NHS
Gloucestershire
Clinical Commissioning Group

Equalities Information – Annual Report

January 2014

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CCG

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1. Introduction

1.1. *Gloucestershire Clinical Commissioning Group* (CCG) is publishing this report as required under the specific equality duty of the Equality Act 2010. The report highlights the work Gloucestershire CCG has undertaken towards meeting its general Public Sector Equality Duty, gaps it has identified and action it is planning to take to improve its performance on equalities.

2. Who are we and what we do?

2.1. The CCG is a membership organisation of local GP practices. From April 2013 it took over responsibility from NHS Gloucestershire Primary Care Trust for buying (commissioning) health services to meet the needs of local people. CCG members bring their clinical knowledge of patient care to look at how services are planned and how the patient's journey through care can be improved.

2.2. All 85 member GP practices have signed up to the Gloucestershire CCG's constitution which guides the CCG's operations. The constitution is available to read at www.gloucestershireccg.nhs.uk under the publications tab.

2.3. Our Governing Body is the main decision making body of Gloucestershire CCG. We are also required by law to take account of the NHS Constitution in our decisions and actions. 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.

2.4. The role of our Governing Body is to ensure that the organisation is making best use of the money available and buying and developing health services that meet the needs of local people. It oversees the clinical programmes e.g. Dermatology, Mental Health and Cancer, looks at specific conditions and how the patient's journey through care can be improved. The Governing Body also makes sure that there is transparency and accountability in decision making and supports localities with the development of programmes and projects to support local communities.

2.5. The Governing Body is chaired by a Clinical Chair, a local GP, Dr Helen Miller and includes a Deputy Clinical Chair, GP liaison leads who represent the localities (e.g. Forest of Dean, North Cotswold) and lay members (members of the public who represent the views of local people and communities). Gloucestershire CCG is led by a range of experienced healthcare professionals who are passionate about securing the highest quality NHS services for local people. Mary Hutton is the Accountable Officer for Gloucestershire CCG.

2.6. Gloucestershire CCG is responsible for planning and buying local NHS services such as emergency care services, operations or treatments that can be planned in advance, mental health and community services.

2.7. These services are provided by a range of 'provider' healthcare organisations, such as NHS Trusts.

2.8. On becoming a statutory public authority with effect from 1 April 2013 Gloucestershire CCG assumed responsibility for commissioning (buying) healthcare services to meet the reasonable needs of the persons in Gloucestershire (i.e. principally for patients registered with their member practices, together with and unregistered patients living in their area). It does not include patients registered with GPs outside of Gloucestershire, members of the armed forces, nor their families if they are registered with Defence Medical Services rather than a NHS GP practice. Nor does it include those detained in prison or other custodial settings.

2.9. Gloucestershire CCG is not responsible for services which are commissioned directly by NHS England or Gloucestershire County Council but the CCG is able to influence the provision of these services by providing timely input as and when appropriate. To understand services which fall under the respective remits of the Clinical Commissioning Groups, NHS England (previously called NHS Commissioning Board) and Local Authority please visit http://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf. Local Authorities provide public health advice and information for example via the Joint Strategic Needs Assessment to the CCGs with respect to commissioning.

3. Profile of Gloucestershire population by protected characteristics

3.1. We use a range of data and information when we develop policies, set strategies, design and deliver our services. We believe that it is important to understand the composition of our population by protected characteristics as this enables us to:

- Engage effectively with different communities to understand their varying health and self-care support needs
- Commission services to meet their health and self-care needs in an appropriate manner
- Assess the likely impact of our decisions on the diverse communities and
- Work with these communities to minimise any adverse impact and maximise any positive impact

3.2. Data published by the Office for National Statistics shows that in mid-2010 Gloucestershire's total population was estimated to be 593,527 persons residing in one of the six districts namely Cheltenham, Cotswolds (North & South), the Forest of Dean, Gloucester City, Stroud and Berkeley Vale, and Tewkesbury. Analysis of Gloucestershire's population by protected characteristics reveals significant variations in different districts. The data below with respect to each protected characteristic is taken from reports published by Gloucestershire County Council.

