Central London Community Healthcare NHS
NHS Trust
Your healthcare closer to home

Equality and Diversity Strategy 2016 - 2018

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CLCH Equality & Diversity Strategy 2016-18

1.0 Introduction

Definition and Context

This strategy outlines the Trust approach to recognising and promoting the equality and diversity of the communities the Trust works with and the workforce that represents and cares for them. One of the principles of the NHS Constitution is that the NHS has a wider social duty to promote equality through its services and to pay particular attention to groups or sections of society where improvement in health and life expectancy are not keeping pace with the rest of the population. Its workforce also needs to be representative of the communities it serves.

This strategy is informed by the patient data and feedback our staff survey and the Workforce Race Equality Standard. The Trust has a patient engagement strategy, quality strategy and clinical strategy that relate to patient outcomes and care. CLCH has an agreed People Strategy which sets the strategic framework for the whole "People" agenda. The People Strategy action plan identifies key delivery milestones for these strategies.

Purpose of Strategy

The purpose of the Equalities & Diversity Strategy is to develop an inclusive organisation that recognises the value of the wide variety of the people we work with and the impact of cultural diversity on health outcomes and service delivery.

The key aim of this Equality and Diversity Strategy and associated Equality Outcomes (as per the requirements of the Equality Act 2010), is to set out our commitment to promoting equality and diversity for all, and to identify how this goal will be translated into measurable outcomes

Promoting equality, diversity and human rights based approach in the delivery of health services is a key priority. We are committed to reducing the health inequalities that affect communities and ensuring that everyone receives the health care they need.

- Diversity and difference is valued and respected – an approach that embraces both visible and non-visible differences

- The workforce which works together effectively in an atmosphere of dignity and respect

- Discrimination and prejudice are challenged and acted upon if evidenced

It aims to improve the performance of the Trust managing across the cultures we encounter on a daily basis. We need to positively value the talents of our very diverse workforce. Central London Community Healthcare NHS Trust (CLCH) is required under the Equality Act 2010 to publish Equality Objectives, these form the basis of our strategy and the actions that flow from these will contribute towards us achieving our purpose.

Consultation and Ownership

This strategy will be implemented in consultation with:

- LGBT Rainbow and BME Staff networks
- Trade unions through the Joint Staff Consultative Committee
- Patient and Community groups such as the Diabetes Users Group, Stroke Focus Group, Healthier Life 4 You, Migrant Resource Centre
- Umbrella Groups such as the BME Health Forum
- Health and Wellbeing Boards
- The NHSE diversity team
- Service users with learning disabilities
- Focus Groups with CLCH staff
- Senior Managers, Executive Leadership Team, and the Workforce Committee

The E & D strategy recognises that responsibility for initiatives designed to improve our performance is shared across the organisation and equality and diversity requires strong leadership that may come from staff or patients themselves, the OD team, the Nursing & Quality Directorate, the Medical Directorate and the Operations Directorates. The Board is fully committed to improving our performance on equalities and diversity.

Monitoring and Governance

The Strategy covers the period 2016-18, and will be reviewed annually. An Action Plan will support the strategy. Progress against the objectives will be reported to the Workforce Committee and the Quality Committee which are sub-committees of the Trust Board.

2.0 Strategic Vision for CLCH 2015-2020

The strategic vision for CLCH is set out in the Integrated Business Plan and so for brevity has not been repeated here. As the trust expands its areas of operations it will need to understand and take into account the needs of the different communities it works with.

Health Inequalities

London is becoming increasingly diverse with over a third of all Londoners now born outside the UK. All the boroughs that CLCH works within are characterised by cultural diversity, a large population of working age, and substantial health inequalities, predominantly between areas of affluence and deprivation. Other factors such as ethnicity, mental health, disability, gender and age also significantly contribute. Evidence suggests that some protected groups experience more health inequalities than others in terms of access to services, experience and outcomes of treatment and care. Examples of this are outlined in appendix A. We need to ensure that our Equality Objectives will address health inequalities experienced by protected groups. As the organisation grows into new areas such as Wandsworth we will need to learn more about the changing health needs of the new communities we work with.

