Rotherham Doncaster and South Humber NHS Foundation Trust

Equality Act 2010: Public Sector Equality Duty (PSED)

Publication of Information

Equality and Diversity Team

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RDaSH leading the way with care

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1. Background

Part 11, Chapter 1 of the Equality Act 2010 specifies the Public Sector Equality Duty. This duty applies to Rotherham Doncaster and South Humber NHS Foundation Trust as a public authority listed in Schedule 19 of the Equality Act.

The purpose of this document is to publish information to show how we are meeting Public Sector Duties. Publishing this information is a requirement specified in the Equality Act 2010 (Statutory Duties) Regulations 2011, section 2: Publishing of Information.

1.1 The General Equality Duty

The Equality Act 2010 introduced a general equality duty requiring organisations, in the exercise of their functions, Section 149 of the Equality Act outlines the general duties to have due regard to the following in the exercising of our functions:

- Eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristic and those who do not; and
- Foster good relations between people who share a protected characteristic and those who do not.

By:

- Removing or minimising disadvantages suffered by people due to their protected characteristics;
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people;
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
- The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.
- Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
- Tackle prejudice and promote understanding.

NHS England 2014/2015 - NHS Standard Contract Service Conditions

13.1 The Parties must not discriminate between or against Service Users, Carers or Legal Guardians on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other non-medical characteristics, except as permitted by the Law.

13.2 The Provider must provide appropriate assistance and make reasonable adjustments for Service Users, Carers and Legal Guardians who do not speak, read or write English or who have communication difficulties (including hearing, oral or learning impairments). The Provider must carry out an annual audit of its compliance with this obligation and must demonstrate at Review Meetings the extent to which Service improvements have been made as a result.

13.3 In performing its obligations under this Contract the Provider must comply with the obligations contained in section 149 of the Equality Act 2010 and section 6 of the Human Rights Act 1998. If the Provider is not a public authority for the purposes of those sections it must comply with them as if it were.

13.4 In consultation with the Co-ordinating Commissioner, and on reasonable request, the Provider must provide a plan or plans setting out how it will comply with its obligations under Service Condition 13.3. If the Provider has already produced such a plan in order to comply with the Law, the Provider may submit that plan to the Co-ordinating Commissioner in order to comply with this Service Condition 13.4.

SC14 Pastoral, Spiritual and Cultural Care

14.1 The Provider must take account of the spiritual, religious, pastoral and cultural needs of Service Users and must liaise with the relevant authorities as appropriate in each case.

1.2 Protected Characteristics

The protected characteristics covered by the Equality Act are:

- Age
- Disability
- Gender
- Gender Reassignment
- Race
- Religion or Belief
- Sexual Orientation
- Marriage/Civil Partnership
- Pregnancy/Maternity

1.3 The Public Sector Equality Duty (PSED)

The Public Sector Equality Duty (PSED), which came into force on 6 April 2011, places additional specific duties on public authorities including NHS Trusts. Two such duties are a requirement on public authorities to:

- Publish sufficient information to demonstrate compliance with the general equality duty by 31 January 2012 and thereafter annually: and
- Prepare and publish 1 or more equality objectives by 6 April 2012 and no more than four years thereafter.

The published information is to include:

- Information on the effect that policies and practices have had on employees, service users and others from the protected groups;
- Evidence of the analysis undertaken to establish whether their policies and practices will (or have) furthered the three equality aims in the general equality duty;
- Details of information used in that analysis; and
- Details of engagement with people with an interest in the aims of the duty.

1.3.1 Equality Objectives 2012 – 2016

NHS Organisations have a statutory requirement to prepare and publish Equality Objectives in support of the Public Sector Equality Duty (PSED) by no later than 6 April 2012. This requirement arose from the Equality Act 2010 (Specific Duties) Regulations 2011.
The Equality Act Guidance on publishing Equality Objectives recommends that NHS organisation using the Equality Delivery System (EDS) choose around 4 or 5 Equality Objectives, at least one per EDS goal.

EDS - Goal One - Better Health outcomes for all.

