NHS
West Leicestershire
Clinical Commissioning Group

WEST LEICESTERSHIRE CCG

Equality and Diversity Annual Report 2017/18

Patients, Practices, Partners

1. Executive Summary

The West Leicestershire Clinical Commissioning Group (WLCCG) 2017/18 Annual Report outlines how the CCG continues to comply with the Equality Act (2010) – the Act, specifically with the key measure in the Act – the Public Sector Equality Duty (PSED).

This report sets out how the CCG has been demonstrating 'due regard' to the PSEDs three aims and provides evidence for meeting the specific equality duty, which requires all public sector organisations to publish their equality information.

Due regard means that the CCG has given advanced consideration to issues of equality and discrimination before making any policy decision that may be affected by them.

It also reports on our progress towards achieving excellence in Equality and Diversity and contains:

- An overview of the processes we use to ensure that equality and diversity is embedded throughout our organisation, making it central to our planning, governance, decision making, policy making and part of everyone's role.

- A breakdown of our staff and our local population - information which enables us to make the right decisions for the people we serve and the people who work for us.

- How the CCG is implementing the refreshed Equality Delivery System (EDS2) to help embed equality and diversity throughout the organisation.

- Our proposed EDS2 grades for 2017/18 and an assessment of the EDS2 gaps we have identified which will underpin our Equality and Diversity Delivery Plan 2018/19.

- This Report is based on our belief that equality should be about outcomes, and making a difference to people's lives, and not ticking boxes.

We recognize and take seriously our responsibilities and duties under the Equality Act (2010), in particular the need to have due regard to equality impacts in our commissioning, service delivery and decision making.

Publication of this 2017/18 Annual Report is part of a wider framework which delivers on our commitment to achieve best practice in Equality and Diversity. Publishing equality information in this way also helps the CCG to meet its PSED, and it helps communicate our commitment to engagement and transparency to all our stakeholders.

2. Introduction

We recognise and value the diversity of the local community and believe that Equality and Diversity is central to the commissioning of modern, high quality health services focused on the patient.

The CCG understands the diverse needs of its population and is committed to reducing health inequalities and improving the quality of health outcomes of its local communities. We also recognise that equality is not about treating everybody the same. Instead, it is about ensuring that access to opportunities are available to all by taking account of people's differing needs and capabilities. We appreciate diversity and seek to recognise and value differences through inclusion.

WLCCG Equality Objectives

1. Reduce health inequalities through targeted approach; and improve access to existing services by protected groups.
2. Improve equality data monitoring for service planning, commissioning and monitoring outcomes and experience.
3. Develop an inclusive working culture which values diversity and supports staff to feel confident to challenge any harassment, bullying or perceived victimisation
4. Maintain good governance to improve equality and diversity performance through the Equality Delivery System (EDS2)

The commitment towards our accountability to the local population, staff and other key stakeholders is demonstrated through our WLCCG Equality and Diversity Strategy 2012 – 2015 (strategy due to be refreshed). This sets out how we intend to ensure compliance with the Equality Act 2010 and promote excellence in equality performance.

The purpose of this Annual Report is to publish information to show how we are meeting the Public Sector Equality Duties (PSED). Publishing this information is a requirement specified in the Equality Act (2010),(Statutory Duties) Regulations 2011, section 2: Publishing of Information.

The PSED requires us to consider equality implications in all we do, and to be pro-active in meeting our legal obligations. Its remit is very broad, including decision-making, policy development, budget setting, procurement, commissioning, and employment functions.

As such, this report contains our:

- Proposed EDS2 Grades for 2017/18
- Workforce Equality and Diversity Monitoring information
- Annual Equality and Diversity Engagement update for 2017/18

In 2017/18, we continued working towards the provision of accessible healthcare and the development of a well-supported workforce that is representative of the population we serve.

In addition, our commitment to embedding equality and diversity considerations into all aspects of our work, including policy development, commissioning processes and employment practices continues from the previous years.

We will also continue to maintain an environment where dignity, tolerance and mutual respect, free from prejudice and discrimination, is experienced by all and where patients and staff feel able to challenge discrimination and unacceptable behaviour.

Whilst this report has been informed by evidence gathering and engagement activities during 2017/18, it is also driven by a number of external and internal strategic policy imperatives that have an impact on our work as a CCG, namely:

- NHS Constitution
- NHS Outcomes Framework
- Joint Strategic Needs Assessment (JSNA) in Leicestershire - our specific local health needs and priorities
- Leicestershire Health and Wellbeing Strategy 2013/16 & 2017/2022
- WLCCG Operational Plan 2016-2017, 2017-2018 and 2018/19
- Better Care Fund
- Better Care Together Five -Year Strategy
- Leicester, Leicestershire & Rutland Sustainability and Transformation Plan

2.1. Leicester, Leicestershire & Rutland Sustainability and Transformation Partnership

The Sustainability and Transformation Partnerships (STP) plan for Leicester, Leicestershire and Rutland, under the banner of Better Care Together (BCT),sets out how, within the resources available, the CCG can ensure that it consistently deliver quality services that are accessible for local people.

The population overall in our sub-region, like many parts of the country, is getting older, and as such people often have more long term illnesses that need managing. We also know that some services aren't currently consistently delivering the quality and access of care that we would want for local people.

The draft STP for Leicester, Leicestershire and Rutland details how those challenges can be tackled in our region and contains the following proposals:

- We are already investing in local services including £45.5 million on a new state of the art emergency department at Leicester Royal Infirmary
- An increase in services delivered in the community by specialised clinical teams;
- Encouraging more people to live healthily and avoid illness;
- Helping to address an LLR projected NHS funding gap of £399 million, caused by a number of factors including an increase in demand for services, and the costs of new treatments

- A movement of hospital beds from the big city hospitals to the community, in hospitals or at home, for those people whom it would benefit
- Plans for reconfiguration of Leicester City Hospitals from three to two acute sites
- The future options for maternity services in Leicester, Leicester and Rutland, including the current standalone midwife led unit in Melton Mowbray
- Reconfiguration of community hospitals and their beds and community-based services

The plan sets out how services can be changed for the better to improve care and the patient experience, while addressing the problem of demand for services continually outpacing the resources available. In order to deliver these aspirations it means the services we deliver, and where and how we offer them, will need to change.

Changes within the plan will be subject to further engagement, building on that has already taken place as part of Better Care Together. Specific areas within the plan will then be subject to formal public consultation where appropriate.

3. A Local Context

WLCCG is responsible for a population of 376,100 (2013), across an area of around 875 square kilometres within Leicestershire. It covers three district council areas, Charnwood, Hinckley & Bosworth and North West Leicestershire. The area comprises a mixture of towns large and small, villages and rural communities, each with their own rich heritage and culture. Key settlements include the market towns of Ashby de la Zouch, Coalville, Broughton Astley, Earl Shilton, Hinckley and Loughborough.

3.1. Demographics

Within the area served by WLCCG there are 48 GP practices providing primary medical care to patients. From these practices, the GPs and practice teams form the basis of the CCGs membership and through locality meetings play a key role in making clinically-led commissioning a reality.

3.2. Population changes in West Leicestershire

From 2013-15, the average life expectancy at birth in Leicestershire was 80.5 years for males and 83.9 years for females. This is significantly higher than the England average which was 79.5 and 83.1 years respectively. In the twelve year period from 2001/03 to 2013/15, life expectancy increased by 2.7 years for men and 2.3 years for women.

The gap in life expectancy between the most deprived areas and the least deprived areas in Leicestershire as a whole was 6.2 years for males and 5.0 years for females in 2012-14. This was driven by deaths from circulatory diseases (heart disease and stroke), cancer and respiratory diseases.

From 2014 to 2039, the population is projected to grow by approximately 18%, with the greatest increase in older age groups :

- 162.2% increase ages 85 years and over
- 49.5% increase ages 65-84 years
- 12% increase ages 0-24 years
- 7% increase in working population

In keeping with national changes, West Leicestershire's population is ageing significantly. In October 2016 there were approximately 94,300 people aged 60 and over in WLCCG area, of which approximately 18,000 were aged 80 and over.

Table 1: Forecast population changes across West Leicestershire Districts (change from 2014)

	2014	2019 (Forecast)			2024 (Forecast)		
Age Group	**Population**	**Population**	**Change**	**%**	**Population**	**Change**	**%**
0 to 4	21,100	21,200	100	0.5	22,200	1,100	5.2
5 to 14	41,700	44,800	3,100	7.4	46,100	4,400	10.6
15 to 24	52,700	51,300	-1,400	-2.7	51,500	-1,200	-2.3
25 to 44	92,000	94,100	2,100	2.3	98,300	6,300	6.8
45 to 64	102,600	106,500	3,900	3.8	106,300	3,700	3.6
65 to 79	53,700	60,100	6,400	11.9	64,500	10,800	20.1
80 and over	18,300	20,700	2,400	13.1	24,600	6,300	34.4
Total	382,100	398,700	16,600	4.3	413,500	31,400	8.2

Source: ONS 2014- based sub national population projections

Likely impact of the predicted increase in the older population in West Leicestershire:

The significantly greater numbers of older people in the population coincides with more people living with long term conditions, increasing the burden of disease and comorbidities. Examples include:

- A projected 74% increase in dementia prevalence in those aged 65 and over in the next 25 years.
- A projected 39% increase in diabetes prevalence in those aged 65 and over from 2015-2030.
- A projected 33% increase in obesity prevalence in those aged 65 and over from 2015-2030.

The complexity of care will therefore require integrated working from all parts of the health and social care system to support this population, especially those living alone. An estimated 15,700 of the over 75 age group in the WLCCG area were predicted to live alone in 2015. This number is projected to increase by 67%, to 26,300 by 2030.

The proportion of the population in paid work will decrease while care needs continue to rise. From 2015-2030, those aged 65 and over living with a limiting long term illness is predicted to increase by 47%. This creates an infrastructure gap which is already partially bridged by people providing unpaid care. This includes the 65 and over population themselves with those providing unpaid care predicted to increase by 34% in the same time period.

The 2001 Census estimates there were around 35,580 people of all ages in the WLCCG area who were providing unpaid care. By 2011, this increased by 10.7 % to 39,400. Those providing unpaid care therefore made up 11% of the WLCCG population in 2011, which was higher than the England average of 10.4%.

3.3. Tackling the gap in life expectancy/health inequality across West Leicestershire

The average/overall health of the population of West Leicestershire is significantly better than the England average. However, within West Leicestershire there are areas that have poorer health outcomes. The main areas affected are Loughborough, Ashby, Coalville and Hinckley.

Inequalities in health need to be addressed in attempts to minimise the gap in life expectancy between the most deprived areas mentioned above, and least deprived areas.

WLCCG has significant inequalities based on communities of interest as well as geographic communities. Significant health inequalities exist for marginalised groups. For West Leicestershire specifically, there are a number of BME communities of interest, including a strong Bangladeshi community in Loughborough and Gypsy/Traveller communities across the area.

Evidence suggests that the most effective way to reduce the gap in life expectancy in the short term is to improve the management of diseases that predominately affect the socially excluded i.e. cardiovascular disease and its risk factors (smoking, high blood pressure, raised cholesterol levels and diabetes) and cancer and its associated risk factors.

Ethnicity

The three districts of West Leicestershire have very different ethnicity profiles. NW Leicestershire and Hinckley and Bosworth have black minority and ethnic (BME) populations of less than 5%, with the largest proportion coming from Irish and White

other communities. In Charnwood 11% of the population are BME, with the highest proportion being Asian, followed by Irish/White Other and black African/Carribean. Loughborough, Hastings and Thurmaston wards have high proportion of BME with Bangladeshi and Indian being the highest proportion. We also have a small but significant number of people in West Leicestershire who identify as being from gypsy and traveller communities (**237** in 2011 census)

Charnwood, Loughborough Hastings and Thurmaston have higher proportions of BME than white British people reporting that they are not in good health.

The present health inequalities related to ethnicity are summarised below:

- Bangladeshi community – concentrated population in Loughborough, in a high deprivation area – high rates of smoking;
- South Asian population: high rates of diabetes and heart disease; 50% more likely to die prematurely from coronary disease. Young Asian women are twice as likely to attempt suicide.
- Gypsy and traveller – profound health inequalities, with life expectancy up to 30 years lower than white British. A seldom heard group, with low literacy rates, therefore standard engagement models are not effective.
- White Irish – higher rates of secondary mental health care use

Religion

There is no dominant minority religion in the area. However, specific communities may have specific local barriers to services. This is difficult to evidence in terms of data and would need qualitative information or information from services.

Sexual Orientation

There is no local information on population size or health needs. Nationally estimates in 2015 found that between 5-7% of the population identifies as lesbian, gay or bisexual. Negative experiences are a recurring finding within sexual minority groups, with known health inequalities exist around:

- cancer screening (especially breast and cervical)
- rates of breast cancer in women
- mental health (e.g higher suicide ideation and self-harm)
- higher rates of body image disorders within gay men, although the rates of obesity are lower
- substance misuse (especially alcohol use in lesbian women and stimulant use in gay men)
- smoking

Transgender and transsexual groups

Recent community engagement with local transgender and transsexual groups has raised issues throughout the health system, although privacy within A&E was a particular issue. Single sexed accommodation in secondary care is a national concern.

Gender

There is no evidence to suggest that the local population is different to the national profile for gender health inequalities.

Marital Status

According to 2011 census data, approximately half of all people over the age of 16 are married:

- Charnwood: **46.9%**
- Hinckley and Bosworth: **52.9%**
- North West Leicestershire: **52.4%**

Disability

The 2011 Census found that the percentage of population with a long term health problem or disability was 15.6% in Charnwood and 17% in Hinckley and Bosworth. Prevalence for these areas was significantly lower than the national value of 17.8%. North West Leicestershire in comparison had a 18.1% prevalence, which was significantly higher.

Barriers to services and poor outcomes are often disability-specific. Nationally there is concern about the physical health of those with mental health problems (especially smoking rates and obesity rates) and those with learning disability. Both groups suffer markedly lower life expectancy. There is limited knowledge about the disability profile of the population served and this is one area for potential development.

