



NHS England response to the specific equality duties of the Equality Act 2010

NHS England's equality objectives and equality information
February 2017 – March 2018

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Acronyms used in this report

5YFV	Five Year Forward View
ADASS	Association of Directors of Adult Social Services
ALB	Arm's-Length Body
BBV	Blood-borne Virus
BAME	Black, Asian and Minority Ethnic
BME	Black and Minority Ethnic
CCGs	Clinical Commissioning Groups
CETR	Care, Education and Treatment Review
CIPOLD	Confidential Inquiry into Premature Deaths of People with Learning Disabilities
CPES	Cancer Patient Experience Survey
CQC	Care Quality Commission
CQUIN	Commissioning for quality and innovation
CSU	Commissioning Support Unit
CSV	Community Service Volunteers
CTR	Care and Treatment Review
CYP	Children and Young People
CYPSE	Children and Young People's Secure Estate
DAWN	Disability and Wellbeing Network
DfE	Department for Education
DH	Department of Health
DHSC	Department of Health and Social Care ¹
DCIoSLRF	Devon, Cornwall & Isles of Scilly Local Resilience Forum
DPP	Diabetes Prevention Programme
DWP	Department for Work and Pensions
EDC	Equality and Diversity Council
EDI	Equality, Diversity and Inclusion
EDS	Equality Delivery System
EDS2	Equality Delivery System 2
EMG	Executive Management Group
EHI	Equality and Health Inequalities
EHIT	Equality and Health Inequalities Team
EHRC	Equality and Human Rights Commission
ESR	Electronic Staff Record
FAQs	Frequently Asked Questions
FTE	Full-time equivalent
GICs	Adult Gender Identity Clinics
GP	General Practitioner
GPG	Gender Pay Gap
HEE	Health Education England

¹ The renamed Department of Health.

HMPPS	Her Majesty's Prison and Probation Service
HQIP	Healthcare Quality Improvement Partnership
HWA	Health and Wellbeing Alliance
IAF	Improvement and Assurance Framework
LDEP	Learning Disability Employment Programme
LeDeR	Learning Disabilities Mortality Review
LGA	Local Government Association
LGB	Lesbian, Gay, Bisexual
LGBT	Lesbian, Gay, Bisexual and Transgender
LTC	Long-term condition
MoJ	Ministry of Justice
NCAPOP	National Clinical Audit and Patient Outcomes Programme
NAVCA	National Association for Voluntary and Community Action
NEDs	Non Executive Directors
NHS	National Health Service
ONS	Office for National Statistics
PCB	People & Communities Board
PHE	Public Health England
PPI	Patient and public involvement
PPV	Patient and Public Voice
PSED	Public Sector Equality Duty
PSEDs	Public sector equality duties
SE	Secure Estate
SEDs	Specific equality duties
SES	Socio-economic status
SMARTER	Specific, measurable, attainable, realistic, time-specific, evaluate, review/revise
SMI	Severe Mental Illness
SOM	Sexual Orientation Monitoring
STP	Sustainability and Transformation Partnership
TCP	Transforming Care Partnership
TCDB	Transforming Care Delivery Board
VCS	Voluntary and Community Sector
VCSE	Voluntary, Community and Social Enterprise
WESC	Women and Equalities Select Committee
WDES	Workforce Disability Equality Standard
WHO	World Health Organisation
WRES	Workforce Race Equality Standard
YCS	Youth Custody Service

1 Introduction and NHS England's equality objectives

1.1 About NHS England

NHS England was established by Parliament under the Health and Social Care Act 2012. NHS England is charged with the stewardship of the National Health Service (NHS) in England. We set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care. As an independent organisation, NHS England works at arm's-length from Government.

NHS England shares out more than £100 billion in funds and holds organisations to account for spending this money effectively for patients and efficiently for the tax payer. A lot of the work that we do involves the commissioning of health care services in England. We commission the contracts for GPs, pharmacists, and dentists and we support local health services that are led by groups of GPs called Clinical Commissioning Groups (CCGs). CCGs plan and pay for local services such as hospitals and ambulance services.

In October 2014, we published the '[NHS Five Year Forward View](#)', our strategic vision for the NHS. In March 2017, we published the '[Next Steps on the NHS Five Year Forward View](#)'. The 'Next Steps' strategy reviews progress made and 'sets out a series of practical and realistic steps for the NHS to deliver a better, more joined-up and more responsive NHS in England.' NHS England is committed to prevention, identifying and delivering improvements in health care and redesigning the NHS. The aims are to ensure that the NHS continues to meet the needs of patients, to ensure that the NHS is financially sustainable and to engage the public in this whole process.

For more information about us please visit [NHS England's website](#).

1.2 Governance and our business plan

Ultimate responsibility for the affairs of NHS England, including compliance with the public sector Equality Duty and our other legal duties, rests with NHS England's Board. Our Board consists of a Chair, eight non-executive directors and four voting executive directors. A number of non-voting executive directors regularly attend Board meetings. Board members bring a range of complementary skills and experience in areas such as finance, governance, health policy, health inequalities and equalities. Key areas of the Board's governance responsibilities support effective compliance with the duties to reduce health inequalities and the public sector Equality Duty. NHS England then assigns staff internally to give effect to this agenda and work programme.

1.3 NHS England's business plan and the Five Year Forward View

'NHS England Funding and Resource 2017-19' is our latest business plan.² It sets out how NHS England will, through the distribution of funding and people, support local health and care systems. This document is an annex to the '[Next Steps on the NHS Five Year Forward View](#)' (5VfV). The 'Next Steps' strategy sets out a series of practical and realistic steps for the NHS to deliver a better, more joined-up and more responsive NHS in England.

1.4 Report overview

This report explains action being taken to meet, or that supports meeting, the public sector Equality Duty (PSED) and it is designed to: i) promote a better understanding of NHS England's equality objectives; ii) provide information about key equality focussed developments and initiatives; and iii) promote greater transparency and greater accountability. Chapter one sets out NHS England's six equality objectives for April 2016 to March 2020. Chapter two explains, and comments on, the relationship between our duties in relation to publishing equality objectives and equality information. It also explains the relationship between the general and specific public sector Equality Duties and our duties in relation to reducing health inequalities provided under the Health and Social Care Act 2012.³ Chapter two also comments on the relationship between the PSED, the NHS Constitution's principles and values and the 'Next Steps on the Five Year Forward View'.

Chapters three to six provide equality information on progress towards the public sector Equality Duty (PSED) under four main headings: i) system leadership, the Equality and Diversity Council, standards, systems and equality information; ii) engagement across the protected characteristics; iii) transforming services and the NHS; and iv) NHS England as an employer. The reporting timetable has changed since 2017. To address this change, this report covers February and March 2017, where key information was not reported in [our last report](#), and financial year 2017/18.⁴ Appendix 1 provides relevant workforce data for NHS England. Key workforce information is reported on up to the end of September or December 2017 because of the time lags associated with reporting on such data. Appendix 2 provides information on progress against the targets associated with each equality objective and identifies where we have refined these targets and/or where targets are ongoing.

² Full title: NHS England Funding and Resource 2017-19: supporting 'Next Steps for the NHS Five Year Forward View'

³ Detailed information on compliance with our duties under the Health and Social Care Act 2012 is set out in NHS England's annual reports and associated documents.

⁴ The reporting timetable has been shifted back from 30 January to 30 March by virtue of the statutory regulations which came into force in March 2017 (see chapter 2.3 for further details). Our last report on compliance with the Specific Equality Duties was published at the beginning of March 2017 but covered activities up to the end of January/February 2017.

1.5 Embracing our equality duties and our equality objectives

NHS England is committed to high quality care for all, now and for future generations. We know from evidence that we cannot successfully achieve this vision without advancing equality and reducing health inequalities. Our values-based commitments embrace important legal duties in relation to equality of opportunity and reducing health inequalities. These duties are provided by the Equality Act 2010 and the Health and Social Care Act 2012; they are briefly explained in part two of this report. NHS England set six equality objectives for 2016 to 2020. These equality objectives are designed to explain what NHS England is seeking to achieve in working towards the equality aims set out in the general Duty. Each equality objective is supported and strengthened by three or more associated targets. The first five equality objectives focus on NHS England's broader functions including our role as an NHS system leader.⁵ NHS England's internal workforce matters are covered by our sixth equality objective.

- **Equality objective 1:** To improve the capability of NHS England's commissioners, policy staff and others to understand and address the legal obligations under the public sector Equality Duty and duties to reduce health inequalities introduced by the Health and Social Care Act 2012.
- **Equality objective 2:** To improve disabled staff representation, treatment and experience in the NHS and their employment opportunities within the NHS.
- **Equality objective 3:** To improve the experience of LGBT patients and improve LGBT staff representation.
- **Equality objective 4:** To reduce language barriers experienced by individuals and specific groups of people who engage with the NHS with specific reference to identifying how to address issues in relation to health inequalities and patient safety.
- **Equality objective 5:** To improve the mapping, quality and extent of equality information in order to better facilitate compliance with the public sector Equality Duty in relation to patients, service-users and service delivery.
- **Equality objective 6:** To improve the recruitment, retention, progression, development and experience of the people employed by NHS England to enable the organisation to become an inclusive employer of choice.

This report references key 5YFV transformation programmes which contribute to progress in relation to the PSED. However, we do not underestimate the profound challenges that face the NHS, NHS England, Social Care and other partner agencies. Whilst we continue to strive to make positive progress, there is much still to be done. We plan to review our equality objectives in 2019/2020. In line with the statutory timetable, we plan to publish revised equality objectives by March 2020.

⁵ Our role as an NHS system leader is explained in part 3 of this report.

2 The general and specific public sector Equality Duties, the health inequalities duties and other key obligations

2.1 The public sector Equality Duty in context

The public sector Equality Duty (PSED) is made up of a general Equality Duty and specific equality duties (SEDs). The general public sector Equality Duty, to which NHS England is subject, and the majority of other public bodies, is set out in primary legislation as section 149 (1) of the Equality Act 2010. This general duty is supported by secondary legislation in the form of statutory regulations. These statutory regulations are called the specific equality duties (SEDs). The Equality and Human Rights Commission (EHRC) has published non-statutory and technical guidance to assist public bodies to comply with the general and specific equality duties.

The EHRC encourages organisations to consider how the public sector Equality Duty (PSED) informs all of their relevant roles. In producing this report, consideration has been given to the EHRC's guidance.⁶

2.2 Understanding the general equality duty

The general public sector Equality Duty, section 149 (1) of the Equality Act 2010, is one of 'due regard' or proper consideration. The general Equality Duty is supported by specific equality duties (SEDs), secondary legislation or statutory rules, designed to facilitate the better performance of the general Duty. In exercising our functions, NHS England is required to 'have due regard to the need to' address three equality aims set out below.

- **Equality aim 1: 'a) eliminate discrimination, harassment, victimisation and any other conduct** that is prohibited by or under this Act'.
- **Equality aim 2: 'b) advance equality of opportunity** between persons who share a relevant protected characteristic and persons who do not share it'.
- **Equality aims 3: 'c) foster good relations** between persons who share a relevant protected characteristic and persons who do not share it.'⁷

The general Equality Duty means that NHS England has to properly consider all three equality aims in all the activities that it undertakes – for example, employing staff, commissioning and procurement, planning services and fulfilling our statutory and legal obligations. This report explains the key actions that we are taking to address this Duty. The general Equality Duty's three equality aims fully cover eight of the nine protected characteristics set out in the Equality Act 2010. These protected characteristics are age, disability, gender reassignment, pregnancy and maternity,

⁶ [Objectives and the Equality Duty](#): A guide for public authorities England (and non-devolved public authorities in Scotland and Wales), EHRC, September 2014. [Technical Guidance on the Public Sector Equality Duty: England](#), EHRC, August 2014.

⁷ Equality Act 2010, section 149 (1)

race (i.e. colour, ethnic or national origins and nationality), religion or belief, sex and sexual orientation. The other protected characteristic listed in the 2010 Act, marriage and civil partnership, is partially covered by the general Equality Duty. In this case, public bodies are required to give due regard to the first equality aim, the elimination of discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010; but public bodies are not required to advance equality of opportunity or foster good relations in relation to marriage and civil partnership.⁸ Specific legal duties, called the specific equality duties, have been agreed by Parliament to ensure that public bodies meet the PSED properly.⁹

2.3 Understanding the specific equality duties

The Equality Act 2010 provided Ministers with the power to ‘impose’ specific legal duties by way of statutory regulation to enable ‘the better performance’ of the three equality aims set out in the general Duty.¹⁰ The statutory regulations, which apply to NHS England, were first published in 2012, are called the Specific Equality Duties.¹¹

The Specific Equality Duties (SEDs) for England require NHS England to publish equality objectives at least every four years.¹² The SEDs also require the annual publication of equality information. NHS England published interim equality objectives in April 2013. Equality objectives were then published in April 2014 and March 2017. Our last report on equality information was published on 3 March 2017. In March 2017, after we published our last report on compliance with the Specific Equality Duties, the requirements in relation to the specific equality duties were significantly strengthened and the reporting timetable changed. The reporting timetable was shifted back from 30 January to 30 March and an important new Gender Pay Gap reporting duty was introduced. This new Specific Equality Duty (SED) applies to public bodies that employ 250 or more full time equivalent (FTE) employees. NHS England is subject to this Gender Pay Reporting Duty.

The current regulations were published in 2017.¹³ The Specific Equality Duties (SEDs) require NHS England and other designated public body in England to:

- publish gender pay gap reporting information annually by 30 March annually (regulation 3);

⁸ The Equality Act 2010, section 149 (7)

⁹ The purpose of the SEDs is to enable ‘the better performance’ of the PSED by public authorities subject to the duty. Equality Act 2010, section 153 (1).

¹⁰ The Equality Act 2010, section 153.

¹¹ The Equality Act (2010) (Specific Duties) Regulations 2011. The National Treatment Agency (Abolition) and the Health and Social Care Act 2012 (Consequential, Transitional and Saving Provisions) Order 2013, schedule 3, article 12, subsection 25, 26, 27.

¹² We refer to the specific equality duties (SEDs) for England because there are separate and different SEDs for Scotland and Wales.

¹³ The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017

- publish ‘information to demonstrate compliance’ with the PSED annually by 30 March annually (regulation 4);
- ensure that the equality information published annually includes ‘information relating to persons who share a relevant protected characteristic’ who are a) ‘its employees’ and b) ‘other persons affected by its policies and practices’ (regulation 4);
- prepare and publish one or more objective to be achieved in order to address one or more of the three equality aims set out in the PSED at least every four years (regulation 5).

The equality information published in this report is intended to inform readers about the progress made towards NHS England’s equality objectives and towards the general Duty’s three equality aims.

2.4 The general equality duty and the health inequalities duties

The World Health Organisation (WHO) defines health inequities or health inequalities as ‘avoidable inequalities in health between groups of people within countries and between countries.’ According to the [World Health Organisation](#), such inequities arise from inequalities within and between societies.¹⁴ Health inequalities can cut across a range of social and demographic indicators including socio-economic status, occupation, geographical location and the protected characteristics set out in the Equality Act 2010.

The Health and Social Care Act 2012 amended the National Health Service Act 2006. The 2006 Act, as amended, sets out a range of legal obligations including duties that require NHS England, and others, in exercising their functions to ‘have regard to the need’ to reduce inequalities in access to health and health outcomes.¹⁵ These legal duties took effect from 1 April 2013. NHS England is required to assess its own compliance with these duties on reducing health inequalities and the compliance of Clinical Commissioning Groups (CCGs). NHS England is also required to publish an annual report which assesses how effectively both it (NHS England) and CCGs have discharged these duties.¹⁶ NHS England’s next annual report is due to be published in the summer of 2018.

¹⁴ The World Health Organisation, social determinants of health, key concepts accessed 31 January 2017.

¹⁵ The Board must, in the exercise of its functions, have regard to the need to— (a) reduce inequalities between patients with respect to their ability to access health services, and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. Health and Social Care Act 2012, section 13G.

¹⁶ The Health and Social Care Act 2012 contained a number of important amendments to the National Health Service Act 2006 in relation to reducing health inequalities, performance assessment, reviews and annual reporting. Key provisions include sections 13G, 13T, 13U and 14Z16.

2.5 The NHS Constitution's key principles and values

The EHRC advises that public bodies should consider how the equality duties complement and support the achievement of the organisation's core purpose. The ['NHS Constitution for England'](#), first published in 2012, sets out seven key principles, set out below, and important values for the NHS. Embracing the public sector Equality Duty and duties to reduce health inequalities are pivotal to the realisation of these principles and values.

1. The NHS provides a comprehensive service, available to all.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism.
4. The patient will be at the heart of everything the NHS does.
5. The NHS works across organisational boundaries and in partnership with other organisations in the interests of patients, local communities and the wider population.
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
7. The NHS is accountable to the public, communities and patients that it serves.

