NHS Corby Clinical Commissioning Group

NHS Nene Clinical Commissioning Group

NHS Nene and NHS Corby Clinical Commissioning Groups

Inclusion and Equality Strategy 2016-2019

Approved and ratified by the Joint Quality Committee on 10 October 2017 on behalf of the Governing Bodies of NHS Nene and NHS Corby Clinical Commissioning Groups

For review : October 2018 (or sooner to comply with legislation)

Version Control

Version No.	Date	Who	Status	Comment
0.1	27-6-2016	Dipen Rajyaguru	For comment	Initial draft submitted for comment.
0.2	16-9-2016	Dan Whalley - Final draft incorporating amendments	Approved	Submitted to and approved virtually by the Inclusion and Equality Leadership Group.
0.3	11-10-2016	Dan Whalley - Addition of the Equality Objectives	Approved/ ratified	Submitted to and approved/ratified by the Quality Committee of behalf of the NHS Nene and NHS Corby Clinical Commissioning Groups.
1.0	24-10-2016	Helen Sutton, Committee Administrator	Published	Published on the websites of the NHS Nene and NHS Corby Clinical Commissioning Groups
1.1	10-10-2017	Dan J Whalley – Reviewed and updated (Updates to sections 2 and 3)	Approved/ ratified	Submitted to and approved/ratified by the Joint Quality Committee on behalf of NHS Nene and NHS Corby Clinical Commissioning Groups
2.0	27-10-2017	Committee Administrator	Published	Published on the websites of the NHS Nene and NHS Corby Clinical Commissioning Groups

Contents

Inclusion and Equality Strategy

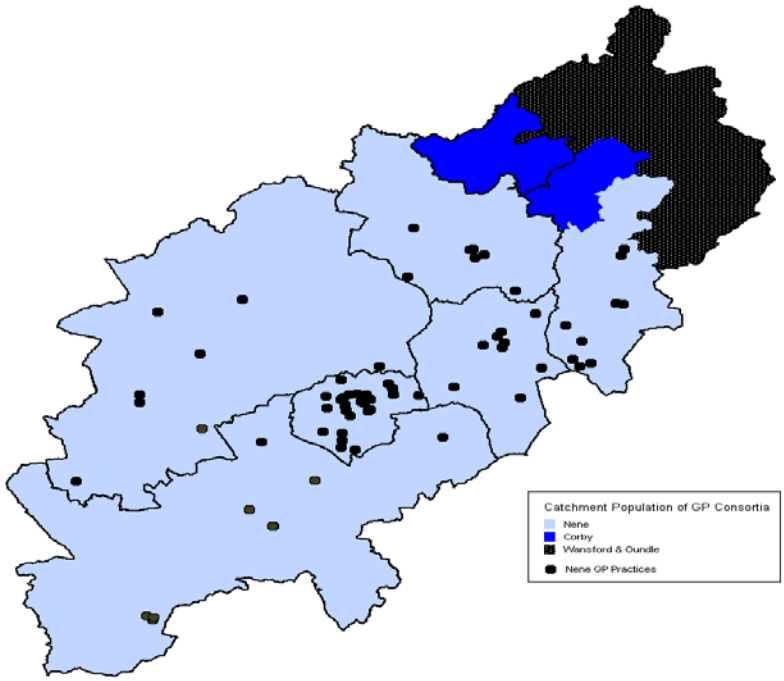
1. Background

NHS Nene and NHS Corby Clinical Commissioning Groups (referred to as the CCGs) are responsible for commissioning most local healthcare services across Northamptonshire. The only parts of the county not covered by the two CCGs are the communities of Wansford and Oundle in the east, who are members of the Peterborough and Cambridgeshire CCG.

Both organisations are committed to ensuring that current and potential staff as well as NHS service users will not be discriminated against on the grounds of social circumstances (including relationship status) or background, gender and gender identity, race, age, disability, pregnancy / maternity status, sexual orientation or religion. We shall work with staff, providers, partners, patients, carers and communities to improve the health of our population and reduce health inequalities for the people of Northamptonshire.

The two clinical commissioning groups shall work closely together to understand and reduce the health inequalities across the population of the county.

Northamptonshire showing coverage of the two CCGs and the area covered by Wansford and Oundle



The area is served by two district general hospitals in Northampton and Kettering and a countywide mental health, learning disabilities and community services trust along with other independent healthcare providers, including the one of the largest independent providers of mental health service in the country at St Andrews Hospital in Northampton. NHS Nene has 70 member GP practices and NHS Corby has five.