3.3. Protected characteristic - Age

Overall 23.4% (vs. UK average of 23.7%) of our population is between 0-19 years old, 57.8% (vs. UK average of 59.7%) is between 20-64 years old and 18.8% (vs. 16.6% UK average) 65 years plus. There are district variations with Gloucester featuring the highest representation of children and young people, and Cotswolds, the Forest of Dean and Tewkesbury having the highest proportion of older people.

Protected characteristic – Disability

The Equality and Human Rights Commission defines someone with a disability in the context of assessing equality as those *'if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities'.* This is consistent with the Census definition of limiting long-term illness.

There were about 99,712 people across Gloucestershire reporting a limiting long-term illness (LLTI) to the Census 2011, representing 16.8% of the total population. This is substantially higher than estimates based on for example disability-related benefits claim. The incidence of LLTI Is highly linked to old age. Nearly 56% of people aged 75+ had a LLTI compared to 16% among 45-59 year old.

3.4. Protected characteristic – Gender

The overall gender split of Gloucestershire population is slightly skewed towards female – a 49.1% male/50.9% female which mirrors the gender distribution in the UK. As ages increase however, the numbers of women are outnumbering men by increasing margins. For 65+ age group the gender split is 44.6% male/55.4% female. For the age group 85+, the gender split is 1:2, as women's life expectancy outlasts men's. This has resulted in the majority of single-pensioner households in the county being headed by a woman. This pattern persists across districts. It is also estimated that among the single –parent households with dependent children, estimated to be around 15,000 in Gloucestershire, about 88% are headed by a woman and 12% by a man.

3.5. Protected characteristic – Gender reassignment

There is no definitive data or official estimates of the number of people with gender reassignment or the number of transgender people in Gloucestershire as nationally publicly collected data on transgender people is virtually non-existent. However, various research reports suggest that between 300,000 to 500,000 adults in the UK are experiencing some degree of gender variance, and therefore could face inequality as a result. These figures are equivalent to 0.6% -1% of the UK adult population.

Applying the same proportion to the Gloucestershire adult population, the number of transgender people in the county could be estimated at between 2,800 – 4,700.

3.6. Protected characteristic – Pregnancy and Maternity

There were around 6,900 pregnancies in Gloucestershire in 2010, slightly higher than the average of 6,500-6,700 in previous years. The highest numbers of pregnancies fall into the 30-34 and 25-29 year age groups, continuing the trend of later motherhood. These are also the ages when women employment rate is one its highest 77.5%.

More than 25% of county pregnancies were in Gloucester, where the under-18 pregnancy rate was also the highest (14.2 per 1,000) in the county.

3.7. Protected characteristic – Sexual Orientation

There is no definitive data on sexual orientation among the local population. Previous estimates by Stonewall, suggest that around 5-7% of the adult population (aged 16+) are gay, lesbian or bisexual. This would translate into between 24,000 and 34,000 adults in Gloucestershire. However, a more recent estimate from the ONS Integrated Household Survey put it at 1.9%. This would equate to around 9,200 adults in the County.

Compared to heterosexual people, gay, lesbian and bisexual people are found to be more likely to be younger (16-44), male, white have no religion, are better qualified and have managerial/professional occupations. (Source: Integrated Household Survey ONS, September 2010)

3.8. Protected characteristic – Marriage and Civil Partnership

Information based on a Gloucestershire County Council's local projection which incorporates official data on marriage trends suggests that cohabitations are increasingly common across all ages and this trend is expected to continue. By contrast, the number of marriages has become static and is predicted to remain so in the near future. The number of lone parents is predicted to rise slightly. With respect to Civil Partnerships total number of formations during the period 2008-2010 was 191.

3.9. Protected characteristic – Race (Including Gypsy and Traveller)

The latest Office for National Statistics data on ethnic population suggests that the number of people in Gloucestershire from Black and Ethnic Minority (BME) origin was around 36,700 in mid-2009, this equates to 6.2% of our population. Almost one in four of these were Asian or Asian British. The largest numbers of BME population were in Gloucester (11,300) and Cheltenham (9.100).

