Newham London

NEWHAM

HEALTH EQUITY ROUTE MAPS.

WE ARE NEWHAM.

BUILDING A FAIRER NEWHAM

CONTENTS

COMMITMENT STATEMENT OF MY ORGANISATION/SERVICE

The first step is to adopt the co-created pledge statement and publish on the corporate website.
The second is to oversee an annual summary of progress.

I _____on behalf of my organisation _____, commit to adopt the Newham Health Equity Route map, and work to progress up its levels ambitions towards and equitable and effective health and care system for Newham. **DATE:** _____

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INTRODUCTION

Newham Health Equity Route Maps to Equitable Health and Care services.

These health equity route maps are designed to help those who provide commission or work in health and care services across Newham turn intentions and commitment to health equity into reality.

The frameworks are built upon the ideas, experiences and insight generated from two Newham Health Equity workshops, attended by people working in health and care services, service users, people with lived experience, the voluntary, community and faith sector and system leaders.

They provide a guide to taking practical steps and action to support services and pathways in the health and care system to take action on reducing health inequalities and promoting equity. They also contain a complementary maturity matrix for each 'level' which scaffolds and benchmarks the processes of discovery and change. Together they support partners in the Newham Health and care system to ask and answer the questions: 'How do we get to Good on Health Equity' and 'Are we there yet?'

There are three separate route-maps in this document, for different levels of the system. The three levels are organisation, service/department/team and individual. The board responsible for oversight of integrated health and care holds a separate fourth borough level system route map.

About the Route Maps

Domains for action

Each route map has six domains. The domains overlap across the different levels, especially domains for the organisation level route map and service/department/team level route-map. Key differences relate to different expectations around influencing, providing support for and delivery of health equity actions and ambitions.

Organisation level route-map:

What can the organisation do to address health inequity?

This is for those who have influence at a strategic/organisational level, and play a role in the running of the entire organisation including shaping and delivering the organisation's strategy. This will be relevant to directors and senior leaders. The domains include:

- Organisational readiness and structure – creating a culture of equity
- Workforce
- Understanding the health inequalities of the communities you serve and underserve
- Supporting service areas with designing and delivering interventions and activities to address inequities identified
- Working with communities
- Making your organisational accountable and responsible

Service/Department/Team route-map:

What can a service/department or team within an organisation do to address health inequity?

This is aimed at the different services, departments or teams within an organisation, and will be relevant to anyone from service managers, team leaders, team members, clinicians and other health care professionals, or any individual wanting to improve quality of the health care service they provide and address health inequities. Domains include:

- Service level readiness – creating a culture of equity
- Workforce
- Understanding the health equity of the communities you serve and underserve.
- Interventions and activities to address the inequities you find
- Working with communities
- Accountability and reporting

Individual Level:

What can I do to help address health inequity?

This guidance is for anyone working in health and care services to help them reflect on what their role is as an individual, and what they can do improve their own understanding of, and how they can contribute to addressing health inequities. Domains include:

- Reflection and understanding health inequity
- Listening and talking to patients, their carers and families
- Listening to and working with communities
- Understanding and addressing the health equity of the communities that make up Newham
- Advocacy
- Learning

Maturity Matrix

The organisational and service/team route maps also come with a complementary 'maturity matrix' of incremental actions and strategies needed to achieve health equity. Each domain outlined in the route-map has a section, which is then tiered in to 'fundamental', 'intermediate' and 'advanced' actions and strategies, indicating various stages of progress. The matrices can also be used as an assessment tool to evaluate the current level of progress towards equity goals.

Every organisation and service will be at a different stage of their health equity journey, and it's okay to be just starting out. It's important to remember this guidance is intended to support and motivate, helping to translate good intention into good action. Whilst the route-maps largely focus on health care services in Newham, the content can be adapted for different organisations involved in the health and wellbeing of Newham residents.

ORGANISATION LEVEL

What can the organisation do to address health inequity?

Domain 1: Organisational readiness and structure

Create a culture of equity, it takes more than just good intentions and a stated purpose

