GREATER MANCHESTER VCSE
DEVOLUTION REFERENCE GROUP

Re-framing Equality to respond to Health Inequalities: Supporting Citizen Led Reform

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A Co-design process September 2017 - February 2018: Summary of Actions

1. **Develop Shared Equalities Vision, Values & Outcomes for Greater Manchester**
   It is proposed to develop a shared vision via a co-design process across GM between voluntary, community and social enterprise (VCSE) & health and social care (H&SC) colleagues that is distinctly focused on reducing inequality by identifying and targeting action to reduce structural inequalities experienced by communities of identity or experience. The development/ agreement of critical high level outcomes will ensure a clear accountable outcome framework from which to drive action.

   There is also an opportunity to widen this to GMCA (Greater Manchester Combined Authority) level and aligning it with the Mayoral priorities regarding School Readiness, Life Readiness, Homelessness and Ageing Well.

2. **Develop a Governance framework that assures Equalities within Governance system** - ‘hardwiring the system’.

2.1 Set up an Equalities Board
It is proposed to set up a Shadow Equalities Board in early 2018 who will develop Terms of Reference, membership, form and function and recruit other members to ensure a functioning GM Equalities Board in 2018.

2.2 Design and Implement a ‘Director Level Equality Assurance Scheme’
It is proposed to develop an approach whereby relevant Director Level posts will hold a portfolio and role to ‘assure’ equalities within the work streams for which they are responsible.

The roles would provide a direct line of accountability from the GM work streams to the Equality Board and existing Governance arrangements.

Requirements of the role will be developed by colleagues from the GM VCSE Devolution Reference Group (the ‘Reference Group’) and key H&SC colleagues for agreement at the Shadow Equalities Board and GM H&SC Senior Management Team.

2.3 Design and Implement ‘Equalities Sponsors Scheme’
Equalities sponsors will be recruited from the VCSE - the sponsor role ensures that the VCSEs is supported to contribute to, shape and influence the implementation of the relevant strategies and work streams. The role of the resourced VCSE Equalities sponsor would be to lead beyond their organisation attending appropriate GM meetings as VCSEs

experts in their field, follow up work, reading, written contributions as appropriate, feeding back to colleagues across the VCSEs and across sectors, contributing to the system leadership required for the thematic area.

This approach would be developed by the Reference Group and key H&SC colleagues for agreement at the Equalities Board and GM H&SC Partnership SMT.

3. **Develop an Equalities Performance Management framework**
A distinct Equality performance management framework must be developed that is driven and monitored by the Equality Board and Director Level Equality Leads (see 2.2) within GMCA/ H&SC Directorates and Work streams. The high level outcomes developed in action 1 to drive the biggest step changes in in-equality must be represented by KPIs and relevant action plans. There is an existing GM Outcomes and Performance Dashboard which will be analysed to ensure it reflects measures to drive a step change in in-equality and additions will be made as a result of Action 1 - Develop Shared Equalities Vision, Values & Outcomes for GM.

The collection of key equalities metrics will also require evaluation to ensure they are fit for purpose and can fulfil the data requirements of the agreed suite of outcomes from action 1.

4. In depth analyses or ‘ equality challenges’ will take place of the **Commissioning , Social Prescribing and Person Centred & Community GM work streams** to ensure that there are effective actions to ensure inequality issues are addressed .

5. **Design and implement a commissioning process to make a step change in reducing health inequalities and a process to invest in the VCSE –** support resilience in the sector and targeted interventions to reduce inequality.

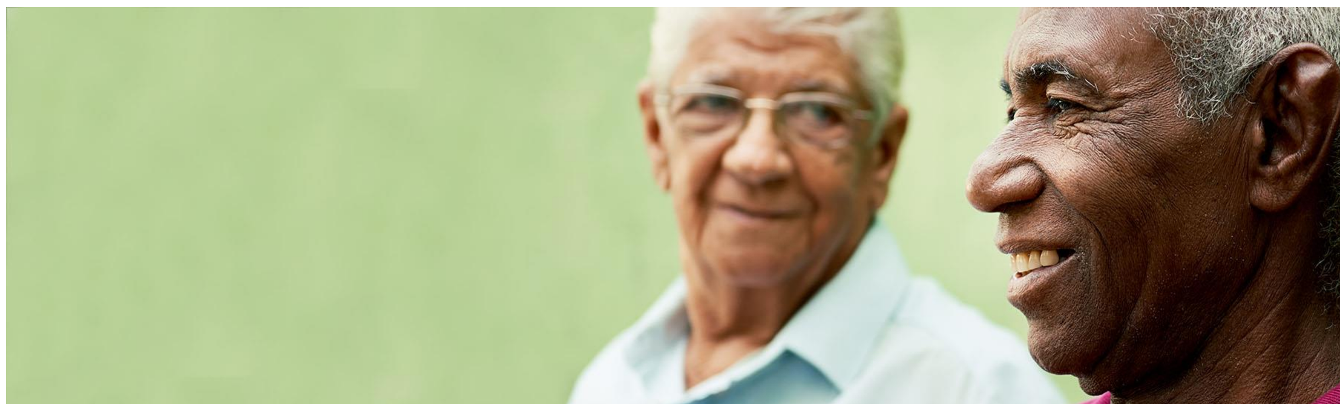
6. **Support, facilitate and encourage co-design, co-production at GM to support citizen led reform.**
Ensure that GM population most affected by inequalities are engaged and supported to be engaged in co-production and citizen led reform.

7. **Develop a/ the GM Social Prescribing Strategy to ensure step change in equalities**
Ensure social prescribing offer is aligned to locality plan priorities in each 10 localities and addresses inequality issues

8. **Develop a GM workforce Equality Plan** – there will be a number elements to this work :- recruitment of new staff to reflect local communities and reduce poverty, development of existing staff and developing organisational knowledge , behaviours and approaches to remove system based/ institutional discrimination.

There are links to the development of GM Equality outcomes, links to EDHR work in Manchester and there may be other linkages.

9. **Develop and Launch the GM Equalities Plan –** formally launch the set-up of the Equality Board and the year one action plan.



1. Introduction and Context - The WHY

"Everyone has the right to the highest attainable standard of physical and mental health. Our health affects the extent to which we can enjoy our other rights. Everyone should have access to good quality health care, without discrimination and with autonomy in decisions. However, there is evidence of differential access to appropriate health services for lesbian, gay, bisexual and transgender people, Gypsies and Travellers, homeless people, some ethnic minority groups, migrant communities, disabled people (including those experiencing mental health problems and disabled parents) and men in their fifties at increased risk of wanting to take their own lives. Recent high-profile investigations have also identified significant flaws in the care of patients, and insufficient respect for privacy and dignity in health and social care. In England and Wales there is a significant disproportionality in the numbers of Black and ethnic minority people detained under the Mental Health Act 1983".

- EHRC Strategic Plan 2016-19[1]

1.1: What are we talking about?

1.1.1: The legal framework of Equality

Removing inequality to accessing health and wellbeing services is not just the right thing to do – the Equality Act 2010 requires public and health services to ensure equality of access and if necessary make changes services to enable access and reduce inequality. The Equality Act brings together over 116 separate pieces of legislation into one single Act to protect the rights of individuals and advance equality of opportunity for all.

The Act simplifies, strengthens and harmonises the current legislation to provide Britain with a new discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society.

The nine main pieces of legislation which were merged are:

- the Equal Pay Act 1970
- the Sex Discrimination Act 1975
- the Race Relations Act 1976
- the Disability Discrimination Act 1995
- the Employment Equality (Religion or Belief) Regulations 2003
- the Employment Equality (Sexual Orientation) Regulations 2003
- the Employment Equality (Age) Regulations 2006
- the Equality Act 2006, Part 2

- the Equality Act (Sexual Orientation) Regulations 2007

The Equality Act refers to Protected Characteristics who are afforded legal protection from the Act:- age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race religion or belief, sex & sexual orientation.

However, our approach to reframe Equality must ensure that we go beyond those listed in the Equality Act - we recognise that health inequalities and structural barriers are faced by many groups within our communities for example those living in poverty.

Therefore, a broader set of rights frame this work: **Economic, Social and Cultural rights.** Rights that concern the production, development, and management of material for the necessities of life. Rights that give people social and economic security, sometimes referred to as security-oriented or second generation rights. Examples are the right to food, shelter, education and health care.

1.1.2: Equality

Equality is about ensuring that every individual has an equal opportunity to make the most of their lives and talents, and believing that no one should have poorer life chances because of where, what or whom they were born, or because of other characteristics. Equality recognises that historically, certain groups of people with particular characteristics e.g. those of certain races, disabled people, women and gay men and lesbians, have experienced discrimination.

1.1.3: Direct discrimination

This refers to less favourable treatment against an individual because of that person's protected characteristic.

1.1.4: Indirect discrimination

This is when a provision, criterion or practice is applied in a way that creates disproportionate disadvantage for a person with a protected characteristic as compared to those who do not share that characteristic, and this is not a proportionate means of achieving a legitimate aim.[1]

1.2: Devolution of power to GM to take charge of health and social care spend offers the opportunity to "radically transform health, social care and wellbeing in Greater Manchester - do things differently to reduce systemic inequality.

The GM Taking Charge strategy identifies a clear case for change. Health outcomes are worse in GM than other parts of the country. It also acknowledges that there often even worse health outcomes for marginalised communities, communities of identity and people who experience economic disadvantage and poverty.

In short, there is a disproportionally worse impact on health outcomes for those who already experience disadvantage.

