Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Equality, Diversity and Inclusion Strategy 2021 to 2025

'Presenting the first collaborative Equality, Diversity & Inclusion Strategy for Leicester City, East Leicestershire & Rutland & West Leicestershire (LLR) Clinical Commissioning Groups (CCGs)'

DATE: APRIL 2021

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Welcome by Alice McGee - Executive Director of People and Innovation

We are pleased to publish our first collaborative Equality, Diversity and Inclusion Strategy covering the period 2021-2025. This provides me with the opportunity to thank all those people and organisations who contributed to the information found within the strategy. This feedback is vital to shaping our future actions.

The publication has been produced during unprecedented times with the impact of COVID-19 compounding some of the health and wider inequalities that persist in our society. Our work at the Leicester, Leicestershire & Rutland (LLR) CCGs is very much about working to address these inequalities and the wider detriments to health. Improving access to services is one mechanism to combat these health inequalities, another is involving people in decisions surrounding their own healthcare and treatments and improving people's experiences of the services we provide. Getting this right is at the heart of providing a patient-led service and ensuring that we treat people with respect, dignity and fairness.

Our first collaborative strategy demonstrates how committed we are to ensuring that Equality, Diversity, Inclusion and Human Rights is embedded into everything we do. We will be proactive and advance equality by working on new initiatives within the CCG and with the wider system.

The organisation values difference and promote equalities, ensuring that all individuals, whether staff or patients, have a high-quality caring experience of NHS services. We are keen to commission the right health care services, by having well-trained staff who can ensure that our providers meet the equality duties set out in the Equality Act 2010.

We are dedicated to developing an organisational culture that promotes inclusion and embraces diversity, ensuring that the focus on equality, diversity and inclusion is maintained across the LLR CCGs.

As we move towards an Integrated Care System (ICS) we realise that we may need to revisit this Strategy and the Equality Objectives to reflect the new system in 2022. We look forward to doing that in partnership with you.

Contents

Introduction

This strategy sets out Leicester City, East Leicestershire & Rutland and West Leicestershire's (LLR) CCGs strategic approach to delivering equality, diversity and inclusion for the benefit of the local population and staff in line with the aims and objectives of the Equality Act 2010 and the Public Sector Equality Duty.

The services the LLR CCGs are responsible for include primary care, most hospital treatment, rehabilitation services, urgent and emergency care, community health services, mental health, and learning disabilities.

The LLR CCGs' are clinically led membership organisations which comprise 135 GP practices and serves a patient population of approximately 1,200,000. **There is a detailed breakdown of the population by protected characteristic in Appendix B.**

About us

The LLR CCGs are located in the East Midlands and are part of the Better Care Together Sustainability and Transformation Partnership (STP).

Currently, there are 25 primary care networks established across the area. The CCGs are a key strategic partner in the Leicester and Leicestershire Health and Wellbeing Boards, which are responsible for overseeing the health and wellbeing of the population from a health and social care perspective.

The main NHS service providers in the LLR area include:

- East Midlands Ambulance Service NHS Trust
- Leicestershire Partnership NHS Trust
- University Hospitals of Leicester NHS Trust

Local authority areas that fall within the area are:

- Blaby
- Charnwood
- Harborough
- Hinckley and Bosworth
- Leicester City
- Melton
- North West Leicestershire
- Oadby & Wigston
- Rutland

Why have we produced one collaborative strategy for LLR CCGs?

The NHS Long Term Plan aims to establish a health service fit for the future. Its ambition is to give everyone the best start in life, deliver world-class care for major health problems such as cancer and heart disease, and help people age well.

The plan, published by the Government in January 2019, identifies local Integrated Care Systems (ICS) as the way forward. These build upon existing Sustainability and Transformation Partnerships (LLRs Better Care Together programme) which are across geographical footprints to bring together NHS organisations in collaboration with local authorities and others such as the voluntary and community sector. The aim is to take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve.

As part of these new arrangements there will be a strategic commissioning voice for each Integrated Care System (ICS), typically in the form of a single clinical commissioning group (CCG). It is expected that an ICS will be in place across Leicester, Leicestershire and Rutland (LLR) by April 2022.

The central purpose of the newly established Leicester, Leicestershire and Rutland CCG will be to:

- Improve the health outcomes of the Leicester, Leicestershire and Rutland population.
- Reduce health inequalities across the Leicester, Leicestershire and Rutland population.
- Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.
- Deliver a sustainable system financial plan – ensuring funding is distributed to where services are delivered.

- Deliver NHS Constitutional requirements.
- Develop and deliver services with providers that are evidenced based and offer value for money.
- Deliver integrated health and social care.

In October 2019, a number of collaborative governance arrangements were established and approved by all three Governing Bodies to enable greater collaboration and avoid duplication in respect of services commissioned across the three CCGs. These were further enhanced in September 2020 when the whole of the Executive Management Team were in post. This involved the establishment of a number of joint committees and meetings to be held in common. More information can be found in **LLR CCGs governance (decision-making) section.**

On this basis the LLR CCGs have agreed to a new collaborative strategy together with equality objectives which reflect the equality and health needs for people living in Leicester, Leicestershire and Rutland.

Executive summary

We are pleased to present our first collaborative Equality, Diversity and Inclusion Strategy for 2021 to 2025. The strategy sets out our commitment to integrating Equality, Diversity and Inclusion within our mainstream activities; whilst demonstrating 'due regard' to the Equality Act 2010 and the Public Sector Equality Duty.

Critical to this approach is to embed equality into all our activities including:

- Decision-making
- Policy and strategy development and review
- Budget planning and allocation
- Service planning and review
- Projects and work programmes
- Commissioning and procurement
- Quality and performance improvement
- Workforce - employee performance, development and relations
- Involving local people.

The strategy is focused on the existing and emerging healthcare needs of our diverse population and how we should work with our staff, patients, member practices and stakeholders to commission high quality services that offer equality in healthcare outcomes for our local population.

The LLR CCGs are committed to working with their partners to achieve better health outcomes for the local population, particularly for people where life expectancy is not keeping pace with the rest of the country. To this end, the strategy includes the system-wide equalities work currently being undertaken with our partners through the LLR Academy.

These have been unprecedented times with the impact of COVID-19 which has compounded some of the health and wider inequalities that persist in our society. It has become increasingly clear that COVID-19 has had a disproportionate impact on many who already face disadvantage and discrimination. The impact of the virus has been particularly detrimental to people living in areas of high deprivation, on people from Black, Asian and minority ethnic communities (BAME), and on older people, men, those with a learning disability and others with protected characteristics.

A central part of responding to COVID-19 and restoring services is to increase the scale and pace of the CCGs and our partners to tackle health inequalities to protect those at greatest risk.

At the time of writing, we are developing a new strategic operating framework which will demonstrate how a new single Clinical Commissioning Group (CCG), will (in its capacity as a strategic commissioner) effect change to the structure of health service provision, look to improve the life outcomes of our population as well as meet the needs of the entire region. The strategy outlines the specific actions that will be taken to ensure the LLR health system benefits from the opportunities presented by the emerging Integrated Care System (ICS).

The new LLR Clinical Commissioning Strategy is a fundamental enabler of Our Five-Year Strategic Plan (2019-24). The Plan has been collaboratively produced by all health partners within the LLR NHS system and individual components supported by Local Authority partners. It outlines how the LLR health system will respond to the requirements within the NHS Long Term Plan.

For our workforce, we want to ensure that we harness and embed inclusive working practices and we will continue to ensure that we are making progress with NHS mandated standards such as the Workforce Race Equality Standard (WRES). The WRES was reviewed in September 2020 and a new action plan agreed for 2020/21 and beyond.

The strategy also sets out our new equality objectives. The LLR CCGs are keen to involve stakeholders in the continuing development and monitoring of our Equality, Diversity and Inclusion Strategy to ensure that we commission the right health care services for our local communities and that our commissioned service providers meet the equality duties set out in the Public Sector Equality Duty and NHS England and NHS Improvement's mandated equality standards.

Over the last five years, we have successfully addressed some of the most prevalent health inequalities in our local population. We will ensure that new models of care, such as Primary Care Networks (PCN's), play a pivotal role in supporting the delivery of this strategy at a neighbourhood level to tackle health inequalities by population. We recognise the importance of meeting our equality, diversity and inclusion priorities and we also recognise the value of working collaboratively with our local providers and partners to advance equality, diversity and inclusion in the work that we do.

Our shared vision with partners

Partners across Leicester, Leicestershire and Rutland have a long and rich history of collaborative working through the Better Care Together Programme.

The programme consists of a collaboration of partners aiming to transform health and care and to create a financially sustainable health and care system for the future. The vision of the programme is:

To develop an outstanding, integrated health and care system that delivers excellent outcomes for the people of Leicester, Leicestershire and Rutland

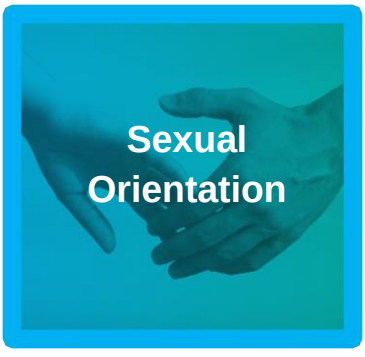
Together with this vision, we have developed 10 system expectations for a sustainable and affordable system that is fit for purpose. These can be found in the Clinical Commissioning Strategy and Quality and Performance Improvement Strategy.

Our equality duties

Equality Act 2010

The Equality Act 2010 makes it unlawful to discriminate, harass or victimise people because of a reason related to their protected characteristic. The Equality Act 2010 protects people from unfavourable treatment. This refers particularly to people from the following groups known as protected characteristics. Further information on the protected characteristic groups is provided in **Appendix B**

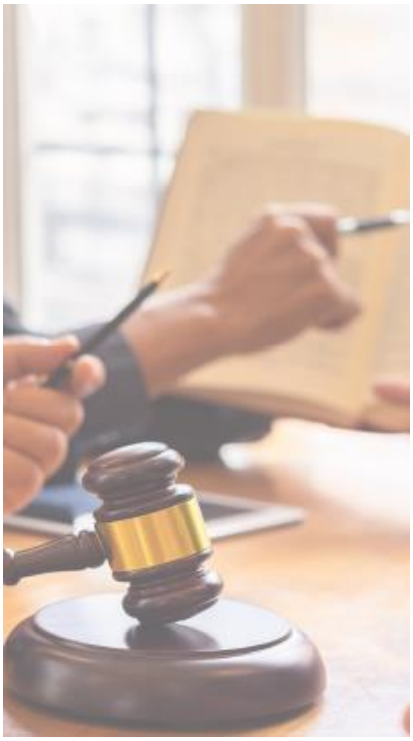
The Protected Characteristics Groups



Other Vulnerable groups

In addition to the protected groups, we also recognise that there are additional groups that experience health inequalities and face disadvantage in society. **There is more information about these groups later in the strategy.** These groups include: (This list is not exhaustive)

Public Sector Equality Duty (PSED) 2011



Section 149 of the Equality Act 2010 applies to public sector organisations and bodies delivering public services. The Public Sector Equality Duty 2011 requires the LLR CCGs address the following duties:

Eliminate unlawful discrimination, harassment, victimisation, and other prohibited conduct

Advance equality of opportunity between people who share a protected characteristic and those who do not

Foster good relations between people who share a protected characteristic and those that do not

The LLR CCGs have specific duties under the PSED to:

- Publish information annually to demonstrate their compliance with the Equality Duties
- Set equality objectives, at least every four years

Human Rights Act 1998

The Human Rights Act 1998 sets out universal standards to ensure that a person's basic needs as a human being are recognised and met. Public authorities have a mandated duty to ensure they have arrangements in place to comply with the Act. It is unlawful for a healthcare organisation to act in any way that is incompatible with the Act. In practice, this means we must treat individuals with **Fairness, Respect, Equality, Dignity and Autonomy** known as the FREDA principles.

