NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

Equality, Diversity & Inclusion (EDI)

Annual Report July 2022 – April 2023

Final

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Accessibility statement

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Freepost Plus RUEE–ZAUY–BXEG
LLR ICB, G30, Pen Lloyd Building,
Leicestershire County Council, Leicester Road
Glenfield, Leicester, LE3 8TB

अगर आपको इस दस्तावेज में शामिल जानकारी समझने में सहायता चाहिए तो कृपया 0116 295 2110 पर फ़ोन कीजिए।

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਵਿਸ਼ਾ ਵਸਤੂ ਸਮੱਝਣ ਲਈ ਮਦੱਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰਕੇ ਇਸ ਨੰਬਰ ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ 0116 295 2110.

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Welcome to our first Equality, Diversity and Inclusion Annual Report as an ICB

NHS Integrated Care Boards (ICBs) are statutory bodies established from 1 July 2022, replacing Clinical Commissioning Groups (CCGs). In Leicester, Leicestershire and Rutland (LLR) this means that the functions of Leicester City CCG, West Leicestershire CCG and East Leicestershire and Rutland CCG became the NHS Leicester, Leicestershire and Rutland Integrated Care Board.

This report sets out how we, as an ICB, fulfil our responsibilities arising from the Equality Act 2010 and other NHS mandated requirements. The Equality Act requires all ICBs to publish appropriate information which demonstrates how we are meeting the Public Sector Equality Duty 2011 (PSED, specific duties) and addressing any significant gaps which may adversely impact on local people who are protected by equalities law.

This Annual Report covers the period of July 2022 to April 2023. An addendum was added to the previous EDI Annual Report covering the period of April to July 2022 when we were still a Clinical Commissioning Group.

Foreword by Alice McGee, Chief People Officer

We are pleased to publish our first Integrated Care Board's, Equality, Diversity and Inclusion (EDI) Annual Report. As an organisation, we are dedicated to developing an organisational culture that promotes inclusion and embraces diversity, ensuring that the focus on EDI is maintained not only within the ICB but as part of the wider Integrated Care System.

Leicester Leicestershire & Rutland (LLR) has some of the most deprived and diverse communities in the UK which have been hit particularly hard by Covid-19, reflecting some of the underlying poor health and inequalities experienced by many of the communities we serve. The diversity of our population is mirrored in the diversity of our workforce. Across Health and Social care, we employ over 76,000 staff, of which current health workforce data suggests 42% are from a black and minority ethnic background, reflecting the diverse race profiles of our population.

Our Integrated Care System aims to deliver a health and care system in Leicester, Leicestershire and Rutland that tackles inequalities in health and improves the health, wellbeing and experiences of local people and provides value for money.

We have a clear purpose:

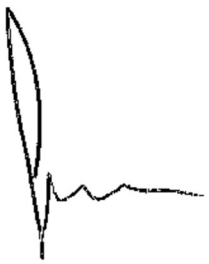
'To work together for everyone in Leicester, Leicestershire and Rutland to have healthy, fulfilling lives.'

We have four main priorities:

To achieve these priorities, we will ensure that success will be seen on the ground with quicker diagnosis, care closer to home in improved facilities, higher quality services, earlier intervention in long-term conditions, improved wellbeing, more digital healthcare options where

appropriate, and greater integration between healthcare providers so patients have seamless care between organisations.

By working with partners, we aim to reduce the unfair and avoidable health inequalities which exist in our community and improve health equity relative to need.



Alice McGee

Chief People Officer

Legal Duties for Equality, Diversity and Inclusion

The Equality Act 2010 protects people from unfavourable treatment, making it unlawful to discriminate, harass or victimise an individual due to a reason related to one of the following nine protected characteristics – see **Appendix A** for more information.

Other Vulnerable Groups (Inclusion Health Groups)

In addition to the nine protected characteristic groups, we also recognise that there are additional groups that experience health inequalities and face disadvantage in society. These include (but are not limited to):

Carers	Rural communities
Veterans and their families	Asylum Seekers and Refugees
People experiencing Homelessness	People experiencing Deprivation
Looked after children and young people	Gypsy, Roma and Traveller communities
People in contact with the justice system	People with poor literacy and/or health literacy
People affected by addiction and/or substance misuse	Sex workers

Public Sector Equality Duty (PSED) 2011

Section 149 of the Equality Act 2010 applies to public sector organisations and bodies delivering public services, and requires the LLR ICB to address the following duties:

1. Eliminate unlawful discrimination, harassment, victimisation, and other prohibited conduct.
2. Advance equality of opportunity between people who share a protected characteristic and those who do not.
3. Foster good relations between people who share a protected characteristic and those that do not.

The Equality Act explains that the second aim involves, in particular, having due regard to the need to:

- Remove or minimise disadvantages suffered by people due to their protected characteristics.
- Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of others.
- Encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

LLR ICB Specific Duties Under the PSED

Leicester, Leicestershire and Rutland ICB has specific duties under the Public Sector Equality Duty (PSED) to:

- Publish information annually to demonstrate their compliance with the equality duties, including information relating to employees who share protected characteristics (for public bodies with 150+ employees), and information relating to people who are affected by the public body's policies and practices who share protected characteristics.
- Set equality objectives, at least every four years. (These can be found in our Equality Diversity and Inclusion Strategy). More on this can be found on page 18.

Our EDI Report is fulfilling the specific duty requirements.

Showing ‘Due Regard’ to the Public Sector Equality Duty

To commission high quality, and inclusive health services, we aim to ensure that protected groups have the same access, experiences, and outcomes as the general population, and where required, to 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.

One of the ways that we demonstrate ‘due regard’ is though our Equality, Health Inequality Impact and Risk Assessment process. More on this can be found on page 13.

Human Rights Act 1998

The Human Rights Act 1998 sets out universal standards to ensure that an individual’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 organisations 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 or above. A key element of the Act is the 'Transparency in Supply Chains' provision, which requires businesses above a certain threshold to produce a 'Slavery and Human Trafficking Statement' outlining what steps they have taken in their supply chain to ensure slavery and human trafficking is not taking place.

Slavery is a violation of a person's human rights. It can take the form of trafficking, forced labour, bonded labour, forced or servile marriage, descent-based slavery, and domestic slavery.

The ICB has a zero tolerance for modern day slavery and breaches of human rights, so we ensure that this protection is built into the processes and business practices that we, our partners and our providers use.

To view our Modern Slavery Act Statement on our website, please click on to the following link: Modern Slavery Act Statement - LLR ICB

The Health and Social Care Act 2022

The ICB has a legal duty under the Health and Social Care Act 2022, to reduce inequalities between people in regard to their ability to access health services, and to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.
The Act also places duties on the ICB to promote the NHS Constitution, to enable choice, and to promote patient, carer and public involvement in shaping health services.

To do this effectively, the ICB works with its partner organisations to reduce health inequalities, and embeds this requirement into its commissioning strategies and policies. The ICB is also required to demonstrate how it provides culturally sensitive services, and ensures all patients can exercise choice and be involved in decision making.

NHS England has a statutory duty under the Health and Social Care Act 2022, to conduct an annual assessment of ICBs. A single oversight framework called the NHS System Oversight Framework was introduced in 2019 for this purpose. This includes oversight metrics for reducing health inequalities and racial inequalities.

More information about the NHS System Oversight Framework for 2022/23 can be found at [NHS England » NHS Oversight Framework 2022/23]

The Care Act (2014)

This sets out carers' legal rights to assessment and support, and relates mostly to adult carers aged 18 and over who are caring for another adult. This is because young carers (aged 17 and under) and adults who care for disabled children can be assessed and supported under children's law.

The NHS Constitution

The NHS Constitution came into law as part of the Health Act in November 2009 and has recently been updated in January 2021. 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 2010 and the Human Rights Act 1998. For example, the first principle requires that the NHS *"is available to all, irrespective of gender, race, disability, age, sexual orientation, religion and belief, gender reassignment status, pregnancy and maternity or marital or civil partnership status."*

Meeting our Statutory Duties, NHS Mandated Equality Standards and other Equality-related Initiatives

Equality and Health Inequalities Impact and Risk Assessments (EHIIRA)

The ICB use 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 first part of this toolkit is a screening assessment tool which is located on an internet platform called UAssure. If a second stage assessment is required, the ICB use a more detailed word template.

The assessments combine equality risk, health inequalities and human rights considerations. The tool enables the ICB 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 people with protected characteristics, equality and human rights.

In July 2022 we improved the accessibility of the EHIIRA stage 2 template which includes new interactive tools such as drop-down menus. Additionally, the health inequalities section has been strengthened to provide the opportunity for a more detailed analysis of inclusion health groups and reflect new requirements such as Core20PLUS5 - see Health Inequalities Section.

Most of our proposed services, polices and functions are subject to an EHIIRA. This also includes (but is 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.

During early 2023, planning is taking place with ICS colleagues to develop a shared equality impact assessment template which we aim to align to the health equity assessment tool and underpin the inclusive decision-making framework noted below on page 15.

The ICB are also developing a joint ICB Quality Impact Assessment and Equality Impact Assessment Policy (EQIA) with links to relevant resources and templates. The current ICB EHIIRA template will be used until we have developed a system version noted in the paragraph above.

Analysis of EHIIRAs undertaken from July 2022 to April 2023

Name of EHIIRA	Stage 1 Screening	Stage 2 (full EHIIRA)
Individual Funding Request (IFR) Policy review	✓	
Children and Young People Pathway review of mental health services	✓	
Redesign of ICB office workspace	✓	
Work experience policy	✓	
LLR PCNs Enhanced access	✓	
Skin Analytics AI Powered Tele Dermatology	✓	
Rosemead Dive GP practice List Closure	✓	
Willows Health Limited – Proposed Practice Merger	✓	✓
Continuous Glucose Monitors	✓	
Employee volunteer policy	✓	
Leicester Place Delivery Plan	✓	
	Total 11	Total 1

Additional EHIIRA Training

Staff are able to access one-to-one training and support on how to complete Equality, Health Inequality Impact and Risk Assessments from the MLCSU Equality and Inclusion Business Partner upon request. During the reporting year two team training sessions were also provided.

Adoption of Inclusive Decision-Making Framework (IDMF)

In July 2020, a number of LLR System Equality, Diversity and Inclusion (EDI) priorities were identified by the Leicester, Leicestershire and Rutland (LLR) EDI Taskforce, including the creation and implementation of an Inclusive Decision-Making Framework.

The Inclusive Decision-Making Framework (IDMF) aims to enhance our decision-making processes and ensure they are not influenced by biases, and thoroughly consider the diverse needs of our patients, our service users, our workforce and the wider community.

Inclusive decision-making involves thorough consideration of equality, diversity, and inclusion when we are developing and implementing strategies, plans, programmes, projects, or commissioning or decommissioning and procuring services.

We have created the framework to support the embedding of equality, diversity and inclusion into our culture, so that it can enable transformation and innovation across the LLR System.

This means promoting inclusive and compassionate leadership so that we can create a diverse workforce which is able to deliver 21st Century care to all of the communities in Leicester, Leicestershire and Rutland. The successful application of this framework ensures that we can integrate equality analyses into our decision-making to reduce health inequalities and attract, retain and develop diverse talent.

The Framework takes into account our role as anchor institutions whose long-term sustainability is tied to the health and wellbeing of the local community we serve.

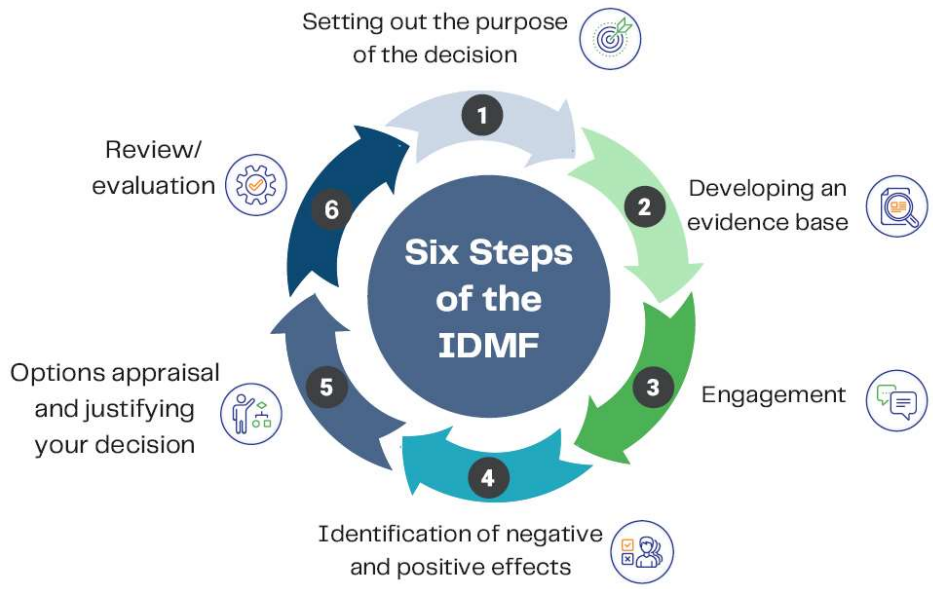
To facilitate effective implementation of the framework three key areas were identified to test the application of the framework in different contexts. These were:

- The Building Better Hospitals (Reconfiguration Programme)
- The implementation of the LLR Health Inequalities Framework
- LLR Clinical Design Group Planning

The Inclusive Decision-Making Framework - the 6 steps

The inclusive Decision-Making Framework consists of a 6-step process and a number of behavioural enablers which take into account the climate in which decision-making takes place and promote inclusivity in decision-making. Equally the Framework identifies the environmental barriers which can lead to sub-optimal biased decision-making. The IDMF recognises that equality is an expectation, diversity is a lived reality, and inclusion is a choice.

