NHS
Central London
Community Healthcare
NHS Trust

Promoting Equality and Tackling Inequality Strategy

2021 – 2025

Contents

1. Foreword

Developing and sustaining a culture of equality and fairness

Promoting equality and tackling inequality needs to be at the heart of everything we do at Central London Community Healthcare (CLCH) and that means ensuring we provide thoughtful services run by staff that understand the importance of our role in promoting equality and preventing inequalities. Similarly our staff cannot provide the best care if they feel undervalued or treated unfairly.

We are a diverse organisation spread over a large geographic area and as such we acknowledge the existence of variations due to the diversity of cultures in our trust. We hope the development of our new strategy promotes change across the whole organisation.

I would like to thank our network chairs as well as our shared governance council members for the role they have played in producing our new strategy.

To implement a strategy to promote equality and tackle inequality that is of real significance, we must recognise and act upon the individual experiences within our workplaces and the communities that we serve.

We have been listening to both our staff and users through honest conversations, and our focus is to ensure a meaningful connection between our trust values and the lived experience of staff and patients.

As an organisation we are committed to creating an inclusive and equitable experience by genuinely considering where disparity, disadvantage and unfairness exist and not tolerating our shortcomings. As such you will see the following threads running through this strategy document:

- Dedication to identifying areas of concern without being defensive
- Being specific about actions that we will undertake
- Welcoming discomfort
- Being accountable
- Learning from each other
- Constantly improving

We want all our people to be the best they can be for themselves, for each other, and for our patients and communities.

Charlie Sheldon
Chief Nurse and Executive Lead
for Equality and Inequality

2. Executive summary

Our strategy for promoting equality and tacking inequality reflects changes in the national, regional and local health policy context, along with a renewed focus on health and workplace inequalities due to the COVID-19 pandemic.

We need to ensure all members of our community can access the right care in the right place at the right time. We also need to ensure equality for our workforce through becoming an employer of choice, where all staff feel included, supported and empowered to do their best and develop to their full potential and that we have a workforce that is reflective of our local population at all levels.

We need to focus on reducing health inequalities within our communities through working in partnership with our Integrated Care Service (ICS) partners, primary care networks, voluntary sector, local authorities and other healthcare collaborators. Importantly, we also need to embed the principles of an Anchor organisation in supporting local communities through procurement and spending power, workforce and training, and estate, thereby advancing the welfare of the populations served.

In order to take forward meaningful and tangible change for the communities we serve and for our staff, we need to ensure that our strategic direction is evidence-based and is underpinned by specific and measurable objectives which are aligned to both national imperatives and to the relevant priorities within our local context.

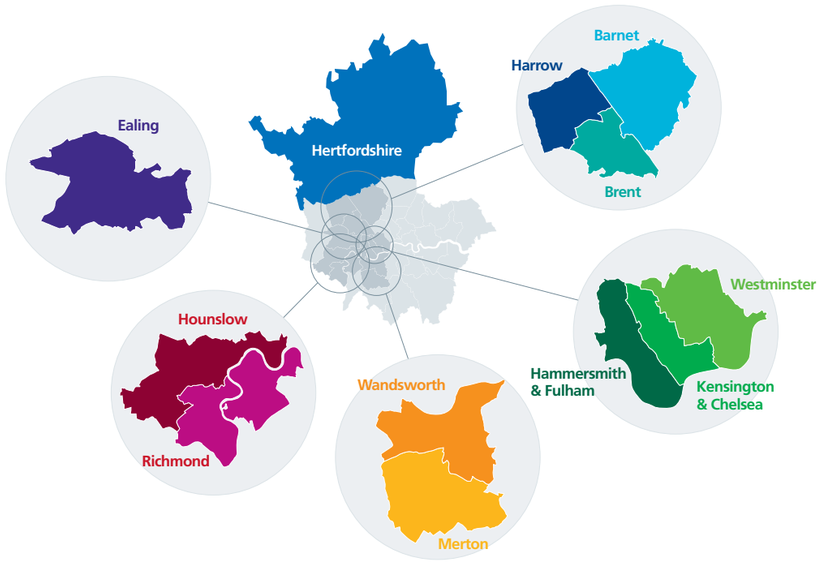
Our strategy focusses on four priority areas (campaigns) of access to services, workforce equality, understanding our communities and becoming an anchor organisation.

At the heart of our strategy, we aim to enable values-based cultural change in which equality, diversity and inclusion become part of everything we do and is embedded at every level of our organisation. Our ongoing work will be underpinned by the principles of effective leadership, partnership, collaboration and enablement.

3. About Central London Community Healthcare NHS Trust

CLCH employed 3960 staff as at March 31, 2020 to deliver community health services to over two million people across 11 London boroughs and Hertfordshire. Our professionals provide high quality healthcare in people's homes and local clinics, helping them to stay well, independent and avoid hospital admissions. We support our communities at key stages in their lives, from birth to end of life – by providing services such as health visiting, community nursing, in and out-patient rehabilitation and palliative care. The areas in which we currently provide services are shown in the illustration below:

Where we work and what we do



Barnet:
- Adult community services
- Children's community services

Brent:
- Brent falls
- Health visiting
- School nursing

Ealing:
- Family nurse partnership
- Health visiting
- School nursing

Hammersmith & Fulham, Kensington & Chelsea and Westminster:
- Adult community services
- Dental services
- Health visiting
- Homeless treatments
- Learning disabilities
- School nursing
- Speech and language therapy

Harrow:
- Adult community services
- Children's immunisation services

Hertfordshire:
- Adult community services (West Hertfordshire)
- Sexual health (County-wide)

Hounslow:
- Children's immunisation services

Merton:
- Adult community services
- Children's community services

Richmond:
- Health visiting
- School nursing
- Sexual health

Wandsworth:
- Adult community services
- Health visiting
- School nursing
- Sexual health

4. Background and context for review

Recent changes in the national, regional and local health policy context, accelerated by a renewed focus on health and workplace inequalities due to the COVID-19 pandemic have required the trust to review its Equality, Diversity and Inclusion Strategy. We need to prioritise objectives and actions where there is clear evidence that outcomes have worsened for some population groups compared with others – e.g. in employment and access to services. This strategy will, as a result focus on fewer objectives, a proportionate set of actions across 5 years, a clear delivery plan and clearer success measures.

Role modelling compassionate, inclusive leadership through open and honest conversations (amongst staff and teams), calls to action for boards and strengthening the role of our staff networks in decision-making are now part of the step-change required of trusts. Trusts are now expected to deliver ambitious plans on equality and health inequality as employers, service providers and anchor organisations - using their economic influence to advance welfare and social mobility in the communities they serve. This was reiterated in the letter dated 31st July 2020 from NHS England Chief Executive, Simon Stevens, on the NHS priorities for the third phase of COVID 19, which includes explicit support for staff and inequalities.

The review has also required us to restructure our Equality Group (our Corporate Equality Steering Group), which was established in 2019 to oversee delivery of the trust's Equality Strategy and Equality Objectives. Chaired by the chief executive, it initially included a cross–section of staff and representatives from staff networks and staff side to oversee the governance of our equality plans. It is now a formal standing group reporting to the Executive Leadership Team, Quality (for services) and People (for workforce) Committees. It ensures that the delivery of the strategy is performance-focussed and rigorous, through the involvement of senior managers, directors, executive leads and representatives from professional groups, staff side and staff networks. The focus, in particular, is on cross-cutting themes affecting the culture of the organisation. The overall objective of the group is to ensure equality, diversity and inclusion are closely integrated with the decision-making process and embedded in the day-to-day business of the organisation. The trust chief nurse is the executive lead for equality and tackling inequality.

5. How we developed our new strategy

In developing this strategy, the trust undertook the following:

- An audit of the existing equality objectives was completed.
- Identification of emerging gaps and priorities from results of the 2019 NHS Staff Survey, the latest equality reports and discussions with a cross-section of stakeholders.
- Agreement of the process for strategy review with by the newly constituted Equality Group.
- Identification of 4 equality campaigns reflecting our key strategic equality objectives.
- An engagement event was held with a range of representatives to discuss the 4 Equality Campaigns and how to embed the strategy in our day-to-day work.
- Consultation undertaken with the trust board, shared governance councils, staff networks, staff side and the Patient Engagement Group.
- Interviews held with staff and service users to capture personal perspectives.
- A 5-year implementation plan was developed for each campaign, with associated actions and measures of success.

Key principles that shape our strategy:

- It is evidence-based – informed by key studies and reports relating to workforce and health inequalities.
- It has been co-designed with staff and patient and public representatives.
- It is informed by lived experience and personal testimonies.
- It will be refreshed in keeping with national and local trends.
- It will be focussed in its scope to address inequalities – prioritising efforts based on evidence of persistent disproportionality and consensus.
- It will be embedded in the day-to-day working of the trust, especially with due regard to the three aims of the General Equality Duty.
- It will be supported by an implementation plan that will be updated at agreed intervals.

7 Minute Learning:
Feedback from Race Equality Network

1. Context and desired outcome:

Key issues

The leadership team and board not representative of BAME staff within CLCH. There is a need for regular uncomfortable conversations between BAME staff and the leadership team.

Listening sessions need to be followed up with timely action.

There is conscious/ unconscious bias and ignorance regarding race within the organisation.

We need senior leaders to role model and endorse inclusive and equitable behaviour – through their communication, allyship and endorsement of anti-racism and zero tolerance of racism.

2. Problems BAME staff face include:

- Lack of understanding/ empathy of the lived experience of BAME staff.
- Nepotism and the lack of transparency regarding recruitment and internal job opportunities.
- Micro-aggression and incidents, which have no consequences.
- The Grievance process needs to be overhauled – investigation panels need to have trained and representative members.
- Protected time needs to be given to clinical staff on panels

3. Contributory Factors

- Silent bystanders.
- Lack of amplification of BAME voices on key decisions.
- Lack of education and awareness of barriers faced by BAME staff.
- Lack of commitment to change status quo among White middle and senior managers.
- Capable BAME staff side-lined when job opportunities arise.
- Lack of understanding of how racism collectively impacts all staff and patient care.

