Central London Community Healthcare NHS Trust

TITLE: **EQUALITY, DIVERSITY AND INCLUSION STRATEGY**

VALID FROM: **June 2019**

EXPIRES: **June 2022**

This document supersedes the Equality and Diversity Strategy 2016-2018

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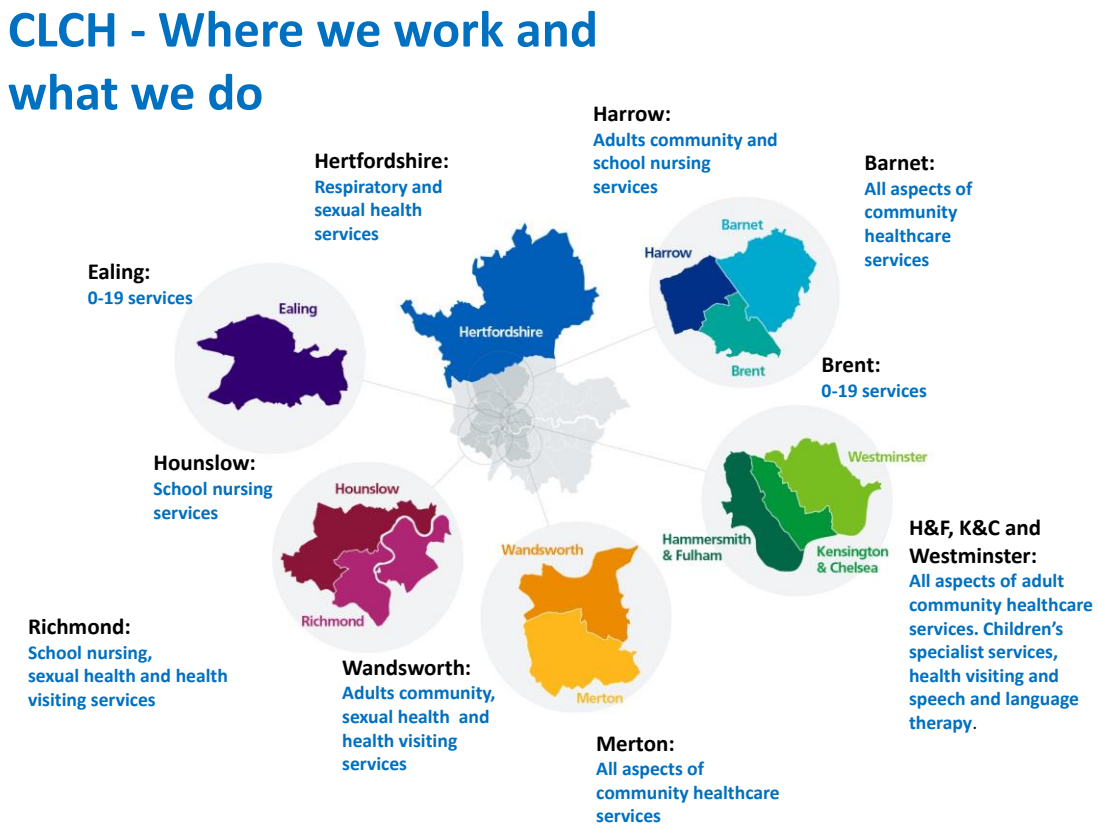
1. Introduction

1.1 Central London Community Healthcare NHS Trust (CLCH) employs over 3500 staff 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 which currently receive services are shown in the illustration below:



We currently provide services in four Sustainable Transformation Partnership (STP) areas in London and Hertfordshire. These include: North West London, North Central London, South West London and Hertfordshire & West Essex. These areas cover disparate population groups – from ethnically diverse urban boroughs in London to a mix of urban and rural communities in Hertfordshire. An overview of the demographic make-up of the populations in the areas we serve is given below. The information is drawn from our Public Sector Equality Duty Report 2018, the Census 2011 and

population estimates for 2017-18 as given on the local authority websites. Only the key headline indicators relevant to diversity and inclusion and the strategy are included.

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 316,096. 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 the year 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 243,500 people live in Harrow with just over 50% being female. Compared to London, the population of Harrow has a greater proportion of older people (over 60) and a lower proportion of people in their 20s and 30s. 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%.