In terms of the values set out in the [NHS Constitution for England](#), NHS England recognises that equality, diversity and reducing health inequalities are central to meeting pledges made to patients and the public and achieving the values enshrined in the NHS Constitution: i) working together for patients; ii) respect and dignity; iii) commitment to quality of care; iv) compassion; v) improving lives; iv) everyone counts.¹⁷

2.6 The Next Steps on the NHS Five Year Forward View and equality – nine improvement areas

Nine improvement areas are set out in the 'Next Steps on the NHS Five Year Forward View' (5YFV). The improvement areas are: 1) Urgent and Emergency Care; 2) Primary care; 3) Cancer; 4) Mental Health; 5) Integrating care locally, through New care models, Sustainability and Transformation Partnerships (STPs), community participation and involvement and Accountable Care Systems; 6) Funding and efficiency; 7) Strengthening our workforce; 8) Patient safety; and 9) Harnessing technology and innovation. Addressing equalities and reducing health inequalities are at the heart of the broader transformation agenda which underpins the Next Steps Strategy. Key equalities focused work is overviewed in chapter 3, 4 and 5 of this report.

¹⁷ The NHS Constitution for England accessed 12 March 2018.

2.7 The Next Steps on the NHS Five Year Forward View and employment equality

NHS England has made a number of equality focused workforce commitments. These commitments include:

- improving staff engagement, diversity and inclusion in our workforce;
- continuing with our focus upon ‘Respect at Work’ driving a zero tolerance approach to poor workplace behaviours, bullying, harassment and discrimination;
- improving the positive experience of people across the organisation;
- continuing to develop our approach to creating a more diverse and inclusive workforce, with a particular focus upon positive support for Black and Minority Ethnic (BME) colleagues to enable more BME staff to achieve senior roles, a central tool being the Workforce Race Equality Standard;
- improving the employment opportunities for people with learning disabilities through the NHS Learning Disability Employment Programme;
- introducing an NHS Workforce Disability Equality Standard.¹⁸

Information on these workforce equality programmes and key developments during 2017/18 is provided in the next chapter of this report.

3 Our work as a system leader, the Equality and Diversity Council, standards, systems and equality information

3.1 Equalities and NHS England’s role as a systems leader

NHS England takes its role as an NHS system leader seriously and, with other NHS system partners and NHS leaders, we signed the declaration on ‘Advancing Equality and Tackling Health Inequalities across Health and Social Care’ in 2014. We remain committed to the actions set out below.

- **Supporting** the Equality and Diversity Council to positively position itself as a body of influence in promoting equality across and beyond the health and care sector.
- **Creating** the environment where everyone can contribute to the delivery of a responsive and equitable health and care service, built on the values of the NHS Constitution.
- **Raising** ambition at every level of the health care system by campaigning to inspire strong leadership, removing barriers to change, and celebrating success.

¹⁸ NHS England Funding and Resource 2017-19: Supporting ‘Next Steps on the NHS Five Year Forward View’

- **Empowering** health care providers, commissioners, regulators, the NHS workforce, patients and the public to achieve a health and care system where “everyone counts”, by supporting continuously improving performance.
- **Embedding** the advancement of equality in the policies of the health and care architecture and in its day to day business; using our influence to help deliver positive change.
- **Impart** and share clear strategic direction, challenge and innovation; providing ongoing insight and a broad range of perspectives.

These commitments support compliance with the PSED and continue to inform NHS England’s approach to addressing the PSED; they also inform our broader work in relation to tackling discrimination and advancing equality of opportunity.

3.2 The NHS Equality and Diversity Council (EDC)

3.2.1 About the EDC, its purpose and key initiatives

The NHS Equality and Diversity Council (EDC) is co-chaired by Joan Saddler, Deputy Director at NHS Confederation, and Simon Stevens, the Chief Executive of NHS England. NHS England’s Equality and Health Inequalities Team (EHIT) provides the secretariat and supports the co-ordination of key work initiated by NHS England and the EDC. The Council aims to provide visible leadership on equality issues across and beyond the health sector. Its purpose is to shape the future of health care from an equality and human rights perspective and to improve the access, experiences, health outcomes and quality of care for all who use and deliver health and care services. The EDC’s diverse membership is made up from across the NHS, partner organisations as well patient, carer, and staff groups. Key initiatives developed by NHS England, working in partnership with the EDC since 2015, are described in this chapter of the report.

3.2.2 Key principles

The principles upon which the EDC works to achieve its ambitions are set out below.

- To improve understanding of how people’s differences, cultural expectations and social status can affect their experiences, health outcomes and quality of care.
- To commission strategic pieces of work that support NHS England and partner organisations in fulfilling their responsibilities on promoting equality.
- To seek and raise ambition at every level of the health care system by campaigning to inspire strong leadership, removing barriers to change, celebrating success, bringing the NHS Constitution to life and championing reform.

- To help to empower health care providers, commissioners, regulators, the NHS workforce, patients and the public to achieve an NHS where “everyone counts”, by supporting continuously improving performance.
- To describe what success looks like and advise on priorities for promoting equality.
- To use its influence to embed the promotion of equality in the policies of the NHS and its day to day business; identifying relevant system levers to ensure a consistency of approach within policy, strategy, and the delivery of services.
- To ensure that the wider health care system continuously improves its performance on equality.

3.2.3 The review of the EDC and the EDC annual report

During 2017, the EDC underwent a review of its form, function and impact. A key aim was to ensure that the work of the EDC going forward would be more aligned to the objectives set out in the '[Next Steps on the NHS Five Year Forward View](#)'. The first meeting of the refreshed EDC took place in July 2017. Members agreed the following three high-level themes for the EDC's 2017 -19 work programme: (i) enabling leadership capability and capacity; (ii) embedding levers and accountability, and (iii) supporting the system architecture. The EDC's [annual report for 2016/17](#) was published in September 2017.

For more information please visit our webpages on [the EDC](#).

3.3 Standards, contracts, mandates and embedding equality

One important way of advancing equality of opportunity is to develop standards to promote understanding, action and internal and external monitoring. NHS England has addressed key recommendations by the EHRC in relation to ensuring that equalities considerations and requirements are embedded in procurement, commissioning and associated contracts. In line with our role as an NHS system leader and our commissioning functions, NHS England is advancing equality across the NHS by using standards, contracts and mandating compliance. The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care. This Standard Contract requires compliance with relevant legal obligations including equality requirements and our equality standards. NHS England has also adopted, and reports against, our equality standards. This part of our report explains each key standard, its current status and key developments between February 2017 and the end of March 2018.¹⁹

¹⁹ Where referencing information not included in our previous report, published in March 2017, may be helpful, relevant information is cited. We have also provided information up to the end of March 2018 where the information was available and this could be helpful to readers.

3.4 The Equality and Delivery System – EDS and EDS2

The Equality and Delivery System 2 (EDS2) is designed to help NHS organisations to improve the services that they provide for their local communities and provide better working environments, free from discrimination, for those who work in the NHS, thereby helping organisations to meet the requirements of the Equality Act 2010. The EDS, developed for the NHS taking inspiration from existing work and good practice, was launched in July 2011. Following an independent evaluation, published in November 2012, EDS2 was launched in November 2013. EDS2 is supported by guidance and a range of resources.

Since April 2015, EDS2 has been mandated in the NHS Standard Contract. It has been cited within the CCG Assurance Framework as a key implementation requirement for NHS clinical commissioning groups (CCGs) and features within the Care Quality Commission's (CQC) inspection process for hospitals in England.

For more information please visit our webpages on [the Equality and Delivery System](#).

3.5 Scoping a Community Languages Standard and Interpretation and translation services

In 2016, NHS England scoped work to reduce language barriers experienced by individuals and specific groups of people when they engage with the NHS. During 2017/18, the EHIT worked jointly with the Primary Care Commissioning Team, to review and align the recommendations outlined in the scoping work for the Community Languages Information Standard (CLIS), completed by the Race Equality Foundation in 2016. From 2018, the CLIS project will be merged with the ongoing work of the Interpreting and Translation Programme, based within the Primary Care Commissioning Team.

The Guidance for commissioners on Interpreting and Translation services (previously known as the Principles) will also complement the Accessible Information Standard (AIS) and work to reduce language barriers experienced by people using the NHS. This is particularly important where these language barriers adversely impact on patient safety and/or increase or prevent the reduction of health inequalities.

For more information please visit our webpages on [Primary Care](#) .

3.6 The Sexual Orientation Monitoring (SOM) Standard

3.6.1 Background and launch in 2017

The Sexual Orientation Monitoring (SOM) Information Standard provides the mechanism for recording the sexual orientation of all patients/service users aged 16

years and over across all health services and Local Authorities with responsibilities for Adult Social Care in England in all service areas where it may be relevant to record this data.

The SOM provides the categories for recording sexual orientation but does not mandate the collection of data. Collecting and analysing data on sexual orientation allows public sector bodies to better understand and respond to Lesbian, Gay and Bi-sexual (LGB) patients' service access, outcomes and experience and provide evidence of their compliance with the public sector Equality Duty (PSED). The Information Standard was launched on 5th October 2017, when NHS Digital issued an [Information Standard Notice and implementation guidance](#).

3.6.2 The SOM's implementation and developments during 2017/18

A Sexual Orientation Task and Finish Group was convened to provide leadership and support across the system for the new standard. The LGBT Foundation was awarded a Voluntary, Community and Social Enterprise Health and Wellbeing Alliance (VCSE HWA) grant to support the awareness and the roll out of the Standard. This included six regional awareness events for the LGB community and the development of [a sexual orientation monitoring guide](#) for service users which is available online. NHS Employers has developed a [FAQs](#) page about the implementation of the guidance. NHS England is also facilitating a series of regional events with Equality and Diversity Leads as well as webinars for local authority and IT personnel to promote the benefits of the standard. Health Education England (HEE) working in partnership with the LGBT Foundation and Stonewall launched an [e-module](#) about the new standard. In addition, NHS Employers worked closely with the LGBT Foundation to support the development, consultation and initial testing of the Standard before formal introduction. The NHS Employers Sexual Orientation Monitoring Pilot Group involved 25 NHS organisations and came together three times during 2017/18 (24th May 2017, 26th Sept 2017 and 14th Feb 2018). Three organisations were featured in the good practice guide, developed by the LGBT Foundation, published with the Standard in October 2017.

The group of 25 trusts continues to meet and are working on capturing their experience of the standard. A series of case studies will be produced and included as part of the evaluation report of the Standard.

A national SOM Implementation Task and Finish Group, co-chaired by NHS England and the LGBT Foundation, was set up to promote the SOM across the health and social care system. An implementation plan was taken forward. In addition, the LGBT Foundation worked with NHS Employers and NHS England to attend regional Equality and Diversity Network meetings to engage with NHS Trusts.

3.7 The Accessible Information Standard

3.7.1 Overview of the Accessible Information Standard

From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly-funded adult social care are legally required to follow the Accessible Information Standard. The Standard, formally known as DCB1605 Accessible Information, sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. Organisations that commission NHS care and / or adult social care, for example Clinical Commissioning Groups (CCGs), must also support implementation of the Standard by provider organisations.

3.7.2 The Review and the scope of the Standard

During January to March 2017, NHS England led a post-implementation review of the Standard to assess its impact and fitness for purpose. Over 1600 people had their say and a [report of the review](#) is available in a range of formats. In August 2017, revised versions of the [Specification](#) and [Implementation Guidance](#) were issued.

3.7.3 The resource hub

An extensive [resource hub](#) is available to support the implementation of the Standard. The hub provides a wide range of resources including fact sheets, checklists, links to e-learning, a toolkit, sample documents and posters, a glossary, as well as a copy of the NHS England's Accessible Information and Communications Policy.

For more information please visit our webpages on [the Accessible Information Standard](#).

3.8 The NHS Learning Disability Employment Programme

3.8.1 Background to the Learning Disability Employment Programme

NHS England and NHS Employers developed, and launched the NHS Learning Disability Employment Programme in 2015. This three year programme is designed to support and encourage NHS organisations to develop local and national solutions to remove barriers facing, and increase the employment of, people with a learning disability in the NHS.

3.8.2 The pledge and the pledged organisations

As at February 2018, 114 NHS organisations had signed the NHS Learning Disability Employment [pledge](#) to support the employment of more people with a learning

disability in NHS organisations. Organisations are encouraged to make a three step pledge consisting of step 1 commitment, step 2 readiness and step 3 success. Readiness is about having created an action plan to employ more people with a learning disability. Success is about having employed people with a learning disability. An interactive map, on NHS Employer's website, shows which organisations have made the pledge and which step has been reached.

3.8.3 Key resources and support

Key elements of the programme include identifying how to remove employment barriers, identifying how to accelerate employment opportunities, facilitating local networks and peer-to-peer learning, developing practical tools and providing advice and guidance.²⁰ During 2017/18, the EHIT commissioned a range of new resources from the [Voluntary Community and Social Enterprise Health and Wellbeing Alliance](#) (VCSE HWA) to support the transition into work of people with a learning disability and/or autism as well as young people experiencing mental health problems.

A downloadable online resource has been developed during 2017/18. The resource will be launched during 2018/19 and it will also support preparatory work on the Workforce Disability Equality Standard. The resource will provide a business case, a narrative, examples of good practice and case studies. It will also provide information on, and links to, key resources and toolkits and if necessary make recommendations for any new resources. In addition, information will be provided on key organisations, sources of support and brokerage services in relation to employing people with a learning disability, autism and mental health needs.

For more information please visit our webpages on the [Learning Disability Employment Programme](#).

3.9 The NHS Workforce Disability Equality Standard (WDES)

3.9.1 Background

The Workforce Disability Equality Standard (WDES) will provide a framework for the collection of the data needed to assess how to advance equality of opportunity for disabled people. The theme of 'disability as an asset' runs throughout this initiative; employing people with lived experience of disability or long-term health conditions enables the NHS to increase the quality of its service and to attract diverse talent. The WDES embraces the concept of 'Disability as an Asset'. Rather than focusing on how disabled people can be 'levelled up' to the capabilities of a 'normally

²⁰ NHS Learning Disability Employment Programme visit
<https://www.england.nhs.uk/about/equality/equality-hub/ld-emp-prog/>

functioning workforce’, ‘Disability as an Asset’ seeks to celebrate diversity and difference, turning a perceived ‘deficiency’ into an asset.

The WDES builds on the Workforce Race Equality Standard (WRES) and research findings including the [‘Experience of Disabled Staff in the NHS’](#) carried out by Middlesex and Bedfordshire Universities as well as [‘Different Choices, Different Voices’](#) carried out by Disability Rights UK and NHS Employers. This research found that disabled people had poorer experiences of working in the NHS in England than non-disabled colleagues. In 2016, a WDES steering group and wider network were established to support disabled staff to drive forward change.

3.9.2 The importance of the WDES

The implementation of the WDES will enable NHS Trusts and Foundation Trusts to better understand the experiences of their disabled staff. It will support positive change for existing employees, and enable a more inclusive environment for disabled people working in the NHS. Research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety. Like the Workforce Race Equality Standard on which the WDES is in part modelled, the WDES will also allow us to identify good practice and compare performance regionally and by type of trust.

3.9.3 Developments during 2017/18

The Equality and Health Inequalities Team (EHIT) worked with the WDES steering and advisory groups to refine the criteria for the metrics and the draft metrics. Ten draft WDES Metrics were piloted by 15 NHS Trusts and an Arms-Length Body (ALB); EHIT also engaged with Disabled Staff Networks within NHS Trusts and similar networks within NHS Trade Unions. Between December 2017 and January 2018, the results of the piloting exercise and survey work were assessed and the draft metrics were updated.

In January 2018, the NHS Standard Contract for 2017-19 (January 2018 edition) was published. NHS England also [announced](#) the indicative timetable for the publication of the WDES and that there would be a series of consultation events during March 2018. The revised NHS Contract states that NHS Trusts and Foundation Trusts will have to implement the WDES in the first year of its roll-out. NHS England also announced that, subject to the feedback from the consultation and Online Survey, the first annual WDES reports, from NHS Trusts and Foundation Trusts, will be due in August 2019. NHS England also announced that there will be further engagement in 2018 to inform the final shape of the WDES metrics and which classes of NHS providers will be subject to the WDES in the second year of its roll-out. During 2017/18, EHIT also held discussions with the NHS Electronic Staff Record (ESR) Team and the NHS England Team responsible for commissioning the NHS Staff Survey. These discussions looked at the challenges in relation to ESR and

encouraging a higher percentage of individuals to declare whether they have a disability or not and the way in which disability is defined within the NHS Staff Survey.

During March 2018, EHIT held six regional consultation events to consult with NHS Trusts and Foundation Trusts about the WDES metrics. The events were attended by over 200 people. EHIT also liaised with our partners, NHS Employers, about the development of their online survey about the WDES metrics. The information from the events and the online survey will inform the final form of the metrics.

For more information please visit our webpages on [the WDES](#).

3.10 The NHS Workforce Race Equality Standard (WRES)

3.10.1 Background

The Workforce Race Equality Standard (WRES) was introduced in response to data and evidence demonstrating systemic patterns of less favourable treatment of black and minority ethnic (BME) staff in the NHS, which impacted adversely on staff health well-being, organisational effectiveness and efficiencies, and patient care and safety.