Age

The growing older population remains the most pressing commissioning challenge for the CCG. Health inequalities have been highlighted nationally around age in oncology (diagnostic tests and treatment); CHD (eg: statin prescription) and mental health (including the overshadowing of common MH disorders)

4. Equality Duty

4.1. Public Sector Equality Duty (PSED)

A key measure in the Equality Act (2010) for public sector organisations is the Public Sector Equality Duty (PSED) – the Equality Duty, which came into force on April 5th 2011.

The Equality Duty is there to make sure that all public bodies play their part in making society fairer by tackling discrimination and providing equality of opportunity for all.

This Government publication summarises the Equality Duty as follows:

"The Equality Duty is a duty on public bodies and others carrying out public functions. It ensures that public bodies consider the needs of all individuals in their day-to-day work – in shaping policy, in delivering services, and in relation to their own employees.

The new Equality Duty supports good decision-making – it encourages public bodies to understand how different people will be affected by their activities so that policies and services are appropriate and accessible to all and meet different people's needs.

By understanding the effect of their activities on different people, and how inclusive public services can support and open up people's opportunities, public bodies are better placed to deliver policies and services that are efficient and effective.

The Equality Duty therefore helps public bodies to deliver the Government's overall objectives for public services."

4.2. Due Regard

The Equality Duty has three aims – it requires a public body to have due regard to the need to:

1) ***Eliminate unlawful discrimination, harassment and victimisation*** *and other conduct prohibited by the Act*

2) ***Advance equality of opportunity*** *between people who share a protected characteristic and people who do not share it; and*

3) ***Foster good relations*** *between people who share a protected characteristic and people who do not share it.*

The nine protected characteristics covered by the Equality Duty and which must be considered during employment, engagement and service delivery monitoring are shown in the Table 2

The Government Equalities Office document[1] goes on to say:

*"Having **due regard** means consciously thinking about the 3 aims of the Equality Duty as part of the process of decision-making. This means that consideration of equality issues must influence the decisions reached by public bodies – such as in how they act as employers; how they develop, evaluate and review policy; how they*

[1] Equality Act 2010: public sector equality duty what do i need to know? A quick start guide for public sector organisations, Government Equalities Office, 30 June 2011

design, deliver and evaluate services, and how they commission and procure from others.

Having due regard to the need to ***advance equality of opportunity*** *involves considering the need to:*

- *remove or minimise disadvantages suffered by people due to their protected characteristics;*
- *meet the needs of people with protected characteristics; and*
- *encourage people with protected characteristics to participate in public life or in other activities where their participation is low."*

More recent guidance [2] outlines how the aims of the Duty need to be proportionate to the issues at hand and case law is more focussed upon how officials give proper, informed consideration to equality issues at the right time and keeping a record of that consideration. EIAs are just one way of demonstrating the necessary compliance with the PSED.

Table 2: The 9 Protected Characteristics

[2] Guidance for NHS commissioners on equality and health inequalities legal duties, NHS England, 14 December 2015

#	Protected Characteristic	Notes
1	Age	This refers to a person belonging to a particular age (e.g. 50 year old) or range of ages (e.g. 18 to 30 year old). Age includes treating someone less favourably for reasons relating to their age (whether young or old).
2	Disability	A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.
3	Sex (Gender)	A man or a woman. Treating a man or woman less favourably for reasons relating to their sex.
4	Gender / Re-assignment	Gender Identity: refers the way an individual identifies with their own gender, e.g. as being either a man or a woman, or in some cases being neither, which can be different from biological sex.
5	Pregnancy and Maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. Protection against maternity discrimination is for 26 weeks after giving birth. This includes treating a woman unfavourably because she is breastfeeding.
6	Race	Race refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins.
7	Religion / Belief	Religion has the meaning usually given to it but belief includes religious convictions and beliefs including philosophical belief and lack of belief. Generally, a belief should affect your life choices or the way you live, for it to be included in the definition.
8	Marriage and Civil Partnership	Marriage is defined as a 'union between a man and a woman'. Same-sex couples can have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters.
9	Sexual Orientation	A person's sexual attraction towards their own sex, the opposite sex or more than one sex.

4.3. Equality Impact Assessments

Since 2016/17, programme managers have used a common template for equality impact assessments (EIAs) as part of project management documentation, so that they could consider the implications and impact of their programmes on the nine protected characteristics. To ensure that we do not intentionally or unintentionally disadvantage people from any of the protected characteristics by the way that the CCG commissions health services, plans new ones, or through its employment practices, an equality impact assessment (EIA) should be carried out at the planning stage. In addition this process also includes completion of a Quality Impact Assessment (QIA)

The CCG does not employ personnel or commission a CSU to specifically provide an equality and diversity function but the key duties are delivered through the corporate affairs team. As capacity has been limited, EIAs have been carried out on a prioritised basis, however this does cover key service changes, procurements, commissioning plans and policies and staff policies. As the CCG increasingly works in a more collaborative way with other local CCGs across LLR, workstreams are either led by WLCCG or other organisations. As a result WLCCG reviews the EIAs which they have undertaken and input as required.

There is a continual need to refresh the process (both within the CCG and across LLR) as well as reminding relevant staff of their obligations and supporting them through training and other guidance. For example staff are required to complete an equality and diversity module as part of their mandatory training.

5. The Human Rights Act (1988) – Meeting Statutory Requirements

Human rights are a set of universal minimum standards that must be met, and are not about protecting particular individuals and groups in society – they are a practical framework to protect the rights of everyone and are enshrined in international, European and domestic law.

The Human Rights Act (1988) came into force in 2000, and is made up of a series of sections whose effect is to codify the protections in the European Convention on Human rights into UK Law.

All public bodies (such as the CCGs, hospitals, local government, courts, publicly funded schools etc.) and such other bodies as carry out public functions have to comply with the rights set out in the European Convention. One of the results of this is that an individual can take human rights cases to domestic courts.

The Human Rights Act (1998) sets out the fundamental rights and freedoms that individuals in the UK have access.

This range of rights have implications for the way the CCG buys services and manages their workforce.

In practice this means that the CCG needs to:

- Act compatibly with the rights contained in the Human Rights Act in everything it does;
- Recognise that anyone who is a ‘victim’ under the Human Rights Act can bring a claim against the CCG (in a UK court, tribunal, hearing or complaints procedure); and
- Wherever possible, existing laws that the CCG as a public body deals with, must be interpreted and applied in a way that fits with the rights in the Human Rights Act 1998.

Since 2016/17 WLCCG has incorporated human rights screening through the EIA process to ensure that decision making, including its commissioning, decommissioning and service redesign programmes, promotes and protects the rights of people all living in West Leicestershire.

6. Accessibility Information Standard

The CCG have a duty to ensure that all providers comply with this standard, which introduced on 1 August 2016, and is supporting local NHS services / GP practices to meet the standard.

The Accessible Information Standard aims to make sure that:

- people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services;
- The Standard tells organisations how they should make sure that patients and service users, and their carers and parents, can access and understand the information they are given. This includes making sure that people get information in accessible formats; and
- The Standard also tells organisations how they should make sure that people get support from a communication professional if they need it, and about changing working practices to support effective communication.

To support implementation the CCG undertook the following actions:

- Communicating on what the standard means for primary care, read codes, position of clinical systems suppliers compliance and where to access further information is being shared with practices.

7. Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) is a benchmarking tool introduced by NHS England to assess the progress of race equality within NHS organisations annually, following an initial evidence baseline gathered in 2015. The WRES is based on new research on the scale and persistence of such disadvantage and the evidence of the close links between discrimination against staff and patient care.

The aim of the Standard is to highlight any differences between the experience and treatment of White staff and BME staff in the NHS with a view to closing the metrics through an action plan. There are nine metrics, three of the metrics are specifically on workforce data and five of the metrics are based on data from the national staff survey indicators and the final metric focuses whether Boards are reflective of the communities they serve.

The CCG Assurance Framework requires CCGs to demonstrate that they are giving “due regard” to using the WRES indicators, and assurance that their Providers are implementing the WRES.

West Leicestershire CCG recognises leadership of the Workforce Race Equality Standard (WRES) must come from the Governing Body, and accordingly has appointed the Quality and Performance Committee to review CCG WRES data, and that of our providers, identifying any areas for development and reporting back to the Governing Body at least annually on its progress in overseeing the implementation the Standard.

West Leicestershire CCG will collate, review and publish WRES data, where appropriate, against the nine indicators in Appendix 4, in accordance with the deadlines set by NHS England. Progress against the WRES will also form part of the 2017/18 Improvement Assessment Framework (under the Leadership domain).

We will also require our main providers to comply with their own requirements in respect of WRES, the NHS England Standard and will seek timely assurance of publication and compliance of the same and providers updates on WRES has been included in section 11 of this report.

The Governing Body will ensure through overview and reporting processes that West Leicestershire CCG is giving 'due regard' to using the WRES indicators to help improve workplace experiences, and representation at all levels within our workforce, for Black Asian and Minority Ethnic (BAME) staff; and assurance, through the provision of evidence, that our Providers are implementing the NHS Workforce Race Equality Standard.

The CCG has collated and analysed its data against the indicators and the results are set out in Appendix 4. However, it is recognised that the small size of the CCG means that a literal application and interpretation of the indicators needs to be approached with caution. The key findings are:

- There is a fair distribution of BAME staff as a proportion of total staff across the bands ie the majority of BAME staff are not concentrated within the lower bands and this is seen in the BAME by pay band graph in appendix 1.
- 20% (17 headcount) of the CCG staff are from a BME background (excluding GPs/ILMs) and is an increase from 16% last year
- 19% of the 16 vacancies (3 out of 16) during 2017/18 were filled by BAME staff, this is a very slight reduction from last year (4 out of 17)
- 20% of the voting members of the CCG Board are from a BAME background (3 GPs)

The CCGs staff survey, run independently by The Picker Institute, does not split the responses between white and BAME staff unlike the national survey used by NHS providers however all the CCGs results are more favourable than the average for CCGs who use The Picker Institute.

8. Managing Equality and Diversity – Governance

8.1. The Governing Body

All members of the Governing Body assume an individual and collective responsibility for supporting the CCG in complying with equalities legislation.

The Board has a strategic lead for the equality and diversity agenda, within the framework of the CCG Equality and Diversity Strategy 2012/15.

In addition, the Board has responsibility for:

8.2. Specific Board Member Responsibilities

Dr Peter Cannon continues as the appointed GP Representative acting as the Clinical Lead for Equality and Diversity on behalf of member practices. He aims to ensure that equality and diversity considerations are incorporated across our member practices.

Gillian Adams continues as the appointed Lay Member who will be the key voice for patient and public involvement and promoting equality/diversity issues and will ensure that:

- Views and concerns of local communities are taken into consideration in all business and at all decision-making levels within the CCG
- Equality of opportunity remains a key consideration and is protected during all patient and public involvement activities and during engagement in CCG's commissioning processes.

As Managing Director for the CCG, Toby Sanders will ensure that:

- Necessary resources are in place to support and promote our equality and diversity priorities
- All key elements of the Equality and Diversity Strategy 2012/15 are managed, supported and measured.

The Director of Performance and Corporate Affairs, Ket Chudasama, will continue to have operational responsibility for:

- Ensuring that equality and diversity priorities remain a key part of the commissioning cycle, and are underpinned by the development of monitoring effective provider service delivery and strong working practices
- Ensuring equality and diversity policies are embedded within all CCG staff management and working practices through the partnership with the CCG's Commissioning Support Unit (CSU), Midlands and Lancashire (M&L).

- Providing evidence to NHS England to demonstrate compliance to the Duty through the annual assurance process (under the Better Health and Leadership domains)

As the CCG Public Health Board Member inequalities lead, Dr Mike McHugh (from Leicestershire County Council, Public Health) provides support in driving the Operational Plan, and also in setting key commissioning priorities to meet any health service gaps identified.

8.3. Sub-Group Responsibilities

All sub-groups (Committees) of the Board associated with supporting the WLCCG Board in delivering its statutory responsibilities have specific responsibilities which have an impact on equality and diversity – in particular:

- The Quality and Performance Committee (Q&P) is the body responsible for ensuring that patient feedback and engagement influence strategic commissioning decisions and that particular issues of patient safety, dignity, and respect are appropriately monitored and swiftly acted upon in line with the patient rights and pledges highlighted within the NHS Constitution. In addition, this committee has specific responsibility for oversight and monitoring of progress of the Equality and Diversity Delivery Plan.

- The Finance and Planning Committee's responsibilities include approval, financial assessment and scrutiny of business cases and investments. All new projects and initiatives presented to this sub-group are expected to have evidence of having conducted an EIA (a process which is built into the business case template). The Committee also coordinates the development of the CCG's commissioning plans, strategies and intentions and monitors delivery and effectiveness. It therefore will pay due regard to the Public Sector Equality Duty and the CCG's equality and diversity objectives in the delivery of its own objectives and throughout all its areas of responsibilities

- The Audit Committee is the key body responsible for ensuring that there are robust systems and processes for governance, risk management and internal control across the CCG's activities. This role will include measuring the delivery of all necessary and appropriate equality and diversity training, which is mandated for all staff within the organisation.

The Committees of the Board are reviewed from time to time and changes are made when required.

8.4. CCG Level

All CCG Board Members, line managers and staff remain responsible for supporting the organisation's priorities and commitment to equality and diversity. There will be support provided to all through annual training and briefings.

9. Workforce Profile

The CCG is committed to developing a representative and supported workforce and we specifically consider equality and diversity for our staff. We aim to ensure that we have fair and equitable employment and recruitment practices as well as holding up to date information about the CCG's workforce.

Legislation requires the CCG to publish an annual workforce profile in order to support the analysis of our employment policies and procedures from an Equality and Diversity perspective.

Accurate records and analysis of the workforce and employment approach in the CCG are essential to ensure a fair, diverse, and committed workforce. The CCG's Human Resources functions during 2017/18 were undertaken by Midlands and Lancashire Commissioning Support Unit. The CCG and CSU securely hold workforce data in line with recruitment and employment processes.

NHS England has agreed that a Workforce Disability Equality Standard (WDES) should be mandated via the NHS Standard Contract in England from April 2018, with a preparatory year from 2017-18. The CCG is taking the necessary steps to incorporate this additional equality standard.

