Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

BNSSG CCG Governing Body Meeting

Date: Tuesday 5 January 2021
Time: 1.30pm
Location: Virtual meeting

Agenda Number :	6.4
Title:	BNSSG CCG Health Inequalities Plan
Purpose: Discussion/For Information	
Key Points for Discussion:	
• Based on discussions at a Governing Body seminar and subsequent Executive Team meetings, Governing Body, we have developed a high level health inequalities plan for Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG) as an organisation in its own right. • The plan covers different aspects of the CCG's functions and responsibilities • Peter Brindle, Medical Director, is responsible for ensuring that details action plans with appropriate timescales are produced.	
Recommendations:	To note the developing BNSSG CCG health inequalities plan
Previously Considered By and feedback :	Governing Body Seminar, August 2020 – gave initial ideas Executive Team, November and December 2020 – built on these ideas and added to them
Management of Declared Interest:	There are no declared interests.
Risk and Assurance:	As a result of the resources needed to respond to the Covid19 pandemic, there is a risk that the CCG will not have the capacity to progress some of the actions set out in the plan. This risk is mitigated in part by the fact that the approach taken to the plan tried to incorporate the actions into work that is done as part of the CCG's business as usual, e.g. reviewing terms of reference, developing the planning process, supporting our workforce. As a result of the CCG raising its own expectations about addressing health inequalities and asking staff to fulfil roles that they may not feel equipped to fulfil, there is a risk that we may unintentionally raise levels of anxiety and fears of 'getting it wrong' among staff. This risk will be mitigated by the action to consider training and development needs and

	also executive directors and other senior managers both explaining the expectations with their teams and showing compassion when expectations are not met.
Financial / Resource Implications:	The main financial implication will be making decisions on the use of existing funds, both the CCG training and development budget and in discussions about how we work with our partners to allocate the overall system budget to respond to the needs we have identified and how meeting them is prioritised.
Legal, Policy and Regulatory Requirements:	The actions described in this paper will support the CCG to meet its legal obligations as set out in the Equality Act 2010 and the Health and Social Care 2012.
How does this reduce Health Inequalities:	The actions described in this paper have been developed in order to use the CCG's functions and responsibilities as a commissioner to contribute to reducing health inequalities.
How does this impact on Equality & diversity	The developing plan should have a positive impact on equality and diversity particularly if the actions for workforce have the desired impact of increasing diversity of staff and thought within the CCG. If we improve the way that we 'do' change, this will also have a positive impact on ensuring that the diverse needs of our population are both fully recognised and responded to.
Patient and Public Involvement:	We have not consulted or engaged directly people living in BNSSG in the development of this action plan. The plan contains actions that are based on • Feedback from communities given as part of national reviews which have informed NHSEI requirements of systems • Insights from our communities
Communications and Engagement:	We will communicate the developing health inequalities plan to our staff, including our staff networks, and this will be done using our existing communication methods. This will give staff the opportunity to ask questions and make suggestions.
Author(s):	Adwoa Webber, Head of Clinical Effectiveness
Sponsoring Director / Clinical Lead / Lay Member:	Dr Peter Brindle, Medical Director

Agenda item: 6.4

Report title: BNSSG CCGG Health Inequalities Plan

1. Background

In August 2020, the Governing Body had a discussion during their seminar about health inequalities and Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Group's (CCG) role both as a commissioner in the system and as an employer in

order to inform an internally focussed plan for the CCG as an organisation in its own right. The three broad areas that were discussed were:

- Governance, assurance, decision-making – How can we be assured that our decision-making does not exacerbate and also improves health inequalities?
- CCG Workforce – How can we ensure that our processes / culture / thinking increases the diversity of our workforce at all levels?
- Population – How can we be assured that we make the biggest improvement to heath inequalities we can with the money and people that we've got?

The suggestions made by Governing Body members informed discussions at Executive Team on 18 and 25 November and 9 December 2020 where more ideas and suggestions were made. This work has resulted in a CCG health inequalities plan.

2. Proposed actions

The table below describes the developing BNSSG CCG health inequalities plan.