The recent ethnic trends suggest that the largest growing ethnic groups in Gloucestershire between 2001-2009 were 'White – Other White' (up by 7,400 people, most likely to be from Eastern Europe) and Indian/Indian British (up by 4,800).

Gypsies and travellers – 2001 Census identifies a total of 2,400 households in the county were living in caravans or other mobile homes. This figure does not distinguish between travellers and non-travellers. In January 2011 there were 395 caravan households of these two-thirds (261) were in Tewkesbury. There is no available data as to the number of residents living in these caravans.

3.10. Protected characteristic –Religion

The only reliable data available on people's religion in the county is taken from the Census 2001. This data suggests that Christianity was the most common religion in Gloucestershire (75.9%), followed by "no religion" (15%) and Muslims (0.6%). The recent increases in East European and Indian/Indian British people suggests that the proportion of people in Gloucestershire whose religion is Christian, Muslims and Hindu may have increased since 2001.

4. Health Inequalities (information below is abstracted from Gloucestershire's Joint Health and Wellbeing Strategy)

4.1. Health inequalities arise from differences in the social and economic conditions in which people are born and live. These in turn influence people's behaviours and lifestyle choices, their risk of illness and the actions they take to deal with illness when it occurs. This inequality is driven by a complex range of factors including; how much we earn; what our job is; our education; where we live and play; our relationships with friends and family; our social networks; the type of community we live in and our access to services and leisure opportunities. These factors change as we progress through the key points in life – from conception to infancy and childhood, through our teenage years, to adulthood, working life, retirement and the end of life. But the healthier we are in early life, the healthier we are likely to be in later life.

4.2. The burden of ill health falls disproportionately on individuals, families and communities in Gloucestershire that have lower incomes and lower educational levels. The people that are most likely to have the very worst health and wellbeing outcomes in our county include those living in the most deprived geographical areas and people who may be vulnerable to experiencing inequalities because of: race, disability, age, religion or belief, gender, sexual orientation and gender identity. Some vulnerable groups, for example people with learning disabilities, or the homeless, have significantly poorer life expectancy than would be expected based on their socioeconomic status alone.

4.3. Local data tells us that in Gloucestershire our main public health challenges, and the three main causes of death and serious illness, are the same as for the rest of the country. These are:

- Circulatory diseases (heart disease and strokes)
- Cancers
- Respiratory diseases (lung diseases) such as Chronic Obstructive Pulmonary Disease (COPD).

4.4. Health inequalities exist for all of these illnesses linked to deprivation. In the most deprived areas of the county early deaths from coronary heart disease (CHD) and stroke are more than double the county rate and the numbers of early deaths from cancer is well above those for the county.

4.5. The pattern is similar for COPD (chronic lung disease, usually caused by smoking), other types of respiratory (lung) disease as well as for diabetes (strongly linked to obesity) and liver disease (usually caused by alcohol misuse). For COPD death rates for all ages and for under 75's are more than double the county rate in the most deprived areas and for diabetes the death rate is one and a half times that of the county.

4.6. National data shows that there is also an association between deprivation and lifestyle behaviours, with those residents in the most deprived areas also being the ones least likely to take exercise and the most likely to have a poor diet. Both national and local data show links between deprivation and the likelihood of being overweight or obese. The overall effect of this 'social gradient' in health is demonstrated by the differences in life expectancy that exist in the county. Life expectancy is a commonly used measure of overall health status. Someone born in Gloucestershire today can expect to live, on average, 79.7 years for men and 83.5 years for women. That's a little longer than the national norm of 78.6 and 82.6 years.

