# Partnership Engagement Network (PEN)

## Report of Conference held on 28th February 2018

### Background

The Partnership Engagement Network (PEN) was established as part of a multi-agency approach to provide public and partners with an identified and structured method to influence the work of public services and to proactively feed in issues and ideas.

The approach ensures that the structures exist to have ongoing conversation with the public and stakeholders and creates forums for people and organisations to get their voices heard, but also to hear about and contribute to the development of public sector programmes and work.

### Introduction

On 28 February 2018 representatives from Tameside Council, NHS Tameside and Glossop Clinical Commissioning Group and Tameside and Glossop Integrated Care NHS Foundation Trust along with public, stakeholders, partners, and voluntary, community and faith sectors came together for the second PEN Conference – the first of which was held in October 2017. There were over 60 participants in total. Over 100 people had registered to attend the conference however due to adverse weather conditions on the day a large number of last minute apologies were received.

Throughout the day participants heard presentations on the topics of Patient Choice, Active Ageing and an update on the Partnership Engagement Network Approach. Participants also took part in three rounds of a choice of six facilitated workshops focussing on specific issues/challenges. A full agenda for the day can be found at appendix 1.

### Facilitated Workshops

Six facilitated workshops took place to gain input on the development of options, emerging ideas and specific issues and challenges currently facing the economy. The approach to the workshops was flexible with the workshop leads invited to facilitate the workshop in the way which worked best for the topic they were delivering. Key points and notes of these discussions are available at appendix 2 onwards.

Participants were invited to take part in a choice of three of the following six workshops:

- Active Ageing
- Preventing Hateful Extremism and Promoting Social Cohesion
- Patient Choice
- One Equality Scheme
- COMPACT
- Public Behaviour Change (Self Care Alliance)

The discussions and feedback captured during these workshops will be used to provide data, information, evidence and insight to the development of public services in Tameside and Glossop. The full notes of each of the workshops are included in the attached appendices (2 to 7).

**Post Conference Feedback Survey**

All participants were invited to take part in a post conference feedback survey. 26 responses were provided. Key results include:

- 100% of participants rated the PEN Conference as Very Good (46.2%) or Good (53.8%) overall.
- 100% of participants rated the organisation of the event as Very Good (57.7%) or Good (42.3%) overall.
- 92.3% of participants rated the presentations as Very Good or Good overall. 7.7% rated the presentations as Poor or Very Poor.
- Participants were invited to make comments about the presentations. Feedback points included:
  - Need to ensure PowerPoint slides are clear and can be seen by all in the room
  - Handouts would be helpful
- In terms of workshops, 96.2% of participants rated these as Very Good or Good overall. 3.8% rated the workshops as Poor or Very Poor.
- Comments about the workshops included:
  - Informative, relevant and useful
  - Gave partners and general public an opportunity to be involved and give their views on services
  - Workshops can be dominated by one or two individuals
- The majority of participants (92.3%) felt that they were given enough opportunity to express their opinions. 7.7% felt they were not given enough opportunity to do so.
- Thoughts and opinions provided on Partnership Engagement Network included:
  - The idea of PEN is good
  - Need to be kept informed of progress made as a result of PEN
  - Partnership working is vital for us to improve services
  - Good networking opportunity
  - An excellent day and some great conversations
  - Very important that groups work together to avoid duplication of work
  - Good to see different people in the room
  - Would be good to see more public representatives / groups representing the public
  - Excellent way for people to express their views
  - Useful to share information and network
- Suggestions for topics to be covered at future conferences included:
  - Dementia care and carers
  - Working together
  - Loneliness and isolation
  - Learning difficulties
  - Integration of neighbourhood teams
  - Mental health
  - Communication and information sharing

A full breakdown of the top line responses can be found at Appendix 8

**Future PEN Conference Dates**

- **Wednesday 27th June**, 9.30am – 2.00pm
  Jubilee Hall, Dukinfield Town Hall, King Street, Dukinfield, SK16 4LA

- **Monday 15th October,** 9.30am – 2.00pm
  Hyde Town Hall, 10 Corporation St, Hyde SK14 1AL

**Appendices**

The following appendices are attached:

- Appendix 1 – Conference Agenda
- Appendix 2 – Workshop notes; Active Ageing
- Appendix 3 – Workshop notes; Preventing Hateful Extremism and promoting social cohesion
- Appendix 4 – Workshop notes; Patient Choice
- Appendix 5 – Workshop notes; One Equality Scheme
- Appendix 6 – Workshop notes; Compact
- Appendix 7 – Workshop notes; Public Behaviour Change (Self Care Alliance)
- Appendix 8 – Post Conference Feedback Survey Findings

**Appendix 1.**

# PARTNERSHIP ENGAGEMENT NETWORK CONFERENCE

Date: Wednesday 28 February 2018

Time: 9.30am – 2.00pm (lunch and networking from 12.55pm)

Venue: Jubilee Hall, Dukinfield Town Hall, King Street, Dukinfield, SK16 4LA

## A G E N D A

| | | |
|---|---|---|
| 1. | **Welcome** (Councillor Brenda Warrington – Executive Leader, TMBC) | 9.30 – 9.35 am |
| 2. | **Introduction** (Ben Gilchrist, Deputy Chief Executive of Action Together and Healthwatch CEO) | 9.35 – 9.40 am |
| 3. | **Patient Choice** (Joanne Brooks, Choice Project Manager NHS England) | 9.40 – 9.55 am |
| 4. | **Active Ageing** (Sandra Whitehead – Assistant Director - Adults, TMBC) | 9.55 – 10.10 am |
| 5. | **Workshops – Round 1** (See overleaf) | 10.10 – 10.50 am |
| 6. | **Feedback – 1 key point from each table** | 10.50 – 10.55 am |
| | **BREAK** | 10.55 – 11.10 am |
| 7. | **PEN update** (Chris Easton, Head of Strategy Development, T&G ICFT and Simon Brunet Policy Manager, TMBC ) | 11.10 – 11.20 am |
| 8. | **Workshops – Round 2** (See overleaf) | 11.20 – 12.00 pm |
| 9. | **Feedback – 1 key point from each table** | 12.00 – 12.05 pm |
| 10. | **Workshops – Round 3** (See overleaf) | 12.05 – 12.45 pm |
| 11. | **Feedback – 1 key point from each table** | 12.45 – 12.50 pm |
| 12. | **Wrap Up** (Ben Gilchrist, Deputy Chief Executive of Action Together and Healthwatch CEO) | 12.50 – 12.55 pm |
| | **LUNCH AND NETWORKING** | From 12.55 pm |

| | WORKSHOPS |
|---|---|
| **A** | **ACTIVE AGEING** – Sandra Whitehead (Assistant Director - Adults, TMBC) and Debbie Watson (Interim Assistant Director of Population Health, TMBC) |
| **B** | **PREVENTING HATEFUL EXTREMISM AND PROMOTING SOCIAL COHESION** – Diane Barkley (Head of Homelessness and Community Safety, TMBC) |
| **C** | **PATIENT CHOICE** - Joanne Brooks (Choice Project Manager, NHS England) |
| **D** | **ONE EQUALITY SCHEME** – Jody Smith (Policy, Research & Improvement Manager, TMBC) |
| **E** | **COMPACT** - Anna Moloney (Consultant Public Health Medicine, TMBC) and Gemma Gaskell (Chief Officer, Diversity Matters North West) |
| **F** | **PUBLIC BEHAVIOUR CHANGE (SELF CARE ALLIANCE)** - Rachel Lord (Partnership Coordinator, Action Together) |

**Appendix 2.**

**Active Ageing**

Experience of older age is strongly shaped by social and economic circumstances, which in turn can lead to inequalities that persist into later life. This can mean reduced life expectancy, earlier ill health and disability, and poorer quality of work or worklessness. Loneliness and social isolation can also be issues experience by older people.

The purpose of the Active Ageing workshop was to seek views on how to ensure Tameside is an age-friendly borough. Input will help shape the GM Active Ageing strategy.

**Workshop 1**

**Transport – what are issues?**

**Is the investment we currently have working as it should?**

- Generally good / ring and ride very good
- Bus passes should be able to be used in other areas
- Communication regarding what is available,
- Promote what is already out there
- Something different for people with mobility problems, this is a problem
- Affordability issues
- How can GM under the new regime arrange a flat fare / a day pass so people can travel easily around the area – from the age of 60-65
- Better partnerships with the private sector
- Echo transport for people with mobility issues and who are socially isolated– working alongside the community and voluntary sector
- Walkable neighbourhoods / cycling – cohesive neighbourhoods

**Outdoor Spaces and Buildings – what are the issues?**

- More greenery in the town centres
- Better town centres
- More indoor facilities for when the weather is cold – places that give us a sense of community
- Tameside in bloom was a great idea – can this be re-instated by some GM investment
- What's on Where Guide
- Promote in GP surgeries

**Housing – what are the issues?**

- Adapt homes so that people can live for longer in their own homes
- Allow people with Dementia to live in their own homes for longer
- We need to engage with people who are hidden, people who are socially isolated who do not access NHS/Social Care etc., - there should be a piece of work trying to identify these people – possibility of using the fire service to identify them and/or other agencies
- Housing officers based in the hospital who can engage with people who are leaving hospital to go home – identifying those who are in most need

- Assisted living – building places that would create a sense of community for older people
- There are increased risks as we go digital for people being excluded – we need to be identifying these people
- More detailed reports to be done by housing on the over 75's

*General Overview - More accessibility via transport and how do we identify people via social networks who are socially isolated / Promote and communicate widely*

**Workshop 2**

**Social Participation – what are the issues?**

- Cost/barriers/time/knowledge
- Ill health – nearly 4m people are diabetic – plenty of evidence that diabetes can be reversed – more education of how people can avoid this type of illness – more health prevention
- Re ill health – don't look at the causes – you need long term ongoing support
- David Unwin report (GP in Southport) – report re diabetic patient case study – diabetes reversal – ran project in his practice and saved practice 40k per year in medical costs.

