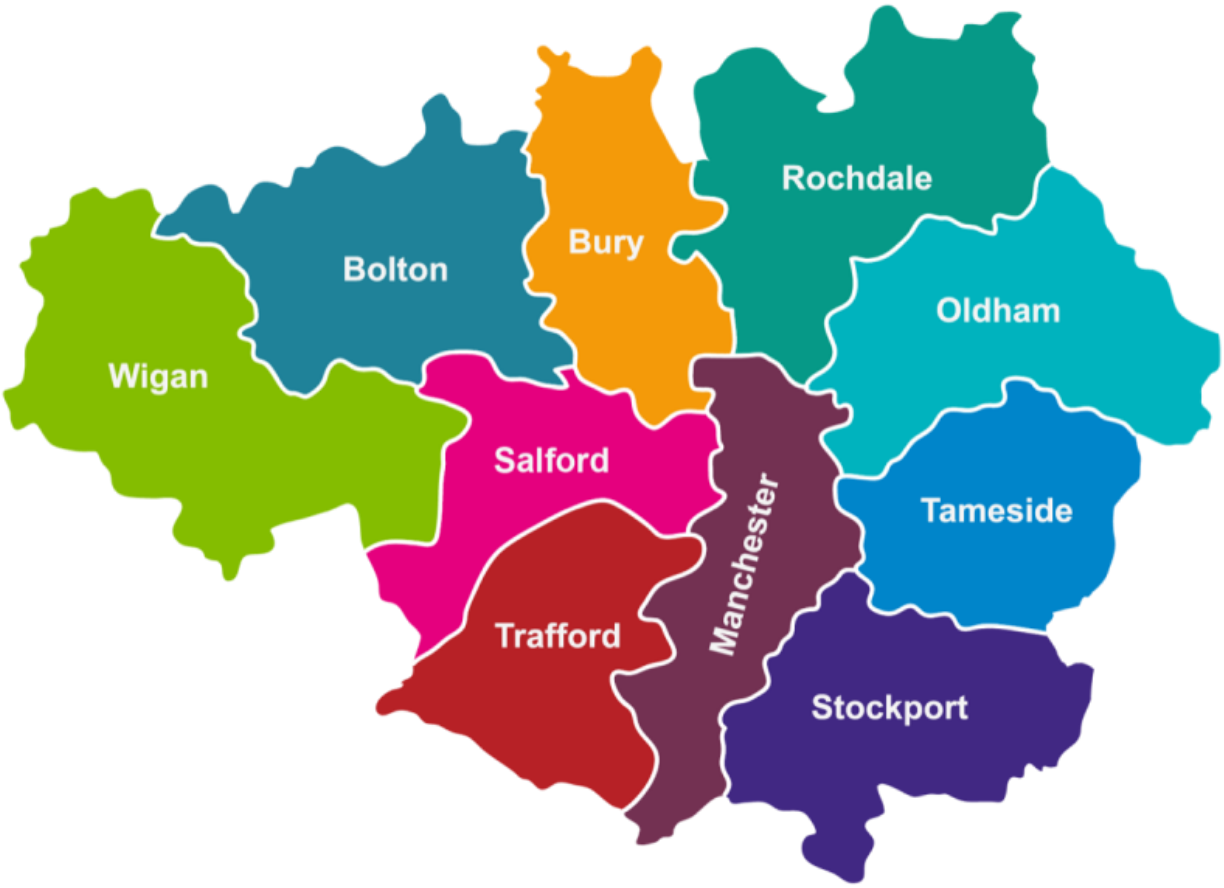
NHS
Greater Manchester
Integrated Care

Public Sector Equality Duty (PSED)

September 2023

NHS Greater Manchester Integrated Care



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Glossary of Terms

Term	Definition
GM Integrated Care Partnership	Greater Manchester Integrated Care Partnership brings together members from all 10 areas of Greater Manchester, including all NHS organisations, councils, GMCA, organisations from across the voluntary, community, faith and social enterprise sectors and others. It is overseen by a statutory committee called GM Integrated Care Partnership Board, which sets the integrated care strategy for the region.
NHS Greater Manchester Integrated Care	NHS GM is a statutory organisation created to plan and oversee NHS services, performance, and finances.
Integrated Care Systems	The Health and Care Act 2022 is making it easier for organisations to work better with each other and the public to improve people's health, plan and deliver effective services while being as efficient as possible. Integrated Care Systems have been set up across the country to support integrated and more collaboration.
Voluntary, Community and Social Enterprise (VCSE) Sector	The Voluntary, Community and Social Enterprise (VCSE) sectors and the social value they create play a crucial role in our journey of transforming we deliver smarter, more thoughtful, and effective health services in partnership, that meet the needs of people across Greater Manchester.

Foreword

At NHS Greater Manchester (NHS GM) we are committed to embedding equality, diversity, and inclusion (EDI) into all aspects of our work, and this is something that is incredibly important to us personally as Chair and Chief Executive.

In today's society it should be possible for everyone to be as healthy as they can be. It should be the case that the social, economic, and physical environments we live in help create health and wellbeing, and that local communities and public services make it possible for individuals to take positive decisions about their own health and feel supported to do so.

We know that wellbeing cannot be created and sustained by the NHS alone. High quality and equitable healthcare and health protection services are vital in improving and maintaining health, addressing health inequalities, and protecting us from communicable and environmental threats. But it's not primarily in our hospitals or our GP surgeries that health is first created. It is in our homes and our communities; in the places we live and through the lives we lead.

We also know the outcomes we need and expect from health and care cannot be achieved without greater diversity of thought, workforce, and more inclusive behaviours. Diverse, inclusive organisations better understand the needs of diverse cultures and backgrounds and create the right conditions for equitable and sustainable access, experiences and outcomes for everyone.

We have engaged widely to develop, agree, and set out our initial equality objectives to create the best possible start to our integrated care system, these are discussed in some detail within the report are focused on three areas:

- Our People
- Our Communities and Insights
- Improving Outcomes

These objectives focus our work on helping us deliver improvements for both our citizens and our staff. They have been informed and shaped by the key statutory requirements and relevant strategic drivers, together with engagement and feedback from our staff, community, and other partner organisations across the Greater Manchester system.

Alongside these objectives, our collective public health priorities set out in the Greater Manchester Integrated Partnership Strategy represent an important milestone. They represent agreement between the NHS, our localities, and our voluntary, faith and community sector about the importance of focusing our efforts to improve the health of our population.

This report sets out:

- the work we continue to do to tackle the health inequalities that prevent good health.
- our approach to improving the health of the population to be fully consistent with our commitment to equality, inclusion and human rights, including the duty we must meet to international obligations and to work in ways that eliminate discrimination, advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not.
- Identify where disparities have become evident for individuals and communities and how we propose to address these.
- how we will collectively advance equality to create the right conditions for fairness to flourish.
- how we will work together and with other parts of the organisation to achieve this change.

Whilst the report demonstrates that we have already made good progress in developing plans and processes towards tacking health inequalities, reducing variations, and creating a diverse and inclusive organisation, we recognise that there is still a way to go to becoming truly inclusive by nature. We will continue to nurture a culture of inclusion where we can all have an equal sense of belonging and where everyone thrives equally.

Mark Fisher, Chief Executive, Greater Manchester Integrated Care Board.

Sir Richard Leese, Chair. Greater Manchester Integrated Care Board.

2.0 Background

2.1 Public Sector Equality Duty – Annual Report

This is the first Annual Report of NHS Greater Manchester (NHS GM), since it was formally established on July 1st, 2022. The report provides an overview of the key highlights and findings for the Public Sector Equality Duty (PSED), sets out how NHS GM has, will, and continues to demonstrate due regard to its equality duties with respect to patients/service users and staff. It highlights arrangements that currently exist within our organisation, collaborations underway with partners and key levers being adopted to mainstream equality, diversity and inclusion as an employer, commissioner of services and facilitator of partnerships.

The report also sets out the context of how we will deliver these through our Greater Manchester Integrated Care Partnership Strategy. NHS Greater Manchester (NHS GM) is the Integrated Care Board (ICB) for Greater Manchester. Covering all ten boroughs of the city region it is a statutory organisation responsible for managing the NHS budget and arranging for the provision of health services.

NHS GM is a part of the Greater Manchester Integrated Care Partnership (GMICP, also known as an ICS) the statutory committee which brings together all health and social care partners including wider public sector and community organisations, to improve the health and wellbeing of the population. Together, it works to tackle the causes of inequality, prevent poor health and improve life chances of the 2.8 million people who live in Greater Manchester.

Local authorities generally have quite comprehensive demographic data on health inequalities due to their statutory responsibility to compile Joint Strategic Needs Assessments (JSNAs) and meet their own Public Sector Equality Duties, but we know that multiple structural, contextual and individual factors determine social disadvantage and health experience. Integrated care systems offer a unique opportunity to work systemically and collectively to address those unfair and unwarranted employment and health disparities.

This report therefore sets out the initial organisational wide baseline equality data related to employment and identifies the key drivers that we need to put in place to address inequalities where they exist and advance equality across the system. (following the disestablishment of Clinical Care Groups and the establishment of Integrated Care Systems in July 2022.).

Addressing inequalities, advancing equality, and achieving environmental sustainability are major strategic organisation focuses for us – as outlined in the principles, targets, and priorities for co-ordinated action in the Greater Manchester Fairer Health for All framework[1] giving us a strong blueprint from which to work.

[1] Fairer Health for All Engagement Summary: https://gmintegratedcare.org.uk/wp-content/uploads/2023/08/109690001-gm-icp-fhfa-final-v2-accessible.pdf

Fairer Health for All Easy Read: https://gmintegratedcare.org.uk/wp-content/uploads/2023/08/3441-c21-creative-communications-fairer-health-for-all-easy-read-v3-web-accessible.pdf

Greater Manchester Integrated Care Partnership

2.2 Our Statutory Equality Duties

The purpose of the equality duty is to integrate consideration of equality and good relations into the day-to-day business of public sector bodies, including NHS GM.

Compliance with the general equality duty is a legal obligation, but it also makes good business sense.

- An organisation that can provide services to meet the diverse needs of its users should find that it carries out its core business more efficiently.

- A workforce that has a supportive working environment is more productive. Many organisations have also found it beneficial to draw on a broader range of talent and to better represent the community that they serve.

- It will also result in better informed decision-making and policy development.

- Overall, it can lead to services that are more appropriate to our users and services that are more efficient and cost-effective.

The Equality Act 2010 Act (incorporating the Public Sector Equality Duty) requires relevant public bodies (of which we are one) to publish appropriate information showing their compliance with that duty usually on or before 31st March each year. As NHS GM only came into statute in July 2022, the publication of this first report covers from our inception in July 2022 to the end of March 2023.

Those subject to the equality duty must, in the exercise of their functions, have due regard to the need to:

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

These are sometimes referred to as the three aims or arms of the general equality duty. The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Section 78 of the Equality Act also requires all employers employing more than 250 staff to meet the statutory requirements for annual reporting of pay gaps between women and men. NHS GM is committed to reporting gender, ethnicity and disability pay gaps as we find this useful evidence to help drive down pay and work disparities across and intersecting these protected characteristics.

The nine Protected Characteristics we are required to give due regard to under the Equality Act 2010 are:

- Age
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and Maternity
- Disability
- Race including colour, nationality, ethnic or national origin.
- Religion or Belief (or lack of)
- Sex
- Sexual orientation

Whilst it is important for us to pay due regard to these characteristics set out in law – because of existing evidence, we know that discrimination can have more than one root cause. We are most often a mix of these characteristics which intersect and interconnect and can give rise to intersectional discrimination.

In addition, disadvantages can be caused or made worse by socio-economic inequalities of income and wealth, differences in access to resources and power, caring responsibilities, and geographical factors. Therefore, when undertaking equality impact assessment, we also consider socio-economic disadvantage, caring responsibilities, and impact on 'inclusion health'[2] groups.

The Health and Care Act 2022 introduced further requirements to address inequalities. NHS GM ICB are required to have regard to the need to:

1. reduce inequalities between persons with respect to their ability to access health services; and,
2. reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

It places a new quality of service duty on us which includes addressing health inequalities and introduces a performance assessment framework for us to demonstrate how we have discharged our functions to reduce inequalities, improve the quality of services and involve and consult residents.

Integrated Care Boards are responsible for the NHS planning and funding allocation, performance and accountability, all which were previously the responsibility of Clinical Commissioning Groups (CCGs). This is alongside the commissioning responsibilities for primary care services and some specialised services.

The new performance assessment framework means that NHS England along with relevant national regulators (including CQC) will annually assess our performance in all aspects of our work, including reducing inequalities, improving quality of service and public involvement and consultation. This report evidences the progress made in respect of reducing health inequalities.

