

Equality, Diversity and Inclusion report 2024-2025

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Accessibility

We want to ensure that the information we communicate is fair and accessible to all sections of our local communities. Patients, the public and staff can request reasonable adjustments such as information converted into other formats for easier reading.

To request information or any of our key documents in an alternative format such as braille, larger print, audio, or other format please email communications@cheshireandmerseyside.nhs.uk quoting your address, telephone number along with the title and date of the publication, plus the format you require. Alternatively, please write to us at:

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In addition, you may require additional support to contact us e.g., a British Sign Language interpreter to support you or you may need language support where your first spoken language is not English.

Cheshire and Merseyside NHS will give due regard to the new Accessible Information Standard from NHS England. For more information, visit the [NHS England website](https://www.nhs.uk/accessible-information-standard/).

Introduction

This document sets out how the NHS Cheshire & Merseyside (NHS C&M) has delivered actions that support the organisation to meet its requirements under the Equality Act 2010 and the Public Sector Equality Duty. As an Integrated Care Board (ICB) we are committed to advancing equality of opportunity and tackling the health inequalities across our sub region. The Cheshire and Merseyside Integrated Care Board was established in July 2022 as the new statutory organisations to lead integration within the NHS. The ICB is responsible for the day-to-day running of the NHS in Cheshire and Merseyside, including planning and buying healthcare services.

This purpose of the report is to evidence that our legislative and regulatory requirements are met whilst acknowledging the need for improvements.

The report outlines our Equality Objectives for the next year and what the NHS C&M will focus on. Our key Equality diversity and inclusion priorities are embedded in our approaches across the organisation and includes our ambition to be an inclusive employer, a leader and to commission services that tackle discrimination and improve outcomes for the communities we serve.

“Promoting equality, diversity, human rights, and inclusion is at the heart of our values, ensuring that we commission, redesign and decommission services fairly and that no community or group is left behind in the improvements that will be made to health outcomes across Cheshire and Merseyside.”

(Source; Equality and Inclusion Strategy)

Our Vision and Values

We are proud of Cheshire and Merseyside's record of collaborative working and there are countless examples of brilliant care, but there are also examples of variation in service which only serve to exacerbate health inequalities.

Our vision is for everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live longer.

We will do this by working together, as equal partners, to support seamless, person-centred care and tackle health inequalities by improving the lives of the poorest fastest.

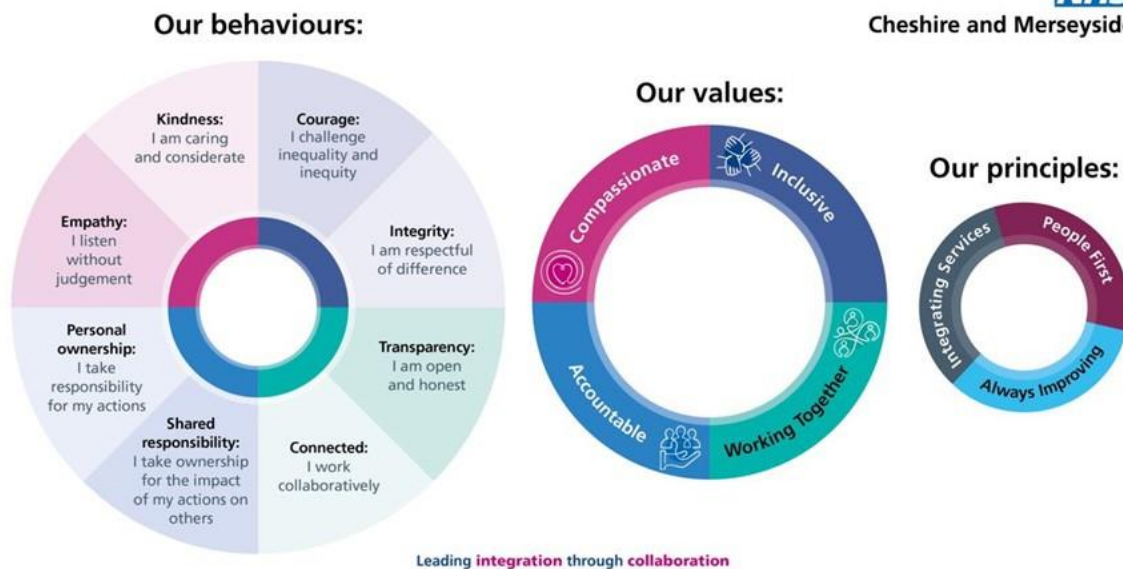
The NHS Cheshire and Merseyside Culture Framework is built on the NHS Constitution, Nolan Principles and Equality Act. It was developed in partnership with staff, tested with leadership and aligned to the direction of our integrated care system's aims to: improve health outcomes, tackle health inequalities, deliver best value and support social and economic growth.

The Culture Wheel brings the Framework to life. The inner ring represents the voice of us an organisation – we want all our staff to put people first and work together towards integrating services. This is what it will take to meet our statutory duty under the Health and Care Act 2022 to drive integration of services through better collaboration.

The middle ring represents the voice of us as a workforce – we believe that to fulfil the duty described above, the conditions we need at work and to be at our best includes compassion, inclusion, working together and mutual accountability in how we work and what we do.

The outer ring defines what our values mean in practice – it describes the behaviours expected of every single member of staff so that we continue to be a trusted employer of partner to and provider of choice when it comes to health and care services.

Our culture framework sits at the heart of our brand, our ways of working, our systems and processes and how we go about our day-to-day work.



Legal Context

NHS Cheshire and Merseyside is committed to promoting equality and eliminating discrimination as an employer and a commissioner of services, ensuring the health care services that we provide are accessible and inclusive.

This report sets out how the NHS C&M is working with the Equality Act 2010 and paying 'due regard' to the Public Sector Equality Duty's (PSED) three objectives to: -

1. Eliminate unlawful discrimination, harassment, and victimisation. This includes sexual harassment, direct and indirect discrimination on the grounds of a protected characteristic.
2. Advance equality of opportunity between people who share a protected characteristic and people who do not share it. This means:
 - Removing or minimising disadvantage experienced by people due to their personal characteristics.
 - Meeting the needs of people with protected characteristics
 - Encouraging people with protected characteristics to participate in public life or in other activities where their participation is disproportionately low.
3. Foster good relations between people who share a protected characteristic and people who do not share it, which means:
 - Tackling prejudice, with relevant information and reducing stigma

- Promoting understanding between people who share a protected characteristic and others who do not.

‘Due regard’ is a legal requirement. Having due regard means considering the above in all decision making, including:

- How the organisation acts as an employer
- Developing, reviewing, and evaluating policies
- Designing, delivering, and reviewing services
- Procuring and commissioning
- Providing equitable access to services.

‘Due regard’ means that the Board of the NHS C&M must consider issues of ‘equality and discrimination’ before making any commissioning or policy decisions that may affect or impact on people who share protected characteristics. It is vitally important to consider equality implications as an integral part of the work and activities that the NHS C&M does.

‘Due regard’ must be paid by the Board or by the NHS C&M decision makers (Committee’s). Officers support this process by developing and presenting information and views to the decision makers. The reports that are presented to the NHS C&M Board or committees are called Equality Analysis reports – commonly known as Equality Impact Assessments (EIAs). These reports will test the proposal/s or changes to policy and say whether it meets the Public Sector Equality Duty (PSED) and ultimately complies with the Equality Act 2010, which is a Statutory Duty. Recommendations are part of the reporting process. The Board must consciously take into consideration the content of the reports as part of their deliberations and decision-making process. EIA reports cannot be undertaken after a decision is made as this is unlawful and could be grounds for Judicial Review (legal challenge).

NHS C&M continues to strengthen internal governance by developing and delivering EIA reports and linking them to the current change programmes. EIA reports need to consider the effect or impact of any change to policy, practice, or procedure against all the protected characteristics this means that there must be a strong link to the consultation and engagement process to identify different people’s perspectives and concerns.

Support is provided to staff making them aware of the EIA process and the NHS C&M ensures strong support mechanisms are in place to help staff and the organisation to develop and deliver timely and accurate reports.

Protected Characteristics

It is against the law to discriminate against anyone because of:

- age
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- disability
- race including colour, nationality, ethnic or national origin
- religion or belief
- sex
- sexual orientation

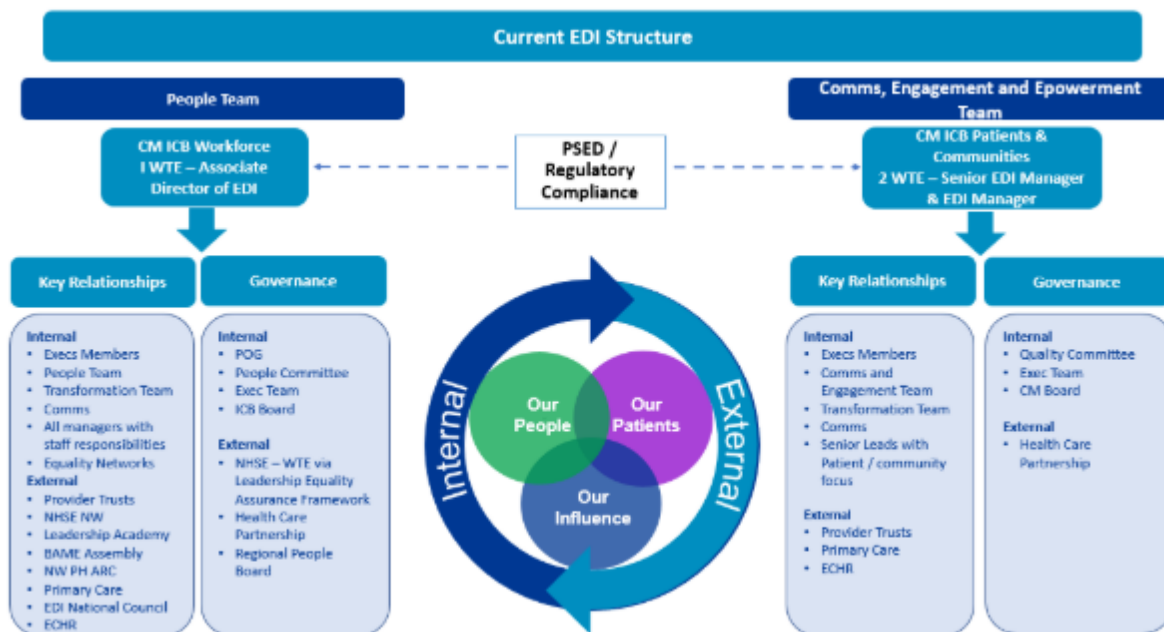
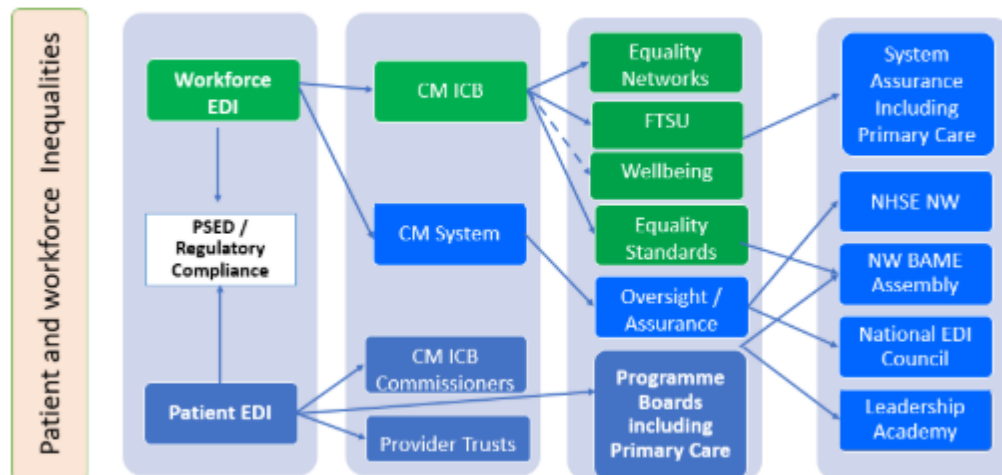
Governance and Management Arrangements

NHS C&M has a responsibility for paying 'due regard' to the Public Sector Equality Duty (Section 149, Equality Act 2010) and for all mandated regulatory Equality Diversity and Inclusion (EDI) requirements. The board provides visible leadership to advance equality of opportunity across NHS C&M and wider system and lead the ICB to become a more inclusive employer.

Strategic EDI leadership currently sits within the Central NHS C&M Director and Senior Leadership Structures. Mike Gibney is the Chief People Officer and Clare Watson is Assistant Chief Executive.

The Chief People Officer is the Senior Responsible Officer for EDI, Workforce and Organisational Development at Board level and the Senior Responsible Officer for EDI from a patient and commissioning perspective is the Assistant Chief Executive Officer. Below is a diagram of our EDI Governance structure and EDI structure.

Improving Inclusion and Belonging



Health Equality for Cheshire and Merseyside

All Together Fairer brings, together public, private and third sector organisations with one shared aim: build a fairer, healthier Cheshire and Merseyside. This work is being coordinated by the Cheshire and Merseyside Health and Care Partnership's

Population Health Board, which is currently chaired by Ian Ashworth, Director of Population Health for NHS Cheshire and Merseyside.

In 2021 the Institute of Health Equity (IHE) was commissioned by the Population Health Board of the Cheshire and Merseyside Health and Care Partnership (HCP) to support work to reduce health inequalities in the region through action on the social determinants of health and to build back fairer from COVID-19.

The recommendations made in the report cover the key social determinants of health – the eight Marmot principles and seven actions across for the Cheshire and Merseyside stakeholders and system. The recommendations are classified in two categories: Year 1 (2022-23) and Years 2-5 (2023-27) and they challenge the region to take actions on the social determinants of health, develop a regional system to take forward these actions and develop a healthier and more equitable region.

Overall, a third (33 percent) of Cheshire and Merseyside population live in the most deprived 20 percent of neighbourhoods in England, with significant negative implications for health.

Austerity policies from 2010-20 in England have had substantial impacts on services offered and subsequently on health and inequalities. Across England, life expectancy for the most deprived areas outside London declined, even before the pandemic and this is likely a direct result of cuts to public services and local government, reductions in benefits and low-quality work and low pay. Within Cheshire and Merseyside life expectancy is generally below the average for England, except in Cheshire West and Chester and Cheshire East.

The COVID-19 mortality rate in Cheshire and Merseyside has been high (5 percent higher than the England and Wales average between March 2020 and April 2021) and the pandemic has exposed and amplified inequalities.

Social Determinants of Health

Health is largely shaped by the social, economic, and environmental conditions in which people are born, grow, live, work and age known as the social determinants of health. The social determinants of health are encompassed by the **Marmot 8 principles**.

Marmot Principles

- ❖ Give every child the best start in life.

- ❖ Enable all children, young people, and adults to maximise their capabilities and have control over their lives.
- ❖ Create fair employment and good work for all.
- ❖ Ensure a healthy standard of living for all.
- ❖ Create and develop healthy and sustainable places and communities.
- ❖ Strengthen the role and impact of ill-health prevention.
- ❖ Tackle racism, discrimination, and their outcomes.
- ❖ Pursue environmental sustainability and health equity together.

“Shifting to a social determinants of health approach means acting in the drivers of ill health as well as treating ill health when it is presented in healthcare settings: the prevention agenda must focus on improving living and working conditions and reducing poverty – as well as focussing on healthy behaviours. As set out in the report, it is almost impossible to live healthily when in poverty.”

22 indicators, aligned with the 8 Marmot themes, covering areas which are considered critical in reducing health inequalities have been recommended. The social determinants indicator set was co-created with Cheshire and Merseyside and will be monitored by the Combined Intelligence for Population Health Action (CIPHA) programme.

- The full report can be found here [Cheshire-and-Merseyside-report_interactive-v6.pdf](https://cheshire-and-merseyside-report.interactive-v6.pdf) (champspublichealth.com)

The 22 Beacon indicators agreed, are embedded within the Cheshire and Merseyside Health and Care Partnership (ICP) interim strategy. This strategy sets out how the challenges will be addressed, and outcomes monitored. Tackling Health Inequalities in outcomes, experiences, and access (our eight Marmot principles) is one of the strategic objectives of the plan.

Health Inequalities

Our Clinical Care Constitution

Our Clinical and Care Constitution



Our Clinical and Care Constitution is a set of principles that underpin all we do. It has been written by clinicians with input from clinical and care colleagues to support the Cheshire and Merseyside Integrated Care System (ICS) to develop with our partners an overarching population health approach, driven by the needs of our communities, with a clear focus on addressing health inequalities.

- We will:**
- ✓ Shift the paradigm from reactive to proactive healthcare
 - ✓ Integrate clinical and care professionals to decision-making at every level of the ICS, creating a culture of shared learning, collaboration and innovation, working alongside patients and local communities
 - ✓ Evidence the return on investment in improving health through measures of both quality and effectiveness
 - ✓ Influence the wider determinants of health through collaboration, education and modernisation

Our 4 pledges:

Quality

Delivering high quality resilient services through an evidence-based approach

- All clinical recommendations will be evidence-based.
- We will make consistent use of intelligence to drive and evidence the impact of action.
- Where there are multiple demands, prioritisation will be via a robust clinically led methodology based on the principle of proportionate universalism (Marmot Review 2010, 2020).
- We will routinely contribute to the evidence base via high quality research.