Improving access to health services is one method to combat health inequalities; another is in taking a person-centred approach by involving people in decisions surrounding their own health care and treatments and also improving people's experiences of the services we provide. Providing compassionate, person –centred care needs to be at the heart of what we do.

Data and Evidence

All of our Equality Objectives are developed using patient and staff data we currently collect, analyse and publish based upon their protected characteristics. We publish our patient equality data annually together with the equality data from the Patient Experience Surveys and the Workforce Race Equality Standard. These reports inform patients, public and our stakeholders of our equality performance for both delivering health services and for our workforce.

Critical Success Factors

The following factors are critical to successfully delivering this strategy:

- **Engagement** of staff at all levels, local interest groups, patients and their families.
- **Leadership** support and buy-in.
- **Training** of staff members every 3 years on our equality objectives.
- **Collaborative** working with our local and regional partners.
- **Measurement** of impact and improvements.

3.0 Key Objectives of the E&D Strategy

The key objectives of the E & D Strategy for 2016/18 are:

- We will deliver more targeted intervention and outreach activities to protected groups in order to promote our health services.
- We will improve how we communicate with diverse patients using alternative and accessible formats.
- We want to provide reasonable adjustments for patients with Learning Disabilities and Dementia who use our mainstream health services.
- We will improve the reporting of discrimination, harassment, bullying or abuse at work and seek to reduce the occurrence of incidents by valuing diversity and difference in our workforce
- We will increase the representation of our BME staff at senior manager levels
- We will improve the number of young people the Trust employs and respond to the challenge of a multi-generational workforce

The strategy is sets out where we are now in relation to these objectives and where want to be by 2018.

OBJECTIVE 1: We will deliver more targeted intervention and outreach activities to protected groups in order to promote our health services

We know that:

Some groups of service users are more likely to access health services than others and this can have an impact on their health outcomes which in turn impacts their quality of life. It may also mean more pressures on higher cost health services if some groups are not actively engaged with community and preventative health services.

Activity	Where are we now?	Activities planned to support in 2017/18	Where do we want to be in 2018
Identifying under and over represented service users	We have reviewed patient data in the past and identified where service users are under-represented and targeted promotion of our services to specific groups e.g. **Diabetes Service**: *South Asian and African Caribbean groups* **Walk-in centres** :*BME groups* **Health Visiting**: *Black and Asian ethnic groups and gypsy / travellers* Staff have been reminded of the need to record equal opportunities data relating to patients to allow us to monitor and refine our services.	To publish the Patient data which has been shared with services in a report format on our website. Link planning on equalities ot the business planning cycle. Commissioners and service managers can then use this to identify groups that are accessing their services and plan how to promote and decrease the under-representation Responding to feedback from patients about how services can better meet their needs, reporting where improvements are made and sharing best practice across the Trust	We feed back to those responsible for data entry the outcome of our analysis and use it to inform discussions with commissioners about service developments Services know who are using their services and can promote their services to under-represented groups to improve health outcomes

Activity	Where are we now?	Activities planned to support in 2017/18	Where do we want to be in 2018
Understanding the diversity of our changing communities to identify how best to meet their health needs	We know a lot about our existing communities in Westminster; Kensington & Chelsea; Hammersmith and Fulham and Barnet.	The Trust is expanded recently into Hertfordshire; Harrow, Merton, Brent, Hounslow and Richmond and will expand into Wandsworth. We need to use census data and JSNA information for us to understand more about the communities we will be working with. We need to develop our relationships with Commissioners to commission for health outcomes and reduce	Able to identify interventions likely to improve health outcomes and reduce health inequality tailored to needs identified by commissioners through the commissioning cycle

How the results will be measured

- Annual Patient Equality Data
- Patient Reported Experience Measures
- Patient Surveys and Complaints

Equality Delivery System grading – 1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities.

OBJECTIVE 2: We will improve how we communicate with diverse patients using alternative and accessible formats.

