Royal Brompton & Harefield NHS
NHS Foundation Trust

Briefing Paper for the Equality & Diversity Steering Group

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 2016 – 31st March 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

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:

- The Trust will tailor its responses to all patients' needs in care, treatment and communication to ensure that the standards of the Equality Act 2010 are met at all times.
- In particular, the Trust will seek to tailor these in respect of older patients, seeking improvements in outcomes for this cohort.
- The Trust will continue to promote equal opportunities in personal, professional and career development for all its staff by making quality educational, developmental and leadership programmes available to all.
- The Trust will continue to promote equal opportunities in recruitment, ensuring that all candidates have an equal chance of appointment based solely on their own merits

These objectives were agreed following consultation with our equality and diversity steering group.
The Trust will focus on these objectives between April 2016 and April 2020.

The information attached at Appendix I and Appendix II will be re published on the Trust web site by 31st January 2018.

Information for Appendix II has been updated for 2016/17 and collated by Jason Trofimczuk. Updating of Appendix I has been undertaken by Gary Clarke.

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 2018 and to act as backing information for finalisation of the Trust Objectives for 2016 -2020 and associated engagement work.

Richard Connett
Director of Performance & Trust Secretary **27th October 2017**

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

Appendix I
Employment Information 2016/17

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 2017 the Trust employed 3590 individual staff in substantive roles and 723 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	1018	(28.4%)
Female	2572	(71.6%)
Transgender	0	(0.0%)

b) Ethnicity

White	2113	(58.8%)
Mixed	95	(2.6%)
BME	1007	(28.2%)
Not Known	375	(10.4%)

c) Age

Aged 0-16	0	(0.0%)
Aged 17-21	7	(0.2%)
Aged 22-59	3421	(95.3%)
Aged 60+	162	(4.5%)

d) Sexual Orientation

Heterosexual	1425	(39.7%)
Bisexual	14	(0.4%)
Homosexual	26	(0.7%)
Not Known	2125	(59.2%)

e) Marital Status

Married	1350	(37.6%)
Single	1499	(41.8%)
Widow(er)	12	(0.3%)
Civil Partnership	15	(0.4%)
Divorced/Separated	115	(3.2%)
Not Known	599	(16.7%)

f) Persons Undergoing Gender Re-Assignment

Known GRA	0	(0%)

g) Persons in maternity/adoption leave

Maternity/Adoption	89	(2.5%)

h) Persons with disabilities

Disabled	48	(1.3%)
Not Disabled	2582	(72 %)
Not Known	960	(26.7%)

i) Religious Beliefs

Atheist	220	(6.2%)
Buddhist	15	(0.4%)
Christian	900	(25.1%)
Hindu	87	(2.4%)
Islam	98	(2.7%)
Jain	1	(0.0%)
Jewish	6	(0.2%)
Sikh	12	(0.3%)
Other	110	(3.1%)
Not Known	2141	(59.6%)

Of the non-substantive staff (723) the Trust declares the following:

a) Gender

Male	246	(34%)
Female	477	(66%)

b) Ethnicity

White	375	(52%)
Mixed	15	(2.1%)
BME	156	(21.5%)
Not Known	177	(24.4%)

c) Age

0-16	0	(0.0%)
17-21	20	(2.7%)
22-59	670	(92.7%)
60+	33	(4.6%)

d) Sexual Orientation

Heterosexual	233	(32.2%)
Bisexual	1	(0.1%)
Homosexual	3	(0.4%)
Not Known	487	(67.3%)

e) Marital Status

Married	178	(24.6%)

Single	310	(42.8%)
Window(er)	2	(0.3%)
Civil Partnership	3	(0.5%)
Divorced/Separated	14	(1.9%)
Not Known	216	(29.9%)

f) Persons Undergoing Gender Re-Assignment

Known GRA	0	(0.0%)

g) Persons in maternity/adoption

Maternity/Adoption	3	(0.4%)

h) Persons with Disabilities

Disabled	8	(1.1%)
Not Disabled	406	(56.1%)
Not Known	309	(42.8%)

i) Religious Beliefs

Atheist	51	(7.0%)
Buddhist	4	(0.6%)
Christian	128	(17.7%)
Hindu	17	(2.4%)
Islam	18	(2.5%)
Jainism	0	(0.0%)
Sikhism	4	(0.6%)
Other	18	(2.5%)
Not Known	481	(66.4%)
Jewish	2	(0.3%)

