A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Briefing Paper for the Equality & Diversity Steering

Publication of Information to meet the requirements of the Public Sector Equality Duty
Update of Information to be published on the Trust Web Site
Period 1st April 2015 – 31st March 2016

Publication Deadline 31st January 2017

Introduction

The Equality Act 2010 came into force on 1st October 2010. It replaces the previous anti-discrimination laws with a single Act and simplifies and strengthens the law.

A key measure within the Act is the Public Sector Equality Duty, which came into force on 5th April 2011. This duty is designed to ensure all public bodies play their part in making society fairer by tackling discrimination and providing equality of opportunity for all.

The new Equality Duty encourages public bodies to understand how different people will be affected by their activities so that policies and services are appropriate and accessible to all and meet different people's needs.

The Equality Duty covers the following 8 protected characteristics:

a) age
b) disability
c) gender reassignment
d) pregnancy and maternity
e) race, including ethnic or national origins, colour or nationality
f) religion or belief
g) sex
h) sexual orientation

The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

1) Eliminate unlawful discrimination

2) Advance equality of opportunity

3) Foster good relations

1. Publication Requirements

In order to support implementation of the Equality Duty, two deadlines have been set by which NHS Foundation Trusts and other public sector organisations must publish firstly information and secondly objectives which show that the organisation is compliant with the public sector equality duty. The dates for publication are stipulated in the Equality Act 2010 (Specific Duties) Regulations 2011.

1.1 Information to demonstrate compliance with the Equality Duty, to be published annually - commencing no later than 31st January 2012

Information must be published to demonstrate compliance with the duty imposed by section 149 (1) of the Act. This information must be updated at intervals not greater than 1 year.

This will include information relating to employment information and information on healthcare services provided by the Trust.[1]

1.2 Equality Objectives – to be published at least every 4 years, First publication was submitted 6th April 2012

The objectives should be informed by analysis of the information published in compliance with section 2.1 above.

Objectives Currently Published on the Trust Web Site:

- To develop the membership of the Foundation Trust in order to ensure that it is representative of the communities we serve
- To review all policies to ensure that they have an equality impact assessment – review to be completed by 5 April 2015
- To review the outcomes for female patients referred to the heart divisions to determine whether the outcomes of management differ from those of matched male patients
- To review recruitment practices and processes in the light of the Equality Act to ensure total fairness and transparency for all.

These objectives were due for review on 6th April 2016. They now either need to be renewed, or superseded by new objectives to cover the 4 year period 6th April 2016 – 6th April 2020.

The information attached at Appendix I and Appendix II will be re published on the Trust web site by 31st January 2017.

Information for Appendix II has been updated for 2015/16 and collated by Jason Trofimczuk. Updating of Appendix I will be undertaken by Paul Mendes.

[1] Equality information and the equality duty: A guide for public authorities, Equality and Human Rights Commission 19th December 2011

This paper is brought to the E&D Steering Group in order to provide an early view of the draft information to be published in January 2017 and to act as backing information for discussion of the Trust Objectives for 2016 -2020 and associated engagement work.

Richard Connett
Director of Performance & Trust Secretary 26Th August 2016

Appendix I
Employment Information 2014/15

Contents:

1) Employee distribution
2) Issues relating to transsexual staff
3) Gender pay gap information
4) Occupational segregation
5) Grievance and dismissal information related to protected characteristics
6) Complaints about discrimination
7) Details of feedback and engagement with staff and trade unions
8) Details concerning research with employees
9) Decision making related to the E&D Duty
10) Policies and Programmes (to address equality concerns)
11) Return to work rates after maternity leave
12) Take-up of training opportunities
13) Flexible working

1. Employee Distribution

On 31st March 2016 the Trust employed 3578 individual staff in substantive roles (3342 whole time equivalent) and 802 currently active staff in non-substantive roles. This non-substantive staffs, known as bank staff, are either occasional workers brought in to fill short term requirements on an as-needs basis or people in unpaid, honorary, positions.

Of the substantive staff, the following is declared concerning protected groups under equality law.

a) Gender

Male	981	(27.6%)
Female		2597 (72.4%)
Transgender	0	(0.0%)

b) Ethnicity

White	2166	(60.5%)
Mixed	85	(2.3%)
BME	1001	(27.9%)
Not Known	326	(9.1%)

c) Age

Aged 0-16	0	(0.0%)
Aged 17-21	9	(0.3%)
Aged 22-59	3375	(94.3%)
Aged 60+	194	(5.4%)

d) Sexual Orientation

Heterosexual	1358	(37.9%)
Bisexual	13	(0.3%)
Homosexual	23	(0.6%)
Not Known	2191	(61.2%)

e) Marital Status

Married	1362	(38.1%)
Single	1507	(42.1%)
Widow(er)	11	(0.3%)
Civil Partnership	21	(0.6%)
Divorced/Separated	133	(3.7%)
Not Known	544	(15.2%)

f) Persons Undergoing Gender Re-Assignment

Known GRA	0	(0%)

g) Persons in maternity/adoption leave

Maternity/Adoption	105	(2.9%)

h) Persons with disabilities

Disabled	42	(1.1%)
Not Disabled	2641	(73.8%)
Not Known	895	(25.0%)

i) Religious Beliefs

Atheist	205	(5.7%)
Buddhist	15	(0.4%)
Christian	883	(24.6%)
Hindu	79	(2.2%)
Islam	91	(2.5%)
Jain	1	(0.02%)
Jewish	5	(0.1%)
Sikh	10	(0.2%)
Other	111	(3.1%)
Not Known	2178	(60.8%)

Of the non-substantive staff (802) the Trust declares the following:

a) Gender

Male	329	(41.0%)
Female	473	(59.0%)

b) Ethnicity

White	301	(37.5%)
Mixed	8	(1%)
BME	152	(18.9%)
Not Known	341	(42.5%)

c) Age

0-16	1	(0.1%)
17-21	36	(4.5%)
22-59	700	(87.2%)
60+	65	(8.1%)

d) Sexual Orientation

Heterosexual	151	(18.8%)
Bisexual	1	(0.13%)
Homosexual	0	(0.0%)
Not Known	650	(81.0%)

e) Marital Status

Married	213	(26.5%)
Single	385	(48.0%)
Window(er)	0	(0.0%)
Civil Partnership	0	(0.0%)
Divorced/Separated	15	(1.8%)
Not Known	189	(23.6%)

f) Persons Undergoing Gender Re-Assignment

Known GRA	0	(0.0%)

g) Persons in maternity/adoption

Maternity/Adoption	0	(0.0%)

h) Persons with Disabilities

Disabled	7	(0.9%)
Not Disabled	475	(59.2%)
Not Known	320	(39.9%)

i) Religious Beliefs

Atheist	28	(3.5%)
Buddhist	1	(0.13%)
Christian	97	(12.1%)
Hindu	8	(1.0%)
Islam	11	(1.4%)
Jainism	1	(0.13%)
Sikhism	4	(0.5%)
Other	9	(1.1%)
Not Known	643	(80.2%)

Observations on the above data

- **Distribution across different pay grades**
  Our medical staff and very senior staff show a different gender balance to the rest of Trust, and are majority male, although not greatly so.

