NHS
Hounslow
Clinical Commissioning Group

Hounslow CCG

Annual Equality report 2017

Contents

Introduction

The Annual Equality Report 2017 sets out the Hounslow Clinical Commissioning Groups (hereafter referred to as the CCG) response to the Public Sector Equality Duty (PSED) and Equality Act 2010.

We are committed to fulfilling our duty as a CCG which means commissioning services to meet the diverse care need of our local population and employing, developing and supporting a high quality workforce. Our commissioning aims to achieve the best clinical outcomes for patients and better patient experience. The way we achieve this is by engaging patients, community groups, staff and clinicians in the design, procurement and monitoring of our services. We use every opportunity to listen to our patients, whether through local Patient Participation Groups (LPPGs) or voluntary sector engagement events, or planned engagement throughout the business planning process and we ensure their views reflect in our commissioning decisions.

We work in partnership with the London Borough of Hounslow Health and Wellbeing Board, NHS England, Public Health, North West London Collaboration CCG's, Local Authority, existing and prospective providers, third sector, voluntary groups, patients and staff, to develop, commission, and procure appropriate and responsive health services that reduce health inequalities, and advance equality of opportunity.

The CCG has been working proactively during 2016/17 to respond the NHS Five Year Forward View and the development of Sustainability and Transformation Planning to ensure services that are fit for the patient population.

The report sets out the most notable developments occurring within the year which demonstrate our response to the general equality duty:

- Eliminate unlawful discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act

- Advance equality of opportunity between people who share a protected characteristic and those who do not

- Foster good relations between people who share a protected characteristic and those who do not

In order to align our reporting requirements we will be publishing an interim report (as part of the Annual Engagement report in March 2018

If you require this report in an alternative format such as large print or in an alternative language please contact HOUCCG.communications@nhs.net

Who we are and what we do

The CCG came into being in 2013 through an authorisation process by NHS England which made it a duty for the CCG to show 'due regard' to the Public Sector Equality Duty (PSED) under the Equality Act 2010 and not delegate it to another organisation. Later on NHS England introduced more guidance and standards for CCGs on how they should demonstrate compliance and keep making continuous improvement.

Our Values

We work together with patients and carers, our partners and each other to achieve high quality healthcare outcomes and protect patients from actual and potential harm.

We do this by:

- Acting with compassion, honesty and integrity, and being accountable for our decisions and actions.
- Engaging with our partners and providing both robust challenge and high support.
- Promoting creativity and innovation enabling improvements in care and system transformation.
- Working together as a team to improve effectiveness.
- Ensuring that public money is used effectively and efficiently to promote and improve healthcare equitably.

CWHHE Collaborative

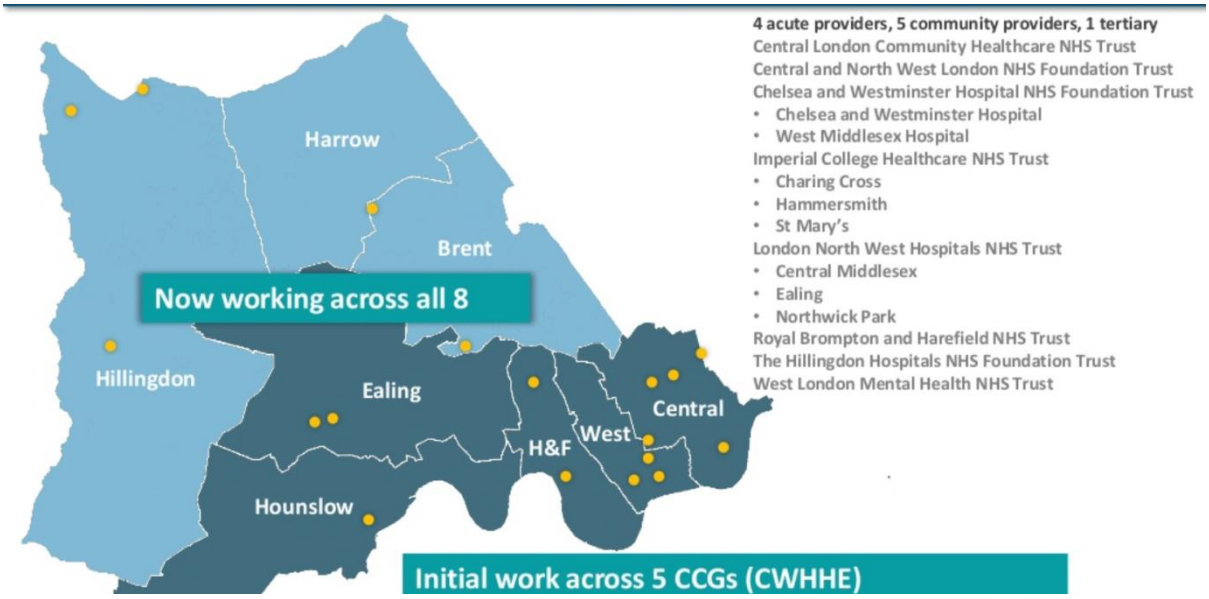
CWHHE Collaborative is the working partnership between Central London, West London, Hammersmith and Fulham, Hounslow and Ealing Clinical Commissioning Groups.

