Equality and Delivery System (EDS) Summary document

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1.0 Purpose of Paper

- To meet the requirements of NHS England's Equality Delivery System (known as EDS)
- To summarise the methodology and information gained for compliance with EDS via community engagement that took place between January to March 2020 and from September to November 2020
- To summarise and comply with the internal staff element of EDS
- To inform the recommissioning of the Interpreting Services contract

2.0 What is EDS – Guidance from NHS England[1]

2.1 The Equality Delivery System (EDS) was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. It is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice.

2.2 The main purpose of the EDS2 was, and remains, to help local NHS commissioners and providers, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

2.3 When using EDS2, it is suggested that, based on evidence and insight, organisations might wish to be selective in their choice of services they review and, where there is a strong

[1] https://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

local need to do so, the EDS2 outcomes that services are assessed and graded against. Organisations might also look at particular aspects of protected characteristics.

2.4 When taking a selective approach, organisations should seek the agreement of local stakeholders including advice on the selections that are made. Choices should embrace a proportionate mix of progress and good practice, on the one hand, and challenges, problems and concerns, on the other. Otherwise a distorted picture of an organisation's performance may be given. NHS organisations should make EDS2 work for them, and adapt its processes and content to suit their local needs and circumstances.

2.5 NHS Sheffield CCG has not undertaken EDS in recent years and therefore chose to utilise the skills and links with community organisations to approach the task from an engagement viewpoint – ensuring that people are listened to and heard and that trust is built along the way.

2.6 The aim is that EDS will be completed as a system in future where providers and commissioners work collaboratively to improve patient experience and services for those where greatest health inequality exists and early discussions are underway with colleagues in other trusts across the city.

3.0 EDS - Reason for choice of service area and timeframe

3.1 The choice of service area for delivery of EDS emerged from feedback received from service users at the Chinese Community Centre and the Refugee Council during previous outreach involvement activity. It was clear that community members were sharing experiences with trusted community leaders about their experience of interpreters when accessing health, and that their experience was poor.

3.2 The communities mentioned were revisited and invited to help us assess what was working well, what was not working well and whether the current interpreting service (which is jointly commissioned by the CCG) required a more in-depth review. In addition to the Refugee Council and the Chinese community centre, an additional seventeen organisations were approached (see appendix B) from high use communities who require interpreters, and nine were able to offer information and data to help complete the EDS process.

3.3 The engagement that took place from January to March 2020 yielded a rich vein of feedback from a broad spectrum of service users and carers. This work was paused between March-August as the CCG was dealing with the pandemic. Information continued to be gathered from community members during this time and interpretation was highlighted by many communities as a concern.

3.4 During October 2020, Sheffield CCG co-ordinated a separate piece of work and this included organisations who had participated in the first tranche of engagement. Interpreting services emerged as a key themes once again. This has enabled us not only to update some of this gathered intelligence, but also to explore further the experiences of service users in the weeks that followed the March lock down and also during the last 3 months, and gather valuable and insightful feedback of the impact of Covid on some of the most vulnerable communities in Sheffield.

4.0 Context – The Sheffield picture

4.1 Sheffield is a diverse and vibrant city, with rich cultural heritage and a proud history as the first UK 'city of sanctuary'. In November 2017, it was estimated that there were 105,861[2] residents from BAME backgrounds, making up 19% of the Sheffield population. Estimates by city leaders in 2020 suggest that in the 2021 census, this will have risen to around 27% of the Sheffield population.

4.2 The wards where people from black, asian and minority ethnic backgrounds are the highest percentage of the total population are Burngreave (62%), Darnall (49%), City (46%), Walkley (30%) and Nether Edge and Sharrow (30%). 38% of the BAME population live in areas that are amongst the most 10% deprived in the country.

4.3 According to the 2011 census, the 10 most common languages spoken, other than English, were: Arabic; 'other Chinese', Urdu, Punjabi, Polish, Somali, Bengali, Slovak, Persian / Farsi and Kurdish.