[2] Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.

2.3 NHS standards

As part of our evidence for our public sector equality duty, we publish information through our NHS Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Equality Delivery System.

3.0 How we work in Greater Manchester to address health and care inequalities.

3.1 Devolution

For many years the ten district councils that make up Greater Manchester - Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford, and Wigan - have worked together voluntarily on issues that affect the region, such as transport, regeneration and attracting investment.

In 2011 this partnership was put on a legal basis, with the formation of the Greater Manchester Combined Authority (GMCA). In 2014 leaders across the ten councils signed a deal devolving a wide range of powers to GMCA and establishing the role of elected Mayor for the city-region. In 2016, Greater Manchester was the first region in England to be given delegated control of the health and social care budget - to the Greater Manchester Health and Social Care Partnership. Further deals have since been agreed to devolve new powers around fire and rescue, transport, planning and criminal justice.

Greater Manchester Combined Authority (GMCA) is governed by the Mayor of Greater Manchester and his Cabinet, made up of the ten district council leaders from the city-region.

GMCA leads the strategic direction of the region, working with other local services, including the devolved health and care system, to improve the city-region. This place-based, system wide approach is essential to effectively tackle the social determinants of health that influence health inequalities.

3.2 Integrated Care Partnerships (ICPs)

ICPs are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. They came into being in July 2022 as part of the Health and Social Care Act 2022.

Greater Manchester ICP connects NHS GM, Manchester NHS Trusts and NHS providers across the whole of primary care with the GMCA, 10 local councils and partners across the Voluntary, Community, Faith, and Social Enterprise (VCSE) sector, the 10 local Healthwatch and the Trades Unions. Together as partners, they take actions which make a difference to the health of the population of Greater Manchester.

GM ICP is responsible for producing the Integrated Care Strategy for how we will meet the health and wellbeing needs of our population, tackling the causes of inequality, prevent poor health and improve life chances

Our GM Integrated Care Partnership Strategy priorities (our 'missions')

- **Strengthen our communities** – We will help people, families and communities feel more confident in managing their own health.
- **Help people to stay well and detect illness earlier** – We will work together to prevent illness and reduce risk and inequalities.
- **Help people get into, and stay in, good work** – We will expand and support access to good work employment and employee wellbeing.
- **Recover core health and care services** – We will continue to improve access to high quality services and reduce long waits.
- **Support our workforce and carers at home** – We will ensure we have a sustainable and supported workforce including those caring at home.
- **Achieve financial sustainability** – We will manage public money well to achieve our objectives.

4.0 Health Inequalities in Greater Manchester

The current population of Greater Manchester, drawn from the 2021 Census data is 2,868,400. The population make up of individual boroughs is shown below:

Borough	Population
Bolton	296,000
Bury	193,800
Manchester	549,900
Oldham	242,100
Rochdale	224,100
Salford	270,800
Stockport	295,200
Tameside	231,200
Trafford	235,500
Wigan	329,800

This is an increase of 185,272 on the 2011 Census and represents a growth of 6.9% across ten years, higher than the growth across England and Wales (6.3%) over the same period.

Greater Manchester's population makes it one of the largest ICS populations (just short of the North-East and North Cumbria ICS population), with some of the country's highest levels of deprivation, diversity, and density of population. Whilst the Census data is one of the most used barometers for population count, we know that

there is underlying capture of communities with some of the worse health outcomes for fear of disclosure. This makes the health inequalities that we can capture likely to carry an under estimation of count.

Life expectancy in the city-region, for both women and men, is one of the lowest in England. Evidence and recommendations are drawn from:

- The Marmot Review in 2010 and the 10 Years On Report in 2020, both evidenced the need to effectively and collectively tackle the social determinants of health that influence health inequalities.
- There was also an Independent Inequalities Commission report published in 2020.

Analysis in the Marmot 10 Years on report shows that rates of mortality from COVID-19 in GM were 25 percent higher than in England as a whole. Greater Manchester had also experienced highly unequal mortality rates: the COVID-19 mortality ratio in the most deprived decile was 2.3 times greater than in the least deprived decile between March 2020 and January 2021. These socioeconomic inequalities in mortality from COVID-19 are wider than in the rest of England.

As a result of the Independent Inequalities Commission Report, the Mayor has since established a range of panels and other networks to engage directly with our diverse communities to help monitor progress against the recommendations, including a Tackling Inequalities Board, an Equalities Alliance, a Disability panel, Race panel, Women and Girls panel, LGBT+ panel, Older People's panel, an Aging Hub, a Faith and Belief panel and a Youth Combined Authority. These panels and networks are partners in our work to address health inequalities.

The "Fairer Health for All" framework has been developed as a GM response to the Marmot reviews and sets out our ambition for doing things differently; building a society based on the principles of social justice. The Fairer Health for All framework (see link[3] to read the Engagement draft which is out for consultation) was co-designed alongside the Greater Manchester Integrated Care Partnership Strategy and GM Integrated Forward Plan. It enables co-ordinated action across neighbourhoods, Locality and at system level to tackle the root causes of inequality and create equity, inclusion and sustainability.

The framework outlines inequality targets (see box 1) and several workforce, leadership and intelligence tools including:

[3] Fairer Health for All Engagement Summary: https://gmintegratedcare.org.uk/wp-content/uploads/2023/08/109690001-gm-icp-fhfa-final-v2-accessible.pdf

Fairer Health for All Easy Read: https://gmintegratedcare.org.uk/wp-content/uploads/2023/08/3441-c21-creative-communications-fairer-health-for-all-easy-read-v3-web-accessible.pdf

The Fairer Health for All Academy[4] , will facilitate shared learning, build capacity and capability for distributed leadership and create spaces for lived experience to be heard across systems and communities. It will bring together examples of best practice interventions, stories of change and training opportunities related to tackling inequalities across Greater Manchester.

The Health and Care Intelligence Hub has been co-designed to consolidate data and insights from public and VCSE sector partners across the city-region into a single space, enabling people and partners to share wisdom and learning about which equality interventions work and why and work with communities to offer more opportunities to stay well and find and treat illnesses earlier.

Fairer Health for All – proposed targets

- Improve the health and well-being to narrow the gap in life expectancy and health life expectancy - Between men and women living in Greater Manchester, between all ten localities, as well as the England average, by at least 15% by 2030.
- Reduce unwarranted variation in health outcomes and experiences.
- Leading to significant reductions in health inequalities between and within localities in avoidable mortality by 2030. Reducing avoidable mortality will also require us to eliminate the fivefold difference between the highest and lowest social groups in the experience of having 3 or 4 multiple health harming behaviours such as smoking and excess alcohol consumption, through whole system approaches.
- Increased social and economic activity because of reduced ill health.
- Narrowing the 15-year gap in the onset of multiple morbidities between the poorest and wealthiest sections of the population to 5 years by 2030
- Reductions in preventable or unmet health and care needs leading to reductions in demand.
- Evidenced in part by closing the health inequalities gap in of smoking prevalence with England by 2030.[5]
- Reduce the difference in life expectancy for those with serious mental illness and the incidence of physical health conditions, narrowing the gap with England by 15% by 2030
- Reducing infant mortality through measures including narrowing the gap with England by 15% by 2030 and closing the school readiness gap within the same period

In September and October 2023 consultation on the draft framework will provide opportunities for colleagues from the VCSE (Voluntary, Community, Faith and Social Enterprise) sector and our service users, partner agencies, practitioners, staff and leaders from across all ten localities to inform and shape the final version which will go to the NHS GMICP board and NHS GM board in November to be ratified.

[4] The Academy website is in development – see GM ADSP (gmtableau.nhs.uk)

[5] **Smoking is our single greatest cause of preventable health inequalities. 1 in 4 hospital patients' smoke and smokers need social care on average 10 years earlier.*

5.0 Our Equality Objectives

Our Equality Objectives help drive the strategic and demonstrable equality improvements identified through wide community engagement and involvement for the people we serve, the people that we employ and in the exercise of our broader activities and functions, interlocking the Equality Act 2010 requirements with the addressing inequalities requirements of the Health and Social Care Act 2022 and the Human Rights Act 1998.

In developing our equality objectives and targets, we have made a conscious decision to ensure that we focus on the requirements of the Equality Act 2010 and Public Sector Equality Duty as the Specific Equality Duties require. We have, however, incorporated current health inequalities targets where these naturally align with our equality objectives and doing so would neither undermine compliance with our existing equality duties nor the new health inequalities duties, powers, or responsibilities.

Extensive engagement has been undertaken to progress the development of NHS GMs Equality Objectives. The objectives have been informed and shaped by key statutory requirements and a range of strategic drivers together with the involvement and feedback from our staff, communities, and partner organisations across the Greater Manchester system.

Building strong relationships with our diverse communities and better understanding the needs and experiences of the population across Greater Manchester and adjusting our approaches accordingly is a key element of our equality objectives, set out below. This report demonstrates the progress we have started to make against the objectives.
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	NHS GM Equality Objectives 2023-2027 Overview
1.	**Our People**
1.1	Strengthen inclusive and accountable decision making and leadership with a clear organisational commitment to advance Equality and Inclusion.
1.2	Improve representation and provide an accessible and inclusive working environment and culture enabling NHS GM Integrated Care to become an employer of choice where all people can flourish.
2	**Our Communities and Insight**
2.1	Engage and involve communities who experience discrimination and disadvantage in planning, design, and delivery of health interventions.
3	**Improving our Outcomes**

3.1	• Build capabilities and confidence across the NHS Greater Manchester Integrated Care workforce to recognise and mitigate disparities experienced by protected groups and their intersectionality across all commissioned services through performance requirements of providers. • Be able to evidence consideration in commissioning expenditure decisions to address inequalities and advance equalities. • Take appropriate and proportionate action at each stage of procurement to incorporate and embed equality objectives into our overarching commercial and procurement policies, with all suppliers, VCSE and consultancy opportunities. • Quality and performance reviews of providers able to identify and measure provider progress towards addressing inequalities and advancing equality in their 6 priority areas (elective care, urgent and emergency care, vulnerable services, clinical services, mental health, learning disability and autism, cancer). • Evidence of meeting agreed targets to reduce inequalities in our Core 20 plus 5 priority areas (maternity, mental health and learning disability, elective care, urgent and emergency care, chronic respiratory, early cancer diagnosis, hypertension, anti-smoking).
3.2	Set equality performance goals and develop a measurement framework to evidence how we are addressing inequalities and advancing equalities.
3.3	Pro-actively address existing systemic and structural racism through the implementation of an anti-discrimination approach for NHS GM Integrated Care. Intersectional by default.

5.1. Our People

We are required to collect and analyse reliable data and listen to their staff to understand how differences between the experience and treatment of different cohorts of staff arise so that we can address the root causes and remove any disparities. We are required to produce annual WRES (Workforce Race Equality Standards) reports. WDES (Workforce Disability Equality Standards) reports currently apply to health providers only, but this is expected to change to include ICB's in the future. We are already collecting WDES data alongside our WRES data.

We will be submitting our first NHS standards report towards the end of 2023. For more information about the WRES and WDES requirements, follow this link.

As a commissioner, we also have a responsibility to ensure that our providers collect and analyse WRES and WDES information. This should be published annually along with measures identified to address disparities, giving a clear picture of employment practices and plans in place to address any areas for improvement.

We set out below an overview of workforce data held on employees of NHS GM workforce, as of 31 December 2022. The full analysis can be found at appendix II.

Data is available for seven of the nine protected characteristics (age; disability; ethnicity; sex; sexual orientation; religion or belief and marriage and civil partnership).[6]

Data is generally expressed as percentages, to avoid potential personal identification within small datasets.

In some instances, more than one category has been combined to give a more meaningful graph where percentages are very small. For consistency, percentage figures are rounded up or down to the nearest decimal place where necessary and may therefore not sum to precisely 100%.

All recommendations given in this section are consistent with the priorities and delivery of the Greater Manchester People and Culture Strategy 2022-25.

5.1.2. Overview for widest evidenced workforce disparities by overall representation (sex, ethnicity, and disability)

	All White Groups	Non-White	Non-Disclosed	Female	Male	Disabled	Non-Disabled	Non-Disclosed
Greater Manchester Population Census Data	76.40%	23.60%		51%	49%	18.3%	81.7%	
Number of staff in NHS GM	1431	308	32	1216	555	129	1488	154
Percentage of staff in NHS GM	80.80%	17.40%	1.8%	68.70%	31.30%	7.30%	84%	8.7%
Over/ Under representation in our workforce	4.40%	**-6.20%**		17.70%	**-17.70%**	**-11%**	2.7%	

[6] Our Electronic Staff Record (ESR) system does not collect data on Gender Reassignment or Pregnancy and Maternity (pregnancy/maternity data is held by our People Services, but the data is not available electronically for analysis), so these characteristics have not been included in this report.