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.

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 is ranked second to bottom for those with no qualifications (10**%**)

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 & 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.

Ealing: The 2017 mid-year population estimate for Ealing was 342,700. 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. **T**he estimates show that the population of Ealing declined from 344,800 in mid-2016 to 342,700 in mid-2017; a decrease of 2,100 - the greatest level of decline amongst the four London boroughs experiencing population decline, ahead of Kensington and Chelsea, Haringey and Merton.

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.

Hertfordshire: In 2012, the population of Hertfordshire was 1,129,000. It is projected to increase over the next 25 years to 1,400,700 in 2037. There were 168,000 Hertfordshire residents aged over 65. People born overseas make up 13.4% of the population. 19.2% of Hertfordshire residents identified themselves in ethnic groups other than "White British", which compares to 11.23% in 2001. Approximately 49.02% of the resident population identified themselves as male compared to 50.98% as female and 14.3% declared they had a limiting long-term illness.

Workforce Profile of the Trust as at March 31st 2019 is as follows:

- The Trust workforce on 31 March 2019 was 3,395. Based on information held on the Electronic Staff Record (ESR) systems, the staff profile by protected characteristics is:
- By Gender: 86.4% female, 13.6% male.
- By Ethnicity: 43.9% White, 43.5% Black, Asian or Minority Ethnic (BAME) and 12.6% of the workforce not having disclosed their ethnicity.
- By Disability: 64.4% declared 'No' disability, 3.2% declared 'Yes' to having a disability and 32.4% either chose not to answer at all ('undefined') or answered that they do not wish to declare ('undisclosed).
- By Religious Belief: 42.3% Christian, 10.4% of another major world religion (Buddhism, Hinduism, Islam, Jainism, Judaism, and Sikhism), 4.7% of another faith, 6.3% atheists and 36.3% chose either undefined or undisclosed.
- By Sexual Orientation: 61.3% Heterosexual, 2.4% Lesbian, Gay or Bisexual and 36.3% chose either undefined or undisclosed.
- By Age: 93.7% were between the ages of 25 and 64. This is evenly spread across the age groups 25 to 34 (21.9%); 35 to 44 (23.6%); 45 to 54 (26.9%) and 55 to 64 (21.3%).
- By Maternity Leave: The average number of women on maternity leave in any given month during 2018/19 was 90.
- Marital status: 43.8% were married, 39.2% were single, 7.7% null, 5.8% divorced or legally separated, 0.9% widowed, 1% were in a civil partnership, and the marital status of 1.5% was unknown.
- Transgender / gender neutral identity: We record gender on ESR as male or female. We use the classification unknown where no information has been provided. We do not record information about staff who have transitioned from one gender to another. When they declare they have

changed their gender, it is changed on ESR based on their guidance. We do not record on ESR the fact that a change has been requested and made. Therefore we cannot report any information on how many transgender staff we have. For those staff who wish to declare a gender neutral identity, they can use the title Mx, which is recorded on ESR at their choice. In the financial year 2017/18, no staff member used the title Mx. For this reason there are no analyses for these characteristics but there is reference to actions and initiatives we have taken in relation to transgender staff.

- By hours worked: 65.9% full-time; 34.1% part-time. Anyone working less than 37.5 hours is classified as part-time. 94.2% of part-time workers are female; 5.8% male. Of Full-time workers, 82.3% are female, 17.7% are male.

Of the total workforce, 2703 (79.6%) are clinicians and 692 (20.4%) are non-clinicians. Of the Clinicians, 52 are medical or dental staff, which is 1.5% of the total workforce.

The biggest groups of clinicians are Qualified Nurses, of whom there are 1499 (44.2%). Of the others, Additional Clinical Services (610) comprise 18.0% of our workforce and Allied Health professionals (487) 14.3% of the same.

1.2 The Trust was rated “Good” by the Care Quality Commission (CQC) in 2018 and has been assigned the highest segment rating of “1” in the National Health Service Improvement (NHSI) single oversight framework.

2. **Purpose of the strategy:** The purpose of the strategy is to improve outcomes for all staff and service users by addressing barriers in employment and service delivery through an evidence-based process. It aims to deliver the Board’s vision on inclusion (see 3.5).