The figure below shows the six steps of the IDMF:



Step 1 Setting out the purpose of the decision

A robust assessment will set out the reasons for the change, how this change can impact on protected and inclusion health groups, as well as whom it is intended to benefit, and the intended outcome. Decision makers should also think about how individual proposals might relate to one another. This is because a series of changes to different services could have a severe impact on particular protected characteristics and inclusion health groups. Joint working with partners will also help us to consider thoroughly the impact of joint decisions on the people we collectively serve.

Step 2 Developing an evidence base

It is important to consider the information and research already available locally and nationally. The assessment of the effect of a change on equality and inclusion health groups should be underpinned by up-to-

date and reliable information about the different groups of people that the change is likely to have an impact on. For example, workforce dashboard data and Public Health England dashboards reporting on health inequalities. A lack of information would not be a sufficient reason to conclude that there is no impact.

Step 3 Engagement

Engagement is crucial to assessing the effect of a change on equality and inclusion health groups. There is an explicit requirement to engage people under the duty to reduce health inequalities, and beyond the legislative imperative it will help our teams to improve the equality, diversity and inclusion information that they use to understand the possible effect of a change or service improvement on diverse groups. No-one can give better insight into how proposed changes will have an impact than the people who would be affected by change.

Step 4 Identification of positive and negative effects

It is not sufficient to state simply that a change will impact on everyone equally. There should be a more in-depth consideration of available evidence to see if particular protected characteristic and inclusion health groups are more likely to be affected than others. Equal treatment does not always produce equal outcomes, and sometimes organisations will have to take particular steps for certain groups to address an existing disadvantage or to meet differing needs. This could be through the use of proportional universalism or positive action.

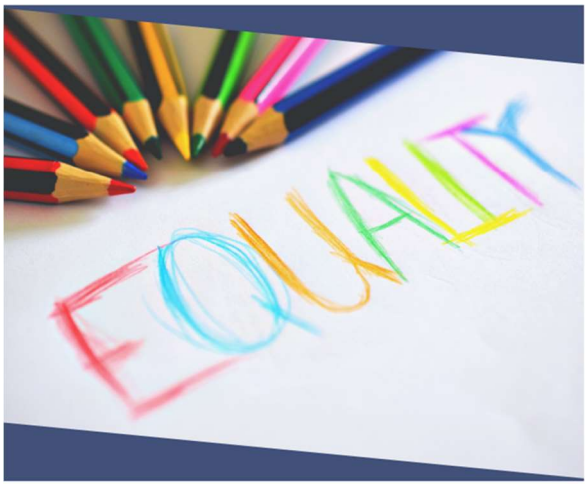
Step 5 Options appraisal and justifying your decision

The assessment should clearly identify the option(s) chosen, and their potential implications, and document the reasons for the decision(s).

Step 6 Review/Evaluation

Although assessments of the effect on of a change on equality and inclusion groups will help to anticipate the likely effect on different communities and groups, in reality the full impact of a decision will only be known once it is introduced. It is therefore important to set out arrangements for reviewing the actual impact of a change once it has been implemented.

LLR CCG/ICB Equality, Diversity and Inclusion Strategy 2021-2025



The Equality, Diversity and Inclusion strategy is designed to cover the initial period of transition of the LLR CCGs becoming the new LLR ICB.

Having the equality objectives in place fulfils our legal obligation until we reshape the strategy once we know what the new structures will look like. There are plans to revise this in the coming reporting year of 2023-24.

The current strategy was approved in May 2021 and sets out our 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, the Public Sector Equality Duty and NHS mandated duties.

To view the EDI strategy, please click on the following link:
https://leicesterleicestershireandrutland.icb.nhs.uk/equality-statement/

Equality Objectives 2023-2027

The ICB EDI strategy presents our current equality objectives for service delivery and employment practices aligned to the Equality Delivery System (EDS). The overarching equality objective is to reduce unacceptable differences in the health inequalities of all people who live within Leicester, Leicestershire and Rutland.

The ICB's current equality objectives are as follows:

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

The action plan at the end of the report provides an update of progress made on these equality objectives.

As noted, we have aligned our current equality objectives to the Equality Delivery System (EDS). Therefore, our equality objectives will change following the adoption of EDS 2022. The change is to reflect the new 'domains'. These domains (our equality objectives) and expected outcomes will form part of our Improvement/Action plan. The outcomes can be found on page 21 of the EDI Annual Report.

We aim for continuous improvement in delivering our three new equality objectives from April 2023 to April 2027. These are:

Commissioned or provided services

Workforce health and well-being

Inclusive leadership

More information on the new domains/equality objectives and expected outcomes can be found in the following EDS section of the report.

LLR ICB Equality Delivery System EDS 2022

The EDS is the foundation of equality improvement within the NHS. It is an accountable improvement tool for NHS organisations in England - in active conversations with patients, public, staff, staff networks and trade unions - to review and develop their services, workforces, and leadership. It is driven by evidence and insight.

The third version of the EDS was commissioned by NHS England and NHS Improvement with, and on behalf of, the NHS, supported by the NHS Equality and Diversity Council (EDC). It is a simplified and easier-to-use version of EDS2.

To take account of the significant impact of COVID-19 on Black, Asian, and Minority Ethnic community groups, and those with underlying and long-term conditions such as diabetes, the EDS now supports the outcomes of the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) by encouraging organisations to understand the connection between those outcomes and the health and wellbeing of staff members. The EDS provides a focus for organisations to assess the physical impact of discrimination, stress, and inequality, providing an opportunity for organisations to support a healthier and happier workforce, which will in turn increase the quality of care provided for patients and service users.

The EDS comprises eleven outcomes spread across three Domains, which are:

- Commissioned or provided services
- Workforce health and well-being
- Inclusive leadership.

The outcomes are evaluated, scored, and rated using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement. The EDS is designed to encourage the collection and use of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and so to help NHS organisations meet the public sector equality duty (PSED) and to set their equality objectives.

During the reporting year relevant NHS organisations have been asked to test the new EDS with full implementation expected from April 2023.

The outcomes for each of the three EDS domains are as follows:

Domain 1: Commissioned or provided services

1A: Patients (service users) have required levels of access to the service *(simpler version of EDS2 2.1)*

1B: Individual patients (service user's) health needs are met *(simpler version of EDS2 1.2)*

1C: When patients (service users) use the service, they are free from harm *(like EDS2 1.4)*

1D: Patients (service users) report positive experiences of the service *(same as EDS2 2.3)*

Domain 2: Workforce health and well-being

2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions (response to COVID-19)

2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source *(like EDS2 3.4)*

2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment, and physical violence from any source (response to Covid-19)

2D: Staff recommend the organisation as a place to work and receive treatment *(like EDS2 3.6)*

Domain 3: Inclusive leadership

3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities (like *EDS* 4.1)

3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed (like *EDS2* 4.2)

3C: Board members, system, and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients (response to Covid-19)

The EDS is integral to core equality work and addressing health inequalities and applies to all the protected characteristic groups.

The use of EDS by single organisations should cease and be applied in partnership, in an integrated approach supported by People Leaders across ICB/UHL/LPT.

Update on progress made during 2022/23: A series of task and finish groups with appropriate experts has been convened to consider each of the domains. The framework and technical guidance provide advice around partner engagement, insights and data needed to collect and the included groups and characteristics to consider within each domain.

Update on Domain 1: System pathways have been accepted by the LLR ICB Health Equity Board and Executive Management Team in August reflecting the clinical priority (and Core20plus5 strategy) areas of:

- Maternity
- Respiratory
- Virtual Wards

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, and public sector bodies must make their websites and apps more accessible by making them 'perceivable, operable, understandable and robust'. This regulation also includes internal websites such as intranets.

The LLR ICB (and providers) websites should contain clear accessibility statements to ensure that the population can access information, resources and documents from the ICB 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 ICB website are presented in plain and easy to understand language.

For a copy of the ICB website accessibility statement please click on the following link: Accessibility Statement - LLR ICB

Accessible Information Standard (AIS) 2016

The aim of the Accessible Information Standard (AIS) is to make sure that people who have a disability, impairment or sensory loss receive information in the best format for them, and receive any communication support that they may require.

The AIS applies to service providers across the NHS and adult social care system, and effective implementation requires such organisations to make changes to policy, procedure, human behaviour and, where applicable, electronic systems.

Commissioners of NHS services and publicly funded adult social care must show due regard to this standard, to ensure that they enable and support compliance through their relationships with provider organisations. This standard is in all of the ICBs NHS Standard Contracts and is monitored by Quality and Performance Key Performance Indicators (KPIs).

A copy of LLR ICBs AIS statement can by clicking on the following link: https://leicesterleicestershireandrutland.icb.nhs.uk/equality-statement/

Provider Compliance Audit 2021-2022

NHS Midlands and Lancashire Commissioning Support Unit's Equality and Inclusion Team Business Partner conducts a desktop provider compliance check of commissioned service provider websites on the following equality-related legal duties and NHS Mandated Standards:

- Equality Objectives published on the provider's website (reviewed every 4 years)
- Published Equality information – e.g., Equality Compliance
- Equality Delivery System Grading and Report (on an annual basis)
- Workforce Race Equality Standard Report (on an annual basis)
- Workforce Disability Standard Report (on an annual basis)
- Up to date Modern Slavery Act 2015 Statement on website (for providers of £36 million and over – on an annual basis)
- Accessible Information Standard (AIS) and Website Accessibility Statement -– see above for more information on what these are.

The table below shows a summary of equality analyses carried out in October 2022. The following providers were reviewed:

- East Midlands Ambulance Service (EMAS)
- Leicestershire Partnership NHS Trust
- University Hospitals Leicester (UHL)

Key completed but not published at time of check

Commissioned Provider	Equality Objectives	Published # Equality Information	Published WRES report	Published WDES report	AIS	Website accessibility statement	Modern Slavery Act Statement
EMAS	✓	✓	✓	✓	✓	✓	✓
Leicestershire Partnership NHS Trust	✓		✓	✓	✓	✓	✓
UHL	✓	X			✓	✓	X

Our Workforce

As an employer we aim to build a great place to work. With a culture of inclusive and compassionate leadership, we strive to create a working environment where all our staff feel included, valued and can fulfil their potential.

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

People Plan

The NHS is made up of 1.3 million employees who care for the people of this country with skill, compassion, and dedication. People work in many different roles, in different settings, employed in different ways, and in a wide range of organisations.

The NHS People Plan was published in July 2020 and sets out actions to support transformation across the whole NHS now and in the future. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as grow our workforce, train people, and work together differently to deliver patient care.

The NHS People Plan is set out in four broad themes:

- Belonging in the NHS
- New ways of working and delivering care
- Growing for the future
- Looking after our staff

The ICB is undertaking many initiatives both organisationally, and with system partners, to advance the above aims. Two such initiatives are detailed below, and others can be seen in the Working in Collaboration with LLR System Partners section.

The Lead, Connect, and Care Festival (looking after our staff)

In June 2022, we held a Lead, Connect and Care Festival. The event was organised by the system Health and Wellbeing Project Team with the support and input from the Looking After Our People workstream, including organisational health and wellbeing leads.

It covered three key themes integral to embedding a culture of health and wellbeing[1] across the LLR health and care system: Leadership, Quality Improvement, Equality, Diversity and Inclusion, and Health and Wellbeing Sessions. Activities throughout the festival week held these themes at the heart of their content, including:

- Eating well to feel well (the link between healthy eating and mental health)
- Alcohol awareness
- Trans health inequality
- Reproductive health and the menopause

There were 450 attendances at sessions across the week with the most well attended session being a masterclass on Compassionate and Inclusive Leadership with Professor Michael West.

The event ended with a family fun-day on 25th June, to celebrate the success of the festival and to give back to our workforce and their families. In attendance were approximately 60 local health and wellbeing activity providers and stallholders who provided valuable information and resources to 235 attendees consisting of staff and their families.

