Sussex Community NHS Trust

Annual Equality Report

2014 - 2015

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Excellent care at the heart of the community

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1 Executive summary

In 2014/15 Sussex Community NHS Trust (SCT) invested to advance equality within healthcare and employment. This summary describes the key achievements within the work programme of the Equality and Diversity Lead, a newly created Trust role appointed in November 2014:

1) Establishment of a new ambition for equitable care at the heart of all our communities, aligned with the Trust's values, in support of the Trust's vision and to signify that excellent care is by definition equitable
2) The re-establishment and first two meetings to date of the Equality and Diversity Group (EDG) as a coalition of influential internal leaders to shape the direction of the Trust and monitor progress to advance equality
3) Identified and developed a database of 240 external stakeholders representing the needs of protected groups and mapped these to target an engagement strategy for the renewal of the Trust's equality objectives
4) Delivered three community engagements: Brighton, Crawley and Worthing and gained 805 individual pieces of feedback from 42 stakeholders about Trust services and their experiences, and commissioned three extensive literature reviews of equity and inequality in community care to inform the development of a new equality strategy
5) The establishment of three new Trust-level equality objectives for 2015-19 to focus the equality agenda on LGBT wellbeing, BME proactive care and being a strong equitable business to strengthen the Trust's position of legal compliance
6) Creation and approval of a new equal opportunities policy to support staff and managers deliver equitable, non-discriminatory services and employment
7) Redevelopment of the Raising Concerns ("Whistleblowing") policy in line with best practice and the Freedom to Speak Up review
8) Development of a new equality and human rights analysis (EHRA) form and scrutiny of 12 policies or coaching sessions with staff to support better, more equitable policy making
9) Developed and rolled out a face-to-face training course to meet the mandatory equality, diversity and human rights training needs of staff. An additional 400 staff were trained using this method, with learner satisfaction surveys indicating that it is one of the most highly regarded courses delivered any where within the Trust. Delivered a Board seminar and a briefing for the executive leadership team on the equality agenda
10) Provided an advice and support service for staff personally experiencing discrimination or harassment, or supporting patients, volunteers or colleagues
11) Supported the creation of a newly emerging disabled staff network to encourage peer support and learning
12) Wrote and won a funding bid submission for management consultancy from a leading equality charity (brap) via the Kent, Surrey and Sussex Leadership Collaborative (KSSLC) to work with the Trust to develop inclusive leadership.

Key achievements of that programme have included seminars, workshops and keynotes at Trust leadership events raising awareness, an internal bullying and harassment survey responded to by 284 staff increasing insight into workplace experiences, and a service specific project to address staff survey concerns and lead to the creation of a toolkit to use with other services with similar results in the future

13) Following changes in the commissioning landscape, the completion within time of new contractual reports to NHS England and the clinical commissioning groups (CCGs) to support the national Workforce Race Equality Standard (WRES)
14) The development of three high-value tender submissions for the Trust in areas ranging from equality and diversity to social inclusion and mixed housing tenures
15) The establishment of new contractual arrangements for the provision of translation, interpreting and support for those with particular communication needs. The management of relations with external agencies at quarterly meetings and scrutinising monthly reports
16) Represented the Trust facilitating a workshop at the Pre-Pride Conference at Brighton Pride in 2015.

All of the above was achieved in a 10 month period on a zero budget, whilst additionally identifying savings for the Trust from improvements to the review of monthly activity reports for translation and interpreting.

1.1 Findings

As well as progress there are areas that require improvement summarised below:

Data quality

The quality of data available to the Trust about equity does not reflect the quality of care provided by staff to diverse patients, carers and families. In particular the IT infrastructure requires improvement as highlighted throughout this report.

Harassment

The Trust does not perform well within staff surveys compared to other community Trusts in relation to harassment. Staff members have indicated they want to see more support from management and senior leadership against bullying and harassment. A new equal opportunities policy has been ratified this year, so a high-profile campaign against bullying and harassment should be resourced and launched to increase awareness

BME Talent management

White staff members are more likely to be appointed than black staff, more likely to attend leadership courses, and more likely to be represented within senior leadership. The Trust should invest more in talent management overall and ensure

that minority staff are represented and supported within the programme to maximise their career ambitions and support their development within (or outside) the Trust.

1.2 Recommendations

Following analysis of the available data for 2014-15, the following recommendations are summarised below:

1.2.1 Care equality recommendations:

1) The Trust's informatics function adopts the data standard appended to this report and initiate an intelligent programme to coordinate the upgrade of retained information systems and those procured in the future to include standardised and compatible equality reporting
2) Establish monitoring of IT capability to support monitoring of ethnicity, disability, sexual orientation and religion and belief
3) Include greater qualitative analysis within future annual reports, including direct testimony of service leads
4) The Trust's clinical leadership function supports an initiative to improve staff practice around taking histories to include identity and equality
5) The Trust's AAA Screening service run awareness sessions at BME community group meetings to promote uptake, self-referrals and knowledge
6) The Trust's patient experience function incorporates – and mandate wherever technically possible – the collection of age, sex, ethnicity, disability, sexual orientation and religion and belief within FFT surveys, including appropriate responses for people to indicate they would prefer not to disclose, as per the standard appended to the back of this report
7) The Trust's patient complaints function incorporates and mandates the collection of ethnicity, disability, sexual orientation and religion and belief of complainants, including appropriate responses for people to indicate they would prefer not to disclose
8) The Trust to initiate a campaign to raise awareness about how to report concerns with discrimination and prejudice
9) The Trust's governance function incorporates and mandates the collection of age, sex, ethnicity, disability, sexual orientation and religion and belief of people concerned within incident reporting, including appropriate responses for people to indicate they would prefer not to disclose
10) The Trust's governance function to update the incident reporting categories for safeguarding issue relating to discriminatory staff practice or harassment witnessed by colleagues, and for hate abuse received by staff as per the data standard appended to the back of this report.