The specific Taking Charge conversations held in 2016 with VCSE organisation identified key issues and recommendations including - "It's all about equality": Participants in the Taking Charge conversations drew a direct connection between structural inequality and ill health, in line with mainstream theory on health inequalities. This suggests that addressing structural inequalities in society has to be at the centre of all health improvement work

[1] EHRC Website www.equalityhumanrights.com/en/secondary-education-resources/useful-information/glossary-terms

Specific recommendations from Taking Charge Conversations:

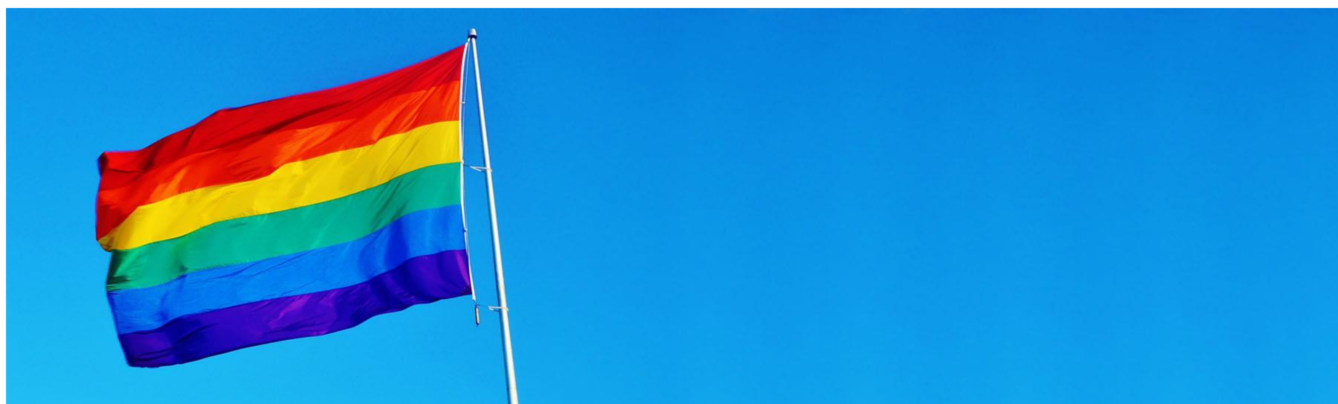
- Ensure health and social care services are accessible and inclusive by mainstreaming accessibility and inclusion to the highest possible level and offering additional targeted solutions to meet the needs of specific groups.

- Invest in both neighbourhood and Greater Manchester level VCSE-led initiatives to reduce health inequalities by targeting specific marginalised communities, and making the most of existing relationships and the position of trust VCSE groups and organisations enjoy vis-à-vis those people and communities most affected.[2]

1.3: GM need to drive change in service approach, design and delivery in order to reduce inequality of health outcomes – this piece of work aims to develop a framework and approach to drive actions.

It was important that any new approach was developed using a co-design approach with GM VCSE Equality organisations and Health and Social Care stakeholders.

[2] Taking Charge Together Final report on VCSE and Healthwatch organisations' Community Engagement Strand Valeska Matziol and Susanne Martikke 15 April 2016 www.gmcvo.org.uk/system/files/takingchargetog_vcsehw_report_final_0.pdf



2: How do we drive transformation and change to achieve reduced inequality?

2.1: The GM VCSE Devolution Reference group agreed in January 2017 that any new approach should:

- Be led by the VCSE in order to engage the knowledge and resources at a GM and locality level and ensure it was led by 'experts by experience'.
- That it must drive step changes to close the gaps not only in Health & Social care but across all the GM Work streams & the Inclusive Growth Agenda was identified as a key platform.
- Facilitate a new approach to strategic service/ work stream development and scrutiny..

2.2: The Methods

A co-design approach was agreed as essential to engender a partnership approach with VCSE equalities groups and ensure buy in from a range of stakeholders & generate ideas beyond a traditional structural governance approach.

A sponsor from the Reference Group - Michele Scattergood, CEO Breakthrough UK and Equalities representative, was commissioned to advance the approach utilising the resources attached to the GM H&SC & VCSE Memorandum of Understanding.

The commission outcomes:-

- Agreed delivery mechanisms to embed equalities
- Action plan to support the maintenance this approach by the Reference Group and internal drivers within H&SC Partnership.

3. Co-design Methodology

3.1: Step One - VCSE Assembly

First key step was a GM VCSE Assembly held in early November 2017 which via presentations of context and current good practice and roundtable discussions sought to elicit:

- What do we know about?
  Equalities work / engagement we are already involved in across GM
  Disproportional impact / barriers on communities

- What have we learned about how to influence, challenge and scrutinise? - our "Like, Lacked, Learned, Longed for?"

The assembly was attended by 33 individuals representing VCSE equality focussed organisations from across GM. From this event 10 -15 participants were sought for a second co-design event with stakeholders from the H&SC Partnership & service users.

3.1.1: Synthesised feedback from GM VCSE Assembly discussions in November 2017

What do we know?

- Need to build on what is known e.g. JSNA. CCG reports (use existing data/ studies etc.)Lack of equality impact assessments – need this to get into details for strategy and rectify adverse aspects - examples of Equality Impact Assessment (EIA) best practice
- Systematic analysis of EDS2 needed
- Outcome measures are not culturally competent
- Lack of sexual orientation monitoring and gender identity monitoring
- Healthier Together – previous equalities work – needs to be built on
- National policy e.g. hostile environment is introducing institutional barriers and confusion.

Barriers within Service provision:

- Adopt and adapt services to individual needs
- Access to MH support – cross cultural concepts, heavy medical focus, western model, labelling – discrimination, can impact upon employment, need to focus instead on people's experiences
- Need lived experience
- Wide access can make access more difficult for a minority

- Need more diverse workforce to enable. Can be an asset too though e.g. more BME staff
- Seeing diversity of people reflected in services – especially in BME Maybe has been noticed as it has been mapped, could be just as poor in other groups
- Denying access to refugees and people seeking asylum
- Cultural requirements re religion - Lack of understanding
- Opportunities for choice e.g. limited food choices
- Diet – diabetes is covered under the Equalities Act but diet doesn't address this
- There are problems in acute sector e.g. not enough wheelchairs at Wythenshawe Hospital
- Language barriers- too little to support people's communication
- Interpreters can't always understand medical terms or cultural needs - learning disability impact too. Interpreters could be informed e.g. by cancer champions. Advocacy needs specialist support
- Online services are a big barrier to already unequal service access – people aren't used to this
- Language barriers – misinformation, need for interpreters and underlying cultural issues e.g. prejudice, conflicts of interest, inappropriate disclosure to family & friends interpreting
- People who can't express their needs need a trained advocate - training need for health professionals so they would know how to approach this issue and know what to do, people also need support to even access the service.
- Fear of discrimination or actual discrimination
- Mental Health makes a big difference to how people access help for other h & SC issues, referrals to multiple services- complexity – even less access (commissioning tends to be by condition)
- If you are disabled and BME …. you may not be 'eligible' to access the service(s) that suit you
- Complex range of problems – lack of integrated services – continual re-direction
- The transition from young people's services to adult services is worse for people from equality groups because they are more reliant on the services provided. Another difficult transition is from 30's into 40's when family support may fall away.
- Targeted services yes but ….e.g. sexual health services help LGBT men, YP but who isn't covered then/
- Independent trusts etc. work at cross purposes to current need, VCSE not integrated
- ABCD work can exacerbate inequalities where people are in minority areas

Wider determinants:

- Fear of losing benefits
- Poverty pockets
- People get used to how they feel
- Health literacy – if poor this impacts on whether people can look after themselves, motivation
- Transport – accessible and cost
- Built environment barriers – for disabled and older people too. Physical, sensory, attitudinal, planning could do more e.g. recent urban design group conference – inconsistent physical barriers e.g. dropped kerbs in different LA areas – prevents independence
- Transport to specialist centres – a challenge as they are further away – accessibility to facilities
- Postcode lottery - moving home in GM impact of services offered

- Awareness of the Equalities Act - people are often unaware of their rights e.g. BSL interpreter if you can't hear. Also entitlement to equipment Specialist services across very diverse areas.

What does good look like?

- A GM equalities strategy
- More radical than EIA's
- Transparency and space to show the gaps – honesty
- Show real resource investment
- Need clarity of everyone's responsibility – transparent accountability?
- Identify a team or named individual in each work stream who makes sure that actions are taken forward from EIA and is a named contact for equalities issues for VCSE sector to communicate wit
- There should be an EIA of every policy and strategy that comes out of HSCP and a team be in place to make sure this happens
- A Governance Group with a clear scrutiny role, it should be fully resourced and take on learning from Cancer Board whereby representatives time is valued by being paid for – learn from EDS2 & Healthier Together
- A person centred approach to equalities where the individual is looked at rather than ticking boxes for different 'characteristics' as we have done in the past – this could be piloted alongside what exists currently

Full write up of all exercises are attached as Appendix ii

3.2: Step Two - Co- design GM H&SC, VCSE and users

Held on 4th December 2017, 27 participants from GM H&SC, GM VCSE organisations and service users attended a facilitated co-design event, the objectives of which were:

- To support the development of an innovative, strengths based and co-designed GM wide approach to Equalities as part of the Health and Social Care Strategy delivery
- To ensure that this is co-produced with all relevant stakeholders
- To support the development of a sustainable approach to the ongoing co-production of the equalities work, and the service delivery outcomes
- To develop a clear idea of the form and function of the equalities work
- To develop a clear set of actions and recommendations

The highly participative four hour event:

- Elicited views and ideas for action on "How well GM were currently "re-imagining Health & Social Care" priorities"
- Re-imagined and set high aspirations in relation to "Radical Upgrade in population and health prevention, transforming community based care and support, acute and specialist care and clinical and back office support" – taken from GMH&SC Taking Charge Strategy[3]
- Explored ideas of what needs to be in place to ensure action, what we need to do differently
- Explored the role of co-production as an enabler, who, how, what and where co-production could be effective
- Developed action plans facilitate a new approach to embedding Equalities within the work of GM H&SC.