The strategy prioritises areas for intervention based on results of key reports and benchmarking exercises such as the annual Public Sector Equality Duty Report (PSED), the Workforce Race Equality Standard (WRES), the Equality Delivery System (EDS2) and the annual staff survey.

3. Trust vision, mission and values

3.1 Our Vision is to deliver: Greater care close to home.

3.2 Our mission is: Working together to give children a better start and adults greater independence.

3.3 The Trust has four core values, which provide a reference point on how to conduct ourselves when working with patients, colleagues and partners. These are:

- Quality: We put quality at the heart of everything we do
- Relationships**:** We value our relationships with others
- Delivery: We deliver services we are proud of
- Community**:** We make a positive difference in our communities.

3.4 In supporting our value on community, staff are expected to demonstrate the following principles which relate to inclusive behaviour:

- I am visible, accessible and approachable
- I ensure people, partners and purchasers are actively engaged in planning services and care
- I embrace difference, diversity and fairness

3.5 Vision on inclusion: In November 2018, the Trust Board developed its vision on inclusion, which is: "*To provide excellent healthcare in and for our diverse communities. We are committed to creating a fair, honest and inclusive workplace - where staff can feel valued, supported and respected to deliver the best possible care to our patients and service users".*

4. Key drivers for the strategy:

4.1 Trust strategies: the Equality, Diversity and Inclusion strategy should be read in conjunction with the following strategies, with which it is aligned:

- The refreshed **Trust's strategic direction for 2017 to 2020** – in particular priorities related to co-designing services with patients, staff and partners.
- The Clinical Strategy, in particular, its focus on place-based care and integration of care.
- The Quality strategy and its 6 Quality Campaigns, in particular, Quality Campaigns 1 and 5, namely, 'A Positive Patient Experience' and 'Here, Happy, Heard and Healthy'.
- The Clinical Workforce Strategy
- The Patient and Public Engagement Strategy
- The People Strategy

4.2 The national and legal drivers for the Equality, Diversity and Inclusion strategy are:

4.2.1 NHS Constitution and Long Term Plan: 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. The NHS Long Term Plan reaffirms this commitment, emphasising the need for employers to be flexible and responsive.

4.2.2 Legal and Regulatory Drivers:

4.2.2.1 The Equality Act 2010 outlaws discrimination, harassment and victimisation of people on the grounds of age, disability, ethnicity, faith, gender reassignment, sexual orientation, marriage or civil partnership and pregnancy and maternity (also called 'protected characteristics'). It introduced the Public Sector Equality Duty (PSED), which require public bodies to show due regard to the general equal duty to eliminate discrimination, harassment and victimisation, advance equality of opportunity and promote good relations between different groups of people. To meet these, public bodies have specific duties of publishing equality objectives and reporting compliance and progress annually.

4.2.2.2 The NHS Standard Conditions of Contract requires healthcare providers to meet the Public Sector Equality duties by:

- Making reasonable adjustments for service users and carers with language or communication difficulties.
- Implementing the Equality Delivery System (EDS2).
- Implementing the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) from 2019.
- Publishing their progress and plans annually through the Public Sector Equality Duty report.

4.3 Staff views, perceptions and feedback have also influenced this strategy, including views from: the Joint Staff Consultative Committee (JSCC), Partnership Forum, staff networks, line managers, Patient Experience Team, the HR and OD Team teams and Executive Leadership Team (ELT).

4.4 Voluntary benchmarking – such as the Disability Confident Scheme managed by the Department of Work and Pensions. The Stonewall Diversity Champions Scheme, which provides guidance on good practice related to inclusion of Lesbian, Gay, Bisexual and Transgender staff(including the

Workplace Equality Index, in which the Trust will be participating in 2019) have also been drivers of this strategy.

5. Approach to developing the strategy

The approach to developing the strategy has included:

5.1 **Gathering and analysing information from the PSED, WRES and the Gender Pay Gap reports for 2018-19.** The Trust has also completed EDS2 assessments for all 4 goals (which relate to services, employment and leadership). The findings have corroborated and helped inform this strategy, notably the equality objectives for 2019-22 (see Section 6).