1.2.2 Workforce equality recommendations:

11) Improve BME representation in senior management and leadership roles through talent management programmes and targeted leadership development
12) Improve the rate of BME people appointed from selection within recruitment to employment through updating management training
13) Promote a culture of respect and transparency surrounding bullying and harassment by developing new team level cultural change toolkits.
14) Initiate an equal pay audit using the NHS Employers toolkit to ensure equal pay for equal work.

1.3 Conclusion

The Trust needs to improve its data and insight into equity, and is putting in place the foundations to achieve this through implementing the recommendations within this report and developing a new equality strategy. As such it remains compliant with the Public Sector Equality Duty within the Equality Act 2010 as summarised below:

- The aim to promote equality of opportunity can be evidenced in particular through the establishment of new corporate equality policies, the creation of new equality objectives and the establishment of supporting governance
- The aim to eliminate discrimination can be shown in particular through the work to improve corporate insight into the experiences of staff who feel harassed in their workplaces and new policies to tackle discrimination
- The aim to foster good relations can be evidenced in particular through the development and roll-out of new staff equality training and the stakeholder engagement programme to support the creation of the equality objectives bringing people from different backgrounds together.

1.4 Next steps

The refresh of the Equality Strategy 2015-19 will address the findings and recommendations within this report, with the exception of finding 5 (AAA screening), which is further recommended to be implemented directly by the service.

The report and the strategy will be published online at www.sussexcommunity.nhs.uk/equality-diversity.htm

2 Introduction

The Trust's ambition is for patients, service users, carers and workers to have equitable care at the heart of all our communities. This is the 2014-15 annual equality report for Sussex Community NHS Trust (SCT) to report on progress.

Equity is a core component of many definitions of care quality in Western health economies and international organisations (Arah, et al. 2006). Equity deals both with the distribution of the burden of paying for health care and with the distribution of health care and its benefits among a people.

To deal firstly with payment benefit / burden ratios, that is beyond the scope of what is technically achievable but is a commitment within the Trust's new equality strategy. This report deals with the distribution of health care and its benefits amongst the 8,000 people a day who access community or specialist services from the Trust.

2.1 Trust overview

Sussex Community NHS Trust was formed in October 2010 following the merger of South Downs Health and West Sussex Health, the Provider arm of West Sussex Primary Care Trust. It is one of the largest community trusts in the country with approximately 4400 staff.

The Trust provides a comprehensive range of community health services to the populations of Brighton & Hove and West Sussex, which amounts to a 1.1million population. The Trust also provides a range of specialist community services to this population and across the South East region.

The Trust has eight community bedded units and 233 beds. The Trust provides home based adult services 24 hours a day, seven days a week to communities across Brighton & Hove and West Sussex to maintain and support people in their homes, from basic care to proactively managing long term conditions. The Trust provides rapid intervention to people in crisis who would otherwise have gone to hospital.

The Trust provides children's services from birth to adulthood in people's homes, clinical settings and with social care partners. The Trust also has a range of specialist community based services where the proportion of people in the population needing care is small or they need a specially trained practitioner.

3 Clinical effectiveness equality analysis

Equality Delivery System Goal 1: Better health outcomes

Clinical effectiveness is aligning care with science and ensuring efficiency (National Advisory Group on the Safety of Patients in England 2013). Another definition is that effectiveness is 'the degree of achieving desirable outcomes, given the correct provision of evidence-based health care services to all who could benefit but not to those who would not benefit' (Arah, et al. 2006).

The method for assuring the equity of clinical effectiveness was to select a long-list of eight relevant indicators of performance. The filtered final selection of three test indicators was initially because of time and resource availability in the testing phase.

The relevance to the health needs of certain protected groups, determined from literature reviews conducted in parallel to this report (available on the Trust's website), combined with a review of the current national reporting requirements, determined the final sample selection (Figure 1)

Figure 1 Clinical effectiveness indicators sample

Name of indicator	Indicator Description	Source
Effective		
Use of a validated, standardised assessment tool	P02. The percentage of patients who were assessed using a validated, standardised assessment tool	Draft national indicator set for community services
Use of mental health tools and screening to support the wellbeing of the service user	P19. Percentage of service users with an identified or diagnosed mental health need who are in receipt of the appropriate screening or assessment tool	Draft national indicator set for community services
HIV09aii. Retention in care of all HIV patients	Proportion of all patients retained in HIV care in the following year	HIV Specialised Services Quality Dashboard Metric Definition Set 2015/16

The selection of mental health care and HIV care indicators was because they are especially relevant to the following groups protected by the Equality Act 2010: older people, disabled people, BME (Black and Minority Ethnic) groups, LGBT (Lesbian, Gay, Bisexual and Trans) people.

The Trust's IT systems could not output the requested sample datasets by results for different demographic groups to measure and analyse equity. To understand this, follow-up interviews with the individual services and performance analysts identified the common following limiting feature: although the collection of some equality data

occurs as part of national data collections, it was not necessarily then extractable from the Trust's IT systems on a local level.

Another cycle of inquiry (Marshall 2001) to scope the quality of clinical equity data involved an interrogation of Trust clinical information systems for the completeness of information about patient ethnicity, produced by the Trust's Performance Team (Figure 2)

Figure 2 Trust information system ethnic code completeness

Trust information systems	2014-15
ATHENA_DATAMART	0
BEST10 LIVE	8,444
Cerner CDS6.2	32,412
Diabetes Staging	2,240
FormicActivity	0
FormicActivity SLTChildren	0
HIVe (Live)	0
Manual Data Spreadsheet	0
PIMS Central	24,276
PIMS West	22,775
PIMS_SDH_DATAMART	217,627
PIMS_WSH_DATAMART	68,678
RIS	0
SEMAHELIX	69,548
SystmOne	0
TPPSystmOne-ICAT-MSK	0
TPPSystmOne-ICAT-MSK-Procs	0
TPPSystmOne-PODIATRY-CFS	0
Grand Total	**446,000**

The Trust's total activity for 2014-15 was 2,246,644 care activities, of which 20% had a patient or user with an ethnic code recorded (446,000). This is likely for many reasons, including that the system does not have that capability or that staff practice is not to either collect and / or input the data.