***Quote from family fun-day participant**: "Loved it! What an absolute treat especially after the past 2 years! My kids thought it was great that they could do all of the things for free and as a single mum that hugely helped my bank balance! Thank you!"*

[1] Due to timelines this event was not captured in the previous annual report for the combined LLR CCGs.

Primary Care Workforce - Health & Wellbeing Programme (looking after our staff)

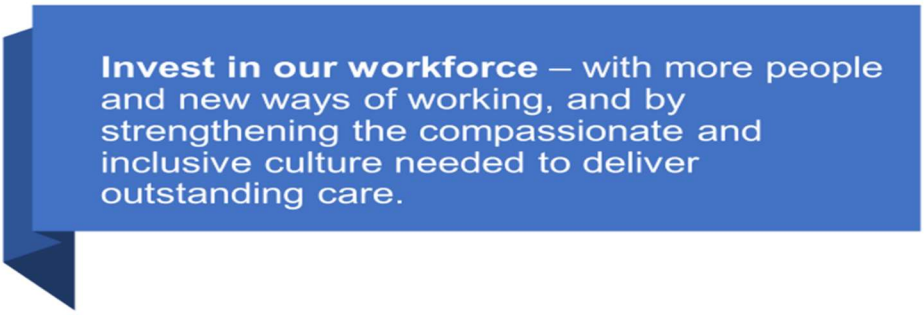
The Primary Care Health and Wellbeing in-reach model:

- Provides a health and wellbeing offer which is accessible to all Primary Care staff.
- Collects baseline information on staff health and well-being and general resilience.
- Provides staff tools for self-help use.
- Provides accessible support and will sign post to existing services where appropriate.

Wellbeing Wednesdays

The programme has been running every Wednesday throughout the Annual Report reporting period. It provides a short, bite size, virtual health and wellbeing led video. NHS staff are able to access the video whenever they want, at their own pace. The videos are no longer than 15 mins and are themed around movement, breathing and achievements.

The Health and Wellbeing programme forms part of the operational planning guidance for 2022/23 which was to:



The People Plan continued…

The People Plan sets out what NHS staff can expect from leaders and each other and includes a focus on fostering *a culture of inclusion and belonging*. Some of the relevant actions are found in our Workforce Race Equality Standard Action plan. The NHS People Plan includes a People Promise, which outlines the actions and behaviours staff should expect from their employers and colleagues, as part of improving the experience of working in the NHS for everyone.

The Inclusive People Promise

Equality, diversity, and inclusion run through the People Plan, changing the culture of NHS services to focus more on learning, belonging, recognition, work life balance, mental health and wellbeing and being the best place for people to work. Details of the inclusive people promise are shown below:

We are a team

- First and foremost, we are one huge, diverse and growing team, united by a desire to provide the very best we can.
- We learn from each other, support each other and take time to celebrate successes.

We work flexibly

- We do not have to sacrifice our family, our friends or our interests for work.
- We have predictable and flexible working patterns, and, if we do need to take time off, we are supported to do so.

We are always learning

- Opportunities to learn and develop are plentiful, and we are all supported to reach our potential.
- We have equal access to opportunities.
- We attract, develop and retain talented people from all backgrounds.

We are safe and healthy

- We look after ourselves and each other.
- Wellbeing is our business and our priority, and if we are unwell, we are supported to get the help we need.
- We have what we need to deliver the best possible care –from clean safe spaces to rest in, to the right technology.

We each have a voice that counts

- We all feel safe and confident to speak up.
- We take the time to really listen to understand the hopes and fears that lie behind the words.

We are recognised and rewarded

- A simple thank you for our day-to-day work, formal recognition for our dedication, and fair salary for our contribution.

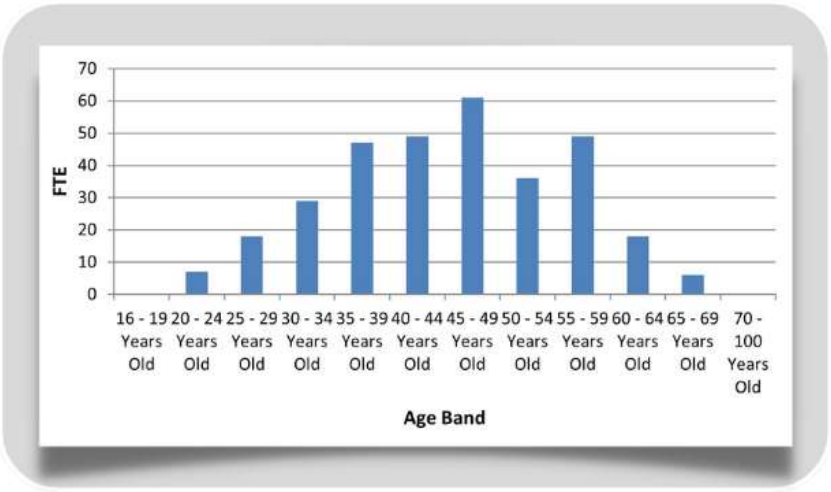
We are compassionate and inclusive

- We do not tolerate any form of discrimination, bullying or violence.
- We are open and inclusive.
- We make the NHS a place where we all feel we belong.

Workforce Profile

Our aim is to employ a diverse workforce that is representative of our local communities as we believe this will support our decision making in the development of health services.

This section illustrates the demographics of Leicester, Leicestershire and Rutland ICB workforce as of 30th September 2022, and compares the figures to Census 2021 local population data[2]. The ICB will use this data for future workforce planning.



Age

The age-band graph above shows that the largest proportions of the Leicester, Leicestershire and Rutland ICB workforce are between the ages of 45-49 (19%), 40-44 (15.3%), 55-59 (15.3%), and 35-39 (14.7%). Whilst at the other end of the scale, the lowest proportions of the LLR ICB workforce are between the ages of 65-69 (1.9%) and 20-24 (2.2%).

Census 2021 data from the Office of National Statistics (ONS[3]) details that 19% of the total resident population of Leicester, Leicestershire and Rutland local authority districts are between the ages of 35-49 so this does mirror the ICB workforce figures. However, Census 2021 data also details that 7.1% of the resident population of Leicester, Leicestershire and Rutland local authority districts are between the ages of 20-24, so this is perhaps one age group that is currently under-represented in the workforce demographic.

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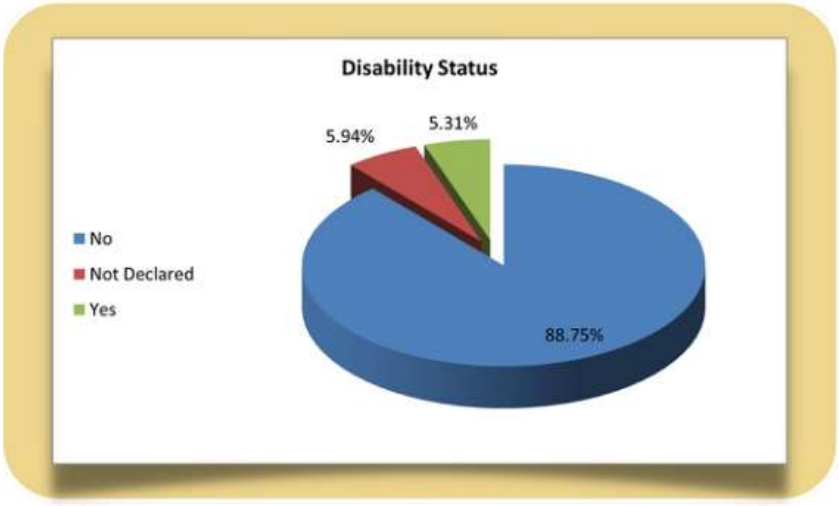
[2] Where percentages are low (under 5%) and can result in staff being identified as a result, we have not presented the data for that particular protected characteristic. However, where this occurs, we have still shown these smaller portions without figures being attributed. This is because it is important to demonstrate that we have people from diverse protected characteristic groups working at the ICB.

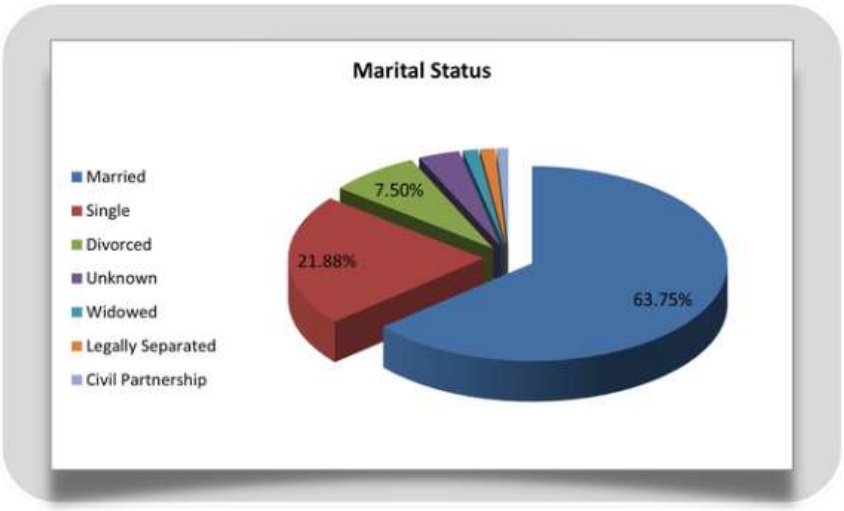
[3] https://www.nomisweb.co.uk/

Disability



The figures shown in the graph above illustrate that 88.7% of the Leicester, Leicestershire and Rutland ICB workforce identify themselves as having no disability, 5.3% declare that they have a disability, and 5.9% opted not to disclose their disability status.

Census 2021 data from the Office of National Statistics (ONS), confirms that 83.8% of the resident population of Leicester, Leicestershire and Rutland local authority districts view themselves as not being disabled under the Equality Act, whilst the local resident population figure for the disabled category was 16.2%. Therefore, the number of ICB workers with a disability is under-representative of the local population who declare a disability by 10.9%.



Marriage and Civil Partnership

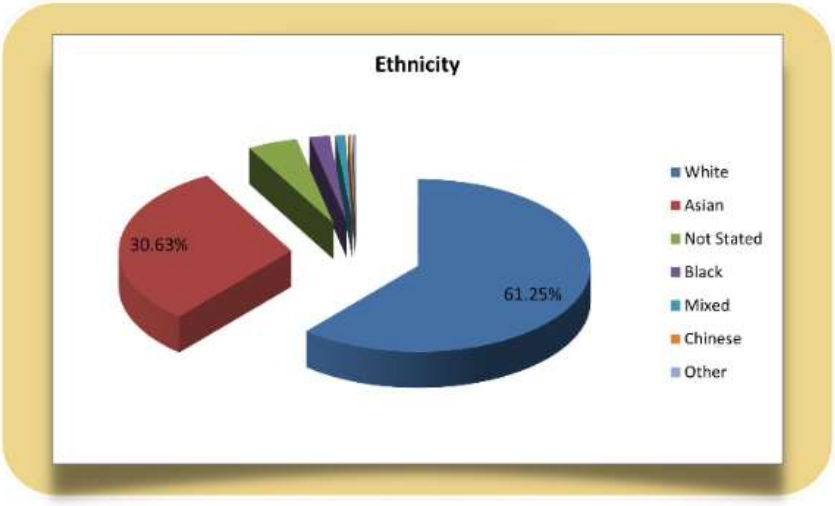
The marriage and civil partnership graph above illustrates that 63.7% of the Leicester, Leicestershire and Rutland ICB workforce identify themselves as being married. This is higher than the Census 2021 data for Leicester, Leicestershire and Rutland local authority districts, which

details that 47% of the total resident population aged 16 and above have listed themselves in the same category.

The proportion of the Leicester, Leicestershire and Rutland ICB workforce who declare themselves to be single is 21.8%. This is lower than the Census 2021 figure for the same category, for Leicester, Leicestershire and Rutland local authority district residents aged 16 and above, which is 36.5%.