  As of 31/3/16 we have 254 male doctors and 182 female, however there is no imbalance with gender across different grades of doctor, with females represented at all grades up to and including Clinical Director.

Within our very senior staff (Band 8c or Consultant and above (c£70,000pa +)) we have 129 women to 172 men (33% to 67%) including 1 (of 6) female executive directors, and 3 (of 6) female non-voting executive directors.

These exceptions aside the distribution of all protected characteristics across all grades and professions is in line with the distribution of these protected characteristics across the entire complement staff.

- **Data accuracy**
  Data collection is hampered across all protected groups by the fact that staff are under no formal or legal obligation to disclose this information to us as their employer, although the level of disclosure has risen since last year. This tends to be problematic in particular areas; for example whilst most staff are happy to disclose their race, far fewer are happy to disclose their religion or sexual orientation.

  These figures may also be compromised by inaccuracies in recording, since all of these attributes are self-declared by our staff members, usually on application for their post or commencement of service. For example a staff member who, by the letter of the law, is mixed may declare themselves as black if they identify with that part of their ethnicity more so than the other.

- **Ethnicity and Nationality**
  This Trust is committed to having excellent staff and will recruit from all countries to obtain them. Recruiting managers are not shown the ethnicity or nationality of candidates when they are short listing them to ensure fairness in all cases.

- **Age**
  We are not able to employ children under 18 in clinical areas due to NHS regulations. Under current NHS pension arrangements staff retire at 60 (although this will change as the new pension schemes begin to affect retiring workers) however they are no longer required to do so and most staff are allowed to return post-retirement in either full or part time capacities.

- **Sexual Orientation**
  The data in these areas is affected by non-disclosure.

- **Marital Status**
  This Trust is subject to the NHS Pension Schemes in respect of benefits offered to married

persons, which also extend to civil partnerships.

- **Gender-Reassignment**
  This data may be hampered by non-disclosure (someone who has been through GRA may very well simply report themselves as their new gender), although we are not currently aware of any staff undergoing this at present.

- **Maternity and Adoption**
  This Trust offers Maternity and Adoption leave to its substantive staff in line with the NHS Agenda for Change provisions. Non-substantive staff-have no entitlement to this leave, which is why the figure for that group reads as zero.

- **Disabilities**
  The data here is affected by non-disclosure although it is fair to assume that the overwhelming vast majority in the "Not Known" category will not be disabled as, being a hospital, there are physical requirements involved in all but the most desk-focused administrative positions. The Trust is a Two Ticks recruiter in respect of disability.

- **Religious Beliefs**
  Again the data is affected by non-disclosure. Both sites of this Trust do, however, contain chaplaincies staffed either substantively or on an honorary/voluntary basis with ministers of several religions. Provision exists to provide a minister of any faith if required by a staff member or patient.

2. Issues Relating to Transsexual Staff

As of 31/3/16 this Trust does not knowingly employ any staff who are transsexual, nor does it knowingly employ anyone undergoing gender re-assignment.

3. Gender Pay Gap Information

This Trust does not have a history gender pay gap issues and there have been no “class action” style equal pay claims here.

One main example of why this has not happened concerns how this Trust handled the relatively common situation of housekeeping staff and porters. Although the majority of our housekeeping staff are outsourced as is fairly common practice in the NHS today, they are paid the same rates that they would be if they worked directly for the NHS. This has been the case since the service level agreement with our contractor (ISS) was put first put in place. As such there has been no gender pay gap between housekeepers, who are largely outsourced, and majority female, and porters who are largely directly employed and majority male.

Within the professional spheres at this Trust we appoint the best people to the job irrespective of gender (or anything else) and therefore we have very senior female doctors, just as we also have very senior male nurses. We appoint to all grades in nursing and in the allied health professions, so the opportunities for people in those (majority female) professions to achieve high earnings are as good as they are for our (majority male) doctors.

Policies and procedures nevertheless do exist to allow individual staff members to bring equal pay claims to the consideration of HR. From 1/4/10 to 31/3/16 5 such claims were brought. 3 were subsequently withdrawn prior to adjudication and the remaining 2 were settled by the Trust.

4. Occupational Segregation

There is no particular issue of occupational segregation at this Trust; the distribution of protected characteristics across the most occupations being near to, or exactly, in line with the distribution across the entire staff.

That said, two occupational areas are majority male (contrary to the general majority female distribution) those being doctors (254 male to 182 female) and Estates staff (125 male to 40 female), not including those parts of housekeeping that are outsourced. It would, however, be a step too far to suggest that males are occupationally segregated into these two occupations, or indeed that females were prevented from entering them as males and females are represented across all grades within these two, and all other, occupations.

Other than the above exceptions there is no occupational segregation, something which can be proven by taken our largest single occupation (nursing) and comparing the three protected characteristics that we have the best data for across the occupation.

	Entire Trust	**Nursing Staff Only**
Male	981 (27.6%)	174 (13.0%)
Female	2597 (72.4%)	1165 (87.0%)
Transgender	0 (0.0%)	0 (0.0%)
-		
White	2166 (60.5%)	816 (60.9%)
Mixed	85 (2.3%)	21 (1.5%)
BME	1001 (27.9%)	363 (27.1%)
Not Known	326 (9.1%)	139 (10.3%)
-		
Aged 0-16	0 (0.0%)	0 (0.0%)
Aged 17-21	9 (0.2%)	1 (0.07%)
Aged 22-59	3375 (94.3%)	1308 (97.6%)
Aged 60+	194 (5.4%)	30 (2.2%)

5. Grievance and Dismissal Information Related to Protected Characteristics

At this Trust, unless a grievance is taken to a formal stage, no formal record is kept and therefore it is not possible to obtain data with relation as to how many of them were specifically related to protected characteristics. Nevertheless discrimination runs contrary to the Trust's general terms and conditions of employment, core values, and employee relations policies and such complaints are taken very seriously (see section 6 below).

