NHS
Birmingham and Solihull
Clinical Commissioning Group

Equality Objectives and Health Inequalities Strategy 2018 - 2021

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Review and amendment log

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Birmingham and Solihull
Clinical Commissioning Group

Contents

Policy overview

Purpose

The Equality Objectives and Health Inequalities Strategy 2018 – 2021 for the newly formed Birmingham and Solihull CCG has been developed to ensure we commission health services that meet the needs of our local diverse communities and populations.

We recognise the link between equality and health inequalities and have developed the Equality and Health Inequalities Strategy 2018-21 to set out our response to tackling this challenging agenda.

Who this policy applies to

This policy applies to all staff, members, and patients.

Key principles

Equity, fairness, equality, diversity, human rights, reducing health inequalities

Legal considerations

The NHS Birmingham and Solihull Clinical Commissioning Group, will operate within the legal framework of the Equality Act 2010, Public Sector Equality Duty, Human Rights Act 1998 and the Health and Social Care Act 2012.

Supporting principles

Our Equality Objectives 2018 – 2021

Through a process of assessment, review, and engagement with stakeholders we have identified the following three high level equality objectives:

1. We will commission health services that are informed by local needs and people, improve access, and reduce health inequalities.

2. We will work with our local partners to improve health outcomes and in doing so, will support the voices of vulnerable and disadvantaged groups and communities to be heard.

3. We will develop our workforce across all levels of the organisation, where staff are engaged and supported, and leaders and managers foster a culture of inclusion, wellbeing, and diversity.

Strategic and measurable actions and commitments are in place to support the implementation of the equality objectives and are detailed within the strategy. An annual action plan will be developed to ensure the delivery of the strategy and will be reviewed annually to ensure ongoing relevance to the needs of the organisation as it continues to evolve and develop.

Our Values

We have developed our organisations values through engagement with clinical leaders and staff. Our values build on the NHS constitutional values and will underpin everything that we do. Our values are;

- **Working together for patients**
- **Respect and dignity**
- **Commitment to quality of care**
- **Compassion**
- **Improving lives**
- **Everyone counts**

The policy

Context

NHS Birmingham and Solihull (BSOL) Clinical Commissioning Group is a new organisation and in the first year of its authorisation. It reflects the merger of three previous CCGs - Birmingham Cross City, Birmingham South Central, and Solihull CCG and mirrors the footprint and ambitions of the Sustainability and Transformation Plan (STP) and Five Year Forward View. The services are delivered across a diverse and complex health economy encompassing 208 practices, two local authorities, a vibrant independent sector, serving a population of around 1.8 million people.
The STP seeks to improve its use of resources by addressing any variation in clinical services due to unjustified variation in quality and access, and by freeing up resources in acute settings by delivery of care in other settings, such as community settings. The BSOL Equality and Health Inequalities Strategy seeks to support the outcomes of the STP.

Leadership and Governance

The BSOL CCG has developed robust governance arrangements for the effective strategic oversight along with effective operational delivery of the equality and health inequalities agenda. The Quality and Safety Committee (QSC) has oversight of the Equality and Health Inequalities Strategy and the Governing Body retains delegated responsibility for the Public Sector Equality Duty. The organisation will develop an operational equality and health inequalities delivery group made up of representatives from across the organisation and its 6 localities to ensure effective communication and implementation of the strategy. The Chief Nurse is the Equality Champion for the organisation. We will undertake bi-monthly equality reporting to the QSC.
There are robust performance and business planning processes in place which ensure all commissioning decisions are assessed for their impacts on equality, health inequalities, social value, and human rights, and this forms an integral part of all policy and commissioned service development. This will be reviewed periodically to ensure effective integration of equality and diversity across the workings of the organisation.

Equality Act 2010 and Public Sector Equality Duty

We have a legal duty to demonstrate due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic and those who do not share it, in accordance with Section 149 of the Equality Act 2010 (the Public Sector Equality Duty), and the Equality Act 2010 (Specific Duties) Regulations 2017. The protected characteristics are:

- Age
- Disability
- Gender
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sexual orientation
- Marriage and civil partnership

We are required to develop our equality objectives in consultation with our communities and publish one or more equality objective on 30 March 2018, and going forward annually (at intervals of no more than one year from the last publication). This includes the Gender Pay Gap report.