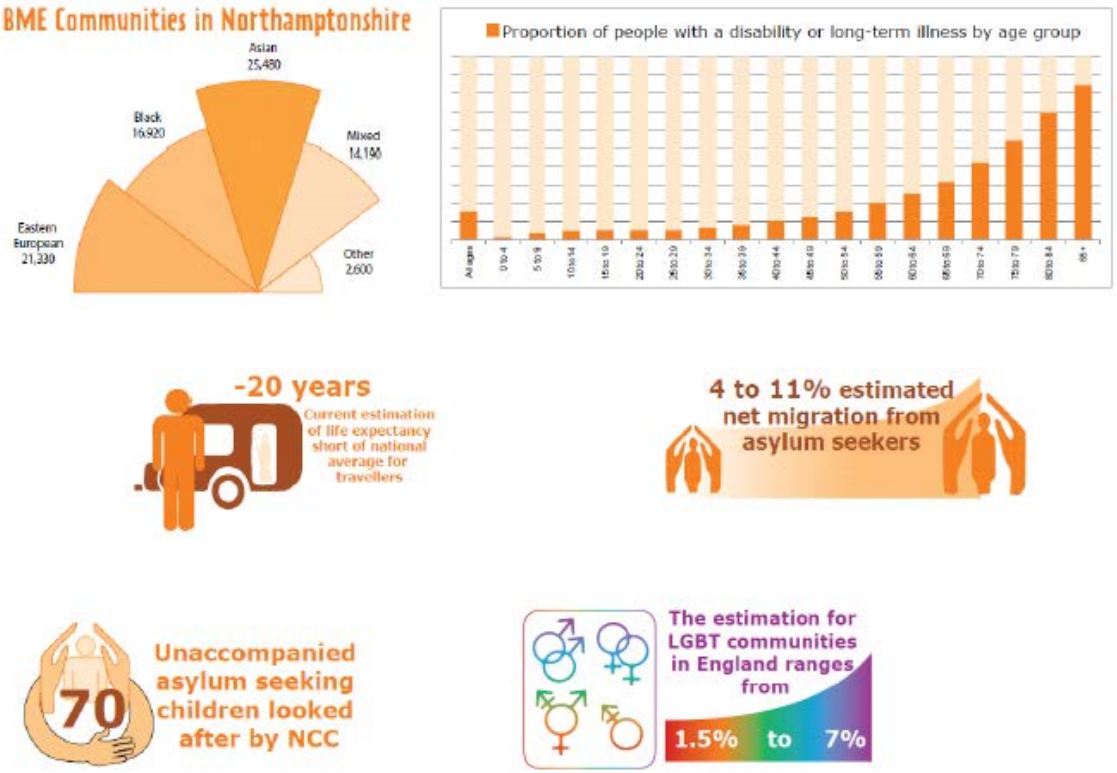
This strategy takes account of the NHS Equality Delivery System (an equality performance framework) launched by Sir David Nicholson in 2011 and also the constitutions of the two CCGs. The organisations strategic objectives, aims and determination to reduce local health inequalities, being transparent and engaging with patients, communities, staff and partners all have an important equality dimension.

1.1 Demographic Information

The two clinical commissioning groups collectively have a catchment area that extends to most of Northamptonshire's districts, except for the communities of Wansford and Oundle on the eastern boundaries of the county. NHS Nene is one of the largest Clinical Commissioning Groups in the country, serving a population of over 625,000. NHS Corby serves the town of Corby as well as surrounding villages in the north east of the county. It serves a population of over 67,000.

Access to accurate up to date information regarding the Health Inequalities across the population that possess one or more of the nine protected characteristics is less than optimal and highly variable.

The main high level national comparators for Northamptonshire are summarised in the info graphic below below.



- Within the county the majority of the population falls within the White ethnic group. Just less than 10% of the population falls outside of this group

- Stonewall suggests that 1 person in 15 is LGBT, for Northamptonshire this would account for 6% of the population

- Special Educational Needs (SEN) within schools in Northamptonshire is calculated at 8,135 places. This represents around 6.5% of those within the 5-19 age bracket. The occurrence across localities shows notable variance, with higher proportions in schools in Wellingborough, Corby, and Northampton.

- As at the last Census (2011) an estimated 112,000 people, or 16% of the population had some form of disability or long-term illness which restricted their day-to-day activities. The distribution found a stronger concentration of this demographic in the more urban areas of Corby, Northampton and Wellingborough

The demographic profile of the county shows that whilst variations of the nine protective characteristics against the national profile are not particularly great, they are significant enough to suggest the incorporation of local context into the development of health interventions is important.

There is a range of documentary evidence relating to the health and wellbeing of the population across the country. We need to understand better how that affects the population we serve in Northamptonshire.