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 31/3/17 we have 277 male doctors and 189 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 128 women to 169 men (43% to 57%) including 1 (of 6) female executive directors, and 4 (of 7) 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**
  Under current NHS Pension arrangements staff can retire without any reduction to their pension at their state pension age (although this will vary if they are in the 1995 or 2008 sections of the scheme) 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 and will be looking to implement and adopt the new Disability Confident Standard.

- **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 31/3/17 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 of gender pay gap issues and there have been no “class action” style equal pay claims here.

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 31/3/17 6 such claims were brought. 3 were subsequently withdrawn prior to adjudication, 2 were settled by the Trust and 1 is currently working its way through the Tribunal system.

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 (277 male to 189 female) and Estates staff (129 male to 42 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	1018 (28.4%)	201 (13.0%)
Female	2572 (71.6%)	1350 (87.0%)
Transgender	0 (0.0%)	0 (0.0%)
-		
White	2113 (58.8%)	913 (58.9%)
Mixed	95 (2.6%)	29 (1.9%)
BME	1017 (39.2%)	391 (25.2%)
Not Known	375 (10.4%)	218 (14.1%)
-		
Aged 0-16	0 (0.0%)	0 (0.0%)
Aged 17-21	9 (0.3%)	0 (0.0%)
Aged 22-59	3375 (94.0%)	1519 (97.9%)
Aged 60+	194 (5.4%)	32 (2.1%)

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).

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 all policies under the Employee Relation Umbrella. 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, 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/Picker NHS National Staff Surveys wherein all Trust staff are polled on a variety of questions most of which are set nationally and some of which are set locally.

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 2016/2017 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 they are employed on Agenda for Change contracts.

As of 31/3/17 89 people are currently on maternity leave, and the expected return to work rate is 92% as this was the rate for the 2016/2017 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.

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.

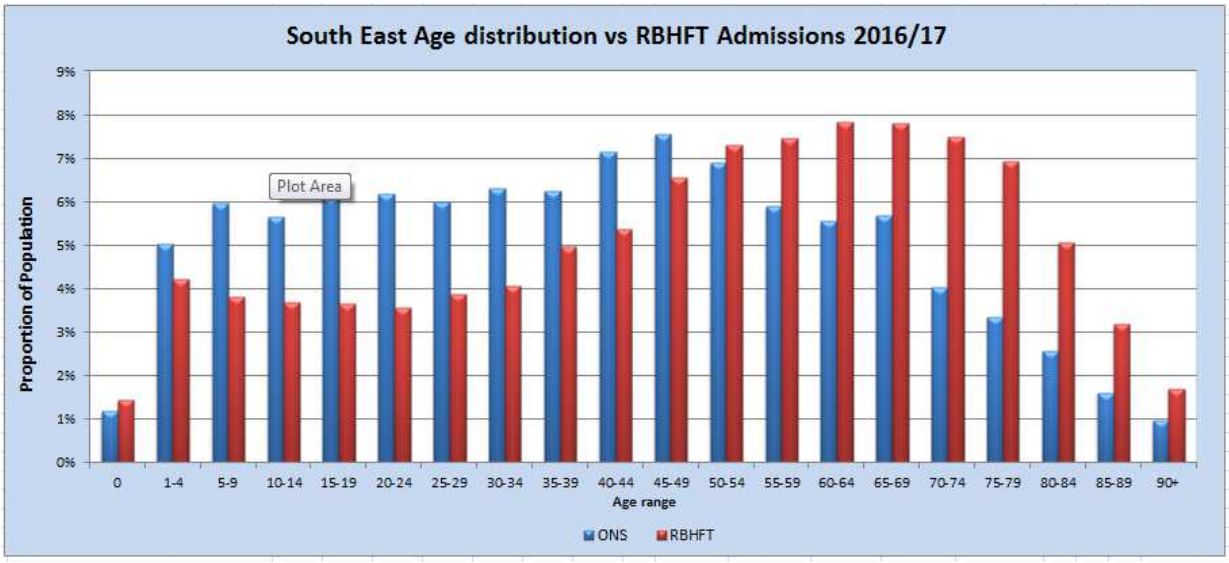
Gary Clarke
Equality and Diversity Lead **28th December 2017**

