NHS
Heywood, Middleton and Rochdale
Clinical Commissioning Group

HEALTHIER PEOPLE,
BETTER FUTURE

ANNUAL EQUALITY DATA PUBLICATION JANUARY 2015

Version	Date	Comments
0.1	December 2014	Reviewed via Director of Ops & Engagement in preparation for distribution/approval via governance within CCG
0.2	December 2014	Reviewed via EMT, ISLT and committees reporting to Governing Body
1.0	January 2015	Final draft for ratification by Governing Body. Approved 16 January 2015

Contents

1. Executive summary

This is NHS Heywood, Middleton and Rochdale Clinical Commissioning Group's second Annual Equality Data Publication. It shows how we fulfill our responsibilities arising from the Equality Act 2010, which requires public bodies to publish relevant, proportionate information showing compliance with the Equality Duty on or before 31 January each year.

This information includes overviews of our role and aims, and of our diverse population and the health challenges it faces. It sets out our legal responsibilities in demonstrating 'due regard' to the public sector equality duty's three aims and will provide evidence for meeting the specific equality duty. It sets out the way in which we strive to commission for inclusion. It shows our four equality objectives and explains how we monitor the equalities performance of our commissioned providers.

We need to be assured that the organisations which provide the services we commission have effective systems in place to ensure data is collected and analysed to improve service provision and give better health outcomes for vulnerable groups in Rochdale. This report is therefore best read in conjunction with the equivalent reports published by our providers, which also must be published by 31 January. Links to the relevant web pages of the providers are contained in section 7.

The report gives examples of work we have undertaken to take account of the needs of our vulnerable communities, looks at the plans we are making to improve the way we commission services and identifies future areas for development. It also shows the equality progress the CCG has made since our first publication in January 2014.

The report highlights any significant gaps we have identified. We aim to use our equality data for service improvements, and to deliver the equality objectives set out in our Equality, Diversity and Human Rights Strategy

This publication is intended to reflect our open and transparent approach to inclusion and to local vulnerable protected groups. It will be available in other formats on request.

2. Background

NHS Heywood, Middleton and Rochdale Clinical Commissioning Group (CCG) began operating on 1 April 2013 and buys, or commissions, health services on behalf of those registered with our GP practices and those people living in the borough of Rochdale but not registered with a GP. We are responsible for making sure:

- Local people have the health services they need
- The services are safe and deliver high quality care
- We deliver this within the budget allocated to us
- We take into account the different needs of all our diverse communities

NHS HMR CCG's vision reflects the needs of its local population: '***We want the people of the Rochdale borough to enjoy longer, healthier lives. Those who need healthcare receive it at the right time and of the highest quality****'.*

Each of the borough's 38 GP practices is a member of the CCG and these GP practices work together to represent the needs of our 235,800 patients.

We commission:

- Planned hospital care
- Rehabilitative care
- Urgent and emergency care (including out-of-hours)
- Most community health services
- Mental health and learning disability services

We are also responsible for improving the quality of the services offered by our member GP practices.

We do not currently commission primary care services (GPs, dentists, opticians, pharmacies) or specialist services (for example cancer services from The Christie NHS Foundation Trust), as these are commissioned by NHS England. However, we have commissioned a number of primary care development programmes to improve health outcomes for particular communities and we are preparing to take on joint responsibility for commissioning some aspects of primary care – GP services – from April 2015.

This Annual Equality Data Publication examines how the services we have commissioned since April 2013 take account of the needs of our vulnerable communities. It will also look at the plans we are making to improve the way we commission services.

3. Demographics and health challenges

Commissioning health services for Rochdale presents particular challenges. Rochdale is a very diverse borough, with a rich and exciting multicultural heritage. It has areas of high deprivation where health outcomes are relatively poor, and areas of affluence where health outcomes are generally relatively good. In addition, different vulnerable groups within the borough have poorer health outcomes than the general population, or experience particular barriers to service access. For example:

Our population is growing. We currently have 211,700 people in the borough (ONS Census 2011). This is expected to rise by a further 3.8% over the next 20 years. The number of people living in Rochdale (211,700) is lower than the number of people registered with our GPs (235,800). Demographic information is given about the Rochdale resident population.

Our population experiences high levels of deprivation. Two fifths of Rochdale borough residents experience relatively high levels of disadvantage, with 18% considered to be in the most vulnerable group and a further 22% at risk of becoming vulnerable. Affluent residents make up only 6% of the borough.