The WRES requires organisations employing almost the entire 1.4 million NHS workforce to demonstrate progress against nine workforce race equality indicators. These indicators include BME Board level representation and narrowing the gaps between the experience and treatment of white and BME staff in the NHS. The aim is to ensure employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Drawing on international and domestic evidence about interventions most likely to impact on race inequality in the NHS, the WRES was introduced in April 2015 as a contractual requirement for NHS providers. Compliance with the WRES is inspected by the [CQC](#) as part of the Well Led domain inspections of hospitals. The WRES also features within the CCG Improvement and Assessment Framework, as well as being cited within the NHS Five Year Forward View as a key tool to help the NHS become a better and more inclusive employer – making full use of diverse talent of its workforce and its communities. The WRES is also being implemented by independent healthcare organisations and national healthcare bodies.

3.10.2 Phase 1 of the WRES [2015 – 2017]

In April 2015, after engaging and consulting with key stakeholders including other NHS organisations across England, the WRES was mandated through the NHS standard contract, starting in 2015/16. The first phase of the WRES programme set out and developed the architecture for collecting and reporting upon workforce race equality data within organisations and across other parts of the NHS. In doing so, it enabled organisations to hold-up a mirror with regards to their performance on this

agenda. Embedding the WRES within the key policy levers for NHS providers and commissioning organisations (as noted above) has helped in achieving 100 per cent response rate in WRES data returns from NHS trusts. Organisations across the country set robust action plans to enable them to continuously improve on their performance in closing the ethnicity gaps in workforce experience and opportunities. NHS providers were expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation. The WRES reporting template is designed to present an overview of the organisation's latest WRES implementation. Once completed, the [report template](#) should be published on the organisation's website using a unique URL.

3.10.3 Phase 2 of the WRES [2017 onwards]

Phase two of the WRES programme builds upon the requirements set out in phase 1 and the system alignment noted above. Phase 2 also looks towards sustainability, cultural and transformational change required within NHS organisations, sectors and regions, to help shift the 'dial' of inequality. A comprehensive programme has been set by the WRES Team, in collaboration with other national healthcare bodies, to support and guide local and national healthcare organisations (including the new and emerging healthcare architecture) to make improvements on this agenda. A national evaluation of the WRES (phase 1), commissioned during 2017/18, will report in 2018/19.

3.10.4 New WRES guidance and resources

In August 2017, NHS England published 'Workforce race equality: Case studies of good practice from non-NHS employers' to provide evidence and examples of good practice around workforce race equality in the NHS. NHS England also published the first part of our two-part guide 'Improving through inclusion: Supporting staff networks for black and minority ethnic staff in the NHS'. The second part was published in February 2018. In February 2018, the WRES Implementation Team completed work on 'NHS workforce race equality: a case for diverse boards'. This report highlights the importance of inclusive boards in the NHS and provides guidance on working towards creating inclusive cultures. In February 2018, NHS England published 'Links between NHS staff experience and patient satisfaction: Analysis of surveys from 2014 and 2015'. Using NHS staff and inpatient survey data, this report identifies the most important aspects of staff experience in predicting inpatient satisfaction. In March 2018, we published research, which we commissioned The King's Fund to carry out, looking at the relationship between Employee engagement, sickness absence and agency staff in NHS trusts. In 2017, the WRES was also supported by updated tools including a [reporting template](#) for NHS providers, a [reporting template](#) for Independent providers and [Technical Guidance](#).

3.10.5 WRES report 2017 and support

In December 2017, the latest [WRES report](#) and associated data were published. The report is the third publication of the annual WRES data analysis for NHS trusts and the second fully comprehensive report that focuses on all nine WRES indicators. It provides an opportunity to examine the level of progress made by NHS trusts and other parts of the NHS over time, and where further concerted support and action is required. For a second year in succession, there was evidence that some organisations are embracing this agenda well and are continuing to develop plans to strive for improvements in their WRES data.

For more information please visit our webpages on [the WRES](#).

3.11 Scoping the development of a Unified Information Standard by reference to protected characteristics

3.11.1 Background

The public sector Equality Duty (PSED) and the associated specific equality duties require the collection and publication of equality data. High quality equality data is required to enable the NHS to assess whether there are unwarranted variations in access to healthcare, healthcare outcomes or the quality of healthcare by reference to protected characteristics. High quality equality data is therefore key to NHS England's agenda, to meeting our duties under the PSED and the duties to reduce health inequalities.

3.11.2 Progress made during 2017/18

During 2017/18, NHS England commenced a scoping exercise to identify the datasets in the NHS Data Dictionary and the position in relation to the collection of equality data by reference to protected characteristics. The scoping exercise has also explored the rationale for gathering data by reference to some but not all protected characteristics and considered lessons from the launch of the Sexual Orientation Monitoring Standard. The results of the scoping exercise will be considered by NHS England and the DHSC in 2018/19.

3.12 Equality information published on NHS England's webpages

NHS England's Equality and Health Inequalities Hub is designed to provide support and assistance to the NHS, and beyond, in promoting equality and tackling health inequalities for patients, communities and the NHS workforce. This hub, and associated webpages, bring together equality and health inequalities resources and provide useful links. It also provides information on relevant legislation, our partners, good practice examples, tools, evidence and data and analytical resources.

For more information please visit our [Equality and Health Inequalities Hub](#).

4 Engagement across the protected characteristics

4.1 The Empowering People and Communities Taskforce

4.1.1 About the Taskforce

The Empowering People and Communities Taskforce was established for one year from its first meeting in December 2017 to strengthen the contribution to delivery of the Next Steps on the Forward View across three areas of focus:

- **People** – Population engagement, participation and co-production in supporting the future delivery of services and policy;
- **Patients** - The role of insight and learning from the experience of patients, families and carers in improving the quality and outcomes of services; and
- **Voluntary Sector** - Our partnerships with voluntary, community and social enterprise (VCSE) sector organisations to both add value to our work and deliver a wider range of services that are holistic in nature and focus on wellbeing.

4.1.2 Meeting our legal duties and public involvement and consultation

The Taskforce engages patients, clinicians and managers through social media and an issue-based workshop focused on one of NHS England's priorities prior to each meeting. It will demonstrate progress to the Board on how NHS England meets its legal duty to involve the public in commissioning and oversees delivery on the ambitions for empowering people and communities set out in the 'Next Steps'.²¹

4.1.3 This new approach

This new approach will improve how NHS England works. It is designed to add insight and value to the priorities and national programmes set out in our Next Steps plan, working collaboratively with each priority area. It will enable the adoption of good practice, demonstrate system leadership, and contribute to good governance evidencing how we meet our legal duties. This is also designed to support the system transformation required as the NHS moves in to integrated and accountable systems of care, ensuring people are at the heart of that transformation. The work of the Taskforce will become embedded as business as usual.

4.1.4 The first meeting

In its first meeting in December 2017, the Taskforce took a detailed look at the Cancer Strategy and feedback from this meeting was taken directly to the NHS England Board. As a direct result the Board has requested a more detailed look at health inequalities. At subsequent meetings the Taskforce will be taking a similar look at NHS England's other national priority programmes.

²¹ The legal duty to involve the public in commissioning is section 13Q of the NHS Act 2006 (as amended).

Please visit the pages on the Edge website on [the Empowering People and Communities Taskforce](#).

4.2 The VCSE Health and Wellbeing Programme

The £11.5m VCSE Health and Wellbeing Programme was redesigned following the VCSE review in 2016. It allows the Department and Health and Social Care (DHSC), NHS England and Public Health England (PHE) to work together with VCSE organisations to drive transformation of health and care systems; promote equality; address health inequalities and; help people, families and communities to achieve and maintain wellbeing. The Programme has 3 objectives.

- To encourage co-production in the creation of person-centred, community-based health and care which promotes equality for all.
- To enable the voice of people with lived experience and those experiencing health inequalities to inform national policy making and shape the delivery of services.
- To build evidence of sustainable, scalable solutions to mitigate and prevent inequalities impacting on health and wellbeing of communities.

The Programme is achieving its objectives through two co-dependent funded mechanisms. First, a national partnership arrangement, the VCSE Health and Wellbeing Alliance. Second, funding for bespoke projects through the VCSE Health and Wellbeing Fund.

For more information please visit our webpages on [the Voluntary Community and Social Enterprise Health and Wellbeing Programme](#).

4.3 The VCSE Health and Wellbeing Alliance

In April 2017, NHS England launched the new Voluntary, Community and Social Enterprise (VCSE) Health and Wellbeing Alliance with the Department of Health (DH) and Public Health England (PHE). This is the successor programme to the Voluntary and Community Sector (VCS) Health and Wellbeing Strategic Partners Programme (2009-2016). The Alliance is made up of 21 VCSE members and exists to act as a bridge between the VCSE sector, the health and care system, and the people who use it. A full list of members can be found [online](#).

Alliance members reach into a wide range of communities facing significant health inequalities, and are able to represent the collective views of the VCSE sector. Most Alliance members are therefore not single condition charities and many are not predominantly health-focused in their objectives but were chosen instead for their reach into communities and their networks across the VCSE sector. A key condition of membership of the Alliance is to amplify the voice of VCSE sector organisations and people with lived experience to inform national policy, facilitate integrated

working between the voluntary and statutory sectors, and co-produce solutions to promote equality and reduce health inequalities. It is therefore a key mechanism for NHS England to involve the VCSE sector in the design and delivery of health. For more information please visit the Government's webpages on [the Voluntary Community and Social Enterprise \(VCSE\) Health and Wellbeing Alliance](#).

4.4 The Health and Wellbeing Fund

The Health and Wellbeing Fund is part of the wider Health and Wellbeing Programme. The Fund is themed around a specific topic each year. In 2017/18, the theme was social prescribing. The aim of the Fund component of the programme is to promote equalities and reduce health inequalities. The three intended outcomes from the Fund in 2017/18 are set out below.

- An increase in system partners' evidence base on sustainable and scalable social prescribing interventions to improve health inequalities.
- New evidence and findings from supported social prescribing schemes informs and influences practice by being available and disseminated to key audiences across the system.
- Evaluation results in increased capability for VCSE sector organisations to capture and evaluate the impact of their work.

4.5 NHS Citizen

4.5.1 Background

Ensuring that the voices of people and communities are heard, acted upon and fed back, is key to realising the engagement and involvement agendas central to the PSED. NHS Citizen is a national programme commissioned by NHS England to give citizens a voice and enable them to influence our work. The programme first ran from 2012/13 up until September 2016, at which point the programme was temporarily placed on hold pending a review. During the initial four-year period, over 4,000 people contributed to both online and offline discussions about the work of NHS England.

4.5.2 Developments in 2017/18

Following the review, a new NHS Citizen team was recruited during the summer of 2017, as part of the Public Participation Team. A new NHS Citizen framework for 'phase 2' was developed during 2017. 'Diversifying Community Voice' is one of the four key strands. The programme is currently heavily involved in the Learning from Deaths programme, which involves other Arm's-Length Bodies (ALBs). In particular, NHS Citizen is working with family members and carers (as well as advocate organisations) to ensure that their views and experiences are captured in the co-production of upcoming guidance. To date, this process has included public events, webinars, monthly email updates, online co-production processes, and the

recruitment of two Patient and Public Voice (PPV) partners to the overall Programme Board. NHS Citizen has also supported the running of a 'Diversity in Participation' event in January 2018. This was co-organised with Dr Josephine Ocloo, who has focused on issues related to diversity within patient safety for many years, following the death of her daughter.

The full 2018-19 programme of work for NHS Citizen (including 'Diversifying Community Voice') is presently being developed, in consultation with others and the NHS Citizen Advisory Group. Please do sign-up to the [In Touch email newsletter](#); and follow the programme's Twitter account @NHSCitizen

For more information please visit our webpages on [NHS Citizen](#).

4.6 The Learning Disability and Autism Engagement Team

4.6.1 Background

Improving health and care for people with a learning disability is a priority area for NHS England and the team works to ensure that people with lived experience of learning disability, autism or both influence and co-produce work across NHS England. The Learning Disability and Autism Engagement Team has four Learning Disability and Autism Network Managers, two of whom are people with a learning disability, autism or both. NHS England has used the co-worker model in this team, where a person with a learning disability job shares with a person without a learning disability, giving a complementary combination of skills, strengths and experience. The Team as a whole uses a combination of lived experience, subject matter expertise and a passion to make a difference in healthcare for people with a learning disability.

The Team has developed a network of people with learning disabilities, autism, family carers and their advocates who can work closely with NHS England on all aspects of its work relating to learning disabilities. The Team has built on the working relationships already developed in programmes like the VSCE Health and Wellbeing Alliance, the Accessible Information Standard and the Care and Treatment Review Programme. The Team also works in partnership with the EHI Team. During 2017/18, the Team has raised awareness within NHS England about the rights of people with a learning disability and the best ways of working with and involving people.

4.6.2 The Learning Disability and Autism Forum

[The NHS England Learning Disability and Autism Forum](#) is a network of people with a learning disability, autism or both, family carers and supporting organisations who want to have a say in the work of NHS England. This forum was set up to improve the health of people with a learning disability, autism or both and the quality

of health services they receive. It does this by working in partnership with a range of people and organisations. In March 2017, the Forum held an event to look at people's experience of complaints, comments and feedback in health and social care. The feedback people gave has shaped the new 'Ask Listen Do Project' which aims to improve the experience of giving feedback, or raising concerns or complaints.

In June 2017, the Forum supported the Better Health, Better Lives event. We shared all the different pieces of work happening to improve the health and lives of people with a learning disability, autism or both. In February 2018, the Forum supported engagement in NHS England and NHS Digital's work to 'flag' disabled people's support needs (reasonable adjustments) between healthcare providers on computer systems. To do this the Forum had an event called 'Letting NHS staff know you need support' and helped develop an Easy Read survey. The ideas people gave us, about how the NHS can share information about how to support people to access health services, are being used to improve computer systems.

4.6.3 The NHS England Learning Disability and Autism Advisory Group

The Advisory Group helps NHS England with work that affects people with a learning disability, autism or both and their families. The Group is made up of 15 experts by experience which includes people with a learning disability, autism or both and their families. Members are used to speaking out and have lots of connections with local and national learning disability and autism groups. This year, the Group has advised us on:

- personal health budgets;
- the Transforming Care evaluation;
- housing within Transforming Care ('strategic resettlement');
- Always Events for autistic people and people with a learning disability (an improvement methodology in trusts that is based on coproduction);
- gaps in support for autistic people;
- RightCare pathways for people with a learning disability, autism or both;
- Annual Health Checks;
- accessible communications.

4.6.4 Accessible communications

In response to feedback from the Forum, an expert by experience peer review and the Advisory Group, we have developed how we talk about the work of NHS England. We have established a 'You Said, We Did' webpage where we share what the Advisory Group has told us (in accessible formats) and say how we are acting on the advice. [Read the You Said, We Did pages.](#)

The Easy Read Newsletter continues to develop sharing information about NHS England's work and opportunities to influence it. The Team is now working directly with Photosymbols in order to increase the number of relevant images in the photobank. We work with a different self-advocacy group with each issue to test the readability.

4.6.5 Developments in 2017/18

Our Insight and Learning Disability and Autism Engagement teams published their bite-size guide to helping people with a learning disability to give feedback. The guidance is in two parts, a general guide and an Easy Read version. This is part of a series of short guides to help providers and commissioners understand the use of patient insight better and to use it effectively in delivering local services; please see our [Bite-size Guides to Patient Insight](#).

4.7 The Equality and Health Inequalities Team

4.7.1 About the EHI Team

The Equalities and Health Inequalities Team (EHIT) is part of the wider Experience of Care and Equalities and Health Inequalities Team and is located within the Experience, Participation and Equalities Division within the Nursing Directorate. EHIT's work is designed to improve the experiences, health outcomes and quality of care for those who use NHS services. The Team supports NHS England and the NHS to be more responsive to the needs of patients and the workforce. To advance equality and tackle unjust and unacceptable health inequalities, EHIT works in partnership and collaboration with NHS England's EDI Teams, NHS England colleagues, NHS organisations and organisations representing patients and communities within, and beyond, the NHS. The Team helps NHS England, the wider NHS and partners to advance equality of opportunity and take action to reduce health inequalities. EHIT supports the work of the NHS Equality and Diversity Council (EDC). Key equality programmes, led by the Team, support the wider NHS to take action to improve quality, to meet the public sector Equality Duty and reduce health inequalities. The Learning Disability Employment Programme and the WDES also feature within the Next Steps of the Five Year Forward View.

4.7.2 Key programmes

Some of the Team's current programmes of work include developing and supporting the roll out of: the NHS Learning Disability Employment Programme; the NHS Sexual Orientation Monitoring Standard; and the NHS Workforce Disability Equality Standard. The Team is also scoping the possible development of a Unified Information Standard for protected characteristics. It also supports other NHS England teams leading on equality focused programmes. The Team co-ordinates the publication of this report annually, this team supports the development and review of NHS England's equality objectives every four years and the Team also assists NHS

England to respond to the Secretary of State's Mandate. Working in partnership with other EDI leads and teams, the Team also provides support to NHS England colleagues and the wider system through our capability building programmes and through its hub. The Capability Training Programme consists of a programme of training courses and a national webinar programme.