Modern Slavery Act 2015

The Modern Slavery Act 2015 (applies to all organisations within the United Kingdom with a turnover of £36 million).

A key element of the Act is the 'Transparency in Supply Chains' provision. Businesses above a certain threshold are required to produce a 'Slavery and Human Trafficking Statement' outlining what steps they have taken in their supply chain and own business to ensure slavery and human trafficking is not taking place.

To view our Modern Slavery Act Statement on our website, please follow https://eastleicestershireandrutlandccg.nhs.uk/about/equality-diversity-and-human-rights/

Health and Social Care Act 2012

The Health and Social Care Act 2012 states that NHS organisations including the LLR CCGS must in exercise of their functions, have regard to the need to:

- Reduce inequalities between patients with respect to their ability to access health services
- Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services
- Promote the involvement of patients and their carers in decisions about the provision of health services to them
- Enable patients to make choices with respect to aspects of health services provided to them

The NHS Constitution

The NHS Constitution came into law as part of the Health Act in November 2009 and was revised in March 2012. It contains seven principles that guide the NHS, as well as a number of pledges for patients and the public. Several of these demonstrate the commitment of the NHS to the requirements of the Equality Act and the Human Rights Act. For example, the first principle requires that the NHS "provides a comprehensive service, available to all irrespective of sex, gender, race, disability, age, sexual orientation, religion or belief."

NHS England and NHS Improvement Mandated Equality Requirements

The Equality Delivery System (EDS) 2015

EDS provides an Equality Performance Framework that applies to NHS Commissioners and NHS Providers and consists of four areas:

- Better health outcomes
- Improved patient access and improvement
- A representative and supported workforce
- Inclusive leadership

The main purpose of the EDS was, and remains, to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010.

The Workforce Race Equality Standard (WRES) 2015

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract.

The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

To view our latest WRES report – view our Equality and Inclusion page on our website https://www.leicestercityccg.nhs.uk/about-us/equality-and-diversity/equality-and-inclusion-publications/

The Workforce Disability Standard (WDES) 2018

The WDES performance indicators relating to the experiences of staff with disabilities. At present, this standard is mandated for NHS Trusts and NHS Foundation Trusts. This includes:

- Requirements to collect and publish workforce and training data.

Currently, Commissioners do not have to submit the WDES data.

The Accessible Information Standard (AIS) 2016

The AIS places a duty on NHS organisations to meet the communication needs of patients. This includes:

- Requirements to collect information about accessible information needs and produce information in accessible formats.

Accessible Information Standard (AIS) Compliance

Commissioners of NHS services must have a regard to this NHS England mandated equality standard; they must ensure that they enable and support compliance through their relationships with provider organisations. This standard is detailed in all the CCGs' NHS Standard Contracts held with commissioned providers and is monitored by Quality and Performance Key Indicators (KPIs). Each year, a compliance check is undertaken to ensure that the CCGs website and content is designed in such a way to meet compliance of the AIS. The CCGs' main commissioned service providers' websites are also checked to ensure that they are compliant with the AIS.

Website Accessibility Standard

The Public Sector Bodies (Website and Mobile Applications) (No. 2) Accessibility Regulations 2018

- Builds on existing obligations to make 'reasonable adjustments' under the Equality Act

- Public sector bodies must make their websites and apps more accessible by making it 'perceivable, operable, understandable and robust'. Also includes internal websites (e.g. intranets)

The LLR CCGs' websites contain clear accessibility statements to ensure that the population can access information, resources and documents from the CCGs in a format that meets their needs, for example via easy read or large print formats. Where possible, information resources and publications hosted on the CCGs' website are presented in plain and easy to understand language.

Annual report and strategy review

Each year, the LLR CCG gathers, stores and publishes evidence such as Equality Impact and Risk Assessments, consultation, engagement and involvement exercises for the purpose of demonstrating our legal compliance and any Freedom of Information requests.

The CCG's Governing Bodies meetings in common monitor activity in relation to our organisational priorities for Equality, diversity and Inclusion. The Equality Lead produces an annual report, which provides progress against actions on our equality objectives and leads on reviewing our strategy every four years.

Our equality objectives 2021-25

Our Equality, Diversity and Inclusion Strategy together with our equality objectives are based on the requirements of the NHS England and NHS Improvement Equality Delivery System (EDS2). This supports the aim to embed equality into all policies and practices whilst moving forward with equality performance and going beyond legislation. We feel by adopting the EDS's 2 Goals as our Equality Objectives will provide the LLR CCG one clear action plan which avoids duplication. It also allows a flexible approach on which services and activities we assess depending upon current priorities. Each year, following the assessment, we will develop a list of actions which will form our actions for the year ahead.

As models of collaboration and integration develop across LLR, NHS organisations are being encouraged to join with other partner organisations in reviewing and improving their equality

performance. There are several ways this new way of reviewing and grading services can be achieved with our partners and these will be considered as we develop a more integrated care system.

It is likely that the EDS2 will be replaced with a newer version during the lifetime of this Strategy and as such we will update our Equality Objectives to reflect this.

There are 4 Equality Objectives to cover the next four years and a number of outcomes which are required to deliver each objective. These outcomes can be found at **Appendix D**

Overarching Equality Objective: to reduce unacceptable differences in the health inequalities of all people who live within Leicester, Leicestershire and Rutland

1. **Equality Objective 1 (EDS Goal 1) Better health outcomes**
2. **Equality Objective 2 (EDS Goal 2) Improved patient access and experience**
3. **Equality Objective 3 (EDS Goal 3) A representative and supported workforce**
4. **Equality Objective 4 (EDS Goal 4) Inclusive Leadership**

Continuing engagement on our objectives

In 2021 and beyond, we will continue to look at how we can use the EDS more effectively across Leicester, Leicestershire and Rutland to ensure the best use of resources and the bringing together of different perspectives. Some of this may be achieved through collaboration with our partners as mentioned above. The impact of COVID-19 will mean that we will continue to look at alternative ways of engaging with staff, the public and partners where face to face meetings cannot take place.

Implementing our strategy

Our approach to implementing the equality, diversity and inclusion strategy will be to assess proposed policies, practices and any services we commission by using the Equality, Health Inequality Impact and Risk Assessment Toolkit adopted from the Equality and Inclusion Team, NHS Midlands and Lancashire Commissioning Support Unit (MLCSU).

Showing ‘Due Regard’ to the Public Sector Equality Duty

To commission high quality inclusive health services, we aim to ensure that protected groups have the same access, experiences and outcomes as the general population and where required, that we focus on equity of service provision. This may mean that some of our protected groups have enhanced access to services. We recognise that there are many things that influence this that we may not have complete control over, but we are committed to working with our communities and partners to ensure that our commitment to our equality duty is central to the work that we do and the decisions we make. The COVID-19 pandemic has not changed the requirement to pay ‘Due Regard’ but has shown that we need to work with our partners to reach out to people in different ways.

Equality, Health Inequality Impact and Risk Assessments (EHIIRA)

The CCGs are using the Equality, Health Inequality Impact and Risk Assessment (EHIIRA) toolkit from the Equality and Inclusion Team at NHS Midlands and Lancashire Commissioning Support Unit (MLCSU).

The EHIIRA toolkit provides a framework for undertaking EHIIRA assessments. The tool combines three assessments; one focusing on equality risk, one on health inequalities and the other on human rights considerations. The tool enables the CCGs to show ‘due regard’ to the Public Sector Equality Duty and ensures that consideration is given prior to any policy or commissioning decision made by the Governing Bodies (or other committees) that may impact upon equality and human rights.

Most of our proposed services, polices and functions are subject to an EHIIRA. This also includes (but not limited to) service and policy planning and review, projects and work programmes, performance management, commissioning and procurement, budget planning and allocation, employee performance, development and relations.

LLR inclusive decision-making framework (IDMF)

During 2020 an Inclusive Decision-Making Framework (IDMF) was developed to embed equality and health inequality considerations within decision making.

The framework is based around six steps in which equality and health inequality considerations are embedded within each stage of decisions being made. The IDFM will help to:

- Foster a culture of Inclusive Decision Making across LLR system
- Provide a shared EDI resource across different partners
- Provide practical steps to ensure that the needs of different communities and staff are considered in the decision plans
- Meet the challenges of delivering the NHS Long Term Plan across LLR
- Meet our legal duties – in terms of equality, reducing health inequalities and human rights

Implementation of the IDMF:

Implementation of the framework will start in spring 2021 with workshops and engagement with key teams. It is envisaged that implementation will go hand in hand with support and resources. These will be available on LLR Academy website.

The implementation of the framework presents a period of transition in terms of processes and systems. In time, all LLR partners (including the CCGs) will be required to align systems, policies and processes to the IDMF.

The IDMF should ensure that information that is currently documented within Equality Impact Assessments will be included within project planning documentation and assurance should be in place to ensure this meets the equality duty and other legislative requirements.

The IDMF is an innovative approach that should embed equality, address bias and improve decision making from the outset of decisions / proposals. Its successful implementation will require support from all partners and staff involved in decision making.

At Appendix A you will find a regional, system and local equalities decision making chart which includes the inclusive decision-making framework.

LLR CCGs governance (decision-making)

Meetings of the LLR CCG's Governing Bodies alternate between matters of business and development. The business meetings are held in public, and members of the public are welcome to attend to observe these meetings. There are also confidential sessions from which the public are excluded. Due to the COVID-19 pandemic the meetings of the LLR CCGs Governing Bodies cannot meet in person at a specified venue, but take place by other means, for example via teleconferencing. All agendas and Governing Body papers are available on each individual CCG website.

At this stage it is proposed that the corporate governance team facilitate an approval and sign off process for all impact assessments:

- Equality Health and Inequality Impact Assessment (EHIIRA) form
- Quality Impact Assessment (QIA) form
- Data Protection Impact Assessment (DPIA) form

This will help ensure a consistent approach to how projects are managed through their lifecycle (i.e., commissioning plans, projects, procurement of a new service, proposals for service change, policy development, etc to consider the relevant impacts are duly considered).

Policy and strategy development and review

Policy and strategy development sets out the intention of the LLR CCGs within specific areas and acts as a guide to measure whether our actions meet our expectations.

Staff responsible for policy and/or strategy development and review need to ensure the policy or strategy meets both our legal duties in relation to equality, diversity and inclusion and that they take on board and reflect the view of our diverse workforce and diverse local communities and population.

Staff responsible for existing policies and strategies need to review the policies and or strategy on a regular basis by revisiting the EHIIRA completed on the original document.

Budget planning and allocation

Budgets ultimately determine if, when and how services are delivered. Staff responsible for budget proposals that introduce new services or deal with reduction or charging for services, need to assess whether there are gaps or opportunities in meeting our equality, diversity and inclusion duties and for meeting the needs of our local communities/population.