All staff in the CCG are required to undertake equality and diversity training via an online module, which staff then have to renew every two years.

In particular, analysis should address and identify any adverse impact that CCG policies and procedures may have on minority and disadvantaged groups within the workforce and population, and also to establish and monitor the progress of our Equality Objectives.

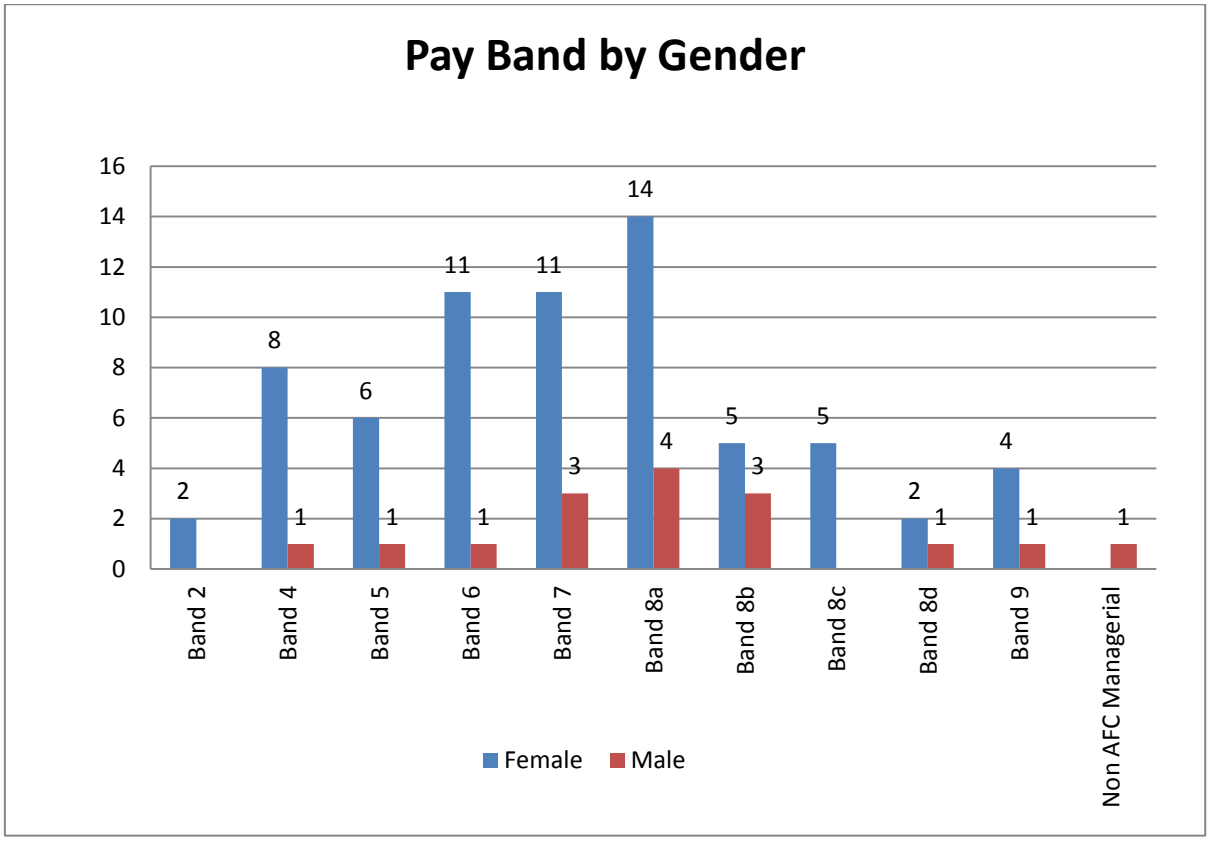
A schedule of data has been collected by the HR Team as a snapshot in time and represents information collated as at March 2018 based upon a headcount of 98 staff (including Board GPs and Independent Lay Members).

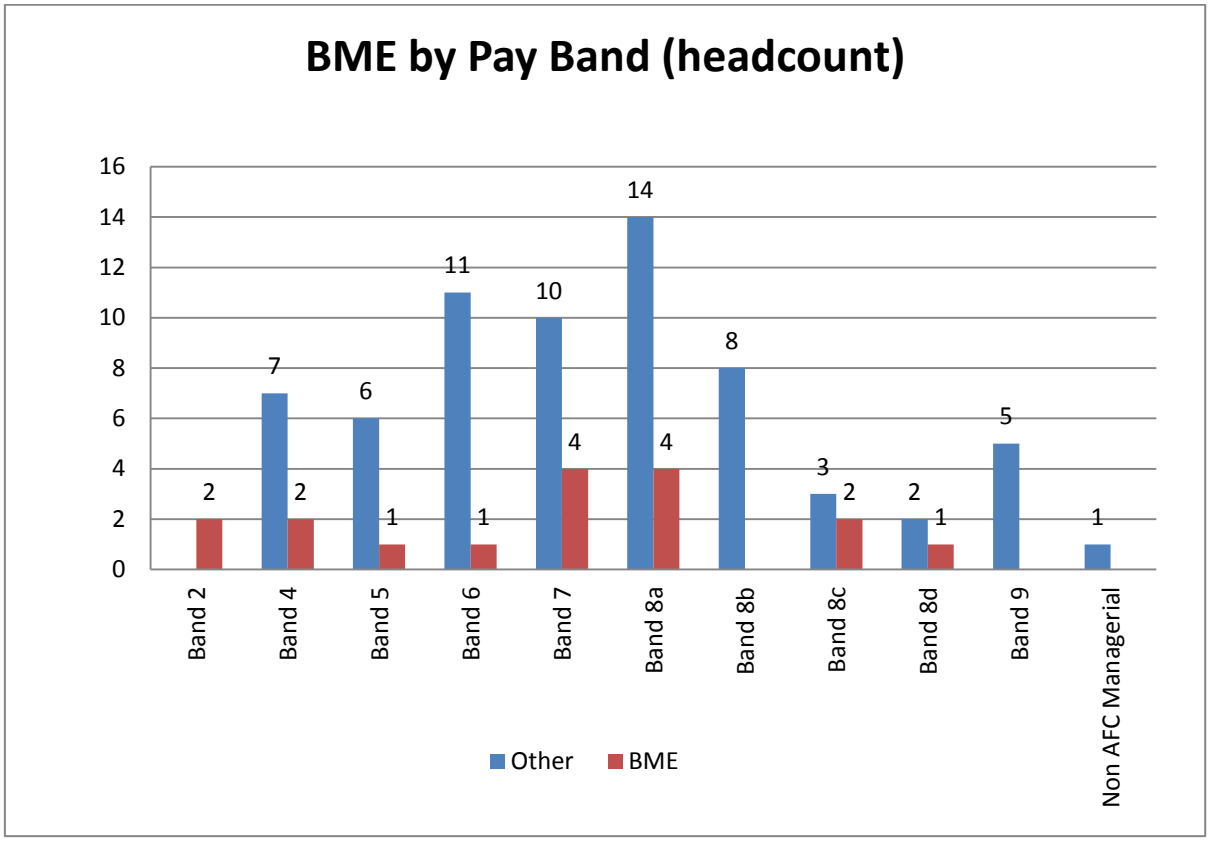
The workforce report is attached as Appendix 1 and shows CCG information against protected characteristics where information was captured through existing systems.

The following is a summary of the key workforce monitoring data for the CCG:

- a significant proportion of the CCG's workforce is female at 70% (69 staff), which is a slight increase from last year (69%)
- 20% of staff (20 out of 98 headcount) have declared themselves to be from a BME background. This figure has shown an increase from last year (from 16%)
- Due to compliance with data protection and confidentiality rules, it is not possible to disclose the number of staff (due to the low numbers) who have declared themselves disabled, declared their sexual orientation or identified themselves within certain categories of religious beliefs.

The Agenda for Change pay system was introduced in October 2004 to ensure that pay in the NHS was consistent with the requirements of equal pay law. As an employer, we analyse our workforce data to monitor any trends for differentials in pay due to gender and BME ethnicity. Focussing specifically on management roles (band 7 to band 9 and including managers on a non AfC contract), there are a headcount of 54 staff from a headcount of 84 eligible staff.





The key points are:

- 76% of senior roles (bands 7 and above) are occupied by females (headcount of 41), males occupy 24% senior roles (headcount of 13). This compares favourably to the overall proportion of females in the CCG (70%) and provides evidence to support there is proportionate equality of pay by gender within the CCG
- 60% of total number of females have roles in senior positions (headcount of 41 out of 68), whereas 81% of total males occupy senior positions (headcount of 13 out of 16). This is a slight decrease for females, but an increase for males from the previous year (from 76% to 81%), indicating that during the year more senior roles have been filled by males following the recruitment processes
- 0 of the 9 currently filled GP Board roles are occupied by females
- 20% of staff are from a BME background (headcount of 17 or 20 if including Board / ILMs), and this has increased from 16% last year
- 20% of senior roles (bands 7 and above) are held by those from a BME background (11 out of 54) and is the same as the proportion of staff who are from a BME background (20%)
- However, 65% of the total number of BME staff have roles in senior position (11 out of 17 headcount). This is generally positive from a WRES perspective when looking specifically at the BME workforce at the CCG

The CCG Staff Survey 2017 did not highlight any material issues on equalities experienced by staff across the range of questions. The Staff User Group, Staff

Survey Action Plan and Individual Personal Development Reviews (PDRs) with their line managers will seek to identify ways to further promote development opportunities within the CCG for staff across all protected characteristics.

10. Workforce Profile – Recruitment and Selection

During 2017/18, WLCCG had 16 vacancies for which there were 311 applicants.

The figures in appendix 2 show the split of the 311 applicants in terms of seven out of the nine protected characteristics for which data is received.

- Sex (Gender),
- Disability,
- Age,
- Race (Ethnicity),
- Religion (Belief),
- Marriage/Civil Partnership,
- Sexual Orientation

We are not currently able to collect and extract information for the other two protected characteristics (gender reassignment and pregnancy and maternity).

As a CCG, there is a duty to be transparent in recruitment practices and treatment of workforce, and cannot favour one protected characteristic over another. When analysing the recruitment and selection data there have been small proportions of people from across the protected characteristics groups applying, being shortlisted and being appointed to posts. For example recruitment across all of the 16 vacancies resulted in:

- 20 people stated they had a disability on their application form, of which 6 were shortlisted and 0 were appointed
- 146 people stated they were of a BME ethnicity on their application form, of which 42 were shortlisted and 3 were appointed (19% appointed from a BME background)
- a fair distribution of staff across the age bands being appointed to the 16 vacancies
- 25 applications were received from people who stated they had a physical impairment or mental health condition, of these 7 were shortlisted and 0 were appointed

There have been no employees who have been subject to formal grievances and disciplinary procedures.

The CCG is working with the CSU, to explore ways of ensuring a comprehensive and consistent level of employment data and analysis is made available. This extends to workforce data collection in all areas of activity related to gender reassignment, and

pregnancy and maternity, however there may be limitations based upon what is required on the NHS Jobs website.

This approach will be pursued by the CCG despite the fact that such levels of employment monitoring are only required under the Equality Act 2010 for public bodies with over 150 employees.

11. Performance Monitoring of Providers

Through its contracts with providers, the CCG will ensure that those organisations are compliant with the Equality Act. Contracts for NHS services are managed across the three CCGs in Leicester, Leicestershire and Rutland and processes to gain assurance from providers are not consistent. This means that it is difficult to gain an holistic picture of our patients' experiences with the interaction with various health services, and to assess the extent to which improvements are being made.

During 2017/18 there has been an improvement in the reporting from providers to CCG contracting teams in relation to the progress being made, however:

- providers still struggle to provide examples of service improvements against specific protected characteristics
- progress on WRES and the AIS could be achieved faster
- newer providers such as TASL have significant progress to make in 2018/19 to bring them up to speed

All the NHS providers with which the CCG contracts are expected to undertake an annual equality performance review using the NHS Equality Delivery System (EDS2).

A summary of the position of our providers in 2017/18 is as follows:

University Hospitals Leicester NHS Trust (UHL)

Area	Update
E&D Plan	The Trust are broadly on track with the actions in the plan targeted to their seven objectives. The Trust has appointed a new Equality and Diversity Lead who commenced his role on 4th September 2017.
Implementation of the Accessible Information Standard	The Trust is not fully compliant with the AIS. The Trust should as a matter of course record, produce and ensure that patients information and communication needs arising from their disabilities are met.
WRES	Overall against the WRES Indicators we have seen an improvement against 5 indicators and a deterioration against 3 indicators with one indicator remaining the same. Whilst we have seen an improvement against indicator 2, UHL were performing poorly against this indicator (likelihood of BME staff being

	appointed from shortlisting) in comparison to other QIM partner organisations / Trust average scores. White British staff were twice as likely to be appointed than BME candidates.

Leicester Partnerships NHS Trust (LPT)

Area	Update
E&D Plan	The Trust through the process described above, graded itself against the Equality Delivery System 2 for which this year, the majority of its grading is Green - achieving. A number of community and staff engagement events and actions have taken place. A workforce equality profile and equality data monitoring on service users is being analysed and associated actions are awaited. An area of risk is the provision of sufficient evidence to demonstrate compliance against goals 1 and 2 of EDS2
Implementation of the Accessible Information Standard	During the year since the effective completion of the Implementation Plan, the following actions have been taken to embed the standard into clinical practice: • Templates/forms/questionnaires have been developed and added to all of our electronic patient record systems. • The Accessible Information Standard Implementation Group has been refocused into the Inclusive Communication Action Group and revisited the membership, which were approved at the Finance and Performance Committee in January 2017. • Completion of the Trusts' Inclusive Communication film featuring staff and service users to illustrate the meaning and importance of the Standard • Development of the work plan to meet the expectations of the Quality Schedule (QSI-10), including the reporting time line • Completion of an audit of use of the Inclusive Communication recording tools on all of the EPRs, to gauge the knowledge and engagement with the work, and to inform a communication campaign. • Development of an Inclusive Communication Guidance document for staff to supplement the revised Patient Information Policy and to align with NHS England expectations. • Engagement with a commercial organisation supporting other Trusts with the provision of information various formats to support service users communication and information needs as part of general contact.