5.2 **Developing a vision on inclusion by the Board**: This was done at a facilitated board workshop on November 29th 2018 (see 2.5). The board's vision gives the strategic direction for this strategy and all key interventions resulting from it.

5.3 **Defining the Board's leadership and responsibility**: The board's involvement in setting the vision and direction for this strategy has helped accelerate the diversity and inclusion work programme.

5.4 **Developing and delivering equality, diversity and inclusion objectives for the Board**: as part of the strategy development process, the Board has set itself objectives on equality, diversity and inclusion. In addition, ELT members have identified themselves as champions for each of the WRES actions and the staff networks. The Workforce Committee and ELT have oversight of all progress reports on equality, diversity and inclusion.

5.5 **Establishing governance arrangements to develop and oversee the implementation of the strategy:** The implementation plan encompasses our equality action plans for addressing issues identified as part of the evidence gathering for the WRES, the Gender Pay Gap and EDS2 and through our JSCC and partnership forum and our staff networks. Executive leadership for the strategy and its implementation will be provided by ELT who will monitor progress. ELT, supported by the Workforce Group, will provide assurance directly and through the Workforce Committee to the Board. This is explained further in Section 7.3 points (c) and (d) and Section 8.1 and 8.2.

5.6 **Supporting the Board and ELT with learning and development and to promote the strategy's development:** Since July 2018, the Board and ELT have received regular progress reports on the Equality, Diversity and Inclusion work plan, including the WRES, Gender Pay Gap and EDS2 reports

and a briefing on reverse mentoring. In addition, they have participated in the Annual Race Equality Network conference, Rainbow network events, such as the Annual London Pride event and supported the launch and development of the Disability and Wellness Network (DAWN). Their participation and support for these developments have accelerated the strategy development process and gained support for the work streams at senior management level.

5.7 **Reviving and establishing staff networks:** This has been a key aspect of the strategy. Since May 2018, the Trust has worked hard to strengthen the influence of its three networks – the Race Equality, Disability and Wellness and Rainbow (LGBT) networks. All three now actively participate in policy and strategy development and influence decision-making. Members of the networks are supported with learning and development opportunities and participate in regional and national events. They are now developing work plans, which complement existing plans related to the WRES and the equality and inclusion plan. Members of the staff networks have participated in the development of the WRES Action Plan – which has extended in scope to improve outcomes for all staff, not just Black Asian and Minority Ethnic employees.

5.8 **Sharing and socialising evidence with staff:** Between September 2018 and June 2019, we have been promoting discussions on our inclusion plans through a number of forums and events including: the Chief Executive's roadshows, meetings of the JSCC, Divisional Directorates, Trust Business Managers meetings, staff networks, the annual Race Equality Network Conference and the EDS2 workshops. A communication and engagement plan is being developed to share regular progress updates with staff and the leadership team. The draft Equality, Diversity and Inclusion strategy has been shared with the JSCC and Partnership Forum, staff networks and Quality Council Lead. Quality Councils are led by frontline staff, to identify improvements to services with the support of patient representatives.

5.9 **Co-designing the equality, diversity and inclusion strategy, objectives and implementation plan**: The content of this strategy, including the refreshed equality objectives and key interventions, were finalised at a workshop held on April 11th 2019, to which were invited representatives from the three staff networks, the WRES Taskforce (which includes two staff-side representatives as permanent members) and the Patient Experience Team. The objectives were developed taking into account the results of the EDS2 reviews for service and workforce (Goals 1-3). The EDS2 service and workforce panels were drawn from a cross section of groups, internal and external to CLCH. The panels completed their assessments at workshops in March. The evidence portfolio for both sessions included access and experience data for service users and staff. Goal 4, which was assessed by an

external partner, East London NHS Foundation Trust has helped with the development of the Board's vision and objectives on inclusion.

5.10 **Building credibility in the strategy, vision and our leadership**: Besides encouraging active participation in co-designing the strategy and related action plans, we have drawn on the wealth of best practice information available through NHS England / Improvement and directly through NHS Trusts. As mentioned above, a communication and engagement plan is being developed to share the strategy, its progress and its impact across our staff and service user groups.