Amongst those services using the newest SystmOne clinical information system, no patients had their ethnicity coded in a way that is extractable using the Trust's current performance reporting system. Upon inquiry from the Performance Team, the reason was that SystmOne did not implement the standard national codes, and instead used a different set of read codes that only the supplier (TPP) could configure.

A subsequent inquiry involved scoping the Trust's data warehouse directly, which determined that the 'patient table' (as at September 2015) has 282,366 patients (60%) with their ethnicity coded, whereas 191,765 patients had 'NULL; recorded within the ethnicity field, out of 474,131 records. There was no way of determining which records are current or historic using this method, which affects the reliability of drawing any conclusions. However, at best it demonstrates that known ethnicity

across all systems may be closer to 35%, still significantly below levels that meaningful conclusions about the equity of care quality would be possible. It also does not change the substantive issue that national research finds people from certain ethnic groups experience relatively worse outcomes across a number of conditions.

It is recommended that the Trust reviews and updates its clinical information systems for capacity to collect, store, code and report performance for different demographic groups so that the Trust can measure care equity, be assured about its duties to promote equality of opportunity and the effectiveness of market segmentation strategies. In addition to the internal situation, a recent national position paper on equality and health inequalities monitoring indicates that NHS organisations can use either Census 2001 and the more advanced Census 2011 based ethnic codes (NHS England 2015).

In the short-term, the Trust should agree the data specification (see Appendix 1: Equality Data Specification (Services) - Draft) for implementation within all Trust systems and applications, and map internal system read codes to both the Census 2011 ethnicity codes to future-proof reporting and the Census 2001 codes for legacy reporting (the two are compatible). The Trust should then seek assurance from TPP that it has implemented the necessary reporting codes and / or mapped the codes as required to support reporting.

The Trust should also audit system capability for reporting care equity for those services that will not be transferring to SystmOne. In the medium-term investment should be secured to ensure that relevant systems are updated to meet the new data specification and codes, and also invest in improving staff practice around monitoring sensitive demographic information so that in the long term care equity can be reported with confidence.

Turning the focus of attention to a particular issue tends to see performance gains (Paton 2006), so it is a general recommendation that the Trust assures itself that the performance report template for ethnic completeness accurately reflects the situation with SystmOne. This indicator forms part of the quarterly Board report benchmarking performance between aspirant community foundation trusts. In addition, it is a medium term recommendation to establish quarterly monitoring of disability, sexual orientation and religion and belief completeness through the Equality and Diversity Group (EDG), so that the Trust can be assured that it has an IT infrastructure capable of supporting the long term aim to promote care equity.

Whilst objective analysis of the distribution of care outcomes and the Trust's contribution towards promoting equity is not yet possible, a mixed method of reporting is recommended for future annual reports to include qualitative accounts of performance drawn from direct clinicians and general managers' testimony. This will

also give services targeted at demographic groups (adults, children, people with learning disabilities, veterans etc.) an opportunity to feedback on progress.

Recommendations

1) The Trust's informatics function adopts the data standard appended to this report and initiate an intelligent programme to coordinate the upgrade of retained information systems and those procured in the future to include standardised and compatible equality reporting
2) Establish monitoring of IT capability to support monitoring of ethnicity, disability, sexual orientation and religion and belief
3) Include greater qualitative analysis within future annual reports, including direct testimony of service leads

Progress	Equality Delivery System
Developing	Outcome 1.1: Services are commissioned, procured, designed and delivered to meet the health needs of local communities
People from only some protected groups fare as well as people overall	
Developing	Outcome 1.5: Screening, vaccination and other health promotion services reach and benefit all local communities
People from only some protected groups fare as well as people overall	

4 Responsiveness equality analysis

Equality Delivery System Goal 2: Improved patient access and experience

Responsiveness refers to how a system facilitates people to meet their legitimate non-health expectations (WHO 2000). Closely related is timeliness; the degree to which health care is provided within the most beneficial or the necessary time window. Also related is accessibility; the ease with which health services are reached. Access can be physical, financial, or psychological and requires that health services are available (Arah, et al. 2006).

A sample of performance indicators was tested to determine the equity of responsiveness of the Trust's care. The measures selected were key measures of access spanning short-term, urgent, outpatient, end of life care and screening / immunisation that were particularly relevant to the health needs of certain groups protected under the Equality Act 2010.

Figure 3 Responsiveness indicators sample

Name of indicator
Improving access to psychological therapies (6 weeks)
Improving access to psychological therapies (18 weeks)
MIU / UTC four-hour wait
Referral to Treatment (RTT) waiting time compliance
S03. Patients who died in their preferred place of death (PPD)
NCSP4. Chlamydia screening notification of results
AA1: Abdominal Aortic Aneurysm screening – completeness of offer
PHOF 3.03 Childhood immunisation

A review of the literature indicated that talking therapy services are particularly relevant to some BME, LGB, Trans and disabled people, to pregnant women and new mothers and to men.

Access to urgent care is particularly relevant to men, working age and BME people as well as to vulnerable people, including those who are experiencing discriminatory abuse.

Preferred place of death is particularly relevant to older people and some disabled people with life-limiting illnesses.

Chlamydia screening is relevant to the under 25's, abdominal aortic aneurysm screening to men over 65 and childhood immunisation to children under 5 years.

As per the situation for clinical effectiveness data described in the previous section, the Trust's IT systems could not output the requested sample datasets by results for different demographic groups to measure and analyse equity, with the exception of AAA screening.

4.1 AAA Screening

Incomplete data: 7.4k White males completed an offer to attend a screening for abdominal aortic aneurysm (AAA) in 2014-15, which is 14.6% of the 50.4k recorded White males between the ages of 60-64 in Sussex at the time of the Census 2011 (ONS). This compares to just 132 BME males, or 11.5%, of the 1.1k recorded at the census. This breaks down further, ranging from 3.0% (7 men) of the eligible mixed race population estimate; 12.4% (16 men) of the eligible black population estimate; 13.5% (86 men) of the eligible Asian / Asian British population estimate; to 16.2% (23 men) for 'other' accessed screening. In addition, 129 males (1.7% of all men screened) did not have their ethnicity recorded when accessing AAA screening.