Equality Objective – One

To further develop systems to improve the data collection and analysis of the protected characteristics of service users.

This relates to:

- Age
- Disability
- Gender
- Race
- Religion and Belief
- Sexual Orientation

Links to:-

- Council of Governors Quality Priorities
    - Personalised Care
- Board of Directors Quality Priorities
    - Personalised Care Planning
    - Record Keeping

EDS – Goal Two – Improved Patient Access and Experience

Equality Objective – Two

To further develop Equality Assessment through the Equality Impact Assessment process and template across all services, policies, functions and events delivered by the Trust Business Divisions and Corporate Services.

Links to:-

Council of Governors Quality Priorities

- Continuously improve communication with and feedback from people who use the service through a wide range of methods.

EDS – Goal Three – Empowered, engaged and included staff

Equality Objective – Three

Initially a 2 year project. Through the development of a Quality Improvement Team the Trust will put into place a range of staff engagement initiatives to improve staff and team involvement.

Links to:

- Council of Governors Quality Priorities

  Effective, knowledgeable, personalised communication from all our staff.

EDS Goal – Four – Inclusive Leadership at all levels

Equality Objective – Four

Managers will support and motivate their staff to ensure that the work environment is free from discrimination and encourages a diverse workforce.

Links to:

- Board of Directors Quality Priorities

Clinical Leadership roles and responsibilities

1.4 Equality Delivery System (EDS)

The NHS Equality Delivery System (EDS) has been introduced nationally by the NHS Equality and Diversity Council as an optional tool for both current and emerging NHS organisations to support them to meet their General Public Sector Equality Duties as required by Section 149 of the Equality Act 2010. Compliance with the below duties is across the 9 protected characteristics under the Equality Act.

The Operating Framework for NHS England 2013/2014 quotes:-

'At a time of change, NHS organisations must act responsibly in fulfilling on going statutory and other core duties. All NHS organisations must comply with the Equality Act 2010 and its associated public sector Equality Duty. The NHS Equality and Diversity Council has developed an Equality Delivery System so that NHS organisations may have a systemic approach to supporting quality performance. The promotion and conduct of research continues to be a core NHS function and continued commitment to research is vital if we are to address future challenges. Further action is needed to embed a culture that encourages and values research throughout the NHS.'

EDS 2 - An informed selective approach

When using EDS2, it is suggested that, based on evidence and insight, organisations might wish to be selective in their choice of services they review and, where there is a strong local need to do so, the EDS2 outcomes that services are assessed and graded against. Organisations might also look at particular aspects of protected characteristics. The premise is that a focus on all services across all outcomes for all aspects of all protected characteristics can be overwhelming and unmanageable. It is much better to manage a comprehensive implementation of EDS2 over three to five years, through the use of informed selective choices at any one time.

Where such choices are made, organisations should not just focus on challenges, problems and concerns but also on situations where progress is being made and good practice can be shared and spread. Often as much can be learnt from what is working well as from what is not working so well. Spreading good practice should become a key part of EDS2 implementation, as well as tackling problems.

When taking a selective approach, organisations should seek the agreement of local stakeholders including advice on the selections that are made. Choices should embrace a proportionate mix of progress and good practice, on the one hand, and challenges, problems and concerns, on the other. Otherwise a distorted picture of an organisation's performance may be given.

People covered by EDS2

EDS2 should be applied to people whose characteristics are protected by the Equality Act 2010.

The nine characteristics are as follows:

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race including nationality and ethnic origin
- Religion or belief
- Sex
- Sexual orientation

NHS organisations should refer to the Equality Act and related guidance for a full understanding of the protected characteristics. In particular, they should note that:

- Within each characteristic the risk of discrimination is greater for some people who use or work in the NHS than others. For example, with regard to “age”, older people can be at greater risk of discrimination than middle-aged people in certain circumstances. With regard to sexual orientation, lesbian, gay and bisexual people can be at greater risk than heterosexual people in certain circumstances.

- The protected characteristic of “disability” is wide and includes a range of physical and sensory impairments, learning disabilities, mental health conditions and long-term conditions. Issues of fairness may arise differently for people with different types of disability.