4.4 Healthwatch Sheffield have worked extensively with the deaf community in Sheffield and reported in 2018[3] that there were 960 people in Sheffield registered at deaf and 560 as heard of hearing.

5.0 Context – The Interpreter Contract

5.1 NHS Sheffield CCG has two existing interpreting contracts. The first contract is a joint contract between Sheffield City Council /Sheffield Teaching Hospital and NHS Sheffield CCG. This contract is for all of the ad hoc interpretation bookings for GP practices, optometrist practices, and dental practices.

5.2 The second contract is solely for the high usage GP practices (6 practices) who have a block booking arrangement and this contract is managed by the CCG.

5.3 The contracts with the provider Language Line Solutions have been extended until September 2021. Feedback about the service received is mixed – some communities have had positive experiences but some have had very negative experiences and therefore reviewing the current contract and service provision is an initial first step to making changes.

5.4 We need to ensure that the service specification appropriately reflects the needs of the population. Within this extension period, the service will be going through a re-procurement process and it will ensure that the service specification and contract appropriately reflects the needs of service users.

6.0 Implementing EDS on behalf of NHS Sheffield CCG

[2] https://www.sheffield.gov.uk/content/dam/sheffield/docs/your-city-council/community-knowledge-profiles/BME%20Community.pdf

[3] https://www.healthwatchsheffield.co.uk/report/2018-01-08/not-equal-experiences-deaf-people-accessing-health-and-social-care-sheffield

6.1 EDS2 focuses on four goals:

1. Better Health Outcomes
2. Improved patient access and experience
3. A representative and supported workforce
4. Inclusive leadership

6.2 For the purposes of this EDS submission, goals 1, 2, and 3 have been our focus. For the purposes of this section of the report, goals 1 & 2 are the focus and relate to the information gathered regarding the interpreting contract. Goal 3 relates to an internal evaluation of our workforce and is included in appendix C.

6.3 Within these goals there are a series of outcomes or exemplars of good practice. We have listened to local people and gathered data, and this has enabled us to collaborate with a range of communities to assess our own performance. An intrinsic part of this process is to agree, with our partners in the community, our performance against ratings of "Undeveloped, developing, achieving, excelling".

6.4 The key aim for this work is self-improvement and an ongoing annual review of progress. The CCG has an opportunity to listen and make tangible changes based on the feedback contained in this report as part of the interpreting contract review which will take place in 2021.

7.0Self-assessment of EDS criteria

7.1Our assessment is based on whether the current interpreter contract is helping or hindering when applied to two key goals - **improving patient access and experience** and enabling **better health outcomes** (whilst being mindful that these are a generic set of descriptors for NHS providers and commissioners and therefore not all will apply in this context).

EDS Goal 1 - Better Health Outcomes
1:1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities
1.2 Individual people's health needs are assessed and met in appropriate and effective ways
1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed
1.4 When people use NHS services, their safety is prioritised and they are free from mistakes mistreatment and abuse
1.5 Screening, vaccination and other health promotion services reach and benefit all local communities

7.2 In collaboration with stakeholders including service users, patient and communities, interpreters and colleagues from more than 11 third sector organisations we have agreed that the Interpreting service in Sheffield, for the goal **'better health outcomes'** is **"Developing**". This is based on an assessment of the overarching information gathered, although it must be noted that some individuals and everyone from the deaf community who

contributed stated that their assessment would be “under-developed”. Please find following the themes and trends and direct quotes from service users that have informed this judgement:

Key theme with regard to better health outcomes: Staff training

7.3 Participants felt that the lived experience of using an interpreter is poorly understood by some clinical staff and contracting teams.

7.4 Participants said they would like to see the perspective of the client included in mandatory cultural awareness training and for this to be an integral part of continuing professional development to receive updates regarding changes to process, procedures etc.