For example:
In May 2013, "The State of Health in Black and Other Minority Groups" was published and highlights the following overarching issues:
Differences in the health of black and other minority groups are most prominent in the following areas of health:

- Mental health.
- Cancer.
- Heart disease and related illnesses such as stroke.
- Human Immunodeficiency Virus (HIV).
- Tuberculosis (TB).
- Diabetes.

Additionally an increase in the number of older Black and other minority people in the UK is likely to lead to a greater need for provision of dementia services as well as the provision of culturally competent social care and palliative care.

For disadvantaged groups with transitory lifestyles – such as Gypsies and Irish Travellers - difficulty registering with a GP is a barrier to accessing primary care. There is also some evidence that health care providers and staff working within primary care settings may restrict access to such services for certain communities. This is also relevant to preventative programmes.

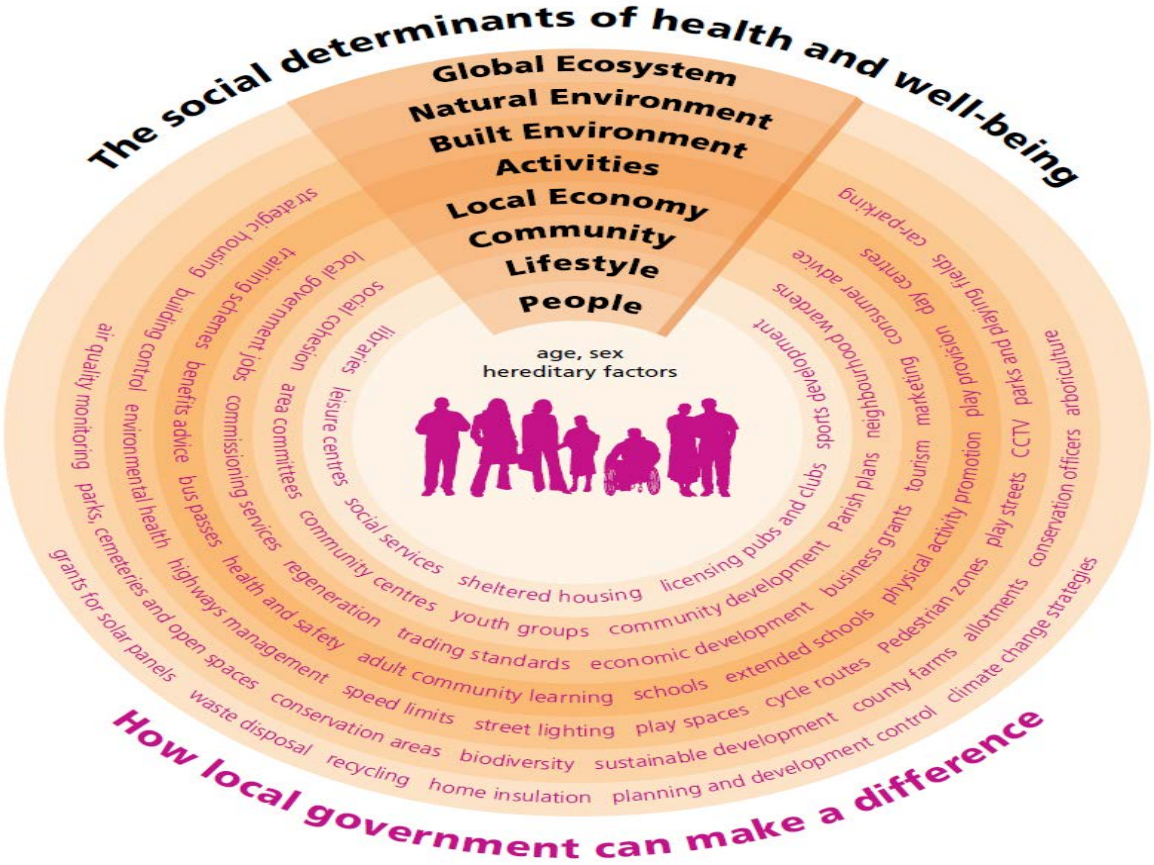
1.2 Overview of CCG health inequalities

Health inequalities are not only apparent between people of different socio-economic groups—they exist between different genders, different ethnic groups, and the elderly and people suffering from mental health problems or learning disabilities also have worse health than the rest of the population. The causes of health inequalities are complex, and include lifestyle factors—smoking, nutrition, exercise to name only a few — and also wider determinants such as poverty, housing and education. Access to healthcare may play a role, and there are particular concerns about 'institutional ageism', but this appears to be less significant than other determinants' (House of Commons Health Committee 2009, p.5).

The Marmot Review into health inequalities in England was published on 11 February 2010. It proposes an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities. The Review highlights the social gradient of health inequalities - put simply, the lower one's social and economic status, and the poorer one's health is likely to be.