The ESR includes marriage and civil partnership as a single category, so no conclusions have been included in this report as it is not possible to identify any discrepancies due to combining the categories. Where we have more granular data within these categories, we have provided it.

5.1.3. Workforce Data

Summary[7]

Ethnicity

- Our snapshot data point shows that as of 31st December 2022, there were 1,771 people in the organisation. 308 of those people belong to a Non-White group, which is 17.4% of all staff. Compared with Greater Manchester population Census 2021 data this is an underrepresentation of Greater Manchester population by 6.2%.

- Bands 8c to Band 9 is where we see the largest decrease in representation of Non-White staff. Out of 129 roles in these bands only 10 are held by Non-White staff. Proportionately, we should expect at least 31 of these roles should be held by Non-White staff.

Sex

- The workforce is over-representative of female staff, with 68.7% of the total number of staff identifying as female, in comparison to 31.3% identifying as male. In the GM population there is a relatively even composition of male and female residents.
- This is a similar pattern to both the national (and global) health and care workforce where the sector is highly feminized. Despite this, the gender pay gap (in NHS GM, as elsewhere) remains a stubborn factor giving rise to disparities favouring men in higher pay bands.

Disability

- Disabled staff make up 7.3% of the organisation, with 129 staff declaring a disability. This is under-representative of the GM population comparison by 11%.

- Disabled staff are underrepresented at all pay bands. The largest under-representation by number occurs at Band 7, however, by percentage Band 2 has the highest deficit. (This could be remedied by the hiring of just one disabled person into Band 2.)

- Workplace disability declaration rates remain low here as elsewhere, this is often due to fear of discrimination, but our recent Foundations for Change Disabled staff programme also indicates barriers remain preventing disabled employees from flourishing in the workplace. The programme is extended to address these barriers.

[7] The full report is available in the appendix II.

Sexual orientation

- The workforce is predominantly made up of people declaring themselves heterosexual or straight (86%)[8] . The remaining 14% is mixed and represents a healthy workforce make up of people who do not define as 'straight'.

- Some 89.3% of Greater Manchester residents described themselves as straight or heterosexual, using the categories available on the 2021 census. This was very similar to the pattern for England as a whole (89.4%). The proportion was highest in Wigan (92.0%) and lowest in Manchester (84.6%).

- There is no existing evidence of disparities in higher bandings for LGB employees, but we remain alert to any further disaggregated figures and staff experience.

Age

- Most of our staff fall between the ages of 30 to 59. This tallies with the generic average age of staff in the NHS broadly which tends to be towards the mid-40s, partly because the NHS has a larger proportion of jobs that require prior professional qualifications than some other sectors.

- Despite being one of the biggest employers in England, only 6% of the NHS workforce is under 25. Greater Manchester has a growing younger population and given our significant workforce shortages, encouraging younger people to consider care-centric careers and boosting the return of over 60-year-olds will be important.

Religion or Belief

- Aside from the largest religious observance group (Christianity, 52 %) in our workforce, 16% consider themselves atheist, and 9 % practice Islam as the two next largest cohorts, followed by a proportionate range of other beliefs to the population. To promote inclusive working cultures, we are mindful to ensure we consider potential disparities and work closely with the Inclusion Staff Network to promote inclusive ways of working. (For further detail, please see Appendix II).

- [8] To note, there is a large percentage of non-disclosure, totaling 11%. The language of sexual orientation and gender identity is evolving and generates different perspectives.

NHS GM Gender Pay Gap (Figures from 31.03.2023)

Gender	Avg. Hourly Rate £	Median Hourly Rate £
Male	28.8710	24.3797
Female	25.3277	22.4026
Difference £	3.5434	1.9771
Pay Gap %	12.2731	8.1097

This table shows that on average, female staff earn £3.54 per hour less than male staff. The median (mid-point) salary is also £1.98 lower.

Quartile	Female %	Male %
1	74.36	25.64
2	66.88	33.12
3	71.50	28.50
4	62.66	37.34

This table shows the percentage of female and male staff in each pay quartile. Given that the percentage of male staff in NHS GM is 31%, female staff are over-represented in the lowest pay quartile and under-represented in the highest pay quartile.

Disability Pay Gap

Calculations for the pay gap are based only on those who have disclosed a disability/ no disability. The percentages for the quartiles also include staff who have not disclosed their disability status.

Disability	Avg. Hourly Rate £	Median Hourly Rate £
Yes	24.6536	24.3790
No	26.2764	22.4026
Difference £	1.6228	1.9765
Pay Gap %	6.1759%	8.1073%

This table shows that on average, disabled staff earn £1.62 per hour less than non-disabled staff. The median (mid-point) salary is also £1.98 lower.

Quartile	Yes %	No %	Not Disclosed %
1	6.27%	84.62%	9.12%
2	8.33%	82.69%	8.97%
3	7.27%	84.85%	7.88%
4	6.85%	83.33%	9.82%

As the percentage of staff in NHS GM who disclosed a disability is 7.3%, the percentage of staff in each quartile is broadly similar.

Actions already undertaken to improve Equality and Inclusion for Our People.

- NHS GM has become one of ten ICBs awarded Pathfinder status for the Universal Family – Care Leavers Covenant Scheme to support the national commitment to employ 250 care leavers into roles in the NHS by March 2024.
- NHS GM is a Level 2 Disability Confident employer and is working towards achieving Level 3.
- All appointment panels for board level recruitment were briefed on awareness of fair and inclusive recruitment practice.
- Undertaken an Equality Impact Assessment of the People and Culture Operating Model, as well as all the new HR policies to understand their impact and begin to develop an action plan to address areas of inequality and actively promote inclusion.
- Creation of the Foundations for Change Disability Framework, to support organisations to be more inclusive of their disabled employees.
- The Inclusive Public Services programme in Bury and Rochdale created a cross organisational mutual mentoring scheme supporting 22 people across six organisations to share their lived experiences as leaders or those experiencing racial inequality or disability. The work has identified six opportunities for change. This work is now being extended across Oldham and Salford.
- The LGBT Foundation has been supported to deliver cross-organisational Anti-Racist Practice and Inclusive Recruitment training to 60 stakeholders.
- Developed a Health Equity Education Advancement Programme in partnership with Salford University.
- Developed a continuous professional development programme for equality professionals across our system.
- Developed a collaborative approach across Greater Manchester equality professionals' networks to better enable good practices, shared learning and joined up working.

Example of proposed actions drawn from our baseline workforce data include:

A 12-point talent plan aimed at the largest banding disparities observed in the datasets – focused on Black staff. (Our initial workforce ethnicity review shows Black staff in our Integrated Care Board workforce at Band 8 and above represent just 0.65% of our entire staff cohort*. This equates to approximately 13 Black staff in Band 8 and above.[9] Proposed actions to address the stagnation of progression for Black staff is our 12-point talent plan.

- A further disaggregation and intersectional review of the data to determine any intersectional disparities we can address.
- A wider talent plan aimed at other identified disparities, including other ethnic groups and disabled staff.
- Robust action plans arising from our pay gaps data, including but not limited to gender pay gaps.

[9] *For the purposes of this research, Black is defined as those self-identifying as black or “mixed: white and black Caribbean” or “mixed: white and black African” in the 2021 census.
*Staff cohort =1,989 as of Oct 2022 when this snapshot was undertaken

The roll out of phase two of our Foundations for Change programme supporting disabled people to thrive in the workplace.

- Work to address the lack of disclosure in disability and religion, by building trust, openness, and inclusive working cultures.
- Raising employment opportunities for younger and older cohorts across GM to join our workforces.

- The development of our NHS Workforce Plan, incorporating all relevant drivers, including the Messenger Review to reduce and remove workplace and leadership disparities.

5.1.4 Race Equality Standard (WRES)

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract.

Staff who experience racism are significantly under-represented in senior management positions and at board level across the NHS. The nationally derived WRES, alongside addressing other disparities, is designed to change this.

NHS organisations, including ourselves are required to collect and analyse reliable data and listen to their staff, and especially staff who experience racism, to understand how differences between the experience and treatment of white staff and staff who experience racism arise so that we can address the root causes.

We expect to complete our first WRES report as an ICB later this year after our first 12-month period of our existence.

As a commissioner, we currently have a responsibility to ensure that our providers collect WRES information, that they analyse and publish this (for example, in their Annual Equality Reports) to give a clear picture of employment practices and have plans in place to address any areas for improvement. When published later in Autumn this year we expect to review our provider WRES/ improvement plans.

5.1.5 Disability Equality Standard WDES

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. NHS organisations use the metrics data to develop and publish an action plan. Year on year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality.

The WDES enables NHS organisations to better understand the experiences of their disabled staff and supports positive change for all staff by creating a more inclusive environment for disabled people working and seeking employment in the NHS.

At a national level, the evidence clearly highlights that many disabled staff continue to experience inequalities in the workplace when compared to their non-disabled colleagues. We will use these findings and our own data to formulate robust action plans, with monitoring and evaluation, to ensure that progress takes place and that ongoing work programmes support positive change.

As a commissioner, we have a responsibility to ensure that our providers collect WDES information, that they analyse and publish this (for example, in their Annual Equality Reports) to give a clear picture of employment practices and have plans in place to address any areas for improvement. When published later in Autumn this year we expect to review our provider WDES improvement plans.

5.1.6. NHS GM Inclusion Staff Network (ISN)

The NHS GM Inclusion Staff Network (ISN) has been set up to ensure that staff who experience discrimination or disadvantage have a safe space to voice concerns, provide critique, and oversee matters related to diversity, equality, and inclusion within the organisation. The purpose of the ISN is to help foster an inclusive working environment and to increase participation of staff in decision making - directly shaping the organisation.

The ISN is open to staff from **all** protected characteristic groups as well as allies who wish to drive change and pose meaningful challenge to the system. Through this Network, staff can:

- Have open and honest conversations.
- Build professional and social networks.
- Develop their careers through workshops and projects.
- Become inclusive leaders.
- Provide feedback on corporate policies, initiatives, and plans.
- Celebrate diversity through events and engagement activities

This year, the ISN has provided a platform to promote our commitment to equality, diversity, and inclusion, showing the value that we as an organisation place in our staff. Through wider engagement, members of the network often commit to helping to educate the wider workforce by writing blogs, hosting events, delivering training, or sharing information.

As a collective voice, the ISN have been bringing issues to the attention of management and driving changes to policies and procedures to make them more inclusive.

The ISN is a good barometer for our organisation, enables employees voice, and promotes inclusion which can directly enhance performance and belonging in the workplace, which in turn builds loyalty and trust and helps us an employer to attract and retain a wide diversity of talent.

5.1.7. Equality Professionals meetings in GM.

Over the last few years, three equalities forums have played key roles in influencing and shaping the direction of the equality agenda across Greater Manchester (including hosting annual events and positive action initiatives).

Health and Social Care are now working more closely on a GM-wide footprint and increasingly, our work intersects with that of other public and voluntary sector.

NHS GM has led on the bringing together of equality professionals across GM employers and sectors to develop more joined up collaborative approaches to addressing inequalities and advancing equality.

It is also now the host of the EDI Professionals Network, and we are keen to explore closer, more joined up structures for the system. For example, we have invested in a GM wide continuous professional development education programme for equality professionals.

5.1.8. EDI professional Development

We have developed a pilot EDI professional CPD - accredited course that is co-designed with the University of Salford. It has been designed the equality's profession from different levels of experience and from different backgrounds. This course is intended to boost equality professional leads' level of knowledge and skills for advancing equality, ability to negotiate and influence positive change and be a critical friend to the system. Finally the course aims to increase their capacity and capability to tackle inequalities in our workforces and services.

5.1.9. Freedom to Speak Up Guardian (FTSU)

The purpose of creating a speaking up culture is to keep our patients safe, improve the working environment of staff and to promote learning and improvement. It is therefore vital that colleagues have confidence that when they speak up, their concern will be listened to, truly heard, and actioned accordingly.

Freedom to Speak up (FTSU) has a much broader definition than the previous term 'whistleblowing' which was often only used in the most extreme circumstances. Over the years since its inception FTSU continues to broaden its support service and runs alongside other support services within organisations.

To support learning and continuous improvement, we are building a community of practice of FTSU guardians across GM, providing appropriate support and sharing best practice with FTSU guardians, picking up emerging themes and issues across the health and care system.

Within the ICB a full-time Freedom to Speak Up Guardian post has been appointed, with an aim of fully embedding the roles into the organisation. The FTSU Guardian will

meet with the Chair and Chief Executive on a quarterly basis to discuss issues, trends and patterns that may be having an impact on staff and/or service delivery.

During Freedom to Speak Up month in October our Manchester Locality Freedom to Speak Up Champion spoke at the staff briefing and put together communication for the keep connected newsletter.