- Start the conversation - create the right space for honest, open and frank dialogue with staff, patients. residents and wider communities about inequity.
  - Acknowledge conversations may be difficult – develop or adapt guidelines and facilitation for having conversations about health equity to establish a set of behaviours and actions that create a space that fosters an inclusive and impactful exchange, and to minimise the risk of creating additional trauma. See for example, the 'See. Hear. Act' approach to discussing race produced by the Mass General Brigham, a Boston based not for profit health care organisation in the USA.
  - Have an offer of support in place to help those cope with any emotional impact of sharing experiences or triggered by listening to stories of lived experience.
- Develop a common language, where terminology is defined and provides a foundation for clear understanding.
- Leverage the people that work in the organisation to help leaders understand what's really happening, for example: community health teams/nurses are invited to board meetings to discuss what is happening in the community.
- Incorporate feedback from conversations into strategic health equity plans.
- Actively seek to hold sessions, events and debates about tackling inequality and inequity, and celebrating diversity e.g. celebrating Black History Month, Race Equality Matters, Pride, International Women's Day.
- Take action to increase awareness of ALL staff (including leadership) of structural determinants to health, including unconscious bias and systemic racism, and how these influence the development of culturally competent policies.
- Embed equity and acknowledge power dynamics into all quality improvement processes.
- Make a commitment to ensure equitable health care is prioritised and delivered to all persons through an overarching health equity plan. Echo commitments through written policies, protocols, pledges or strategic planning documents by organisational leadership and board of directors.

Domain 2: Workforce

Consider your workforce and how representative they are of the communities you work with

Your organisation my need to increase workforce diversity especially at leadership and governance levels.

- Carry out a workforce assessment of the organisation, including leadership teams and boards, to assess if it is reflective of the communities served.
- Put in place a strategy to ensure equitable recruitment - including peer reviewing of job applications before recruitment to remove any language or specifications that may exclude people or groups from applying, using recruitment platforms designed to facilitate equality and diversity, and using diverse panels at interview.
- Provide long term commitment to ensure the workforce at all levels is representative of the communities and populations it works with, through written policies, protocols, pledges or strategic planning documents by organisational leadership and board of directors.
- Consider the skills of your team so they can improve the quality of the relationships they build with residents.
- Train staff to have an understanding of the wider determinants of health.
- Train staff to use approaches like Making Every Contact Count (MECC) or MECC Plus to provide information or connect residents to other services that may benefit them
- Train staff to use strength based approaches or similar to allow people to identify their skills, abilities and relationships in order to recognise their own value, what is important to them and what they would like to achieve. It then allows a person to move that value forward and capitalize on their strengths, promoting empowerment.

Domain 3: Understand the health and challenges of the communities you serve and underserve.

The steps to make this happen may take place at service, department, team or pathway level. Where the below is happening at those levels, the organisation needs to ensure the right IT systems, policies, protocols, tools and resources (including human) are in place so that service/departments/pathway team can ensure they can do the following:

- Data quality and collection – make sure the right data is being collected including measures such as access, uptake, experience, outcomes, stratified by race, ethnicity, other protected characteristics and wider determinants of health – see maturity matrix below and data starter toolkit.
- Data sharing– allowing staff to access and use data (according to GDPR protocols) to help with quality improvement/equity work.
- Data stratification and analysis – having the right people with the right skills to be able to help with:
  - Looking at variety of measures such as access, uptake, experience, outcomes, stratified by race, ethnicity, other protected characteristics and wider determinants of health.
  - Asking the right questions to optimise the insight you generate from the data.
  - Triangulating quantitative and qualitative data to build a rich picture.
  - Creating health equity population profiles.
  - Identify what and where the issues are, and who they impact.
- Explore the cause using tools such as root cause analysis, qualitative research, deep dives – can be in partnership with other organisations e.g. VCFS, Public Health, other providers.

Domain 4: Interventions and activities to address inequities identified

Supporting service areas with designing and delivering

- Regularly communicate and promote across all service areas the need to develop interventions that take into account specific healthcare disparities in the primary service area. For example, redesign of processes, system improvement projects or development of new services. Conversely, have mechanisms in place to support upwards communication, where the need to develop interventions has been identified at service, team or individual level.
- Ensure there are the tools, resource and skills for service/departments to design and develop interventions that take into account specific healthcare inequities in their service area.
- Provide support for service areas/department so that they can actively involve key stakeholders including patients and families and/or community partners, especially those who are identified as underserved, in the planning, development and implementation of health equity interventions and strategies.
- Have processes in place for ongoing review, monitoring and evaluation and give service areas opportunity to amend/adjust interventions (as needed) to ensure outcomes are measured, evaluated and are sustainable.
- Hold service directors accountable for implementing interventions that demonstrate a meaningful impact on reducing healthcare inequities.

Domain 5: Working with communities

Develop and maintain strong networks and trusting relationships with community based groups, including those that don't usually have a seat at the table, and other organisations who serve priority populations

- Identify and assesses existing community partnerships and level of community participation to identify gaps or areas for enhancement for example: stakeholder mapping with community organisations is undertaken to identify any missing groups or where engagement can be strengthened.
- Identify community networks and understand how they work
- Agree an organisational approach to engaging with communities and community organisations, e.g. via numerous channels including a community advisory board, and has inclusive methods for gathering opinion.
- Actively seek representation from community groups to co-design, co-produce, co-deliver and co-monitor strategies, plans and interventions and fully embed the community voice into decision making, commissioning and priority setting.

