Equality and Diversity Plan 2012-15

Evidence for authorisation	Domain reference	Criteria button number	Signpost (eg, paragraph 3, section 6 on page 10 of document A)
CCG can demonstrate compliance with public sector equality duty, and is using the EDS or an equivalent to attain compliance and ensure good equality standards	4.2.1 - I	67	Equality duty – Section 2, Page 6 EDS – Section 5

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About this document

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Acknowledgements

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NHS
Ipswich and East Suffolk
Clinical Commissioning Group

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1 INTRODUCTION

a. NHS Ipswich and East Suffolk Clinical Commissioning Group (CCG) is your local NHS commissioner, led by GPs and responsible for planning and buying the best of modern healthcare. We lead the local NHS, and we work on your behalf with all health and social care providers to improve health and local services.

b. Established in April 2012, after two local GP commissioning consortia joined together, Ipswich and East Suffolk CCG includes 42 GP member practices with a registered population of approximately 385,000. It includes the Borough of Ipswich and parts of the Districts of Suffolk Coastal, Mid Suffolk and Babergh and a small part of St Edmundsbury. The area is predominantly rural. There is one major town - Ipswich with a population of 133,400 and three towns with populations of more than 10,000 people - Felixstowe; Stowmarket; and Woodbridge.

1.1 Our vision

1.1.1 Our vision is 'long and healthy lives for everyone in Ipswich and East Suffolk'.

1.1.2 By '*long and healthy lives'* we mean people's physical and mental health and wellbeing.

1.1.3 By '*everyone'* we mean children, young people and adults. We are committed to reducing the inequalities which individuals currently experience.

1.2 Our mission

1.2.1 Our mission is to work with the community and clinicians to plan and commission safe, high quality services which meet the health needs of the people we serve, while maintaining financial balance.

1.3 Our values

1.3.1 Our values, the way in which we all – member practices, Governing Body members and staff – want to work are centred around the people we serve – patients. Our values are:

Patients first

Action orientated – drive and deliver quality improvements

Teamwork – clinical leadership, patients, public, providers and staff

Integration for improved results

Equality of opportunity

Never overdrawn – a balanced budget

Timeliness – decisions – results

Safe, sustainable systems

1.4 Our clinical priorities

1.4.1 Our eight clinical priorities have been developed through a process engaging all of our stakeholders and approved by our clinical executive and our Governing Body. They are:

1. To improve health and educational attainment for children and young people
2. To improve outcomes for patients with diabetes to above national averages
3. To improve care for frail elderly individuals
4. To improve access to mental health services
5. To allow patients to die with dignity and compassion and choose their place of death
6. To improve the health of those most in need
7. To ensure high quality local services, where possible
8. To promote self care

2 EQUALITY AND DIVERSITY: BACKGROUND

2.1 Meeting the equality duty in policy and decision-making

We have a legal obligation to meet the requirements of the Equality Act, including the public sector equality duty. We need to understand the effect of our policies and practices on people with protected characteristics and this is an important part of complying with the equality duty.

2.2 Equality Act 2010

The Equality Act 2010 was introduced in October 2010 to bring together and strengthen all previous anti-discrimination law. The Equality Act protects people with the following nine 'protected characteristics' from discrimination:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation

A detailed breakdown of the Ipswich and East Suffolk population can be seen at appendix one.

A major part of the Act is the public sector equality duty.

2.3 Public sector equality duty

There are two parts to the public sector equality duty: the general equality duty and the specific duties.

2.3.1 The general equality duty requires public bodies in the course of developing policies and delivering services, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act

- Advance equality of opportunity between people who share a protected characteristic and those who do not

- Foster good relations between people who share a protected characteristic and those who do not

2.3.2 The term 'having due regard' means:

- Removing or minimising disadvantages suffered by people due to their protected characteristics

- Taking steps to meet the needs of people from protected characteristics where these are different from the needs of other people

- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low

2.3.3 **The specific duties** have been designed to help public bodies meet the requirements of the general equality duty. This means that NHS Ipswich and East Suffolk CCG will:

- Publish equality information every year to demonstrate our compliance with the general equality duty: including equality information on Ipswich and East Suffolk's communities and our staff

- Prepare and publish one or more equality objectives every four years, to prioritise our work on equality and diversity

2.3.4 Understanding the effect of our policies and practices on people with protected characteristics is an important part of complying with the equality duty.

2.3.5 One such process is to embed the process of equality analysis (formerly known as equality impact assessments, or EqIAs). We need to understand the impact of our functions on people with protected characteristics for new and existing:

- organisational policies and functions,
- key decisions, and
- policies that set criteria or guidelines for others to use.

Assessments should start early in the policy or service development process, or at the early stages of a review.

3. DIVERSITY IN IPSWICH AND EAST SUFFOLK

3.1 A wide range of people from different backgrounds and with different protected characteristics use healthcare services in Ipswich and East Suffolk. People of different ages – young and old – people from a wide range of ethnic groups and religions, people with different gender identities, sexes, abilities and disabilities, sexual orientations and many more characteristics.

3.2 The latest figures about our communities are attached at Appendix 1. More detailed, up to date and relevant figures will be available on release of full Census 2011 statistics. These will be available from November 2012.

3.3 Ipswich and East Suffolk's population

3.3.1 People in Ipswich and East Suffolk are relatively healthy compared to those in other parts of the country although there are still some significant issues to be addressed, including tackling health inequalities in some areas. In addition, the growth in the elderly population brings with it extra demands for age-related services and support.

3.3.2 Life expectancy at birth for Suffolk in 2007-09 for both males and females was higher than in England as a whole by 2 and 1.5 years respectively. However, there are significant health inequalities with a 5.5 year gap for men and a 4.3 year gap for women in life expectancy between those living in the most deprived areas, many of which are in Ipswich, and the least deprived areas.

3.3.3 The main causes of death in the Ipswich and East Suffolk area are similar to England with over three quarters of all deaths caused by cancer, circulatory disease (including coronary heart disease and stroke) and respiratory diseases. Coronary heart disease (CHD) is the most prevalent cause of health inequalities in NHS Suffolk, and cancer is the leading cause of premature mortality.

3.4 Age

At 31 March 2012, 387,997 patients were registered with a GP in Ipswich and East Suffolk. Of these 87,976 (22.7%) were aged 19 years or under and 76,848 (19.8%) were aged over 65 years.

3.4.1 The age distribution of the East Suffolk population (excluding Ipswich) includes a lower proportion of children and young people (up to age 44 years) and a higher proportion of middle-aged and elderly people

compared with Suffolk overall and with England. The age distribution of the Ipswich population is similar to that of England but has a higher proportion of children and young people (up to age 44 years) and a lower proportion of middle aged and elderly people compared with Suffolk overall.

3.4.2 The population of East Suffolk (excluding Ipswich) is projected to increase by 16-32% between 2008 and 2031. The projected population growth will be accompanied by substantial growth in the elderly population. The population of Ipswich is also growing and is projected to increase by 33% between 2008 and 2031. However, the projected population growth will not be accompanied by substantial change in the population age distribution.

3.5 Disability

In September 2011, it was estimated that in Ipswich and East Suffolk there were:

- 7,573 people with learning disabilities, 1,587 of whom had moderate or severe learning disabilities
- 37,358 people with common mental health disorders; 1044 people with a borderline personality disorder; 817 people with antisocial personality disorder; 928 with psychotic disorders and 16,726 with psychiatric comorbidity
- 18,840 people with a moderate physical disability and 5,692 people with a severe disability
- 6,823 people with a serious visual impairment
- 45,260 people with a moderate or severe hearing impairment and 951 people who were profoundly deaf

3.6 Gender reassignment

Data is not currently collected on the number of transgender people in England. Moreover, many people who have been through the gender reassignment process may not wish to be identified as transgender, but as male or female. Estimates vary from 0.1% to 0.6% for all adults (Huntingdonshire County Council, 2011). By applying these estimates to Ipswich and East Suffolk CCG, it is estimated that there may be 388 to 2,328 transgender people.

3.7 Pregnancy and maternity

In 2010 there were 4,310 births in Ipswich and East Suffolk, a 12% increase on 2003.

3.8 Race

2009 data estimates based on ONS estimates are only available for the Ipswich area or Suffolk-wide. According to these estimates, the largest black and minority ethnic group in Ipswich was Asian (7,900), followed by 'white other' (3,600).

3.8.1 Population at a county and local authority level by ethnic group for 2009 estimated that 10.9% (64,800) of the NHS Suffolk population were from a non-white British ethnic group. The largest other ethnic group was 'white other' at 3.4% (20,300) of the population. The next largest group was Asian or Asian British at 2.6% (15,400).

3.8.2 Approximately 10% of Gypsies and Travellers in the Eastern region live in Suffolk giving a total estimated population of between 3,000-5,000 Gypsies and Travellers in the county as a whole.

3.8.3 Data held on the number of calls made to NHS Suffolk's telephone interpreting service can give an indication of the range and prevalence of particular communities. In 2010/11, Polish (44%) and Mandarin (19%) accounted for the greatest number of calls.

3.9 Religion or belief

There is no recent data on religious diversity. However 2001 census data for Ipswich showed Christianity as the largest proportion at 74%, with 9% for other religions.

3.10 Sex

The proportion of males and females in Ipswich and East Suffolk is equal at 31 March 2012. There are more females in each age group with the exception of those aged 0-4 years, however this gap becomes more significant in the age group 75-84 years (2.8% more females) and over 85 years (13.4% more females).

3.11 Sexual orientation

Estimates for the lesbian, gay or bisexual population in England vary from 0.3% to 7%. By applying these estimates to the number of registered patients in Ipswich and East Suffolk, it is estimated that there may be 1,164 – 27,160 lesbian, gay or bisexual people in Ipswich and East Suffolk.