Appendix II - Information on Services

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

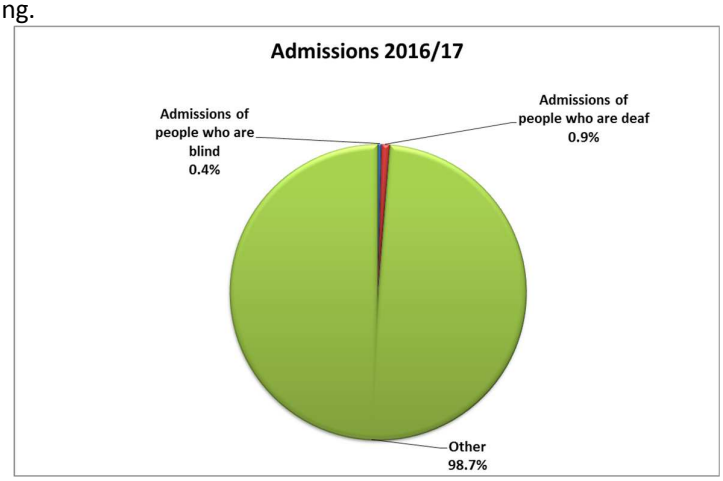
Age

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 2016/17 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.



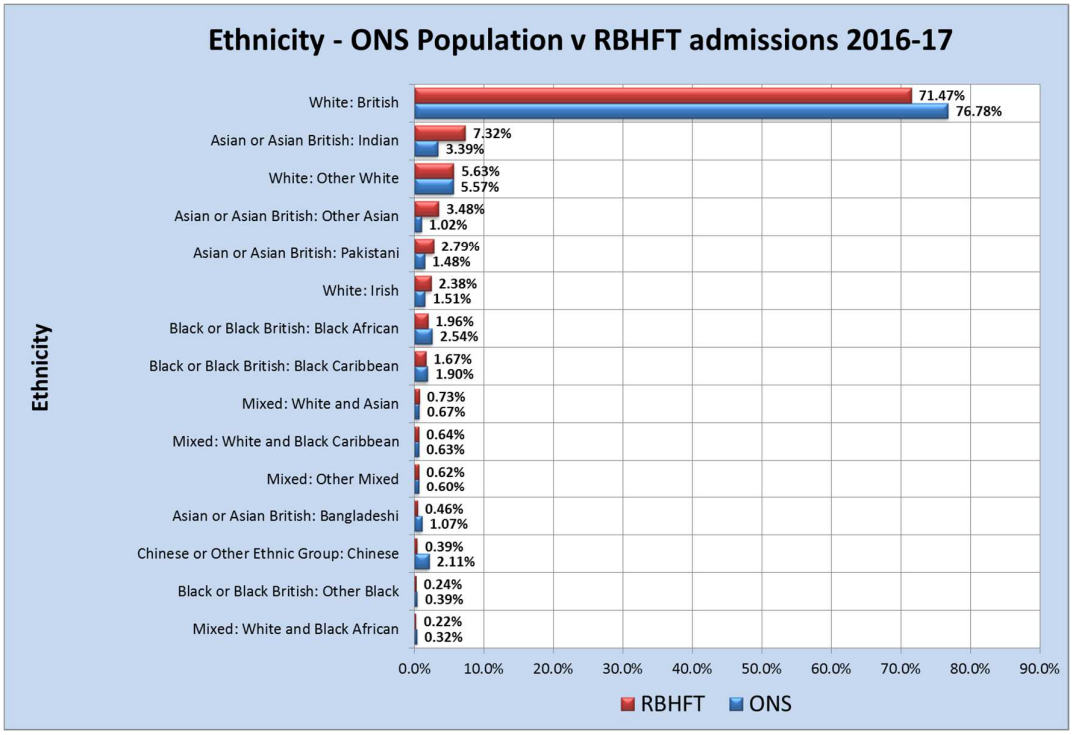
- The number of trust admissions of people who are blind is slightly higher than the national figure.
- The number of trust admissions of people who are deaf is about twice the national figure.