We know that:

- 24% of deaf or hearing-impaired people miss appointments and 19% miss more than five appointments because of poor communication (such as not being able to hear their name being called).
- Gradual deterioration of the ear called presbyacusis occurs in both ears and affects over half of all people over 60 years old, making it the second most common cause of disability in older people. A significant proportion of patients accessing our adult services are aged over 65
- In an RNIB study 81% of blind respondents said they did not get information about their prescribed medicines, in a format they could read

- Mencap argue that people with learning disabilities may need more support to understand information about their health, to communicate symptoms and concerns, and to manage their health in a way that respects their human rights

Area	Where are we now?	Activities Planned to Support in 2018/19	Where do we want to be in 2018?
Improve how we communicate (both verbally and written) with patients from the following groups: • Patients whose first language is not English • BME groups • People with sensory impairments (hearing, visual) • People with learning disabilities	We have been working on ensuring the trust is able to meet the Accessible Information Standard requirements to identify and flag on our clinical systems patients who need information in different ways to access our services. We have updated the Trust website Learning Disabilities information to include the Trust Learning Disability protocol, links to changing places (venues with adapted facilities for those with a Learning Disability), links to Easy read information and the People first website (a dedicated site for Patients with a Learning Disability. We have dedicated appointments for patients who require reasonable adjustments such as a longer appointment times. We have a tailored patient experience survey for patients with a Learning Disability.	Training for frontline staff on communicating with patients who may have: • Dementia • Learning disability • Visual or hearing disability • English as a second language Testing of our access arrangements by user groups	We want to improve the experience of services by these protected groups to • Access information in a way they can understand it • reduce DNAs; • feel empowered to take decisions about their • their healthcare, treatment and place of treatment; • Improve patient satisfaction levels Ensure our staff have the skills to support our ageing population

How the results will be measured

- Annual Patient Equality Data
- Patient Reported Experience Measures

- Patient Surveys and Complaints
- DNAs (patients not arriving for appointments)

2. We will improve how we communicate with diverse patients using alternative and accessible formats.
Equality Delivery System grading – 1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways.

OBJECTIVE 3: We want to provide reasonable adjustments for patients with Dementia and learning disabilities who use our mainstream health services.

We know:

- One in 6 people age 80 and above have dementia but only 44% of those with dementia have a formal diagnosis.
- There are 670,000 carers of people with dementia in the UK who are entitled to have a carer's assessment if they wish
- 80 per cent of people living in care homes have a form of dementia or severe memory problems.

- Two thirds of people with dementia live in the community while one third live in a care home. (all data from Alzeimers.org.uk)
- It is estimated that in England in 2011 1,191,000 people have a learning disability. This includes 905,000 adults aged 18+ (530,000 men and 375,000 women) (Source: People with Learning Disabilities in England 2011)

- People with learning disabilities are 2.5 times more likely to have health problems than other people. (Source: Report - Equal Treatment: Closing the Gap)
- People with learning disabilities are less likely to receive regular health checks including people with Downs syndrome . (Source: Kerr et al., 1996b; Welsh Office, 1995; Whitfield et al., 1996),

- Mortality rates among people with moderate to severe learning disabilities are three times higher than in the general population, with mortality being particularly high for young adults, women and people with Down's syndrome

The following table sets out an overview of our current and desired position for 2018 and activities planned to support this during 2016/17.

Area	Where are we now?	Activities to support in 2017/18	Where do we want to be in 2018?
Adjusting our service to become more "dementia	We know many of our service users are suffering from memory problems and dementia and that this may mean difficulties in remembering appointments, medication routines, as well as difficulties in communicating. Our staff	We need to think about how we adjust our services to be more dementia friendly and support efforts to increase early	We want to support those with dementia, and their carers, to live full and active lives in the community for as long as possible.

Area	Where are we now?	Activities to support in 2017/18	Where do we want to be in 2018?
friendly"	are receiving dementia awareness training. The national PLACE assessments now assess whether environments are Dementia Friendly providing guidance for the Trust on areas where improvement can be made. We now have a number of Dementia Friends in the Trust and Dementia Care Champions (individuals who have received level 3 training and are undertaking local projects to improve the experience and environment for patients with Dementia) We have a Trust Carers' strategy in place.	diagnosis We need to think about the support we offer to maintain the health of carers of people with dementia We need to develop a carers' forum in order to implement the carers' strategy and improve the experience of carers.	
Adjusting our service to meet the needs of patients with Learning Disabilities in our communities	We have made changes to some of our services to ensure they meet patient needs such as community dentistry by considering appointment times, environment and clinical needs. We work closely with GP's, commissioners and the local authority to ensure patients with Learning Disabilities are assessed, able to access care and services as needed and supported to live independently.	We need to identify adjustments to some of our mainstream services to ensure the needs of people with learning disabilities are met We need to ensure IT systems support the identification of patients with a Learning Disability (between GP, services) in order to ensure reasonable adjustments can be made and supported	Improved patient experience outcomes for patients with learning disabilities