**Community Support and Health Services – what are the issues?**

- No longevity in the projects that are set up, not sustained and are not holistic generally focus on one condition – specifically in GP services e.g. over 75's project
- Gaps in services, services not talking to each other
- Problematic District Nursing service who are more qualified than general nurses but are not able to prescribe
- District Nursing working protocols are inflexible, policies collide with the hospital and community it's not joined up - very stressful for carers and relatives
- Policies need to be person centred
- Not enough District Nursing staff in the community
- People need to understand who does what, when and how
- Issues with community diabetes care

*General Overview – barriers and supporting people earlier, everyone is individual and everyone has different needs – services need to be 'person centred' – one size doesn't fit all – get rid of old cultures in services, we want services that work for us not services which work against themselves*

**Workshop 3**

**Communication and Information**

- Some older people are really knowledgeable on the internet
- GP and supermarkets, hairdressers, church groups need more information
- Need more social clubs
- We need to ask people how they want to be communicated with

- More co-production and co-design – longer term engagement so that we really know what people want and need – too much emphasis on consultation
- Need more things at weekend and in the evening
- Need to drill down and collect the intelligence that we have locally and do something with it to create better solutions for local people
- Outreach work needs to be done for those who are most isolated and build networks so that people become more engaged. Getting commissioners (health and social care) to look at the small stuff e.g. photography groups etc., that will work in the longer term
- We need to know where the demand is and how we can meet that demand – we need to know what the right techniques are to engage these types of people

**Older people and volunteering – Staying connected**

The group discussed volunteering opportunities for older people. This is a great way of using skills/hobbies/interests. This should be part of a pre-retirement plan.
There should be discussions with employees who are reaching retirement age and how this can be embedded into their future plans.

- The volunteering process at the Hospital Trust was too long. Up to 6 months to go through relevant checks.
- Older people are not asked if they would like to be part of a volunteer scheme
- Lots of opportunities out there – Hospital, Willow Wood, Miles of Smiles, Schools, Age UK, Community Groups.
- Set up a working group to look at volunteering opportunities with older people.
- There are gaps in services and their support during weekends/evenings – How can we support to help those services that need volunteers at those times of the day?
- My Life in Tameside & Glossop Web and passport (new initiative) can encourage workers to have those person centre approaches with older people. The web will have a wealth of information and how it would tailored to meet the volunteering needs of older people
- A Launch of the Website will be on the 4th of April (details to follow)
- Using more assets including Sheltered Housing Scheme lounges, community rooms to set up more events to support older people. Maybe volunteer day to promote what opportunities are out there. Use the above venues to host volunteer days.

***General note: People don't like the word 'Age'***

**Appendix 3.**

## Preventing Hateful Extremism and Promoting Social Cohesion

Following the Manchester Arena attack, the Mayor of Greater Manchester established a Commission to prevent hateful extremism and promote social cohesion.

### Workshop 1

### Social exclusion and wider determinants of social exclusion

The definition of social exclusion is when people cannot participate in usual things that people generally have access to. It affects both the quality of life of individuals and impacts on society.

What makes you feel you belong and why?

- LGBT young people should feel secure in the home; families don't understand, leads to isolation, sometimes homelessness. Teachers aren't trained in awareness of this issue.
- Awareness and acceptance; people caring about them e.g. through role models or family understanding.
- Using the correct language and using the right labels. Often language people use is negative and 'puts people in a box' which leaves them out of the wider community.
- Being part of a smaller group where gives people confidence to move into wider circles. Need to change perception & ideology not to judge people. E.g. neighbours getting to know one another.
- Friendships. Lack of awareness can be solved by people getting to know one another.
- If accessing services you want to feel you can turn up and be understood, not judged etc.

Challenging hateful extremism – what leads people to become radicalised? Economic factors; being vulnerable e.g. due to age

- Young people are a definite target. They replicate the behaviour of adults.
- Lack of opportunities in Tameside. Investment would help. Lack of opportunity is significant in people becoming isolated, radicalised. If opportunities are available then it leads to a greater sense of community and belonging.
- Media is irresponsible in their coverage of extremism
- Use of the word 'lone wolf'. Subtle undertone language that says you can be a 'lone wolf'.
- Social media is a double edged sword – invites backlash as well as reception of messages.
- Raising awareness; some young people may have an opinion but don't know what to do about it. E.g. improvised bomb in Stockport – what leads to this? A bad experience maybe with a service. Can lead to built-up hatred.
- Hateful language is being normalised.
- Having nothing to lose! When an individual has been labelled, they can feel as if they have nothing to lose. E.g. being on a prevent list? Nothing left to lose once authorities are aware.
- If motivated by an ideology, individuals may feel that they have everything to gain by acting on it.
- Children spending a lot of time with technology/internet – grooming? Youtube related videos.

**One point to feed back to the Commission**

- Language used in the media. Positive role models and positive influences are much needed

**Workshop 2**

**How do we challenge hateful extremism and radicalisation?**

What do we think leads people to feel hatred and prejudice of other people? Personal? Wider society?

- A lack of understanding of other people's cultures.
- Reluctance to talk to others about their cultures or traditions.
- Racist attitudes. (Diversity Matters do a lot work on awareness raising) Need to bring communities together just to allow for people to talk to one another.

What should we do as individuals?

- Unison do work address these issues.
- Prevent children learning language of racism in schools.
- Social media messages have an impact. The way information is generated promotes certain ideas. E.g. when it's inciting hatred it's difficult to have it removed. No control at the moment although it is against the law. Maybe bring in fines if it can't be removed? Stronger regulation of social media. Hateful messages currently seen as normal.
- The prevent agenda contributes to a lot of issues. The prevent agenda needs to be addressed because it promotes backlash – e.g. on social media.
- Problem with prevent is that it uses a criminal justice perspective to deal with the issues – friends, family, co-workers have to be criminal justice professionals. Should be about creating steps to get to know people individually. Instead they've actioned people to go out in a framework of fear. Prevent is about profiling not safeguarding.
- Ageing community – influence of social media, tabloid journalism. It's not as simple as someone saying they hate someone. Lots of ideas are fear driven among older people.
- Not only prevent agenda but how it's delivered in neighbourhoods. Segregation of religion/cultures.
- Ideas behind prevent need to come from the bottom upwards. Need awareness at the top.
- Prevent agenda causing more community disruption than good. This needs to be looked at.

What is it that leads people to having those views?

- Negative role models
- The Media
- Access to online material
- Lack of belonging and a negative social environment
- Isolation, poverty, deprivation, mental health; (although mental health can be a trigger?)

**One point to feed back to the Commission:**

- Take away the prevent agenda and focus on the community aspect instead. E.g. using our own safeguarding procedures. Empowering people to better themselves to challenge behaviour that is wrong.

**Workshop 3**

What makes people feel like they belong?

- Ability to access services without fear of exclusion, participate in society in a normal way. Feeling that doors are open to you e.g. libraries, shops.
- Buying into the mainstream narrative of society and seeing that as legitimate. E.g. shared values, consumption and trust of information in press.
- Sense of place, e.g. bees, poems, art after the bombing.
- Anti-climax of the sense of community after the big event. How do you then go back and do something about community cohesion?

What makes people feel isolated or excluded?

- Not fitting in, language difference, not feeling part of the rest of the community; cultural differences segregate communities.
- Minority groups are not what is considered 'normal' in the mainstream.
- Social and economic exclusion– this happens to all ages, children, young people, older people.
- Social media paints a picture that isn't necessarily true e.g. happiness. Need more transparency.
- Political debate is toxic which feeds social exclusion. Need to look at how people express their views? There is a step to it becoming truly hateful.
- Influence of social media on people's views: people sharing views on social media that they wouldn't discuss in real life – the online self is different from real life.
- If people already feel isolated in real life, social media can allow people to access hateful views or vice versa they are preyed upon if vulnerable and groomed into certain ideology. Showing you are angry/vulnerable is a target for groomers.
- Focus on the internet is prevention – parental controls whereas if you explore the internet with children – the bad as well as the good – and foster an open debate about the bad content on the internet and that prevents secret viewing/consumption of information. How you interact with others on social media is limiting so not as easy to challenge hateful views.
- Poor societal integration e.g. in Ashton. Difficult to get people more integrated, promote social cohesion. Can't breach anybody's views for the sake of social cohesion!
- Some segregation is actually visible – bridge in Blackburn with white/Asian communities on either side of it.

What leads people with these views to act on them?