The Capability Training Programme was delivered to NHS England staff and a pilot programme was delivered to CCGs, Sustainability and Transformation Partnerships (STPs) and others. The national webinar programme, developed in partnership with other NHS England Teams and other partners, was open to staff from NHS England, CCGs and providers. The programme covered a range of clinical policy areas (e.g. mental health and LGBT communities, older people and mental health, improving access to primary care and CQC approaches to equality and diversity). Between February 2017 and March 2018, 90 participants attended the training programmes and 440 people participated in our webinar programmes.

For more information please visit the EHIT [resource hub](#). More information is also available on our webpages on [the Next Steps on the Five Year Forward View](#).

4.8 The Diversity and Inclusion Team

An NHS England Diversity and Inclusion Team, led by a newly appointed Head of Diversity and Inclusion has recently been established, under the remit of NHS England's Transformation and Corporate Operations Directorate. The Team supports staff and senior leaders in NHS England to develop expertise and retain ownership of the Diversity agenda.

The Diversity and Inclusion Team priorities include accelerating progress on diversity issues, joining up different strands of work, sharing good practice, providing equalities expertise and advice and collating research and evidence. Close collaboration between the Diversity Team, staff engagement networks and partnership forums ensures that the voices of staff from diverse backgrounds influence and improve NHS England's approach to supporting our workforce. As a system leader, NHS England has an important role to play in modelling an inclusive way of operating. To enable this, the Diversity and Inclusion Team uses external equality monitoring standards to help us focus on the needs of staff with protected characteristics. These include publication of the Gender Pay Gap report, reporting on the Workforce Race Equality Standard and the Stonewall Equality Index.

4.9 The WRES Team

4.9.1 About the team

The NHS England Workforce Race Equality Standard (WRES) Team provides strategic and operational support to local and national healthcare organisations, as well as to independent healthcare organisations that provide NHS services, to continuously improve on workforce race equality. The Team oversaw the development of the WRES indicators and undertakes the annual collection and analyses of WRES data for NHS trusts; this was recently extended to the national healthcare organisations and will, in the near future, also include Clinical Commissioning Groups (CCGs). The WRES team managed the inclusion of workforce race equality within the key policy levers for NHS trusts and CCGs – including within the NHS Standard Contract, the Care Quality Commission’s inspection process for hospitals, and within the CCG Improvement and Assurance Framework (IAF). The WRES also features within the Next Steps on the NHS Five Year Forward View.

The team is developing, and rolling out to the wider NHS, a number of resources that help support the implementation of the WRES and the promotion of workforce race equality across the system. These include commissioning and development of research reports on the agenda; a series of roundtables and seminars for senior leaders across the NHS; training and development opportunities for NHS staff, including frontline staff.

4.9.2 Looking forward

The WRES Implementation team has increasingly focused on supporting local and national healthcare organisations in the endeavour to close the workforce race inequality gaps. Going forward, the team will further support demonstrable leadership, the embedding of accountability and sustainability on this agenda – building cultures of continuous improvement in all NHS-funded services.

For more information please visit our webpages on [the WRES](#).

4.10 Other forums, networks and partnership working

4.10.1 The importance of forums and networks

Forums, networks and partnerships are important to NHS England. They help us to engage with a greater number and a wider range of patients, carers, service users and members the public, and to reach specific groups, including people from ‘seldom heard’ communities and groups that experience health inequalities. By working in partnership we are able to gather views, connect people, hear different perspectives and make our activities more accessible and inclusive. Alongside our established networks and forums – some of which are highlighted below – we also work regularly

with other partners on public participation approaches and activities, including Healthwatch and the wider voluntary and community sector.

4.10.2 NHS Youth Forum

Since 2013, NHS England has worked with the British Youth Council (BYC) to develop and deliver a model for young people's participation through the NHS Youth Forum. The model includes annual recruitment of 25 young people (aged 14 to 25) to the Forum, with a commitment to recruiting young people from diverse backgrounds. Members come together three times a year at residential weekends to meet with NHS England commissioners and policy leads, and occasionally with colleagues from PHE and the DHSC.

Following discussion at residential events, the NHS Youth Forum members are able to rapidly review, consider and respond to emerging NHS England priorities and offer a 'young people's lens' to key work programmes. In addition, a wide online network, focused on the [NHS Youth Forum Facebook](#) page which has over 3,000 followers and Twitter feed (@NHSYouthForum) with over 6,000 followers draws on the views and participation of many more young people from across the country.

Key achievements of the NHS Youth Forum in 2017/18 include:

- Rolling out a campaign on the impact and value of peer support, through which hundreds of young people have been inspired to start talking about and engaging with peer support, exploring its benefits, how to enthuse healthcare professionals to refer to it and what would make young people take it up. This programme continues into 2018 with a series of films, posters and guidance that are currently being developed.
- Inputting into the Youth Select Committee on Body Image – co-chaired by a Youth Forum member – which published a [report and recommendations](#) for NHS England and other public sector partners (currently being taken forward).
- Attending the Royal College of General Practitioners Annual Conference and speaking directly with experienced, new and trainee GPs about engaging with young people.
- Ongoing work to champion youth social action as part of the NHS70 celebrations, including supporting NHS England's commitment to growing youth involvement in advocacy, peer support and hands-on volunteering strategies. This has been supported by a 'key lines of enquiry' resource that all organisations can use to challenge themselves on how they are creating volunteering opportunities for, and with, young people.

4.10.3 Older People's Sounding Board

The NHS England Sounding Board is a reference group of older people who provide 'critical friend' input into NHS England's work. The group includes the 'older old',

people from different geographic areas of the country, people from urban and rural areas, and a wide range of experiences, backgrounds and circumstances including several carers.

By inputting into projects, programmes and initiatives at a different of stages of development, Sounding Board members contribute to improving health and care for older people across a wide range of topics. They offer constructive challenge, raising concerns where there is a risk of work not meeting the needs of older people, but also welcoming and supporting ideas that will lead to improvements. In 2017/18, the Sounding Board built on its successful pilot in 2016/17 and recommenced with discussions focusing on 'Over The Counter' medications and Sustainability and Transformation Partnerships (STPs).

Following discussion in the pilot about the language of frailty, the Sounding Board was invited to run a workshop in September 2017's National Frailty Conference on the subject. This well-received session saw three members of the Sounding Board put the question of "how to have conversations about risk of frailty" back to clinical staff, welcoming their professional insight and experience as well as sharing their own understanding of the importance of language in framing discussions as an opportunity to build on resilience rather than focusing on vulnerability.

4.10.4 The CCG Patient and Public Involvement Lay Members' Network

Through this network, NHS England supports [patient and public involvement \(PPI\) lay members](#) from Clinical Commissioning Groups (CCGs) and Trust Non-Executive Directors (NEDs) to connect with each other, and supports CCG PPI lay members to develop in their role. NHS England produces a monthly newsletter, supports access to learning and development and has funded opportunities for lay members and NEDs to come together with key strategic policy leads.

NHS England also works collaboratively with other system partners, including NHS Improvement, NHS Clinical Commissioners and NHS Providers, to provide joint training, development, peer support and information sharing across lay member and NED networks.

For more information please visit our webpages on [NHS England's partnerships](#).

5 Transforming services and the NHS

5.1 The importance of service transformation

In this part of our report, we highlight some of our important equality focused developments and work in relation to service development and transformation. These initiatives and developments further NHS England's broader goals and priorities and contribute to meeting the PSED.

5.2 Primary care and improving access for all in General Practice

5.2.1 The importance of access

In September 2016, NHS England published the [NHS Operational Planning and Contracting Guidance 2017-19](#).²² This set out the funding, trajectory and core requirements for delivering improved access, including evening and weekend appointments, to general practice across England by March 2019. NHS England published an update to the planning guidance in February 2018. 'Refreshing NHS Plans for 2018-19' requires CCGs to provide extended access to GP services, including at evenings and weekends, for 100% of their population by 1 October 2018.

In delivering this extended access, NHS England has set a number of core requirements that CCGs must follow including one on addressing inequalities in access to GP services. Commissioners must demonstrate they are addressing "issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions to resolve in place".²³ The objective is for the whole population to be able to access general practice services in a place and at a time that is most convenient for them. No population groups e.g. those in work, the homeless or travelling communities should be disadvantaged.

5.2.2 Engagement

In late 2016 and early 2017, we consulted with stakeholder groups which involved working with groups with protected characteristics such as BME groups and LGBT communities, as well as other identified 'Inclusion Health' groups such as asylum seekers and refugees, to ensure that extended access proposals are assessed for adverse impact and positive opportunities. This work also enabled us to clarify key issues for specific patient groups, including identifying additional barriers to general practice and to identify and bring together best practice case studies for sharing across the primary care community. Between August and December 2017, we held a series of webinars which were attended by 180 people.

5.2.3 Improving access for all

In July 2017, we produced "[Improving Access for all: reducing inequalities in access to general practice services](#)". This important resource is designed to support commissioners and providers meet their statutory duties on inequalities, and provide advice and guidance to support their delivery of the specific core requirement on addressing inequalities in access. The resource provides guidance

²² <https://www.england.nhs.uk/gp/gpfv/redesign/improving-access/reducing-inequalities-in-access-to-gp-services/>

²³ <https://www.england.nhs.uk/gp/gpfv/redesign/improving-access/reducing-inequalities-in-access-to-gp-services/>

on assessing local issues, supporting local equality analyses and examples of how barriers arise at different points on patient pathway journey, starting at the point where the patient identifies a health problem through to getting appointments and the experience of attending general practice services. Our resource also provides practical tips on a wide range of issues related to protected characteristics and other groups who experience barriers to healthcare, for example through homelessness. In addition, there are quick links to video clips, learning materials for practice staff, case studies, examples of good practice and a wealth of information on NHS England's website. This resource was developed in conjunction with various groups such as those from BME and LGBT communities, as well as other identified 'Inclusion Health' groups such as asylum seekers and refugees, to ensure that extended access proposals are assessed for adverse impact and positive opportunities.

The 'Improving Access to General Practice' page on NHS England's [website](#) contains a wide range of products and resources, together with lessons learned from the 57 GP Access Fund pilot schemes. This includes posters, email/web banners and other display materials, which are available to [download](#).²⁴ The guide includes practical advice on developing a range of communications activities, in addition to information on developing a communications plan, identifying local target audiences and other stakeholders. A variety of advertising templates accompany the guide, produced in a range of formats for use in print, web, email and social media communications.

5.2.4 Assurance and assessment

Assurance of the core requirements for CCGs to deliver the commitments, as set out in the planning guidance, is monitored through quarterly assurance meetings. This is supported by evidence from the undertaking of an equality and health inequality impact assessment and supporting action plan, to address any issues identified and actions to resolve them. We have also developed an Equality and Health Inequalities Analysis (EHIA) for the improving access to general practice services policy. This analysis considered those groups with protected characteristics under the Equality Act 2010 and also those who are within NHS England's "Inclusion Health" definition. Our aim is to publish this in the spring 2018.

5.2.5 Case studies

We have been working on a series of new case studies looking at addressing inequalities. These will be published in the spring 2018. Some GP Access Fund pilot schemes (Morecambe, Warrington and West Wakefield) have targeted projects at seldom heard groups or areas of socio-economic deprivation. Another widespread strategy has been to target patient groups amongst which there is a known high demand for primary care services, for example the frail and elderly (Darlington,

²⁴ Communications guide and resource pack, visit <https://www.england.nhs.uk/gp/gpfv/redesign/improving-access/communications-guide/>

DCIoS and Herefordshire) children and young people (DCIoS, Herefordshire and Slough) and those with complex or long term conditions (BHR and Workington).²⁵, More work will be done with these pilots in 2018/19 to gather evidence on these initiatives.

For more information please visit our webpages on [reducing inequalities in access to general practice services](#).

5.3 Cancer and equalities

5.3.1 Tackling cancer inequalities

NHS England's two-year progress report on delivering the cancer strategy 2015-2020, outlining the significant progress made to deliver world-class cancer services in England was published in October 2017.²⁶ The report reaffirms NHS England's commitment to ensuring equity in cancer care delivery and tackling inequalities. This includes tackling inequalities that adversely affect the delivery of cancer care to those living in deprived UK communities where, for example, there is a higher prevalence of smoking. NHS England is also committed to improving access to information on reducing cancer risk, access to screening to increase earlier diagnosis, and access to the Recovery Package which aims to address the longer-term physical, financial and psychological impact of cancer.

The National Cancer Patient Experience Survey tells us that Black, Asian and minority ethnic communities report poorer experiences of cancer care. We are therefore working with Cancer Alliances to ensure they use the best evidence when planning, commissioning and monitoring services for these communities.

5.3.2 Research on cancer and equalities

During 2017, the research agency OPM was commissioned to identify potential solutions to under-representation of BME people in responses to CPES. This work was commissioned in direct response to 'Recommendation 54' from the Cancer Strategy. OPM completed a literature review of existing best practice and a series of focus groups were held. The final paper is expected in quarter 2 of 2018.

A marketing campaign promoting the 'Cancer Patient Experience Survey' (CPES) was implemented in quarter 3 of 2017 through media outlets such as local radio and the Voice to promote the uptake of the questionnaire with the BME population.

The human rights charity 'brap' was commissioned to review the impact of previous national policy and strategy in cancer services on the experience of BME people

²⁵ Devon, Cornwall and the Isles of Scilly (DCIoS).

²⁶ Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020 Progress Report 2016-17

receiving cancer care. The report interrogates the implementation of previous strategies to reduce BME inequalities in cancer services. Brap was also commissioned to work with CCGs/ Commissioning Support Units (CSUs) to examine how cancer services for the BME population were being commissioned. A literature review and telephone interviews were conducted to assess interventions and to offer support.

During 2017, two face to face events were held for the CCGs and CSUs to meet and share good practice. Information was provided about the best of use of data, the use of surveys and information about equalities legislation. The findings of this work will be disseminated through the Cancer Alliances for wider implementation of the learning.

An online social network has been developed to enable discussion around the best measures to address inequity in the provision of cancer services. As well as BME interventions there are also groups in the network discussing LGBT issues and issues that affect people with a learning disability. Membership of the network is by invitation and the people involved in the conversation are internal and external to NHS England. The site is moderated by the Equalities Cancer 2020 programme and the emphasis is on enabling discussions around best practice. The site has a current membership of 135 and a full launch is planned for later this year.

5.3.3 People with a learning disability and cancer

The learning disabilities charity CHANGE was commissioned to examine the inequities in cancer care experience by this population. The paper, reports on the issues faced by this population with regards cancer services. Issues are reported along the cancer pathway with particular emphasis on the issues surrounding access to treatment. The paper sets out recommendations to ensure that reasonable adjustments are made and the NHS RightCare Team and Learning Disability Programme are providing support to this project to assist in the recommendations that will be made to the Cancer Alliances about future provision for this population.

5.3.4 The Cancer Alliances

The delivery and implementation mechanism for the cancer strategy is through the Cancer Alliances which have been established throughout England. All the learning from our work will be shared to help the Alliances embed actions to ensure inequalities issues are addressed. The Alliances will be offered support to design local interventions to ensure that measures taken are sustainable; give voice to the communities affected, are commissioned using the best data and will have measurable outcomes.

5.3.5 The Cancer Patient Experience Advisory Group (CPEAG)

The Cancer Patient Experience Advisory Group (CPEAG) is a body made up of representatives from the voluntary sector, DHSC, Arms-Length Bodies (ALBS) and other NHS stakeholders. The Group also contains representatives of people with a lived experience of cancer and its remit is to provide an oversight to the work of the Patient Experience Team. The Group hears, discusses and provides influence to the work that is done and ensures that programmes of work are always driven by the people, patient and voluntary sector voice.

5.4 Diabetes

5.4.1 Background

One of the protected characteristics under the Equality Act 2010 is disability. Diabetes is one of a number of long term conditions which may be defined as a disability under the Equality Act 2010. Diabetes is also associated with other disabilities and long-term conditions. Most people would be shocked to know that around 22,000 people with diabetes die early every year. Type 2 diabetes is a leading cause of preventable sight loss in people of working age and is a major contributor to kidney failure, heart attack, and stroke. The risk of developing diabetes is also significantly higher in people from BME groups. In relation to Type 2 diabetes, different patient groups are affected unequally and there are large differences concerning gender, age and race. Socio-economic status (SES) may influence access to and quality of care, social support and availability of community resources. It may also influence diabetes-related knowledge, communication with providers, treatment choices and the ability to adhere to recommended medication, exercise and dietary regimens.

5.4.2 The importance of prevention and action

There are currently 3.4 million people with Type 2 diabetes in England with around 200,000 new diagnoses every year. While Type 1 diabetes cannot be prevented and is not linked to lifestyle, Type 2 diabetes is largely preventable through lifestyle changes. One in six of all people in hospital have diabetes – while diabetes is often not the reason for admission, they often need a longer stay in hospital, are more likely to be re admitted and their risk of dying is higher. As well as the human cost, Type 2 diabetes treatment accounts for just under nine per cent of the annual NHS budget. This is around £8.8 billion a year. There are currently five million people in England at high risk of developing Type 2 diabetes. If these trends persist, one in three people will be obese by 2034 and one in ten will develop Type 2 diabetes. There is strong international evidence which demonstrates how behavioural interventions, which support people to maintain a healthy weight and be more active, can significantly reduce the risk of developing the condition.