Ethnicity

The graph below compares the ethnicity of our admissions in 2016/17 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. 71.47% 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.

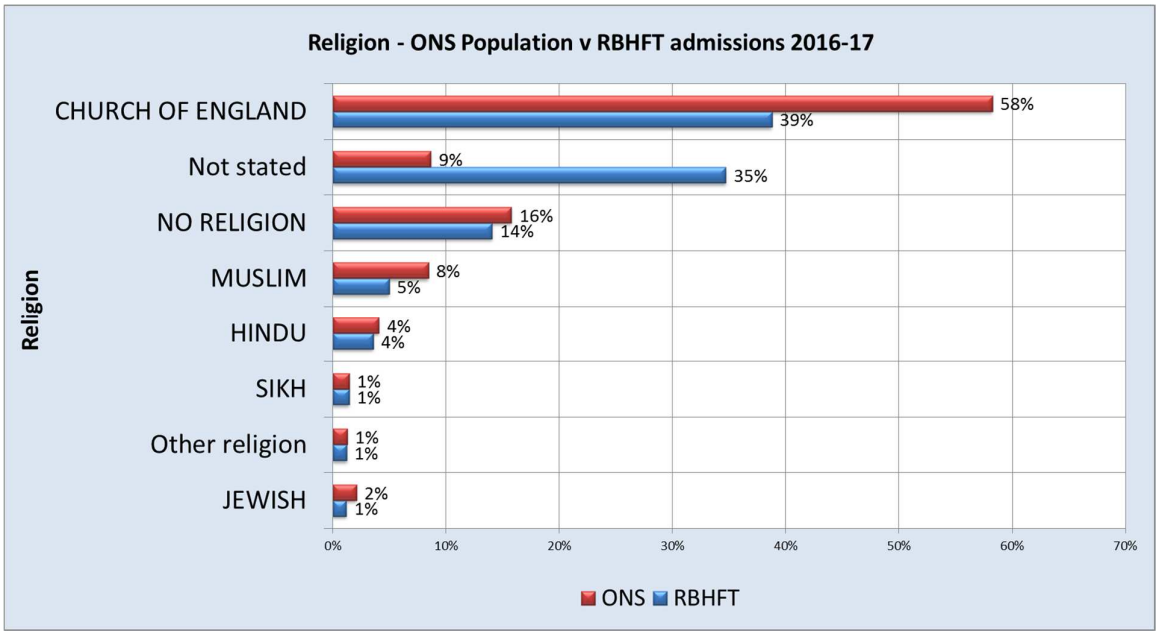


Religion

The graph below compares the religion of our admissions in 2016/17 with the ONS population of London.