Visibility and accessibly of the Guardians is key, so monthly team meetings are held with them, and regular communication takes place about the Guardians.

FTSU provision is in place across all four disciplines of Primary Care, with independent routes of speaking up in secondary care.

We are committed to ensuring outstanding care to service users and to being an excellent employer. We focus on providing an environment where our staff can achieve the highest standards of conduct, openness, and accountability. The Chief Executive is accountable for ensuring that FTSU arrangements meet the needs of the staff across the organisation.

5.2. Community Involvement

We want everyone in Greater Manchester to live a good life with improved health and wellbeing. When they need it, they should have access to high quality care from health and care services that work together and are sustainable. We know we can improve our services by involving those communities who face the most significant health inequalities in the design and delivery of those services.

From a health care perspective, communities have great insight and intelligence on what they need from health services, and on what works in improving health. Linked to this, directly engaging people from the most marginalised groups and those most likely to be affected by health inequalities is important in addressing these inequalities through formal health services and other means.

To be successful we must therefore work with more localities and neighbourhoods where connection to community is stronger, including the voluntary, faith and community sector to address wider issues and inequalities. We also want to ensure we address and better understand intersectional inequalities, for example the different health outcomes of Asian women and Asian men and so on, and so our involvement strategy will flex and nuance to different access, experience and outcomes for different groups of people.

NHS GM has a statutory responsibility to involve the public in its work. However, the prime reason we want to involve residents in our work is the weight of evidence shows that meaningful engagement with local people - such as capturing their lived experiences, gathering views, needs and issues will allow NHS GM to make better and more informed decisions and reduce inequalities. We are building on our successful interventions across the Covid pandemic to better disaggregate demographic data, involve grass roots communities in health and care interventions,

directly address the needs of our inclusion health groups and adapt our services to individual need.

We are mindful our delivery model must include ways of engaging with both those who are known and actively engaged with the health and care system; as well as those who are not routinely engaging with the health and care system. If we have a stronger understanding of those in the latter group, it is likely that we will make greater progress in realising the underlying reasons for health inequality and devise more effective approaches to addressing them.

5.2.1. Planning engagement

To enable us to advance equalities through our engagement work, all our engagement programmes undergo an equality impact analysis to ensure we are reaching those who most need to be heard in an accessible way.

We have a range of ways to ensure our engagement is accessible including developing easy read information, interpreters, British Sign Language films, information in different languages, along with support for people to get involved should they require it.

Our engagement follows the principles of NHS England's CORE20PLUS5 approach. This ensures that we prioritise those who are experiencing the greatest disadvantage and discrimination and thus at a higher risk of experiencing the poorest health outcomes.

Reaching underserved communities

We take an asset-based approach to engagement: utilising the skills, knowledge, and experience of the VSCFE sector who we believe are best placed to engage underserved communities and have known and trusted relationships.

This is evident in our most significant piece of pan-GM engagement, the GM ICP Big Conversation on health and care. The aim of the Big Conversation was to inform the new GM ICP strategy, which at the time was under development.

The Big Conversation

The Big Conversation rolled out in two phases. Phase one ran between March and May 2022, with the aim of consulting on the proposed vision and aims that had been suggested by the ICP leaders following a stakeholder engagement event. 1332 people gave their views and the majority of respondents agreed with the proposed aims and visions.

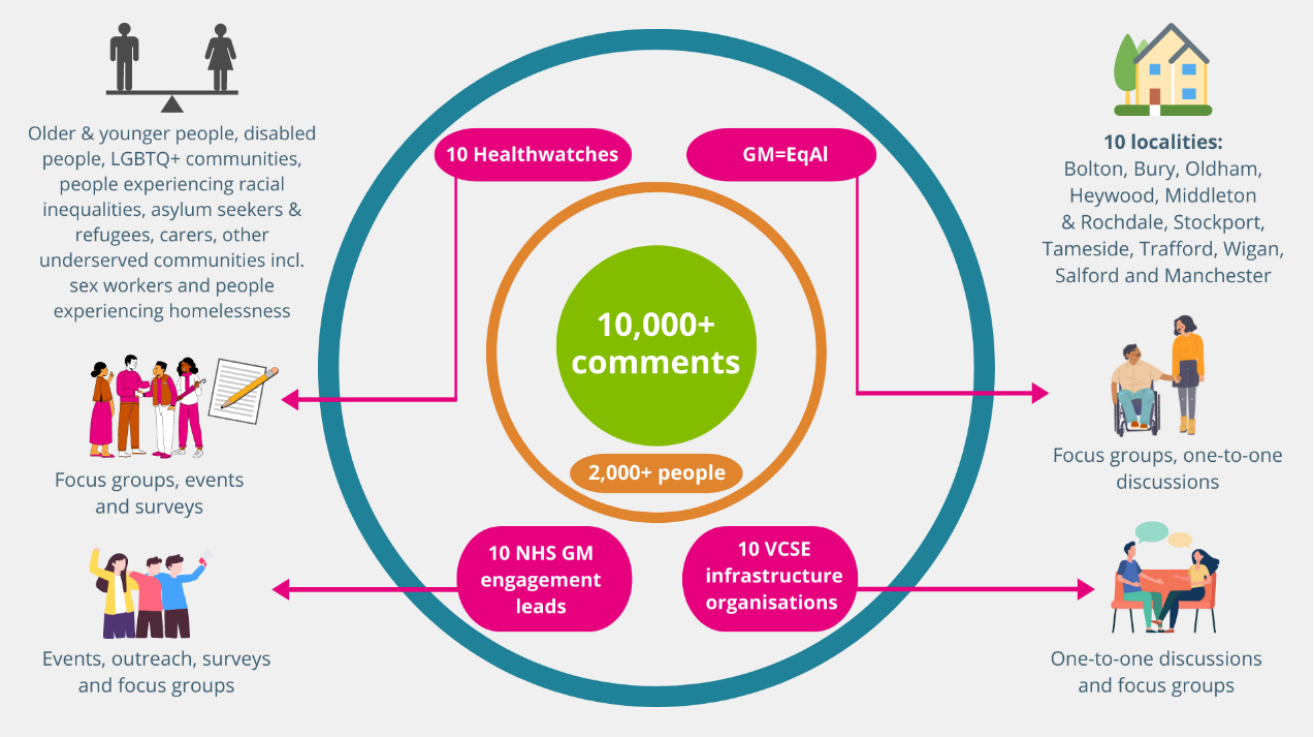
Phase two ran in October 2022 with the aim of ensuring GM ICP had the insight it needed to be able to understand what mattered most to communities across all ten

localities - to help shape the priorities and actions for the strategy with a focus on underserved communities.

We asked people and communities.

1. What would make the biggest difference to your life (or the communities you service) in relation to being healthier, happier, and better?
2. What's stopping this?
3. What would help this?
4. What's the most important thing health and care services need to improve?

We reached over 2,000 people and received over 10,000 comments. The VCSE engagement model enabled us to reach those who would not usually take part in traditional engagement exercises such as responding to an online survey, including those with protected characteristics, inclusion health groups and those experiencing socio-economic disadvantage.



This Big Conversation approach enabled us to reach deep into communities and involve those who were typically less likely to take part in surveys or provide their views in traditional ways. We reached over 2000 people and collected over 10,000 comments.

Five main themes were identified as priorities from the engagement.

1. Better access to the NHS including GP appointments and hospital waiting lists.
2. Properly funded and resourced services.
3. Healthier lifestyles.
4. Action on the cost of living and other determinants of health.
5. Equal opportunities to be listened to and understood.

These priorities are reflected in our 5-year Strategic Plan and each place has received a locality report to help prioritise local actions within their delivery plans.

All the reports including easy read can be found at Big Conversation | Greater Manchester Integrated Care Partnership (gmintegratedcare.org.uk)

Engagement Case studies

Whether we are engaging at a GM level or in one of the ten localities, we will make engagement fully accessible. The case studies below provide examples as to how we have achieved this.

Trafford's review of urgent care services

The Trafford Locality team of NHS GM have worked with their locality partners to undertake the first phase of their review of their Urgent Care services.

This initially began with a desk-based review of what was already understood about the local experience of urgent care and then was followed by an Equality Impact Assessment and stakeholder mapping exercise to identify gaps in understanding around the provision and establish lines of enquiry for engagement.

A series of engagement activities were undertaken in January and February 2023 to capture the experiences of people and communities. People were able to request alternative versions of the survey e.g., in a different language or printed copy.

Eleven listening sessions were also held with established community groups in varying locations, particularly targeting those that analysis had shown may be disadvantaged in some way.

Wigan's children and young people's special education needs and disability (SEND) project.

As a result of the high levels of complaints and the informal sharing of lived experience from patients, parents caters and guardians it was recognised by the NHS GM Wigan Locality Team that there was a need for a targeted piece of formal engagement work looking into SEND services for children and young people in Wigan.

Engagement officers working in the Wigan locality team responded by creating a Typeform survey which incorporates bespoke questions designed for children and

young people, parents, carers, guardians, and professionals into one platform. The children's questions are also accompanied by a video which reads the questions.

In addition to launching this innovative survey the Wigan team set up a SEND stakeholder group and involved multiple partners including the local VSCFE sector groups who it is recognised are best placed to engage their local SEND cohort.

Salford/Deaf community, Improving Access to Health and Care

Salford's d/Deaf community have highlighted several barriers to accessing and experiencing health and care services in Salford, and several discussions had taken place with service users and professionals to understand what needed to change. Using co-production, the engagement team commissioned a VCSE organisation to facilitate a workshop bringing professionals and service users together to better understand the issues and agree priorities for action.

The workshop was led by a BSL user and a lipreader. The facilitators worked with a professional videographer and communications expert to create a multi communication style promotional film to invite d/Deaf people to get involved. The film also invited d/Deaf people to submit their thoughts and ideas before the event via a range of accessible means.

Full communication support was provided for the face-to-face workshop, with D/deaf participants and this raised awareness of the complexity and subtlety of the different communication needs of d/Deaf people and the range of support services available to health and care service representatives. Communication professionals supporting the event included, BSL interpreters, lip-speakers, and Palantypist typists.

As a result, the group identified four priorities for action. Task and finish groups will be established including service users to codesign solutions, the first of which will focus on improving access to Salford's health and care complaints systems.

Another example of where we have involved communities in our work to address inequalities in long-term health conditions is in the project planning, design, and delivery of a cardiovascular disease (CVD) prevention project. The ambition for the GM CVD Prevention Oversight Group was to deliver a project in partnership with Health Innovation Manchester that addressed health inequalities for communities most disproportionately impacted by poor cardiovascular health. The Strategic Transformation Fund (STF) was identified as a vehicle to deliver a project in GM, targeting the highest risk cohorts for cholesterol optimisation interventions.

An evaluation of the data available identified that the South Asian community in Rochdale and the Black Caribbean community in Manchester experienced the worse health outcomes for CVD and therefore were targeted as being the highest risk cohorts for the interventions outlined.

The approach for the design and delivery of the 12-month project was to involve those VSCFE organisations with lived experience to provide insight into how best to remove barriers to patient access and to promote the adoption of best practice in

secondary care through engagement and the creation of culturally appropriate care pathways.

The project is currently in its delivery phase. The approach for delivery is cycles of reflection and action. A series of workshops will support this work which aims to create a blueprint for other localities/communities in the future.

Working with communities during the pandemic.

During the COVID-19 pandemic and as part of the vaccination programme we engaged with faith leaders and organisations to have vaccination clinics in mosques, temples, and churches and to host webinars to address confidence in the vaccine and answer questions and we held deep dive conversations / listening events. We worked extensively across Greater Manchester with our communities during the pandemic, an example of one locality, Manchester, is given below.