Hounslow CCG joined the Collaborative on 1 December 2013. We work as collaborative in certain areas because we have a stronger influence and this means better outcomes for you. It also allows us to provide greater scrutiny and influence on any decision that affects our area.

Improving patient safety and the quality of services local people receive from our hospitals and other providers are just two areas we have more influence on if we join together. For example, we have a collaborative safeguarding team, working across the five CCGs providing support to us all, including Hounslow CCG. By working together we are able to fulfil our statutory safeguarding duties with regards to children and other vulnerable patients, which is an important aspect of the work we do.

Alongside the CCG's dedicated team, we share a larger collaborative team with the other four CCGs mentioned above; this includes our Chief Officer Clare Parker. The Collaborative is not an organisation or legal entity, the individual CCGs are the statutory organisations responsible for commissioning healthcare in this area.

The Map below shows the CWHHE regional map with Acute and Community Healthcare Providers



Our population

Hounslow population profile

1. Increasing Diversity

Hounslow is one of the most diverse populations in London. In the 2011 census the three most common ethnicities were white British, Indian and Pakistani. Hounslow has a number of new communities including Afghan, Bulgarian, and Nepalese communities.

In the 2011 Census 49% of borough residents were from Black And Minority Ethnic backgrounds, in 2016 it was estimated at 51% and it is projected to rise further.

2. Lone Parents

The 2001 Census recorded a total of 6,000 lone parent households in Hounslow which then increased to 7,600 in the 2011 Census. This represents an increase from 7.2% of all households being a lone parent, to 8%.

3. Overcrowding

In the 2001 Census 16.2% of households were deemed to be living in overcrowded[1] conditions. By 2011 this had increased to 21.8%. Overcrowding is likely to worsen as the population grows and housing costs continue to rise.

Source: GLA short term trend based ethnic group population projections, 2015 round.

Hounslow population profile

[1] Overcrowding: Where the number of rooms is less than the number of people and the relationship between them, Census 2011 and NOMIS

Population: 184,000 residents of a working age, and 59,000 aged between 0-15

Education and training: 21% of people have no qualifications

Housing: Hounslow has 13,000 Council tenants, 2,000 Council leaseholders and 1000 sheltered and supported tenants

Transport: 42% of households have no car

Crime & safety: There are approximately 29,000 reported crimes each year

Communities and environment: 82% of residents are satisfied with their local area as a place to live

Health & wellbeing: 15% of adults have a limiting long-term illness

Vulnerable groups: 14,000 children are living in poverty. 400 young people are carers, and 5000 people provide over 50 hours care a week

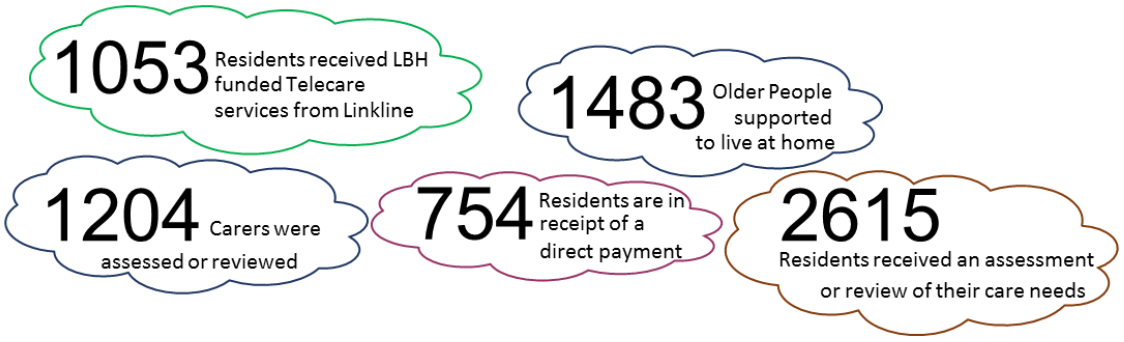
Sources: GLA population estimates 2015. GLA SHLAA-based household projections 2016. Census 2011 (Qualifications, Car ownership, Long term illness, carers). Recorded crime offences 2016 – www.police.uk. Residents Survey 2016. Department for Work and Pensions (2012-2014).