Sir Michael Marmot, 2010

The causes of health inequality are complex but they do not arise by chance. The social, economic and environmental conditions in which we live strongly influence health. These conditions are known as the social determinants of health, and are largely the results of public policy.



Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community. Health inequalities are largely preventable. Not only is there a strong social justice case for addressing health inequalities, there is also a pressing economic case particularly to the NHS.

The Review highlights the social gradient of health inequalities - put simply, the lower one's social and economic status, the poorer one's health is likely to be. People living in the poorest neighbourhoods in England will on average die seven years earlier than people living in the richest neighbourhoods. In the NHS Nene & Corby region 17% of the population fall into the poorest category which is better than the England average of 20.4%.

Nevertheless, people living in poorer areas not only die sooner, but spend more of their lives with disability - an (England) average total difference of 17 years. In Northamptonshire this difference is 16 years for males and 18 years for females (PHOF, 2016).

The slope index of inequalities (SII) in healthy life expectancy (HLE) provides a local measure of inequality in HLE at birth. The SII measures how much HLE varies with deprivation. It takes account of health inequalities across the whole range of deprivation within the local authority and represents a range in years of HLE across the gradient from most to least deprived. In Northamptonshire this range is 12.7 years for females and 13.7 years for males (PHOF, 2016).

Summary of Local Findings

- It is estimated that over the next 25 years 43% of the population growth will be the result of migration.
- The incidence of child disability is relatively consistent across the county, with two specific diversions from this; in Corby it is notably higher at 4.2% whilst in South Northamptonshire it is significantly lower at 2.5%. The polarised extent of deprivation experienced in these two localities suggests that whilst not always the principal factor, a higher level of socio-economic deprivation may contribute to the progression of specific conditions and their effect on individuals' lives.
- We can expect 1300 more children living in Northamptonshire each year up to 2021.
- Overall for the county there were 8,784 births in 2014. There was a slightly lower proportion (25.6%) of births to mothers born outside the UK compared to the national average (27.8%). However, there were higher proportions within the county in Corby and Northampton with 32% and 37% respectively (ONS and NCC, 2015).
- Around 24,000 children (dependent under 20 years) in the county live in poverty, which is approximately 1 in 6 children, ranging from 19% in Corby to 6% in South Northants (PHOF, 2016).

2. Legislative Framework

2.1 Equality Act 2010

The Equality Act received Royal Assent in 2010 with the majority of the provisions coming into force on 1st October 2010. Further provisions came into force as follows:

- Positive action; recruitment and promotion – 5 April 2011
- Public Sector Equality Duty (PSED) – 5 April 2011
- Age discrimination protections in the provision of services and public functions – 1 October 2012

In addition to the Act, specific duties were identified and came into force on 10th September 2011 as The Equality Act 2010 (Specific Duties) Regulations 2011. From 31st March 2017, these regulations were superseded by The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

The new 2017 Regulations have amended the previous specific duties and also introduced requirements for public bodies to publish information in relation to pay equality.

The specific duties are:

1. Gender pay gap reporting;
    a. Applicable to all public bodies with 250 or more employees.
    b. Utilising data from 31st March 2017 to analyse and publish by 30th March 2018 and annually thereafter.
    c. Publish the information in a manner that is accessible to all its employees and to the public, for a period of at least three years beginning with the date of publication.

2. Publication of information demonstrating compliance with s149(1) Equality Act 2010;
    a. Publication must include information relating to persons who share a relevant protected characteristic who are;
        i. its employees (providing it employs 150 or more employees);
        ii. other persons affected by its policies or practices.
    b. Publish information not later than 30th March 2018.
    c. Subsequently at intervals of not greater than one year beginning with the date of last publication

3. Preparation and publication of one or more, specific and measurable, Equality Objectives;
    a. Published not later than 30th March 2018 (aligning to any current Equality Objective commitments).
    b. Subsequently at intervals of not greater than four years beginning with the date of last publication.

The Equality Act unifies and extends the previous 100 equality legislations and regulations.