7.5 Respondents said that it was common for assumptions to be made when assigning an interpreter to a client or patient, purely based on the country of origin of the client

“So I went to the walk in centre and I didn’t have interpreters and I was trying to speak English…I was angry…they were talking English and I couldn’t understand all of what was being said…, at the hospital they said that there was nothing wrong, they got an interpreter to explain I needed tests – but I DO have a problem with my leg, they thought I was wasting their time, the nurse was not respectful of me at all…”

Somali female service user

“So I went the next day and they told me to ring the bell, but then they don’t let me in, and that I couldn’t see the doctor. I was so angry I started crying and I said “I tried to call you, you said the doctor would call, he didn’t call…I was so upset”

Egyptian female service user

“When I arrived at the hospital there weren’t any interpreters, it was so stressful, but they called someone with Google and we managed to understand each other”

Somali female service user

Key theme with regard to better health outcomes: Interpreter training

7.6 Participants in each group said that they had experienced sessions where the interpreter had not understood basic clinical terminology and had relayed inaccurate clinical information.

Key theme with regard to better health outcomes: Issues pertinent to specific communities

7.7 There are specific issues in relation to the Chinese Community, most notably the feedback that the standard of spoken Mandarin and Cantonese during interpreting sessions was viewed as being "appalling". Interviews with 8 older Chinese people took place where respondents said they felt overwhelmed at the prospect of accessing an interpreter.

> *"It's simple, we would like to have face to face interpreters and someone to walk with us on the journey".*
>
> *Chinese service user*

7.8 People who are Deaf: The Heathwatch report "Not Equal: The experiences of Deaf People accessing health and social care in Sheffield 2018" provided a snap shot of barriers deaf people experience in using health and social care in Sheffield. There has been engagement with members of the Deaf community (meeting with a member of the Deaf Community support team and feedback from a Focus group facilitated by Healthwatch Sheffield). We are mindful that participants from the deaf and hard of hearing community regard the Interpreting service as "underdeveloped".

> *"Staff don't seem to understand my needs to allow me to tell them about my health worries. Appointments are changed at the last minute and they try to call me to tell me – they just don't understand what I need to be able to communicate with them."*
>
> *Deaf service user*

> *"Staff seem to want to use email but my main language is BSL so I find it difficult to understand what is said in the message. They make assumptions without asking and this means I can't always get the help I need."*
>
> *Deaf service user*

> *"Often the BSL interpreter just doesn't show up – sometimes because it hasn't been arranged. That means I can't communicate with the health professionals. I feel off the radar."*
>
> *Deaf service user*

EDS Goal 2 – Improved Patient Access and Experience
2.1 People carers and communities can readily access hospital community health or primary care services and should not be denied access on unreasonable grounds
2.2 People are informed and supported to be involved as they wish to be in decisions about their care
2.3 People report positive experiences about the NHS
2.4 People's complaints about services are handled respectfully and efficiently

7.9 In collaboration with stakeholders including service users, patient and communities, interpreters and colleagues from more than 11 third sector organisations we have agreed that the Interpreting service in Sheffield, for the goal **'improved patient access and experience'** is **"Developing**". Please find following the themes and trends and direct quotes from service users that have informed this judgement:

Key theme with regard to improving access and experience: Service delivery

7.10 The face to face Interpreting service is generally viewed as working well and two of the groups (Somali Carer's Group and exercise class at Sharrow Shipshape) said the service worked very well.