Health and Social Care Act 2012

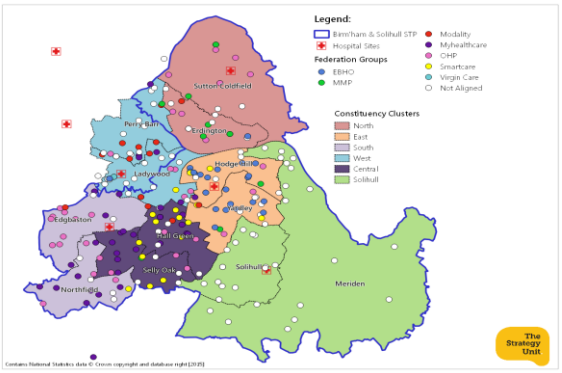
We will also demonstrate due regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities, in accordance with the Health and Social Care Act 2012.
Avoidable health inequalities are – by definition - unfair and socially unjust. A person's chance of enjoying good health and a longer life is determined by the social and economic conditions in which they are born, grow, work, live and age. These conditions also affect the way in which people look after their own health and use services throughout their life. Addressing such avoidable inequalities and moving towards a fairer distribution of good health requires a life course approach and action to be taken across the whole of society.
The NHS Five Year Forward View sets out the need to address the health and wellbeing gap, preventing any further widening of health inequalities. To do so requires a move towards greater investment in health and health care where the level of deprivation is higher.
There is clear evidence that reducing health inequalities improves life expectancy and reduces disability across the social gradient. Tackling health inequalities is therefore core to improving access to services, health outcomes, improving the quality of services and the experiences of people. It is also core to the NHS Constitution and the values and purpose of the NHS.

Our Population

A range of data and information has been brought together and assessed to understand the demography of our population and to determine the key health needs and health priorities for Birmingham and Solihull. This information has been drawn from a range of sources including Public Health Birmingham, Census 2011, Health Observatory, and the Office for National Statistics population estimates.

Localities

The organisation is structured around 6 localities which will ensure that local health needs are identified and services designed and commissioned to meet the needs of local people and places.



LOCALITY	Parliamentary Constituency	Population
NORTH	Sutton Coldfield	94,661
	Erdington	100,954
EAST	Hodge Hill	127,751
	Yardley	111,208
SOUTH	Edgbaston	101,633
	Northfield	102,929
WEST	Perry Barr	109,312
	Ladywood	138,025
CENTRAL	Selly Oak	106,288
	Hall Green	118,546
SOLIHULL	Solihull	100,622
	Meriden	109,823

Locality data is informed by district constituency data, practice level data, public health data, and demographic profile information. We will develop detailed profiles for each of our localities which will set out local data and information that will shape and inform planning of local health population needs and identify and manage health inequalities.

Birmingham and Solihull Key Population Features

Deprivation

Birmingham

- With a population of 1,073,045 Birmingham is the second largest city in the UK with the largest Local Authority in both the UK and Europe. Ranked the ninth most deprived Local Authority in England out of 354 with around six in ten of the Birmingham population living in the 20% most deprived neighbourhoods in England. Birmingham's life expectancy is lower than England as a whole for both men and women. There is a nine -year difference in the life expectancy of people who live in deprived communities and those from more affluent areas. People in this decile are 3x more likely to be in contact with mental health services, be admitted for ambulatory sensitive conditions, or die from conditions amenable to healthcare. Across the STP the proportion of people with a learning disability on the GP register receiving an annual health check is the lowest across all STP's (28.6%). NHSE has set a target of 75% by 2020. We are also becoming more diverse as a population, with different expectations and requirements of health and care services.

Solihull

- With an estimated population of 210,445 Solihull is a broadly affluent borough in the both the regional and national context. Levels and extent of deprivation are limited with only 22 of the borough's 134 Lower Super Output Areas (LSOAs) in the most 20% deprived areas in the country and just eight in the bottom 5%. The Wards of Chelmsley Wood, Kingshurst & Fordbridge and Smith's Wood and most notably impacted by deprivation. Deprivation issues include fuel poverty and access to transport. There is a life expectancy gap of eleven years between the most and least affluent. 21% of 0-4 were recorded as living in poverty in 2013, compared to 13% of 11-15 year olds and 10% of 16-19 year olds, residing in the north regeneration wards.

Age

Birmingham

- Characterised by its younger population 66% of Birmingham residents are under 45 years and 17% in the 20-29 age group. 13% of the population is over 65 years old and is set to remain stable with many retirees continuing to move out of the City. The health needs of young people show that they have a relatively unhealthy start in life. The health of children in Birmingham is worse than England overall. This is reflected in a high level of infant mortality, low birth weight babies and high childhood obesity rates. Birmingham's teenage conception rate is one of the highest in the country.