Commissioning and procurement

Each year, LLR CCGs enter into contracts with providers of health services. Commissioning and procurement not only provide core services to our local population, but also generates and sustains jobs in the local area. We have a statutory duty to ensure that public money is spent in a way that ensures best value and provides equality of access and outcomes for all our local communities. Staff responsible for commissioning and procurement should ensure that the consideration of equality, diversity and inclusion are part of all procurement processes. This should include potential providers giving assurance and evidence of their compliance to equality and human rights legislation and the NHS equality related mandated duties.

As we move towards a more integrated care system, we are working to a new model of collaboration to deliver improved integrated models of care across LLR.

The role of a strategic commissioning organisation will be significantly different to that of existing CCGs. No longer will the focus be on specifying the way in which services are delivered in a particular area or procuring and monitoring individual contracts.

Instead, the focus will be on taking a whole system view of the requirements of the patient population based on known needs and health inequalities and setting clear expected outcome improvements for those groups. It will also be responsible for allocating resources to providers, who will operate collaboratively at existing upper tier local authority levels, and in partnership with statutory Health and Wellbeing Boards, to decide upon the best approaches to delivering those desired outcomes, based on a detailed local knowledge of populations.

Quality and performance management

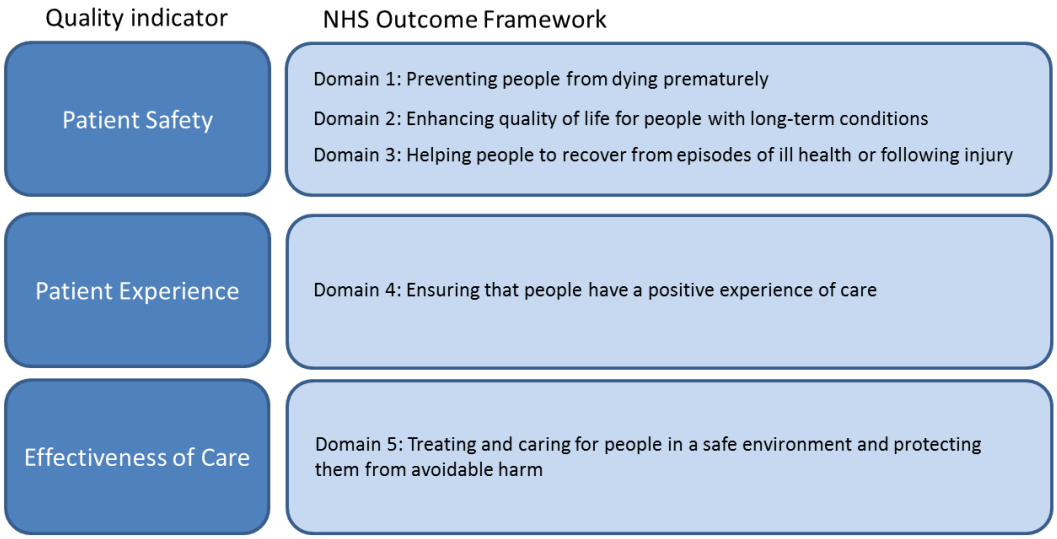
Delivering safe, high quality health, social care and support to patients and citizens in Leicester, Leicestershire and Rutland (LLR) is at the centre of our ambitions. Combining quality of care alongside performance improvement at System, Place and Neighbourhood levels is the driver to delivering assurance.

What is Quality?

Since the publication of High-Quality Care for All in 2008, the NHS has used a three-part definition of quality. NHS England describes this as: 'the single common definition of quality which encompasses three equally important parts". These are:

- Care that is clinically effective - not just in the eyes of clinicians, but in the eyes of patients themselves;
- Care that is safe; and,
- Care that provides as positive an experience for patients as possible.

- The NHS Outcomes Framework (2016-7) builds on these dimensions of quality by breaking down the three quality indicators into five domains:



The Five Year Forward View was published in 2014 and set out a vision for the future of the NHS. Its focus was on closing three widening gaps: the health and wellbeing gap; the care and quality gap and the funding and efficiency gap through a focus on prevention; breaking down barriers in care; better use of resources and a reduction in unwarranted variation.

In terms of performance

In Leicester, Leicestershire and Rutland the primary purpose of a Quality and Performance Improvement Strategy is to provide the system as a whole with a structure with which to make systematic, continuous improvements to performance enabling achievement of its objectives.

Our approach to implementing the Quality and Performance Improvement Strategy will be to assess proposed policies, practices and any services we commission by using the Equality, Health Inequality Impact and Risk Assessment (EHIIRA) process. This enables the CCGs to show 'due regard' to the Public Sector Equality Duty and ensures that consideration is given prior to any policy or commissioning decision made by the Governing Bodies (or other committees) that may impact upon equality and human rights.

Workforce - employee performance, development and relations

The organisation has robust policies and procedures in place which ensure that all of the staff are treated fairly and with dignity and respect. The organisation is committed to promoting equality of opportunity for all current and potential employees

The Executive Management Team receives and reviews a workforce dashboard each quarter which contains a number of workforce metrics. The dashboard includes information relating to the composition of the workforce, including gender, BAME and staff with a disability. The report also includes details of turnover, sickness absence plus statutory and mandatory training compliance.

The LLR CCGs have all participated in this year's National Staff Opinion Survey for the first time which will provide a baseline against which an action plan can be developed. Previously Staff surveys had taken place annually where CCGs could produce their own surveys.

Education, learning and development

The CCGs are committed to the education, learning and development of all its employees to fulfill organisational objectives and to assist with lifelong learning. Learning and development needs are identified at individual, team and organisational level. Individual learning and development needs are identified and planned for through the Personal Development Review (PDR) and Personal Development Plan (PDP) process. The full range of personal development options are explored to

provide appropriate and cost-effective solutions. Learning and development needs at team and organisational level are identified and planned for between managers, HR Business Partners and Organisational Development leads. The CCGs have a process for prioritising learning and development needs where required due to budgetary or resource constraints. There is also a programme of mandatory training which includes Equality and Diversity training.

In addition, the national direction with regard to people development has provided LLR with an opportunity to collaborate and co-design people development practices that will enable our organisational and system workforces to be supported and developed with a cohesive and consistent approach. The cross-system development approach affords a valuable opportunity to share, design and deliver resource via the LLR Academy. Some examples of the projects that are being progressed are: Coaching, mentoring and buddying; Reverse mentoring programme; and Inclusive decision-making programme.

We are the NHS People Plan 2020/21

'We are the NHS: People Plan 2020/21 – action for us all', along with 'Our People Promise', sets out what people who work for the NHS can expect from their leaders and from each other. It builds on the creativity and drive shown by our NHS people in their response, to date, to the COVID-19 pandemic and the interim NHS People Plan. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as take action to grow our workforce, train our people, and work together differently to deliver patient care.
This plan sets out practical actions for employers and systems, as well as the actions that NHS England and NHS Improvement and Health Education England will take, over the remainder of 2020/21. It includes specific commitments around:

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a particular focus on tackling the discrimination that some staff face
- **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
- **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return

The actions from the People Plan will form part of our approach to an ambition to create a world class workforce in LLR that thrives and delivers the best patient care for our population.

Within Leicester, Leicestershire & Rutland – System-wide equalities work

We are developing, with our partners a system-wide people strategy containing actions Leicester, Leicestershire and Rutland (LLR) health and care system will collectively take. This is a plan for LLR which reflects our response to the NHS People Plan but is more far reaching in its purpose and intent. The document outlines how the system will continue to work together and take action over the remainder of 2020, and beyond to:

- Respond to new challenges and opportunities
- Look after our people
- Ensure Belonging in the NHS and Local LLR System
- Deliver New ways of working and delivering care
- Grow for the future
- Support its people for the long term
- Align and Collaborate across health and care systems

During COVID-19 the CCGs became partners of an LLR COVID-19 Equality, Diversity & Inclusion (EDI) Taskforce working collectively on risk reduction and broader EDI activity, impacting on both staff and citizens (across Health and Social Care). Much of this work is co-ordinated through the LLR Academy. Central to this group is the 'system people plan' and the delivery of the equality, diversity and inclusion agenda.

There are currently three aims. These are:

- To create a great place to work where everyone feels valued and that they truly belong
- To pursue high-quality, equitable care for all focusing on health inequalities, community development and the impact of COVID-19 on our people
- To put in enabling mechanisms to create a culture where our workforce thrives and are nurtured and there is inclusive decision making and governance

Actions identified for 2020/21include:

- Establish baseline system position from available WRES, WDES, GPG and EDS2 data and identify areas of greatest underrepresentation
- Publish progress on closing the ethnicity gap in rates of disciplinary action
- Publish progress against Model Employer goals
- Review current EDI training across system partners with a key focus on development in Cultural Intelligence
- Review recruitment and promotion practices, agree diversity targets and address bias in systems and processes
- Support system-wide staff network collaboration and review governance arrangements to ensure staff networks are able to contribute to and inform decision making processes
- Implement the LLR Academy Development Plan to build compassionate and inclusive system leadership capability
- Commence LLR Living Systems Leadership Development Programme
- Participate in national High Potential Scheme with key focus on the development of under representative groups
- Agree, test and Implement system wide Inclusive Decision-Making Framework to support embedding of EDI into our culture and enable transformation and innovation
- Scale up the Reverse Mentoring Programme and ensure alignment to Cultural Change and Talent Management

A number of new initiatives are also being worked on since these were agreed.

In March 2021, a new Midlands Workforce Race, Equality, and Inclusion Strategy was launched as a response to the people plan. The aim of the strategy is to create an anti-racist, compassionate and inclusive working culture. It currently highlights the priorities for the next 3 to 12 months. Although focusing on the race agenda, there are principles embedded in this strategy that will apply to all the other protected characteristics as set out in the Equality Act 2010. The strategy looks at a collaborative approach across systems and what is expected withing each local system/ICS. A new website interactive tool to promote the strategy will be available in May **(LINK)**

At a CCG level, we have recently developed a 5-year action plan to deliver the Workforce Race Equality Standard (WRES) and relevant elements of 'We are the NHS People Plan 20/21' & Model Employer. This will be reviewed and updated regularly and at least annually to meet the Workforce Race Equality Standard (WRES) reporting cycle.

Health inequalities and emerging issues

At a national level, the NHS Long Term Plan sets out a concerted effort to tackle health inequalities with a focus on areas where there are high levels of deprivation.

The LLR CCGs geographical communities face different health challenges. Health is determined by a complex mix of factors including income, housing and employment, lifestyles and access to health care and other services. Significant inequalities in health exist between individuals and different groups in society. In particular, there is a 'social gradient' in health; neighbourhood areas with higher levels of income deprivation typically have lower life expectancy and disability-free life expectancy.

On top of the pre-existing disparities, health inequalities have been compounded for some groups of people during the global COVID-19 pandemic. This is explored in the section below entitled **COVID 19 – Beyond the data**

We will work to ensure that the most appropriate services and support are available to meet the needs of different populations. Doing nothing is simply not an option. We cannot meet these future challenges without change.

The CCGs Equality, Heath Inequality Impact and Risk Assessment has a section specifically on health inequalities and protected characteristics which require project leads to populate to assess for adverse impacts. LLR health inequalities data is used by all Design Groups to inform these assessments. The CCG will consider the needs of, and impact on, populations in Leicester, Leicestershire and Rutland when undertaking its functions as a commissioner and employer by undertaking robust equality analysis on its decision making.