© The Marmot Review: Leaders' Strategy Review of health inequalities in England 2010-2020

Collaboration

Working collaboratively with resilient patient focus

- Collaboration is at the heart of our mission.
- The primary responsibility of our workforce will be to deliver the best for all our patients.
- Through resilient patient focus we will drive our vision.
- We will encourage and promote to support our shared goals.
- We will use co-production with patients and the public to develop our plans.
- Where we deliver best outcomes in our role, we will share the success with our partners and the population they represent.

Health

Improving health outcomes

- The wider determinants of health will be considered in all our programmes and we will promote collaboration with our local authorities.
- Our efforts will improve health, not simply respond to sickness.
- Prevention is better than cure.
- Our resources will be shared equitably and be accessible to their services.
- We will train, develop and support our workforce to deliver the highest quality care and services.
- We will support all of our organisations, in every sector, to be safe, effective, caring, responsive and well-led.

Value

Transformation for value

- All patients and partners must be heard, that must be based on health inequalities.
- We will use a proportionate universalism approach.
- We will integrate clinical services and support to making difference in our services, that change with value.
- We will ensure a strong clinical focus.
- We will work with our partners, locally, nationally and internationally, to ensure we are making the most use of resources.

Enablers:

- Wide engagement across health, social care and the voluntary, community, faith and social enterprise sector
- Clinical strategy informed by the richest intelligence and supported by QI methodology
- World-class research and innovation in partnership with our academic institutions
- Clinical and care professional leadership framework with a focus on workforce development

Quality

Pledge 1: Quality

Designing and delivering high quality resilient services through an evidence based approach

- all clinical recommendations will be evidence-based.
- we will make consistent use of intelligence to drive and evidence the impact of action.
- where there are multiple demands, prioritisation will be via a robust clinically led methodology based on the principle of proportionate universalism (Marmot Review 2010, 2020).
- we will routinely contribute to the evidence base via high quality research.

Collaboration

Pledge 2: Collaboration

Working collaboratively with relentless patient focus

- collaboration not competition informs all our endeavours.
- the primary/secondary care interface will be actively considered in all our programmes.
- through relentless patient focus we will eliminate silo working.
- we will empower our population to support our shared goals.
- we will use co-production with patients and the public to develop our plans.
- where we agree new approaches in any one part of our system, we will ensure that there is no detrimental impact on other stakeholders and the population they represent.

Health

Pledge 3: Health

Improving health outcomes

- the wider determinants of health will be considered in all our programmes and promote collaboration with local authorities.
- our efforts will improve health not simply respond to sickness. Prevention is better than cure.
- our population will be offered equitable and fair access to services.
- we will train, develop, and support our workforce to deliver the highest quality care and services.
- we will support all of our organisations in every sector to be safe, effective, caring, responsive and well led.

Value

Pledge 4: Value

Transformation for value

- all projects and schemes must evidence their positive impact on health inequalities.
- we will use consistent improvement methodology.
- as an integrated system we are all committed to working differently when assured that change adds value to the health and wellbeing of our communities.
- all our work will improve quality effectiveness and patient experience whilst ensuring best use of resources.

Tackling Race Discrimination

Ethnic minority groups often experience worse outcomes in the social determinants of health, such as income, quality of employment and housing conditions – this relates to experiences of discrimination and exclusion. Ethnic minority populations are more likely to report being in poor health and have poor experiences using health services than the White British population. The COVID-19 pandemic has revealed the stark inequalities in health and economic and social inequalities for many of the UK's ethnic minority communities. (All Together Fairer¹). Despite years of trying to address issues of racism in the NHS, there has only been a limited amount of success. We have seen many short-lived race equality initiatives designed to improve outcomes but unfortunately, with no long-lasting or significant effect. Strategies are often defeated by deep-rooted cultural norms.

There is no substantial evidence that any singular intervention will make a significant difference.

We understand that this lack of progress is complex and that this is an uncomfortable issue. To address the structural racism, we must all:

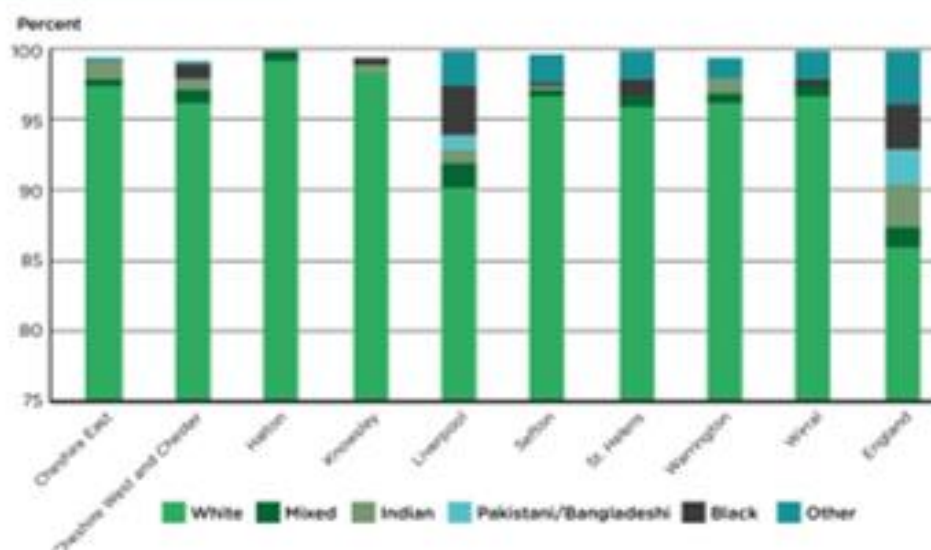
- Acknowledge the problem and take this seriously through demonstrable action.
- Improve our understanding of the depth and complexity of the issue.
- Ensure that commitment is followed up with positive and targeted action.
- Be prepared to be held accountable and hold others to account.
- Be prepared to face the consequence of our behaviour is unacceptable and causing harm to others.
- Create equality of opportunity for under-represented groups if in a position of power and privilege.

Centuries of racial discrimination have hard-wired inequality into our institutions and people's ways of thinking. These inequalities have ensured that White people get better chances in life. These issues are complex, and a sustainable strategy should be based on educating, supporting and challenging. (NHSE- Tackling racism and other types of discrimination²).

Approach of the NHSC&M

- To demonstrate this commitment to eliminating structures that support discriminatory practices and thereby improve health inequalities, Cheshire and Merseyside ICB has approved the ***implementation of the Northwest BAME Assembly's Anti-Racism Framework***³. The Framework is a tool designed to support NHS organisations to become intentionally anti racist by tackling structural racism and discrimination through collaboration, reflective practice, and accountability. It recognises that this intention requires committing to undertaking a journey that involves the continuous review of progress and being intentional about actions for change. The NHSC&M Associate Director of EDI will facilitate a Primary Care Group to support the implementation of the framework.
- Another key issue to resolve is the need for comprehensive, good-quality data which is essential for enabling policymakers and health care professionals to identify the specific needs of different ethnic groups, respond with tailored strategies for addressing inequalities, discrimination and track the impact of these strategies.

Figure 4.46. Ethnicity as percentage of population, Cheshire and Merseyside lower-tier local authorities and England, year ending September 2021



Source: Office for National Statistics (ONS)

Women's Health

Women's Health Strategy

The Cheshire and Merseyside Women's Health and Maternity Programme has facilitated the Cheshire and Merseyside Women's Health Strategy, in response to the government's first [Women's Health Strategy for England](#)⁶– August 2022.

While women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men. And while women make up 51% of the population, historically the health and care system has been designed by men for men.

This 'male as default' approach has been seen in:

- research and clinical trials
- education and training for healthcare professionals
- the design of healthcare policies and services

Currently, Gynaecology services have the longest waiting times in across C&M. There are currently 4 Special Interest Groups (SIG) set up to tackle some of the greatest needs within C&M.

- Menopause
- Cytology

- Endometriosis
- Paediatric and adolescent Gynaecology

Maternity

The Cheshire and Merseyside Women's Health and Maternity Programme (WHaM) facilitates the Cheshire and Merseyside Local Maternity and Neonatal System. The Equity & Equality Action Plan ⁴(EEAP) has been developed to improve equity for mothers, birthing people, and their babies and embed race equality for NHS staff in Maternity and Neonatal settings. The EEAP contains the detail to specifically address the following requirements:

Priority 4. Accelerate preventative programmes that engage those at greatest risk of poor health outcomes.

- a Understand your population & co-produce interventions.
- b Action on maternal mortality, morbidity, and experience
- c Action on perinatal mortality and morbidity
- d Support for maternity and neonatal staff
- e Enablers

The COVID-19 pandemic highlighted the urgency of the need to prevent and manage ill health in groups that experience health inequalities, which was also outlined within the NHS Long Term Plan. To help achieve this, NHS England and NHS Improvement issued guidance as part of their phase 3 response to the Covid-19 pandemic, setting out eight urgent actions for tackling health inequalities. The 2024 priorities and operational planning guidance⁵: Implementation guidance asked systems to focus on five priority areas, distilled from the original eight actions:

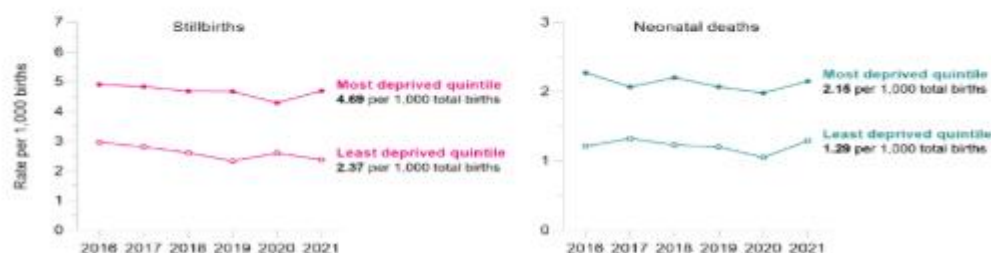
C&M LMNS & WHaM already have many programmes in place to reduce variation by tackling health inequalities which includes the NHS CORE20PLUS5 priority clinical areas. We have listened to women, birthing people, their families, carers (including unpaid) maternity, and neonatal staff with the aim to use the feedback and information to plan co-produced activity to design interventions which transform and:

- Improve equity and reduce health inequalities for mothers and babies from Black, Asian, Minority Ethnicity, Socially Deprived and Protected Characteristic Groups.
- Support the embedding of race equality for Maternity & Neonatal staff across C&M LMNS.

The EEAP specifically focuses on the C&M LMNS Equity & Equality Analysis (EEA) findings and the ["All Together Fairer" Working as one to build a fairer, healthier Cheshire and Merseyside #AllTogetherFairerCM Strategy.](#)

i There was a widening of inequalities in stillbirth rates by deprivation between 2020 and 2021.

Figure 4: Stillbirth and neonatal mortality rates by mothers' socio-economic deprivation quintile of residence: United Kingdom, for births in 2016 to 2021



Children and Young Peoples Mental Health Services

NHS Cheshire and Merseyside has published its [Children and Young People's Mental Health Plan for 2024-26](#).

You can read the plan in full or the easy read version [here](#).

<https://www.cheshireandmerseyside.nhs.uk/media/auyfwlcu/4311-nhs-cheshire-merseyside-cyp-mental-health-plan-easy-read-v5.pdf>

We have also developed a Three-year plan for *Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme*. This was published in September 2024.



This plan sets out how inpatient services better fit the needs of Cheshire and Merseyside residents, while making better use of available funds.

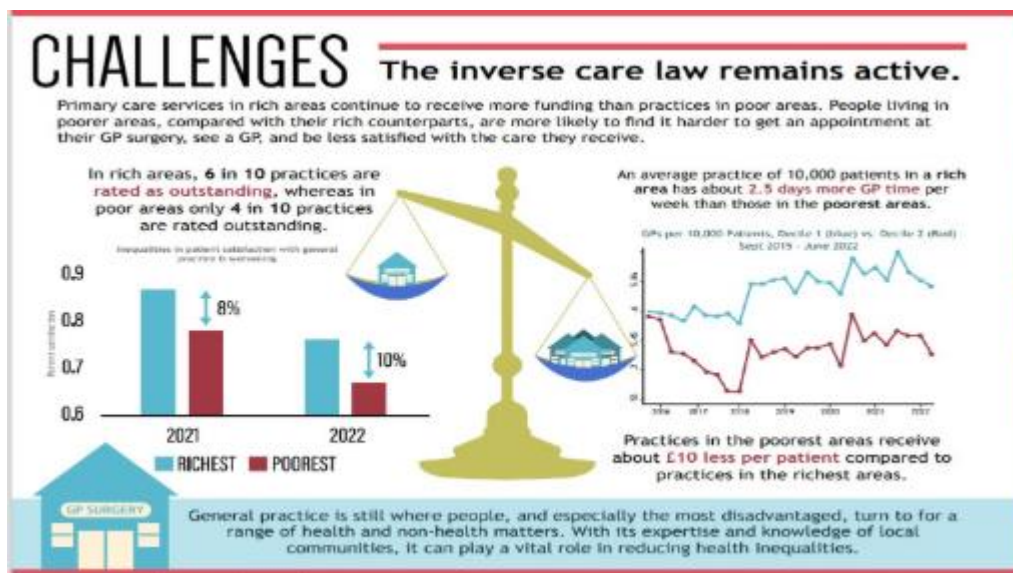
Coproduced with key stakeholders, the plan focuses on three key areas:

1. **A good quality inpatient offer** - ensuring that someone is admitted to hospital only when they need it and that their carers and families are fully involved in shared decision-making and co-produced care planning.
2. **Flow through inpatient services** - ensuring that people are able to access the right care, support and intervention for their needs quickly and in the right place.
3. **Community alternatives** - continued development and collaboration to provide strong community alternatives to inpatient services so people can spend more time at home and in their communities.

Read the plan in full [on our website](#).

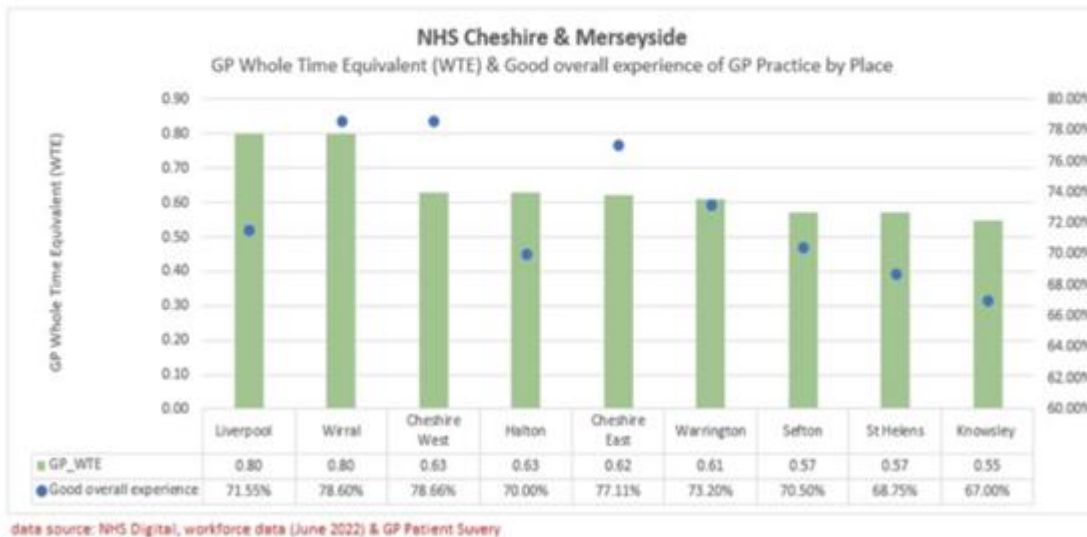
[Three-year plan for Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme published - NHS Cheshire and Merseyside](#)

Supporting Primary Care in areas of high deprivation and inverse care.



GP practices in more deprived areas of England are relatively underfunded, under-doctored, and perform less well on a range of quality indicators compared with practices in wealthier areas.