7.11 During the pandemic, some of the issues raised related to issues accessing Interpreters in a primary care setting, and the general high level of anxiety that prevails in some communities about approaching surgeries, due to fears of catching covid

7.11 In relation to the shift from face to face access to primary care to online methods, there are high levels of anxiety in relation to the technologies that need to be accessed when English is a second language

"Yes, the GP does do that (call the patient). I say "I need an appointment, I don't speak English, I speak Arabic…..yes they give me an appointment, they say "at such at time the GP will call" and they do, with an interpreter. The GP is very good with us (Firth Park) even if there is a delay they respond to the request and put interpreters on…"

Palestinian male patient

"Just the lack of face to face appointments with physios and people like that. Sometimes when you are in pain you can't describe that over the phone"

Iraqi male service user

Key theme with regard to improving access and experience: Method for interpreting

7.12 The telephone interpreting service is unpopular (pre Covid) and has been cited in all groups as being an impediment to effective communication between patients and clinical

staff. The main reason given for the very high stress levels that were commonly experienced was due to the fear of a confidentiality breach ("I need to see their face"). Without visual clues, respondents said the key messages of the interpreting sessions were harder to understand and process.

7.13 Telephone sessions were cited as being difficult to engage with as phone lines were sometimes poor, particularly when the interpreter was making the call from a car.

7.14 Generally, accessing telephone sessions was viewed by participants as being relatively straightforward. However, accessing face to face sessions was viewed as problematic by some participants.

7.15 A common theme that emerged across the groups was participants saying that they or a third party had booked a face to face interpreter and then would later find that the interpreting session was actually a telephone session

> *"I like the way it used to be (Pre Covid). You just walk in and you get an appointment…..you could call reception, you could say "Somali", and they would get you an interpreter"*
>
> *Somali female patient*

7.16 Detailed information about peoples lived experience and possible suggestions for improvements are included in appendix A.

8.0 Recommendations

- SPEEEC approves this work as fulfilling the CCG requirement to undertake EDS2 and this summary is uploaded to our website
- The information contained in appendix A is reviewed by the Interpreting Contract Group, that will include service users and Healthwatch, and a plan is developed regarding what is in scope in relation to the review of the current specification and contract and appropriate actions are taken
- Information outside the scope of the contract and specification review is disseminated to the Reducing Health Inequalities group who oversee that appropriate action to be taken (which could include the CCG, primary care teams, providers, LA and VCF sector).
- Outputs from this work are reviewed alongside community organisations and individuals to ensure progress is made on an annual basis

Appendix A - **Summary of issues raised – for action and oversight by the interpreting contract group**

	Issue identified by service users from at least 2 of the participating community groups	**Suggestions made by service users to resolve issue**
1	**Brief the Interpreters before a Session**: Service users said that they find it stressful having to repeat their symptoms and personal context in a primary and secondary care setting, and that sometimes things became very confused as certain information had not been relayed. They said it was often exhausting to have to start from scratch explaining their situation to an Interpreter. In turn, Interpreters said that they sometimes feel they are going "blind" into sessions with no basic details about the person they are assigned to help, and the level of complexity.	Participants said that it would be helpful if interpreters were given a short briefing before the interpreting session, and when asked how this could happen they spoke of this being included in their induction training. This theme also emerged from discussions with Interpreters, as they felt they could deliver a better service to clients if they were better informed. Service users said they thought this should be included in the interpreting contract as a basic requirement.
2	**Confidentiality and fear of confidentiality breach.** This was the main reason given for the very high stress levels that were commonly experienced was fear of a confidentiality breach ("I need to see their face"). Participants said that they often felt that the lived experience of needing to use the Interpreting service is poorly understood by clinicians and medical teams, GPs and surgery staff. People spoke of feeling very vulnerable, and exposed in what should be a private discussion. The fear of a confidentiality breach would appear to be the common driver for some clients preferring a face to face interpreter session rather than a telephone session. Without visual clues, respondents said the key messages of the interpreting sessions were harder to understand and process. Telephone sessions were cited as being difficult to engage with as phone lines were sometimes poor, particularly when the interpreter was making the call from a car.	Training that includes the perspective of the client was suggested by participants in 3 of the groups. It was suggested by one group (Somali Women's Carer Group) that this should not only be part of the training for Interpreters, but part of cultural mandatory awareness training for all NHS staff. They went further in their suggestions saying that cultural awareness should be part of continuing professional development, and that staff should receive updates regarding changes to process.
3	**Interpreters abilities to translate basic and medical and pharmaceutical terminology needs**	Participants felt that a simple solution to this issue would be to adapt the training provided