Because of the very small numbers attending from some broad ethnic groups it is difficult to draw a conclusion about equity of AAA screening take-up but a subsequent dialogue with the Trust's clinical lead suggests that lower take up from men from minority ethnic backgrounds is consistent with the national picture.

Recommendations

4) The Trust's clinical leadership function supports an initiative to improve staff practice around taking histories to include identity and equality
5) The Trust's AAA Screening service run awareness sessions at BME community group meetings to promote uptake, self-referrals and knowledge

Progress	Equality Delivery System
Developing	Outcome 2.1: People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
People from only some protected groups fare as well as people overall	

5 Care equity analysis

Equality Delivery System Goal 2: Improved patient access and experience

Patient-centeredness is core to patient experience (National Advisory Group on the Safety of Patients in England 2013) and is the degree to which a system actually places a patient or service user at the centre of its healthcare delivery and is often measured as patient experiences of caring (Arah, et al. 2006)

The relevance to the care needs of certain protected groups, combined with a review of the current national reporting requirements, determined the final sample selection:

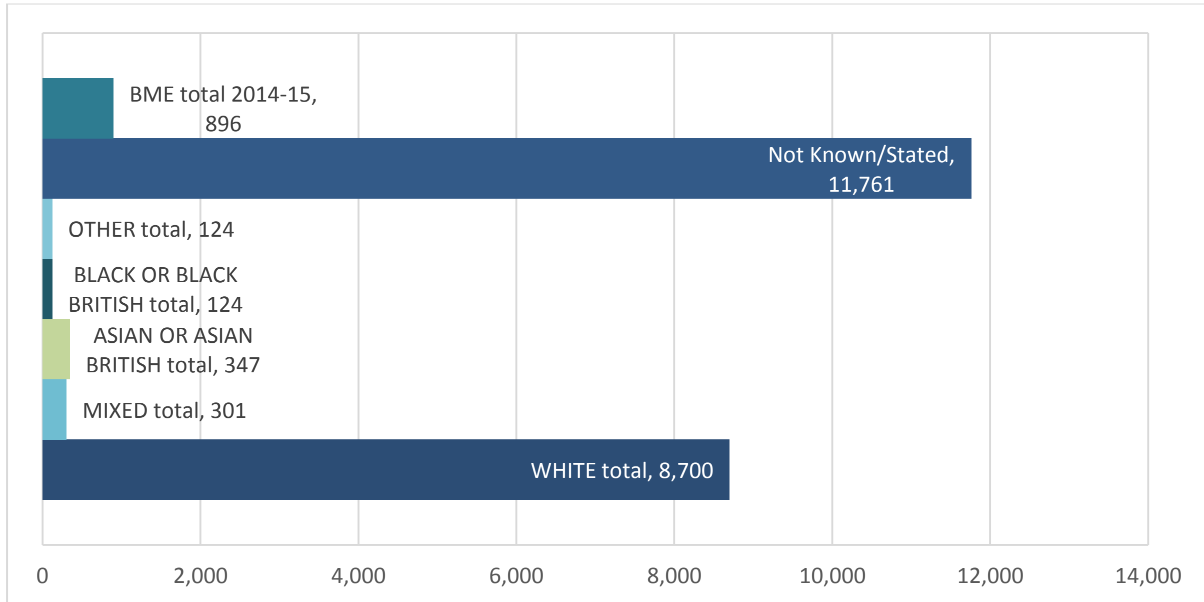
Figure 4 Care indicators sample

Name of indicator
Friends and family test – Trust wide
Friends and family test – Inpatients
Friends and family test – MIU / UTC Responses
Friends and Family Test Star Rating
Communication complaints per population size
Complaints per population size
Complaint response times per population size
Discrimination complaints reported per population size
Age discrimination complaints
Disability discrimination complaints
Trans discrimination complaints
Race discrimination complaints
Religion or belief discrimination complaints
Sex discrimination (including sexual harassment) complaints
Pregnancy and maternity discrimination complaints
Sexual orientation discrimination complaints

5.1 Friends and family test (FFT)

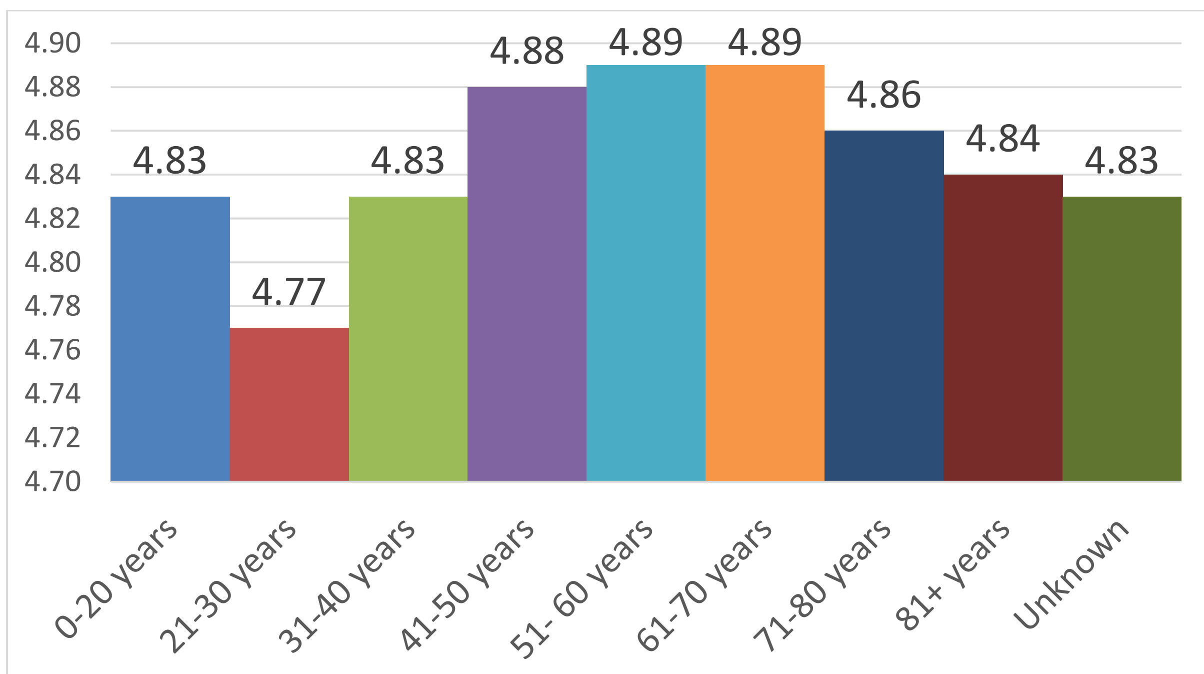
The Friends and Family Test (FFT) is a simple, comparable test that provides a way to identify both good and bad experiences.