GP Workforce

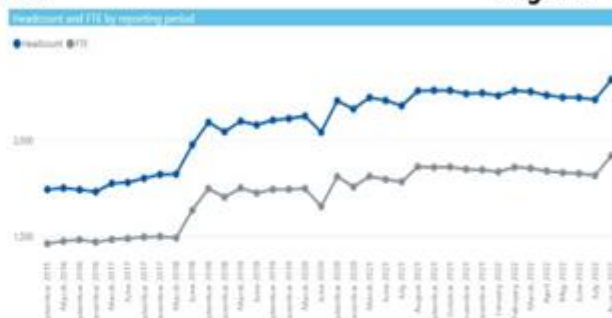


Cheshire and Merseyside General Practice Workforce Doctors

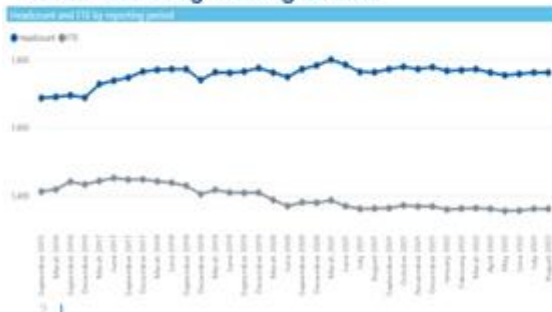
Overall headcount increase may plateau as trainee allocation achieved.
Limited growth seen when excluding training grades.
Wirral has the highest GP/100k patients in C&M
Knowsley has the lowest GP/100k patients in C&M

ICB Name	Fellowship				Mentors Trained Mentors
	GPs year 1	GP year 2	Nurses year 1	Nurse year 2	
NHS Cheshire And Merseyside ICB	32	9	3	0	19

All GP



All GP Excluding Training Grades



All GPs (including GPs in Training Grades) FTE	Comparison to Baseline (Mar 19)				Comparison to Target (Mar 24)			
	Latest Mar Aug 22	Latest Mar 19 Baseline	Trend from Mar 19 Baseline	% Difference	Target* 2023/24	Variation from target against Aug 22	Movement towards target	% Difference
NHS Cheshire and Merseyside ICB - 270 Cheshire	535	480	55	11.3%	557	-22	+	-4.0%
NHS Cheshire and Merseyside ICB - 017 Halton	81	81	0	12.0%	94	-13	+	-5.8%
NHS Cheshire and Merseyside ICB - 011 Knowsley	103	82	21	25.7%	99	4	+	4.2%
NHS Cheshire and Merseyside ICB - 004 Liverpool	448	420	28	6.4%	475	-27	+	-5.6%
NHS Cheshire and Merseyside ICB - 017 South Sefton	98	100	-2	-2.0%	118	-20	+	-15.2%
NHS Cheshire and Merseyside ICB - 019 South Wirral and Knowsley	76	82	-6	-7.3%	95	-18	+	-18.4%
NHS Cheshire and Merseyside ICB - 017 St Helens	127	120	7	5.7%	140	-13	+	-9.3%
NHS Cheshire and Merseyside ICB - 017 Warrington	128	120	8	6.4%	157	-29	+	-18.5%
NHS Cheshire and Merseyside ICB - 017 Wirral	203	201	2	1.0%	208	-5	+	-2.4%
Cheshire & Merseyside	3,819	3,700	119	3.2%	4,021	-202	+	-5.0%
England	37,085	36,736	349	0.9%	40,736	-3,651	+	-9.0%

GP practices serving more populations in areas of high deprivation receive around 7% less funding per patient than those serving more affluent populations, NHSC&M will work with PCNs to make GP access equitable and specifically target areas where general practice is either under the greatest pressure and of poorest quality.

General practice should be funded using proportionate universalism whereby all universal services are adequately resourced, and additional funding is provided to areas where the degree of need is higher.

NHSC&M have also started to develop a programme of Deep End General Practices, whereby primary care staff who work in practices in the most socioeconomically deprived areas of Cheshire and Merseyside seek to collaborate and make positive changes to tackle localised health inequalities for their patients and communities.

NHSC&M Considerations

- NHS C&M must maintain a system wide view of GP services and work with PCN's to make access equitable where there is the greatest need, pressure, and poorest quality.
- NHSC&M must maintain a system wide/ helicopter view on the cumulative impact of GP closures (including branch closures) in areas in the greatest priority need.
- NHSC&M to consider resource allocation in the areas of greatest priority need.

NHSC&M have also started to develop a programme of Deep End General Practices, whereby primary care staff who work in practices in the most socioeconomically deprived areas of Cheshire and Merseyside seek to collaborate and make positive changes to tackle localised health inequalities for their patients and communities.

Commissioning Health Care Services

NHS C&M works with our partners and the people of Cheshire and Merseyside to commission services and improve the health and wellbeing of the people and communities across the sub region. The programmes are being developed and will to be based on evidence about the population, with a focus on health needs and inequalities. These include:

- Population Health Management data
- CIPHER Medical
- Qualitative feedback – Friends & Family surveys, GP surveys, CQC feedback
- Ward level public health profiles
- Delivery of the NHS Long Term Plan

- Delivering safe, high-quality services
- Building relationships with communities
- Acting on health inequalities and the local strategy for health and wellbeing
- Quality intelligence
- CHAMPs intelligence and evidence findings and recommendations
- Fairer together

We commission 17 organisations across the region to deliver healthcare services to the people of Cheshire and Merseyside. As part of our Equality, Diversity and Inclusion function, we ensure that all the provider Trusts have EDI firmly embedded into their services and workforce, and that people receive fair and equitable access to health care provision.

The NHS Cheshire and Merseyside ICB are responsible for commissioning or “buying” health and care services for the people of Cheshire and Merseyside, using our budgets to ensure high-quality, sustainable healthcare for our patient population of 2.7 million people.

Each ICB has mechanisms in place to ensure that their main provider organisations comply with their equality duties. The ICBs work in partnership with the main provider organisations to include equality, diversity and human rights clauses within its contracts. The ICBs Quality and Performance Teams regularly review their main providers’ patient experience and staff engagement along with analysing that the main providers are meeting their Key Performance Indicators (KPIs).

1. NHS Standard Contract requirements

The NHS Standard Contract prohibits discrimination based on the nine protected characteristics set out in the Equality Act (2010) – this is a mutual obligation on both the commissioner and the provider.

Service Condition 13 of the NHS Standard Contract 2022/2023 relates specifically to ‘Equality of Access, Equality and Non-discrimination’ and states:

- **13.1** – The Parties must not discriminate between or against Service Users, Carers or Legal Guardians on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation, or any other non-medical characteristics, except as permitted by law

- **13.2** – The Provider must provide appropriate assistance and make reasonable adjustments for Service Users, Carers and Legal Guardians who do not speak, read or write English or who have communication difficulties (including hearing, oral or learning impairments). The Provider must carry out an annual audit of its compliance with this obligation and must demonstrate at Review Meetings the extent to which service improvements have been made as a result
- **13.3** – In performing its obligations under this Contract, the Provider must comply with the obligations contained in Section 149 of the Equality Act (2010), the Equality Act 2010 (Specific Duties) Regulations and Section 6 of the Human Rights Act. If the Provider is not a public authority for the purposes of those sections, it must comply with them as if it were
- **13.4** – In consultation with the Co-ordinating Commissioner, and on reasonable request, the Provider must provide a plan setting out how it will comply with its obligations under SC13.3. If the Provider has already produced such a plan to comply with the Law, the Provider may submit that plan to the Co-ordinating Commissioner to comply with this SC13.4.
- **13.5** – The Provider must implement EDS2 (NHS Trust/FT only)
- **13.6** – The Provider must implement and comply with the National Workforce Race Equality Standard and submit an annual report to the Co-ordinating Commissioner on its compliance.
- **13.7** – The Provider must ensure that it has in place effective procedures intended to prevent unlawful discrimination in the recruitment and promotion of Staff and must publish:
 - 13.7.1** - a five-year action plan, showing how it will ensure that the black, Asian and minority ethnic representation a) among its Staff at Agenda for Change Band 8a and above and b) on its Governing Body will, by the end of that period, reflect the black, Asian and minority ethnic representation in its workforce, or in its local community, whichever is the higher; and

13.7.2 - regular reports on its progress in implementing that action plan and in achieving its bespoke targets for black, Asian and ethnic minority representation amongst its Staff, as described in the NHS Model Employer Strategy (NHS Trust / FT only)

- **13.8** – The Provider must implement and comply with the National Workforce Disability Equality Standard and submit an annual report to the Co-ordinating Commissioner on its compliance. (NHS Trust/FT only)
- **13.9** – In performing its obligations under this Contract, the Provider must use all reasonable endeavours to:

13.9.1 - support the Commissioners in carrying out their duties under the 2012 Act in respect of the reduction of inequalities in access to health services and in the outcomes achieved from the delivery of health services; and

13.9.2 - implement any Health Inequalities Action Plan.

- **13.10** – The Provider must nominate a Health Inequalities Lead and ensure that the Coordinating Commissioner is kept informed at all times of the person holding this position. (NHS Trust / FT only)

2. Main Provider Compliance – Assurance

The Equality and Inclusion Team conduct a desktop provider compliance check of commissioned service provider websites on the following equality-related legal duties and NHS equality mandated standards:

- Equality Objectives published on the provider's website (reviewed every 4 years)
- Equality Strategy
- Published Equality information – e.g., equality compliance annual report
- Equality Delivery System grading and report (on an annual basis)
- Workforce Race Equality Standard report (on an annual basis)
- Workforce Disability Standard report (on an annual basis)
- Accessible Information Standard compliance information

- Modern Slavery Act 2015 Statement on website (for providers of £36 million and over – on an annual basis)

The table below shows equality compliance analyses carried out in April 2024 for the following providers:

- Alder Hey Children's NHS Foundation Trust
- Bridgewater Community Healthcare NHS Foundation Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Clatterbridge Cancer Centre NHS Foundation Trust
- Countess of Chester NHS Foundation Trust
- East Cheshire NHS Trust
- Liverpool Heart and Chest NHS Foundation Trust
- Liverpool University Hospital NHS Foundation Trust
- Liverpool Women's Hospital NHS Foundation Trust
- Mersey Care NHS Foundation Trust
- Mid Cheshire Hospital NHS Foundation Trust
- Northwest Ambulance Service NHS Trust
- Mersey and West Lancashire Teaching Hospitals NHS Trust
- The Walton Centre NHS Foundation Trust
- Warrington and Halton Hospitals NHS Foundation Trust
- Wirral Community Health and Care NHS Foundation Trust
- Wirral University Teaching Hospitals NHS Foundation Trust

Commissioned provider	Annual Report	Equality objectives	EDS	WRES	WDES	AIS	Modern Slavery Statement
Alder Hey CFT		Strategy 22-27	2022	2024	2024	Accessibility statement	In place
Bridgewater CHC NHS FT	2025	Objectives 24-26 / strategy 24-27	2024	2024	2024	Accessibility statement	In place
CWP NHS FT	2024	Update in reporting	2022	2024	2024	Updated 2024	In place
Clatterbridge CC NHS FT	2022-23	Strategic Plan	2022	2024	2024	Accessibility statement	In place

C of Ch NHS FT	2023 24	In place until 2026	2024	2024	2024	Accessibility statement	In place
East Cheshire NHS Trust	24-25 in progress	24-25 in progress	2024	23-24	23-24	Accessibility Statement and information	In place
Liverpool Heart and Chest NHS FT	2024	EDIB Strategy 22 - 25	Published 2024	2024	2024	Accessibility Statement	In place
Liverpool University Hospital NHS FT	2024	2024	2024	2024	2024	Accessibility Statement	In place
Liverpool Women's Hospital NHS FT	2024	23-27	2024	2024	2024	Accessibility Statement	In place
Mersey Care NHS FT	24-25	In place	2024	2024	2024	Accessibility Statement	In place
Mid Cheshire Hospital NHS FT	2024	In place	24-25	2024	2024	AIS statement in place	In place
Northwest Ambulance Service NHS Trust	23-24	In place	2025	2024	2024	Accessibility Statement	In place
Mersey and West Lancashire Teaching Hospitals Trust	24-25	Strategy 22-25	2024	24-25	24-25	Accessibility Statement / Accessible website functions	In place

The Walton Centre NHS Trust	2024	2024	2024	2024	2024	Accessible Information policy	In place
Warrington and Halton Hospitals NHS FT	24-25	Strategy and objectives to 2026	24-25	24-25	24-25	AIS page and resources	In place
Wirral Community Health and Care NHS FT	23-24	Strategy and objectives 22-27	24-25	24-25	24-25	Statement and action plan	In place
Wirral University Teaching Hospitals NHS FT	2024	2024	2024	2024	2024	Web page available	In place

Procurement

In addition to monitoring EDI compliance, our EDI team assist in the procurement of health services by evaluating questions asked of organisations in our tender processes. Questions are asked in relation to equality and diversity, social value and compliance with the Equality Act and the Public Sector Equality Duty. Our Invitation to Tender process is robust and thorough. Once contracted all our commissioned services provide the EDI team with quarterly updates and are supported to develop progress.

Equality Delivery System (EDS)

NHS Cheshire and Merseyside will continue to drive forward our Equality Objectives and all the aspects outlined within this report. We will support the development of our staff groups ensuring that they are listened to and are involved in policy development and decision making.

We will support our commissioned services to fully implement the Public Sector Equality Duty and to progress with the Equality Delivery System. Patients and our workforce will remain our priority in delivering effective, efficient, and equitable services. Health inequalities will continue to be addressed and monitored across the

region. Our Equality Objectives will underpin the values of the organisation as we continue to improve equality, diversity, and inclusion.

Each provider was required to let the ICB know their grade, or if they wouldn't grade this year. At the time of writing, only one provider is in the process of obtaining their final grades and when those results are known, they will be shared in the ICB.

Equality Delivery System 2022 (EDS 2022)

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

The EDS provides a focus for organisations to assess the physical impact of discrimination, stress, and inequality, providing an opportunity for organisations to support a healthier and happier workforce, which will in turn increase the quality of care provided for patients and service users. EDS 2022 comprises eleven outcomes spread across three domains, which are:

Domain 1: Commissioned or provided services

- 1A:** Service users have required levels of access to the service
- 1B:** Individual service user's health needs are met
- 1C:** When service users use the service, they are free from harm
- 1D:** Service users report positive experiences of the service

Domain 2: Workforce health and wellbeing

- 2A:** When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions (response to Covid-19)
- 2B:** When at work, staff are free from abuse, harassment, bullying and physical violence from any source
- 2C:** Staff have access to support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source (response to Covid-19)
- 2D:** Staff recommend the organisation as a place to work and receive treatment

Domain 3: Inclusive leadership

- 3A:** Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities
- 3B:** Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed
- 3C:** Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients (response to Covid-19).

The outcomes are evaluated, scored, and rated using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement. Scoring in conjunction with key stakeholders to determine if the organisation is graded as:

- Underdeveloped
- Developing
- Achieving
- Excelling

The completion of the EDS, and the creation of interventions and actions plans in response to the EDS findings, can contribute to NHS system and provider organisations achieving delivery on the Core20Plus5 approach and Health Inequalities priorities.

Domain One implementation

NHS C&M and the 16 NHS Provider Trusts implemented EDS 2022 for 2022/25. For domain 1, the ICB asked each trust equality / patient experience lead to liaise with executive colleagues of their respective organisation to identify services to review. Trusts selected the following services.

NHSC&M ratings for domain 1 is **Achieving** across each outcome. This is the Mean rating, as taken from the all the sixteen NHS Provider trust's individual service review ratings.

Cheshire & Merseyside NHS Provider Trusts	Domain One EDS grades 24/25
Countess of Chester Hospital NHS Foundation Trust	Score 8. Achieving

East Cheshire NHS Trust	Score 8 Achieving
Liverpool University Hospitals NHS Foundation Trust	Score 5 Developing
Liverpool Women's NHS Foundation Trust:	Score 7 Achieving
Mid Cheshire Hospitals NHS Foundation Trust:	Score 10 Excelling/Achieving
Mersey and West Lancashire Teaching Hospitals NHS Trust:	Score 9. Achieving
Warrington and Halton Hospitals NHS Foundation Trust:	Score 8 Achieving
Wirral University Teaching Hospital NHS Foundation Trust:	Score 8 Achieving
Mersey Care NHS Foundation Trust:	Score 8 Achieving
Bridgewater Community Healthcare NHS Trust:	Score 6 Developing
Wirral Community NHS Foundation Trust:	Score 10 Excelling / Achieving
Alder Hey Children's Hospitals NHS Foundation Trust	Score 8 Achieving
Liverpool Heart and Chest NHS Foundation Trust	Score 8 Achieving
The Clatterbridge Cancer Centre NHS Foundation Trust	Score 8 Achieving
The Walton Centre NHS Foundation Trust	Score 8 Achieving
Cheshire and Wirral Partnership FT	Score 8 Achieving
Total Mean C&M ICB	Score 7.9 Achieving

EDS 2022 and compliance monitoring with Equality Act 2010 are monitored via the quality contract for quarters two and four. As well as submitting evidence, the ICB undertakes an audit of compliance of NHS Provider Trusts, across a range of statutory and regulatory requirements.

EDI Campaigns

Working as part of a Communications team, a campaigns group was established in 2024. We moved away from monthly briefing to create a comprehensive annual EDI calendar which highlights all key events, awareness days, religious holidays and health initiatives. Key campaigns over the past year have been International Women's Day, LGBT History month, Carers Week and other items including, Mental Health Awareness campaigns, religious festivals, Disability campaigns and anti-racism initiatives. Below is an example of EDI Campaigns work.

Case Study Equality, Diversity and Inclusion Campaign

Introduction

Recognising the diversity of our staff, we have continued to support several Staff Networks to provide a safe space for our staff, raise awareness of issues within the wider ICB and provide a support for staff who may be facing challenges. We had seven staff networks established by April 2024, these were Menopause, working carers, Race Equality Network, LGBTQI+, early careers, disability and neurodiverse and armed forces family support network.