Within LLR we are taking a **systems approach to public health management** where we are working towards implementing an integrated system at System, Place and Neighbourhood levels which incorporates the four pillars of population health:

- The wider determinants of health
- Our health behaviours and lifestyles
- An Integrated health care system

- The places and communities we live in and with

Establishing integrated systems of wellness promotion, illness prevention and agile and responsive models of care and treatment allows us to value and mobilise the contribution of system partners and the strengths and assets of communities themselves, to deliver better health and resilience across the whole life-course of the populations in LLR. It acknowledges that partners are often better placed than the NHS, by reasons of legislative responsibility or cultural fit, to positively influence the wider determinants of health and the engagement with people. This system approach also acknowledges the complex drivers of health inequalities which are at play across the whole life course and provides part of our strategic framework for a comprehensive response to addressing these inequalities. The ultimate aim is to improve the health outcomes of our population.

At the time of writing, Leicester, Leicestershire & Rutland (LLR) is currently working on a Health Inequality Reduction Framework which includes reference to specific issues such as vaccine and cancer screening uptake, TB prevalence and Inclusion groups. Place based planning in 2021 led by Public Health in collaboration with the CCGs will include specific focus on reducing inequalities.

An LLR Health Inequalities Unit (HIU) may be formed – part-funded by the CCGs with external partners (Universities and Local Authorities). The HIU would collate & benchmark all relevant data on LLR inequalities, train, share good practice and support research.

An LLR Health Inequality Reduction Task and Finish Group has been formed, chaired by Executive Director of Strategy and Planning, the Senior Responsible Officer for Health Inequalities. The Task and Finish group is a sub-group of the LLR Prevention and Health Inequality Board, chaired by the Director of Public Health for Leicestershire and Rutland.

Key themes relating to health inequalities include:

Life expectancy

Best fit data used for Local Authority areas:

Indicator	Period	England	your area list	Leicester	Leicestershire	Rutland
Life expectancy at birth (Male)	2016 - 18	79.6	-	77.2	80.7	82.8
Life expectancy at birth (Female)	2016 - 18	83.2	-	81.9	84.2	85.9

Mortality profiles

Table showing under 75 mortality rates from all causes:

Indicator	Period	England	your area list	Leicester	Leicestershire	Rutland
Under 75 mortality rate from all causes (Persons)	2016 - 18	330	-	413	284	223
Under 75 mortality rate from all causes (Male)	2016 - 18	402	-	512	341	266
Under 75 mortality rate from all causes (Female)	2016 - 18	263	-	315	229	182

Causes of death

Under 75 mortality rate from all cardiovascular diseases (Persons) 2016 - 18 — Directly standardised rate - per 100,000

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	102,334	71.7	71.3	72.1
LLR	–	-	-	-	-
Leicester	–	710	107.1	99.2	115.4
Leicestershire	–	1,203	61.1	57.6	64.6
Rutland	–	51	41.8	31.0	55.0

Source: Public Health England (based on ONS source data)

Under 75 mortality rate from heart disease (Persons) 2016 - 18

Directly standardised rate - per 100,000

Export table as image | Export table as CSV file

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	54,406	38.2	37.9	38.5
LLR	–	-	-	-	-
Leicester	–	400	61.2	55.3	67.6
Leicestershire	–	638	32.4	29.9	35.0
Rutland	–	27	22.4	14.7	32.7

Source: Public Health England (based on ONS source data)

Under 75 mortality rate from stroke (Persons) 2016 - 18

Directly standardised rate - per 100,000

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	18,309	12.8	12.6	13.0
LLR	–	-	-	-	-
Leicester	–	125	19.0	15.8	22.7
Leicestershire	–	196	9.9	8.6	11.4
Rutland	–	9	*	-	-

Source: Public Health England (based on ONS source data)

Under 75 mortality rate from cancer (Persons) 2016 - 18

Directly standardised rate - per 100,000

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	188,722	132.3	131.7	132.9
LLR	–	-	-	-	-
Leicester	–	961	144.9	135.7	154.5
Leicestershire	–	2,370	120.7	115.8	125.6
Rutland	–	140	109.9	92.3	129.9

Source: Public Health England (based on ONS source data)

Under 75 Mortality rate from breast cancer 2016 - 18

Directly standardised rate - per 100,000

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	14,973	20.4	20.1	20.7
LLR	–	-	-	-	-
Leicestershire	–	196	19.9	17.2	22.9
Leicester	–	69	19.1	14.9	24.3
Rutland	–	10	15.9	7.6	29.4

Source: Public Health England (based on ONS source data)

Under 75 mortality from colorectal cancer (Persons) 2016 - 18

Directly standardised rate - per 100,000

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	16,946	11.9	11.7	12.1
LLR	–	-	-	-	-
Leicester	–	77	12.0	9.4	15.0
Leicestershire	–	236	12.0	10.5	13.6
Rutland	–	12	9.3	4.8	16.4

Source: Public Health England (based on ONS source data)

Under 75 mortality rate from liver disease (Persons) 2016 - 18

Directly standardised rate - per 100,000

Export table as image | Export table as CSV file

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	26,558	18.5	18.3	18.7
LLR	–	-	-	-	-
Leicester	–	151	21.4	18.1	25.1
Rutland	–	18	14.9	8.7	23.6
Leicestershire	–	276	14.3	12.7	16.1

Source: Public Health England (based on ONS source data)

Under 75 mortality rate from respiratory disease (Persons) 2016 - 18 — Directly standardised rate - per 100,000

Export table as image | Export table as CSV file

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	49,351	34.7	34.4	35.0
LLR	–	-	-	-	-
Leicester	–	303	47.2	41.9	52.9
Leicestershire	–	529	26.7	24.5	29.1
Rutland	–	21	16.1	9.9	24.6

Source: Public Health England (based on ONS source data)

Under 75 mortality rate from injuries (Persons) 2016 - 18 — Directly standardised rate - per 100,000

Export table as image | Export table as CSV file

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	19,490	13.2	13.0	13.4
LLR	–	-	-	-	-
Leicester	–	129	14.8	12.3	17.7
Leicestershire	–	213	11.5	10.0	13.2
Rutland	–	11	9.2	4.6	16.6

Source: Public Health England (based on ONS source data)

Source: Public Health England. Public Health Profiles. [29/05/2020] https://fingertips.phe.org.uk © Crown copyright 2020

What do the figures mean?

- Nationally and locally, there is variation across life expectancy for males and females. Males have higher mortality rates across all causes compared to females
- There are variations for life expectancy across the LLR area with Leicester City having significantly lower life expectancy compared to most parts of Leicestershire and Rutland – although it is important to note that health inequality is relative and exists on a gradient in all parts of the region. There are examples of inequality of outcomes in the counties as well as the city.
- There are variations for mortality rates from differing causes across the LLR area with Leicester City having significantly worse mortality compared to Leicestershire and Rutland for the following causes:
    - Cardiovascular diseases
    - Heart disease
    - Stroke disease
    - Heart disease
    - Respiratory disease
    - Cancer (males)
    - Liver disease (males)
    - COVID-19

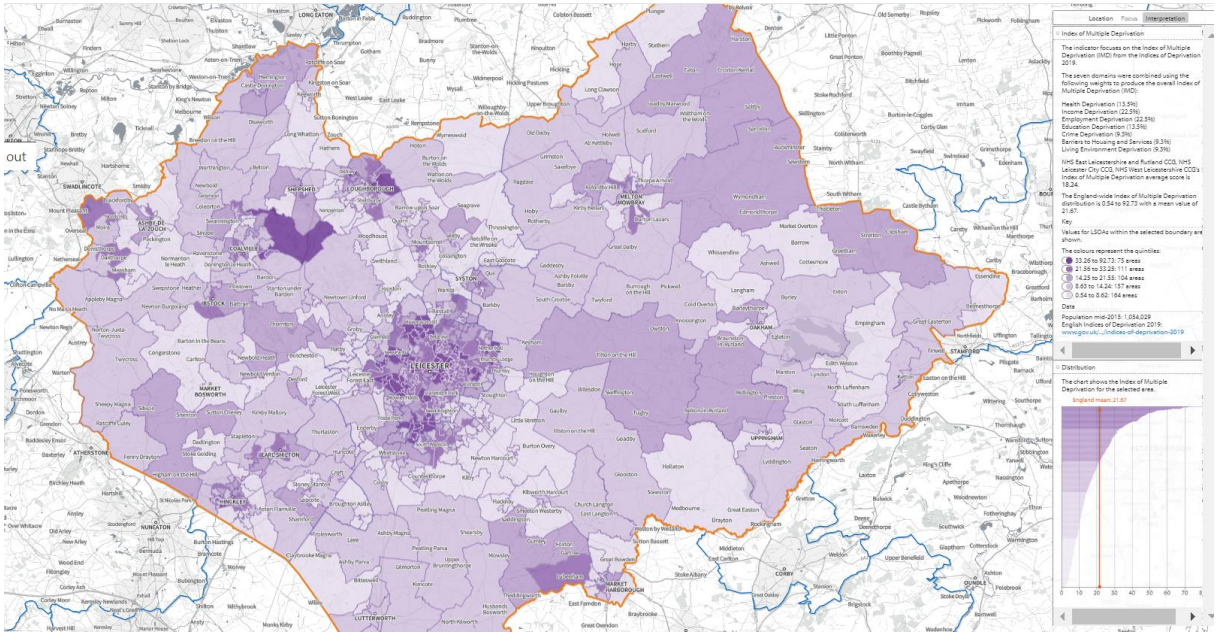
Smoking is the greatest single cause of preventable death; smoking rates are higher in deprived areas. Prevalence is higher amongst those of white ethnicity and significantly lower in under 19s, overs 65s and in Asian ethic groups.

Further information can be found within the Rightcare Health Equality and Inequality report: https://www.england.nhs.uk/about/equality/equality-hub/equality-and-health-inequalities-rightcare-packs/

Deprivation

Indicator	Period	England	your area list	NHS East Leicestershire And Rutla...	NHS Leicester City CCG	NHS West Leicestershire CCG
Deprivation score (IMD 2019)	2019	21.7	-	10.7	30.9	13.3
Deprivation score (IMD 2015)	2015	21.8	-	11.0	33.1	13.4

Higher deprivation areas denoted by darker shades of purple:



What do the figures mean?