Domain 6: Make your organisational accountable and responsible

- Be transparent about findings from data analysis and any further investigations, and communicate these to staff, service users, residents and wider communities.
- Use transparent reporting on your equity plans and achievement of equity goals/ KPIs
- Introduce a health equity scrutiny process and incorporate health equity into all quality improvement reporting processes/programmes.

ORGANISATION LEVEL HEALTH EQUITY ROUTE MAP (MATURITY MATRIX)

STEP	AREA	FUNDAMENTAL	INTERMEDIATE	ADVANCED
Create a culture of equity	**Starting the conversation**	Organisation uses internal communications to raise awareness about health equity and health equity missions, and has a process in place to gather staff feedback and opinions on the organisation's current health equity efforts.	Organisations uses different communications vehicles to 'start the conversation' on health equity with staff, residents, community groups other key stakeholders and organisations, with a process in place to gather feedback and opinions on the organisation's current health equity efforts. Organisation leverages the people that work in the organisation to help leaders understand what's really happening. For example: community health teams/nurses are invited to board meetings to discuss what is happening in the community. The organisation actively seeks to hold sessions, events and debates about tackling inequality and celebrating diversity e.g. Unconscious bias training, celebrating Black History Month, Race Equality Matters, Pride, International Women's Day.	Organisation actively seeks feedback from residents, using inclusive methods, on perception of the organisation and its current efforts to address health inequity, and develops a common language, where terminology is defined and provides a foundation for clear understanding. Feedback is analysed and used in organisational strategic equity planning and communicated to all staff/teams.
	Learning and commitment	Everyone, including leaders and senior management, undertakes training on structural determinants to health, including unconscious bias and systemic racism, and how these influence the development of culturally competent policies.	Training should routinely involve community, patient and family/carer input and can include cultural competency/intelligence regarding racial and ethnic minorities; patients with physical and mental disabilities. The organisation has named an individual (or individuals) who has leadership responsibility and accountability for health equity efforts, engages with clinical champions, patients and families and/or community partners.	Organisation has made a commitment to ensure equitable health care is prioritized and delivered to all persons an overarching health equity plan. Commitments are echoed through written policies, protocols, pledges. Commitment to priorities are understood by all staff and broadly communicated to external stakeholders. Health equity is embedded into all quality improvement processes and programmes.

STEP	AREA	FUNDAMENTAL	INTERMEDIATE	ADVANCED
Workforce	**Workforce diversity**	A workforce assessment is carried out of organisation, including leadership teams and boards, to assess if it is reflective of the communities served the across the organization.	Strategy is in place to ensure equitable recruitment – including to leadership and boards, including peer reviewing of job applications before recruitment to remove any language or specifications that may exclude people or groups from applying, using recruitment platforms designed to facilitate equality and diversity, using diverse panels at interview. Opportunities for progression are equitable and access to experience is available through things such as mentoring, internships or apprenticeships.	Long term commitment to ensure there is workforce, at all levels, including leadership teams and boards, is representative of the communities and populations who it serves, through written policies, protocols, pledges or strategic planning documents by organisational leadership and board of directors.
	Considering the skills of your team and how they can be used to improve the relationships they build with residents	Staff are trained to have an understanding of the wider determinants of health.	Staff are trained in and use approaches like Making Every Contact Count (MECC) or MECC Plus to provide information or connect residents to other services that may benefit them.	Staff are trained to use strength based approaches or similar to allows for people to see themselves at their best in order to see their own value.
Understanding the health challenges of the communities you serve	**Collecting the right data: quantitative data**	Policies and IT systems are in place so that services collect race, ethnicity and language data for at least 95% of their patients with opportunity for verification at multiple points of care, inpatient units, etc). Data is self-reported to collect race, ethnicity and language for all patients. More detailed categories as used in the latest Census should be used, and clear, reassuring explanations given as to why this data is collected (i.e. for health equity purposes). Staff are trained in how to collect race, ethnicity and language data and the reasons why this data is important for health equity planning and goals.	Policies and IT systems are in place so other patient self-reported demographic data is collected i.e. other protected characteristics, geography, mental illness, resident/migrant status, employment and/or other social determinants of health (SDOH) or social risk factors. Staff are trained in how to collect self-reported data and the reasons why this data is important for health equity planning and goals.	Collected data can be accessed and used at all levels within the organisation, for analysis purposes, whilst conforming to GDPR policies. For example, removing identifiers where necessary so workforce can access data for purposes of informing health equity strategies and interventions.