Background:

Practical examples supporting us in hearing the voice of our diverse staff and improving staff experience are below:

- Defence Employer Recognition Scheme (ERS) – NHS Cheshire and Merseyside is one of only three ICBs in the country to have received the silver accreditation status under the Defence Employer Recognition Scheme. The ERS recognises the commitment and support from UK employers for defence personnel. In gaining the silver accreditation the ICB has demonstrated they have adjusted corporate policies and workplace culture to ensure our Armed Forces community, and their

families are supported and not disadvantaged. The ICB have now committed to Step into Health to ensure our recruitment processes are fair and armed forces candidates are not disadvantaged.

- Celebrating our diverse staff – we have produced an animation, using our staff network representatives, to highlight the importance of staff reporting their demographics on ESR so we have a better understanding of our workforce. Our networks have also supported all staff events during LGBT History Month to celebrate our workforce and discuss challenges and support available. The Disability and Neurodiverse network held an all-staff event with an external speaker discussing the challenges that staff face with ADHD and the support that is available.

The EDI Collaborative Forum

The collaborative (formally known as the Patient Equality Focused Forum) is made up of equality leads, patient experience and other key officers from across the healthcare system. This group works collaboratively to share best practice, identify issues to collaborate on, and provide recommended actions to their respective organisations to advance equality of opportunity and support NHS C&M to address health inequalities and barriers in accessing healthcare services to improve patient journey and experience.

Equality Impact Assessments

The ICB carries out Equality and Health Inequality Risk and Impact Assessments on all service changes and improvements, restructures, workforce and clinical policies, and strategies. The EDI officers complete and review these assessments and offer advice and support across the organisation to ensure these are of a high standard and fit for purpose. Over the past year, we have carried out over 100 EIAs including Human Resource policies, clinical policies, Financial Recovery Programme Initiatives and changes to services. Many of the clinical policies underwent public consultation and we use this information to inform the EIAs, which, in turn, inform our decision-making processes. Furthermore, our EIA process will be reviewed and strengthened this year to support our robust commissioning role. Our EDI team coach and support staff in completing thorough Impact Assessments and offer training. EIAs are scrutinised by our governance groups and assist the Board in decision making ensuring that the Public Sector Equality Duty is adhered to and that protected groups are duly considered. Our staff groups are consulted with and feedback from public consultation is also considered.

Policy Harmonisation Work

Clinical Policies (Improving Access and Patient Outcomes)

Harmonisation of Clinical Policies and Human Resources Policies

In 2022 9 NHS Clinical Commissioning Groups (CCGs) joined together to form Cheshire and Merseyside Integrated Care Board. It was identified that there were disparities in many of the clinical policies governing health care across the region. This meant that people living in different areas could be subject to variation in treatment. Some of the policies contained criteria that was inconsistent across Cheshire and Merseyside and could potentially cause inequalities in application. The ICB determined that the harmonisation of clinical policies was a priority in addressing inequality in access to services and patient outcomes. In light of the variation between existing policies, and in some cases the age of the existing policies, it was essential that any single suite of harmonised clinical commissioning policies for C&M reflects and is based on up-to-date clinical practice and research, but also takes into account the current commissioning landscape, legislation, equality, diversity and inclusion, the changing needs of the C&M population and the duties on the ICB to ensure that health care services are available to meet the reasonable needs of the population.

A policy harmonisation working group was established, governed by a Policy Harmonisation Steering Group. The Steering Group was established with Terms of Reference and included Clinicians, policy development officers, Communication and Engagement Leads and Equality and Inclusion officers.

Over the period 24-25, we continued to harmonise and improve these policies in line with the most up to date clinical evidence and guidance. We have ensured that policies are in line with NICE guidance. NICE is the National Institute for Health and Care Excellence. NICE guidance is evidence-based recommendations for the health and social care sector, developed by independent committees including professionals and lay members, and consulted on by stakeholders, helping practitioners and commissioners get the best care to patients.

Our EDI team carried out these Equality and Healthy Inequality Impact and Risk Assessments. The EHIRAs are an important part of the process as they inform the policy development work, ensuring that due regard and consideration has taken place when developing the policies and making decisions. The EHIRAs also ensure that the Public Sector Equality Duty (PSED), Equality Act 2010, and the Human Rights Act 1998 have all been considered. The assessments also inform the Communication and Engagement planning, helping to identify which groups of patients / potential patients and organisations should be prioritised in consultation

and engagement work. 35 clinical policies went out for public consultation. This task is now complete, and we will take on board all the feedback received.

In addition to the suit of 35 clinical policies we carried out an in-depth engagement exercise to gain feedback on the review of our Gluten Free Prescribing policy. We ensured that relevant and specific groups were informed of the proposed changes, including Coeliac UK. The feedback is being considered as part of our review of the policy.

Individual Funding Requests (IFR)

Individual Funding Request Panel

Individual Funding Requests (IFR) are made by GPs on behalf of patients in cases where additional funding may be required for an additional element to health care. These may include physical adaptations or aids, communication aids or further courses of clinical treatment. An Equality and Inclusion officer participates in the panel meetings and gives advice on cases whereby the Public Sector Equality Duty may be applicable. This process ensures that any individual case that is exceptional or unusual is duly considered and that decisions consider equality and inclusion and reasonable adjustments.

Accessible Information Standard (AIS)

The AIS Partnership Group

The AIS Partnership was established, and it is still developing in several ways. The Terms of Reference are draft; however, I am happy to share the essence of them as they outline our direction. The membership is also developing as there is an ambition to involve more partners across the footprint of the ICB from a 'Place' level. We also need to identify resources to drive forward the development of the group.

Accountability

As a steering group we make plans, recommendations, share best practice approaches and support/ guidance on implementing:

- the Accessible information standard across NHSC&M and working with system partner including Sefton Place, NHSC&M corporate functions and Places and wider system partners including Primary Care networks, and NHS Providers and Local authority social care organisations.

Group Membership- currently membership includes:

- LA officers- engagement and accessible information officer Sefton MBC)
- Consultation Communication and engagement lead (Sefton MBC)
- Communication and engagement lead (NHSC&M)
- Digital inclusion leads (I Merseyside)
- EDI officer Cheshire and Merseyside (NHSC&M)
- EDI leads NHS Providers (Mersey Care and LUFT)
- EMIS digital support
- PCN information & marketing officers

Aims and objectives of the group are to:

1. Review requirements for the implementation of the AIS
2. Understand the relationship of the reasonable adjustment flag and AIS
3. Web accessibility -Accessibility Guidelines (WCAG).
4. Develop awareness and communication
5. Ensuring information uploaded onto websites is accessible.
6. Developing a repository of training and resources to enable improved accessibility.
7. Accessible meetings and events guide
8. Developing and formalising procedures across the ICB to access translation and interpretation (T&I) services. (Language, BSL, Easy read and range of different formats through the NHSC&M T&I framework)
9. Developing a how to guide to support functions across ICB, Places and Primary Care Networks to improve accessibility and quality.
10. Use of CYPHER at Place to support community centred approaches and understanding accessibility needs, including average reading ages and adult literacy.
11. Feeding work into the digital exclusion / inclusion team
[barriers_digital_inclusion_cheshire_merseyside.pdf](#)
[\(cheshireandmerseyside.nhs.uk\)](#)
12. Communication at all levels and leadership.
13. Roll out Accessible information advocate programme developed in Sefton

Commissioning

ICB Contracts include a requirement to meet the AIS. Contracts are monitored on a regular basis as per NHS Contract requirements. In addition, the Equality Impact Assessment process includes reference to the AIS and as such, requires consideration.

5 Rights Campaign

The 5 Rights campaign aims to:

- Increase awareness amongst NHS staff of the 5 core rights of all patients with communication needs and/or language barriers when accessing any NHS healthcare.
- Increase awareness amongst individual patients with communication needs, and their carers/relatives, about what their rights are when receiving NHS care – and how to ask to for/access the communication support they need.
- Support patients with communication needs to have a better overall experience of care.

We will continue to work with our partners to ensure that the requirements of the AIS are met, and that good practice is shared across Cheshire and Merseyside.

Interpretation and Translation

The areas that we provide health care services for across Cheshire and Merseyside have a diverse population, with several languages being used. Languages may be used for either spoken or written word, and it important to acknowledge that because a patient may speak English, they may not understand the written language or may have low literacy skills and / or other communication needs. CM NHS has a comprehensive Language and Interpretation policy and as described at the beginning of this report, requests can be made for language and interpretation needs.

The table below shows how the languages our communities use differs by area.

	NHS Cheshire and Merseyside Integrated Care Board	Halton LA	Knowsley LA	Liverpool LA	Sefton LA	St Helens LA	Warrington LA	Wirral LA	Cheshire West and Chester LA	Cheshire East LA
Main language (detailed) / (23 categories)										
English (English or Welsh if in Wales)	2328527	121114	144261	425452	261763	172666	193572	303454	335329	370917
Does not apply	76349	4044	5757	15648	7816	5641	6272	9511	10221	11440
Other European language (EU): Any other European languages	30178	1240	1193	9585	3083	1690	3885	1567	3064	4871
Other European language (EU): Polish	21850	663	1011	4809	2353	1077	3015	974	2843	5102
East Asian language: Mandarin, Cantonese and other Chinese languages	8735	162	215	5085	446	285	623	792	515	614
Arabic	8115	242	202	5743	351	266	224	357	422	310
Portuguese	6519	98	422	3283	884	220	199	189	604	621
West or Central Asian languages	6113	145	144	3984	264	132	430	309	290	415
South Asian language: Any other South Asian languages	4952	66	334	1810	257	162	480	540	498	802
Spanish	4475	110	172	2145	293	158	215	266	589	525

Source:

<https://ukdataservice.ac.uk/learning-hub/census/census-explainers/language/>

<https://www.ons.gov.uk/census/census2021dictionary/variablesbytopic/ethnicgroupnationalidentitylanguageandreligionvariables/census2021/mainlanguage>

CM ICB Workforce

Equality Data

We monitor the diversity of our staff in line with protected characteristics. We collect data on age, ethnicity, religious belief (or no belief), sexuality, disability, gender and marital status. This data is collected on joining the organisation and staff are also able to update it on their Electronic Staff Record (ESR) at any time throughout their employment with us. It is important to note that this is voluntary and there is an option of choosing 'prefer not to say'. Our staff are made aware of what the information is used for and that we monitor the demographics of the workforce to understand patterns and to identify any issues or barriers for people.

The available data available for reporting and monitoring includes:

- Workforce demographic data
- NHS CM WRES and WDES data - In addition to our annual data report, we also complete the Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES). These standards are required by NHS England; they include data collected via our staff survey and are published on our website.
 - https://www.cheshireandmerseyside.nhs.uk/media/e5fe1xmp/workforce-disability-equality-standard-report-2023_2024.pdf
 - https://www.cheshireandmerseyside.nhs.uk/media/5efpagko/workforce-race-equality-standard-report-2023_2024.pdf
- Pay Gap data
- Workforce complaints, HR data on grievances and appeals
- Recruitment and shortlisting success rate analysis
- Previous consultation feedback from staff networks
- Staff survey data (e.g. NHS Staff Survey)

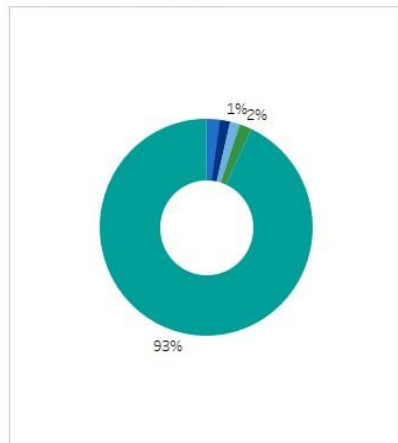
Data Gaps:

- Not all individuals have disclosed their equality monitoring information, including data related to protected characteristics.
- Data is lacking at the granular (directorates / places / pay grade banded) level for intersectional analysis

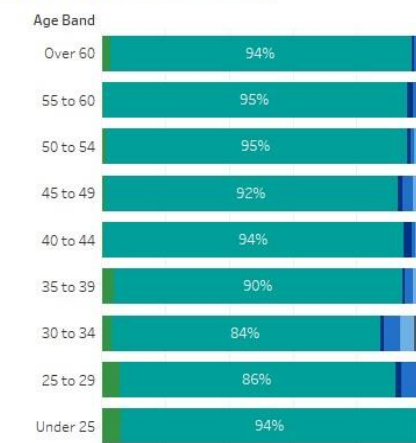
Below are the Cheshire and Merseyside ICB's workforce demographic profiles as at April 2024

ESR Secondary Care Equality, Diversity and Inclusion Profile Detail - Ethnicity

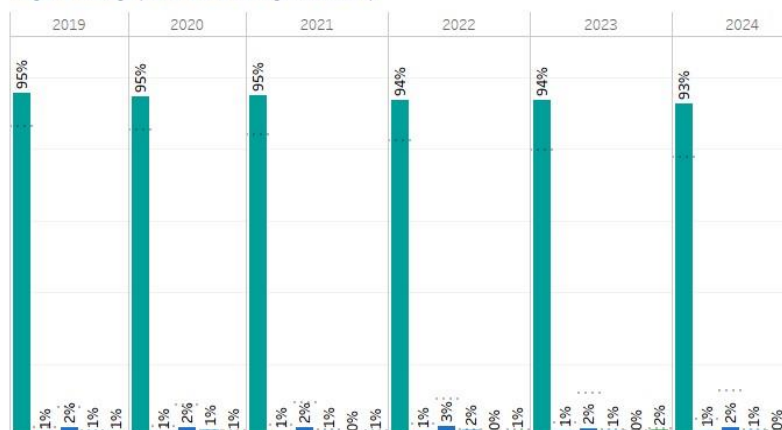
Ethnicity Split - April 2024



Latest Age Bands Breakdown



Percentage Split, by Ethnicity, by Year (for corresponding month of latest data). Dotted Line shows Regional Average (national when all regions selected).



Rounding
0dp

Region name
North West

ICS
NHS Cheshire and Mersey

Organisation Type
All

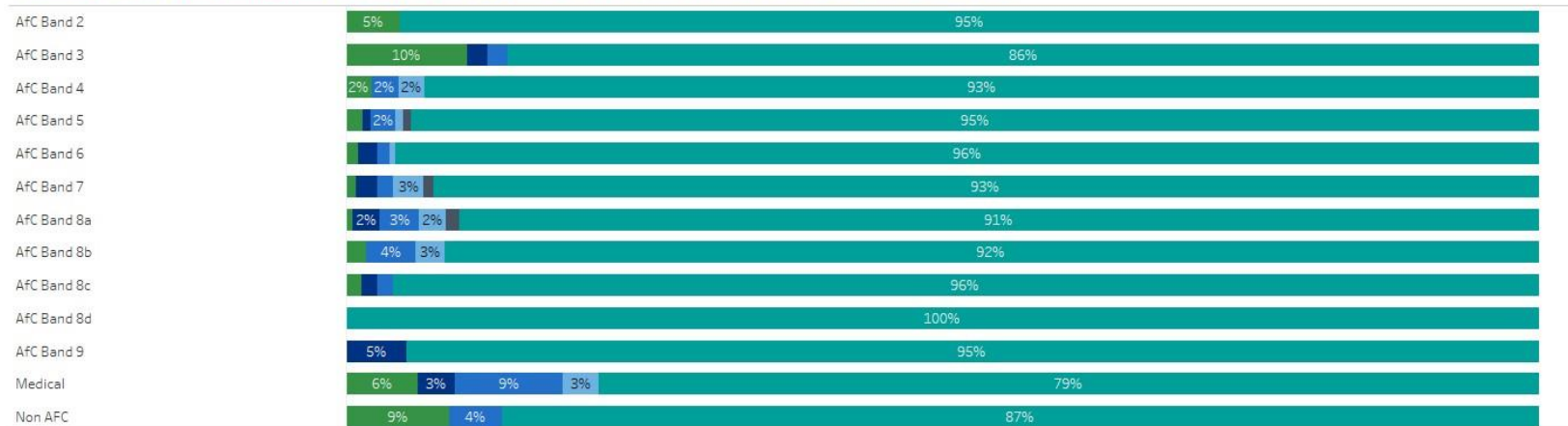
Organisation
NHS CHESHIRE AND MERSEY

Staff Group
All

Profession
All

Selected Dimension
Ethnicity

Percentage Split, by AfC Band/Grade and Ethnicity - 2024 (for corresponding month of latest data) - Select data items to filter dashboard



Split by
AfC Band/Grade

Year
2024

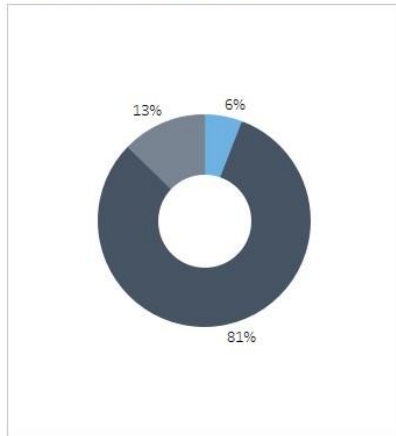
Selected Dimension
White
Black, African, Caribbean or Black
Asian or Asian British
Mixed or Multiple ethnic groups
Any other ethnic group
ND

Latest Data

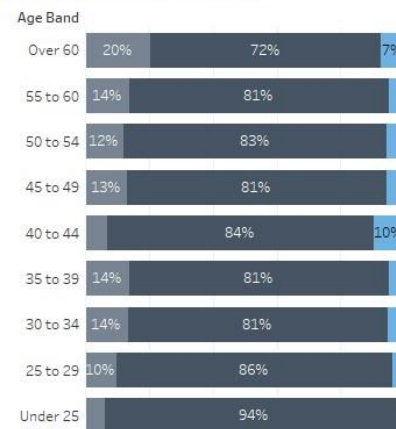
April 2024

ESR Secondary Care Equality, Diversity and Inclusion Profile Detail - Disability

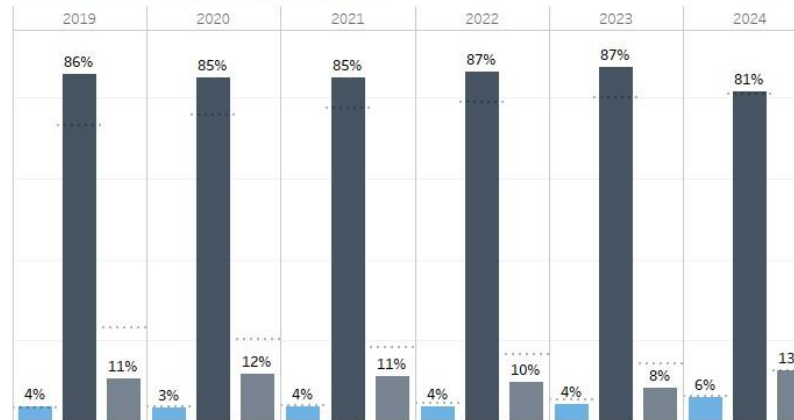
Disability Split - April 2024



Latest Age Bands Breakdown



Percentage Split, by Disability, by Year (for corresponding month of latest data). Dotted Line shows Regional Average (national when all regions selected).