	Issue identified by service users from at least 2 of the participating community groups	Suggestions made by service users to resolve issue
	to improve Male and female participants spoke of interpreting sessions where interpreters were not able to convey accurate medical information. They felt this was because the Interpreter did not have the breadth of vocabulary to translate basic medical pharmaceutical and clinical terminology. In addition, participants said that they often felt rushed and it was difficult to absorb what was being said. This was a common theme and appeared in 3 of the group discussions.	to Interpreters to include a component that covers common medical terms procedures and diseases and common medications and treatments. Participants said that it should also acknowledged that the pace of such discussions has to be realistic to allow the client time to absorb information and to ask any follow up questions.
4	**Confusion/stress when a face to face appointment is cancelled and replaced with a telephone session, without prior warning** Face to face appointments arranged (pre Covid) and when patient arrives, the interpreting session is taking place via telephone. This scenario was common across all groups that participated.	Participants felt that the service is sometimes under pressure and understand that provision will sometimes vary. However, they asked if there could be a greater sense of awareness re how this impacts on the patient. Communication can be difficult without visual clues, and several participants said that if they had known it was a telephone session they would have made arrangements with family for preference. Again, they suggested it could be highlighted in training sessions.
5	**Feedback highlighted the need for cultural awareness training regarding the trauma refugees have experienced and the additional barriers that they have to navigate to access health care services, including language barriers** Three separate meetings with Mental Health Professionals, Interpreters and managers took place pre Covid at the Refugee Council. We have received 22 detailed COVID survey reports (includes responses from service users). The main issue that was raised by a broad spectrum of respondents pointed to a poor level of	It was suggested that cultural awareness training should be mandatory across all bands of NHS employees and enhanced to include a section on the experiences of Refugees and the specific extreme scenarios many have encountered.

	Issue identified by service users from at least 2 of the participating community groups	Suggestions made by service users to resolve issue
	understanding of the challenges and pressures experienced by refugees. Respondents spoke in detail of a general lack of understanding of the psychological impact of the migration trajectory (arrival, transit, and destination) in primary and secondary care settings. These challenges are ongoing and multi layered, and includes accessibility of health care due to legislative financial and administrative barriers. In addition, refugees have experienced the acute anxieties and concerns of covid compounded by language difficulties while also in the process of navigating primary and secondary care services for diseases and injuries caused by war and conflict. Refugees are supported admirably by the Refugee Council, as they navigate their way around the health and social care systems in Sheffield. They employ their own interpreters but the refugees who use their services have also used LanguageLine services in GP and secondary care settings. Staff and service users have spoken of a lack of organisation and coordination between services. These barriers proved particularly problematic for access to specific services: mental health, sexual and reproductive care, child and adolescent car and victims of violence.	
6	**Deaf Community**: **Patients who are deaf continue to speak of increasing and ongoing multiple barriers and obstacles that they encounter while interfacing with primary and secondary care.** There are 3 main areas highlighted in the Healthwatch report "Not Equal, the experiences of Deaf people accessing health and social care in Sheffield January 2018" Recently, Health watch facilitated a Focus group (November 2020) that produced valuable additional feedback that explored these key areas further and identified additional communication barriers. Participants discussed how these complex areas could be addressed. A transcript of the focus group will be available January 2021, following	The Health watch report "Not Equal: The experiences of Deaf people accessing Health and Social Care in Sheffield, January 2018" concludes with 3 main recommendations and 5 main areas for service improvement (see below). The Service User Focus group (facilitated by Health Watch November 2020) generated many insightful and constructive suggestions about how the Interpreting service could be improved for deaf