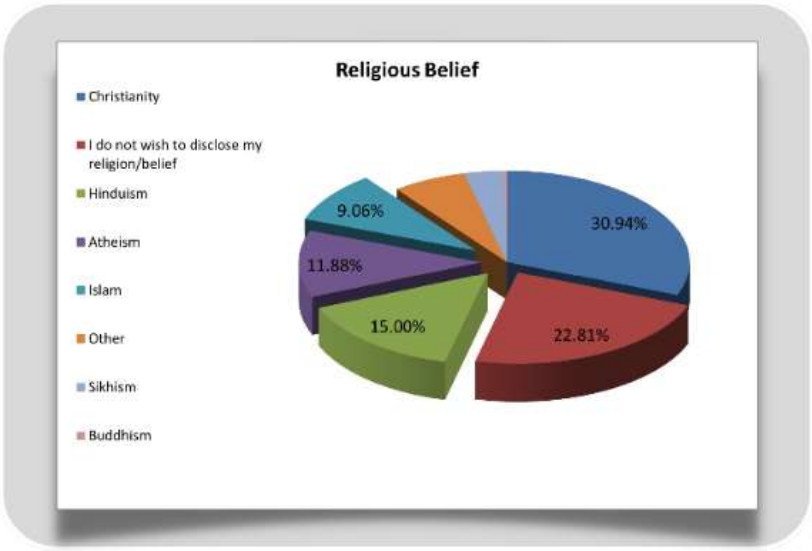
As is shown above, 7.5% of the LLR ICB workforce identify themselves as divorced. This proportion is similar to the Census 2021 figure for Leicester, Leicestershire and Rutland local authority districts for the same category, at 8.3%.

Race



The figures shown in the graph above illustrate that 61% of the Leicester, Leicestershire and Rutland ICB workforce identify themselves as White, and 30% identify as Asian. The total BAME population for the ICB workforce is 32.8%.

Census 2021 data from the Office of National Statistics (ONS), confirms results of 72.5% and 19.5% respectively, for the White and Asian ethnicity categories for the total resident population of Leicester, Leicestershire and Rutland local authority districts, and a total BAME population of 23.3%. Therefore, the BAME workforce is more than representative compared to the local population.

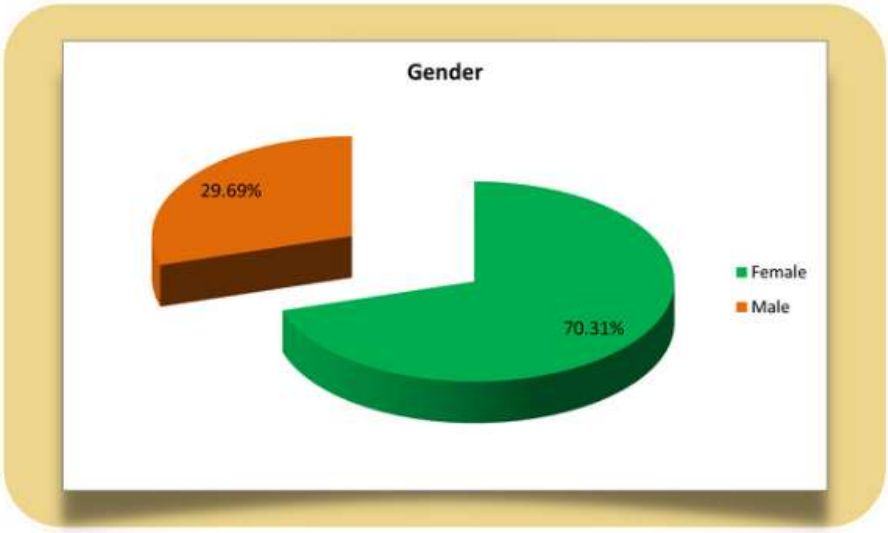


Religion and Belief

The graph above illustrates that 30.9% of the Leicester, Leicestershire and Rutland ICB workforce identify themselves as being Christian, 9% identify as Muslim, and 15% as Hindu. The Christian and Muslim figures mirror those of the 2021 Census, which gives results of 39.2% and 9.2% respectively, for the total resident population of Leicester, Leicestershire and Rutland local authority districts. The number of Hindu employees, is however, almost twice as high as the total number of local residents identifying themselves in that category, which is 8.2%.

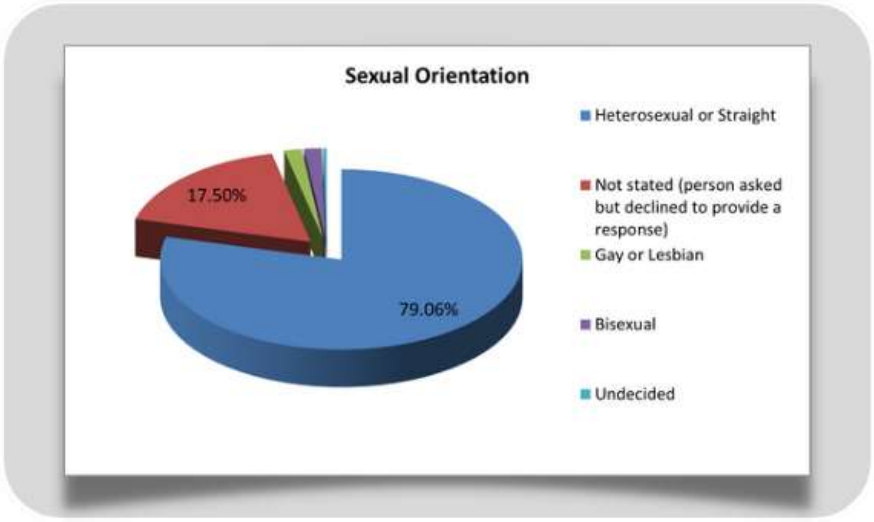
The proportion of the Leicester, Leicestershire and Rutland ICB workforce who chose not to declare their religion is 22.8%. This is almost four times higher than the Census 2021 figure for the same category, for Leicester, Leicestershire and Rutland local authority district residents, at 5.5%.

Sex



The graph above shows that two thirds of the Leicester, Leicestershire and Rutland ICB workforce are female. This reflects the latest available statistics from NHS Digital, which detail that 76.7% of the total NHS workforce are women[4].

In contrast, Census 2021 data from the Office of National Statistics (ONS) shows that 49.5% of residents in Leicester, Leicestershire and Rutland local authority districts are male, and 50.5% are female. This also mirrors the data for both the East Midlands region and England as a whole. Therefore, the number of females who work for the ICB is over representative compared to the local population.



Sexual Orientation

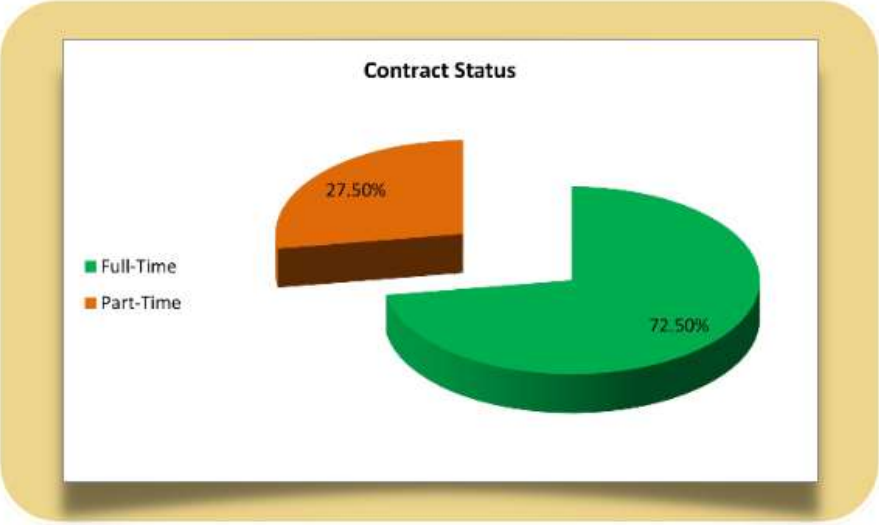
The sexual orientation graph above illustrates that 79% of the Leicester, Leicestershire and Rutland ICB workforce identify themselves as heterosexual or straight. This is slightly lower than the Census 2021 data for Leicester, Leicestershire and Rutland local authority districts, which details that 89.5% of the total resident population aged 16 and above have listed themselves in the same category.

As is shown above, 17.5% of the Leicester, Leicestershire and Rutland ICB workforce chose not to declare their sexual orientation status. This figure is almost ten percent higher than the Census 2021 data for Leicester, Leicestershire and Rutland local authority districts, which details that 7.8% of the total resident population over the age of 16 chose not to answer this question on their census form.

The total lesbian, gay or bisexual ICB workforce population is slightly higher than the equivalent population for England and Wales at 2.8%, as reported in the Census 2021 results.

[4] https://www.england.nhs.uk/2021/03/nhs-celebrates-the-vital-role-hundreds-of-thousands-of-women-have-played-in-the-pandemic/

Contract Status



The contract status figures shown in the graph above illustrate that just over two thirds of the total LLR ICB workforce are employed on a full-time basis. This mirrors the Census 2021 data from the Office of National Statistics (ONS), which details that 69.3% of the total population of Leicester, Leicestershire and Rutland local authority districts who are aged 16 and over and were in employment a week before the census, are contracted on a full-time basis also.

Workforce Race Equality Standard (WRES) 2022

The Leicester, Leicestershire and Rutland ICB is required to demonstrate “due regard” (consideration) to the Workforce Race Equality Standard (WRES), and in meeting our requirements of the ICB Assurance Framework, which means monitoring and supporting NHS and other large provider organisations with progression of the Standard.

We aim to fully understand the diversity of our workforce to ensure non-discriminatory practice, work with staff and staff representatives. The Standard helps identify and eliminate barriers and discrimination in line with the Public Sector Equality Duty (PSED), the Equality Act 2010 and Employment Statutory Code of Practice. Ultimately, it is about ensuring an inclusive approach with regards to recruitment, training and promotion.

Since its introduction in 2015, the WRES has required NHS trusts and clinical commissioning groups (now ICBs) to self-assess annually, on nine indicators of workforce race equality. These include indicators related to BAME (black, Asian, and minority ethnic) representation at senior and board level. The WRES requirement for ICBs was paused during the reporting year as we were newly established organisations.

Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) was introduced in April 2019 as a mandated data collection for NHS provider trusts. The WDES is a collection of 10 metrics that aim to compare the workplace and career experiences of disabled and non-disabled staff. NHS Trusts and Foundation Trusts are required to report and publish data, on an annual basis, for each of these metrics.

At present, Integrated Care Boards (ICBs) are not required to undertake the WDES assessment. However, as part of our commitment to workforce equality and inclusion we included an action in our Equality, Diversity & Inclusion (EDI) Action Plan to voluntarily commence work on the WDES for the new Integrated Care Board (ICB). It is also important as the ICB plays an active role in the development of EDI across the system.

In October 2022 we presented a report of our first voluntary analysis to the Operational Delivery Group. We will be looking to run a development session with this group to discuss the results when we have next year's data for comparison. This report can be found in Appendix B.

The Gender Pay Gap Reporting

The specific duty regulations contain an obligation for public bodies with 250 or more staff to publish gender pay gap information each year. This duty to publish will apply to ICBs from 30 March 2024. However, the published data will cover our workforce profile on 31 March 2023, so will be collected and recorded. This is known as a snapshot.

Training and Development Opportunities

Welcome sessions

The aim of these sessions is to welcome new starters to the LLR ICB and to provide them an overview of who we are, the system that we are operating in, what they can expect from working for us as well as signposting to useful information. The welcome sessions include an EDI workshop exploring people's knowledge, and explaining the basic concepts, relevant legislation and organisational requirements.

EDI Mandatory training

LLR ICB staff are required to complete an on-line EDI training module every 3 years which is accessed via the Electronic Staff Record (ESR). The table below shows the level of compliance for all ICB staff including lay members as of September 2022:

Competency	All Workers	
	Match	No Match
NHS|CSTF Equality, Diversity and Human Rights - 3 Years	90.03%	9.97%

Details of other training and development can be found in the action plan at the end of this report, and in the Working in collaboration with LLR System Partners section.

Communication with Staff and the Wider Community

A range of communication options are regularly viewed by our staff via the following methods:

- LLR Connect – fortnightly newsletter
- Five on Friday – top 5 articles for our partners and stakeholders
- Social media (Facebook, Instagram and Twitter)
- Regular staff briefings (Virtual)
- Regular team meetings
- Pulse Survey
- Stakeholder bulletin – circulated every Thursday to external partners, MPs and stakeholders
- Annual Staff Survey

- Ad-hoc email communications to all staff
- MP briefings

Each month, we share equality awareness articles in our staff newsletters. The articles raise the profile of key equality related dates across the UK, and allows us to draw attention to local awareness and celebration events.