- Isolation – made to feel important if they were to commit hateful acts – martyrdom.
- Coverage of extremist acts
- Public figures turning a blind eye? They need to address issues that people have by talking about them publically and opening up a debate where everyone feels they have a voice. E.g. Councillors not addressing segregation of communities. But how do we incorporate the views of all groups? Change of the language we use.
- Wider world political determinants – anger at western wars in the Middle East.

**One point to feed back to the Commission:**

- The media plays a significant role, both positive and negative, in relation to extremism

**Appendix 4.**

## Patient Choice

The Personalised Care Group is working with partners across health and social care to enable patients to personalise their care in order to better meet their needs and preferences and enhance their choice and control. The group plays a key role in taking forward the vision of the Five Year Forward View in empowering patients to have far greater control over their own care.

Patient surveys have shown that levels of patient awareness of choice have been around 50% for a number of years, the Choice team are actively seeking to improve this.

A quick overview of Patient Choice was provided via a central presentation before the round table discussions commenced, the presentation outlined what patient choice is, the benefits, where information can be found (to help choose) and what has been done to raise awareness.

The aim of the round table discussions was to better understand what patients would wish to know (key messages) and how to best publicise/ raise awareness.

The majority of those in attendance were unaware of the NHS Choice Framework, yet many had been referred – examples were plentiful of no choice having being offered.

Overarching feedback from those partaking was that yes they do want to have an awareness of patient choice but that the main emphasis in raising awareness must reside with primary care. Incentives need to be considered (for the change to occur) else patient choice should be mandated. Voluntary and Community groups in attendance were keen for available literature (especially the Easy Reads) to be made available to them, having them in different languages would be beneficial too.

Workshop 1

- Awareness raising needs to reside within GP practices need to 'fix' the system (as opposed to a patient awareness raising campaign). i.e. 'If your GP refers you' leaflets should be handed out by GPs when a referral is required and patients should be given time to absorb the information/ research (as opposed to leaving with a hospital location, date/time). Easy Read leaflets should also be considered where appropriate.
- Leaflets are great but they need to be used appropriately else it can be too much information – who would read?
- There needs to be an incentive to 'push' a behavioural change.
- Consider approaching CQC as regulators (to check whether patient choice is promoted).

Workshop 2

- Available transport and cost of travel will, for some, impact on patient choice (i.e. patient choice will only work well for certain groups).
- GPs are a barrier to patient choice – examples were given. It was agreed that some are better than others.

- GPs, especially surgeries that are 'business' focussed, need to understand how patient choice can help the practice/ how it can reduce their workloads.
- Consider attending GP networks to get GPs to talk about patient choice as well as Practice Manager Meetings (would afford an opportunity to understand barriers and how to overcome).
- Promote the 'If your GP refers you' leaflets and Easy Read leaflets to VCSE organisations (Local Authorities have a database of contacts). Also Tameside Library website has a list of local community groups – it was suggested the BME Communities would be happy to assist in raising awareness.
- Promote the leaflets on Armed Forces websites (for veterans who use NHS Services).
- Consider social media (local press/ radio).
- Consider adding patient choice questions to the 'Friends and Family Test'.

Workshop 3

- Many examples of patient choice were discussed as well as issues around lack of local provision (i.e. have choice but not necessarily the means to travel).
- The GP/ Patient relationship needs to be 're-framed' away from "Dr knows best".
- For 'active signposting', Care Navigators have been trained within Tameside and Glossop (accredited West Wakefield course).
- Need to consider 'social inclusion' – who is/ who is not aware.
- How is patient choice, (or lack of) fed back?
- For awareness raising; need to focus on commissioners and have conversations with primary care.

Overall a very beneficial day, clearly there is still much to learn regarding the barriers to patient choice and how they should be addressed. All the points raised will be actioned as appropriate; in the meantime I welcome any further ideas or suggestions:

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**Appendix 5.**

## One Equality Scheme

One Equality Scheme 2018-22 is the first joint Equality Scheme of Tameside & Glossop Strategic Commission (Tameside Council and NHS Tameside and Glossop Clinical Commissioning Group). The creation of the Strategic Commission has allowed us the opportunity to jointly set out our approach to equality and diversity for residents, patients and service users across Tameside and Glossop for the first time.

The draft Scheme sets out our approach to equality and diversity guided by a joint set of equality objectives. We want to ensure that our objectives are the right ones for Tameside & Glossop.

The objective of the workshop was to obtain feedback from participants on the fourteen objectives and five themes of the draft Equality Scheme. The feedback from participants is listed in bullet-points under each objective or theme.

**Workshop 1**

Groups Represented: T&G ICFT, Anthony Seddon, Diversity Matters North West (formerly Hyde Community Action), Seven Day Access, Population Health, Sling Library, Healthwatch, PPG

- 14 objectives across five themes

**Theme: Reduce Inequalities & Improve Outcomes (Objectives 1-3)**

*Objective 1:*

*Address key priority quality of life issues such as health inequalities, educational attainment, access to skills, training and employment opportunities, and health and wellbeing, across equality groups and the vulnerable and disadvantaged, with a view to narrowing the gap*

- The fact that you might have a mental health issue can stop people from being able to make an informed choice
- Advocacy in Tameside could be improved, only feasible if someone has been sectioned
- People with post-natal depression and anxiety are struggling to keep their heads above water
- Engaging with the really hard to reach people in the community is becoming more difficult, as mainstream services are pulled then it is more difficult to reach people with language barriers, no formal interpreters so informal interpreters have to do this

*Objective 2:*

*Help people to continue to live independent lives, and support the most vulnerable in our communities to access services that exist to support this aim, through targeted interventions and tailored service provision*

- The people that the mental health professionals are dealing with are difficult to reach, but we do not have the capacity to knock on every door - but partnership working between Council, NHS, third sector needs to be better to help the most people

- We need to be sharing information, resources better between the public sector services
- When people approach the DWP with mental health issues, but cannot provide a sick note, they may not necessarily get the financial help they need and might end up on the street, but better joined up working could avoid this
- Vulnerable people getting more at risk as austerity bites, i.e. universal credit, access to NHS to get right medication, but joining up services can help combat this
- There are logistical issues between geographical boundaries of organisations
- Public transport not good enough to connect people to the services that they need
- Choice at the moment for NHS patients is a word, an ideal, not a practicality yet

*Objective 3:*

*Aim to increase the level to which people believe that Tameside and Glossop is a place where people get on well together, amongst the population as a whole and by protected characteristic group. A key focus of this aim is to raise awareness and support the prevention of hate crime across the locality.*

- Agreed is a good objective
- A current foster carer notes that vulnerable ethnic minority children that have come through the foster system have not been supported enough by the Council whilst children; the onus is too much on care leavers
- A care leaver notes that there is not enough support for care leavers either, that there is PR focus on a few individuals, but not enough wide-scale support across the many hundreds of care leavers

**Theme: Meeting our obligations under the Equality Act 2010 (Objectives 4-6)**

*Objective 4:*

*Publish our equality objectives and ensure that they are published in a manner that is accessible*

*and*

*Objective 5:*

*Publish our workforce monitoring information by equality group (where known)*

- The main place the One Equality scheme will be published is TMBC website and NHS T&G CCG website, although it is conceded this is not accessible to everyone
- In the Asian communities, there is not enough information given out to let people know about which boxes to tick in the demographic aspects of the survey, i.e. if somebody is British but of Pakistani origin.
- Clearer information on the surveys themselves, about how to fill out the ethnicity questions and the disability questions
- People who are diabetic may not tick the disabled box, but they could be considered disabled, but then again some people who are diabetic may choose not to
- Perhaps a better explanation of demographic forms could help more people participate

- Other ways of collecting data rather than Census being collected by individual on the doorstep
- Issues between the overlap of outsourcing for health and other services between Tameside and Glossop
- Overlap of Derbyshire and Tameside/SCF's equality scheme?
- Put the One Equality scheme or objectives on posters in children's centres, GPs, libraries, in the free press
- It feels as if some of the objectives are process based/complying with legal obligations, rather than being aspirational, inspiring
- Legally we have to have a set of objective
- Remind colleagues of their legal objectives regarding equality
- Have legal requirements at the top but not as part of the objectives themselves

*Objective 6:*

*Undertake to produce and publish Equality Impact Assessments (EIAs) to support service delivery and commissioning decisions to be published with papers. These will help us to understand the impact of our policies and practices on persons sharing a relevant protected characteristic*

- If we fulfil legal obligations we may be ahead of some organisations,
- We need to follow the same best practice standards as public sector organisations, a shared best practice where we learn from one another
- Something like Healthwatch allows you to go outside of the regular system of the public sector, need independent aspects to public services

**Theme: Equality Training, Development and Awareness (Objectives 7-8)**

*Objective 7:*

*Ensure that employees are appropriately trained on equality legislation and their responsibilities under it - this includes Equality Act 2010, Equality Delivery System 2 (EDS2), Accessible Information Standard, Workforce Race Equality Scheme, Workforce Disability Equality Scheme and the requirements of the EDHR contract schedule. Staff are offered support and guidance through a range of methods and approaches such as briefing notes, training sessions and workshops*

*and*

*Objective 8:*

*Raise awareness and understanding of equality and diversity by working with partners (such as voluntary organisations, community groups and service providers) to ensure that those from protected characteristic groups are represented and supported*

- If services are working towards this they should take into account whether some services need interpreters
- Qualifications in TMBC are not recognised, not official, whereas the qualifications that NHS employees work towards and attain are recognised and official
- We rely on volunteers and the third sector more than ever due to cuts, but is there adequate training for volunteer staff?