Addressing diabetes is therefore both an equalities issue and a health inequalities issue. Failure to address diabetes will increase the number of people with a range of disabilities; diabetes is also potentially life altering and life threatening. Reducing the impact of diabetes contributes to advancing equality of opportunity by improving the life opportunities for people with diabetes.

5.4.3 The Healthier You: NHS Diabetes Prevention Programme

The Healthier You: NHS Diabetes Prevention Programme (NHS DPP) identifies those at high risk and refers them onto a behaviour change programme. [The NHS DPP](#) is a joint commitment from NHS England, Public Health England and Diabetes UK. During 2017/18, the first report on the programme was published in a peer reviewed journal 'Progress of the Healthier You: NHS Diabetes Prevention Programme: referrals, uptake and participant characteristics; First progress report of the Healthier You: NHS Diabetes Prevention Programme', Barron et al, Published in Diabetic Medicine, December 2017.

The report explored characteristics of participants referred between June 2016 and March 2017 and identified that 25% of people referred onto the programme were from Black, Asian and minority ethnic groups. Participant characteristics and subgroup attendance rates are described in table 2 of the report. Attendance rates were significantly higher for Asian, Afro-Caribbean, mixed and other ethnic group participants compared to White European participants, 119 vs. 68 per 100,000.

Attendance rates varied significantly by deprivation with higher rates in the most deprived quintile versus the least deprived quintile 72 vs. 60 per 100,000. However, there was a significant interaction between ethnicity and deprivation, so that while attendance rates were significantly higher in the most deprived quintile versus the least deprived quintile for Asian, Afro-Caribbean, mixed and other ethnic groups, they were not significantly different for White European groups. This suggests that the programme is reaching those who are both at greater risk of developing Type 2 diabetes and who typically access healthcare less effectively.

5.4.4 The National Diabetes Treatment and Care Programme

As part of the "[National Diabetes Treatment and Care Programme](#)" NHS England has invested £42 million in 2017/18 in proposals from individual CCGs, CCG collaborations and Sustainability and Transformation Partnerships (STPs) to improve the treatment and care of people with diabetes.

5.4.5 NHS Rightcare and diabetes

NHS RightCare is a programme committed to reducing unwarranted variation to improve population health. NHS RightCare is about delivering the best care to patients, making the NHS's money go as far as possible and improving patient outcomes. All 207 local health economies are now using the RightCare approach

and the programme is working at both a national and local level, through a team of NHS RightCare Delivery Partners to implement this approach. The NHS RightCare Pathway: Diabetes looks at specific areas of intervention where the return on investment is likely to have the biggest benefit beyond the financial benefits. It also looks at clinical areas which need to be tackled in order to benefit the population living with, or at risk of developing, diabetes.

For more information please visit our webpages on [the NHS Diabetes Prevention Programme](#).

5.5 Gender identity services

5.5.1 Background

NHS England has committed to addressing the significant sustainability and capacity challenges in the current model for delivering specialised gender identity services, and to responding to concerns about poor patient experience. A Trans Network, comprised of service users and trans campaign groups has convened regularly with the purpose of defining the problem statement and offering potential solutions.

In 2016, the report and recommendations of the Women and Equalities Select Committee (WESC) on Transgender Equality were published. NHS England gave evidence to the Committee and has used the WESC's recommendations to inform our work in developing new service specifications for gender identity services and exploring alternative models of care. A Programme Board for Gender Identity Services was established in 2017 chaired by the Medical Director for Specialised Services. Membership includes four independent people from the trans communities who were appointed via an open recruitment process.

5.5.2 Consultation during 2017

A stakeholder testing group, for registered stakeholders to help shape the specifications for the purpose of consultation, met in January 2017. In July 2017, we opened a fourteen week consultation on proposals for two new service specifications. The consultation closed in mid-October 2017. The consultation was supported by face-to-face engagement opportunities in Manchester, Leeds, Cardiff, London and Brighton including at trans festivals, and we also ran webinars (virtual meetings). If adopted, these service specifications describe how specialised gender identity services for adults will be commissioned and delivered in the future for the people of England. The service specifications were for surgical intervention and non-surgical interventions. The consultation was supported by our "Guide to Consultation: Specialised Gender Identity Services for Adults". The Guide included an Equality Impact Assessment that used the outcome of a specific piece of work that we undertook in 2017 to consider the protected characteristics of "race" and "religion and belief".

5.5.3 The final service specification

Over 800 responses were submitted to consultation. The responses were analysed by an independent third party organisation. The final version of the service specifications will be used to inform a process of competitive procurement later in 2018/19, and this will determine which organisations are best placed to provide specialist gender identity services for people in England in the future.

We aim to make final decisions on the service specifications in the spring of 2018 having considered the outcome of the consultation. An update will be provided, including the plans for a process of national procurement to identify which organisations are best placed to deliver specialised gender identity services in the future, and to describe potential alternative models of care.

5.5.4 Partnership working

In 2017, we also convened regular symposiums involving a number of other organisations who have an interest in helping NHS England address the concerns of transgender and non-binary people. A competency framework for non-medical professionals working in gender identity services was developed by Health Education England (HEE); and in 2018 the Care Quality Commission (CQC) will be working with NHS England to develop new guidelines to help inspectors assess whether good standards of care for trans people are embedded into general NHS services. A priority issue for NHS England in 2018 will be to meet the needs of transgender people in offender and secure settings, working with the National Offender Management Service.

For more information please visit our webpages on [future specialised gender identity services](#).

5.6 Learning disabilities - Transforming care

5.6.1 Background to, and the importance of, this programme

The learning disabilities programme is about transforming the treatment, care and support available to people of all ages with a learning disability, autism or both so that they can lead longer, happier, healthier lives in homes not hospitals.

NHS England continues to transform services, as set out in 'Building the right support', published in October 2015, jointly with ADASS and the LGA. 'Building the right support' set out plans to develop community services and decommission inpatient facilities, so that people with a learning disability, autism, or both who display behaviour that challenges, including those with a mental health conditions, are able to live lives of their own choosing in the community. Significant progress had been community services are coming online across the country, hundreds of

people have been discharged from hospital, and beds are being decommissioned.

To support this NHS England has made available up to £30 million of revenue funding, to be matched by CCGs which equates to up to £10m per year and is available until March 2019. In addition to this in 'Building the Right Home', published in December 2016, NHS England outlined its intention to make up to £100 million in capital funding available between 2016 and 2021 to support these Transforming Care projects which equates to up to £20m available per year, until 2021.

5.6.2 The Transforming Care Delivery Board (TCDB)

The work of the programme across the health and social care system is managed by the Transforming Care Delivery Board (TCDB) which includes people from each of the partner organisations leading the Transforming Care Programme nationally. They are: NHS England; the Association of Directors of Social Services (ADASS); the Care Quality Commission (CQC); the DHSC; the Department for Education (DfE); Skills for Care; Health Education England (HEE); and the Local Government Association (LGA).

5.6.3 Who is leading this work in local areas?

48 Transforming Care Partnerships (TCPs) across England are leading the implementation of 'Building the Right Support'. TCPs are made up of CCGs, NHS England's specialised commissioners and local authorities. Nationally, NHS England employs a number of people of experts by experience to support work across a number of work streams including people with a learning disability, autism or both and family carers.

For more information please visit our webpages on [Transforming Care Partnerships](#).

5.6.4 Annual Health Checks

Annual health checks are part of NHS England's goal to transform the treatment, care and support available to people of all ages with a learning disability, so that they can lead longer, happier, healthier lives in homes not hospitals.

The Annual health check is available to those patients on the GP register who are over the age of 14. Annual health check help to reduce recognised health inequalities as well as having their reasonably adjusted care needs communicated more effectively to other NHS partners.

To ensure more people with a learning disability benefit from Annual Health Checks, in the 18/19 planning guidance NHS England and NHS Improvement set an ambition so that the number of people receiving an annual health check from their GP is 64% higher in 2018/19 than in 2016/17. CCGs should achieve this by both increasing the

number of people with a learning disability recorded on the GP Learning Disability Register, and by improving the proportion of people on that register receiving a health check.

The number of people with a learning disability who had an Annual Health Check increased from 75,731 in the first 9 months of 2016/17 to 88,326 in the first nine months of 2017/18. This is an increase of 12,595 (17%) in the first 9 months of 17/18 compared to 16/17.

5.6.5 Care and Treatment Reviews

Care and Treatment Reviews (CTRs) are part of NHS England's commitment to transforming services for people with learning disabilities, autism or both. CTRs are for people whose behaviour is seen as challenging and/or for people with a mental health condition. They are used by commissioners for people living in the community and in learning disability and mental health hospitals, to help ensure people are getting the right support and are being supported to return home as soon as possible.

In March 2017, we published a revised CTR policy which included a new annex for children and young people and made a number of changes to improve the effectiveness of CTRs. This included making changes to the way these were conducted for children and young people. Importantly, for children and young people, we changed these to "Care, Education and Treatment" (CETRS) to better reflect the vital role education plays within children's lives.

The proportion of inpatients reported as never having had a CTR was reported to be 13% in February 2018, down from 21% one year ago in February 2017. The number of people receiving community CTRs (also called pre-admission CTRs) also continues to improve. From April 2017 to January 2018, 43% more pre-admission CTRs were undertaken than in April 2016 to January 2017, with 79% leading to a decision not to admit into inpatient care.

5.6.6 STOMP

STOMP was launched in 2016 and expanded during 2017. STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines. Psychotropic medicines affect how the brain works and include medicines for psychosis, depression, anxiety, sleep problems and epilepsy. Psychotropic medicines can cause problems if people: take them for too long; take too high a dose; or, take them for the wrong reason. This can cause side effects like: putting on weight; feeling tired; and serious problems with physical health. Sometimes they are also given to people because their behaviour is seen as challenging.

People with a learning disability, autism or both are more likely to be given these medicines than other people. These medicines are right for some people and they can help people stay safe and well. However, sometimes there are other ways of helping people so they need less medicine or none at all. It is important to note that it is not safe to change the dose of these medicines or stop taking them without help from a doctor. STOMP has three aims:

- to encourage people to have regular check-ups about their medicines;
- to make sure doctors and other health professionals involve people, families and support staff in decisions about medicines; and
- to inform everyone about non-drug therapies and practical ways of supporting people so they are less likely to need as much medicine, if any.

STOMP is a national project involving many different organisations which are helping to stop the over use of these medicines. NHS England launched STOMP in 2016 working in partnership with The Royal College of Nursing, The Royal College of Psychiatrists, The Royal College of GPs, The Royal Pharmaceutical Society and The British Psychological Society. By the end of February 2018, the STOMP pledge had been signed by 24 professional Royal Colleges and societies and over 150 social care providers supporting over 50,000 people with a learning disability, autism or both. In addition, over 1000 pharmacy staff have been trained to support STOMP.

5.6.7 Resources

In September 2017, NHS England and the Local Government Association (LGA) published guidance “[Developing support and services for children and young people with a learning disability, autism or both](#)”, setting out the importance of effective prevention, early help and intervention in improve the long term outcomes for children and young people, alongside specialist treatment. The guidance supports ‘Transforming Care Partnerships’ to ensure they are implementing the commitments set out in ‘Building the Right Support for children and young people’.

For more information please visit our webpages on [Homes not hospitals](#).

5.7 Learning disabilities – the learning disabilities mortality review

5.7.1 CIPOLD

The 2010-13 [Confidential Inquiry into Premature Deaths of People with learning disabilities](#) (CIPOLD), carried out by the University of Bristol, found that nearly a quarter of people with a learning disability were younger than 50 years when they died, with women dying on average at a younger age than men. Elsewhere, CIPOLD reported that up to a third of the deaths of people with a learning disability were from causes of death amenable to good quality healthcare (i.e. they could possibly have been addressed by better healthcare provision). The establishment of a national

[mortality review programme](#) for people with a learning disability was one of CIPOLD's 18 key recommendations.

5.7.2 The Learning Disability Mortality Review (LeDeR) Programme

NHS England is committed to making sure that people with a learning disability receive the right care in the right settings, with the right support. This is one of our national priorities. We know that we urgently need to understand and reduce health inequalities amongst this group, which is why, as part of our programme of work we have commissioned the [Learning Disabilities Mortality Review \(LeDeR\) Programme](#). The LeDeR Programme is the first of its kind in the world, it has been commissioned by Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. The Programme is being led by the University of Bristol's Norah Fry Centre for Disability Studies. Funding is provided by NHS England until June 2019.

The LeDeR programme was established to help support improvements in the quality of health and social care service delivery for people with a learning disability.²⁷ By reviewing the deaths of people with a learning disability, health and social care professionals and policy makers have been, and are, assisted to consider what has worked well in the person's care, as well as what could have been improved. Potential improvements to care can be included in recommendations for service improvements to be taken forward locally or nationally. A central focus of these reviews is to understand causes of death and to identify the central factors contributing to premature mortality for people with a learning disability and to identify good practice and appropriate interventions which improve the quality of care and reduce premature mortality rates for people with a learning disability. The LeDeR Programme is working with other agencies such as the Learning Disability Public Health Observatory, NHS Improvement and NHS Sustainable Improvement to reduce the health inequalities faced by people with a learning disability.

5.7.3 Review of deaths

A key part of the LeDeR Programme is to support local areas to review the deaths of people with a learning disability. The Programme has developed and rolled out a review process for the deaths of people with a learning disability, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision. The LeDeR Programme collates and shares anonymised information about the deaths of people with a learning disability nationally, so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

²⁷ The LeDeR programme is part of a suite of programmes previously known as confidential enquiries. It has approval from the Secretary of State under section 251 of the NHS Act 2006 to process patient identifiable information without the patient's consent.

5.7.4 Additional LeDeR projects

A further part of the LeDeR programme is to conduct a series of additional projects. There have been four key additional projects. The first focused on finding out more about the age and cause of death of people with a learning disability in England by linking different data sets. The second focused on finding out more about the provision of 'reasonable adjustments' for people with a learning disability. The third focused on providing better guidance so that the cause of death written on death certificates of people with a learning disability is recorded in a consistent manner. The fourth established a collection of reports about people with a learning disability from which we can learn more about commonly occurring problems.

5.7.5 GPs and Primary Care Teams

In April 2017, the LeDeR Team wrote to General Practitioners and to Acute and Specialist Hospitals to advise them about the LeDeR programme and how they might be asked to participate in it. We also explained the basis on, and by which, which patient identifiable information could be shared with the review team. There are two specific ways that GPs and Primary Care Teams may be involved in the LeDeR Programme. The first is with regard to notifying the death of any of their patients with a learning disability. The second is to input into a review into the circumstances leading to the death, of those aged 4 years and older. More detailed information is provided in FAQs.

5.7.6 Learning from LeDeR pilot sites

In 2017, the University of Bristol and NHS England published '[Learning from LeDeR Pilot sites](#)'. The report supplements a series of information sharing events held during 2016 and 2017 by collating the combined learning from the pilot sites to assist those establishing the LeDeR programme in their area. The report provides guidance on a wide range of issues including: i) steering groups; ii) programme governance; iii) roles and responsibilities; iv) training; v) communication; vi) reviews of deaths; vii) confidentiality and privacy; viii) funding and resources; ix) support; x) culture; xi) programme outcomes; xii) learning and sharing events; and xiii) legacy issues.

For more information please visit the [LeDeR website](#) hosted by the University of Bristol.

5.8 Maternity Transformation Programme

5.8.1 Background

Pregnancy and maternity is a protected characteristic under the Equality Act 2010. Improvements in pregnancy and maternity services improve equality of opportunity and health outcomes for women and children including reducing the potential for disability and/or death. The Marmot review and the BMA Board of Science agree that

one quarter of all deaths under the age of one would potentially be avoided if all births had the same level of risk as those to women with the lowest level of deprivation.²⁸ 'Better Births', the report of the National Maternity Review, published in February 2016, set out a clear vision for maternity services across England to become safer, more personalised, kinder, professional and more family-friendly. The [Maternity Transformation Programme](#) was launched in July 2016. The [Maternity Transformation Programme Board](#) has been tasked with driving forward the implementation of Better Births, the [report](#) of the National Maternity Review, published in February 2016, including work to reduce the rate of stillbirths, neonatal and maternal deaths in England. Implementing the vision set out in Better Births is being undertaken by the Maternity Transformation Programme with an overarching ambition to improve safety of maternity care, alongside personalisation and choice.

5.8.2 Local Maternity Systems and developments during 2017

The programme is working through 44 Local Maternity Systems working on Sustainability and Transformation Partnership (STP) footprints. During the last year, they have produced local strategies setting out how they plan to plan to deliver on the overall vision for improved safety and greater personalisation and choice. This gives us a good understanding of how we will be able to reduce health inequalities through the programme. Local Maternity Systems have specifically been asked to meet a number of deliverables, including those set out below.