Use of health and care services

Hounslow has 47 GP practices with a registered population of 305,000 patients. 7 practices are located in Brentford and Isleworth, 8 in Chiswick, 14 in Feltham, 9 in Heart of Hounslow and 9 in Heston and Cranford. On average there are approximately 1.5 million consultations between a patient and GP or practice nurse each year.

Sources: GLA population estimates 2015. GLA SHLAA-based household projections 2016. Census 2011 (Qualifications, Car ownership, Long term illness, carers). Recorded crime offences 2016 – www.police.uk. Residents Survey 2016. Department for Work and Pensions (2012-2014).

In 2016/17 there were 5738 residents supported by adult social care, 3068 (53%) were people aged 65 years and over, and 991 were aged 85 and over. 776 were open to the Learning Disability Team, 534 were open to the Mental Health Team and there were 1204 Carers who received an assessment of which 623 were receiving support.



Health Inequalities

The Marmot Review into health inequalities in England was published on 11 February 2010. It proposes an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities.

Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups. The diagram below shows the Social Determinants of Health

The Determinants of Health (1992) Dahlgren and Whitehead

Health inequalities are the unjust and **avoidable** differences in people's **health** across the population and between specific population groups.. They do not occur randomly or by chance, but are socially determined by circumstances largely beyond an individual's control. These circumstances disadvantage people and limit their chance to live longer, healthier lives.

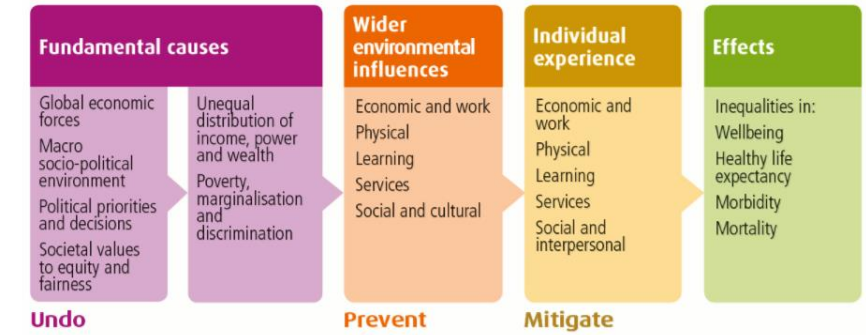
The Causes of Health inequalities

As shown in the diagram below, the fundamental causes of health inequalities are an unequal distribution of income, power and wealth. This can lead to poverty and marginalisation of individuals and groups.

These fundamental causes also influence the distribution of wider environmental influences on health, such as the availability of

- work
- education
- good quality housing.

They can also influence access to services and social and cultural opportunities in an area and in society.



• To reduce health inequalities we need to act across a range of public policy areas, with policies to tackle economic and social inequalities alongside actions with a specific focus on disadvantaged groups and deprived areas.

• We need to shift the focus from meeting the cost of dealing with health or social problems after they have developed to prevention and early intervention.

The Chart below shows the protected characteristics and health and wellbeing issues to consider alongside local health inequalities.