[3] www.greatermanchester-ca.gov.uk/downloads/file/125/taking_charge_of_our_health_and_social_care_in_greater_manchester

Full write up of all exercises are attached as Appendix iii

3.2.1: Key Themes which emerged from the event are as follows with examples of comments / issues raised

Themes	Comments
Integrated/joined up working **Integrated action – GM Equality Plan** **Holistic - action across the wider determinants of health**	• Finding commonalities between people and catering for them • Looking at economies of scale at GM level • Streamlining all the standards into GM standards – 1 approach • System wide approach to equalities • Ensuring that specialist services for specific communities of identity are commissioned alongside locality-based services (which tend to be more generic) • Shared understanding of what needs to be done • Clear road map to reduce inequality
Governance Leadership **Accountability** **Shared action vision and principles**	• Leadership and accountability • Challenge and scrutiny • A shared understanding of scale of issues • A shared understanding of barriers and needs • A shared understanding of equality and inclusion etc. • Leadership and commitment to working together • Resourcing solutions • Develop shared values
Co-production/ People powered/ Value Lived experience **Personalisation**	• Ask the experts • System to support citizen led reform • Ability for service users to inform and shape – system to support listening • Investing in patient and public involvement • Empowering and resourcing self-care • Challenge and scrutiny • Taking a person centred approach not a condition or content approach. • Prevention and enabling behaviour change • Let go of power • Community ownership • Develop relationships • Support and coach • Take risks

	• Invest in access to primary care/ developing community services to reduce impact on acute – equality sensitive and specialised/ accessible community services where necessary • Peer support – has HIGH impact • Personalised Approach – understand, train , behaviour • Must influence commissioning
Knowledge & Data **Identify the assets that will help address inequality**	• Knowledge of communities / understand local population • Data and insight • Collect the right data in the right way • Local community knowledge • Knowledge of VCSE orgs – e.g. BME Cancer • Support the building of asset databases • Value and invest in Community Hubs • Workforce who are also members of a local community – big asset • Peer support • Must influence commissioning
Eligibility and standardisation **(tension with person centred ?)**	• Standardisation • Eligibility Criteria - personalisation, personal approach • Workforce equalities skills levels • Streamlining all the standards into GM standards – 1 approach • Review all policies and procedures against an asset based approach • Need to put community and individual need above data rules
VCSE community and partnership	• Enabling the VCSE to be even more effective – not just the big players but community groups • Partnership with VCSE and community • Investing in VCSE • Effective and real commissioning • Dynamic commissioning • Ensuring a fit with Communities of Identity who may not be place specific • Rich Knowledge of VCSE orgs – e.g. BME Cancer • Value and invest in Community Hubs

Recognising diversity	- Prevention and enabling behaviour change - Services for people seeking asylum and refugees - Mental Health - Mental health in people living with long term chronic conditions. - Complex needs of refugee communities and people with LD - Ensure carers included
Diverse and reflective workforce **Knowledgeable workforce**	- Invest in workforce - System leadership skills, knowledge and values - Workforce equality knowledge – inc in co-production - Ensure legislative knowledge - Diverse workforce at all levels – positive programmes to make step changes at faster rate - Integrate Asset approach, reduce deficit / sick model. Shift from ‘fix –it’ to person centred / empowerment – needs skills resources, training to support culture shift - Workforce need different skills to work in an asset based way - Review all policies and procedures against an asset based approach

3.2.2: Action Planning

A key part of the day began to flesh out Action Plans against the key themes that had emerged from the first assembly and throughout this co-design event. This action plans is summarised below. The action plan was then taken forward to Step Four – a second GM VCSE Assembly which sense checked the outcomes of the two design events and spent time on the detail within the Action Plans (see Section 4)

The broad outcomes & proposals from the VCSE Assembly & the Co-design session:

	Key action	Specific Steps	By When
1.	**Governance / Assurance / VCSE voice in Governance system** *‘hardwiring the system’*	**a) Core Board** in place asap to scrutinise Action Plan and develop the remit and approach of a ‘Board’ and connection to GMH&SC system **b) Other Boards / Committees?** (Input into Transformation Board **c) Director Led Assurance Scheme** Develop Champions and leads in the system, level in organisation to affect change Role description and recruit/ identify	a)Core group set up in Jan 18 b) Agree by Mid Feb – request to GM VCSE Ref Group to identify members c)Process to identify leads and draft role description (LS)

		1st task oversee EIAs of each Taking Charge work stream – action plan **d) VCSE Sponsors** / **Experts by Experience** for work streams/ projects. Develop Role description and recruit/ identify resource **e) Ensure Equality Panels/ VCSE representation at Locality Level** – GM standards requirements by LCOs?	d) VCSE sponsors identified – via GMVCSE ref Group / GMCVO / 24th Jan date Assembly Feb 26th or before via network
2.	**a. Develop Shared Vision and Values & Outcomes to contribute to the reduction of inequality** *(x 2 groups identified this so the task has been amalgamated)* **b. Develop Performance Management framework**	**Organise an accessible workshop to develop :** - **Outcomes core principles** - **Values** - **Vision** - **Measures to demonstrate change (KPIs)** **Methods** – -Rolling roadshow format x GM -Analyse, Sense check - Publicise/ launch **Action –** requires a method to integrate into PMS / governance system Scrutiny - Assurance Leads within H&SC & within Governance *** see action 1** **Measures** – PMS **to contribute to the reduction of inequality** – see workforce KPIs for equality issues (see issue/ barrier identification in 1. To identify the KP areas) Review system data fields – to ensure correct equality metrics are collected.	By end of March 2018
3a.	**Identify barriers in service provision, improve commissioning, learn from bad & good & gain data**	**a. Mapping case studies which identify barriers to health and social care – interaction analysis.** 10 pathways (2/3) from each protected group 9 equality 1 homeless Refugee & asylum Seekers Migrant Workers	Structure project by Jan Collect & analyse studies by end of Feb/ early March Analysis till mid-March Proposals to a H&SC Board by end of March 18

		b. Create standard template for collection (Voice of service user) Collect Analyse Identify barriers **c)Develop plans to mitigate and remove barriers from 'system'**	
3b	**Design a GM commissioning process to overcome identified barriers and meet needs**	Compare current commissioning processes Utilise case study from GM LGBT study Develop plans to remove barriers from system How to influence LCO Commissioning processes? Minimum requirements? Social Value VCSE % commissioned as providers? Support / resource to facilitate consortium and partnerships at local level?	
5.	**Support , facilitate and encourage co-design, co-production at GM (& LCO level?)** **System to support citizen led reform** **Empowering people to challenge system**	Link to GM PCCA Work to date Test re equalities Tools Guidance Skilled workforce – see action 8 Workforce Scrutiny / assurance role over 10 GM and LCO Skill up local people – TLAP National Co-production model Strengthen VCSE work in this area to skill people up so they can actively challenge – encourage citizen leadership	

7.	**a. Develop a GM Social Prescribing Strategy Ensure social prescribing offer is aligned to locality plan priorities in each 10 localities and addresses equality issues** **b. Establish & maintain a database of community assets (social prescribing opportunities) for each locality**	Mapping what exists Identify the gaps How to connect VCSE effectively Develop services activities of quality Identify existing good practice in GM and elsewhere Agree a specification based on the above Investment identified Build Resource	June 2018 ?
8.	**Develop a GM workforce - who embrace asset based approach**	Pilot work e.g. Cancer workforce strategy Systems Leadership - opportunities 'Leading GM' ALL current GM workforce development to be reviewed through an equalities lens	
9.	**GM Equalities Plan**	Turn these actions into a GM Equalities Plan Owned Launched Visible (web site etc.)	

3.3: Step Three – Sense check and developing the Approach and Action Plan with the GM VCSE

On 26th February 2018 the second GM VCSE Equalities Assembly met (Programme attached as Appendix iv)

This event was used as an opportunity to:

- Reflect back to the wider GM VCSE Equality Sector the work to date
- Utilise the time the flesh out the actions proposed from the Co-design Event as described in previous section,
- Identify any key gaps in the action plan, identify organisations with capacity and interest to drive the action plan
- Seek support for the set-up of a GM Equality Board – in shadow format initially
- Seek organisations with capacity, interest and knowledge to be involved in 'equality challenges' on specific subjects.

The event was attended by 22 individuals from GM VCSE Equality organisations and the co-design approach well received. GM Equality representatives worked hard in small groups to flesh out the actions within the draft plan which are detailed below. All attendees were given time to comment on each plan – building on the work from previous groups using a 'snowball technique'.

The event closed with a healthy question and answer session with **Warren Heppolette, Executive Lead, Strategy & System Development -** Greater Manchester Health & Social Care Partnership.

Questions / issues raised / included :

- Whether an Equalities Board would allow the majority of system to abdicate their responsibilities?
- Important that any Equality Board had real 'power'
- Importance of co-production and participation of the 'service user' to influence transformation and influence good practice. 'Experts by Experience' approach as a model.
- Citizen led reform important.
- Ensure Human Rights is driving force and intersectionality issues – whilst complex must be addressed
- Need to ensure Workforce development is not a tick box approach – draw on staff experience too
- Utilise new / different experiences to support a change in behaviour

Warren Heppolette responded by:

Stating his support for Citizen Led Reform – and recognised it as a very positive description.

Outlining some of the progress made to date at GM Level on Equalities agenda; Person Centred and Community Approach as a critical work stream at GM - drawing on real and lived experience is recognised as critical.

Acknowledging that GM Equalities approach must apply to both GM and locality level – ensure progress and benefits are comprehensively applied.

Stating this work has forced GM not to abdicate responsibility – and conversations have already been stimulated with Asylum & Refugee communities, Trans & Faith communities.

Stating that GM has ‘teed up’ its leadership to expect the Equality Board which will place an important challenge in the system - challenge is to ensure it is not just ‘proxy’ representation - must be more Inclusive Approach.

Board to Board discussions will be important.

Tools need to be developed to support other Boards’ work e.g. Cancer Board has embraced and responded to inequality.

And reassured the Assembly that GM remain faithful to high ambition not superficial engagement.

The meeting closed by agreeing support for a GM Equality Board (Shadow format initially) to drive forward the Actions arising from the co-design approach.

4. The Action Plans

During the second VCSE Assembly held in February 2018 the following action plans taken forward from the co-design event in December 2017 were added to and commented upon in by GM VCSE Equality organisations who attended the Assembly.

4.1: Action 1: Develop Shared Equalities Vision, Values & Outcomes for GM

It is proposed to develop a shared vision via a co-design process across GM between VCSE & H&SC colleagues that is distinctly focused on reducing inequality and which would incorporate critical high level outcomes.

There is an opportunity to widen this to GMCA level an aligning it with the Mayoral priorities regarding School Readiness, Life Readiness, Homelessness and Ageing Well to ensure that equality is re-framed across the broader GM agenda.

