Trust Management Executive: Day, date 2011

Paper number

Title	**Equality and Diversity Monitoring and Activity Reports.** **Report of progress 2010 -2011**

Purpose of paper	To provide an Executive Summary to the reports: Equality and Diversity Monitoring Report 2010/2011 (workforce) and Equality, Diversity and Human Rights Activity Report 2010/2011, detailing progress and recommendations for further work in line with the Equality Act 2010.
Board Lead(s)	Elaine Strachan-Hall. Chief Nurse. Sue Donaldson. Director of Workforce.

Key purpose – make bold the relevant word(s)	Strategy	**Assurance**	Policy	**Performance**
Strategic Goals	To be the hospitals of choice To be an excellent employer			
Strategic Objectives	Customer care founded on making people feel welcome and treating them with respect and kindness; Working with a growing membership and a diverse range of supporters and volunteers.			
Links to Board Assurance Framework/Trust Key Risks/CQC Registration	Board assurance framework: Risks: Previous Case Law has shown that organisations are at risk if they do not have evidence			

	that equality issues have been considered. CQC registration: Regulation 17 outcome 1; Regulation 4 outcome 4; Regulation 11 outcome 7; Regulation 16 outcome 11; Regulation 15 outcome 10; Regulation 19 outcome 3; Regulation 22, outcome 13; Regulation 23, outcome 14.

Resource and financial impact	
Consideration of legal/ equality /diversity/engagement/risk issues	To meet the legal requirements of the Equality Act 2010. National Health Service Act 2006 Section 242, duty to involve the public. Risk to patient safety if staff are not aware of individual patient needs. The risk of not promoting equality and human rights activity has far greater implications with regard to potential cost of complaints, employment tribunals and litigation.

Executive Summary

Introduction

1. The Equality Act 2010 became statute in October 2010. All public sector organisations must:

   1.1 Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.

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

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

2. The protected characteristics of The Equality Act 2010 relate to disability, age, gender, gender re-assignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Marriage and civil partnerships are also included in the Act.

3. The specific duties were published in July 2011 and guidance is awaited however

   3.1 The Trust is required to publish information to demonstrate its compliance with the duty imposed by section 149 (1) of the Equality Act 2011, not later than 31st January 2012 and at least annually after that.

   3.2 The information must include information that relates to persons who share a particular characteristic who are its employees; and other persons affected by its policies and practices.

   3.3 The Trust must prepare and publish one or more objectives not later than 6th April 2012 and subsequently every four years. Objectives must be specific and measurable.

4. To assist NHS organisations to comply with equality legislation the Department of Health has created a framework known as The Equality Delivery System (EDS). The framework will help NHS organisations to meet the evidence requirements of the statutory public sector equality duty, contained within the Equality Act (2010) and the statutory duty to consult and involve patients, communities and other local interests. (NHS Act 2006). The EDS is due to be launched in November 2011.

5. The Trust must provide evidence that equality issues have been taken into account within all core activity; business plans, proposals, policies and projects as well as on-going day to day activity. Past equality impact assessments are on the Trust website. A new equality analysis form has been developed and current work is focussing on improving understanding and equality analysis for planning and policy writing. The

analysis will be published on the intranet with the relevant policy or plan for evidence.

6. Equality legislation requires the Trust to publish workforce data, subsequent action plans and to report progress on activity listed in the Single Equality Scheme on an annual basis and this data has been available since 2005.

7. The Trust's Single Equality Scheme runs from 2009 to 2012.

8. As a requirement of the Equality Act 2010 the Trust needs to publish its objectives and action plan for the next four years by 6th April 2012.

9. The Trust has produced two equality reports for the year 2010/2011: the Workforce Equality and Diversity Monitoring Report and the Equality, Diversity and Human Rights Activity Report. The two reports detail workforce data and activity across the Trust services, progress, and include recommendations for further work.

Summary of Equality & Diversity Workforce Monitoring Report 2010/2011

10. The monitoring report is based upon workforce data, including promotions and appraisals information, recruitment activity, employee relations cases, leavers and training data for 2010/2011 according to protected characteristics (gender, ethnicity, age, disability, religion and religious belief and sexual orientation).

11. This report illustrates the diversity of the workforce within the Oxford Radcliffe Hospitals and identifies areas of note.

12. The data from the 2001 census in Oxfordshire shows that people with a BME background represent 4.5% of the population. The current estimate is 15% of the Oxfordshire population have a BME heritage; 20% of Trust staff have a BME heritage, which reflects the diversity of the workforce and exceeds the percentage of the local BME population. The Trust is attracting applicants from a wide range of ethnic groups.

13. 13% of the workforce has notified of their status concerning disability, of which 0.5% declared themselves disabled.

14. The Trust has no available data on the Religious Belief and limited data on Sexual Orientation of its workforce, however it does draw this data from application forms.

15. It should be noted that the number of Employee Relations (ER) cases has decreased in 2010/2011 from 150 to 98. Much work has been undertaken on Policies and Procedures and increasing levels of confidence in managing cases at an informal stage. The number of ER cases remains relatively small within a workforce of 10,066, less than 1%.

16. There has been a 2% reduction in the number of BME staff subject to performance and conduct investigations in 2010/2011 compared to 2009/2010. There were 16% BME cases in 2010/2011 compared to 18% in 2009/2010.

17. The majority of grievance cases were raised by staff with a white ethnic background, with only one case involving staff with a BME heritage.

18. There were no cases of bullying and harassment investigations involving staff from the BME group in 2010/2011 compared to four cases in 2009/2010.

19. One individual from the BME group instigated an Employee Tribunal case in 2010/11, compared to four in 2009/2010.

20. Equality and Diversity training has increased in supply during 2010/2011. 1524 staff completed training compared to 1078 in 2009/2010.

Summary of Equality, Diversity and Human Rights Activity 2010/2011 (service provision)

21. The focus of equality and diversity activity has been to improve patient experience, customer care and equality of access over the last year using the Single Equality Scheme action plan as a framework for activity. All topics within the action plan are covered within this report.

22. The increase in activity includes:

    22.1 The provision of communication aids such as easy read information;

    22.2 Echo Mini-tech machines and language interpreting;

    22.3 Data collection, monitoring and analysis and producing adequate evidence that equality issues have been considered by using an equality impact assessment tool.

    22.4 Equality Impact Assessments are published on the Trust website. Involvement of people who are normally marginalised and who have a protected characteristic is important and there have been quarterly outreach activities in order to allow different voices to be heard. Issues raised through involvement have been reported to PALS and individual departments.

    22.5 A new interpreting contract has been agreed and awareness of the need to provide interpreting is increasing.

    22.6 A staff conference was held to raise awareness of development opportunities for staff from black and minority ethnic backgrounds, to encourage a more diverse workforce in all pay bands.

23. It is a legal requirement to be compliant with equality legislation. The Department of Health has concluded that very few NHS organisations are already compliant, so it is essential for plans to be in place to improve equality performance.

Recommendations

24. The Trust should continue its efforts to improve the quality of workforce reporting to evidence fulfilment of the Public Sector Equality Duty:

    24.1 By undertaking a staff census to identify the make up of the workforce.

    (This exercise is scheduled for autumn 2011).

    24.2 Complete the appraisals data input onto the Electronic Staff Record (ESR) for all staff.

    24.3 Review equal pay and maternity data for future monitoring.

25. The Trust should ensure that the decrease in use of policy at a formal stage is an enhancement and arises from better use of Policies and Procedures at the informal stage; that managers are adequately equipped to manage a diverse workforce through application of appropriate procedures and in light of the introduction of the clinically led management structure.

26. Continue to promote Equality and Diversity Training.

27. For Divisions to accept responsibility to:

    27.1 Record and monitor training figures and capture rates of patient ethnicity data and for the data to be reported within divisional governance meetings and quarterly quality reports.

    27.2 Ensure new policies and plans have robust equality analysis built into the process.

28. Endorse communications of NHS Constitution statements to promote equality, diversity and human rights, privacy and dignity within communications across the Trust.

29. Understand and support the requirements that equality issues are considered within all Trust activity to imbed valuing difference and provide individualised patient care to improve patient experiences.

30. To implement the steps necessary to fulfil the Equality Delivery System requirements by April 2012 and beyond.

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Part One: Workforce

Introduction

1. The Trust is required to report on its workforce as a requisite of equality legislation which has been brought together under the Equality Act 2010.

2. The Trusts Single Equality Scheme sets out the requirement to produce an annual monitoring report and to publish the results.

3. The report provides information based upon headcount of current workforce, employee relations cases, recruitment activity, leavers and training data for 2010/2011 according to ethnicity, disability, gender, age, religious belief and sexual orientation to comply with the statutory duty and makes recommendations for further work.

4. The legal framework is outlined in detail within the Single Equality Scheme.

Ethnic monitoring within the HR Function

Staff in Post

5. The Trust currently asks staff to supply their ethnicity on the appointment form and this information is entered onto the HR system, Electronic Staff Record (ESR).

6. Reports can be produced from ESR which details staff ethnicity broken down into profession, gender etc.

7. The Trust has 90% of its staff coded to known codes.

Impact

8. Having monitored the data any issues that have arisen will be addressed by the implementation or revision of policies, procedures or processes, the success of which will then be reviewed by ongoing ethnic monitoring.

Local Population of Oxfordshire

9. The 2001 census states that 4.5% of Oxfordshire population is made up of black and minority ethnic groups (BME), compared to 12% in Oxford and 9% in Banbury. Oxford's figure is higher than the national average of 6.4%. The current estimate for the BME population of Oxfordshire is 15%.

Current Workforce Data

10. This data represents the workforce as it is at April 2011. The data has been taken from the Electronic Staff Record (ESR) and represents Headcount and not Whole Time Equivalent.

11. The data is based on a head count of 10,066 staff employed and paid by the Oxford Radcliffe Hospitals NHS Trust. This number does not include contractors, agency workers or staff on honorary contracts.

12. The previous year's data will be known as 2009/2010. In 2009/2010 headcount was 10,136.

13. The workforce profile is illustrated in chart format in Appendix A.

Gender

14. Females represent 77% (7767) of the workforce, compared to males at 23% (2299). A 1% increase on male employees when compared to 2009/2010.

15. The highest number of females are employed in Bands 5 and 6 (3623 employees). The highest number of males are employed in Consultant/Medical grade posts (800 employees) and then in Band 2 and 5 (610 employees).

16. Females are most represented by the Nursing and Midwifery professional group which comprise 37% of the female workforce and 29% of the total Trust workforce. Medical and Dental staff has the largest number of males which represent 23% of the Trust's male workforce.

Ethnicity

17. Black Minority Ethnic (BME) groups represent 20% of the workforce. A 1% decrease compared to 2009/2010 percentage figures. White ethnic groups remain at 69% of the workforce.

18. 11% (1096) of the workforce have not declared their ethnicity compared to 10% in 2009/2010 figures.

19. White British are the largest workforce population with 63% (6329) of the workforce. A 1% increase from 2009/2010. Asian or Asian British are the second highest with 10% (923) of the workforce. No change from 2009/2010.

20. The Nursing and Midwifery professional group has the highest number of BME staff (27%) which comprise 42% of the Trust's BME workforce (no change from 2009/2010). The Medical and Dental staff group has the second highest number of BME staff with 13% of the BME workforce (2% reduction from last year). White staff are most represented by Nursing and Midwifery and Administrative and Clerical staff groups.

Age

21. The most represented age group for staff is 31 - 35, followed by 36 – 40. The smallest groups are in the ranges 16 – 20 and 66 plus. No change from 2009/2010.

22. Many of the posts within the trust require professionally qualified staff. Professional qualifications may take three to four years after school education and this limits the number of posts available to applicants aged 16-20.

23. 2% are either aged 66 plus (115) or aged 16-20 (73). No change from 2009/2010.

Disability

24. 13% (1309) of the workforce have provided information indicating whether they have a disability or not. This represents a 4% increase on 2009/2010. 47 (0.5%) declared that they are disabled.

25. Nursing and Midwifery has the highest percentage of disabled staff with 0.2% (20).

Sexual Orientation

26. 14.7% (1478) of the workforce provided information indicating sexual orientation. 14% (1442) declared themselves as heterosexual.

Promotions

27. There were 301 promotions with females accounting for 84% of the number (253). In 2009/2010 there were 351 promotions, of which 78% were female.

28. Nursing and Midwifery staff group has the highest number of promotions (121) representing 40% of all promotions. This was followed by Administration and Estates with 16% (50). In 2009/2010 Nursing and Midwifery represented 31% of promotions and Administration and Estates with 15%.