6. Key findings – Evidence and Areas prioritised for action

6.1 All the sources of information (hard and soft intelligence) referenced above, including the WRES, PSED and the Gender Pay Gap reports, staff survey results, feedback from the JSCC and staff networks, the FTSU Guardian reports and Quality Teams have been used to inform development of the strategy. The findings are summarised here:

- The Trust needs to undertake a strategic study to ensure services are accessible and delivered to address known health inequalities in the different geographic areas it operates.
- Disclosure rates by protected characteristic (for staff and patients) continue to be an area of concern.
- Services need to improve efforts to meet the religious and spiritual needs of patients.
- The Trust needs to continue to undertake targeted community outreach to ensure services are promoted to seldom-heard groups.
- Staff experiences around recruitment and selection continue to be a priority, with BAME and disabled staff found to be less likely to be appointed from shortlisting when compared with their White and non-disabled peers. With respect to gender, women were found to be less represented in senior medical and dental roles.
- The staff survey for 2018 (as for 2017) highlight that staff continue to experience high rates of bullying, harassment and aggression within the workplace and in interactions with patients and their families. This is disproportionately higher for disabled and LGBT staff.
- The number of formal disciplinary proceedings has dropped since 2017. This is an area that is being monitored closely with the introduction of the 'Incident Decision Tree'. In 2016 and 2017, BAME staff were found to be disproportionately over-represented in formal disciplinary proceedings compared with White staff. The Incident Decision Tree seeks to encourage greater informal resolution of problems.

- Career progression and opportunities for development (and perceptions related to it) continue to be an area of concern for many.
- Making reasonable adjustments for disabled staff needs to be an area of focus.
- Flexible working needs to be monitored to ensure as many staff as need to and is practicable are able to benefit from it, while those with caring responsibilities are prioritised.
- Target setting and benchmarking needs to be undertaken systematically and made part of business as usual for services and workforce.

6.2 These findings have been used to assess progress in achieving the 2016-2018 equality strategy objectives, which were as follows:

- 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 Black Asian and Minority Ethnic (BAME) 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.

6.3 Progress against the 2016-18 objectives: the Trust is now delivering targeted interventions and outreach for vulnerable groups. It has commissioned DA Languages to provide a comprehensive interpretation service (including BSL Sign Language) for service users and carers with communication support needs. Guidance on the Accessible Information Standard is readily available for all frontline services. The Patient Experience Team has worked with Mencap and the Trust's Dementia carers' group to support patients with learning disabilities and dementia. For more detail, see pages 23-25 on the PSED Report on https://clch.nhs.uk/application/files/2115/4158/6411/CLCH_-_Public_Sector_Equality_Duty_Report_2018.pdf.

6.4 The findings summarised (as they emerged) have been used to prioritise our objective setting and action planning during the last 12 months and will also inform the 2019 to 2022 strategic objectives and implementation plan, as explained in the table below. Some of the actions are already in train.

Key findings and topics	**Suggested priorities for objectives and action plans**
Health inequalities	Undertake a strategic review of services to ensure the level of accessibility for service users is based on known health inequalities. In line with the clinical strategy, and the business planning processes of the Trust, the operational divisions will be reviewing access to services. This is likely to evolve to population health analytics in line with the development of Integrated Care Partnerships and Primary Care Networks"
Service – Patient profile	Improve data collection by protected characteristics.
Patient/service user needs	Develop learning opportunities for staff to meet religious and spiritual needs of service users through a co-production process.
Outreach	Continue to engage different sections of the community, in particular to promote services and address barriers experienced by hard-to-reach groups. In line with the clinical strategy, and the business planning processes of the Trust, the operational divisions will be reviewing access to services. This is likely to evolve to population health analytics in line with the development of Integrated Care Partnerships and Primary Care Networks"
Workforce and patient profiles (Source: ESR, WRES and PSED reports)	Improve data collection by protected characteristics to reduce the percentage of undefined responses. This is particularly relevant for disability, sexual orientation and religion and faith, where the proportion of undefined responses is disproportionately high. Continue to improve disclosure around ethnicity towards a

