Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Meeting of BNSSG ICB Board

Date: Thursday 2 October 2025

Time: 12:45 – 16:00

Location: MS Teams

Agenda Number:	6.1
Title:	Update on progress against BNSSG ICB Equality Objectives
Purpose: Discussion/For Information	
Key Points for Discussion:	
• The Equality Act 2010 Public Sector Equality Duty requires BNSSG ICB to publish equality objectives that are based on an understanding of equality issues the ICB faces. • The ICB developed equality objectives in the areas of maternity, ethnicity recording, workforce and cardiovascular disease which were approved by the BNSSG ICB Board in March 2025. • This paper describes the progress being made towards achieving the objectives.	
Recommendations:	To note the progress being made against the BNSSG ICB equality objectives. To discuss any strategic or other considerations the ICB Board would like the work to consider
Previously Considered By and feedback:	Each of the equality objective areas has been discussed by their relevant governance group: Maternity – BNSSG Local Maternity and Neonatal System Ethnicity recording – BNSSG Clinical Informatics Cabinet Workforce – ICB Executive Team and BNSSG ICB Inclusion Council Cardiovascular disease – Long Term Conditions Operational Delivery Group
Management of Declared Interest:	There are no declared interests in relation to this paper.
Risk and Assurance:	Main risks: • For workforce, there is a risk of further reducing organisational diversity through the recruitment process to the new organisation that will be part of organisational change. This is being mitigated by the development of further recruitment guidance and training for staff. • For ethnicity recording, there is a risk that if the current proposal is not achievable due to changes at NHSE or

	technical reasons. The mitigation for this risk is being developed.
Patient and Public Involvement:	There was no public involvement in the development of the equality objectives. However, the areas covered are ones that have been highlighted by the public and staff as areas of equality and equity concern. The work to deliver the maternity and CVD objectives as involved patients / people with lived experience.
Financial / Resource Implications:	The financial implications for delivering the objectives have not yet been fully assessed. Any financial resources needed for delivery will need to be decided on and allocated by the relevant decision-making group and/or ICB executive director in line with governance processes and Standing Financial Instructions.
Legal, Procurement, Policy and Regulatory Requirements:	Agreeing, publishing and achieving the equality objectives contributes to BNSSG ICB meeting the general and specific duties set out in the Equality Act 2010 Public Sector Equality Duty. It also contributes to meeting the health inequalities requirements set out in the Health and Social Care Act 2022.
How does this impact on health inequalities, equality and diversity and population health?	Making progress towards achieving the equality objectives will both increase our understanding of where unfair and avoidable differences exist and help to measure whether interventions designed to reduce the difference are effective. Progress will also have a direct impact on reducing unfair and avoidable differences in the delivery of specific healthcare interventions.
ICS Green Plan and the Carbon Net Zero target?	The impact of each of the equality objectives on the ICS Green Plan and the Carbon Net Zero target has not yet been formally assessed.
Communications and Engagement:	Each of the relevant improvement groups overseeing the equality objectives will have communicated their work and be engaging with the relevant stakeholders, both health and care partners and to varying degrees, service users and staff.
Author(s):	Adwoa Webber, Head of Quality and Clinical Excellence
Sponsoring Director:	Dr Joanne Medhurst, Chief Medical Officer

Agenda item: 6.1

Report title: Progress on BNSSG ICB's Equality Objectives

1. Background

The Equality Act 2010 Public Sector Equality Duty states,

A public authority must, in the exercise of its functions, have due regard to the need to-

a) Eliminate discrimination, harassment, victimisation;
b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c) Foster good relations between persons who are a relevant protected characteristic and persons who do not share it

These are the three aims of the general equality duty. The specific duties are that,

Public bodies must publish:

1) Gender pay gap information
2) Equality information – service users and workforce
3) Equality objectives

This paper focuses on the BNSSG ICB Equality Objectives. The BNSSG ICB Board approved a set of equality objectives in March 2025. This paper describes the progress being made against each of those objectives.