Our population is ethnically diverse, with 21.4% of residents from a black and minority ethnic (BME) origin. In our most disadvantaged groups, around a quarter of people are of Asian origin. These groups are also generally younger than the general population.

Rochdale has a greater proportion of 0 to 14-year-olds than either Greater Manchester or England and Wales (ONS Census, 2011). Compared to Greater Manchester, Rochdale has a smaller proportion of 15 to 44-year-olds, though a larger proportion of older working age people aged 45-64. Rochdale has a similar proportion of people aged 65 and over to Greater Manchester. However, we also have a growing proportion of older people. In future, we expect there to be a greater proportion of elderly residents compared to those of working age as people are living longer. The population aged 65 or over in Rochdale borough is expected to increase by 34.6% between 2008 and 2025 (ONS 2010).

People in the Rochdale borough have a life expectancy of two years less than nationally, and within the borough a person living in a deprived area might expect to live 10 years less than someone in an affluent area. This is a serious health inequality.

Around 4,270 people in the borough (2%) are likely to be affected by severe mental health disorders requiring support from secondary mental health services. Of these, 800 are estimated to have a psychotic disorder. Levels of common mental disorders, including anxiety, depression and phobias, are estimated to affect 30,178 people (14% of the population).

About 600 local people (aged 18-64) have profound or severe learning disabilities and are in receipt of services, which vary in accordance with individual need. The Rochdale borough Mental Health and Learning Disabilities Needs Assessments (2009) used national prevalence data to estimate that there are around 3,500 people with a moderate level of learning disability, of whom 17% are known to services.

For more information about specific communities and their needs, see:

- Rochdale Joint Strategic Needs Assessment (JSNA)
- Rochdale Health Profile

4. Legal obligations

We are committed to ensuring fair access to healthcare for all our residents, to reducing the barriers and disadvantages, and to improving the poorer health outcomes experienced by particular vulnerable groups. This commitment includes meeting the requirements of the Equalities Act 2010 – the UK's discrimination law.

The Equalities Act 2010 legally protects people from discrimination and unfair treatment, both in the workplace and in wider society. It replaced previous anti-discrimination laws with a single act, making the law easier to understand, strengthening protection in some situations and promoting a fairer and more equal society. It also includes meeting the requirements of the Public Sector Equality Duty (PSED) and sets out the different ways in which it is unlawful to treat someone.

The Public Sector Equality Duty protects people from discrimination, harassment and victimisation in work, education and when accessing services, including healthcare.

All public bodies must make sure they:

- Eliminate unlawful discrimination, harassment, or victimisation
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it
- Foster good relations between people who share a protected characteristic and people who do not share it

Protected characteristics in the context of the Public Sector Equality Duty are defined as:

- Age
- Gender
- Disability
- Gender reassignment (transgender)
- Race
- Religion or belief
- Sexual orientation
- Pregnancy, maternity and breastfeeding mothers

- Marriage and civil partnership

The above are sometimes referred to as ‘vulnerable groups’.

We also consider carers as a protected characteristic when making commissioning decisions.

For more information, see the Equality and Diversity page on our website.

4.1 What this means for healthcare commissioning

We aim to commission services which give all our vulnerable groups the same opportunities to access healthcare as the general population and to ensure they experience the same health outcomes as the general population. This means we pay due regard to:

- Reducing inequalities in health outcomes and experience between patients. We do this by working in partnership with Rochdale Borough Council and others to plan services which address the needs of vulnerable groups as shown in the Joint Strategic Needs Assessment (JSNA).
- Reducing any barriers or inequalities faced by more vulnerable protected community groups in accessing healthcare (including making reasonable adjustments to enable particular groups to access our services). Ways of removing barriers include making sure all premises and services are accessible by people with different disabilities or providing choice of appointment times to suit carers’ needs.
- Minimising disadvantages suffered by people due to their protected characteristics. For example, by commissioning an interpreting service and ensuring deaf people have access to a loop system or a British Sign Language signer.
- Raising awareness of our health services and the benefits of accessing healthcare among communities who are traditionally less likely to use health services.
- Engaging and involving patients and their carers in decisions about the way their healthcare is designed, commissioned and provided.
- Enabling patients to make choices about different aspects of health services, such as the treatments or hospitals available to them.

‘Due regard’ means that the CCG has given advance consideration to issues of equality and discrimination before making any policy or key healthcare decision which may impact on local protected groups. This is an integral and important part of the mechanisms by which we fulfill the aims of the Equality Act 2010.