Only 8 people were dismissed in 2015/2016, as such it is not possible to extrapolate any meaningful equality data out of such a small sample.

6. Complaints About Discrimination and Prohibited Conduct from Staff

Discrimination and other prohibited conduct under the E&D act runs contrary to the general terms and conditions of employment at this Trust, as well as the Trust's Core Values, E&D Policy, and Employee Relations Policy. It is therefore a serious disciplinary offence and complaints of this nature made are taken very seriously and investigated under the Grievance Policy. This will normally involve one informal and (if necessary) two formal stages, although any misconduct found at any stage will be dealt with irrespective of the ultimate fate of the complaint. Beyond our own internal procedures all employees also have recourse to Employment Tribunals.

7. Details of Feedback and Engagement with Staff and Trade Unions

The Trust holds a monthly Joint Staff Committee in order to cover feedback and engagement.

The JSC comprises of (at least) one representative from every trade union and college recognised by the Trust as well as several independent staff side representatives.

The Chief Operating Officer and the Director of Human Resources sit on this committee to represent management side, and provisions exist for any other person to attend on either staff or management side if they have something pertinent to present. (For example if a reform to the arrangements for Study Leave was under discussion then the Head of Learning and Development would attend on the management side to explain what was proposed).

The JSC is chaired by the Chair of Staff Side, a Trust appointment made on the advice of the JSC. Minutes of every JSC are taken and kept on file.

8. Details concerning research with employees

Simple data on employees is held in the NHS Electronic Staff Record, and it is from this, for example, is where the E&D information is held. Data regarding employee's training and development is held in the Trust's Learning Management System, as provided to us by under SLA by AccessPlanIT.

For all other research we are participant in the CQC/Capita NHS National Staff Surveys wherein a random selection of staff are polled on a variety of questions most of which are set nationally and some of which are set locally.

In the areas of equality and diversity, it was indicated in the 2010 staff survey that few staff had received equality and diversity training, and as such new E&D training programmes were introduced in 2011 (see section on Training below).

9. Decision Making Related to the E&D Duty

Decisions at Trust level which are covered under E&D legislation are not normally made without reference to the Joint Staff Committee first (see above).

Decisions made at local level are guided by the Trust policies for various matters. All Trust policies written since the Equality Act 2010 are required to have E&D Impact Assessments. Those written before that time are updated to include them when they are either altered or reviewed (whichever occurs first). All workforce related policies are now compliant in this way.

10. Policies and Programmes (to address equality concerns)

No matters of E&D concern were raised formally by our trade unions within the 2015/2016 period.

11. Return to Work Rates after Maternity

This Trust grants maternity pay and leave as per the national NHS Agenda for Change Terms and Conditions and extends these terms to all directly employed staff, whether or not they are employed on Agenda for Change contracts.

As of 31/3/16 105 people are currently on maternity leave, and the expected return to work rate is 92% as this was the rate for the 2014/2015 year.

12. Take-up of training opportunities

We are rated as above average in our Staff Surveys in relation to staff development with over 80% of our respondents stating that they received work-related development in the past year.

On average each individual staff member received 31.3 hours of training and development in 2015/2016 where 26.3 of those were mandatory training as detailed by the Trust's Safety Training policy (things that they *must* do) and 5.0 hours were developmental training (things that they *can* do).

The Trust provides training in all Safety Training subject areas and co-ordinates and enforces this to ensure all comply. Safety Training areas include Fire Safety, Health and Safety, Moving and Handling, Infection Control and, from this year Equality and Diversity. The trust also provides Learning and Development in areas of personal, leadership and clinical development. The Trust also funds staff for external courses by application to periodically held funding panels, chaired by the Head of Learning and Development.

All training is usually open to all staff, although some more specialist courses may have prerequisite requirements (e.g. a higher level leadership courses normally requires completion of a lower level one first). Take-up of training is excellent and all classes consistently run at better than 91% of capacity.

13. Flexible Working

The Trust allows flexible working in line with the national NHS Agenda for Change Terms and Conditions and extends these conditions to all directly employed staff whether or not they are employed on Agenda for Change contracts.

All staff may apply for Flexible Working for any reason and the decision is made whether or not to grant it by their local management depending on the needs of the service. In the event of a dispute Human Resources will arbitrate.

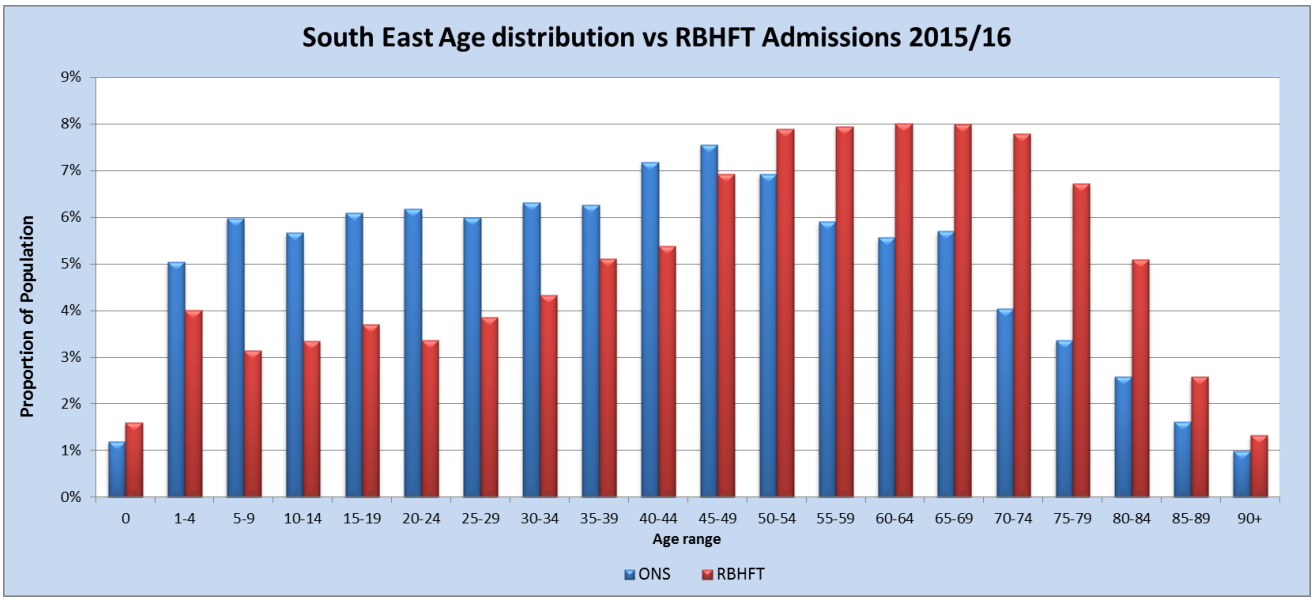
Paul Mendes
Head of Learning and Development **23rd of August 2016**