Solihull

- Conversely, Solihull is characterised by its older population. Between 1995 and 2015 the population aged 65 and over increased from 16% to 21% of the total so that there are now 9,200 more residents aged 65 to 84 years and 3,500 more aged 85 years and over than 20 years ago. Population projections based on the 2014 population estimates indicate the relative ageing of the Solihull population will continue and by 2033 those aged 65 and over will account for one in four of the borough population, with those aged 85+ numbering nearly 12,000 (5% of total). The growth in the numbers of those aged 85 and over represents a significant and growing challenge in terms of health and social care.

Ethnic and Religious Diversity

Birmingham

- Ethnic diversity is a significant feature for Birmingham's demography with a Black and Minority Ethnic (BAME) profile of around 42% and a range of languages spoken. Christianity is the largest religion at 46%, followed by Muslim at 22%. Around 22% of Birmingham's residents are born overseas and 15% of the population is classified as having a main language other than English. There is a recognised link between poor health outcomes and English language needs. Wards with the highest number of recent migrants (arriving between 2001 and 2011) were Ladywood 73%, followed by Nechells (59.5%) and Harborne (50.7%).

- Figures for the West Midlands region shows the top three country of origin for international migrants arriving before 1961 were Ireland, India and Jamaica. For each subsequent decade until 2001, Pakistan, India and Bangladesh were the most reported countries of origin. Since 2001, it has been Poland followed by Pakistan and India. GP registration data on new patients who are recorded as being born outside the UK (Flag 4 data) shows

an increase of 81,314 in overseas migrant registrations within Birmingham between 2013-2016. The highest number of new registrations were from those from Romania (11,715), followed by Pakistan (6,704) and China (6,095). Most applications for work come from Romania, Poland, and Bulgaria. Migrant health priorities include tackling Female Genital Mutilation (FGM), communicable diseases such as HIV and TB, access to screening and vacs, and mental health.

- Birmingham has a substantial Gypsy Roma Traveller (GRT) community, with estimates of more than 1000 GRT people living in Birmingham and a planned traveller site located in Aston. There are also 70 gypsy or Irish Travellers living in Solihull a new population group introduced for the 2011 Census.

Solihull

- In Solihull, the BAME population has more than doubled since the 2001 Census and now represents nearly 11% of the total population. On this basis the borough is less diverse than England as a whole (and significantly less so than Birmingham), but with BAME groups representing a relatively higher proportion of young people in Solihull (over 17% of those aged 15 and under) this representation is set to increase. In terms of religion, the majority of Solihull residents describe themselves as Christian (65.6%), with no religion the 2nd largest group (21.4%). The largest BAME group in Solihull is Asian or Asian British with over 13,500 residents (6.6% of the total population or 60% of all BAME residents), followed by mixed race (4,400), and Black or Black British (3,200). 15,386 (7.4%) Solihull residents were born outside of the UK, which proportionally is much lower than the England (13.8%). Of those born outside of the UK 70% have been resident in the UK for 10 years or more, this shows that immigration has been a less significant feature of Solihull's demography than many other parts of the country.

Disability

Birmingham

- 9.1% of the Birmingham population reported a life limiting condition or disability, with a further 9.3% of the population classified as their day to day activities were limited a little by a life limiting condition; with significant prevalence for those aged 65 years and over. Mental illness is associated with one in every five people occupying a hospital bed each day in Birmingham. The percentage of the population who suffer from a mental health condition in Birmingham is 1% compared to the NHS England's indicator of 0.8%.

- The most common mental health problems in Solihull are neurotic disorders and depression. Large numbers of people in Solihull, over 24,000, are estimated to be suffering from these conditions - this represents 1 in 6 of the population aged 15-74. These conditions are more common in women and affect all age groups. 45.5% of Birmingham population has very good health compared to 47% of Solihull population. Across the STP the proportion of people with a learning disability on the GP register receiving an annual health check is the lowest across all STP's (28.6%). NHSE has set a target of 75% by 2020.

Sexual Orientation and Gender Identity (Trans and Non Binary People)

- Birmingham Lesbian Gay Bisexual Transgender (LGBT) organisation stated (in their report 'Out and About: Mapping LGBT lives in Birmingham') that whilst there are no agreed figures as to the percentage of the LGBT population, estimates of between 6% and 10% are popularly used. There is evidence that indicates LGBT people experience discrimination when using health services and report having a poorer patient experience.

- There is a lack of good quality statistical data regarding trans people in the UK. Current estimates indicate that some 650,000 people are "likely to be gender incongruent to some degree". There is research evidence which indicates that trans people experience fear and discrimination when accessing health services.
- The CCG will work to support the findings of the review into NHS National Gender Identity Services Review which is due to report in early 2018.