STEP	AREA	FUNDAMENTAL	INTERMEDIATE	ADVANCED
	Collecting the right data: qualitative data	Assessment is undertaken of the current ways the organisations engages with communities to get insight into the health inequities they face. For example, the organisation undertakes an audit of methods used by its services to get community insight, with a view to seeing where there are gaps or areas for enhancement.	Uses the community relationships established and uses appropriate and inclusive methods for seeking information and stories from residents and communities to generate insight to help build a picture of health inequities. Questions are co-designed where possible, and tested to ensure they are the 'right' questions. E.g. inclusive community surveys with co-designed questions about patient experiences carried are out on a regular basis. E.g. Active listening techniques are used to in collecting the stories and experiences of residents.	Data can be accessed and used at all levels within the organisation, for analysis purposes, whilst conforming to GDPR policies. For example, removing identifiers where needed so workforce can access data for purposes of informing health equity strategies and interventions.
	Analysing the data: thinking about what the data tells us.	Policies, systems and resources (e.g. skilled workforce) are in place so that data can regularly be stratified and analysed by at least one safety/ quality/access outcome measure by race and ethnicity and a process to evaluate and compare service level data to local demographic community data/ regional data/ national data is in place.	Policies, systems and resources (e.g. skilled workforce) are in place so that data is stratified and analysed more than one safety/quality/access outcome measure by race and ethnicity, and by other protected characteristics, geography, mental illness, migrant status, employment and/or other SDOH risk factors.	Stratified data is used to produce community health profiles which are made available for all departments and teams to use for identifying health inequities/potential health inequities and informing planning. Tools are resources are available to help clinical services/departments investigate causes of inequity e.g. through Quality Improvement processes, root cause analysis, qualitative research, deep dives.

STEP	AREA	FUNDAMENTAL	INTERMEDIATE	ADVANCED
Supporting service areas with designing and delivering interventions and activities to address the inequities they find	**Interventions and actions to address health inequalities and inequities**	Organisation regularly promotes to services the need to develop interventions that take into account specific healthcare disparities in the primary service area. For example, redesign of processes, system improvement projects or development of new services.	Organisation ensures there are the tools, resource and skills for service/departments to design and develop interventions that take into account specific healthcare inequities in their service area. Service users, resident groups and underserved communities are consulted in intervention design	Service/department actively involves key stakeholders including patients and families and/or community partners, especially those who are identified as underserved, in the planning, development and implementation of health equity interventions and strategies. Has a process in place for ongoing review, monitoring and evaluation and opportunity to amend/adjust interventions (as needed) to ensure outcomes are measure, evaluated and are sustainable. Board holds service directors accountable for implementing interventions that demonstrate a meaningful impact on reducing healthcare inequities.
Working with people and communities	**Co- production & developing and maintaining strong networks and trusting relationships with community-based groups**	Organisation identifies and assesses existing community partnerships and level of community engagement to identify gaps or areas for enhancement for example: stakeholder mapping with community organisations is undertaken to identify any missing groups or where engagement can be strengthened. Networks are identified and understood.	Approach agreed to engaging with communities and community organisations, e.g. via numerous channels including a community advisory board, and has inclusive methods for gathering opinion. For example: Community consultation results inform strategic planning and decision-making.	Organisation actively seeks to co-design and co-produce strategies, plans and interventions and fully embed the community voice in decision making and priority setting

STEP	AREA	FUNDAMENTAL	INTERMEDIATE	ADVANCED
Reporting and scrutiny	**Accountability**	Organisation has Health Equity Strategic plan and associated measurable outcomes/KPIs.	Organisation implements strategic plan and holds to account services/departments in producing their own equity plans with associated measurable outcomes/KPIs. Disproportionality/health equity improvement goals are widely communicated and incorporated into organisational performance dashboards.	Inequity data is reviewed and monitored on a regular basis, and reports made and shared, including recommendations. Scrutiny panels assess level of success/identify issues with delivery of plans.

SERVICE/DEPARTMENT/TEAM LEVEL

What can a service/department or team within an organisation do to address health inequity?