The need to make ‘reasonable adjustments’ is an anticipatory duty – in other words, we need to find out what the barriers for protected groups might be in advance (as far as possible) and put arrangements in place to mitigate them. One way of doing this is through equality analysis. For more details see section 9 below.

We set equality objectives once every four years, and collect annual equality data in relation to workforce and service delivery issues. We also highlight any significant data areas for improvement, with links to improvement plans. We need to do this so we can target resources where they will make the most difference. We have to publish these in an Annual Equality Data Publication on our website by 31 January each year.

4.2 Meeting statutory human rights requirements

We are committed to working with members of the public (including patients, carers and partner organisations) to build a culture through which we treat everyone with fairness, respect, equality and dignity, and respect their autonomy (the FREDA principles).

We will ensure our HR policies, including recruitment policies, exit interviews and restructures, are fair and transparent. We also regularly review complaints and Patient Advice and Liaison Service (PALS) issues, patient stories and clinical incidents to ensure no breaches of human rights have occurred. We also ensure these are scrutinised for discrimination by protected characteristic (including violent discrimination or hate crime) and that we have procedures in place to record and report such discrimination through our quality governance structures so that we:

- Act according to the requirements of the Human Rights Act in everything we do
- Recognise that anyone who is a victim under the Human Rights Act can bring a claim against the CCG (in a UK court, tribunal, hearing or complaints procedure)

We recognise that, as a public body, existing laws which apply to us must be interpreted and applied in a way that fits with the rights in the Human Rights Act.

5. Workforce report

When fulfilling their public sector equality duty, public service employers may have to monitor matters such as recruitment, promotion, training, pay, grievances and disciplinary action by the protected characteristics of their staff. Some larger organisations (150+ staff) choose to monitor equality information as a matter of course, to check if any equality-related issues are a cause for concern, for example: staff satisfaction levels; gender pay audits; job applicants, grievances and disciplinary action – all by protected groups.

We are not required to publish workforce data as we have fewer than 150 staff; however, an annual workforce report will be received and reviewed by our Governing Body. We can ensure our recruitment, selection and training policies and practice are fair and equitable, and that our workforce is protected from discrimination because of protected characteristics. A brief table of the workforce findings for the year to September 2014 is shown here.

Over represented in the workforce ⇧

Under represented ⇩

Broadly similar to local demographics or no clear picture ⇨

Protected group	Rochdale borough population	CCG Workforce 2013/14	Comparison		CCG workforce 2014/15	Comparison	
Age	Most common age band: 15-44 (40.4%), 45-64 (25.4%)	Largest age band: 50-54 (29%), 55-59 (17.7%)	⇧	Overly representative in some age bands	Largest age band: 50-54 (27%), 45-49 (18.3%), 35-39, (18.3%)	⇧	Overly representative in some age bands
Disability	11.3% of working age adults live with a limiting long-term illness, health problem or disability	3.2% disabled *low levels of disclosure*	⇨	No clear picture	1.4% disabled *low levels of disclosure*	⇨	No clear picture
Ethnicity	21.4% BME	4.8% BME	⇩	Not representative	7% BME	⇩	Not representative

Gender	51% female, 49% male	77.4% female 22.6% male		Not representative (but typical of the NHS nationally)	70.4% female 29.6% male		Not representative (but typical of the NHS nationally)
Gender identity	**No local data**	**No staff data**		No clear picture	**No staff data**		No clear picture
Pregnancy / maternity	**No local data**	**No staff data**		No clear picture	**No staff data**		No clear picture
Marriage / civil partnership	44.2% married households, 0.2% civil partnerships	67.7% married, no civil partnerships		Overly representative / No clear picture	70.4% married, no civil partnerships disclosed		Overly representative / No clear picture
Religion or belief	60.6% Christian, 10.5% Muslim	25.8% Christian, 17.7% do not wish to declare *low levels of data*		Not representative	23.9% Christian, 66.2% do not wish to declare *low levels of data*		Not representative / No clear picture
Sexual orientation	No local data – estimated to be 5-7% nationally	14.5% heterosexual *low levels of data*		No clear picture	23.9% heterosexual *low levels of data*		No clear picture

6. Our equality objectives

We are keen to involve local people in the continuing development and monitoring of our equality objectives to ensure we commission the right healthcare services, provide well trained staff to deliver them, ensure our providers meet the equality duties set out in the Equality Act 2010 and promote people's rights.