Figure 5 FFT responses Trust wide 2014-15



Because of the considerable number of FFT responses where the patient ethnicity is unknown (11,761) it is not possible to analyse this data or draw conclusions about performance in relation to racial equality. The quality of data available should be improved as per the recommendation section below.

Figure 6 FFT star rating 2014-15



In 2014-15 there were 21,357 people who completed an FFT survey of which 2,101 people did not disclose their age. At 90% known data it is not possible to draw conclusions with commonly accepted levels of statistical confidence, however the pattern emerging of younger people scoring lower service satisfaction than older people is in line with the national picture.

It should be noted that there is difficulty comparing between different FFT datasets (NHS England 2014) in part due to mode bias (electronic, paper etc). Non-response effects of the FFT survey method (survey administration differences, priming effects, framing effects etc.) affect statistical certainty and specifically because there is no demographic data of groups in the eligible patient population (e.g. age-bands), the responses cannot be adjusted to match the relative size and improve accuracy.

Recommendations

6) The Trust's patient experience function incorporates – and mandate wherever technically possible – the collection of age, sex, ethnicity, disability, sexual orientation and religion and belief within FFT surveys, including appropriate responses for people to indicate they would prefer not to disclose, as per the standard appended to the back of this report.

5.2 Complaints

Figure 7 Complainant by sex and age-band

Sex	Female Complainants	Male Complainants
Total 2014-15	**69**	**56**
≤19 years	9	13
20-29 years	5	4
30-44 years	7	3
45-59 years	9	3
60-64 years	3	3
65-74 years	7	11
75-84 years	16	12
85-89 years	8	6
90+ years	5	1

There were more complaints where the person concerned was female (69) than where they were male (56), with the majority of that difference occurring in people older than 75 years old. None of the ethnicity, disability, sexual orientation or religion and belief of complainants were recorded in 2014-15.

Complaint response times were not recorded so was not available for analysis. In addition, there were no communication complaints registered in 2014-15.

Recommendations

7) The Trust's patient complaints function incorporates and mandates the collection of ethnicity, disability, sexual orientation and religion and belief of complainants, including appropriate responses for those who would prefer not to disclose

5.3 Discrimination complaints

There were only two discrimination complaints registered in 2014-15. Both of these were for disability discrimination or harassment, and both involved male complainants. This data is very low and indicates a problem in the reporting culture when considered alongside the staff survey.

8) The Trust to initiate a campaign to raise awareness about how to report concerns with discrimination and prejudice

Progress	Equality Delivery System
Developing	Outcome 2.3: People report positive experiences of the NHS
People from only some protected groups fare as well as people overall	

6 Safety equality analysis

Equality Delivery System Goal 1: Better health outcomes

The equality indicators in this section measure the culture of reporting harm and learning from it. Patient safety incidents reported, describes the readiness of the Trust to report harm. A patient safety incident describes 'any unintended or unexpected incident(s) that could have, or did, lead to harm for one or more person(s) receiving NHS funded healthcare'. The following indicators were requested:

Figure 8 Safety indicators sample

Name of indicator
Patient safety incidents reported
Incidents involving severe harm or death
Discrimination incidents reported
Age discrimination incidents reported
Disability discrimination incidents reported
Trans discrimination incidents reported
Race discrimination incidents reported
Religion or belief discrimination incidents reported
Sex discrimination (including sexual harassment) incidents reported
Pregnancy and maternity discrimination reported
Sexual orientation discrimination reported

No data was available. The reasons for this include the incident reporting system not including the capability to record the identity of the person concerned in an incident or this information not being inputted.

There were no incidents of discrimination or harassment witnessed by staff or abuse against staff recorded on the system in 2014-15. This data is not in line with casework from that period and indicates an issue within the reporting.

Recommendations

9) The Trust's governance function incorporates and mandates the collection of age, sex, ethnicity, disability, sexual orientation and religion and belief of people concerned within incident reporting, including appropriate responses for people to indicate they would prefer not to disclose
10) The Trust's governance function to update the incident reporting categories for safeguarding issue relating to discriminatory staff practice or harassment witnessed by colleagues, and for hate abuse received by staff as per the data standard appended to the back of this report.

Progress	Equality Delivery System
Developing	Outcome 1.4: When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
People from only some protected groups fare as well as people overall	