Rounding
0dp

Region name
North West

ICS
NHS Cheshire and Merse..

Organisation Type
All

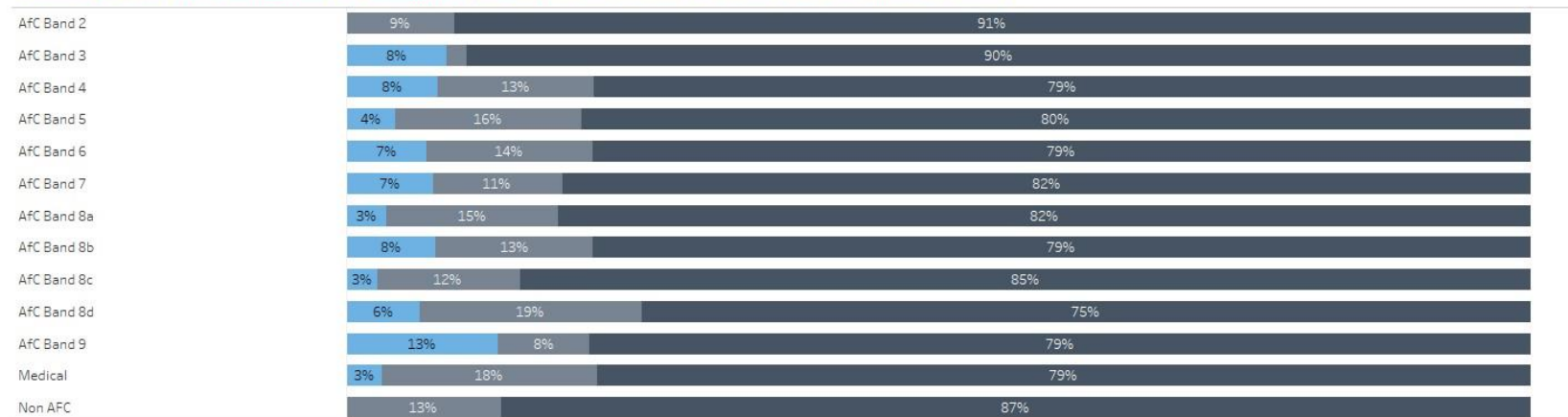
Organisation
NHS CHESHIRE AND MER...

Staff Group
All

Profession
All

Selected Dimension
Disability

Percentage Split, by AfC Band/Grade and Disability - 2024 (for corresponding month of latest data) - Select data items to filter dashboard



Split by
AfC Band/Grade

Year
2024

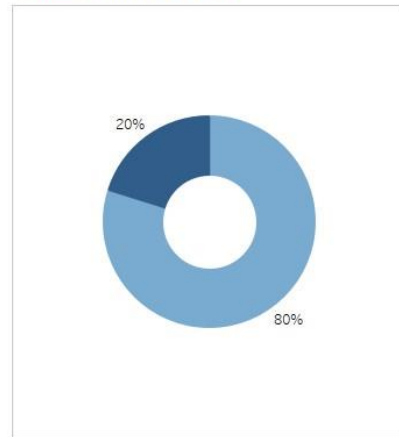
Selected Dimension
Disabled
Not Disabled
Not Disclosed

Latest Data

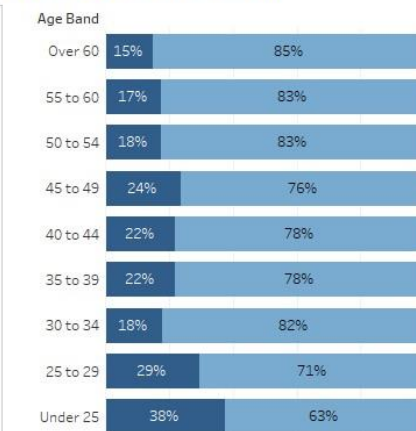
April 2024

ESR Secondary Care Equality, Diversity and Inclusion Profile Detail - Gender

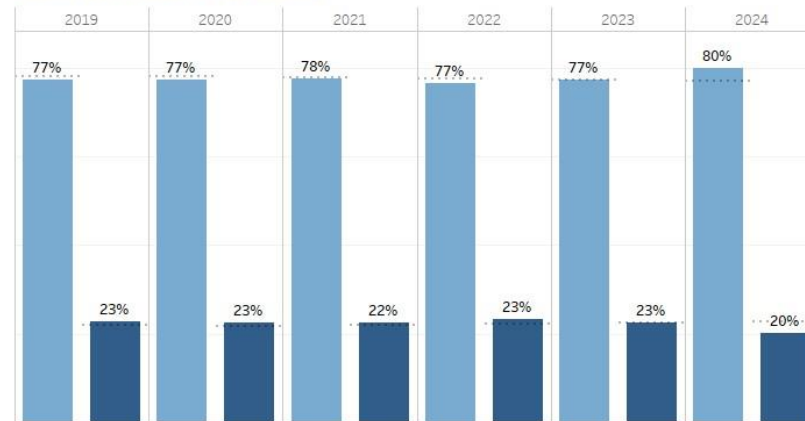
Gender Split - April 2024



Latest Age Bands Breakdown



Percentage Split, by Gender, by Year (for corresponding month of latest data). Dotted Line shows Regional Average (national when all regions selected).



Rounding
0dp

Region name
North West

ICS
NHS Cheshire and Merse..

Organisation Type
All

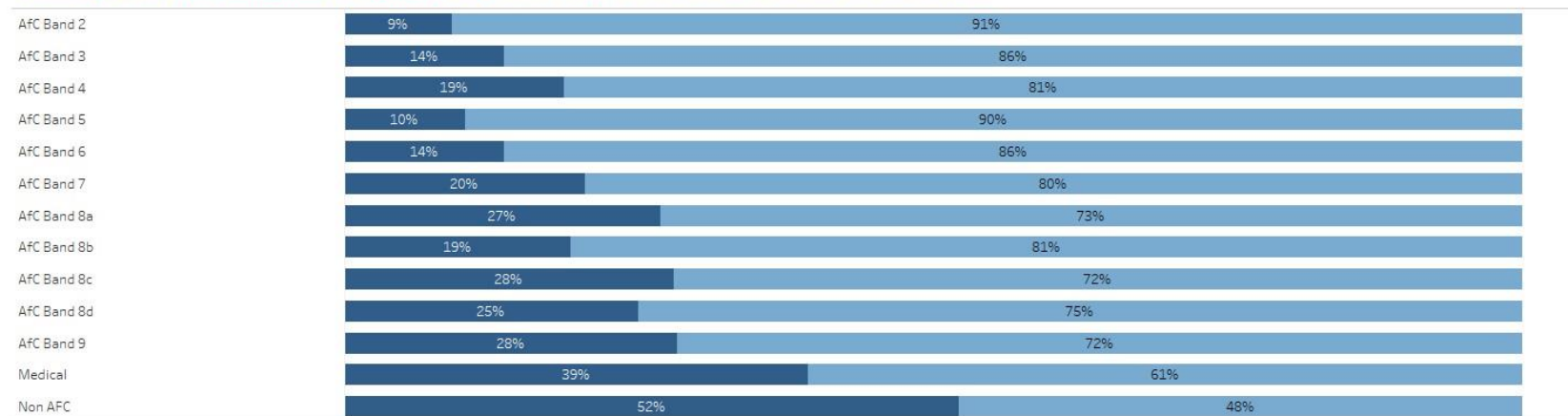
Organisation
NHS CHESHIRE AND MER..

Staff Group
All

Profession
All

Selected Dimension
Gender

Percentage Split, by AfC Band/Grade and Gender - 2024 (for corresponding month of latest data) - Select data items to filter dashboard



Split by
AfC Band/Grade

Year
2024

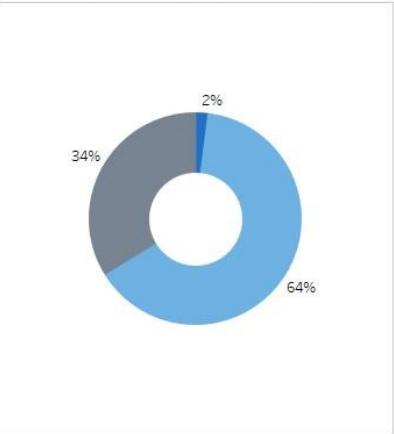
Selected Dimension
Female
Male

Latest Data

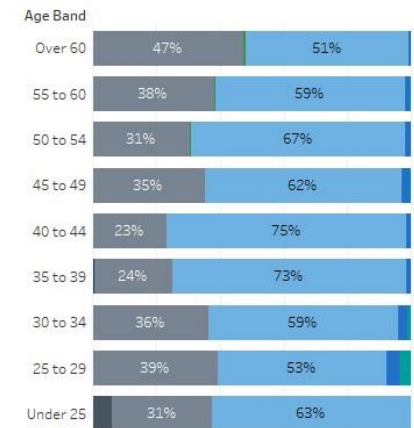
April 2024

ESR Secondary Care Equality, Diversity and Inclusion Profile Detail - Sexual Orientation

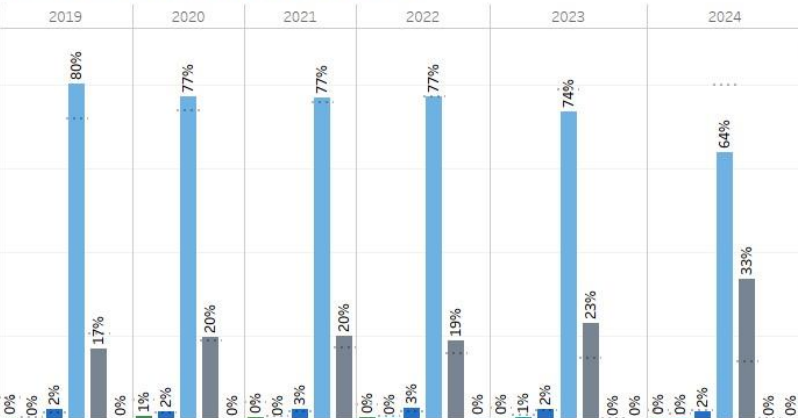
Sexual Orientation Split - April 2024



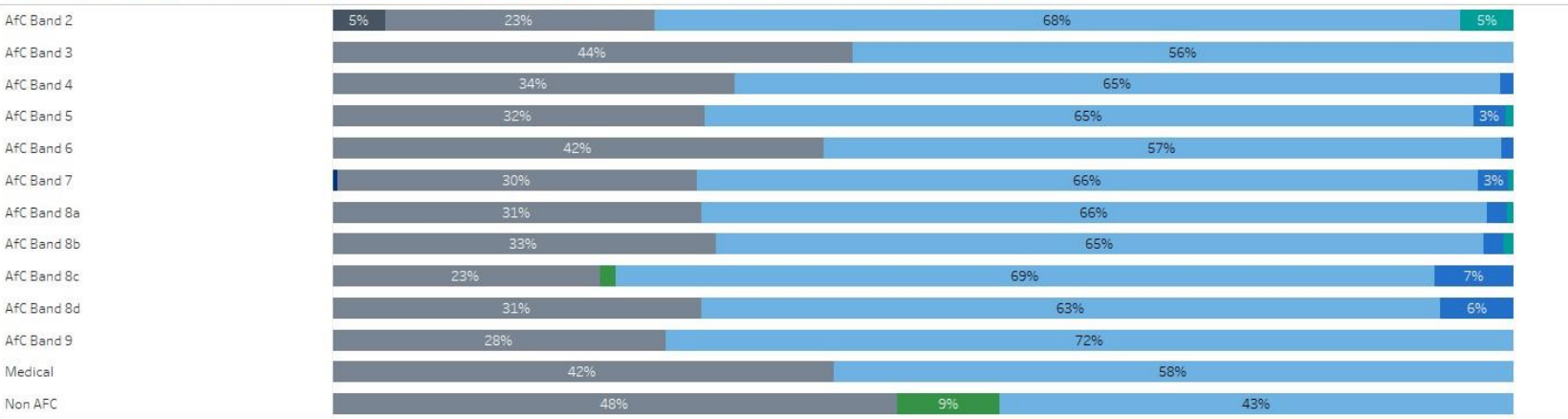
Latest Age Bands Breakdown



Percentage Split, by Sexual Orientation, by Year (for corresponding month of latest data). Dotted Line shows Regional Average (national when all regions selected).



Percentage Split, by AfC Band/Grade and Sexual Orientation - 2024 (for corresponding month of latest data) - Select data items to filter dashboard



Rounding
0dp

Region name
North West

ICS
NHS Cheshire and Merse...

Organisation Type
All

Organisation
NHS CHESHIRE AND MER...

Staff Group
All

Profession
All

Selected Dimension
Sexual Orientation

Split by
AfC Band/Grade

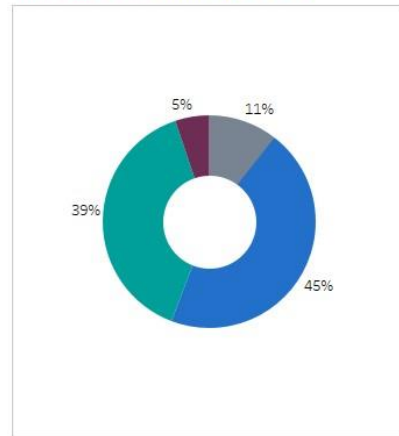
Year
2024

Selected Dimension
ND
Bisexual
Gay or Lesbian
Heterosexual or Strai...
Not stated (person as...
Other sexual orientat...
Undecided

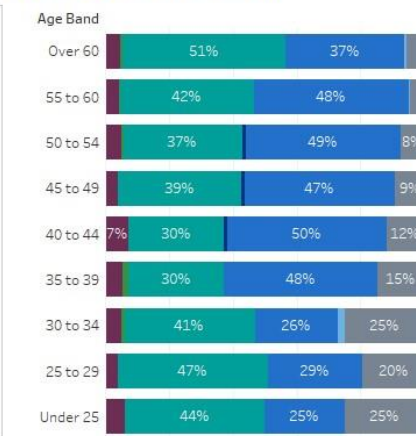
Latest Data
April 2024

ESR Secondary Care Equality, Diversity and Inclusion Profile Detail - Religious Belief

Religious Belief Split - April 2024



Latest Age Bands Breakdown



Percentage Split, by Religious Belief, by Year (for corresponding month of latest data). Dotted Line shows Regional Average (national when all regions selected).



Rounding
0dp

Region name
North West

ICS
NHS Cheshire and Merse...