From July 2022 to February 2023, the ICB has promoted a range of events that promote awareness and celebration of protected characteristics and other groups including (but not limited to):

- Eid al-Adha
- South Asian Heritage Month (July-August 2022)
- World Alzheimer's Day (September 2022)
- Navratri
- Active bystander programme was mentioned at LLR ICB staff brief by Andy Williams CEO 06/09/22. Advertised in LLR connect October 28th, 2022
- Diwali promoted by Rachna Vyas Chief Operating Officer in a video clip
- International Day of Older people October 2022
- Black History Month October 2022
- World Mental Health Day: 10 October 2022
- Events for International Men's Day November 2022
- Women in Clinical leadership conference. Guest speakers included Alice Mc Gee Chief People Officer LLR ICB, Dr Nil Sanganee, Chief Medical Officer LLR ICB and Rebecca Carlin Senior OD and Workforce Manager LLR ICB November 2022.
- Anti-bullying week Nov 22
- Chinese or Lunar New Year - 'Gong Hei Fat Choy' (Happy New Year) message Jan 2023.
- Race Equality Week with an organisational anti-racist pledge made by Alice Mc Gee, Chief People Officer February 2023
- LGBTQ+ History Month with a pledge to the month made by Alice Mc Gee, Chief People Officer February 2023

Support for Staff

We have several policies in place to support staff when they have a concern about abuse, harassment, bullying or violence. Equality Impact Assessments were recently undertaken on the following policies:

- Grievance Policy
- Harassment and Bullying at Work Policy
- Health & Wellbeing policy
- Whistleblowing Policy

We will be piloting **Your Voice** in 2023, which is an online reporting tool for staff experiencing harassment, victimisation and discrimination (see the Working in collaboration with LLR System Partners section below for more information).

Working in Collaboration with LLR system partners

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.

Working collaboratively, the LLR systemwide Equality, Diversity and Inclusion (EDI) Group recently identified a number of priority areas. A brief explanation and update on each area is provided below:

- **Reverse Mentoring** – seeks to pair a BAME, Disabled or LGBT+ member of staff with a senior NHS leader in a co-mentoring relationship. **Update:** Four pairs were matched from the ICB during this reporting period. There is also information about the celebratory event which took place in December where we shared feedback from the participants on page 45.
- **The Inclusive Decision-Making Framework** – is a new way of embedding Equality, Diversity and Inclusion into our culture and addressing bias in decision making. See page 15 of this report for more information.
- **Six High Impact Actions** - developed by the Midlands NHSE regional EDI Team. This forms the priority actions contained in the Midlands Workforce Race Equality Standard (WRES) and is

included in our WRES Action Plan as well as the updated action plan contained in this report. **Update:** These priority actions are now part of a wider system self-assessment tool to deliver the Workforce Strategy. The last collaborative system report was produced in December 2022.

- **Active Bystander Programme (ABP)** – a pro-active organisational approach to address harmful behaviours, promote an inclusive and compassionate culture, and role model our system values and expectations. **Update:** A pilot phase of the programme was successfully implemented across LLR, with 100 places offered across 5 groups between October 2022 and February 2023. Workshops are being followed up with monthly Action Learning Sets to embed learning, create a community of practice, and foster cultural change in 2023. Plans for a regional scale up of the ABP across Midlands ICS organisations is in the 'set up' phase and the national scale up offer is in the 'design' phase for summer 2023.

- **Your Voice** – an online tool for LLR NHS staff is (in its initial phase) for reporting experiences of harassment, victimisation and discrimination. Signposting to support available will be part of the tool. **Update:** An engagement exercise including workshops to establish and support the tool across LLR NHS organisations has been completed, and work on the design of the Your Voice platform pages for Leicester Partnership Trust and LLR Integrated Care Board is underway. This work has supported University Hospitals Leicester to explore and strengthen the support framework within the organisation.

- **LLR Staff Networks** – **Update:** The Staff Network Chairs forum has been set up with a schedule of quarterly meetings. Group members can also attend the new Equalities Advisory Committee – see below.

- **Equality, Diversity and Inclusion Advisory Committee** – a new LLR EDI Advisory Committee held its inaugural meeting in November 2022.The Committee has been set up to create a continued focus on the approach LLR takes to EDI both for its staff and our communities. The EDI advisory committee will be focussed on learning, developing and testing thinking around the equality, diversity and inclusion agenda.

  The delivery of the People Plan, of which EDI is a key component, remains the responsibility of the People and Culture Board. However, the Advisory Committee will be responsible for looking at our health

and social care priorities from a lens of our staff and our diverse population to ensure we are considering factors relating to diversity in our decision making.

The Advisory Committee is not a formal decision-making committee, but one whose format and purpose is to learn together in an open way, challenge issues in a respectful manner and collaborate to pool expertise to ensure progress is made.

The membership will have Non-Executive Directors, Directors, Staff Network representatives and EDI experts from across health, social care and the wider public sector.

The advisory committee meets quarterly to review progress and learn together. It is anticipated that the outputs of the advisory committee will form agenda items for both the NHS Integrated Care Board and the Health and Well Being Partnership.

- **Cultural Competency –** currently developing 'Cultural Enablers' which is a programme of work to support colleagues to be more culturally competent and to support enablers across the system.

Developing Diverse Leadership Programme (DDL)

LLR is focussed on creating and sustaining an inclusive culture for people working in, and people accessing our health and care system. To deliver great health and care across LLR, we know that it is important to encourage and support colleagues from diverse backgrounds to step into leadership roles. Whilst we have many success stories, our Workforce Race Equality Standard (WRES) data showed that there are differences around progression for nursing, Advanced Allied Professionals (AHP) and midwifery colleagues from BAME backgrounds compared to other ethnic groups.

The 'Developing Diverse Leaders (DDL)' tailor-made LLR pilot programme for aspiring black, Asian and minority ethnic leaders in the workplace, was designed and launched in October 2022, and was specifically aimed at Midwifery, Nursing and Allied Health Professionals AHP (Bands, 5-7) and their line managers.

The programme aims to support our leaders of the future, increase diversity at a leadership level - leading to better outcomes for colleagues

and the communities we serve - and to offer opportunity and access to development and career progression to BAME colleagues.

First Steps

In LLR we set out to embed diverse leadership differently – rather than just creating an isolated development programme for up to 40 BAME colleagues that want to move into leadership roles, we created a holistic programme that includes:

- An aligned development programme for the line managers of the participants
- Shared Action Learning Sets for participants and line managers to learn, grow and develop together
- Deep levels of organisational support via organisational leads
- Committed executive sponsorship and commitment to developing colleagues
- Informal networking and support opportunities for participants
- Further support via ‘drop-in’ sessions with executive leaders, organisational leads during the programme and access to coaching and/or mentoring via the LLR Leadership Academy
- Ongoing check-ins and career reporting to understand each participant’s career aspirations and career successes over the next two-years

This approach means that participants have access to ongoing support and development, outside of just attending a traditional training programme. We hope that by taking a systemic and long-term approach like this, we can enable participants to achieve their leadership aspirations.

Positive Change

The pilot programme has only been running for 4-months at the time of writing, but already feedback from participants and line managers has been incredibly positive. We are delighted to report that:

- relationships and trust have been developed within the groups, which appear to be consolidating into ongoing peer-to-peer support.
- participants have reported key ‘moments of impact’, such as personal branding, unconscious bias, intersectionality and privilege, and that their confidence levels have increased significantly.

- opportunities for reflective practice have been welcomed, and many participants are already sharing their new knowledge and understanding with other colleagues.

The project will be tracking the longer-term outcomes of this programme over the next 12-18 months, but this pilot programme is already demonstrating the power and impact that comes from BAME colleagues having the opportunity to focus on their own development. We are seeing our staff blossom with confidence and optimism to have the careers they want for themselves!

Time for Celebration

Success at the Midlands Inclusivity and Diversity Awards

There was success for the local NHS in Leicester, Leicestershire and Rutland (LLR), at the first MIDAS awards, with a hat trick of wins!

This year, NHS England – Midlands launched a new award scheme which recognises innovative and excellent ways of working by staff, managers, and leaders across the region, to make the Midlands a more inclusive place to work for all our NHS people.

The Midlands Inclusivity and Diversity Award Scheme - also known as 'MIDAS' – aims to celebrate and share good practice following the launch of the Midlands Workforce Race Equality and Inclusion Strategy (WREIS) last year.

The first MIDAS awards ceremony was held virtually on Friday 18 November 2022, with LLR winning three of the seven awards:

- **Inclusive Integrated Care System (ICS) of the Year Award** – awarded to Leicester, Leicestershire and Rutland ICS
- **Excellence in Executive Inclusive Leadership Award** – awarded to Angela Hillery, Chief Executive at Northamptonshire Healthcare NHS Foundation Trust and Leicestershire Partnership NHS Trust
- **EDI Champion of the Year Award** – awarded to Asha Day, Head of International Recruitment at Leicestershire Partnership NHS Trust

For a full list of winners and runners up, visit:
https://www.england.nhs.uk/midlands/wrei/midas-awards/

Rachna Vyas, Chief Operating Officer for the Leicester, Leicestershire and Rutland ICB, named as one of the 50 most influential Black, Asian and Minority Ethnic people in health

An article published by the Health Service Journal (HSJ) highlighted Rachna's work on the design and delivery of transformed models of care and the development of integrated services at place and neighbourhood level across Leicester, Leicestershire and Rutland.

Leicester is one of the country's most diverse cities and some of Rachna's work has focused on ensuring covid vaccination rates in the area are as high as possible.

Reverse Mentoring Celebration Event

ICB colleagues (including the CEO Andy Williams, Dave Sissling Independent Chair, and Alice McGee Chief People Officer) were part of the reverse mentoring celebration event which took place on the 9th December together with other system colleagues. The event celebrated all those who have been involved with the programme over the past 3 years.

Feedback from the event:

Mentees, mentors and attending leaders were asked to provide feedback on their reverse mentoring experiences, its impact and what changes they believed we can make going forward to go from good to excellent:

- As a mentor one has to have courage to empower others, make changes and take action.
- Reverse mentoring provided a safe space to have difficult conversations about differences, mutuality.
- It leads to better understanding about difficult subjects and mistakes made in the past.
- It brought forth emotions like being uncomfortable, awkward moments of silence, fearful of the unknown and its outcomes, sadness, shock, anger, trauma, assumptions, vulnerability, fear, guilt, anxiousness, ignorance, unconscious biases and personal traits. But it also brings forth experiences of excitement,

happiness, connectedness, positive intrigue, belief, acceptance, lifelong learning and lessons.

- Mentors put themselves forward to show vulnerabilities, fragilities and impact change.
- It raises awareness that we don't have all the answers.
- It helps people understand what it means to have white privilege.
- You need to have a willingness to understand and break down barriers.
- It gives you courage to empower others, make changes and take action.

The Impact of Reverse Mentoring:

- It helps you consider all perspectives, to look at equality and equity
- Reverse mentoring helps challenge thought processes and assumptions.
- As mentors and mentees, we learnt together about history, race, love, life, and health.
- We have personal growth, feel stronger and feel Reverse Mentoring has changed us forever.
- We can use the experience to impact wider change.
- We can question and challenge others.
- We have gratitude for the time taken to complete the programme.
- It builds relationships and trust beyond the programme

Health Inequalities

Health inequalities are avoidable and unfair differences in health between different groups of people. Health inequalities concern not only people's health but the differences in care they receive and the opportunities they have to lead healthy lives.

Those living in the most deprived areas often have poorer health, as do some ethnically diverse groups and vulnerable/socially excluded groups. These inequalities are due to many factors, such as income, education and the general conditions in which many people are living. In addition, the most disadvantaged groups are not only more likely to get ill, but less likely to access services when they are ill.

Health Inequalities have been made worse by the Coronavirus pandemic, which has hit hardest the groups who already did not have the best health. The rate of people dying from the virus has been higher in more economically deprived areas and among some ethnically diverse communities and amongst disabled people. People in crowded housing, on low wages, unstable or frontline work have also experienced a greater impact from Covid 19.

The NHS contributes to tackling inequalities in health in three distinct ways:

1. **Influencing multi-agency action to address social determinants of health -** The role of integrated care systems (ICSs) working with local authorities and local communities is particularly critical here.

2. **The NHS is a significant economic actor in its own right -** The choices we make as an employer, a purchaser and a local 'anchor institution' can help moderate inequalities.

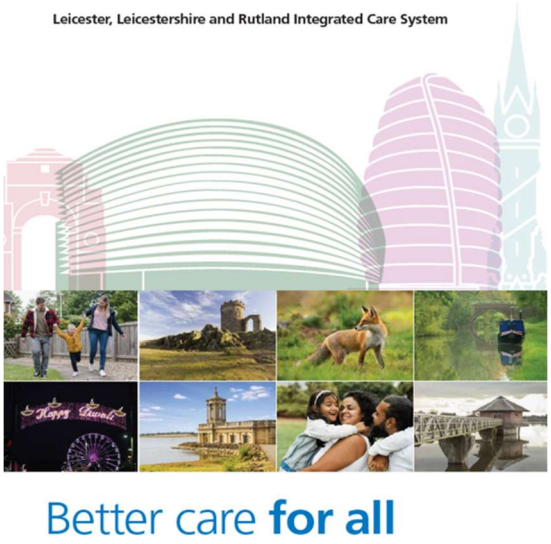
3. **Tackling inequalities in healthcare provision -** This is our direct responsibility and must be the prime focus of our action. The enduring mission of the NHS is high quality care for all. That means tackling the relative disparities in access to services, patient experience and healthcare outcomes.