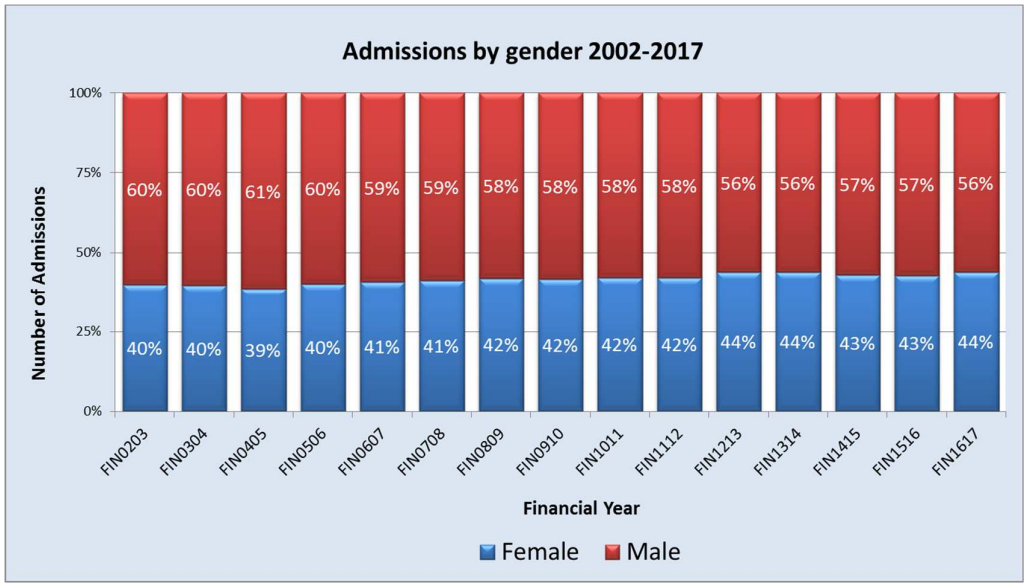
The graph shows that the Trusts admissions generally correlate closely to the religion of the London population. The Trust has 19% less admissions from the Church of England than the ONS. However this is likely to be because the ONS records different branches of the church under Church of England whilst we record it separately under 'Other religion'.

The Trust has a large number (35%) 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 5% 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 2016/17 56% 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 **26th September 2017**

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 **26Th September 2017**

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

During the year (1st April 2016 – 31st March 2017) there were 3 Formal Complaints and 10 PALS concerns involving issues of discrimination and equality.

Concern 1: A patient visiting the pacemaker clinic wanted to feedback about her recent experience at the Trust She felt that communication could have been improved as she is disabled, registered blind and lives in a care home. The manager had written to staff detailing how best to support her and help with medication but this was not looked for by staff. Outcome: An apology was given and the patients comments were shared with the ward matron who agreed to discuss this issue with the ward staff. The patient was happy with this outcome.

Concern 2: Relatives of a deceased patient raised concerns that the Security Officer and porter who arrived on the ward to transfer the patient to the mortuary refused to allow them to say their last rites and prayers. Staff members were rude and disrespectful to them. Outcome: Site Services manager apologised profusely for their experience as it was unacceptable that they could not perform their last rites. This was reported as an incident and the Security Officer received an improvement notice.

Concern 3: Partially sighted patient had great difficulty in using the lift to the outpatient department. There are a number of buttons in the lift but due to his disability he could not work out which one to press. He had to wait for someone else to come into the lift to press the button on his behalf. Outcome: The signs in the lift were checked and will be made clearer. Patient was advised to ask for help from a staff member in future.

Concern 4: Patient is unhappy as she would like all references to mental health removed from her records as she believes that this has negatively affected the way she is treated by other services. Outcome: A written response was sent and the patient informed that the job title of the Clinical Nurse Specialist who saw the patient includes the term 'Mental Health'. The patient was referred to the CNS not to imply the patient had a mental illness but offer psychological support during an anxious period. The records made were the opinion of a healthcare professional and cannot be removed. However the patient is able to submit a note saying which parts of the records she disputes and why and this would be added to her record.

Concern 5: Relative of an inpatient raised concerns regarding wheelchair access to RBH and the lack of disabled parking bays available. Outcome: The property and estates director replied explaining this Trust like other central London hospitals has very limited parking which has to be managed carefully. He has reminded the parking attendant of the need to assist visitors with external parking alternatives locally.

Concern 6: An anonymous patient reported that Middle Eastern visitors to the Trust were using the public toilets to wash their feet thus soaking the floor and blocking the toilets with blue paper towels. Outcome the Head of Estates and Facilities replied that this is a complex problem to resolve the Trust and he has been in discussions about this with the Trust's Chaplain but has been unable to identify a suitable room for foot washing. The trust is in the process of replacing paper towels with hand dryers in public facilities.

Concern 7: Mother of a patient with learning difficulties complained that her daughter was sent a letter advising she needed a 4 day admission as she is also blind the letter had to be read out to her and this caused her a lot of distress. When the family called to find out about the letter they were told it was sent in error. They then received a medical report which was not in an accessible format so the patients support worker had to read it to her again. Outcome: Apology given for the letter sent in error. The outpatient's manager has constructed template letters which can be emailed to the patient who can then access them via the software on her computer. A note has also been put on the patients file to say she requires a significant amount of notice prior to an admission so as not to cause acute distress.