- Improving the safety of maternity care so that by 2020/21 all services have reduced rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% and are on track to make a 50% reduction by 2025. We know that stillbirths, neonatal deaths, maternal deaths and serious brain injuries are statistically more likely to occur with women living in areas of multiple deprivation and with women from BME backgrounds. Action to tackle these poor outcomes is therefore likely to disproportionately improve care for disadvantaged families and reduce health inequalities.
- Improving choice and personalisation of maternity services so that all pregnant women have a personalised care plan, and that most women have continuity of clinician caring for them. We know that a more individualised approach to care makes a difference in particular to disadvantaged women who are less likely to find that standard services work for them. We also know that some women may derive a disproportionately greater benefit from continuity of carers. In particular, caseload midwifery appears to confer increased benefits and reduced harmful outcomes for women with complex social factors.

²⁸ Growing Up in the UK: Ensuring a healthy future for our children, BMA Board of Science, chapter 3, 2013 <https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/child-health/growing-up-in-the-uk>

In March 2017, we published [‘Implementing Better Births: A resource pack for Local Maternity Systems’](#) to help Local Maternity Systems lead and manage that local transformation. This provides guidance on implementing the recommendations of ‘Better Births’ that require local action, it also describes the role and purpose of the Local Maternity Systems and explains the national policy that will support implementation.

5.8.3 The Maternity Challenge Fund and funding in 2017

The Maternity Challenge Fund builds on the success of the Friends and Family Test and supports NHS England’s plans for more effective use of patient insight data. The Fund provides an opportunity to test the feasibility of ideas for adding value from patient feedback in maternity services and to see whether, in practice, they work and could be transferable to other trusts. In the second round of the Fund, trusts were invited to apply for funding from a total pot of £150,000 set up to support further advances in this area. [Three projects](#) were each awarded £50,000 by NHS England to explore innovative ways to use women’s and their partners’ feedback to improve maternity services.

5.8.4 Better Births Early Adopters

During 2017 and 2018, we have invested £8m over 2 years in 7 [Early Adopter](#) (EA) sites across England, covering 29 CCGs and 29 providers of maternity care, who are implementing Better Births at scale across their LMS and at pace. This means that maternity services in the Early Adopter sites are working hard to provide safer and more personalised care for over 240,000 women and babies during the 2 years and sharing the learning from the sites across all LMS. The Early Adopter sites, which were carefully chosen by a selected panel, are testing a range of new and innovative ways of working to help transform maternity services, such as:

- using small teams of midwives to offer greater continuity of care to women;
- creating single points of access to a wider range of maternity services;
- making better use of electronic records to provide more joined up care;
- improving postnatal care;
- providing better personalised care planning.

For more information please visit our webpages [on the Maternity Transformation Programme](#).

5.9 Mental health

5.9.1 Background

The independent Mental Health Taskforce, formed in March 2015, brought together health and care leaders, people who use services and experts in the field to create a

Five Year Forward View for Mental Health for the NHS in England. Improvements in access to high quality services, choice of interventions, integrated physical and mental health care, prevention initiatives, funding and challenging stigma were people's top priorities as to how the system needs to change by 2020. This feedback directly shaped the [Five Year Forward View for Mental Health](#), the national strategy for mental health, which covers care and support for all ages, was published in February 2016. The strategy signifies the first time there has been a strategic approach to improving mental health outcomes across the health and care system, in partnership with the health arm's-length bodies.

Deprivation has been identified as both a significant factor in and consequence of mental health problems. This means that understanding, measuring and taking practical steps to address socio-economic inequalities in relation to mental health is an important part of the programme (such as supporting people with mental illness to find and retain meaningful employment). In addressing inequalities we also need to pay particular consideration to the experience of intersectional discrimination e.g. how people may experience multiple disadvantages as a result for example of their sexuality, age and race. There are also significant geographical inequalities in access to mental health care that the Five Year Forward View is taking steps to address. For example, in 2015/16 fewer than 15 per cent of localities provided effective specialist community perinatal services for women with severe or complex mental health conditions. By 2020/21, all women who need it should be able to access this care, wherever they live in England (an additional 30,000 people). The programme seeks to make a significant contribution to closing these gaps with a clear set of ambitious and commitments.

5.9.2 Access to Psychological Therapies

Psychological therapies are effective for older people, and so increasing the number of older people in Improving Access to Psychological Therapies (IAPT) services is likely to not only improve the mental health of those receiving treatment but also have a positive impact on national performance against the 50% IAPT recovery standard. Access for people over 65 is increasing year on year, but growing slowly, and most access falls within the 65-75 age range. One in five over-65s is affected by depression but despite IAPT services being open to all adults, older people, especially those aged 65+, are underrepresented amongst those accessing these services. During 2015/16, only 7% of the 953,522 patients referred to IAPT services who entered treatment were aged 65 and over. This is despite over-65s accounting for almost 23% of the adult population. Analysis at a national level (Quarter 4 2016/17) shows that recovery outcomes for BME groups are below White British levels (47.3% BME vs. 51.8% of White British in November 2017).

To address this, the Older Adults and BME Quality Premium has been introduced: Age and BME vs White Briton specific mental health metrics are now included as a

subset of the mental health dashboard. The current [dashboard](#) covers the period April to September 2017 and brings together key data from across mental health services to measure the performance of the NHS in delivering our plans. The programme is now convening an Older Adults External Advisory Group to review progress.

5.9.3 Suicide Prevention

The Five Year Forward View for Mental Health (MH5YFV) set the ambition that the number of people taking their own lives be reduced by 10% nationally by 20/21 compared to 2016/17 levels (from 4820 in 2015 to 4340 in 2020/21). The National Suicide Prevention Strategy and [its refresh](#) (published in January 2017) outlined a need to target particular high risk groups. High risk groups can be broken down into: those who self-harm (and attend A&E); those with mental health problems (within secondary services); and men and co-morbidities, in particular middle-aged men (who do not attend services). All STPs should also be delivering against an STP-wide multi-agency suicide prevention plan. Of the £5 million of transformation funding available in 2018/19, over £4m has been allocated to priority STP footprints that have either significantly higher suicide rates in middle-aged men (aged 45–49) or a high age-standardised rate.

5.9.4 Severe Mental Illness (SMI)

The life expectancy for people with Severe Mental Illness (SMI) is 15–20 years lower than the general population, one of the greatest health inequalities in England. There is a 65% point gap between the employment rates of people being supported by specialist mental health services who have more severe health problems and the general population. This disparity in health outcomes is partly due to physical health needs being overlooked. To achieve the 5YFV goal of reducing premature mortality for people with severe mental illness (SMI), we have committed to ensuring that by 2020/21 280,000 people have their physical health needs met. This will be achieved by improving access to, and the quality of physical health checks, and follow up interventions. In practice, this equates to ensuring that approximately 60% of people on the General Practice (GP) SMI register receive a comprehensive physical health assessment and follow-up care. This goal is to be delivered across both primary and secondary care. Delivery in secondary care has been incentivised by the development of a CQUIN.²⁹ To support delivery in primary care, funds have been made available in CCG baselines and the requirement for investment has been reiterated in Refreshing NHS Plans for 2018/19.

For more information please visit our webpages on the [Mental Health Taskforce](#).

²⁹ CQUIN stands for commissioning for quality and innovation. The system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.

5.10 Secure estates and healthcare in prison

5.10.1 Context setting

Whilst the relationship between health and social influences on offending and re-offending behaviour is complex, in some areas there is a clear link with improved health outcomes offering the prospect of reducing offending and re-offending rates through health related interventions. There is a distinct set of health needs faced by those in, or at risk of being in, secure and detained settings. This patient population, in general, experiences a disproportionately higher burden of illness, poorer access to treatment and prevention programmes, problems with substance misuse. People who are detained also have a disproportionately higher levels of mental health presentations. Furthermore, health concerns are often complicated by social issues, such as homelessness, unemployment and poor levels of education; and there is a growing cohort of older prisoners whose health and social care needs are increasing.

The correlation between limited access to health services and higher levels of health inequalities for patients who are detained is well understood. Levels of substance misuse in this population are high. According to a MoJ survey most adult offenders (79%) reported having taken illegal drugs at some point in their lives. The ONS Psychiatric Morbidity survey-suggests that 72% of adult male and 71% of female prisoners may have 2 or more mental disorders (e.g. personality disorder, psychosis, anxiety and depression, substance misuse) with 20% being described as having 4 or more mental disorders. Adults in prison were more likely to be living with long term conditions. As approximately 87% of the offender population have a nicotine dependency, as against 19% of the general population, smoking related diseases are prevalent amongst the population.

5.10.2 The Lammy Review

In September 2017, David Lammy MP released his [Independent review](#) into the treatment of and outcomes for, Black Asian and Minority Ethnic (BAME) individuals in the Criminal Justice System (CJS). This report highlighted the significant BAME over representation in our prison populations. 25% of the prison population came from BAME backgrounds although BAME men and women made up 14% of the population. Furthermore, the experiences and treatment of BAME people of the Youth and Criminal Justice Systems often leaves people distrustful of authority. Such distrust may mean that BAME patient populations within the estate may not seek health care at the earliest opportunity. BAME communities have also expressed concerns about whether they are given timely access to suitable medical care. Late medical interventions could have the potential to further marginalise an already underserved group. The health services that are commissioned seek to respond to the health needs presented by these communities and seek to ensure screening and immunisation services are relevant and developed across the estate.

5.10.3 Commissioning health services in prison

It is understood that these patient populations will have significant health issues and will be burdened by a number of inequalities, health inequalities being one of them. Every commissioned service will have a Health Needs Assessment to underpin appropriate service offers. These Health Needs Assessments scope the particular needs of the patient populations. The aim is to ensure that the subsequent service specification, against which health providers are contracted, are fit for purpose and will meet the needs of these populations. From an NHS England perspective, we have made significant progress on commissioning consistent standards of care across the secure environment – a must for delivering improvements and central to driving evidence based and outcome focused access to health services. In support of this, we have developed new specifications for mental health and substance misuse services in secure premises, as well as an improved screening process that is being rolled out across the system.

5.10.4 Partnership and collaboration

The [Rebalancing Act](#) was published in January 2017 by the Revolving Doors Agency, with support from NHS England, Public Health England and the Home Office. Building on the Balancing Act, published in 2013, it seeks to move the agenda on by looking at more concrete ways in which partnership and collaboration can be strengthened to address the health inequalities faced by those in contact with the criminal justice system. To find out more about its progress, visit the [Revolving Doors website](#).

5.10.5 Dual diagnosis

In relation to substance misuse and dual diagnosis, NHS England has developed a revised and improved substance misuse specification which identifies and describes the required management and critical issues in relation to psychoactive substance misuse and the attendant wider health impact of such use.

5.10.6 Mental health

With regard to improving mental health service provision, we are revising secure hospital transfer guidance and are contributing to the review of the Mental Health Act, ensuring the mental health needs of those in detained settings are not overlooked. In addition, the National Liaison and Diversion programme continues its roll out and is on track for 100% coverage by 2020. As part of this, we are working with partner organisations to deliver a peer support model, an enhanced Crown Court service and a women's care pathway. A significant piece of work has been undertaken, alongside colleagues in specialised commissioning, in improving the mental health service offer for people in prisons and securing a more transparent, consistent and timely secure hospital transfer for seriously mentally ill patients.

5.10.7 Children and young people and ensuring adequate assessment and mental health services

Mindful of the particular complexities facing children and young people within secure settings, action is being taken to ensure that they are appropriately supported. The aim is that they leave detention healthier than on arrival and those gains made during a child's time in a secure setting are not lost. Significant investment has been made in mental health services, along with delivery of the 'Framework for Integrated Care' ('Secure Stairs') project, specifically for the children and young people in the Secure Estate, which addresses the health needs of this patient group. In addition further work is being delivered through joint localised health service provision and partnership work, with a focus on safeguarding and minimising deaths in custody and near misses. The Anna Freud National Centre for Children and Families has been appointed by NHS England to undertake an independent evaluation of 'Secure Stairs'.

The implementation of 'Secure Stairs' aims to support trauma-informed care and formulation-driven, evidence-based, whole-systems approaches to creating change for young people within the Children and Young People Secure Estate. During 17/18, as part of the 'Framework for Integrated Care Project, 'Secure Stairs' was developed as the response for the current Children and Young People Secure Estate (CYPSE). All CYPSE sites (20) were scoped and findings set out in a report and currently 14 Secure Children's Homes and 1 Secure Training Centre (STC) have a signed off Implementation Plan and the 4 Young Offender Institutions will be completed by June 2018. Key Performance Indicators have been developed and an Independent Evaluation has been procured.

One of the core principles of the framework is that the day-to-day staff are at the centre of the intervention, recognising that they have a key role in developing the environment and relationships that can manage risk, make young people feel safe and can make change for the young people. With this framework in use, the impact of these day to day staff, rather than specialist 'in-reach' services, will have the most impact on how young people will change within secure settings.

'Formulation' aims to explain the development, functions and maintenance of the concerning behaviours, identify strengths and protective factors and result in a whole system understanding of the child/ young person, which underpins all plans of intervention. This formulation underpinned plan is connected to the development of the child and is focussed on reducing risk factors and on increasing the protective factors that will bring about positive change.

NHS England is working with their partners in the MoJ, the Youth Custody Service (YCS) and the DfE to better meet the needs of children and young people held in youth justice or welfare detention. Rainsbrook Secure Training Centre was the first

secure setting to have started using the 'Secure Stairs' approach. 'Secure Stairs' is mobilising in all youth justice secure settings from April 2018.

5.10.8 Older People

From an older person's perspective, we have adopted a joint approach to managing their healthcare. Men who are 50 years and over are the fastest growing population in the Secure Estate and are resident in establishments that were, in general, designed for fit young men. We have, therefore engaged with Her Majesty's Prison and Probation Service (HMPPS) to ensure that establishments have older people /dementia friendly cells and that access and mobility for this patient population is integral to planning for service delivery. Cells have been knocked together to enable space for hospital beds and hoists to be fitted and showers and toilets fitted to support mobility and access. Specialist dementia care is being developed and delivered across establishments where the population is predominantly in their later years. In addition to this work NHS England have developed a Dying Well in Custody Charter, which mirrors the [Dying well in the Community Charter](#) to ensure where planned deaths are being managed they support best practice and meets the test of equivalence between services delivered in prisons and in the community insofar as this is possible given the constraints of a secure environment. The Dying Well in Custody Charter is scheduled for publication in Spring 2018.

5.10.9 Women

NHS England has initiated bi-annual prison health summits that each cover the North, South and Midlands' geographies of the women's estate. These summits share good practice and consider where regional resources would benefit the women patient population. The north region has developed a maternity pathway specification for women which the other areas are aligning with. Her Majesty's Prison and Probation Service (HMPPS) have delivered a whole system 'Being Trauma Informed' approach to the women's estate and we have been able to secure training for this approach to be delivered in Yarl's Wood, our only women's Immigration Removal Centre. We are also working with HMPPS in the development of their women's strategy, specifically helping formulate more effective care continuity on release particularly as the majority of women in prison are sentenced to a relatively short period in custody. In addition to the above, we are also supporting the delivery of a reducing Suicide and Self-harm (SASH) strategy for women with specific reference to the improved Mental Health specification.

In respect of health services for women in prisons, development of improved health pathways is well underway and NHS England is working with Her Majesty's Prison and Probation Service (HMPPS) to support gender targeted best practice to drive improvements in the experience of women. HMPPS has also ensured that all women's prisons work to the principles of delivering services across a Being Trauma-Informed environment.

5.10.10 People and infectious diseases

To address the issue of a disproportionately high number of people within the secure setting having infectious diseases, work is also underway with partner organisations to eliminate Hepatitis C amongst this patient cohort and prepare for, and manage, pandemic outbreaks. Blood-borne Virus Opt-Out (BBV) opt out services have been developed across the estate to improve uptake of TB screening. It is recognised that people in prison, in general, physically present as 10 years older than their chronological age so this is recognised by the physical health checks programme and the approach to targeting.

For more information please visit our webpages on [Addressing health inequalities within the criminal justice system](#).

For more information on the Rebalancing Act please visit the [Revolving Doors website](#).

6 NHS England as an employer

6.1 Our people commitments in support of the public sector Equality Duty

NHS England's People and Organisation Development Team has supported the organisation to promote equality of opportunity and to address inequalities within the NHS England workforce. In order to further accelerate progress the People and OD team secured additional resource to support recruitment of a Corporate Diversity and Inclusion Team. Building on existing progress, the Head of Diversity has worked closely with stakeholders to develop a Corporate Diversity and Inclusion strategy. This has involved close analysis of existing duties and commitments, ESR data and staff survey results as well as a review of the business case for Diversity and Inclusion. Staff views have been gathered through a period of engagement with senior managers, chairs of staff engagement networks, the diversity and inclusion steering group and people working within NHS England directorates and regions.