2. Maternity

Equality objective - To increase the administration of optimally timed antenatal steroids and magnesium sulphate in our population racialised as Black at risk of pre-term birth within BNSSG by March 2026

Accountable Executive Director - Rosi Shepherd, Chief Nursing Officer

Progress

Preterm birth disproportionately affects women and birthers racialised as Black and Brown, with systemic racism hypothesised as a key contributing factor. The BNSSG Local Maternity and Neonatal System (LMNS) team is undertaking a pioneering qualitative study to explore how racial bias influences experiences and outcomes across the preterm birth pathway. Early data analysis revealed inequities in preterm optimisation interventions and highlighted barriers to engagement with complaints processes, particularly due to the historical absence of racial identity data.

To centre lived experiences, six interviews are being conducted with Black birthers who have experienced preterm birth in BNSSG. These conversations are facilitated by anti-racism experts with lived experience, ensuring racial congruence and minimising harm. Preliminary findings reveal disparities in neonatal care, with participants reporting feelings of neglect and racial bias in neonatal intensive care unit (NICU) settings. Additionally, racialised stigma during preterm birth led to concerns being dismissed, reinforcing harmful stereotypes.

This work aims to break the silence on racial bias in perinatal care and inform quality improvement initiatives. By co-producing solutions with those most affected, the project seeks to create safer, more equitable maternity services. The insights gained will be transferable across systems committed to addressing racial inequity in healthcare.

3. Ethnicity data recording

Equality objective – Increase the completeness of ethnicity recording in the patient administration systems of University Hospitals Bristol and Weston NHS Foundation Trust, North Bristol NHS Trust and Avon and Wiltshire Mental Health Partnership NHS Trust to 80% for BNSSG patients by 2027.

Accountable Executive Director – Deborah El-Sayed, Chief Transformation and Digital Information Officer

Progress

Initial investigation of the problem of recording and sharing ethnicity data suggested that the ICB collating the best available data on ethnicity from across the system in the Federated Data Platform (FDP), and making sure all system partners could access this data might provide an answer. However, this approach requires the Intelligence Centre's technical solution to be in place. As the business case has been paused during the NHS reorganisation, and the solution is still to be developed, an alternative set of supporting actions have been identified.

Our current proposal is to try and get the ethnicity data from the central NHS data storage. This updates the most recent information on any patient based on their last interaction with any NHS organisation and can provide this data directly into provider systems (this is called the NHS Spine). Ethnicity recording is more complete in the NHS Spine, and it is automatically updated and refreshed, but it is not currently a field that is accessible or synchronises when updating a patient record, i.e. our local providers cannot get the data "off" the Spine and into their systems. If this information, along with other protected characteristic information, was more easily and consistently accessible, then all organisations would have access to most up to date and complete information on a patient's ethnicity. This data could be automatically available in the systems our providers use. This would be a big step forward in the achievement of this objective.

In order to progress, this ICB colleagues are going to pursue NHSE colleagues to establish what would be required for BNSSG to work with the national team to get this data from the Spine in a routine way.

4. Workforce

4.1 Equality objectives:

- To make recruitment practice more equitable, making year on year improvements in hiring outcomes for those from racialised communities as compared to 2023-24 disparity data.
- A year on year reduction in the disparity for colleagues from racialised communities and those with disabilities in relation to bullying, harassment and discrimination from managers and colleagues as reported in staff survey data in comparison to 2024 data.
- To increase the proportion of staff from racialised communities in Band 8a or above to 12% by April 2028.
- To continue to reduce the gender pay gap year on year, ensuring that the proportion of females within the upper quartile are comparable to overall organisation composition.