	Issue identified by service users from at least 2 of the participating community groups	Suggestions made by service users to resolve issue
	authorisation and verification from Health watch and the participants. Participants at the focus group were asked a series of questions about their experiences interfacing with Primary and Secondary care and some common themes from the feedback includes examples such as changes to appointments being conveyed by telephone, even though it is recorded on the patient's notes that the patient is deaf. There is a strong sense that many NHS staff are not deaf aware.	people. However, the service improvement suggestions listed below underpin much of what was discussed and these five areas are still considered to be unfulfilled. Some general examples of issues and service improvement suggestions from the November 2020 focus group included: • Deaf Awareness training for NHS staff is seen as an essential next step, highlighting common barriers such as the assumption that telephone calls are appropriate. There were examples of patients who had requested to use WhatsApp and Facetime but the Clinic was not able to respond to these requests. Patients were then asked to use email instead -something many BSL trained patients have difficulty with because they are fluent in BSL, not written English. • There are examples of Interpreters not attending pre booked appointments that result in the patient leaving without the appointment in clinic taking place.

	Issue identified by service users from at least 2 of the participating community groups	Suggestions made by service users to resolve issue
		This booking process needs to be scrutinised and weak links in the process identified • Like the general population, many deaf people are digitally excluded (figure is around 60%). There needs to be a joined up approach to this issue and needs of deaf people need to feature in work streams that are looking at this. • Deaf people spoke of a lack of clarity about how to complain. One example of service improvement from the focus group was for close collaboration between CCG complaints manager/team and Health watch. • The booking process and referral process, in both cases it should be simplified and clarified and communicated widely to NHS and social care staff via mandatory training routes and Continuing Professional Development routes. • Signlive is not generally popular and the sense is that it provides a poor

	Issue identified by service users from at least 2 of the participating community groups	Suggestions made by service users to resolve issue
		service to people who are deaf, and does not take into account the fact that many people who are trained in BSL are not fluent in written English skills. The general use of Ipads to convey complex sentences and instructions often fails to convey key messages due to the communication processes used by BSL users. (N.B. – these are some of the suggestions and not a complete reflection of all conversations expressed at the Focus Group). **Health Watch report "Not Equal: The experiences of Deaf people accessing health and social care in Sheffield, January 2018"** Key findings: • The communication needs of Deaf people are not routinely recorded and flagged by Providers of NHS or Adult Social Care. • The communication needs of Deaf people are not routinely shared between GPs and Hospitals.

	Issue identified by service users from at least 2 of the participating community groups	Suggestions made by service users to resolve issue
		• Provision of British Sign Language interpreters is inconsistent and unreliable, causing people to disengage from services and to suffer unnecessary distress. The report concludes with 5 main areas for service improvement and in summary these are: 1. NHS and Social Care Providers should recognise the legal requirement to meet the 5 elements of the Accessible Information Standard and ensure that they are embedded and consistently applied within their organisations 2. Commissioners should consider the use of measure and or incentives to ensure the Accessible Information Standard is being implemented by providers 3. Contract monitoring of Language Line solutions should include the experiences and view of Deaf People. 4. NHS providers should ensure that staff have a basic understanding of

	Issue identified by service users from at least 2 of the participating community groups	Suggestions made by service users to resolve issue
		the needs and problems experienced by Deaf and people and are aware of their responsibilities under the Equality Act 2010. 5. Local providers should act to ensure information about their complaints and concerns is accessible and available in BSL, including information about the NHS complaints advocacy.
7	**Accessing the appropriate interpreter within appropriate time frame** Generally, accessing telephone sessions was viewed by participants as being relatively straightforward. However, accessing face to face sessions was viewed as problematic by some participants. The Chinese Community and the Refugee Council flagged issues about accessing an appropriate interpreter within an appropriate time frame. For example, at the Refugee Council, extensive delays have been incurred while clients were waiting for an IAPT assessment, due to problems accessing an interpreter. Participants felt that part of the problem was a perceived lack of collaboration between LA, NHS and local community centres.	Participants spoke of the need for a "clear systematic and simplified booking system, and more flexible slots for a walk in service". It was also suggested that staff from differing organisations should meet to identify how they can work together more efficiently.
8	**Looking at new ways to provide Interpreting Services and acknowledgement of digital exclusion in BAMER and people who are deaf.** Participants from Somali Carers Group and the Focus groups arranged by the Chinese Community Centre talked about Digital exclusion and one participant said that "NHS should take into account that not everyone has access	Participants made several suggestions re how to how to address this issue 1. Lack of access to kit, WIFI and training and its negative impact on accessing services should be highlighted in mandatory