6.2 Talent Management for under-represented groups

NHS England workforce data indicates gradual improvements in the representation of staff at senior bands and recent Staff Survey responses have demonstrated an increase in the percentage of staff believing that NHS England is an equal opportunities employer. We will build on this progress by establishing a series of Positive Action Talent Management programmes which will be co-designed with BME staff and Executive Group members. These approaches will be combined with senior level sponsorship and reverse mentoring programmes to support measurable and sustainable improvements for staff from under-represented groups.

6.3 Supporting open and fair approaches to recruitment

We have robust processes to support high quality, fair and transparent recruitment processes. These will be improved further through delivery of the recently piloted Equality and Diversity Representatives (EDR) programme. EDRs provide independent equality perspectives for recruiting managers from creation of job advertisements and job specifications through to shortlisting and interview processes.

6.4 Creating an inclusive culture where everyone is valued and respected

We will ensure that the principles of Diversity and Inclusion are embedded throughout NHS England People and Organisation Development programmes and policies. This includes supporting the Freedom to Speak Up Guardians initiative and Respect at Work Contact programme to reflect the communities we serve. The successful Line Management Development programmes and Senior Line Manager Development Programme will ensure that the concepts of compassionate and inclusive leadership are embedded throughout and measured as part of ongoing evaluation. Diversity and Inclusion principles will be embedded in the existing NHS England capabilities review and the Transforming NHS England programme.

6.5 Developing and making use of high quality data

We actively analyse data gathered from Electronic Staff Records (ESR) to provide clarity about gaps in recruitment, promotion and development opportunities for groups with protected characteristics. We also collate feedback about what it feels like to work in NHS England through the staff survey responses. We will further enhance reports provided through ESR and Staff Survey data by including narratives and personal accounts from staff to demonstrate positive and negative working practices. Diversity Data profile packs will be created for NHS England Directorates and Regions to increase personalised accountability for progress on Diversity priorities.

ESR disclosure rates relating to Ethnicity, Religion, and Disability or Long-Term conditions have increased by 2%. However, we still see a gap in data relating to Sexual Orientation with 20% of staff leaving this box blank or actively choosing not to declare. In relation to religion and belief 25% of staff are choosing not to declare their religion or belief. The Executive Management Group (EGM) has already agreed that National and Regional directors will encourage staff to update demographic data. This will be further supported through internal engagement with NHS England Workforce Systems and Communication teams to encourage staff to reduce the “undefined” gap which occurs when ESR data fields are not completed.

6.6 Co-designing change with staff engagement networks

Our staff diversity networks continue to flourish with annual increases in membership: This includes the BME network; Lesbian, Gay, Bisexual, Trans + network; (LGBT+ network) Disability and Wellbeing network (DAWN); Women's Development network and a recently established Carers network. Networks provide an opportunity for people to influence change, gather feedback and present their views on the topics that are most important to them including policy and staff development, raising awareness and celebrating diversity.

In addition to providing support for separate staff networks, the Diversity and Inclusion team will work closely with co-chairs of staff networks to explore the concept of intersectionality and how networks can collaborate to understand multiple protected characteristics. An overarching action plan will be co-designed with networks to support increase in membership for all networks as well as wider staff engagement. Staff networks play a key role in supporting us to celebrate diversity and improve our policies as well as holding the organisation to account by monitoring the impact of diversity and inclusion priorities.

6.7 Embedding Diversity and Inclusion in all that we do

6.7.1 Engagement and standards

The NHS England Diversity and Inclusion Group, established in 2016 continues to bring together key partners and stakeholders, including trade unions to help create a fairer and more inclusive workforce for NHS England. We will continue to engage with external equality standards and partnerships using them both as a lever for change within NHS England and as an opportunity to learn from and share good practice as it develops.

6.7.2 Our first Gender Pay report and our annual WRES report

To support delivery of our commitment to publishing our Gender Pay report alongside other ALBs, we published our [Gender Pay Report](#) on 28th March 2018. To address issues raised by gender pay gap returns a robust action plan is being co-designed with staff, senior leaders and the Women's Development network. Our internal work will include a review of policies which reduce the risk of gender discrimination including those relating to pregnancy, maternity and sexual harassment. Our annual Workforce Race Equality Standard returns demonstrated progress across all elements of the WRES framework. To accelerate progress even further, we are participating in the WRES Experts programme, providing board level sponsorship for the internal WRES programme.

6.7.3 Disability Confident

In October 2016, NHS England was awarded Disability Confident Employer status by the Department for Work and Pensions (DWP) in recognition of our commitment to recruiting and retaining disabled people and people with long term health conditions for their skills and talent. More intensive activity to support improvements in access for all staff is being led by a recently established Reasonable Adjustments task and finish group which works closely with the Disability and Wellbeing (DAWN) staff network. This work will be further enhanced through engagement with the Workforce Disability Equality Standard. It is NHS England's ambition to be at the forefront of engaging with and implementing this new standard.

6.7.4 LGBT+ communities

Continued improvement in our organisation's approach to supporting staff from LGBT+ communities is enhanced through our work with the Stonewall Workplace Equality Index, supporting our commitment to the visibility of the agenda, communication and engagement on key LGBT+ issues. This includes ongoing engagement with the LGBT+ network to support workforce policy improvements as well as increasing the number of LGBT+ allies who will actively support progress in this area of work.

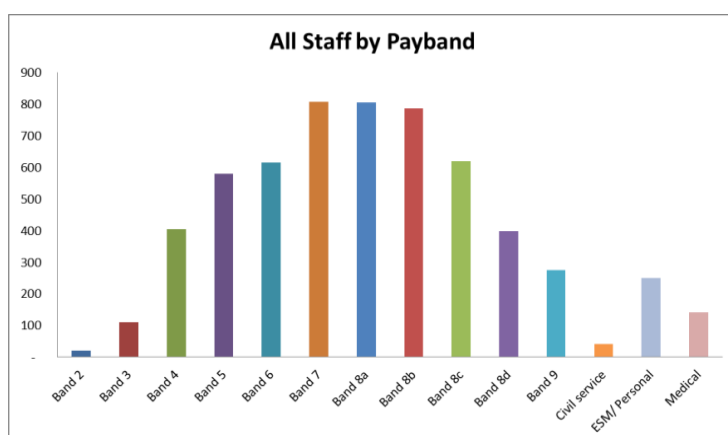
Appendix 1: NHS England – workforce data report

Our organisation and people: Data report

As at 31 December 2017, NHS England directly employed 5,854 people.³⁰ Of these, 4,601 people were permanently employed on recurrent, open-ended contracts of employment, based around the country within seven directorates. In addition, a further 1253 people were employed on payroll on fixed term contracts of employment. A further 984 individuals are engaged in an off-payroll capacity these include agency staff and secondees.

Member	No of people employed
Chair and Chief Executive's Office	16
Operations and Information – London	505
Operations and Information – Midlands and East	1027
Operations and Information – North	1095
Operations and Information– South	798
Finance	221
Medical	109
Nursing	223
Operations and Information – Central	849
Specialised Commissioning	260
Strategy and Innovation	278
Transformation & Corporate Operations	473
Total	5854

All staff by pay band

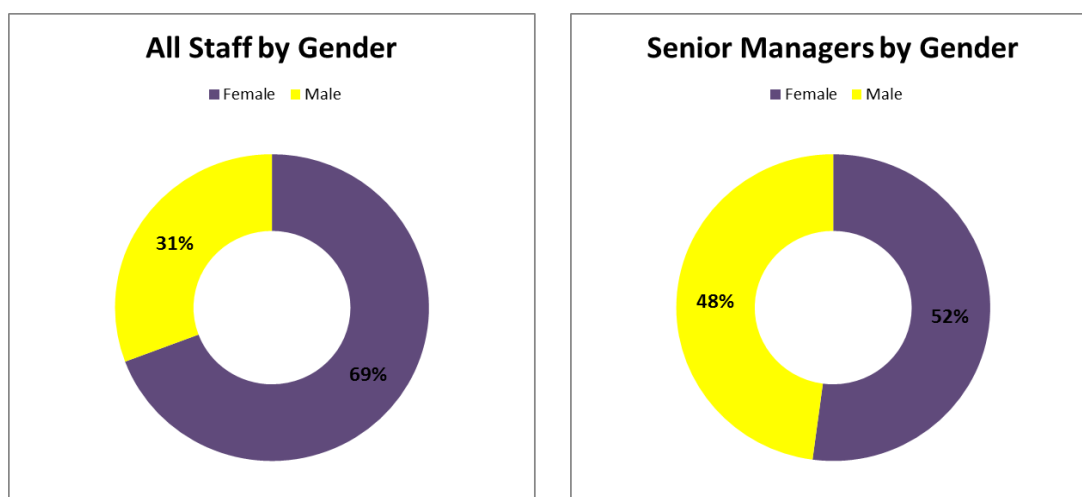


³⁰ Commissioning Support Unit staff are employed via the NHS Business Services Authority and are therefore not included in this analysis.

Table 2: Headcount by grade		
Grade	Posts	Percentage
Band 2	21	0.4%
Band 3	109	1.9%
Band 4	405	6.9%
Band 5	579	9.9%
Band 6	615	10.5%
Band 7	807	13.8%
Band 8a	806	13.8%
Band 8b	787	13.4%
Band 8c	619	10.6%
Band 8d	399	6.8%
Band 9	275	4.7%
Civil service	40	0.7%
ESM/Personal	250	4.3%
Medical	142	2.4%
Grand total	5854	100.0 %

NHS England has seen an increase in headcount of 8% since 2016/17, as we continue to reduce reliance on agency and contract labour. The biggest increases in headcount can be seen at Band 4 (salary range £19, 409 - £22,683 per annum) across Band 8 (salary range £40,428 - £83,258 per annum) and Medical and Dental pay grades.

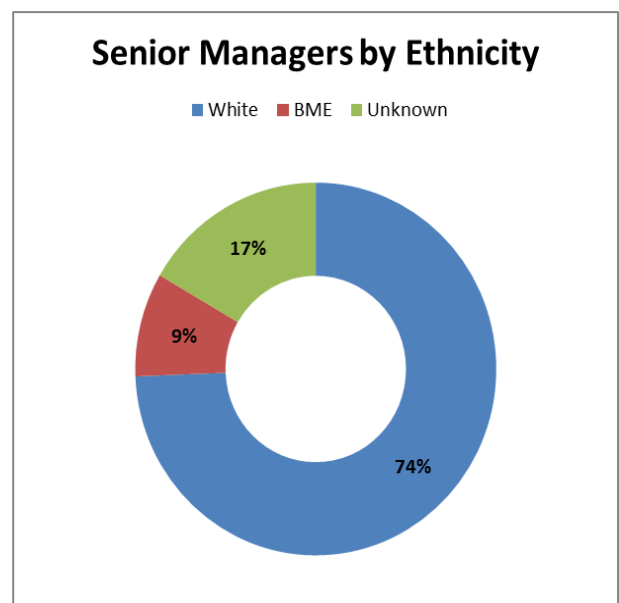
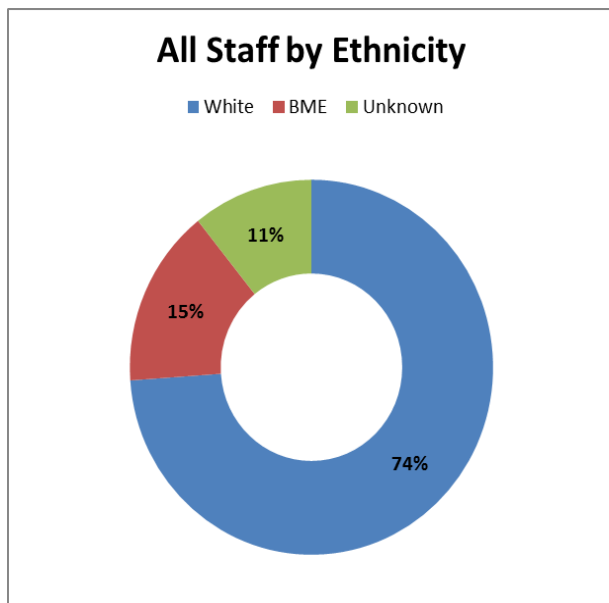
All staff by gender and Senior managers³² by gender



The gender proportions of the total on payroll workforce remain largely unchanged, however the proportion of females in senior manager roles has increased by 1% over the year (2016/17: 51% female, 49% male).

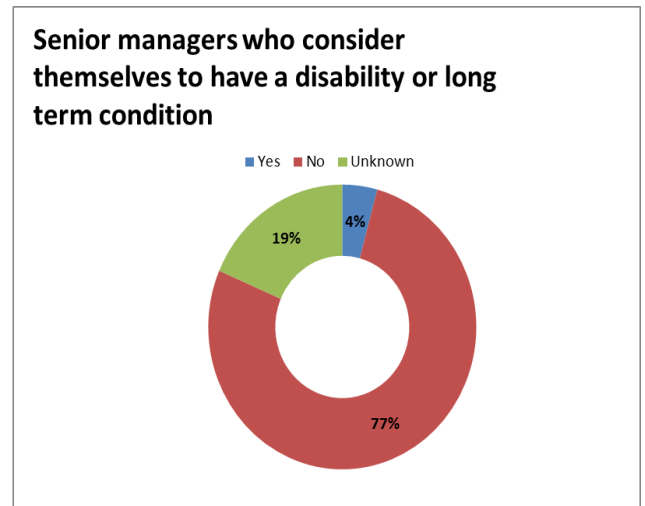
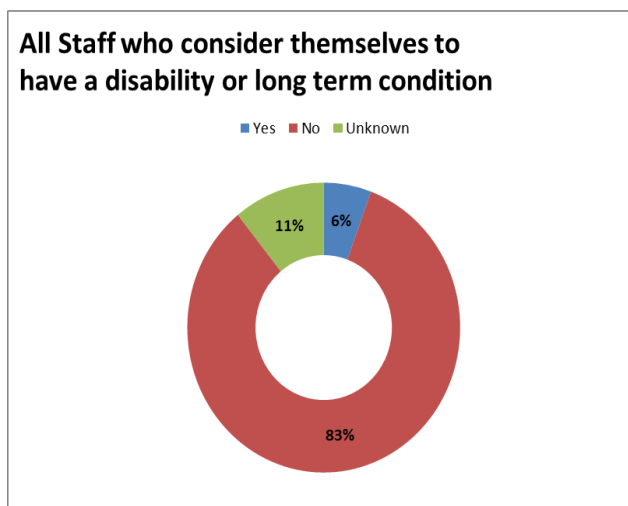
³² The term 'senior manager' denotes all staff remunerated at or above the pro-rate salary of £79,415 per annum (This includes the top tier of Band 8d). This is consistent with the definition used within Cabinet Office and HM Treasury returns.

All staff by ethnicity and senior managers by ethnicity



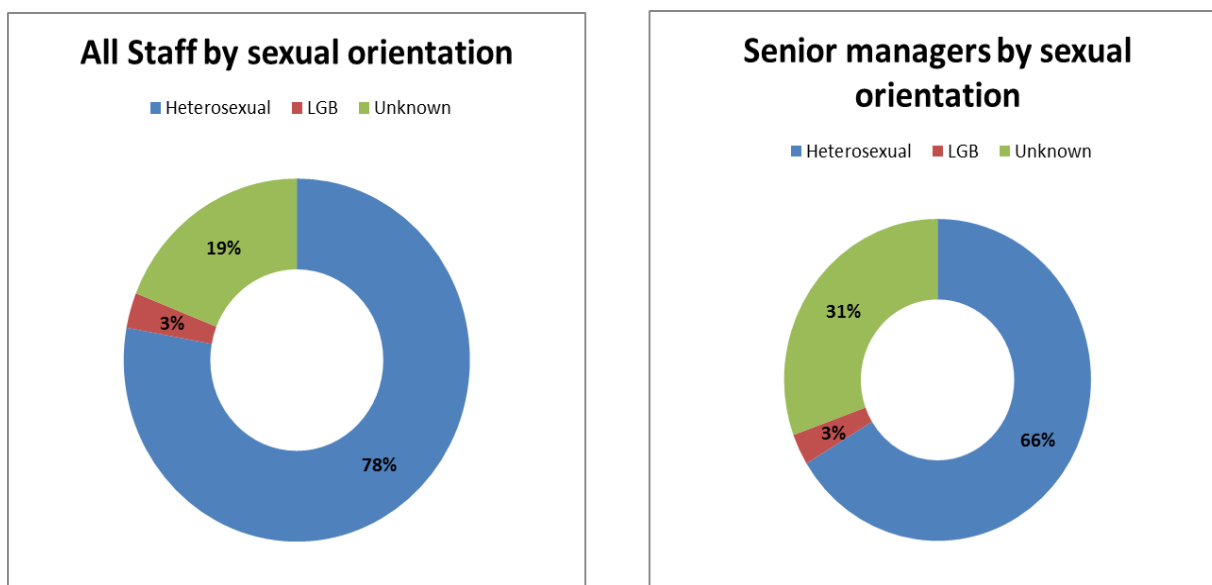
The proportion of people employed by NHS England that consider themselves to be from a black or minority ethnic (BME) heritage has increased by 1% over the year (2016/17: 14% all staff, 8% senior managers).