WRES	The Trust has a three year WRES plan (2016-19) and is reported and monitored at Strategic Workforce Group and Trust Board. The trust have reviewed the benchmarking findings in this report – LPT was highlighted under Indicator 3 (likelihood of BME staff entering the disciplinary process relative to White staff) as a Trust where practice appears good according to this indicator. An action plan has been drawn out from the workforce equality data report and the WRES, highlighting key areas of work to improve staff experiences.

TASL

Area	Update
E&D Plan	TASL are not on a Standard NHS contract and therefore their adherence to reporting requirements differs slightly to the rest of provider contracts we hold. The organisation does not have an E&D plan yet and has not got the processes to capture any of the required data. TASL have been issued a contract performance notice in relation to failure to provide quality information/reports and this E&D data will form part of the remedial action plan to ensure it is captured
Implementation of the Accessible Information Standard	TASL do not yet have a policy/process to manage AIS this will form part of the action plan.
WRES	TASL have not yet received the data transferred from Arriva to understand WRES and have not yet set up internal processes to capture this information. Again this will form part of the remedial action plan to ensure it is captured

East Midlands Ambulance Service (EMAS)

Area	Update
E&D Plan	
Implementation of	The Trust has introduced the Equality Crib Sheet to capture

the Accessible Information Standard	evidence for their EDS2 submission when attending community events. They have been rated as developing in the current EDS2 Submission. Nottinghamshire Police and United Hospitals of Leicester carried out the process. Equality Impact Assessments – Equality Analysis - Due Regard have been introduced for all policies, procedures and practice. The current gaps are lack of training for staff on equality monitoring and recording of data. Training is planned in how to carry out equality analysis.
WRES	The Trust has introduced positive action plans / campaigns to proactively address staff representation and underrepresented groups and are working closely with Health Education England.

12. Communications and Engagement – key highlights in engagement with local people and stakeholders 2017/18

Patients are at the heart of everything we do and it's important that they are involved in decisions not just about their care, but in designing better care for others. We are champions of patient engagement and empowering patients to shape services and the care that they receive. Our aim is to involve as many people as possible and to specifically seek out the views of those previously not heard.

We continued to use the Experience Led Commissioning (ELC) approach and methodology that is built around the idea that if we listen to and deeply understand people's experiences, we will design better, more person-centred services that deliver better care for our people.

We have also used other methodologies and techniques to capture qualitative insights from patients, carers, staff and stakeholders who are using or providing the services.

People have either been interviewed at the point of care or delivery using face-to-face or telephone techniques. We have also used online surveys to reach out to a diverse range of people across the full demographic and epidemiological profiles.

The insights captured are then analysed and evaluated and the key themes and high impact actions for improvements are then used to co-design new services and enhance existing ones. These themes and high impact actions are continual tested through activities like co-design and co-production events, where patients and their carers come together with health professionals to co-design or co-produce healthcare.

Here are three case studies outlining initiatives undertaken this year:

Case Study 1

Over the counter medicines including Vitamin D and infant formula

What was done?

An online survey was undertaken between 17 July and 9 August 2017 to understand the impact of any changes on people in relation to:

The prescribing of medications available to buy over the counter for minor ailments.
The prescribing of Vitamin D and Vitamin D3.
The prescribing of Infant Formula excluding specialised products

The sorts of conditions we reviewed included headaches, indigestion, head lice, travel sickness, hay fever, diarrhoea and insect bites and stings. We also reviewed Vitamin D supplements and specialised infant formula which can be prescribed for babies with reflux or lactose intolerance.

We wanted to understand how people would be affected if they had to buy these types of medicines, that are easily bought over the counter, instead of requesting a prescription.

The survey reached out to communities that could be affected by any change. To ensure that responses had been received by as wide a number of community groups as possible, the survey included a number of equality and diversity questions which were optional to complete.

What was achieved?

Through the online survey we captured quantitative and qualitative insights from.

- 269 people with regard to medications available to buy over the counter and Vitamin D supplements
- 23 people with regard to Infant Formula

The feedback was themed into those area that most mattered to people. We learnt that the majority of people do already buy their own medicines to treat minor ailments. We also learnt that the majority of people are willing or very willing to buy medicines for minor ailments.

People also told us that the information, advice and guidance that the pharmacists gave them was really helpful and that it was unnecessary to see their GP and they would rather people only used their GP for series conditions which in the long run would improve access for everyone to their GP surgery.

There were some people who were concerned particularly if they had a long term condition and wanted to understand a little more about the effect of mixing

medicines. Other people wanted to know more about the quality and strength of over the counter medicines. Some people were concerned about affordability of some medicines.

The full analysis can be found at www.westleicestershireccg.nhs.uk

Who did the survey reach?

Here are topline information:

- 90% of people regarded themselves as English, Welsh or Scottish
- Remainder regarded themselves as Ianida, Caribbean, White/black African, African, Bangledeshi, Pakistani or of other Asia origin
- 51% were over 55 the remainder were 54 and under
- 92% regarded themselves as heterosexual
- 72% didn't consider themselves as having a disability or long term ilness

Outputs and outcomes

The CCG think that the NHS belongs to everybody and the results of our survey showed that patients feel the same way. Patients also told us that they think resources need to be used in the best possible way for all patients. We therefore asked GPs not to prescribe medicines on a prescription for the short term treatment of minor ailments, low dose vitamin D supplements for prevention of deficiency and some specialised infant formulas. We worked with patients via their GP practice to ask them to purchase them over the counter instead. We also asked patients not to request these items on their prescription.

We also commenced a self-care to support those patients who had concerns about the changes, informing people of a fairer way of utilising resources wisely. Most of the prescribing items can be purchased in pharmacies and supermarkets at a low cost, but cost the NHS more to prescribe on a prescription. The infant formulas selected for self-purchase are similar in cost to standard infant formulas.

The review told us that many people already feel that their community pharmacist is their first point of contact. They support them with a range of ailments and they prefer to talk to them about minor conditions saving GP appointment time for more urgent problems.

We promoted Community Pharmacists as the best place to seek help and advice for patients regarding suitable treatments for common ailments. However we also assured people that if they are worried or their symptoms get worse or persist they can still make an appointment to see a GP.

We took all the patient questions, queries and concerns from the review and responded to them and added other information which we think that patients would find useful and put this together in a toolkit for GP practices. The toolkit contained posters, web copy, patient questions and answers and articles – all to help practices inform patients of how to receive support and care in other ways.

Case Study 2

Promotion of flu vaccination 2017/18

What was done?

Worked with health economy, voluntary and communications and social care to Implement proactive communications campaign to encourage people to receive the flu vaccination.

Identifiied practice in Leicester, Leicestershire and Rutland with lowest update of flu jab to population ratio and worked with them to contact patients who were over 65 and those with chronic respiratory conditions to encourage the to receive the flu vaccination.

What was achieved?

Coverage on BBC East Midlands Today/Radio Leicester/Leicester Mercury/Hinckley Times

Black, Asian and Minority Ethnic engagement:
Sabras Radio segment – 140,000 weekly listeners, primarily south east Asian.
1 hour show focusing on flu and why you need to be vaccinated (also included 111 messaging)

Screens shown on repeat at Diwali lights switch on – approx.. 40,000 people

Leicester Caribbean Event in October - approximately 1000 NHS 111 leaflets, 10 NHS 111 posters and 500 Flu leaflets distributed

Belgrave Health Event talking directly to 270 people along with partners from – Cancer Charity, Alzheimer's Society, Richmond Followership –mental health.

Toolkits for partners/volcomm/PPG issued to empower staff/PPG members to communicate importance of flu jab with end users:

- Flu messages published in Your Leicester – October 2017 (Leicester City Council email - 12,000 subscribers)
- Flu messages published in Leicester City Care Homes Bulletin October edition.
- Flu messages for staff published in FACE - Leicester City Council newsletter, sent to 6000 council employees
- Age UK Leicester Shire & Rutland EngAGE Magazine Winter Edition – 5000 copies printed and distributed – targeting over 65s
- Voluntary Action Leicester – Included in October newsletter - reaching voluntary and community workers across all protected characteristics

- Social media content from packs used by UHL and LPT to boost flu message on twitter and facebook.

Supporting materials for partners:

- General Stay Well Materials (posters, flyers etc) distributed to health and social care partners - 2890
- Community outreach packs sent to community centres- 112
- Children's Centre Packs sent to children's centers and Surestarts- 67
- GP Packs distributed to practices – 111

Outreach workers to visited individual member practices and supported calling target groups to book flu appointments for people over 65 and with chronic respiratory conditions. 30 practices were contacted with offer of support with 12 practices accepting,

746 records were accessed with consent and people contact and 121 appointments made.

Outcomes

Provisional data on the seasonal flu vacination uptake to the end of January 2018 show the following take up across each CCG
Over 65 – 74% take up in East Leicestershire and Rutland; 70% take up in Leicester City and 74% take up in West Leicestershire.
6 months to 65 years in at risk groups – 48% take up in East Leicestershire and Rutland; 49% take up in Leicester City and 49% take up in West Leicestershire.

Case Study 3

Clinical Navigation Hub

What was done?

The project sought to provide an evidence base and rich insights into stakeholders' perspective of urgent care and particularly the clinical navigation hub being tested in Leicester, Leicestershire and Rutland.

Research was undertaken with patients and carers using the clinical navigation and hub and with staff providing services including NHS 111 staff, out-of-hours GPs and nurses and other teams.

The focus commissioning question was "*How is the new urgent care model changing the experiences of staff, family carers and patients and people who use the service*?"

The trial period provided the ideal time to talk to patients, family carers, parents and health care professional to look at what was good about the service and what needed improvement.

The insights collected from undertaking qualitative telephone and face-to-face interviews were independently analysed and evaluated and triangulated to produce a report including high impact measure to improve services.

A 'confirm and challenge' event was held with commissioners and providers to understand the insights and gain agreement on the high impact actions for change going into the commissioning on the service in the long term.

What was achieved?

Insights emerged from 37 people who use the clinical navigation hub service and 18 frontline teams who provide the service.

We now have a better undersanding as commissioners and providers of how the clinical navigation hub is working for patients, carers and staff.

Eight high impact actions were agreed and are now being taken forward for implementation by the CCG Quality Team and the Urgent and Emergency Care Contract Team:.

- Increasing an earlier exit from the triage process as it doesn't service those with complex care needs. A number of elements support this including the wider use of summary care records
- Gaining reassurance quickly and being able to share what is wrong at the first point of contact; increasing the patients' sense of continuity and being listened to through access to and use of summary care records and high quality handover notes that clinicians and other staff, who speak to people later, use to reflect back what people have already shared with others.
- Make improving self-care and long term community resilience a core service outcome.
- Reviewing demand and capacity planning by recognising the predictable quieter shifts, planning and reducing pressure on staff.
- Improving and supporting information on electronic systems including for staff an explanation of simple words to explain complex medical terms, so that patients have a better understanding of their condition and the treatment needed.
- Ensure patients always get a call back and understand that this will be the case.
- Improve access to the City hubs particularly where there are border issues and contractual barriers.
- Ensure insights were used to support staff to reflect and improve their care and support through their training and development, professional reviews, staff briefing and other staff engagement.

We use a range of other tools to people to ensure that we can access as wide a range of communities as possible, including those people. We also work collaboratively with our partners to understand what matters most to service users.
Patient Participation Groups

Patient Participation Groups (PPGs) play a pivotal role in helping us to shape and improve health services. It's important that patients are involved in decisions not just about their care, but in designing better care for others. The feedback we get from our PPGs help shape the decisions that we make and directly influence the services we commission for all our patients and carers.

PPGs help to identify where improvements can be made for patients and act as a 'critical friend' to ensure services, plans and activities respond to patients' needs and priorities. They also provide practical support to GP practice teams, such as conducting patient surveys and organising health awareness events.

PPGs are also involved with raising awareness of health issues in their area, helping the local practice to make an impact in the community by organising events, distributing information and keeping the community healthy.

Four times per year PPG members from across West Leicestershire meet as part of the PPG Network Hub to share best practice, hear about the latest updates to services and the work which the CCG is doing to improve healthcare in their area. The topics under discussion in 2017/18 included:

- Integrated urgent and primary care services
- Adapting and transforming services whilst managing the financial challenges facing the NHS
- Social care in Leicestershire
- Enhanced summary care records
- The work of public health in Leicestershire
- Better Care Together – the Sustainability and Transformation Partnership for Leicester, Leicestershire and Rutland
- PPG's -a reflection on how they have evolved and their successes
- GP Forward View – stabilising and transforming primary care
- Integrated Locality Teams
- PPGs – building better participation and sharing best practice
- Releasing time to care – Active Signposting
- First Contact Plus and Local Area Co-ordinators
- Mental Health – 5 year transformation of mental health services
- Improving support to care homes

Locality PPGs have continued to development in 2017/18, with four localities - North West Leicestershire, South Charnwood and North Charnwood. They continue to engage with their local federation, the CCG and voluntary and community organisations and identify joint working opportunities particularly supporting patients to self-care and encourage wellbeing through prevention messages.

The PPG Network Hub, available at http://www.westleicestershireccg.nhs.uk/page/ppg-network-hub contains minutes of the PPG Network meetings, as well as the presentations.

CCG Patient Database

The Patient Database allows us to build stronger relationships with communities and to offer them information which reflects the aspects of the CCG's work which they are most interested in depending on their demographic or epidemiological profile.

We communicate with patients through our patient the database on a regular basis through monthly newsletters and regular updates.

How people interact with the communications issued are monitored in order that messages can be refined. We are continually encouraging people to sign-up to our mailing list by capturing details at events and during engagement work and have increased the number of the database by 600 this year.

Social Media

Our social media presence has continued to develop this year, with a focus on engagement with patients and other health organisations, identifying Twitter as the best place to converse with these groups. We've added 382 new social media followers across 2017/18 and achieved a total of 365k impressions on our Tweets, increasing our reach significantly.