29. 36% of promotions (108) were to Band 6 compared to 38% in 2009/2010.

30. The BME group represents 14% (41) of promotions. In 2009/2010 the figure was 13%.

31. 77% (229) of promotions were from White ethnic groupings. 10% (30) had not stated their ethnicity. Asian or Asian British make up 5% (16) of promotions in contrast to 2009/2010 where the percentage was 7%.

32. The highest percentage of promotions 20% (59) were from the 26-30 age range followed by the 31-25 age range with 17% (50).

Appraisals

33. 6,300 Non Medical staff and Consultants had appraisals during 2009/2010. This equates to 84% of Consultants and 64% of staff. Exclusions were those on maternity leave, long term sick, under 12 months' service or junior doctors.

Recruitment Data

34. The data in this report is taken from the Recruitment Website 'NHS Jobs' for the period 1 April 2010 to 31 March 2011 and is referred to as 2010/2011 data. 35,117 application forms were received during this period.

35. The previous year's data is referred as 2009/2010 data. There were 21,914 applications in 2009/2010.

36. The recruitment data is illustrated in chart format in Appendix B.

Gender

37. Females were the largest group of applicants, representing 65% of applications received, males representing 35%. In 2009/2010 females represented 62% of applications submitted and males 38% of applicants.

Applicants that Declare Disability

38. 1073 (3%) applicants disclosed a disability and this represents no change to 2009/2010.

Ethnicity

39. In 2010/2011 White British was the largest ethnic group of applicants representing 45% of all applicants. The second highest was Asian or Asian British – Indian with 13%. In 2009/2010 White British represented 43% of applications and Asian or Asian British – Indian 16%.

Religious Belief

40. The Religious Belief category with the most applicants was Christianity with 51% of applicants. In 2009/2010 Christianity represented 53% of applicants. The second highest in 2010/2011 were Islam and Atheism respectively with 11%. Islam and Atheism have increased by 1% since 2009/2010. Hinduism remains at 8%.

Age

41. The majority of applications received were from the age ranges 20 - 24 (9,474 applications) and 25 - 29 (8,349 applications) representing 51% of all applications received. A 4% increase on 2009/2010 figures. The smallest number of applicants were from the combined over 55's category with 3% of applications. In 2009/2010 the percentage figure for this category was 2%.

Sexual Orientation

42. In 2010/2011 30,855 applicants declared themselves as heterosexual (88%). 3,384 (10%) did not disclose their sexual orientation on their application form.

Short Listed

43. 6,846 applicants were short listed.

44. 78% (5305) of applicants short listed were female compared to 22% (1531) of males. This compares with the current workforce statistics.

45. Black Minority Ethnic (BME) groups represent 29% of applicants.

Appointed

46. 920 applicants were appointed.

47. 21% (193) of applicants appointed were male compared to 79% (725) of females.

48. BME groups represent 20% of applicants.

Employee Relations Cases

49. Employee Relations (ER) cases are monitored in accordance with Trust policy relating to performance and conduct investigations, bullying and harassment investigations, grievances, capability and employment tribunal cases. These have been analysed according to ethnic origin, gender, age and disability.

50. In 2010/2011 there were 98 new or on-going ER cases, compared to 150 new or on-going cases in 2009/2010.

51. Capability in 2010/2011 is separated into either sickness related incapability or performance related.

52. The employee relations case data is illustrated in Appendix C.

Ethnicity

53. Of the 56 performance and conduct cases, 9 (16%) involved staff from the Black Minority Ethnic (BME) group, 36 (64%) involved staff with a white ethnic background and the ethnicity of 11 cases was not stated. This represents a reduction in cases involving staff from the BME group compared to 2009/2010 when there were 16 BME cases.

54. The majority of grievance cases were raised by staff with a white ethnic background, where ethnicity was known, with only 1 case involving staff from the BME group. Of the 11 grievances, 2 were instigated by groups of individuals. The adjusted number is 9 cases, compared to 8 individuals raising grievances in 2009/2010.

55. With the exception of one case where ethnicity was not stated, there were no cases of bullying and harassment investigations involving staff from the BME group in 2010/2011 compared to 4 cases in 2009/2010.

56. Only one individual instigated an Employee Tribunal case in 2010/11 involving a staff member from the BME group, compared to 60% in 2009/2010.

Gender

57. 73% of all ER cases involved females. This is comparable to the workforce which comprises 78% females.

58. Females represent 62.5% of the performance and conduct (P&C) cases, which is a 2.5% increase on 2009/2010.

59. Bullying and harassment (B&H) decreased to 6 cases in 2010/2011 from 26 cases in 2009/2010, with 67% (4) females instigating investigations compared to 33% (2) of males.

Age

60. In 74 of the 98 cases there was an almost equal split between the 26-35, 36-45 and the 46-55 age ranges. 45 cases out of the 74 relate to performance and conduct and bullying and harassment cases. In 2009/2010 there was an equal split between the 26-35 and 36-45 age range within performance and conduct cases.

61. The single Employment Tribunals claim was raised by a staff member in the 46-55 age range.

Disability

62. As in the previous year, 5% of all ER cases related to staff who had declared that they have a disability, which represents 5 of the 98 cases. 54% of staff stated that they did not have a disability compared to 41% where the disability status was unknown.

Leavers Data

63. There were 1565 leavers in 2010/2011 compared to 1679 leavers in 2009/2010.

64. The Trust turnover level is reported at 10.19% (which excludes junior medical staff and rotations).

65. Leavers data is illustrated in chart format in Appendix D.

Gender

66. Females represent 69% of leavers compared to 70% in 2009/2010.

67. The highest number of female leavers were employed in Band 5 and Medical grades (16% respectively). The highest number of males left from Medical grade posts (16%). This compares with the statistics of the current workforce.

68. The Nursing and Midwifery professional group had the highest number of female leavers (21%). The highest number of male leavers (16%) was from the Medical and Dental professional group. This represents a decrease of 1% from 2009/2010.

69. Medical staff training is based upon a planned cycle of rotational employment which drives up the number of starters and leavers.

Ethnicity

70. BME groups represent 20% of leavers and White ethnic groups make up 63% of leavers. The BME group figure compares with the current BME workforce statistic of 20%.

71. White British make up 55% of leavers. Asian or Asian British are the second highest group representing 10% of leavers. These ethnic groups compare with the current workforce largest ethnic groups.

72. Medical and Dental staff group has the highest number of BME leavers with 52% of the BME leavers (an increase of 7% from last year) and 29% of Medical and Dental leavers. Nursing and Midwifery staff group has the second highest number of BME leavers with 18% (a decrease of 8% from last year).

Age

73. The most represented age group was 26-30 with 25% of leavers followed by the age range 31-35 with 17%. This compares with 2009/2010.

74. 2% of leavers were aged 16-20 while 1% of leavers were aged 66+. No change from 2009/2010 figures.

Training Data

75. There were 29,761 instances of training during 2010/2011 compared to 20,384 in 2009/2010.

76. The training data details gender, ethnicity and age of those who undertook training and is illustrated in chart format in Appendix E.

Gender

77. Females undertook 83% of training instances. A 1% increase on 2009/2010.

Ethnicity

78. White British make up 62% of training instances. Asian or Asian British are the second highest group representing 11% of training instances. These ethnic groups compare with the current workforce majority ethnic groups.

Age

79. The most represented age range for staff was 26-30 receiving 16% of training instances, followed by the 31-35 age range with 15%.

80. In 2009/2010 the age range 21-25 received the majority of training instances (17%), followed by the 26-30 age range with 16%.

81. The over 55's combined age group undertook 7% of training instances. A 1% increase on 2009/2010.

Equality and Diversity Training

82. 1524 staff attended Equality and Diversity Training compared to 1078 in 2009/2010. The compliance figure for 2010/2011 was 1090.

83. In 2010/2011 of the 1524 trained, 1098 undertook classroom training with 426 completing on-line training. 80% were female. The age ranges 26-30 and 31-35 received 31% of the training.

Conclusion

84. This report illustrates the diversity of the workforce within the Oxford Radcliffe Hospitals and identifies areas of note.

85. The Trust has no available data on the Religious Belief and limited data on Sexual Orientation of its workforce however it does draw this data from application forms.

86. 13% of the workforce have notified their status concerning disability, of which 0.5% declared themselves disabled. The low number of staff declaring a disability is too small to draw any conclusions.

87. The introduction of reporting on appraisals into the Electronic Staff Record (ESR) will, in future, enable the Trust to produce more detailed analysis.

88. The data from the 2001 census in Oxfordshire shows that BME staff represents 3.3% of the population. 20% of Trust staff are from the BME group which reflects the diversity of the workforce and far exceeds the percentage of the local BME population. The Trust is attracting applicants from a wide range of ethnic groups.

89. It is noted that the number of staff employed past the age of 50 years decreases as the age increases. This could be because many professional staff are able to retire at the age of 55 and a Mutually Agreed Resignation Scheme (MARS) extends staff choice over when to exit the organisation. The information correlates with the Recruitment data where there is a reduction in applicants as age increases.

90. Retire and Return, changes in age legislation and state pension entitlements should uplift this figure over time by increasing the number of employees remaining within the workplace for longer.

91. It should be noted that the number of ER cases has decreased in 2010/2011 from 150 to 98. Much work has been undertaken on Policies and Procedures and increasing levels of confidence in managing cases at informal stage. The number of ER cases remains relatively small within a workforce of 10,066, less than 1%.

92. There has been a 2% reduction in the number of BME staff subject to performance and conduct investigations in 2010/2011 compared to 2009/2010. There were 16% BME cases in 2010/2011 compared to 18% in 2009/2010.

93. The majority of grievance cases were raised by staff with a white ethnic background, where ethnicity was known, with only one case involving staff from the BME group.

94. There were no cases of bullying and harassment investigations involving staff from the BME group in 2010/2011 compared to four cases in 2009/2010.

95. One individual from the BME group instigated an Employee Tribunal case in 2010/11, compared to four in 2009/2010.

96. Equality and Diversity training has increased in supply during 2010/2011. 1524 staff completed training compared to 1078 in 2009/2010.

Recommendations

97. The Trust should continue in its efforts to improve the quality of reporting to evidence fulfilment of the Public Sector Equality Duty:

    97.1. Undertake a staff census to identify the make up of the workforce. (This exercise is scheduled for autumn 2011.)

98. Complete the appraisals data input onto the Electronic Staff Record (ESR) for all staff. This will improve monitoring for future reports.

99. The Trust should assure itself that the decrease in use of policy at formal stage is an enhancement and arises from better use of Policies and Procedures at informal stage; that managers are adequately equipped to manage a diverse workforce through application of appropriate procedures and in light of the introduction of the clinically led management structure.

100. Review Equal Pay data for future monitoring.

101. Continue to promote Equality and Diversity Training.

102. To implement the steps necessary to fulfil the Equality Delivery System by April 2012.

Part Two: Equality, diversity and human rights activity. Progress report 2010-2011

Overview

103. This report focuses on equality requirements for service provision to improve patient experience, customer care and equality of access over the last year. Key areas of action were: provision of communication aids such as easy read information, Echo Mini-tech machines and language interpreting; data collection, monitoring and analysis and producing adequate evidence that equality issues have been considered by using an equality impact assessments tool. Equality Impact Assessments are published on the Trust website. Involvement of people who are normally marginalised and who have a protected characteristic is important and there have been quarterly outreach activities in order to allow different voices to be heard. Issues raised through involvement have been reported to PALS and individual departments.

104. This paper reports on activity included in the Single Equality Scheme action plan.

Monitoring Compliance

105. The Equality Steering Group meets quarterly and monitors progress; this group is chaired by the Chief Nurse or a delegated deputy. The Department of Health has recommended that compliance with equality legislation be included on Trust risk registers as consideration of equalities is a promotion of patient safety. Equality legislation is currently not part of the Trust risk register. The Trust Equality Scheme includes clear plans to become compliant with the law, with planned systems and processes being set in place for the long term. Key speakers have been invited to give presentations to the Steering Group to ensure the Trust remains up dated. Last year speakers included NHS Employers and Stonewall.

106. The Trust is required to publish annual progress reports and publish certain information, which currently appear on the Trust website.

107. Demographic analysis is beginning as the data collection and analysis improves. It is important that the need to monitor by protected characteristic is taken into account as the Trust prepares for electronic patient records. The Trust should have a 95% capture of ethnicity of in-patients and this needs monitoring by divisions, at clinical governance meetings, using the ORBIT data. Divisions have been alerted to this requirement and will be required to report to the Equality Steering Group.

