Central London Community Healthcare NHS
NHS Trust

Barnet | Hammersmith and Fulham | Kensington and Chelsea | Westminster

Equality Objectives 2012-2016

6 APRIL 2012

Summary

1. **We will deliver more targeted intervention and outreach activities to protected groups in order to promote our health services.**
2. **We will improve how we communicate with diverse patients using alternative and accessible formats.**
3. **We will educate and raise awareness of our health services amongst our patients based upon their protected characteristic.**
4. **We want to provide reasonable adjustments for patients with Learning Disabilities who use our mainstream health services.**
5. **We will increase the number of CLCH staff disclosing their disability by providing reasonable adjustments and individual support for our disabled staff.**
6. **We will increase the representation of our BME staff at senior manager levels.**

Background

One of the principles of the NHS Constitution[1] notes 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.

It is important to differentiate between 'equality' - when everyone is treated the same way regardless of need – and 'equity' – when people with equal needs are each treated in the same way but those in greater need are given priority over others.

Central London Community Healthcare NHS Trust (CLCH) is required under the Equality Act 2010 to publish Equality Objectives by 6th April 2012. CLCH is committed to mainstreaming diversity and equality into our roles as a provider of health services and as an employer. Our Equality Objectives set out below will contribute towards us meeting this commitment.

Health Inequalities

All four 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. There are considerable health inequalities within Barnet, Hammersmith & Fulham, Kensington & Chelsea and Westminster (see Annex A).

Health inequalities are closely linked to poverty, with the burden of ill health carried disproportionately by the more deprived communities. Other factors such as ethnicity, mental health, disability, gender and age also significantly contribute[2]. 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.

We need to ensure that our Equality Objectives will address health inequalities experienced by protected groups. See Annex B which list some of the health inequalities experienced due to an individual's protected characteristic.

Workforce

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[1] http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/nhs-constitution-interactive-version-march-2010.pdf

[2] Health Inequalities Framework, NHS Kensington & Chelsea

We have a diverse workforce and we aim to encourage a culture in which diversity is managed; and to have a workforce that reflects the diversity of our local populations in Barnet, Hammersmith & Fulham, Kensington & Chelsea and Westminster at all levels of the organisation. The Equality Objectives will contribute towards our commitment of mainstreaming equality and diversity into our workplace policies and practices.

Development of Equality Objectives

We are under pressure from commissioners, and other regulatory bodies to improve performance, delivering quality healthcare that ensures equitable outcomes for all our patients and service users. At the same time we are facing demands to make further efficiencies and savings which create challenges.

To meet these challenges, the proposed Equality Objectives will:

- Contribute towards improving the performance of our services across CLCH;
- Achieve better health outcomes for all patients;
- Ensure we have a motivated and committed workforce to provide quality healthcare.

Consultation and Feedback

Using the Equality Delivery System for the NHS, we have measured our equality performance by gathering evidence and feedback from patients, interest groups and staff from the different protected groups. These groups have included:

- Diabetes Users Group
- Stroke Focus Group
- BME Health Forum
- Service users with learning disabilities from the short respite service.
- Stakeholder Reference Group
- Mothers from the White City Baby Clinic
- Healthier Life 4 You (BME Community Group)
- Migrant Resource Centre
- The Diversity & Inspire Network (BME Staff Network)
- Lesbian, Gay, Bi-sexual and Trans Staff Network
- Focus Groups with CLCH staff

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. Recently, we published our 2010 patient equality data[3], the equality data from the Patient Experience Surveys [4] and the 2012 Workforce Equality Report[5]. 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 the Equality Objectives:

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[3] Patient Equality Data Report 2012
[4] Patient Experience Surveys: Equality data summary report 2012
[5] Workforce Equality Information Report 2011

- **Engagement** of staff at all levels, local interest groups, patients and their families.
- **Leadership** support and buy-in.
- **Training** of staff members every 2 years on our equality objectives.
- **Collaborative** working with our local and regional partners.
- **Measurement** of impact and improvements.

CLCH Equality Objectives

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

What we want to achieve

- Increase access to a number of identified health services concentrating on certain protected groups. The groups identified are: **Race** - BME groups and Gypsies / travellers; **Gender** – men; **Disability**: people with physical disabilities, and people with mental illness.

- Some protected groups were identified as being under-represented in accessing the following services. The Equality and Human Rights team will work with the relevant senior managers to develop the activities required to meet this objective:

    - **Diabetes Service**: *South Asian and African Caribbean groups*
    - **Psychological therapies**: *BME groups, men, people with disabilities and gypsies / travellers.*
    - **Walk-in centres** (Barnet centres and Charing Cross): *BME groups*
    - **Children's Community Nursing** (Hammersmith & Fulham and Kensington & Chelsea): *BME groups*
    - **District Nursing** (Westminster and Hammersmith & Fulham): *Men aged over 65*
    - **Stop Smoking Service**: *BME men particularly Bangladeshi and Eastern European Men.*
    - **Health Visiting**: *Black and Asian ethnic groups and gypsy / travellers.*

How we will achieve this

- Working with community groups who represent these protected groups.
- Distributing information about our services at community based venues (eg. place of worship, community centres etc).