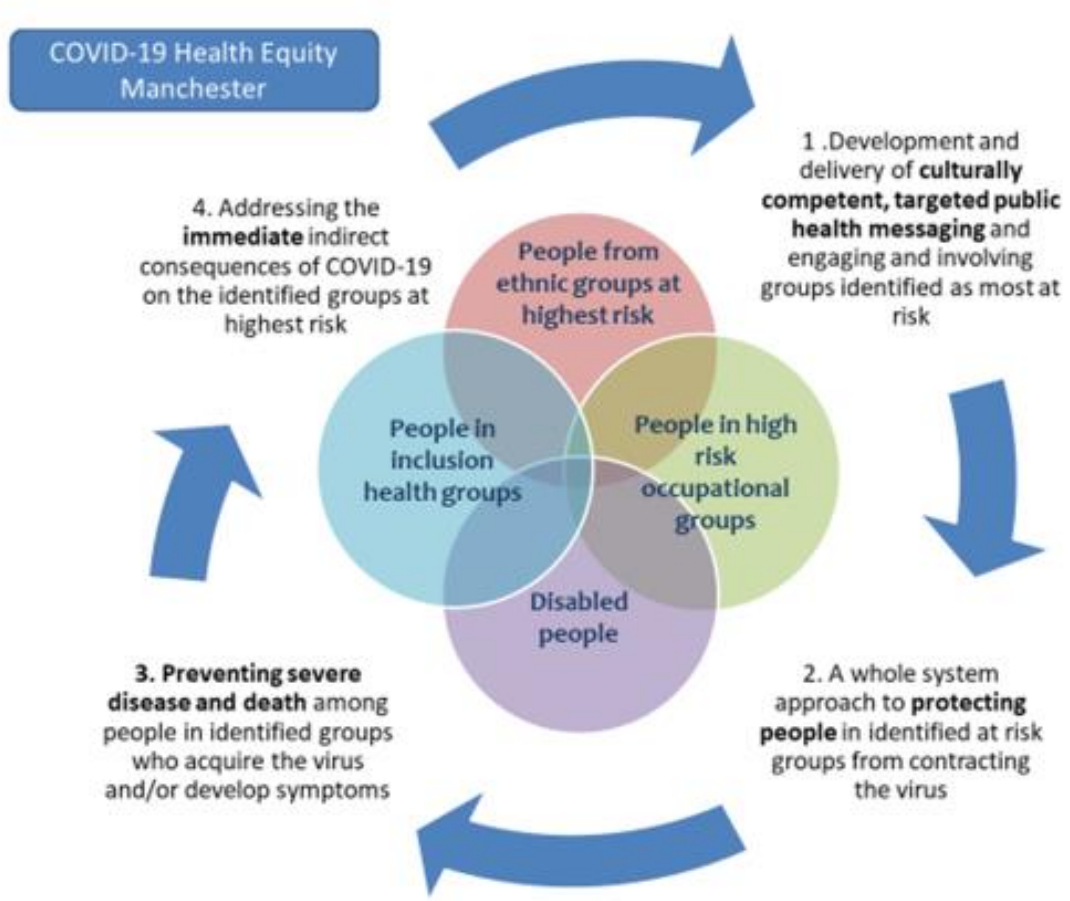
The Covid Health Equity Manchester (CHEM) strategic partnership was established to help reduce the risk of transmission, severe disease, and death among groups of people who have been identified as most risk including.

- Black, Asian and minority ethnic communities
- People born outside the UK or Ireland
- People in specific occupational groups
- Disabled people
- Inclusion health groups - Asylum Seekers and Refugees, Gypsies & Travellers, Sex Workers, and Ex-offenders

- The CHEM group was co-chaired by Manchester Health and Care Commissioning and Public Health, Manchester and included representation from across the system and VSCE organisations with lived experience.

- The work of the group was co-designed across the system and amongst all equal partners.

- The plan below sets out the groups' remit and approach. The work of the group was necessarily one of rapid response, learning and building COVID resilience for the 'at risk' communities.



5.2.2 Working with our voluntary, faith and community sector.

Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups. Health inequalities go against our principles of social justice because they are largely avoidable if we address systemic discrimination.

Health inequalities do not occur randomly or by chance; they are socially determined by circumstances largely beyond an individual's control. These circumstances disadvantage people and limit their chance to live longer, healthier lives.

Active involvement of voluntary organisations, community groups and social enterprises is a key priority for our equality objectives - building confidence, trust, and co-design with service users.

These organisations contribute enormously to the wellbeing of communities across Greater Manchester, and investing in co-production helps us to create stronger relationships with those communities who experience the worst health outcomes across GM. Their work brings benefits to the health service in scrutiny, advice and informing the design and delivery of commissioning and services.

We are committed to ensuring we empower local communities to raise their voice, to engage with us in a way that suit them, to be part of shaping local services and to

build on strength-based approaches and community empowerment models – supporting local communities to identify the outcomes which matter to them, and the solutions in accessing and receiving high quality care that meets their needs.

The NHS GM equality objective of involving communities who experience discrimination and disadvantage enables us to strengthen our design and delivery of health interventions. We have built on existing strong relationships and developed new opportunities to ensure the sector's unique capabilities are an integral part of how our new health and care system operates, allowing us to work together to tackle health inequalities in a way that is meaningful for our communities.

This year, as well as building GM wide relationships across the sector, advising on the right community involvement for our big GM programmes (maternity, mental health, cancer, CVD and elective care programmes have all been supported to develop their health equity programmes through the equality team and community involvement work), the equality team has been establishing baseline data to understand how our procurement and contracting investments are supporting (or limiting) the sustainable growth and capacity of the sector to contribute as equal partners to addressing health inequalities. Our anchor institution status and social value opportunities will be optimised as a result.

Anchor institutions have significant assets and spending power and can consciously use these resources to benefit communities. The health and care organisations in Greater Manchester are uniquely positioned to optimally use its resources to ensure care is delivered to local communities in an inclusive way.

NHS GM can make a difference in the following ways:

- **Widening access to quality work**: Being a good employer, paying people the real living wage and creating opportunities for local communities to develop skills and access jobs in health and care. As one of the region's largest employers, GM ICP has a key role in setting an example in widening access to good quality work resulting in both physical and mental health benefits for communities.
- **Purchasing for social benefit**: Purchasing supplies and services from organisations, including SMEs, CVSE and minority led organisation, that consider their environmental, social and economic impacts. Sustainable procurement practices have social benefits and impacts the health of local communities. Locally sourced purchases can help bring local economic opportunities, reduce the carbon footprint, thereby improving the air quality in our local spaces.
- **Using buildings and spaces to support communities**: Widening the collective use of our buildings and spaces, working with partners to support high-quality, affordable housing, supporting the local economy and providing access to green space, access to nutritious food and drink and opportunities for active travel.

- **Reducing its environmental impact**: Reducing consumption and waste to reduce carbon emissions and achieve net zero whilst looking to protect and enhance the natural environment.
- **Working closely with local partners**: Collaborating with communities to help address local priorities and build on their energy and skills; and work with other anchors and partners to increase and scale impact.

In November 2017 and on behalf of the GMCA, an Accord was signed by the Mayor of Greater Manchester with the Voluntary, Community and Social Enterprise (VCSE) sector, which set out new, improved standards of working with VCSE organisations. The GM VCSE sector also entered a Memorandum of Understanding (MOU) with the Health and Social Care Partnership. Since that time, we have implemented a wide range of collaborative work and the relationship between the public and VCSE sectors has increased in strength, particularly during the Coronavirus pandemic. NHS GM has become a core part of the GM VCSE Accord Commitments Delivery Group.

Next steps

The final version of our People and Communities Engagement Framework will be co-designed with partners across GM including those who represent the voice of equality groups and underserved communities.

The framework will include performance measures to help us understand and improve how we engage with those underserved communities. We will also set out how we will benchmark our engagement against the GM population and develop ways to measure engagement from a people and community perspective to understand their engagement experience with NHS GM.

As part of GM ICPs ongoing approach to working with people and communities there is a focus on working with people from communities who experience the greatest health inequalities and addressing how we can build trust and develop better relationships.

More information on the Plan, and how the feedback informed the final plan, can be found here

5.2.3. GM Women's Health Strategy (GM WHS)

Gender inequality damages the physical and mental health of girls and women, and of boys and men despite the many tangible benefits it gives men through resources, power, authority, and control. These benefits to men do not come without a cost to their own emotional and psychological health, often translated into risky and unhealthy behaviours, and reduced longevity. Taking action to improve gender equity in health and to address women's rights to health is one of the most direct and potent ways to reduce health inequities overall and ensure effective use of our health resources.

The GM Women's Health Strategy is our response to the National Women's Health Strategy 2022. The strategy will set out key priority areas, informed by data, lived experience and in line with our ICP Strategy and relevant to localities agendas. We have partners contributing to it across public, academic and third sector bodies that provide services relevant to the social determinants of health.

As the first Marmot City Region, and within our trauma informed, strengths-based Fairer for All principles, we are engaging extensively across our organisations to embed a strategy that goes to the heart of both systemic discriminations in health and care design and interventions but also and also tackling the social determinants that contain women and girls into particular roles, causing discrimination and disadvantage.

Through the development of the GM wide WHS Steering Group, we are engaging extensively with partner organisations across the breadth of localities, academia, public and community and voluntary sectors and wider civil society to consolidate all contributions towards advancing women's health outcomes across Greater Manchester in one overarching 10-year strategy to capitalise on the combination and culmination of the various actions across sectors to enhance women's health outcomes.

As part of this strategy, we are currently developing our first GM wide women's health hub. Within this concept approach, we propose to develop Primary Care led women's health hubs to advance access to women's health interventions from contraception to menopause and other gynaecological services, building in health equity from the outset by working with our third sector partners to improve access to those women least able to access these services.

5.3 Service Improvement

5.3.1 Core 20 plus 5

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population:

- The 'Core20' which are the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD) PLUS population groups should be identified at a local level. Populations we would expect to see identified are ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, known as inclusion health groups coastal communities (where there may be small areas of high deprivation hidden amongst relative affluence). Inclusion health groups include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, '5' focus clinical areas requiring accelerated improvement.

    - Cancer.
    - Maternity.
    - Severe mental illness (SMI).
    - Hypertension.
    - Chronic respiratory disease - Chronic Obstructive Pulmonary Disease (COPD).

The approach, which initially focussed on healthcare inequalities experienced by adults, has now been adapted to also apply to children and young people.

There are ten clinical areas (five for adults and five for children) of focus which require accelerated improvement. Governance for these focus areas sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims.

We set out below GMs addressing health inequalities priorities, incorporating our response to Core 20 plus 5

Core 20+5 tables

Clinical Area 1: Maternity

Focus Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.

Position and Latest Data from NHSE Maternity Dashboard (latest available information published Feb 2023), taken from 2021 sources and RAG rated against national figures

Indicator	NHS GM local maternity network (LMNS)	National
User experience indicators		
Adequacy of time spent on antenatal discussions	74	73.1
Consistent HCP presence during labour	74.2	74.7
Feeding support and encouragement	67.8	69.2
Involvement in antenatal care decisions	77.1	76.9
Kindness during postnatal hospital care	75.6	75.6
Response to concerns during labour and birth	84.9	84.4
Responsive post-natal hospital care	56	54.2
Choice and Continuity of care indicators		
Adequacy of time spent with midwives postnatally	78.1	75.1
Enabling an informed choice of birthplace	45.7	47.3
No choice of birthplace offered	18.2	19.5
Respect for choice of feeding method	85.7	85
Clinical indicators		
Stillbirth rate (per 1,000)	3.7	3.3
Neonatal mortality rate (per 1,000)	1.5	1.5
Woman reported continuity of carer	10.1	11.4

Clinical Area 2. Severe mental illness (SMI)

Ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).

From NHS Digital. Figures from the GP mental health register at 31st March 2023 collected via SDCS. GM and locality figures mapped against the target of 60%

Region	SMI register	Percentage
England	535,204	58.5%
North West	79,012	56.3%
Locality		
NHS BOLTON	3,218	61.4%
NHS BURY	2,167	49.1%
NHS HEYWOOD, MIDDLETON AND ROCHDALE	2,672	60.2%
NHS MANCHESTER	8,230	61.1%
NHS OLDHAM	2,597	60.6%
NHS SALFORD	3,064	56.6%
NHS STOCKPORT	2,884	65%
NHS TAMESIDE	1,958	60.1%
NHS TRAFFORD	2,443	61.3%
NHS WIGAN BOROUGH	3,096	59.2%
GM total	**32,329**	**59.9%**

Clinical Area 3. Chronic respiratory disease

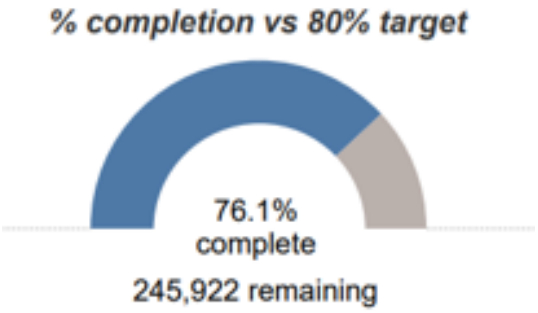
A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

Provisional end of February 2023 cumulative uptake data for Greater Manchester ICB on influenza vaccinations.