Domain 1: Service area readiness

Creating a culture of equity - it takes more than just good intentions and a stated purpose

- Start the conversation - Have open and frank dialogue with team members, patients, residents and the communities you work with about health inequities.
  - Acknowledge conversations may be difficult – develop or adapt guidelines and facilitation for having conversations about health equity to establish a set of behaviours and actions that create a space that fosters an inclusive and impactful exchange, and to minimise the risk of creating additional trauma. See for example, the 'See. Hear. Act' approach to discussing race produced by the Mass General Brigham, a Boston based not for profit health care organisation in the USA. Consider working with local facilitators like Variety Pack or Red Quadrant to improve skills and awareness.
  - Have an offer of support in place to help those cope with any emotional impact of sharing experiences or triggered by listening to stories of lived experience.
- Develop a common language (if not developed at organisational level), where terminology is defined and provides a foundation for clear understanding.
- Get involved in or hold learning sessions, events and debates about tackling inequality and celebrating diversity e.g. Unconscious bias training, celebrating Black History Month, Race Equality Matters, Pride, International Womens' Day.
- Feedback from all equity conversations is incorporated into agreed areas or ambitions for the service/team.
- Train team members, including managers, in structural determinants to health, including unconscious bias and systemic racism and incorporate service user experience into training plans.
- Embed organisational values on equity into everyday practice.
- Embed equity and acknowledge power dynamics into all quality improvement processes.

Domain 2: Workforce

Consider the diversity of your team and how representative it is of the communities you work with

- Carry out a workforce assessment of service's team/s staff including management to assess if it is reflective of the communities it serves/reflective of local population.
- Put in place strategies to ensure equitable recruitment - including peer reviewing of job applications before recruitment to remove any language or specifications that may exclude people or groups from applying, using recruitment platforms designed to facilitate equality and diversity, using diverse panels at interview.
- Ensure opportunities for progression in the team are equitable and CPD and access to work experience is made available through things such as shadowing, mentoring, internships or apprenticeships.

Consider the skills of your team so they can improve the quality of the relationships they build with residents

- Train staff to have an understanding of the wider determinants of health.
- Train staff to approaches like Making Every Contact Count (MECC) or MECC Plus to provide information or connect residents to other services that may benefit them.
- Train staff to use strength based approaches or similar to allow people to identify their skills, abilities and relationships in order to recognise their own value, what is important to them and what they would like to achieve. It then allows a person to move that value forward and capitalize on their strengths, promoting empowerment.

Domain 3: Understanding the health equity of the communities you serve and underserve. (See Newham data starter kit for more detail)

- Data quality and collection – make sure the right data is being collected, including measures such as access, uptake, experience, outcomes, stratified by race, ethnicity, other protected characteristics and wider determinants of health (see maturity matrix below and data starter toolkit for more detail).
- Data stratification and analysis
  - Think about the right questions you need to ask to optimise the insight you generate from the data.
  - review your service data on a variety of measures such as prevalence, access, uptake, experience, outcomes, stratified by race, ethnicity (using Office for National Statistics/Census categories), other protected characteristics and wider determinants of health.
  - Gather more data through speaking with and listening to people, understand their experiences and stories. Triangulate quantitative and qualitative data to build a rich picture.
  - Create health equity population profiles.
  - Identify what and where the issues are, and who they impact.
- Explore the cause of inequity using tools such as Quality Improvement, root cause analysis, qualitative research, deep dives – can be in partnership with other organisations e.g. VCFS, Public Health, other providers.

Domain 4: Interventions and activities to address the inequities you find

Designing local plans, interventions and activities

- When you know what the inequity is, think about the intervention or activity needed to address it. There are lots of tools and frameworks that can help assess impact of current or new services, policies and practice on health inequalities, and processes that can help identify health inequity sources. See (See Newham data starter kit for more detail).
- You may need to form a project group or similar to get started.
- Consider who the groups the activity is targeting (can be, and is often more than one for successful change to happen):
  - Patient
  - Communities or certain population groups
  - Departments or teams/pathways
  - Workforce groups
  - Whole organisation
  - Policy
- Think about whether your service is accessible, relevant, and trusted (ART) to the groups who should be using it.
- Look at the evidence to see what intervention may work to address the particular issue for the particular audience.
- Embed engagement with service users, their carers and families, communities and underserved communities ideally co-producing or co-designing activities.
- Think about unintended consequences as well as intended ones.
- Think about and develop outcome measures and an evaluation plan.

Implementing plans and activities

- Prototype and pilot interventions and activities, using multidisciplinary teams, including patient and community groups.
- Use tools and frameworks such as PDSA (Plan, Do, Study, Act), design thinking and behavioural science.
- Learn as you go and be transparent with what you find - actively involve key stakeholders including patients and families and/or community partners, especially those who are identified as underserved.
- Measure the impact effectively and accurately and communicate results of the intervention internally to the wider organisation and to external stakeholders including residents and community groups.
- Has a process in place for ongoing review, monitoring and evaluation and opportunity to amend/adjust interventions (as needed) to ensure outcomes are measure, evaluated and are sustainable.
- Board/senior management teams holds service directors accountable for implementing interventions that demonstrate a meaningful impact on reducing healthcare inequities.