Visitors to our website have also continued to increase with over 60,336 visits in 2017/18, representing nearly 6,328 additional sessions compared with 2016/17.

Staff engagement and communication

The CCG has a range of internal communications and engagement channels. Staff briefings have been held on a regular basis during the year to enable the Corporate Management Team to discuss with staff a range of hot topics, and strategic and operational issues.

Our HR Business Partner hosts regular drop-in clinics for staff at our Woodgate headquarters to allow staff the opportunity to discuss any issues. Other updates have been sent to staff electronically on a regular basis throughout the year.

The Heads of Service also meet on a regular basis to ensure that the independencies on projects are understood and capitalised on.

We also have a regular email newsletter which is sent to all staff which has received positive feedback with staff feeling that they are well informed.

Staff survey

The 2017 Staff Survey managed by the Picker Institute on an annual basis showed that we were significantly better than average across all organisations surveyed. The response rate from West Leicestershire CCG staff to the survey was good with a 92.5% response rate compared with 90.4% last year. Only the answers to one question showed a significantly worse position with 21 significantly better.

The CCG compared well against the national average in areas such as staff feeling able to make improvements happen; teams sharing their objectives; management

support; levels of pay; flexible working and recommending the CCG as a place to work.

Compared to last year we significantly improved in the completion rates of our mandatory training and employees feeling there was enough staff at the CCG to do their job properly. However we had worsened in our discussions with staff about organisational values as part of the appraisal/performance review and time passing quickly for staff when at work.

We take the result of the survey and staff feedback very seriously and have shared and discussed the findings at our March Staff Briefing. Our CCG Staff User Group, which has representation from all teams, are working to review the findings and agree actions to make improvements in the areas needed.

Engaging our member practices

We continue to work collaboratively with our member practices, engaging them in leading and developing new pathways and services to improve the quality of care for our patients. We are continuing the delivery of extended access to general practice which focuses upon improving availability of routine appointments at evenings and weekends, issues of inequalities in patients' experience and service availability during peak times of demand.

Regular Locality forums and Federation meetings support our operational teams to solicit and maintain practice engagement. Following the launch of our intranet for GP practices we have continued its development -providing information for GPs, practice managers, practice nurses and practice teams. Articles and new information continue to be promoted through our monthly GP newsletter. Practice appraisal and training and development are also among the range of communications techniques we employ to enhance communications with our practices.

As part of the CCG annual assurance process, NHS England commission an independent organisation - IPSOS Mori the social research institute, to co-ordinate the survey. The national CCG 360 survey is a key part of ensuring the NHS West Leicestershire Clinical Commissioning Group has strong and effective relationships in place in order to be a successful commissioner. This survey allows our stakeholders to provide feedback on our working relationships. Stakeholders included GP member practices, other CCGs, the Health and Wellbeing Board, Local authorities, Healthwatch, other patient groups and NHS providers.

This year's survey was carried out between 15 January and 28 February 2018.
We will be looking at the results in detail to see where we are doing well, where there is a need for improvement and how we can act on the feedback we have received.
70% (33 out of our 47) GP member practices completed the survey.

Results indicated that 82% of our member practices rated the effectivenesss of their working relationship with the CCG as either very good or fairly good and 73% had

confidence in the clinical leadership of the CCG. However only 48% had confidence in the way that the CCG monitors continuous quality of the services it commissions. Although remaining relatively positive, there are areas that will need to be addressed – such as improving 'clear and visible leadership' and providing member practices with more opportunities to influence the CCGs plans and priorities.

Feedback from our member practices has been incorporated into our practice appraisal programme.

MPs and other key stakeholders

We continue to ensure that we have a regular dialogue with our local MPS and parliamentary candidates ensuring they are aware of and involved in the work of the CCG and the health system collectively.

We also liaised closely with our local authorities and councillors a good example of which is the work we continue to do with Hinckley and Bosworth Borough Council who we work in partnership with to improve the lives of residents in the area. This partnership has been particularly fruitful in introducing us to and creating and maintaining closer links with voluntary and community groups in the local area.

Voluntary and Community Organisations

Voluntary and communication sector organisations have supported the health economy to deliver messages to patients and carers. Support has particularly been given to get messages out about the urgent and emergency care system and self-care.

Either by working directly with this sector and via Voluntary Action LeicesterShire, the CCG has put together communications toolkits containing articles, press releases, social media messages and web copy and asked for information to be cascaded to different communities.

13. NHS Equality Delivery System (EDS2)

The following is an extract from "A Refreshed Equality Delivery System for the NHS – EDS2: Questions and Answers"[3]:

"Why EDS is needed is a key question.

A key principle of the NHS is that everyone counts – this is at the heart of the NHS Constitution and should be a principle that applies to everyone in the NHS: patients, carers, voluntary organisations and the people who work in the service were involved in the design of the EDS2 toolkit.

[3] *"A Refreshed Equality Delivery System For The Nhs – Eds2: Questions And Answers"* (November 2013, NHS England)

With the EDS2 toolkit, the CCG can work out how it's performing with regard to its equality performance, how it can make it better, and how it can get to where it wants to be.

EDS2 provides a ready-made way for the NHS to respond to the Public Sector Equality Duty. Without the EDS, each NHS organisation would have to work out its own response – at considerable cost. At one level it's a simple framework which organisations can use to analyse their own priorities. By focussing efforts and making better informed commissioning or making changes to service delivery, we can improve both cost effectiveness and quality."

In its simplest form, EDS2 gives the CCG the tools to work out its equality performance in relation to:

- How good performance is now
- How good the CCG could be
- What the CCG can do get there

Part of this involves listening to patients, to carers, to people who work in the NHS, and to the community, and voluntary sector.

At the heart of the EDS2, are 18 Outcomes grouped into 4 Goals.

The outcomes cover things that patients and staff tell us matter the most to them. Working with patients, staff and local voluntary organisations, NHS organisations can analyse their performance against the 18 outcomes and use the results to identify equality objectives for the next business planning round.

Table 3: NHS EDS2 Goals and Outcomes

The Goals and Outcomes of EDS2		
Goal	**#**	**Description of outcome**
Better health outcomes	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
	1.5	Screening, vaccination and other health promotion services reach and benefit all local communities
patient acces and	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
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
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 to be managed
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

The outcomes of EDS2 are aligned with key mainstream levers for the NHS – including the NHS Outcomes Framework, the NHS Constitution, and the Care Quality Commission's (CQC) key inspection questions.

By delivering on the EDS2, organisations can also deliver, to an extent, on mainstream business.

Table 4: The 4 grading levels for EDS2

NHS EDS2 Grading Levels	
Excelling	People from all protected groups fare as well as people overall
Achieving	People from most protected groups fare as well as people overall
Developing	People from only some protected groups fare as well as people overall
Undeveloped	People from all protected groups fare poorly compared with people overall *OR* evidence is not available

13.1. EDS2 Grading for 2017/18

To support the assessment of the CCG against the 18 outcomes, the following information was taken into account:

- refresh of the health inequalities information provided by public health colleagues
- review of the CCGs commissioning activities during the year
- provider performance information received on equality and diversity
- our engagement activities with local people and our stakeholders
- our staff survey results and staff engagement activities
- analysis of staff recruitment, retention and HR policies

Based upon this it is proposed that no changes are made in 2017/18 to the grades awarded to the 18 outcomes assessed in 2016/17. These grades are presented in Appendix 3.

13.2. Equality and Diversity Delivery Plan 2018/19

The 2018/19 CCG Equality and Diversity Plan will ensure that both Equality Objectives and forward actions emanating from gaps identified during implementation of EDS2 are mainstreamed into core business and throughout all commissioning activities through the 2018/19 Operational Plan, BCF and wider STP.

The plan will be discussed at the Quality and Performance Committee and the key areas of focus aimed at achieving positive outcomes for our service users will need to include:

a) Proactive review and challenge of implementation of E&D activities / strategies at a CCG, provider and STP level

b) Better understand the impact of planned QIPP schemes during their development and / or prior to implementation.

c) Collate and review E&D evidence from BCF and other commissioned services to determine access and service quality for protected characteristics groups and other hard to reach groups.

d) Pushing providers to provide documented evidence of specific improvements to service delivery for protected characteristics groups and other hard to reach groups

e) Review CCG recruitment processes ie having diverse interview panels etc

f) Consider how we can make progress towards promoting a 50/50 gender balance by 2020 on the CCG Board, particularly with female GPs on the Board

g) Refresh E&D training for CCG staff and improve the completion of equality impact assessments across all projects

h) Provide regular updates on the delivery plan to the Q&P Committee

i) Build on the engagement work already undertaken by the CCG and through the STP workstreams to further involve the voluntary and community sector and protected characteristics groups to inform service delivery

j) Consider further mechanisms to maximise feedback from public and key stakeholders specifically on the CCGs duty to meet PSED.

14. Publishing Our Equality and Diversity Documentation

Public authorities have **specific duties** under the Equality Act to ensure they comply with the public sector equality duty.

Public authorities – such as WLCCG - must do the following:

- Prepare and publish a strategic Equality Plan and equality objectives
- Engage with equality groups when carrying out the other specific duties
- Publish information about how they've complied with the equality duty
- Carry out assessments on the impact of proposed policies and practices and then monitor the impact after they are introduced.

As such, WLCCG will post equality and diversity reports on our web page as they are completed and approved.

15. Summary

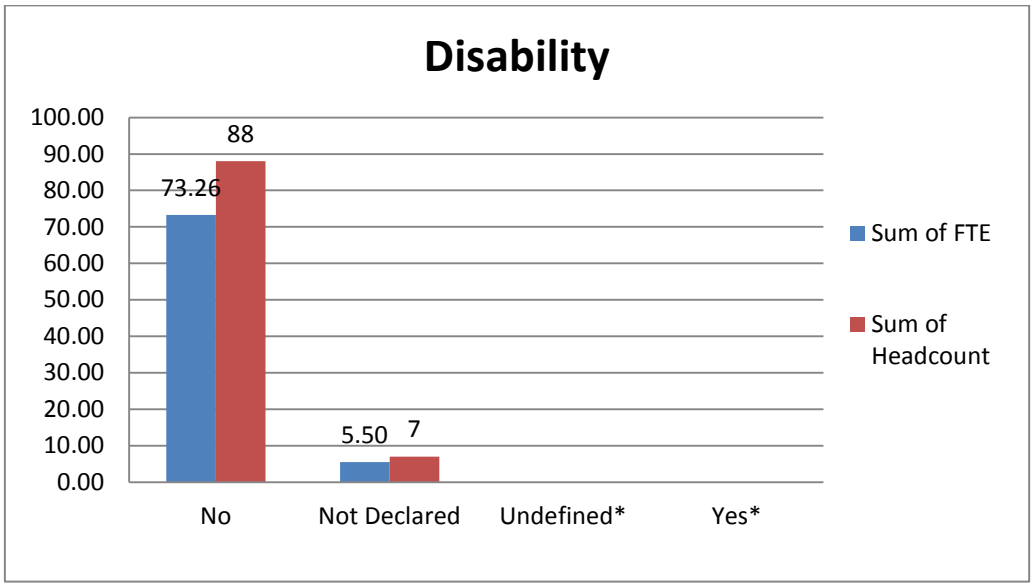
WLCCG is committed to reducing health inequalities in West Leicestershire, and we will work to promote equality and value diversity as part of our planning and commissioning processes.

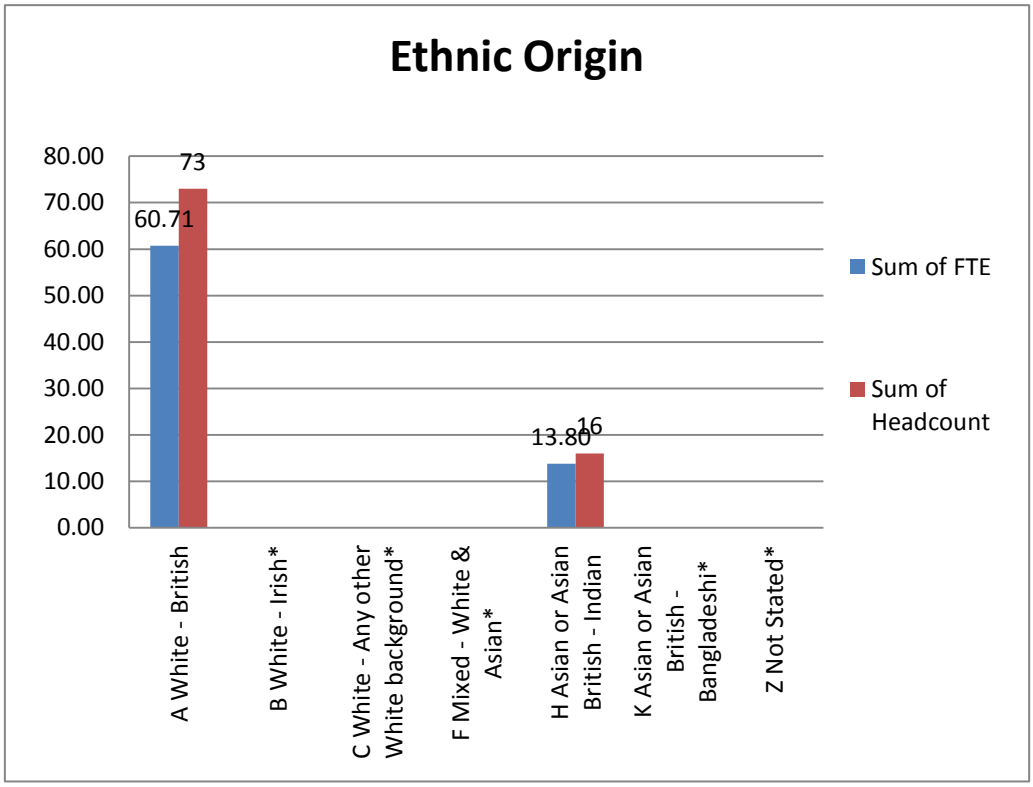
This Annual Equality and Diversity Report outlines the work undertaken by the CCG We have had some success in implementing our EDS2 objectives that were linked to the EDS2 goals and outcomes, but we have some continuing work to do to achieve our intentions to ensure that we meet the needs of patients, carers, the public, and CCG staff.

