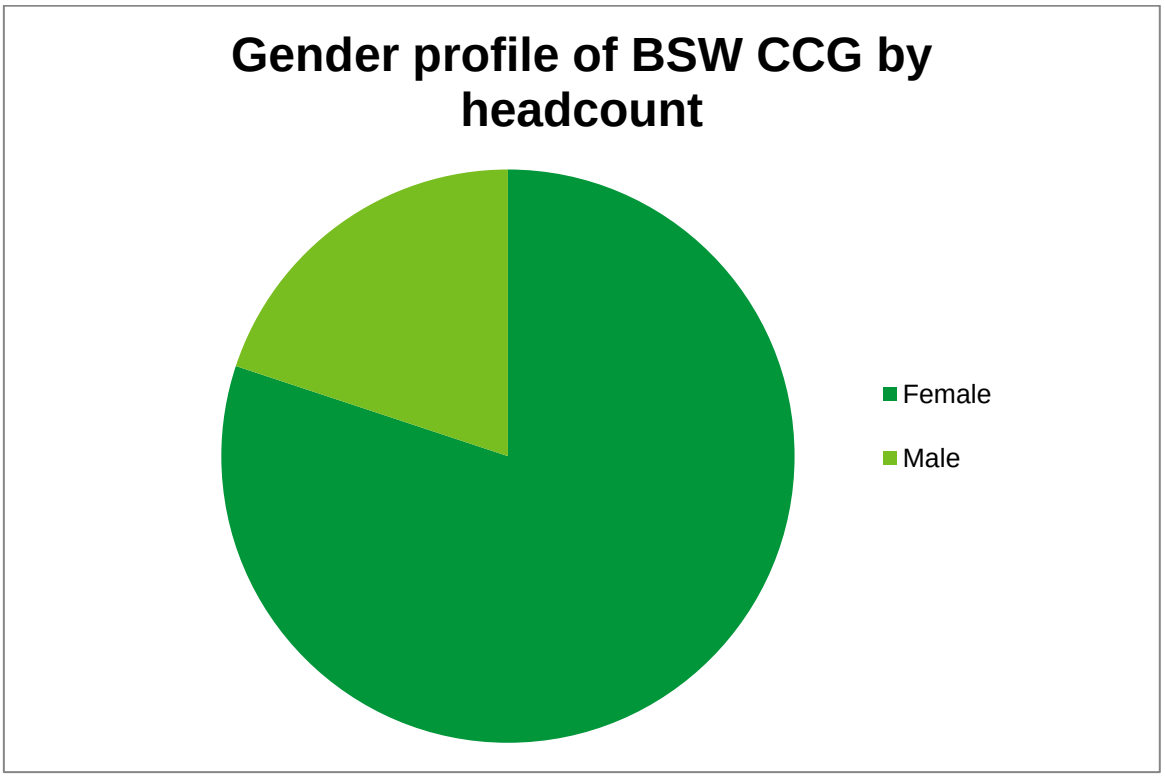
People with a learning disability often have poorer physical and mental health than other people and we know that too many people with a learning disability are dying earlier than they should have from things which could have been prevented.

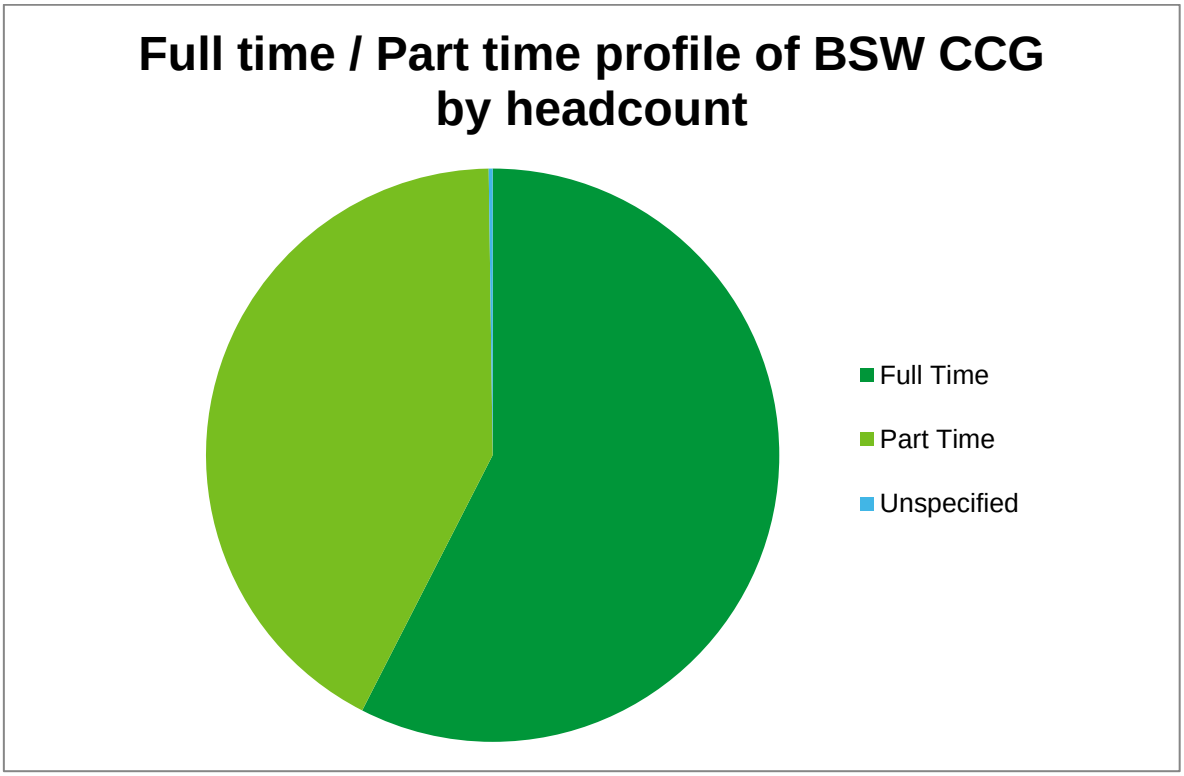
The LeDeR programme is a national process to report and review the deaths of people with a learning disability (LD). The purpose of LeDeR is to identify good and poor practice to improve future care by learning from deaths of people with a learning disability. Local and national learning is discussed and shared such as the national highest cause of death for someone with LD is pneumonia.