Our agreed equality objectives for 2013-16 are:

- Improved data monitoring, collection and usage
- Joined-up approach to complex care
- Information and engagement
- Engaged and fully equipped staff

For more information, see the Equality and Diversity page on our website.

7. Monitoring provider organisations

We can commission services from any service that meets NHS standards and provides the right value for money and quality of service. These can be NHS hospitals, social enterprises, charities, or private sector providers. However, we must be assured of the quality of services they commission, taking into account National Institute for Health and Care Excellence (NICE) guidelines, the Care Quality Commission's (CQC) data about service providers and their compliance with the Public Sector Equality Duty.

The majority of our budget for contracts is spent with the following providers:

- The Pennine Acute Hospitals NHS Trust (acute services)
- Pennine Care NHS Foundation Trust (mental health and community services)

As a commissioner of healthcare, we have a duty to ensure all of our local healthcare service providers meet their statutory duties under the Public Sector Equality Duty. As well as regular monitoring of performance, patient experience and service access, we will work with our service providers to analyse their annual publications and monitor progress on their equality objectives and the Equality Delivery System (see section 12).

With the support of the North West Commissioning Support Unit's (NWCSU) Equality, Diversity and Human Rights team, we assure the quality of provider services from an equality, diversity and human rights point of view by:

- Ensuring contracts with provider organisations and specifications for services contain appropriate equality requirements.
- Ensuring providers meet the requirements we have specified in their contracts. The equality, diversity and human rights schedule in the contracts requires particular reports about inclusion in their service delivery and their workforce to be submitted to commissioners by 1 November each year. A proposed revised schedule has been developed for use across Greater Manchester. This will give a greater focus to information about particular areas (to be agreed between commissioners and providers).This will give more extensive information on which to base service improvements to give better outcomes for vulnerable groups.
- Scrutinising the equality and diversity information on provider organisations' websites to ensure they show information about how they meet their obligations under the Public Sector Equality Duty. The scrutiny extends to their Annual Equality Data Publications.
- Ensuring provider websites show how they meet their PSED requirements by publishing the outcomes from their latest Equality Delivery System (EDS) public grading by local protected characteristic groups (or their plans to complete EDS 2 by March 2015) as laid down in the new contract schedule.
- Holding regular meetings with provider organisations to develop a collective approach to gathering evidence of good practice in promoting improved health outcomes for vulnerable groups.
- Working with provider organisations to improve their understanding of equality, diversity and human rights and their compliance with the Public Sector Equality Duty.

Individual provider organisations will also be publishing Annual Equality Data Publications. These show how protected characteristic groups use their services by locality and also workforce information, to show how they are meeting the requirements of the Public Sector Equality Duty. In some cases, the proportion of a particular protected characteristic (eg disability) using services can be compared to the proportion of people with a disability in the general Rochdale population. This enables commissioners to identify areas or communities where people do not use services or overuse them, and to commission services to respond to this. Plans to improve the collection or analysis of data are usually included in these reports. We will scrutinise these reports to obtain assurance that provider organisations understand the improvements required and have action plans in place to address them.

The table below shows compliance from our main providers:

NHS or other providers	Equality objectives agreed and published	Published equality information in 2014	Undertaken EDS grading on 2013-14 performance
Pennine Care NHS Foundation Trust	Yes	Yes	Yes

(community services and mental health)			
The Pennine Acute Hospitals NHS Trust	Yes	Yes	Planned for early 2015

More information about equality, diversity and human rights in these provider organisations, including their Annual Equality Data Publications (when available), can be found on the equality and diversity pages of their websites:

- Pennine Care NHS Foundation Trust
- The Pennine Acute Hospitals NHS Trust

8. Patient experience and engagement

8a. Patient engagement

We are accountable to local people for the way we decide to allocate our resources. We must continue to invest time and effort into engaging with our patients and demonstrate our commitment to listen and act on what they tell us.