7 Workforce equality analysis

Equality Delivery System Goal 3: A representative and supported workforce

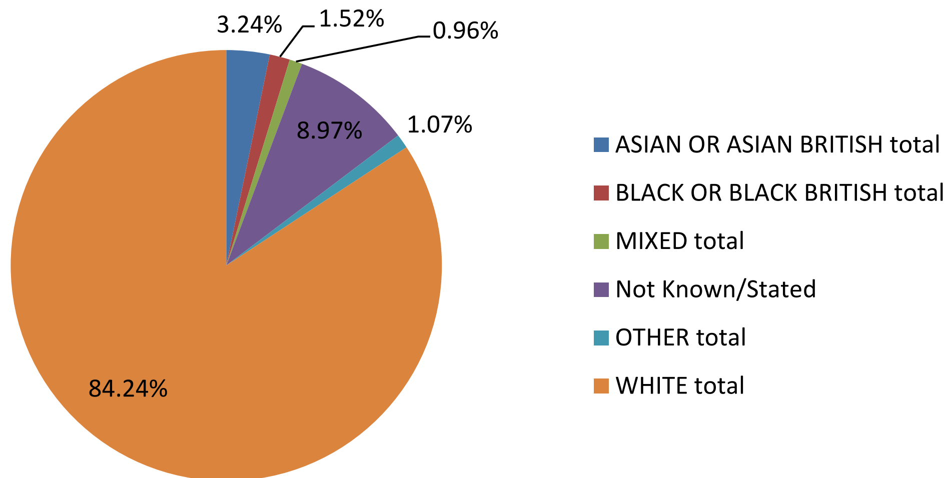
7.1 Workforce

The workforce analysis below considers representation overall as well as recruitment, promotions and leavers. Agenda for Change (AfC) are the national pay scales used for most members of staff who are not doctors or very senior members of staff who have negotiated pay locally.

Where the term 'senior management' is used below it refers to people with jobs on AfC bands 8a, 8b, 8c and 8d.

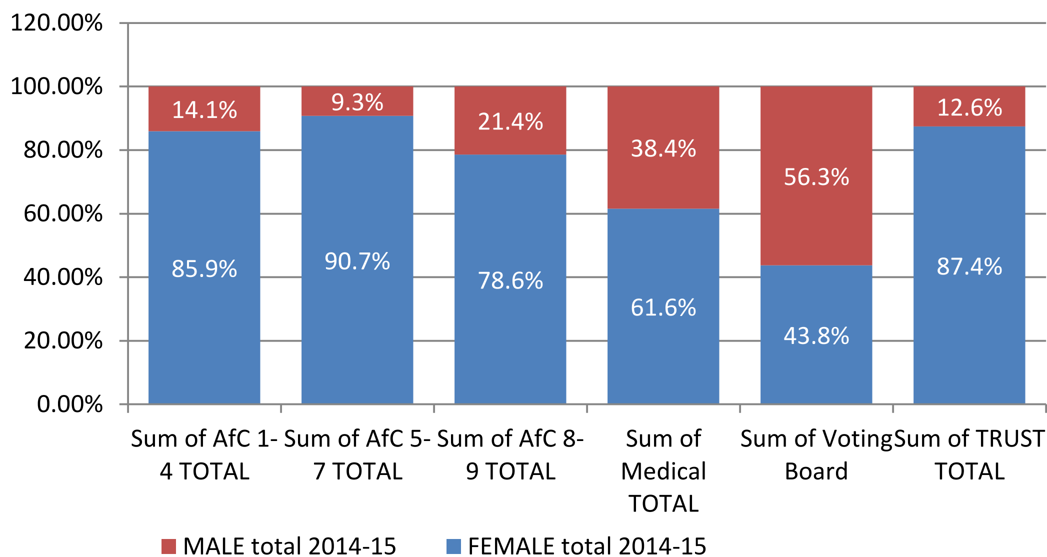
7.1.1.1 Ethnicity

There were 348 individuals (6.8%) who identified as black and minority ethnic (BME) in the 2014-15 workforce overall. The combined BME population in Brighton & Hove and West Sussex is 7.5% (ONS, 2011)



7.1.1.2 Sex

43.8% of the voting board are female compared to 87.4% (4,482 posts) in the workforce.



7.1.1.3 Disability

4.2% of the workforce is recorded as being disabled (213 people). Reported rates between broad contract types are 2.7% for doctors and 4.8% for Agenda for Change. Census statistics indicate disability prevalence in Sussex population at is 18.1% (ONS, 2012).

7.1.1.4 Sexual Orientation

2.1% of the workforce overall is recorded as LGB (109 people). 5-7% of the underlying population is estimated to be LGB (DTI, 2003)

7.1.1.5 Religion or Belief

44.7% of the workforce identified as Christian (2,292 people) compared to 57.9% in the Sussex population (ONS, 2011)

7.2 Workforce Race Equality Standard

The Equality and Diversity Council (EDC), with NHS England as system lead mandated the Workforce Race Equality Standard (WRES) from April 2015. It requires organisations employing almost all of the 1.4 million NHS workforce to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of Black and Minority Ethnic (BME) Board representation.

7.2.1.1 Current workforce race equality performance

This is the first year of the WRES implementation so reliable benchmarking is largely not possible. Presented below are key findings as of 31 March 2015:

- The percentage of BME staff in senior management (including executive Board members and senior medical staff) is 5.5% compared with the percentage of BME staff in the overall workforce at 6.8%. This is a difference of -1.3%, which demonstrates a relative deficit in minority ethnic representation at a senior level. This gap is smaller than a year earlier when it was -2.8%
- White people are 1.3 times more likely to be appointed from shortlisting than BME people
- White staff members are 1.4 more likely to attend non-mandatory leadership related training than BME staff. This difference is greater than the year previous at 1.2
- 34.8% of BME staff reported experiencing harassment, bullying or abuse from patients, relatives or the public in the staff survey 2014 compared to 25.6% for white staff (staff survey)
- 75% of BME staff reported they believe the Trust provides equal opportunities for career progression and promotion in the staff survey 2014 compared to 92.4% white staff. This is a decrease on the previous year when 100% of BME staff reported this (staff survey)
- 13% of BME staff reported they personally experienced discrimination from a manager / team leader or other colleague at work in the staff survey 2014 compared to 5.3 of white staff. This is a decrease of 12% on the previous year (staff survey)

- During 2014-15 the Board black and minority ethnic representation was 6.3% compared to 7.5% in the underlying population (Brighton & Hove and West Sussex combined) from the Census 2011 (ONS).

Recommendations:

11) Improve BME representation in senior management and leadership roles through talent management programmes and targeted leadership development
12) Improve the rate of BME people appointed from selection within recruitment to employment through updating management training
13) Promote a culture of respect and transparency surrounding bullying and harassment by developing new team level cultural change toolkits.
14) Initiate an equal pay audit using the NHS Employers toolkit to ensure equal pay for equal work.