**Workshop 2**

Groups Represented: NHS T&G CCG, Tameside Youth Service, Organisation Development from Care Together, Derbyshire CC Public Health, People First Tameside, Housing TMBC

**Theme: Consultation and Engagement (Objectives 9 to 11)**

*Objective 9: Consult and engage with our communities through a broad range of methods and forums, such as surveys, consultation events and customer feedback to ensure comprehensive and meaningful coverage*

*Objective 10: Disaggregate the results of monitoring, surveys, feedback and consultation exercises by equality group (where appropriate and practical) to inform our understanding of the needs of different groups and individuals*

*Objective 11: Develop specifically tailored consultation and engagement activity where appropriate and when required for certain equality groups and disadvantaged / vulnerable people across Tameside and Glossop*

- Communities refers to people of all 9 protected characteristics
- Targeting specific and harder to reach groups so it's not always the same old people turning up to events or filling in surveys
- A range of approaches, going to shopping centres, interviews etc.
- Working with groups that are already in the community to reach harder to reach people
- Consultation and engagement can be perceived by communities as a tick-box exercise
- Communities perceive the council or NHS T&G CCG as making their decisions regardless of what people say, so what's the point of consultation?
- Engagement and consultation are very different things
- To work well with the community and voluntary sector, consultation and engagement needs to be done with their help so it is structured in the right way to reach the groups
- One barrier against consultation and engagement can be money, however money can be used more efficiently and effectively if consultation and engagement is channelled through voluntary and third sector groups that are in the community
- Need to think outside the box in terms of how we consult and engage
- E.g. 1 day a month all council officers could do something outside their office and their work-role, i.e. volunteering, this would help build relationships with the voluntary and third sector organisations. The benefits outweigh the cost
- Third sector or voluntary sector regularly have one or two day placements from students, where it can be perceived as the students doing this and taking away from the experience, but not there long enough to benefit the organisations in terms of time it takes to train them etc.
- Whereas if people with expertise volunteer with voluntary or third sector they can help the organisation, so this could perhaps be done with a database of skills that people are volunteering, i.e. web developers, coders, excel etc.
- In Derbyshire communities are consulted with a lot, but not enough feedback to people about how the information is used and why it is done
- Hard to reach people can be reached
- It's about organisations making the extra effort for hard to reach groups
- Most people don't feedback to the people who are consulted with
- Add to objective 9 about actually feedback to people
- Person centred approach to consultation, tailor the method of consultation to the people you are trying to consult with
- Perhaps not enough faith in the elected representatives

- ‘Consult and engage truthfully’
- Do the public know the extent of the cuts, are they fully informed, are issues explained enough to them prior to consultation so as to boost participation
- User led meetings
- On, for example, a commercial housing development, could there be links between the public, the council, and the housing developers
- It is always pertinent to involve the people being consulted with the process of designing the consultation

**Workshop 3**

Groups represented: T&G ICFT/Macmillan, Tameside Arts, Self-Care T&G ICFT

**Theme: Information, Intelligence and Need: Understanding Service Use and Access (Objectives 12 to 14)**

*Objective 12: Use a range of intelligence gathering, customer monitoring and insight tools, together with specific pieces of analysis, to inform both our understanding of residents, service users, service delivery and design, and to develop services that provide a varied, flexible and accessible offer*

*Objective 13: To encourage and promote the use of customer monitoring and disaggregation of data by equality group (where practical)*

*Objective 14: Use a variety of tailored communication methods to increase the accessibility and understanding of council and CCG services, that allows our different customers, residents and service users to make informed choices*

- Need to make sure it’s a deeper understanding of the communities arising from service users
- Lots of public sector organisations collecting data, but combining data from different organisations, i.e. ICFT and fire, creates a richer portrait of areas
- If we can share data to improve health or outcomes it makes sense
- ICFT and GMFRS interconnecting fire incident data with health and social care aspects of users, a number of areas in Tameside have been identified and targeted as part of this process
- Crime, drugs and alcohol, empty buildings, social isolation, cigarette smoking, all of these aspects are closely linked to fire for example
- Reinforcing messages could be done through a shared platform, i.e. if a person is getting 10 different messages from 10 different organisations, it can be difficult to process, but if this is all delivered through a single platform with a combined message, this can be easier to process
- Tameside Insight might fit in with the work that ICFT are doing with GMFRS
- Being too focused on targets may result in losing quality
- We have the data, but we need to make sure we use this data in a positive way
- It’s about making data meaningful
- Although you may know the demographics of a person via their responses to an equalities form, perhaps it would be useful if there was an option for the person to provide information they think organisations need to be aware of in order to talk to work with them properly
- To make people aware of why the data is being collected
- Sometimes if things haven’t been clarified there can be confusion if one organisation has referred somebody to another organisation
- Demographic forms may be filled out by an advocate or a carer if the person is unable to complete the form

- With self-reporting you have to rely on the information provided
- Engagement depends on the individual, some people may not have a laptop, just a smartphone
- People tend to do things that are quick and easy in terms of consultation and engagement, so this will boost participation
- People who have learning difficulties could be engaged with on a bi-annual basis with a multi-skilled team present, i.e. social worker, interpreter if necessary, and easy read system etc.
- Housing association are getting more easy read documents
- Public sector isn't good in general with communicating to the public, whether its interpreters, easy read, jargon etc.
- Complexities within the language where different words in the equality scheme mean different things to different people, need to use plain language

**Appendix 6.**

## COMPACT

Historically, the public sector has had a written agreement with the VCFSE sector on how we do business together. This agreement or "COMPACT" is being reviewed, but this time we'd like to do something different and more meaningful for both sectors.

Three Commitment Pledges have been developed (these terms may change based on feedback) covering:

1. Hear local voices more directly and more often

2. A partnership built on trust

3. Investment that matches the vision

Participants were asked the following two questions;

**Q1. How can the public and voluntary sector work better together?**

- Feedback should be provided from providers and the voluntary association
- The size of a partnership matters as a small group may not be taken seriously
- Certain groups may not want to engage with the "little people"
- Coaching could be provided for both the voluntary and public sector to ensure that any conversations are directed appropriately
- The way in which the voluntary and public sector work together needs to become more modernised
- The term "joint partnership" can allow for a more positive way of working, rather than one sector feeling that the other is placed on a "pedestal".
- SMART objectives could be used when overseeing each commitment
- The COMPACT agreement should be overseen on a practical level
- How will we know that we have captured the voices of the people?
- There is no mention of the private sector. There should be a balance between private and community groups.
- How will the outcomes of the COMPACT agreement be measured and how will this be communicated?
- The commitment statement's for some groups could be quite complex, maybe a more refined overview is required.
- Feedback should be provided to communities to show what actions have been made as part of the COMPACT agreement
- There is a need to hear people's voices more directly
- How do we ensure that we are not excluding certain individuals and communities
- People felt in general that both commitment 1 and commitment 2 tie in together as trust between an individual and organisation will need to be built before a person is able to share their opinion and have their voice heard

**Q2. How could a different way of working help to improve life and wellbeing in Tameside?**

- Financial support would allow for better resources to be put in place
- A range of different skills and knowledge should be acknowledged from other areas
- The view of each individual and should be embraced
- Diversity and equality should be considered
- Feedback forms should be better produced
- Planned, realistic timescales should be set
- Members of the public should be consulted initially before any decisions are made

- There are currently barriers between organisations and GP's which would need to be overcome
- Social isolation and an ageing population mean that people are not always aware of what services are available
- More volunteers are needed
- How do people feedback regarding the commitment?
- Knowing "clients" well
- Get VCFSE feedback - reach to communities
- Democracy?
- Confidence building
- How do you know if the commitment pledges are working? How do you feel?
- People will have specialist knowledge which is key but we have to remember, this can take different forms i.e. - employing people, working with small community groups etc.
- Work with providers in the private sector so we can maximise opportunities around social value
- Have a clear policy on how to work with outside agencies (trainee, insurance)
- A clear route is required when working together for the benefit of the person
- Engage with the real community through successful groups already in place – then appoint community champions to represent their community
- Somehow make a database of voluntary organisations which is more accessible to GP's and their staff
- A specialist team of people could be linked together within NHS – maybe a database of "trusted" organisations that HCP's can refer on to?
- Commitment 1 – input community voices that have the greatest need based on known health inequalities
- Questions or agenda's which allow clients the opportunity to feedback
- A member of staff could attend local community groups to explain the COMPACT initiative
- Make the cause and reasons simple to understand
- The public sector should be utilised to find and create groups
- The commitment pledges should fit in with the PEN Strategy - Strategic, Thematic, Neighbourhood
- Build partnerships and trust through communication – knowing which partners are building partnerships and developing and improving communication
- The sharing of video's and work would be beneficial
- Size of enterprise impacts on partnership working – too restrained
- Communicating intelligence
- Publish in the Advertiser
- Real Partnership - jointly running services
- Include diverse voices and those who are isolated
- A review process should be put in place
- Workforce focus – employing from communities
- Spaces for partners to meet to share specialisms

**Summary**

All three workshop groups agreed that the three commitment pledges can be used as a valuable tool, which will allow Tameside VCFSE and Public Sector Partners to work more closely together in the future.