Appendix II
Information on Services

1. Access to services or participation rates for people with the different protected characteristics

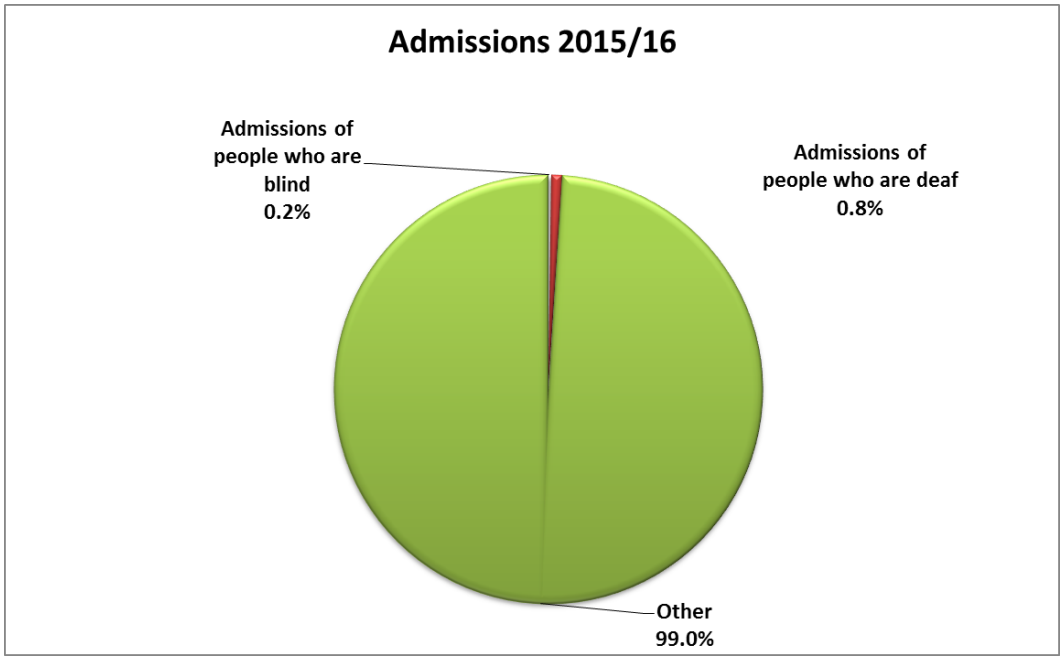
Age

The following graph shows the Office for National Statistics (ONS) age distribution for the South, South East and London. The red bars show how Royal Brompton & Harefield Foundation Trust's admissions compare. As would be expected our patient population is older than that of the general population.



Disability

The following graph shows the number of people admitted during 2015/16 who were coded as being either blind or deaf. According to the Royal National Institute of Blind People 0.27% of the population of England are registered as blind. According to the NHS Information Centre 0.4% of the population of England are registered as deaf or hard of hearing.



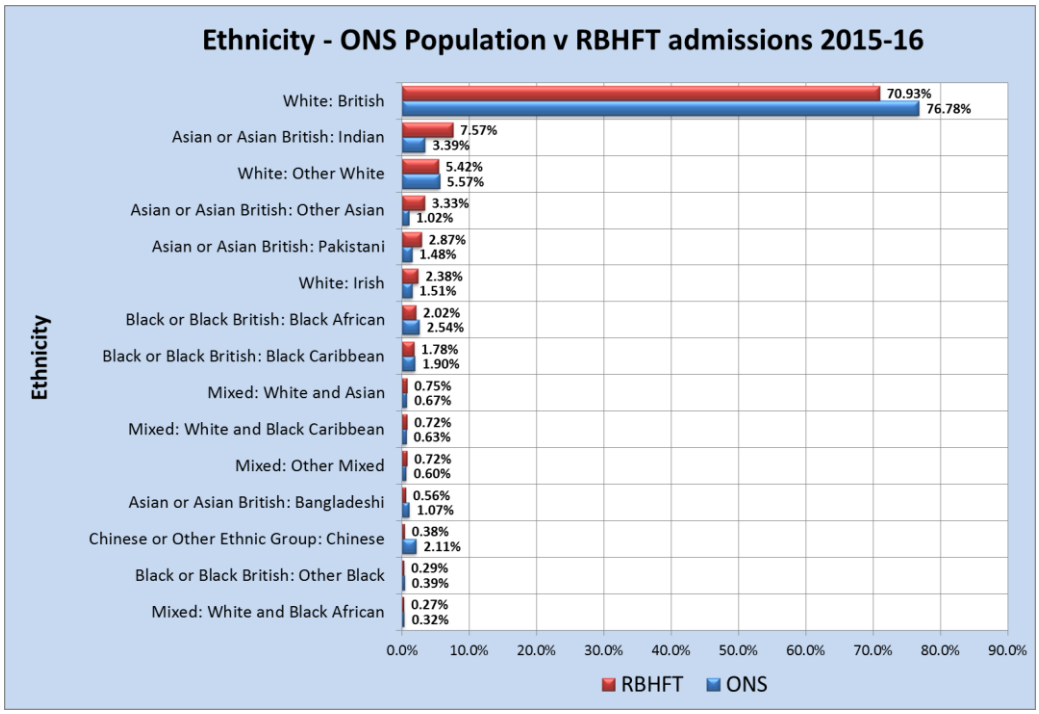
- The number of trust admissions of people who are roughly matches the national figure.
- The number of trust admissions of people who are deaf is about twice the national figure.

Ethnicity

The graph below compares the ethnicity of our admissions in 2015/16 with the ONS population of South, South East and London.

Our figures are similar to that of the general population and generally within 2% for each ethnic group. 70.93% of our admissions are White British which is close to the population of 76.78%.

We have a larger proportion of Indian patients compared with the general population. This could be related to an increased prevalence of heart and lung disease amongst the demographic but more work would have to be done to establish this correlation.