4. Root causes:

Systemic and structural and institutional racism –and discrimination. Denial of institutional discrimination coupled with white privilege/ fragility. Limited lived socialisation with BAME communities – leading to ignorance.

5. Recommendations include:

- Amplification of BAME voices, their participation and involvement in inclusion and decision-making.
- Speaking up and challenging micro-aggressions, racial comments/jokes and behaviours indirect and direct when heard or/witnessed.
- Be open to challenge.
- Consciously and intentionally consider impact of structural systems of oppression on BAME staff through research, engagement and evidence.
- Timely aspirational goals to be set for workforce and board representation based on robust methodologies.

6. Learning:

Lived experience of BAME staff is real and impacts detrimentally on their health and well-being.

Racism impacts life chances, aspirations and outcomes. Structural racism affects recruitment, retention and progression of BAME staff. This impacts patient care. An unhappy workforce = unhappy patients. Racism leads to poorer health – increased allostatic load, stress, mental illness and CVD.

7. Discussion points

Involve BAME staff when planning and making decisions which impact their lives and career opportunities.

Allyship is about unitedly addressing systemic and structural racism. Senior managers and executive team should attend Race Equality Network meetings at least quarterly.

Clear endorsement of race equality/Inclusion at all levels – senior managers to share learning with colleagues.

6. Strategic context

6.1 Legal and Regulatory Drivers

There are a number of legal requirements, national standards and contractual obligations that the trust must meet to eliminate discrimination, and advance equality and cohesion. The table below summarises these requirements and what they mean for the trust. The NHS Standard Conditions of Contract also mandates that trusts demonstrate compliance through an annual report which sets out how it is meeting its equality duties given in Table 1:

Table 1: Legal and Regulatory Drivers

Legal and Regulatory Drivers	Implications for the trust
Human Rights Act 1998	• Protecting human rights in clinical and organisational practice by adhering to core values of fairness, respect, equality, dignity and autonomy (FREDA) and placing them at the heart of policy and planning. • Empowering staff with knowledge and skills to achieve a human rights-based approach. • Enabling meaningful involvement and participation of all key stakeholders. • Non-discrimination and attention to vulnerable groups.
Equality Act 2010	To ensure we consciously consider the impact of our decisions and actions on people protected by this legislation and other marginalised groups and strengthen their voice and participation. The Equality Act 2010 offers legal protection from discrimination in the workplace and access to services. The Act requires us to show due regard to the following three aims: 1. Eliminate unlawful discrimination. 2. Advance equality of opportunity between people, and 3. Foster good relations between people who share a protected characteristic and those who do not. To meet the General Duty, we have two specific duties: To develop equality objectives once every 4 years at least and to publish an annual report which analyses workforce and service user trends by protected characteristics.
Health and Social Care Act 2010	Under this act, trusts have a duty to ensure they: • Have due regard to the need to reduce inequalities in access and outcomes of care • Promote involvement of patients and their carers in decisions relating to their health, and • Enable patients to make choices on health services provided to them.
Public Services (Social Value) Act 2012	• This calls for all public sector commissioning to incorporate economic, social and environmental well-being into procurement processes. For example, it requires all NHS organisations to consider how the services they procure might improve the social, economic and environmental well-being of the area in which they operate.
Workforce Race Equality Standard (WRES)	To narrow the gap in experience and outcomes for BAME staff compared with White staff, prioritising: • Fair recruitment practices and career progression opportunities leading to a representative workforce. • A healthy work culture, which reinforces positive behaviour. • Restorative dialogue to pre-empt formal disciplinary action. • A representative board which reflects the make-up of the workforce and community.
Workforce Disability Equality Standard (WDES)	To narrow the gap in experience and outcomes for staff with disabilities, prioritising: • Disclosure of disabilities across the workforce and board. • Strengthening the voice, influencing and participation of people with disabilities in decisions that affect them. • Training and awareness-raising on best ways to attract, recruit and retain staff with disabilities and ensuring reasonable adjustments. • A healthy, positive work culture for disabled staff. • Equal opportunities for their career development.
Gender Pay Gap Report	To address imbalances in median and mean pay between men and women, prioritising: • Root cause analysis on issues related to career progression and pay disparities • Ensuring staff leaving and returning from maternity/adoption leave have access to guidance, support and pastoral care. • Preventing occupational segregation by gender and building confidence among male and female staff through widening access to career opportunities and promoting flexible working at all levels.
Equality Delivery System (EDS2)	• Create a culture of continuous improvement on equality, diversity and inclusion. • Develop an integrated approach in the review and assessment of our equality performance and to set objectives and improvement plans. • Build improvement actions into business plans as part of the annual planning cycle.
Accessible Information Standard (AIS)	• To ensure service users with language and communication support needs arising out of a disability are supported systematically in keeping with our AIS policy.
Public Services (Social Value) Act 2012	• This calls for all public sector commissioning to incorporate economic, social and environmental well-being into procurement processes. For example, it requires all NHS organisations to consider how the services they procure might improve the social, economic and environmental well-being of the area in which they operate.
Sexual Orientation Monitoring Standard	• To ensure sexual orientation monitoring is part of the service equality monitoring and LGBT patients.

6.2 National Context and Drivers

The NHS Constitution – outlines its commitment to deliver services for all regardless of their characteristics or circumstances, paying particular attention to those with poorer health outcomes when compared with the rest of the population. It states that respect, dignity and compassion should be central to how patients and staff are treated, because good patient care is the result of staff feeling valued and empowered. It states "the NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it."

NHS Long Term Plan - The NHS Long Term Plan reaffirms the commitment set out in its constitution and emphasises the need for employers to be flexible and responsive. It states that the NHS will 'do more to develop and embed cultures of compassion, inclusion and collaboration across the NHS' to 'create an inclusive and just culture that leads to outstanding staff engagement and patient care'.

NHS People Plan - Under the NHS People Plan 2020/2021, the NHS has pledged to build a 'compassionate and inclusive culture' to 'value our people, create a sense of belonging and promote a more inclusive service and workplace so that our people will want to stay'.

COVID-19 – Phase 3 Letter - In Simon Stevens' letter to the NHS of July 2020, Stevens asked us to 'take account of lessons learned during the first COVID peak', namely its effect on different communities and members of staff. He wrote that COVID has 'further exposed some of the health and wider inequalities that persist in our society' and that it is 'essential that recovery is planned in a way that inclusively supports those in greatest need'.

Health Inequalities and COVID: Recent findings

Recently published reports summarised overleaf demonstrate that health inequalities are often socio-economically patterned and whilst COVID-19 did not create them, it certainly exposed and exacerbated risks for different population groups.

Emerging evidence suggests that the impacts of the COVID-19 crisis arising from the direct and indirect effects of contracting the illness, as well as the lockdown measures put in place to control spread of the virus, are significant and unequal. The second wave and the impacts of not just the disease but the differential impacts of the measures the new alert systems will have on different groups in the population will continue to ingrain effects far beyond health and economics, with some potentially having long-term consequences.

As there was already an inequality crisis across many domains such as income, wealth, living standards, labour market participation, health, education and life chances, COVID-19 has exacerbated many of these pre-existing inequalities and exposed the vulnerability of some population groups to adverse shocks. The crisis has also drawn out more harshly the effect of deprivation for multiple inequalities and poor outcomes.

Key findings from recent reports are as below and more detail can be found in Appendix 1:

Public Health England (PHE), Beyond the data: Understanding the impact of COVID-19 on BAME groups – Public Health England published a report in June 2020 detailing the disparity between different demographic groups and the impact of COVID-19. The report into the differences that have emerged in the risk of infection and death from COVID-19 showed that while increased age is the largest risk factor, it is closely followed by gender (male), certain ethnicities and areas of deprivation.

It found that working-age men with COVID-19 were twice as likely as their female peers to die from the disease, while the death rate in the most deprived areas was more than double that in the least deprived, for both sexes.

Research found that the highest age standardised diagnosis rates per 100,000 population were in people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of white ethnic people (220 in females and 224 in males).

The report found that younger disabled males were 6.5 times more likely to have died due to COVID-19 than non-disabled males, while disabled females between nine and 64 had a rate of death 11.3 times higher than non-disabled females in the same age group.

PHE's data review suggests that people of BAME groups may be more exposed to COVID-19, due to factors such as occupation (including likelihood of being key workers), population and use of public transport amongst others. The report recommends a number of actions to mitigate this, including mandatory comprehensive ethnicity data collection as part of routine NHS and social care data collection systems,

supporting community participatory research, accelerating the development of culturally competent occupation risk assessment tools and improving access and outcomes of NHS commissioned services for BAME communities.

Marmot Review (2010 and 2020) – The Marmot report, first published in 2010, highlighted the scale of health inequalities in England and discrepancies in life expectancies between wealthier and poorer regions of the UK and suggested ways to remedy such inequalities. However, the second Marmot report, published ten years later in 2020, found that health inequalities had, in fact, continued to widen in the intervening decade. The report concluded that continuous improvements in life expectancy had stopped, compounded by years of austerity measures that had taken a disproportionate toll on deprived communities.

NHS Confederation, Health Inequalities, Time To Act – In September 2020, the NHS Confederation published a report on the need to act upon health inequalities in light of the effects of COVID-19. The report states that the pandemic has 'thrown into sharp focus the issue of health inequalities in the UK and exposed the consequences of long-standing failure to tackle this deep-rooted and multi-faceted problem'. It states that COVID-19 deaths among people born outside the UK and Ireland have also been higher, with the biggest relative increase among those born in Africa, the Caribbean, South-East Asia and the Middle East[1], demonstrating just one of the clear demographic discrepancies between those affected by the pandemic.