The Act identifies nine characteristics as protected by the Act:

- **Age** - including specific ages and age groups
- **Disability** - including cancer, HIV, multiple sclerosis, and physical or mental impairment where the impairment has a substantial and long-term adverse effect on the ability to carry out day-to-day activities
- **Race** - including colour, nationality and ethnic or national origins
- **Religion or belief** - including a lack of religion or belief, and where belief includes any religious or philosophical belief
- **Sex**
- **Sexual orientation** - meaning a person's sexual orientation towards persons of the same sex, persons of the opposite sex and persons of either sex
- **Gender re-assignment** - where people are proposing to undergo, are undergoing or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex
- **Pregnancy and maternity**
- **Marriage and civil partnership**

2.2 Public Sector Equality Duty (PSED)

Section 149 of the Equality Act 2010 imposes a duty on public authorities in the exercise of their functions to have due regard to the need to:

1. Eliminate unlawful discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
3. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

1. Eliminating discrimination:

- The Act prohibits direct and indirect discrimination, harassment and victimisation of people with relevant protected characteristics

2. Advancing equality of opportunity involves:

- Removing or minimising disadvantage experienced by people due to their personal characteristics
- Meeting the needs of people with protected characteristics
- Encouraging people with protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

3. **Fostering good relations involves:**
    - Tackling prejudice, with relevant information and reducing stigma, and
    - Promoting understanding between people who share a protected characteristic and others who do not.

Having due regard entails considering the above three aims of the PSED in all the decision making as in:

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

The legislation acknowledges that in some circumstances compliance with the PSED may involve treating some persons more favourably than others, but not where this would be prohibited by other provisions of the Act.

2.3 Specific Duties for Public Sector Bodies

Public authorities for the purpose of the Public Sector Equality Duty (PSED) are listed in Schedule 19 of the Act. NHS organisations are listed as public authorities. In addition, bodies that exercise public functions are subject to the PSED in the exercise of those functions (see section 149(2) of the Act). The provision of commissioned NHS services is a 'public function'.

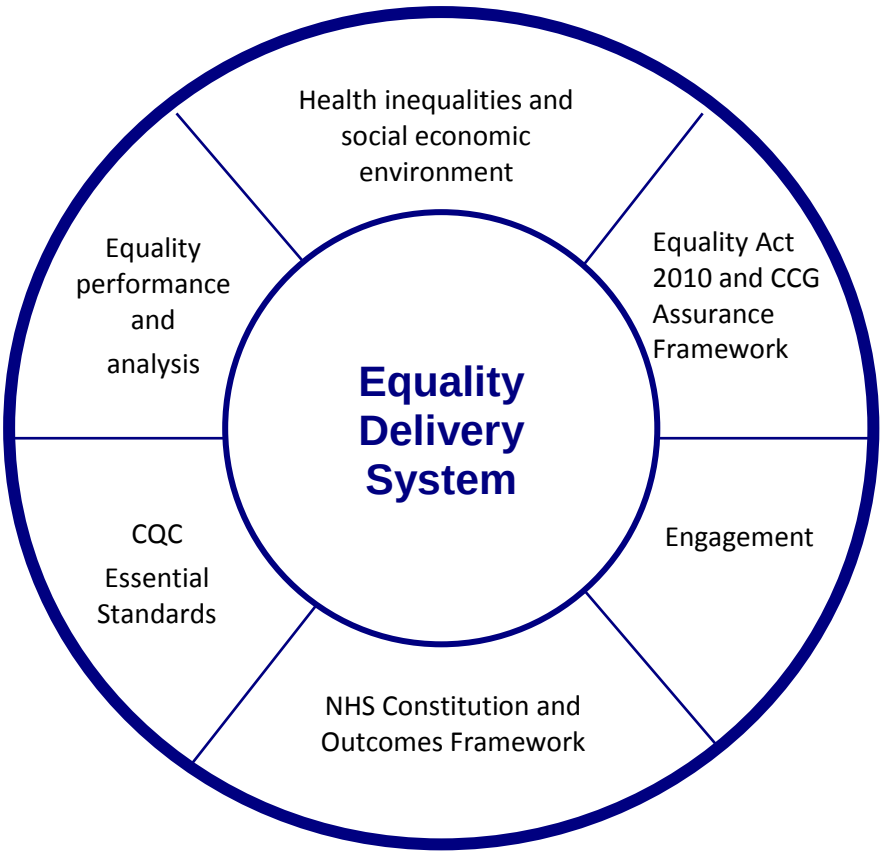
The publication of information needs to include the following:

- It's employees (for authorities with more than 150 staff).
- People affected by its policies and practices (for example, service users).
- Procurement and commissioning (anyone who exercises public functions, must also, in the exercise of their functions have due regard to this duty).
- The information must be published in a manner that is accessible to the public.