OBJECTIVE 4: We will improve the reporting of discrimination, harassment, bullying or abuse at work and seek to reduce the occurrence of incidents

We know:

- According to the 2016 staff survey
    - 13% of staff reported that they had experienced discrimination at work

- The number of staff experiencing violent incidents from staff or the public reduced to 7% in 2016 compared to 13% in 2015.

- According to the 2016 staff survey
    - 25% of staff reported that they had experienced harassment bullying or abuse at work from patients
    - 23% of staff reported that they had experienced harassment bullying or abuse from other staff

51% of staff reported the harassment, bullying or abuse had taken place, which was an improvement on the 2015 result. We have established procedures to deal with harassment, bullying and abuse from patients and their families as well as staff and managers, but staff may not be aware or feel confident in using them.

Area	Where are we now?	Activities in support 2016/18	Where do we want to be in 2018?
Encouraging the reporting of incidents and raising concerns	We have a revised policy on raising concerns and a variety of formal and informal ways to resolve conflicts. We have established a mediation service and had a number of concerns around bullying and harassment investigated and addressed. Datix is well established as a reporting tool for incidents including violence and harassment. Reporting is encouraged by the new Freedom to Speak Up Guardians	Continuing to promote the importance of raising concerns and more informal ways of resolving conflicts	To have increased the level of reporting of violent incidents from 71% to 76%; for harassment and bullying from 44% to 54%

Area	Where are we now?	Activities in support 2017/18	Where do we want to be in 2018?
Publicise our approach to support staff suffering from harassment bullying and abuse from patients	There is an agreed protocol for dealing with incidents of violence, harassment, bullying and abuse of staff which starts with the employee reporting the incident to their line manager. Due to high staff turnover and confidentiality concerns it may be staff are not aware that action can and is taken in response to incidents. Some staff may feel it is just "part of the job" and that they are expected to tolerate bad behaviour	We need to publicise anonymously when actions have been taken to raise confidence in reporting incidents Information is provided to new starters in the induction and mandatory training on the importance of reporting incidents	To have increased the level of reporting of violent incidents from 71% to 76%; for harassment and bullying from 44% to 55%
Provide team interventions to support positive relationships between colleagues	We provide team interventions when team relationships breakdown or become strained and allegations of bullying have occurred.	We need to do more to promote positive behaviours and encourage staff to challenge inappropriate behaviour or comments.	Everyone is clear about the types of behaviour that is acceptable and they take responsibility for maintaining positive relationships at work
Provide more positive inclusive messages around protected characteristics in the trust	We have sporadic communications in relation to E&D issues to celebrate issues such as black history month. This can help to promote understanding and empathy between staff	We need a communications plan for the year which highlights when we put out key messages and staff stories in relation to diversity issues to help create a climate where all our staff feel valued and accepted	A reduction in the number of staff saying they have experienced discrimination Those with inappropriate behaviours feel uncomfortable in working for CLCH as their views don't fit with the organisation's publicised values

OBJECTIVE 5: We will increase the representation of our BME staff at Band 8a and above

We know:

- The NHS is the biggest employer of BME staff in Europe
- BME staff are currently under-represented at a senior level in the Trust - this is in line with the national picture across the NHS and this has been the case since the early years of the NHS
- From the 2018 staff survey 18% said CLCH did not act provide equal opportunities for career progression/promotion regardless of ethnic background, gender, religion, sexual orientation disability or age
- Staff from BME backgrounds are disproportionately represented in our disciplinary proceedings, performance management processes, grievances and bullying complaints.