Organisation Type
All

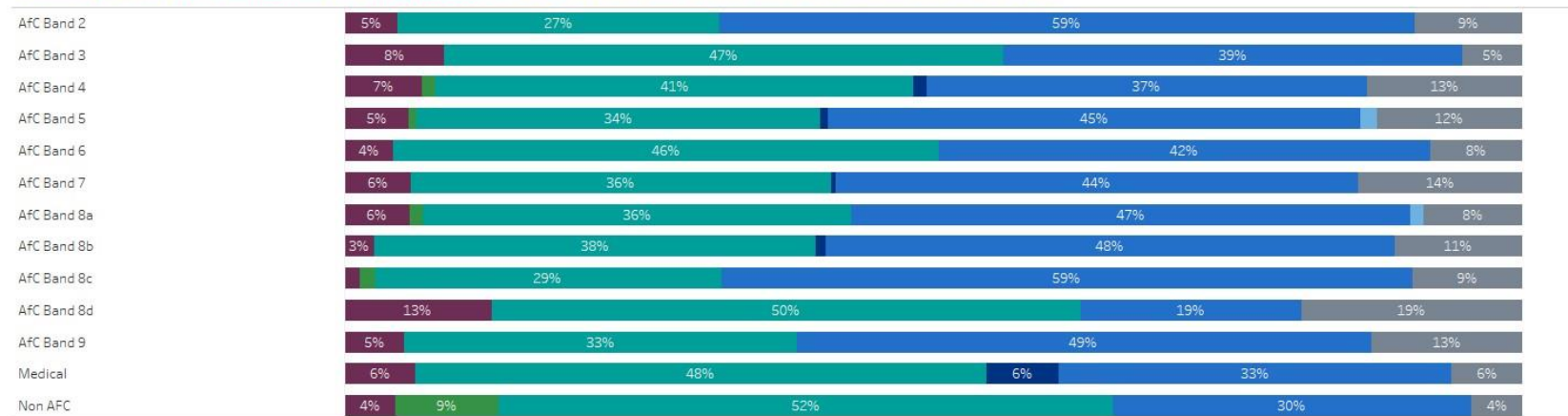
Organisation
NHS CHESHIRE AND MER...

Staff Group
All

Profession
All

Selected Dimension
Religious Belief

Percentage Split, by AfC Band/Grade and Religious Belief - 2024 (for corresponding month of latest data) - Select data items to filter dashboard



Split by
AfC Band/Grade

Year
2024

Selected Dimension
ND
Atheism
Buddhism
Christianity
Hinduism
I do not wish to disclo...
Islam

Latest Data
April 2024

Gender Pay Gap for 2022/ 2023 (Extracted from ESR 09 04 24)

Gender	Avg. Hourly Rate	Median Hourly Rate	Quartile	Female	Male	Female %	Male %
Male	31.7751	24.8164	1	200.00	39.00	83.68	16.32
Female	25.8282	22.4026	2	199.00	55.00	78.35	21.65
Difference	5.9469	2.4138	3	166.00	59.00	73.78	26.22
Pay Gap %	18.7157	9.7267	4	198.00	85.00	69.96	30.04

Equality Training

All our staff are required to complete mandatory Equality, Diversity and Human Rights Training every 3 years. Our current compliance rate is 94%. In addition to mandatory training, Equality Impact Assessment training is offered as well as development sessions on issues such as Neurodiversity and anti-racism.

Requirement	Compliant	Not Compliant
NHS CSTF Equality, Diversity and Human Rights - 3 Years	93.95%	6.05%

Staff Engagement

The ICB is committed to staff engagement and 'Listening Well' and we have adapted NHS England's Listening Well Guidance. We have many mechanisms as part of our staff engagement strategies including NHS Staff Survey, Pulse Survey and local listening including Freedom to Speak Up Guardians and Ambassadors, mapping of teams local staff briefings and away days, new starter questionnaires, exit interviews and our monthly We Are One all staff broadcast.

Two of our other main methods of staff engagement are our Staff Engagement Forum and our Staff Networks.

Our Staff Engagement Group has been established since May 2023 with the aim to provide two-way communication, an opportunity to engage and involve staff in developments, work programmes and enabling them to contribute to the success of the organisation in delivering our values, vision and strategy objectives. The Forum meet monthly, with representatives from each team. Topics the forum have been involved in included supporting our NHS Staff Survey action plan, discussing a staff suggestion scheme, temperature checks and listening activities and our health and wellbeing offer.

Recognising the diversity of our staff, we have established several Staff Networks to provide a safe space for our staff, raise awareness of issues within the wider ICB and provide a support for staff who may be facing challenges. We had seven staff networks established by April 2024, these were Menopause, working carers, BAME, LGBTQI+, early careers, disability and neurodiverse and armed forces family support network. Practical examples supporting us in hearing the voice of our diverse staff and improving staff experience are below.

Defence Employer Recognition Scheme (ERS) – NHS Cheshire and Merseyside is one of only three ICBs in the country to have received the silver accreditation status under the Defence Employer Recognition Scheme. The ERS recognises the commitment and support from UK employers for defence personnel. In gaining the silver accreditation the ICB has demonstrated they have adjusted corporate policies and workplace culture to ensure our Armed Forces community and their families are supported and not disadvantaged. The ICB have now committed to Step into Health to ensure our recruitment processes are fair and armed forces candidates are not disadvantaged.

Disability History Month – As part of the month, we used the national messages to celebrate the achievements of our staff with disabilities, including a blog and a video from the Chair of our staff network, raised awareness of what a disability is to staff, encouraged staff to record their disability on ESR and have open conversations with their managers and reviewed our recruit processes to ensure that they were inclusive and accessible. The ICB, supported by the staff network, is now working towards Level 1 of the Disability Confidence Standard.

Anti Racist Framework – Working internally and with our partners we are championing the Northwest BAME Assembly Anti-racism Framework. The framework is a tool designed to support NHS organisations to become intentionally anti-racist by tackling structural racism and discrimination through collaboration, reflective practice and accountability. We recognise that our commitment to this journey will require continuous review of our progress and our intentional actions for change. As part of our commitment we asked our staff to pledge how they will be actively anti-racist and we held a 'Power of the Pledge' event, for all staff to hear from our Chair and staff about their life experiences, learn more about the anti-racist framework and how we can all support each other. The ICB is working towards the Bronze level of the Anti – Racist Framework.

Our current networks are listed below.

- Armed Services Families Group
- Menopause Support Network
- Working Carers Network
- Race Equality Network
- Disability and Neuro-diverse Network

- LGBTQI+ Network
- Early Careers Network

Staff are encouraged to participate in the networks as they play an important role in our organisational development.

Leadership Equality Assurance Framework (LEAF)

The Leadership Equality Assurance Framework (LEAF) is used as a practical tool to assess the level of compliance against the key EDI activities where assurance is required.

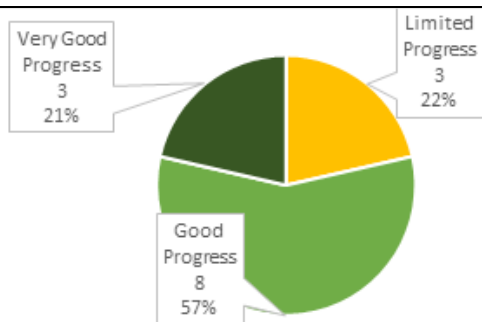
The tool provides insight at different forums, in relation to EDI mandated standards assurance, compliance, progress, highlight and challenges. It:

- Acts as a regional monitoring tool, to provide overall assurance.
- Collects and shares your best practice highlights on what has worked well.
- Provides a collective sense of some of your key challenges / areas of concern are and how we can all support each other.
- Helps us to design and shape communities of practice and online resources, through a NW EDI Futures platform.

CM ICB System Results

Section 2 EDI Improvement Plan High Impact Actions																	
HIA	Standard	Progress															
1	Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.	<table border="1"> <caption>Progress Distribution Data</caption> <thead> <tr> <th>Progress Level</th> <th>Count</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Very Good Progress</td> <td>5</td> <td>36%</td> </tr> <tr> <td>Excellent Progress</td> <td>21</td> <td>77%</td> </tr> <tr> <td>Limited Progress</td> <td>1</td> <td>7%</td> </tr> <tr> <td>Good Progress</td> <td>5</td> <td>36%</td> </tr> </tbody> </table>	Progress Level	Count	Percentage	Very Good Progress	5	36%	Excellent Progress	21	77%	Limited Progress	1	7%	Good Progress	5	36%
Progress Level	Count	Percentage															
Very Good Progress	5	36%															
Excellent Progress	21	77%															
Limited Progress	1	7%															
Good Progress	5	36%															
Good Practice		Challenges															
• EDI Objectives: Have been identified in Board member appraisals. • Executive Champions: CEOs and executive leaders sponsor / champion equality staff network to better understand needs and identify how best they can support work to improve outcomes in experience. • Equality Analysis and Accountability: Every Executive has committed to taking a responsibility around EDI Leadership, including ensuring and compliance with equality impact assessments related to their executive portfolio; and this is a standing item in Executive Board meetings • NW Anti-Racist Framework: Boards have committed to implementing the framework and undertaken a																	

facilitated Board development day focused on anti-racism	
ICB Area Analysis	
Of the organisations that completed the template, 93% have made good to excellent progress in this area. The whilst most executive board members have identified EDI objectives through their appraisal processes. Several organisations have gone further and committed to ensuring compliance with their PSED within their portfolios. All Boards have committed to implementing the NW BAME Anti-racism Framework.	

HI A	Standard	Progress												
2	Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	 <table border="1"> <thead> <tr> <th>Progress Category</th> <th>Count</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Very Good Progress</td> <td>3</td> <td>21%</td> </tr> <tr> <td>Good Progress</td> <td>8</td> <td>57%</td> </tr> <tr> <td>Limited Progress</td> <td>3</td> <td>22%</td> </tr> </tbody> </table>	Progress Category	Count	Percentage	Very Good Progress	3	21%	Good Progress	8	57%	Limited Progress	3	22%
Progress Category	Count	Percentage												
Very Good Progress	3	21%												
Good Progress	8	57%												
Limited Progress	3	22%												
Good Practice		Challenges												
Recruitment - The process of implementing a fair and inclusive recruitment process has started with the recruitment of volunteer inclusive recruitment representatives (IRRs) who will be involved in the whole recruitment journey. - Inclusive recruitment training package has been developed in readiness of roll out. - Implementation of a Positive Action scheme on TRAC, where automatic interviews are offered global majority applicants who meet the minimum criteria. This is being introduced as part of our WRES action plan. Additionally, the Anti-Racism Team will be auditing Trust recruitment processes to inform inclusive recruitment training - Development of relationships with service user organisations e.g. Downs Syndrome Association to		- Lack of support from region. - Lack of time and resources to develop processes and support managers to become inclusive recruiters. - The positive action scheme has worked effectively. However, practically, there are technical challenges with TRAC that make it harder for recruiting managers to identified candidates from racially marginalised backgrounds who wish to be considered for a guaranteed interview.												

open up employment opportunity for individuals with Downs Syndrome https://fb.watch/twEgij1in5/ - As part of the Trust's Anchor Institute commitments local recruitment is prioritised with active engagement and involvement by Trust teams in schools and colleges, local Job Centre Plus, and care leavers. Promotion of Trust employment opportunities is optimised through attendance at local events. - EDI representatives present during executive post interviews.																			
Talent Management - Ring-fenced BME places set on leadership training programmes as a positive action. - Shadow Board initiative being developed with positive action to recruit BME colleagues																			
ICB Area Analysis																			
78% of system organisations report that they are making good/very good progress towards embedding fair and inclusive recruitment processes and talent management strategies. Good practice includes implementing positive action schemes through TRAC. A lack of regional support and resources to progress work in this area is a common challenge.																			
HIA	Standard																		
3	Develop and implement an improvement plan to eliminate pay gaps.																		
Progress																			
<table border="1"><thead><tr><th>Progress Category</th><th>Count</th><th>Percentage</th></tr></thead><tbody><tr><td>Not started / No progress</td><td>1</td><td>7%</td></tr><tr><td>Very Good Progress</td><td>1</td><td>7%</td></tr><tr><td>Excellent Progress</td><td>1</td><td>7%</td></tr><tr><td>Limited Progress</td><td>5</td><td>36%</td></tr><tr><td>Good Progress</td><td>6</td><td>43%</td></tr></tbody></table>		Progress Category	Count	Percentage	Not started / No progress	1	7%	Very Good Progress	1	7%	Excellent Progress	1	7%	Limited Progress	5	36%	Good Progress	6	43%
Progress Category	Count	Percentage																	
Not started / No progress	1	7%																	
Very Good Progress	1	7%																	
Excellent Progress	1	7%																	
Limited Progress	5	36%																	
Good Progress	6	43%																	
Good Practice																			
- Trust Board receive monthly reports detailing the number of racially marginalised staff in senior roles. - Regular reviews of disaggregated data by staff band to identify any inequity by the EDI and Anti-Racism Lead undertaken. - Ethnicity pay gap is incorporated within WRES Report.																			
Challenges																			
- The aspiration to deliver an Ethnicity and Disability pay gap report is currently hampered by lack of guidance and support from NHSE on the metrics and approach to be take. - Lack of time and resources to effectively address identified pay gaps.																			

- Range of interventions implemented to support retention and progression include: - Provision of onsite nurse for staff. - Implementation of a Flexible working campaign - Establishment of Women and Menopause networks - People Promise Manager role in place supporting advancement in flexible / agile working pilots in clinical areas.	Poor quality data - self-reporting of data for disability and sexual orientation particularly. Disability data especially shows a disparity with reported figures in the annual NHS Staff Survey
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ICB Area Analysis

57% of system organisations report that they are making good/very good/excellent progress in implementing improvement plans to eliminate pay gaps. Those who are, have been able to apply good levels of scrutiny to disaggregated data which is regularly reported. Poor quality data and a lack of resources to progress in this area remain key significant challenges.

HIA	Standard	Progress																		
4	Develop and implement an improvement plan to address health inequalities within the workforce.	<table border="1"> <thead> <tr> <th>Progress Category</th> <th>Count</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Very Good Progress</td> <td>3</td> <td>22%</td> </tr> <tr> <td>Excellent Progress</td> <td>2</td> <td>14%</td> </tr> <tr> <td>Limited Progress</td> <td>1</td> <td>7%</td> </tr> <tr> <td>Not started / No progress</td> <td>7</td> <td>50%</td> </tr> <tr> <td>Good Progress</td> <td>7</td> <td>50%</td> </tr> </tbody> </table>	Progress Category	Count	Percentage	Very Good Progress	3	22%	Excellent Progress	2	14%	Limited Progress	1	7%	Not started / No progress	7	50%	Good Progress	7	50%
Progress Category	Count	Percentage																		
Very Good Progress	3	22%																		
Excellent Progress	2	14%																		
Limited Progress	1	7%																		
Not started / No progress	7	50%																		
Good Progress	7	50%																		

Good Practice

- Good universal well-being processes and support mechanisms in place for its staff, ranging from access to Occupational health provision, and access to MHFA, carers and Menopause support groups.
- Health Needs Assessment (HNA) survey and analysis undertaken and health inequality plans developed.
- Establishment of Independent race trauma service provides for BAME colleagues 1-2-1 support. Service also provides reflective practice and cultural awareness training.
- Health inequalities addressed through the implementation of social prescribers, and promotion of health and wellbeing initiatives to all staff groups.
- Bespoke health and wellbeing initiatives targeted at specific groups of staff belonging to populations with high health inequities e.g. those living in areas which have the highest morbidity factors.
- Equality and Health Inequalities Impact Assessment launched aligning to the Health Equity Assessment Tool and current equality analysis process, reviewing through the lens of workforce, patients and public/community.

Challenges

- Disaggregated data relating to the health needs of those with protected characteristics is not available due to a combination of factors: the lack of functionality in ESR; incomplete data; low sharing of protected characteristics by staff. The ability to set meaningful KPIs and target action in this area is therefore a challenge.
- Barriers to accessing wellbeing programmes by an understaffed workforce especially clinical based colleagues and ancillary workers.

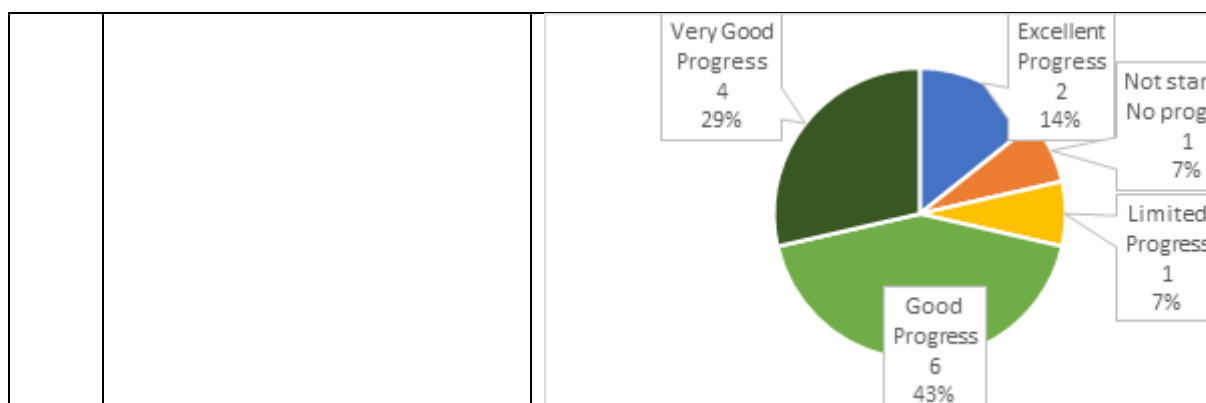
• A Health Inequalities Focus Group in place to identify opportunities for further improvements in workforce health • Workforce EDI Dashboard in place – mapping data against local census and population health information. • Mapping of EDS Domain 2 to focus on health inequalities / interlink between Anti-Racist BAME Assembly framework. • Trust awarded Investors in People Gold award for our Health and Wellbeing package • Launch of Menopause Policy • Period poverty campaign launched – with free sanitary products offered to staff. • SALS service available to all staff and learners underpinned by the principles of person-centred compassionate care.	• Lack of time and resources - health initiatives were supported by system funding which was time limited. Due to current financial challenges the positive impacts from this across our wider workforce cannot be extrapolate • Linking EDI with wider health inequalities work can be challenging. Support with establishing a mechanism for measuring improvements in workforce health inequalities outside of patient/public e.g. CORE20Plus5 would be helpful.
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ICB Area Analysis

84% of system organisations report that they are making good/very good/excellent progress in this area. This progress has been supported by the development and implementation of several excellent processes/services including the establishment of independent race trauma service; establishment of a Health Inequalities Focus Group; establishment of a Workforce EDI Dashboard that maps data against local census and population health information.