Methods	Who should be involved?	Ideas/ Issues
a) Design an accessible workshop to develop vision , values and outcomes *Concentrate on a small set of practical outcomes*	GMH&SC Partnership GMCA Mayoral Office Equalities Shadow Board (see 2)	*How can we ensure inclusivity of all groups? Involve local staff.*
b) Rolling roadshow of the workshop across x 10 **Or just x1 GM event?**	10 GM CVS's *Local radio stations* *Local Facebook forums and social media*	10 GM CVS's Anyone specifically *Bolton TM*
c) Pull together findings & propose final set of Values, Vision & Outcomes		*Lost in GM wide messages* *Resources needed* *Embed from top to bottom – leadership team need to know question/accountable* *Use social media - develop microsite* *Content:* *Ensure that the GM Vision has social justice/challenging injustice written into it.*

		Commit to social model of disability (about barriers and not the person) *Need to build on good practice.*
d) Publish/ Sign up event? Equality MOU?	GMCA GMHSCP VCSE	
e) *Develop an informed narrative on why it matters*	*Local people in public & commercial settings, education settings, community groups and digital settings.*	*Barber shop, places of worship, community groups, hairdressers, taxis*

4.2: Action 2: Develop Shared Equalities Vision, Values & Outcomes for GM

4.2.1: Set up an Equalities Board

It is proposed to set up a Shadow Core Equalities Board in March 2018 who will develop Terms of Reference, membership, form and function and recruit other members to ensure a functioning GM Equalities Board by end of April 2018.

Methods	Who should be involved?	Who can help?
a) Set up a Shadow Core Board: - Develop the remit and approach and membership of an Equalities Board and its connection to GMH&SC system To oversee delivery of the Action Plan from the report	Shadow Board proposal: Equalities leads from GM VCSE Ref Group x3 GM VCSE Ref Group 10 GM rep GM H&SC Partnership Equalities Lead Wirin Bhatiani – ex Chair Healthier Together Equality Advisory Group	Comments on this proposal approach? *Good idea and will this be replacing existing GM structures, groups and boards?* *What is the purpose of this? Maybe have an oversight group instead of a board?* *Ensure participation of refugee groups & asylum seekers – training to be given on attending and preparing for meetings.* *FN4M, CAHN* *WHEPP Relationships across in GM already need to be considered when Shadow Board is formed.* *The Board must have formal powers, including the power of enforcement and ability to remove contracts in instances where services aren't*

	GMCA portfolio holder for Equality, Fairness and Inclusion	*performing against their equality duties. Include the ability to do audits on services and give awards to recognise good practice.* *The Board should not just be related to H&SC but to all areas of activity across GM.* *Equality & human rights impact assessment – need a robust framework for this*
b) Design an approach to recruit members of Equality Board from across VCSE	Shadow Board	*Need capacity to recruit & attend board meetings - who has this?* *VCSE sector needs payment for participation to recruit effectively. Need to recruit positively from sectors that are traditionally underrepresented e.g. learning difficulties.*
b) Ensure connectivity of Equality Board/ members to other GM / GM H&SC Boards/ Committees	**GMHSC Partnership** *VCSE Partners*	*Need to have an equalities agenda item at each board/committee meeting*

4.2.2: Design and Implement a 'Director Level Equality Assurance Scheme'

It is proposed to develop an approach whereby relevant Director Level posts will hold a portfolio and role to 'assure' equalities within the work streams for which they are responsible.

The roles would provide a direct line of accountability to the GM work streams for the Equality Board and existing Governance arrangements. Requirements of the role will be developed by colleagues from the GM VCSE Ref group and key H&SC colleagues for agreement at the Shadow Equalities Board and GM H&SC SMT.

Methods	Who should be involved?	Who can help?
a) Develop a Role description for a Director Level Assurance Role	Shadow Board H&SC Partnership staff GM VCSE Ref Group	*People from VCSE sector to input into development of the role description* *Important to ensure that the statutory organisations & VCSE sector work together* *Linkage to wider EDS/RES leadership roles which have been in the NHS for years*
b) Identify Champions and leads in the GMCA & H&SC Partnership	Shadow Board H&SC Partnership staff	*Need regular patient/customer input and feedback* *Each Director level post should spend X number of days per year with a VCSE Equalities organisation meeting people from those communities in*

system, of a level in organisation to affect change		*non-formal settings plus a day shadowing a worker/volunteer/adviser within that service or organisation. They should also have to mentor an equalities leader.*
c) Identify key tasks / **outcomes of role for year 1** e.g. Overseeing an EIA for each Taking Charge work stream – action plan?		*Also need to think about years 2 – 5* *Each Director level post should spend X number of days per year with a VCSE Equalities organisation meeting people from those communities in non-formal settings plus a day shadowing a worker/volunteer/adviser within that service or organisation. They should also have to mentor an equalities leader.*
d) Champion agendas in the workplace – know your community		*GM Law Centre, Breakthrough, The Proud Trust, Advocacy Focus Trafford*

4.2.3: Design and Implement 'Equalities Sponsors Scheme'

Equalities sponsors will be recruited from the VCSE - the sponsor role ensures that the VCSEs is supported to contribute to, shape and influence the implementation of the relevant strategies and work-streams. The role of the resourced VCSE Equalities sponsor would be to lead beyond their organisation attending appropriate GM meetings as VCSEs experts in their field, follow up work, reading, written contributions as appropriate, feeding back to colleagues across the VCSEs and across sectors, contributing to the system leadership required for the thematic area.

This approach would be developed by GM VCSE Ref group and key H&SC colleagues for agreement at the Equalities Board and GM H&SC Partnership SMT.

Methods	Who should be involved?	Who can help?
a) Develop Role description VCSE Sponsors / **Experts by Experience** for work streams/ projects.	Mental Health/ Carers leads who have recently conducted a similar exercise (Simone Spray / Lynne Stafford GM VCSE Ref Group)	*– Ensure that 'experts by experience' are connected with the community that they have been recruited to represent and that there are robust feedback mechanisms/regular opportunities for them to identify current issues facing that community. Also ensure that 'experts by experience 'represent the gender/faith of that community (in case of BME representatives)* *Champion agendas for the workplace e.g. trans, Gypsy, trafficked people.* *Peer support for participants*

b) **Develop recruitment methods**	GM VCSE Devolution Reference Group	
c) **Identify panel/ process/ timetable**	GM VCSE Devolution Reference Group	*VCSE Equality Groups, CAHN, Faith Network for Manchester, GMBME Network*
d) **Confirm Resource – Equalities MOU Budget**	GM VCSE Devolution Reference Group	*Ensure that the budget is spread equally across the GM VCSE Sector and make the fund easy to access. Access costs to be included e.g. interpreters.* *Any such scheme needs to be monitored and evaluated to show what impact this approach has had and what can be done to make it more effective?*

4.3: Action 3 - Develop an Equalities Performance Management framework

A distinct Equality performance management framework should be developed that is driven and monitored by the Equality Board and Director Level Equality Leads within the directorates and work streams.

The high level outcomes developed in action 1 to drive the biggest step changes in in-equality must be represented by KPIs and relevant action plans which will be presented within the existing GM Performance management approach.

There is an existing GM Outcomes and Performance Dashboard which will be analysed to ensure it reflects measures to drive a step change in in-equality and additions will be made as a result of Action 1 - Develop Shared Equalities Vision, Values & Outcomes for GM.

The collection of key equalities metrics will also require evaluation to ensure they are fit for purpose and can fulfil the data requirements of the agreed suite of outcomes from action 1.

Methods	Who should be involved?	Who can help?
a) **Develop a suite of high level Equality outcomes** (from Action 1)	Outcomes from Action 1 Equalities Board	*Involve key VCSE partners* *Think about protected characteristics and identities* *Need to cast a wider net than 9 PCS's e.g. poverty, asylum seekers etc.* *Look for examples of good practice* *Incorporate a properly funded and resourced independent scrutiny mechanism that examines progress against a performance management*

		framework (ensuring that the voices of service users and patients are captured and not just the providers of services. *Equality input assessments – must make sure that these do not miss those with no voice* *Involve small & medium sized organisations not just 'the usual suspects' in the range of £1-5 million.*
b) **Analyse GM Outcomes and Performance Dashboard -** reflects measures to drive a step change in in-equality?	Equalities Board GMCA & H&SC Partnership work stream/ performance leads	VCSE Sponsors *Must meet absolute equality standards and legal/lawful equality otherwise not paid/funded.* *Health inequality redress – quality of life is also essential to measure*
b) **Review system data /fields** – to ensure correct equality metrics are collected to measure outcomes.	H&SC Partnership: Performance/ data analysts staff Work stream Leads Director led Equality Assurance Leads when in place Task finish group?	VCSE Sponsors? Experts by experience *Must meet absolute equality standards and legal/lawful equality otherwise not paid/funded.* *Health inequality redress – quality of life is also essential to measure* *Not just data 50% of what we collect must be qualitative and seldom heard voices, particularly of transient communities e.g. gypsy community, domestic violence survivors, must be included and heard.*
c) **Propose any data metric collection changes** to Equality Board	Task finish Group	*Ensure proposals from VCSE sponsors & organisations* *Influence localities and their equality indicators – how?*

4.4: Part 2 – Equality Challenges

The remaining proposals from the co-design process were made by those attending the events without the detailed knowledge of work already underway at the Partnership.

Therefore, it is proposed that 'equality challenge' exercises take place with the **Commissioning, Social Prescribing and Person Centred & Community work streams** to ensure that there are effective actions to ensure inequality issues are addressed. Ensure that GM population most affected by inequalities are engaged and supported to be engaged in co-production and citizen led reform.