Accountable Executive Director – Jo Hicks, Chief People Officer

4.2 Progress

Within the Organisational Development Plan for BNSSG we had included a number of actions to support improvement against the workforce equality objectives, these included:

- A programme of work to create an inclusive culture across the organisation including:
  - full inclusive recruitment review (from advert to appointment) to make improvement at each stage of the recruitment journey.
  - An anti-racist development programme for executive and extended leadership teams followed with organisation wide anti racism development
- Developing line managers specifically in relation to 'difficult conversations'
- Incorporate EDI objectives within all appraisals
- Improve attendance and directorate representation at the Inclusion Council
- Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur including focus on sexual safety charter & refreshed Freedom to Speak Up

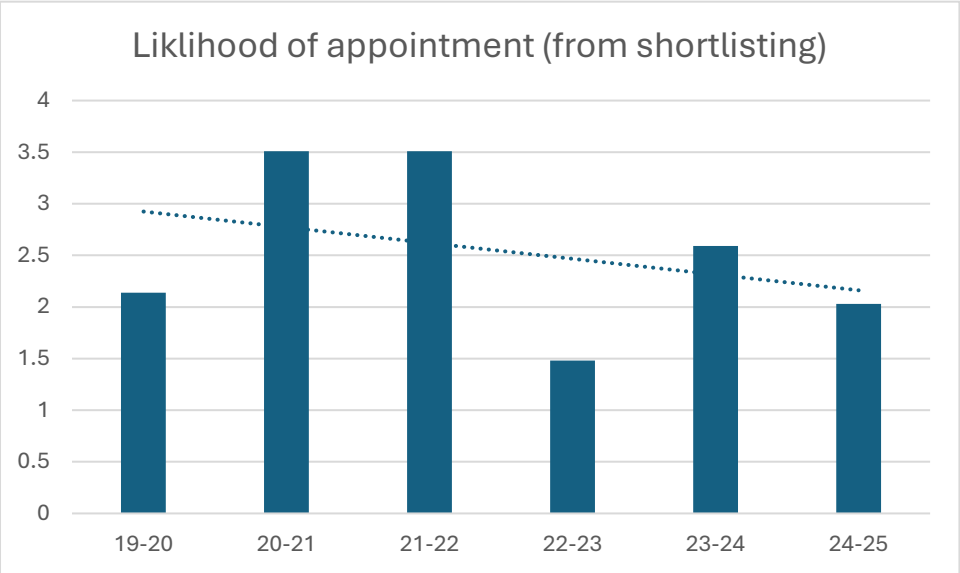
Unfortunately, due to the announcements of 50% reductions and the resulting organisational change working, we have been unable to focus on implementing the organisational development plan meaning that there has been a limited focus on these areas.

4.2.1 To make recruitment practice more equitable, making year on year improvements in hiring outcomes for those from racialised communities as compared to 2023-24 disparity data.

The annual Workforce Race Equality Standard (WRES) data for 2024-2025 shows a slightly improved picture in terms of overall organisational representation from 9.75% (47 individuals) in 2023-24 to 11.68% (55 individuals) in 2024-25. It is worth noting that the percentage of staff identifying as white has only seen a reduction of 0.17% vs a reduction in unknown being 1.76%.

WRES data also shows a small improvement in the disparity data from shortlisting to appointment, showing a reduction from 2.59 to 2.03 (a figure above 1 indicates that individuals who identify as white are more likely to be hired). This follows an overall reduction trend although we have not yet returned to 22-23 levels of 1.48. See Figure 1

Figure 1 Likelihood of appointment from shortlisting for people from racialised communities