Great work is happening across a number of organisations to address healthcare inequalities and we are committed to working with our partners to further enhance and accelerate this.

There is always going to be variation in health outcomes within a population, some variation is unavoidable, due to people's age or genetics, but many differences in health are avoidable, unjust and unfair.

It is because we are concerned about this that the LLR Health Inequalities Framework – Better care for all, has been developed.

The LLR Health Inequalities Framework



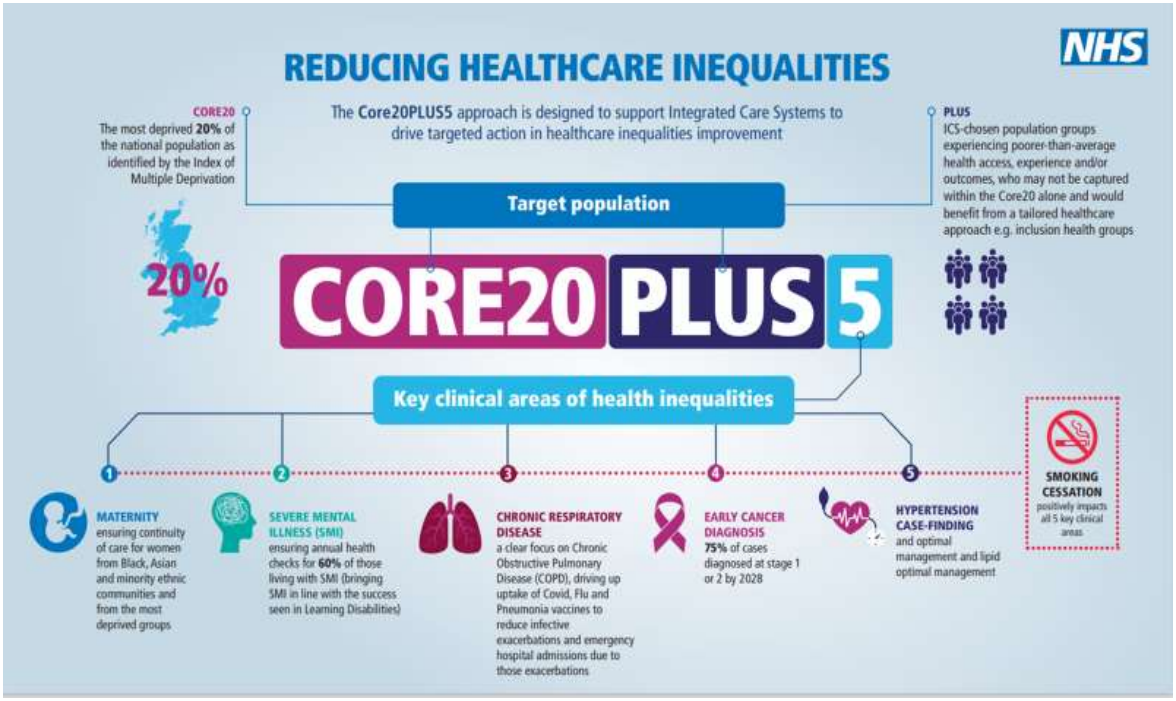
The LLR Health Inequalities Framework is the result of a collaboration of partners from across LLR, including the local NHS, Public Health, Health Watches and Local Authorities. It sets out our commitment to reducing health inequalities as a core purpose for the ICB, and for the future partnership which the Integrated Care System (ICS) represents.

The document sets out the principles we will work to, and the key actions we will take at system level to improve access to, experience of, and outcomes from local NHS services. This framework has been very positively received at regional and national levels.

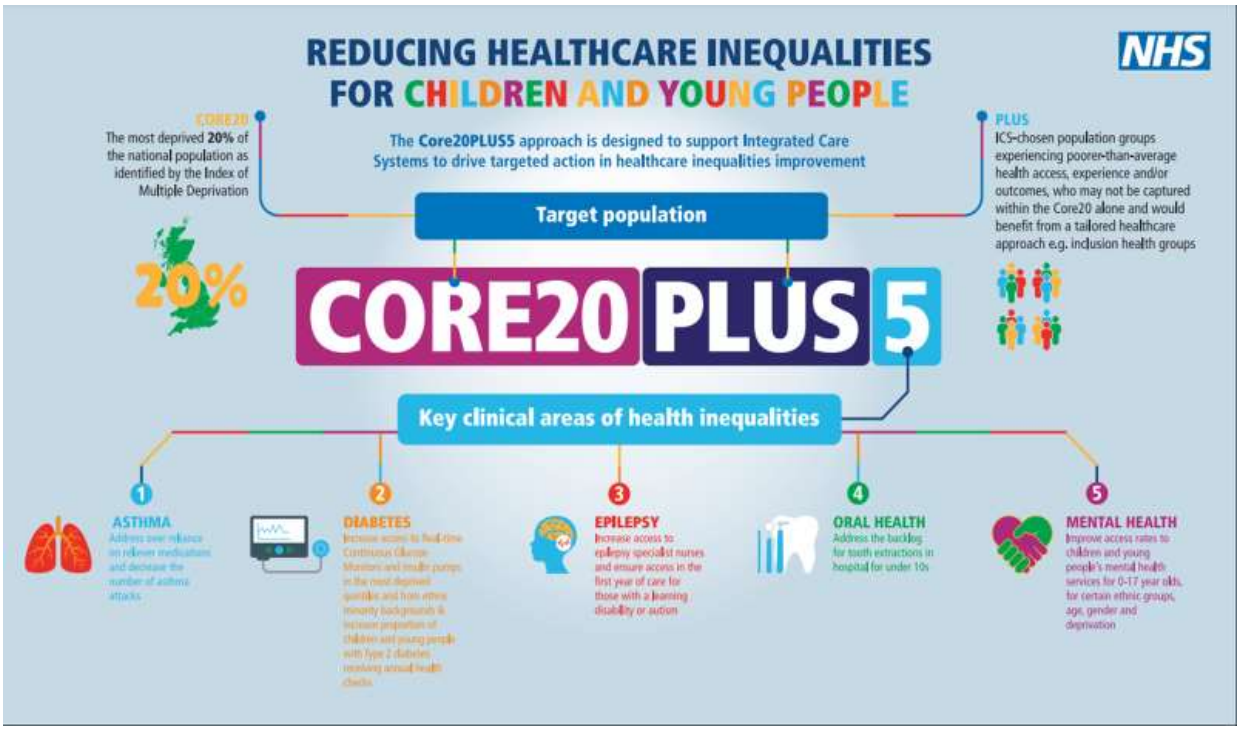
Core20PLUS5 Framework

The NHS focus on reducing healthcare inequalities is stronger each year. The LLR ICB will be working on this agenda using the CORE20Plus5 framework. The framework asks the NHS to have developed specific plans for how it will improve access, experience and outcomes for:

- people in the least affluent 20% of the population (**Core 20**)
- for locally identified additional vulnerable populations such as those who are homeless and those with a learning disability etc. (**Plus**)
- any of the following five key clinical areas of healthcare – cancer, severe mental illness, high blood pressure, pregnancy and birth, lung problems (**5**)



In November 2022, the Core20Plus5 framework was expanded to include children and young people in five different key clinical areas – asthma, diabetes, epilepsy, oral Health and mental Health:



These frameworks emphasise that the detailed plans to reduce health inequalities in each of the three “places” in LLR – Leicester City, Leicestershire, and Rutland – will be led by the local Health and Wellbeing Boards, based on their knowledge of their population’s needs. These plans will be published in each area as a refresh of their Health and Wellbeing Strategies.

Five National Key Priorities for Systems and Providers

There are also five national key priorities for systems and providers that we will focus on in Leicester, Leicestershire and Rutland and they are as follows:

Priority 1: Restoring NHS services inclusively

NHS performance reports should be broken down by patient ethnicity and Index of Multiple Deprivation (IMD) quintile, focusing on:

- Under-utilisation of services (e.g., proportions of cancelled appointments)
- Waiting lists
- Immunisation and screening
- Late cancer presentations

Priority 2: Mitigating against 'digital exclusion'

- Ensure providers offer face-to-face care to patients who cannot use remote services
- Ensure more complete data collection, to identify who is accessing face-to-face, telephone and/or video consultations (broken down by patient age, ethnicity, IMD quintile, disability status or condition)

Priority 3: Ensuring datasets are complete and timely

- Improve collection of data on ethnicity, across primary care, outpatients, A&E, mental health, community services and specialised commissioning.

Priority 4: Accelerating preventative programmes

- Flu and Covid vaccinations
- Annual health checks for people with severe mental illness (SMI) and learning disabilities
- Continuity of maternity carers
- Targeting long-term condition diagnosis and management

Priority 5: Strengthening leadership and accountability

- System and provider health inequalities leads to access Health Equity Partnership Programme training, as well as the wider support offer, including utilising a new Health Inequalities Leadership Framework (to be developed).

Fair Allocation of Resources for GP Practices

The model, created by one of our ICB primary care doctors was developed using local population health data. The new model aims to ensure that practices have a fair allocation of funding based on the needs of our resident population. Practices in areas where health outcomes are poor will need greater resources to help bring these outcomes up to the level of the healthiest places in LLR. This model will help achieve that over time. LLR is the first place in the country to do this and our work has received some very positive interest from NHS England as a possible model for other areas.

Equality Impact Assessments and Health Inequalities

The ICBs Equality, Health Inequalities, Impact and Risk Assessment template has a section specifically on health inequalities and protected characteristics which require project leads to assess for adverse impacts.

In July 2022 we improved the accessibility of the EHIIRA stage 2 template which includes new interactive tools such as drop-down menus. Additionally, the health inequalities section has been strengthened to provide the opportunity for a more detailed analysis of inclusion health groups and reflect new requirements such as Core20PLUS5.

During early 2023 planning is taking place with ICS colleagues to develop a shared equality impact assessment template which we aim to align to the health equity assessment tool and underpins the inclusive decision-making framework noted on page 15.

The ICB 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.

Engagement

LLR ICB People and Communities Strategy (2022-2024)

This past year we have focused on the development of the LLR ICB People and Communities Strategy (2022-2024). This collaborative strategy sets out how the ICB will work with people and communities. It has been developed by partners in the health system and after discussion with stakeholders.

The Strategy has been built on firm foundations of participation, involvement and engagement with people and communities over many years in LLR organisations - commissioners, providers and partners. We have recognised what has worked well and what can be done better, reflected on it and implemented improvements. We have identified many priorities through the strategy with the main objective of embedding public and patient engagement and involvement at all levels through the ICB.

Voluntary, Community and Social Enterprise (VCSE) Alliance

One of the first areas for implementation was the development and launch of a new Voluntary, Community and Social Enterprise (VCSE) Alliance, aimed to grow strong and mutually beneficial relationships with the voluntary and community sector, social enterprises and volunteers to tackle health inequalities and empower communities. Co-designed with VCSE organisations from across LLR, we have created a unique and successful way to share, collaborate and promote projects with the sector, and actively give it a voice through the ICB regardless of size, reach or experience.

With over 100 local organisations now VCSE Alliance members, we can reach into the most diverse communities and to those with whom we often seldom engage.

The VCSE Alliance plays an integral and central part of our decision making and through this model we can demonstrate we have the right methods and processes in place to reach people in the best way. This often is through collaboration, and by working with both our NHS partners and the VCSE, we can tailor our approaches to suit targeted audiences.

Through the VCSE Alliance, we remain committed to working with and commissioning organisations that can offer us specific and specialist engagement on our behalf when it is best to do so.

Specialist Engagement with Communities

In November 2022, we commissioned a local VCS organisation to coordinate rural engagement on the Hinckley hospital (which begins in January 2023), to undertake specific outreach with population cohorts to ensure that they were aware of the engagement and encourage people to take part and have their voices heard.

In January 2023, we invited VCS organisations to bid to reach out to people and communities who have used the A&E at Leicester Royal Infirmary but could have been more appropriately seen and treated elsewhere.

Through this funding opportunity, we are looking to reach those who live within a 1mile radius of Leicester Royal Infirmary and communities living in the Leicester City boundary on the main arterial roads into Leicester City, most specifically:

- Families with babies and young children under the age of 10
- People within the age group of 21-30 years (young professionals) and 31-40 years. These groups are also most likely to have children 10 years or under
- People experiencing homelessness
- Refugees and asylum seekers
- Eastern European and black, Asian, and minority ethnic communities
- Other groups with particular barriers to healthcare access.

The contract term will run from February 2023 to the end of April 2023 and will be managed through the new VCSE Alliance model.

Insights, Behaviour and Research Hub

As an Integrated Care Board (ICB) we are an organisation who are rich with data and insight. The current issue is there is no central point to access this insight, which can aid many of our collaboratives, design groups and workstreams. There is an opportunity with the implementation of a systematic and structured hub to help address this issue and make the ICB partners work more efficiently.