Progress	Equality Delivery System
Developing	Outcome 3.1: Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
Staff members from only some protected groups fare well compared with their numbers in the local population and/or the overall workforce	

8 Conclusion

The Trust needs to improve its data and insight into equity, and is putting in place the foundations to achieve this through implementing the recommendations within this report and developing a new equality strategy. As such it remains compliant with the Public Sector Equality Duty within the Equality Act 2010 as summarised below:

- The aim to promote equality of opportunity can be evidenced in particular through the establishment of new corporate equality policies, the creation of new equality objectives and the establishment of supporting governance
- The aim to eliminate discrimination can be shown in particular through the work to improve corporate insight into the experiences of staff who feel harassed in their workplaces and new policies to tackle discrimination
- The aim to foster good relations can be evidenced in particular through the development and roll-out of new staff equality training and the stakeholder engagement programme to support the creation of the equality objectives bringing people from different backgrounds together.

9 Next steps

The refresh of the Equality Strategy 2015-19 will address the findings and recommendations within this report, with the exception of finding 5 (AAA screening) which is further recommended to be implemented directly by the service.The report and the strategy will be published online at www.sussexcommunity.nhs.uk/equality-diversity.htm

Appendix 1: Equality Data Specification (Services) - Draft

This draft document sets outs data standards for the recording, handling and reporting of information that relates to the Equality Act 2010 in terms of service-delivery. This is presented below under the headings 'Discrimination Monitoring' and 'Equal Opportunities Monitoring'. This standard does not apply to the workforce or employee systems.

Discrimination data specification

Systems capability

- Incident reporting systems must include the capability to record, code and report all of the incident types indicated in Figure 9 below
- Prevent staff from removing the coding of incidents relating to breaches of the Equality Act 2010 unless authorised by the Equality and Diversity Lead or a system administrator
- Code **any** type of incident as a breach of the Equality Act 2010 as appropriate. A coding function which limits causes, such as by limiting to just two possible fields (primary or secondary causes) must include a 'universal' method to code breaches. For example, an incident cause may primarily relate to 'patient safety' and secondarily to 'medication', however if part of the incident relates to the person concerned being wrongly advised they were too old to receive a drug treatment there should be a 'universal' way of capturing this age discrimination
- Systems must include the function to capture and report information about incidents relating to breaches of the Equality Act 2010 down to departmental level and maintain an organisational structure / hierarchy that is compliant with the structure set-out in ESR
- Report periodically and break down incidents within any given reporting period (e.g. monthly, quarterly or annually)
- Maintain backwards compatibility with previous codes for reporting against previous periods
- Incident, risk and complaints systems must maintain a way to link individual related records
- Accessible for disabled people to report incidents.

Practices

- Information about incidents of discrimination, harassment, victimisation and other prohibited conduct under the Equality Act 2010 can be reported by anyone
- The perceptions of any person concerned or witness (including staff members) about the type of incident must be coded appropriately, even where there is disagreement about whether something actually amounted to discrimination
- An individual should be supported to record an incident that is a breach of the Equality Act 2010 including by arranging for support and reasonable adjustments
- Incidents about breaches of the Equality Act 2010 must not have their coding changed without seeking the advice of the Equality and Diversity Lead
- Signpost or refer individuals to individuals or agencies who can offer practical or emotional support
- Hate incidents or sexual assaults must be reported to Security and the Police
- Incident reporting should always consider the Trust's safeguarding duties
- Staff-on-staff breaches of the Equality Act 2010 must be reported to the Head of HR so it can be assessed and work to follow this up can be allocated.

Incidents of discrimination, harassment, victimisation and other prohibited conduct specification

Question 1: Does any person involved (including you) perceive unlawful discrimination, harassment, victimisation or other conduct prohibited by the Equality Act 2010? (Consider: age, disability, gender reassignment, race, religion or belief, sex, pregnancy and maternity or sexual orientation)

Yes / No

Question 2: Please include all the relevant types (see column three in table below)?

Figure 9 Equality Act 2010 Incidents (for reporting purposes)

Incident themes	Incident groups	Incident types
Ageism	Age discrimination	Direct age discrimination
		Age discrimination by association
		Age discrimination by perception
		Indirect age discrimination
	Age harassment	Age harassment
Ableism	Disability discrimination	Direct disability discrimination
		Disability discrimination by association
		Disability discrimination by perception
		Discrimination arising from disability
		Indirect disability discrimination
	Disability harassment	Disability harassment
	Failure with a duty to make reasonable adjustments	Failure with a duty to make reasonable adjustments
Cissexism	Gender reassignment discrimination	Direct gender reassignment discrimination
		Gender reassignment discrimination by association
		Gender reassignment discrimination by perception
		Indirect gender reassignment discrimination
	Gender reassignment harassment	Gender reassignment harassment
		Less favourable treatment of a worker because they submit to, or reject, harassment related to gender reassignment
Racism	Race discrimination	Direct race discrimination
		Race discrimination by association

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		Race discrimination by perception
		Indirect race discrimination
	Race harassment	Race harassment
Religion or belief discrimination	Religion or belief discrimination	Direct religion or belief discrimination
		Religion or belief discrimination by association
		Religion or belief discrimination by perception
		Indirect religion or belief discrimination
	Religion or belief harassment	Religion or belief harassment
Sexism	Sex discrimination	Direct sex discrimination
		Sex discrimination by association
		Sex discrimination by perception
		Indirect sex discrimination
	Sexual harassment or harassment related to sex	Sex harassment
		Sexual harassment
		Less favourable treatment of a worker because they submit to, or reject, sexual harassment or harassment related to sex
Pregnancy and maternity discrimination	Pregnancy and maternity discrimination	Pregnancy and maternity discrimination
Sexualism	Sexual orientation discrimination	Direct sexual orientation discrimination
		Sexual orientation discrimination by association
		Sexual orientation discrimination by perception
		Indirect sexual orientation discrimination
	Sexual orientation harassment	Sexual orientation harassment
Victimisation	Victimisation	Victimisation
Other prohibited conduct	Instructing, causing, inducing or aiding contraventions	Instructing, causing or inducing contraventions
		Aiding contraventions