108 Training: the number of staff who have taken the equality and diversity training, which is available via e-learning or classroom based sessions is reported quarterly to the Equality Steering Group. It is hoped as systems improve this will also be monitored at divisional level. See workforce report for figures.

109. It is interesting to note that only 426 people completed the e-learning package whilst the remaining 1098 persons attended a classroom session. The age distribution is

fairly evenly spread across the age bands, but with regard to gender 1227 females attended the training and only 296 males. 1524 people completed the training over the year, exceeding the target of 1090 persons. Equality and human rights considerations need to be part of everyone's responsibility and this includes participating in the training.

Data collection and analysis.

110. Age. The in-patient demographic data is available for 2010 -2011. Out of the 216,662 in-patients during the year 17% were 0 to 25 years old; 31% were 25 to 55 years old; 22% were 55 to 70 years old; 24% were 70 to 85 years old and 6% were over 85 years.

111. Gender. The distribution of gender of all in- patients is fairly balanced with 50.3% females and 49.6% males.

112. Ethnicity. 4% or 9001 in-patients did not have their ethnicity recorded. 82% of in patients had white British backgrounds; 0.6% white Irish; 3.4% "Any other white background"; Indian (1.5%) and Pakistani (1.6%). Overall 9.2% of total in- patients came from a black or minority ethnic background. (Current estimate for Oxfordshire population is 15%).

113. Whilst it is possible to record a patient's age, gender, race and religion or belief, the Trust currently does not record disability; sexuality; and gender identity. This will be needed to obtain the evidence that is required by the Equality Act 2010; therefore a request has been made to have this information collected within the electronic patient record systems. The collection of this new data will need to be endorsed at national level before local collection begins. It will be some time before recording of full demographic detail is given, but the opportunity to do so is important if inequalities in health and access are to be analysed.

114. The demographic breakdown has been produced by speciality so, as the data improves it will be possible for services to carry out an equity audit and analyse their data for equality of access to the services offered. It is hoped that the Joint Needs Assessment (PCT and Local Authority produced) will eventually contain additional equality analysis by protected characteristic, to assist all public sector organisations locally.

115 The Oxfordshire Profile is now available from the Public Health Observatory for 2011. The analysis of the 2011 census will provide more accurate population data than is currently available.

116. Complaints. Collection and reporting of ethnicity data from the complaints service is part of equality guidance. It has been recommended that this information be taken from PAS. National research suggests that people from minority ethnic backgrounds may be less likely to be referred to secondary care and less likely to complain about their care.

117. Demographic analysis of the national in patient survey is now part of the routine reporting from Picker Europe. The proportion of people completing the survey from minority ethnic backgrounds continues to be very small.

Equality impact assessments (EIA) and equality analysis.

118. Evidence of analysis is required for all policies and new initiatives although the requirement to publish this evidence has now been withdrawn.

119. Equality impact assessments have been carried out as policies come up for renewal, and can be seen on the Trust website. The EIA process is included within the Policy Writing Policy. As a result of changes in the Equality Act 2010, the actual process of analysis needs to improve and will in the future be far more focussed on the analysis and evidence, rather than simply concluding that there is no risk of discrimination, without providing the evidence. The quality of the equality analysis needs to improve and is currently a focus for attention.

Accessibility and communication

120. The production of easy read publications is being lead by the Patient Information Group and Media Office. The general in and out patient booklets are available on the Trust website. The Media Office has now obtained access to the Photo-shop library of pictures, in order to produce easy read information within the Trust. Collaboration with the self advocacy organisation "My Life My Choice" regarding the production of easy read information has increased.

121. Interpreting. For the year 2010-2011 the total cost of interpreting was £75,944.00. Overall usage is fairly consistent over the years and Oxfordshire is known for the large range of languages required. Overall Polish remains the most frequently requested language. There has been extensive collaboration with other Oxfordshire NHS Trusts plus Social Care (children and families) within the Oxfordshire Interpreting Consortium. The process of tendering for a new interpreting contract was commenced last autumn, lead and co-ordinated by the PCT. The suppliers for the new contract will continue to be those who have provided services for the last four years: Hertfordshire Interpreting Service (face to face interpreting); Language Line (telephony) and Deaf Direct (British Sign Language and other communication aids for people who are deaf or hard of hearing.)

    121.1 Telephony language interpreting is being promoted for general out-patient appointments where the appointment is short; there is a risk of the appointment changing or a patient not attending. Usage of telephony has increased over the year and total expenditure was £6,980.00. The six most requested languages were: Polish, Arabic, Punjabi, Urdu, Portuguese and Bengali. There is potential for far more widespread use of telephony across services for short straight forward communications in order to convey medical information and ensure the non English speaking patient is not disadvantaged and fully understands and engages with treatments.

121.2 The most requested languages for face to face interpreting were Polish and Portuguese. Expenditure over the year totalled £40,754.26. There will always be a need for face to face interpretation when the appointment is longer or messages and communication more sensitive or complicated.

121.3 British Sign Language (BSL) interpreting is essential for people who are deaf or hard of hearing and use BSL as their first form of communication. Raising awareness of the needs of deaf people and the need to pre-book an interpreter has continued. Expenditure for the year totalled: £ 24,963.45. Deaf Direct who supply BSL interpreting have plans to introduce video conferencing to increase the speed in which this form of communication can be accessed for emergency admissions. Awareness raising of the needs of deaf people continues, so that reliance on brief, hurried written paper communication exchanges is minimized.

122. Ten Echo-Mini-tech machines (personal listening devices purchased by Charitable Funds) are now available from the Equipment Library and at the Horton Hospital the PALS, to assist patients who are hard of hearing.

123. The Text Relay Service provided by RNID and Communicator Guides continues to be available when required to assist patients who are deaf.

124. Translation of written information is hardly used. Hertfordshire Interpreting Service report no usage for 2010-2011 and Language Line report 2 requests to translate documents for private patients at a cost of £129.00 in total. Pre-translated material is increasingly available via the internet from the different support charities for example the British Heart Foundation. It is difficult to define why translation requests are so few; it could be younger patients can access additional written information via the internet and older patients may prefer messages conveyed orally, but there is currently no evidence.

Public involvement and engagement.

125. All issues from individual patient experiences that are received during outreach visits are recorded on the PALS system. Links have been maintained with Oxfordshire Carers organisations to promote awareness of how to signpost carers for information or support. All carer support is now available through one Carers Oxfordshire contact number.

126. Oxfordshire Unlimited a group of about forty members with physical or sensory impairments has continued to assist the Trust by identifying their priorities of a fully accessible toilet for level 2 at the John Radcliffe Hospital and better way-finding and signage. This has now informed Estates planning.

127. Communication and links with the learning disability self advocacy organisation "My Life My Choice" has continued. The need for adequate toilet "changing places" has been raised; currently the Trust does not provide adequate toilet facilities for people with disabilities. My Life My Choice has helped with the production of easy read Trust leaflets.

Staff networks

128. This last year action has focussed on engagement of staff from a black or minority ethnic background, with a highly successful "Breaking Through in Oxfordshire" event being held for all Oxfordshire NHS staff. Ninety six people attended to hear national speakers talk of their personal experiences or national initiatives. Workshops were held on a range of topics and the day generated motivation and energy. Thirty seven members signed up to join a BME Network. The day was funded by Charitable Funds and the League of Friends provided refreshments.

Religion or belief:

129. The Chaplaincy service liaised with representatives from other faith groups. A quiet space has now been made available in the West Wing foyer. The quiet space in the Churchill entrance area awaits external identification and a sign. A general quiet space in addition to the chapel has to be identified at the Horton Hospital. The national inpatient survey report highlighted the need for patients to be able to "practice their religion or belief"; this includes attending to dietary requirements and wishes on the wards.

Equality Delivery System.

130**.** There has been constructive partnership working with other NHS Trusts particularly in Oxfordshire and Buckinghamshire, but also across the South Central area to progress understanding of the EDS and to plan and hold engagement events in the community. The EDS is due to be launched by Sir David Nicholson in November 2011.

131. The Equality Delivery System (EDS), is a framework to:

131.1 Improve the equality performance of NHS organisations, making it part of main-stream business for NHS Boards and all staff.

131.2Help NHS organisations to meet the evidential requirements of the statutory public sector equality duty, contained within the Equality Act (2010) and the statutory duty to consult and involve patients, communities and other local interests. (NHS Act 2006)

EDS Background

132. The Equality and Diversity Council (EDC) was formed in 2009 with representatives from the Department of Health, NHS and other interests. It is chaired by Sir David Nicholson, and reports to the NHS Management Board. The EDC supports the NHS

deliver services that are fair, personal and diverse to promote continuous improvement. Major EDC products under development are the EDS and guidance on the Equality Act 2010.

133. It is planned that the EDS will become a core part of NHS systems and NHS commissioners and providers will be issued with a set of Equality Objectives and Outcomes, against which each NHS organisation will analyse and grade its performance in the form of Red, Amber, Green and Gold Star rating, in collaboration with local interests.

134. Central to the EDS are its goals and outcomes. NHS organisations analyse their equality performance against 18 outcomes grouped under the following four goals:

134.1 Better health outcomes for all
134.2 Improved patient access and experience
134.3 Empowered, engaged and well-supported staff
134.5 Inclusive leadership at all levels

135. As a result of the analysis, NHS organisations, again in discussion with local interests, will confirm their Equality Objectives for the coming business planning period (as required by the Equality Act) and agree a limited number of priority actions. Performance against the selected priorities should be annually reviewed. These processes should be integrated within mainstream NHS business planning.

136. The process of deciding baseline grades requires involvement of local organisations such as the Local Involvement Network/Healthwatch and involves assessing progress so far against all the 104 factors in the EDS grades manual. Given the required criteria many NHS organisations including this one will score either red – under developed or developing – amber.

137. Where provider organisations are large, with multiple sites and/or departments, they should ensure that the analysis of performance and resulting grades, takes account of different levels of performance across sites and departments. Such an approach can help to justify the awarding of a good EDS grade.

138. It is intended that the priorities and grades of all NHS commissioners shall be confirmed to the NHS Commissioning Board, and that the grades for both NHS commissioners and providers shall be published nationally. The Care Quality Commission (CQC) will take account of concerns highlighted by the EDS through the Quality Risk Profiles it maintains on all registered NHS providers.

139. The EDS does not replace legislative requirements for equality; rather it is designed as a performance and quality assurance mechanism for the NHS and a means by which NHS organisations are helped to meet the requirements of the Equality Act (2010) and the NHS Act (2006).

Benefits of the EDS Once implemented the EDS will:

140 Help the NHS deliver on the Government's commitment to fairness and personalisation, including the equality pledges of the NHS Constitution.

141. Deliver improved and more consistent performance on equality.

142. Help organisations to respond more readily to the Equality Act duty – something they will need to do in any event.

143 Support commissioners to develop commissioning plans that meet the needs of their communities, and will help providers to respond better to CQC registration requirements.

144 Improve efficiency and bring economies of scale by providing a national equalities framework for local adaptation.

145. Retain a focus on fairness, personalisation and equality during transition.

146. As the foundations of the NHS are being recast, it is an ideal opportunity to hardwire fairness into the architecture of the new NHS. The introduction of the EDS as a vehicle that will help NHS organisations to meet their statutory public sector equality duty obligations from 1 April 2011 is timely.

Contribution to reducing health inequalities

147. Social class, poverty and deprivation are often closely related to the incidence of ill-health and the take-up of treatment. In addition, many people with characteristics afforded protection under the Equality Act 2010 are challenged by these factors, and as result experience difficulties in accessing, using and working in the NHS. For this reason, work in support of protected groups is best located in work to address health inequalities in general. This approach has two implications for organisations when using the EDS:

147.1 When analysing the EDS outcomes, organisations and local interests should consider extending the analysis beyond the protected groups to other groups and communities who face stigma, and difficulties in accessing and using the NHS. It should be up to local organisations and interests to decide whether or not to take this approach; and if they do, which groups and communities to consider depending upon local needs and circumstances. Work on "Inclusion health" (DH, 2010) points to people who are homeless, sex workers and people who use drugs as potential targets.

147.2 When working on Equality Objectives and priority actions, organisations should locate all work in support of both protected groups and other groups facing stigma, within their mainstream work on tackling health inequalities

with regard to health conditions, health promotion, general issues of patient access, safety and experience, or workforce development.

147.3 The initial listening event, involving all Oxfordshire NHS Trusts has been held in West Oxford Community Centre with 40 participants with a range of protected characteristics; the results of this day are currently being analysed to inform the development of local priorities, objectives and actions.