**Appendix 7.**

**Public Behaviour Change – Self Care Alliance**

The Self Care Alliance is part of the wider Self Care Programme across Tameside and Glossop.

The aim of the Alliance is to support individuals, families and communities to

• **Choose Well** – People transacting appropriately with health services

• **Manage Well** – People with ongoing care and support needs managing conditions better

• **Live Well** – People living healthier lives and therefore less pressure on the 'system'

Through promoting and cascading the key themes and messages of self-care amongst the communities of Tameside and Glossop, supporting its members and the wider network in developing the skills and awareness of how to promote and encourage behaviour change amongst those they support and developing a marketing campaign to enable the wider promotion of self-care.

Participants were asked to give examples of a time when they had successfully self-cared or a time that they had successfully supported another to self-care.

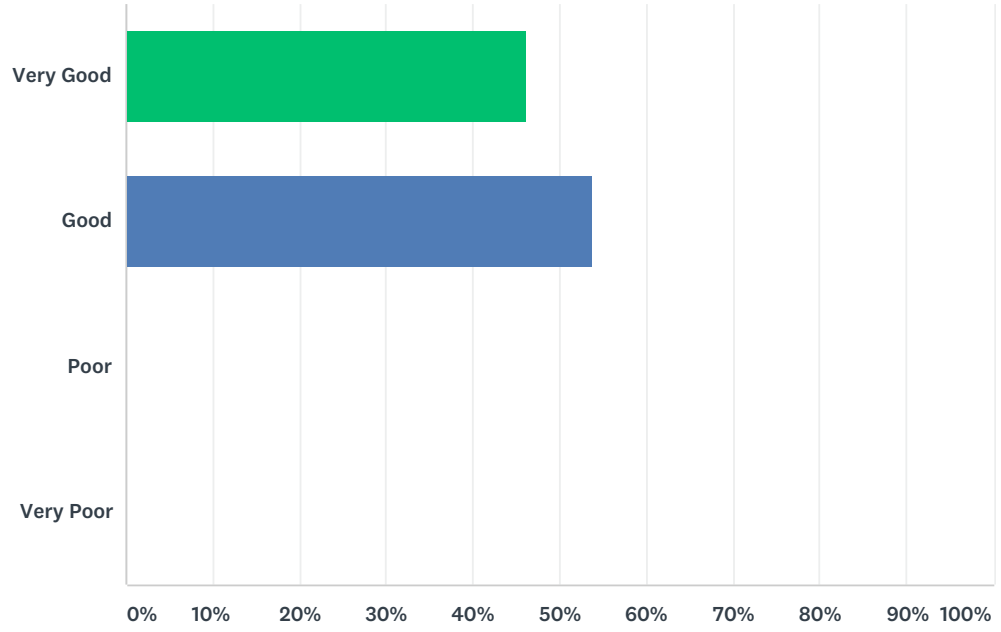
This lead to some examples and general points about self-care.

- Dealing with the death of my wife – rebuilding my life through support from my family and taking up interests in travel and photography. Brought up to look after self-first.
- I bring my children up to take responsibility for themselves and to understand self -care.
- I supported a guy from the armed forces who was at risk of becoming homeless, losing benefits etc. With some help at the beginning he has managed to get himself to a better place and become more self-sufficient when dealing with benefits, housing, GP appointments etc.
- It's a state of mind to recognise that you must take responsibility.
- When supporting others perseverance is the key to success. It is difficult when people have been 'done to' all the time. Some people are resigned to stay where they are
- Try to catch people earlier – preventative.
- Generational differences – some people access YouTube, social media etc.
- Access! We must remember that self-care is not an easy route to access for some. Deprivation, education, work commitments, family commitments etc. all have an impact or can block how people are able to self-care.
- Systemic problems – schools, workplaces, etc. – we need to ensure that they encourage self-care.
- There is a myth that certain communities look after their own (i.e. BME communities are often perceived to look after their families and this is not always the case – people are not always able to).
- Isolation is the biggest issue.
- We have to stop doing for everyone but understand the barriers.

- Private sector – How do we involve the private sector? We need to start with the work place. Its where a lot of us spend most of our time. We need to encourage work places and to give them evidence that it is beneficial to give people time to self-care. For example – service set up in local supermarket doing health checks. When they asked if staff could have health checks they were told that staff could not do this in staff time.
- How do we use businesses? What can they offer? For example, Pets at Home in Stockport taking animals out to older people's groups.
- More positive local role models who have made changes or manage a condition well. We need to use local people as examples.
- Education – and mainstream media - Dr in the House.
- Stop using the word volunteers! We are all just people or community.

# Q1 How would you rate the Partnership Engagement Network Conference overall? (Please tick one box only)

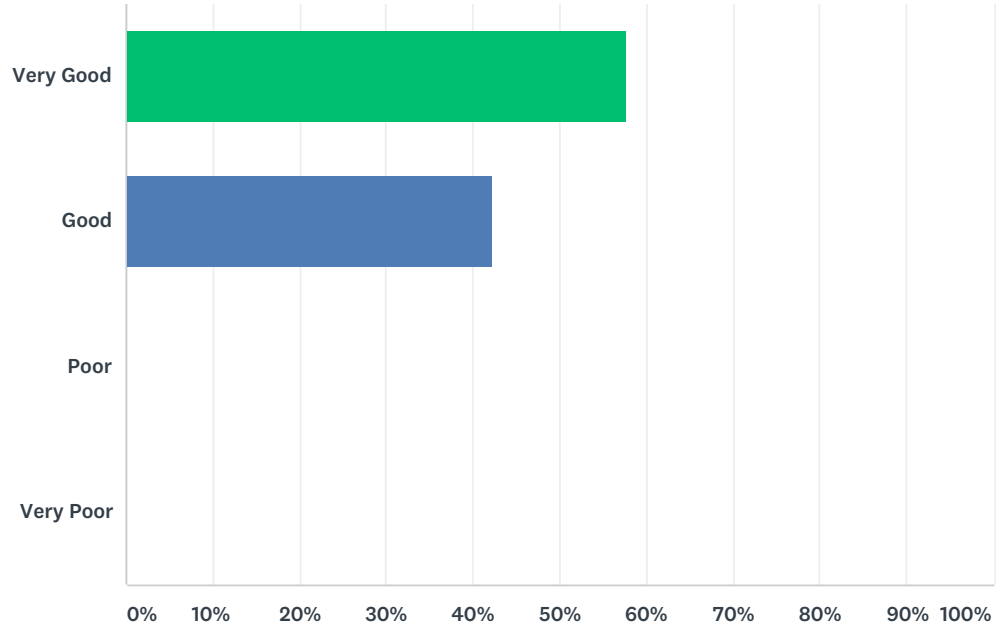
Answered: 26 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Very Good | 46.15% | 12 |
| Good | 53.85% | 14 |
| Poor | 0.00% | 0 |
| Very Poor | 0.00% | 0 |
| TOTAL | | 26 |

# Q2 How would you rate the organisation of the event? (Please tick one box only)

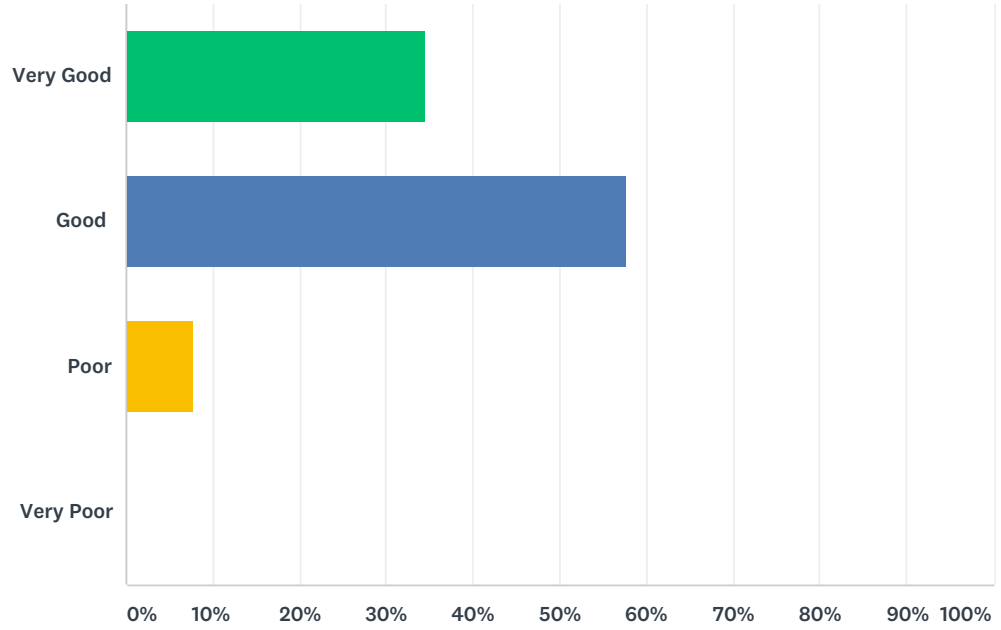
Answered: 26 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Very Good | 57.69% | 15 |
| Good | 42.31% | 11 |
| Poor | 0.00% | 0 |
| Very Poor | 0.00% | 0 |
| TOTAL | | 26 |