There has been considerable engagement between CCG staff and local protected groups. Engagement activity to date has included:

- We have an established Patient Experience Assurance Committee (PEAC) which provides us with assurance that the views and experiences of patients, carers and the public influence the development, design and commissioning of services. It also makes sure their views are clearly evidenced within commissioning plans and influence the performance management of the services we commission. Third sector organisations representing protected groups are key members of this committee. The PEAC is a formal committee of our Governing Body. A key aspect of the work undertaken by this committee is focusing on equality and diversity. Monitoring of client groups to establish representation is diverse is undertaken by this committee.
- We hold meetings and workshops with young people to encourage them to engage with commissioners and providers on health issues through a Youth Health Forum and possibly become health action champions.
- Holding the first in a planned series of lesbian, gay, bisexual and transgender (LGBT) focus groups to better engage the LGBT community and understand key heath issues. A full report will be sent to the PEAC and Governing Body. We will feed back through the Lesbian and Gay Foundation and our website, highlighting any action taken.
- A project funded through the Social Investment Fund in partnership with BME Health Matters to look at dementia and how it affects South Asian communities. This has been established through the DERA (a small plot of land used for cultivation and community discussion) and a reminiscence project.
- Holding quarterly health drop-in events in Sparth, Crimble Croft, Demesne and Butterworth Hall community centres. This enables us to capture local views from many different communities about health and social care issues.
- We have plans to engage with teenagers and older pupils from Redwood School to inform and advise young people with moderate to profound disabilities about a range of health and wellbeing issues and identify the issues which are important to them. We then plan to extend this engagement to each high school in the borough. The purpose will be to engage the student council at each school about what they believe are the key healthcare issues for young people in the borough. So far, meetings have been arranged with two local high schools.

- We have commissioned Rochdale and District Disability Action Group (RADDAG) to conduct workshops and one-to-one interviews with people with disabilities (including young and older people and LGBT people with disabilities) and with homeless people, to give the CCG an insight into their experiences of health and social care services within the borough.
- We have plans for a large workshop event to ensure local people are aware of the integrated care agenda, know what is proposed and how it's progressing.
- This year, we have renewed our communication and engagement strategy. Within this, there is a commitment to:
    - Increase our efforts to engage with minority and vulnerable groups
    - Continuously monitor the demographics of individuals engaged to identify any underrepresented groups
    - Develop an action plan to address gaps in representation

For more information about how we engage with protected characteristic groups, contact Phil Burton on phil.burton@nhs.net.

8.2 Patient experience

All providers are required, through their contracts, to disaggregate their patient experience (eg surveys, complaints and PALS) information to establish whether:

- Their complaints process is accessible to all sections of the community
- One group has a disproportionally worse experience than another

The information depends on the willingness of patients to disclose protected characteristics. It is hoped that the new EDHR contract schedule, with a focus on one specific area, will enable provider organisations and the CCG to gather richer patient experience information.

9. Making decisions (equality analysis – EA)

The CCG Chair and Governing Body take the embedding of equality and human rights seriously. We want to be sure the decisions we take make a positive difference to the lives of our patients. But we cannot simply assume our decisions will be equally beneficial for everyone.

We need to test our assumptions. If we assess the effects of a decision on particular populations, we can increase the probability that a decision will promote equality of access and equity of outcomes.

We have adopted an equality analysis toolkit to ensure consistency. This tool is used to analyse the effect of our decisions on equality and human rights.

Any paper going to the Governing Body for consideration must include an equality analysis and human rights risk assessment. CCG commissioners have carried out a range of equality analysis and human rights screening when carrying out their duties to ensure the CCG is paying due regard to the three aims of the Public Sector Equality Duty and the Human Rights Act.

The following are examples of the equality analysis undertaken in 2014 to date:

- SIGN Improving Access to Psychological Therapies (IAPT) service
- Immedicare Pilot
- Totally Health Pilot
- Healthy Minds (IAPT)

- BARDOC (out of hours GP provision)
- My health, my community
- Urgent Care Centre (for service review)
- Community Intra-venous service (for service review)
- Integrated Neighbourhood Teams
- Intermediate Tier of Service

10. Governance structures

The governance structures are intended to assure the Governing Body that all decisions we take have regard to improving patient outcomes and to the regulations which govern NHS organisations. Equality is assured by the following means:

- Front sheets of papers to Governing Body require a statement that 'Equality Analysis / Human Rights Assessment completed' to ensure appropriate assurances to Governing Body members before information is considered or decisions are made.
- Equality analysis scrutiny of key changes for any adverse impacts is now embedded into commissioning practice and will be scrutinised by the EDHR lead, with any issues noted by the project leader and brought to the attention of the Clinical Commissioning Committee, the Quality and Safety Committee or the Patient Experience Assurance Committee as appropriate.
- These are part of our formal governance procedures and are committees of the Governing Body, who receive the minutes. The Governing Body is therefore assured that decisions are equitable and any potential disadvantages are mitigated.
- We plan to develop an equality analysis timetable, linked to plans for key changes, to ensure equality analysis can be robustly scrutinised.
- Our Governing Body is trained and aware of its responsibility for recognising any equality and human rights business risks and ensuring the CCG is effectively managing them.
- The Patient Experience Assurance Committee, which is chaired by our lay member with responsibility for public and patient engagement, is now starting to triangulate equality and diversity, quality, commissioning decisions, communications and engagement to ensure a holistic view of decisions.
- Our Equality, Diversity and Human Rights Action Strategy sets out our plans for further development in a number of key areas.
- A new EDHR schedule is being developed for 2015/16. This will require providers to examine specific services in detail to give richer information to form the basis for service improvements for protected groups and to show how protected group patients fare compared to people in general.
- Our EDHR lead carries out at least two EDHR compliance check visits each year on main providers to provide additional assurance for the Governing Body.

11. Our main priorities

The services we commission fall under the following key programmes and areas:

- **Unplanned care** – this is the care given to people at short notice and is often for an emergency or for urgent or unexpected health needs.
- **Elective care** – this is the assessment, diagnosis and treatment of health problems which are not considered to need urgent or emergency care. It is delivered by many different practitioners including GP practices and hospitals.
- **Long term conditions** – these are conditions which can't be cured at the moment, but can be controlled by medication or other therapies, and are likely to last for more

than one year, for example diabetes, asthma and coronary heart disease. Long term conditions are more common in people living in deprived circumstances and in older people.
- **Cancer** – we want to improve earlier diagnosis and treatment of cancer.
- **Mental health and learning disabilities**
- **End of life care** – this is about ensuring people's needs, priorities and preferences are met regarding care at the end of their life.
- **Children and maternity** – we want to significantly improve the health and wellbeing of children, young people and pregnant women.
- **Health improvement and inequalities** – we want to reduce health inequalities and make lives as healthy as possible for as long as possible.

For more information, see our Strategic Commissioning Plans 2012-15 and the Everyone counts: Planning for Patients 2013/14 guidance.

12. Equality Delivery System (EDS) and EDS2

The EDS is intended to drive up equality performance and embed equality into mainstream NHS business. It was designed to help NHS organisations, in the current and new NHS structures, to meet:
- The requirements of the Public Sector Equality Duty
- Equality aspects of the NHS Constitution
- Equality aspects of the NHS Outcomes Framework
- Equality aspects of CQC's Essential Standards
- Equality aspects of the Human Resources Transition Framework.

We adopted the NHS Equality Delivery System as a performance framework to help us demonstrate to our patients how we meet the three aims of the PSED. We intend to hold a public grading of its equality performance using the NHS Equality Delivery System (EDS2) in early 2015.

More information about EDS can be found on our equality and diversity web page. More information about EDS2 can be found here.

13. Joint commissioning

We are an active member of Rochdale Health and Wellbeing Board (HWBB). This forum brings together key leaders from the local health and care system to work together to improve the health and wellbeing of all people across the borough and to reduce health inequalities.

Health and Wellbeing Boards:
- Ensure stronger democratic legitimacy and involvement across health systems
- Provide leadership across health and social care
- Strengthen working relationships between health and social care
- Encourage the development of more integrated commissioning of services
- Work collaboratively to achieve the aims of their Health and Wellbeing Strategies.

We and the other members of the HWBB are taking a partnership approach to assessing health needs across the Rochdale borough and have joint targets for the area. The HWBB aims to work together to commission services which improve the health outcomes of all the borough's residents, especially for vulnerable or disadvantaged groups who currently

experience poorer health outcomes or experiences of care. In all our joint work, we want to use and enhance the assets of local people and communities and influence partners to improve health within the provision of their services. Some of our joint projects include:

- Participating in the implementation of integrated programmes around health improvement, sexual health, and Five Ways to Wellbeing.
- Prioritising support for carers by updating and implementing our joint carers strategy.
- Promoting preventative programmes within communities which are less likely to access them. Programmes include health checks, screening and immunisation.
- In conjunction with Public Health England and Rochdale Borough Council, supporting a pilot campaign to raise awareness of the seriousness of breathlessness and encouraging people struggling with shortness of breath to visit their doctor.
- Plans to jointly commission drug and alcohol services with the local authority, police and probation service.
- Plans to jointly redesign services for children with disabilities as part of the Special Educational Needs and Disability Pathfinder programme.
- Plans to improve child and adolescent mental health services (CAMHS).
- Plans to increase the number of looked after children nurses to meet the health needs of looked after children residing in the borough.
- Plans to jointly fund dementia service proposals from providers, including voluntary and independent sector.