3.12 Inequality

3.12.1 Groups suffering inequality, particularly health inequality, are not limited to the nine protected characteristics listed in 2.2 above. We will take an inclusive approach which will not only deliver on our legal obligations but also support our work to improve the quality of services and address health inequalities.

3.12.2 We will extend our analysis and engagement beyond the protected characteristics to other groups and communities who face stigma and challenges in accessing, using or working in the NHS, such as carers, the homeless and those living in areas of deprivation. Ararna was commissioned in 2009 to map 'hard to reach groups' in Suffolk and the common themes experienced by those groups in accessing health care. This can be seen in diagram one overleaf.

3.12.3 Deprivation, for example, can be a key factor in health inequality. While wards in Ipswich can be clearly defined for their level of deprivation, there is 'hidden' deprivation in rural areas of East Suffolk where the data is not statistically significant. The CCG will work, through this strategy and with its partners, to define other factors to health inequality and develop actions accordingly.

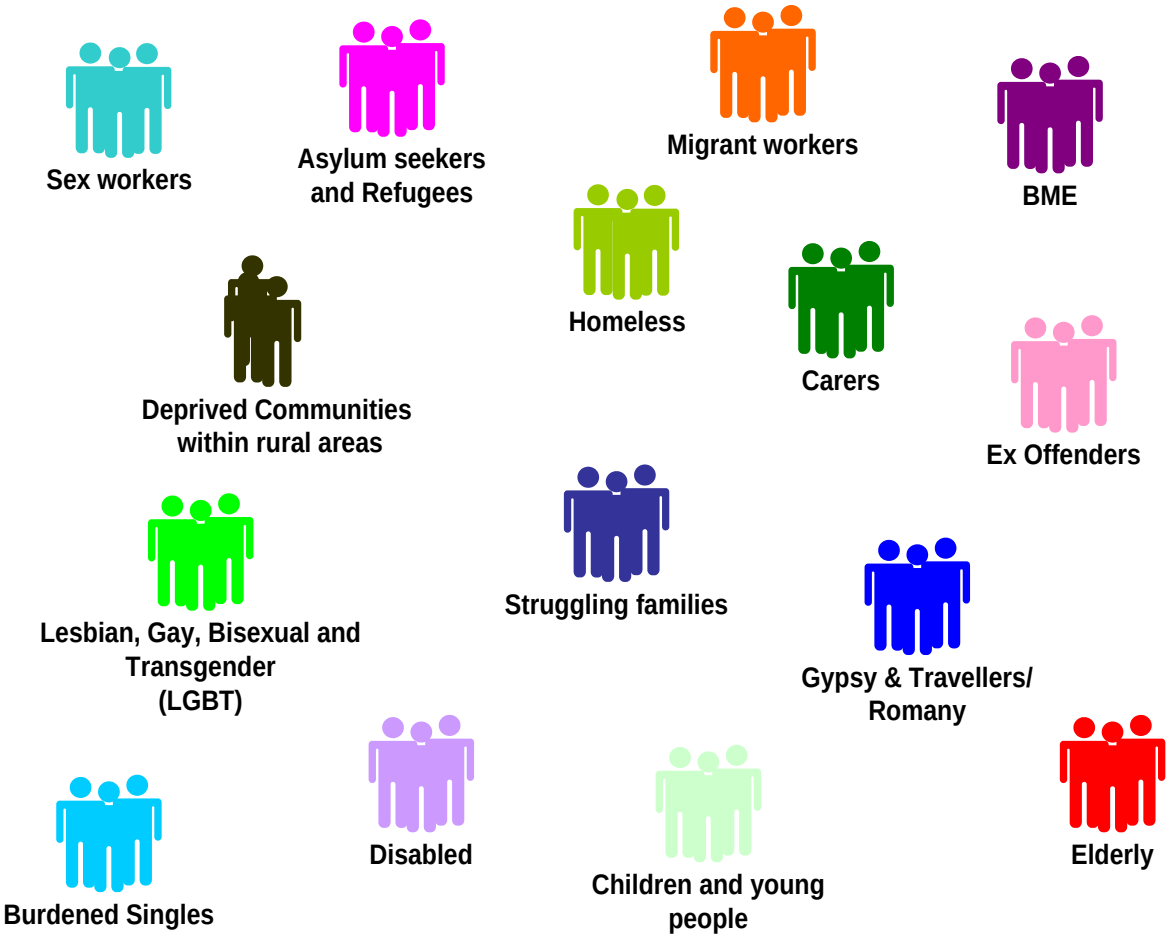


Diagram one
Identified marginalised communities in Suffolk
Ararna 2009

4 WHAT WE HAVE DONE

4.1 We will continue to develop our own compliance with legal obligations and the implementation of the EDS while NHS Suffolk remains legally responsible for delivering the public sector and equality duty and the Equality and Delivery System (EDS) until 31 March 2013.

4.2 Three equality objectives were agreed across Suffolk with local groups for delivery in 2012 – 2013. These are:

- Changes across services for individual patients are discussed with them, and transitions are made smoothly
- Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds
- Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination

4.3 These three equality objectives were chosen by NHS Suffolk and local interest groups as they were areas that scored either red or amber in the EDS assessment. Objectives were published on NHS Suffolk's website by April 2012.

4.4 We will adopt the existing EDS objectives that have been developed and published by NHS Suffolk. We have established a more active work programme to renew and develop our own dedicated objectives, as set out in Section 5 of this document.

4.5 We will adopt the current NHS Suffolk methods for evaluating the impact of our policies and the commissioning of services. The NHS Suffolk tool for equality impact assessments will be used initially but is being reviewed and revised to ensure it is fit for purpose for the CCG.

4.6 Equality and diversity is an important focus for us. Our vision and our clinical priorities have been developed with equality and the diversity of our population in mind. Along with our Governing Body lead (the lay member for patient and public involvement) we also have two GP leads who champion equality and diversity on behalf of the CCG and a GP lead for health inequalities.

4.7 Since our inception, we have been involved in many community engagement activities. A list of these activities can be seen at Appendix 2. Attendance and feedback from these events enabled the

development of this strategy. Activities include membership or attendance at the following groups and events:

- Suffolk Local Involvement Network BME sub group
- HealthWatch pathfinder
- Suffolk NHS Community Conversations
- NHS Suffolk Community Reference Group
- Ipswich and Suffolk Council for Racial Equality
- Suffolk Indian Mela
- "1 Big Multicultural Festival"
- Suffolk Disability and Health Action Group
- Disability Involvement Day
- Bangladeshi Support Group

4.8 We are continuing to build our understanding of our communities through research. We are building on work undertaken by Ararna for NHS Suffolk in 2009, which identified the common themes identified by groups when accessing healthcare. These can be seen in Appendix 3.

4.9 The CCG and its predecessor, NHS Suffolk, have recently commissioned a community service for marginalised and vulnerable adults. The lead GP on this project was Dr Mike McCullagh, a member of the CCG Clinical Executive.

4.10 The service is designed to work with GPs and primary care services to provide an enhanced level of care particular to individuals and groups. The service works with community leaders and community groups, to support individuals in accessing mainstream services. This service will be regularly reviewed and further developed as appropriate in response to our work on equality and diversity.

5 WHAT WE WILL DO – DEVELOPING OUR EQUALITY DELIVERY SYSTEM

5.1 The CCG has two **GP champions** for black and minority ethnic group (BME) issues on the Clinical Executive – Dr. Imran Qureshi (who is also chair of the Clinical Executive) and Dr. Juno Jesuthasan. They, along with Dr. Rosie Frankenberg who is the CCG lead for health inequalities, will lead the focus of the CCG and provide leadership on BME issues. This work will complement the Governing Body focus led by the lay member for patient and public involvement, Ms Gulshan Kayembe.

5.2 The CCG will embed its focus on equality and diversity systems into its core business to ensure it is part of the culture and ethos of the organisation. Equality and diversity will form part of a wider community engagement group consisting of the Governing Body lay member for patient and public involvement (as chair), other key members of staff and representatives from relevant voluntary and community sector organisations. We will reach out to community sector organisations.

5.3 The Community Engagement Group will meet regularly and will include a standing agenda item for equality and diversity within each meeting so that it can monitor and scrutinise our progress. It will report to the Governing Body, as required.

5.4 The **NHS Equality Delivery System** (EDS) is a performance management tool designed to support NHS authorities to improve equality performance and embed equality into core NHS business. We will adopt the EDS to ensure we meet and exceed our requirements under the Equality Act 2010 and Public Sector Equality Duty.

5.5 An important part of meeting the Public Sector Equality Duty is to understand the effect of policies and practices on people with different protected characteristics. We will embed equality analysis into our decision-making to ensure this happens. Initially, we utilise the NHS Suffolk 'Equality Impact Assessment Toolkit' to carry out equality analysis. This method will be constantly reviewed, to ensure it is effective.

5.6 Our Organisational Development Plan for 2012-2015 sets out how we are identifying and addressing our capacity and capability gaps in order to develop an organisation, and clinical leaders, that can and will deliver upon our aims.

5.7 Given the ambitious nature of the three equality objectives set by NHS Suffolk, we will continue to progress work against them. Equality

objectives will be reviewed regularly, to monitor progress and ensure relevance.

5.8 Our clinical priorities

The CCG GP member practices, through a strong locality group structure, and the Clinical Executive have developed and agreed eight clinical priorities for the CCG to guide our work over the next two years. These are set out at 1.5. Each of these clinical priorities includes a clear focus on equality and diversity and health inequality issues and is supported by SMART (specific, measurable, attainable, realistic and time-bound) objectives. These priorities and SMART objectives were informed by the JSNA and form part of our Integrated Plan and are aligned to the Health and Wellbeing Board Strategy and objectives and ensure that the CCG actively monitors its own performance and delivery. The clinical priorities are as follows:

Clinical priority 1: To improve health and educational attainment for children and young people

Safeguarding and promoting the welfare of children – and in particular protecting them from significant harm and improving their health and well-being depends on effective joint working between agencies and professionals that have different roles and expertise. Individual children, especially some of the most vulnerable children and those at greatest risk of suffering harm and social exclusion, will need coordinated help from health, education, early years, children's social care, the voluntary sector and other agencies, including youth justice services.