Key findings and topics	Suggested priorities for objectives and action plans
	target of 95% for BAME (by 31.07.20 and improve (reduce) by 6% the level of staff who have undisclosed for disability, sexual orientation and religion and faith by 31.07.20.
EDS2 Goals 1 and 2 – Review of Hertfordshire Sexual Health Service. Service rated overall Achieving for Goal 1 and Excellent for Goal 2. Lessons learnt from review to be shared with all services. Panel included: commissioners, voluntary sector representatives, partner agencies, clinical and administrative staff and a Trust Board member.	Continue to engage partners, patients and public in improving the design and delivery of services Promote positive recognition of staff through sharing good feedback to motivate and encourage discretionary effort. Train staff to work more effectively with vulnerable service users, such as people with learning disabilities. Benchmark services regularly with peer groups.
Recruitment and Selection – addressing the risk of unconscious / conscious bias in selection processes. (Source: WRES indicators, staff survey, staff networks and WRES Taskforce)	Reduce the risk of unconscious / conscious bias and support effective recruitment processes by: • Strengthening knowledge and awareness among managers. • Providing recruitment and selection training for recruiting managers and staff networks members. (Training will address unconscious bias). • Using diverse interview panels and assessment centres. • Ensure robust, feedback based selection practices. The target is to train 150 managers by March 2020. More guidance is needed for managers on robust recruitment practices through an e-learning module. Selection processes will be audited after March 2020.
Improving staff experience, especially in relation to formal disciplinary proceedings, harassment, bullying and aggression	Raise awareness of the policy on violence and aggression and how it should be applied in service and employment,

Key findings and topics	Suggested priorities for objectives and action plans
(Source: WRES indicators, staff survey, EDS2)	using: • A reflective learning approach. This has been started through a workshop session held at the March 2019 Trust Business Managers meeting and will be cascaded across services and teams. • A campaign on Tackling Unacceptable Behaviour, which includes conflict resolution training and corporate messaging. • Shared governance quality councils • Staff networks Raise managers' awareness on use of 'Yellow and Red Cards' when staff are faced with aggressive patients and carers. Promote the updated Violence and Aggression at Work Policy. Raise awareness on how to manage stress resulting from service pressures (leading to bullying). Give staff confidence to report inappropriate behaviour without fear of reprisal.
Career Progression (source WRES indicators, staff survey and Gender Pay Gap report)	Strengthen career planning and development and improve career progression equality of opportunity by: • Introducing a constructive, supportive career planning and development conversation as part of the annual PADR (performance appraisal and development review). • Providing staff with the training to develop their personal effectiveness in a range of professional scenarios. • Providing cultural intelligence training and self-assessment tools for managers to help them understand their own cultural preferences and how

Key findings and topics	Suggested priorities for objectives and action plans
	to manage and develop a diverse team. • Giving staff at all grades time off to attend training and skills development courses. Understand the root causes of relatively lower numbers of female medical and dental professionals at senior level.
Reasonable adjustments and capability reviews for disabled staff. The feedback from staff through a number of sources is that we need to do this better: be more aware of the issues for staff, be more open and receptive to how they can be resolved, and be more active in making the adjustments in a timely way. (Source: JSCC, DAWN and staff survey)	Review and improve the support and guidance given to line managers when undertaking capability reviews for disabled staff in a timely manner. We will aim to ensure managers acknowledge requests for reasonable adjustments within 2 working days, hold meetings to discuss the required reasonable adjustment with the concerned staff member within 5 working days and the request is processed within 15 working days.
Flexible working (source: Gender Pay Gap Report)	Promote and review (at agreed intervals) flexible working to support fair and equitable access to this benefit. Recognise the needs of women returning from maternity leave; and that subject to it being practicable to do so, we should make flexible working available to as many staff as seek to work in this way.
EDS2 Goal 3 – Review of workforce experiences. The grading was undertaken by a panel, which included representatives from the JSCC, Staff networks, a CBU manager, service head, team leader and administrative staff. Overall Goal 3 was graded 'Developing'. The findings support those in the WRES report. The EDS2 panel concluded that the actions being taken in relation to race	The EDS2 panel considered what actions should be prioritised. Issues were similar to those voiced by the JSCC, the WRES Taskforce, and the staff networks, as were the solutions. For completeness the EDS2 Employment actions are set out below, recognising that they repeat what may have been said in relation to specific areas of concern. • Ensure robust, feedback based selection practices. • Staff at all grades to be given time off to attend training and skills development courses.