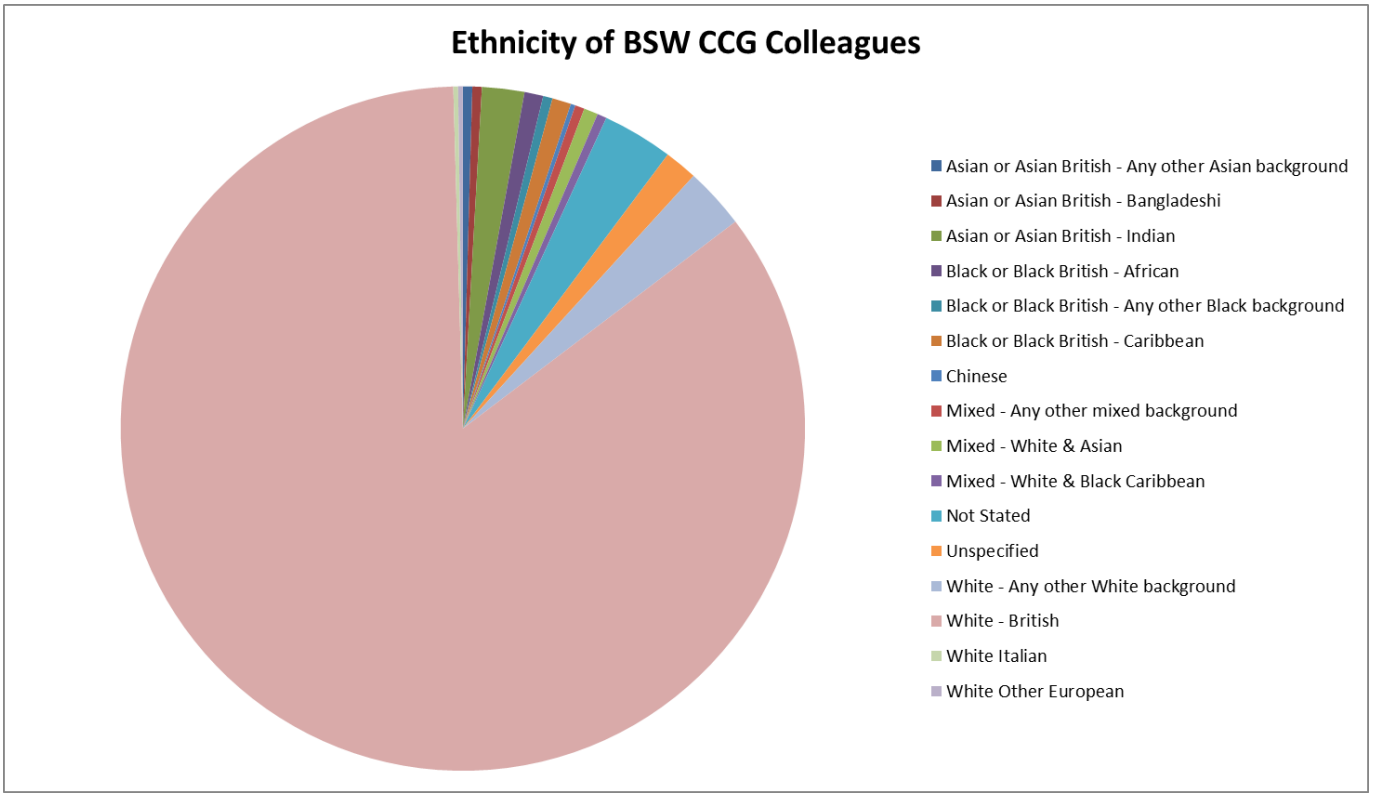
For further information, see the NHS webpage: Learning Disability Mortality Reviews

14. Appendix 3: Equalities profile of BSW CCG Colleagues






Full time / Part time profile of BSW CCG by headcount
Full Time
Part Time
Unspecified


Ethnicity of BSW CCG Colleagues
Asian or Asian British - Any other Asian background
Asian or Asian British - Bangladeshi
Asian or Asian British - Indian
Black or Black British - African
Black or Black British - Any other Black background
Black or Black British - Caribbean
Chinese
Mixed - Any other mixed background
Mixed - White & Asian
Mixed - White & Black Caribbean
Not Stated
Unspecified
White - Any other White background
White - British
White Italian
White Other European