One of the ways we are doing this is through the development of a Family Nurse Partnership (FNP) Scheme which will go live in April 2013, after being licensed by the Department of Health. The scheme will provide a licensed programme of support to targeted first-time mothers until the child reaches two years of age.

Clinical priority 2: To improve outcomes for patients with diabetes to above national averages

Currently the outcomes for patients diagnosed with diabetes across Ipswich and East Suffolk are, by a number of indicators, worse than the national average despite recorded prevalence rates near to the national average.

We have identified that some elements of the existing system of care provision across both primary and secondary care settings could be enhanced through the development of an integrated system of care. This will focus on ensuring that all patients have optimum outcomes through improved pathways and communication, supported by education programmes for both professionals and patients. The delivery of this integrated system will involve providing care in community locations and working across the traditional divisions of hospital and primary care. Importantly, the integrated system will be responsible for improving outcomes for **all** patients within the population who are diagnosed with diabetes.

As part of this, the CCG will devise a culturally sensitive programme of patient and community education, initially targeted at ethnic groups with a high prevalence of diabetes. This will begin in 2013/14.

Clinical priority 3: To improve care for frail elderly individuals

Falls represent the most frequent and serious type of injury for anyone over the age of 65 years. 50% of people over 80 years will fall every year; for Ipswich and East Suffolk this means over 4,000 people.

Hospital admission rates for falls increase with age. Analysis by the Public Health team has shown that the rates for persons aged 65-74 years, 75-84 years and 85 years and over were respectively over two times, over nine times and over thirty times the rate for persons aged under 65 years.

One of our key actions, working closely with Suffolk County Council and partners, is to develop and implement a comprehensive geriatric service across hospital and community settings and with leadership responsibility for whole system relationships.

Clinical priority 4: To improve access to mental health services

Our priority is to ensure that mental health services are open and accessible to everyone who needs them, regardless of their age, diagnosis and severity of their mental health condition(s) and include those marginalised from society.

To achieve this, we are commissioning a wellbeing service and a psychiatric liaison service between the hospital and the mental health trust. This will result in a reduction in the number of admissions from self harm and a reduction in the number of deaths by suicide within three years.

Clinical priority 5: To allow patients to die with dignity and compassion and choose their place of death

A large majority of deaths follow a period of chronic illness such as heart disease, cancer, stroke, chronic respiratory disease, neurological disease or dementia. High quality care should be available wherever the person may be, at home, in a care home, in hospital, in a hospice or elsewhere.

Our priority is to ensure that patients who could benefit from such care are identified, that there is a robust communication system between all of our partners so that patients are able to choose their place of death and that the CCG responds to the experiences of carers.

Clinical priority 6: To improve the health of those most in need

Health inequality can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mortality rates between people from different socioeconomic groups. Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned.

Our Public Health Profiles show that life expectancy at birth for Suffolk in 2007-9 for both males and females was higher than in England as a whole by 2 and 1.5 years respectively. However, the report showed significant health inequalities between those living in the most and the least deprived areas of Suffolk, with a 5.5 year gap for men and a 4.3 year gap for women in life expectancy.

This is a key area of focus for us with many programmes of work underway. We are committed to:

- 10% reduction by 2015 in the difference in mortality due to circulatory disease (including coronary heart disease and stroke) in people under 75 years between people living in the 20% most deprived areas of the CCG compared with the other 80% (based on figures for 2009-11)
- Support to reduce smoking in pregnant women, where currently the proportion smoking at the time of delivery across the whole of NHS Suffolk is 13.4%.

- 100% of children being registered on both primary care and health visitor list within two years
- Improving breastfeeding rates (currently measured at six weeks) in the worst areas up to the level currently enjoyed by the best areas within two years
- Collaborating with the local community and services to ensure that 100% of clients known to the marginalised and vulnerable adults service are registered with primary care within one month of first contact
- 20% reduction in use of A&E by homeless adults service within one year, using baseline figures for 2012 once they are available at CCG level

Clinical priority 7: To ensure high quality local services, where possible

We are committed to securing high quality services which are safe, effective, patient-centred, timely, efficient and equitable. We have a crucial role in holding providers of healthcare to account for these dimensions of quality, and this is reflected in all of our priorities. A key enabler, detailed in this section, will be far greater and more intelligent use of patient feedback and data on outcomes.

A number of initiatives will be delivered and these are set out in more detail in the integrated plan. The key areas linking to our work on equality and diversity are:

- The introduction of modified SERVQUAL assessments for new services to measure systematically, service gaps as perceived by patients, on behalf of commissioners. These will then feed into the established Quality Boards;
- We will ensure that in 2013/14 standard delivery contracts contain enhanced measures to ensure quality, such as **Safety** (Safeguarding, SIRIs, patient surveys, environment); **Access (**travel time reduction, times of service delivery, and use premises compliant with DDA and CQC); **Equality and diversity** (policies of CCG to be included in all contracts); **Responsiveness and empathy** including timely appointments and appointment management.

Clinical priority 8: To promote self care

We strongly support an approach that empowers patients, where appropriate, to manage their health needs. The average patient spends three hours per year with an NHS professional.

Suffolk County Council, like all first-tier local authorities, will shortly be taking on a leadership and commissioning role for public health, including the improving of the wider determinants of health such as housing and education and facilitating healthy lifestyles. The NHS Commissioning Board will take responsibility for screening programmes, such as those designed to detect breast cancer and cervical cancer. The CCG, however, still has a large contribution as much of this support will be provided by NHS professionals including GP member practices. Examples include support in initiating breastfeeding and advising patients on lifestyle measures to reduce their blood pressure.

One of the ways we are doing this is by nominating a lead General Practitioner to work with the Director of Public Health to work on reducing variations in uptake of public health interventions in GP member practices. We are beginning with investigating reports of low uptake of cervical screening in GP member practices with a large proportion of Bangladeshi patients. We will support action to engage this community if the reports are proven.

5.9 The clinical priorities set out above were developed in the context that Ipswich is the most deprived part of NHS Suffolk. Most of the fifteen general practices fall within the most deprived general practices in NHS Suffolk. Cardiovascular disease, for example, accounts for 30% of the difference in life expectancy between people living in the least and most deprived areas in Suffolk. The risk of dying prematurely from coronary heart disease in the most deprived areas of the county compared to the least deprived has risen from 18% to 40% for males and tripled for females, from 18% to 70% over the last ten years. This signifies that inequalities were getting wider between different groups and geographical areas in Suffolk, where individuals experience worse health outcomes compared to the rest of the Suffolk population

5.10 Through our Healthy Ambitions programme we are committed to becoming the Most Active County. This requires coordinated action at all levels to promote healthy active lifestyle, shift sedentary or inactive behaviours and address any barriers for participation and living and active life. The total avoidable health cost of physical inactivity in Suffolk is over £10 million each year.

5.11 We are commissioning LiveWell Suffolk to provide healthy lifestyle services which link back into our clinical priorities and the Healthy Ambitions programme. Much of this work targets those people with the nine protected characteristics including increasing smoking quitters in the most deprived areas, reducing the number of pregnant women who smoke and increasing the number of health checks offered and delivered to people from the most deprived areas.

5.12 Milestones and next steps

Our work on equality and diversity is an ongoing process and forms part of our core business. This is the first version of our strategy and will form part of our ongoing discussions with representatives of our community. This, and the specific equality and diversity work programmes set out in our clinical priority SMART objectives, will inform future versions of the strategy and will help us to monitor our progress.

The immediate milestones for our work on equality and diversity are:

Milestone/ action	Date
Publish information to demonstrate our compliance with the public sector equality duty, including: • our equality objectives for 2013-14 • equality information about our service users and public, including population statistics • staff diversity profiles • our EDS action plan for 2013-14	January 2013
EDS training for all Governing Body members, GP members and CCG staff, including monitoring its effectiveness. This also forms part of our organisational development plan.	February 2013

Regularise our communications and engagement, through implementation of our Communications and Engagement Strategy, with community groups and ensure systematic reporting is in place. Review progress against the 2009 Ararna report and agree actions for improving the quality of primary care in marginalised and vulnerable groups. Monitor and review progress against our clinical priorities through the SMART objectives set out in our integrated plan Review equality objectives, through engagement with our communities, staff and 'local interest groups'. Review methodology for equality analysis with staff.	April 2013
Review progress against our EDS action plan and equality objectives and report to Governing Body. Review and update this strategy. Monitor and review progress against our clinical priorities through the SMART objectives set out in our integrated plan.	October 2013
Publish information to demonstrate our compliance with the public sector equality duty, including: • equality information about our service users and public, including population statistics • staff diversity profiles • progress against our EDS action plan Review our equality objective(s) for 2013-14 and if appropriate, set new objectives for 2014-15.	January 2014

Milestone/ action	Date
Publish equality objectives for 2014-15 (if new objectives have been set). Monitor and review progress against our clinical priorities through the SMART objectives set out in our integrated plan.	April 2014
Review progress against our EDS action plan and equality objectives and report to Governing Body. Review and update this strategy. Monitor and review progress against our clinical priorities through the SMART objectives set out in our integrated plan.	October 2014
Publish information to demonstrate our compliance with the public sector equality duty, including: • equality information about our service users and public, including population statistics • staff diversity profiles • progress against our EDS action plan Review our equality objective(s) for 2014/15 and if appropriate, set new objectives for 2015/16.	January 2015
Publish equality objectives for 2014/15 (if new objectives have been set). Monitor and review progress against our clinical priorities through the SMART objectives set out in our integrated plan.	April 2015
Review progress against our EDS action plan and equality objectives and report to Governing Body. Review and update this strategy. Monitor and review progress against our clinical priorities through the SMART objectives set out in our integrated plan.	October 2015