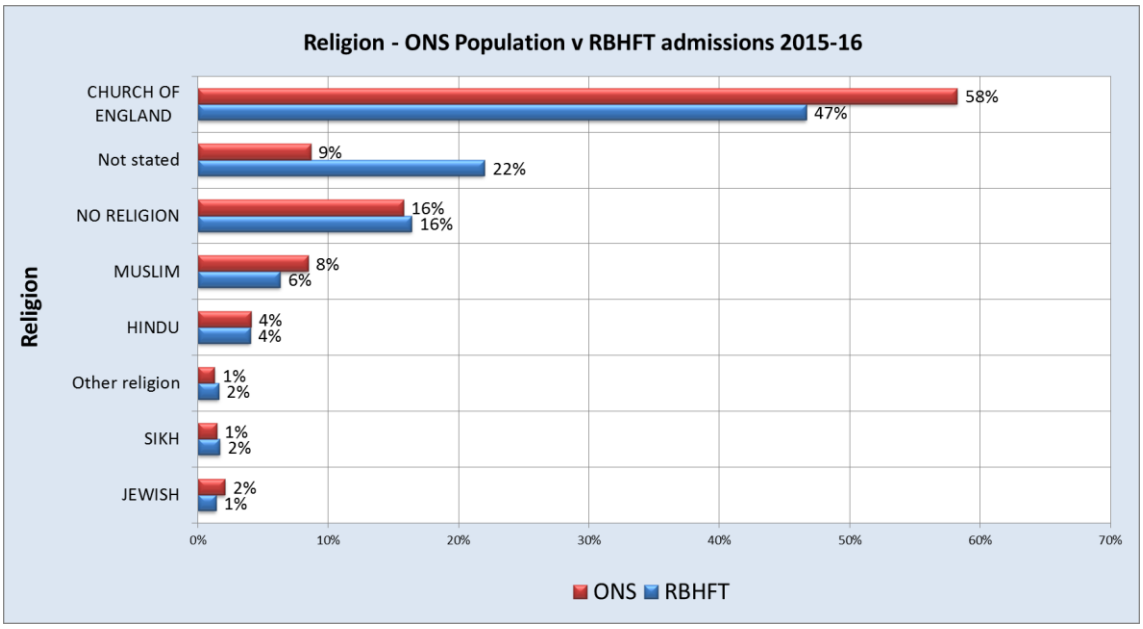


Religion

The graph below compares the religion of our admissions in 2015/16 with the ONS population of London.

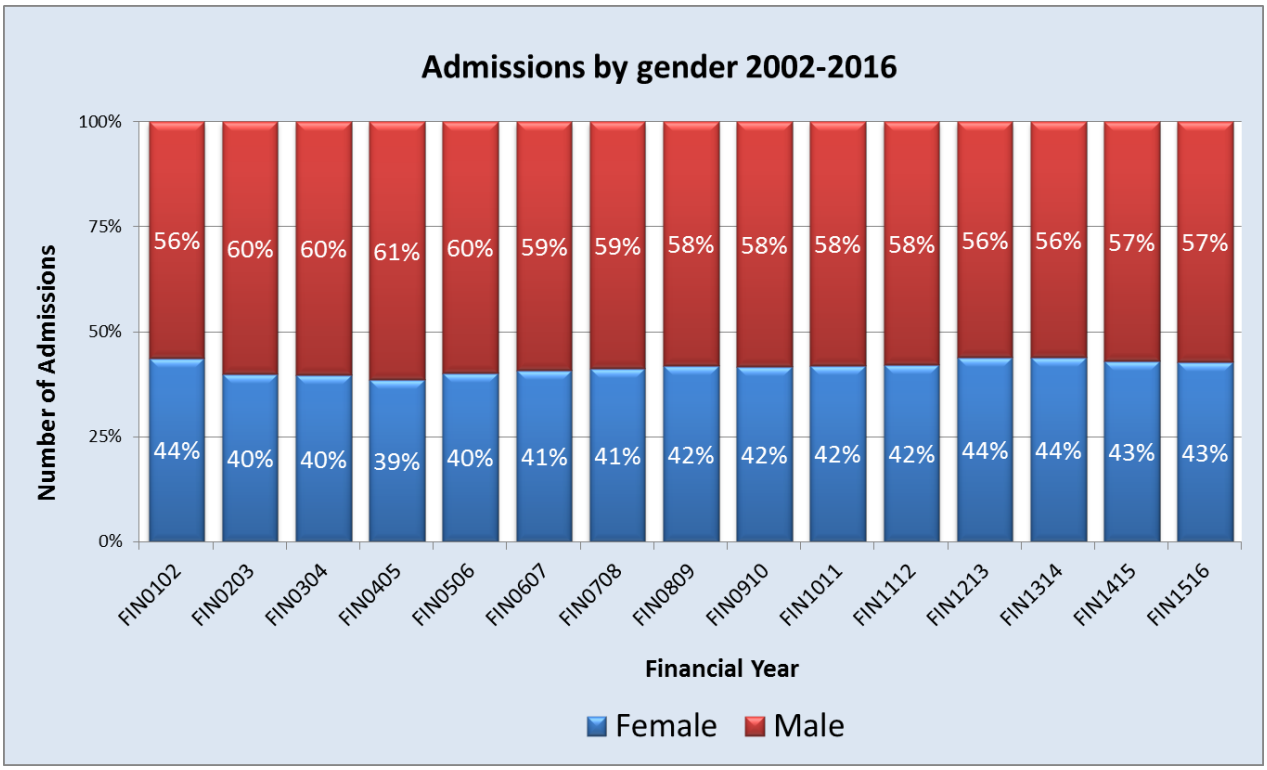
The graph shows that the Trusts admissions generally correlate closely to the religion of the London population. The Trust has 9% less admissions from the Church of England than the ONS. However this is likely to be because the ONS records different branches of the church under Church of England whilst we record it separately under 'Other religion'.

The Trust has a large number (22%) of patients where the religion is 'not stated'. This may explain why the Trust has a lower percentage for most religions than the general population, e.g. Muslim the Trust has 6% and the ONS has 8%. This is a data quality issue which will be addressed in the future by the Data Quality team.



Gender

The following table shows admissions by gender for the last 15 years. In 2015/16 57% of admissions were male which has decreased from 60% in 2002/03. Further work will need to be done to establish whether this is a national trend and what the gender ratios are nationally for people with heart and lung disease.