2.4 NHS Equality Delivery System (EDS2)

"EDS2 will support CCGs to provide fair, accessible and appropriate services to meet the health needs of all patients while helping to ensure equity in quality and reduced health inequalities." (Dr Amrik Gill, GP)

The Equality Delivery System (EDS2) framework (see Appendix 2) was designed by the NHS to support NHS commissioners and providers to meet their duties under the Equality Act. The EDS2 has four goals, supported by 18 outcomes. The two CCGs will use the EDS as a tool kit to meet the requirements under the Equality Act and we believe this will impact positively in other areas of work as in the diagram below:



2.5 Workforce Race Equality Standard (WRES)

In 2014, NHS England and the NHS Equality and Diversity Council agreed action to ensure employees from Black and Minority Ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. It was agreed that a Workforce Race Equality Standard (WRES) should be developed for all providers subject to the NHS standard contract 2015/16, except 'small providers' (with contracts less than £200,000) and primary care, are expected to implement the WRES from April 2015. NHS Nene CCG as a relatively large CCG falls into the reporting category.

The WRES reporting metrics cover nine areas in relation to workforce, staff survey responses and representation at Board level.

Further information on the national work supporting WRES can be found here: https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/

The table below provides the detail to the current NHS WRES metrics.

	Workforce indicators For each of these four workforce Indicators, compare the data for white and BME staff
1.	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: • Non-Clinical staff • Clinical staff - of which - Non-Medical staff - Medical and Dental staff Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of Medical and Dental staff, which are based upon grade codes.
2.	Relative likelihood of staff being appointed from shortlisting across all posts Note: This refers to both external and internal posts
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year.
4.	Relative likelihood of staff accessing non-mandatory training and CPD
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	Board representation indicator For this indicator, compare the difference for white and BME staff
9.	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board Note: this is an amended version of the previous definition of Indicator 9

3. Inclusion and equality

Responding to the requirements as outlined above offers many challenges and opportunities for the CCGs. Responding to them individually will ensure compliance and unnecessary duplication. Taking account of the CCGs constitutions, their vision and priorities, the need to be transparent, accessible and engaging with patients and communities and making sure that they take account of the diverse health needs of their growing complex and diverse communities require an inclusion and equality strategy to ensure direction. The strategy seeks to embrace everything that the two CCG aspire to achieve in the coming years.

At the heart of this strategy is a new approach to integrate inclusion and equality issues into everything that we do. By becoming an inclusive organisation, one that listens, and responds to the people (patients, staff, partners and stakeholders) it serves, by meeting their diverse needs and addresses the local health inequalities successfully, the two CCGs will be efficient, effective and productive organisations.

The inclusive approach will not only deliver on legal obligations but also provide a direct synergy with the work on quality and addressing health inequalities. This can be achieved by focussing on improving organisations' performance whilst reducing inequitable health gaps between characteristic groups and communities. These are usually associated with poor levels of ill-health, take-up of treatment, and the outcomes from healthcare given that some people from protected groups are at times disproportionately affected and as a result experience difficulties in accessing, using and working in the NHS.

When analysing the outcomes for services and employment, we will also extend the analysis and engagement beyond the protected groups to other groups and communities who face stigma and challenges in accessing, using or working in the NHS. For example, carers, people who are homeless, sex workers and people who use recreational drugs.

By developing this integrated model of addressing inequalities and providing an equitable and fair service to all the residents in the area we believe we will be more successful in meeting our various obligations and local needs.

3.1 Strategic Aims and Equality Objectives

Aim

Our vision is of a community where local people and local clinicians work together to improve healthcare quality and outcomes. We are committed to ensure the objectives of the clinical commissioning groups focus on equality in everything we do.

Objectives

The agreed objectives the CCGs will focus on over the next three years are to:

1. **Continue to integrate inclusion and equality considerations into the decisions we make.**

2. **Develop as an inclusive employer to ensure staff are aware of and supported to meet the evolving needs of the organisation and local communities.**

3. **To focus on understanding gaps in health outcomes for the diverse local communities and working to reduce inequality.**

3.2 Governance of Equality and Inclusion

Following a restructure in early 2017, responsibilities for progressing Equality and Inclusion activities have been allocated to the relevant Committees for each CCG with a Strategic Inclusion and Equality Oversight Group formed to ensure commitment and leadership from each CCG.
The CCGs Joint Quality Committee will provide the scrutiny of the operational activity for equality and inclusion workstreams including:

- Collation of the CCGs EDS2 evidence portfolio.
- Progression of Equality Objectives.
- Embedding of effective Equality Analysis processes.

3.3 Equality Analysis and Due Regard

Following on from the CCGs work in creating appropriate and effective governance processes for its business, the CCGs are committed to ensuring there is an effective, proportionate and live method of considering equality, inclusion and human rights (EIHR) for all relevant decisions it makes that is consistent across the organisation.

The process of Equality Analysis and demonstrating 'Due Regard' for adverse impacts upon any of the Protected Characteristics is designed to embed EIHR considerations into the CCGs business processes and enable a more evidenced approach.