4.7. Whilst the life expectancy of the county overall continues to increase, the health of the less well-off is improving more slowly than the rest of the population and the gap in life expectancy between the most and least deprived areas in Gloucestershire is not narrowing. This is shown using a measure known as the Index of Multiple Deprivation (IMD). This is measured nationally by ranking all neighbourhoods in the country by their deprivation status and grouping them into quintiles or fifths. Gloucestershire's most deprived quintile contains neighbourhoods mainly located in central Gloucester City and central Cheltenham which are comparable with the 20% poorest neighbourhoods nationally. Our least deprived quintile contains those neighbourhoods that are comparable with the most affluent 20% of neighbourhoods nationally; include areas from all six districts in the county. According to the IMD 2010, 7.4% of Gloucestershire residents (about 45,000 people) live in neighbourhoods considered to be among the fifth most deprived in England. In contrast, 32.8% of Gloucestershire residents live in the fifth most affluent areas in England.

4.8. In Gloucestershire, men living in the fifth most deprived communities live, on average, 5.3 fewer years than those living in our fifth least deprived areas –the pattern is similar for women with those living in the most deprived areas living on average 4.1 fewer years than those in the least deprived areas. Gloucestershire Health and Wellbeing Strategy 2012-2032 – Fit for the Future gives detailed account of health variations across the county. This strategy may be viewed by following the link below. http://www.gloucestershire.gov.uk/CHttpHandler.ashx?id=53311&p=0

5. Key health priorities for our population

5.1. In Gloucestershire many people live long, healthy and active lives. Life expectancy is increasing and whilst this is a good thing, not everyone who lives longer does so in good health. The CCG has published a summary of its plans for 2013/14 in its prospectus which can be obtained using the following link:

http://www.gloucestershireccg.nhs.uk/wp-content/uploads/2012/12/Prospectusweb1.pdf

5.2. As life expectancy increases there will be more people living with illness or disability unless we can prevent those illnesses from happening or help people to recover and maintain their independence. This is why Gloucestershire CCG is an active partner of the Gloucestershire Health and Wellbeing Board. Our Chair, Helen Miller is the Vice-chair of this Board.

5.3. Led by the County Council, the Health and Wellbeing Board has developed a joint Health and Wellbeing strategy to help tackle the challenges of the future and to support communities. Following a public consultation in 2012 (*Fit for the future*), the Board has agreed that the CCG's focus will be on the following priority areas for improvement:

- Tackling health inequalities
- Improving mental health
- Reducing obesity (promoting healthy weight)
- Improving health and well-being
- Reducing the harm caused by alcohol

5.4. A *fit for the future* plan has been developed involving all organisations on the Health and Wellbeing Board. This plan includes a whole range of initiatives to make the most of the skills and expertise within communities, make connections and to support the most vulnerable.

5.5. Some examples of the initiatives we are developing include dementia friendly communities, training programmes for 'front line' staff and 'community builders' to promote healthy lifestyles (including mental health) and a marketing programme with families and schools in communities where there are higher levels of childhood obesity.

5.6. Local Public Health priorities

Using the latest intelligence available (Joint Strategic Health Needs Assessment – www.jsna.gloucestershire.gov.uk), public health priorities have been identified for each CCG locality. Many of these relate to the main priorities set out above. The CCG has established Locality Executive Groups to implement local priorities in each of the districts. The Local Executive Groups are working with Public Health, local Councils and other community partners to develop public health plans at a local level. This will help to inform what services and community support the CCG localities commission (buy) for their residents.

6. Our approach to meeting the Public Sector Equality Duty

6.1. We have adopted an integrated and holistic approach to understanding health care needs of the CCG's population and commissioning services to meet these needs. We aim to develop a strong clinical and multi-professional focus with significant member engagement and meaningful involvement of patients, carers and the public in all our work. Our constant clinical focus is on improving quality and patient outcomes/experience. Health outcomes and patient experience are therefore key considerations in all our commissioning decisions and reducing health inequalities with particular regard to the nine protected characteristics as outlined in the Equality Act 2010 is viewed as a key factor in all our decision-making. Our aim is to consider equality considerations into our day to day business and not as an after-thought. To this end:

- ✓ The Governing Body of Gloucestershire CCG has designated accountability for ensuring that the CCG's policies, procedures and operation comply with its statutory obligations with respect to equality, Human Rights and health inequalities to its Integrated Governance and Quality Committee.
- ✓ The Governing Body has assigned lead responsibility for equalities to two of its members, namely Dr Marion Andrews-Evans, Executive Nurse and Quality Lead and Ms Valerie Webb, Lay Member, Business.
- ✓ With the support of Central Southern Commissioning Support Unit Gloucestershire CCG has completed a comprehensive equality and diversity internal audit which has identified what the CCG is doing well (for example engagement with diverse communities) and where improvements (for example more effective use of outcomes from our Equality Impact Analysis to inform our decision-making) are required in delivering the Public Sector Equality Duty most effectively
- ✓ As a result of the recommendation of the Internal Audit Gloucestershire CCG has revised its equality impact analysis process so that it is an integral part of the planning process and output of the impact analysis is effectively used to influence the Governing Body's decisions
- ✓ The CCG has delivered training on the new Equality Impact Analysis process to key staff.
- ✓ Members of the CCG's Governing Body have participated in Equality and Diversity Awareness Raising Workshop and other Equality and Diversity Training delivered by local providers
- ✓ Introduced equality clauses in all our contracts to monitor the equality performance of our providers.
- ✓ Published its equality objectives as follows:
    - ➢ To develop a fresh strategy and action plan for promoting equality, diversity, Human Rights, inclusion and reduction in health inequalities including the implementation of the revised Equality Delivery System.
    - ➢ To increase awareness of the importance of promoting equality/ reducing health inequalities agenda within the CCG and across member practices
    - ➢ To improve quality of and accessibility to demographic profile of Gloucestershire by protected characteristics and identify variations in health needs to enable staff to undertake meaningful equality impact analysis on the work as it develops.
    - ➢ Support staff to put equality/reduction in health inequalities at the heart of commissioning cycle.

6.2. Gloucestershire CCG is committed to taking the necessary action and working in partnership with Gloucestershire County Council and diverse communities across Gloucestershire to ensure that promotion of equality and reduction of health inequalities is at the heart of commissioning. We believe that this will enable the CCG to deliver tangible improvement to patient outcomes and experiences in a variety of settings. We are also committed to developing an inclusive workplace and support staff to develop their equality competency.

7. Workforce Equality

7.1. Equality, diversity and inclusion in employment continue to be at the heart of the NHS strategy.

7.2. Gloucestershire CCG recognises that investing in a diverse NHS workforce is essential to the delivery of more inclusive services and improvements required in patient care. This is why we are committed to developing, maintaining and supporting an inclusive workplace where staff are treated fairly, equitably, and where they can realise their potential whatever their age, race, colour, nationality, ethnic origin, creed, disability, sexual orientation, sex, gender identity, marital or civil partnership status, parental status, religion, belief or non-belief, social or economic class, employment status, or any other criteria that cannot be shown to be properly justifiable.

7.3. A summary of our workforce information can be found at Appendix 1.

Appendix 1
Gloucestershire CCG Quarterly Workforce Profile

January 2014

Below is a short summary of the workforce profile for Gloucestershire CCG as at 01/01/2014

Workforce Information

Gloucestershire CCG employs 150 people. Of these 82 (54.67%) are employed full time and 68 (45.33%) are part time roles.

The total full time equivalent employed is 131.31 (FTE).

The workforce hold 176 job contracts, which consists of 139 employees on permanent contracts, 9 on fixed term contracts, 19 on bank and 9 on other contracts.