Transgender

The trust doesn't currently record on PAS whether a patient is transgender. The gender options are either male or female. Accurate patient identification is required in order to avoid mixed sex accommodation onwards. The term "Indeterminate" may be used only for newly born babies. There isn't currently any information in the NHS data dictionary regarding transgender persons.

Jason Trofimczuk - Senior Performance Analyst 18rd August 2016

2. Customer satisfaction with services including any complaints (and the reasons for complaints)

For information about patient surveys, patient feedback and engaging patients to advance service improvement and the patient experience please refer to section 5 b and c below. For information about complaints please refer to section 4 below.

3. Performance information for functions which are relevant to the aims of the general equality duty, especially around service outcomes (e.g. attainment, recovery rates)

All services review their clinical outcomes and performance on a regular basis and this includes review of indicators which are clinically important and meaningful for each care group.

Within the Thoracic Surgery service, prior to surgery all patients are assessed using the Thoracoscore to predict the possibility of postoperative mortality. Indicators that are assessed using this scoring method include age, gender and co-morbidities.

Patients in adult cardiac surgery are assessed pre-operatively using Euroscore which indicates risk of mortality in post-operation using risk factors; this includes the use of age and gender along with other co-morbidities. For adult bypass surgery we also use the Brompton Harefield Infection Score (BHIS©) score which indicates risk of infection post-surgery, this score also accounts for gender. These scoring methods are used when clinically significant. Age, gender and ethnicity also form part of the Congenital Heart Disease minimum data set which is regularly submitted to the NCHDA (National Congenital Heart Disease Audit)

Carol Rayne - Q&S Lead 18th August 2016

4. Complaints about discrimination and other prohibited conduct from service users

During the year (1st April 2015 – 31st March 2016) there were 0 Formal Complaints and 15 PALS concerns involving issues of discrimination and equality.

Concern 1: A patient who is a powered wheelchair user informed transport but when they arrived they did not have space for his wheelchair. Outcome: The manager of the car company has apologised for the situation that occurred. He has spoken with the driver concerned; who it appears had misread the request regarding the transport requirements. The information had been sent correctly on to the car company from the Trust. The manager has spoken with the patient's carer, who has accepted this apology and explanation. The patient has been assigned another appointment.

Concern 2: Relative of a patient who is profoundly deaf and dumb and coming for surgery wanted to know whether we can get a BSL interpreter and how the patient will be communicated with after surgery. Outcome: Step daughter contacted and advised to raise all her concerns with the Consultant. Also advised that the ITU have symbol boards to communicate with patients and that when the date has been set for admission then an interpreter could be booked to speak to patient and the family about what to expect. Also about what services might be needed when the patient is discharged.

Concern 3: Patient concerned about the attitude and manner of a member of nursing staff and feels that the nurse does not treat everyone ‘equally’ and that she is not accepting of Arabic patients. Outcome: The manager has spoken to the nurse in question in terms of the way she is perceived especially to the foreign patients because of her body language. She is aware that this can be an issue and is undergoing mentoring which is focusing on her behaviour/ reactions to certain situations, body language and tone and how to manage situations in a less abrupt and calmer manner.

Concern 4: Relative concerned as his mother is from Kashmir and unable to speak English and says a nurse was rude and asked how long she had been in the country. Outcome: Nurse explained that the intention of asking how long patient has been in the country was to establish if the patient knew any English. Advised son and patient that bilingual staff were available and if there was any problems issues with communication between nurses and patient the son would be called.

Concern 5: Mother of disabled daughter had concerns about the disabled toilets accessibility and the facility itself and would like the Trust to review this. Outcome: The estate and facilities manager responded directly to the enquirer informing her of RBH's future plans re: facilities.

Concern 6: Patient requested a female surgeon and anaesthetist due to cultural beliefs and was told this would happen. However on the day of the procedure only male staff were available. She complained to male surgeon who was abrupt and aggressive and said she could go elsewhere. Patient felt that her cultural beliefs had been dismissed. Outcome: Patient was allocated an alternative Consultant.

Concern 7: Deaf mother of deaf patient complained that she was late arriving for her appointment due to heavy traffic. A BSL interpreter was booked but did not wait for her to arrive. There was no specific time the interpreter was booked for and, therefore, it is surprising that s/he chose to leave. The mother said that although her mother can sign, it is unreliable. Outcome: The booking for the interpreter had been left open so it is not certain why he left after an hour. The Receptionist in clinic said he was never willing to wait. OneStop (interpreters will look into this) It was suggested that their interpreters exercised more sensitivity and asked some questions before leaving.

Concern 8: Disabled patient had an appointment at Fulham wing. This patient needed to go to the cashiers' office to claim their reimbursement for travel. But found it difficult and inconvenient to get to the Sydney Street building due to their disability. Outcome: Patient was contacted directly and it was explained that a porter could have been called to take him across to Sydney Wing in a wheelchair and there is also a shuttle ambulance which runs between Fulham Wing and Sydney Wing and he could have been given access to that for his transfer.

Concern 9: The mother of a disabled adult (18 year old) is unhappy that she has to pay for accommodation charges. She feels that her son is being discriminated against, as he is disabled and needs his parents in the same way that children under 18 need their parents. She feels that we are unjustly charging her. Outcome:
Arrangements made with Social Services and Accommodation to charge the mother half-price for the accommodation.

Concern 10: Sister and carer of a patient who is disabled asked for transport which has not been forthcoming. They are concerned there are questions around a recent holiday the patient went on and her ability to move around. Outcome: Further information was received from the GP and transport has now been booked.

Concern 11: Relative drove her father to hospital and was unable to park in the hospital grounds so parked in the road and received a fine asked if this could be waived as father has a blue badge. Outcome: Relative advised that her father would need to appeal the fine with the local council.

Concern 12: Patient who is deaf and does not have a phone has received a letter asking him to call the department to make an appointment. He requests e mail contact as a mode of communication. Outcome: Service Manager arranged for this to dealt with.

Concern 13: Relative concerned about the attitude of car park attendant who refused to allow him to park in the disabled bay to drop off his uncle (who is blue badge holder) for admission. Outcome: PALS apologised to visitor regarding his experience and spoke with the car park attendants. Concerns passed to manager for follow-up.

Concern 14: Concerns raised by drivers that car park attendants are unhelpful when dealing with disabled patients. Outcome: It was explained that attendants should demonstrate compassion but that if the driver is able bodied he should be allowed to bring the patient in but then park in the street in the appropriate disabled bays.