Conclusion and achievements.

148. The Equality Steering Group has met quarterly throughout the last year. There has been progress including: familiarization with the 2010 Equality Act and the specific requirements for the Trust; the ORH has participated in regional discussions on the Department of Health Equality Delivery System. The topics within the single Equality Scheme (SES) action plan have been included within this report except for health promotion; there are now health promotion leaflet stands at most main hospital entrances. SES topics are: training; data collection, monitoring and analysis; equality impact assessments; communication and public involvement. Procurement now adheres to standard NHS procurement guidelines to include equality considerations. Improvement is required across all activity, particularly equality analysis within the different service specialities.

149. Communications regarding equality issues have slowly increased, examples are: information on the Equality Act 2010 in the Team Brief in April 2011 and briefings on identifying individual patient needs and the use of yellow alert stickers in autumn 2010.

150. The Trust has participated in the tendering process for a new interpreting contract which commenced on 1st June 2011.

151. An Oxfordshire NHS conference was held to improve awareness of development opportunities; interest in a BME[1] Network was also expressed.

152. Awareness has grown across the Trust of the need to provide interpreting appropriately and the need to consider equalities when creating a policy or proposal. This can be "measured" by the regularity of calls for assistance or clarification.

153. The equality intranet has an extensive range of information.

154. Liaison with carers groups in Oxfordshire has continued and information on carers support is available on all Trust sites.

155. A quiet space has been created on two sites for general use.

[1] BME = black and minority ethnic

156. Involvement of people with various disabilities has been actively encouraged. There are now plans to adapt the general blue area out- patient doors and to improve toilet facilities on level 2 at the John Radcliffe Hospital.

157. Liaison with Stonewall to explore the possibility of working more closely with this national organisation to improve support for members of the workforce and patients who are lesbian, gay, bi sexual or trans-gender.

158. All divisions have identified an equality champion to attend and contribute to the Equality Steering Group and progress activity within the divisions. These are usually the Divisional Nurses.

Recommendations

159 For Divisions to accept responsibility to:

159.1 Record and monitor training figures and capture rates of patient ethnicity data and for the data to be reported within divisional governance meetings and quarterly quality reports.

159.2 Ensure new policies and plans have robust equality analysis built into the process.

160. Endorse communications of NHS Constitution statements to promote equality, diversity and human rights, privacy and dignity within communications across the Trust.

161. Understand and support the requirements that equality issues are considered within all Trust activity to imbed valuing difference and provide individualised patient care to improve patient experiences.

162. To implement the steps necessary to fulfil the Equality Delivery System requirements by April 2012 and beyond.

Board lead: Elaine Strachan-Hall Chief Nurse

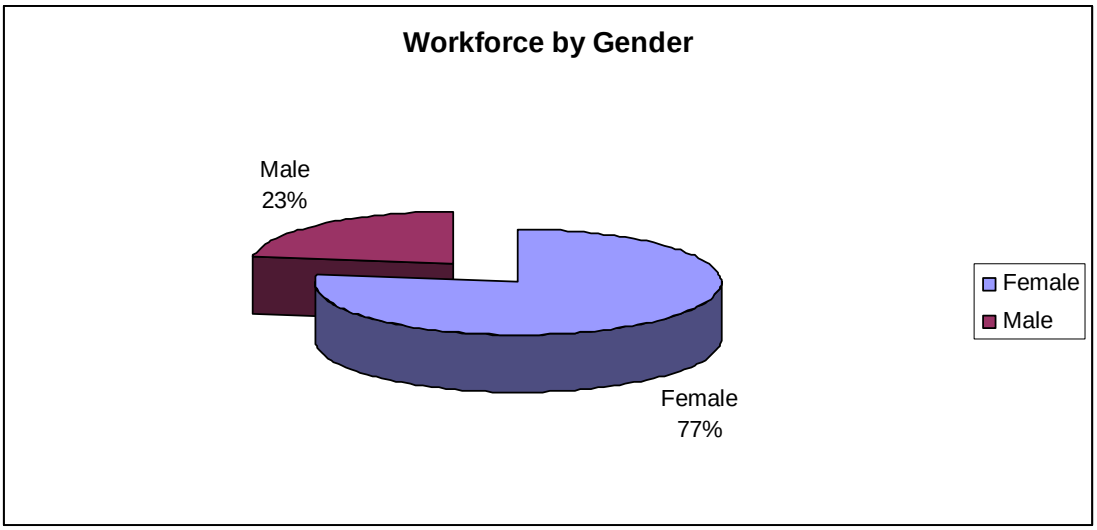
Sue Donaldson Director of Workforce

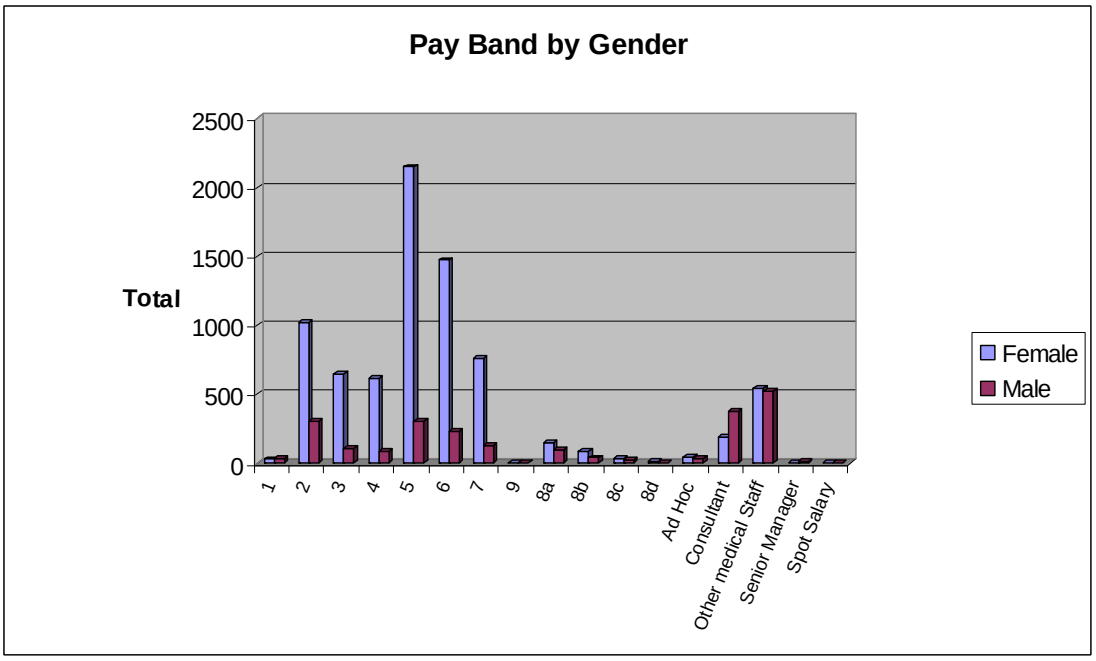
Authors: Joanna Brennan HR Consultant (Workforce section)

Jan Cottle Health Improvement Manager (service section)

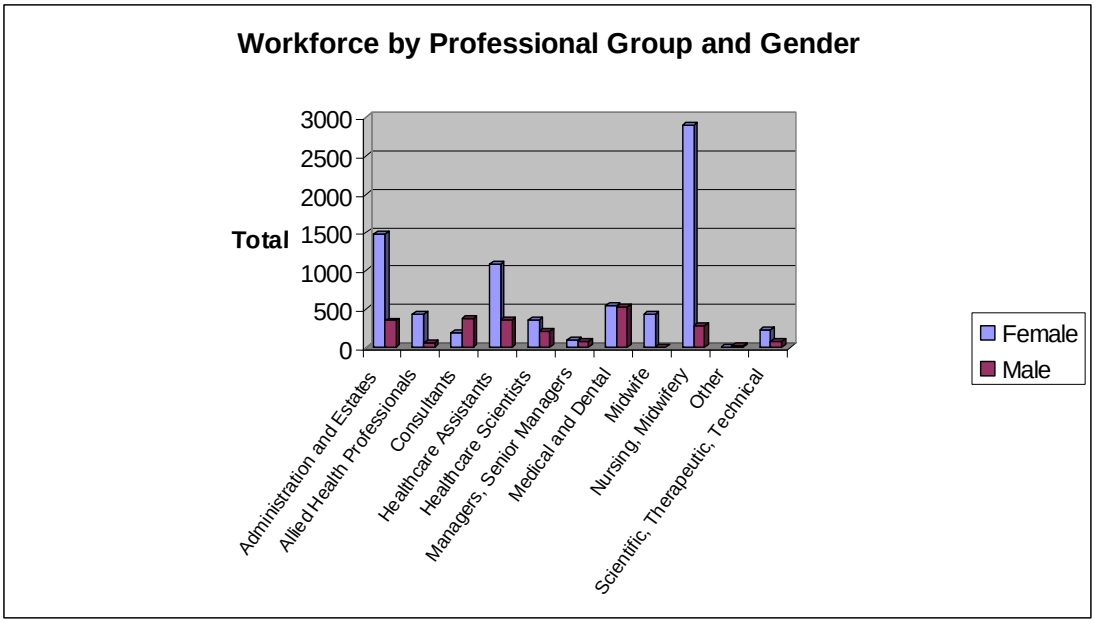
Department of Health EDS information September 2011