Concern 8: A blind patient attending a sleep study raised issues about her care. Transport arrived early without an explanation and the assistant had not been trained how to care/guide blind patients. Outcome: The transport

manager discussed the issues with the patient directly. The company that transported this patient closed down and a new company has been appointed to provide transport for the Trust. The transport manager is currently in discussion with the company regarding the level of training they provide to their staff on impairments such as visual, hearing, dementia and other disabilities.

Concern 9: The mother of a learning disabled adult wants to know who the Trust's disability Nurse Specialist is. Her son is unable to take tablets and there is inconsistency from staff. She feels that staffs need to have training in disability awareness. Outcome: Patient was being discharged on the day the mother raised her concerns so she was given a copy of a Hospital Passport used for learning disability patients whom she can fill in and bring back to the hospital if her son is admitted again. A copy can be kept at the bedside and should aid communication between staff members and also with the patient. PALS manger to raise the issue of the current lack of a disability specialist in the Trust due to long term sick leave.

Concern 10: Patients son complained that his mother's operation was cancelled 3 times. He and his family spoke to the senior nurse and security were called. He accused the security staff of using racially inappropriate language and had recorded some of their conversation. Outcome: Apology and explanation given regarding the cancellations. The Site Manager instigated a formal investigation in conjunction with the Human Resources Department and the Security Guard in question. The outcome of this investigation was shared at a later date.

Concern 11: Patient reported that she went to the Multi Faith room and was shocked to find the floor filled with carpets a separate area with another 3-4 carpets and folding chairs left on the side. She said she did not feel welcome and would like to know if the room was still a 'Multi-Faith' room. Outcome: The Chaplain responded directly to the patient advising her that her comments would be considered and that a review was being undertaken of the Trust's spiritual spaces.

Concern 12: A Trust nurse contacted PALS regarding advice as a deaf patient was going to be admitted for an operation and required a sign language interpreter pre and post op. Outcome: Member of staff was advised to book an interpreter through the usual Trust's service provider.

Concern 13: The sister of a patient with learning difficulties raised concerns that he had been discharged on warfarin despite not being able to manage the fluctuation in doses required to achieve a stable INR. Outcome: A member of the medical staff called the patients sister and has agreed to see the patient in his local clinic and switch his medication from Warfarin to rivaroxaban which does not require changes to daily dosages.

There were a total of 1593 contacts in PALS for this period, which includes PALS concerns, formal complaints, and comments. Therefore 0.8% of concerns, complaints and comments received in 2016/2017 related to discrimination and equality. This is a slight decrease on last year.

We have had no concerns raised that patients have been discriminated against for raising a concern or making a complaint. However some of our older patients prefer not to raise concerns until they have left the hospital as they feel it may impact on their care. 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, staffs are informed at the Staff Induction PALS session that patients must not be discriminated in any way for making a complaint. Staffs are also encouraged to ask patients if they have any concerns during intentional rounding on the ward. In this way staff can demonstrate that they are open to feedback and problems can be resolved in a timely way.

Sharon Gurney Complaints Lead/PALS Officer **19th October 2017**

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 11,063 at the end of March 2017 members are made up of: patients, members of the public, 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 2016-2017, members were involved in a number of key trust activities. These included: the annual members' meeting, which was held on 20th July 2016, Members events which included a tour of the Hybrid Theatre at the Royal Brompton Hospital 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 **7th September 2017**

b. Patient surveys and patient feedback

For 2016-17 RBHT participated in three national surveys; The National Inpatient Survey, The National Children's and Young People's Survey and the National Cancer Survey; each with response rates of 50%, 36% and 67% respectively. On a monthly basis the Trust participates in the Friends and Family Test (FFT); in 2016-17 the Trust achieved a response rate of 35% or better and a score of 96% or better, i.e.96% of respondents would recommend the Trust.

On a regular 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. PICU locally surveys all parents/carers who had children admitted to the unit.