The implication of the points made above is that NHS organisations should choose which aspect of each protected characteristic to focus on when using EDS2. (It does not mean that NHS organisations can choose between the protected characteristics, covering some but not others.) Local insight and evidence, and discussion with local stakeholders, should inform the choice. At any one time, assessing and grading the performance of NHS organisations across all the aspects of each protected characteristic will not be useful if it draws attention away from either significant progress or the most serious inequalities. However, it would be sensible for NHS organisations to ensure that all aspects of all characteristics are explored in the longer-term, in a balanced way.

Other disadvantaged groups

EDS2 can also be readily applied to people from other disadvantaged groups, including people who fall into “Inclusion Health” groups, who experience difficulties in accessing, and benefitting from, the NHS. “Inclusion Health” was defined in a Social Care Task Force and Department of Health publication of 2010.

These other disadvantaged groups typically include but are not restricted to:

- People who are homeless
- People who live in poverty
- People who are long-term unemployed
- People in stigmatised occupations (such as women and men involved in prostitution)
- People who misuse drugs
- People with limited family or social networks
- People who are geographically isolated

As with the protected groups, NHS organisations may assess and grade how well other disadvantaged groups fare compared with people overall, with a view to improving NHS performance, where there is local evidence that indicates the need to do so. For some of the above groups there are significant overlaps with people whose characteristics are protected by the Equality Act. These links should be borne in mind when work on either protected or other disadvantaged groups is taken forward.

There is also a clear connection between the difficulties in using the NHS experienced by other disadvantaged groups and the broader health inequalities agenda that NHS organisations and local authorities, including public health departments, have been tackling for many years. Under the Health and Social Care Act 2012, clinical commissioning groups must, in the exercise of their functions, have regard to the need to (a) reduce inequalities between patients with respect to their ability to access health services, and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

The Marmot Review, “Fairer society healthier lives” 2010, proposed universal action to reduce the steepness of the “social gradient” of health inequalities, but with a scale and intensity that is proportionate to the level of disadvantage.

Applying EDS2 to disadvantaged groups is likely to support organisations to deliver on aspects of their health inequalities work.

The goals and outcomes of *EDS2*

Goal	Number	Description of outcome
Better health outcomes	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
	1.5	Screening, vaccination and other health promotion services reach and benefit all local communities
Improved patient access and experience	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care
	2.3	People report positive experiences of the NHS
	2.4	People's complaints about services are handled respectfully and efficiently
A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
	3.3	Training and development opportunities are taken up and positively evaluated by all staff
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
	3.6	Staff report positive experiences of their membership of the workforce
Inclusive leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

2. Equality in RDaSH

2.1 Equality, Diversity and Human Rights Strategy

Our vision and approach for equality is set out in the Equality, Diversity and Human Rights Strategy (currently under review)

The Strategy will be made available on our website:

2.2 Chaplaincy / Spiritual Care

The Trust's commitment to the health, wellbeing and recovery of its service users is expressed within a person-centred approach. Spiritual care is essential to this approach. All members of care teams have a responsibility for spiritual care and can call on any member of the chaplaincy team for consultation. The chaplaincy team give support to increase understanding of this aspect of care. The chaplaincy handbook is available on our website: http://nww.intranet.rdash.nhs.uk/trust-services/the-chaplaincy/chaplaincy-publication/

The appointment of Reverend Meg Burton as head of chaplaincy completed the team in Rotherham and Doncaster along with Father Andy Graydon and June Rutherford. One of the first priorities identified was to ensure that chaplaincy ward visitors received special training for their role. The training was one day a month for three months. This has been enhanced by a day workshop on Loss and Bereavement.

In collaboration with one of the Rotherham psychiatrists, a spiritual assessment tool has been developed, based on the work of Dr Christina Puchalski. This is explained to new staff at their induction, helping them understand their own spirituality and, thus, helping them better assess and meet the spiritual needs of their patients and service users.

We are very pleased that we have appointed a chaplain who is based at Great Oaks, Scunthorpe. Reverend Jenny Baker is an Anglican priest and is working 16 hours a week. She is quickly getting to know the staff and patients in Scunthorpe and making links with the surrounding community.