Homeless

- Birmingham accounts for almost half of all homelessness acceptances in the West Midlands and 9 per cent of the national total. In comparison with neighbouring authorities and core cities, rates of homelessness are disproportionately high.

- The main reasons for homelessness amongst priority homeless households are parents, relatives or friends no longer willing to accommodate (31 per cent of acceptances). Domestic violence is the single highest reason for households making homeless applications.

- Understanding the issues around homelessness is important in terms of access to healthcare, GP registration issues and discharge from hospital.

Equality and Health Inequality Issues and Priorities

Health Inequalities

Deprivation

Practice level deprivation scores for 2016/17 indicate that of the 208 practices across BSOL 144 are within the national upper quartile of most deprived, and 19 practices in the lower quartile of least deprived (10 of the least deprived practices are within Solihull).

Healthy Life Expectancy

This is a measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health. Healthy life expectancy is significantly lower in Birmingham at 58.4 years for men and 59.4 years for women compared to 63.4 and 64.1 years respectively for England.

Years of Life Lost

Another way to measure premature mortality is the number of years of life lost (YLL) due to people dying before the age of 75. Using this indicator, it is possible to identify the major health conditions that contribute to the gap in this measure of life expectancy and the England average.

Birmingham's life expectancy is lower than England as a whole for both men and women. There is a nine-year difference in the life expectancy of people who live in deprived communities and those from more affluent areas. There is an eleven-year life expectancy gap between the least and most deprived areas of Solihull.

The top conditions (excluding infant mortality) contributing to excess years of life lost in Birmingham are:

- Coronary Heart Disease
- Lung Cancer
- Alcoholic Liver Disease
- Other Heart Disease
- Pneumonia

The top conditions (excluding infant mortality) contributing to excess years of life lost in Solihull are:

- Heart Disease
- Stroke
- Cancer

A&E Attendance

For 2016/17 there were 452,878 A&E attendances across BSOL. Just under half of these attendances (43%) occurred in the most deprived (Index of Multiple Deprivation) neighbourhoods indicating a correlation between high levels of deprivation and higher rates of A&E attendance. 31% of all A&E attendances resulted in admission in the most deprived neighbourhoods, compared to 47% in the least deprived neighbourhood. There is a lower proportion of emergency admissions in the most deprived areas in relation to the overall numbers of A&E attendances, indicating a higher level of inappropriate use of A&E services.

Access to Primary Care

Addressing the inequity of access to primary care services is a priority for the City and wider BSOL CCG footprint. There is variability in GP services in terms of consistent access, levels of provision, and quality of service. The BSOL CCG has an ambition to minimise any unfair variations to improve overall access and utilisation of primary care provision and will take forward the STP universal offer for primary care.

Dementia Diagnosis

The national target for recording dementia diagnoses is 66.7% of the estimated underlying prevalence. As of December 2017 the estimated overall prevalence of dementia for Birmingham and Solihull is 13,865 patients with an actual diagnosis rate of 67.43%. There are an estimated 4516 patients who may be suffering from dementia but are not being captured within GP clinical systems at present. 85 of our 208 practices are achieving the national target (40.87%). There is variation across our localities in dementia diagnosis.

Diabetes

Across BSOL CCG practices there is a diabetic register total of 100,263 of a list size of 1,094,053 (17+ years) patients, indicating a prevalence rate of 9.16%. This is in line with Public Health estimates. However, there is significant variation at the practice level with a minimum practice level prevalence of 0.83% and a maximum of 19.35%. Some of this variation is due to the small numbers involved and also factors such as population age (due to high numbers of students within some localities). There is variation across our localities in diabetes diagnosis.

GP Registration and Access

There is evidence that many patients and in particular those from vulnerable and disadvantaged backgrounds including migrants, asylum seekers, gypsy roma travellers, homeless, and LGBT, find it difficult to register and maintain a registration with some GP practices. This is due in part to an inability to provide documentation to the practice in support of who they are or where they live. This results in poorer access to healthcare overall and can lead to inappropriate use of A&E and exacerbating health inequalities for some sections of the community.

Access to a GP appointment also remains a high concern for patients with results from the Patient Survey 2017 indicating a variation in patient experience of getting an appointment across the three former CCG areas.