4.4.1: Design and implement a commissioning process to make a step change in reducing health inequalities and a process to invest in the VCSE

Methods	Who should be involved?	Who can help?
a) **Equality Deep Dive into existing GM Commissioning work**	Protected Characteristics experts Plus, other homeless/ refugee & asylum seekers Migrant workers	Volunteers from VCVSE Assembly Interest? Capacity? Sign UP …. *Nigel Rose - MACC* *Estelle Worthington Asylum Matters*
b) **Compare current commissioning processes**	VCSE Ref Commissioning Sub Group	*Co-produce commissioning* *Explore progressive and radical commissioning models*
c) **Utilise case study from LGBT Foundation study**	Paul Martin LGBT Foundation	*Amelia Lee – the Proud Trust*
d) Develop plans to remove barriers from system		*Direct Commissioning* *Engage anchor organisations to deliver local actions*
e) **Set up Commissioning Sub group of Equality Group?**		*Involve people in areas of poverty, high economic & social disadvantage e.g. North Manchester, Oldham, Rochdale.*
f) **How to influence the Commissioning processes at locality level?** **Ideas?** • Minimum requirements? Social Value? • VCSE % commissioned as providers?		*Increase/insert local KPI's - work with VCSE sector* *Insure collaboration* *Commissioning training on how to embed inequalities into commissioning using social value including VCSE trainers* *Re-examine procurement strategy to ensure local contracting NOT GM wide* *Ethical supply chain process so sub-contractors are treated fairly*

• Support / resource to facilitate consortium and partnerships at local level?		*Ensuring monitoring of KPI process for equalities are embedded into the commissioning process so services are not recommissioned if they do not meet these*

4.4.2: Design and implement a commissioning process to make a step change in reducing health inequalities and a process to invest in the VCSE

Methods	Who should be involved?	Who can help?
Deep Dive on Person Centred & Community Approaches Work	Giles Wilmore & PCCA Team - GMH&SC Partnership	Volunteers from VCSE Assembly Interest? Capacity? Sign up …. *Charles Kwaku-Odoi from the Caribbean and African Health Network* *Sebastian Lynn- GMCDP*
b) Tools Guidance Skill up H&SC workforce in PC & CA	With LCOs and locality leads	*Training of VCSE members especially will need experience and understanding of range of issues.* *Co-design of consultation - what actual changes have been made through co-design ….?* *ACHN & MacMillan Co-Design example - Linda Hill and Charles Kwaku-Odoi* *Record, monitor and evaluate examples of co-design to gauge progress change, agreed standards etc.*

c) How to influence the PC & CA at locality level?	10GM – Ben Gilchrist	Tameside example *OMDP - HSC work stream* *Ensure hidden voices are involved – look at who is missing. People with lived experience* *Set out to ensure the most excluded and marginalised are involved in coproduction e.g. those experiencing MCN's*
d) Skill up local people – e.g:TLAP National Co-production model Strengthen VCSE work in this area to skill people up so they can actively challenge – encourage citizen leadership Co-production	10GM – Ben Gilchrist	*More empowering opportunities* *Invest in 3rd/VCH sector – pay for my services* *Maximum salary for everyone and ensure living wage - recognise the economic climate we are living in.*

4.4.3: Develop the GM Social Prescribing Strategy to ensure step change in equalities

Ensure social prescribing offer is aligned to locality plan priorities in each 10 localities and addresses inequality issues

Methods	Who should be involved?	Who can help?
a)**Deep Dive on GM Social Prescribing Work stream**	GM H&SC Partnership	Volunteers from VCSE Assembly Interest? Capacity? Sign UP …. *Atiha Chaudry* *Nigel Rose – MACC* *Breakthrough UK/ GMCDP disabled peoples issues*

b) Ensure social prescribing offer is aligned to locality plan priorities in each 10 localities and addresses equality issues <u>Ideas?</u> • Mapping what exists -Identify the gaps • How to connect VCSE effectively? • Develop services activities of quality • Identify existing good practice in GM and elsewhere	GMH&SC Partnership LCOs 10 GM	Sponsors – Experts by Experience *Breakthrough – Jackie Driver* *Tameside & Glossop ICFT – Chris Easton* *Sebastian Lynn* *MDPAG* *Information system – what's the VCSE offer? - essential to make SP work – need to make it easy for GPs* *VCSEs have a positive conversation with GPs* *Ensure social prescribing for people with no recourse to public funds is prioritised and opportunities for resourcing are explained.*

4.5: Develop a GM workforce Equality Plan

There will be a number of elements to this work:

- Recruitment of new staff to reflect local communities and reduce poverty,
- Development of existing staff and developing organisational knowledge,
- Encouraging behaviours and approaches to remove system based/ institutional discrimination.

There are links to the development of GM Equality outcomes, links to EDHR work in Manchester and there may be other linkages.

Methods	Who should be involved?	Who can help?
a) **Deep Dive current recruitment/ workforce development / OD strategies processes**	GMH&SC Partnership Equalities Lead/s	Volunteers from VCSE Assembly Interest? Capacity? Sign UP …. *Mark Nesbitt BME Network* *Donna Miller - BHA* *Breakthrough UK*
b) Identify existing Equality Training resources/ organisations Other ideas?		GM VCSE Orgs with experience in Equality Training / HR advice *Caribbean & African Health Network* *A wide range of trainers are needed from equality sector - need to tailor for audience/bespoke training* *Look at pre-existing good practice.* Link to Manchester EDHR Work? Jackie Driver/ Karin Connell
c) Develop KPIs – for action 3		

5: Mobilising Action – 'The HOW'

Throughout the co-design process the GM VCSE Devolution Reference Group and H&SC partners were kept updated on process and proposed actions. Specific key meetings included the GM VCSE Devolution Reference Group meeting on 24th January 18 who received a report and action plan for comment and to identify resources a proposed approach to mobilising.

Partners within GM H&SC Partnership received the draft report and action plan and a discussion was held on 30th January to sense check, build on recommendations & identify places in system to be discussed/ endorsed/ owned.

Finally, the draft action plan and a call to action at the GM VCSE Equalities Assembly Monday 26th February – agreed that a GM Equalities Board aligned to GM H&SC / GMCA be set up to oversee these actions and continue engagement with the sector.

As a step towards the Equality Board it was agreed that a Shadow Equalities Board should be convened to oversee the development of the GM Equality Board - this would include the development of Terms of Reference, placement in GM Governance structure, membership, recruitment to the membership – the first meeting of the Shadow Board takes place in June 2018.

This document was developed for the Greater Manchester VCSE Devolution Reference Group by Breakthrough

Appendices

Appendix i: Early thoughts on the function of any Equalities Governance Group from VCSE Lock in Feb 17

Ideas for its role?

- Scrutiny/ challenge/ advise
- Links to communities/ networks/ opportunity to deliver specific pieces of work.
- Do we want a role to drive / require Equality Impact Assessments for locality plans/ work streams?
- Promote offer our services to support & scrutinise services design /ideas? (call off work)
- Encourage co-productive methods with Communities of Identity / equalities groups
- Stimulate / engage in discussion by encouraging round tables as per 'joint commitments' (section 8 MOU) eg disabled people and employment
- High level targets/ outcome measures to scrutinise / drive change

Appendix ii: Agenda and complete write up from VCSE Assembly 8/11/17

Developing an innovative strength based and co-designed GM wide approach to reduce inequality within the GM H&SC Taking Charge Strategy

8th Nov 4-6 pm St Thomas Centre

4pm Welcome, Chair

4.05 Introductions and context
Paul Lynch Assistant Director Strategy & System Development GM HSC Partnership followed by Q&A

4.15 What do we know?

4.16

Roundtable activities to analyse current GM H&SC work streams in relation to:-

- Equalities work / engagement already we are involved in across GM
- Disproportional impact / barriers on communities - what do we know?
- What do we know Equality Metrics?

16.45 Feedback from facilitators

16.55 Good practice example of working with Communities of Identity on GM level

a) Pride in Practice – Laurence , LGBT Foundation
b) Cancer Equalities Impact Assessment – Donna Miller

17.10 How to influence, challenge and scrutinise?
Activity on seated tables with facilitator
"Like, Lacked, Learned, Longed for?"

17.40 Feedback by facilitators

17.55 Next steps

Have opportunity be involved in a co-design event on 4th December 2- 6pm - sign up sheet on table at front of the room
Assembly 2 – January 2018 feedback

18.00 Close

WRITE UP

What do we know about equality metrics and measures with our communities in our geographies?

- Collect demographic monitoring for Ambition for Ageing
- Citizens Advice monitors all 10K clients and shares nationality and locality and includes long term health conditions
- GM coalition of disabled people - fully monitors for funders but struggle to target BAME and PWLD (how do you target people and demonstrate accessibility?)
- Seashell Trust monitors all service users
- GDPR initiatives - up for debate in terms of what's next ….. How do we share data across agencies and geographies?
- WHL (?) monitoring of disability – what type of disability? They are often all 'lumped together'
- Do all organisations monitor sexual orientation/trans identity?
- Employment status can be outdated with new approaches to work/life balance
- Importance of service users and people with lived experience
- Analysis isn't done on an intersectional level
- Proud Trust – wrote own MIS. Worked with Sheffield University to write a new system as the existing one was not fit for purpose. New system enables effective integration of all data.
- RAAS – transitory nature if peoples' lives, not available at ward level
- GDPR – is missing data/political will, risks exposure in terms of disclosure
- Action on Hearing Loss – monitors data, sends information nationally, how to access this information locally?
- Autistic Foundation – collects data on registered people with autism across GP's
- Organisations can get tied up with admin/data collection and not 'see the wood for the trees'
- What about the people who don't engage /who are not part of the 'picture'
- How does data drive improvement? How do we use it?
- Meaningful training – how to ask questions appropriately?
- Some people actively resent data inclusion, 'turns people off'
- Cultural issues relating to asking certain questions at risk of offending/alienating people….
- Need to consider language barriers/digital inclusion
- Data risk – knowledge poor, too little integration
- People don't always want to identify with their own demographic

What equalities/engagement work we are involved in or aware of across GM?