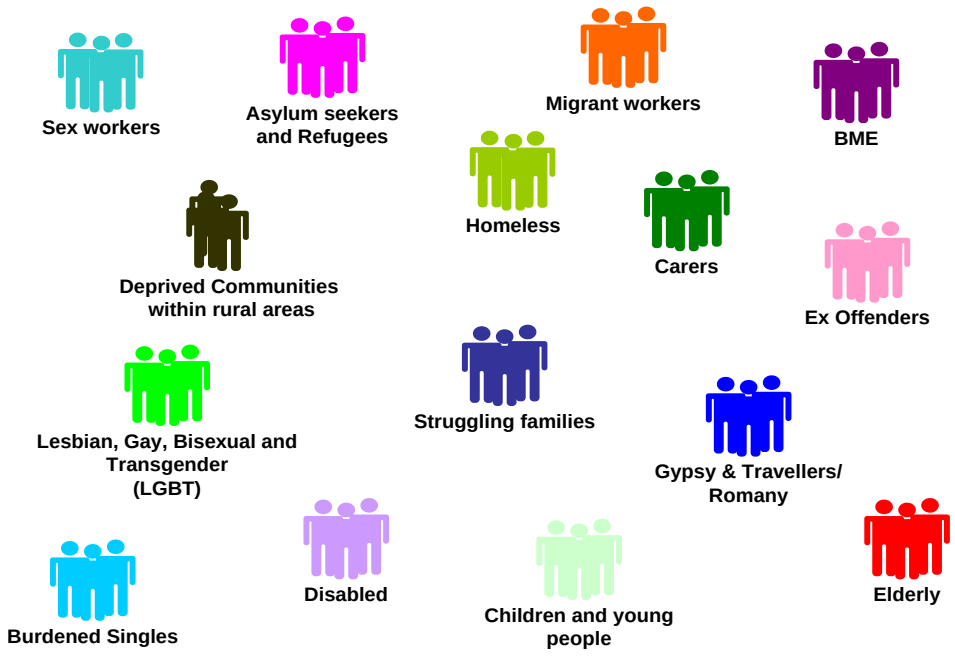
Appendix 1

Equality and Diversity data summary

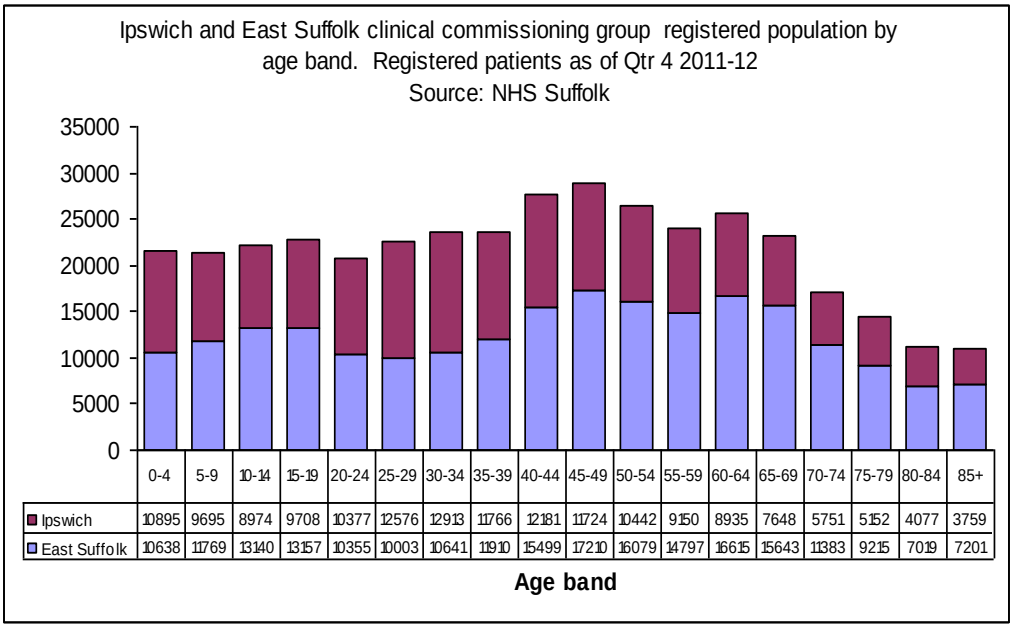
To protect nine characteristics:

Characteristic	Data available
1. Age	*Data from NHS Suffolk/ Ipswich and East Suffolk region*
2. Disability	*Data from NHS and estimated for Ipswich and East Suffolk*
3. Gender re-assignment	*Estimates for Ipswich and East Suffolk*
4. Marriage and civil partnership (in respect of eliminating discrimination)	*No data*
5. Pregnancy and maternity	*Data for Ipswich and East Suffolk*
6. Race (this includes ethnic or national origins, colour or nationality)	*Some data for Suffolk and Ipswich*
7. Religion or belief	*Data from 2001 for Ipswich*
8. Sex	*Data for Ipswich and East Suffolk*
9. Sexual orientation	*Estimates for Ipswich and East Suffolk*

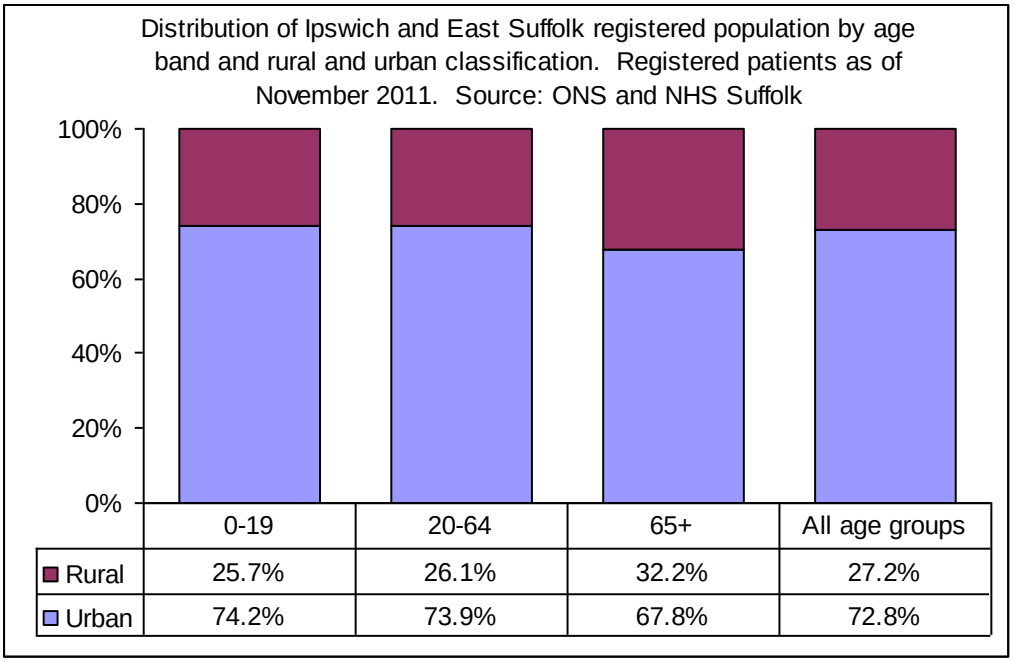
Identified marginalised communities in Suffolk
Ararna 2009



1. Age



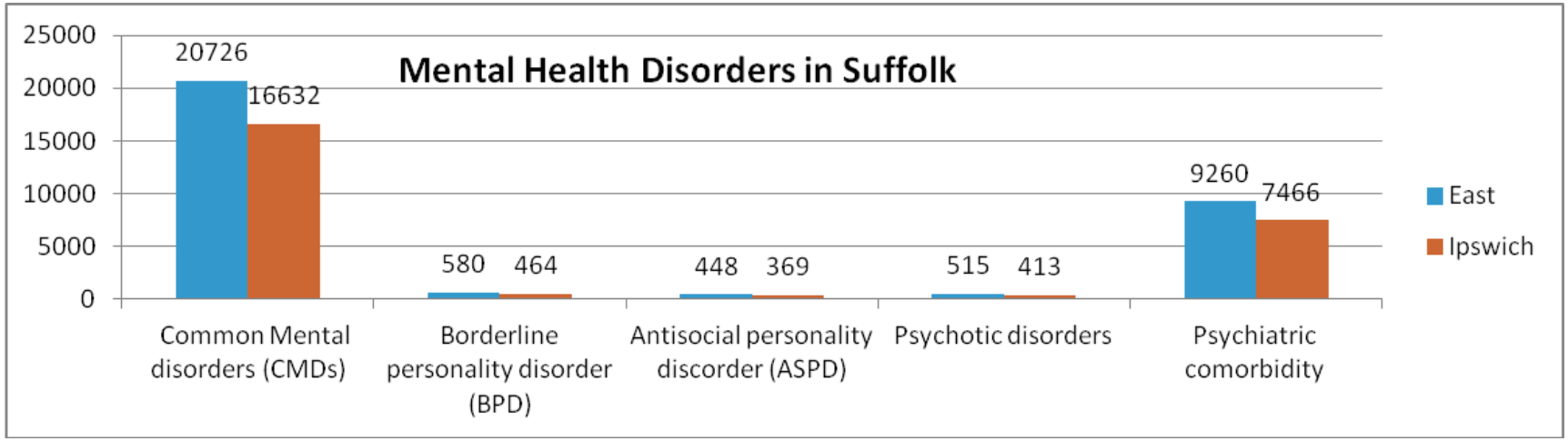
	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Ipswich	10895	9695	8974	9708	10377	12576	12913	11766	12181	11724	10442	9150	8935	7648	5751	5152	4077	3759
East Suffolk	10638	11769	13140	13157	10355	10003	10641	11910	15499	17210	16079	14797	16615	15643	11383	9215	7019	7201