Age (Older adults)	Diagnoses and management of Long Term Conditions including dementia. Social isolation; falls (65 years+); flu vaccination (65 years+); excess weight (35 years +); preventable sight loss (AMD). Reliance on carers, the Community Voluntary Sector and adult safeguarding and supported accommodation.
Disability	Excess weight; LD and smoking; LD and screening uptake. Increase in safeguarding enquiries and social care assessments. Supported accommodation needs.
Gender reassignment	A small number of residents identify themselves as transgender, international evidence suggests a vulnerable population with mental health needs and a higher risk of cardiovascular disease.[1]
Marriage and civil partnership	National evidence suggests marriage or civil partnership is a protective factor against risk taking behaviours[2], and long term conditions including mental health. However These are only where the relationship is a supportive one. Poor relationships affect the adults concerned and any children that they care for[3].
Pregnancy and maternity	Giving children the best start in life, tackling low birth weight, and maternal mental wellbeing. Appropriate contraception services, and reduction in terminations.
Race	Vegetable consumption; Excess weight; Diabetes and Coronary Heart Disease[4], TB. Asylum seeker and travellers needs. Hate crime, Sexually Transmitted Diseases[5].
Religion or belief	International reports that some religious groups are correlated with higher prevalence of Cardiovascular disease and diabetes, however they have not factored in the relationship between religion and ethnicity[6]. There is some national evidence that suggests a link between smoking and religious group.
Sex	Females: MusculoSkeletal related injuries, Violence Women and Girls, employment, FGM, Cervical screening, respiratory mortality. Males: School attainment, Cardiovascular disease mortality; Mental Health, Emergency readmission to hospital
Sexual orientation	National evidence for LGBT people suggests higher rates of HIV, smoking drug and alcohol use, and an observed reluctance to engage with primary care[6].

Dhejne,C., Boman,M.,Johansson,A.,Langstrom,N.andLanden,M.(2011) Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. PloS ONE,6,(2).
Murphy M. Family living arrangements and health. In: Office for National Statistics. (Ed.) Focus on families. Hampshire: Palgrave Macmillan; 2007
Mooney A, Oliver C, Smith M. Impact of family breakdown on children's well-being: evidence review. London: Department for Children, Schools and Families (RB113); 2009
British Heart Foundation (2010) Ethnic Differences in Cardiovascular Disease. Available from http://www.bhf.org.uk/publications/view-publication.aspx?ps=1001549. (Internet 2014).
Aspinall, PJ. (2014). (Centre for Health Services Studies, University of Kent). Hidden Needs. Identifying Key Vulnerable Groups in Data Collections: Vulnerable Migrants, Gypsies and Travellers, Homeless People, and ex Worker; Inclusion Health 2014.
The Scottish Government . Scotland. Equally Well: Report of the Ministerial Task Force on Health Inequalities (2008) Available from http://www.scotland.gov.uk/Publications/2008/06/25104032/4 and www.phoutcomes.info
Williams,H.Varney,J.,Taylor,J.,Fish,J.,Durr,P., and Elan-Cane ( ) The Lesbian, Gay, Bisexual and Trans.Public Health Outcomes Framework Companion Document. UK: Department of Health and Public Health England.

Our Local health inequalities

Hounslow

People are living longer across England and in Hounslow, since 1991-93, life expectancy in Hounslow has risen by 4 years for women and 7 years for men, to 84 years for women and 80 years for men. However, there remain a number of preventable causes of ill health in Hounslow;

1. Smoking. In Hounslow there are an estimated 28,000 smokers, 14% of all adults

2. Inactivity and obesity. In Hounslow there are an estimated 126,000 overweight adults (63%), and 54,000 inactive adults (27%)

3. Alcohol. In Hounslow there are an estimated 48,000 adults that consume more than 14 units of alcohol a week (24%)

There are many types of inequality, for example men are more likely to die early (under 75) because of cardiovascular disease, and women are more likely to die early because of respiratory disease (based on 2010-2014 death data). A more comprehensive range of inequality characteristics can be found in Appendices 1 & 2.

Due to a growing ageing population and the improved awareness and diagnosis of individuals, diagnosis of dementia is expected to increase between 2012 and 2020 by 23.5%. The volume of younger adults with learning disabilities id also due to increase by 3.6%.

Embedding Equality

The CCG has developed robust governance structures to provide assurance to the Governing Body, that in working within the parameters set nationally and locally, the organisation meets all of its statutory duties including those related to the equality legislation. Actions taken can be summarised under the following four areas:

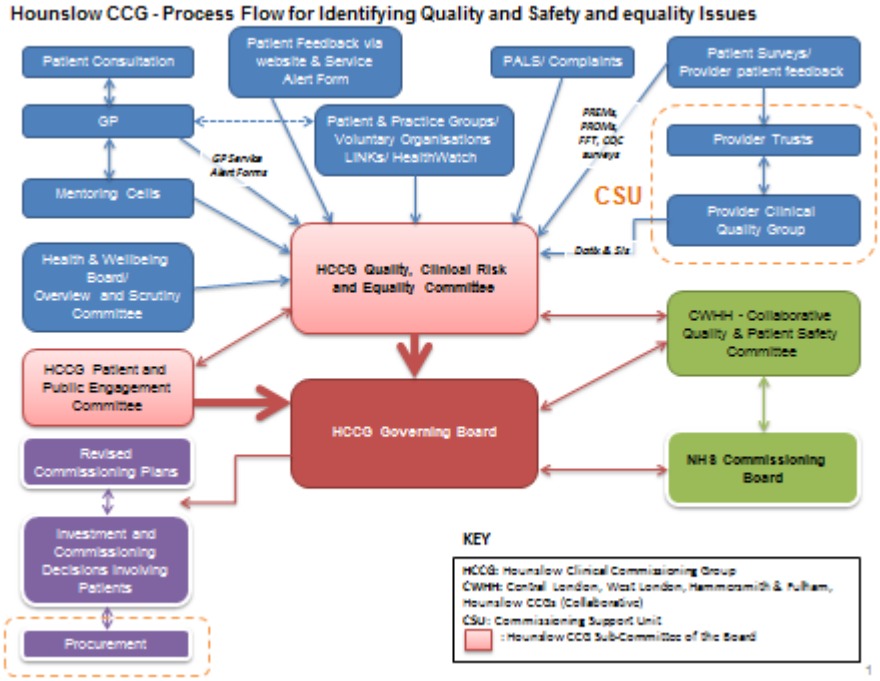
1) Embedding equalities in its governance structures and business processes

2) Progressing its equality objectives

3) Using national and local health inequalities insight to inform its Equality Impact Assessments (EQIAs) and commissioning plans

4) Provider Assurance

Governance



Governing Body duties in relation to Equalities

A. Compliance: The Governing Body is aware that it is, as a matter of law, responsible for ensuring compliance with equality law. This affects individual rights for staff and the population, as well as the proactive 'public sector duties' that apply specifically to NHS bodies.
B. Assurance and Accountability: The Governing Body, relevant committees and the Exec. Team receive regular reports on progress with tangible outcomes against equality objectives.
C. Governing Body Equality Champion will be identified and supported to effectively carry out their responsibilities.
D. CCG Senior / Executive Lead identified to embed and lead equalities and inequalities agenda.

Equality Objectives / Equality Delivery System

The CCG have identified our (2013-2016) equality objectives through a process that has involved local people, CCG staff, the CCG Governing Body and our neighbouring CCGs. Specifically, we have:

•Reviewed the needs of our population in respect of equality and diversity. The key sources here were:

oThe Public Health Equalities Profile: 'Profile of the population of the 'Protected Characteristics' of the CWHH CCGs Areas

o Joint Strategic Needs Assessment (JSNA)

o Carers JSNA or any other
https://www.hounslow.gov.uk/info/20125/communities_and_vulnerable_groups/1582/carers_-_jsna

We reviewed key themes contained within the then JSNA, findings from the CCG's patient and public engagement work stream and other available information to identify a number of equality priorities. These formed the basis of the four-year Equality and Diversity Objectives as required by the PSED (specific duties), which were likely to make the most difference to Hounslow CCG decisions and drive improvement for our communities.

The objectives are aligned to the 4 overarching themes of Equality Delivery Scheme EDS the (); progress is demonstrated below and RAG rated.

How we will developed our Equalities Objectives 2017-2020

We have developed our Equalities Objectives through a range of processes that has involved local people, CCG staff, the CCG Governing Body, our neighbouring CCGs in addition to frontline NHS and Local Authority staff, community groups and voluntary sector organisations working across Hounslow.. Specifically we have:

- Reviewed the needs of our local population with specific regards to equality and diversity through the available data available including:
    - The Joint Strategic Needs Assessment (JSNA)
    - Other specific JSNAs including: Carers, Learning Disabilities and Mental Health
    - Public Health Outcomes Framework data tool
- Developed our local equality objectives so that they meet the national goals set out in the legislative framework, and in particular the four EDS goals
- Worked with frontline NHS and Local Authority staff, community groups and voluntary sector organisations working across Hounslow to support us in understanding the current and changing equalities priorities through an online survey throughout May 2015
- Engaged with local residents, community and voluntary sector groups through an equalities workshop in February 2016 to support the CCG identify local equalities priorities
- Discussed and developed the Equalities Objectives with neighbouring CCGs via the Equalities leads forum to ensure there is consistency across CWHHE CCGs
- Discussed and developed the Equalities Objectives with the CWHHE Equalities Lead who has oversight across the five boroughs, to ensure consistency is across the board
- Ensured that colleagues and committees shaping Sustainability and Transformation Plans (STP) and Health and Wellbeing strategies are sighted on the Equalities Objectives for the next three years
- Shared the draft objectives and action plan with:
    - Attendees to the equalities workshop
    - our Patient and Public Engagement Committee including patients, local residents, Healthwatch, community and voluntary sector representatives
    - our Engagement and Organisational Development committee