- Action on Hearing Loss – 'Hearing Matters' report looking at unrecognised hearing loss and the impacts of this e.g. isolation, Alzheimer's prevalence and proposed actions including encouraging medical professionals to recognise issues earlier
- Proud Trust – works with LGBT+ young people across NW. Has specific projects supporting BAME young people, those with addictions through recovery. Runs LGBT+ Centre including a café which is open to the public. Works with schools to deliver educational activities with pupils and training with staff and has set up a Rainbow Flag

quality assurance framework for primary and secondary schools. Pushed for a review of CAMS service in Salford and has resulted in changes to the way LGBT+ young people are treated in the system.
- Rainbow Haven – a group that supports women seeking asylum – runs a support group for new mothers.
- Autistic Foundation – small volunteer-led organisation that uses a bio-psycho-social model to support people newly diagnosed as autistic to overcome barriers caused by transition points in their life e.g. points of crisis, independent living, and finding employment. They provide training and are setting up a digital platform to support people.
- Asylum Matters – Supports refugees and people seeking asylum in NW. Captures barriers for people accessing public services e.g. primary healthcare. In Manchester there are a group of medics and advocates in the healthcare profession that have helped to push improvements in access to healthcare for these communities.
- Mental Health campaign – based on removing medical labels given to people with mental health issues – cultural barriers being broken down by a 'link' person working with people from their own community
- Manchester Disability Plan – HSCP involved in this
- Pennine Trust – working on making information more accessible and supporting physical access issues in hospitals
- Just Psychology CIC – providing support for young people in Trafford with mental health issues are not meeting increasing thresholds for CAMS support and services as more people are entering the system
- Many clinical psychologists working outside of the system with community based groups e.g. veterans/homelessness support groups
- Emotional health and wellbeing programme led by CAMS working in primary schools – working with teachers to implement emotional/wellbeing support for children from an early age
- Imams/Mosques coming together to develop mental health support programme in response to an identified community need. They are seeking support from professionals to do this.
- 360 giving website – overview of what funding has been given to localities and this could be a way of finding out about very small scale local projects. A small payment could be made available to encourage projects to have their details entered onto this website. It would allow for better co-ordination of funding.
- Places of worship – MoU with faith sector developed – needs better publicity widely and audit of what projects are happening within faith sector
- 'Maternity of Sanctuary' developed as part of Manchester's 'City of Sanctuary' work
- Manchester BME Network have run a project with University of Manchester midwifery department whereby they run cultural awareness course with 1st year students. They get to speak to community groups in additional to traditional cultural awareness lectures. Brings training into the workforce and has been running for 4 years. The university are now looking to bring this into the pharmacy department next.

Disproportionate impact/barriers

- We do know what the barriers are so we need to build on what is known e.g. JSNA. CCG reports
- Lack of awareness – can't find appropriate donors, need for different service provision and support related to this.
- Stigma and shame as further barriers
- Adopt and adapt services to individual needs
- Diet – diabetes is covered under the Equalities Act but diet doesn't address this – hospitals aren't dealing with this.

- Fear of losing benefits
- Need leadership
- Travel expenses – only cover public transport – awareness, training
- Lack of equality impact assessments – need this to get into details for strategy and rectify adverse aspects - examples of EIA best practice.
- There are problems in acute sector e.g. not enough wheelchairs at Wythenshawe Hospital
- Language barriers- too little to support people's communication
- Interpreters can't always understand medical terms or cultural needs - learning disability impact too. Interpreters could be informed e.g. by cancer champions. Advocacy needs specialist support
- Online services are a big barrier to already unequal service access – people aren't used to this
- Built environment barriers – for disabled and older people too. Physical, sensory, attitudinal, planning could do more e.g. recent urban design group conference – inconsistent physical barriers e.g. dropped kerbs in different LA areas.
- Access to MH support – cross cultural concepts, heavy medical focus, western model, labelling – discrimination, can impact upon employment, need to focus instead on people's experiences
- Need lived experience
- Need more diverse workforce to enable. Can be an asset too though e.g. more BME staff
- Denying access to refugees and people seeking asylum
- Systematic analysis of EDS2 needed
- Outcome measures are not culturally competent
- Healthier Together – previous equalities work
- Cultural requirements re religion - Lack of understanding

Disproportionate impact/barriers

- Lack of sexual orientation monitoring and gender identity monitoring
- How to replicate good practice quicker?
- Transport to specialist centres – a challenge as they are further away – accessibility to facilities
- Opportunities for choice e.g. limited food choices
- Postcode lottery – moving home in GM impact of services offered
- Conversations go back a long way on this and need to be acknowledged
- Specialist services across very diverse areas
- One size does not fit all e.g. online doesn't suit all
- Size and attitude of some providers
- Wide access can make access more difficult for a minority
- Times services can be delivered – HIV testing, IAPT
- Complex range of problems – lack oif integrated services – continual reidrection

Barriers – what do we know?

- Poverty pockets
- Language barriers – misinformation, need for interpreters and underlying cultural issues e.g. prejudice, conflicts of interest, inappropriate disclosure to family & friends interpreting
- Fear of discrimination or actual discrimination
- Seeing diversity of people reflected in services – especially in BME Maybe has been noticed as it has been mapped, could be just as poor in other groups

- Mental Health makes a big difference to how people access help for other h & SC issues, referrals to multiple services- complexity – even less access (commissioning tends to be by condition)
- Health literacy – if poor this impacts on whether people can look after themselves, motivation
- People get used to how they feel
- If you are disabled and BME …. you may not be ‘eligible’ to access the service(s) that suit you.
- The transition from young people’s services to adult services is worse for people from equality groups because they are more reliant on the services provided. Another difficult transition is from 30’s into 40’s when family support may fall away.
- Targeted services yes but ….e.g. sexual health services help LGBT men, YP but who isn’t covered then/
- Independent trusts etc. work at cross purposes to current need, VCSE not integrated
- ABCD work can exacerbate inequalities where people are in minority areas
- Awareness of the Equalities Act - people are often unaware of their rights e.g. BSL interpreter if you can’t hear. Also entitlement to equipment.
- People who can’t express their needs need a trained advocate - trained need for health professionals so they would know how to approach this issue and know what to d, people also need support to even access the service.
- National policy e.g. hostile environment is introducing institutional barriers and confusion.

What do we know about equality metrics?

- Equality demo – age, gender
- We have good data on certain multi impacted groups e.g. black than on non-traditional ‘groups’ such as young men.
- Contracting/commissioning – eq measures within (social value)
- Data not collected consistently
- VCSE do not have resources
- VSCE hold data
- Use of services - same information not standard
- Who uses the service/services
- Info of needs of population
- Deprivation measures – JNSA – information needs to be collected in
- GM Ambition for Ageing
- Qualitative/soft/individual data measures
- Employment data
- Health Watch data
- We need a more intelligent way through which we collect data – we can use national/local data sets
- Utilise LA research and intelligence units – ask for analysis of data for specific geographies and related neighbourhood issues e.g. employment
- Public Health intelligence team
- Poverty Commission - CVS – Universities
- Need focussed outcomes – understand the inequality gaps and data need
- Need neighbourhood/local data but aware this may not tell the whole story especially in small neighbourhoods – GM level data still needed.
- Reliant on PS data – not city teams
- When there are gaps in data – how do we demonstrate need and what’s important in our communities?

What does success look like?

- Review people's data fields – as doesn't reflect people's identities or people get labelled unhelpfully
- The definition of disability given within the cancer presentation was far too limited – needs broadening
- Will our contribution lead to success? Action planning is crucial – named officers are essential to enable follow up & progress
- Locality action plans are important but ensure communities of identity are included.
- Conversation changed from equality only to equality and diversity as one equally. It's about discrimination as well as barriers
- Acute sector – need to re-establish disability panels
- Sector representation needs to be fully inclusive and should take into account the needs of all groups.
- How can we learn from each other and share information?
- How do we accurately estimate inequality across GM and how so we ensure the most appropriate training is delivered?
- Need commitment from GM H & SCP to additional resourcing
- There must be consequences to organisations that consistently break equality laws, rules & frameworks, especially for those who break contracts and funding agreements
- More GP endorsement via Quality Assurance schemes.

What does good look like?

- A GM equalities plan?
- Transparency and space to show the gaps – honesty
- Where does this work fit?
- Show real resource investment
- Are equalities really cross cuttings?
- What about those who tick many boxes?
- Need clarity of everyone's responsibilities
- Where's the accountability? Need to evaluate this properly and know the people to hold to account!
- More radical than EIA's

What would good look like?

- GMHSCP – need to have a clear 'Equalities Strategy' OR different work streams have to have one that acknowledges the equalities obligations they have to meet.
- There should be an EIA of every policy and strategy that comes out of HSCP and a team be in place to make sure this happens
- Identify a team or named individual in each work stream who makes sure that actions are taken forward from EIA and is a named contact for equalities issues for VCSE sector to communicate with
- The group that is being developed should have a clear scrutiny role, it should be fully resourced and take on learning from Cancer Board whereby representatives time is valued by being paid for
- EDS2 scrutiny group could be reformed and reinvested in as did lots of very good work previously – needs to look back the Healthier Together work and learn from that
- It would be good to encourage a person centred approach to equalities where the individual is looked at rather than ticking boxes for different 'characteristics' as we have done in the past – this could be piloted alongside what exists currently

Appendix iii: Agenda and complete write up from VCSE Assembly 8/11/17

<table>
<tr><th>Time and Activity</th><th>Detail</th></tr>
<tr><td>2pm
Arrive and entry boards</td><td>What do you want to get out of today?
Names on cards – add comment on speech bubble!

Rating:
In relation to equalities - How well do you think we are reimagining health and social care in GM currently

- Radical upgrade in population health and prevention
- Transforming community based care and support
- Standardising acute and specialist care
- Standardising clinical support and back office service
- Transformed relationship between VCSE and the statutory sector
- Coproduction.</td></tr>
<tr><td>2.10 pm</td><td>Introduction and scene setting (and housekeeping)

Your space – to think creatively about

Warren</td></tr>
<tr><td>2.15</td><td>What are the key areas of priority in relation to health and social care and equalities in GM
- Particular conditions
- Particular cohorts of people
- Etc</td></tr>
<tr><td>2.30

Lets reimagine

Highest aspirations…

Creating a new image…

1 board for each heading</td><td>In relation to the 4 key areas of GMHSC partnership work.
- Radical upgrade in population health and prevention
- Transforming community based care and support
- Acute and specialist care
- Clinical support and back office service

Put yourself in the heart of community….

1) Skills and Knowledge and Values needed to support address the equality issues in that community

2) Identify the assets that will realise the skills, knowledge and values to address equality issues
Personal, Social, Neighbourhood, Community assets etc… (with definitions)</td></tr>
<tr><td>3.15pm

On the reverse of the 4 boards…</td><td>How can we best utilise the assets identified to enable us to reimagine how we engage with people in relation to equalities…

- What needs to be in place to ensure that happens
- What do we need to do differently
- Where might we need to be located? Go to?