The Due Regard element of the process is where the CCG can evidence that decisions have been influenced appropriately by the Equality Analysis that has been undertaken therefore ensuring a proactive approach to inclusive practice while also meeting the requirements of the of the Public Sector Equality Duty under the Equality Act 2010.

NHS Nene and NHS Corby Clinical Commissioning Groups are committed to ensuring that commissioning decisions, business cases and any other business plans are evaluated for their impact on both quality and to ensure that we give 'due regard' to their impact on equality as required by the Equality Act 2010. NHS Nene & NHS Corby CCGs have refreshed the Quality Equality Integrated Impact Assessment Policy to include method and further guidance on conducting analysis and providing 'Due Regard' can found in Appendix 3 the process flow chart is Appendix 2.

The purpose of the Quality Equality Integrated Impact Assessment Policy is to set out the responsibilities; process and format to be followed when undertaking an combined impact assessment and analysis of the effects on the population and specifically the .Protected Characteristics. To ensure we are compliant with the Public Sector Equality Duty, we use equality information and the evidence from our consultations and engagement to identify the likely or actual effects on individuals, groups and communities in respect of the different protected characteristics. We look for opportunities to promote equality, as well as identifying any actual or potential adverse impact so that, where possible, it can be removed or mitigated.

4. Information sharing and engagement

A cornerstone of the NHS reforms and delivering on the PSED will be how we communicate, share information and engage with:

- Patients
- Carers
- Staff
- People from the protected characteristic groups
- Voluntary sector, and
- Others

This effectively will deliver a two-way flow of information. By developing an inclusive approach with sustained engagement with local interests including protected and disadvantaged groups will assist in collating evidence and using the evidence to influence our performance and decision making.

By promoting collaboration within the local health economy and partners such as local authorities to share best practice, undertake joint engagement activities, encourage joined-up thinking, sharing qualitative and quantitative evidence in addressing local inequalities. Local links and cooperation with public health and also the health and well-being board will help to identify needs and develop local solutions.

4.1 Accessible Information Standard (AIS)

The Standard applies to service providers across the NHS and adult social care system, and effective implementation will require such organisations to make changes to policy, procedure, human behaviour and, where applicable, electronic systems. As Commissioners of NHS and publicly-funded adult social care Nene and Corby CCGs must also have regard to this standard, in so much as they must ensure that contracts, frameworks and performance-management arrangements with provider bodies enable and promote the Standard's requirements.

The Equality Act 2010 duty to make reasonable adjustments relates specifically to people with a disability – and this is the primary legal framework for the **Accessible Information Standard**. In addition, the Care Act 2014 details specific duties for local authorities with regards to the provision of advice and information, this includes the requirement that, *"Information and advice provided under this section must be accessible to, and proportionate to the needs of, those for whom it is being*

provided." The NHS Constitution also states that, *"You have the right to be involved in discussions and decisions about your health and care…and to be given information to enable you to do this."* the Standard should be considered by NHS organisations as part of applying and implementing EDS ('Equality Delivery System '), including as a tool and guide for improving performance.

NHS Nene & Corby CCGs have a duty to ensure that actions, especially through contracting and performance-management arrangements (including incentivisation and penalisation), enable and support provider organisations from which they commission services to implement and comply with the requirements of the Standard.