	Issue identified by service users from at least 2 of the participating community groups	Suggestions made by service users to resolve issue
	to…technical devices and WIFI to access online support and information about changes to appointments"	training Cultural awareness training. 2. Funding to be made available to VCF organisations to provide bespoke IT training to its service users
9	**Establish which language will be understood most clearly and accurately:** Participants said that it was common for assumptions to be made when assigning an interpreter to a client or patient, purely based on the country of origin of the client. The example given was the wide variations in dialect and also variations in how Arabic is spoken in different parts of Somalia. The service improvement suggestion here was "it is important to get the right interpreter for the client and to establish which language will be understood most clearly and accurately"	The service improvement suggestion here was repeated in several settings and one participant summarized the action needed as " it is important not to make assumptions, and to get the right interpreter for the client and to establish which language will be understood most clearly and accurately"
10	**Poor standard of Cantonese and Mandarin interpreting was reported** There are specific issues in relation to the Chinese Community, most notably the feedback that the standard of spoken Mandarin and Cantonese during interpreting sessions was viewed as being "appalling". Interviews with 8 older Chinese people took place where respondents said they felt overwhelmed at the prospect of accessing an interpreter. Respondents said they found the process confusing and would avoid the process altogether if possible.	When asked how the service could improve the answer was "that's simple, we would like to have face to face interpreters and someone to walk with us on the journey". They also said that they would like to see the problem of the poor quality of Mandarin and Cantonese interpreting acknowledged and improved.

Appendix B – Engagement Activity Overview

Table of participants:

1.1 Engagement was primarily concerned with community engagement activity that took place with local organisations, as was agreed at the SPEEEC meeting in December 2019. Contact was made with the following organisations to ask them to be involved. These were:

- Shelter
- Roundabout
- Sheffield Chinese Community Centre
- Sheffield Chinese Association
- Firvale Community Hub
- PACA
- SpringBoard Social Café at PACA
- Links to Roma families through Darnall Wellbeing
- Yemeni Association Furnival Community Projects
- Yemini Community Association
- ISRAAC (Somali Community and Cultural Association)
- Using existing networks (Terminus Initiative and Darnall Wellbeing for e.g.) to have contact with Kurdish families, as no known organisations are working solely with members of this community.
- Terminus Initiative
- Sharrow Ship Shape
- Refugee Council
- Members of the Deaf Community

1.2 In November, Healthwatch arranged for a focus group of 6 Deaf people to meet via Zoom, facilitated by a BSL interpreter. The purpose of this meeting was to explore further the barriers that had been identified previously in the Healthwatch report. This has been transcribed and has added a rich vein of intelligence in relation to known barriers and many specific service improvement suggestions have been identified in relation to the Interpreting services contract. Further collaborative work is in the process of being planned with Healthwatch, to ensure that this valuable feedback in captured in the recommissioning process.