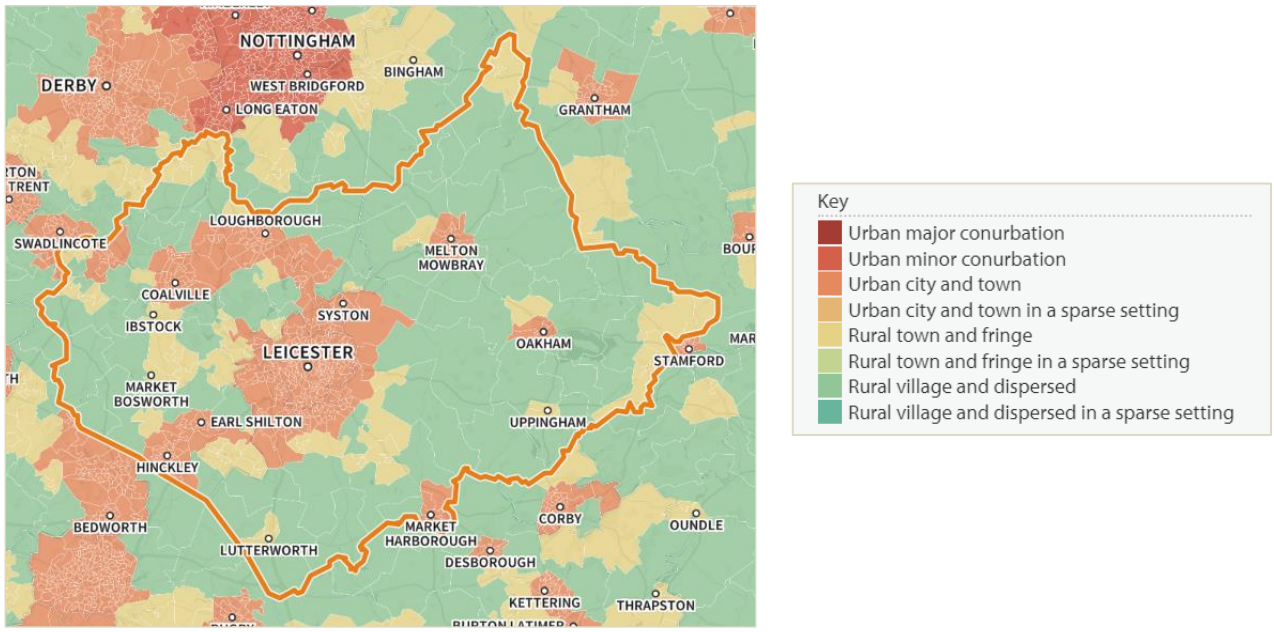
- There is variation across LLR for deprivation levels with large rural areas being relatively affluent. As digital pathways for health and care expand however, this will expose a “digital divide” which means that even in relatively affluent rural areas for example, poor digital infrastructure may lead to inequity of access to digital care offers. In more deprived areas the issue may be one of access to devices and data capacity rather than to the infrastructure required for connectivity. This will need to be taken into account as we seek to reduce inequalities and inequity for all.
- Using the indices of multiple deprivation, we can see that the population is spread across areas which range from some of the least deprived in England (Rutland; ranked 148th least deprived out of 152 English upper tier authorities) to areas of very significant deprivation (39 of the Leicester City Lower Super Output Areas (a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales - LSOAs) are in the top 10% most deprived in England and four neighbourhoods in Leicestershire fall into the most deprived decile in the country).
- There are pockets of relative inequality and poorer health outcomes seen across and within the area at System, Place and Neighbourhood levels. Within Leicester City in particular, (though not exclusively there), the impact of deprivation is compounded by inequalities related to race and ethnicity.

Rural issues

The Office for National Statistics rural-urban classification (RUC2011) allows for a consistent approach when viewing rural/urban datasets.

Output areas are defined as rural if there is a population size of 10,000 or less. Output areas with a population size of over 10,000 are classed as urban. Further information regarding the rural-urban classification is available on the ONS website.

Map showing LLR area rural-urban population



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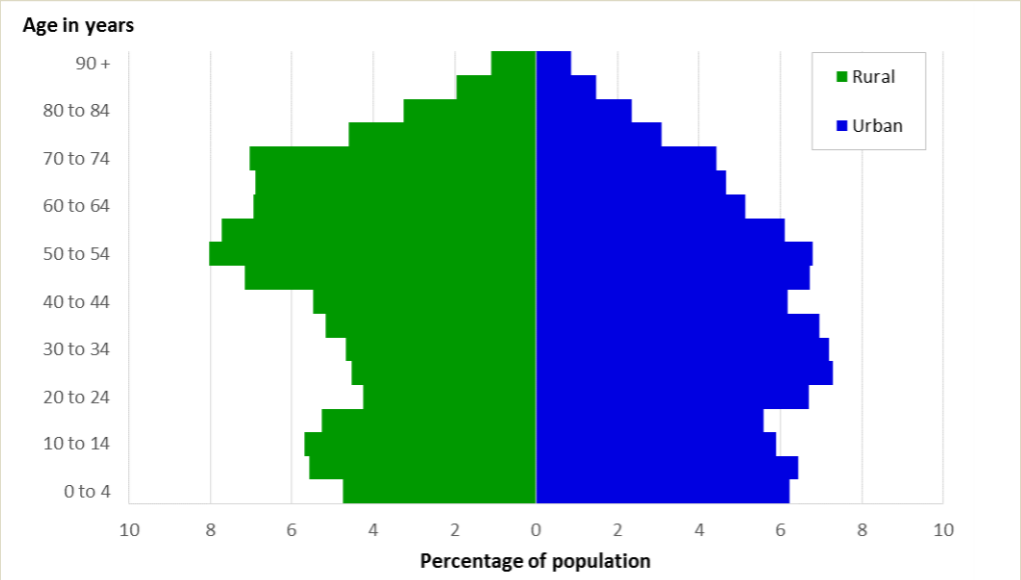
9.5 million (17% of population) people live in areas defined as rural in England. It is challenging to fully understand rural areas as available data is limited and less specific in focus compared to urban data. The population in rural areas has a higher proportion of older people compared with urban areas.

Percentage of population within age bands by rural-urban classification (LSOA) in England, 2018:



What do the figures mean?

- East Leicestershire and Rutland and West Leicestershire have a slightly higher older population in comparison with England with East Leicestershire and Rutland having a notable older population and lower rates of people aged 44 to 20 compared to the rest of the region and England
- In terms of ethnicity, the proportion of BAME groups has risen slightly over the last five years in rural areas. However, 97.6% of the rural population in England falls into White ethnic groups
- LLR comprises a mixture of urban areas surrounding major towns and cities such as Leicester, Melton Mowbray and Loughborough, along with large rural stretches made up of towns and villages.

As there is complexity and diversity in rural areas that make it difficult to understand rural areas as a whole, caution must be taken when considering the needs of rural communities. However, available data highlights that there are general demographic and health-related considerations for this vulnerable group:

- Population pattern – outward migration of young people and inward migration of older people, are leading to a rural population that is increasingly older than the urban population, with accompanying health and social care needs

- Access to health and social care services e.g., longer travel distances, increased travel costs and scarcity of public transport links to access services
- Digital exclusion resulting from a combination of older population and the unavailability of high-speed broadband / mobile phone networks are leading to an increasing digital gap
- Social isolation/exclusion. This may also include marginalisation and lack of social connections felt by protected groups such as LGBT and/or people living with a disability, as well as those who are divorced or living alone
- Health impacts of rural housing and/or fuel poverty.

Other Vulnerable groups

We also recognise that there are additional groups that experience health inequalities and face disadvantage in society. These groups include (this is not an exhaustive list):

Within LLR we also recognise that the Gypsy, Traveller and Roma communities face significant health challenges.

COVID-19 – Beyond the data

With the publication of Public Health England (PHE) reports on disparities for COVID-19 outcomes and stakeholder feedback - Beyond the Data, there is clear evidence that COVID-19 does not affect all population groups equally. For example, many analyses have shown that older age, ethnicity, male sex and geographical area, are associated with the risk of getting the virus, experiencing more severe symptoms and higher rates of death. This work was commissioned by the Chief Medical Officer for England to understand the extent that ethnicity impacts upon risk and outcomes. The reports provide a growing picture of groups at risk and look to address structural health inequalities which may contribute to poorer health outcomes and prevalence.

The Public Health England review of disparities in the risk and outcomes of COVID-19 shows that there is an association between belonging to some ethnic groups and the likelihood of testing positive and dying with COVID-19. Genetics were not included in the scope of the review.

An analysis of survival among confirmed COVID-19 cases showed that, after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British. Death rates from COVID-19 were higher for Black and Asian ethnic groups when compared to White ethnic groups. This is the opposite of what is seen in previous years, when the all-cause mortality rates are lower in Asian and Black ethnic groups.

In summary identified at risk groups include:

- Age – over 80's more likely to die
- Males higher risk
- Black and Asian Minority Ethnic (BAME) groups
- Those working in certain professions – caring/transport/security guards
- Deprivation – higher diagnosis and health rates in areas of high deprivation
- People experiencing homelessness and living in care homes
- People with multiple long-term conditions
- People with a learning disability
- Geography – London has highest death rate

Within Leicester, Leicestershire and Rutland

- Within the East Midlands, the highest rates of COVID-19 cases are within Leicester which mirrors the risk factor data for deprivation, BAME population and care home/nursing beds and high respiratory conditions.
- Areas such as Rutland, which has higher rates of older population has the lowest rate of COVID-19 cases, but is accompanied with low rates of deprivation, a low BAME population and low rates of respiratory disease.
- Across East Midlands, there is variation across the number of COVID-19 related deaths, which would be expected due differing population sizes.

- Deaths in care homes are highest in Leicester, mirroring the higher rate of care home and nursing beds for over 75's.

Below is an example of an initiative to help tackle Covid 19 and reduce health inequalities

Covid-19 Vaccination Hesitancy Project

At the time of writing, the Sustainability and Transformation Partnerships are making plans to invest (as required) to support:

- Activity to increase vaccine uptake
- Intensifying existing engagement activity
- Local systems to develop a plan for longer-term strategic and systematic engagement to address local need.

Funding is provided to help develop and deliver local solutions to vaccine hesitancy in ethnically diverse groups and should be focused on intensifying existing or novel local engagement activity that focuses on one or all of the following:

- Confidence (vaccine hesitancy)
- Convenience (barriers to access)
- Complacency

a) Understanding the reasons for hesitancy, especially in BAME communities,
b) Developing solutions for overcoming hesitancy, especially with BAME communities
c) Understanding the barriers to access, especially for health inclusion groups,
d) Addressing, minimising or removing barriers, especially for health inclusion groups
e) Understanding the reasons for complacency in certain groups, especially younger populations, and
f) Developing local solutions to support civic and individual responsibility, especially in younger populations

Initial national data that largely aligns with the local Leicester, Leicestershire and Rutland information is showing:

- Black African communities have the highest hesitancy compared to other ethnic groups

- Pakistani and Bangladeshi communities have higher hesitancy than White British/Irish and Indian communities
- Gypsy, Roma and Traveller communities, people experiencing homelessness and Asylum seeker, Refugee and migrant populations may need additional routes to access the vaccine
- Income and socio-economic circumstances correlate with lower levels of uptake

The CCG working with partners will systematically contact all communities representing relevant cohorts, working through leaders and voluntary and community sector to set up focused events to look at confidence, convenience and complacency around vaccinations.

Another central part of responding to COVID-19 and restoring services is to increase the scale and pace of the CCG and our partners to tackle health inequalities to protect those at greatest risk. For example:

GPs registrations project

Leicester City CCG are looking to identify and register patients who are not already registered with a General Practice. This is because there are a considerable number of people who have not registered which leads to worse health outcomes among some population groups and contributes considerably to health inequalities. This also leads to inappropriate and ineffective use of services, and in some cases high rates of A&E use, leading to increased costs for the NHS.

Low rates of registration and service use are a result of multiple barriers, such as lack of understanding of the healthcare system, negative previous experiences, communication and language issues, and stigma and discrimination.

To address the registration gap, Leicester City CCG has recruited two GP Registration Officers. The purpose of these posts is to support primary care providers to identify patients that reside within the Leicester City area but are not registered with any general practice. The project is generic, however, some of the pre-determined groups the project will target are; people who live in urban communities, people who are homeless, people living in deprived areas, young people, asylum seekers, migrant workers and refugees, the BAME community, people with different faiths and beliefs and the travelling community.

Improving help for people who need Mental Health and wellbeing support

We will shortly be engaging and involving stakeholders on the proposals to reconfigure services to improve access to support for people who need mental health support and to provide more services closer to home. Mental health problems represent the largest single cause of disability in the UK. One in four adults' experiences at least one diagnosable mental health problem in any given year, and the life expectancy of people with severe mental illnesses can be up to 20 years less than the general population.