In a survey of NHS Confederation members, over 9 in 10 of respondents agreed that addressing health inequalities must be at the forefront of recovery and majority of respondents agreed that COVID-19 has shown that the NHS itself must deliver a step change in how it cares for diverse communities. One of the commitments in the report includes the recent launch of the NHS Race and Health Observatory, hosted by the NHS Confederation, which will work to find evidence-based, actionable insights into health inequalities and find solutions to them.

[1] Health Inequalities: Time to Act, NHS Confederation, 2020

7. CLCH strategies

This strategy is closely aligned with and supported by our Organisational Strategy 2020-22, with its focus on integrated care, place-shaping and sustainability to address inequality. The trust strategy reinforces the organisational commitment to health protection, equality and engaging communities around needs and priorities, especially in light of the disproportionate impact of COVID on some population groups more than others. This strategy is enabled as well by the People, Quality and Clinical strategies.

Organisational Strategy	People Strategy	Clinical Strategy	Quality Strategy
Key themes include: Leading in local systems. Achieving integration of services as local partners. Putting our collective CLCH expertise to work. Ensuring a sustainable future.	**Priorities from our people and clinical workforce strategies include**: Keeping and growing our own workforce Supporting staff to do their best Develop leadership Promote staff wellbeing Raise levels of staff engagement Develop new roles that work across traditional organisational boundaries	**Priorities include:** A focus on getting the basics right. Developing our sense of Place Understanding our community assets Increasing the trust focus on public health Strengthening connectivity	**4 Quality campaigns:** Positive Patient Experience Preventing Harm Smart, Effective Care Modelling the Way

Staff story from Rainbow Network

How does it feel to work day-today at CLCH?

How does it feel to work day-today at CLCH?
I worked in a private hospital for about a decade, and then moved about 18 months ago as I really wanted to work in the NHS. This was partly because of things like the Rainbow Network and because I wanted the opportunity to work in an organisation that would champion inclusivity and diversity, as opposed to one where that felt quite removed. CLCH itself feels very inclusive.

The team I work with closely have been very excited and eager to do anything they can to learn more about LGBTQ+ and wider inclusion, such as pledging with the rainbow badges, along with joining other workshops run by the Disability and Race Equality Networks. They were all very excited about what we do to celebrate Pride and LGBTQ History Month. We actually did a Pride themed breakfast - everyone got dressed up in pride flag colours, flew pride flags, and brought food of different colours from the pride flag, which was great. That's just a bit of fun, but from what I've seen everyone is very keen to embrace diversity.

Is this felt across the LGBTQ community?
I can't speak for other people, but from my perspective I think there should be greater trans visibility. It's something our teams and I could benefit from more training on, particularly around trans awareness. Some has been done but I'd be interested to know what people across the LGBTQ spectrum think about that. I have been impressed by other training sessions run by other networks, such as the Race Equality Network and workshops run through CLCH – I know there has been a big push recently, so it's good to see CLCH respond to that.

Are there any changes you would personally like to see in the workplace?
From my perspective – it's not that I feel that my colleagues or I discriminate against LGBTQ clients, but we work with a lot of older people where there tends to be an avoidance of asking about sex, sexuality and relationships. I'm really keen to make sure that our initial assessment document has a section on sexuality and relationships, as it doesn't currently. It's on the six-month stroke review, but that's a standardised template. We should work on improving people's confidence about asking those questions, it's something we can constantly improve on. I'm hoping to do some training around sexuality and neurological injury in general, but will look to include information about giving permission to talk about sex and sexual orientation. It will be interesting to hear about LGBTQ clients' experiences.

CLCH RAINBOW NETWORK

8. Where do we want to get to?

Based on the results of our Staff Surveys, our key equality reports, namely our WRES, WDES and Gender Pay Gap and EDS2 reports and recent studies, we are aware that the following areas need to be prioritised:

- The need to actively promote a positive and healthy work culture to ensure we prevent bullying and harassment of our staff.
- There will be an emphasis on the adoption of active measures to prevent bullying and harassment as outlined below.
- Increased career development opportunities for BAME and disabled staff to address low confidence levels related to career planning and progression.
- Representation and voice to ensure greater participation in decision-making among under-represented groups.
- Ensuring services are designed and made accessible to all sections of the local community to address disproportionality in terms of health outcomes, which have been highlighted by the COVID pandemic.

Chart 1: Supporting and training colleagues and managers to identify, investigate, challenge and support those experiencing and perpetrating bullying and harassment.

CLCH Values and Culture
Firmly challenging all behaviours, including bullying and harassment, that are in conflict with CLCH values.

Communications
Sharing stories on the impact of bullying and harassment on wellbeing and campaign through showcasing success stories of effective management and elimination of the behaviour.

Victim support
Supporting those who have experienced bullying and harassment.

Training
Supporting and training colleagues and managers to identify, investigate, challenge and support those who are experiencing bullying and harassment and those who may be perpetrating the bahaviour.

8. Where do we want to get to?

- Addressing health inequalities through population-based studies, primary care networks and integrated working with health, local authorities and voluntary sector partners and our partners in our STPS and Integrated Care Systems.

Through this strategy we want to ensure we have the knowledge, tools and capability to attract, retain and develop all our staff to their full potential and provide services accessible to all sections of the community, so as to minimise disparity in health outcomes for different population groups.

We want to be an employer of choice, an excellent provider of services and a community leader committed to promoting socio-economic well-being in the communities we serve.

To ensure we are able to meet our ambitions, in particular on equality and inclusion, we are focussing our strategy on four Equality Campaigns, namely:

Campaign 1:
Access to services

Campaign 2:
Workforce equality

Campaign 3:
Understanding our communities

Campaign 4:
Our role as an anchor organisation

Case Study:
Race Equality Network (REN) – COVID Sub-Group

In April 2020, 13 members from the Race Equality Network (REN) stepped up to be volunteers to support other Black Asian and Minority Ethnic (BAME) staff in the trust affected by COVID anxiety. Under the sponsorship of the Director of Nursing and Therapies (Quality and Safety), the volunteers, who began the You Are Not Alone Campaign, offered information, signposting and a willing ear to support colleagues experiencing loss, stress, bereavement or related anxieties arising from COVID-19 and the death of George Floyd.

Since the campaign began members have supported over 100 staff on a range of issues and continue to meet and share ideas. They have built their own resilience through training on motivational interviewing and acceptance therapy from the trust psychologist.

The group have worked to organise telephonic and face-to-face support for colleagues. They have developed fact-sheets on a range of topics, such as nutrition and Vitamin D, and provided information and other resources to colleagues through the REN intranet page.

They were instrumental in shaping the risk assessment framework and ensuring cleaning and domestic staff (many of whom are BAME agency staff) had access to the same infection prevention guidance as the rest of the workforce.

The volunteers helped to significantly improve the engagement of BAME staff in the trust. The REN has since grown in size and meets fortnightly. Members have taken ownership to bring more colleagues into the network, organise an annual conference and act as critical friends to the trust through working groups overseeing the implementation of the WRES Action Plan.

Case Study: Big Diversity and Race Conversation – Speech and Language Therapy (SLT) Clinical Business Unit (CBU)

In September 2020, the Speech and Language Therapy CBU held a Diversity Big Conversation event for its staff. Staff members engaged in interactive discussions looking at a range of concepts including, white privilege, micro-aggression and disparity between the demographic make-up of the Speech and Language Therapy Team and its service user group and the impact of racial inequality in healthcare. The seminar was aimed at fostering curiosity, self-awareness, reflection and improving the experience of holistic person-centred care for service users.

Over 40 SLT CBU staff attended the event and provided very good feedback. They welcomed the opportunity to have authentic conversations about race within SLT, including discussing barriers experienced by service users. Since the event, 13 SLT staff volunteered to become Diversity and Inclusion Champions to continue discussions and facilitate positive change and improvement for staff and service users. They are planning to hold the next SLT Diversity and Inclusion Race Conversation in November.

The service has plans to work closely with partners, including schools/ education settings and a range of stakeholders to develop this area of work, raising awareness, and promoting speech and language therapy as an attractive career option for students from a range of backgrounds and communities, including areas of deprivation.

9. Patient and public involvement

The vision for our involvement and engagement work is to enable everybody to have the opportunity to influence the decisions that affects them and recognises the benefits of working together, empowering patients to work collaboratively with clinicians to help determine the decision making about their care.

Service users, carers and the public are offered the opportunity to be involved in the development, planning, design and delivery of the trust's services and are fully supported to do so. Our mission is working together to give children a better start and adults greater independence.

Our engagement and involvement is also driven by our local context. Central London Community Healthcare NHS Trust (CLCH) serves a diverse area covering a growing population across London and Hertfordshire, currently estimated at 4 million people made up of a number of different cultures and backgrounds.

10. Digital inclusion

In order to successfully use digital services patients and staff need digital skills, connectivity (equipment and suitable internet connection), accessibility and inclusivity in terms of well-designed services. Digital inclusion is all about reducing barriers to using these services.

We know that there are areas within which we provide care that will experience digital exclusion. This is based on factors like 4G availability, access, digital skills and social indicators. Overall, London is in a strong position for digital technology, with perhaps Harrow and Brent flagging as areas to focus inclusion efforts. Although within all areas it is recognised there will be communities requiring support to enable this level of digital engagement.

An increased level of work is required to build our local knowledge of the population we serve in terms of digital services. Specifically, we need to ensure that the data in our clinical systems is complete and enables us to report on activity and outcomes by patient groups. Without this we will struggle to track progress or assess impact of digital working on experience or outcomes.