Appendix C

EDS Goal 3 – A representative and supported workforce

3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
Grade: Achieving

Evidence drawn upon for rating:

- Recruitment and Selection Policy
- Equality and Diversity Policy
- Recruitment and Selection Training for Managers / Recruiting Officers
- Line Management Essentials Training for all Line Managers
- Roles advertised via the NHS Jobs website
- NHS Jobs equality monitoring reports
- Workforce Race Equality Scheme
- Workforce reports shared with Directors and formal committees
- Disability Confident employer

3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
Grade: Achieving

Evidence drawn upon for rating:

- Job Descriptions in place for all roles within the CCG
- NHS Job evaluation scheme
- Evaluations for current roles
- Workforce reports shared with Directors and formal committees (including workforce diversity profiling)
- Regular Job Evaluation Panels
- National NHS terms & conditions applied
- We adhere to nationally negotiated annual pay uplifts across all staff groups
- We benchmark VSM and GB pay against other Clinical Commissioning Groups
- Gender Pay Gap report and action plan

3.3 Training and development opportunities are taken up and positively evaluated by all staff
Grade: Achieving

Evidence drawn upon for rating:

- Mandatory and Statutory Training quarterly monitoring reports which show continuing high levels of compliance
- Staff are supported to undertake professional and other educational training opportunities
- Participant evaluation of courses
- Organisational Development programme rolled out and completed across whole of workforce
- In-house developmental training opportunities offered to all staff

- Most recent national staff survey results - Quality of non-mandatory training, learning or development, staff appraised in the last 12 months, Quality of appraisals

3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source
Grade: Achieving

Evidence drawn upon for rating:

- Staff survey 2020 – the CCG commissioned a bespoke staff survey with a section of questions dedicated to staff experience with regards to abuse, harassment, bullying and violence. An action plan will be created in conjunction with the staff engagement group and shared with all staff.
- Dignity at Work Policy (Bullying and Harassment) Policy and Procedure
- Exit interviews offered to all staff that leave the organisation
- Workforce indicators
    - Staff turnover for the financial year 2019 – Headcount: 14.79%, FTE: 14.48%
    - Sickness absence for the financial year 2019 – FTE absence = 3.85%
- Staff have multiple routes to raise issues/concerns – including via the Grievance Policy and Procedure
- Active staff engagement group
- Personal Development Review process includes consideration of individual's adherence to corporate values and behaviours

3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives

Grade: Achieving

Evidence drawn upon for rating:

- Addition of personalised leave in the Annual and Special Leave Policy
- Flexible Working Policy
- Special Leave Policy
- Employment Break Policy
- Maternity, Adoption and Parental leave Policy
- Workforce reports confirm that a high proportion of Barnsley Clinical Commissioning Group staff have a flexible working pattern

3.6 Staff report positive experiences of their membership of the workforce
Grade: Achieving

Evidence drawn upon for rating:

- Staff survey results 2020
- Actions shared with the SMT from the Staff Engagement Group and vice versa
- Workforce indicators (staff turnover and sickness absence)

GOAL: INCLUSIVE LEADERSHIP

4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
Grade: Achieving

Evidence drawn upon for rating:

- Equality, Diversity & Inclusion training
- Sheffield Clinical Commissioning Group Vision & Values
- Equality Impact Assessment requirements
- Committee reports required to show consideration of Equality Diversity & Inclusion
- Support apprenticeships in the CCG and primary care
- Strategic approach to engagement, equality and patient experience agenda demonstrated by SPEEEC – 6 Governing Body members sit on the committee and champion the 3 agendas in all arenas within the organisation and externally

4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
Grade: Achieving

Evidence drawn upon for rating:

- Proforma templates for reports presented to Governing Body and other committees have mandatory field to complete to show consideration for equality, diversity & inclusion
- Equality Impact Assessments

4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

Grade: Achieving

Evidence drawn upon for rating:

- Dignity at Work (Bullying and Harassment Prevention) Policy
- Equality & Diversity - Mandatory & Statutory Training record
- Organisational Development Programme rolled out across whole of workforce
- Professional Development Review process includes consideration of individual's adherence to corporate values and behaviours
- Regular staff surveys undertaken and action taken where issues are identified
- Facility/space made available for religious observances