For more information, contact Ian Mello on ianmello@nhs.net or Charlotte Booth on charlotte.booth@nhs.net.

14. Achievements

In 2014/15, we have made many decisions to improve health outcomes and patient experience for vulnerable groups. For example:

- We commissioned a street mental health triage pilot (until the end of March 2015) to provide 24/7 advice and support for incidents attended by the police and ambulance service, where an individual has a mental illness. The aim is to reduce the number of people who are detained under Section 136 of the Mental Health Act, ensuring those who do need care and treatment receive the right support quickly.
- We are improving GP support for carers – we are asking people to consider whether they provide unpaid help or support to family members (including children), friends, neighbours or others because of long-term physical or mental ill health or disability, problems relating to old age or issues relating to addiction. If they do, they are being urged to visit their doctor's practice for advice and a support pack to help them carry on caring.
- We started a trial project to improve access to a GP, offering extended appointments including evening and weekends in specific demonstrator areas. In the six months since the scheme launched, additional appointments have been made available, benefitting more than 1,500 patients in Middleton, and 3,000 patients in Heywood to date.
- We have commissioned two experienced physiotherapists to work with the Children's Community Nursing Team and the Adult Pulmonary Team to establish a joined up service for patients with a neuromuscular condition. Patients will receive a better overall experience, including support through the transition from children's to adult services.
- We have commissioned a new five-bed facility at Rochdale Infirmary, which will allow the assessment and diagnosis of patients with dementia and confusion arriving at

hospital with other acute medical conditions, either through the Urgent Care Centre, the Clinical Assessment Unit (CAU) or through direct GP referral.

- We have launched a new integrated end of life and palliative care service to increase the number of patients who receive palliative and end of life care in their preferred place while reducing the number of end of life treatments and inappropriate deaths in hospital.
- We have commissioned 99 new health projects for the Rochdale borough from local charities, community and voluntary organisations to address specific needs including targeted breast cancer awareness for hard-to-reach BME groups, gardening activities for the elderly, a scheme supporting families affected by behavioural difficulties and autism and football in the community for all ages

For more information, contact Sandra Croasdale on scroasdale@nhs.net or Charlotte Booth on charlotte.booth@nhs.net.

15. Plans

We have plans for future initiatives to improve health outcomes for vulnerable groups, which include:

- Commissioning more health projects for the Rochdale borough from local charities and community and voluntary organisations to address specific needs through our Social Investment Fund (SIF). This is specifically aimed at innovation to improve local health
- Providing and promoting free flu vaccine for carers
- Building stronger engagement links with:
    - Young people
    - The traveller community
    - New and emerging communities such as Black Africans and Eastern Europeans
    - Faith communities
    - The LGBT community

16. Recommendations

We and all our provider partners need to improve the collection of information about protected characteristics so we can better understand the views of different community groups about current service provision. The new EDHR contract schedule should help to improve this, but we should continue to hold providers to account.

In order to continue improving our equality, diversity and human rights performance, the following recommendations will be considered:

- We will ask all service providers to disaggregate patient satisfaction levels by protected characteristics to provide assurance that no community group is experiencing a worse service than others.
- We will ensure that our equality lead holds four-monthly face-to-face visits with provider equality leads to support compliance requirements throughout the year.
- We will ensure providers develop an EDHR compliance action plan to achieve and maintain full compliance within a reasonable timescale.
- We will raise any variances at the quality and contract meetings to resolve any issues and provide assurances to CCG of required progress.

- We will demonstrate that staff (including Governing Body members) have engaged with local groups to learn more about a particular community and understand their healthcare needs and how best to promote provision of fair access for that community.

17. Conclusion

This report demonstrates that we have undertaken significant work in relation to equality and diversity. We believe this report demonstrates our commitment to commissioning for equal access to healthcare and improving health outcomes for vulnerable groups. It also demonstrates our compliance with the requirements of the public sector equality general and specific duties as well as providing data with respect to our commissioning and engagement activities. It shows how we have made our commissioning decisions, and what needs to be undertaken in the next year to continue commissioning for diversity.