In November 2020, 19% of adults experienced some form of depression, indicated by moderate to severe depressive symptoms, while 17% of adults experienced some form of anxiety. This was according to the Office of National Statistics. A number of other national surveys carried out over the course of the first lockdown during the Coronavirus pandemic show how anxiety levels are increasing across many of our communities since before the lockdown started in March 2020. They included concern about personal health and health of loved ones; concern about personal finances; worry about the wellbeing of children and feelings of loneliness and isolation.

In addition, the pandemic has had a disproportionate impact on certain groups of people in society, particularly those on low income; people with an existing mental health condition; children and young adults and people from Black, Asian and Minority Ethnic (BAME) communities. However, the impact of Covid on pre-existing lifestyles is also marked and has had a profound impact on the wellbeing of many local people.

It is a priority for us to engage and link with as many local communities as possible to understand how Covid has impacted on wellbeing and mental health needs. This will help our system partners to work together to meet local need, improve lives and proactively address health inequalities.

Developing joined up approaches to tackle mental health issues is a key priority in England, outlined in the NHS Long Term Plan (published 2019) https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/. It is also a priority in Leicester, Leicestershire and Rutland. Mental health care locally is disconnected from wider health and care services and many of the different mental health services provided locally are disconnected from each other.

We propose to join up mental health services provided to people when it is urgent or an emergency and coordinate them with physical health and wider social services to improve the health and wellbeing of the local population.

In addition, it is our plan to ensure that people could access mental crisis care quicker and easily, whether this need is in the community, in people's homes, in emergency departments, inpatient services or transport by ambulance.

LONG COVID

Increasing medical evidence and patient testimony is showing that a small, but significant minority of people who contract COVID-19 cannot shake off the effects of the virus months after initially falling ill. This has become known as Long COVID and is a new illness. Evidence on how to treat it is rapidly emerging. **NHS support is available for people recovering from COVID-19 (www.yourcovidrecovery.nhs.uk)**

Involving local people

Patient Participation Groups (PPG)

Every GP practice across LLR has a Patient Participation Group (PPG), which allows patients of the practice to be involved in the activities of their surgery and the work of the NHS on a local level.

The CCGs continue to facilitate networks of individual PPGs by bringing together representatives from every PPG to share their work and address any shared issues. At present, COVID-19 restricts this and they are currently operating virtually.

The CCGs recognise the importance of PPGs as a vital mechanism for gathering patient feedback and as a means of communication with the wider registered population of our member practices. As a result of our close relationship with PPGs, the CCGs have also been able to highlight PPGs' work in the local media, with the aim of encouraging more local residents to take an active role in the activities of their registered GP practice. Many practices now operate an online PPG through platforms such as Facebook alongside their physical meetings (hopefully to be resumed post COVID-19) to encourage increased accessibility and participation from local residents.

With the developing Primary Care Networks, PPGs will start to develop and take on a new role, working across practice boundaries with other organisations at a community level.

Public and Patient Involvement Assurance Group (PPIAG).

In September 2019, the CCGs started recruitment to a new Leicester, Leicestershire and Rutland – wide Patient and Public Involvement Assurance Group.

The established PPIAG comprises of fourteen individuals who meet monthly working within an agreed assurance framework to offer strategic assurance that:

- effective mechanisms are in place to fully involve patients and the wider public in the development of the Better Care Together programme.
- the insights gathered from involving patients and the wider public have influenced the way services are designed, organised and delivered.

This new approach will support us to deliver the five-year strategic plan, our system response to the NHS Long Term Plan and strengthen engagement and communication moving towards an Integrated Care System.

Citizens Panel

We also recently established a Citizens' Panel which will proactively engage with people that reflect the diverse demographic make-up of society in the LLR area.

The Citizens' Panel, which is mainly an online group, will provide the Better Care Together partners with an additional systematic approach to gather insight and feedback on a range of health and care issues from a representative sample of our population. It will also assist in aligning the PPIAG with the views of citizens that demographically and attitudinally are representative of the citizens of LLR.

The Citizens' Panel will be in addition to other existing involvement and engagement activities and provide an extra avenue to reach local people, predominantly in an online community, but also asking people to join face-to-face focus groups on topics which interest them (post COVID- 19). It will not replace other activities that we undertake with our stakeholders, patients, carers and the population and should link in with them in all cases.

Our stakeholders and partners

We are committed to continuing our work to develop working relationships with key groups, individuals, partners and other organisations who support us to meet our deliver our equality agenda. These stakeholders include, but are not limited to:

- Key colleagues and counterparts from NHS and local authority organisations e.g. NHS England and NHS Improvement, Health and Wellbeing Board, other NHS Trusts and councillors

- Patient representatives, e.g., Healthwatch, voluntary sector organisations, charities and patient groups.

These strong relationships help us to develop our approaches, disseminate information, share insight and resource; and widen our networks to even the hardest to reach areas. We also have a comprehensive stakeholder database which gives the CCGs access to thousands of contact names and addresses of organisations which can be contacted at short notice to inform them of CCG advances, engagements and consultations.

The database has been developed with consideration for each equality strand and supports the CCGs commitment to the due regard principles.

The CCGs are committed to building strong relationships with all of our diverse communities including those who don't always have their views heard (this includes, for example; Gypsy, Roma and Travellers, homeless people, rural communities, asylum seekers, migrants and refugees). This has been demonstrated through recent funding projects, where we have financially supported local groups to deliver activity using the specialist knowledge of the communities they represent.

Healthwatch

With the information patients provide, Healthwatch Leicester and Leicestershire and Healthwatch Rutland work on their behalf to:

- Tell service providers about the experiences of care and hold them to account.

- Represent these views to the Health and Wellbeing Board and ensure they are taken into account when local needs are assessed.

- Report concerns about the quality of health and social care to Healthwatch England, our national body.

We are committed to working in partnership with our local Healthwatch's to understand their feedback and aim to work collaboratively on the priorities for health across LLR.

Measuring success

The success of embedding equalities within the new LLR CCG and/or Integrated Care System (ICS), will be demonstrated by improved outcomes for staff and patients. From 2021 and beyond, we will measure the four outcomes which are contained in the Equality Delivery System (EDS) and which forms our equality objectives (see Appendix D). (If the EDS is updated by NHSE, during the lifetime of this strategy we will change our objectives to reflect this.)

The main purpose of the EDS was, and remains, to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the public sector Equality Duty (PSED).

Each year we will assess a number of services. We will look to demonstrate how we are reducing unacceptable differences in the health inequalities of people who live within Leicester, Leicestershire & Rutland and assess if patients have received improved access and experiences. We will also work towards developing a well-supported and representative workforce and ensure that leaders contribute to the advancement of the equalities agenda which underpins inclusive leadership.

The assessment of our objectives and development of this strategy will continue to be based on analysis and evaluation of the insights and business intelligence we gather as part of the ongoing engagement with have with our communities across LLR, and with the partnership work we undertake across the health and social care system. More focused work will take place during the summer of 2021 to help to inform our wider approach to the development of an ICS.

We will work effectively across Leicester, Leicestershire and Rutland to ensure the best use of resources and the bringing together of different perspectives through collaboration with our system partners and the LLR Equality Diversity & Inclusion (EDI) Task Group.

Finally, depending upon the development of the ICS, the strategy may need to be reviewed to reflect any changes.

We have pleasure in publishing our new collaborative Equality and Diversity Strategy 2021-25.

This Strategy was produced on behalf of Leicester City, East Leicestershire & Rutland & West Leicestershire CCGs by the Equality and Inclusion Team at Midlands and Lancashire Commissioning Support Unit. If you have any feedback about the content of this strategy, please email equality.inclusion@nhs.net.
April 2021