Why we have chosen this objective.

- The consultation with patients showed that:
    - a significant proportion of the BME patients felt they were not given information about the services available to make a decision about health care and did not take an active part in decisions about their care, treatment and place of treatment.
    - some of the disabled patients (mostly from Diabetes User Group) said that the health services provided by CLCH did not meet individual health needs and they were not given information about the services available to make a decision about health care.

- National findings identify poorer health and life expectancy for some BME groups such as those from Pakistani or Bangladeshi backgrounds.
- Compared with the white population, Type 2 diabetes is up to six times more common in people of South Asian descent and up to three times more common in those of Black African and Black Caribbean descent.
- Infant mortality nationally is poorer for Black and Asian groups.
- In the inner London boroughs the Black ethnic groups are over-represented among inpatient psychiatric admissions.
- BME patients are under-represented in the Kensington & Chelsea psychological therapies compared to the local population data.
- Higher rates of smoking (among men), as has been evidenced locally among some other groups such as Eastern Europeans.
- Gypsy and traveller mothers are 20 times more likely than the rest of the population to have experienced the death of a child.
- Life expectancy for gypsy and traveller men and women is lower than the national average (one study in Leeds revealed a life expectancy of 50 years).
- Health conditions such as anxiety, asthma, bronchitis, depression, and long-term illness are significant for gypsy and traveller adults.

How the results will be measured

- Annual Patient Equality Data
- Patient Experience Surveys
- Patient Reported Outcome Measurements

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. **AMBER / DEVELOPING**

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

What we want to achieve

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

This will:

- improve the take-up of services by these protected groups;
- reduce DNAs;
- provide more information about the services for patients to make a decision about their healthcare, treatment and place of treatment;
- And improve patient satisfaction levels.

How we will achieve this

As a minimum we will provide information in alternative formats when requested by patients and their carers. Other accessible formats we will encourage services to use include: easy read for people with learning disabilities; translating documents (into other languages) including patients' records if requested; audio format for people who are visually impaired; ensuring that venues have induction loops for people with hearing impairments; and ensuring that the text reminder system is taken up by people with sensory impairments and for those whose first language is not English.

Why we have chosen this objective

- 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.

How the results will be measured

- Annual Patient Equality Data
- Patient Experience Surveys
- DNAs (patients not arriving for appointments)

Equality Delivery System grading – 1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways. **AMBER / DEVELOPING**

3. We will educate and raise awareness of our health services amongst our patients based upon their protected characteristic.

What we want to achieve

Increase access to all our services for:

- BME groups;
- Men;
- people with disabilities (including mental illness);
- people with learning disabilities;
- older people;
- LGBT people;
- and gypsies and travellers.

How we will achieve this

This will be achieved by improving our information, marketing and promoting our services through our Patient and Public Engagement activities. Also working with our staff to better enable them to promote our services and utilise various forms and documents for communicating.

Why we have chosen this objective

- Patient feedback has highlighted that patients are not aware of the health services provided by us and the referral routes (ie that some services are self-referral).
- Nationally, issues have been highlighted around a lack of trust and/or understanding between LGBT groups and health professionals.
- Gypsies & travellers have also been found to be more likely to use emergency services over routine services.
- Younger people both nationally and locally are more likely to use A&E rather than their GP.
- In the inner London boroughs analysis has identified high 'Did not attend' rates among some ethnic groups for hospital services.
- 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.

How the results will be measured

- Annual Patient Equality Data
- Patient Experience Surveys
- Patient Reported Outcome Measurements

Equality Delivery System grading – 1.1 Changes across service for individual patients are discussed with them, and transitions are made smoothly. **RED / UNDER-DEVELOPED**

4. We want to provide reasonable adjustments for patients with Learning Disabilities who use our mainstream health services.

What we want to achieve

We want all of our staff to work more effectively with people with learning disabilities and ensure we meet our legal requirements within the Equality Act and Mental Capacity Act.

How we will achieve this

We will provide 'reasonable adjustments' such as: longer appointment times or offering the first appointment, providing orientation visits to services, offering home visits rather than at a clinic, and adapting the environment such as avoiding noisy areas or bright lightening. This objective will be delivered in partnership with the national charity Mencap and they have been commissioned to help us to develop principles and practices that are applicable to service users with a range of disabilities and access issues.

Why we have chosen this objective

- Nationally, learning disability is associated with low life expectancy and high rates of obesity and heart conditions.
- The health inequalities faced by people with learning disabilities in the UK start early in life, and result, to an extent, from barriers they face in accessing timely, appropriate and effective health care.
- 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.

How the results will be measured

- Patient Experience Surveys
- CQUIN monitoring
- PPE activities

Equality Delivery System grading – 2.4 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised. **AMBER / DEVELOPING**

5. We will increase the number of CLCH staff disclosing their disability by providing reasonable adjustments and individual support for our disabled staff.

What we want to achieve

We want to increase the number of staff disclosing if they have a disability or long term illness.