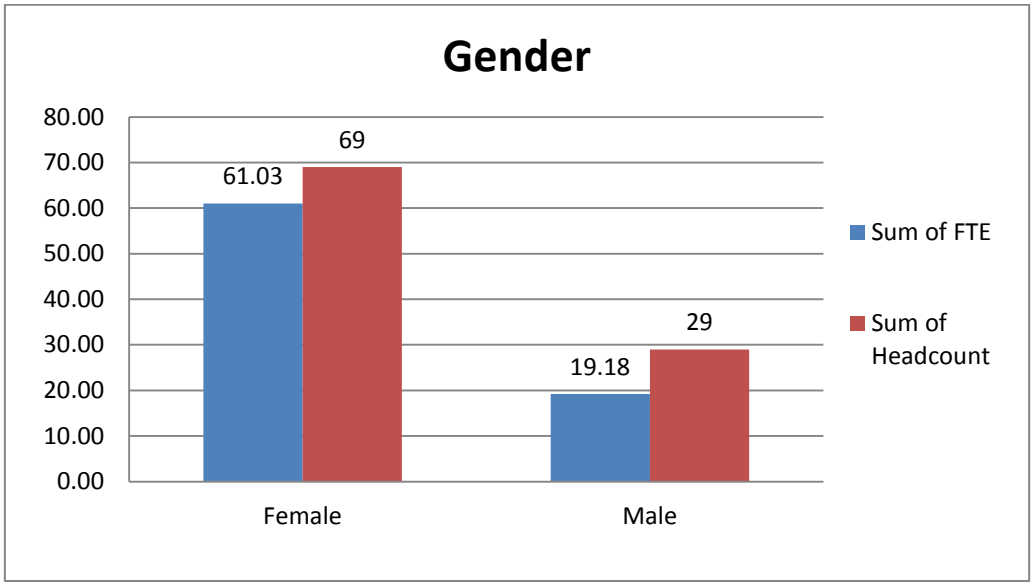
Once the 2018/19 Equality and Diversity Delivery plan is approved, we will monitor our progress against Plan, and report progress with implementing the delivery plan to the Quality and Performance Committee on a quarterly basis.

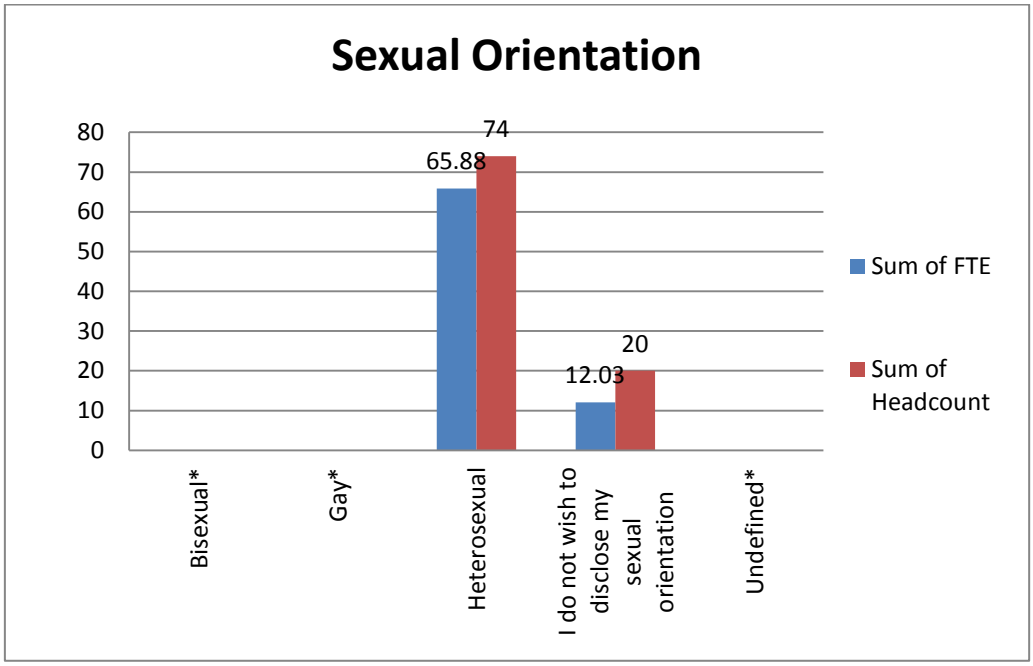
APPENDIX 1: WORKFORCE PROFILE *(all data as at March 2018)*

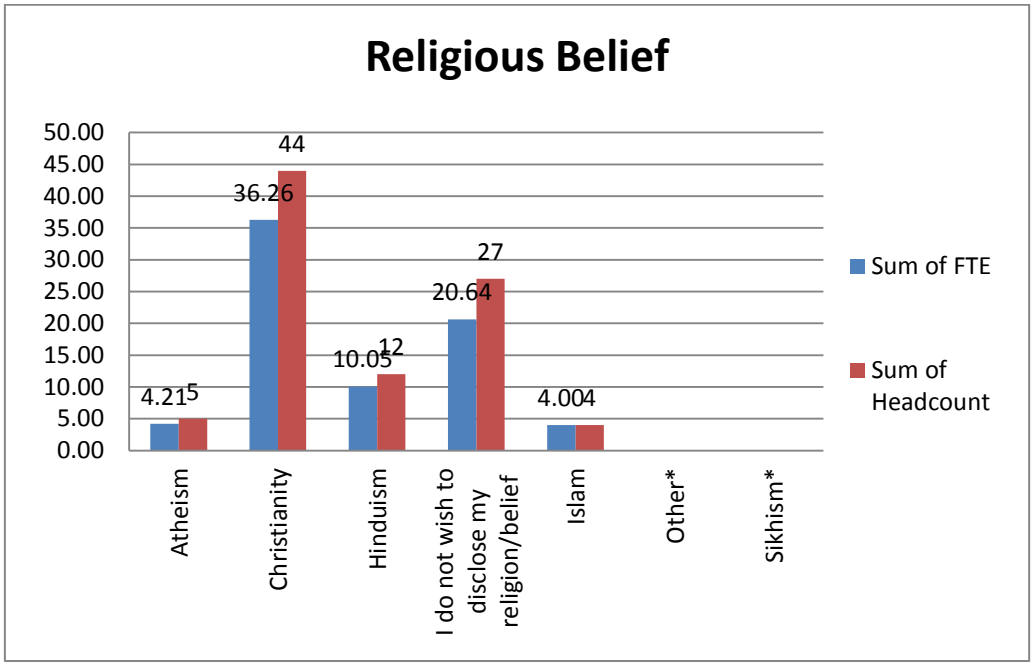
*Denotes information withheld by the CCG for staff confidentiality purposes

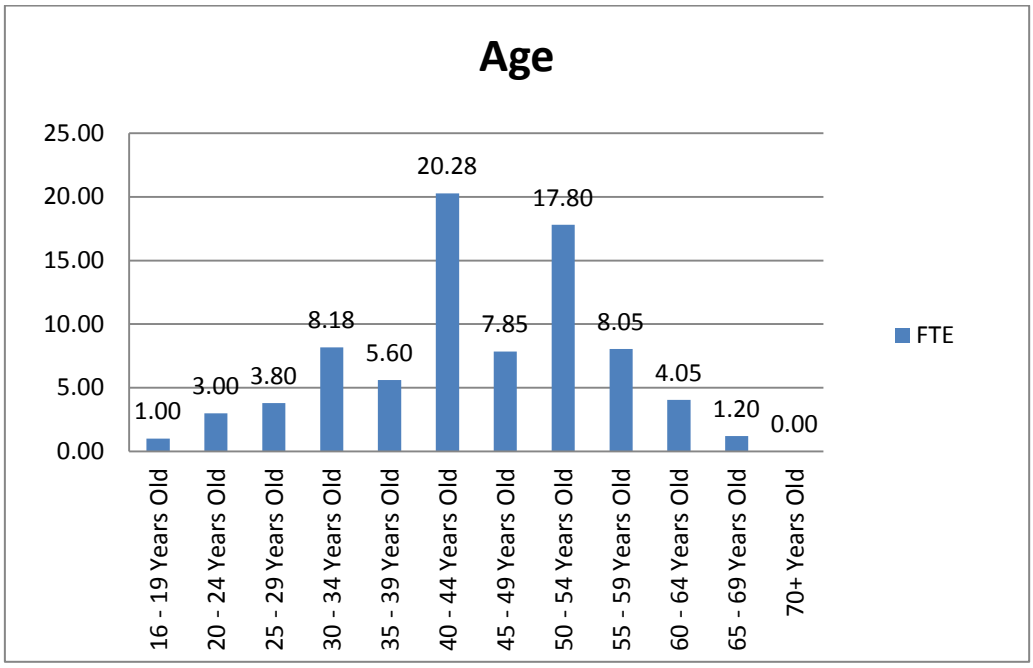


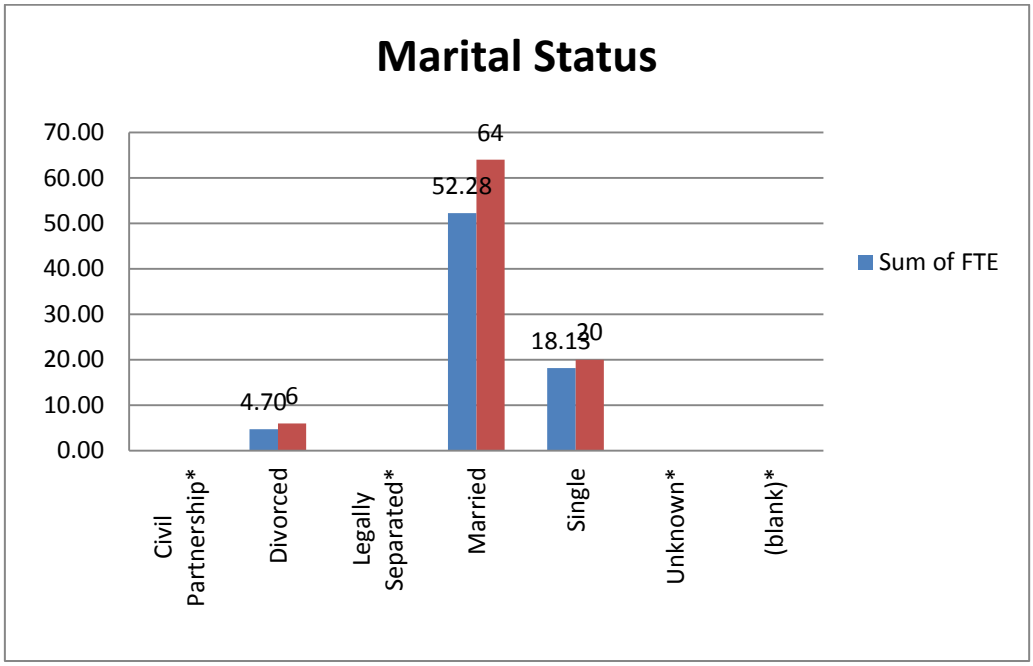


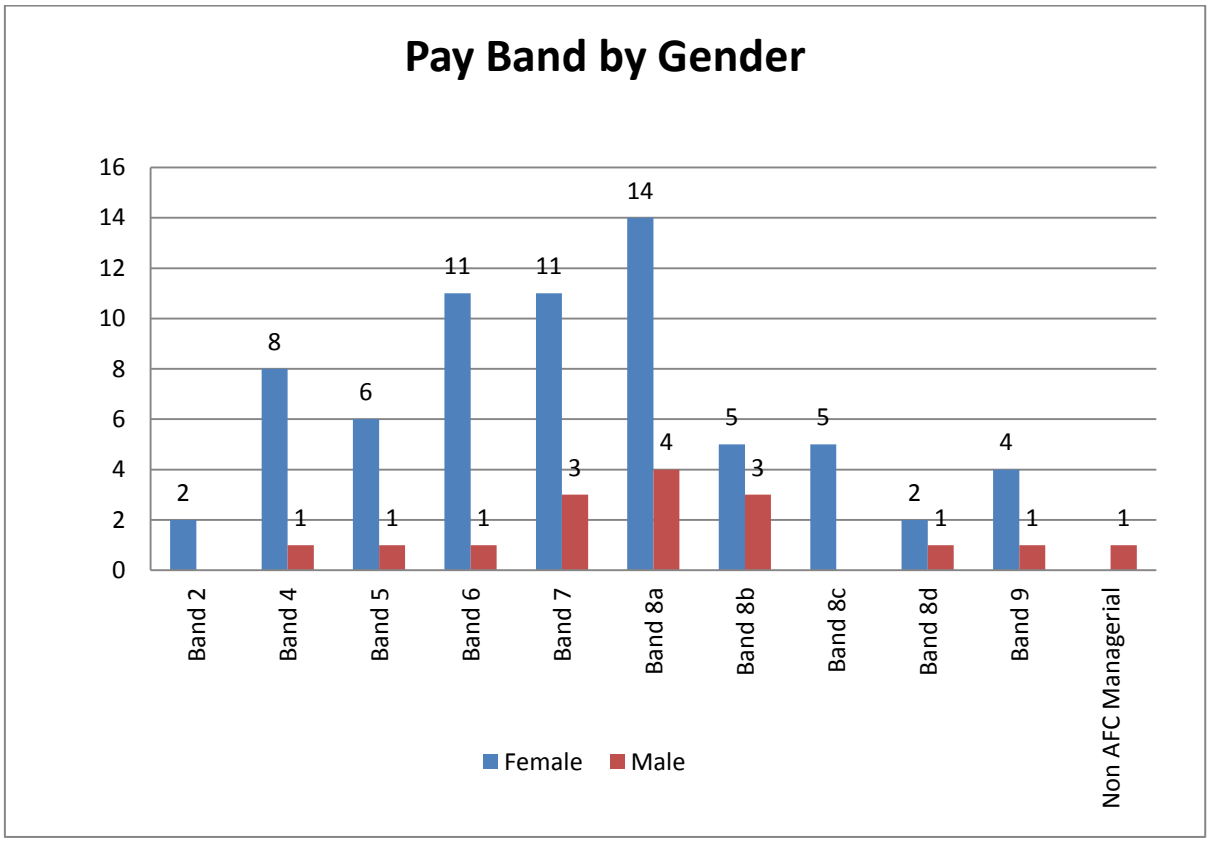

Gender
80.00
70.00
60.00
50.00
40.00
30.00
20.00
10.00
0.00
61.03
69
19.18
29
Female
Male
Sum of FTE
Sum of Headcount