All staff who consider themselves to have a disability or long term condition and senior managers.



This year an additional 1.2% staff have chosen to disclose whether they have a disability or long term condition (2016/17: 12% all staff, 21% senior managers). Whilst the proportion of senior managers disclosing a disability or long term condition has remained constant, there has been a marginal increase in the percentage of staff disclosing a disability or long term condition (2016/17: 5% all staff, 4% senior managers).

All staff by sexual orientation and senior managers by sexual orientation.³³



Disclosure rates relating to sexual orientation have increased by 2% during the year. The number of staff reporting that they are lesbian, gay or bisexual has remained constant at 3%.

Table 3: Disclosure rates by protected characteristic

	Sep-16	Sep-17	Dec.-17
Ethnicity	87%	89%	89%
Gender	100%	100%	100%
Age	100%	100%	100%
Religion	73%	75%	76%
Sexual Orientation	79%	80%	81%
Disability/ LTC ³⁴	87%	89%	89%

Disclosure rates for ethnicity and disability data have reached 89%. There is a gap in disclosure rates for religion and belief (76%) and Sexual Orientation (81%).

³³ It is not possible to record whether staff members classify themselves as transgender on the NHS electronic staff record (ESR), this is a national functionality restriction within ESR and not something that NHS England is able to address locally.

³⁴ LTC means Long Term Condition

Appendix 2: Our equality objectives and summary progress against and revising our equality targets

Appendix 2: Summary progress against our equality targets and revised targets	
Equality objective 1: To improve the capability of NHS England’s commissioners, policy staff and others to understand and address the legal obligations under the public sector Equality Duty and duties to reduce health inequalities introduced by the Health and Social Care Act 2012.	
Progress made in 2017/18	
See chapter 4.7. The programme of training delivered by EHIT in 2016/17 informed the new programme developed and delivered in 2017/18. The expanded programme delivered in 2017/18, included two pilot programmes offered to an internal team and externally to STPs and CCGs. An expanded WebEx programme was delivered by EHIT working in partnership with NHS England Teams. Discussions within teams in the Experience, Participation and Equalities Division commenced during the latter part of 2017/18 about whether a new joint offer can be developed to support CCGs, STPs and other new care models. Decisions on priorities and the delivery mechanisms will support decisions made by NHS England’s Board.	
Original targets 2016-2020	Notes and/or revised targets ³⁵
Target 1: To deliver an open in-house capability programme to NHS England staff through a mixture of 1 and 2 day sessions (2016/17).	Ongoing target 1: To deliver an open in-house capability programme to NHS England staff through a mixture of 1 and 2 day sessions (2018/19).
Target 2: To evaluate the open in-house capability programme delivered in 2016/17 and assess how to improve access to the programme, via targeting and delivering customised programmes to improve the achievement of key programme outcomes (2016/17).	Revised target 2: To deliver a programme on PSED compliance to STPs, CCGs and other new care models as part of a wider offer from NHS England.
Target 3: Subject to the evaluation of the programme, to deliver an open in-house programme, customised in-house	Revised target 3: To deliver a programme of WebExes in 2018/19 and 2019/20.

³⁵ Where key information is included in the main report, the relevant chapter is referenced first in the overall progress update. If the target has been completed a note signifies this. If the target is ongoing, the target is cited as ongoing. If the target has been revised, this is also identified.

Appendix 2: Summary progress against our equality targets and revised targets

programmes and, as appropriate, use other effective delivery models (e.g. WebExes) to develop individual capability (2017/18, 2018/19 & 2019/20).

Target 4: To explore how best to build the capacity of other teams with culture-changing remits and influence over others in relation to the PSED and the duties to reduce health inequalities. This will be done by evaluating where co-production has worked effectively and has enabled teams to better embed this work into their areas (2017/18, 2018/19 & 2019/20)

Revised target 4: To respond to the priorities identified by NHS England's Board in relation to addressing health inequalities and equalities (2018/19 and 2019/20).

Equality objective 2: To improve disabled staff representation, treatment and experience in the NHS and their employment opportunities within the NHS.

Progress made in 2017/18

See chapters 3.8 and 3.9 on the LDEP and the WDES. The WDES was mandated for NHS Trusts and Foundation Trusts in the revised NHS Standard Contract (2017-19) published on 3rd January 2018. The WDES was not published in 2017/18 in order to allow for more time to engage with stakeholders (see chapter 3.9). New resources were developed during 2017/18 to support both the Learning Disability Employment Programme and the WDES. These resources will be launched in 2018/19. Discussions have commenced with the NHS Electronic Staff Record (ESR) Team to develop the strategy for increasing the number of people with disabilities to declare a disability on ESR and address the issue of disability equality monitoring. Work has also commenced with the Team responsible for commissioning the NHS Staff Survey to address questions about the definitions of disability used within the staff survey that have come up as part of the WDES programme.

Original targets 2016-2020

Target 1: To develop the Workforce Disability Equality Standard (2016/17).

Revised targets 2018/19 – 2019/2020

Revised target 1: To finalise the development of the WDES and roll out the new standard (2018/19).

Revised target 2: To work with the NHS ESR Team and the Insight Team to improve the disability declaration rate on

Appendix 2: Summary progress against our equality targets and revised targets

	ESR, to resolve issues around the definitions of disability used in the NHS Staff Survey and explore the issues of associated with definitions of protected characteristics (2018/19 & 2019/20).
Target 2: To ensure that the Workforce Disability Equality Standard is mandated as part of the NHS Standard Contract and that an information and engagement programme supports the process (2016/17 and 2017/18).	Revised target 3: To consult on and subject to the consultation assess which NHS providers, in addition to NHS Trusts and Foundation Trusts, should be mandated to comply with the WDES in future years.
Target 3: To monitor the implementation of the Standard and evaluate what meaningful targets can be set. To identify any additional opportunities for embedding the Standard (2017/18, 2018/19 and 2019/20).	Revised target 4: To monitor the implementation of the Standard and evaluate what meaningful targets can be set. To identify any additional opportunities for embedding the Standard (2018/19 and 2019/20).
Target 4: To facilitate and drive effective ongoing leadership at national, regional and local levels to maintain the programme's implementation and impact (2016/17, 2017/18, 2018/19 and 2019/20).	Ongoing target 5: To facilitate and drive effective ongoing leadership at national, regional and local levels to maintain the programme's implementation and impact (2018/19 and 2019/20).
Equality objective 3: To improve the experience of LGBT patients and improve LGBT staff representation.	
Progress made in 2017/18	
See chapter 3.6. The Sexual Orientation Monitoring (SOM) information standard was published by NHS England on 5 October 2017 so target 1 was completed in 2017/18 (see chapter 3.6). As part of their work programme with NHS England, NHS Employers led the development the LGBT Action Plan. Details of the work of the Group was highlighted in the EDC Annual Report which was published in 2017.	
Target 1: To further develop the Sexual Orientation Monitoring (SOM) Standard (2016/17).	Revised target 1: To support and facilitate appropriate monitoring of the implementation and take up of the SOM Standard within NHS England and across the NHS (2018/19 & 2019/20).
Target 2: To facilitate the development of the LGBT Action Plan (2016/17).	Note: Work was undertaken in 2017/18 by NHS Employers.

Appendix 2: Summary progress against our equality targets and revised targets

Target 3: To facilitate the effective implementation of the LGBT Action Plan (2017/18).	Revised target 2: To review how best to implement the LGBT action plan working in partnership with NHS Employers and other partners.
Target 4: To develop and deliver an effective engagement programme and secure feedback on the roll-out and take up of the SOM Standard within NHS England and across the NHS (2017/18).	Revised target 3: To develop and deliver an effective engagement programme and secure feedback on the roll-out and take up of the SOM Standard within NHS England and across the NHS (2018/19).
Target 5: To support and facilitate appropriate monitoring of the implementation and take up of the SOM Standard within NHS England and across the NHS (2017/18, 2018/19 & 2019/20).	Revised target 4: To support and facilitate appropriate monitoring of the implementation and take up of the SOM Standard within NHS England and across the NHS (2018/19 & 2019/20).
Target 6: To draw on the lessons learnt from the Workforce Race Equality Standard, the Workforce Disability Equality Standard and the SOM's roll-out, to identify the most effective ways to embed the SOM across the NHS and maintain the necessary momentum and leadership (2017/18).	Note: The national evaluation of the WRES was not published during 2017/18 and WDES is not due to be published until the Autumn 2018. Relevant activities have been built into the revised targets 3 and 4.
<p>Equality objective 4: To reduce language barriers experienced by individuals and specific groups of people who engage with the NHS with specific reference to identifying how to address issues in relation to health inequalities and patient safety.</p>	
<p>Progress made in 2017/18</p>	
<p>See chapter 3.5. The scoping work was completed by the end of 2016/17. From 2018/19, a joint programme of work on interpreting and translation services is under consideration.</p>	
Target 1: Develop a scoping document on developing a Community Languages Information Standard ensuring alignment with NHS England's Interpreting and Translation Principles (2016/17).	The original target 1 was completed in 2016/17.

Appendix 2: Summary progress against our equality targets and revised targets

<p>Target 2: To consult on a draft community language information standard, moving towards implementation subject to sponsorship and resources (2017/18).</p>	<p>Revised target 1: The Community Languages Information Standard Project will be aligned with NHS England Guidance Note: Commissioning Interpreting and Translation Services in Primary Care Guidance (2018/19).</p>
<p>Target 3: To explore associated issues around health literacy among target communities and whether these can be addressed as part of this programme (2017/18).</p>	<p>Revised target 3: To explore health literacy among asylum seekers and the deaf communities, collaboratively working with the Primary care commissioning team (2018/19)</p>
<p>Target 4: To identify potential good practice examples from NHS providers and voluntary and community sector providers in a range of settings and whether and/or how these examples can be publicised (2017/18).</p>	<p>Revised target 4: To identify, collate and share good practice examples and models on interpreting and translation services. (2018/19)</p>
<p>Target 5: To examine the practical and associated cost implications of introducing the main options identified and secure effective leadership and ownership. This will recognise that a one size fits all approach is unlikely to work, given the number and diversity of community languages spoken in some urban/city areas and the different challenges posed by dispersed populations speaking community languages, for example in some rural areas (2017/18).</p>	<p>Note: Some of the approaches outlined will be picked up in the delivery outlined in the updated Targets 1, 3 and 4. Relevant elements of this target have been incorporated into the revised targets set out above.</p>
<p>Target 6: To work with selected NHS and voluntary and community sector providers to review and develop their practices and explore how to introduce, develop and share good practice and good practice models (2018/19 and 2019/20).</p>	<p>Note: The actions outlined in Target 6 are now being picked up in Target 4 and so the original target 6 has been removed.</p>

Appendix 2: Summary progress against our equality targets and revised targets

Equality objective 5: To improve the mapping, quality and extent of equality information in order to better facilitate compliance with the public sector Equality Duty in relation to patients, service-users and service delivery.

Progress made in 2017/18

See chapter 3.11. During 2017/18, a small team undertook a scoping exercise together key information on data currently held by reference to protected characteristics by mapping the data held in the NHS Data Dictionary and other key NHS datasets by reference to protected characteristics. As part of this work, we have liaised with the NHS Digital and the ONS. The ONS will publish a White Paper on their proposals for the 2021 census categories in a White Paper. However, the precise timetable has not been announced. Given the significance of the ONS proposals in relation to the national approach to defining protected characteristics and associated subcategories, we will need to await the proposals, in the White Paper on the 2021 Census, before making final recommendations in relation to the approach of NHS England to changes to the definitions of subcategories of protected characteristics. These developments have been factored into, and informed, the revised targets.

Target 1: To use the development work examining a Unified Information Standard to identify how best to address definitional issues around monitoring protected characteristics (final quarter 2016/17 to end 2nd quarter 2017/18).

Revised target 1: To produce an interim report on options for the development of improved arrangements for monitoring by reference to protected characteristics across the NHS identifying issues that will be informed by the ONS 2021 Census White Paper (2018/19).

Target 2: To map what equality information is gathered by reference to protected characteristics and identify key gaps in information gathering processes that may be valuable in identifying differences in access to healthcare or health outcomes for different protected characteristics (final quarter 2016/17 to end 2nd quarter 2017/18).

Revised target 2: To produce a report on what equality information is gathered by reference to protected characteristics and identify key gaps in information gathering processes that may be valuable in identifying differences in access to healthcare or health outcomes for different protected characteristics (2018/19 quarter 1 or 2).

Target 3: To identify how improvements in relation to gathering equality data and the use of said data can be made and assess whether it would helpful to align this work with improvements to relevant NHS England workforce data (final

Revised target 3: To produce a report on what steps can be taken to improve the use of equality data already gathered prior to the implementation of any new information standard(s) for gathering equality information (2018/19 quarter

Appendix 2: Summary progress against our equality targets and revised targets

quarter 2016/17 to 2018/19).

2/3).

Revised target 4: To update the interim report in light of the ONS White Paper and, the subsequent legislation in relation

Equality objective 6: To improve the recruitment, retention, progression, development and experience of the people employed by NHS England to enable the organisation to become an inclusive employer of choice.

Progress made in 2017/18

Some progress has been made on improving disclosure rate in relation to protected characteristics (see chapter 6.5). We have also made progress in relation to working with staff engagement groups, improving talent management and improving diversity (see chapter 6). The Diversity and Inclusion Team will be working in partnership with the EHI Team in the discussions with the NHS ESR Team to develop the strategy for increasing the number of people with disabilities to declare a disability on ESR and address the issue of disability equality monitoring. The Diversity and Inclusion Team will be working in partnership with the EHI Team in the discussions with the Insight Team which is responsible for commissioning the NHS Staff Survey to address questions about the definitions of disability used within the staff survey (targets 1, 2 and 4).

Target 1: To identify opportunities to promote and encourage employees to voluntarily disclose their self-classification diversity data to ensure NHS England's actions as an employer are evidence led and improvement focussed. To annually publish the NHS England workforce profile and outcomes for the 9 protected characteristics, where data is available, to inform improvement plans (2017-2020).

Ongoing target 1: To identify opportunities to promote and encourage employees to voluntarily disclose their diversity data to ensure NHS England's actions as an employer are evidence led and improvement focussed. To annually publish the NHS England workforce profile and outcomes for the 9 protected characteristics, where data is available, to inform improvement plans (2018/19-2019/20).

Target 2: To implement and report progress against the NHS England response, as an employer, to the WRES and WDES (2017-2020).

Ongoing target 2: To implement and report progress against the NHS England response, as an employer, to the WRES and WDES (2018/19-2019/20).³⁶

Target 3: To actively engage with, promote, support and encourage the

Ongoing target 3: To actively engage with, promote, support and encourage

³⁶ Note: In relation to the WDES, the first report will be in 2019.

Appendix 2: Summary progress against our equality targets and revised targets

<p>work of the NHS England staff networks (BME, LGBT+, Disability and Wellbeing (DAWN) and Women’s Development Network) and recognised trade unions to ensure the lived experience of NHS England staff, represented by these networks and partners, directly contributes to improvement actions and organisational policy development (2017-2020).</p>	<p>the work of the NHS England staff networks (BME, LGBT+, Disability and Wellbeing (DAWN) and Women’s Development Network) and recognised trade unions to ensure the lived experience of NHS England staff, represented by these networks and partners, directly contributes to improvement actions and organisational policy development (2018/19 & 2019/20).</p>
<p>Target 4: To ensure that the experience of NHS England staff, as measured via the NHS England staff survey and other relevant staff feedback mechanisms, is reviewed for variations based upon protected characteristics and for improvement actions to be taken (2017-2020).</p>	<p>Ongoing target 4: To ensure that the experience of NHS England staff, as measured via the NHS England staff survey and other relevant staff feedback mechanisms, is reviewed for variations based upon protected characteristics and for improvement actions to be taken (2018/19 & 2019/20).</p>
<p>Target 5: To review the equality impact of key organisational policies for differential impact in areas such as: recruitment and selection, learning and development, supporting attendance at work, respect at work (anti-bullying and harassment); talent management; appraisal (performance development review) disciplinary, grievance and job evaluation (2017-2019).</p>	<p>Ongoing target 5: To review the equality impact of key organisational policies for differential impact in areas such as: recruitment and selection, learning and development, supporting attendance at work, respect at work (anti-bullying and harassment); talent management; appraisal (performance development review) disciplinary, grievance and job evaluation (2018/19 & 2019/20).</p>
<p>Target 6: To seek external review, challenge and accreditation of NHS England’s actions as an employer by actively participating with relevant equalities standards and benchmarks (e.g. the Stonewall Workplace Equality Index, the Disability Confident Standard, the Workplace Wellbeing Charter, etc.) (2017-2020).</p>	<p>Ongoing target 6: To seek external review, challenge and accreditation of NHS England’s actions as an employer by actively participating with relevant equalities standards and benchmarks (e.g. the Stonewall Workplace Equality Index, the Disability Confident Standard, the Workplace Wellbeing Charter, etc.) (2018/19 & 2019/20).</p>