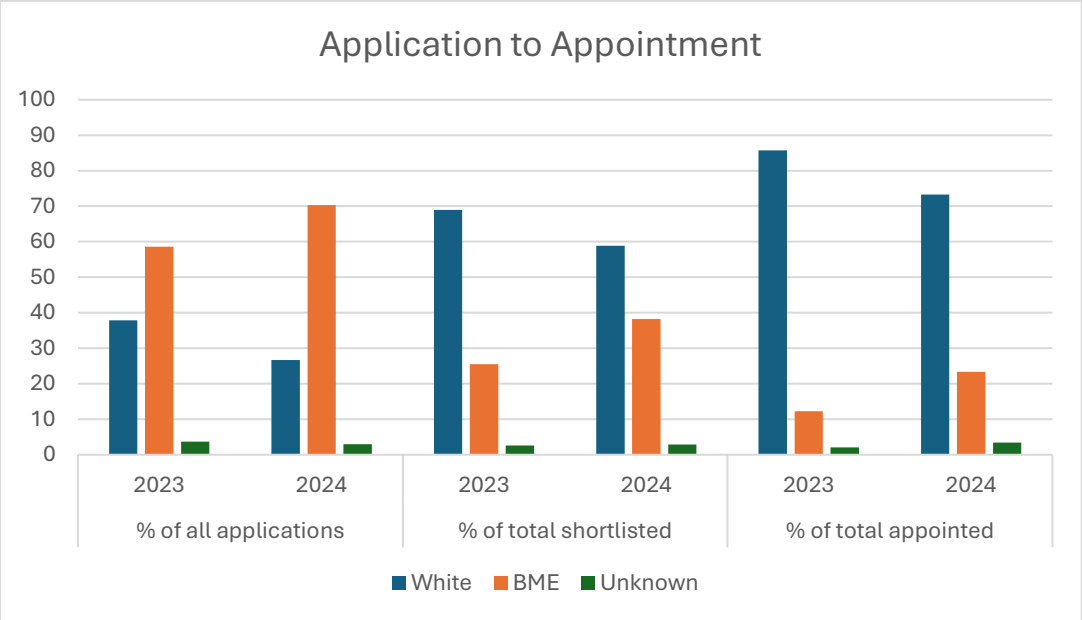


WRES data review has been more in depth this year and has recognised that the disparity in likelihood of appointment from shortlisting is increased when looking at a more detailed breakdown of ethnicity specifically for candidates who identify as Black/Black British and Asian/Asian British.

2024 Ethnicity Grouping	**Likelihood of appointment from shortlisting**
White/White British to BME	2.03
White/White British to Black/Black British	11.5
White/White British to Asian/Asian British	8

A review of the data from application to shortlisting (not included in WRES reporting) indicates a significant disparity for candidates racialised as black or brown with a disparity of 48.9 when comparing likelihood of appointment from application for White / White British vs Black/Black British and White / White British vs Asian/Asian British. See Figure 2.

Figure 2 Comparison of likelihood of appointment from application for “White”, “BME” and “Unknown”



While we have been unable to undertake a full inclusive recruitment review and associated actions, we have recognised that throughout organisational change we need to ensure that competitive selection practices are equitable and do not further reduce organisational diversity. Guidance for interview panels has been created, this includes;

- Ensuring the guaranteed interview scheme is embedded where there is internal open competition (noting 'at risk' employees have priority). This scheme guarantees an interview for individuals who have a disability, long term condition of impairment, those who are a veteran or reservist and those who are care experienced, if they meet the essential role criteria.
- Reasserting the expectation that reasonable adjustments will be made to ensure an accessible process.
- Development of a short Equality & Diversity Representation online session which all members of interview panels are expected to complete plus signposting to a range of additional knowledge build resources.

Once we have moved past organisational change, we would expect to reinvigorate our inclusive recruitment work building on the above, this must include a focus on 'pre shortlisting' to understand how we improve this disparity as we already follow best practice in this area including anonymised shortlisting.

4.2.2 A year-on-year reduction in the disparity for colleagues from racialised communities and those with disabilities in relation to bullying, harassment and discrimination from managers and colleagues as reported in staff survey data in comparison to 2024 data.

Our staff survey data shows a mixed picture in this area between 2023 and 2024.

In relation to ethnicity, we have seen a decrease in those experiencing harassment, bullying or abuse at work from patients / service users and managers as reported in the staff survey.

We have seen an increase in those experiencing this from other colleagues. In relation to discrimination this is more of a steady state picture although we do see a small increase recorded.

In relation to disability, we have seen a decrease in those experiencing harassment, bullying or abuse at work from patients / service users, managers and colleagues as reported in the staff survey. There has however been a 1% increase in those reporting discrimination from patients / services users and a 2% increase in those experiencing discrimination from managers or colleagues

Within the 24-25 financial year we had 2 informal and 1 formal grievance raised none of these cases were related to protected characteristics. Similarly we had 2 informal and 2 formal disciplinary cases within this timeframe none of which were connected to protected characteristics.

It should be noted that the percentage of those with a disability who answered yes to the question “Has your employer made reasonable adjustment(s) to enable you to carry out your work?” rose from 46% in 2023 to 59% in 2024.