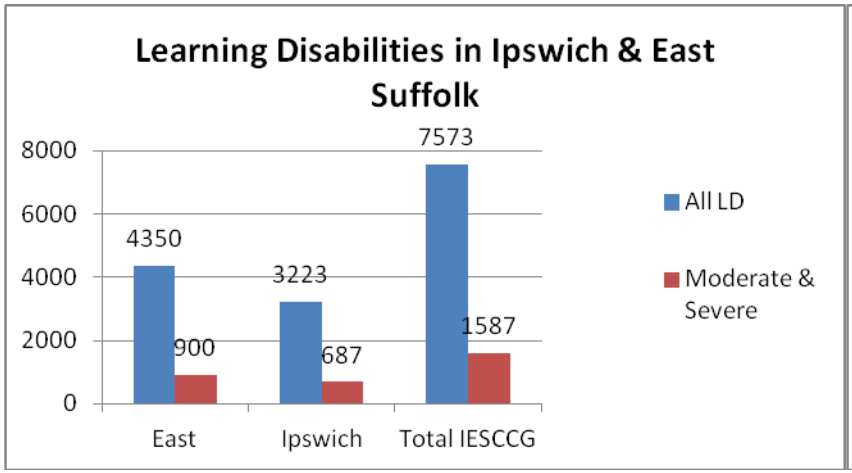


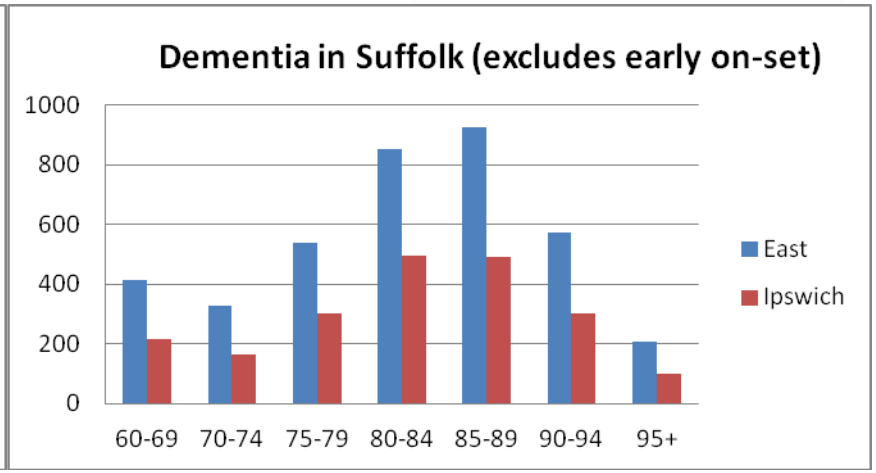
	0-19	20-64	65+	All age groups
Rural	25.7%	26.1%	32.2%	27.2%
Urban	74.2%	73.9%	67.8%	72.8%

2. Disability

NB. Estimated figures based on NHS Suffolk registered population - Sep 2011







Severe Visual Impairment

Age Group	East	Ipswich	Total
18-24	10	9	19
25-34	13	16	29
35-44	18	16	34
45-54	21	14	35
55-64	21	12	33
65-74*	1457	726	2183
75+*	2886	1604	4490
Total	**4426**	**2397**	**6823**

*moderate and severe

Hearing Impairment	East	Ipswich	Total
Moderate & Severe	29082	16178	45260
Profound deafness	621	330	951

3. Gender re-assignment

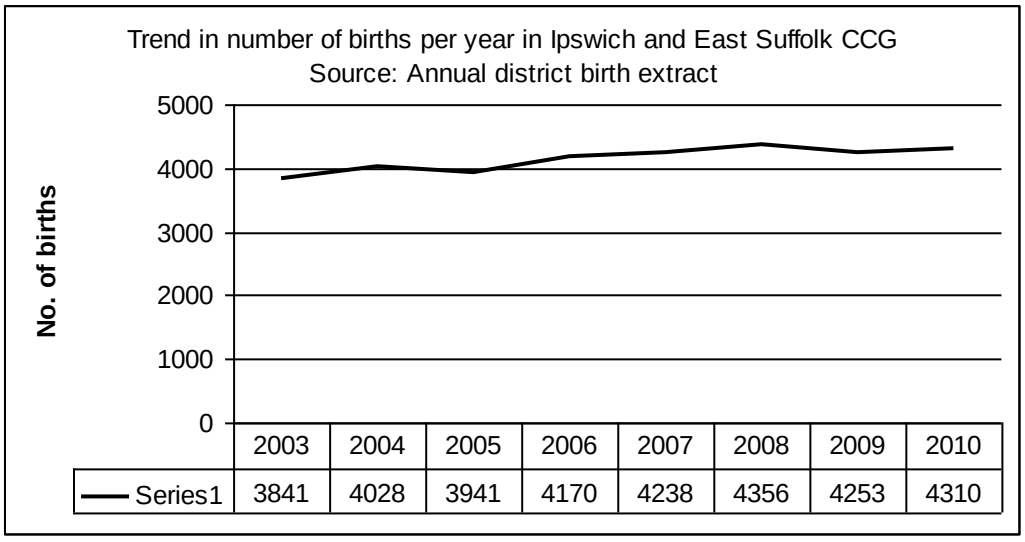
Data is currently not collected on the number of transgender people in England and estimates vary from 0.1% to 0.6% for all adults (Huntingdonshire County Council, 2011). Based on the above prevalence there are 388 to 2328 transgendered people in Ipswich and East Suffolk.

4. Marriage and civil partnership (but only in respect of eliminating discrimination)

No helpful data

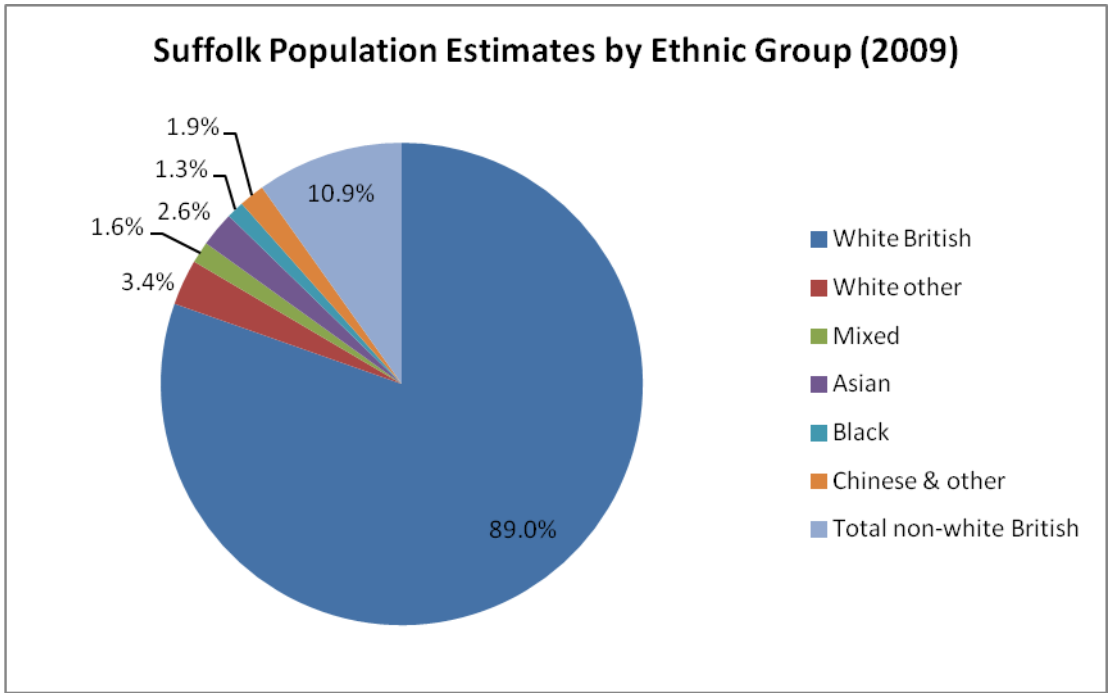
5. Pregnancy and maternity

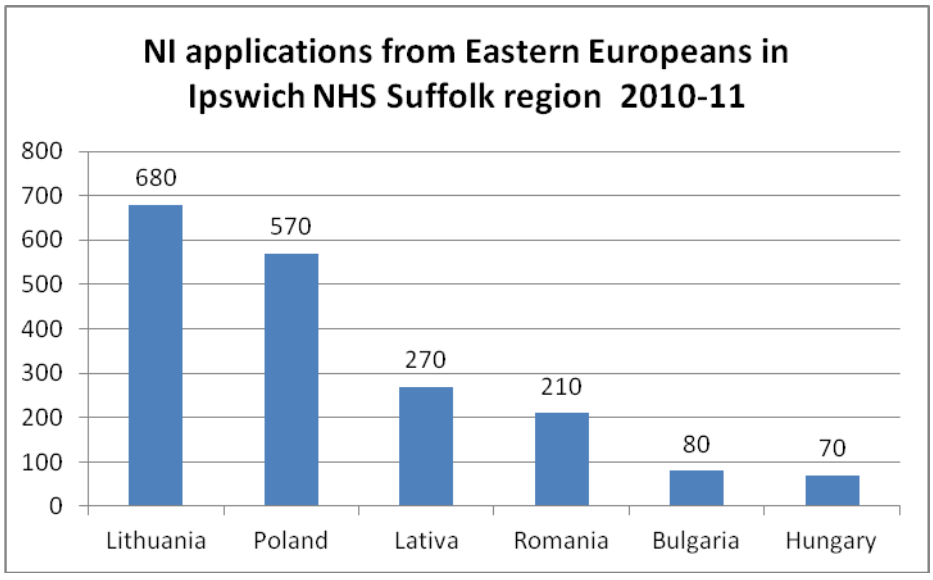
In 2010 there were 4310 births in Ipswich and East Suffolk CCG, which is a 12% increase on 2003.