Case Study:
Clinic U - Patient Story

I am a new patient to Clinic U, and had not been tested in over a year, a friend told me about the LGBTQ clinic and that it was a good clinic to go to. Previously I used London clinics for screening and treatment. I attended for a routine screen and consultation after booking an appointment through the appointment line. I was very impressed with the service and friendliness of staff at reception, and the atmosphere when arriving in the clinic. It was clean and inviting.

My consultation was on time and the depth that the practitioner went into when taking a history, was extensive. I also disclosed that I regularly partake in chem sex and this was discussed, and further interventions and organisations accessed at time of appointment to discuss risk reduction strategies. The practitioner was truthful at this time and stated that I was high risk for contracting HIV or Hep C and discussed at my first visit how I would feel with a diagnosis of this nature. I felt that this was above and beyond what I had experienced in other clinics and was grateful for the support. We also discussed and had tests completed for potential PrEP initiation should my results when returned be negative for HIV. I was made an appointment for review of results rather than a text message due to the risk that 1 or more results would be positive. I also received a direct referral into spectrum for help and advice about my chem sex practices.

At my next visit I was prepared for the results that were about to be given to me. Although still initially I was shocked, I had been prepared at my first appointment and had time to observe the potential implications. I was given and reactive HIV test and a reactive Hepatitis C result. At this appointment secondary samples were taken for confirmation of Hep C but the HIV had been confirmed. This appointment allowed for further bloods to be taken in order to speed up results allowing for a doctor visit at the clinic to decide on treatment.

The first few days post diagnosis was rough, and I found myself when alone ruminating on where I had caught both infections. I, as suggested by clinic, also started my own partner notification as I had over 30 casual sexual encounters in the last 6 months through a variety of gay apps. The health advisor worked with me to ensure as many as possible were contacted or notified. During this time, the nurses at the clinic contacted me several times to make sure I was coping with the diagnosis and to check on my wellbeing.

I attended for my doctor appointment at Clinic U and further issues were discussed, I was not going to be a straight forward HIV patient as also had Hep C and had a resistance to certain drugs.

I have now started my treatment, and received support in doing so, I have accessed Spectrum and have had support to stop chem sex activities and ongoing appointments made to check on progress. The Doctor stated that due to my resistant HIV under no circumstances would the medication given be compatible with chem sex drugs, I am now 3 weeks into treatment start, have not had chem sex and am feeling positive about also starting Hep C treatment when I can.

The support Clinic U has given has been exceptional, I am so glad I attended here for testing again. They do such an amazing job and have helped me through a very difficult diagnosis and time.

11. Our four campaigns

Campaign 1: Access to services

Outcome: All services show equal access to services in terms of protected characteristics (analysed by waiting times and take up in case of self-referrals)

Lead Director: James Benson, Chief Operating Officer

Objectives	Measures of Success Apr 2021 – Mar 2022	Measures of Success Apr 2022 – Mar 2023	Measures of Success Apr 2023 – Mar 2024	Measures of Success Apr 2024 – Mar 2025
We will protect the most vulnerable from COVID, through enhanced analysis and community engagement, to mitigate risks associated with protected characteristics and socio-economic conditions.	Confirm the patients that are most vulnerable from COVID. All services will develop clear strategies, implementation and evaluation plans to mitigate the risks from COVID for the most vulnerable.	Implementation of strategies and plans to be monitored locally to evidence focus on the most vulnerable.	Assess evidence of a successful focus on the most vulnerable with targeted support and interventions.	Evaluation of implementation to evidence effectiveness and sharing learning.
We will restore NHS services inclusively, so that they are used by those in greatest need – guided by new performance monitoring of services, access and outcomes among those from most deprived neighbourhoods and BAME communities.	Waiting lists for services will be reviewed regularly by protected characteristics to identify where additional action may be needed to increase access and reduce inequality.	N/A	N/A	N/A
We will develop digitally-enabled care pathways and review effectiveness and take-up by different patient groups	Pilot digital investment and innovation to improve access for marginalised patient groups to assess effectiveness	Roll out plans to address digital solutions where this will reduce inequalities Seek external investment where available nationally or locally for digital solutions to help target groups.	N/A	Evaluate implementation to evidence effectiveness and share learning.

Campaign 1: Access to services

Outcome: All services show equal access to services in terms of protected characteristics (analysed by waiting times and take up in case of self-referrals)

Lead Director: James Benson, Chief Operating Officer

Objectives	Measures of Success Apr 2021 – Mar 2022	Measures of Success Apr 2022 – Mar 2023	Measures of Success Apr 2023 – Mar 2024	Measures of Success Apr 2024 – Mar 2025
We will prioritise preventative programmes which engage those at greatest risk of poor health outcomes. This includes take-up of flu vaccines, better targeting of services to support prevention of long-term conditions and management programmes, obesity reduction programmes, self-referrals into the Diabetes Prevention Programme and health checks for people with learning disabilities.	Develop equalities portal for our data to provide tools for analysis by protected characteristics. Provide access to demographic data for locality based teams to enable comparative analysis of take up of services. Analysis will be published for flu vaccine take-up, obesity reduction programmes, self-referrals to the Diabetes Prevention Programme and health checks for those with learning disabilities.	Develop local tools including dashboards so teams can undertake local analysis of data to understand how better to prioritise interventions and evaluate implementation to evidence effectiveness and share learning improve access to services for those most at risk of health inequalities.	N/A	N/A
We will record and review patient ethnicity and all other protected characteristics to monitor and respond to trends related to inequality in terms of access and outcomes.	The completion rate for ethnicity monitoring will improve throughout the year, with action targeted where it is most needed, linking in with community leaders to identify and respond to trends and patterns.	Quarterly reports monitoring increases in demographic information collected and reporting against initiatives delivered to tackle health inequalities. Reduce the number of complaints received relating to health inequality.	Assess evidence of a successful focus on the themes identified through the collection of demographic information and review of complaints data, with targeted support, interventions and projects.	Evaluation of implementation to evidence effectiveness and sharing learning

Campaign 2: Workforce equality

Outcome: Better staff experiences reflected in equal and improved staff survey results. Better outcomes reflected in recruitment, retention and promotion data

Lead Director: Louella Johnson, Director of People
(Access to Education: Holly Ashforth, Deputy Chief Nurse)

Objectives	Measures of Success Apr 2021 – Mar 2022	Measures of Success Apr 2022 – Mar 2023	Measures of Success Apr 2023 – Mar 2024	Measures of Success Apr 2024 – Mar 2025
1. We will promote a positive culture for our staff by: (a) Improving processes for escalating and resolving internal complaints from staff.	QI project on resolving internal staff complaints – mapping out key steps and processes from the point of receiving a complaint to resolving it. To conclude with guidance, metrics and information on support services.	Staff and managers have readily available tools and resources to address performance and conduct issues early. Proportion of formal disciplinary within confidence levels outlined in Model Employer guidance on disciplinaries.	Staff experiences on bullying and harassment show year-on-year improvement Investigations of grievances concluded with timescales set out in guidance. Monitoring and review of complaints processes to see how improvements can be sustained.	Improved staff survey scores on morale, engagement, bullying and harassment and discrimination, with reduced variations between BAEM and White staff, Disabled and non-disabled staff. Overall improvement in recruitment and retention of staff and employees referring the organisation as a great place to work in.
(b) Raising awareness of the impact of poor behaviour at the workplace.	Anti-Bullying Week (Nov 16-21) – followed by monthly awareness-raising on The Hub/through SG Council and training.	Awareness-raising of impact of workplace incivility, including understanding of bullying, harassment and victimisation to be ongoing. Greater clarity on values and expectations on behaviours through annual appraisals.	10% reduction in the number of reported staff on staff bullying allegations from agreed 2020/21 baseline criteria. A minimum of one staff bullying and/ or harassment story shared in Divisional Meetings a quarter.	20% reduction in the number of reported staff on staff bullying allegations from an agreed 2020/21 baseline criteria. A minimum of one staff bullying and/ or harassment story shared in Divisional Meetings a quarter
(c) Protecting staff from abuse from the public and patients through system-wide collaboration.	Support for staff reporting Violence and Aggression and link up with system-wide partners to campaign against abusive behaviour from public and patients.	Greater confidence among managers and staff to report and respond to aggression annually.	10% improvement in the management of unacceptable behaviour reported on Datix by auditing the reporting of sanctions from a 2019/20 baseline.	20% improvement in the management of unacceptable behaviour reported on Datix by auditing the reporting of sanctions from a 2019/20 baseline.
(d) Providing staff access to a range of support networks (e.g. Freedom To Speak Up Guardian and champions, staff networks, staff side, helplines and shared governance councils).	Updated list of full range of forums, networks and support services to be published on The Hub and promoted. Support for divisions to run engagement sessions and address localised challenges.	Increased staff engagement through forums and networks at corporate and divisional levels – reflected in improved staff survey scores on staff engagement, morale, well-being, bullying and harassment, discrimination and feeling valued.	Staff feel supported – reflected in fewer internal complaints, improved staff survey scores on staff morale, well-being, bullying and harassment and discrimination.	N/A

Campaign 2: Workforce equality

Outcome: Better staff experiences reflected in equal and improved staff survey results. Better outcomes reflected in recruitment, retention and promotion data

Lead Director: Louella Johnson, Director of People
(Access to Education: Holly Ashforth, Deputy Chief Nurse)