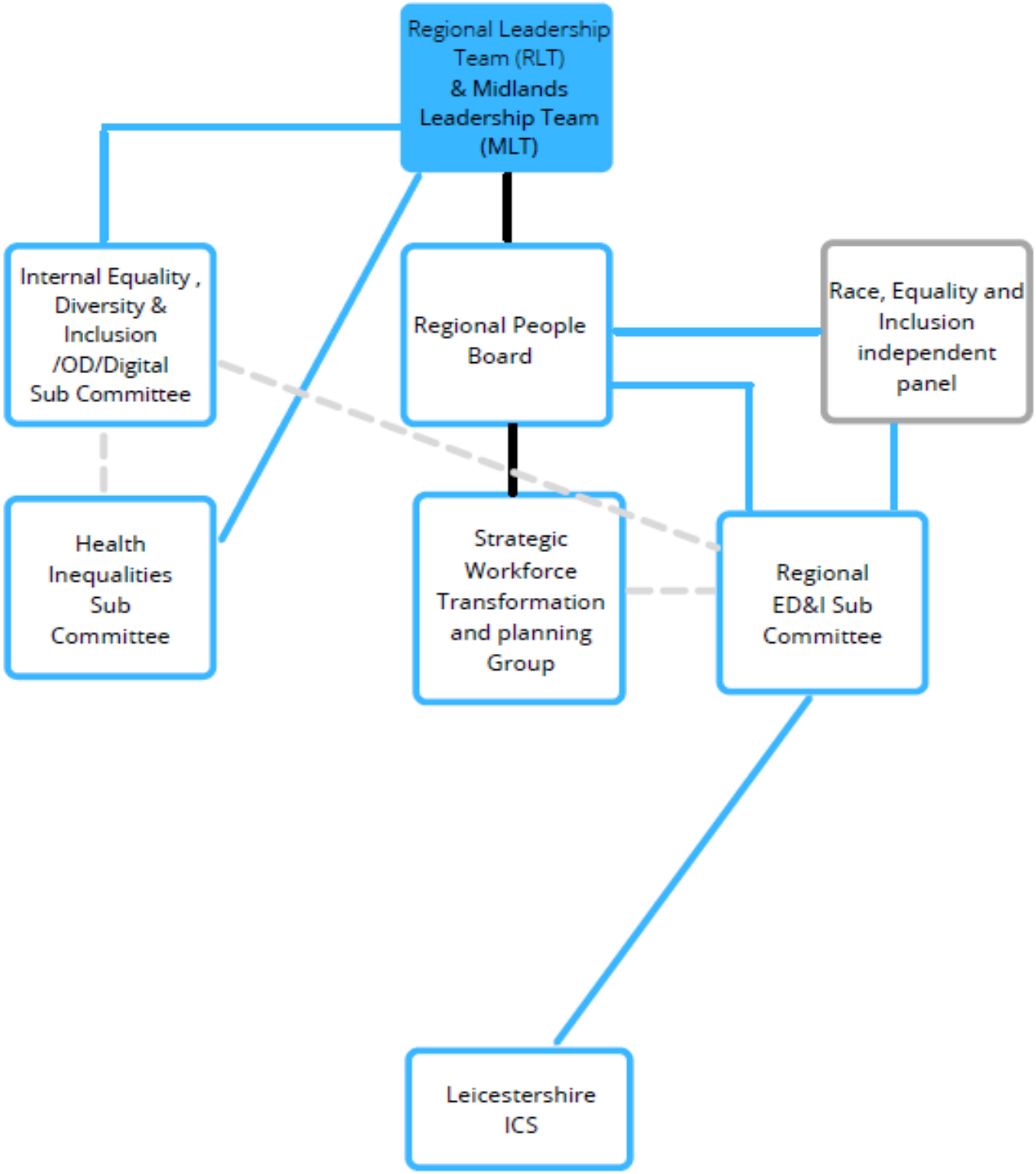
Appendices

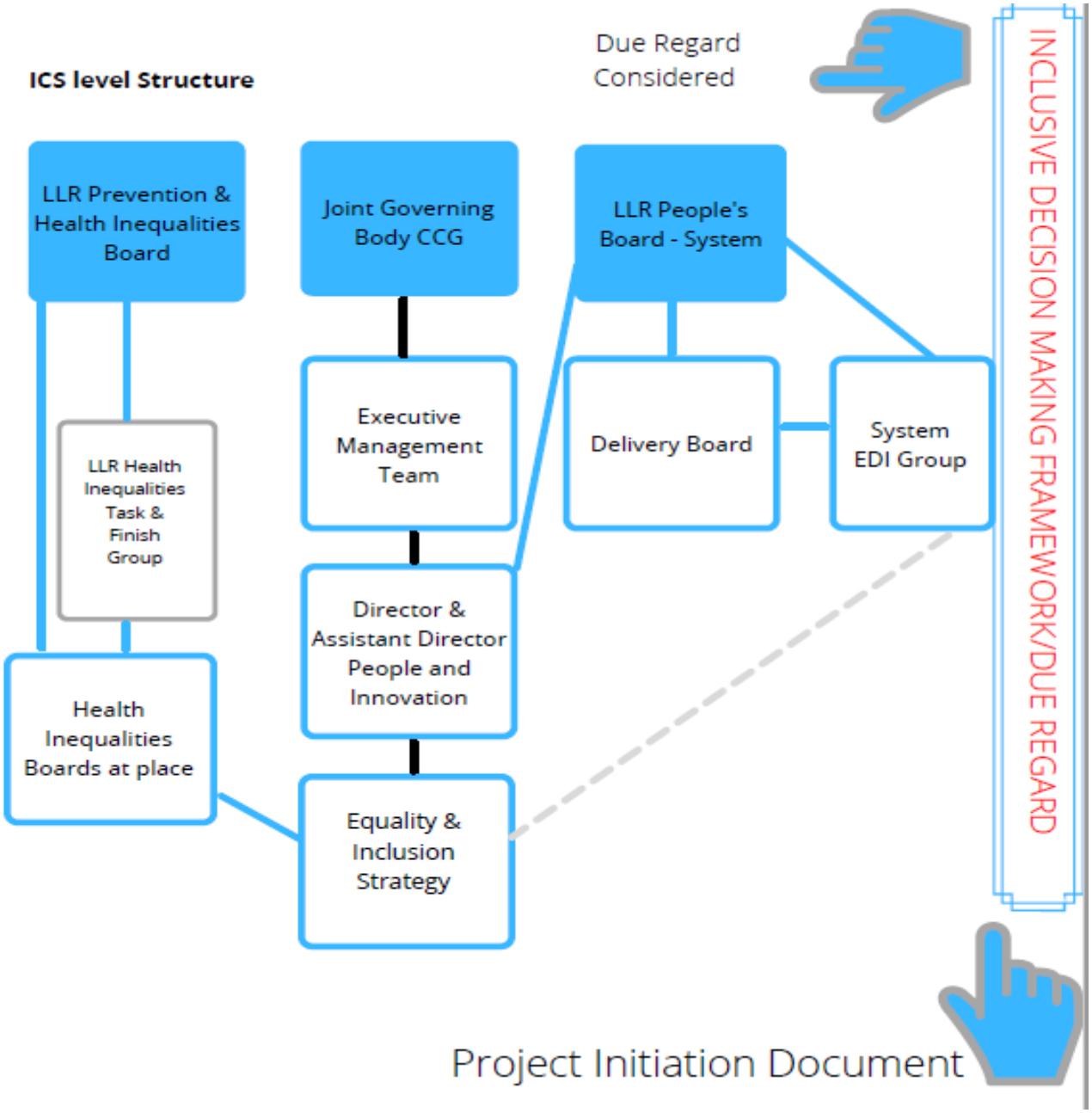
Appendix A:

Equalities Decision Making Structure Chart

NHS
Midlands and Lancashire
Commissioning Support Unit

EDI Regional Governance



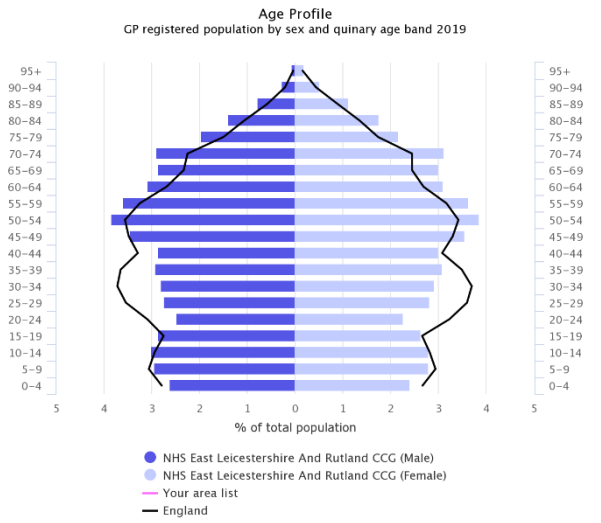

ICS level Structure
Due Regard Considered
INCLUSIVE DECISION MAKING FRAMEWORK/DUE REGARD
LLR Prevention & Health Inequalities Board
Joint Governing Body CCG
LLR People's Board - System
LLR Health Inequalities Task & Finish Group
Executive Management Team
Delivery Board
System EDI Group
Director & Assistant Director People and Innovation
Health Inequalities Boards at place
Equality & Inclusion Strategy
Project Initiation Document

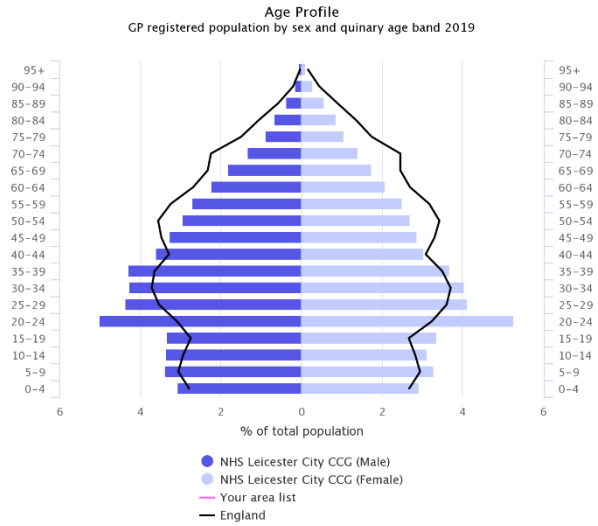
Appendix B:

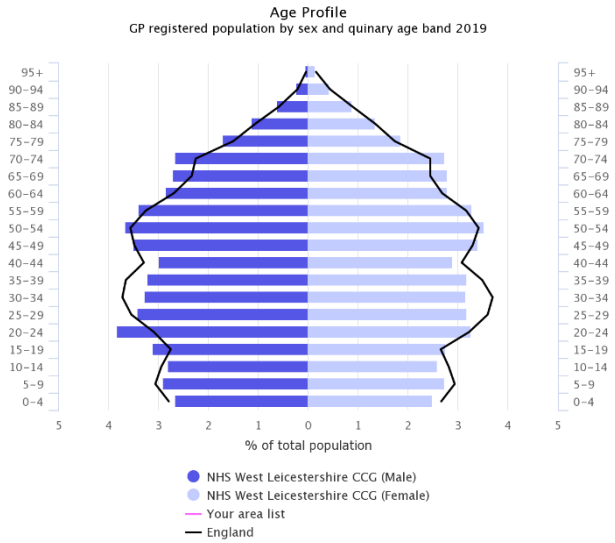
Our Population

Protected characteristic of Age

The following age profiles are shown for each CCG, with data for the male and female population







What do the figures mean?

- Across the area, there is notable variation in age
- The Leicester City area has significantly higher younger population with most people in the area aged between 20-24 – these high rates may be due to the student population attending Universities in the Leicester City area
- Leicester City also has significantly lower rates of people aged 45 and above in comparison with national rates
- East Leicester and Rutland and West Leicestershire have a slightly higher older population in comparison with England with the East Leicester and Rutland having a notable older population and lower rates of people aged 44 to 20 compared to the rest of the region and England
- The number of people aged 85 and over in Rutland is predicated to grow by 142.9% which is higher than the predicated national rate of 127.1%.

Protected characteristic of disability

Disability prevalence

Government data shows:

Disability prevalence by region/country 2017/18, United Kingdom

Region/Country	Millions of people	Percentage of people
United Kingdom	**13.3**	**21**
Country		
England	10.9	20
Region		
North West	1.6	23
East Midlands	1.0	22
West Midlands	1.2	21

https://www.gov.uk/government/statistics/family-resources-survey-financial-year-201718

Learning disability / long term conditions / carers:

Indicator	Period	England	your area list	NHS East Leicestershire And Rutla...	NHS Leicester City CCG	NHS West Leicestershire CCG
Learning disability: QOF prevalence	2018/19	0.5*	-	0.4	0.6	0.4
% with a long-standing health condition	2019	51.5*	50.4*	53.0	47.0	51.5
% with caring responsibility	2019	16.9*	16.6*	17.3	16.0	16.6
Recording of employment status: % of people in contact with mental health and learning disability services with employment status recorded (end of quarter snapshot)	2019/20 Q2	29.2*	20.5*	19.4*	17.8*	24.4*
Recording of accommodation status: Percentage of people in contact with mental health services with accommodation status recorded (end of quarter snapshot)	2019/20 Q2	31.8*	23.1*	22.7*	18.7*	28.2*
Service users with crisis plans: % of people in contact with mental health services (end of quarter snapshot)	2019/20 Q2	12.2*	0.5*	0.4*	0.3*	0.7*
% reporting learning disability	2019	1.6*	1.5*	1.0	2.1	1.3

Source: Public Health England. Public Health Profiles. [29/05/2020] https://fingertips.phe.org.uk © Crown copyright 2020

What do the figures mean?

- The prevalence of patients with a learning disability is similar to the England prevalence

  There is variation across the area with percentage of long-term conditions. A quarter of Leicester households in which at least one person has a long-term health problem or disability, also include dependent children.
- The percentage of carers across the area is similar to England rate

Visual impairment

2020 data set: RNIB	England	LLR AREA
Number of people living with sight loss	182,000	34,560
Percentage of people from population with sight loss	3.21%	3.16%

Best fit data – Local Authority level. Further data available on sight data on age, ethnic group. *Source: https://www.rnib.org.uk/professionals/knowledge-and-research-hub/key-information-and-statistics/sight-loss-data-tool*

Hearing impairment

Estimated prevalence (%) of hearing loss of 25 dBHL or more in the adult population (people aged 18 and over)

CCG	2015	2020	2025	2030	2035
Leicester City CCG	16	16	17	18	19
East Leicestershire and Rutland CCG	24	25	27	29	30
West Leicestershire CCG	21	23	24	26	27
England	21	22	23	24	25

Mental health

Indicator	Period	England	your area list	NHS East Leicestershire And Rutla...	NHS Leicester City CCG	NHS West Leicestershire CCG
Common Mental Disorders						
Estimated prevalence of common mental disorders: % of population aged 16 & over	2017	16.9*	-	12.9*	20.6*	14.2*
Estimated prevalence of common mental disorders: % of population aged 65 & over	2017	10.2*	-	8.3*	12.7*	8.8*
Depression: QOF incidence (18+) - new diagnosis	2017/18	1.6	1.7*	1.7	1.7	1.7
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17	13.7	-	11.0	14.6	13.8
Depression: Recorded prevalence (aged 18+)	2017/18	9.9	10.7*	11.2	9.4	11.5
Severe Mental Illness						
Long-term mental health problems (GP Patient Survey): % of respondents	2018/19	9.9	-	8.2	11.4	10.4
New cases of psychosis: estimated incidence rate per 100,000 population aged 16-64	2011	18.1*	23.9*	18.4*	34.1*	18.4*

Source: Public Health England. Public Health Profiles. [29/05/2020] https://fingertips.phe.org.uk © Crown copyright 2020

What do the figures mean?