Patient Survey 2017: Patients were asked to rate their overall experience of making an appointment

	Overall % good experience	Lowest performing practice within CCG %	Highest performing practice within CCG %
Birmingham Cross City CCG	66%	33%	97%
Birmingham South Central CCG	70%	38%	96%
Solihull	69%	41%	96%

We are committed to improving access to Primary Care by undertaking effective needs assessment and planning at the locality level through the development of locality structures and through the identification of health inequalities and health needs for local communities and patient populations. In addition, we will monitor the Care Quality Commission (CQC) ratings of all GP practices.

Migrant Health

The profile of migrants within Birmingham is changing and growing. There is evidence that many migrants are relatively healthy upon arrival but that good health can deteriorate overtime in the receiving society. A number of factors impact on migrant health including mental health, social isolation, dispersal into society, and poverty:

- There are higher rates of unmet mental health needs including depression, post-traumatic stress disorder, anxiety and psychosis. There are different cultural perspectives on mental health which may not be expressed.
- Barriers to primary care include being unable to register due to inability to provide documentation, a lack of trust in GPs due to a lack of agency and knowledge of the healthcare system, and different cultural expectations of care and treatment.
- Language barriers
- Communicable diseases such as HIV, TB and Measles
- Access to screening and vaccinations – particularly for pregnant migrant women
- Female Genital Mutilation (FGM) impacting on migrants from some African countries
- Fears about healthcare charging, confidentiality, and confusion in the system

We are committed to improving the health of migrant communities through;

- the removal of barriers in primary care through review and promotion of Safe Surgeries Toolkit and GP learning events;
- working with mental health providers to improve access and promote inclusive practices;
- tackling FGM through improvements in recording in primary care and implementation of the Birmingham FGM Strategy.

Mental Health

Mental health needs and demand for mental health services has grown significantly with the ambition of achieving parity of esteem with physical health services. There are a number of areas in which access to mental health services will be improved:

- Increase access to psychological therapies for groups particularly where there is evidence of poor access (young people, migrant communities and BAME communities)
- Better mental health care for new and expectant mothers
- Improved care for children and young people through NHS-commissioned community services
- Work with providers to deliver inclusive mental health care and provision

People with Learning Disabilities

The aims of the 'Transforming Care' agenda are to transform care locally for people with learning disabilities and /or autism who display behaviour that challenges / mental health needs. We are committed to

- Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism
- Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population
- Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check
- Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism.
- Reviewing the Accessible Information Standard and Patient Passport to ensure effective communication support to disabled people

Children and Young People

Infant mortality

Birmingham is a national outlier for infant mortality (7.1 in Birmingham, 4.9 in Solihull – Deaths/1,000 live births). This is compared to the national average of 4 per 1,000 live births.

We are committed to improving mental health care for new and expectant mothers, and to implement the national maternity services review, Better Births, through local maternity systems which will have a positive impact on pregnancy and maternity. We will also support the STP ambition to improve infant mortality and child health.

0-25 years Mental Health

We commission Forward Thinking Birmingham to deliver community mental health services to children and young people up to the age of 25 years. We are committed to improving access to mental health services to young people:

- More high-quality mental health services for children and young people
- Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases
- Improve access to psychological therapies for children living in deprived areas

What we learned from our Equality Delivery System 2 Assessments

The Equality Delivery System 2 (EDS2) is an NHS equalities framework tool which enables organisations to assess their equality performance in respect to patients and staff. Implementing EDS2 became a mandatory requirement for NHS Organisations and CCGs in 2015. The three CCGs each undertook an assessment and grading exercise to establish the equality performance along with establishing some of the priority equality issues.

We entered into a period of consultation from 1 January to 31 January 2018 where we sought the views of our patients, staff, communities, providers, GP members, third sector and other stakeholders to ensure our equality objectives reflect the most pressing needs and priorities for protected and vulnerable groups and communities and are reflective of the most significant health equality issues impacting on the organisation and the population and communities across Birmingham and Solihull.

The consultation process took the form of an on-line survey, and two focus group sessions. A list of the stakeholders participating in EDS2 and in the consultation can be found in appendix 1.

The key themes and issues identified through our analysis of data, Equality Delivery System 2, and from stakeholder input revealed the following equality and health inequality issues for Birmingham and Solihull:

EDS2 Issues	What we learned
Access	• **There are delays and challenges for people experiencing mental health to receive the mental health care they need, particularly young people and people from BAME communities.** • Accessibility barriers for disabled patients – there is evidence that many patients miss appointments because of **failures to provide appropriate accessible adjustments or poor referral information**. • **Accessibility to GP appointments – a number of barriers were highlighted including access to the surgery, availability of on-the day and weekend appointments, registration process can be inaccessible and inconsistent, dignity and privacy at reception.** These structural barriers add to the societal and cultural barriers that can prevent people from accessing health care support when they need it. • **Barriers to registering** with primary care services for Gypsy Roma Traveller communities, homeless, patients in nursing homes, LGBT patients, and migrant communities – identified need to address transiency and diversity. Migrant communities experience barriers to ring with a GP due to fears of not having a post code or identification and also fears of health care charges. • We need to understanding the impacts of the **Accessible Information Standard (AIS)** has had on disabled patients and their access to health services.