# Q3 How would you rate the presentations overall? (Please tick one box only)

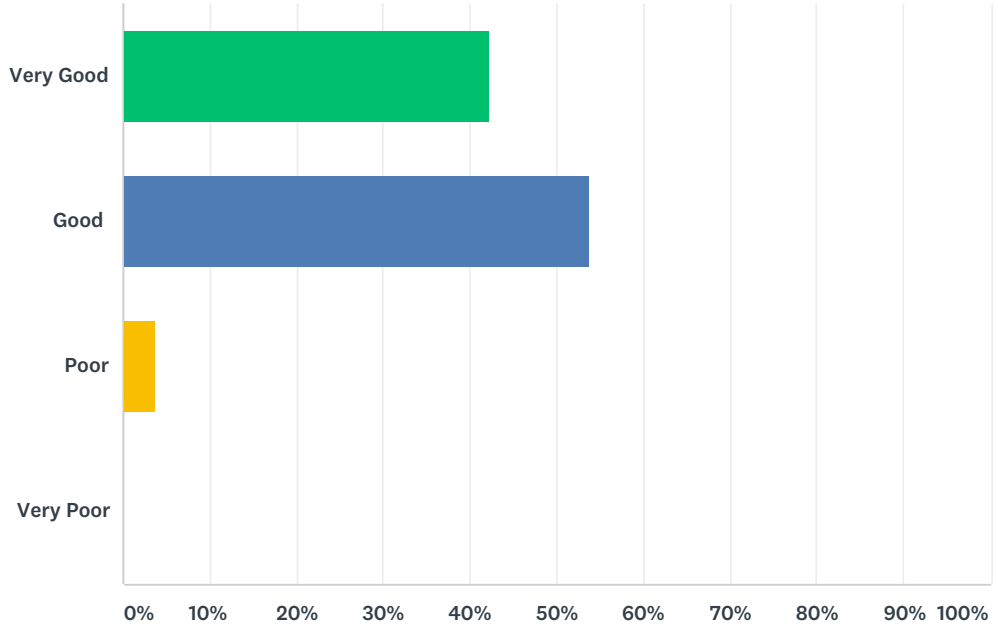
Answered: 26 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Very Good | 34.62% | 9 |
| Good | 57.69% | 15 |
| Poor | 7.69% | 2 |
| Very Poor | 0.00% | 0 |
| TOTAL | | 26 |

# Q5 How would you rate the workshops overall?

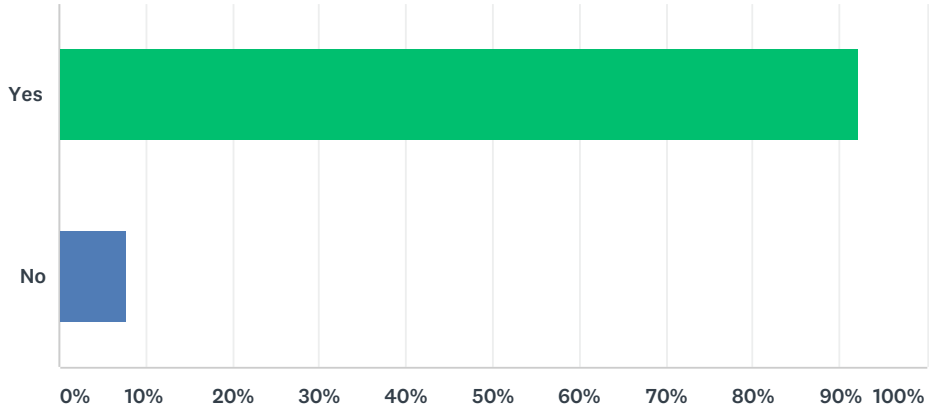
Answered: 26 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Very Good | 42.31% | 11 |
| Good | 53.85% | 14 |
| Poor | 3.85% | 1 |
| Very Poor | 0.00% | 0 |
| TOTAL | | 26 |

# Q7 Do you feel you were given enough opportunity to express your opinions? (Please tick one box only)

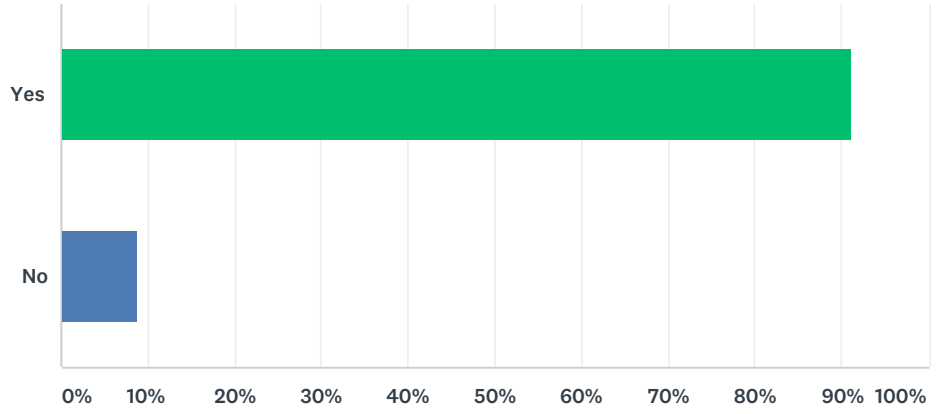
Answered: 26 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 92.31% | 24 |
| No | 7.69% | 2 |
| TOTAL | | 26 |

# Q11 Would you like to be kept informed of the latest events and consultation activity in Tameside and Glossop?

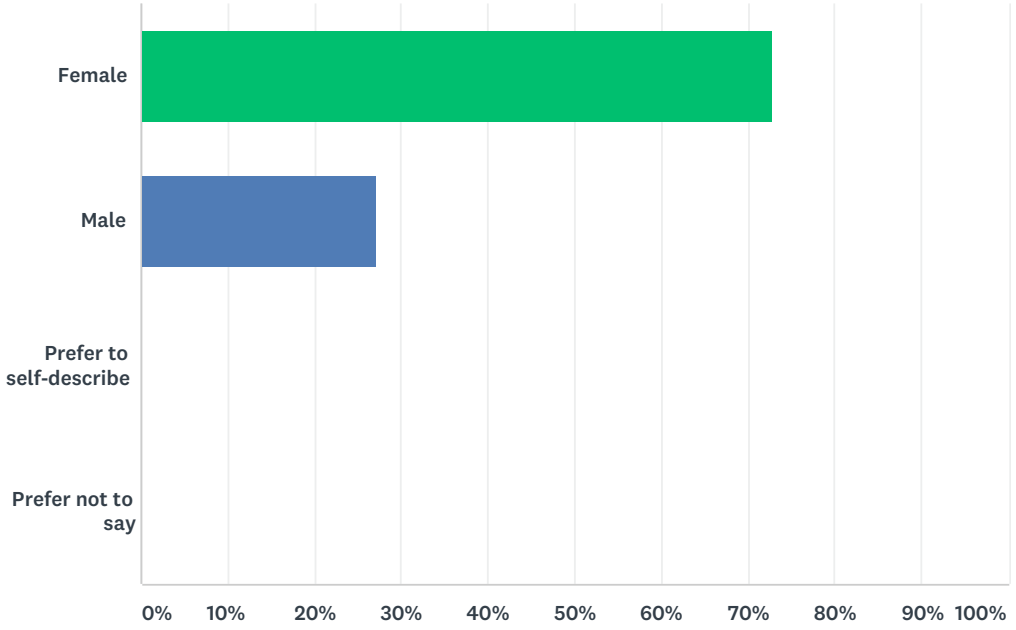
Answered: 23 Skipped: 3




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 91.30% | 21 |
| No | 8.70% | 2 |
| TOTAL | | 23 |

# Q12 What best describes your gender? (Please tick one box only)

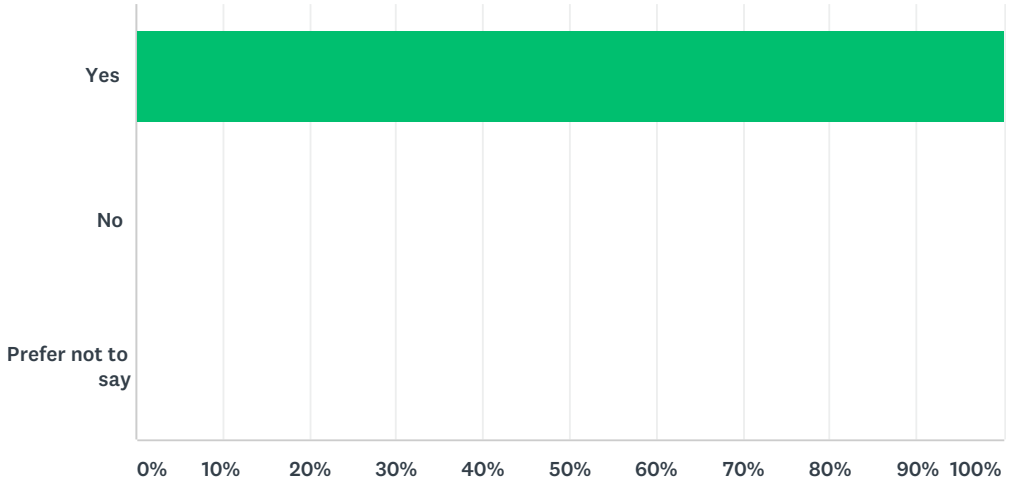
Answered: 22 Skipped: 4




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Female | 72.73% | 16 |
| Male | 27.27% | 6 |
| Prefer to self-describe | 0.00% | 0 |
| Prefer not to say | 0.00% | 0 |
| TOTAL | | 22 |