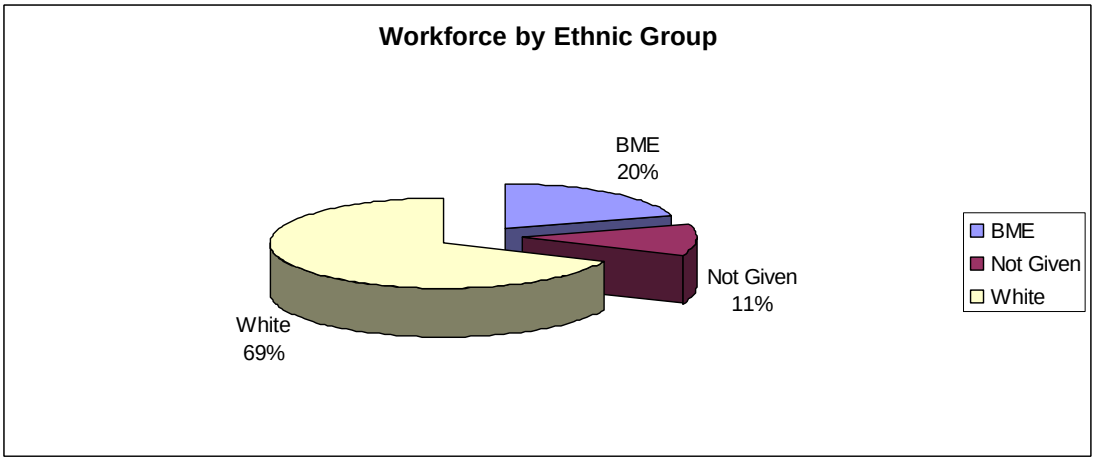
Appendix A: Workforce profile 2010/2011



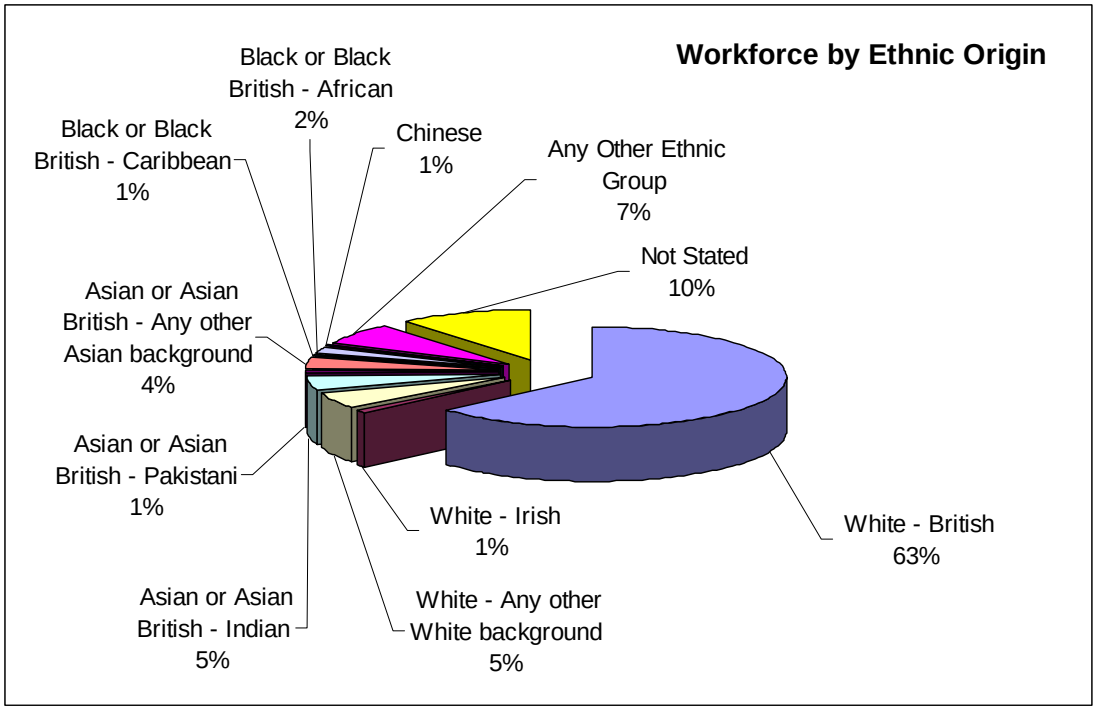


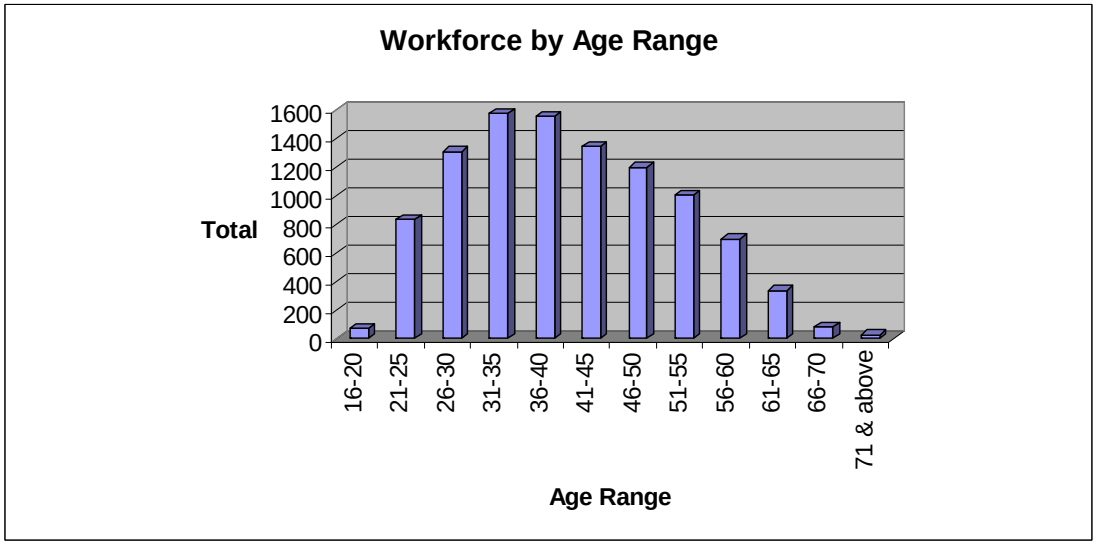
Appendix A: Workforce profile 2010/2011 continued



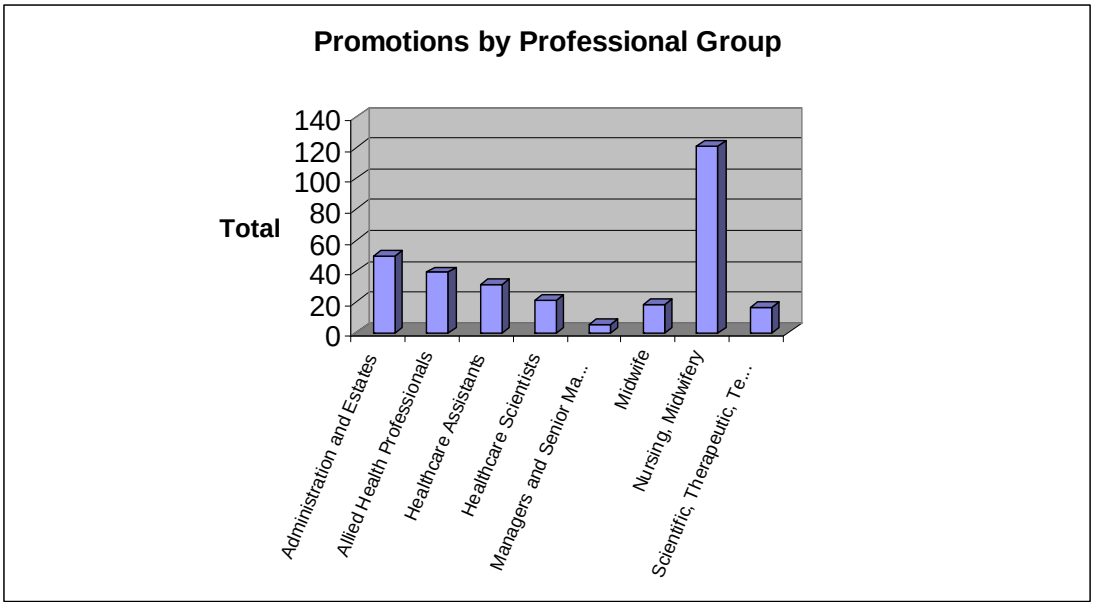


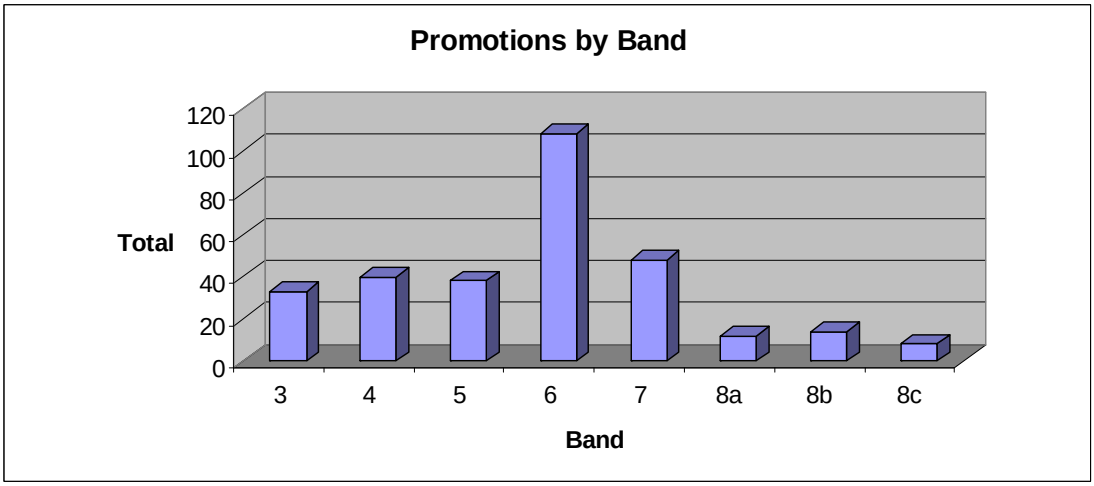
Appendix A: Workforce profile 2010/2011 continued