The objectives of the Insights, Behaviour and Research Hub are to:

- Provide information and aid in identifying gaps to help to promote understanding of what people need (including our most vulnerable groups) from local NHS services.
- Support the Integrated Care System (ICS) teams and delivery groups to interpret, utilise and identify gaps from the data in planning and decision-making processes.
- Provide the system Quality and Safety Committee with robust data that supports them to provide assurance to the ICB Board with regard to the safety and quality of care to the population we serve.
- Enable patterns of poor quality to be identified and reported to the Quality and Safety Committee and other appropriate committees.
- Tackle health inequalities by helping to ensure that we are involving a true representation of our population.
- Encourage collaboration with delivery groups to identify the impact of intelligence and articulate clearly, the difference it has made.
- Promote collaboration between initially the ICB, Leicestershire Partnership Trust (LPT) and University of Hospitals Leicester (UHL). In the longer term it will also support joint working with Healthwatch organisations, local authorities and other organisations with common interests for added value for organisations and patients.
- Provide and encourage data sharing securely across organisations which encourages financial savings by developing joint systems and processes that reduce duplication.
- Feedback to people and communities so that they can see how their voice has impacted services.
- Allow information provided by partners to be accessible in the hub.
- Ensure that the information is structured by place and communities that aligns with the ICB strategy.

We are currently in a 6-month pilot with a software company to develop the Hub, to ensure it can meet our needs and is effective to support the ICB and wider health system in the future.

Action Plan Update July 2022 – March 2023

Overarching Equality Objective: To reduce unacceptable differences in the health inequalities of all people who live within Leicester, Leicestershire & Rutland		
Equality Objective	**Linked to EDS Goal**	**Update**
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	Last year's Equality Delivery System (EDS) analysis highlighted some of the key findings of the GP practice survey broken down by 8 protected characteristics. The survey and its findings related to EDS goals one and two. Following the initial response and recommendations the LLR CCG/ICB worked with the voluntary and the community sector (VCS) together with carers across Leicester, Leicestershire, and Rutland to explore their views and experiences of GP-led primary care services during the Covid-19 pandemic. As well as exploring any issues it was important to explore these because of the low response rates from certain equality groups. The follow up involved in-depth and group interviews with members of VCS and carers. These interviews were carried out via video calls and face-to-face. A number of new recommendations were developed to ensure they picked up the issues noted in the EDS analysis. The analysis was presented to Public and Patient Involvement Assurance Group (PPIAG) in February 2022 and the recommendations from this meeting has also be taken forward. The section below explores some of the work undertaken this year. A summary of the the EDS analysis was presented in the previous

		Annual Report. For a copy of the Annual Report 2021/22 or the EDS analysis please email: equality.inclusion@nhs.net.
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	EDS primary care (access and experience): We continue to work closely with primary care colleagues, GP practices and practice managers on their improvement plans for patient access and experience. To assist, we have commissioned work with the voluntary and community sector (VCS) to share messages across communities, particularly promoting the new 'Get in the Know about local health services' campaign. We have chosen 10 GP practices to work with, offering additional support with website development, events and surveying. We continue to work with the Patient Public Involvement (PPI) Assurance Group to share developments, and with Patient Participation Groups (PPGs) to share best practice. We are supporting a digital access programme with Age UK which is trialling the training of patients on the use of computers to order prescriptions, make appointments and have online consultations.

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	**3. & 3.1** Overview: In May 2021, the NHSE/I Midlands EDI team launched their Workforce Race Equality and Inclusion Strategy (WREI). Whilst primarily focussed on addressing inequality for BAME staff it is also aimed at all the protected characteristics. Initially, there were 6 actions identified as priorities. Most of these (which we are progressing on/working towards) are also found in the ICBs WRES Action Plan and are linked to our recruitment, selection and progression process. • Ensure ESMs own the agenda as part of cultural changes with improvements in BAME representation (and other underrepresented groups) e.g., targets linked to recruitment. • Diverse interview panels • Organise talent panels • Enhance EDI support available • Overhaul the interview process • Adopt resources guides and tools for productive conversations around race Subsequently the Midlands NHSE team developed an assessment tool containing the priorities above and a number of other actions to deliver all the requirements in the WREI strategy. This is updated on a regular basis and submitted to the Regional team. The last collective assessment was held on 6/12/2022.

		We have a number of workstreams taking place across the system to support a representative and supported workforce and more information on these can be found in the Working in collaboration with LLR system partners section. The ICB also voluntarily reported against the Workforce Disability Equality Standard (WDES) in October 2022. A copy of the analysis can be found in **APPENDIX B. The workforce Race Equality Standard (WRES) was suspended for the reporting year.** **3.3 – Training & Development** The ICB is actively involved in the system wide training and development initiatives taking place such as Active Bystander and the Cultural Competency enabler programme. For more information see Working in collaboration with LLR system partner's. **3.4** Free from abuse, harassment, bullying, violence at work **See 'Your Voice' and Active bystander programme in the working in collaboration with LLR partners section. This information is also captured in the WDES (attached at appendix B) and staff survey.** **3.5** – We have a new revised Flexible Working Policy. The policy outlines that the ICB is committed to offering flexible, modern employment practices which recognise that all our employees want to strike a sensible balance between their work and home life. LLR ICB recognises that different balances may be needed at different times during an employee's working life.

		The purpose of this policy is to highlight the options available for managers and employees to consider when trying to achieve the right work life balance for an employee. **3.6** The results of the staff survey will be incorporated into our staff survey action plan and is not available at the time of reporting.
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	**4.1** In March 2021, a report on the external peer review of goal 4 for 2020/21 was approved at the Governing Board. One of the recommendations was: To include an EDI section in the staff newsletter and ensure that we have that dedicated focus on EDI including how the board are supporting this on a monthly basis. This could include the promotion of EDI awareness events throughout the year e.g., Diwali & Eid. A number of these events and others in the report have been promoted by senior leaders and are found in the main report and in the section called 'communication with our staff and wider community'. **4.2 The n**umber of EIAs undertaken July-February is **12** The ICB are also developing a joint ICB Quality Impact Assessment and Equality Impact Assessment Policy (EQIA) with links to relevant resources and templates. The current ICB EHIIRA template will be used until we have developed a system version.

		At the time of writing the ICB are also looking at a new governance structure for reviewing EIAs and Quality Impact Assessments.

Conclusion

The development of the ICS will allow a greater focus on preventing ill-health and managing long-term health conditions proactively to keep people well and out of hospital wherever possible.

We still face major operational challenges: tackling backlogs, meeting deferred demand, new care needs, changing public expectations, tackling longstanding health inequalities, enabling respite and recovery for those who have been at the frontline of our response, and re-adjusting to a post-pandemic financial regime. The intensity of the incident may have abated, but we are still managing exceptional pressure and uncertainty, with differential impacts across the country.

As we respond, Integrated Care Systems (ICSs) will play a critical role in aligning action between partners to achieve their shared purpose: to improve outcomes and tackle inequalities, to enhance productivity and make best use of resources and to strengthen local communities. To this end, system partners working on the equalities agenda have worked on many collaborative projects noted in this report and will continue to do so. The new Equality Delivery System is very much based on collaborative working.

The LLR ICB continues to demonstrate compliance to our legal and mandated equalities duties. We continue to embed equality considerations into decision making. This includes commissioning decisions that impact our communities and also internal workforce changes which directly or indirectly impact on our workforce.

END

This report was produced by Leicester, Leicestershire and Rutland ICB in conjunction with the Equality, Diversity and Inclusion Team at Midlands and Lancashire Commissioning Support Unit. If you have any feedback about the content of this report, please email equality.inclusion@nhs.net

Appendix A - Protected Characteristics

Age:

This can refer to people of a specific age (e.g. 50 years old) or belonging to a particular age range (e.g. 18 to 30 year olds or the general working age population). Age discrimination includes 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, 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. People with a past disability which falls under the definition remain protected.

Certain medical conditions are protected under the characteristics of disability. These include cancer, HIV and multiple sclerosis. People with genetic conditions would also be protected under this characteristic if the effect of the condition has a substantial and long-term adverse effect.

Sensory impairments such as sight loss, hearing loss and communication difficulties are included under the definition of disability.

Most people will link this characteristic solely to people with visible disabilities such as limited mobility but disability also includes a wide range of invisible disabilities which may be physical or non-physical in their nature.

Invisible disabilities may include learning disabilities and conditions relating to mental health conditions and mental illness. Conditions such as dementia should also be included under this characteristic. Within in the Equality Act, there is no requirement that the mental illness is clinically recognised – the focus is on the impairment rather than the cause.

Autistic Spectrum Conditions (ASC) (sometimes termed as Autistic Spectrum Disorder or Autism) may fall within the definition of disability.

Conditions such as dyslexia and dyscalculia are generally terms as ‘learning difficulties’ and, depending on their impact on the individual, may fit the definition of ‘disability’ under the Equality Act.

In some circumstances, disfigurement may also fit the definition under the Equality Act.

Gender Reassignment:

This refers to a person proposing to undergo, who is undergoing (at any stage of the process), or has undergone the process of reassigning their sex by changing physiological or other attributes of sex. A person does not need to have undergone any specific clinical treatment or surgery to change from birth sex to preferred gender in order to be protected under this characteristic. The term ‘transgender’ is also protected under this characteristic.

Marriage and Civil Partnership:

Protection under this characteristic is given to people that are legally married or in a legal civil partnership. Marriage is defined as a union between a man and a woman, or between same-sex couples. This characteristic only recognises people in formally recognised unions and, therefore, does not include people that are not married, cohabiting couples, widows, divorcees and fiancées. Same-sex couples can also have their relationships recognised as civil partnerships. Civil partners must not be treated less favourably than married couples.

Under the Equality Act, legal protection of this group applies in an employment context only and does not extend to service provision.

Race:

Race includes skin colour, nationality, and/or ethnic or national origins. Nationality is determined by citizenship. This can include specific inclusion health groups such as Gypsy, Roma and Traveller communities, or Asylum Seekers and Refugees.

NHS organisations have adopted the term 'ethnically diverse' to describe groups that are not White British.

Religion and Belief:

The Equality Act does not provide a explicit definition of religion or belief. It includes the main world religions such as Christianity, Islam, Judaism, Hinduism, Sikhism, Humanism, Secularism and Paganism. The Equality Act protects any religion, religious or philosophical belief – this also includes a lack of religion / belief such as Atheism.

Sex:

Sex refers to individual male and female people, but also includes males and females as groups. Sex discrimination involves treating a male or female, or males and females, less favourably for reasons relating to their sex. People describing themselves as non-binary are not currently recognised within the Act.

Sexual Orientation:

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

Pregnancy and Maternity:

The Equality Act protects people that are discriminated against due to their pregnancy or maternity status – which includes breastfeeding. This protection may relate to current or previous pregnancy. Maternity protection extends for 26 weeks from the date of the birth. Protection also includes where a baby was stillborn in cases where the pregnancy progressed for at least 24 weeks prior to birth.

Further information on the nine protected characteristics can be found at: https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

Carers:

A carer is anyone, including children and adults, who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care that they give is unpaid.

Under the Equality Act, it is illegal to discriminate against a carer because of their responsibilities as a carer, or because of the individual(s) they care for.

Appendix B - NHS Workforce Disability Equality Standard (WDES) 2021-22

Analysis

Introduction

1. The aim of this analysis is to raise awareness of the work currently taking place on the NHS Workforce Disability Equality Standard for the ICB.
   The Workforce Disability Equality Standard (WDES) was introduced in April 2019 as a mandated data collection. The WDES consists of 10 metrics (see Appendix A) that aim to compare the workplace and career experiences of Disabled and non-disabled staff. NHS Trusts and NHS Foundation Trusts are required to report and publish data, on an annual basis, for each of these metrics.

2. At present, Integrated Care Boards (ICBs) are not required to undertake the WDES assessment. However, as part of our commitment to workforce equality and inclusion we included an action in our Equality, Diversity & Inclusion (EDI) Action Plan to voluntarily commence work on the WDES for the new Integrated Care Board (ICB). It is also important as the ICB plays an active role in the development of EDI across the system.

3. It is anticipated that ICBs will be required to undertake a WDES assessment possibly in the next reporting year. This analysis will provide baseline data for most of the metrics and will enable a better understanding where any inequalities for disabled colleagues exist.

4. It should be noted that the report is based on the combined LLR CCGs data for the reporting period 2021-2022.

National context

5. The national NHSE 2021 WDES data analysis highlights that Disabled job applicants are less likely to be appointed through shortlisting, whilst Disabled NHS staff are:

- more likely to go through performance management capability processes
- more likely to experience harassment, bullying or abuse
- less likely to feel that they have equal opportunities for career progress or promotion
- more likely to feel pressured to attend work
- less likely to feel valued for their contribution to the organisation, and less likely to feel engaged.