Objectives	Measures of Success Apr 2021 – Mar 2022	Measures of Success Apr 2022 – Mar 2023	Measures of Success Apr 2023 – Mar 2024	Measures of Success Apr 2024 – Mar 2025
(e) Promoting restorative dialogue through training, feedback and coaching for staff and managers to support early resolution of concerns. Developing line managers' competency to: Lead culture change so that they manage diversity and inclusion effectively. Build a consistent standard of race and cultural awareness. Conduct 360 feedback and coaching. Develop key skills around self-awareness and conversations that make a difference. Offer peer support and space for reflection.	Academy implementing new LPD programme for 2000 line managers focusing on management and leadership. HR Team to provide ongoing coaching. OD and Culture Team to provide staff access to awareness-raising through network meetings, culture and behaviour self-assessment templates, bespoke workshops and annual conferences. Develop a learning culture – through a range of different learning opportunities – from classroom, to staff stories, Schwartz Rounds, discussion and debate sessions and workshops.	More listening sessions within divisions, dialogue and confidence to report and resolve conflict. Line managers demonstrate greater cultural competency, actively support efforts on speaking up, inclusion and allyship. All staff engaged in identifying equality objectives for self, team and division. Greater openness to learning about workplace barriers – willingness to learn and share about how to improve employment conditions for all. Drive to improve patient care matched with support for staff at all levels to ensure the same. Willingness to acknowledge blind spots and adopt a no-blame, just and learning culture. Improved staff survey scores on EDI	Improved staff survey scores, feedback from pulse surveys, networks and exit interviews on workplace behaviour and morale.	N/A

Campaign 2: Workforce equality

Outcome: Better staff experiences reflected in equal and improved staff survey results. Better outcomes reflected in recruitment, retention and promotion data

Lead Director: Louella Johnson, Director of People
(Access to Education: Holly Ashforth, Deputy Chief Nurse)

Objectives	Measures of Success Apr 2021 – Mar 2022	Measures of Success Apr 2022 – Mar 2023	Measures of Success Apr 2023 – Mar 2024	Measures of Success Apr 2024 – Mar 2025
2. We will enable career for all through targeted improvement initiatives to address disproportionality by: Promoting access to learning and career development opportunities through the Academy and OD team through targeted initiatives, such as: line manager training, Reverse Mentoring, Capital Nurses Programme for BAME nursing staff, Disability Champion and the Unlocking Your Potential programmes.	Training offered by Academy: Line managers' training Reverse mentoring training for staff at Band 8B and above (3rd cohort to start in Jan 2021). NWL BAME Capital Nurse Programme underway Disability Champions programme – to conclude in February 2020. Resources on reasonable adjustments and disabled staff stories to be promoted through The Hub. Unlocking Your Potential (for BAME staff at B7 and below and their sponsors) – 2 cohorts commissioned. Inclusive Leadership training for managers Learning resources on race and diversity to be posted on special page on intranet. New behaviour framework to go live.	Equitable access to career development opportunities across trust.	Career/personal development reflected in progression and staff morale – across all protected characteristics. Workforce profile improves in terms of representation Greater awareness and confidence on equality and inclusion. Line managers more culturally competent, engage well with issues related and race, disability, LGBT and other equality and inclusion issues. Managers show greater awareness and willingness to address structural barriers to progression.	Workforce representative at all levels, organisation more culturally intelligent and shows confidence in managing inclusion – reflected in greater allyship of minority groups, improved participation at all levels, an openness to constructive challenge and an improvement and innovation culture to addressing workplace issues – leading to improved recruitment and retention.
Offering mentoring, coaching and training to equip staff with tools and resources to progress their careers effectively.	Career mentoring and coaching to be promoted through OD page on The Hub.	Staff have greater confidence to pursue personal and career development plans through mentors, coaches and shadowing opportunities.	Mentoring and coaching leads to greater confidence and morale among all staffing populations – which leads to career development.	Mentoring and coaching leads to improved workplace relations and a more representative workforce across all levels.
Ensuring that ED&I are integrated within appraisal systems and Personal Development Plans.	New EPADR system to go live. Includes section on personal development plans and guidance and question on setting equality objectives + question on reasonable adjustments.	All staff develop personal and career development plans – and set equality objectives at individual, team and divisional level.	Improved equality, diversity and inclusion scores,	N/A

Campaign 2: Workforce equality

Outcome: Better staff experiences reflected in equal and improved staff survey results. Better outcomes reflected in recruitment, retention and promotion data

Lead Director: Louella Johnson, Director of People
(Access to Education: Holly Ashforth, Deputy Chief Nurse)

Objectives	Measures of Success Apr 2021 – Mar 2022	Measures of Success Apr 2022 – Mar 2023	Measures of Success Apr 2023 – Mar 2024	Measures of Success Apr 2024 – Mar 2025
3. We will promote representation and voice of staff at all levels by: (a) Setting aspirational workforce goals for staff at Band 8A and above to ensure fair representation in terms of ethnicity at senior levels.	New aspirational goals set for BAME representation at Band 8A and above following remodelling of workforce profile based on Model Employer Guidance.	Workforce representation representative in terms of ethnicity and gender at all levels – to be informed by ethnicity and Gender Pay Gap reports as well workforce modelling.	Workforce profile, pay bands and reward and progression opportunities start to demonstrate greater parity. Representation and voice consciously considered when making key decisions and in any marketing and public relations work. Staff networks inform and influence policies and decisions.	Workforce representative at all levels, supported by fair and robust internal and external recruitment.
(b) Ensuring CLCH Board is representative of our staff and communities.	Develop a pathway for a representative board.	Talent pipelines developed in partnership with ICS partners.	Board representative of our communities and staff.	Board representative of our communities and staff
(c) Strengthening existing staff networks and setting up 3 new ones for women, new parents and faith and spiritual care.	Existing staff networks are supported and continue to develop and work together. 3 new staff networks to be launched – for new parents, women and faith and spiritual care.	Staff networks participate and inform policies and decisions.	Increased engagement and overall morale and satisfaction levels. Staff recommend the organisation as an employer of choice.	N/A

Campaign 3: Understanding our communities

Outcome: Reduction in health inequalities for targeted groups (where we have identified we need to improve outcomes for targeted groups, such as areas of deprivation)

Lead Directors: Dr Joanne Medhurst, Medical Director and Elizabeth Hale, Director of Improvement

Objectives	Measures of Success Apr 2021 – Mar 2022	Measures of Success Apr 2022 – Mar 2023	Measures of Success Apr 2023 – Mar 2024	Measures of Success Apr 2024 – Mar 2025
We will prioritise areas for intervention relating to evidence of disproportionality in health outcomes on the basis of: Areas of deprivation, occupational / demographic group and disease.	Building on Action 4 in Access to services we will undertake **analysis of health outcomes** and **patient experience** in areas of deprivation to prioritise interventions to improve outcomes and experience. We will do a detailed analysis of the wider impact of COVID-19 on health in community areas in London and Hertfordshire, to understand clearly the impact of COVID across the life course.	Actively target and evaluate interventions to improve health outcomes for priority groups identified through our analysis in 2020/21. Actions resulting from this will be used as part of the trust's Clinical Strategy.	We will be established as a population health focussed organisation that influences our commissioners to support us in the provision of targeted services based on need. We will publish annual health improvement plans	We will be influential in the ICS population health role evidenced by senior practitioners within ICS governance structures across the 4 ICSs where the trust works. We will monitor and evaluate the changes in outcomes and the impact of our services on agreed preventative areas to influence further commissioning the development of the public health prevention system
We will enable our staff to develop the skills and knowledge to understand equality, diversity and inclusion within the context of our community.	Training will be provided to all staff to support their knowledge and understanding of health inequalities using data from their services and localities	Population health skills master classes to be run to develop higher levels of expertise and to share learning with partners via the academy	Develop a community health informatics programme to undertaken joint training within PCN/ICP through the academy	Work with an Academic partner to become a supplier of educational material on population health in community settings
We will share learning and best practice through the Hub and quarterly seminars with our local partners e.g. Primary Care networks.	We will share knowledge internally and engage with partners including commissioners and the development of the new ICS to share learning.	Regular publication of case studies to share knowledge and impact of work across the trust and with partners. We will evidence in published papers how we have made a significant contribution to the local and national population health system.	Annual conference/ master classes held to share key insights and expertise developed internally – organised via the academy.	Work with an Academic partner to become a supplier of educational material on population health in community setting.

Campaign 3: Understanding our communities

Outcome: Reduction in health inequalities for targeted groups (where we have identified we need to improve outcomes for targeted groups, such as areas of deprivation)

Lead Directors: Dr Joanne Medhurst, Medical Director and Elizabeth Hale, Director of Improvement

Objectives	Measures of Success Apr 2021 – Mar 2022	Measures of Success Apr 2022 – Mar 2023	Measures of Success Apr 2023 – Mar 2024	Measures of Success Apr 2024 – Mar 2025
We will prioritise preventative programmes targeted at those at greatest risk of poor health outcomes. This includes take-up of flu vaccines, long-term conditions and health management programmes, such as obesity reduction, self-referrals into the Diabetes Prevention Programme and health checks for people with learning disabilities	Building on work in Action 4 in Access to Services we will pilot and evaluate targeted action for preventative programmes to improve take up and outcomes in 3 areas within the trust: 1. Population living with diabetes. 2. Uptake of vaccinations in children. 3. Older population. Information about inequities in diabetes care will be mapped Identify + target communities with low Vaccination and Immunisation uptake Facilitate whole system development and design of interventions to support and encourage our population and older population to take responsibility to maintain good mental and physical well-being.	Information about inequities in diabetes care will be used to create a gold standard model for diabetes care across the organisation. Awareness campaign – culturally aware and aligned with partners, agencies. Agreed and published strategy that sets out a suite of self-management interventions with an increased use of community assets.	Annual plans to mitigate variation in diabetes outcomes published by each team. Increased input from young people to design services related to their mental and physical health. Increased offer + uptake levels of activity in 65+ populations. Publish research and learning from evaluation of targeted initiatives.	Proactive plan for prevention of diabetes and pre-diabetes linked to a suite of health and wellbeing initiatives published in our Clinical Strategy. Chapter in clinical strategy co-designed with Children and Young People. Increased offer + uptake levels of activity 65+ population.
We will ensure robust community engagement is in place to ascertain qualitative feedback on experience and effectiveness of service provision.	Identify best practice in community engagement internally and externally and develop a community engagement model that can be implemented locally. Agree funding/central support for community engagement to support local teams.	Identify key community engagement initiatives and evaluate impact. Establish community engagement community of practice to share learning across CLCH. Draw on learning from and resources of partners to support community engagement.	N/A	N/A