# Q13 Is your gender identity the same as the sex you were assigned at birth?

Answered: 23 Skipped: 3




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 100.00% | 23 |
| No | 0.00% | 0 |
| Prefer not to say | 0.00% | 0 |
| TOTAL | | 23 |

# Q14 What is your age? (Please state)

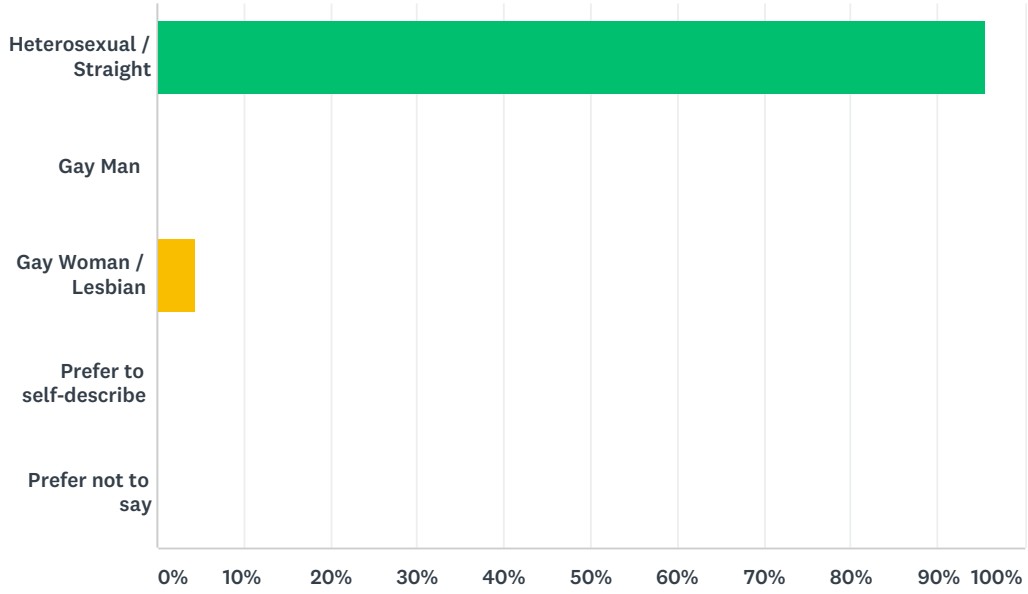
Answered: 21 Skipped: 5

# Q15 What is your postcode? (Please state)

Answered: 21 Skipped: 5

# Q16 What is your sexual orientation? (Please tick one box only)

Answered: 23 Skipped: 3




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Heterosexual / Straight | 95.65% | 22 |
| Gay Man | 0.00% | 0 |
| Gay Woman / Lesbian | 4.35% | 1 |
| Prefer to self-describe | 0.00% | 0 |
| Prefer not to say | 0.00% | 0 |
| TOTAL | | 23 |

# Q17 Which ethnic group do you consider yourself to belong to? (Please tick one box only)

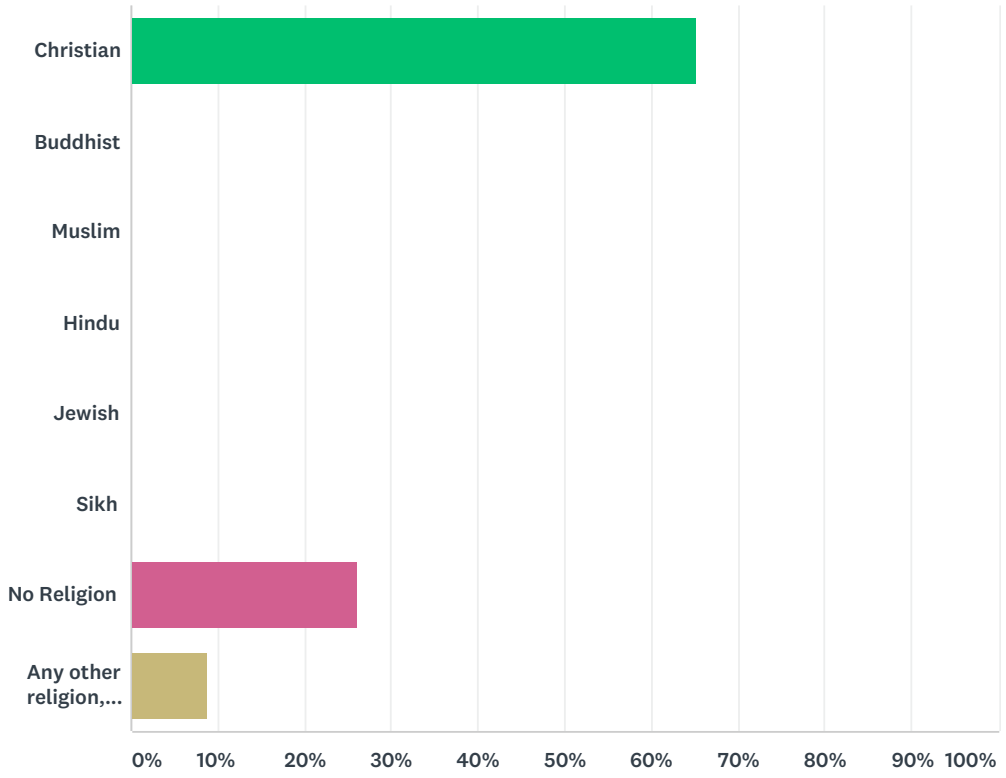
Answered: 23 Skipped: 3


| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| White – English / Welsh / Scottish / Northern Irish / British | 100.00% | 23 |

| | | |
|---|---|---|
| White - Irish | 0.00% | 0 |
| White - Gypsy or Irish Traveller | 0.00% | 0 |
| Other White background (please specify in the box below) | 0.00% | 0 |
| White & Black Caribbean | 0.00% | 0 |
| White & Black African | 0.00% | 0 |
| White & Asian | 0.00% | 0 |
| Other Mixed / Multiple ethnic background (please specify in the box below) | 0.00% | 0 |
| Asian / Asian British - Indian | 0.00% | 0 |
| Asian / Asian British - Pakistani | 0.00% | 0 |
| Asian / Asian British - Bangladeshi | 0.00% | 0 |
| Asian / Asian British - Chinese | 0.00% | 0 |
| Other Asian background (please specify in the box below) | 0.00% | 0 |
| Black / Black British - African | 0.00% | 0 |
| Black / Black British - Caribbean | 0.00% | 0 |
| Other Black / African / Caribbean background (please specify in the box below) | 0.00% | 0 |
| Arab | 0.00% | 0 |
| Any other ethnic group (please specify in the box below) | 0.00% | 0 |
| TOTAL | | 23 |

# Q18 What is your religion? (Please tick one box only)

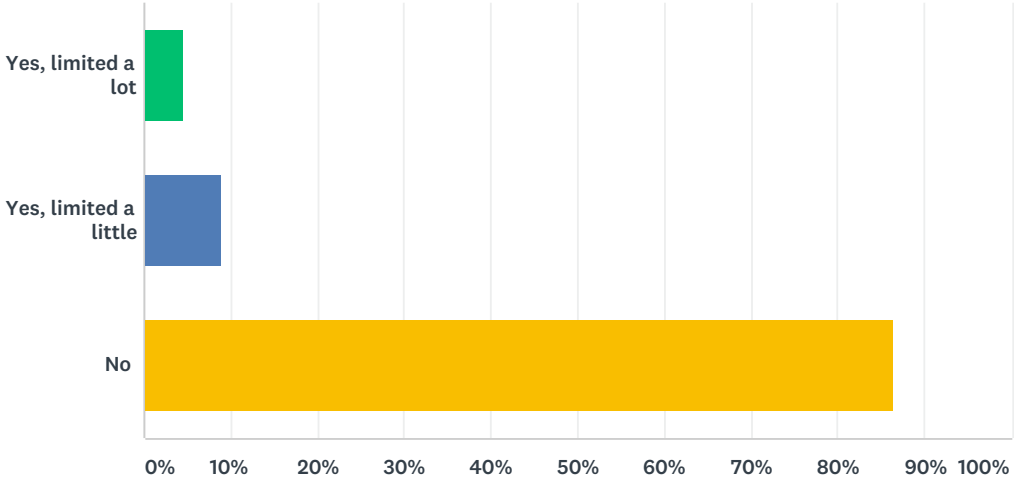
Answered: 23 Skipped: 3




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Christian | 65.22% | 15 |
| Buddhist | 0.00% | 0 |
| Muslim | 0.00% | 0 |
| Hindu | 0.00% | 0 |
| Jewish | 0.00% | 0 |
| Sikh | 0.00% | 0 |
| No Religion | 26.09% | 6 |
| Any other religion, please state | 8.70% | 2 |
| TOTAL | | 23 |

# Q19 Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? Include problems related to old age. (Please tick one box only)