- There is variation across the CCG areas with Leicester City having highest prevalence of common mental health disorders and psychosis incidence – which are significantly above the England rate
- The prevalence of depression is higher in Leicester City CCG and West Leicestershire CCG compared to England in general.
- More information on mental health can be found in the health inequalities section.

Dementia

	England	LLR area	Leicester City CCG	East Leicestershire CCG	West Leicestershire CCG
Dementia prevalence all ages	0.8%	0.8%	0.6%	1.0%	0.9%

Source: Public Health England. Public Health Profiles. [01/06/2020] https://fingertips.phe.org.uk © Crown copyright 2020

Protected characteristic of gender reassignment

Population data for this group is not collected within national census data, however, estimate figures are thought to be in the region of 0.5%

Collectively, the three Leicester, Leicestershire and Rutland CCGs serve a population of 1,200,000 people, therefore, the **local trans population is estimated at approximately 5000**.

Estimated figures also suggest that around 1% of the population identify as non-binary.

Protected characteristic of marriage and civil partnership.

Not used as it relates to employment and can identify people.

Protected characteristic of race

Ethnic Group	England		NHS Leicester City		NHS East Leicestershire and Rutland		NHS West Leicestershire		Combined LLR	
	number	%	number	%	number	%	number	%	number	%
All usual residents	53,012,456	100.0	329,839	100.0	317,922	100.0	369,936	100.0	1017697	100.0%
White	45,281,142	85.4	166,636	50.5	286,830	90.2	344,238	93.1	797704	78.4%
White: English/Welsh/ Scottish/Northern Irish/British	42,279,236	79.8	148,629	45.1	278,636	87.6	335,037	90.6	762302	74.9%
White: Irish	517,001	1.0	2,524	0.8	1,890	0.6	1,855	0.5	6269	0.6%
White: Gypsy or Irish Traveller	54,895	0.1	417	0.1	190	0.1	279	0.1	886	0.1%

White: Other White	2,430,010	4.6	15,066	4.6	6,114	1.9	7,067	1.9	28247	2.8%
Mixed/multiple ethnic groups	1,192,879	2.3	11,580	3.5	4,460	1.4	4,480	1.2	20520	2.0%
Mixed/multiple ethnic groups: White and Black Caribbean	415,616	0.8	4,691	1.4	1,618	0.5	1,529	0.4	7838	0.8%
Mixed/multiple ethnic groups: White and Black African	161,550	0.3	1,161	0.4	343	0.1	394	0.1	1898	0.2%
Mixed/multiple ethnic groups: White and Asian	332,708	0.6	3,388	1.0	1,657	0.5	1,746	0.5	6791	0.7%
Mixed/multiple ethnic groups: Other Mixed	283,005	0.5	2,340	0.7	842	0.3	811	0.2	3993	0.4%
Asian/ Asian British	4,143,403	7.8	122,470	37.1	22,914	7.2	18,228	4.9	163612	16.1%
Asian/Asian British: Indian	1,395,702	2.6	93,335	28.3	17,756	5.6	10,955	3.0	122046	12.0%
Asian/Asian British: Pakistani	1,112,282	2.1	8,067	2.4	1,543	0.5	594	0.2	10204	1.0%
Asian/Asian British: Bangladeshi	436,514	0.8	3,642	1.1	200	0.1	2,120	0.6	5962	0.6%
Asian/Asian British: Chinese	379,503	0.7	4,245	1.3	1,242	0.4	2,385	0.6	7872	0.8%
Asian/Asian British: Other Asian	819,402	1.5	13,181	4.0	2,173	0.7	2,174	0.6	17528	1.7%
Black/African/ Caribbean/ Black British	1,846,614	3.5	20,585	6.2	2,238	0.7	1,800	0.5	24623	2.4%
Black/African/ Caribbean/ Black British: African	977,741	1.8	12,480	3.8	995	0.3	1,111	0.3	14586	1.4%
Black/African/ Caribbean/ Black British: Caribbean	591,016	1.1	4,790	1.5	963	0.3	523	0.1	6276	0.6%
Black/African/ Caribbean /Black British: Other Black	277,857	0.5	3,315	1.0	280	0.1	166	0.0	3761	0.4%

Other ethnic group	548,418	1.0	8,568	2.6	1,480	0.5	1,190	0.3	11238	1.1%
Other ethnic group: Arab	220,985	0.4	3,311	1.0	339	0.1	532	0.1	4182	0.4%
Other ethnic group: Any other ethnic group	327,433	0.6	5,257	1.6	1,141	0.4	658	0.2	7056	0.7%

What do the figures mean?

There is variation in the ethnic backgrounds of populations across LLR.

- West Leicestershire and East Leicestershire areas are predominantly white British – with higher representation compared to England population
- Leicester City has higher rates of BAME groups compared to England rates – with:
    - Percentage of people from Asian background representing 37.1% of the population compared to the England rate of 7.8%
    - Percentage of people from Black / African / Caribbean backgrounds representing 6.2% compared to the England rate of 3.5%
    - 28% of the population do not define English as their main language in comparison to the national average of 8%.

Protected characteristic of religion & belief

Religion	NHS East Leicestershire and Rutland CCG	NHS Leicester City CCG	NHS West Leicestershire CCG	Combined LLR	England
Christian	60.7%	32.4%	60.8%	51.6%	59.4%
Buddhist	0.2%	0.4%	0.3%	0.3%	0.5%
Hindu	3.2%	15.2%	2.3%	6.7%	1.5%
Jewish	0.1%	0.1%	0.1%	0.1%	0.5%
Muslim (Islam)	1.5%	18.6%	1.2%	6.9%	5.0%
Sikh	2.0%	4.4%	0.5%	2.2%	0.8%
Other religion	0.4%	0.6%	0.4%	0.4%	0.4%
No religion	25.4%	22.8%	28.1%	25.6%	24.7%
Religion not stated	6.6%	5.6%	6.4%	6.2%	7.2%

Source: NOMIS accessed 28/05/2020

Please note the data in the table above relates to the 2011 Census, and therefore may not reflect current populations in CCG areas.

What do the figures mean?

- Across the LLR area, the most common religious affiliation is Christianity – however, the proportion of people identifying as Christian is lower than the national comparator (51% in LLR against 59% in England)
- There are significant populations of people who identify as Hindu, Sikh or Muslim across the LLR area (particularly in the NHS Leicester City CCG area)
- Overall, there is a slightly higher proportion of people in the LLR area that identify as having no religion compared with the England rate

Protected characteristic of sex

Cross reference with Age section, which contains population profiles for male and females cross referenced with age.

Chart showing males and females with comparison of national population:

	Population sex profile (GP registered population)				
	NHS Leicester City	**NHS East Leicestershire**	**NHS West Leicestershire**	**Combined LLR CCGs**	**England**
Male	212,595	164,107	201,331	578,033	29,849,678
Female	203,964	168,631	197,186	569,781	29,909,960
Total	416,559	332,738	398,517	1,147,814	59,759,638

Source: Public Health England. Public Health Profiles. [08/06/2020] https://fingertips.phe.org.uk © Crown copyright 2020

What do the figures mean?

- Across the area, there are significantly more males than females – differing from the national sex demographic
- There is a total of 8252 more males than females living across the region
- The difference in the rate of males to females is largest in the NHS Leicester City CCG area
- There are more females than males living in the NHS East Leicestershire CCG area
- The population of Leicestershire is projected to increase by 15.8% to 787,500 by 2041.

Protected characteristic of sexual orientation

Table showing estimated lesbian, gay and bisexual population:

Estimate source	% LGB	Estimate population who are Lesbian, gay and bisexual	% heterosexual
England – Stonewall	5-7%	-	93-95%
England - ONS	2.2%	-	94.6%
LLR CCGs	2.2% to 7%	25,251 to 80,346	

ONS data highlights that the proportion of people who identify as heterosexual or straight in the UK is approximately 94.6% This figure has decreased since 2014 (when 95.3% of the population identified as heterosexual or straight).

In terms of age and sexual orientation, ONS data shows that people aged 16-24 were more likely to identify as LGB compared to other age groups. The proportion of people identifying as LGB decreases in each successive age group.

Other vulnerable groups

As mentioned earlier, in addition to the protected groups, we also recognise that there are additional groups that experience health inequalities and face disadvantage in society. these groups include but are not inclusive of:

Appendix C:

Definition of the Protected Characteristics

Age: This refers to a person belonging to a particular age (e.g. 50-year-old) or range of ages (e.g. 18 to 30-year-old. Age discrimination involves treating someone less favourably for reasons relating to their age (whether young or old).

Disability: A person has a disability if they have a physical or mental impairment, learning disability or sensory impairment which has a substantial and long-term adverse effect on their ability to carry out normal day to day activities.

Gender Reassignment: The process of transitioning from one gender to another. Gender Identity refers to the way an individual identifies with their own gender, e.g. as being either a man or a woman, or in some case being neither, which can be different from biological sex.

Sex : A man or a woman, but also includes men and women as groups. Discrimination based on sex occurs when a man or woman or men and women are treated less favourably for reasons relating to their sex.

Race: Race refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins.

Religion Belief: Religion has the meaning usually given to it, and belief includes religious convictions and beliefs including philosophical belief and lack of belief. Generally, a belief should affect your life choices or the way you live, for it to be included in the definition.

Pregnancy and Maternity: Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in employment context. Protection against maternity discrimination is for 26 weeks after giving birth. Discrimination based on maternity includes treating a woman unfavourably because she is breastfeeding.

Sexual Orientation: A person's sexual attraction towards their own sex, the opposite sex or more than one sex. This includes people who are lesbian, gay, bisexual or heterosexual.

Marriage and Civil Partnership: The definition of marriage varies according to different cultures, but it principally means someone who is legally married or in a civil partnership. Marriage can either be between a man and a woman, or between partners of the same sex. Civil partnership is between partners of the same sex.

Appendix D

Overarching Equality Objective	To reduce unacceptable differences in the health inequalities of all people who live within Leicester, Leicestershire & Rutland
Equality Objective 1	**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 the 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
Equality Objective 2	**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 as involved as they wish to be in decisions about their care 2.3: People report positive experiences of the NHS 2.4: People's complaints about services are handled respectfully and efficiently
Equality Objective 3	**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 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 3.3: Training and development opportunities are taken up and positively evaluated by all staff 3.4: When at work, staff are free from abuse, harassment, bullying and violence from any source 3.5: Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives 3.6: Staff report positive experiences of their membership of the workforce
Equality Objective 4	**EDS Goal 4: Inclusive Leadership** 4.1: Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations 4.2 Papers that come before the Board and other major Committees identify, equality-related impacts including risks, and say how these risks are managed

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

Final 11/05/21