Campaign 4: Our role as an anchor organisation

Outcome: Evidence of positive impact on local communities served by trust through targeted employment, procurement and estates initiatives

Lead Directors: Mike Fox, Director of Finance and Holly ASHFORTH, Deputy Chief Nurse

Objectives	Measures of Success Apr 2021 – Mar 2022	Measures of Success Apr 2022 – Mar 2023	Measures of Success Apr 2023 – Mar 2024	Measures of Success Apr 2024 – Mar 2025
We will develop the culture to reflect the ethos and principles of an Anchor organisation by: • Establishing clear and visible leadership to embed anchor practices within our organisation. • Enable staff to act on a collective vision for enhancing community health and wellbeing. • Support the sharing and spread of ideas through networks by engaging with communities to ensure that anchor initiatives meet the needs of local people and impact on narrowing inequalities.	Publish and promote an Anchor Institute Annual report in March 2022 building on a baseline undertaken in March 2021 Develop an Anchor Institution community of Practice for CLCH Be an active participant in Anchor Institution networks and publish at least 3 case studies of action taken by CLCH and its impact. Use the CLCH Business Case Policy to ensure investments consider wider community and sustainability benefits.	Evidence how our work has been integrated alongside local communities to better understand how we can help and support especially those at most risk of deprivation and health inequalities.	Evidence how by integrated alongside local communities we have helped and supported those at most risk of deprivation and health inequalities.	N/A
We will commit to recruiting to our workforce from our local communities by: • Conducting a baseline audit of current recruitment practice. • Setting targets relating to recruitment from our local communities. • Enabling access to work opportunities paying the London living wage. • Setting expectations relating to local recruitment with our recruiting managers	Establish KPI for local recruitment focused on in-target groups	Report annual progress in relation to action on London Living Wage and local recruitment	Report annual progress in relation to action on London Living Wage and local recruitment	N/A

Campaign 4: Our role as an anchor organisation

Outcome: Evidence of positive impact on local communities served by trust through targeted employment, procurement and estates initiatives

Lead Directors: Mike Fox, Director of Finance and Holly ASHFORTH, Deputy Chief Nurse

Objectives	Measures of Success Apr 2021 – Mar 2022	Measures of Success Apr 2022 – Mar 2023	Measures of Success Apr 2023 – Mar 2024	Measures of Success Apr 2024 – Mar 2025
We will support our communities through our procurement and spending power. • Establishing expectations within our procurement processes in relation to equality, diversity, inclusion and environmental sustainability. • Identify opportunities to procure from within our local communities • Use our existing resources creatively, such as our Estates, to offer employment opportunities and facilities within our communities. • Use our existing resources creatively, such as our Estates, to offer employment opportunities and facilities within our communities.	Revise procurement requirements so they are strengthened in relation to protected characteristics, inclusion, local suppliers and environmental sustainability. Embed London Living Wage requirements into all procurements Ensure the trust and divisional estates strategies have priorities relating to environmental sustainability and creative use of our estate to support development of facilities for our communities. Use the CLCH Business Case Policy to ensure investments consider wider community and sustainability benefits	Report annual progress in relation to procurement actions Report annual progress in relation to estates actions	Report annual progress in relation to procurement actions Report annual progress in relation to estates actions	N/A

12. Embedding the strategy into everyday business

Critical to the success of this strategy is ensuring that the four campaigns are embedded in the day-to-day business of the trust. To ensure a continued focus on our strategic aims, they will be integrated into the trust business planning cycle as illustrated in the flow chart below. This will ensure there is a golden thread that runs through the business of the trust. The trust already requires an equality impact assessment for all new policies which will continue.

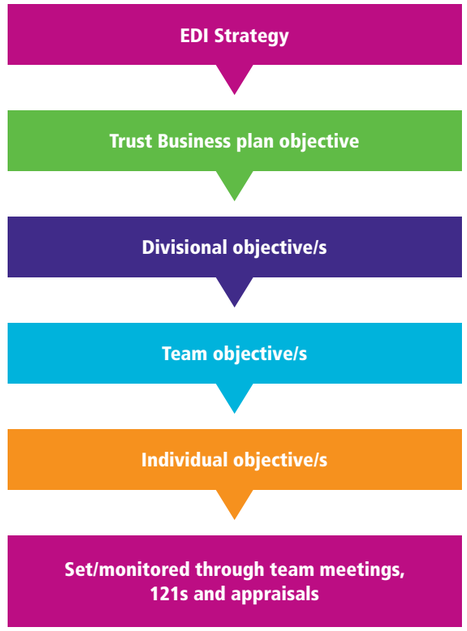


Chart 2: Mainstreaming the Promoting Equality and Tackling Inequality Strategy 2021-25

13. How we will measure success

The success of the strategy will be monitored through the outcomes identified under each campaign. The trust will produce a quarterly report on Equality and Inequality.

14. Governance

Robust governance is about having a system in place that delivers effective oversight of the trust's operations to ensure it is operating in the best interests of patients. This strategy is supported by other trust enabling strategies and outlines the processes in place to provide an oversight of quality and reinforces our commitment to continuously improving our governance arrangements.

We have a good culture of organisational learning and continue to explore every opportunity to share learning from all adverse events through our local governance structures, targeted trust-wide learning media, right through to our Board patient and staff stories. We have continued to work with staff, patients and carers as partners in care and other key stakeholders to ensure we identify learning opportunities and continue to deliver harm-free care.

The Equality Group will be responsible for monitoring the implementation of the Promoting Equality and Tackling Inequality Strategy and Implementation Plan, reporting progress to the Executive Leadership Team.

Governance for the Workforce Equality Campaign will lie with the People Committee, while the Quality Committee will be responsible for the governance for the campaigns on: Access to Services, Understanding our Communities and Our Role as an Anchor Organisation (for service delivery).

15. Shared governance

Shared governance promotes collaboration, shared decision-making and accountability for improving quality of care, safety, and enhancing work life. Models of shared governance first evolved in the USA over 30 years ago but are now a methodology for creating and sustaining well led, engaged organisations across the world. It is clear that empowering front line staff to make patient-focused change has visible benefits for patients and staff alike.

All current shared governance models both nationally and internationally bring front line staff together to make decisions related to the delivery of care but at CLCH we have uniquely decided to also include patients, carers and members of the public in our model of shared governance. Shared Governance Councils will become an integral part of how we deliver our strategy. We will continue to support and promote the Quality Division shared governance process to achieve our aspirations.

16. Inequality / Equality Action Team

Things don't always go to plan and we know that the best meaning staff and teams can go through periods of challenge and standards can drop. Over the next 5 years we will concentrate our efforts on not just responding quickly to signs of concerns in a service or team, but also putting in place a support structure to turn around poor practice and celebrate outstanding work.

We have found that sometimes teams, who have been supported through difficult times, have not just stopped poor performance but have, in fact, become exemplar sites. With this in mind, we will build on the very successful work of our Quality Action Teams and introduce Equality Action Teams which will provide a process for supporting teams where indicators or feedback suggests that we need to improve equality standards for either our patients or staff. Equality Action Teams will be chaired by a trust executive director or director and report progress to the Quality Committee.

Appendix 1:

Demographic and health inequality profile in areas where CLCH provides a service

Barnet: In 2018, the population of Barnet was estimated to be 394,400, which was the largest of all the London boroughs. The number of people aged 65 and over was predicted to increase by 33% between 2018 and 2030, compared with a 2% decrease in young people (aged 0-19) and a 4% increase for working age adults (aged 16-64), over the same period. The Barnet population is projected to become increasingly diverse, with the proportion of Black, Asian and Minority Ethnic (BAME) people in the borough population rising from 39.5% in 2018 to 42.3% in 2030. Women in Barnet have a significantly higher life expectancy than men, with the life expectancy of people living in the most deprived areas of the borough being on average 7.4 years less for men and 7.8 years less for women than those in the least deprived areas.

Wandsworth: The population of Wandsworth was estimated to be 329,700 in 2019 (ONS). While the majority of the Wandsworth population was notably young and healthy, there were significant areas of deprivation and the older population were more likely to have poor health and live in deprivation than that of other areas of South West London. There were approximately 2,800 deaths in Wandsworth in 2016-17 and approximately 1,000 of these were of people under the age of 75. The two most frequent underlying causes of death in the under 75's were cancer and circulatory disease. Approximately 71.4% were White, 5% were mixed, 10.9% Asian, 10.6% Black and 2.1% were defined as 'Other' and 13% stated they had a limiting long-term illness.

Harrow: Around 251, 200 people live in Harrow, according to the mid-population census 2019, with the male-female ratio being approximately 50:50. Nearly 63% of Harrow's residents were of working age (16-65 years); children aged 15 and under were 21%, while 16% of residents were 65 and over. Life expectancy at birth for males was 83.3 years and for females 86 years in 2016-18, according to the borough's Local Authority Health Profile 2019. In 2011, 43% of the Harrow population were from an Asian / Asian British background, the percentage from a White ethnic background was almost equal at 42% and a further 8% were from Black / African / Caribbean / Black British ethnic background. Over the next 10 years it is predicted that the local Black, Asian and Minority Ethnic (BAME) population will increase from almost 54% to 68%. Harrow's population increased by 0.4% over the past year and 7.6% over the decade.