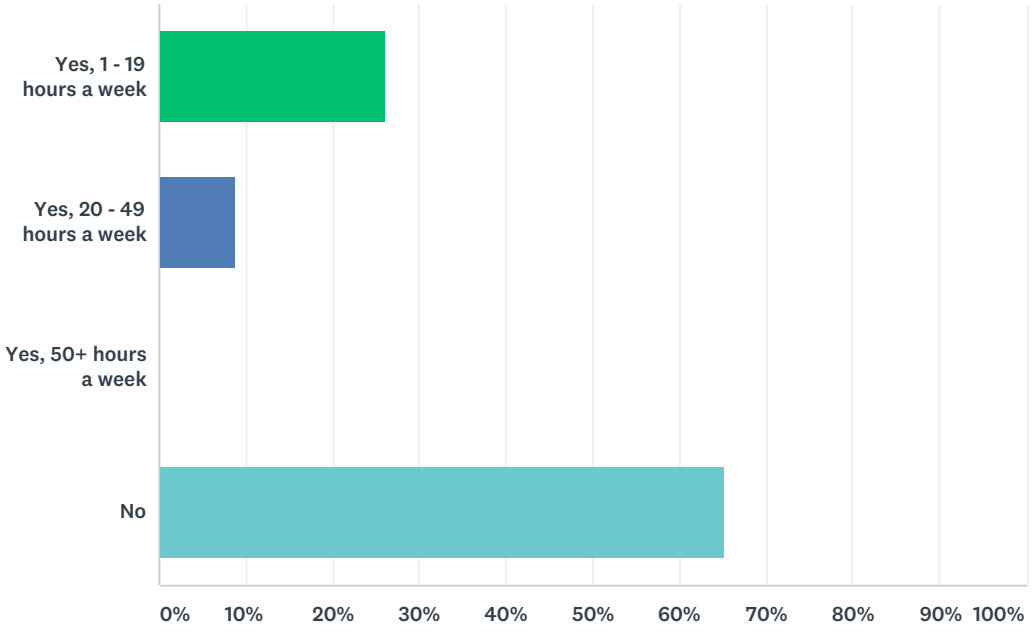
Answered: 22 Skipped: 4




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes, limited a lot | 4.55% | 1 |
| Yes, limited a little | 9.09% | 2 |
| No | 86.36% | 19 |
| TOTAL | | 22 |

# Q20 Do you look after, or give any help or support to family members, friends, neighbours or others because of either, long term physical or mental ill-health / disability, or problems due to old age? (Please tick one box only)

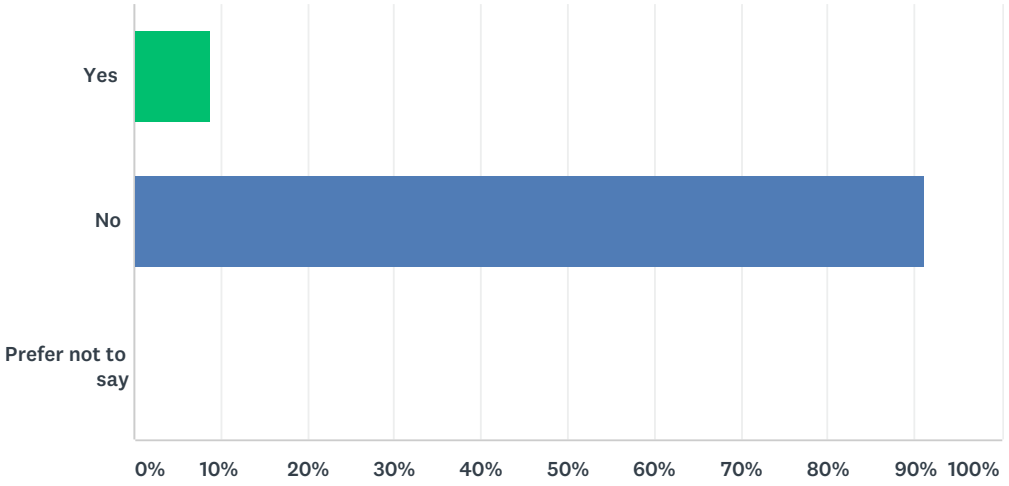
Answered: 23 Skipped: 3




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes, 1 - 19 hours a week | 26.09% | 6 |
| Yes, 20 - 49 hours a week | 8.70% | 2 |
| Yes, 50+ hours a week | 0.00% | 0 |
| No | 65.22% | 15 |
| TOTAL | | 23 |

# Q21 Are you a member or ex-member of the armed forces? (Please tick one box only)

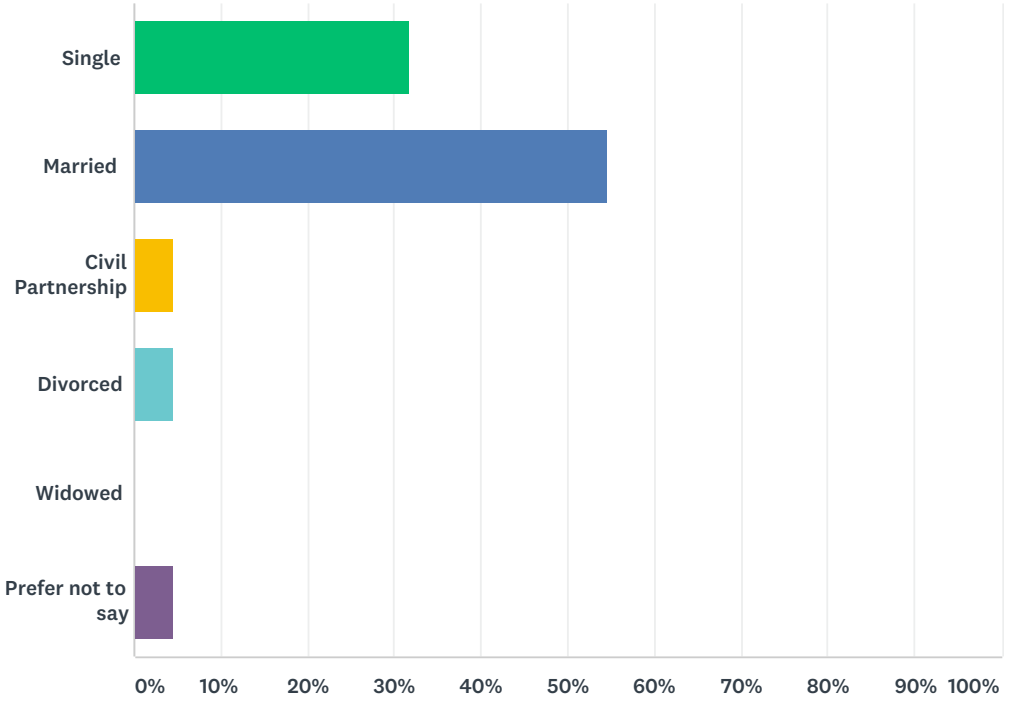
Answered: 23 Skipped: 3




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 8.70% | 2 |
| No | 91.30% | 21 |
| Prefer not to say | 0.00% | 0 |
| TOTAL | | 23 |

# Q22 What is your marital status? (Please tick one box only)

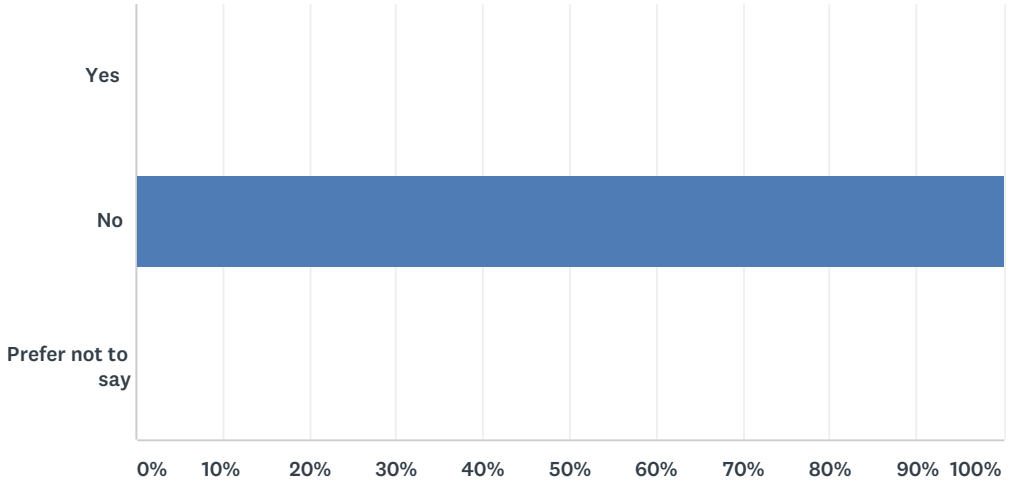
Answered: 22 Skipped: 4




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Single | 31.82% | 7 |
| Married | 54.55% | 12 |
| Civil Partnership | 4.55% | 1 |
| Divorced | 4.55% | 1 |
| Widowed | 0.00% | 0 |
| Prefer not to say | 4.55% | 1 |
| TOTAL | | 22 |

# Q23 Are you pregnant, on maternity leave or returning from maternity leave?

Answered: 23 Skipped: 3




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 0.00% | 0 |
| No | 100.00% | 23 |
| Prefer not to say | 0.00% | 0 |
| TOTAL | | 23 |