Appendix 1: Lewisham Health Inequalities & Health Equity Programme:

Workforce Toolbox Summary & Recommendations

1. Introduction

1.1 A key component of addressing health inequalities in Lewisham is increasing awareness and capacity for health equity within practice. The Workforce Toolbox workstream of the Lewisham Health Inequalities and Health Equity Programme 2022 – 24 aims to do so by:

- Developing resources for staff, volunteers, and others to develop knowledge and skills for health equity.
- Supporting the upskilling of workforce on capability, opportunities, and motivations.

1.2 Through the development of the workstream, the workstream group agreed that to achieve the aforementioned aim, a Workforce Toolbox made up of a range of health inequalities related training and resources needed to be developed and implemented across the Lewisham Health and Care Partnership to staff.

1.3 This paper covers the process that the Workforce Toolbox workstream group have followed, the training needs assessment questionnaire, best practice from elsewhere, the initial options considered and our recommendation to the Health and Wellbeing Board.

2 Background & Rationale

2.1 A decision was taken at the September 2021 meeting of the Health and Wellbeing Board, to plan the next steps for the Board's work to address health inequalities in Lewisham. A developmental approach was agreed to support system leader and organisational change through supporting individual development and organisational development.

2.2 A refreshed plan of action to tackle health inequalities and work towards achieving health equity in Lewisham was proposed and developed in March 2022. The plan covered the next two years taking learning from the challenges identified from the existing work and building on the achievements and opportunities to take the work forward with stakeholders. An outline of the proposed health inequalities and health equity programme includes eight intersecting work streams being progressed over 2022/23 – 2023/24

2.3 Resourcing from Health and Wellbeing Board partners was secured to develop, co-produce and implement this plan, aiming to take a community-centred approach in tackling health inequalities to achieve health equity in Lewisham. This work aimed to build on community-centred approaches taken to date in line with those outlined in the Public Health England (PHE) Community-centred public health: taking a whole system approach.

2.4 Building trust and collaboration with communities is a key part of this work and includes a continued focus on tackling ethnic health inequalities particularly for Black and other racially minoritised communities within Lewisham.

2.5 Part of the ambitions of the programme is to increase awareness and capacity for health equity within practice by developing resources for staff, volunteers, and others to develop knowledge and skills for health equity. This will be supported by the prioritisation and implementation of specific opportunities for action (OFA's) from the BLACHIR report as part of the proposed programme, to support the upskilling of the workforce on capability, opportunities and motivations.

2.6 The following BLACHIR opportunities for action recommend:

- Local Councils and Health and Wellbeing Board Partners - BLACHIR OFA 3: Review staff equality and diversity training to ensure that this is a core part of the delivery of training, co-delivered by diverse individuals with lived experience.
- Local NHS providers and Community Mental Health Trusts - BLACHIR OFA 23: Ensure practitioners use culturally competent (cultural understanding) trauma informed patient-centred engagement styles and interventions.

- Local Health and Wellbeing Boards and Integrated Care System Partnerships - BLACHIR OFA 25: Promote cultural competency training within healthcare services, the criminal justice system, and the police force.
- Local Health and Wellbeing Boards and Integrated Care Systems - BLACHIR OFA 26: Apply the use of culturally competent language, including using language that considers stigma within communities, such as 'wellbeing' rather than 'mental health'.
- Local Directors of Public Health and NHS Prevention Leads - BLACHIR OFA 35: Ensure prevention services are fair, appropriate and consider the needs of Black African and Black Caribbean populations, and there is proactive work to address issues with health literacy. This could include:
- Whole system workforces, across all partners and professions including front-line, back-office and system leaders, to complete anti-racism training, with ongoing independent evaluation

3 Process Followed

3.1 The Workforce Toolbox workstream of the Lewisham Health Inequalities and Health Equity Programme 2022-24 was initiated in July 2022. The terms of reference were written and agreed by the group. A concerted effort was made to engage and involve a wide range of stakeholders across the Partnership both in and out of the workstream meetings. This has continued up until the present day. The logic model for the workstream was also developed during this first phase.

3.2 The workstream group then aimed to conduct a scoping exercise to find out the details of the respective teams, services and organisations' learning and development offer in relation to health inequalities. To do so, members of the Public Health Team created a training needs assessment questionnaire for stakeholders to complete to provide these details. The results can be found in the next section. Engagement in this workstream hasn't always been at the desired level and the same was true of the response rate to the questionnaire.

3.3 Following the questionnaire, we used this to frame our discussion around current provision, the gaps in our offer and the options we could take to achieve the workstream's aims. These options, the discussion that followed and our recommendation can be found in the following sections.