65 and over	**Under 65 (at-risk only)**	**Pregnant**	**50 to under 65 years and NOT in a clinical risk group**	**50 to under 65 years and IN a clinical risk group**
Vaccine Uptake %	Vaccine Uptake %	Vaccine Uptake %	Vaccine Uptake %	Vaccine Uptake %
78.0	**46.7**	**33.5**	**36.3**	**59.6**
England				

79.9%	49.1%	35%	40.6%	62.4%

Covid-19 Booster metrics Winter 2022



Data sources – Vaccination Feed (from Arden and Gem CSU; Population Data – Master Patient Index (GP records) Data updated 6/6/23

(Target of 80% of eligible people vaccinated)

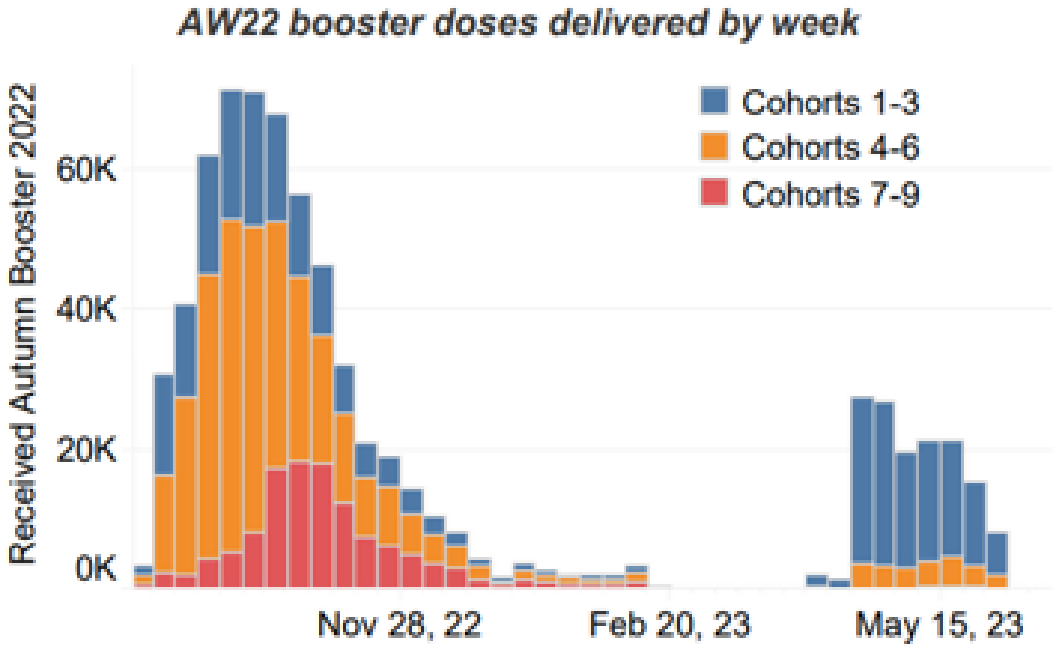
JCVI Cohort	Total Population	Total Eligible Population	AW22 Boosters Delivered	AW22 Booster Uptake (Total)	AW22 Booster Uptake (Eligible)
1: Care Home Residents & Carers	10,247	9,953	9,639	94.1%	96.8%
2.1: H&SC Workers	180,651	171,699	82,200	45.5%	47.9%
2.2: 80+	162,023	155,767	116,943	72.2%	75.1%
3: 75-79	101,268	96,449	86,928	85.8%	90.1%
4: 70-74 & CEV	118,191	110,305	91,636	77.5%	83.1%
5: 65-69	128,669	116,569	88,924	69.1%	76.3%
6: 16-64 At Risk	467,274	378,132	177,113	37.9%	46.8%
7: 60-64	79,590	67,512	42,390	53.3%	62.8%
8: 55-59	104,234	85,768	45,296	43.5%	52.8%
9: 50-54	119,130	94,186	42,081	35.3%	44.7%
Grand Total	**1,471,277**	**1,286,340**	**783,150**	**53.2%**	**60.9%**

The tables below show how many of each category of eligible people actually had the vaccine

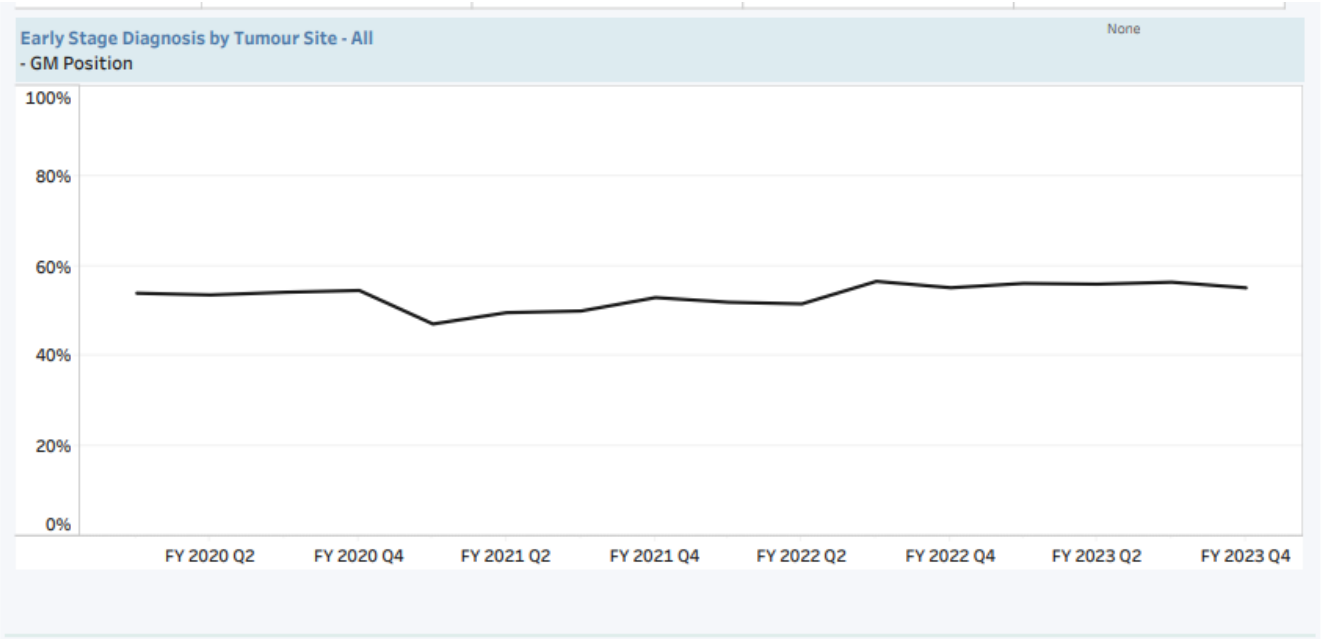
AW22 booster uptake by locality

46.1% 74.8%

	STO	TRA	WIG		BUR	TAM	BOL	HMR	OLD	SAL	MAN	Total
Cohorts 1-3	74.8%	73.0%	70.4%	68.9%	71.2%	69.4%	70.6%	70.1%	69.4%	64.3%	56.0%	**68.2%**
Cohorts 4-6	69.1%	66.7%	62.0%	62.1%	62.9%	60.5%	58.9%	57.7%	54.1%	56.0%	49.8%	**59.1%**
Cohorts 7-9	61.4%	62.4%	51.5%	57.0%	52.2%	52.4%	51.2%	49.6%	49.0%	48.0%	46.1%	**52.4%**
Total	**69.6%**	**68.1%**	**62.8%**	**63.8%**	**63.6%**	**61.8%**	**61.0%**	**59.9%**	**57.9%**	**57.5%**	**51.3%**	**60.9%**



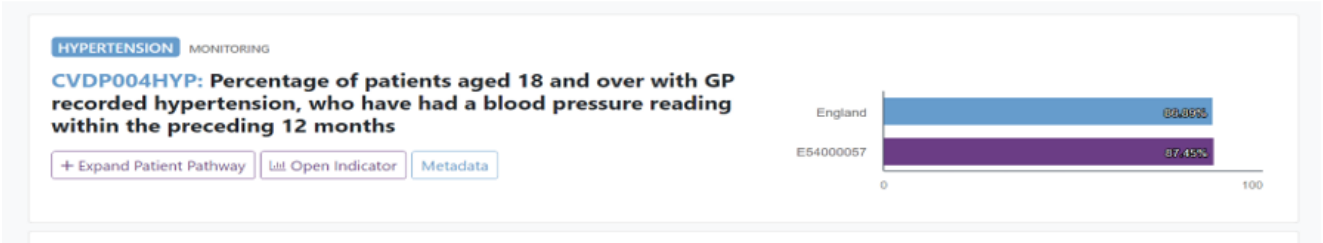
Clinical Area 4. Early cancer diagnosis
Target - 75% of cases diagnosed at stage 1 or 2 by 2028.



Data to end Q4 2023 (M31st March 2023). Not disaggregated by protected characteristics.

Clinical Area 5. Hypertension case-finding and optimal management and lipid optimal management

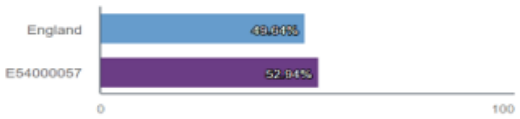
Target To allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.



CHOLESTEROL MANAGEMENT

CVDP006CHOL: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 10% or more, on lipid lowering therapy

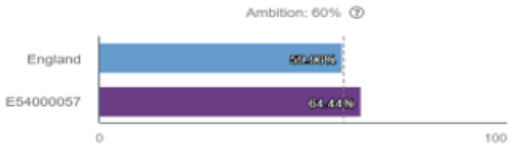
+ Expand Patient Pathway | Open Indicator | Metadata



CHOLESTEROL MANAGEMENT

CVDP003CHOL: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy

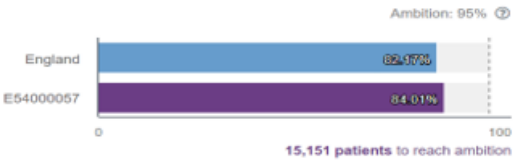
+ Expand Patient Pathway | Open Indicator | Metadata



CHOLESTEROL MANAGEMENT

CVDP009CHOL: Percentage of patients aged 18 and over with GP recorded CVD (narrow definition), who are currently treated with lipid lowering therapy.

+ Expand Patient Pathway | Open Indicator | Metadata



CHOLESTEROL MANAGEMENT

CVDP007CHOL: Percentage of patients aged 18 and over, with GP recorded CVD (narrow definition), in whom the most recent blood cholesterol level (measured in the preceding 12 months) is non-HDL cholesterol less than 2.5mmol/l or LDL-cholesterol less than 1.8mmol/l

+ Expand Patient Pathway | Open Indicator | Metadata

ATRIAL FIBRILATION MANAGEMENT

CVDP002AF: Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy

+ Expand Patient Pathway | Open Indicator | Metadata

Data taken from CVD prevent, figures at March 2023

Across Greater Manchester health equity programmes have been commissioned to continue improving health outcomes for the residents of Greater Manchester. The information below sets out our Big 6 GM Programmes and their work to address health inequalities.

Cancer - A Greater Manchester Tackling Inequalities in Cancer Strategy has been developed which sets out a plan to tackle inequalities in cancer incidence and outcomes and improve equity in access and experience of cancer care. To move this work forward a GM Cancer Health Inequalities Programme Board has been set up which consists of health professionals, VCSE groups and stakeholders. The priorities for the Board include but are not limited to; working with partners to reduce the inequalities in prevalence of behavioural risk for cancer, working to improve equitable access to healthcare and cancer screening and reduce inequalities in signs and symptom knowledge and working to tackle inequalities in access and experience of diagnosis, treatment, and care.

Greater Manchester continues to close the regional and national smoking prevalence gap, and now sits just 0.9 percentage points above the North West (13.4%) and 1.6 percentage points above England (12.7%) – the narrowest the gap has ever been

14.3% of adults (equivalent to around 316,000 people) in Greater Manchester were smoking in 2022 – an estimated 24,000 fewer smokers compared to 2021.

The This Van Can initiative was set up to as an engagement campaign for prostate cancer as we know Black men over 45 have an increased risk of prostate cancer. The van is touring around Greater Manchester as a way of reducing barriers such as transport and location as well as raising awareness of prostate cancer. Patients are able to make appointments through a phone call, email or visiting their GP.

Maternity – The Greater Manchester and Eastern Cheshire Maternity Strategic Clinical Network and Local Maternity and Neonatal System (LMNS) have developed an Equality and Equity Action Plan for 2022 – 2027. The action plan describes the steps that will be taken over the next five years to improve maternity and perinatal services in the region, with a particular focus on improving outcomes for those who experience health inequalities, particularly people from ethnic minority backgrounds and those living in deprived areas. These steps are:

- Inclusively Restoring NHS Services following the pandemic
- Mitigate against digital exclusion.
- Ensure datasets are complete and timely.
- Accelerate preventative programmes that engage those at greatest risk of poor health outcomes: understand your population and co-produce interventions, action on maternal mortality, morbidity and experience & action on neonatal mortality and morbidity, action on perinatal mortality and morbidity and support for maternity and neonatal staff.