Health Inequalities	• A robust strategic response to reducing health inequalities and **undertaking place based commissioning** – understanding our localities, local communities and the health priorities for these communities

Inclusion	• Inclusion need to be a consideration at every stage and aspect of someone's journey through the health system, and must be commissioned as such
	  • *E.g. "the **Patient Passport works well if people know about it**, and are empowered to use it. We were told that more work needs to be done to promote the Patient Passport, the formats in which is it available, and explore how it can benefit other vulnerable groups as well as disabled people"*
	  • *E.g. the most effective **reasonable adjustment** someone can make for a disabled person is a simple change in attitude".*
	• There is also variation in the ability of organisations in the **provision of language and interpretation services** at the correct intervention points to ensure patient safety and improve patient experience.
	• **Standards of practice around interpreting** were identified as preventing vulnerable people from either accessing their healthcare appointment or not being able to make proper decisions about their care plan, safeguarding issues could also become hidden behind family members acting as interpreters - variations in the quality and level of resource were highlighted as barriers.
	• **Screening and health checks for vulnerable groups** including people with learning disabilities, migrant communities, and older males.
	• It was felt that there was **insufficient focus on children's health** - concerns were expressed around the removal of children's services out of children centers into hubs and access to mental health support

Patient Experience and Voice	• We need to provide opportunities for **'seldom heard groups'** to shape health services E.g. pregnant migrant women and LGBT people • We need to provide better **feedback to patients** • **Partnership working with third sector and community** groups was seen as an opportunity to delivering care closer to home and building trust within local communities • LGBT – sexual health provision and **poor patient experience** of local primary care services was identified as an issue

Birmingham and Solihull
Clinical Commissioning Group

Equality Objectives

The Birmingham and Solihull CCG has identified the following three equality objectives through consultation with its stakeholders:

1. **We will commission health services that are informed by local needs and people, improve access, and reduce health inequalities.**

2. **We will work with our local partners to improve health outcomes and in doing so, will support the voices of vulnerable and disadvantaged groups and communities to be heard.**

3. **We will develop our workforce across all levels of the organisation, where staff are engaged and supported, and leaders and managers foster a culture of inclusion, wellbeing, and diversity.**

The equality objectives are strategically aligned to the following drivers:

- NHS Equality Delivery System 2
- Birmingham and Solihull CCG Commissioning Strategy
- Birmingham and Solihull Organisational Values
- NHS Constitutions
- NHS Standards
- Sustainability and Transformation Plan
- Five Year Forward View

The equality objectives have a lifecycle of 3 years. Action plans will be developed annually to ensure the objectives are operational and progress is measured and reviewed. The performance measures and indicators will be developed, monitored and reviewed over the lifetime of the objectives. The performance measures will be aligned to the Quality Outcomes Framework (QOF) and NHS and Public Health Business Intelligence.

The Equality Objectives and Health Inequalities Strategy 2018 – 2021 will be published on 30th March 2018 and overseen and governed by the Quality and Safety Committee.

Equality Objective 1

We will commission health services that are informed by local needs and people, improve access, and reduce health inequalities.

Why is this important?

Our priority is to develop, commission, and procure health services that are responsive to the needs of local people and communities, where the needs of the most vulnerable and those with greatest needs can be identified and met. We know

- There is a ten-year difference in the life expectancy of people who live in deprived communities and those from more affluent areas with unacceptable variations in access to health services.
- People with learning disabilities are less likely to have a health check, have longer periods of hospitalisation and more likely to die early from conditions that are amenable to health care.
- People with disabilities continue to experience barriers to accessing the reasonable adjustments they need to access appointments.
- There are barriers to accessing health care for people from certain backgrounds and communities including Gypsy, Roma, Travellers, homeless people, migrant communities including migrant pregnant women.
- People from BAME and migrant backgrounds have poorer access to mental health care services,
- Some people from Lesbian, Gay, and Bi-sexual community report having a more negative experience of the NHS and prefer to use non NHS providers.
- Equality monitoring forms the basis of good equality information to help us identify any equality impacts on our commissioning decisions. Improvement is required in the equality information we gather on patients and services.