Domain 5: Working with communities

Develop and maintain strong networks and trusting relationships with community based groups, including those that don't usually have a seat at the table, and other organisations who serve priority populations

- Identify and assesses existing community partnerships and level of community participation to identify gaps or areas for enhancement for example: stakeholder mapping with community organisations is undertaken to identify any missing groups or where engagement can be strengthened, or system mapping to identify system players and levers.
- Identify and understand existing networks. Have an agreed approach to engaging with communities and community organisations, e.g. via numerous channels including a community advisory board, and has inclusive methods for gathering opinion. For example: Community consultation results inform equity plans/ intervention design and delivery.
- Actively seek representation from community groups to co-design, co-produce, co-deliver and co-monitor strategies, plans and interventions and fully embed the community voice into decision making, commissioning and priority setting.

Domain 6: Accountability and reporting

- Incorporate Health Equity in plans and develops associated measurable outcomes/ KPIs.
- Ensure your service/department is accountable for delivering on plans via reporting
  - Be transparent about findings from data analysis and any further investigations, and these to staff, service users, residents and wider communities.
  - Inequity data is reviewed and monitored on a regular basis, and reports made and shared, including recommendations.
  - Use transparent reporting on your delivery of your equity plans and achievement of equity goals/KPIs, including reporting to senior boards and patient groups to demonstrate meaningful progress.

SERVICE/DEPARTMENT/TEAM LEVEL HEALTH EQUITY ROUTE MAP (MATURITY MATRIX):

STEP	AREA	FUNDAMENTAL	INTERMEDIATE	ADVANCED
Create a culture of equity	**Starting the conversation**	Managers and team leaders create a space for open and honest conversations on health equity, bias and racism, for example through workshops, facilitated conversations.	Team members have regular opportunity for voicing opinions and managers actively encourage views to be aired. Teams get lead on/get involved in or hold learning sessions, events and debates about tackling inequality and celebrating diversity e.g. Unconscious bias training, celebrating Black History Month, Race Equality Matters, Pride, International Women's Day.	Service/department/team actively seeks feedback from residents, using inclusive methods, on perception of the service and its current efforts to address health inequity. A common language (if not developed at organisational level) is agreed, where terminology is defined and provides a foundation for clear understanding. Feedback is incorporated into agreed priority targets for the service/team.
	Learning and commitment	All team members undertake training on structural determinants to health, including unconscious bias and systemic racism and how they impact delivery of health care.	Training routinely involves community, patient and family/carer input and includes cultural competency/ intelligence regarding racial and ethnic minorities; patients with physical and mental disabilities.	The team has made a commitment to ensure equitable health care is prioritized and delivered to all persons, through adhering to organisational equity policies, team pledges and in service planning documents. Commitment to these priorities is understood by all team members and broadly communicated to external stakeholders. Health equity is embedded into all quality improvement processes and programmes.

STEP	AREA	FUNDAMENTAL	INTERMEDIATE	ADVANCED
Workforce	**Considering the diversity of your team and how representative it is of the communities you work with**	Workforce assessment is carried out of service's team/s staff including management to assess if it is reflective of the communities it serves/reflective of local population.	Strategy is in place to ensure equitable recruitment - including peer reviewing of job applications before recruitment to remove any language or specifications that may exclude people or groups from applying, using recruitment platforms designed to facilitate equality and diversity, using diverse panels at interview.	Opportunities for progression in the team are equitable and CPD and access to work experience is made available through things such as shadowing, mentoring, internships or apprenticeships.
	Considering the skills of your team and they can be used to improve the relationships they build with residents	Staff are trained to have an understanding of the wider determinants of health.	Staff are trained in and use approaches like Making Every Contact Count (MECC) or MECC Plus to provide information or connect residents to other services that may benefit them.	Staff are trained to use strength-based approaches or similar to allows for people to see themselves at their best in order to see their own value. It then allows a person to move that value forward and build on their strengths rather than focus on their negative characteristics. Staff are supported to explore listening, cultural safety /cultural competence /allyship via training.