- our Governing Body

Equality Impact Analysis

An Equality Impact Assessment (EQIA) involves assessing the impact of new or revised policies, practices or services against the requirements of the public sector equality duty. The duty requires all public authorities to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. It covers people in respect of all aspects of equality (age, disability, sex, race, religion or belief, sexual orientation, gender reassignment and pregnancy and maternity). It helps to ensure the needs of people are taken into account during the development and implementation of a new policy or service or when a change is made to a current policy or service.

We follow the Brown Principles of 'Due regard', which were developed in the case R (Brown) v Secretary of State for Work & Pensions [2008]. These principles are:

• Those responsible for the duty to have due regard must consciously bring it to mind when considering the duty. If they don't or if their appreciation of the duty is incomplete or mistaken, the courts will deem that due regard has not been applied.

• The due regard duty must be fulfilled before and at the time that a particular policy is being considered. Compliance with the duty should not be treated as a rear guard action after a decision to implement the policy in question.

• It must be exercised with rigour and with an open mind. Due regard involves more than a tick box exercise. The "substance and reasoning" of the decision must be examined. However, a failure to make explicit reference to the relevant positive equality duty will not, of itself, be fatal to a decision.

• It is good practice for public authorities to keep an adequate record showing that they had actually considered their equality duties and pondered relevant questions.

• The due regard duty cannot be delegated to a third party by the public authority charged with it.

• The duty is on-going.

• When applying the "due regard" test, the public authority must take into account whatever countervailing factors are relevant in the circumstances.

Significant EQIAs conducted over the year include the following:

- Choosing wisely

- Choosing wisely EQIA validation session

Provider Assurance

Providers are expected to ensure compliance from sub-contracts in order to provide assurance to the CCG for the sub-contracted services. This includes ensuring an up to date safeguarding policy, Safeguarding training which includes Prevent & Workshop to Raise Awareness of Prevent (WRAP) where applicable, safeguarding referrals, serious incident reporting, complaints and patients' experience. Hounslow CCG has the duty through our Quality schedules and contracts to receive assurance from our Providers that they are meeting their Public Sector Equality Duty (PSED) but also their Workforce Race Equality Standard, Accessible Information Standard, Equality Objectives and the Equality Delivery System (EDS)

Engagement

We will be producing our Engagement report for publication in March 2018. However, here are a few highlights of the engagement we have had throughout the year:

- Emerging communities engagement
- Stay well winter
- Let's talk about mental health
- Diabetes updates and presentations
- Falls prevention
- Cancer awareness workshops
- Older people and carers forums

Going Forward

The CCG will continue to engage with residents and collaborate with partners to address health inequalities and increase access, improve patient experience and health outcomes for service users in Hounslow. Our forward plans include:

- Create an aligned single Equality & Engagement report from March 2018
- Continue to progress the CCG's Equality Objectives
- Work with Quality team to streamline provider reporting on patient experience and equalities to include EDS2 and the Workforce Race Equality Standard

Hounslow CCG Equalities Objectives

Goal	Outcome	Theme	Objectives	Lead	Description	Outcomes	Progress
(1) Better Health Outcomes and (2) Improved Patient Access & Experience	1.1, 1.2, 1.3, 1.4 & 1.5 and 2.1, 2.2, 2.3 & 2.4	Patient Experience and Patient Voice. This is predominately translated as data collection and outcome measurement	Publish a JSNA for Equalities with Public Health	Equalities Leads/Public Health	There is a current lack of equality data, especially for the LGBT community in Hounslow. We rely heavily on the JSNA data but there is not a specific JSNA for equalities or each of the protected characteristics yet. We have numerous providers who collect data but not a systematic approach or ability to monitor the outcomes	• Better informed commissioning • Comparable data across all providers • Equity of access to disclose • Evidence for Equalities Objectives 2019 onwards	• Identify and disseminate best practice guidance for equality monitoring, including new Sexual Orientation Monitoring information standard, to ensure local data is collected Sexual Orientation Monitoring Information Standard published October 2017 https://www.england.nhs.uk/about/equality/equality-hub/sexual-orientation-monitoring-information-standard/ • Borough Equality Profiles - including health profiles of each equality group • Access, Experience and Quality of care data as well as profile for equality and inequality groups with any identified differentials • Differentials in access, experience and quality of care in different health and care settings (e.g primary care, community care, acute – including mental health – care homes)