Equality monitoring specification (services)

Systems capability

- Service users should have information about their protected characteristics recorded where relevant
- Information handled about protected characteristics should be drawn from existing patient administration systems / clinical information systems whenever possible to prevent duplication
- Systems must have appropriately controlled functions to allow for information to be updated or amended on individual records
- Fields relating to information about sex, age, disability, ethnicity, sexual orientation, religion or belief, communication preferences should be mandatory
- Records relating to the previously recorded gender identity of a person must be archived securely and should prevent staff linking (or even indicating) them to that individual's new records unless authorised by the Head of Health Records or the patient / service-user them self
- Flagging is not the same as equal opportunity monitoring but systems must include the ability to separately flag information about a person's protected characteristics (e.g. learning disability or dementia) when it is disclosed
- Systems must be compliant with regulations around information sharing, data protection and in particular the Gender Recognition Act.

Practices

- All care activities should include review of information about the service users protected characteristics where it is indicated that information is missing (which excludes where the record indicates that the individual has voluntarily withheld this information) and measures put in place to collect the missing information
- All information about protected characteristics should be collected sensitively and in private
- Information about protected characteristics should always be collected from the person concerned. Assumptions made by anyone else (including carers) are unacceptable unless the person concerned indicates otherwise (and there are no safeguarding concerns) or where an individual is exercising legal powers over another's affairs
- Change processes must be in place to allow for information about protected characteristics to be updated or amended by individuals once, but which trigger processes to update their information across all records relating to that individual held by the Trust, unless that person indicates otherwise
- Methods to track the records relating to the a transgender individual's previous gender / sex must be maintained but must be known only to the Trust's Head of Health Records (akin to the practices used for the health records of adoptees)
- Information disclosed about a person's protected characteristics is sensitive personal information and should be handled as such by staff as per local information governance policies and procedures.

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Equal opportunities and protected characteristics specification

This specification standardises the categories for equality monitoring of patients, service-users, carers and volunteers, with the recommendation for implementation within the Trust's information systems and other patient data collections (e.g. surveys) where relevant.

Prefix *(honorific)*

Mr	Rev
Mrs	Sir
Ms	Lady
Miss	Lord
Master	Mx*
Dr	

Ethnicity

A White
English/Welsh/Scottish/Northern Irish/British
Irish
Gypsy or Irish Traveller
Any Other White Background, write in….
B Mixed/multiple ethnic groups
White and Black Caribbean
White and Black African
White and Asian
Any other mixed/multiple ethnic background
C Asian/Asian British
Indian
Pakistani
Bangladeshi
Chinese
Any other Asian background write in….
D Black/African/Caribbean/Black British
African
Caribbean
Any other Black/African/Caribbean background, write in…
E Other ethnic group
Arab
Any other ethnic group, write in…
Do not wish to disclose

* Please note that the prefix list follows the standard national categories with the addition of Mx, a prefix that purposefully does not indicate gender. For further information please refer to Appendix 1 of the Report of the Overview and Scrutiny Committee, Trans Equality Scrutiny Panel (Brighton and Hove City Council 2013)

Disability

In response to the question: Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

No
Yes, a little
Yes, a lot
- Behavioural and emotional
- Hearing
- Manual dexterity
- Memory or ability to concentrate, learn or understand (learning disability)
- Mobility
- Perceptions of physical danger
- Personal, self-care and continence
- Progressive conditions and physical health (e.g. HIV, Cancer, Multiple sclerosis, fits etc.)
- Sight
- Speech
- Other impairment(s), write in…
Do not wish to disclose

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Reasonable adjustments

In response to the question: Do you require reasonable adjustments?

Yes, please write in…
No

Sex

Female
Male

Sexual Orientation

Heterosexual
Lesbian, Gay
Bisexual
Questioning *(only applies in C&YP services)*
Do not wish to disclose

Age

Age should be captured if appropriate from date of birth information. If this is not suitable (e.g. on certain anonymous survey forms), then the following age bands should be used:

0-4 years
5-7 years
9-9 years
10-14 years
15 year
16-17 years
18-19 years

20-24 years
25-29 years
30-44 years
45-59 years
60-64 years
65-74 years
75-84 years
85-89 years
90+ years
Do not wish to disclose

Religion or belief

Christian
Buddhist
Hindu
Jewish
Muslim
Pagan
Sikh
Other religion, write in…
No Religion
Do not wish to disclose

Gender identity

In response to the question: Do you, or have you ever considered yourself as Trans?

Yes
No
Do not wish to disclose

Carer

In response to the question: are you a carer?

Yes
- Parent
- Child with special needs
- Partner / spouse
- Friend
- Other family member
- Other, please write in…
No
Do not wish to disclose

Armed Forces

In response to the question: Are you currently serving in the UK Armed Forces (this includes reservists or part-time service, eg: Territorial Army)?

Yes
No

In response to the question: Have you ever served in the UK Armed Forces?

Yes
No

In response to the question: Are you a member of a current or former serviceman or woman's immediate family/household?

Yes
No

Pregnancy

In response to the question: Are you pregnant?

Yes
No
Do not wish to disclose

Language

Akan (Ashanti)
Albanian
Amharic
Arabic
Bengali & Sylheti
Brawa & Somali
British Signing Language
Cantonese
Cantonese and Vietnamese
Creole
Dutch
English
Ethiopian
Farsi (Persian)
Finnish
Flemish
French
French creole
Gaelic
German
Greek
Gujarati
Hakka
Hausa
Hebrew
Hindi
Igbo (Ibo)
Italian
Japanese
Korean
Kurdish
Lingala
Luganda

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Makaton (sign language)
Malayalam
Mandarin
Norwegian
Pashto (Pushtoo)
Patois
Polish
Portuguese
Punjabi
Russian
Serbian/Croatian
Sinhala
Somali
Spanish
Swahili
Swedish
Sylheti
Tagalog (Filipino)
Tamil
Thai
Tigrinya
Turkish
Urdu
Vietnamese
Welsh
Yoruba
Other