One of the aims is to increase the number of staff coming into the maternity profession by improving career progression, retention and for the workforce to represent the diverse women, birthing people, and families that we care for in Greater Manchester and Eastern Cheshire. You can read more about this here.

Elective Care – There are approximately 550,000 people on the total Greater Manchester Referral to Treatment (RTT) waiting list, which equates to 1 in 6 people living in the region (as of September 2023). Tackling the waiting list backlogs is a key priority for the health and care system. We know from local and national insight that if you are a woman, live in a more deprived area or are from an ethnic minority background you are more likely to wait longer.

Working with people and communities who experience health inequalities and supporting them to access services with clear communications is a key part of our approach to addressing health inequalities in elective care. We are committed to 'poverty-proofing' services through ensuring that services are person-centered in recognition that many people in our communities need flexibility and targeted support to be able to attend appointments or access treatment, for example transport. We have also ensured our 'While You Wait' information is available in different community languages and British Sign Language (BSL) to support communication with people on the waiting lists.

For further information please go to the Elective Care Hub.

Cardiovascular Prevention - GM has the worst outcomes related to premature cardiovascular death in England. Furthermore, CVD is intimately linked with causing, worsening, and perpetuating health inequalities, making this a major issue in GM.

The Cardiovascular Prevention Plan identifies that CVD is highly linked to inequalities and the purpose of the plan is to tackle inequalities in CVD by making every contact count and take a person-centered approach to creating care for individuals. The aims of the plan are:

- Recovery from COVID-19
- Meet the national ambitions for the detection and control.
- Reduce inequalities.
- Support ICS priorities

A CVD Prevention oversight group has been established to influence and change health inequalities with the perspective that this is everyone's responsibility.

The group has been able to create a CVD prevention toolkit for clinicians and have also been successful in a bid to the Strategic Transformation Fund, working with Health Innovation Manchester and local people to design a programme to raise understanding about Lipids Management amongst the Pakistani community in Rochdale and Black Caribbean communities in South Manchester.

Sustainable Services

The aim of the Sustainable Services programme is to improve outcomes for patients and ensure services are clinically & financially sustainable, deliver good outcomes, build on the strong links to Cancer, Diagnostics and Elective Services Programmes of work and develop end to end service transformation based on assessment of need.

We have developed a Sustainable Services System Board which follows the principles of:
reducing the negative impact that unplanned service failure can have on patients, the public and the health and care system, providing support and mutual aid to and to involve colleagues from across the wider system to support in improving the sustainability of potentially vulnerable services in communities and hospital sectors.

Population Health Management

The Health and Care Intelligence Hub is part of our Fairer Health for All approach to enable adaptive capability for population health management in relation to our people, systems, and analysis. It has been co-designed to consolidate data and insights from public and VCSE sector partners across the city-region into a single space, enabling people and partners to share wisdom and learning about which interventions work and why and work with communities to offer more opportunities to stay well and find and treat illnesses earlier.

6.0 Building equality into our decision making.

6.1 Equality Impact Assessment

The Public Sector Equality Duty (PSED) requires public bodies to consider inequality when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees. NHS GM is committed to commissioning the very best care for the diverse populations we serve, recognising that services need to be designed with equality, inclusion, and human rights at the core of business and decision-making. Equality Impact Assessments help us to evidence how we redress imbalances and health inequalities, enabling us to build in equality from the outset, rather than try and bolt on at cost after designing our health interventions.

All employees of NHS GM are required to undertake Equality Impact Assessments before designing, changing, or decommissioning services, or implementing policies or procedures that affect NHS GM staff or service users, optimising opportunity to advance equality in those decisions.

The Equalities team have provided Equality Impact Assessment (EIA) masterclasses and continue to advise and support the process of identifying the impacts of our new or existing policies and services on our diverse communities and staff.

We have used equality impact assessments to inform a wide range of activities including but not limited to:

- Our operating models and restructure across all the new NHS GM functions
- Corporate plans including the GM Strategy, Women's Health Strategy, and the Green Plan
- Workforce and organisational development policies for the NHS GM and wider system workforce plans for the ICP.
- All new NHS GM and ICP policies, including within finance, contracting, procurement, commissioning, decommissioning, population health, service design, primary care service delivery, large GM programmes (including cancer, mental health, maternity, elective care, vulnerable services, Core 20 plus 5 priorities), IT and digital projects, digital services delivery, governance, and accountability.

We are currently developing an electronic equality impact assessment platform to replace our current system for improved assurance, check and challenge. This will enable us to better ensure that the supporting actions are followed up and identified mitigations are reducing inequalities.

6.2 Contracts

NHS GM is responsible for commissioning or "buying" high-quality, sustainable health and care services for the people of Greater Manchester.

There are mechanisms in place to ensure that the main provider organisations comply with their equality duties and work in partnership, this includes equality, diversity, and human rights clauses within current contracts. The NHS GMs Quality and Performance Teams regularly review provider's patient experience and staff engagement along with analysing that they are meeting their Key Performance Indicators (KPIs).

All the providers we contract are expected to demonstrate compliance with equality and inclusion legal, mandatory, and non-mandatory requirements and to publish an annual equality and inclusion report on their website. The current NHS Standard Contract prohibits discrimination as set out in the Equality Act (2010) – this is a mutual obligation on both the commissioner and the provider. It also requires providers to assure appropriate assistance and make reasonable adjustments for service users, carers and legal guardians who may have communication barriers when using their service.

Health providers must also implement their own annual NHS Equality Delivery System improvement plans and comply with the National Workforce Race Equality Standard and Workforce Disability Equality Standard.

In 2022, NHS Midlands and Lancashire Commissioning Support Unit's Equality and Inclusion Team conducted a desktop provider compliance check of our key service provider websites on the following equality-related legal duties and NHS equality

mandated standard. This formed the baseline of compliance with equality information and standards across our footprint.

Previous Greater Manchester Clinical Commissioning Groups commissioned a wide spectrum of health and care services with numerous providers; as a result, there are a significant number of contracts still in train held with these providers.

These contracts will be transferred to either NHS GM or another locality organisation. In preparation for this transfer a set of consistent contracting principles were approved in September 2021 by Chief Finance Officers and Directors of Contracts (DoC's) and adopted across GM. This information enables NHS GM to tout equality requirements within our contracts going forward.

In terms of improving inequality outcomes, having parity across contracts should ensure that there is a consistent standard across GM. Providers should be involved in the development, sign off, and implementation of the NHS GM equalities objectives and action plan, including:

- The analysis of data,
- Communication and engagement with residents
- Referrals
- Service improvements
- Accessible information standard
- Action on health literacy
- Anchor/social value

6.3 Equality Delivery System

The Equality Delivery System (EDS) is an 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, workforce, and leadership - driven by evidence and insight.

The EDS is designed to generate regional and local conversations about what is working well and what is not working so well, enabling organisations to make necessary improvements, with lessons being learnt more widely.

It assists local NHS organisations, in discussion with local partners including local populations, to review and improve their performance for patients, service users and the broader public, and supports organisations in keeping 'Everyone counts' as the key principle that applies to everyone served by the NHS in line with the NHS Constitution.

The EDS is designed to encourage the collection and use of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and so to help NHS organisations meet the public sector equality duty (PSED) and to set their equality objectives.

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

1) Domain 1 - Commissioned or provided services.
2) Domain 2 - Workforce health and well-being
3) Domain 3 - Inclusive leadership

2022/23 has been used as a transition year, for organisations to use this period to get used to applying the EDS 2022 in a new way, in a new system. In 2023 Systems are to apply Domain 1 to three services, of which at least one must fall within one of the five Core20PLUS5 clinical areas.

The EDS is a requirement of the NHS Standard Contract so all NHS organisations are expected to use the EDS 2022 to help them improve their equality performance for patients, communities, and staff, as well as helping them to meet the requirements of the PSED. Reports will be published after grading by residents in March 2024

For more information see NHS England's EDS page.

6.4 Governance

Equality and human rights are central to the way we plan and operate as a public body, an employer, and a planner of healthcare services. We continue to strengthen this commitment through our governance and financial systems.

We have appointed an Equalities Lead on our Board, Dr Vish Mehra, and the portfolio lead for strategic equality and inclusion also attends the Board. We also have an executive lead for women's health, our Chief Medical Officer, Professor Dr Manisha Kumar.

We are working to develop a system wide senior leads Equalities Working Group to provide assurance direct to board on progress across our equality objectives.

An Equality and Inclusion team member attends the GM Systems Quality Group (SQG) that considers reports from place-based meetings, provider collaboratives, primary care and mental health quality meetings, clinical senates, thematic work (e.g., advisory/task and finish group), national policy work and other sources to address inequalities emanating from amongst system partners and group members.

As a public body, we must ensure best use of public money. We have a new System for Thorough Assessment of Resources (STAR) process for proposed expenditure over £10,000. This process includes consideration as to how the proposal will address health inequalities and advance health equality. After progressing through the STAR process, a full EIA is required before the expenditure can be approved.

7 – Working in Localities

In addition to the collaborative work and aspirations set out in our 5 year strategy, there are integrated initiatives addressing the wider determinants of health and inequalities within each locality to address inequalities. Below, there is one example from each locality of this work.

7.1 Bolton – Cancer test trials

Hundreds of volunteers from Bolton from diverse backgrounds have been participating in NHS-Galleri trial, which asks participants to give blood samples in consecutive years as part of research to establish whether a multi-cancer blood screening test can help to detect cancer early before symptoms appear.

Those taking part were all aged 50 to 77 when they enrolled and had not been diagnosed or treated for cancer in the last three years. The second blood sample was given in Spring 2023 and a third will be given in 2024.

The NHS-Galleri trial is being run by The Cancer Research UK and The King's College London Cancer Prevention Trials Unit in partnership with the NHS and the healthcare company, GRAIL.

The tests could help to detect cancers that are typically difficult to identify early – such as head and neck, bowel, lung, pancreatic and throat cancers. It works by finding chemical changes in fragments of DNA that leak from tumours into the bloodstream. If it is found to be successful, the test could play a major part in achieving our NHS Long Term Plan ambition to catch three quarters of cancers at an early stage, when they are generally easier to treat.

The trial is operating with the support of eight NHS Cancer Alliances across England that span Cheshire and Merseyside, Greater Manchester, the North East and North Cumbria, West Midlands, East Midlands, East of England, Kent, and Medway, and South East London.

In its first year, the trial has referred a small proportion of trial participants for urgent NHS cancer investigations, following detection of a positive Galleri cancer signal.

We know that nationally and in GM, fewer cancers are diagnosed early in the most deprived areas when compared to the least deprived areas. The cancer trials aim to support in changing the ways tests are conducted to reduce some of the barriers people face when testing for cancers.

7.2 Bury – Military Veterans' health

Work has been led in Bury to improve the health of military veterans by collaborating with the veteran's groups that exist in Bury. As part of the work centred on building relationships with Veterans and ex-Armed Forces personnel in the borough, pre-employment questions around service in the Armed Forces have been changed, new ways of engaging with veterans have been agreed, and all Bury GPs are being encouraged to become military veteran-friendly, along the lines of Pride in Practice training. Some 50% of GP's in Bury have taken up this offer so far.
The work involved Health Conversations with armed forces groups in their spaces resulted in a rapid Health Needs Assessment (HNA). National research has indicated that veterans are more likely to be impacted by the following health related issues:

- Mental health
- Musculoskeletal problems
- Neurological problems
- Hearing problems
- smoking related illnesses- such as lung cancer and cardiovascular disease
- Wider determinants-including housing

The Bury rapid HNA established that services for veterans also needed to consider:

- LGBTQ+
- Gambling
- Tinnitus
- Women
- Digital services
- Improvement to use of covenant
- COVID-19
- More accurate coding of veterans on GP records.

Working in collaboration with ex-Armed Forces personnel, community groups and health professionals has created a strong collaborative partnership, that is tackling health inequalities in Bury for Military veterans by adding value to existing health services through Health Needs Assessments. This decreases the wait in for relevant services for this cohort.

7.3 Heywood, Middleton and Rochdale - SEND

The Raising Rochdale integrated SEND service, a multi-disciplinary, multi-agency project, is a five-year plan jointly launched last year by Rochdale Borough Council and health, education, and voluntary sector leaders, to support every child and young person with or without a SEND diagnosis. improving outcomes for children and young people with special educational needs and disabilities (SEND) in Rochdale

The project aims to develop of a fully integrated system for providing SEND support and that prioritises early help to prevent needs from reaching crisis point. It has brought together 70 stakeholders that make up its “entire system”, including the children and families that use local services, Teams delivering services across health, the local authority and care are managed as one enabling clear decision-making around the needs of the child rather than the organisation.
Discussions were held with the Council for Disabled Children (CDC) about whether it was possible to achieve a fully integrated SEND system. The CDC contributed funding which helped to enable the formation of a SEND alliance and engagement with its stakeholders through co-production and co-design of services with the people that intended to use them.