We had originally planned for our executive and extended leadership team to undertake a 6 month anti racism development programme earlier this year, this programme was cancelled due to the initial organisational change timescale. Following confirmation of an elongated timeline we are now looking to start a programme for a cohort of 20 individuals in November 2025. Two staff members have also undertaken an Anti-Racism train the trainer programme and following organisational change we would look to implement an organisational wide programme as well as embedding expectations within induction and one to ones.

As part of our organisational change work, we have reiterated our expectations in relation to reasonable adjustments with significant input from our Disability Staff Network. Additionally, the inclusive interviewing guidance mentioned above should support greater understanding of organisational expectations. We will look to reinvigorate more focused organisational development work in this area following organisational change.

4.2.3 To increase the proportion of staff from racialised communities in Band 8a or above to 12% by April 2028

Within our non-clinical roles we have seen a 2.4% increase in those from racialised communities in bands 8a and 8b however a drop of 1.1% in 8c to VSM. Within our clinical workforce, while we have seen an increase in representation within bands 5-7, we have seen no change at 8a and above.

Banding	Non Clinical %						Clinical %					
	BME		White		Unknown		BME		White		Unknown	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
<1 to 4	15.7	18.3	80	80.3	4.3	1.4		0.0		0.0		0.0
5 to 7	6.00	6.6	88.7	88.2	5.3	5.3	15.5	18.8	77.4	76.5	7.1	4.7
8a & 8b	8.00	10.4	86.6	85.1	6.0	4.5	9.1	9.1	87.9	87.9	3.0	3.0
8c to VSM	8.60	7.5	84	87.5	8.0	5.0	0.0	0.0	100	100	0.0	0.0

Organisationally this represents and increase proportion of staff racialised as black or brown in roles 8a or above from 7% in 2023 to 9% in 2024.

As with previous comments, we are working to ensure we do not become a less diverse organisation as a result of organisational change, noting that, at this time, we do not have oversight of the staffing demographics within Gloucestershire ICB. Following organisational change additional consideration should be given to how we use positive action within the talent management arena.

4.2.4 To continue to reduce the gender pay gap year on year, ensuring that the proportion of females within the upper quartile are comparable to overall organisation composition.

In 2024-25 we have seen a small reduction in the median pay gap from 12.88% to 12.61% which continues the overall trend since 2019. The median pay gap however has increased from 17.86% to 18.11%. The median pay gap is generally considered more accurate for measuring the pay of a "typical" employee because it's not skewed by a small number of very high or very low earners.

This can be explained by the proportion of females in the lowest pay quartile rising by 2.21% and the proportion in the highest quartile falling by 2.72%.

We have updated and promoted both our flexible and hybrid working policies to allow flexibility within roles and will look to refine inclusive recruitment practice and managerial guidance following organisational change.

5. Cardiovascular Disease

Equality objective – As cardiovascular disease (CVD) is one of the largest contributors to health inequalities, BNSSG aims to improve the treatment of high blood pressure in our Black African and Caribbean populations so that 80% reach treatment targets by 2029. We will also reduce the gap between our Black African and Caribbean populations and our white population to within 3 percentage points.

Accountable Executive Director – Dr Joanne Medhurst, Chief Medical Officer

Progress

A system working group was established under the Long Term Conditions Operational Delivery Group (LTC ODG) in March 2025. The aim of the group is to co-produce commissioning recommendations for BNSSG ICB, and the local authority partners, to implement in 2026 and to catalyse further action.

The group includes 12 core members, including two public contributors and four VCSE alliance ambassadors, to ensure lived and learnt experience informs the work. The group agreed that over a third of the people present at any meeting must be of Black African or Caribbean heritage to be quorate.