The structure is as below:

Business Unit	full time	part time	total	%
843 709681 CHC	4	1	5	3.33%
843 709686 Continuing Healthcare & Assessment	1	0	1	0.67%
843 711271 CEO/Board Office	5	4	9	6.00%
843 711276 Chair & Non Exec's	0	26	26	17.33%
843 711291 Clinical Support	6	0	6	4.00%
843 711296 Commissioning	23	13	36	24.00%
843 711301 Communications & PR	4	1	5	3.33%
843 711321 Corporate & Governance	2	0	2	1.33%
843 711336 Emergency Planning	0	1	1	0.67%
843 711351 Finance	9	2	11	7.33%
843 711391 Medicines Management	3	1	4	2.67%
843 711406 Patient & Public Involvement	2	7	9	6.00%
843 711426 Quality Assurance	7	1	8	5.33%
843 711431 Recharges (Director of Commissioning Implementation)	1	2	3	2.00%
843 711441 Strategy & Development	15	9	24	16.00%
Grand Total	82	68	150	100.00%

Demographics

126 (72.00%) of the workforce is female and 49 (28.00%) are male, but 58 (74.36%) of the part-time workforce is female.

The workforce age profile is:

Age Group	No. of Emps	%
00-19	0	0.00%
20-29	8	4.57%
30-39	39	22.29%
40-49	57	32.57%
50-59	53	30.29%
60-69	15	8.57%
70+	3	1.71%
Grand Total	175	100.00%

The diversity profile is:

Ethnic Group	No. of Emps	%
Asian or Asian British	2	1.31%
Black or Black British	2	1.31%
Mixed	1	0.65%
Other	1	0.65%
White - British	143	93.46%
White - Other	4	2.61%
Total (without 'Unspecified')	153	100.00%
Unspecified	22	12.57%
Grand Total	175	0.00%

The average age of an employee is 46.

Disability

Disabled	No. of Emps	%
Yes	1	1.72%
No	57	98.28%
Total (without 'Unspecified')	58	100.00%
Unspecified	117	66.86%
Grand Total	175	0.00%

A disabled person is defined as someone who has a physical or mental impairment that has a substantial and long term adverse effect on his or her ability to carry out normal day to day activities.

Religion & Belief

Religion	No. of Emps	%
Atheism	14	9.27%
Buddhism	0	0.00%
Christianity	68	45.03%
Hinduism	0	0.00%
Islam	1	0.66%
Sikhism	0	0.00%
Other	4	2.65%
I do not wish to disclose my religion/belief	64	42.38%
Unspecified	24	
Grand Total	175	0.00%
Total (without 'Unspecified')	151	100.00%

Sexual Orientation

Sexual Orientation	No. of Emps	%
Bisexual, Gay and Lesbian	2	1.32%
Heterosexual	96	63.58%
I do not wish to disclose my sexual orientation	53	35.10%
Unspecified	24	13.71%
Grand Total	175	100.00%
Total (without 'Unspecified')	151	100.00%

Length of Service (at Gloucestershire CCG)

175 (100.00%) of staff have been employed less than 5 years and 0 (0.00%) have been employed for 20 years or more.

The average length of service for a Gloucestershire CCG employee is 0 years.

Sickness

The average full time equivalent days lost per month for the period 01-OCT-2013 to 01-JAN-2014 is 1.24.

Staff Turnover (permanent and fixed term staff)

The staff turnover for the period 01-Oct-2013 to 01-Jan-2014 is 6.08%. (No. of Leavers / Headcount)

Starters

For the period 01-Oct-2013 to 01-Jan-2014.

Role	Total
Clerical Worker	2
Community Nurse	5
Senior Manager	3
Officer	1
Grand Total	11

Leavers

For the period 01-Oct-2013 to 01-Jan-2014.

Role	Total
Clerical Worker	4
Community Practitioner	1
Analyst	1
Officer	3

Salary

The following shows contracted basic salary per assignment (so reflects the part-time salary if applicable)

Salary Band	Assignment Count	%
£0 - £9,999	25	14.20%
£10,000 - £19,999	33	18.75%
£20,000 - £29,999	35	19.89%
£30,000 - £39,999	29	16.48%
£40,000 - £49,999	24	13.64%
£50,000 - £59,999	9	5.11%
£60,000 - £69,999	9	5.11%
£70,000 - £79,999	4	2.27%
£80,000 - £89,999	3	1.70%
£90,000 - £99,999	3	1.70%
£100,000+	2	1.14%
Grand Total	176	100.00%

The average salary is £32,110.72.

End