STEP	AREA	FUNDAMENTAL	INTERMEDIATE	ADVANCED
Understanding the health equity (inequity) of the communities you serve	**Collecting the right data: quantitative data**	Service collects race, ethnicity and language data for at least 95% of their patients with opportunity for verification at multiple points of care, inpatient units, etc). Data is self-reported to collect race, ethnicity and language for all patients. Seek to make this standard and comparable, and appropriate to local demographics- More detailed categories, as used by ONS, should be used. Clear, reassuring explanations given as to why this data is collected (i.e. for health equity purposes). Staff are trained in how to collect race, ethnicity and language data and the reasons why this data is important for health equity planning and goals.	Service collects other patient self-reported demographic data is collected. i.e. other protected characteristics, geography, mental illness, resident/ migrant status, employment and/or other social determinants of health (SDOH) or social risk factors. Staff are trained in how to collect self-reported data and the reasons why this data is important for health equity and the reasons why this data is important for health equity planning and goals.	Collected data can be accessed and used at all levels across the service, for analysis purposes, whilst conforming to GDPR policies. For example, removing identifiers where necessary so team members can access data for purposes of informing health equity strategies and interventions.
	Collecting the right data: qualitative data	Assessment is undertaken of the current ways the service / team engages with communities to get insight into the health inequities they face. For example, the service/team undertakes an audit of methods used to get community insight, with a view to seeing where there are gaps or areas for enhancement.	Uses the community relationships established and uses appropriate and inclusive methods for seeking information and stories from residents and communities to generate insight to help build a picture of health inequities. Questions are co-designed where possible, and tested to ensure they are the 'right' questions. E.g. inclusive community surveys with co-designed questions about patient experiences carried are out on a regular basis. E.g. Active listening techniques are used to in collecting the stories and experiences of residents.	Data can be accessed and used at all levels across the service, for analysis purposes, whilst conforming to GDPR policies. For example, removing identifiers where needed so workforce can access data for purposes of informing health equity strategies and interventions.

STEP	AREA	FUNDAMENTAL	INTERMEDIATE	ADVANCED
Understanding the health equity (inequity) of the communities you serve	**Analysing the data: thinking about what the data tells us.**	Appropriate systems and resources (e.g. skilled staff in the team, or access to analytical support) are in place so that data can regularly be stratified and analysed by at least one safety/quality/access outcome measure, by race and ethnicity and, a process to evaluate and compare service level data to local demographic community data/ regional data/ national data is in place.	Appropriate systems and resources (e.g. skilled staff or access to analytical support) are in place so that data is stratified and analysed more than one safety/quality/access outcome measure by race and ethnicity, and by other protected characteristics, geography, mental illness, migrant status, employment and/or other SDOH risk factors.	Disproportionality and inequities in outcomes are rigorously analysed. Stratified data is used to produce community health profiles for the service / pathway. For example: Equity audits and impact assessments are incorporated into decision making and service planning. Causes of inequity are investigated using tools e.g. Quality Improvement, root cause analysis, qualitative research, deep dives – can be in partnership with other organisations e.g. VCFS, Public Health, other providers. Findings inform plans, resource allocation and disparity improvement goals. The findings are reported to the wider team and also to senior management/board.
Designing and implementing local plans, interventions and activities to address the inequities you find and the causes you have identified	**Interventions and activities to address health inequalities & inequity**	Clinical services develop pilot interventions that take into account specific healthcare disparities in the primary service area. For example, redesign of processes, system improvement projects or development of new services.	Service/teams implement interventions that take into account specific healthcare inequities in their service area, and reports / educates staff on regarding outcomes. Service users, resident groups and underserved communities are consulted in intervention design.	Service/department actively involves key stakeholders including patients and families and/ or community partners, especially those who are identified as underserved, in the planning, development and implementation of health equity interventions and strategies. Has a process in place for ongoing review, monitoring and evaluation and opportunity to amend/adjust interventions (as needed) to ensure outcomes are measure, evaluated and are sustainable. Board holds service directors accountable for implementing interventions that demonstrate a meaningful impact on reducing healthcare inequities.

STEP	AREA	FUNDAMENTAL	INTERMEDIATE	ADVANCED
Working with people and communities	**Co- production & developing and maintaining strong networks and trusting relationships with community-based groups**	Service/team identifies and assesses existing community partnerships and level of community engagement to identify gaps or areas for enhancement For example: stakeholder mapping with community organisations is undertaken to identify any missing groups or where engagement can be strengthened. Networks are identified and understood.	Service has an agreed approach to engaging with communities and community organisations, e.g. via numerous channels including a community advisory board, and has inclusive methods for gathering opinion. For example: Community consultation results inform equity plans/intervention design and delivery.	Organisation actively seeks to co-design co-produce, co-deliver and co-monitor strategies, plans and interventions and fully embed the community voice into decision making and priority setting.
Reporting and scrutiny	**Accountability**	Service/department has incorporated Health Equity in plans and develops associated measurable outcomes/KPIs.	Service/department implements strategic plan and holds to account services/departments in producing their own equity plans with associated measurable outcomes/KPIs. Disproportionality/health equity improvement goals are widely communicated to senior leadership and community stakeholders.	Inequity data is reviewed and monitored on a regular basis, and reports made and shared, including recommendations. Services report into organisational boards or committees to demonstrate meaningful progress.