Merton: In 2018, Merton had an estimated resident population of 209,400, which was projected to increase by about 3.9% to 217,570 by 2025. The age profile was predicted to shift over this time, with notable growth in the proportions of older people (65 years and older) and a decline in the 0-4 year old population. Approximately 77,740 people were from a BAME background and by 2025 this is predicted to increase to 84,250 people (38% of Merton's population). There is a gap of 6.2 years in life expectancy for men between the 30% most deprived and 30% least deprived areas in Merton, and the gap is 3.4 years for women. Overall, life expectancy for men at birth is 81 and for women 84.3.

Kensington and Chelsea: In 2017, the population of the Royal Borough of Kensington and Chelsea was estimated to be 155,700. 39.3% of the population are White British, 4.1% Arab and 3.5% Black African. Approximately, 61% of residents have a UK passport, the lowest proportion of any local authority in England and Wales. After UK and Irish, the borough has the highest proportion of residents with EU passports (20%). It is ranked first in England and Wales for the proportion of residents born in Germany, Iran, France, Italy, Spain or the Philippines. Approximately 1000 residents in the borough are in a registered civil partnership, the eighth highest in England and Wales. More than one-fifth of all households (16,389) have a first language that is not English; this is the fourth highest proportion in the country. Kensington and Chelsea are ranked second to bottom for those with no qualifications (10%). Life expectancy is 14.5 years lower for men and 10.1 years lower for women in the most deprived areas of Kensington and Chelsea than in the least deprived areas (Local Authority Health Profile 2019). In Year 6, 23.6% (156) of children are classified as obese, worse than the average for England.

Hammersmith and Fulham: In 2017, the population of the London Borough of Hammersmith and Fulham was 183,000. 44.9% of the population are White British, 19.6% Other White, 5.8% Black African and 3.5% White Irish. Nearly 29% of residents had national identities that are not British; the sixth highest proportion in England and Wales. 14.5% of households have no people that speak English as a main language; this is the thirteenth highest proportion in England and Wales. Approximately 48.7% of its population was male and 51.3% female and the average age of people in Hammersmith and Fulham is 35, while the median age is lower at 32. Life expectancy is 6.6 years lower for men and 4.4 years lower for women in the most deprived areas of Hammersmith and Fulham than in the least deprived areas (Local Authority Health Profile 2019).

Ealing: The 2018 Mid-Year shows that the population of Ealing further declined for a second consecutive year, from 342,700 in mid-2017 to 342,000 in mid-2018; a decrease of 700 (-2%). The borough's population had decreased by just over 2000 people between 2016 and 2017 – the greatest level of decline among the four London boroughs experiencing population decline, ahead of Kensington and Chelsea, Haringey and Merton. In 2017, there were 169,175 males and 169,274 females living in Ealing. There were 67,042 people over the age of 55 and 76,605 people under the age of 18. Life expectancy is 5.8 years lower for men and 3.6 years lower for women in the most deprived areas of Ealing than in the least deprived areas. In the School Year 6, 24.3% (1,010) of children are classed as obese, worse than the average for England (Local Authority Health Profile 2019).

In 2016, Ealing's largest ethnic groups were: White British (26.9%), Other White (17.1%), Indian (13.8%) and Other Asian (11.0%). Its BAME community is expected to grow by 14.1% between 2016 and 2026, and 33.0% between 2016 and 2050. In 2050, it is estimated that the largest ethnic groups in Ealing will be: Other White (20.1%), White British (20.0%), Other Asian (14.5%) and Indian (14.1%). Amongst West London Authorities, Ealing has or is expected to have the third highest proportion of BAME residents in both 2016 and 2026, after Brent and Harrow, but will be overtaken by Hounslow and Hillingdon by 2050, moving the borough to the fifth position. It has an equal male/female gender spilt overall and approximately 14% of its population had a long-term limiting illness.

Richmond-upon-Thames: The population of Richmond in 2020 was 199157, with approximately 49% being male and 51% female (GLA, Census 2020). Approximately 16.2% of the population

Appendix 1: Demographic and health inequality profile in areas where CLCH provides a service

identified themselves as BAME, lower than the London average of 44% and 15% as Other White. 17% of the residents identified themselves as non-UK nationals, compared with the London average of 22.3%. After Englash (spoken by 89.6% of the population), 3.9% spoke Other European languages and 1.4% a South Asian language.

The health of people in Richmond is generally better than the England average, with the borough being one of the 20% least deprived districts/unitary authorities in England. However, about 8% (2,700) of children live in low income families. Life expectancy for both men and women is higher than the England average. It is 7.2 years lower for men and 3.6 years lower for women in the most deprived areas compared with the least deprived areas.

Hertfordshire: The mid-2019 estimated population of Hertfordshire was 1,189,519 (ONS), of which 49% were male and 51% female. Population density in the county was highest in Watford, followed by Stevenage. By mid-2041, the total population of Hertfordshire is projected to be

1,364,100. The health of people in Hertfordshire is generally better than the England average, according to the Local Authority health Profile 2019. Hertfordshire is one of the 20% least deprived counties/unitary authorities in England, however about 11.5% (25,280) children live in low income families. Life expectancy for both men and women is higher than the England average. Life expectancy for men at birth in Hertfordshire is 81 years, while for women is 84.2 years. This is 7.6 years lower for men and 5.4 years lower for women in the most deprived areas of Hertfordshire than in the least deprived areas.

Of the estimated population of Hertfordshire at mid-2019, 739, 879 (62.2%) were aged 16-64 (of working age). Of the estimated male population, 62.6% were aged 16-64. Of the estimated female population of Hertfordshire at mid-2019, 61.8% were of working age. People born overseas make up approximately 13.4% of the population (Census 2011). Approximately 19.2% of Hertfordshire residents were from an ethnic minority compared with 11.23% in 2001, while 3.7% were born in a non-UK EU country.

Approximately 14.3% declared they had a limiting long-term illness. 58.3% of residents stated Christianity to be their religion, followed by 26.5% who said they followed no religion and 7.2% who did not state their religion. 2.8% declared themselves as Muslim, 1.9% as Jewish and 1.9% as Hindu.

Health Inequalities and impact of COVID-19 in London:

As the Marmot Review[6] update in 2020 states, since 2010, life expectancy in England has stalled; the first period that life expectancy hasn't increased since 1900. The review also concluded that life expectancy follows the social gradient – the more deprived the area, the shorter the life expectancy – as demonstrated in Figure X in London below. However, it should be noted that Marmot states that the largest increases in life expectancy nationally occurred between 2010 and 2020 in the least deprived 10 percent of neighbourhoods in London.

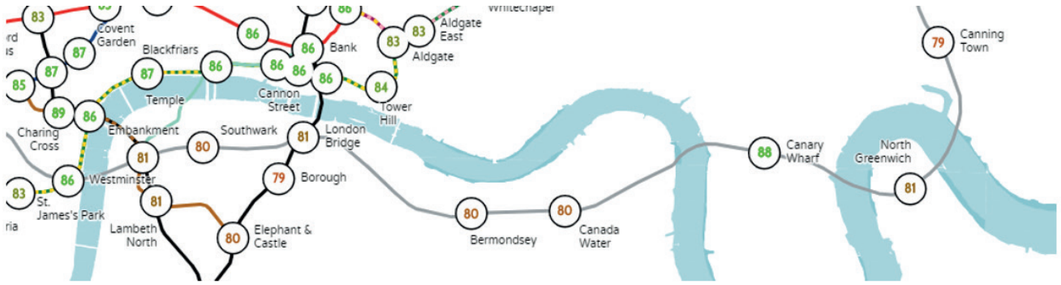
Figure 1: Lives on the Line (UCL/CRDC)[7], 2nd October 2020

University College of London academic, James Cheshire, initially devised the map above to reflect life expectancy changes along the London Underground lines across the city. His project takes ultra local-level life expectancy data from the Office for National Statistics (ONS) and maps it with London's Tube stations. Health inequalities amongst our communities and our staff in London are issues that must be focused on, with such inequalities having been exposed by COVID-19. Cheshire wrote that one popular analogy used is that life expectancy generally used to reduce by a year each stop along the Jubilee Line from Westminster to Canning Town when travelling eastward. Whilst this is not strictly the case today, there is still a clear discrepancy between wealthy and more deprived areas when travelling across London, as demonstrated by the latest data on the Jubilee Line, as shown above.

[6] https://www.health.org.uk/sites/default/files/2020-03/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_executive%20summary_web.pdf

[7] https://tubecreature.com/#/livesontheline/current/same/U/*/FFTFTF/13/-0.1177/51.5164/

Figure 2: Lives on the Line (UCL/CRDC)[8], 8th October 2020



The issues associated with health inequalities are particularly acute in London, namely due to the city's population in relation to ethnicity, migration, gender identity, sexual orientation and socioeconomic position. London has the UK's highest proportion of people from an ethnic minority and LGBTQ+ people, as well as higher levels of overcrowding, substandard housing, the highest rates of income and expenditure poverty and high rates of migration and mobility.

According to research reported by the Greater London Authority (GLA), the city recorded the highest proportion of deaths of anywhere in the UK due to COVID-19 during the first wave of the pandemic in March and April 2020. During these first two months, of the 10 local authorities with the highest age-standardised COVID-19 mortality rates, nine were in London, with Brent having recorded the highest overall age-standardised rate with 210.9 deaths per 100,000 populations.

In London, there was a clear link between deprivation and deaths involving COVID-19, particularly in inner-city boroughs where accommodation is more crowded. The ONS reported that once age was taken into account, the rate of deaths at that time involving COVID-19 was roughly twice as high in the most deprived areas of England as in the least deprived.[9]

Furthermore, West and North West London saw a 162% increase in joblessness claims between March and July 2020 [10]- the highest rate recorded in London - and the effects of which are likely to exacerbate existing inequalities between different geographical areas.