1) Time to think through ideas in relation to the above under each of the same 4 headings… (reverse of board)
2) Barriers/Obstacles – a few minutes to highlight any immediate barriers/obstacles</td></tr>
</table>

	3) Key recommendations/Actions
4pm	BREAK
4.15pm Co-production	Co-production and ensuring that people with lived experience and communities are at the heart of this work. Building on the discussions so far – some time to reflect on what coproduction actually means in relation to the equalities work and what needs to be in place/done differently in terms of enabling this to happen… again in relation to the 4 key areas. - Radical upgrade in population health and prevention - Transforming community based care and support - Acute and specialist care - Clinical support and back office service Who should we coproduce with Where should we do this How should we do this What is the potential impact of doing this? How does this influence current enablers… Key recommendations/actions
5pm…	Develop the Action Plans – one pre-printed template in relation to each of the 4 areas…. Reflections and feedback Next Steps

Appendix iv: Equalities Workshop – 4th December 2017 – Typed pin board feedback

Entry activities:
What do you hope we will achieve this afternoon? Participants were asked to capture their thoughts about this on cards as they arrived:

Theme	Comments
Person Centred and Co-produced	• Person centred approach • To understand to what degree service users will be involved in the development of VCSE • How personalisation will address inequalities • A clearer understanding of our plan to embed equalities and for public involvement • New ideas of how to embed equalities that will re-frame as a person centred approach not system led. • A clear understanding of the way forward and an approach that has all equalities/inequalities public involvement under one roof • Defines a way forward for inclusion and addressing inequalities as a priority

Shared Action, Vision and principles	• Actions – not just fine words. • Clear understanding of how we turn joint commitment into action • What we mean by equality and inclusion • Shared principles and a better understanding of the needs across different groups • To understand the needs and the way forward • So we can get it right • Collective commitment to working together to tackle inequalities - clearer pathway for information sharing. • A plan of action – jointly owned – to make a difference • A better understanding of how everyone in the room (and not) can work together to make a difference • Commitment to action to reduce health inequalities and barriers to access for equalities groups (especially refugees and people seeking asylum) • Shared understanding and vision – DEEDS not words
Shared approach and ACTION	• A clearer understanding of what needs to be done to reduce health inequalities across GM • A shared vision and a plan of how we avoid duplication • Shared vision and prioritised actions • A shared approach that will capture the scope of what we need to achieve • Develop a clearer understanding of where we are now, what we need to do and how we work together to achieve the plans in GM • A clearer idea of how we can address equality and diversity issues at a GM level. How can we work together to do this? • I wish to gain an understanding of how we are aligining equalities at GM and local level. Also who is leading this agenda at GM • Shared and agreed plan of action with clear targets and timeline. • Clear road map for ensuring needs of equalities groups are met in GM health and social care. • A better understanding of how equality and diversity will be fitting into agenda at GM level. How holistic will it be? • An outline plan on how to implement our equality strategy. Turning our thoughts and discussions into meaningful / tangible/ measurable actions.

What are the key areas of priority in relation to health and social care equalities in GM?
Participants also asked to capture their thoughts in relation to this on cards prior to the workshop starting formally.

Theme	Comments
Integrated/joined up working	• Stop silo working • Finding commonalities between people and catering for them • Looking at economies of scale at GM level • Streamlining all the standards into GM standards – 1 approach • System wide approach to equalities • Ensuring that specialist services for specific communities of identity are commissioned alongside locality-based services (which tend to be more generic) • Alignment and coordination of all the equalities events • Finding commonalities between people and catering for them

Personalisation	• Personalisation • Personalised Approach
Leadership	• Leadership and accountability • Challenge and scrutiny
Eligibility and standarisation	• Eligibility Criteria • Standardisation • Eligibility Criteria, personalisation, personal approach • Finding ways of ensuring local healthcare services to remain accessible and free to vulnerable equalities groups (NOTE: threat of recent healthcare charging regs) • Workforce equalities skills levels • Streamlining all the standards into GM standards – 1 approach
Co-production	• System to support citizen led reform • Ability for service users to inform and shape • Investing in patient and public involvement • Challenge and scrutiny • Patient and public involvement • Taking a person centred approach not a condition or content approach. • Prevention and enabling behaviour change
VCSE community and partnership	• Enabling the VCSE to be even more effective – not just the big players but community groups • Partnership with VCSE and community
Recognising diversity	• Prevention and enabling behaviour change • Services for people seeking asylum and refugees • Mental Health • Mental health in people living with long term chronic conditions. • Access to health services for communities with barriers • Complex needs of refugee communities and people with LD
	• Sophisticated advanced work on transport challenges • Transforming accessibility to services beyond transport BUT with an initial STRONG focus on transport

What does Coproduction mean to you?: Brief activity to capture thoughts around what coproducing this work actually means…:

Theme	Comments
Inclusive – system leaders thinking	• Coproduce and co-deliver and create sustainable models • Keep strengthening the systems leadership input • Value everyone's perspective and contribution • Citizens and residents – are they involved/engaged • Ensure engage with the correct people – service user input • Define outcomes together – locality flexibility for delivery • Strategy implementation coproduced - Plan – Act – Do - Study cycle – coproduction all through, • Develop shared vision, values, resource risk • Accountability • Recognising peoples value as a role and financial empowerment • Use existing materials that define values and principles of coproduction
Creativity and TIME	• Stick with it – it wont all be plain sailing • Be creative – keeping trying different things AND evaluate them.

	• Inclusive and ongoing dialogue • Benefitting from shared learning and lived experience
RADICAL	• GM to be the champion of radical changes (not looking at organisation) • Radical look at clinical pathways (*system configuration and funding) • GM and Locality – clarity of strands of work • Trial occasional RADICAL approach (something different)
Safe, accessible and valued	• Make sure that people who use services/patients feel safe to make their concerns known – that there wont be any negative repercussions for them or their care. • Accessible meetings – layout, format, assistive technologies and building accessibility. • How to reach people in ways that work for THEM - eg the supermarket, screening successful pilots. • Maximise opportunities to find out peoples views • Build trust so we can have the difficult conversations
Outcomes focussed	• Outcome focussed • Know what matters TO communities
Training and development.	• Equalities learning and training opportunities for ALL the workforce

Main Workshop – Activity 1:

Imagine yourself in the heart of the community – what are the skills, knowledge and values needed to address the equality issues in that community in relation to:
Participants reflected on this in 4 groups each one in relation to the four key elements of the Taking Charge Together Strategy.

1) A radical upgrade in population health and prevention.

Theme	Comments
Holistic	• Social mobility • Housing • Education • Good accessible employment opportunities
Knowledge and Data	• Knowledge of the community • Data and insight (not just data) • Ability to self (community) to identify what needs are. • Key influencers • Supporting communities of identity especially those who aren't geographically specific • Clarity of definition of community – places/identity
Coproduction, People Powered	• To let go of power • Voices and representation at all levels • Co-production – allocation of finances • Leadership willing to change • Support and coach • Coproduction on the communities terms • TAKE RISKS • Accessible and relevant languages • Community Ownership • Clarity of definition of community – places/identity

	• Support and Coach
Valuing lived experience	• Recognising individuals health and social care needs, truly listening • Recognising strengths and weaknesses (lived experience)
	• A role for the private sector – employment, provision • Services and screening that's local and relevant
	• Take Risks • Evolution of work rather than constantly reinventing • Good leadership and willing to change • Allocation of finances
Identify the assets that will help to address equality	
	• Local community knowledge • To be listened to • Understanding local population • Insight into local population
	• Community centres • Resources • Activate the potential of GP practices
	• TIME • Resources (money, time, values)

Imagine yourself in the heart of the community – what are the skills, knowledge and values needed to address the equality issues in that community in relation to:

2) Transforming Community Based Care and Support

Theme	Comments
Diverse workforce and leadership…	• System Leadership Skills, knowledge and values • Workforce Equality Knowledge • Diverse Workforce all the way through – carers to high levels.
Value diversity and complexity	• Involving all parts of our diverse populations • Supporting communities of identity especially those who aren't geographically specific • Complexities of communities • Knowledge of where inequality exists • Equitable access to community services • Reach to carers – partnership with them
Co-production	• Recognising the attributes and qualities of services users and providers in coproduction and delivery • The 'peoples' knowledge of their health and care needs • Reach to Carers and partnership with them
Integration with VCFSE	• Integration with CVFSE sector (and business sector!)
Data and legislation	• Knowledge of legislation • Data knowledge and skills to interpret
Clearly communicated vision	• Explaining and communicating the 'vision' • Links between localities and GM (Do it once and do it well)
Online and face to face	• Online skills complemented with person facing reach
Possible barriers	• Prevent introduction of additional barriers to community healthcare services (eg new rules to charge certain migrants up-front for these services)

Identify the assets that will help to address equality.	
People and communities	• Public involvement in decision making • Champions in communities • Empowering and resourcing self care • Value of persistence don't give up on people • Self care experience • Relationships • Cultural understanding of communities
Workforce and leadership	• Relationships • Asset – workforce • Broadening scope of services and practitioners • Leadership ready to do things differently • Shared Values
	• Specialist outreach
	• Cultural understanding of communities • Services have choice over access options
VCSE potential	• Anchor organisations • Untapped VCFSE sector and business strengths
Cross boundary working and risk sharing	• Risk sharing • Breaking down organisational boundaries • Holistic picture of workforce
Resource and info	• Money • Data

Imagine yourself in the heart of the community – what are the skills, knowledge and values needed to address the equality issues in that community in relation to:

3) Clinical Support

Theme	Comments
What Matters TO People…	• Change Training for clinicians • Ability to ask right questions to understand whole person • Relationship skills • Listening skills • Values – Empathy • Values – Respect
Understanding of population/ communities	• Understanding the population – make up • What are the needs of the local population • Impact of socio-economic circumstances and how affects health and treatment • Communication, language barriers • Real impact assessment – using the info • Knowing what's available locally and being able to signpost
Coproduction	• Recognising the attributes and qualities of service users and providers in coproduction and delivery • Knowing community and making connections
Eligibility etc…	• Need to adopt a global eligibility and assessment process • Capacity and Resource • Quality and safeguard • Supporting communities of identity especially those who aren't geographically specific.
Identify the assets that will help to address equality.	