INDIVIDUAL LEVEL

What can you do to address health inequity?

Domain 1: Reflection and understanding health inequity

- Start or get involved in the conversation - be open to having honest and frank (and sometimes uncomfortable) dialogue with other team members, patients, residents and the communities you work with about health inequities. Conversations can be difficult or make you feel uncomfortable. Research guidelines or toolkits designed to help having these conversations, for example the 'See. Hear. Act' approach to discussing race produced by the Mass General Brigham, a hospital in the USA.
- Reflect on your own experiences, opinions, biases, and begin to do this before you start to have conversations about equity.
- Listen to the communities your service is aimed at and seek to listen to those you may be underserve. Respectfully ask about and listen to their stories and experiences.
- Think about where you can read about wider determinants of health and how they may impact the health needs and outcomes of different people and communities.
- Attend training designed to increase your awareness on unconscious bias, racism, equity, other protected characteristics, and social determinants of health.
- Get involved in running or attend hold learning sessions, events and debates about tackling inequality and celebrating diversity e.g. Unconscious bias training, celebrating Black History Month, Race Equality Matters. Remember other intersectionalities e.g. sex/gender.
- Reframe any perceptions of 'hard to reach populations' by looking at it as the problem being in the approach for reaching them.

Domain 2: Listening and talking to patients, their carers and families

- Develop professional curiosity and practice active listening to understand what matters to people (patients, people we work with, residents we are attending to), understand their experiences and any inequities they face.
- Think about how you can be flexible when considering individual needs, for example language support, cultural and religious context, digital access or lack of access.
- Consider ways to support individuals in a wider sense by thinking about other services that may be help, or link them in with other support networks or groups for more holistic care. Learn about approaches like Making Every Contact Count (MECC) or MECC Plus to provide information or signpost residents to other services that may benefit them.
- Learn about strength based approaches or similar to allow for people to see themselves at their best in order to see their own value. It then allows a person to move that value forward and capitalize on their strengths rather than focus on their negative characteristics.

Domain 3: Listening to and working with communities

- Listen to those whose voices are not often heard, or communities that are not accessing or using your service when they perhaps should be, and engage these groups in to planning and decision making when making changes.
- Read about co-production, co-design, assets-based approaches and community hosting (see for example King's fund explainer **https://www.kingsfund.org.uk/publications/communities-and-health**).
- Use co-design and co-production approaches in service redesign and interventions.
- Build trust with communities and establish networks that you can draw upon to support design and delivery of health equity plans.

Domain 4: Understanding and addressing the health equity of the communities that make up Newham.

Thinking about the data you collect, what it tells you and where the gaps/issues are.

- Be curious. Seek to learn and understand data, what data you should be collecting, and how you can analyse it.
- Learn about a variety of measures such as prevalence of disease, access, uptake and experience or services, and health outcomes, and how these can be stratified by race, ethnicity, other protected characteristics and wider determinants of health.
- Incorporate understanding inequity into your day to day work to help build a bigger and better picture of health inequities.
  - Where you can, listen and engage with residents, to understand their experiences and stories, to build a rich picture.
  - Create, or ask relevant teams or departments (for example, data intelligence teams) to create health equity population profiles.
  - Identify where the issues are, and who they impact.
- Get involved in health equity data activities, such as being part of an exercise in data collection or data analysis. Domain 3 in the service/department/team route map takes you through the things you should consider, and the Newham Basic Equity Starter Toolkit provides practical steps to get started.
- Get involved in designing and delivering interventions and activities to address inequity in a service area Domain 4 in the service/department/team route map takes you through some practical steps.

Domain 5: Advocacy

- Speak up at the next meeting you're in to ensure health equity remains a priority.
- Advocate for individual patients and their families and speak up for them where necessary when engaging with other health professionals who share responsibility for their care.
- Advocate for a greater focus on the social determinants of health in practice and education in your service / Trust.

Domain 6: Learning

- Share findings with other colleagues about inequities gaps and issues and encourage open conversation and dialogue about health inequities.
- Share work you are doing or plan to do to tackle inequity and disproportionality.
- Share learning from activities that went well as well as what didn't work.
- Think about forming or joining a community of practice – a group of stakeholders sharing a practice /service area of interest who wish to work together to co curate, share and disseminate challenges and tips, ideas and evidence, here to support embedding equity promoting health and care delivery.

Newham Health Equity Route Maps and Maturity Matrices

Newham Council Public Health, 2022

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Acknowledgements: The frameworks are built upon the ideas, experiences and insight generated from two Newham Health Equity workshops, attended by people working in health and care services, service users, people with lived experience, the voluntary, community and faith sector and system leaders. We would like to thank everyone who attended for their valuable contributions.