4 Training Needs Assessment Questionnaire

4.1 A training needs assessment questionnaire was sent out to representatives from across the Lewisham Health & Care Partnership to gather best practice on training and resources in relation to health inequalities as well as to identify gaps in current provision. The response rate was not as high as desired but of those that responded, rich information was gained.

5 Best Practice from London Councils

5.1 London Councils have developed a Tackling Racial Inequality standard that details three levels of practice for work programmes, initiatives and practices on race equality:

Developing practice (1 point)	Established practice (2 points)	Leading practice (3 points)
Inclusive mentoring programmes are established with a matching scheme.		Inclusive mentoring and reverse mentoring programmes are established with a matching scheme that provides mentor support.
Black, Asian and Ethnic Multi-Ethnic staff and line managers		

have regular 1-2-1 meetings, which focus on career aspirations and development.		
There are dedicated resources available and accessible for supporting the development of Black, Asian and Ethnic Multi-Ethnic staff.		
	Facilitator-led workshops are mandatory for all staff focusing on anti-racism and EDI, including types of bias and micro-aggressions.	
	Data arising from annual staff surveys are used to design EDI training.	Data arising from annual staff surveys and facilitated safe spaces are used to design EDI training.
	Mandatory EDI recruitment training for all hiring managers, including combatting types of bias.	Mandatory EDI recruitment training for all hiring managers, including combatting types of bias and anti-racist hiring practice. Specialist EDI training and initiatives for the hiring process in Senior Leadership Teams.
		Leadership training is specifically designed for Black, Asian and Ethnic Multi-Ethnic staff to facilitate the progression of diverse staff and close the ethnicity pay gap.

5.2 The standard is instructive in setting our ambitions and assessing our performance on the journey to achieving those ambitions and maintaining the standard.

6 Initial Options Considered

6.1 The following options were initially considered by the workstream group.

6.2 Option 1: In-house training

6.2.1 This option would utilise best practice from all partners and would deliver the training in-house. The best practice identified through the training needs assessment questionnaire would be utilised.

6.2.2 This option would rely on partners committing to extending current training initiatives to wider partners. There would be a significant resource implication as a result. There are some gaps within the pooled training offer and these would either need to be answered or left to persist.

6.2.3 This option is likely to be the least costly and would draw upon the extensive areas of best practice we have across our partners.

6.3 Option 2: Commissioned training

6.3.1 The second option is to commission an organisation or organisations to co-design and deliver the entirety of the training.

6.3.2 This option is likely to be the costliest financially. The timelines of a commissioning process would also need to be considered.

6.3.3 This option would, however, allow us the opportunity to co-design in detail the training that is identified as needed. It carries less of a resource implication for our workforce. It also allows us to widen our pool of expertise in working with providers.

6.4 Option 3: Mixture of in-house and commissioned training

6.4.1 Responses from the Workforce Toolbox Training Needs Assessment Questionnaire, which was circulated to staff members from across the workforce (February 2023), has identified some areas of best practice of training being offered across the workforce.

6.4.2 Taking into consideration recommendations from Health and Wellbeing Board partners, the opportunities for action from the BLACHIR report and the survey results it would be beneficial to further build on the already established workforce training. The training should also include an element of evidence-based training delivered by an experienced external provider.

6.4.3 Additional recommendations for development of this training should consider that the training needs to be tailored to the need of the whole system. This should also include working with local communities and grass roots organisations to co-design it. Learning and meaningful measurement of change should be captured throughout the training cycle to inform evaluation and future training programme design.

7 Discussion Following Options Appraisal

7.1 The workstream group considered the options detailed above in a workstream meeting. The group made some key observations and suggestions:

- The name 'Workforce Toolbox' should be changed so that it more accurately describes what it is
- Communities should be involved in the development of the Workforce Toolbox
- That training should be mandatory
- It should be available to voluntary and community sector groups too
- Training sessions should be held in person where possible
- The impact should be measured effectively
- The Workforce Toolbox needs to be owned by the Partnership and strong commitment is needed by leadership
- That leadership should be trained first
- The Workforce Toolbox should be tailored for the Lewisham workforce

8 Recommendation

8.1 Taking into consideration the resource implications and funding available to this Programme, we recommend that we commission an organisation to develop a framework for the Workforce Toolbox including what training to deliver and how to deliver it according to our aims and the standard we want to achieve. This framework can then be used by all partners. Community engagement in the development of the framework by the appointed organisation would be mandated.

8.2 Following this, we would recommend that the first round of training completed would be for senior leaders across the Partnership.

8.3 The framework would enable us to have a more accurate view of the resource implications of the rollout of training to all members of staff in the Partnership.