NHS
Birmingham and Solihull
Clinical Commissioning Group

Equality Analysis

(Health Inequalities, Human Rights, Social Value)

(Communications and engagement strategy)

Before completing this equality analysis, it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

1. Background

EA Title	Communications and engagement strategy 2018/20		
EA Author	Jen Weigham/Gemma Coldicott	**Team**	Communications and Engagement
Date Started	28/08/18	**Date Completed**	06/09/18
EA Version	2	**Reviewed by E&D**	06/09/18

What are the intended outcomes of this work? Include outline of objectives and function aims

The strategy is designed to support NHS Birmingham and Solihull Clinical Commissioning Group (CCG) to reach its objectives and vision. It sets out the CCG's approach to communication and engagement; both within the organisation, and externally with our many stakeholders.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc. Explain how they might be affected.

A high-level stakeholder analysis is including within the strategy; this describes the broad stakeholder groups. All communications and engagement projects will undertake a detailed stakeholder mapping exercise, to identify specific stakeholders and enable to CCG to tailor communications and engagement interventions appropriately. The CCG has a comprehensive stakeholder database.

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	Research/Publications	Clinical Experts
Randall, S. (2015*), Using communications approaches to spread improvement*. London: The Health Foundation.	Gladwell, M. (2000), *The Tipping Point: How Little Things Can Make a Big Difference*. London, UK: Little, Brown and Company	Governing Body GPs
The Economist (2014), Schumpeter: *We want to be your friend*. UK.	Robertson, R. Appleby, J. Evans, H. (2018), *Public satisfaction with the NHS and social care in 2017.* The King's Fund. UK	
Clark, B. (2015), *How to Use the 'Rule of Three' to Create Engaging Content*	Page, B. (2008), *Where are we now?* Political Monitor, Ipsos MORI. UK	
CCG social media analytics data: 31 July 2017 – 31 July 2018	Bowen, F., Newenham-Kahindi, A., and Herremans, A. (2010), *When Suits Meet Roots: The Antecedents and Consequences of Community Engagement Strategy.* Journal of Business Ethics	
Government Communications Service (GCS); OASIS	NHS Identity; brand identity guidelines.	

campaign planning framework		
NHS England. (2014), *Five Year Forward View.*	Vize, R. (2017), *Swimming together or sinking alone. Health, care and the art of system leadership.* London: Institute of Healthcare Management.	
InHealth Associates. (2013). *Engagement strategy, cultures and systems.*	Nicols, B. (2010-2014), *Corporate communications lectures*. Buckinghamshire New University.	
McTernan, J. (2017), *10 Rules of Winning.* NHS England.	Seale, B. (2016), *Patients as partners: Building collaborative relationships among professionals, patients, carers and communities.* The King's Fund.	
CCG Equality Objectives and Health Inequalities Strategy: 2018 – 2021		

3. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

Age:

- *Birmingham has a younger population with 66% under 45 years and 17% in the 20-29 age group. 13% of the population is over 65 years old and is set to remain stable with many retirees continuing to move out of the city. The health needs of young people show that they have a relatively unhealthy start in life. The health of children in Birmingham is worse than England overall. This is reflected in a high level of infant mortality, low birth weight babies and high childhood obesity rates. Birmingham's teenage conception rate is one of the highest in the country.*

- *Conversely, Solihull is characterised by its older population. Between 1995 and 2015 the population aged 65 and over increased from 16% to 21% of the total so that there are now 9,200 more residents aged 65 to 84 years and 3,500 more aged 85 years and over than 20 years ago. Population projections based on the 2014 population estimates indicate the relative ageing of the Solihull population will continue and by 2033 those aged 65 and over will account for one in four of the borough population, with those aged 85+ numbering nearly 12,000 (5% of total). The growth in the numbers of those aged 85 and over represents a significant and growing challenge in terms of health and social care.*

Our stakeholders span a wide range of age groups; therefore the CCG needs to adopt a flexible approach to communicate and engage to meet a wide range of preferences.

3. Impact and Evidence:

With this in mind, a range of communication and engagement channels have been developed to ensure that we reach the right people, at the right time, with information that is relevant to them. This is supported by the communications and engagement principles within the strategy.

The CCG has a very strong presence on social media; evidence suggests that in the Birmingham area, over 80% of the population have access to a smartphone. Facebook, for example, is most popular with ages 25-44.