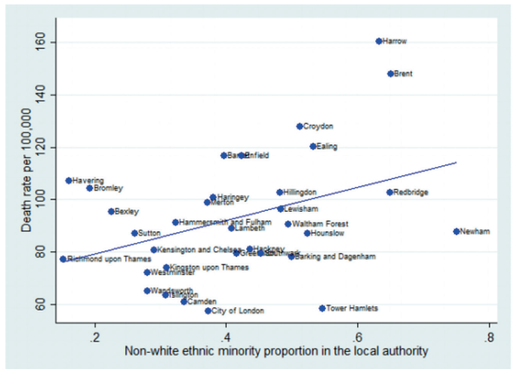
[9] https://www.bbc.co.uk/news/52282844
[10] https://www.smf.co.uk/publications/lockdown-in-london/

Appendix 1: Demographic and health inequality profile in areas where CLCH provides a service

COVID-19 also impacted different demographics across London in different ways. As mentioned, even after considering differences in age, geographical factors, socioeconomic conditions and health, across the UK the risk of COVID-19-related mortality compared with White men and women was 1.9 times greater for Black men and women, 1.8 times greater for Bangladeshi and Pakistani men and 1.6 times greater for Indian men.

Whilst there is no data on COVID-19 infection and mortality rates by sexual orientation or gender identity, the GLA reports that research has found that 79% of LGBTQ+ people have found that the lockdown negatively impacted their mental health, with many young LGBTQ+ people reporting feeling unsafe in their housing conditions during the lockdown.[11] A Health Equality and Rights Organisation (HERO) and Outlife survey found that 15% of LGBTQ+ people reported experiencing violence or abuse during lockdown, with rates twice as high for Black and South Asian LGBTQ+ people compared to White LGBTQ+ people.[12]

Figure 3: COVID-19 related morality and proportion of ethnic minority people in London boroughs, deaths up to 31st July



This graph[13], using data from the ONS, further demonstrates the correlation between mortality rates and non-white ethnic minority proportions across local authorities in London. This is a clear visualisation of the health inequalities that need to be addressed.

[11] https://airdrive-secure.s3-eu-west-1.amazonaws.com/london/dataset/rapid-evidence-review-inequalities-in-relation-to-COVID-19-and-their-effects-on-london/2020-09-29T09%3A15%3A05/Rapid%20Evidence%20Review%20-%20Inequalities%20in%20relation%20to%20COVID-19%20and%20their%20effects%20on%20London.pdf?X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIAJJDIMAIVZJDICKHA%2F20201008%2Feu-west-1%2Fs3%2Faws4_request&X-Amz-Date=20201008T220309Z&X-Amz-Expires=300&X-Amz-Signature=37d58c3494c5e7b801ec3a75b4b254cbde8d7250cf22a13bd2cc1d8b593c64bd&X-Amz-SignedHeaders=host, p. 3
[12] Ibid, p.41
[13] Ibid, p.19

Appendix 2:
Definitions

Equality – refers to equal treatment before the law.

Diversity – recognises that different people have different needs and perspectives based on a range of factors such as, life experiences, cultures, learning styles and personalities which influence how they approach and solve problems.

Inclusion – is about creating an environment where everybody can share their views, be heard and feel valued[2]. An inclusive leader has a strong sense of self-awareness, but has the ability to flex their style to connect with teams and individuals from different cultures, backgrounds, values and working styles.

Equity – Equity is defined as offering fair, equal and impartial treatment. This translates as offering all our staff and patients equitable treatment and opportunities under our policies and practices. This includes access to development opportunities and supporting all talent.

Intersectionality – People encompass more than one characteristic at a time. We are not defined solely by our race, gender, sexual orientation or any other facet of who we are. We are a combination of those characteristics and much more. It is important to recognise that identity is complex and somebody can be discriminated against in many different ways. Intersectionality is a theory coined by Black feminist scholar, Kimberlé Williams Crenshaw, in 1989[3], which explains that each individual is a combination of many different indicators of identity. One person's experience of privilege and discrimination is unique. For example, the life experiences of a Black heterosexual man will be markedly different to those of a Black LGBT+ woman, even though they share the same race. We hope that when enacting the recommendations of this strategy, staff, managers and leaders will embody the principle of intersectionality and recognise the diversity of experiences within different communities.

Institutional Discrimination – occurs when individuals in an organisation may not themselves have prejudiced or discriminatory beliefs or behaviours, but are carrying out policies, processes or procedures that disadvantage people from specific protected groups. The Macpherson Report's definition of institutional racism is: "The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people".[4]

Health inequities – have been described by the World Health Organisation as a failure to avoid or overcome inequalities that infringe on fairness and human rights.

Health Inequalities are unfair and avoidable differences in health across the population, and between different groups within society. They arise because of the conditions in which we are born, grow, live, work and age, which influence our opportunities for good health, and how we think, feel and act. It shapes our mental health, physical health and wellbeing[5].

Our health is influenced by a wide range of factors, known as determinants of health. Where protected groups experience differences in these wider determinants of health, this can lead to health inequalities. Under the Equality Act and NHS Long Term Plan, we aim to work to create a healthier population by ensuring that our patients and staff feel they have equal access to quality healthcare treatment.

[2] Inclusive leadership, Sweeney, C and Bothwick, F. (2016)
[3] Crenshaw, K: Mapping the Margins: Intersectionality, identity politics, and violence against women of colour. www.racialequitytools.org/resourcefiles/mapping-margins.pdf

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277111/4262.pdf
[5] https://www.england.nhs.uk/ltphimenu/definitions-for-health-inequalities.

Homeless Health: A Patient's Story

'Homeless isn't who I am, it was part of my life but I'm not there anymore'

What was it like to be a patient under the Homeless Health service?
The whole experience was great and it wasn't too intense, you (the nurses and outreach team) would come and find me and try to get me to engage, but you would never give up when I would tell you to leave me alone.

What do you remember the most about what we did?
You would use different ways to get me to engage, sometimes the outreach team would buy me a milkshake or the nurses would bring me the health pack (these little things meant everything), you never tried to force me off the streets, the information was there but you never pushed me in to doing anything I didn't feel comfortable with. The nurses were fantastic, they dressed my hands and my head on the streets; their care saved my life.

Is there anything significant about the care you can remember?
You would come and find me and try to engage me, you would remember what was discussed previously. All the staff knew about me across the nursing and outreach teams, it never felt like it was one person was looking after me, it really felt like a multi-disciplinary approach, and I was treated as an individual. You (the nurses) even though it must have been hard to accept what I was doing- "killing myself" – you accepted it, let me get on with what I needed to do, but you still wouldn't give up. You treated me as human and not another homeless person or "just an addict". It made me feel much better about myself. You became a stable element in my life – which gave me confidence in the NHS.

Was there anything that surprised you about what we did?
Yes, the fact that you always came to find me, it really surprised me at the beginning, you looked at the complex life I was living and you tried to meet my needs as much as you could. I didn't have expectations at the time. Not needing appointments was really useful; the Homeless Health Service is key to bridging the gap and it helped me access health care. You enriched my life and look where I am now! If it wasn't for this team, I would be dead.

One thing that concerned us was that you would die on the street, did this worry you?
It never came across my mind when I was on the street that I could die, I was using so much heroin, crack and alcohol I often felt invincible. Now I am not using, I have clarity about my situation and can now see why you were all worried and why you continually tried to see me on the streets. I have lost 2 fingers, I had wounds all across my body and you all kept saying how I needed to be in hospital for treatment, but as I felt invincible; it didn't worry me.

What was the turning point that you decided that you needed to get off the street?
If I had planned it, I would probably still be on the street. I became unwell and ended up in hospital. The individualised care across the homelessness service helped me get that clarity on my life and I knew that you would support me and not judge me. If it hadn't been for you contacting my family, they probably still wouldn't know where I am and I don't think I would now be in the position I am in now - housed again and having the support of my family. You took the time to meet me, my mum and sister together and helped us make choices and assured us that just because I was homeless and on drugs, it wasn't the end of my journey.

Appendix 2: Definitions

7 Minute Learning:
Feedback from Disability and Wellness Network

1. Context and desired outcomes for disabled staff:

The culture has not always been one of inclusivity towards disabled people, but it is changing. It is important for disabled people to be able to tell managers what they want.

Some disabilities, such as dyslexia, are often hidden.

70% of disabilities are in people who have become disabled over time. It could happen to any of us.

Disabled people want to be getting on with their lives with things that can help them.

2. Problems disabled staff face:

A lack of inclusivity and willingness to understand and respond to people's needs and the support they require.

A balancing act between a person's disability not being recognised and the person not being defined by it.

We can make assumptions, for example, that everyone can understand one another. This can lead to missed communication.

3. Contributory factors

The ways in which we can support disabled staff is not always publicised enough.

The current limitations in what we can provide as adaptations are not always evident to those with disabilities.

Visual and hearing disabilities are most prominent, but adaptions such as see-through masks which are compliant with requirements have not yet been developed.

4. Root causes:

A lack of awareness, skills and knowledge in enabling an inclusive culture which is proactive and responsive to the individual needs of disabled staff.

5. Recommendations include:

There is a need for posters (and related promotions) to explain the ways that we can support disabled staff and the adaptations that are available.

Disability training should be mandatory, especially for managers. Just knowing how to talk to people with a disability is important.

One thing we can all do to help disabled people is ask them. Just ask: "How are you coping? Is there anything we can do? Have there been any changes? How can we help you?"

6. Key Learning:

Developing awareness, skills and knowledge in supporting disabled people is important.

It is important to treat each person as an individual in relation to supporting their needs.

People are not always aware of what is and isn't available, such as adaptations. Publicising them is important.

7. Discussion points

As an inclusive employer how can we to demonstrate examples of inclusivity?

Any of us could develop a disability over time.

We should all think about how we would like to be addressed if we were disabled.