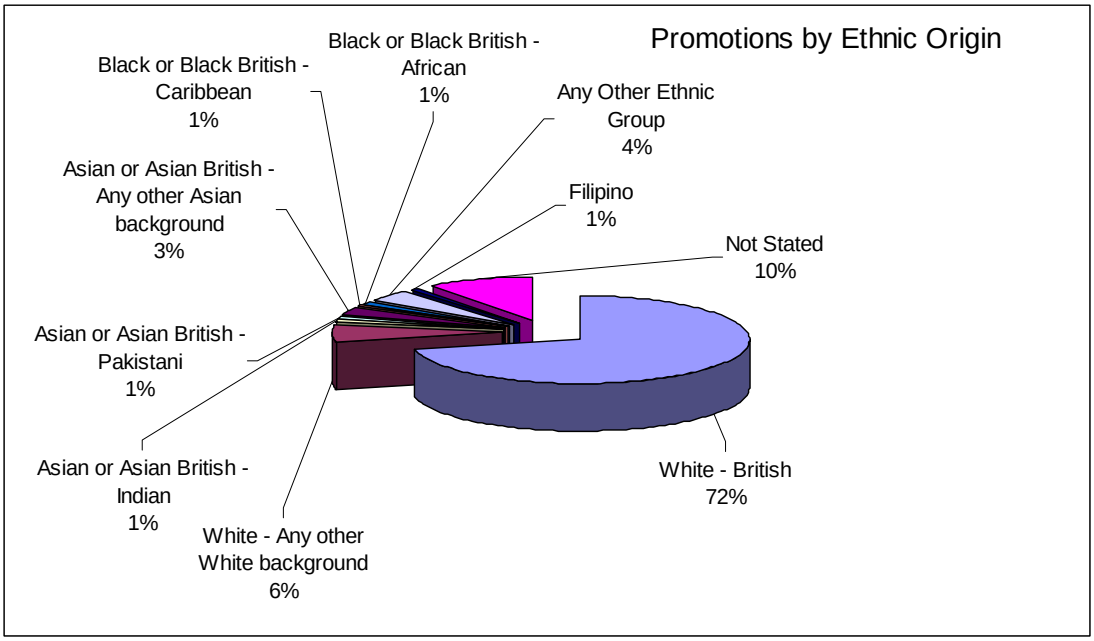


Appendix A: Workforce profile 2010/2011 continued

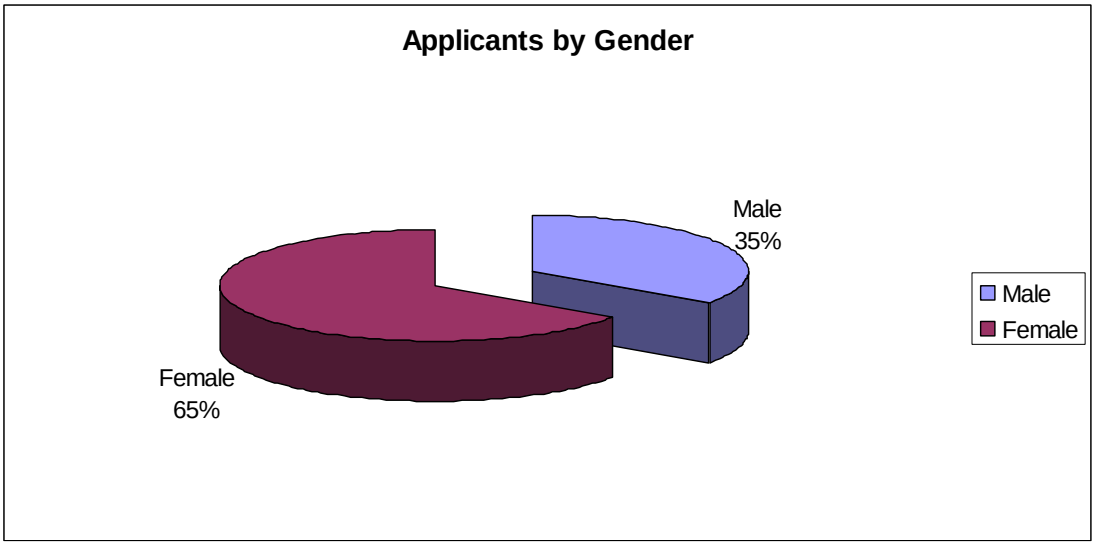


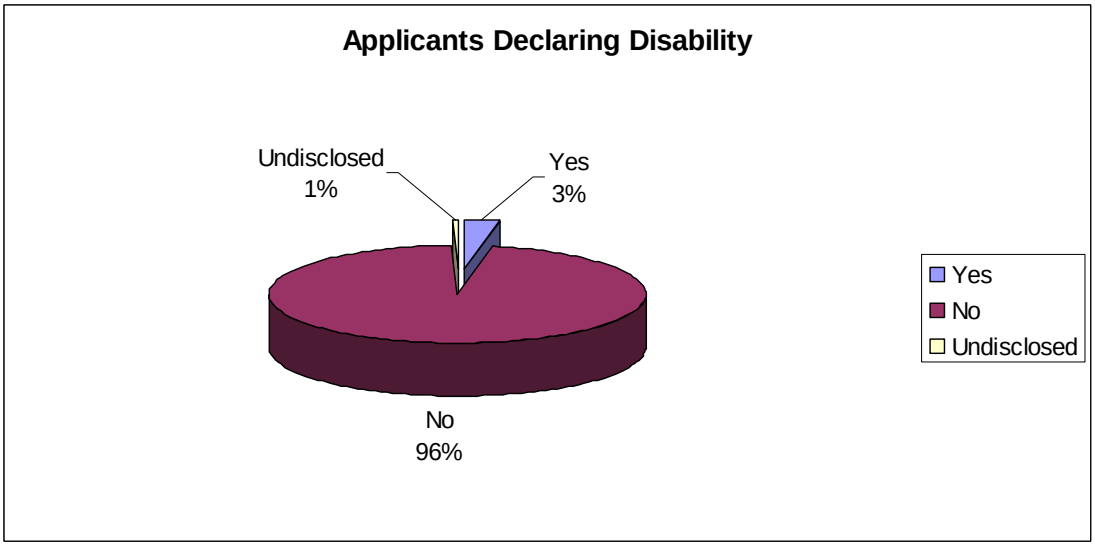


Appendix A: Workforce profile 2010/2011 continued



Appendix B: Recruitment Data





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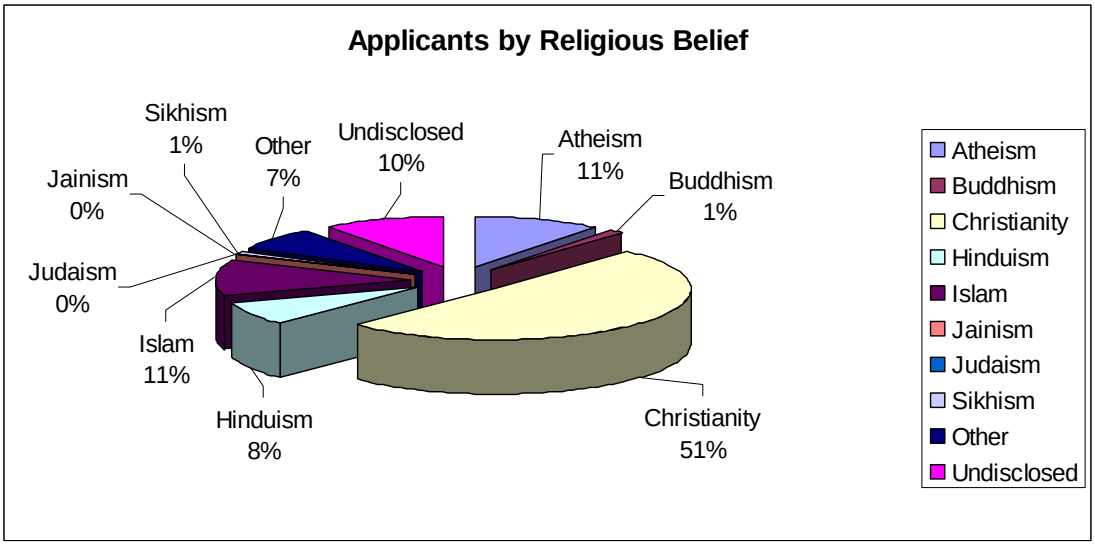
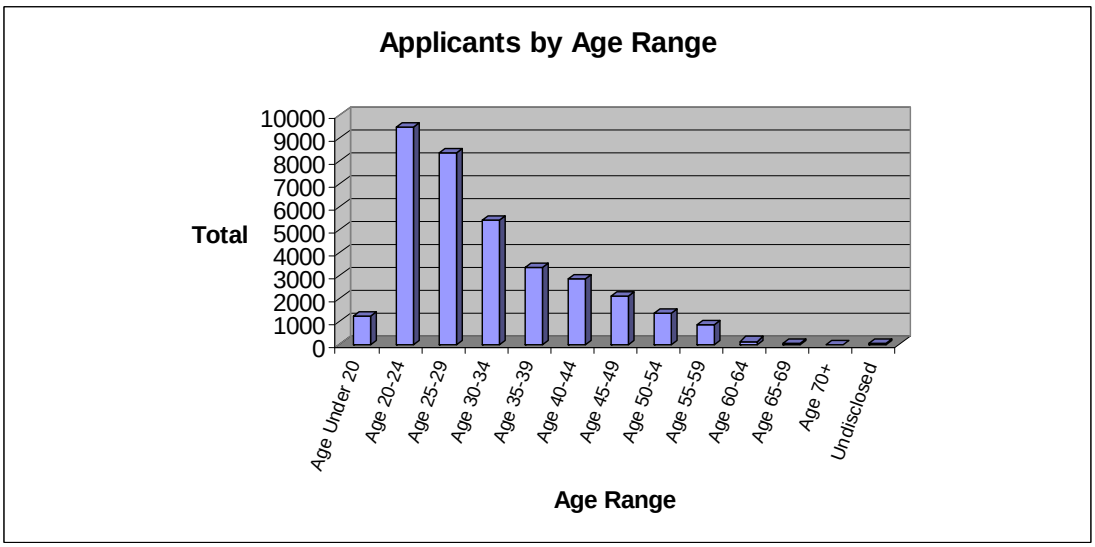
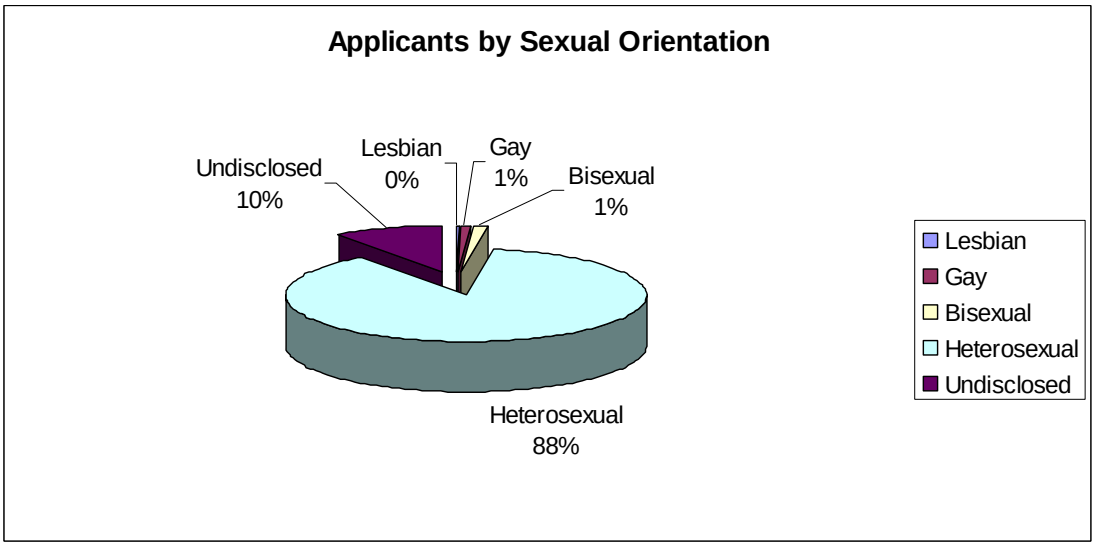
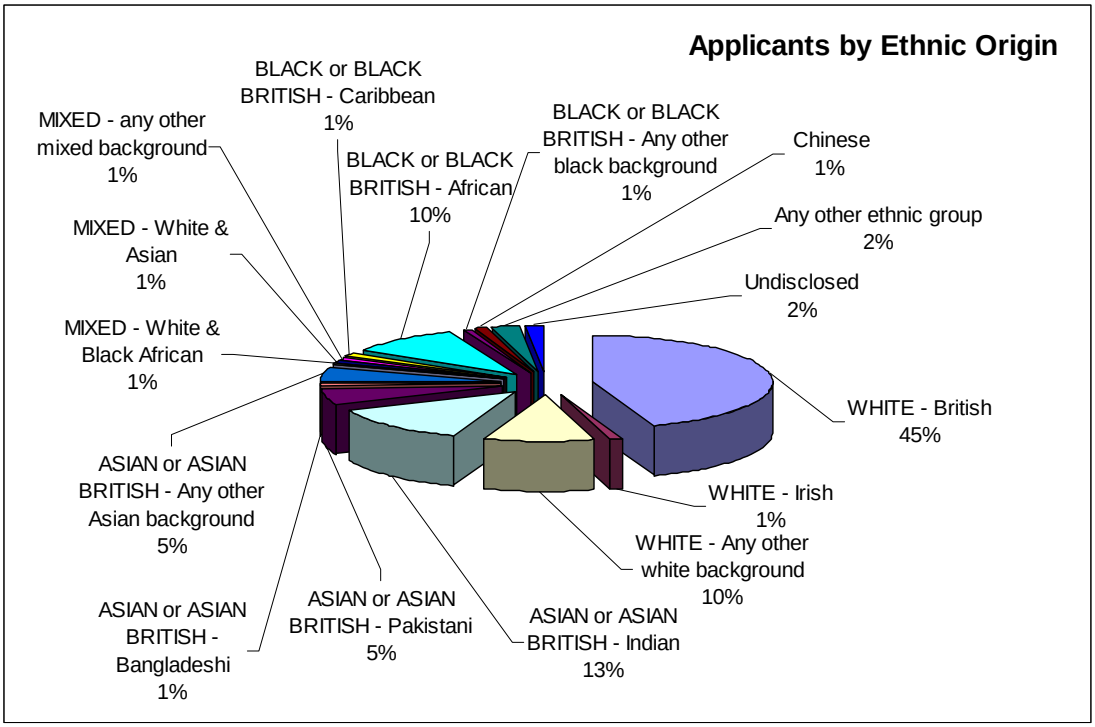