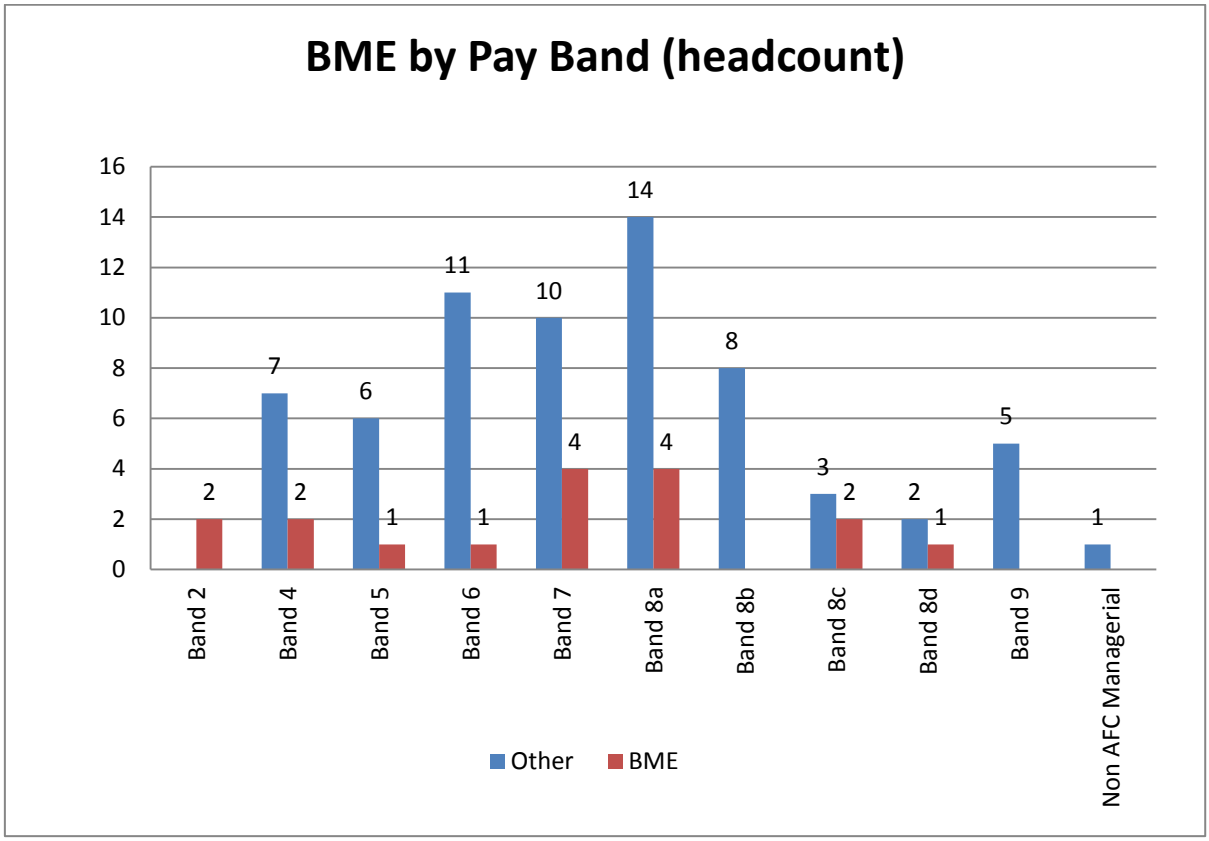

Sexual Orientation
80
70
60
50
40
30
20
10
0
65.88
74
12.03
20
Bisexual*
Gay*
Heterosexual
I do not wish to disclose my sexual orientation
Undefined*
Sum of FTE
Sum of Headcount


Religious Belief
50.00
45.00
40.00
35.00
30.00
25.00
20.00
15.00
10.00
5.00
0.00
4.21
5
36.26
44
10.05
12
20.64
27
4.00
4
Atheism
Christianity
Hinduism
I do not wish to disclose my religion/belief
Islam
Other*
Sikhism*
Sum of FTE
Sum of Headcount


Age
25.00
20.00
15.00
10.00
5.00
0.00
1.00
3.00
3.80
8.18
5.60
20.28
7.85
17.80
8.05
4.05
1.20
0.00
16 - 19 Years Old
20 - 24 Years Old
25 - 29 Years Old
30 - 34 Years Old
35 - 39 Years Old
40 - 44 Years Old
45 - 49 Years Old
50 - 54 Years Old
55 - 59 Years Old
60 - 64 Years Old
65 - 69 Years Old
70+ Years Old
FTE

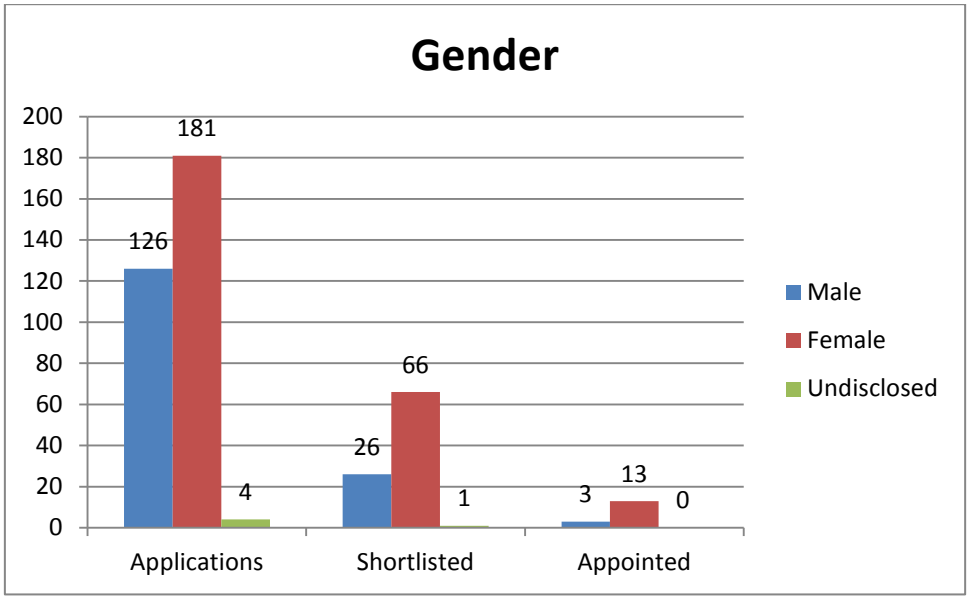

Marital Status
70.00
60.00
50.00
40.00
30.00
20.00
10.00
0.00
4.70
6
52.28
64
18.13
20
Civil Partnership*
Divorced
Legally Separated*
Married
Single
Unknown*
(blank)*
Sum of FTE

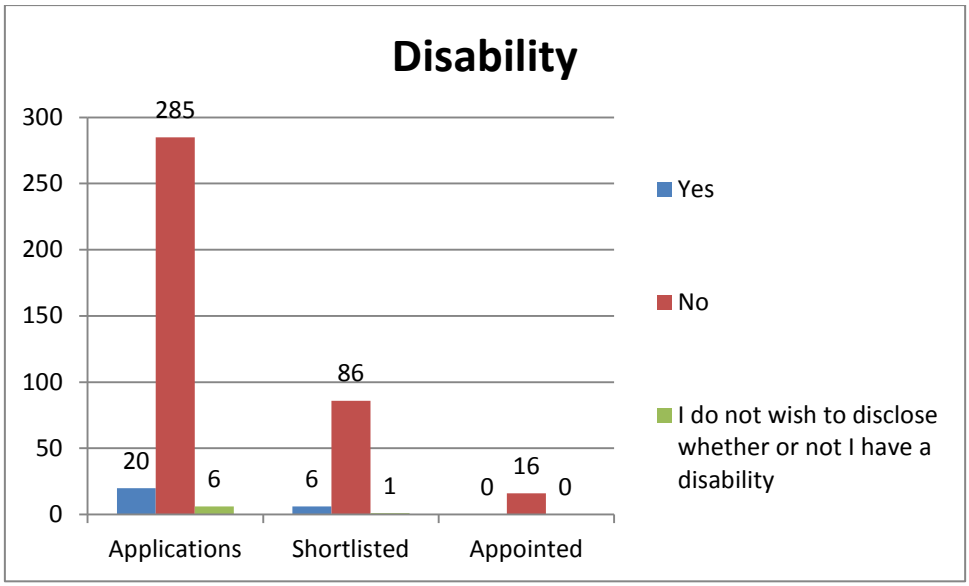

Pay Band by Gender
16
14
12
10
8
6
4
2
0
2
8
1
6
1
11
1
11
3
14
4
5
3
5
2
1
4
1
1
Band 2
Band 4
Band 5
Band 6
Band 7
Band 8a
Band 8b
Band 8c
Band 8d
Band 9
Non AFC Managerial
Female
Male

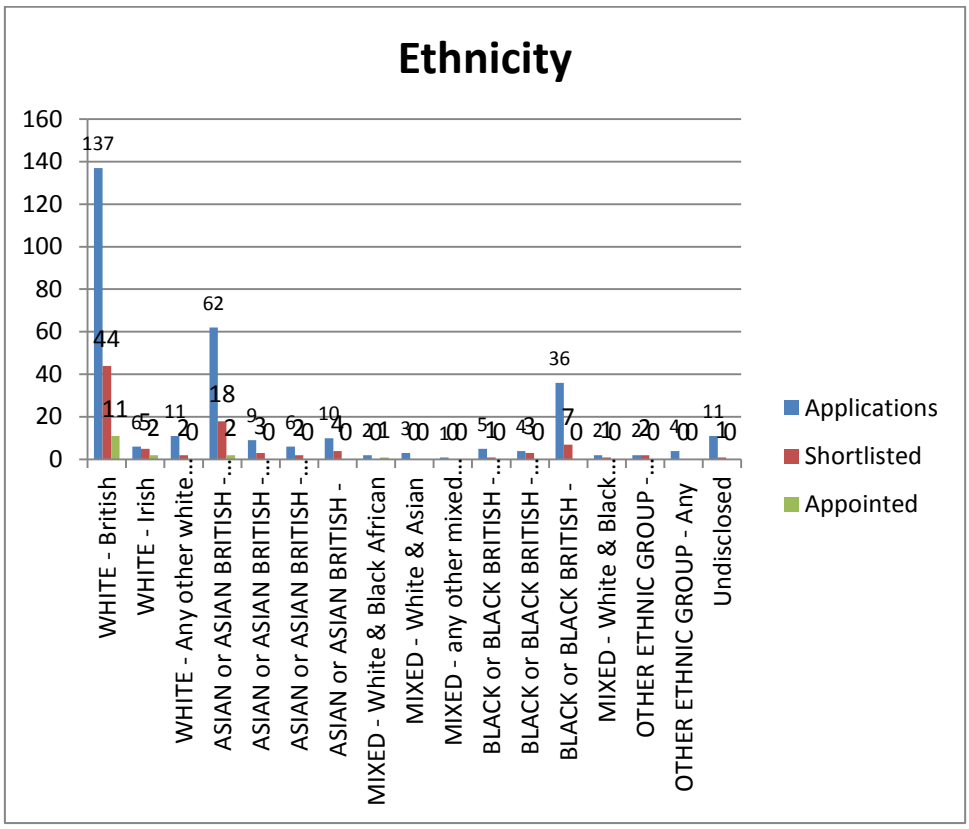

BME by Pay Band (headcount)
16
14
12
10
8
6
4
2
0
2
7
2
6
1
11
1
10
4
14
4
8
3
2
2
1
5
1
Band 2
Band 4
Band 5
Band 6
Band 7
Band 8a
Band 8b
Band 8c
Band 8d
Band 9
Non AFC Managerial
Other
BME

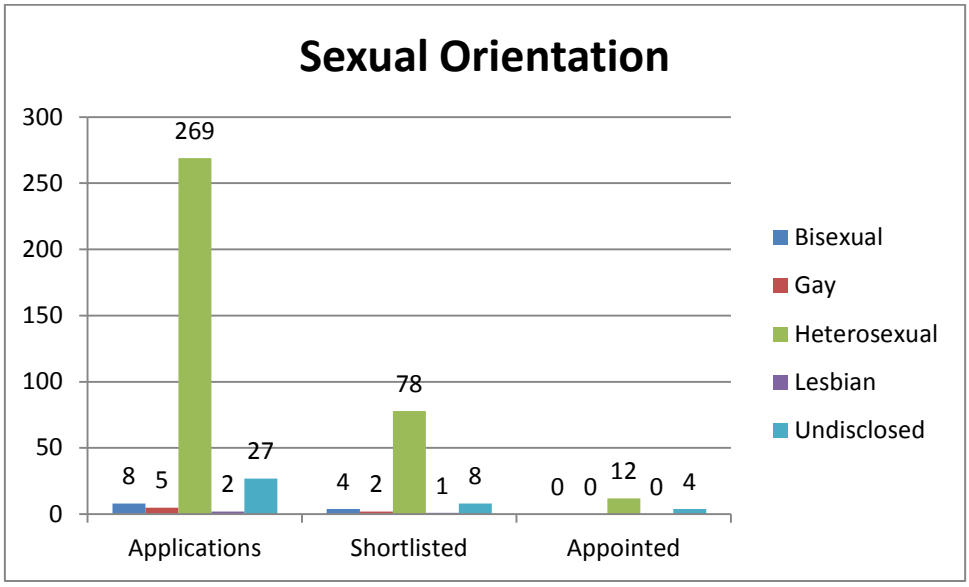
APPENDIX 2: WORKFORCE RECRUITMENT

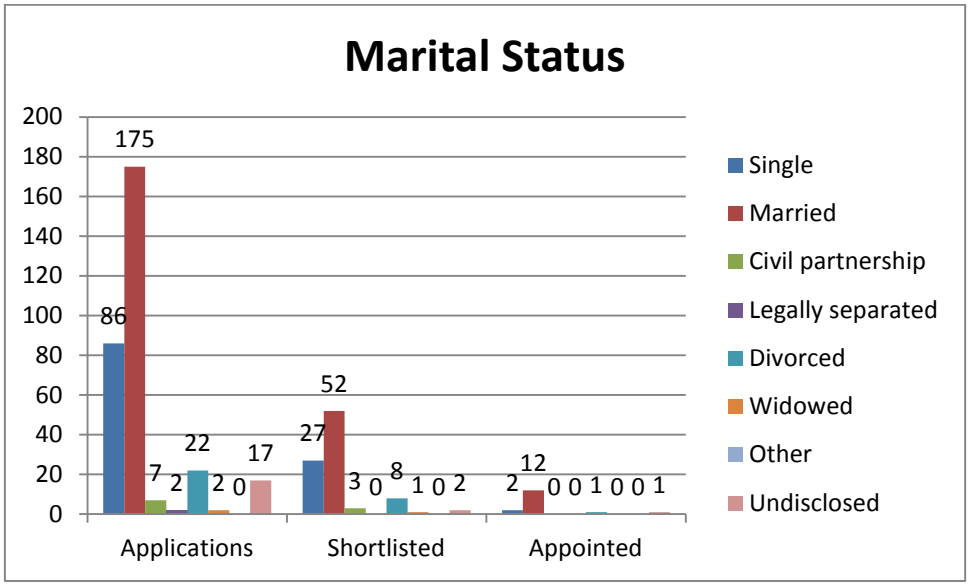
Of the Job Applicants to WLCCG (April 2017 – March 2018)
Job Applications, Shortlists, Appointments
(all data as at March 2018)