Key findings and topics	Suggested priorities for objectives and action plans
equality through the WRES Taskforce need to be broadened to support all protected groups. Targeted action was found to be needed for two specific groups in particular: • Disabled staff around reasonable adjustments • Admin staff many of whom are from a BAME background and who have concerns around access to training, career pathways and bullying and harassment, and pay.	• Benchmark pay and grading of specific staff groups (such as Admin staff rather than Trust wide). • In relation to Admin staff, provide more shadowing opportunities in different roles/areas – including in clinical roles. • More awareness on how to manage stress resulting from service pressures (leading to bullying).Give staff confidence to report inappropriate behaviour without fear of reprisal. • Raise managers' awareness on use of Yellow / Red Cards when staff faced with aggressive patients and carers. • Promote updated Violence and Aggression at Work Policy. • Review flexible working arrangements at agreed intervals. • Consider requests for reasonable adjustments for disabled staff as an integral part of the Agile Working project and recognise how this affects ability to work flexibly, in keeping with time scales given above. • Managers should support staff to review their Job Descriptions as part of appraisal. • Managers need to promote cultural awareness in non-clinical as well as clinical teams / staff o ensure the needs of Administrative staff are given a higher profile More celebration of Cultural Diversity is required in non-clinical teams as unlike patient-facing teams there is not a requirement to understand diverse communities as part of their day job.
EDS2 – Goal 4 – Inclusive Leadership. This review was done internally. Outcome 4.3 was graded as part of the Goal 3 assessment on March 23rd. External	• Board members and ELT to continue to support and develop the equality, diversity and inclusion programme.

Key findings and topics	Suggested priorities for objectives and action plans
validation of Outcomes 4.1 and 4.2 is being validated by East London Foundation Trust as part of a reciprocal arrangement.	• For key board papers which have an impact on equality, diversity or inclusion, the Executive Director leads will complete an equality-related risk analysis (or equality analysis) to inform decision-making.
Development of the three staff networks has progressed throughout the last 12 months. All three are being supported by the Equality, Diversity and Inclusion Lead to define their remit / terms of reference, to increase their membership, to use their voice, to develop their work plans and events calendar.	Continue to support the networks and their chairs with training and resources for work plans.

7. Strategic objectives and interventions

7.1 Based on the findings of our statutory reports and in particular, the EDS2 reviews and feedback from the Equality Strategy workshop held on April 11th 2019, the following equality objectives have been drafted. In keeping with guidance from the Equality and Human Rights Commission, the objectives focus on areas that are seen as gaps or continuing concerns. Progress on the equality objectives will be reported upon annually through the PSED report and refreshed as required after 3 years:

7.2 The Equality Objectives for 2019-22, including the ones form the 2016-18 strategy that we will continue to implement, are as follows:

(1) We will improve the level of accessibility for service users based on known health inequalities and deliver targeted community outreach, promoting our health services to seldom heard groups.

(2) We will meet the religious, spiritual and cultural needs of patients through co-designing guidance for staff with service users and carers

(3) We will improve data on protected characteristics of staff and patients. Note 1: The percentage of staff with undisclosed ethnicity has dropped marginally since last year from 12.99% in 2017-18 to 12.7% in 2018-19. The target for undisclosed ethnicity recorded on ESR is 9% by 31 January 2020, and 5% by 31st July 2020.

Note 2: The percentage of staff with undisclosed disability / non-disability is above the national average by 6%. The target is to reduce the level of undisclosed (because not known, as opposed to a preference not to disclose) by 6% by 31st March 2020 for disability, sexual orientation and religion/faith.

(4) We will improve the reporting of discrimination, harassment, bullying or abuse by staff and patients and the public and promote opportunities for staff to share concerns.

(5) We will increase the representation of Black Asian and Minority Ethnic (BAME) staff at senior manager levels to meet the Trust Workforce KPI current from time to time. The 2019/20 Trust target for BAME representation at Band 7 and above is 35%.

(6) We will embed fair, transparent, feedback-based recruitment and selection processes valued by candidates and managers.

(7) We will reinvigorate our approach to learning and career development to support managers and staff.