Access to quality disaggregated data relating to the health needs of those with protected characteristics remains a significant challenge. This means that most interventions are universal in nature.

HIA	Standard	Progress
5	Implement a comprehensive induction, onboarding and development programme for internationally recruited staff.	



Good Practice

- Provision of pastoral support for internationally recruited staff.
- Attainment of NHS Pastoral Care Quality award for the adoption of an international recruitment Pastoral care framework
- Implementation of an International Nurse Development Programme.
- Dedicated resources committed to supporting the onboarding of internationally recruited staff.
- Introduced the SIFE Process for HCAs with overseas nursing qualifications.
- Working collaboratively with others and sharing resources in relation to the recruitment and development of international staff.
- Implementing rewards and recognition programmes for IR staff.
- Delivery of Cultural competency training including a bespoke Cross-Cultural Communications Training programme.
- Provision of ring-fenced scholarships for ethnic minority nurses.

Challenges

- Retention impacted by low availability of quality accommodation and community support.
- Maintaining the positive experience of the onboarding process for IR staff once they migrate onto multiple wards, and the cohorts lose a sense of their collective identity.
- Lack of resources to support effective integration and a sense of belonging.

ICB Area Analysis

74% of system organisations report that they are making good/very good/excellent progress in this area. The provision of pastoral support, targeted development opportunities and development of workforce cultural competence appear to be key features to this progress. A lack of resources to support and/or maintain effective integration of international staff appears to be the significant challenges faced.

HI A	Standard	Progress												
6	Create an environment that eliminates the conditions in which bullying, harassment and physical violence at work occur.	<table border="1"> <caption>Progress Data</caption> <thead> <tr> <th>Progress Level</th> <th>Count</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Very Good Progress</td> <td>5</td> <td>36%</td> </tr> <tr> <td>Good Progress</td> <td>7</td> <td>50%</td> </tr> <tr> <td>Limited Progress</td> <td>2</td> <td>14%</td> </tr> </tbody> </table>	Progress Level	Count	Percentage	Very Good Progress	5	36%	Good Progress	7	50%	Limited Progress	2	14%
Progress Level	Count	Percentage												
Very Good Progress	5	36%												
Good Progress	7	50%												
Limited Progress	2	14%												
Good Practice		Challenges												
Cultivating a Zero-tolerance culture through the: • Implementation of robust FTSU processes and undertaking a campaign to raise awareness across the workforce. • Recruiting FTSU champions from across the organisation ensuring that their diversity is reflective of local populations and that they receive wrap around training and support to undertake their roles. • Mapping of data and incident reporting through the Board Assurance Framework – reporting to the Strategic People Committee and Trust Board • Provision of targeted support for areas with high incidents of bullying identified through the staff survey, cultural diagnostics and concerns identified through FTSU Guardians or wider sources of intelligence • Implementation of equality standards – that require the organisations to demonstrate how they are addressing B&H. • The provision of peer support through adequately resourced staff networks. • Implementation of a Restorative and Just Learning Culture supports addressing allegations of bullying, abuse and untoward conduct. • Adoption of Anti-Racism Perfect Care Goal 3-year strategy,		• Capacity and a lack of resources/funding to support work required to create an environment that eliminates the conditions in which bullying, harassment and physical violence at work occur is an ongoing challenge.												

covering training, reflective practice sessions, leadership on allyship and Board training. • Implementation of Mandatory Anti-Racism online training • Appointment of a dedicated BAME / Race Cultural Sensitivity Lead/ Freedom to Speak Up Guardian, to work with EDI and OE functions to improve the reporting and address conditions and environment in which bullying, harassment and physical harassment occurs. • Provision of resources to support staff and managers in addressing bullying and harassment. • Implementation of a sexual safety action plan • Implementation of a values and behaviour framework to support processes adopted to eliminate bullying and harassment, including anonymous online reporting. • Undertaking a range of activities to support the development of a zero-tolerance culture e.g. - o Violence Reduction Strategy, Body Camera and Policy Liaison of Violence - o Violence Drop-In session with Security - o Comprehensive policy framework including Respect & Dignity, Abusive Behaviour from Patients, Domestic Abuse, Safeguarding, Grievance and Disciplinary processes. - o Signed Sexual Safety Charter, rolling out awareness and training offer. - o Developed Harassment webpages with advice and signposting. - o Training for Managers on Harassment and Discrimination; Unconscious Bias. - o Extensive EDI awareness events on BHM, EDI Week, IWD, Disability HM, Prides etc.	
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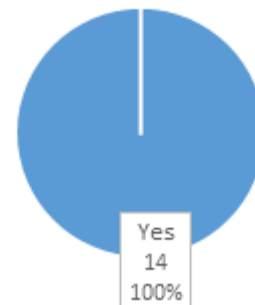
ICB Area Analysis

86% of system organisations report that they are making good/very good/excellent progress in this area, primarily achieved through implementing initiatives and practices that cultivate a zero-tolerance culture that is aligned to speak up and anti-bullying and harassment processes and the provision of staff support and development.

79% of organisations have a named Domestic Abuse and Sexual Violence (DASV) Lead.

Section 3 Anti-Racism Framework (ARF)

Have you signed up to the NW BAME Assembly Anti-Racism Framework?



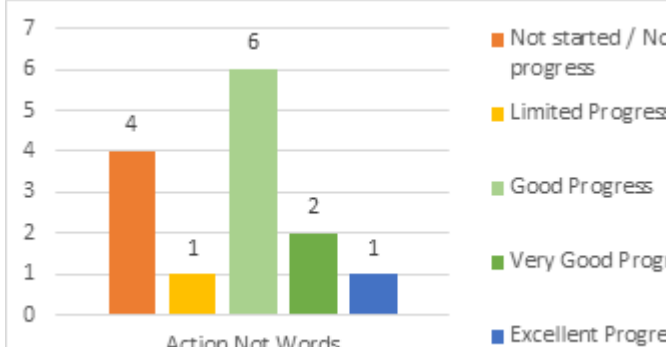
Are you working towards a different Anti-Racism Framework (ARF)?

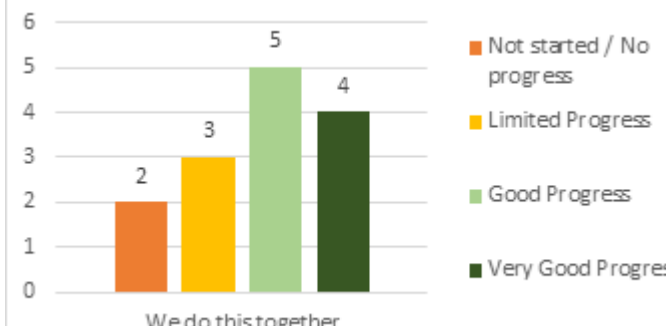


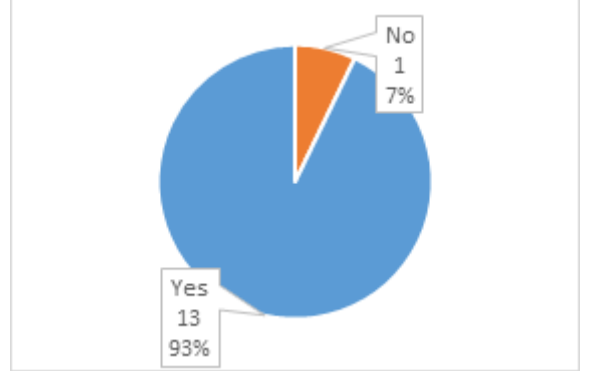
ARF	Standard	Progress										
1	Leading from the front - The appointment of an executive or director level EDI sponsor with a commitment to advancing anti-racism within the organisation.	<table><thead><tr><th>Progress Level</th><th>Count</th></tr></thead><tbody><tr><td>Limited Progress</td><td>4</td></tr><tr><td>Good Progress</td><td>3</td></tr><tr><td>Very Good Progress</td><td>2</td></tr><tr><td>Excellent Progress</td><td>1</td></tr></tbody></table>	Progress Level	Count	Limited Progress	4	Good Progress	3	Very Good Progress	2	Excellent Progress	1
Progress Level	Count											
Limited Progress	4											
Good Progress	3											
Very Good Progress	2											
Excellent Progress	1											
Good Practice		Challenges										
CEO and Chair the executive sponsor are both invited members and sponsors of the Race Inclusion Network.		Lack of demonstrable and meaningful commitment to the agenda. Opportunities for anti-racism development are too often de-prioritised by many executives.										

• Exec lead for Equality in place, together with a full time Director of Equality and Inclusion. • Exec Directors have Equality objective in place which is linked to advancing anti-racism • Executives leading the anti-racism Perfect Care Goal have all had extensive antiracism training with assistance from an external training agency BRAP. • NED appointed as Trust representative on the Northwest BAME Assembly. • Provision of anti-racism coaching by EDI Lead, to the Executive Leadership Team every 6 weeks. Meeting provides space for reflective practice, challenging Executive Leaders to engage in conversations about race and to understand potential areas of influence across the Trust and the wider system.		• Lack of diversity within the executive teams/boards. • Misaligned ideologies.										
ARF	Standard	Progress										
2	Anti-Racism as Mission Critical - Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.	<table><caption>Anti-Racism as Mission Critical Progress Data</caption><thead><tr><th>Progress Category</th><th>Count</th></tr></thead><tbody><tr><td>Not started / No progress</td><td>1</td></tr><tr><td>Limited Progress</td><td>4</td></tr><tr><td>Good Progress</td><td>4</td></tr><tr><td>Very Good Progress</td><td>5</td></tr></tbody></table>	Progress Category	Count	Not started / No progress	1	Limited Progress	4	Good Progress	4	Very Good Progress	5
Progress Category	Count											
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Very Good Progress	5											
Good Practice		Challenges										
• Publication of an anti-racism statement on website and which is shared at corporate induction. • Publication of anti-racism pledges on staff hub • Anti-racism built into organisational Strategy • Provision of anti-racism training to develop leaders/managers skills in managing and supporting people from marginalised groups. • Creation of an Anti-Racism Hub which will include clinical and non-clinical roles.		• Capacity and a lack of investment to support work.										

- Non-Clinical roles: Anti-Racism Lead (full time), OD and Inclusion Facilitator (full time), Anti-Racism Officer (0.2 wte) and assistant psychologist (0.2 wte) - Clinical roles: 2 x Band 7 Clinical Leads (0.4 wte and 0.6 wte), 2x Band 7 Pas - Provision of EDI Mandatory Training which includes different type of racism, race related health inequalities, microaggressions, unconscious bias, cultural competence and allyship;	
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ARF	Standard	Progress												
3	Action Not Words - An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.	 <table border="1"><thead><tr><th>Progress Category</th><th>Count</th></tr></thead><tbody><tr><td>Not started / No progress</td><td>4</td></tr><tr><td>Limited Progress</td><td>1</td></tr><tr><td>Good Progress</td><td>6</td></tr><tr><td>Very Good Progress</td><td>2</td></tr><tr><td>Excellent Progress</td><td>1</td></tr></tbody></table>	Progress Category	Count	Not started / No progress	4	Limited Progress	1	Good Progress	6	Very Good Progress	2	Excellent Progress	1
Progress Category	Count													
Not started / No progress	4													
Limited Progress	1													
Good Progress	6													
Very Good Progress	2													
Excellent Progress	1													
Good Practice		Challenges												
- Provision of race trauma offer, - commissioned NAFSIYAT intercultural centre in London to provide specialist support - Stretch target is linked to Elevate – A leadership programme which takes the form of positive action to help Black Asian and Minority Ethnic colleagues realise their leadership aspirations. Minimum of one additional cohort in 2024 (additional 24 delegates) - The Executive Leaders have EDI objectives that are focussed on anti-racism and inclusion work across their different areas of responsibility. - Implementation of EDI and anti-racism focussed PDR objectives for Senior Leaders, Band 8A and		- Capacity and a lack of resources/funding to support work. There is a need for a centralised funding support and oversight to reduce cost and effort of individual organisations trying develop development programmes. - Mitigating the risk or perception of positive discrimination as a consequence of misinterpretation of key messages - Resources and the lack of specialist counsellors from the global majority who can provide race trauma support and related therapy approaches.												

above, ensuring that the Anti-Racism programme is embedded into the organisation. • Undertaking of an independent cultural survey of staff, service users, leavers, partners, volunteers & students to better understand current baseline and through a process of engagement and analysis inform each of next steps in a programme of work. A reputable third-party organisation commissioned to deliver the cultural review and act as a critical friend on the work of anti-racism and inclusion. • Development of a comprehensive EDI Operational Plan, and 1 Year Plan which includes a number of race equality specific activities.												
ARF	Standard	Progress										
4	We do this together - The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.	 <table><thead><tr><th>Progress Category</th><th>Value</th></tr></thead><tbody><tr><td>Not started / No progress</td><td>2</td></tr><tr><td>Limited Progress</td><td>3</td></tr><tr><td>Good Progress</td><td>5</td></tr><tr><td>Very Good Progress</td><td>4</td></tr></tbody></table>	Progress Category	Value	Not started / No progress	2	Limited Progress	3	Good Progress	5	Very Good Progress	4
Progress Category	Value											
Not started / No progress	2											
Limited Progress	3											
Good Progress	5											
Very Good Progress	4											
Good Practice		Challenges										
• A dedicated community inclusion teams, staffed by multi-lingual colleagues from over17 ethnic backgrounds, was established. They attained an Excelling rating in the EDS 2022 for their work on individualised assessments and care for people of minority communities who access our services. They worked extensively with asylum-seekers, Traveller, Somali, Chinese, other African and other minority communities from within the global majority peoples across our catchment area and sometimes beyond, in partnership with other agencies.		• Identifying and addressing specific race health inequalities within the workforce in a meaningful and measurable way is very challenging. There is little intelligence to identify what health inequalities impact on our staff, rather than generic "national" trends which may not apply. Additionally, ESR and EDI dashboards lack the functionality to provide meaningful data. • Capacity and a lack of investment to support work. • Consolidating what is being done across organisations to evidence achievement of this deliverable.										

ARF	Standard	Progress
5	Zero Tolerance - The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.	
Good Practice		Challenges
- Implementation of a communications campaign, 'Call It Out, Stamp It Out', which works alongside the Trust's Fair and Just Culture practice and the adoption of a Trauma Informed Care approach to supporting the health and wellbeing of staff who need psychological and health and wellbeing support for racial trauma - zero tolerance position communicated through posters. - Signing up to support the Sexual safety in healthcare-organisational charter		- Again, Resources. - Inconsistent implementation of a zero-tolerance approach as demonstrated by the lived experience of our staff and patients. - Resistance to engaging with and / or talking about race by managers.
ICB Area Analysis		
All system organisations have committed to implementing the NHS NW BAME Assembly Anti-Racism Framework. 2 Trusts have achieved Bronze status and have made significant progress to achieving Silver status. A lack of demonstrable and meaningful commitment to the agenda signalled by a lack of investment in the effective development of processes/ initiatives/staff and competing senior leadership priorities are posing significant challenges to progressing achievement of deliverables.		
Section 4 Workforce Race Equality Standard		
Do you have a Workforce Race Equality Standard Action Plan for 2023 / 2024?		
Good Practice	Challenges	
Positive action agreed by Board that all posts as 8c and above to be advertised externally to increase likelihood of applications from ME applicants	- Actions to improve ethnicity outcomes are included in the wider EDI Plan. - This relates once again to resources and capacity.	