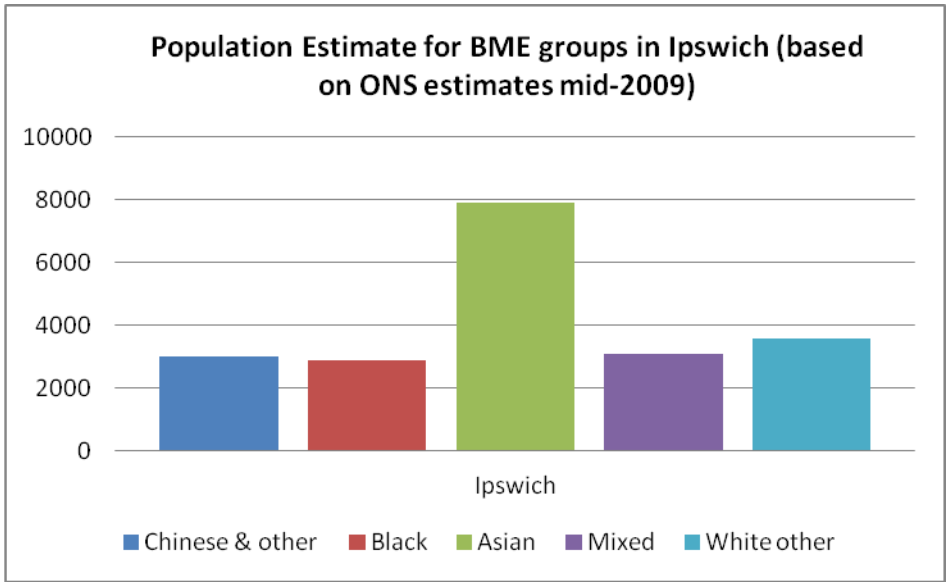


6. Race (this includes ethnic or national origins, colour or nationality)

Data for Ipswich and Suffolk as a whole (no East Suffolk specific data available)

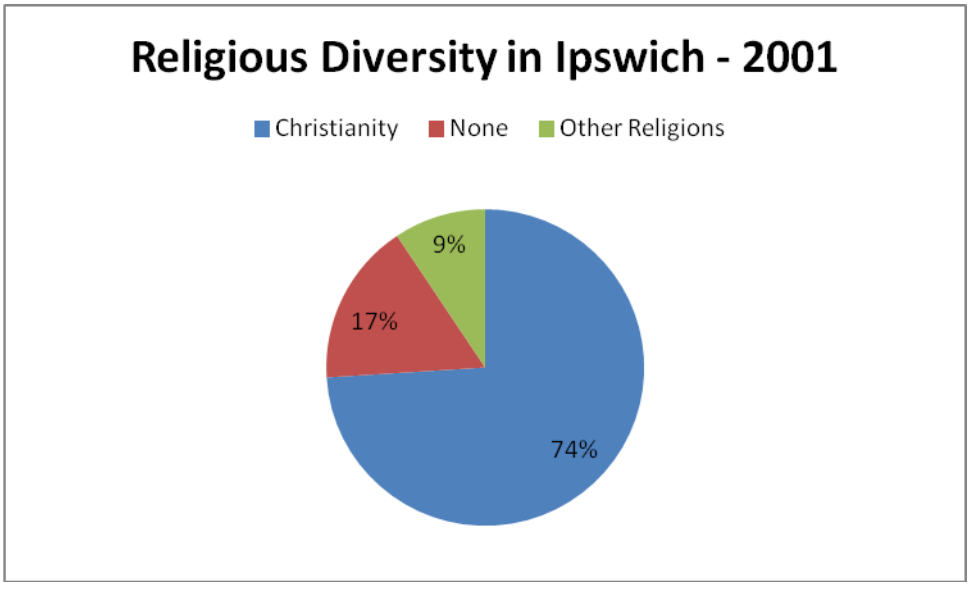




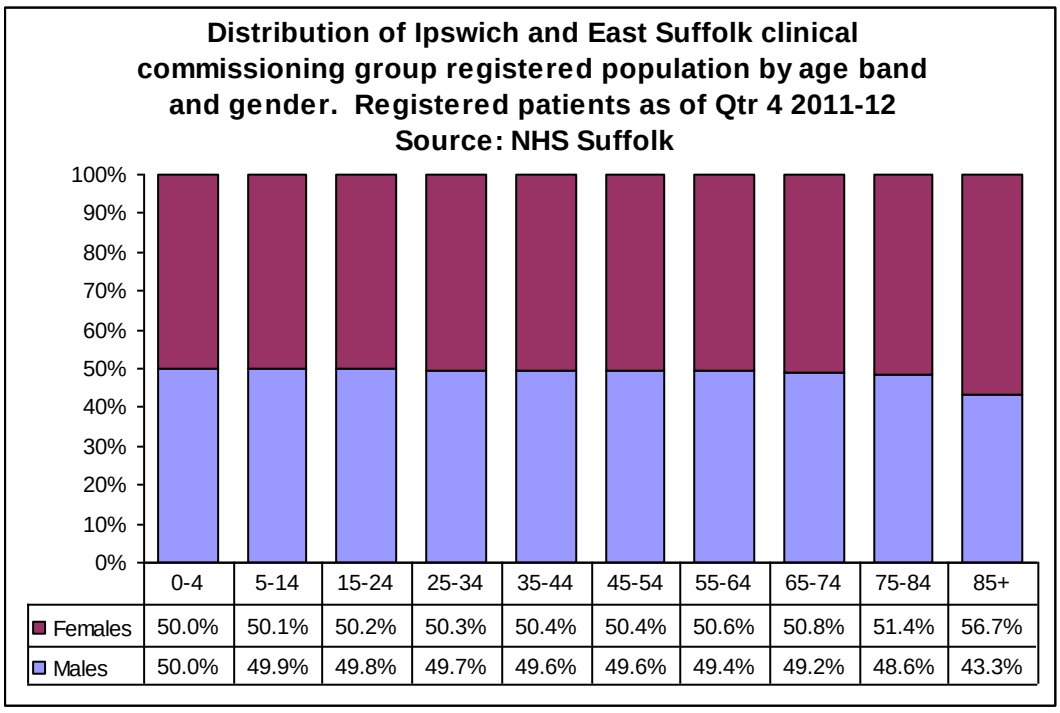


7. Religion or belief

No recent data



8. Sex



	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Females	50.0%	50.1%	50.2%	50.3%	50.4%	50.4%	50.6%	50.8%	51.4%	56.7%
Males	50.0%	49.9%	49.8%	49.7%	49.6%	49.6%	49.4%	49.2%	48.6%	43.3%

9. Sexual orientation

Estimates for the lesbian, gay or bisexual population in England varies from 0.3 to 7 per cent (Ahmed, T., Cock, J.C., Irurita, M.I., Hammerton, C. and Pilmer. B, 2010). Based on these limits the lesbian, gay and bisexual population in Ipswich and East Suffolk is estimated to be between 1164 and 27,160.

Appendix 2: Ipswich and East Suffolk CCG - Engagement events and meetings since June 2012

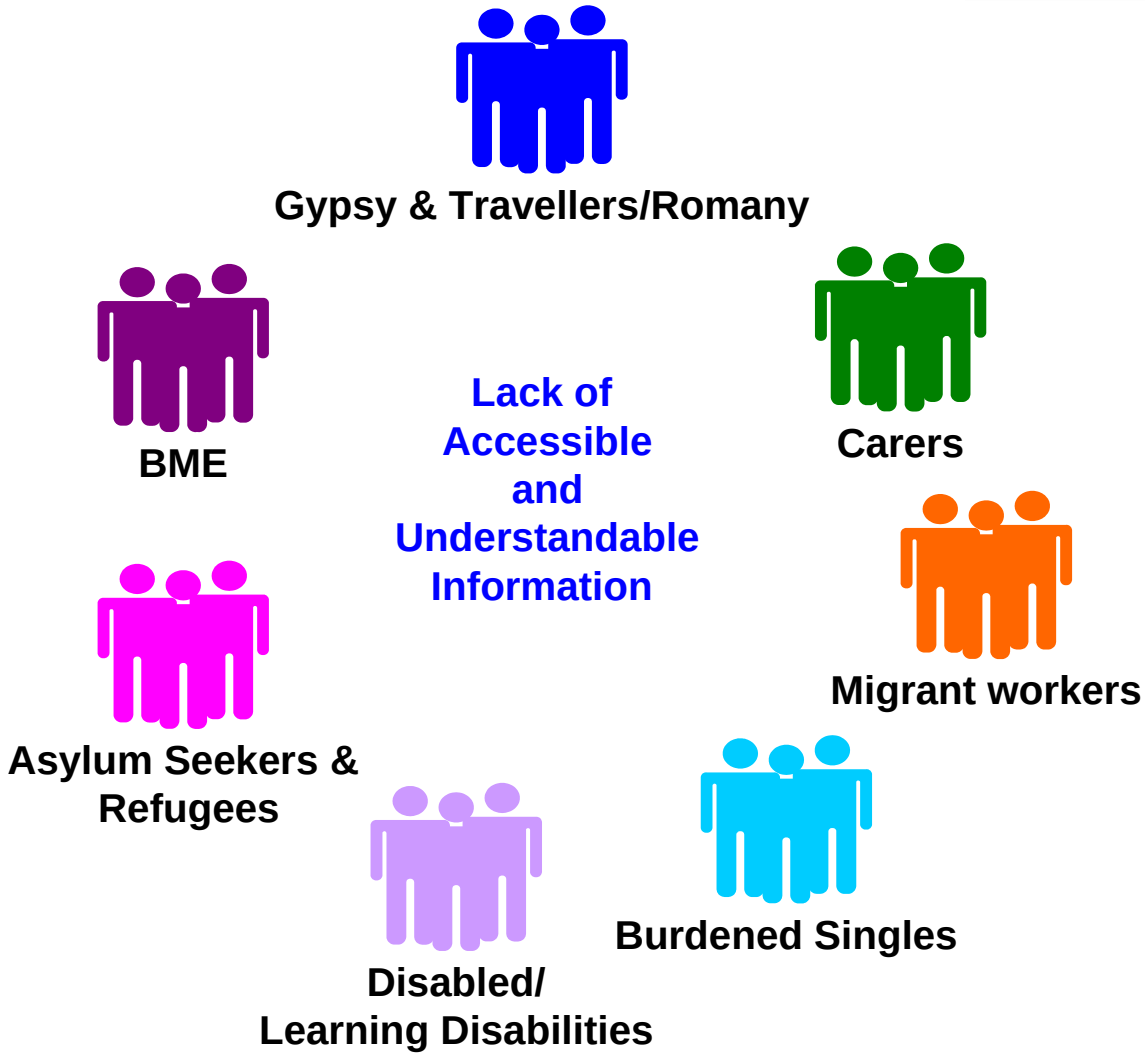
COMPLETED ENGAGEMENT ACTIVITIES				
Event/ meeting	**Engagement with**	**Engagement by**	**Purpose**	**Date**
Suffolk Local Involvement Network (LINk) BME subgroup	Black and minority ethnic (BME) groups	Maddie Baker-Woods, Deputy COO	• To raise awareness of the CCG amongst Suffolk's BME communities • To discuss methods of engagement and involvement	12 June
Suffolk Local Involvement Network (LINk) BME subgroup	Black and minority ethnic (BME) groups	Dr Juno Jesuthasan, GP	• To raise awareness of the CCG • To answer any questions related to health and the CCG • To feed the views and concerns of the group back to CCG management	10 July
NHS Community Conversations	Patients and public	Rosie Frankenberg, GP	• To hear the views and 'healthcare stories' of patients and members of the public and feed these back into the CCG	10 July
NHS Suffolk Community Reference Group	A small group (12) of experienced lay members with role of influencing healthcare decisions at a strategic level	Maddie Baker-Woods, Deputy COO	• To hear the views and concerns of the group and feed back • To help shape the transition of the group from NHS Suffolk to become an effective engagement group for the CCG • 1st meeting of the new Ipswich and east Suffolk group to be held on 1st November 2012 •	12 July