Area	Where are we now?	Activities in support in 2017/18	Where do we want to be in 2018?
Reviewing our approach to recruitment	We aim to ensure fairness in our recruitment processes but according to the WRES indicators white staff are still much more likely to be successful at the interview stage	We need a new approach that ensures fairness but also flexibility to ensure we can create development opportunities for our staff so we grow our own, and improve internal promotions We will be working towards BME staff becoming more involved in senior appointment processes and in auditing the recruitment decision making process. Support for BME staff with interview process	Staff will have been trained in the new recruitment policy and fair selection principles Recruitment and selection training includes unconscious bias BME staff feeling more confident of success and fairness in applying for senior roles.
Empowering BME staff	We have run empowerment programmes for BME staff in bands 2-7. BME staff representation at bands 8a and above has increased from 17% 2014 to 28% in 2017	To have a second BME staff conference and re-invigorate the BME staff network.	At 32% BME staff at Band 8a and above Using best practice from elsewhere to promote a more diverse talent pipeline
Using the Workforce Race Equality Standard to	The experience of some BME staff at CLCH is not as	We need to review our disciplinary, sickness and grievance policies to ensure they promote early	To have a well-established and influential BME staff network that has influenced a

improve the experience of BME staff in CLCH	positive as it should be. We have delivered unconscious bias training, which has a big impact, but cultural differences need more time and discussion.	resolution of issues and fair outcomes. We need to promote more discussion around cultural issues and challenges of managing a diverse workforce. We need to invest in a network to support BME staff in CLCH	change in attitudes within the Trust

The details of our actions in relation to this objective are contained in our annual Workforce Race Equality Standard Action Plan.

OBJECTIVE 6: We will increase the number of young people the Trust employs and understand the challenges of a multi-generational workforce

We know:

- In 2016 just 81 or 2.68% of its workforce in the 18-24 age range with limited apprenticeship schemes designed to attract young people
- Most of our professions currently require a degree which means a likely entry point at age 21 or higher and make it difficult for young people to progress from apprenticeships into careers and for us to identify suitable opportunities. If students are self-funding degrees the interest in qualification routes that combine work and study is likely to grow and employer lead training is a current political priority
- Under government policy there is an expectations that we will increase the number of apprentices we employ in order to reduce the impact of the training levy in 2017
- While the numbers of young people are small they are likely to feel isolated and can experience inappropriate behaviours from older colleagues. Older people can also experience discrimination or feel their skills are not valued. They may be less willing or able to commit to full time work in physically demanding roles but can provide support to training and mentoring the next generation of the workforce. Given the skills shortages we will need to retain the older generations in the workforce for as long as possible. Different generations have different expectations and experiences of employment, education and technology and our current managers and leaders will need to adapt their management styles to meet employee's needs.

Area	Where are we now?	Activities to support 2017/18	Where do we want to be in 2018?
Increasing the number of young people in the workforce	We have limited opportunities that are marketed at young people; most of the young people we employ are graduates in entry level nursing or AHP roles. Currently 3.75% at August 2017 of the workforce are aged under 25 compared to 2.68% in 2016. The target is to get to 5% by March 2018.	We will implement our apprenticeship strategy to increase the number of opportunities for young people	The target in our strategy is to have 70 apprentices employed across the Trust
Designing roles and career progression routes identified for apprentices	For health and social care roles the progression from apprentice into health and social care professionals is not clear. For business administration roles progression without a degree qualification is possible but opportunities where staff can be properly supervised need to be identified	Developing career pathways so staff can see how they can develop their career. Holding careers clinics with staff so they can talk to senior staff about how to develop.	To have addressed some of our skills shortages through the creative use of apprenticeship roles
Designing roles for older workers and valuing their contribution	Some staff retire and then choose to return to work for us, often on the bank. This is not clearly promoted as an option to all staff.	We need a clear process for ensuring "retire and return" happens and to promote this more widely as a way of retaining skills in the workforce. Long service will be recognised at the staff awards ceremony.	Older workers feel valued as part of the workforce and understand the choices available to them as they approach retirement age. Long service award scheme established

10.0 Delivery of the E&D strategy

Accountability for Equalities and Diversity will sit with the new Director of People and Communications role. However delivering change in this area is very much shared responsibility across the whole workforce. The OD team will develop, commission and/or participate in the delivery of a range of programmes to support:

- Management and leadership development; including the empowerment programme
- Team/service development; including addressing team behaviours, challenging unacceptable behaviour and bullying
- Management skills training e.g. Cultural Competency training, Appraisal skills, "Having Courageous Conversations", Managing individual performance issues such as sickness.
- One to one support for individual members of staff including support with issues, coaching, mentoring and career development.