The group has met five times since April 2025 with a final meeting scheduled in October 2025. With the support of the ICB Health Inequalities and Prevention team they have:

- Sense checked a range of data sources and evidence to understand the scale of the issue locally, causes, and possible solutions.
- Explored and developed the complicated combination or 'nexus of factors' (see tables below) impacting why hypertension, and CVD more broadly, disproportionately impacts Black populations. These will inform the recommendations to commissioners.
- Identified the top barriers to hypertension treatment adherence we need to overcome to achieve the objective. These are broadly
    - a **lack of trust,** particularly mistrust in the health system and the complexity of hypertension treatment fueling mistrust**,** and
    - **health literacy**, noting the impact of the wider determinants of health, denial about diagnosis, not appreciating the severity of risk, and concerns with medications[1].
- Identified intermediate outcomes we need to achieve to deliver on the objective and example solutions or models to achieve these outcomes and overcome barriers.
- Co-designed a briefing for GP pharmacists working on the 2025/26 hypertension Prescribing Quality Scheme improvement plans.
- Contributed to a University of Bristol bid to NIHR CVD inequalities five year consortium led by an academic member of the working group. Outcome expected in November 2025.

[1] Examples of medication concerns:
- using multiple medications, side effects and people stopping medication without advice when they feel unwell
- preferring alternative medicines that they feel clinicians will disapprove of and feeling medication is pushed above lifestyle changes
- length of taking medicine ("*on it for life"* is off putting)
- why different medications may need to be tried over time if they don't work
- why you would take two or three combination medications from the start (as per guidelines)
- why there is a different treatment pathway for *"Black African or Afro Caribbean origin without Type 2 diabetes or Chronic kidney disease"* (see Remedy).

Discrimination and racism (feeds into all boxes)

Racism, discrimination and stereotyping behaviours create barriers for Black people. This can reinforce and exacerbate the risk of CVD[7,8]

Benchmarking tools amongst majority groups

Nutritional guidance is benchmarked to majority populations and does not account for cultural differences E.g. salt consumption of 6g or less is thought to be inadequate guidance for Black people[9].

Race-based medicine on explaining inequities

Concerns about NICE hypertension guidelines (section 3) recommending doctors do not prescribe ACE inhibitors/ARB to people of Black African or Caribbean origin and how doctors determine ethnicity[10,11,12] Some evidence of adverse outcomes for Black patients treated with ACE inhibitor/ARB[13]

Chronic stress and racial trauma

Black people are more likely to suffer long-term structural racism and discrimination leading to mental health problems that manifest in CVD[14]. The stressors can have a lifetime and intergenerational effect upon the health[15]. Chronic stress[16,17], perceived discrimination[18]and 'racial burnout', a prolonged fatigue response to racial prejudice, are posited as underlying determinants of disparities in hypertension, but further research is needed[19].

Prescribing and health service provision

GP data shows Black people are less likely to access primary care[20], be prescribed an anticoagulant for atrial fibrillation, hypertension is more prevalent and they are less likely to be treated to target, and they're least likely to have a recorded prescription for a lipid lowering therapy[21]

Lack of access to tailored educational resources and services

Local insights that there is a lack of understanding specific needs of different communities and providing tailored CVD communications e.g. word of mouth for some older people, oversimplification around translating resources.

Clinical knowledge around CVD prevention varies

Local insights around potential variation in GP knowledge of CVD prevention treatment, such as antihypertensive drug treatment pathways. Suggestion that a lack of confidence in options available may impact on communication with patients and increase the likelihood of bias or racism.

GP access

Local insights that people struggle to contact their GP, have long waits for appointments, dislike remote consultations and have concerns around sharing medical information with receptionists. Short appointment times and lack of GP continuity is problematic for properly exploring hypertension treatment options.

Lack of trust

In the medical health system

Impact of fear and mistrust and mistreatment across services such as in mental health result in fear and Black people engaging less and late in preventative services.[22] For some this comes from historical and ongoing disparities and lasting sense of mistrust in the medical establishment[23,24]. A recent UK survey found 49% of Black participants reported that primary care providers treat them differently due to their ethnicity, impacting trust[25]

Lack of patient- health care professional interpersonal trust (summarised as trust earned through a belief that one's best interests are being served by their doctor) can be a problem[26]

In medication

Local insights highlighted mistrust of medication is one of the main issues with some African Caribbean people not being treated to target for hypertension, which is less of a concern for Black African people.