What we need to do

In order to reduce health inequalities and improve health outcomes for protected and vulnerable groups we will ensure resources are directed to where there is greatest need where services are accessible, appropriate to need, and free of barriers.

- Ensure all commissioning decisions are informed by population equality and health inequality data, and are assessed for their impacts on advancing equality and reducing health inequalities.
- Ensure locality development and planning is informed by equality and health inequality data and intelligence to promote equality and reduce health inequalities at the local level through the development of locality profiles.
- Improve access to primary care for all and remove barriers to registration, screening, and primary care services for those groups at risk of exclusion (Gypsy Roma Traveller communities, homeless people – including those at risk of becoming homeless due to domestic abuse, and migrant communities) by raising awareness of the needs and issues experienced by these groups through training, review, and promoting best practice – E.g. review and roll out of the Safe Surgeries Toolkit
- Ensure our providers to comply with statutory and NHS equality requirements

- Roll out the Identification Referral to Improve Safety (IRIS) Programme across Birmingham and Solihull.
- Undertake patient experience and engagement activities on pregnancy and maternity pathways in secondary care for pregnant migrant women

- Work with providers to enhance accessibility for disabled patients by promoting best practice and audit and review of the Accessible Information Standard and use of reasonable adjustments.
- Review the deaths of people with Learning Disabilities; mortality reviews
- Reduce the numbers of LD patients in hospital settings - Transforming Care
- Complete a review of the Patient Passport for its usage and effectiveness on the health experiences of disabled people.
- Improve access to mental health services for BAME communities, migrant communities, and young people by removing language and cultural barriers, developing inclusive provision and ensuring appropriate and accessible access routes into services – through the contract
- Integrate equality and inclusion across patient experience, quality assurance, and patient safety processes.

How we will know we are achieving it

We will measure / monitor:

- % years of life lost
- % of people with LD on GP register receiving an annual health check
- % BAME accessing psychological therapies
- % Young people accessing mental health provision
- Number of practices and practice staff completing CCG equality learning
- Infant mortality rate by deprivation and locality
- The number of A&E attendances by deprivation and locality
- Number of LD patients in hospital settings (Transforming Care)
- FGM cases reported to Primary Care
- GP Patient Survey: patient access to appointment
- CQC Inspection Ratings: Primary Care
- Number of IRIS referrals
- Provider contracts: equality schedule

We will ask patients:

- Patient experience of accessing an appointment - Friends and Family Test
- Patient experience of access through the health care system as part of patient experience visits in maternity services and mental health services
- Patient experience of using language and interpretation support

We will audit / review:

- The Patient Passport
- Primary Care Quality Framework
- Accessibility of GP Registration - mystery shopping exercise
- Accessible Information Standard
- Locality Profiles

Equality Objective 2

We will work with our local partners to improve health outcomes and in doing so, will support the voices of vulnerable and disadvantaged groups and communities to be heard.

Why is this important?

Embedding robust and meaningful engagement structures and processes with patients is instrumental to establishing a climate of improvement and trust in the health services we design and commission. Equality and diversity is central to patient access and experience and giving protected and vulnerable groups a voice, particularly those whom are 'seldom heard' and is an important part of understanding diversity of health needs across Birmingham and Solihull.

What we need to do

- Develop engagement structures that are inclusive and reflective of the diversity of Birmingham and Solihull.
- Ensure locality development and planning is informed by local people engaging the third sector and building relationships with groups and communities that are 'seldom heard' and their representatives such as; Gypsy Roma Traveller, young people, homeless people, migrants.
- Work with our third sector providers to reach our patient populations and prevent ill health from occurring – developing appropriate equality/ inclusion targets within CQUINS.
- Work with providers to promote best practice and improve standards around and access to language interpretation provision
- Raise awareness of the healthcare challenges impacting on protected and vulnerable groups through conferences and events.
- Review the effectiveness of the Accessible Information Standard in removing barriers to accessible information and communication support to disabled people, and develop a set of recommendations for improvement.
- Develop a programme of work to engage and support the health needs of the LGBT communities.
- Develop targeted engagement interventions with protected and vulnerable groups with the most pressing needs;
    - migrant communities and pregnant migrant women,
    - Gypsy Roma Traveller community
    - Lesbian, Gay, Bi-sexual, Trans and Non-binary
    - Disabled people
    - Young people with mental health needs

- Regularly feedback to patients and communities using simple language *"you said … we did… this made a difference to ..."*
- Conduct integrated patient experience visits that highlight and address any patient experience issues for protected and vulnerable groups

How we will know we are achieving it

We will measure/ monitor:

- The equality profile of patient representation forums/structures at the CCG level and locality level
- The number and level of targeted engagements with protected and 'seldom heard' groups.
- Third sector contracts - CQUINS equality / inclusion case studies

We will ask patients:

- Patients experience of accessing translation and interpretation
- The development of new services through consultation and engagement processes
- Patient Experience visits
- Patient Stories

We will audit / review:

- The Accessible Information Standard
- Locality Profiles

Equality Objective 3

We will develop our workforce across all levels of the organisation, where staff are engaged and supported, and leaders and managers foster a culture of inclusion, wellbeing, and diversity.