Concern 15: Patient enquired about toilet facilities for her stay including a full set of grab rails and space to manoeuvre a powered wheelchair with a ceiling hoist or portable hoist and space for 2 carers and a bidet as she has one at home. Outcome: This is an on-going problem which requires refurbishment of bathroom in Sleep Labs. This has been brought to the attention of the Healthcare for All group which will monitor the situation. Patient asked to prioritise what is needed as an initial improvement.

There were a total of 1495 (PALS concerns, formal complaints, and comments) received in this period, therefore 1% of all concerns, complaints and comments received related to discrimination and equality. This is an increase on last year which is most likely to be due to the improved recording of concerns regarding equality and diversity.

We have had no concerns raised that patients have been discriminated against for raising a concern or making a complaint. Patients and their relatives are informed that they will not be discriminated against for making a complaint in the PALS leaflet and the Complaints booklet. In addition, staff are informed at the Staff Induction PALS session that patients must not be discriminated in any way for making a complaint.

Sharon Gurney Complaints Lead/PALS Officer **2nd August 2016**

5. Details and feedback of engagement with service users

a. Foundation trust and membership

Royal Brompton & Harefield NHS Trust became a FT in June 2009. As a foundation trust there is a requirement to have a membership base and elected governors. The Trust had a membership of The Trust had a membership of 11,038 at the end of March 2016 members which are made up of: patients, public members, carers and staff. As per the trust's constitution the role and function of members is that:-

"*All members may attend and participate at members' meetings; vote in elections for the Governors' Council; stand for election to the Governors' Council, and take such other part in the affairs of the Trust as is provided for in this constitution and set out in the membership strategy*" (Para. 10- p. 8)

The Trust therefore uses its members as a means of engagement in trust decision-making and activities. In 2015-2016, members were involved in a number of key trust activities. These included: the annual members' meeting, which was held on 22nd July 2015, Members events which included a tour of the paediatric sleep laboratory and talks by medical staff. Patients also had the opportunities to attend a number of patient open day and events that were organised by staff in various clinical departments.

A Membership Steering Committee was established in April 2011. Its remit is to oversee the recruitment of new members, ensure that membership is representative of the communities it serves and to investigate new ways of engaging with members.

Philippa Allibone – Membership manager **26th July 2016**

b. Patient surveys and patient feedback

For 2015-16 RBHT participated in two nationally required annual surveys; The National Inpatient Survey and the National Cancer Survey; each with response rates of 54% and 70% respectively. On a monthly basis the Trust participates in the Friends and Family Test (FFT); in 2015/16 the Trust achieved a response rate of 30% or better and a score of 96% or better, i.e.96% of respondents would recommend the Trust.

On an annual basis RBHT Paediatric program commissions The Paediatric Intensive Care Audit Network (PICANet) to survey parents and carers experiences during the admission of their child to a paediatric intensive care unit (PICU). “Your Experience Counts” – the EMpowerment of PArents in THe Intensive Care (EMPATHIC-30) survey tool is used to collect data for all discharges in the months of February and July (last done in July 2016). Results are then compared to other PICUs across the UK and Ireland. PICUs are divided into two groups depending on the number of paediatric intensive care admissions: small (<500 admissions per annum) and large (500+ admissions per annum). For 2015 RBHT PICU response rate was 17%, results overall were positive.

In 2015/16 the RBHT received 9,426 FFT comments from patients. 96% of these comments were positive. Over 880 comments were collected from the RBHT 2015 inpatient survey. The majority (84%) were positive. The 2015 National Cancer Survey final results were answered by 21 RBHT patients with a score of 92% for RBHT for the question used as a national marker for peer review: Q59 Patient`s average rating of care scored from very poor to very good.

2015/16 monthly communication reports show that there are on average approximately 22 social media comments per month about the care received at the Trust. The majority (87%) are positive. To date there has never been any specific posts related to discrimination and equality.

The results of the surveys and all other forms of patient feedback are used to monitor trends over time and drive continuous quality improvements within the trust. Accounting for all sources (national surveys, social media, Patient Advisory Liaison Services (PALS) inquiries) the top 5 themes identified are issues related to: Information and Communication (710), Waiting (681), Food (491), Care (general) (187), and Cleanliness/Toilets/Facilities (140). The Comments & Complaints Working Group review these in greater detail and work with service users to set priorities and focus going forward. In addition the Discharge Improvement work started in 2015-16 based on the National Inpatient Survey results will continue into 2016-17.

Feedback from the FFT comments are monitored, collated and given to inpatient and day-case ward leaders, and outpatient department service managers to review and act on where appropriate. Any changes or improvements to services are shared with patients through communication channels including ‘You said We did’ posters displayed in clinical areas and via newsletters and other publications. To date there has never been any specific feedback related to discrimination and equality. There are meetings held every quarter with ward leaders to review all patient comments and discuss how these can be turned into improvements. Any “quick wins” are discussed initially and monitored until implementation. Themes are also discussed and meetings are being set up with appropriate parties.

Where improvements cannot be made due to current legislation (e.g. Nurse call system noise) it has been agreed that posters will be created to inform patients as to the reason for the level of volume on the nurse call system to mitigate any complaints which may be made.

At a Trust level there were 10 major initiatives in 2015-16 to improve patient experience; based on national initiatives such as “Protected Mealtimes” or specific feedback from patients. For example the Digital Signage Initiative is meant to assist with providing timely and relevant information to ease some of the discomfort of long waiting periods and improve communication.

Locally there were several excellent examples of where individual programmes or service providers made significant improvements based on their specific patient population feedback. Each example does include the principle of co-design; i.e. working collaboratively as service providers and service users to find solutions that will make a better experience for all.

PLACE (2015)

On an annual basis the Trust conducts a Patient-Led Assessment of the Care Environment (PLACE). PLACE replaced the former Patient Environment Action Team (PEAT) inspections in 2013. The assessments apply to all organisations providing NHS funded care. These assessments are designed to provide patients and other stakeholder’s assurance on how their local health and care services are run. Areas of assessment are:
cleanliness, nutrition and hydration, privacy and dignity and building condition and appearance. Assessments are carried out by several members of staff together with patient representatives from Healthwatch and volunteers. In 2015 there was a special focus on disability access assessment for PLACE.