Disability: Describe disability related impact and evidence. This can include attitudinal, physical, communication and social barriers, as well as, mental health, learning disabilities and cognitive impairments:

- *9.1% of the Birmingham population reported a life limiting condition, or disability, with a further 9.3% of the population classified as their day-to-day activities were limited a little by a life limiting condition; with significant prevalence for those aged 65 years and over. Birmingham has 3.6% of children under the age of 15 years claiming disability living allowance. Mental illness is associated with one in every five people occupying a hospital bed each day in Birmingham. The percentage of the population who suffer from a mental health condition in Birmingham is 1%, compared to NHS England's indicator of 0.8%.*

- *The most common mental health problems in Solihull are neurotic disorders and depression. Large numbers of people in Solihull, over 24,000, are estimated to be suffering from these conditions - this represents 1 in 6 of the population aged 15-74. These conditions are more common in women and affect all age groups. 45.5% of Birmingham population has very good health compared to 47% of Solihull population.*

Some of the CCG's stakeholders may have disabilities and/or impairments, which mean they may not be able to interact with the CCG in the traditional ways. This may impact on people's ability not only to interact with the CCG, but to participate in engagement, consultation and also access healthcare information and resources. Therefore a flexible approach is required, with meets people's differing needs.

In the strategy, the CCG has committed to providing materials in accessible formats, such as easy read. The CCG also ensures key documents are tested by a public reader's panel, to ensure plain English and not jargon.

The CCG has a published patient expenses policy to help facilitate attendance at face-to-face events, through the reimbursement of travel and carers costs.

Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment:

- *The Birmingham Lesbian Gay Bisexual Transgender (LGBT) organisation stated (in their report 'Out and About: Mapping LGBT lives in Birmingham') that whilst there are*

3. Impact and Evidence:

no agreed figures as to the percentage of the LGBT population, estimates of between 6% and 10% are popularly used. There is evidence that indicates LGBT people experience discrimination when using health services and report having a poorer patient experience.

- *The CCG will respond to the national review of gender identity services locally.*

National NHS communication material, and imagery, has previously not been as inclusive as it could have been to reflect the communities it serves. This has meant that some communities such as the lesbian, gay, bi and trans communities could feel ostracised or 'invisible'. The CCG is aware of this and will make efforts in improve inclusiveness.

The CCG works with GPs to provide training on these issues, and are also working closely with Birmingham LGBT to understand the issues that the LGBT community face in relation to health and healthcare.

The CCG's People's Health Panel collects member's protected characteristics (they can choose 'prefer not to say'), so that the CCG can understand how representative it's channels are. There is a good representation of LGBT people on the panel.

There is a specific equality objective deliverable within the communication and engagement strategy, focussing on gender reassignment and LGBT communities.

Marriage and civil partnership: Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part-time working, and caring responsibilities:

No impacts identified.

Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities:

People who are pregnant, or on maternity/paternity leave, may find it more difficult to participate in our CCG engagement and consultation activities due to their family commitments. With this in mind, we use a range of methods to reach out to people who have differing time and resources available, to interact with us. Events and meetings must be planned to enable as many people to participate, in as meaningful way, as possible.

The CCG has a published patient expenses policy to help facilitate attendance at face-to-face events, through the reimbursement of travel and carers costs.

3. Impact and Evidence:

Race: Describe race related impact and evidence**.** This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers:

- *Birmingham is characterised by its ethnic diversity with a Black and Minority Ethnic (BAME) profile of around 42% and a range of languages spoken. Around 22% of Birmingham's residents are born overseas and 15% of the population is classified as having a main language other than English. There is a recognised link between poor health outcomes and English language needs. In Solihull, the BAME population has more than doubled since the 2001 Census and now represents nearly 11% of the total population.*

- *GP registration data on new patients who are recorded as being born outside the UK (Flag 4 data) shows an increase of 81,314 in overseas migrant registrations within Birmingham between 2013-2016 - Poland followed by Pakistan and India.. The highest number of new registrations were from those from Romania (11,715), followed by Pakistan (6,704) and China (6,095).*

There is a huge amount of ethnic diversity in the population that the CCG covers. For those who do not have English as a first language, it can be difficult for them to participate and receive information. It can mean confusion with access to services, and unfortunately it can mean encountering problems with registering for services too.

To enable people from different ethnic backgrounds to fully interact with services, there are language services for translation/interpreting. In terms of CCG communication, people may not be able to understand materials written in English and therefore have an instant barrier. The CCG has a standard offer, written in the top ten local languages, where people can request CCG documents in their chosen language.

Work will take place within communities promoting inclusion and building relationships to aid engagement and reduce stigma.

Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues:

- *In Birmingham, Christianity is the largest religion at 46%, followed by Muslim at 22%.*
- *The majority of Solihull residents describe themselves as Christian (65.6%), with no religion the 2nd largest group (21.4%).*

There are a number of different religions and beliefs observed locally; the CCG is committed to ensuring that individuals from different faiths are represented and are visible in CCG's communications and engagement, and that it is sensitive to cultural differences.