Goal	Outcome	Theme	Objectives	Lead	Description	Outcomes	Progress
							In terms of ownership of the project, this need to have the CCG Equality GB and Senior Exec lead to own it and champion it so that it moves forward. ➔ Senior Champion in each CCG –Stuart Dalton is for HCCG. Find out terms of reference and membership and latest minutes from steering group ➔ PPE strategy: demographic info included – JSNAs cover some protected characteristics. ➔ Map out what we already know from previous JSNAs – and work out what the gaps are. ➔ Public Health ➔ **PROGRESS:** BCF patient experience portal
			Improve Primary Care data collection for protected characteristics	Primary Care Team/ Engagement Team			- Each engagement lead working with their primary care team & GP Fed to determine level of uptake of registration

Goal	Outcome	Theme	Objectives	Lead	Description	Outcomes	Progress
							forms, review registration form and GP survey ensure covers all protected characteristics, and ensure that its use is promoted Consider implementation of "Pride in Practice" to ensure Primary Care is LGBT inclusive. Pride in Practice is a well-established programme from LGBT Foundation in Manchester for enabling Primary Care to be LGBT inclusive. It is being rolled out in some London boroughs e.g. Wandsworth. - - What is being done with the data? - How does this fit in with direction of travel - GP patient survey and registration forms? - Local Healthwatch data too - Analysis: who's accessing primary care, prevalence data, FFT, patient online
			Ensure consistency with the monitoring and the action planning of data	Contracts Team/ Commissioning Teams			- Different providers use different ways of gathering and

Goal	Outcome	Theme	Objectives	Lead	Description	Outcomes	Progress
			across providers at CQG's				monitoring: look at standard NHS contracts and ask contract teams - Assurance back from provider trusts on AIS: patient passport work. - Patient experience reports and Datix complaints reports etc and annual report. - Review the annual report and see what it tells us and it will flag up specific areas for more work. - Find out the data which has been collected. - Performance team to share breakdown – used not to have demographic breakdown but we might now. - PROGRESS: accessible info standard - For eng leads to check with contract teams previous quarterly and Dipen to look at latest pt experience report and demographics - Dipen to speak to all contracts teams to see what data they're collecting on equalities

Goal	Outcome	Theme	Objectives	Lead	Description	Outcomes	Progress
			Centrally monitor and strengthen governance around data collection and outcomes measurement of small contracts	Small Contracts Team/ Commissioning Teams			- Dipen to highlight to contract teams - Ensure outcomes uniform for 9 protected characteristics
			Co-design a series of workshops around outcomes measurement with Nesta and/or Health Foundation to ensure best practice, innovation and ROI ➔ Refresh this objective	SMT/Engagement Team			- Look at best practice on outcomes measurement – do we need standardised tools, advice, guidance. - Inclusive approach towards - Co-designing outcomes with the community - How we ensure we are measuring ROI - PROGRESS: STP engagement and BCF work service redesign and co-design, you said we did - Annual report – use this for evidence - & mapping how providers are doing this
		Accessing health services and reducing stigma	Establish and support the work of the Mental Health Transformation Board to improve patient access within North West London. Are there sufficient 'talking therapies' to meet the needs of diverse population at both	Mental Health Commissioning Team/Joint Commissioning Team	Central London, West London and Hammersmith & Fulham CCGs held an Equalities Workshop, with the aim of reviewing the last three year objectives and setting new priorities in February 2016. Concerns were raised by the stakeholders present around the: 1. The barriers our LGBT	• Patients are better informed about mental health and accessing services Commissioners understand the barriers to	Talk to Ray at CWHHE Consider:- 1. The barriers our LGBT community face in accessing health services 2. The inequalities faced by our BME population, particularly the Bangladeshi, Polish and Somali