(8) We will support flexible working for staff, prioritising reasonable adjustments for staff with disabilities

7.3 The above objectives and suggested priorities for action have been considered against the four categories of the NHS England Model Employer guidance, to check if we have addressed those factors which are important to successful achievement of the equality, diversity and inclusion in terms of both legal compliance and culture change. The objectives for services are in line with the development of Integrated Care Partnerships and Primary Care Networks. The priorities are related to the following:

- Leadership and cultural transformation
- Positive action and practical support
- Accountability and assurance
- Progress and benchmarking.

Planned activities under each of these interventions include:

(a) Leadership and Cultural transformation:

- Executive sponsorship of WRES, WDES and Gender Pay work streams.
- Executive sponsorship of equality networks.
- Board members to mentor staff networks.
- Board and executive members to participate in network meetings and events.

- Reverse mentoring based on requests by ELT members.

(b) Positive Action and Practical support. This is set out in detail in 6.4 above which will form the basis of the equality, diversity and inclusion strategy implementation plan.

(c) Accountability and Assurance**:**

- Provide progress reports to workforce committee, workforce group, ELT (and through them to the Board), JSCC, staff networks and the emerging Equality Taskforce. This would include plans for WRES, EDS2, Gender Pay Gap and WDES.
- Senior leaders and board members to have inclusion objectives built into their performance appraisal.
- Building the capability and capacity of all staff networks, and supporting them to participate in decision making related to inclusion.

(d) Monitoring Progress and Benchmarking

- As mentioned above, executive leadership for the strategy and its implementation will be provided by ELT who will monitor progress. ELT, supported by the Workforce Group, will provide assurance directly and through the Workforce Committee to the Board.
- Information will be gathered regularly and consistently through the annual WRES, WDES, Gender Pay and PSED data collection exercise
- Staff survey results (the national staff survey and the Staff Friends and Family Tests) will provide further information and highlight areas for further investigation
- EDS2 assessments and other benchmarking exercises such as the Stonewall Workplace Equality Index and the benchmarking provided by national WRES team will all be referenced as means of assessing progress year on year and against other organisations inside and outside of the NHS
- Comparing performance with peer authorities and participating in practitioner networks to learn best practice
- We will continue to maintain our links established with best practice NHS trusts to sustain our learning and progress
- Study best practice across sectors to build competitiveness
- Cross reference to feedback from PLACE inspections

8. Strategy Implementation

Governance and monitoring:

8.1 The Equality, Diversity and Inclusion implementation plan will be developed, delivered and monitored through an Equality Taskforce, modelled on the workings of the WRES Taskforce which was found to be an effective way of taking forward the race equality agenda during 2018-19. The Taskforce will report to the Workforce Group and from there to ELT and the Board.

8.2 Performance against workforce KPIs and PIs, which remain unchanged, will be monitored through the integrated performance report at Finance, Resources and Investment Committee (FRIC).

8.3 Duties and responsibilities

8.3.1 The Trust Board is accountable for all actions and omissions in relation to equality and human rights legislation.

8.3.2 The Chief Executive carries overall responsibility for ensuring that the Trust has the appropriate resources and processes in place to support its staff in relation to this strategy.

8.3.3 The Director of People and Communications has overall responsibility for the implementation, and review of the Equality, Diversity and Inclusion Strategy and associated policies to reflect changes in legislation or employment practice. They will be responsible for ensuring workforce information and progress reports are made in a timely manner to national bodies and local commissioners and the required updates are made to the workforce committee, ELT and Board.

8.3.4 Within the Human Resources and Organisational Development Department (H&OD), the Diversity and Inclusion lead is responsible for leading on the Equality, Diversity and Inclusion Strategy. The Workforce Information Team is responsible for maintaining records of the Trust's employees and analysing staff survey trends to monitor changes in workforce profile and perceptions and provide reports in collaboration with the D&I Lead to appropriate committees. The HR Business Partners and HR Advisors help implement the strategy through advice and guidance to managers.

8.3.5 The Patient Experience Team is responsible for leading on the service access and patient experience interventions in collaboration with the HR and OD teams. They will make progress reports as required in these areas to the Quality Committee.

8.3.6 All managers and staff have a responsibility to participate in and support activities that help to implement this strategy.