CCG communications and campaigns represent a wide range of cultures, as far as possible, so that people feel included and encouraged to take action and/or

3. Impact and Evidence:

participate.

The CCG is committed to ongoing relationships and partnerships with local faith organisations who work closely with particular communities, who can reach them much more effectively.

Sex: Describe any impact and evidence on men and women. This could include access to services and employment:

- *Both Birmingham and Solihull have a gender breakdown of 51% female and 49% male.*

No impacts identified.

Sexual orientation: Describe any impact and evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers:

- *Birmingham Lesbian Gay Bisexual Transgender (LGBT) organisation stated (in their report 'Out and About: Mapping LGBT lives in Birmingham') that whilst there are no agreed figures as to the percentage of the LGBT population, estimates of between 6% and 10% are popularly used. There is evidence that indicates LGBT people experience discrimination when using health services, experiencing poorer mental health, and report having a poorer patient experience.*

The CCG needs to ensure that LGBT communities are visible and represented in communications and engagement activities The CCG works closely with Birmingham LGBT on campaigns and consultations, in order to gather the views on the LGBT community; Birmingham LGBT is seen as the lead organisation in the area.

See also gender reassignment.

Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities:

- *The 2011 Census indicated that 107,380 people in Birmingham provide unpaid care (10% of usual resident population). Of those who provided unpaid care over 26% provided 50 or more hours a week.*
- *There are nearly 21,000 carers in Solihull equating to 10.5% of the total population, higher than the national average of 9.9%. This correlates with the larger 65+years population in Solihull*
- *Unpaid carers - data shows that a higher proportion of the CCG's population are undertaking care for family / relatives than the England average, this can be linked to the diverse communities identified within the population and must be considered in*

3. Impact and Evidence:
commissioning decisions. *The CCG understands and appreciates that many carers have limited time to participate in CCG engagement and consultation, but their contributions are extremely valuable. The CCG believes that digital communications channels better facilitate the involvement of carers in the CCG's work.* *The CCG has a published patient expenses policy to help facilitate attendance at face-to-face events, through the reimbursement of travel and carers costs.*
Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive) *The CCG fully recognises that it can be challenging to reach all of the different communities in the large and diverse population serviced. It is acknowledged that we may not fully achieve this fully through owned communications and engagement channels. Therefore, the CCG has a strategic approach to ongoing relationship and partnerships with local third sector organisations who work closely with particular communities, who can reach them much more effectively. The CCG will also work with other public sector organisations, to ensure a comprehensive and joined-up communications and engagement approach.*

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	Yes	*People who experience the highest health inequalities must be able to engage with the CCG and receive relevant information, in order for health inequalities to be reduced.*
Is there any impact for groups or communities living in particular geographical areas?	No	N/A
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	Yes	*The CCG must ensure that communications and engagement activities are accessible to all; regardless of the factors listed.*
How will you ensure the proposals reduce health inequalities?		

The strategy sets out how people who experience greater health inequalities will be able to become more involved in the CCG's communications and engagement activities, facilitating their involvement in decision making, and ensuring health services and responsive to their needs.

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	N/A
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	N/A
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	N/A
	How will this affect a person's right to freedom of thought, conscience and religion?	N/A
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	N/A
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	N/A
Right to **Life**	Will or could it affect someone's right to life? How?	N/A
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	N/A

6. Social Value	
Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.	
Marmot Policy Objective	**What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?**
Enable all people to have control over their lives and maximise their capabilities	N/A

Create fair employment and good work for all	N/A
Create and develop health and sustainable places and communities	N/A
Strengthen the role and impact of ill-health prevention	N/A

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	Protected Characteristic/ Group/ Community	Date
Review of strategy by patient representatives.	A number of patient representatives from across Birmingham and Solihull.	31 August 2018
Review of strategy by Expert by Experience.	Visual impairment LGBT.	31 August 2018
Review of strategy by Healthwatch Birmingham.	Independent Patient Champions.	05 September 2018
Healthwatch Solihull invited to review strategy.	Independent Patient Champions.	N/A

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

All relevant comments and feedback received have been incorporated into the strategy.

No adverse equality impacts were highlighted as a result of the consultation.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

N/A

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

N/A

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance

indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):
N/A

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):
N/A

12. Publication

How will you share the findings of the Equality Analysis?

This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages.

Governing Body – 18 September 2018

Publication on CCG website – September 2018

13. Sign Off

The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality and Diversity or Manager for Equality and Diversity **and** signed-off by a delegated committee

	Name	Date
Quality Assured by:	Bal Everitt – Senior Manager Equality / Inclusion	06-09-18
Which committee will be considering the findings and signing off the EA?	Governing Body – 18 September 2018	
Minute number (to be inserted following presentation to committee)		