Generally the Trust does well and there has never been any specific feedback to discrimination and equality. At times the age of the buildings does not allow for suitable physical access for those patients with a physical disability; the Trust is aware of these locations and makes suitable alternative arrangements.

c. Engaging Patients to advance Service Improvement and the Patient Experience

The Trust’s Quality and Safety Department isdivided into 3 divisions; Heart Division at Harefield Hospital, Heart Division at Royal Brompton and the Lung Division across both sites. Each division is responsible for ensuring their patients have adequate opportunity to provide feedback on a regular

basis. Actions and improvements to services are taken based on that feedback. . On an annual basis many care groups host “Patient Experience or Information Days” where patients and clinicians meet to discuss their specific care pathway and how to improve it for both.

The Trust is dedicated to involving patients and the public in the design, execution and dissemination of our research and in raising public awareness and interest in our work through a range of education and media activities. Public involvement and engagement (PIE) focuses on people with a 'lay' interest in lung and/or heart research.

Since 2010, our cardiovascular and respiratory biomedical research units have gained a reputation for delivering quality public involvement and engagement in research. Our research public involvement and engagement strategy 2013-2016 will enable this work to be rolled out across all research within the Trust - increasing numbers of effective patient/researcher partnerships and opportunities for patients and public to find out more and discuss our research.
The RBHT’s strategic aim is to actively involve patients and the public in our work to ensure we continue to produce high quality research focused on patient benefit, and increase public awareness and interest in our heart and lung research.

Jan McGuinness – Director of Patient Experience & Transformation **August 2016**

6. Quantitative and qualitative research with service users e.g. patient surveys

For information about patient surveys, patient feedback and engaging patients to advance service improvement and the patient experience please refer to section 5 b and c above.

General comments about Equality and Diversity

Membership

In respect of membership, the Trust has targeted specific under-represented groups in terms of: age, gender and ethnicity to ensure a representative membership to reflect our patient and public constituencies In October 2014 a recruitment drive was undertaken for new public members. The membership profile was analysed and groups which were under represented were identified. It was decided to concentrate on the constituency of the North West London and members of the public aged between 21 and 39 who belonged to ethnic minority groups. Campaign teams concentrated on locations such as Libraries, Leisure Centres and Shopping Centres. This recruitment was very successful and over 500 members were recruited.

Disability

The Annual National In-Patient Survey includes 2 questions about Disability:

1. Question 1 asks Patients to indicate if they have any of the following long standing conditions: deafness or severe hearing impairment, blindness or partially sighted, a long standing physical condition, a learning disability, a mental health condition, a long standing illness such as cancer, HIV, Diabetes, chronic heart disease, or epilepsy

2. The second question asks if the condition identified in the first question causes any difficulty with any of the following: everyday activities, at work, access to buildings, streets or vehicles, reading or writing, people's attitudes to them, communication, any other activities.

From the results (2014) RBHT has approximately 30% of patients with no identified long standing disability; 30% with a physical disability; 40% with a long standing illness. Access to buildings and doing everyday activities cause the most difficulty for patients accessing the Trust. The Trust uses the annual PLACE assessment to address areas of that require enhanced accessibility.

Religion

The Annual National In-Patient Survey includes a question about patients' religious beliefs.

Philippa Allibone – Membership manager
Jan McGuinness – Director of Patient Experience & Transformation August 2016

7. Records of how you have had due regard to the aims of the duty in decision-making with regard to your service provision, including any assessments of impact on equality and any evidence used

The Trust continues to focus on specific projects which involve patients and their carers with access to specialist services and supported decision making.

People with a Learning Disability and their carers are members of the North West London Collaboration of Commissioning Groups and CWHHE CCG[2] Team Adults Learning Disability Health Steering Group and contribute to local and pan London projects. The Trust together with the other acute Trusts are represented by the their respective LD leads at these meetings. Feedback is available from service users from RBKC through the RBKC LD Health Facilitator for specific projects and work streams.

The Trust continues to consult Action Disability Kensington & Chelsea (ADKC) for guidance on making the hospital as accessible as possible for those with disabilities as well as using recommended signage recommended by the Trust Lead.

Eve Cartwright – PALS Manager on behalf of Felicia Cox - Lead Nurse in Pain Management/Head of Pain Service (ANT) July 2016

[2] Central London, West London, Hammersmith & Fulham, Hounslow, Ealing Clinical Commissioning Group

8. Details of policies and programmes that have been put into place to address equality concerns raised by service users.

Policies

There is a Trust policy: `Policy for Policies' which is in two parts. Part 1 outlines how policies should be written and formatted and Part 2 provides explicit guidance for the development of Trust policies and details for their completion. For the majority of Trust policies, staff are given the opportunity to provide feedback. Policies remain current for between 1 and 3 years following their approval and a review commences three months prior to this date. The policy, however, may be reviewed at any time before this as a result of legislative or organisational changes and in response to the ongoing review of its effectiveness. Please refer to Part 2 – p. 10 of the policy for guidance in relation to consultation and engagement. All policies are required to have an equality impact assessment conducted.

All Trust Policies will contain an Equality Statement. An Equality Impact Assessment will be completed for all policies. An example of this taken from "Adult Enteral Feeding Policy" is shown below:

7.0 SINGLE EQUALITIES ASSESSMENT

An Equality Impact Assessment has been completed for this policy and the following consideration is considered to be required:

The placement, maintenance and removal of nasogastric, nasojejunal and gastrostomy tubes may for some patients be uncomfortable and distressing.

Consideration should be made for specific groups as follows:

- The intervention of play specialists who help children understand procedures
- Patients for whom English is not their first language may require the use of interpreters
- The use of Mental Capacity Advocates should be considered as / when required

There are no Human Rights issues arising from this document, although issues relating to consent need to be considered at all times.

Programmes

The Trust holds Healthcare for All Steering Group meeting 2-3 times p.a.. The terms of reference for this meeting include:

- Communication training with a focus on learning Disabilities for departments Training for Learning Disability

- Representation and engagement in planning and development services
- Mechanisms to identify and flag patients with special needs
- Accessible Information

Training on disability, discrimination, safeguarding, deprivation of liberty and mental capacity is available to all Trust staff. The Trust continues to provide training that explores communication, Learning Disability and the use of Makaton to enhance communication. The communication training is provided by a highly specialist Speech and Language Therapist who also includes some basic Makaton signs. Makaton is a form of sign language used by some people with learning or communication difficulties. Staff are being sought to train as Trust BSL interpeters/translators.

Eve Cartwright, PALS Manager on behalf of Felicia Cox - Lead Nurse in Pain Management/Head of Pain Service (ANT) 27th July 2016.