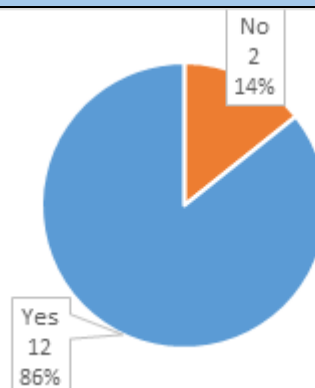
- Antiracism programmes provided by BRAP to Executive Management Group and Support Leads Cohorts through 2023 to 2024. Bespoke training delivered to Board. - Wellbeing Offer and Psychological support systems was reviewed with newly commissioned Racial Trauma Support service with NAFSIYAT intercultural Centre launched in 2023, with reflective practice sessions delivered by NAFSIYAT. - PCG indicators integrated into new People and Culture Plan Dashboard including WRES. Analysis of new RADAR system records on racism related incidents has been collated and will be benchmarked with Q4 and Q4 data for reporting into EDI Steering Group. New RADAR system incorporates microaggressions and allows for one or more protected characteristics to be included in analysis - Improved representation at AfC B6 as a result of a push to develop the leadership skills of colleagues from Black, Asian and Minority Ethnic backgrounds. - Incorporation of pastoral care into on-boarding programme for internationally educated staff, involving their managers and team members. - Data for ethnically diverse staff in formal and informal disciplinary are presented and discussed as a standard agenda item at the bi-monthly People Committee.	Organizational preference not to produce a comprehensive WRES action plan but instead to incorporate actions into a wider EDI plan.
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Do you have a Workforce Race Equality Standard Action Plan for 2024 / 2025?	<table><thead><tr><th>Response</th><th>Count</th><th>Percentage</th></tr></thead><tbody><tr><td>Yes</td><td>7</td><td>50%</td></tr><tr><td>In Progress</td><td>5</td><td>36%</td></tr><tr><td>No</td><td>14</td><td>14%</td></tr></tbody></table>	Response	Count	Percentage	Yes	7	50%	In Progress	5	36%	No	14	14%
Response	Count	Percentage											
Yes	7	50%											
In Progress	5	36%											
No	14	14%											
Good Practice	Challenges												

• Actions to improve ethnicity outcomes are included in the wider EDI Plan.	• Actions to improve ethnicity outcomes are included in the wider EDI Plan. Lack of Capacity within the EDI function impacts progress. • The key again, is resources.
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Section 5 Workforce Disability Standard

Do you have a Workforce Disability Standard Action Plan for 2023 / 2024?



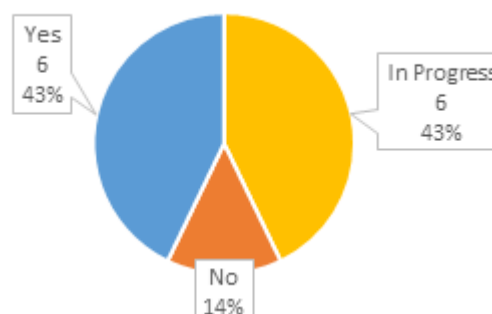
Good Practice

- RADAR incident system records on ableism-related incidents have been collated and will be benchmarked with Q4 and Q4 data for reporting into EDI Steering Group
- Significant development of EDI webpages on disability topics
- Achievement of HPMA Excellence Award for work on disability Reasonable Adjustments
- Achievement of Disability Confidence Level 3 (Leader)

Challenges

- Actions to improve ethnicity outcomes are included in the wider EDI Plan. Lack of Capacity within the EDI function impacts progress.
- The challenge is trying to provide parity of support with competing priorities – the main focus of work has been on becoming an anti-racist organisation.
-

Do you have a Workforce Disability Standard Action Plan for 2024 / 2025?



Good Practice

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Challenges

- Actions to improve ethnicity outcomes are included in the wider EDI Plan. Lack of Capacity within the EDI function impacts progress.

	The challenge is trying to provide parity of support with competing priorities – main focus of work has been on becoming an anti-racist organisation.
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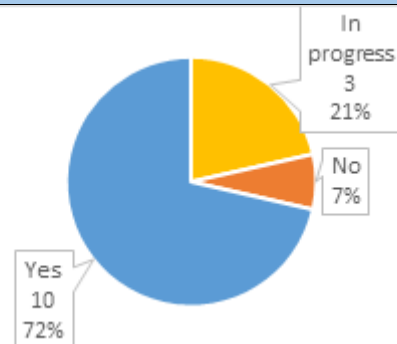
ICB Area Analysis

Overall, work towards improving WRES/WDES outcomes is being aligned with, and supported by work, to achieve the Anti-racism Framework and EDI Plan. 93% and 50% of system organisations reported having a WRES Plan in place for 2023/24 and 2024/25 respectively. This drops to 86% and 43% respectively for WDES Plans.

Whilst progress and some areas of good practice is being reported, poor quality data (disability in particular), capacity and a lack of resources remain challenges to progress.

Section 6 EDS22

Have you published your EDS22 report for 2023 / 2024?

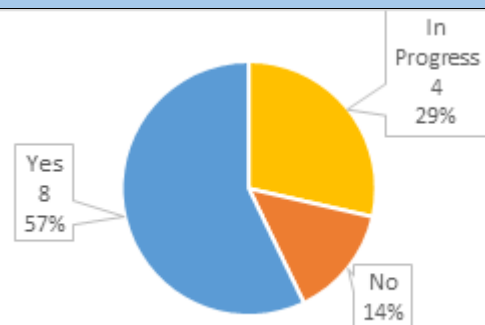


ICB Area Analysis

72% of system organisations have published their EDS22 report for 2023 / 2024.

Section 7 Pay Gap Reporting

Have you published your Gender Pay Gap Report for 2023 / 2024?



Do you have a Gender Pay Gap improvement plan to eliminate / reduce any gender pay gaps?	<table border="1"><thead><tr><th>Response</th><th>Count</th><th>Percentage</th></tr></thead><tbody><tr><td>Yes</td><td>11</td><td>79%</td></tr><tr><td>In Progress</td><td>1</td><td>7%</td></tr><tr><td>No</td><td>14</td><td>14%</td></tr></tbody></table>	Response	Count	Percentage	Yes	11	79%	In Progress	1	7%	No	14	14%
Response	Count	Percentage											
Yes	11	79%											
In Progress	1	7%											
No	14	14%											
Good Practice	Challenges												
	Addressing the bonus pay gaps for medical staff.												
ICB Area Analysis													
57% of system organisations published their Gender Pay Gap Report for 2023 / 2024. Whilst 79% have developed improvement plans to address pay gaps identified.													
The main areas of focus of work have been to offer flexible working, carers support, and menopause support.													

Have you published your Ethnicity Pay Gap Report?	<table><tr><th>Response</th><th>Count</th><th>Percentage</th></tr><tr><td>In Progress</td><td>7</td><td>50%</td></tr><tr><td>No</td><td>5</td><td>36%</td></tr><tr><td>Yes</td><td>2</td><td>14%</td></tr></table>	Response	Count	Percentage	In Progress	7	50%	No	5	36%	Yes	2	14%
Response	Count	Percentage											
In Progress	7	50%											
No	5	36%											
Yes	2	14%											
Do you have an Ethnicity Pay Gap improvement plan to eliminate / reduce any ethnicity pay gaps?	<table><tr><th>Response</th><th>Count</th><th>Percentage</th></tr><tr><td>In Progress</td><td>7</td><td>50%</td></tr><tr><td>No</td><td>7</td><td>50%</td></tr></table>	Response	Count	Percentage	In Progress	7	50%	No	7	50%			
Response	Count	Percentage											
In Progress	7	50%											
No	7	50%											
Good Practice	Challenges												
	Failure to address biased recruitment, progression processes and talent management as signified in WRES results due lack of resources to develop inclusive												

	processes and support manager development. • Lack of functionality in ESR to produce Ethnicity pay gap data in same way as GPG. • The quality of ethnicity pay gap reporting is impacted by disclosure rates in ESR • Lack of guidance and templates similar to that provided for GPG reporting to ensure consistent and accurate reporting year on year and across the system.
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Have you published a Disability Pay Gap Report for 2023 / 2024?	<table><thead><tr><th>Response</th><th>Count</th><th>Percentage</th></tr></thead><tbody><tr><td>Yes</td><td>1</td><td>7%</td></tr><tr><td>In Progress</td><td>21</td><td>21%</td></tr><tr><td>No</td><td>10</td><td>72%</td></tr></tbody></table>	Response	Count	Percentage	Yes	1	7%	In Progress	21	21%	No	10	72%
Response	Count	Percentage											
Yes	1	7%											
In Progress	21	21%											
No	10	72%											

Do you have a Disability Pay Gap improvement plan to eliminate / reduce any disability pay gaps?	<table><tr><th>Response</th><th>Count</th><th>Percentage</th></tr><tr><td>No</td><td>9</td><td>64%</td></tr></table>	Response	Count	Percentage	No	9	64%
Response	Count	Percentage					
No	9	64%					

Good Practice	Challenges
	• Failure to address biased recruitment, progression processes and talent management as signified in WDES results due lack of resources to develop inclusive processes and support manager development. • Lack of functionality in

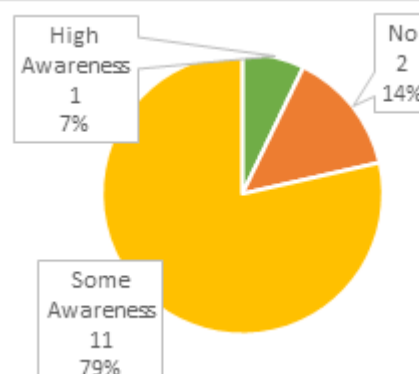
	ESR to produce Ethnicity pay gap data in same way as GPG • The quality of the disability pay gap reporting is significantly impacted by disclosure rates in ESR • Lack of guidance and templates like that provided for GPG reporting to ensure consistent and accurate reporting year on year and across the system.
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ICB Area Analysis

14% and 1% of system organisations have reported publishing their Ethnicity and Disability Pay Gap Reports respectively. 50% (ethnicity) and 5% (disability) are in the process of developing plans to eliminate identified gaps. Disclosure rates, ESR functionality and biases within recruitment processes continue to pose challenges to making progress in this area.

Section 8 Model Health Care System

Are you aware of your organisations Model Health System EDI Report?

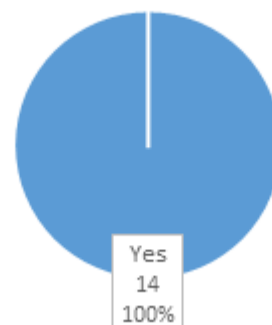


Do you use your organisations Model Health System EDI Report to evidence and inform your EDI Plans?	A pie chart showing the distribution of responses. The largest slice is grey, labeled '(blank)' with 11 responses (79%). A smaller orange slice is labeled 'No' with 2 responses (14%). A small blue slice is labeled 'Yes' with 1 response (7%). <table><thead><tr><th>Response</th><th>Count</th><th>Percentage</th></tr></thead><tbody><tr><td>(blank)</td><td>11</td><td>79%</td></tr><tr><td>No</td><td>2</td><td>14%</td></tr><tr><td>Yes</td><td>1</td><td>7%</td></tr></tbody></table>	Response	Count	Percentage	(blank)	11	79%	No	2	14%	Yes	1	7%
Response	Count	Percentage											
(blank)	11	79%											
No	2	14%											
Yes	1	7%											
Would you find a session on how to access, use and apply the EDI Model Health System reporting tool useful?	A pie chart showing the distribution of responses. The largest slice is blue, labeled 'Yes' with 12 responses (86%). A smaller orange slice is labeled 'No' with 2 responses (14%). <table><thead><tr><th>Response</th><th>Count</th><th>Percentage</th></tr></thead><tbody><tr><td>Yes</td><td>12</td><td>86%</td></tr><tr><td>No</td><td>2</td><td>14%</td></tr></tbody></table>	Response	Count	Percentage	Yes	12	86%	No	2	14%			
Response	Count	Percentage											
Yes	12	86%											
No	2	14%											

Section 9 Further Support

Overall, how would you rate your organisations performance on Equality, Diversity and Inclusion?	<table border="1"><thead><tr><th>Rating</th><th>Count</th><th>Percentage</th></tr></thead><tbody><tr><td>Good</td><td>9</td><td>64%</td></tr><tr><td>Average</td><td>4</td><td>29%</td></tr><tr><td>Poor</td><td>1</td><td>7%</td></tr></tbody></table>	Rating	Count	Percentage	Good	9	64%	Average	4	29%	Poor	1	7%
Rating	Count	Percentage											
Good	9	64%											
Average	4	29%											
Poor	1	7%											
Are there any other areas of your EDI work you would like to describe and highlight, that can be shared as helpful resources for other organisations?	• Achievement of Rainbow Badge Phase 2 Bronze award • Navajo charter mark holder • Disability Confident Leader • Policy improvement and practices - Staff networks now core members of policy ratification												

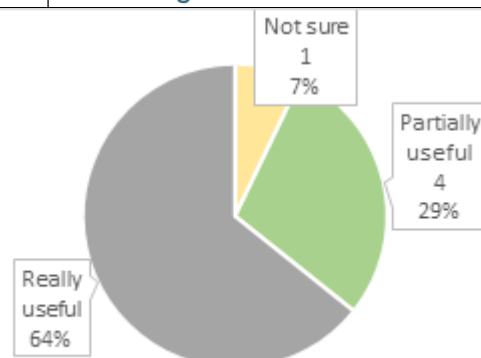
Would you find it useful to have EDI specific Communities of Practice?



If yes, what would you like the Communities of Practice to focus on?

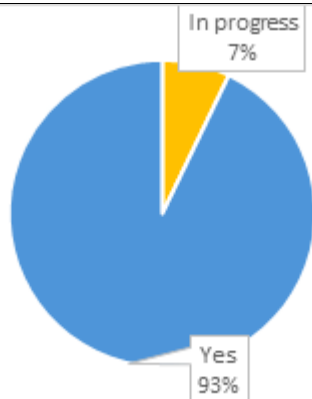
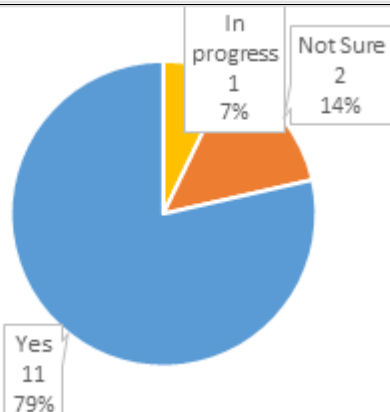
Model Health Care System	9
EDS22	9
Anti Racism Framework	9
Sexual Safety Charter	8
High Impact Actions	8
Gender Pay Gap	5
WRES	3
WDES	3

Would you find a single NW EDI Futures site useful, which included a page for your organisation to share best practice?



Please describe any other areas of challenge or concern below.

- Significant lack of EDI resource and Investments in building EDI capability within the organisation not helped by national communications (Steve Barclay's letter)
- The primary objective of embedding EDI into all organisational processes takes time with stakeholders (see above point), time that can't be invested in when the mandated and regionally reporting requirements are so high.
- Lack of coordinated system wide approach to EDI training/development programmes & funding.
- The data in Model Health Employer is very limited and therefore of limited use.

	- There is very poor regional collaboration, repeated requests for feedback are met with silence. A regional interactive mailbox for sending and receiving correspondence would be very useful. - The lack of ICB and NHSNW EDI coordination of EDI initiatives on behalf of the region is resulting in duplicated requests.												
Please re-confirm that your organisation has signed up to the NHS England Sexual Safety Charter?	 <table><tr><th>Response</th><th>Count</th><th>Percentage</th></tr><tr><td>Yes</td><td>93</td><td>93%</td></tr><tr><td>In progress</td><td>7</td><td>7%</td></tr></table>	Response	Count	Percentage	Yes	93	93%	In progress	7	7%			
Response	Count	Percentage											
Yes	93	93%											
In progress	7	7%											
Does your organisation have a named Domestic Abuse and Sexual Violence (DASV) Lead?	 <table><tr><th>Response</th><th>Count</th><th>Percentage</th></tr><tr><td>Yes</td><td>11</td><td>79%</td></tr><tr><td>In progress</td><td>1</td><td>7%</td></tr><tr><td>Not Sure</td><td>2</td><td>14%</td></tr></table>	Response	Count	Percentage	Yes	11	79%	In progress	1	7%	Not Sure	2	14%
Response	Count	Percentage											
Yes	11	79%											
In progress	1	7%											
Not Sure	2	14%											
If you have a named Domestic Abuse and Sexual Violence (DASV) Lead, can you please provide their name and email address?													

The LEAF report was prepared by Thomasina Afful, Associate Director for Equality Diversity and Inclusion.

Conclusion

NHS Cheshire and Merseyside will continue to drive forward our Equality Objectives and all the aspects outlined within this report. We will support the development of our staff groups ensuring that they are listened to and are involved in policy and service development and decision making.

We will support our commissioned services to fully implement the Public Sector Equality Duty and to progress with improving access to services for patients, better outcomes for patients and reducing health inequalities. Patients and our workforce will remain our priority in delivering effective, efficient, and equitable services. Health inequalities will continue to be addressed and monitored across the region. Our Equality Objectives will underpin the values of the organisation as we continue to improve equality, diversity, and inclusion. We will continue to ensure that services are equitable and that there are no disparities across Cheshire and Merseyside for patients accessing healthcare. As a commissioning body we will continue to quality check and measure the quality, equality and effectiveness of the services provided.