How we will achieve this

We will raise awareness with staff by providing information on the mandatory training and through the HR department. There will be a clear message that disclosing their disability will give them access to JobCentre Plus funding and guidance for reasonable adjustments such as;

- Acquiring equipment,
- Changes to working patterns,
- Work tasks or physical environment,
- Communication needs,
- Meeting training needs.

Why we have chosen this objective

Currently, 2.8% of the workforce have disclosed their disability however 16% of the respondents from the 2011 Staff Survey stated that they had a disability or long-term illness.

How the results will be measured

- Increase in number of staff disclosing their disability.
- Increase number of annual reviews undertaken with staff with disabilities to review their reasonable adjustments.

Equality Delivery System grading – 3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided approximately. **AMBER / DEVELOPING**

6. We will increase the representation of our BME staff at senior manager levels.

What we want to achieve

We want to increase the representation of staff from Black and Minority Ethnic (BME) backgrounds at Agenda for Change bands 8a and above.

How we will achieve this

- Delivering the Empowerment programme for BME staff at bands 2-7.
- Piloting a 'diversity talent pipeline' by offering short-term secondment opportunities for BME staff.
- Facilitating and empowering the Diversity & Inspire Network to represent the interests of our BME staff.
- Consistently following the recruitment and selection procedures to eliminate bias within the process and ensure the process is equal and fair.

Why we have chosen this objective

Only 19% bands 8a and above are staff from BME backgrounds compared to BME staff being 35.5% of the overall workforce. It makes good business sense to nurture a workforce that represents our patients. By having a more diverse workforce and diversity amongst decision-makers we will be able to deliver a service that meets the needs of all its patients.

How the results will be measured

- Annual Workforce Equality Monitoring Report: ethnicity representation and recruitment / selection data.

Equality Delivery System grading – 3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades. **AMBER / DEVELOPING - GREEN / ACHIEVING**

Review

The Associate Directors and Senior Managers responsible for the services that were identified as a priority will be involved in the production of a 4 year action plan. In addition, the Human Resources teams will be involved in delivering the 2 workforce objectives. The action plan will set out milestones, lead person responsible, contingency plan, milestones and deadlines.

We are required to publish information relating to the progress we are making towards meeting our Equality Objectives as part of the general equality duty within the Equality Act. Therefore, an annual progress report outlining the progress in meeting these agreed Equality Objectives will be produced and published on the CLCH website. This will be presented to the Equality and Human Rights Committee and the Board of Directors in April 2013.

Appendix A – BOROUGH INFORMATION

Hammersmith & Fulham has a very high proportion of young working age residents, with fewer children and older people than elsewhere. Like other parts of Inner London, the area is characterised by both wealth and deprivation. The borough has a life expectancy of 79.4 years for men and 84.3 years for women, which are slightly higher than the London and England averages. Parts of the borough, particularly in the north (White City and Shepherd's Bush), Hammersmith, and Sands End in the south, have poor health, deprivation and associated chronic diseases. Hammersmith & Fulham's population is culturally and ethnically diverse, with populations from Western Europe, Eastern Europe (particularly Poland), Australia and the Middle East. The northern wards of Wormholt & White City and College Park & Old Oak have the highest black and minority ethnic populations in the borough, at over 30%. The most common faith after Christianity was Islam, at 1 in 10 of the population in 2001.

Kensington & Chelsea is one of the UK's wealthiest boroughs and is also the most densely populated. Overall good health masks variations in life expectancy and parts of the north of the borough in particular have a much higher burden of disease and lower life expectancy. Around half the population in these areas live in social housing and these areas are more likely to be home to residents belonging to a number of the protected groups - such as those with a disability and those from black and minority ethnic groups. Only 4 out of 10 residents were born in the UK, the lowest of any borough in the country. Communities range from the more affluent – Western European, American, and Australian – to more vulnerable – Middle Eastern and North African.

Westminster is one of the most prosperous boroughs in the UK in terms of average income, and residents enjoy the second highest life expectancy in the country after Kensington & Chelsea, at 83.8 years for men and 86.7 years for women. It is also unusual in that it is a huge daytime population, predominantly workers, tourists and those visiting entertainment in the borough. The borough is, like Kensington & Chelsea, culturally very diverse, with large numbers of residents from Western Europe and America, and the largest Arabic-speaking population in the country. The borough has the largest difference in life expectancy of anywhere in the country, with an absolute difference between affluent and deprived areas of 17 years for men and 10 years for women. Areas such as Church Street and Queens Park in the north of the borough are among the most deprived in the country. Populations in these areas are characterised by ethnic diversity, poor health outcomes and worklessness.

Barnet is a very diverse borough with 33.1% of the local population belonging to non-White communities. It is already London's most populous borough with over 349,800 residents in 2011. Over the coming years, Barnet is forecast to become increasingly diverse with it estimated that 35% of the local population will be non-White by 2016. There is an estimated 4,600 people ages 18-64 with a serious physical disability of which 1,700 are predicted to have a serious personal care disability. The number of residents over 65 with serious physical disabilities is forecast to increase by ten percent by 2015 which is twice the average rate of growth. Almost half of all Incapacity Benefit claimants are receiving benefit due to mental health issues (4,040 people).

APPENDIX B - 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).