The SEND service has recruited extra staff, with parents and carers were represented on interview panels and young people with SEND were also involved in the recruitment process.

By improving and integrating services for children with a SEND diagnosis, the Raising Rochdale Integrated SEND service aims to improve life expectancy and experiences of children and young people with special educational needs and disabilities in through reducing barriers faced by this community.

7.4 Manchester – Integrated Health and Learning Hub

In November 2022 a community integrated health and learning Hub was opened in Gorton, one of the most deprived wards in Manchester. It brings together a range of local services under the same roof for the first time, creating a one-stop-shop for local people to access a GP, health and social care services, employment support, cafe and a new Gorton library – all in a purpose built, highly accessible development. This allows residents to access different support services much more easily, while also creating a new welcoming community space within the building.

The Gorton Hub houses:

- A library and learning space.

- NHS community health teams, such as district nurses, health visitors and physios
  and treatment rooms for both children and adults
- Manchester Adult Education Service (MAES)
- Jobcentre Plus

Further services will move into the hub including a new home for the Gorton Medical Centre GP practice and a pharmacy.

The Hub has added social value by providing volunteering opportunities with local community groups, a partnership that provides provide NHS funded 'gardening on prescription' by Sow the City for all ages and backgrounds, hosting a Getting Connected employment event for refugees and asylum seekers, engaged with local schools to raise aspirations, promote inclusivity and future careers.

Further Hubs will be opening in the city on a phased basis. The hubs aim to make it easier for people living in areas of deprivation to access services that are affected by wider social determinants of health and reducing inequalities caused by poverty.

7.5 Oldham – Recruitment

NHS Greater Manchester and key partners across the system have delivered a number of recruitment events in localities.

Events in Salford and Oldham collectively attracted more than 500 people, with 144 job offers made on the day, 26 individuals registered for pre-employment programmes, and 122 were offered a volunteering opportunity to build skills and experience. Over 100 of these have progressed to an unconditional offer so far. Candidates secured entry-level roles as Healthcare Support Workers, porters, care workers, as well as roles in primary care and the voluntary sector.

Analysis of the events also revealed potential cost savings per candidate, and the time spent hiring was also significantly reduced.

Plans are in place to support other localities to run similar events, including working with the Prince's Trust to support younger people into health and care roles. The model and accompanying resources will be shared freely via the forthcoming Greater Manchester Recruitment and Retention Toolkit.

These events are developing a novel recruitment model that benefits both organisations and potential candidates from disadvantaged groups and areas as it:

- Helps break down barriers to recruitment.
- Puts greater emphasis on lived experience.
- Enables filling vacancies at scale.
- Reduces the time and costs to recruit.

By offering employment opportunities to a wider cohort of the population, who cannot be reached through "standard" methods, organisations aim to increase the diversity of their workforce through more inclusive recruitment methods. This will support to create more inclusive services with people from diverse communities with

various skills and experiences and support diverse communities to obtain secure employment which will positively impact reducing socio-economic deprivation.

7.6 Salford - Improving access to services.

Equity Events. The council's public health team are leading a series of events, bringing services, commissioners, and communities of identity together to address barriers to heath and care. Events have been held to explore needs and identify solutions. The third event will focus on coproducing projects to improve access.

Identifying barriers to health and care by bringing patients from diverse backgrounds together with health professionals bring the voices of lived experience to the forefront to support the work happening to tackle health inequalities.

Inclusive Communications. In response to community feedback, partners are working together to improve communications for communities of identity and people whose first language isn't English, which includes.

- A co-production group to develop primary care information for refugees and asylum seekers.
- Bringing together service users, commissioners, communications teams, and frontline services to coproduce improvements for the Deaf community (beginning in 2023).
- A quality improvement project at Salford Care Organisation to improve communication for the Deaf community.

Access to information in the right format; language, front, easy read format, is a common and large barrier that communities of identity experience. Actively creating inclusive communications supports our work to reduce wider health inequalities.

7.7 Stockport – One Health and Care Plan

One Health and Care Plan
Health and wellbeing are at the forefront of Stockport's vision for 2030, to be delivered through a single, system-wide plan for health and care over the next 5 years. The One Health and Care Plan is the strategy for the delivery of the One Heart element of Stockport's Borough Plan.

This 5-year plan brings together existing strategies and plans, including Stockport's Locality Plan, the Health and Wellbeing Strategy and local partners' strategies into a single document and ONE vision for health and care. This is the new locality plan for health and care in Stockport as part of the Greater Manchester Integrated Care System.

Stockport are currently reviewing this plan considering changes in the health landscape, for example the recovery from the COVID-19 pandemic and in terms of the new integrated structures.

At the centre of the plan is Stockport's One Heart, One Home, One Future ethos. Ensuring that services meet the diverse needs of our communities within Stockport and engaging with a range of communities will support this.

Training In February 2023, The One Stockport Academy ran a free training programme for people aged 19 and over who are unemployed, possibly with no prior relevant experience or qualifications. The six-week course aimed to help people gain the skills, knowledge and experience they need to work in health and social care in Stockport. It includes college sessions, placements with a local employer and a guaranteed interview for a permanent role.

Supporting young people into employment by providing them with skills and knowledge to work in the health and social care sector within the Borough reduces some of the barriers people face to employment such as transport, work experience, knowledge and "foot in the door", reducing wider determinants to health.

7.8 Tameside

Over the last 12 months, the Primary Care Network (PCN) in Hyde is working to improve the health and wellbeing of the most deprived 10% of its population. The PCNs works closely with community, mental health, social care, pharmacy, hospital, and voluntary services to provide integrated services to the local population.

The Healthy Hyde programme aims to make changes to someone's life early on, to improve their life before they hit crises.

Much of their work is with the homeless population, refugees, asylum seekers, food bank users, children struggling in schools, and parents with young children. The range of support includes help with employment, housing, health, nutrition, social care, pre- and post-natal education.
This programme is funded through the Locally Enhanced Service (LES) scheme. The Healthy Hyde is run from the PCN offices covering a variety of health and wellbeing practitioners and partners with organisations such as housing, domestic violence, voluntary and community groups, the local council, housing shelters and statutory services at a variety of levels.

By taking the time to get to know their communities, listen to what they want and adapt their offer to fit their needs, Healthy Hyde has introduced a number of initiatives, including English lessons for refugee and asylum seekers with incorporated wellbeing checks, advice sessions at local food banks, health drop-in sessions for homeless people, post-natal courses, mum and toddler groups with an emphasis on health matters, and a memory café run by mental health practitioners aimed at combating loneliness among carers.

As result of this integrated collaboration with the local community, voluntary and faith groups, they managed to gain their trust in the health and care services which enables the organisation to provide even better service where most needed and follow the motto 'prevention is better than cure'.

7.9 Trafford

Historically, Trafford CCG worked very closely in partnership with Trafford Council, and this closeness has continued with the transition to GM NHS GM. They jointly produced a 2022-25 Equality Strategy which now feeds into the Council and NHS GM plans. Work has continued with the NHS GM, Trafford Council and the VCSE on projects including stop smoking support for people with serious mental illness.

BlueSci, the provider of Trafford Primary Care Mental Health and Wellbeing Service and Social Prescribing Service were commissioned to deliver stop smoking support to people with serious mental illness (SMI). Tobacco-related harm is the biggest cause of premature mortality within this cohort and people with SMI are 7 times more likely to smoke than the general population. BlueSci recruited a stop smoking practitioner and trained their staff in smoking support. This service will receive referrals predominately through the annual SMI Health Checks delivered in primary care. It is also being delivered alongside work delivered by GM Integrated Care, who are working with Greater Manchester Mental Health to deliver stop smoking support to inpatients.

NHS Organisations have a target of offering annual physical health checks to 60% of people with SMI. By linking a stop smoking service to these checks, they have been able to capture people at an early contact and reduce the likeliness of no return. This supports residents who have multiple health concerns to not feel overwhelmed or pressured into visiting numerous people.

7.10 Wigan

Hawkley Brook Medical Practice in Wigan became the first health and care employer in Greater Manchester to receive membership of the Greater Manchester Good Employment Charter, in recognition of their work improving employment standards within the practice. The Greater Manchester Good Employment Charter is a voluntary membership and assessment scheme which has been created to improve employment standards across all Greater Manchester employers, regardless of size, sector, or geography. Organisations – including public sector bodies, private sector businesses, service providers, the third sector, and voluntary and community organisations – can sign up to the Charter.

The Charter was developed through a process of co-design, involving the Greater Manchester Combined Authority (GMCA), all GM districts, Trade Unions, and employers and employees from all sectors. In order to become a member, employers need to demonstrate that they excel across the seven characteristics of good employment, which include flexible working, payment of the real living wage, wellbeing and inclusive recruitment.

Within GM there are significant instances of unstable and low-paid work, wages not meeting the cost of living and roles not offering accessibility of flexibility which leads to a workforce that is underpaid and often belong to communities of identity. The Good Employment charter is a major step towards ensuring that new and existing jobs across GM are underpinned by a commitment to equality, fair pay and giving employees a say in how their workplaces are run.

Conclusion and Next Steps

2022/23 has been a year of major change for the NHS with the passage and implementation of the Health and Care Act 2022 and the establishment of NHS Greater Manchester. However, throughout these changes our commitment to the Public Sector Equality Duty (PSED), and addressing system wide inequalities and advancing equality has been sustained, as well as measures taken to create a more inclusive and equitable environment for our staff and communities.

Throughout this report, we have highlighted the progress made and opportunities to continuously make improvements to fulfill our obligations under the PSED and beyond. While much has been achieved, we acknowledge that there is still work to be done.

As an Integrated Care System, our overall health is unacceptably poor and many people living in our most deprived communities still experience poorer health than those living in our wealthier areas. This is the challenge we rise to in our newly established system.

Our healthy life expectancy – the years we live in good health – varies significantly across our communities and localities. This variation has a huge impact on individuals, on communities and on Greater Manchester as a whole. This variation is unwarranted and unacceptable. We want the city region to be a place where everybody thrives. We want to reset how we tackle health inequalities. Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups.

As we move forward, the following key actions will help ensure that the principles of the PSED and our core purpose of improving outcomes in population health and healthcare, tackling inequalities and variation in outcomes, experience and access remain at the forefront of our organisation's activities:

1. Continued Engagement with stakeholders, including staff, service users, and the wider community, to ensure that their voices are heard, and they remain very much part of the decisions we make and the way we operate.

2. Robust data collection and analysis will remain a priority, we are building a robust equality measurement framework allowing us to identify disparities and areas requiring targeted interventions as well evidencing progress in addressing inequalities and advancing equality in both workforce and service delivery.

3. Provide ongoing training and development opportunities for our staff to enhance their understanding of equality and Inclusion, so they are able embed these principles into their individual, team, place, and functional responsibilities.

4. Progress on our commitments to adopting the North-West Assembly's anti-racism framework to reduce and remove institutional racism where it continues to exist, with a commitment to work towards achieving and maintaining the gold status of the framework.

5. Implement **the NHS Equality, Diversity, and Inclusion Improvement Plan,** the improvement plan sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals.

The Equality Diversity Inclusion (EDI) improvement plan supports the NHS Long Term Workforce Plan by improving the culture of our workplaces and the experiences of our workforce; to boost staff retention; and attract diverse new talent to the NHS.

The improvement plan prioritises six high impact actions to address the widely known intersectional impacts of discrimination and bias:

- Measurable objectives on EDI for Chairs, Chief Executives and Board members.
- Overhaul recruitment processes and embed talent management processes.
- Eliminate total pay gaps with respect to race, disability and gender.
- Address Health Inequalities within their workforce.
- Comprehensive Induction and onboarding programme for International recruited staff.
- Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

These actions will be implemented in partnership with trade unions / staffside colleagues and forums, and in collaboration with staff networks.

6. Strengthen understanding of taking an intersectional approach to equality and human rights.

7. Better co-ordinate and join up work across our system through our Women's Health Strategy to create the conditions for optimising women's health outcomes.

8. Progress on driving higher achievement to delivering services through accessible information using the new Accessible Information Standard framework.

9. Strengthen equality impact assessment of commissioning, contracting and procurement opportunities to advance equality using our financial and other resources.

10. Continue to make progress on the delivery of our Equality Objectives, including the implementation of the 12-point talent plan aimed at the largest banding disparities observed in the datasets – focused on Black staff.

Finally, we extend our gratitude to all those who have contributed to these efforts, and we look forward to the continued collaboration and progress that the next year will undoubtedly bring.