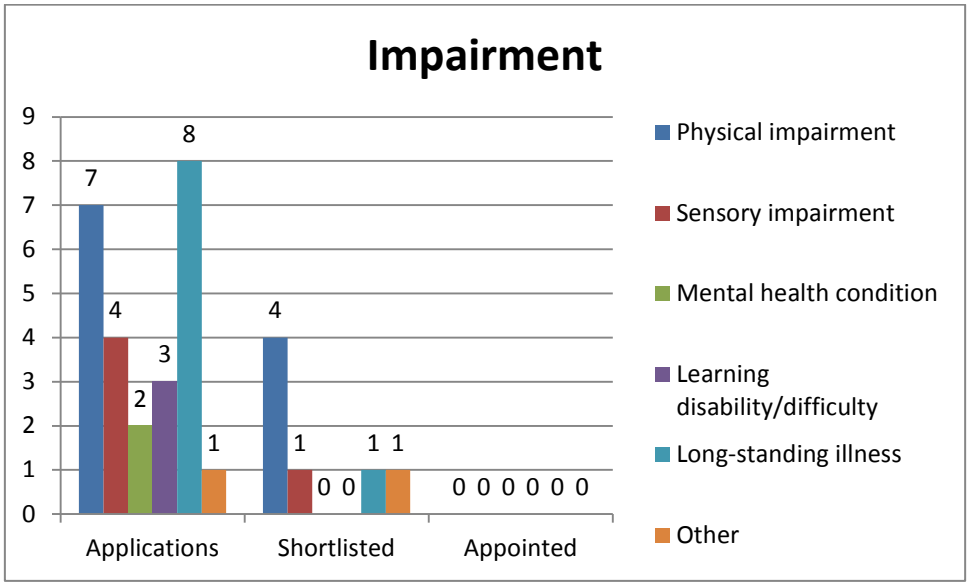


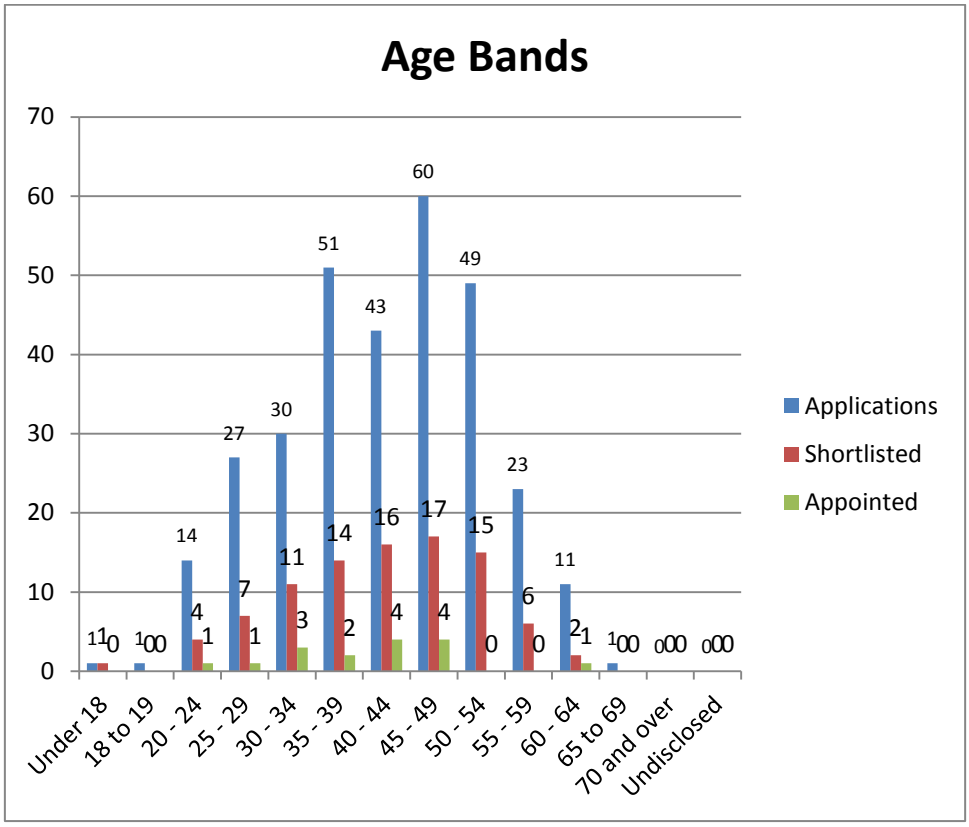


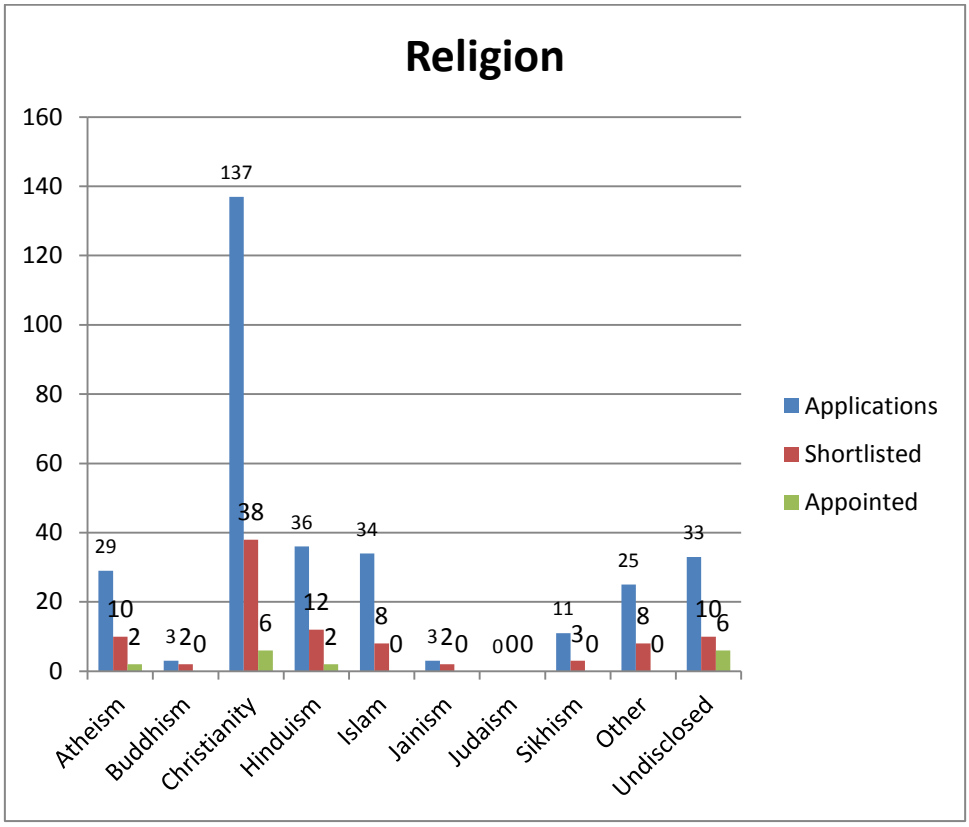

Ethnicity
160
140
120
100
80
60
40
20
0
137
44
11
6
5
2
11
2
0
62
18
2
9
3
0
6
2
0
10
4
0
2
0
1
3
0
0
1
0
0
5
1
0
4
3
0
36
7
0
2
1
0
2
2
0
4
0
0
11
1
0
WHITE - British
WHITE - Irish
WHITE - Any other white...
ASIAN or ASIAN BRITISH -...
ASIAN or ASIAN BRITISH -...
ASIAN or ASIAN BRITISH -...
ASIAN or ASIAN BRITISH -
MIXED - White & Black African
MIXED - White & Asian
MIXED - any other mixed...
BLACK or BLACK BRITISH -...
BLACK or BLACK BRITISH -...
BLACK or BLACK BRITISH -
MIXED - White & Black...
OTHER ETHNIC GROUP -...
OTHER ETHNIC GROUP - Any
Undisclosed
Applications
Shortlisted
Appointed


Sexual Orientation
300
250
200
150
100
50
0
8
5
269
2
27
4
2
78
1
8
0
0
12
0
4
Applications
Shortlisted
Appointed
Bisexual
Gay
Heterosexual
Lesbian
Undisclosed


Marital Status
200
180
160
140
120
100
80
60
40
20
0
175
86
7
2
22
2
0
17
52
27
3
0
8
1
0
2
12
2
0
0
1
0
0
1
Applications
Shortlisted
Appointed
Single
Married
Civil partnership
Legally separated
Divorced
Widowed
Other
Undisclosed


Impairment
9
8
7
6
5
4
3
2
1
0
7
4
2
3
8
1
4
1
0
0
1
1
0
0
0
0
0
0
Applications
Shortlisted
Appointed
Physical impairment
Sensory impairment
Mental health condition
Learning disability/difficulty
Long-standing illness
Other


Age Bands
70
60
50
40
30
20
10
0
Under 18
18 to 19
20 - 24
25 - 29
30 - 34
35 - 39
40 - 44
45 - 49
50 - 54
55 - 59
60 - 64
65 to 69
70 and over
Undisclosed
Applications
Shortlisted
Appointed


Religion
160
140
120
100
80
60
40
20
0
Atheism
Buddhism
Christianity
Hinduism
Islam
Jainism
Judaism
Sikhism
Other
Undisclosed
Applications
Shortlisted
Appointed

APPENDIX 3: WLCCG EDS2 Gradings 2014/15, 2015/16, 2016/17 and 2017/18

WLCCG The goals and outcomes of EDS2						
Goal	**#**	**Description of outcome**	**14/15**	**15/16**	**16/17**	**17/18**
Better health outcomes	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	A	D	D	D
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways	D	D	D	D
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	D	D	D	D
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	A	A	A	A
	1.5	Screening, vaccination and other health promotion services reach and benefit all local communities	A	D	D	D
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	D	D	D	D
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	A	A	A	A
	2.3	People report positive experiences of the NHS	A	A	A	A
	2.4	People's complaints about services are handled respectfully and efficiently	D	D	D	D
A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	D	D	D	D
	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	A	A	A	A
	3.3	Training and development opportunities are taken up and positively evaluated by all staff	D	D	D	D
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	D	D	D	D
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	A	A	A	A
	3.6	Staff report positive experiences of their membership of the workforce	E	A	A	A
Inclusive Leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	A	A	A	A
	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	D	D	D	D
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	D	D	D	D

Grading Guide	**Undeveloped**	**Developing**	**Achieving**	**Excelling**
	People from all protected groups fare poorly compared with people overall *OR* evidence is not available	People from only some protected groups fare as well as people overall	People from most protected groups fare as well as people overall	People from all protected groups fare as well as people over

APPENDIX 4: WRES Metrics

No	WRES Metric	2016	Pickers CCG average
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.		
	Non Review Body Band 2	100%	n/a
	Non Review Body Band 4	22%	n/a
	Non Review Body Band 5	14%	n/a
	Non Review Body Band 6	8%	n/a
	Non Review Body Band 7	29%	n/a
	Non Review Body Band 8 - Range A	22%	n/a
	Non Review Body Band 8 - Range B	0%	n/a
	Non Review Body Band 8 - Range C	40%	n/a
	Non Review Body Band 8 - Range D	30%	n/a
	Non Review Body Band 9	0%	n/a
	Non AFC	0%	n/a
2	Relative likelihood of staff being appointed from shortlisting across all posts.	Of Total applications - 47% BME Applied 44% BME Shortlisted 19% Appointed	n/a
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	0	n/a
4	Relative likelihood of staff accessing non-mandatory training and CPD.	tbc	n/a
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	5%	10%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	n/a	n/a
6a	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. Manager	10%	15%
6b	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.?other colleagues	12%	14%
7	Percentage believing that trust provides equal opportunities for career progression or promotion.	88%	82%

8	In the last 12 months have you personally experienced discrimination at work from any of the following?b) Manager/team leader or other colleagues	5%	8%
	Board representation indicator		
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	60%	

West Leicestershire Clinincal Commissioning Group

55 Woodgate
Loughborough
Leicestershire
LE11 2TZ

Approved by WLCCG Board on Tuesday 8 May 2018

Senior Responsible Clinician – ***Dr Peter Cannon***
Lay Member – ***Gillian Adams***
Senior Responsible Officer – ***Ket Chudasama***

Telephone: 01509 567700
E-mail: enquiries@westleicestershireccg.nhs.uk