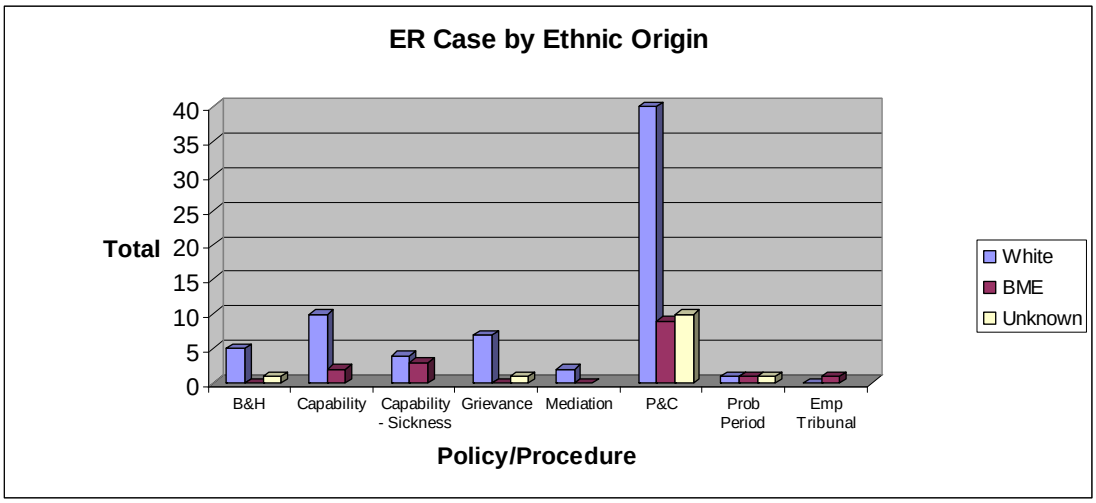
Appendix B: Recruitment data continued



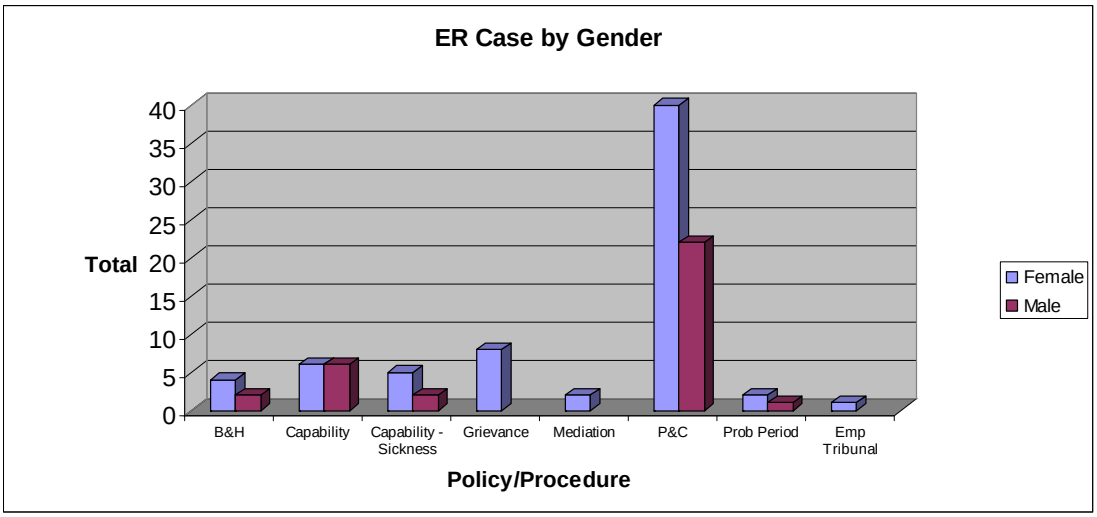
Appendix C: Employee Relations Cases

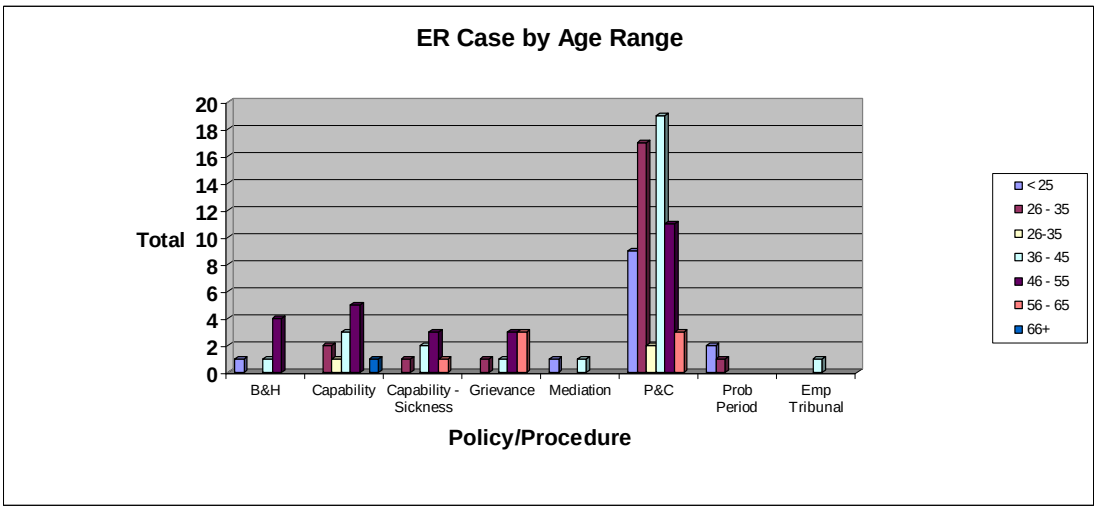
Case type	Total 2010-2011	Total 2009-2010
B&H	6	26
Capability	12	11
Capability - Sickness	7	9
Grievance	11	10
Mediation	2	
Other		1
P&C	56	
PP	3	87
Emp Tribunal	1	6
Grand Total	98	150

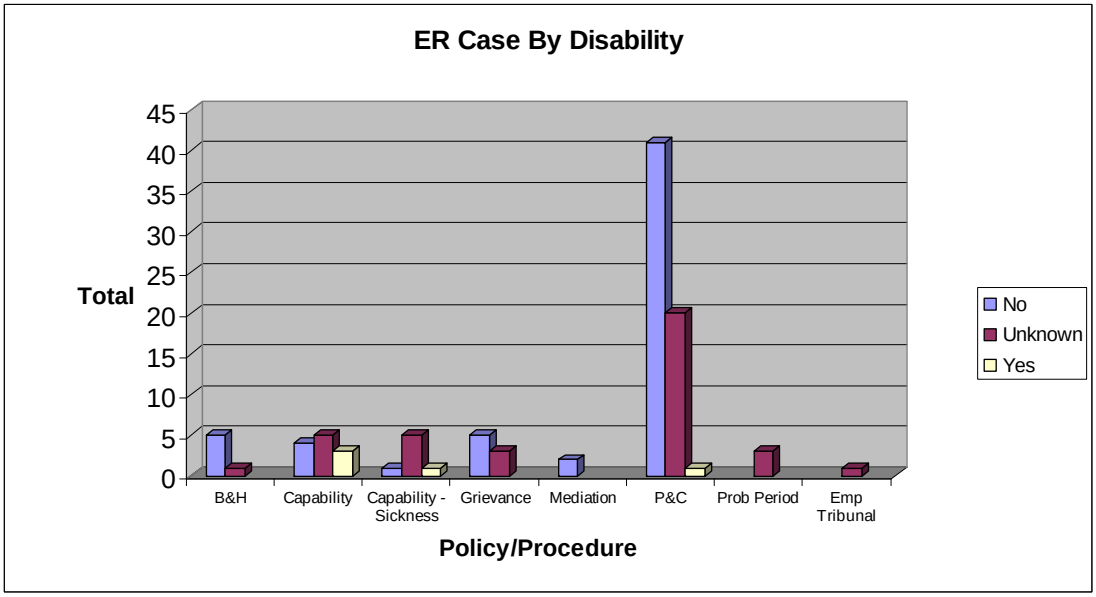
Key: B&H = Bullying and harassment
P&C = Performance and conduct
PP = Probationary period
Emp Tribunal = Employment Tribunal



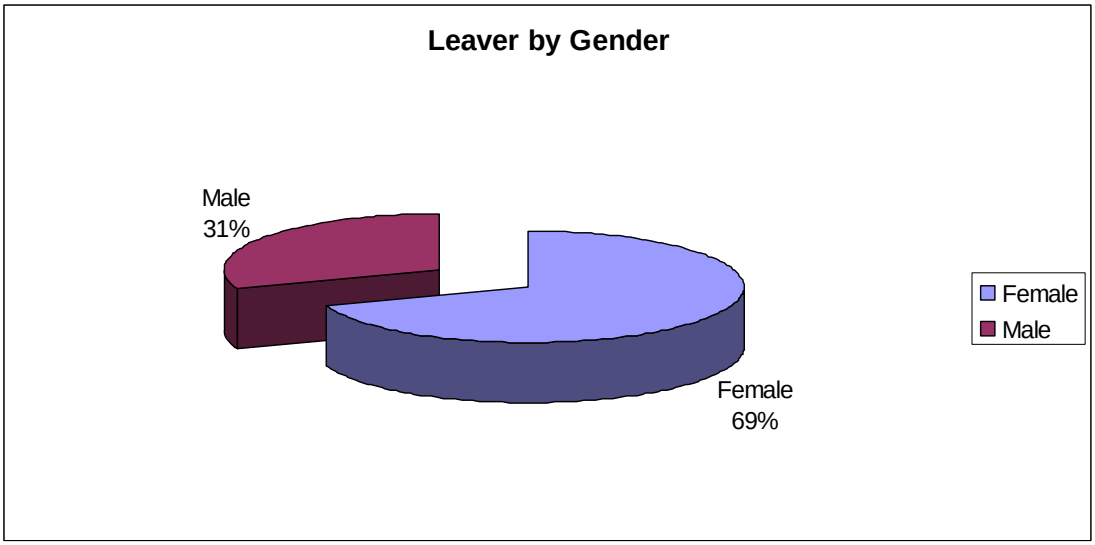
Appendix C: Employee Relations Cases continued

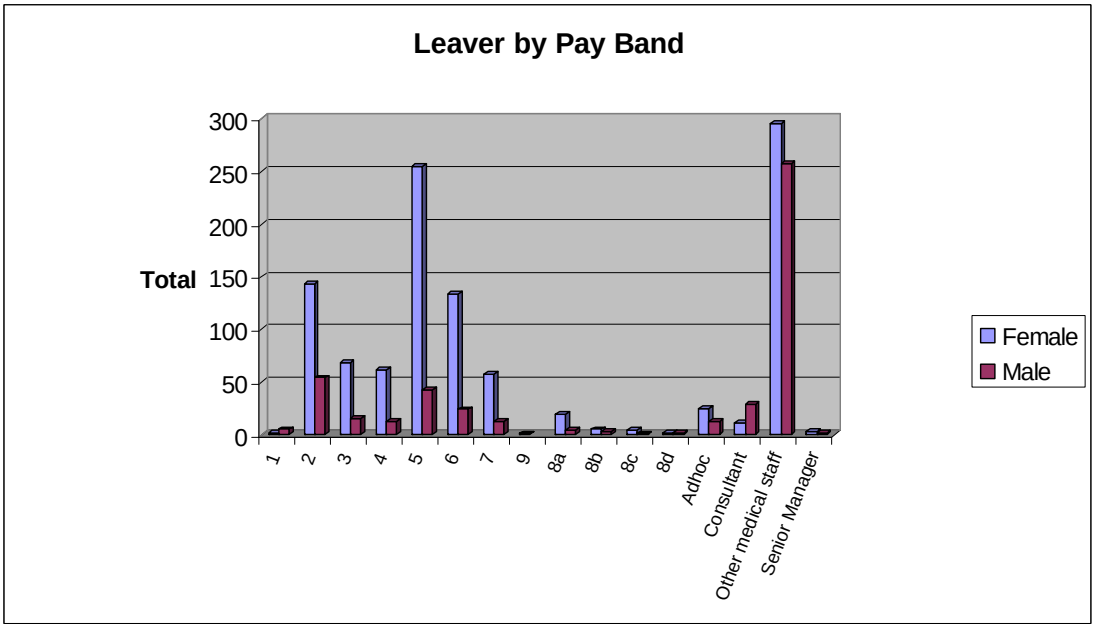






Appendix D Leavers data





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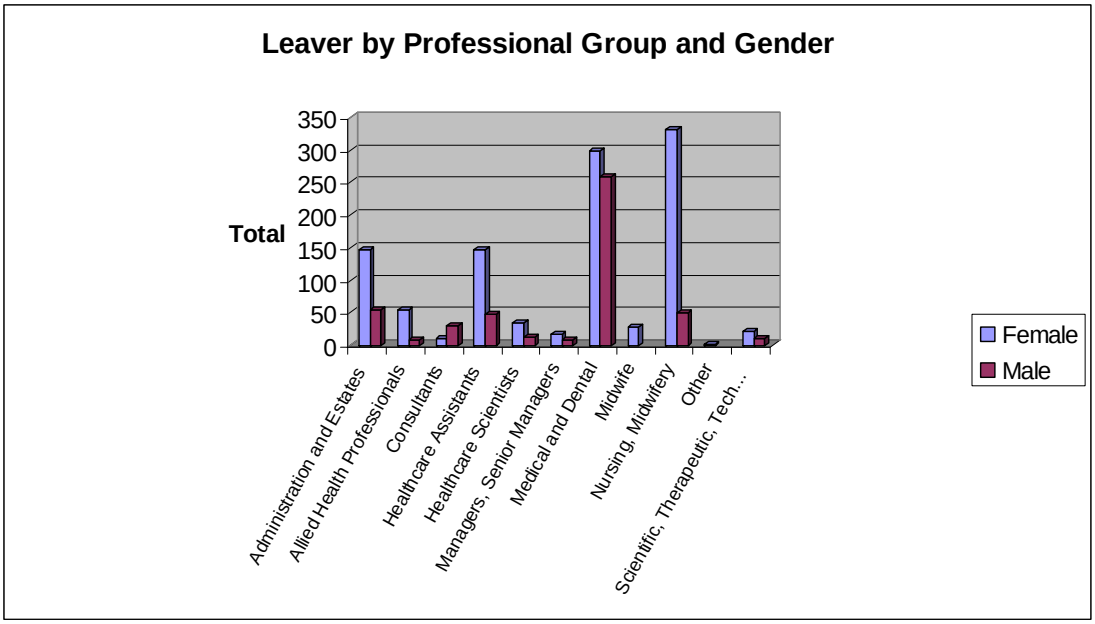