Local insights describe concerns around polypharmacy and side effects, people stopping medication without advice (when unwell), challenges with prescriptions, mixed explanations of medication, that they would like more information about medication: when it needs review, how long they need it.

Awareness & communication (incl. health literacy)

Communication with the GP and at diagnosis

Local insights that there are concerns around being "misinterpreted" when attending GP Practice and people would like more information at diagnosis: what happens next/how long will you be on medication for/how often are you reviewed/what are concerning symptoms. Value of SMS reminders highlighted. A recent UK survey found that poor communication directly impacted future engagement with healthcare services[27].

Understanding of hypertension

Local insights that the asymptomatic nature of the condition means people are not always aware it's a problem, long term risks of hypertension (beyond stroke) and the importance of long term medication use. Those who have had a stroke emphasised the importance of better understanding risks.

USA evidence of perceptions that hypertension is an episodic, symptomatic disease, and use of medications to treat perceived intermittent hypertensive episodes or infrequently to avoid addiction and dependence[28]. A systematic review identified understanding of the causes and effects of hypertension was critical in explaining non-adherence: common themes of believing hypertension caused symptoms such as headaches and dizziness and absence of these symptoms or triggers precluded need to take anti-hypertensive drugs[29]

Culture and religious beliefs

Adherence to medicine and lifestyle guidance

There is evidence that cultural beliefs and practices, and spiritual or religious influences impact medication adherence[3031] alongside general lack of understanding of hypertension USA studies[32] and local insights suggest for some African Caribbean people there is a distrust of modern Western medical practices and use of medication long term, as well as a preference for alternative or complementary medicines. Use of home remedies have been reported[33], although reasons for non-adherence is not a binary issue[34]

Lack of cultural competence in GP

Local insights highlighted concerns around a lack of cultural competence in GP such as: language barriers, not understanding variation in social structure such as family needing to support medication adherence, and the importance of culturally tailored guidance on dietary changes.

Wider determinants of health and structural racism

Black people are less likely to access primary care and other preventative services due to an array of wider determinants and structural racism[35].

Socioeconomic factors – poverty, housing

CVD mortality is almost double in the most deprived areas and Black and minority ethnic groups are disproportionately affected by deprivation.
People living in social rented housing is highest in Black, Mixed White-Black, White Gypsy or Irish Traveller groups[36]

Employment

Local insights around the high number of people working stressful/intense jobs and night shifts, and the need for research around impact on blood pressure.

Health literacy and digital gap

Local insights that health literacy is an issue and there is a digital gap for older generations of Black African and Caribbean people.

Modifiable risk factors

Evidence of limited ethnicity-specific data and guidelines are available on CVD primary prevention interventions for most modifiable CVD risk factors[37]

Low Physical activity

Local insights suggest lower physical activity in Black groups is more likely due to wider determinants of health

Dietary intake

Local insights from African Caribbean men that busy jobs can effect diet.
Evidence reducing salt intake has greater effect on reducing blood pressure in Black and Asian populations with hypertension[38]

Healthy weight

Black African and Caribbean groups have higher prevalence of obesity[39] and evidence of differences in body mass index and waist circumference thresholds and needing tailored interventions[40]. 2025 revision to NICE BMI guidelines to recommend lower BMI Thresholds, suggest even higher prevalence (13% percentage points increase in Black ethnic groups)[41]

Smoking and alcohol use

Local insights of differences in habits between ethnic groups e.g. higher smoking among Black Caribbean people than Black African.
Evidence Black people may have higher hypertension risk at the same level of alcohol consumption[42]. There is general evidence from a UK Bio Bank study around obese people being at higher risk of smoking[43]

Sleep

Local insights that sleep is a challenge for a high proportion of Black people working night shifts, which impacts on conditions such as hypertension.

Non-modifiable risk factors

Genetic makeup and inadequate research around genetic factors

There is evidence that family history and genetics contribute to CVD risk factors, alongside environmental factors[44].
Historically there has been an assumption of race being biological and that genetic differences between ethnic or racial groups exist and medical treatment should differ. However data shows that there is much more genetic variation between individuals within the same racial groups, compared to between different racial groups[45]. Relates to concerns around hypertension guidelines (see 'Discrimination and racism' box). Calls for more research to clarify the extent to which ethnicity can present a differential genetic risk[46].