Ipswich and Suffolk Council for Racial Equality (ISCRE)	The directors of ISCRE	Gulshan Kayembe, Lay Member	• To establish a relationship with the racial equality council	20 July
Suffolk Indian Mela	Members of the public	Gulshan Kayembe, Lay Member	• To engage with a diverse range of members of the public at an event organised by the Ipswich and Suffolk Indian Association	27 August
1 Big Multicultural Festival	Members of the public	Gulshan Kayembe, Lay Member; Dr Imran Qureshi, GP; Dr Ben Solway, GP	• To engage with a diverse range of members of the public at an event organised by the Bangladeshi Support Centre	2 September
Suffolk Local Involvement Network (LINk) BME subgroup	Black and minority ethnic (BME) groups	Gulshan Kayembe, Lay Member	• To awareness of the CCG • To answer any questions related to health and the CCG • To feed the views and concerns of the group back to CCG management •	11 September
Ipswich and East Suffolk CCG launch event	Members of the public	Several members of the CCG governing body, GPs and senior staff	• To raise awareness of the CCG • To listen to people's views on what the CCG's priorities should be • 'Points of view' forms distributed to attendees – with over 280 people registering their details with the CCG	11 September
Suffolk Disability and Health Action Group	Members of the public representing views/concerns of disabled people	Gulshan Kayembe, Lay Member	• To listen to the views and concerns of local disabled people and feed into the CCG • To raise awareness of the CCG	15 October

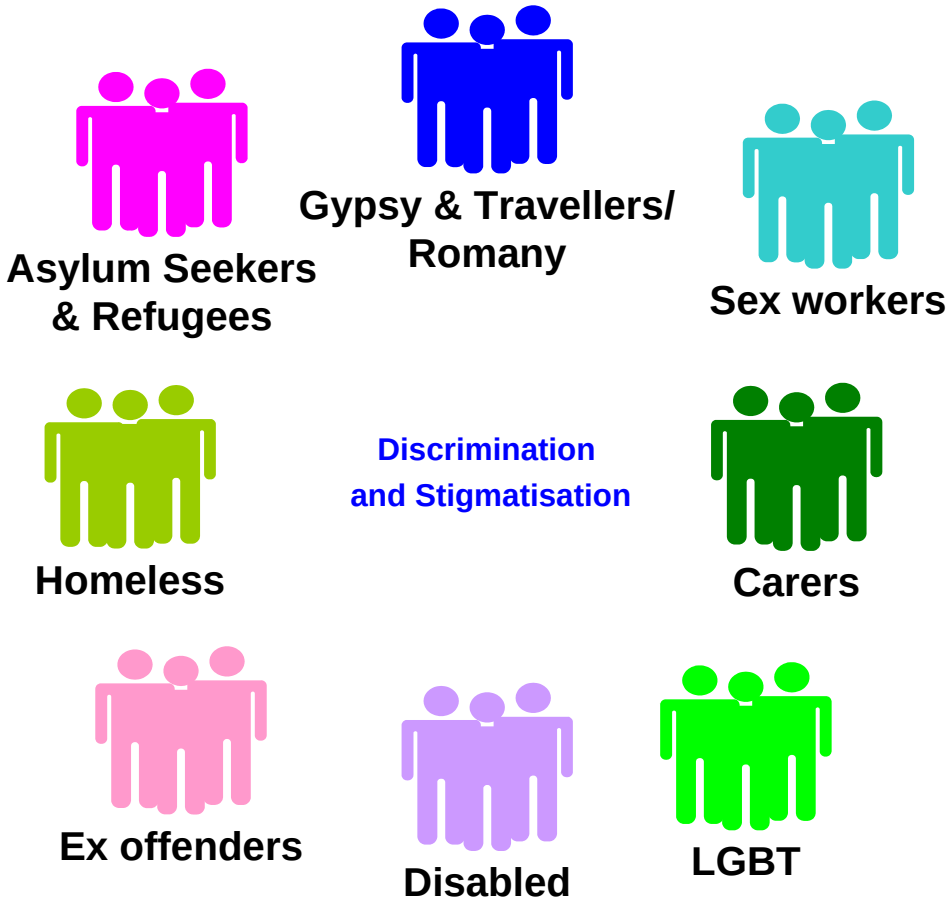
PLANNED ENGAGEMENT ACTIVITIES				
Event/ meeting	**Engagement with**	**Engagement by**	**Purpose**	**Date**
Ipswich and East Suffolk 'Community Reference Group' (name of group TBC)	A small group of experienced lay members with role of influencing healthcare decisions at a strategic level	Gulshan Kayembe, Lay Member (Chair of group)	• To develop an effective engagement group of lay members to influence healthcare decisions at a strategic level	1 November
Disability Involvement Day	Local disabled people and disability groups	Gulshan Kayembe, Lay Member; Dr Imran Qureshi, GP	• Engage with and listen to local disabled people and disability groups to feed into the CCG	1 November
HealthWatch Pathfinder	Partners	Gulshan Kayembe, Lay Member; Maddie Baker-Woods, Deputy COO	• To assist in the transition from LINks to HealthWatch	Ongoing

Appendix 3

Common themes



Ararna 2009


Asylum Seekers & Refugees
Gypsy & Travellers/ Romany
Sex workers
Homeless
Discrimination and Stigmatisation
Carers
Ex offenders
Disabled
LGBT

Ararna 2009

BME

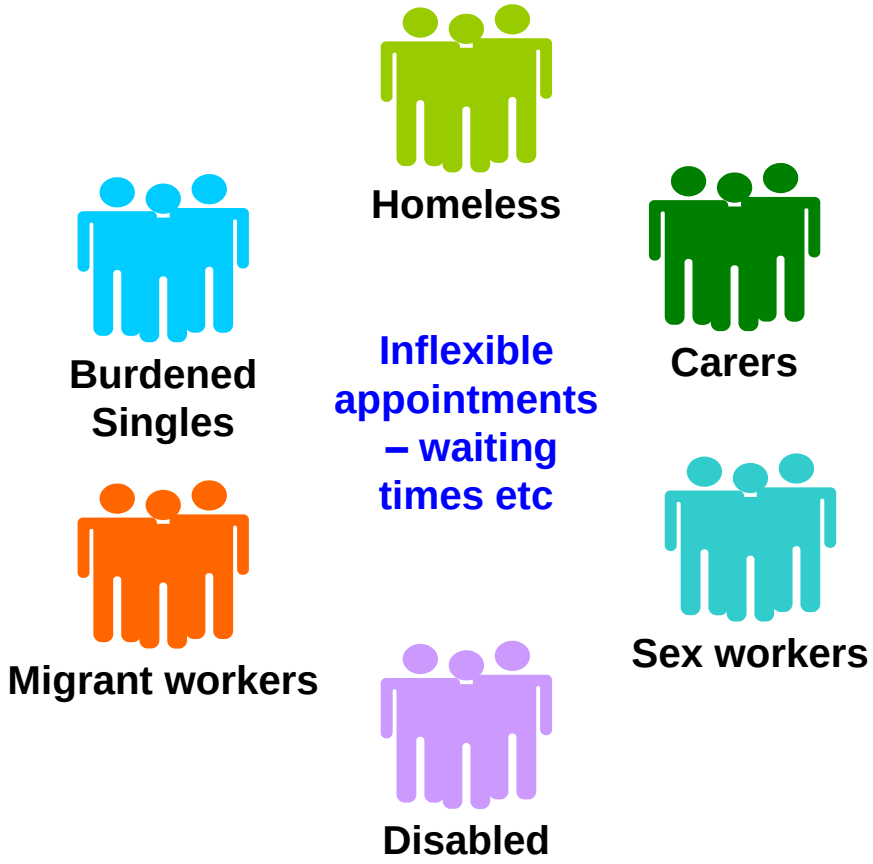
Asylum Seekers & Refugees

Language barrier – Unaware of translation services, do not know how to fill out forms etc