In 2016 a total of 494 patients from the Trust were sent a questionnaire as part of the National Children and Young People's survey. 487 patients were eligible for the survey, of which 177 returned a completed questionnaire, giving a response rate of 36%. The average response rate for the 71 trusts that Picker collected results for was 26%.

For the purposes of this survey results from children (8-11 years), young people (12-15 years) and parents are distinguishable.

Key facts about the 177 who responded to the survey:

- 66% of returned questionnaires were the parent/carer version (0-7 years), 14% were the

Children's survey (8-11 years), and 20% were the young person's questionnaire (12-15 years).

- 13% of admissions were emergency whereas 87% of attendances were planned.
- 69% had an operation or procedure during their stay.
- Overall: 96% of parents rated care 7 or more out of 10.
- Hospital staff: 85% of parents always had confidence and trust in the members of staff treating their child (0-15 years).
- Overall: 91% of parents stated they were always treated with dignity and respect by the people looking after their child (0-7 years).

RBHT improved significantly on 7 questions and did not do significantly worse on any question when compared to the other "Picker" Trusts and results from 2014 (survey not done every year). The statement the Trust scored less than the average on was: "Parents not able to prepare food in the hospital but wanted to."

When RBHT is benchmarked externally with the other 71 "Picker" Trusts the results in all categories and overall are better than the average of most other NHS Trusts who participated in the Children and Young People's survey

In 2016-17 the RBHT received over 10,000 comments from patients. 96% of these comments were positive. Over 800 comments were collected from the RBHT 2016 inpatient survey. The majority (67%) were positive.

The 2016 National Cancer Survey final results were answered by 53 RBHT patients (up from 21 in 2015) with a score of 9 for the question used as a national marker for peer review: Q59 Patient`s average rating of care scored from very poor (1) to very good (10).

2016-17 monthly communication reports show that there are on average approximately 16 social media comments per month about the care received at the Trust. The majority (96%) is positive; this is an increase from 2015/16 which saw 87% of comments as positive.

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 (e.g. Nurse call system noise) it has been agreed that posters will be created to inform patients as to the reason why.

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 (all surveys, social media, Patient Advisory Liaison Services (PALS) inquiries) the top 5 themes identified for 2016-17 are issues related to: Information and Communication (478), Waiting (386), Food (384), Care (general) (178), and Cleanliness/Toilets/Facilities (104). 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 has continued to focus on issues identified in the National Inpatient Survey results

At a Trust level there were 14 initiatives in 2016-17 to improve patient experience; based on national initiatives such as Nursing's Compassionate Care Program, Quality Improvement Projects or 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 (2016)

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
- 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 and 2016 the focus was on dementia.

The Trust has performed well in the 2016 PLACE assessment and was better than the national average in the majority of the assessment areas, showing a major improvement in food and hydration and how well equipped our hospital sites are in meeting the needs of people with dementia.

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 is divided 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 **September 2017**

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

The Trust has a duty to ensure that its membership is representative of the population that it serves. The Trust's membership database, hosted by Membership Engagement Services, has functionality which enables comparisons to be made between the general population of the UK and the membership of the Foundation Trust. This information is kept under review by the membership manager. Areas of under representation include some minority ethnic groups.

These areas of under representation are borne in mind when recruitment drives take place both n out-patient clinics and on the wards. Patients who have recently been discharged from the hospital are written to inviting them to join the membership. Patients and members of the public attending Focus groups at the Trust are also invited to join the membership.

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 **September 2017**

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 carer's with access to specialist services and supported decision making.

People with a Learning Disability and their carer's 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 their respective LD leads at these meetings.

The Trust has access to 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.

The Trust continues to participate in the PLACE assessments. Assessments are carried out by several members of staff together with patient representatives from Healthwatch and volunteers.

Ana Paz Trust Lead for Learning Disabilities and Adult Safeguarding /Katharine Scott Trust Lead for Older People - September 2017

[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

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 interpreters/translators.

Ana Paz Trust Lead for Learning Disabilities and Adult Safeguarding /Katharine Scott Trust Lead for Older People - September 2017