Goal	Outcome	Theme	Objectives	Lead	Description	Outcomes	Progress
			primary and secondary care levels? ➔ **Self-management: Expert Patient Programme – recommendation of a way forward. Evidence collected. NWL – self-care programme: e.g. social prescribing, & Like-Minded** ➔ **Talk to Aaron Porter on the latest** ➔ **Community Champions work** ➔ **How we are addressing our objectives**		community face in accessing health services 2. The inequalities faced by our BME population, particularly the Bangladeshi We also have access to data from the BME Health Forum, local voluntary sector and Public Health	access • VCS is engaged as an active partner to support communities to access services without stigma • To see a decline in health inequality for BME	We also have access to data from the BME Health Forum, local voluntary sector and Public Health http://www.bmehf.org.uk/index.php/about/about-bme-health-forum/

Goal	Outcome	Theme	Objectives	Lead	Description	Outcomes	Progress
			Promote the self-management agenda, particularly the scope of the expert patient programme and the wider programme of work. This will ensure we commission services that reduce stigma and we support patients to have better management of conditions and decrease their attendance in primary or secondary care.	Commissioning Team/ Engagement Team			

Goal	Outcome	Theme	Objectives	Lead	Description	Outcomes	Progress
		Partnership working	Improve collaborative working across the system, particularly with the Voluntary and Community Sector through joint projects and the commissioning of a BME Health Forum in Hounslow	Engagement Team	The CCGs understand they need to work alongside colleagues across the health and social care landscape to reduce health inequalities They are exploring opportunities to share objectives with their local Councils and will ensure the objectives are reflective of wider strategies, such as the Health & Well-being Board Strategy There is already commitment by the CCGs to partnership working by the commissioning of a BME Health Forum in Hounslow, the Mental Health User Forum, the Diabetes Programme and Expert Patient Programme Contracts, as well as the Community Champions project	• Greater awareness of whole systems equalities objectives • Improved 360 data with providers • An increase in capacity for partnership working with voluntary sector	- Health and well-being equalities forum – action plan with voluntary sector - Rob Flann discuss with martin waddington - Sophie Bird on Diabetes User Group - Community champions, small grant projects, - Social prescribing model Seek alignment with Mayor of London's Health Inequalities Action Plan, especially investment in infrastructure to underpin social prescribing => early adopter or pilot - Awareness raising talks Community Champions funding – Aine Hayes, local authority. Be mindful of the capacity of such programmes in Hounslow, prevalence of in-work poverty, extended
			In the light of the wider system changes and the ideas around devolution, consider how we support infrastructure. This involves considering how to bring together investment and pool resource across Public Health, the Council and the CCGs	SMT/Engagement Team			

Goal	Outcome	Theme	Objectives	Lead	Description	Outcomes	Progress
							family caring responsibilities, geography etc may limit the number and scale of such volunteer activity. - - £35k a year to Voluntary and Community Sector programme – GP volunteers Community engagement gaps - Consider working with specific 'communities of interest' across multiple boroughs e.g. West London Alliance area, whereby they may have sufficient scale to engagement more than on an individual borough basis. N.B. communities are likely to be significantly different in Hounslow & other outer boroughs than K&C or Westminster - - Send Dipen HCCG engagement and communications strategy

Goal	Outcome	Theme	Objectives	Lead	Description	Outcomes	Progress
							- Co-production and co-design with VCS – could be a stretching objective to move us ahead on this. & sharing learning across CWHHE. - Ensuring representation across protected characteristics
A representative, supportive workforce	3.1,3.2, 3.3 & 3.4						- OD working group on 9 characteristic - Equalities in workforce - Healthy Workplace Charter - Staff survey - Disability confident employer - try to get level 1 – check with HR - LGBT network:- who does it report to? – to share with Dipen for comments and input - Look to adopt Workforce race equality standards: NHSE moving this forward to the CCGs. Talk to HR - Staff networks: Quality and Safety Committee (equalities attached to this)

Goal	Outcome	Theme	Objectives	Lead	Description	Outcomes	Progress
Inclusive Leadership	4.1, 4.2 & 4.3		Leaders can confidently articulate equalities challenges and progress across all protected characteristics				- Away days - Goals for our leaders - Equalities goals for our leaders - GP Federation - Snowy capped peaks report - Developing leaders: Governance leads can answer this - Training to GB - Looking to see what the last GB equalities training refresher involved and how we can follow on from that - Primary care strategy work and equalities training for GPs - Health inequalities workshops in Hounslow with VCS - Staff stories: protected characteristics – leaders - Regular stories to GB - Human Library – 9 protected characteristics and inclusion groups – each GB chooses a book what would be a positive patient story - Reverse mentoring for GBs