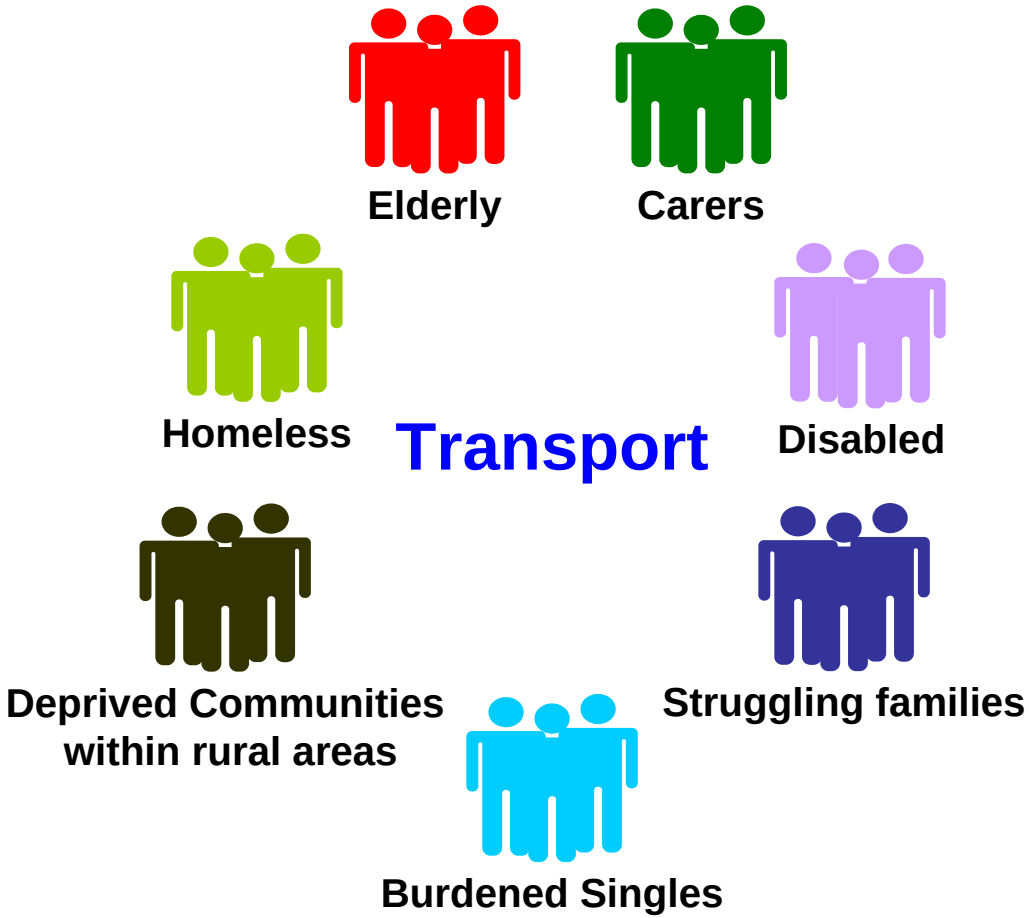
Migrant workers

Carers (if BME)

Ararna 2009


Homeless
Burdened Singles
Inflexible appointments – waiting times etc
Carers
Migrant workers
Sex workers
Disabled

Ararna 2009


Elderly
Carers
Homeless
Transport
Disabled
Deprived Communities
within rural areas
Struggling families
Burdened Singles

Ararna 2009

Gypsy & Travellers/Romany

Homeless

Trust

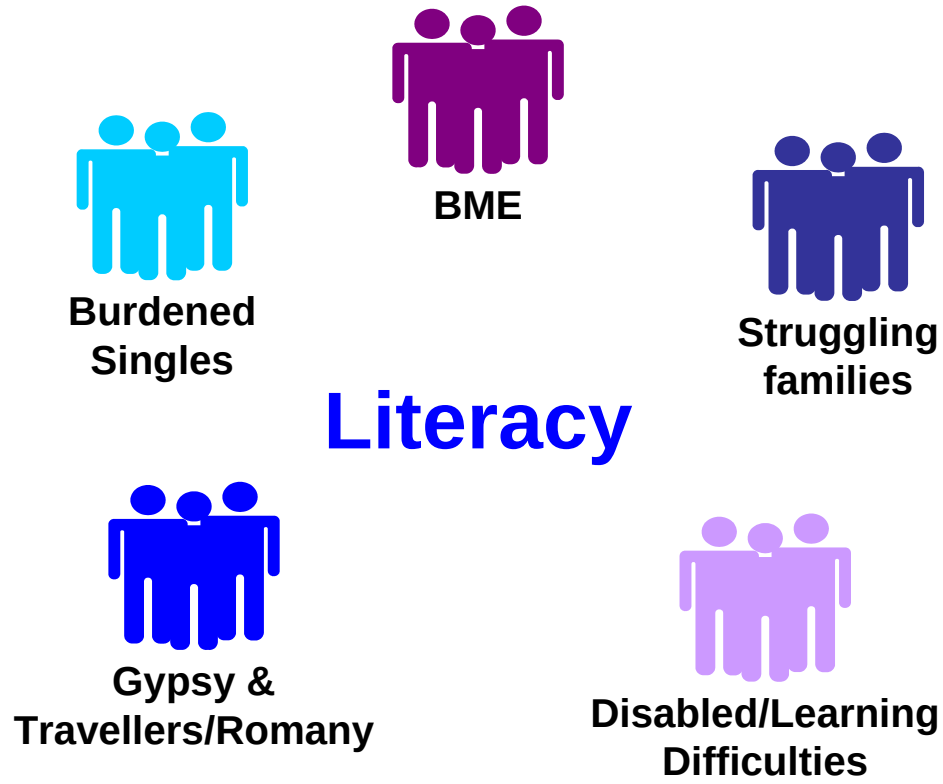
Sex workers

Ex offenders

LGBT

Asylum seekers & Refugees

Ararna 2009


BME
Burdened Singles
Struggling families
Literacy
Gypsy & Travellers/Romany
Disabled/Learning Difficulties

Ararna 2009

Ex offenders

BME

GP Registration Issues

Asylum Seekers & Refugees

Gypsy & Travellers/ Romany

Homeless

Ararna 2009

Gypsy & Travellers/Romany

Disabled

Communication

BME

Migrant workers

Asylum Seekers & Refugees

Homeless

Ararna 2009

Gypsy & Travellers/Romany

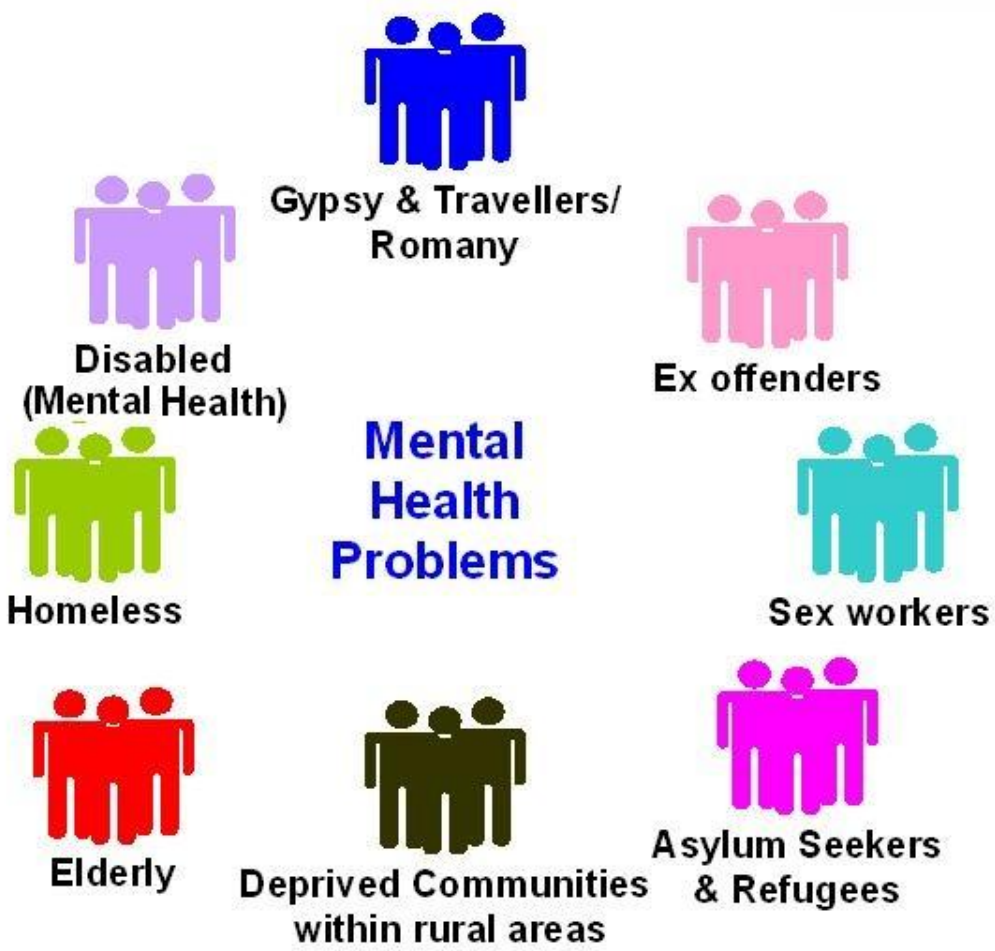
Homeless

Substance misuse

Sex workers

Ex offenders

Ararna 2009


Gypsy & Travellers/
Romany
Disabled
(Mental Health)
Ex offenders
Mental
Health
Problems
Homeless
Sex workers
Elderly
Deprived Communities
within rural areas
Asylum Seekers
& Refugees

Ararna 2009

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