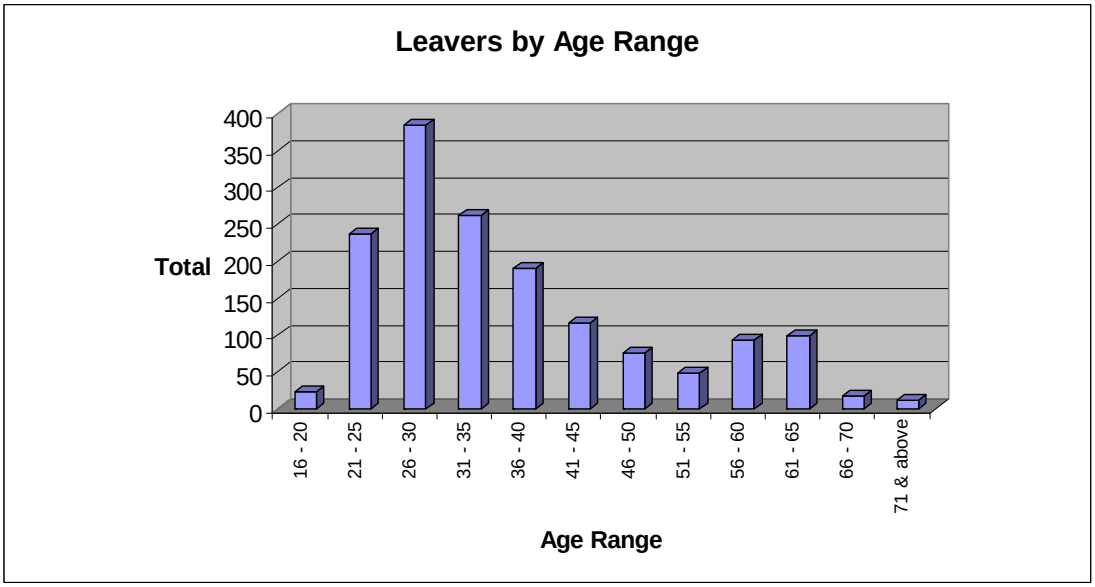

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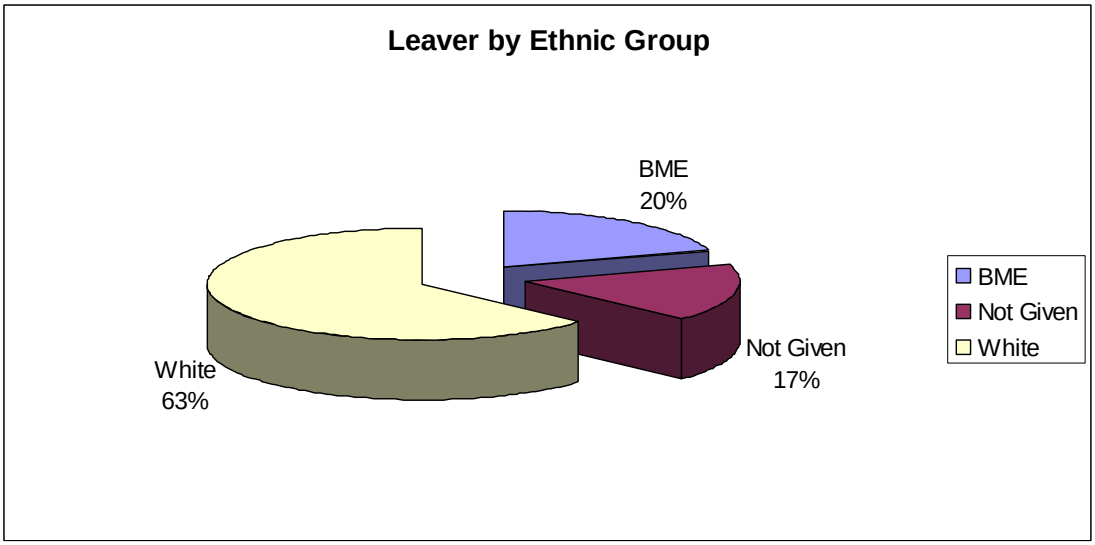
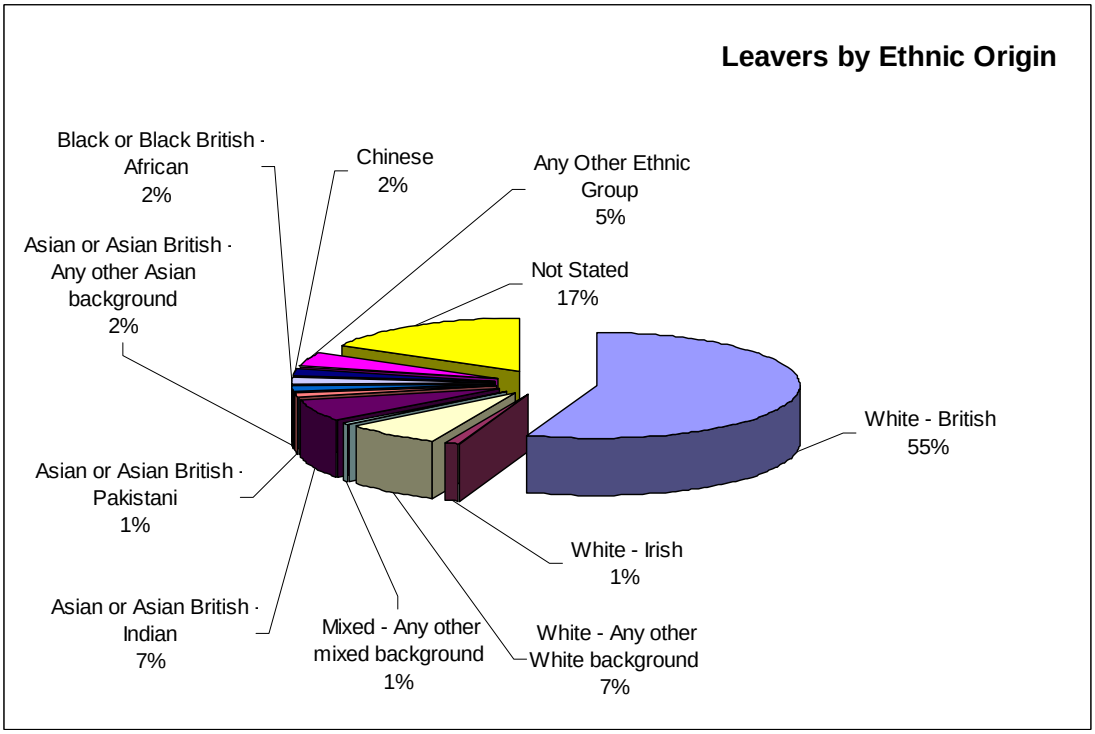
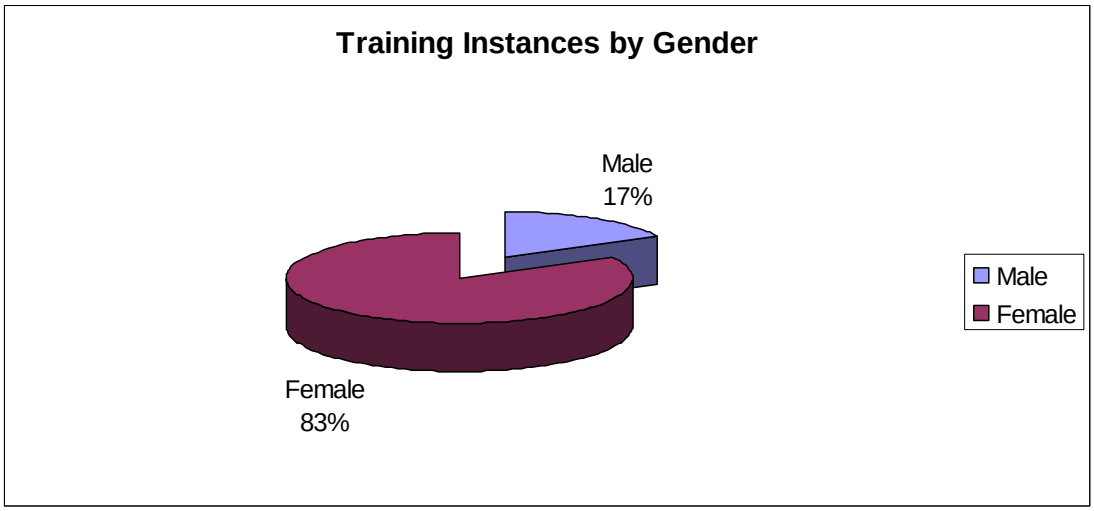
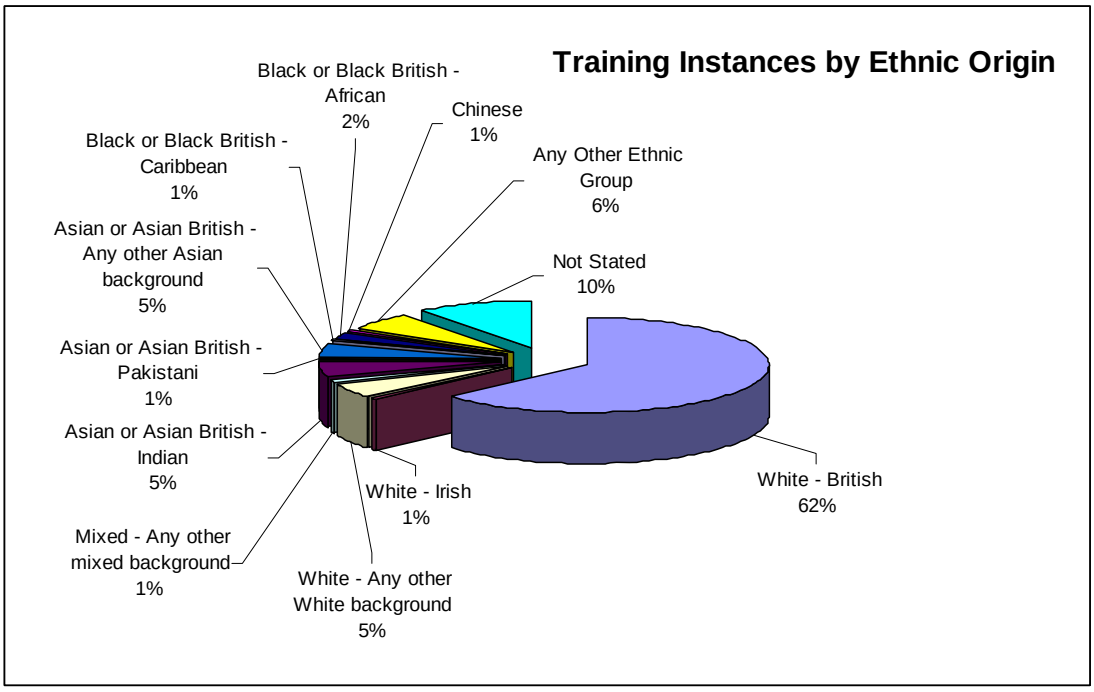




Appendix E: Training Data





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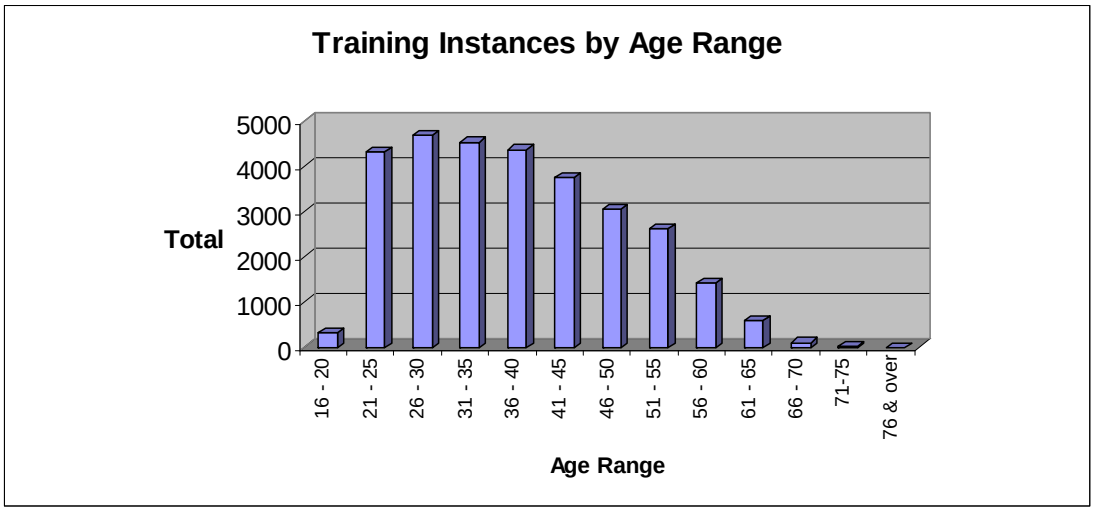

NHS Constitution.

The Health Act 2009 places a statutory duty on NHS bodies to have regard to the Constitution.

Statements from the NHS Constitution and supporting information, for patients:
You have the right to be treated with dignity and respect in accordance with your human rights.

You have the right not to be unlawfully discriminated against in the provision of NHS services including on the grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability and mental illness) or age.

For the workforce:
To a working environment free from unlawful discrimination on the basis of race, gender, sexual orientation, disability, age or religion or belief.

Staff duty: Not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.