What matters TO people	• What CAN the patient do
Community Hubs	• Get neighbourhood hub to manage asset database • Building simple asset database for local communities • Bring services together in hub • Working together on programmes eg – diabetes management etc, cooking skills etc
Workforce	• Using out workforce who are also members of our local community
GM Faith and Health	• Assets – places of faith

Imagine yourself in the heart of the community – what are the skills, knowledge and values needed to address the equality issues in that community in relation to:

4) Acute and Specialist Care

Theme	Comments
VALUES	• VALUES – commitment to improving individuals experience • Trust • Respect • Empathy
Different skills	• Recognising individuals health and social care needs, truly listening • Interpersonal skills • Language and communication skills • Technical and professional skills
Value existing and upskill	• Specialisation in existing assets and upskilling
Knowledge of population needs and barriers	• Knowledge of health issues specific to locality and its population • Knowledge of the barriers to good health • Understanding of local community and health needs
Accessibility	• Accessibility to services
In relation to refugees and people seeking asylum	• Commitment to addressing mental health as well as physical health needs • Commitment from medical professionals to putting needs of patients first (above office demands to share patient data and new rules to charge for health care) • Interpretation services and cultural sensitivity
Communities of identity	• Supporting communities of identity – especially those who aren't geographically specific
Identify the assets that will help to address equality.	
Co-design, commitment, and coproduction	• Cross sector involvement in co-design/co-production • Commitment to improving access to primary care and early intervention = reduce use of acute care services • Access to places for all • Opportunity to access VCSE support – youth workers for young people for example • Working together to reduce acute need – i.e. mental health crisis
VOL sector – different approaches	• Voluntary sector support groups – specialist in specific health issues eg cancer

	• Thinking differently about investment in social care services by VCSE (eg homelessness services can prevent 'bed blocking' by migrants with NRPF)
PEOPLE	• Local insight and expertise • PEOPLE • Refugees and people seeking asylum are resilient and good at providing peer support, despite practical barriers (language and cultural (and structural barriers (national policies)
WORKFORCE/STAFF	• Commitment of public service staff • Solidarity - willingness to help
Money	• Money

Workshop - Key Activity 2

How can we best utilise the assets identified to enable us to reimagine how we engage with people in relation to equalities….? Participants asked to continue the conversation under the 4 key headings – but to identify how, the barriers to achieving the how, and the key recommendations /actions.

1) Radical Upgrade in Population and Prevention:

Ideas:	**Barriers/Obstacles**
Co-production! • Champions and ambassadors supported • Ask and Trust the community to help – and tell the story • Recognises the expert – YOU not just the professional • Co-produce, delegates (champions) and financial allocation following assessment of strengths and weaknesses. • Coproduction of models to improve needs **Clear Pathways** • Step up – step down pathways • Explore EVERYONES assets and incorporate into pathways – self-care, advice, info, face to face, step down **Value of employment / workforce** • Share Levies – ie apprenticeships • Getting / keeping people in work • Support the workforce – private, voluntary and public sectors **Creative communications** • Use social media to deliver messages • Support primary schools – work with communities • Make the messages positive – not just tell **Better use of existing assets (more creative use)** • Better utilisation of all assets – eg specialist nurse supporting health education… (cat note – some great egs in Stockport as part of rapid testing work)	• Organisational competition • Competition for resources • Shared risk – risk averse public sector • Shared resource

Key recommendations/actions
Competition/Awards? • Competition for services on patient outcomes (experience and health) **REMEMBER – qualitative data…** • USE BOTH qualitative and quantitative date at all times **Experience led design/commissioning** • ALL OF THIS through the eyes of communities to truly understand how people FEEL • Ask HOW does it FEEL? Act accordingly • Hold ourselves to account for living our values • GM values (and what they look like in practice) **Celebrate success** • Celebrate where we ARE making changes **Collaborative working** • Occie health as an income generating service, providing O/H to private/CVS • Ensure the services are not just in central hubs OR • Care for the people around the patient.

How can we best utilise the assets identified to enable us to reimagine how we engage with people in relation to equalities….?

2) Transforming Community Based care and support:

Ideas:	**Barriers/Obstacles**
Evidence and value the VCFSE and what they offer… • Build on existing VCFSE (and business) strengths • Creating evidence of VCFSE impact together • Commissioning more VCFSE providers to deliver community services to new and emerging communities = act as gateway to NHS. Reduce access barriers and health inequalities **Support from…** • TLAP **Coproduction** • Pitch things at a level of people who are not 'experts' • Widespread engagement with communities to talk about this agenda • Community involvement – service users and providers (coproduction/co-design) – CHAMPIONS • Multiple ways to bring carers, 'champions' and volunteers together – use existing networks and new ones. • Develop self-care offer – using existing strengths eg peer support • Multiple forums to invest in relationships – NOT just meeting agendas **Vision and Values:**	• Even personalised care is still based on statutory systems and processes. • Peoples lack of confidence to get involved and challenge • Shared language needs work • Different cultures • Communication and Trust

• Articulate values together and respect and vision **Creative use of data:** • Use date we have but share widely for understanding and to provoke creative responses • Leadership training – across sectors, INCLUDING permission to do things differently • Workforce training – together across sectors	
<u>**Key recommendations/actions**</u> **Coproduction:** • Empower the public – draw on their experience; engagement • Allowing people to use their lived experience to inform change • We want to see people at the forefront of decisions • Lived experience – 'champions', 'hubs', 'reference groups' (methods to support, volunteer and funded) • Asset based conversation + formal coproduction + expertise from those with lived experience – 'reference group' **Review policies and procedures** • REVIEW ALL POLICIES AND PROCEDURES against an asset based APPROACH • Define the issues – language, data, vision, values • Develop a common H&SC language **Include the workforce in coproduction.** • Holistic workforce agenda – involved in conversation re change – space to test	

How can we best utilise the assets identified to enable us to reimagine how we engage with people in relation to equalities….?

3) Clinical Support

<u>**Ideas:**</u>	**Barriers/Obstacles:**
Person Centred/Co-production • Start with the person –don't make assumptions based on the conditions, age etc • Dependent on patient need/condition • Upskilling people/patients to challenge decisions about their own care – shared decision making • Engage young people • Community engagement and involvement • Empowered patients and public to 'take charge' with lots of support **Understanding and evidencing** • Social accounting (give2gain) • Understanding the evidence re social prescribing **Creative and up to date:** • Using modern technology and revised assessment and eligibility processes and practices to conform with personalisation	• Inequality in infrastructure • Empowering people to challenge and take charge • Social prescribing is more than signposting • Interoperability of systems • Resources (funding)

• Up to date database of community assets – accessible and usable. Neighbourhood focussed and communities of identity. • Making sure that changes in organisational form undergo a full equality impact assessment • Creative sustainable and resilient	
<u>Key Recommendations/Actions</u> **Coproduction and infrastructure** • COPRODUCTION is key – enable people who use series to vocalise their concerns, feelings and ideas… • Taking charge needs to be visible/accessible in whole community • Neighbourhood infrastructure • A youth offer for the neighbourhood • Make sure people feel safe to vocalise concerns – that there won't be any repercussions (form them/their care)	

How can we best utilise the assets identified to enable us to reimagine how we engage with people in relation to equalities….?

4) Acute and specialist care:

<u>Ideas:</u>	**<u>Barriers/Obstacles</u>**
Coproduced and dynamic • COPRODUCED –have a best practice and quality framework and recognise qualities and best practice in delivery • DYNAMIC commissioning • Mapping individual case studies to make system change **Invest in VCSE and pathways** • Invest in VCSE delivered health – advocacy service for new and emerging communities • Routes to community support from hospital **Invest in workforce** • Workforce education, training and development **Improved MH support and pathways** • Aim for a more equal relationship between statutory health and social care services and VCSE in terms of prioritising referrals (especially in relation to mental health) • Refugees and people seeking asylum – invest in specialist community mental health and primary care services for this community = reduced reliance on acute services. **More BME staff in leadership** • Work with BME staff to create better career opportunities for leadership roles (VCSE)	• Some refugees and asylum seekers area chargeable for services up-front under new NHS rules • Data sharing agreement between NHS Digital and Home Office for immigration enforcement purposes = confidentiality breach • Communication barriers to coproduction with YP • Resistance to Change
Key recommendations/Actions: *NONE RECORDED FOR THIS GROUP.*	

Appendix 4: VCSE Equalities Assembly (2)

Reframing Equalities with GM Health & Social Care Partnership

Monday 26th February 4-6 pm

3.45 Arrivals and coffee

4.00 Welcome – Michele Scattergood & Ben Gilchrist
Overall task / opportunity - Why are we doing this?
Remind of MOU
Journey to date

4.10 Snap shot of key issues that emerged from co-design sessions

4.20 The proposed Action Plan from the Co-design sessions
Executive Summary to whole group on Powerpoint

4.30 Developing the action plans and making it real
X 4 tables – each given x 2 different action plans then rotate:

- *Add more detail/ ideas of the how?*
- *Sign up interest in being involved ?*
- *Sign post to others and other things they know about that can support that action*
- *Move action plans around after 10 mins x 4 times so have a chance to see all and snow ball additions*

(5pm Warren Heppolette - Executive Lead, Strategy & System Development - Greater Manchester Health & Social Care Partnership to arrive)

5.10 Feedback
X2 key points from each table & any new ideas not included

5.20 Building blocks - GM Health &Social Care Partnership – Warren Heppolette

- General approach – VCSE Board and Committee membership (via MOU) is working well across the partnership
- GM Outcomes framework in development

& specifically a few lines on:-

- GM Commissioning LGBT tracking work
- Person Centred and Community Approaches
- GM Social Prescribing & Stockport exploratory model
- Workforce

Opportunity : Interest/ time capacity to be involved in these existing work streams to support ‘equality challenges’ giving attention to Inequality issues - sign up, but a recruitment process will follow to allow those not at the Assembly to submit EOI

Q&A with Warren

5.55 Closing remarks – Michele / Ben

Whats Next?

Action 1a – Shadow Board to be set up – develop Form and Function, Terms of Reference and broader membership

Action 1b – recruit to Equality Challenges for Work streams

Thanks

6pm CLOSE