Why is this important?

We recognise that engaged, happy, healthy staff are vital to delivering our ambitions and are committed to supporting and developing all our staff. We are committed to promoting an organisational culture that supports staff wellbeing, enabling a workforce that is engaged, and where every employee feels a sense of belonging and ability to participate. Ensuring inclusive workforce practices are a key part of achieving this ambition. In addition, we recognise the importance of having inclusive and diverse boards to ensure fresh perspectives, challenge and experience.

What we need to do

- Support and equip managers with the skills they need to design and commission healthcare services that are relevant and responsive to the needs of a diverse population through appropriate learning and development skills and opportunities.
- Monitor and report on the equality profile of the organisation
- Monitor staff retention and turnover
- Develop and maintain a programme of wellbeing initiatives for staff
- Develop a Carers Policy and monitor the number of carers within the organisation
- Adopt the Disability Confident employer pledge and progress through the charter
- Ensure ongoing recruitment and selection training incorporating unconscious bias for recruiting managers
- Survey staff on their staff equality experience and staff satisfaction and provide opportunities for staff to raise and discuss equality and inclusion issues.
- Establish a process for staff recording of non-mandatory learning activities linked to Personal Development Review (PDR), in line with the requirements of the Workforce Race Equality Standard (WRES).
- All staff and managers have equality and diversity competencies built into their PDR.
- Integrate equality and diversity into the staff induction processes.
- Raise awareness and celebrate workforce diversity through a range of learning opportunities
- Support the principle of equal pay for work of equal value, and publish Gender Pay Gap (GPG) information

How we will know we are achieving it

We will measure/ monitor:

- Workforce profile by protected characteristic
- Board diversity
- Staff retention / turnover
- Disability Confident – progress through the levels
- Workforce Race Equality Standard
- Workforce Disability Equality Standard
- 100% Staff complete mandatory staff equality and diversity training
- 100% Staff have a PDR
- No of Staff and Managers participating in non-mandatory learning on equality and diversity
- Gender Pay Gap / Equal Pay Audit

We will ask staff:

- Staff experience through an Annual Staff Survey
- Staff Focus Group sessions
- Staff Council

Appendix 1

Stakeholders List
We express our gratitude to the following groups and individuals who participated and were represented in the EDS2 and equality objectives consultation process:

- Patients
- GPs and GP Practice Staff
- Patient Participation Groups
- British Red Cross
- Stroke Association
- Polish Expats Association
- Pocklington Trust
- Bethel Health and Healing Network
- Forward Thinking Birmingham
- Birmingham Cross City CCG Staff and Governing Body Members
- Birmingham South Central CCG Staff
- Solihull CCG Staff
- Arden and Gem CSU
- Solihull Metropolitan Borough Council
- Birmingham City Council
- NHS Heart of England Foundation Trust
- NHS England
- The Royal Wolverhampton NHS Trust
- Sandwell and West Birmingham CCG
- Birmingham and Solihull Mental Health Trust

Appendix 2

Glossary

A&E – Accident and Emergency

AIS – Accessible Information Standard

BAME – Black and Minority Ethnic

BSOL – Birmingham and Solihull

CCG – Clinical Commissioning Group

CQUINS – Commissioning for Quality and Innovation Framework

CQC – Care Quality Commission

EDS2 – Equality Delivery System 2

FGM – Female Genital Mutilation

GP – General Practitioner

GPG – Gender Pay Gap

GRT – Gypsy Roma Traveller

IRIS – Identification Referral to Improve Safety

IMD – Index of Multiple Deprivation

LD – Learning Disability

LGBT – Lesbian, Gay, Bi-sexual, Transgender

NHSE – National Health Service England

PDR – Personal Development Review

PSED – Public Sector Equality Duty

STP – Sustainability and Transformation Plan

YLL – Years of Life Lost

WRES – Workforce Race Equality Standard

WDES – Workforce Disability Equality Standard

QOF – Quality Outcomes Framework