Age

Local insights from community health checks of a higher incidence of hypertension in under 40s in Black ethnic groups compared to other groups.
Research around the disproportionate impact of stroke on younger Black people and support groups not being available to them[47]

Sex and gender

Sex differences in CVD e.g. Black women have higher rates of hypertension[48] and high blood pressure disorders like pre-eclampsia than women of other ethnic groups[49]. Pre-eclampsia is linked to higher rates of maternal mortality and increase the risk of future cardiovascular events[50].

6. Summary

Progress has been made in taking actions that will contribute to the achievement of BNSSG ICB's equality objectives. Organisational change and responding to the direction set in the NHS 10 Year Plan presents both,

- Challenges – for example, how to ensure that the current disparities in recruitment do not persist when recruiting to the new organisation and
- Opportunities – for example ability to incorporate the recommendations for commissioners on hypertension into the commissioning and delivery of neighbourhood health

7. Financial resource implications

The financial implications for delivering the objectives have not yet been fully assessed. Any financial resources needed for delivery will need to be decided on and allocated by the relevant decision-making group and/or ICB executive director in line with governance processes and Standing Financial Instructions.

8. Legal and procurement implications

Agreeing, publishing and achieving the equality objectives contributes to BNSSG ICB meeting the general and specific duties set out in the Equality Act 2010 Public Sector Equality Duty. It also contributes to meeting the health inequalities requirements set out in the Health and Social Care Act 2022.

9. Risk implications

There are risks to progress caused by the ICB and NHSE organisational change. The main risks are:

- For workforce, there is a risk of further reducing organisational diversity through the recruitment process to the new organisation that will be part of organisational change. This is being mitigated by the development of further recruitment guidance and training for staff.

- For ethnicity recording, there is a risk that if the current proposal is not achievable due to changes at NHSE or technical reasons. The mitigation for this risk is being developed. For the workforce objective on equitable recruitment practice and improvement in hiring outcomes, the disparities could remain or get worse during recruitment to the new organisation.

10. How does this impact on health inequalities, equality and diversity and population health?

Making progress towards achieving the equality objectives will both increase our understanding of where unfair and avoidable differences exist and help to measure whether interventions designed to reduce the difference are effective. Progress will also have a

direct impact on reducing unfair and avoidable differences in the delivery of specific healthcare interventions.

11. Public Involvement including any Formal Consultation and Communication matters

There was no public involvement in the development of the equality objectives. However, the areas covered are ones that have been highlighted by the public and staff as areas of equality and equity concern. The work to deliver the maternity and CVD objectives as involved patients / people with lived experience.

12. ICS Green Plan and the Carbon Net Zero target

The impact of each of the equality objectives on the ICS Green Plan and the Carbon Net Zero target has not yet been formally assessed.

Glossary of terms and abbreviations

Equality Act 2010 Public Sector Equality Duty	The purpose of this duty is to make sure that public authorities and organisations carrying out public functions think about how they can improve society and promote equality in every aspect of their day to day business
Antenatal steroids and magnesium sulphate	Giving these to people who are at risk of giving birth very early (pre-term) reduces the risk of their baby having problems with the development of their nervous system. Problems can result in conditions such as cerebral palsy.
Patient Administration System	The system used by healthcare providers to record details of patients, appointments, etc.
Cardiovascular disease (CVD)	A general term for conditions affecting the heart or blood vessels.
High blood pressure / hypertension	Blood pressure is the pressure of blood in the arteries. There needs to be a certain level of pressure in the arteries to move blood around the body. If blood pressure is higher than recommended over time it increases the risks of cardiovascular diseases such as stroke or hearty attack.
Intelligence Centre	A central data hub that will allow teams to visualise, analyse and export anonymised population data.
Federated Data Platform	This platform securely connects data and breaks down information silos. It provides insights to assist in decision-making, reduce costs and improve patient outcomes.