5. Review and Renewal

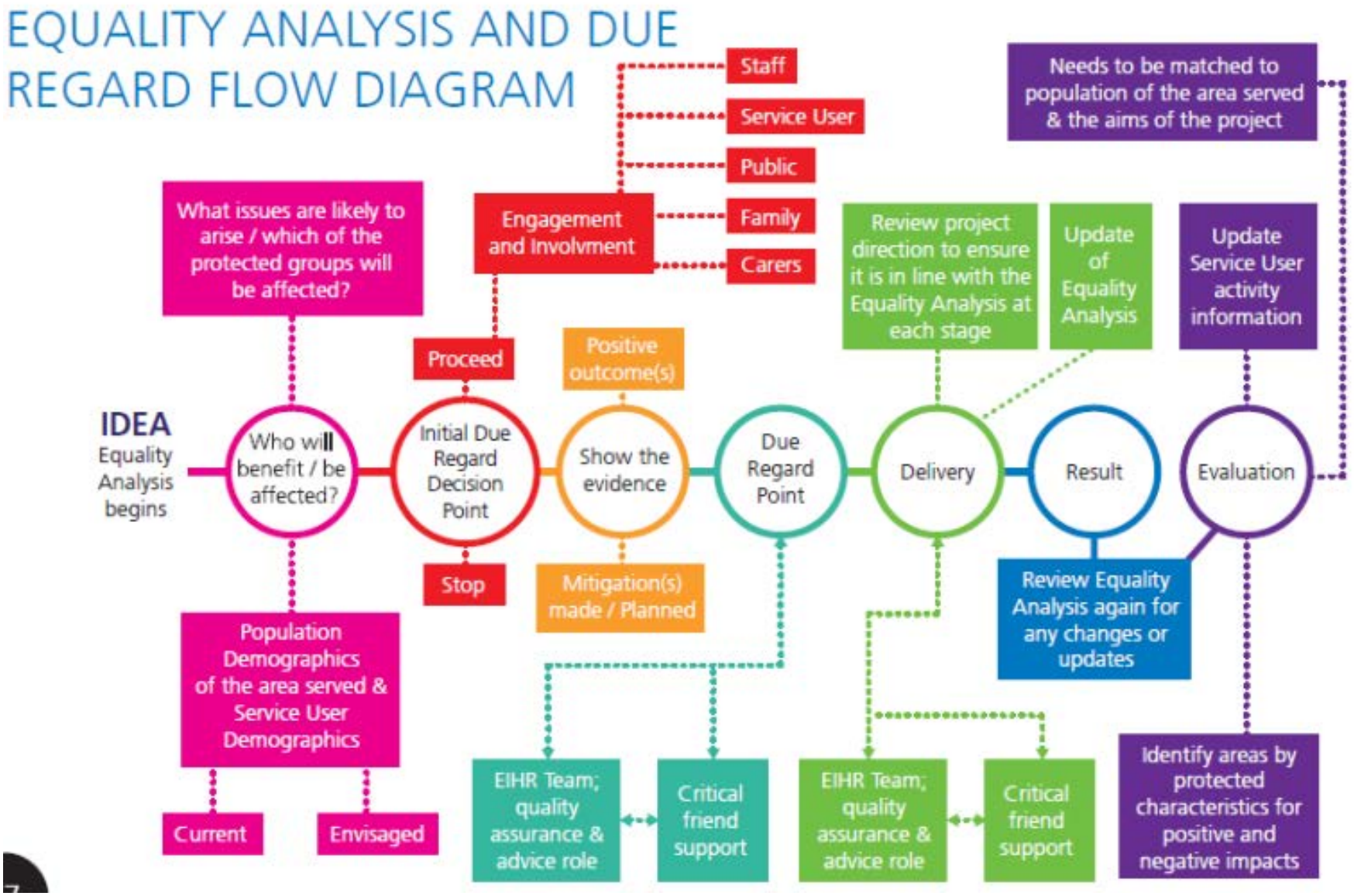
The CCGs Joint Quality Committee will continue to regularly review and update this strategy and publish updates accordingly.

Appendix 1: Equality Delivery System (EDS2) – Objectives and outcomes

The goals and outcomes of *EDS2*		
Goal	**Number**	**Description of outcome**
Better health outcomes	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
	1.5	Screening, vaccination and other health promotion services reach and benefit all local communities
Improved patient access and experience	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care
	2.3	People report positive experiences of the NHS
	2.4	People's complaints about services are handled respectfully and efficiently

A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
	3.3	Training and development opportunities are taken up and positively evaluated by all staff
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
	3.6	Staff report positive experiences of their membership of the workforce
Inclusive leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

Appendix 2: Equality/Due regard Flow diagram



Appendix 3: Equality/Due regard Guidance sheet

The CCG as a public body has a duty to have Due Regard to the need to:

1. Eliminate discrimination, harassment and victimisation and any other conduct prohibited by the Equality Act 2010
2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not.
   This involves considering the need to:
   - Remove or minimise disadvantages suffered by people due to their protected characteristics
   - Take steps to meet the needs of people with protected characteristics that are different from the needs of people who do not share them
   - Encourage people with protected characteristics to participate in public life or in other activities where their participation is law
3. Foster good relations between people from different groups. This involves tackling prejudice and promoting understanding between people from different groups.

It is necessary to actively seek opportunities to fulfil the above duties.

Protected Characteristics

- Age
- Disability (& carers)
- Gender Re-assignment
- Marriage & Civil Partnership
- Pregnancy & Maternity
- Race
- Religion & Belief
- Sex
- Sexual Orientation

Questions to consider

- Does Due Regard apply and why / why not?
- Which Protected Characteristics / Human Rights could potentially be impacted negatively?
- What is the potential impact?
- What data and information sources would you use to inform your work to help apply Due Regard?
- Who do you need to talk to / involve?
- What are the relevant factors?
- Have all views been considered?
- What mitigations could be considered? Are they practical / doable?
- If the mitigations are not practical / doable, what is the justification?

Human Rights; 5 principles

- **F**airness
- **R**espect
- **E**quality
- **D**ignity
- **A**utonomy

Think NHS Constitution;

- Duty to protect and promote Human Rights for every individual