	Proposed action	Rationale	Responsible Executive Director	By when
1	Review terms of reference for sub-committees of Governing Body to ensure that their responsibilities in reducing health inequalities are made explicit	The sub-committees of the Governing Body have delegated responsibility for aspects of decision-making and assurance and therefore it is important that they agree their health inequalities responsibilities.	Sarah Truelove	February 2021
CCG Performance Reporting				
2	The activity element of the BNSSG Quality and Performance Report will show overall activity (increases and decreases as now) for each of cancer referrals (particularly the cancer sites of concern such as lung), electives, outpatients and emergency care and what that activity looks like in relation to the people from the 20% most deprived neighbourhoods in BNSSG and Black, Asian, Minority Ethnic (BAME) background. Issues and mitigations will then be highlighted in the report as they are in general terms currently.	Health outcomes are poor for those living in deprived areas and many of those from BAME backgrounds and we need to understand differences in access to services in BNSSG in order to take mitigating actions where needed. NHS England and Improvement (NHSEI) states, “Monthly NHS reporting will in future include measures of performance in relation to patients from the 20% most deprived neighbourhoods (nationally and locally, using the Index of Multiple Deprivation), as well as those from Black and Asian communities where data is available.” and “we would encourage systems to also look at performance (inclusive access) among the relatively most deprived neighbourhoods within the system (e.g. the most deprived 20% within	Lisa Manson and Sarah Truelove	March 2021

	Proposed action	Rationale	Responsible Executive Director	By when
		your system) alongside other local population analysis." Please note: Certain characteristics that a person or community has, e.g. poor/low income, prison leaver, migrant, BAME background, mean that they are more likely to be living in a deprived area		
Using the information about population need and experience to inform planning of our work				
3	Use the PHPI Steering Group's Health Inequalities Profile and subsequent deep dives to further define what we are trying to improve, for the CCG to then decide what actions and by when it needs to take to make improvements (internal actions as an organisation in our own right).	The Profile will highlight the major differences in health outcomes within the BNSSG population – what these are, where, amongst whom, and what might be the pathways leading to these outcomes, and the opportunities to intervene. This will help further define what we are trying to improve, for us to then decide by when and what the actions we will take to make improvements. This supports the 'assessing need' and 'deciding priorities' parts of the commissioning cycle	Peter Brindle	March 2021
4	Use the Health Inequalities Profile and subsequent deep dive (which use the PHM work) and other information to inform system-wide planning.	The CCG plays a key role in the system in focussing on population health and in co-ordinating the planning process and can therefore influence the extent to which population need informs system-wide planning	Peter Brindle and Sarah Truelove	January 2021
5	Work with each Primary Care Network's (PCN) named health equality champion and together as a collective, to use their knowledge and experience to inform planning and actions. In	As part of the Phase 3 eight urgent actions on health inequalities, each PCN was required to nominate their clinical director or an alternative lead to champion health equality. Their	Dave Jarrett and Colin Bradbury	February 2021

	Proposed action	Rationale	Responsible Executive Director	By when
	the short term, this could support the work being done to ensure that the roll out of the Covid-19 vaccine proactively addresses inequalities in take up.	knowledge and experience, support and challenge could be used to further understand their population's need		
Equality Impact Assessments - robustness of assessment and their review at decision-making meetings				
6	Develop a plan for improving the robustness of Equality Impact Assessments and their review at decision-making meetings. CCG Inclusion Co-ordinator, the CCG's specialist in this area, to attend Executive Team with a proposal that moves us from the fact that we need to improve standards and expectations, to action quite urgently	Governing Body and Executive Team recognised the need to make improvements to the robustness of assessments and their review at decision-making meetings and build on the work done to support staff.	Deborah El-Sayed	January 2021
7	Health Equity Assessment Tool (HEAT) to be introduced to CCG staff	We need to think about how to identify what action can be taken to reduce health inequalities and promote equality and inclusion at the start of pieces of work. The Public Health England HEAT is designed to help people to do this.	Peter Brindle	Starting now and ongoing
Explicit leadership and clear identified focus				
8	CCG staff who have a Senior Responsible Officer role in CCG or Healthier Together programmes or steering groups are to be made aware that they are accountable for ensuring health inequalities are properly covered. This can include nominating a member of the programme or steering group to be work's health	This will provide support and challenge to programmes and steering groups.	Peter Brindle	January 2021

	Proposed action	Rationale	Responsible Executive Director	By when
	inequalities champion.			
9	• Consider whether the training and development needs of SROs should form part of the CCG delivery of the NHS People Plan • Work with the Healthier Together Workforce Steering Group to progress this for SROs across the system.	This recognises that people may need support to ensure that the programme or steering group they are SRO for ensures that health inequalities are properly covered.	Sarah Truelove Peter Brindle	February 2021 January 2021
Workforce				
10	Recruitment processes; reverse mentoring – set up more systematically; working with our workforce to understand the challenges – all to be progressed by the CCG's People Plan Steering Group and CCG Inclusion Group.	The NHS People Plan includes a number of actions under 'Belonging in the NHS' and commitments that the NHS will be open and inclusive; ensuring that staff have a voice; compassionate and inclusive leadership;	Sarah Truelove	March 2021
Understanding the challenges and thinking about how we're working with different communities to 'do' change				
11	Work with CCG teams to develop a way to join up a) the insights work the CCG has done to date and b) the insights that our communities give us 'unprompted' by us with both the work that the CCG and system design groups (project and steering groups) do and the way that they do it.	In order to achieve true co-design, we need to move from "designing at people" to "led by the people"[1]	Deborah El-Sayed	July 2021