6. Disabled people also continue to be underrepresented in middle to senior pay bands and on Boards.

The importance of WDES

7. The WDES is deeply rooted in the fundamental values, pledges and responsibilities set out in the NHS People Plan and the NHS Constitution.

8. Section 149 of the Equality Act sets out the Public Sector Equality Duty (PSED), which offers protection in relation to employment, as well as access to goods and services. The PSED strengthens the duty on employers to eliminate discrimination and advance equality of opportunity for staff with protected characteristics, including disabled people. Implementing the WDES will assist the ICB to ensure that they are complying with the provisions of the Equality Act 2010, and the aims of the PSED.

9. As of December 2021, 8.4 million people of working age were identified as Disabled. This represents 20% of the working age population and is an increase of 327,000 from 2019. Across the UK, 52.3% of Disabled people were in employment, compared to 81.1% of non-disabled people. In relation to unemployment, the rate for Disabled people was 8.4% in October-December 2021, up from 6.9% a year previously. This compared to an unemployment rate of 4.6% for non-disabled people. (Ref: WDES guidance: House of Commons Library April 2021)

The WDES Metrics (Summary)

10. There are ten (10) WDES metrics.

    - Three (3) metrics focus on workforce data.
    - Five (5) are based on questions from the NHS Staff Survey.
    - One (1) metric focuses on disability representation on boards.
    - One (1) metric (metric 9b) focuses on the voices of Disabled staff. This asks for evidence to be provided within trusts' WDES annual reports.

11. The data on workforce profiles metrics 1,2 and 10 for 2012-22 was not available for the reporting period 2021-2022.

These are:

- Percentage of staff in AfC (Agenda for Change) pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.
- Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.
- Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the board. • By Executive membership of the board.

Analysis of WDES (based on LLR CCG combined data for the reporting period April 2021 - March 2022)

12. The analysis is based on the LLR CCGs data mainly relating to the NHS staff survey. The staff survey offers a snapshot in time of how people experience their working lives. The analysis is to act as a baseline for the anticipated ICB mandatory reporting requirement.

13. Metrics 1 & 2 data not available as noted in paragraph 11.

14. Metric 3 - Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

We cannot meaningfully report against this metric given the very small number of formal capability cases we have in the ICB (then CCG).

15. WDES Metrics 4-9a - LLR CCGs National NHS Staff Survey results 2020 & 2021 *LTC – Long term condition

	LLR CCGs National NHS Staff Survey results 2020 &2021: WDES indicators/Metrics 4-9a				
Metric No	**Staff survey question**	**Disabled people (%)**	**Disabled people (%)**	**Non Disabled people (%)**	**Non Disabled people (%)**
		2020	**2021**	**2020**	**2021**
4a.i	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months	3.4	4.7	4.3	3.6
		Median benchmark* 11.4	**Median benchmark*** 12.0	**Median benchmark*** 8.7	**Median benchmark*** 8.0
Number of respondents		**29/205**	**43/252**	**162/205**	**194/252**

Analysis: The percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives, or the public has risen slightly by **1.3% from 3.4 %** to **4.7%.** This is still substantially below the median of 12%.

In comparison the data shows that non-disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public has decreased slightly by **0.7% to 3.6%** which is also below the median of 8.0%.

The survey results suggest that disabled staff were slightly more likely to experience harassment and bullying, from the public etc., than non-disabled staff **(4.7% compared to 3.6%).**

Metric No	**Staff survey question**	**Disabled people (%)**	**Disabled people (%)**	**Non Disabled people**	**Non Disabled people**

				(%)	(%)
		2020	**2021**	**2020**	**2021**
4a.ii	Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months	24.1	11.6	12.9	7.7
		Median benchmark* 16.9	**Median benchmark*** 12.7	**Median benchmark*** 8.7	**Median benchmark*** 7.2
Number of respondents		**29/205**	**43/252**	**163/205**	**194/252**
4a. iii	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	20.7	9.5	13.6	5.2
		Median benchmark* 18.0	**Median benchmark*** 15.6	**Median benchmark*** 9.1	**Median benchmark*** 8.1
Number of respondents		**29/205**	**42/252**	**162/205**	**194/252**

Analysis of 4a ii & iii - bullying and harassment from managers and colleagues Disabled staff experiencing harassment, bullying or abuse from managers has decreased significantly **from 24.1% to 11.6%.** There was also a **11.2%** decrease in harassment etc., from other colleagues from **20.7% to 9.5 %.** These figures are also under the median values.

Non-disabled staff experiencing bulling and harassment from managers has decreased from **12.9% to 7.7%** and from colleagues from **13.6% to 5.2%.**

There has been a decrease in harassment etc., for both metrics for disabled and non-disabled staff in the 2021 survey. However, the results suggest that disabled staff were more likely to experience harassment etc., from managers **(11.6% compared to 7.7%)** and other colleagues **(9.5% compared to 5.2%).**

Metric No	Staff survey question	Disabled people (%)	Disabled people (%)	Non Disabled people (%)	Non Disabled people (%)
		2020	**2021**	**2020**	**2021**
4.b	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	-	-	33.3	25.0
		Median benchmark*	**Median benchmark***	**Median benchmark***	**Median benchmark***
		45.5	46.2	43.2	46.4
Number of respondents		**9/205**	**7/252**	**33/205**	**28/22**
Analysis: There were no disabled staff members (2020 &2021) who said that the last time they experienced harassment, bullying or abuse at work, they or a colleague formally reported it. The responses from non - disabled people decreased by **8.3% to 25.0%** and is significantly lower than the median of 46.4%. The number of staff responding to this question in the survey was low.					

Metric No	Staff survey question	Disabled people (%)	Disabled people (%)	Non Disabled people (%)	Non Disabled people (%)
		2020	**2021**	**2020**	**2021**
5.	Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	48.1	63.0	63.9	65.8
		Median benchmark*	**Median benchmark***	**Median benchmark***	**Median benchmark***
		55.5	56.5	61.5	63.0
Number of respondents		**27/205**	**46/252**	**169/205**	**202/252**

Analysis: The percentage disabled respondents believing that the organisation provides equal opportunities for career progression or promotion has seen a significant increase of **14.9% to 63.0% from 48.1%.** This is above the median of 56.5%

Non-disabled staff believing that their organisation provides equal opportunities for career progression or promotion increased slightly from **63.9% to 65.8%** which is also above the median of 63.0%.

Metric No	Staff survey question	Disabled people (%)	Disabled people (%)	Non Disabled people (%)	Non Disabled people (%)
		2020	**2021**	**2020**	**2021**
6.	Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	11.8	12.5	14.5	15.4
		Median benchmark* 19.8	**Median benchmark*** 15.0	**Median benchmark*** 12.7	**Median benchmark*** 11.2
Number of respondents		**17/205**	**32/252**	**76/205**	**91/252**

Analysis: The data shows that both disabled and non-disabled staff who have felt pressure from their manager to come to work, has increased slightly, despite not feeling well enough to perform their duties; from **11.8% to 12.5%** for disabled staff and from **14.5% to 15.4%** for non-disabled staff.

The figure for disabled staff is below the median of 15.0%, while the figure for non-disabled staff is above the median of 11.2%.

The figures suggest that non-disabled people are more likely to feel pressure to come to work disabled people when feeling unwell.

Metric No	Staff survey question	Disabled people (%)	Disabled people (%)	Non Disabled people (%)	Non Disabled people (%)
		2020	**2021**	**2020**	**2021**
7.	Percentage of staff satisfied with the extent to which their organisation values their work	20.7	50.0	45.9	55.9
		Median benchmark* 49.4	**Median benchmark*** 51.1	**Median benchmark*** 59.8	**Median benchmark*** 58.9
Number of respondents		**29/205**	**46/252**	**170/205**	**202/252**
Analysis: The percentage of staff satisfied with the extent to which their organisation values their work has increased on the previous year by **29.3% to 50%** for disabled staff and by **10% to 55.9%** for non-disabled staff					

Metric No	Staff survey question	Disabled people (%)	Disabled people (%)	Non Disabled people (%)	Non Disabled people (%)
		2020	**2021**	**2020**	**2021**
8.	Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work	87.5	81.8	-	-
		Median benchmark* 85.8	**Median benchmark*** 81.3	**Median benchmark*** -	**Median benchmark*** -
Number of respondents		**16/205**	**22/252**	**-**	**-**
Analysis: Although in line with the national average, there has been a decrease of **5.7%, from 87.5% to 81.8** of disabled staff saying that reasonable adjustments have been made. It suggests that **18.2%** of disabled staff had not received their adjustment at the time of reporting.					

Metric No	Staff survey question	Disabled people (%)	Disabled people (%)	Non Disabled people (%)	Non Disabled people (%)
		2020	**2021**	**2020**	**2021**
9.a	*Staff engagement score (0-10)	6.4	6.6	7.0	7.1
		Median benchmark*	**Median benchmark***	**Median benchmark***	**Median benchmark***
		6.9	6.9	7.3	7.2
Number of respondents		**29/205**	**46/252**	**170/205**	**202/252**
*The staff engagement score is a composite score calculated using the responses to nine individual questions There has been a slight improvement in engagement score for disabled staff and non-disabled staff.					

***Table includes the 2017, 2018, 2019 and 2020, 2021 CCG and benchmarking group median results.

16. **Metric 9.b Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?** (Yes) e.gs include, initial stage of developing a system staff network and the development of 'your voice' – see initiatives below.

17. **Metric 10**

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- By voting membership of the Board.
- By Executive membership of the Board.

18. We do not have the data for the reporting year as a CCG. However, by using the current 2022 ICB Board membership the data shows that there were no members who declared a disability.

19. **Some initiatives currently happening for disabled people within the ICB and in collaboration with system partners:**

- The ICB have committed to signing up to 'Disability Confident'.
- The Reverse Mentoring scheme has continued to be rolled out and is open to disabled members of staff. The scheme helps increase confidence and hopefully representation in the workforce.
- We are currently developing a System Staff network(s) which will act as a group where staff can connect with colleagues with a shared characteristic, experience, or interest. Networks give development opportunities to staff who face inequality in the workplace, as well as producing events and insight for the organisation which all staff can learn and benefit from.
- The development of 'Your Voice' an online reporting tool will help to report bullying and harassment and will be piloted in the ICB 2023.
- The development of the systemwide 'Active Bystander' programme will help to address harmful behaviours, promote an inclusive and compassionate culture, and role model our system values and expectations.

Other proposals

- Re-publicise the bullying and harassment policy.
- Launch a campaign to encourage more people to complete the equality monitoring on ESR and declare their disability if they have one.
- To run a development session with the Operational Delivery Group following year two results.

Workforce Metrics

For the following three workforce metrics, compare the data for both Disabled and nondisabled staff.

Metric 1	**Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce**. Organisations should undertake this calculation separately for nonclinical and for clinical staff. Cluster 1: AfC Band 1, 2, 3 and 4 Cluster 2: AfC Band 5, 6 and 7 Cluster 3: AfC Band 8a and 8b Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members) Cluster 5: Medical and Dental staff, Consultants Cluster 6: Medical and Dental staff, Non-consultant career grade Cluster 7: Medical and Dental staff, Medical and dental trainee grades **Note:** Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.
Metric 2	**Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.** **Note:** i) This refers to both external and internal posts ii) If your trust implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on via the narrative WDES data return to ensure comparability between organisations.
Metric 3	**Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.** **Note:** i) This metric will be based on data from a two-year rolling average of the current year and the previous year ii) This metric applies to capability on the **grounds of performance and not ill health**.

National NHS Staff Survey Metrics For each of the following four Staff Survey Metrics, compare the responses for both Disabled and non-disabled staff	
Metric 4 Staff Survey Q13a-d	**a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:** i) Patients/Service users, their relatives or other members of the public ii) Managers iii) Other colleagues **b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it**
WDES Metrics **Metric 5** **Staff Survey Q14**	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
Metric 6 **Staff Survey** **Q11e**	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
Metric 7 **Staff Survey Q5f**	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.
The following NHS Staff Survey metric only includes the responses of Disabled staff	
Metric 8 Staff Survey Q26b	**Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.**
NHS Staff Survey and the engagement of Disabled staff For part a) of the following metric, compare the staff engagement scores for Disabled and non-disabled staff For part b) add evidence to the Trust's WDES Annual Report	

Metric 9	**a) The staff engagement score for Disabled staff, compared to non-disabled staff.** **b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)** **Note: For your Trust's response to b)** **If yes,** please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. **If no**, please include what action is planned to address this gap in your WDES annual report. Examples are listed in the national WDES 2019 Annual Report.
Board representation metric For this Metric, compare the difference for Disabled and non-disabled staff.	
Metric 10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.