The OD team will work closely with relevant staff across the Trust to ensure that equalities activities across the Trust are properly joined up. In order to deliver aspects of the strategy an increase investment may be required which will be subject to a separate business case.

APPENDIX A - HEALTH INEQUALITIES FACING PROTECTED GROUPS

AGE

- In the inner London boroughs and nationally, age is associated with poorer health and chronic disease, as well as greater levels of disability.
- Depression is relatively common but sometimes undiagnosed among older people, and the high proportion of older people living alone locally may impact on social isolation.
- Nationally and locally, older people are less likely to be accessing psychological therapies services for mental health problems.
- Nationally, they are also less likely to experience dignity and respect in hospital settings.
- Nationally, six out of 10 older people are at risk of becoming malnourished, or of their situation getting worse, while they are in hospital.
- Younger people both nationally and locally are more likely to use A&E rather than their GP.
- Nationally, there is a high suicide rate among people over 75; for men in this age group, the rate is 19 per 100,000 population.

DISABILITY

- There are an estimated 11 million disabled adults in the United Kingdom (1 in 5 of the total adult population) and 770,000 disabled children.
- Many of these disabled people often have less obvious or non-visible impairments.
- Nationally, mental health has been identified as one of the primary causes of disability.
- Those with chronic physical diseases are also likely to have a common mental illness.
- In the inner London boroughs there are very high rates of working-age incapacity benefit for mental health reasons in some wards in the boroughs, primarily in areas of deprivation (as well as much higher prevalence of severe and enduring mental illness).
- Nationally, learning disability is associated with low life expectancy and high rates of obesity and heart conditions.
- Young people with learning difficulties and disabilities nationally are also twice as likely to be unemployed or not in education or training than young people in general, which has a significant impact on health and well-being of these groups.

ETHNICITY

- National findings identify poorer health and life expectancy for some groups such as those from Pakistani or Bangladeshi backgrounds.
- Those from Asian or Black ethnic groups tend to have a greater susceptibility to diabetes and CHD in particular.
- Infant mortality nationally is poorer for black and Asian groups.
- Higher rates of smoking (among men), as has been evidenced locally among some other groups such as Eastern Europeans.
- National data has consistently shown that BME groups disproportionately use emergency services over routine/ GP services and some experience of challenges communicating with health professionals.
- Gypsies & travellers have also been found to be more likely to use emergency services over routine services.
- In the inner London boroughs analysis has identified high 'Did not attend' rates among some ethnic groups for hospital services.

- Nationally, Black groups have been found to be more likely to be detained under mental health act and those from the black ethnic group are over over-represented among inpatient psychiatric admissions in the inner London boroughs.
- There are also differences in the incidence of cancer and cancer survival rates between different ethnic groups, although deprivation may be a causal factor in this.

GENDER

- Men in general are less likely to access primary healthcare than women
- Smoking and the incidence of lung cancer are on the increase for women whilst decreasing in the male population
- Men are three times more likely to take their own lives.

LESBIAN, GAY, AND BI-SEXUAL

- According to Stonewall, the size of the lesbian and gay population in the country may be in the region of 5-7% of the population.
- Nationally, lesbian, gay, bisexual and transgender (LGBT) groups are more likely to experience mental health problems and self-harm.
- The use of alcohol, tobacco and illegal drugs is higher among LGB people.
- Social exclusion, low self-esteem, anxiety and depression are common experiences for many young LGB people.
- The inner London boroughs have among the highest rates in the country for HIV transmitted through sex between men, with very high rates in Soho and Earl's Court in particular, suggesting the gay population may be larger in these areas than elsewhere.
- National research has shown that four out of 10 gay men have not disclosed their sexuality to their GP.

GENDER REASSIGNMENT

- Nationally, around 1,500 people aged over 15 years present for treatment for gender dysphoria per year.
- There is also rapid growth (15% per year) in the number of people, of all ages, who are seeking medical treatment for profound and persistent gender dysphoria.
- 34% of transgender adults reporting at least one suicide attempt (GIRES,2009)