[1] https://www.beyondstickynotes.com/what-is-codesign

3. Next steps

This paper has provided a high level plan. Peter Brindle, Medical Director, will be responsible for ensuring that detailed action plans with appropriate timelines are produced.

4. Financial resource implications

The main financial implication will be making decisions on the use of existing funds, both the CCG training and development budget and in discussions about how we work with our partners (service providers and other commissioners such as local authority) to allocate the overall system budget to respond to the needs we have identified and how meeting them is prioritised.

5. Legal implications

The actions described in this paper will support the CCG to meet its legal obligations as set out in the Equality Act 2010 and the Health and Social Care 2012.

6. Risk implications

As a result of the resources needed to respond to the Covid19 pandemic, there is a risk that the CCG will not have the capacity to progress some of the actions set out in the plan. This may result in progress being slow. This risk is mitigated in part by the fact that the approach taken to the plan tried to incorporate the actions into work that is done as part of the CCG's business as usual, e.g. reviewing terms of reference, developing the planning process, supporting our workforce. This encourages looking at what we do through an inequalities lens.

As a result of the CCG raising its own expectations about addressing health inequalities and asking staff to fulfil roles that they may not feel equipped to fulfil, e.g. champion health inequalities in a project team, there is a risk that we may unintentionally raise levels of anxiety and fears of 'getting it wrong' among staff. This may result in poorer staff wellbeing. This risk will be mitigated by the action to consider training and development needs and also executive directors and other senior managers both explaining the expectations with their teams and showing compassion when expectations are not met.

7. How does this reduce health inequalities

The actions described in this paper have been developed in order to use the CCG's functions and responsibilities as a commissioner to contribute to reducing health inequalities.

8. How does this impact on Equality and Diversity?

The developing plan should have a positive impact on equality and diversity particularly if the actions for workforce have the desired impact of increasing diversity of staff and thought within the CCG. If we improve the way that we 'do' change, this will also have a positive impact on ensuring

that the diverse needs of our population are both fully recognised and perhaps more importantly, responded to.

9. Consultation and Communication including Public Involvement

We have not consulted or engaged directly with the BNSSG CCG population in the development of this action plan. The plan contains actions that are based on:

- Feedback from communities given as part of national reviews which have informed NHSEI requirements of systems, e.g. the Phase 3 eight urgent actions on health inequalities
- Insights from our communities, both through the CCG/Healthier Together work and from community produced reports and feedback from groups such as the Bristol Race Equality Covid-19 Steering Group.

We will communicate the developing health inequalities plan to our staff and this will be done using our existing communication methods such as Have We Got News For You to give a broad overview and then Executive Directors and Senior Managers using their existing team meetings, including with our staff networks, to discuss the plan in more detail and give staff the opportunity to ask questions and make suggestions.

Glossary of terms and abbreviations

<table>
<tr><td>Health inequalities</td><td>These are unjust and avoidable differences in people’s health across the population and between specific population groups.
They do not occur randomly or by chance
They are socially determined by circumstances largely beyond an individual’s control</td></tr>
<tr><td>Health outcomes</td><td>Changes in health that are a result of specific health care investments or interventions
Result of a medical condition that directly affects the length or quality of a person's life
Changes in health status that result from the provision of health (or other) services.</td></tr>
<tr><td>Co-design</td><td><table><tr><th>From</th><th>To (Co-design)</th></tr><tr><td>Making decisions for people with lived experience</td><td>Making decisions with people with lived experience</td></tr><tr><td>Valuing professional expertise above all</td><td>Valuing professional and lived experience equally</td></tr><tr><td>Seeing marginalised people as a burden</td><td>Seeing marginalised people as resilient, creative and capable</td></tr><tr><td>Believing that resources are scarce</td><td>Seeing an abundance of experience, ideas and energy for change</td></tr></table></td></tr>
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to make change	
Focusing on ‘consumer’ councils and committees	Embedding participation in everyday practice
Rushing to solutions	Slowing down to listen, connect and learn