As was noted in last year's report, Reverend Meg Burton has a particular expertise in palliative care. After the report chaired by Baroness Julia Neuberger about the Liverpool Care Pathway (LCP), Meg representing the College of Health Care Chaplains was appointed to the group that is looking into what will happen after July 2014, when the LCP must be withdrawn from use. The group is taking the opportunity to look more widely at how people coming towards the end of their life are cared for and how their families can be supported.

Supporting staff and helping them improve their well-being is a very important part of the role of the chaplains, and all members of the chaplaincy team have an open door for anyone who wishes to speak with them. An innovation last autumn was the starting of the RDaSH Community Choir, which meets on Tuesday lunchtimes in the chapel. Members find they benefit from being able to leave their workplace to come together to sing. Their first performance, at the Doncaster NHS Carol Service in December was very well received. They are planning further performances, including singing at the special service to commemorate the beginning of World War 1 in August 2014.

3. Policies and Practice

We are reviewing and updating policies and practice guidance, relating both to staff and service users, to ensure that they reflect the general duty and address the needs of people of all protected characteristics.

Equality Analysis

Equality Impact Assessments (EIA's) are undertaken routinely on all new and reviewed services, policies, strategies, events held for the public and services provided for the public. The Equality Impact Assessment tool has been revised to incorporate all of the protected characteristics, although Social and Health Inequalities was not brought into force with the Equality Act, RDaSH considered the implications of this and decided that this would be Best Practice for the population it served to be incorporated as 'Disadvantaged Groups' as part of the equality impact assessment process.

A tracking document is completed for all policy proposals to ensure that decisions are informed and take account of actual or potential impact on our staff, communities or stakeholders.

Further information and completed equality impact assessments can be found on our website: http://www.rdash.nhs.uk/information-for-the-public/equality-and-diversity/

4. Equality and Diversity Monitoring Analysis

Introduction

ESR (Electronic Staff Record) is the integrated Human Resources and Payroll system within the Trust. It enables relevant data on staff to be collated and facilitates up to date reporting for workforce monitoring purposes. A data cleansing exercise is undertaken each year to ensure that accurate information is reported.

An Equality and Diversity Monitoring Information report is produced and published by the Human Resources Department annually presenting workforce equality data. The report contributes to demonstrating the Trust's compliance with our Public Sector Equality Duty as outlined in the Equality Act 2010.

The data is analysed against demographic information for each of the localities served by the Trust (which is taken from National Census data) and any actions or recommendations are implemented and reviewed as appropriate, in order to ensure that, as far as possible, the Trust's workforce is representative of the communities it serves.

It should be noted that the Staff in Post figures changed significantly from September 2012 to September 2013 (comparison timeframe) due to the transfer of approximately 300 staff to another care provider in August 2013.

Ethnicity

Headcount				
	Male	Female	Total	Total %
WHITE	**637**	**2,814**	**3,451**	**90.79%**
White – British	613	2,769	3,382	88.98%
White – Irish	9	9	18	0.47%
White – Any other White Background	15	36	51	1.34%
MIXED	**4**	**17**	**21**	**0.55%**
Mixed – White & Black Caribbean	1	6	7	0.18%
Mixed – White & Black African	0	2	2	0.05%
Mixed – White & Asian	1	6	7	0.18%
Mixed – Any other mixed background	2	3	5	0.13%
ASIAN	**28**	**43**	**71**	**1.87%**
Asian or Asian British – Indian	16	17	33	0.87%
Asian or Asian British – Pakistani	6	13	19	0.50%
Asian or Asian British – Bangladeshi	1	2	3	0.08%
Asian or Asian British – Any other Asian background	5	11	16	0.42%
BLACK	**16**	**24**	**40**	**1.05%**
Black or Black British – Caribbean	5	12	17	0.45%
Black or Black British – African	10	11	21	0.55%
Black or Black British – Any other Black background	1	1	2	0.05%
OTHER	**5**	**4**	**9**	**0.24%**
Chinese	1	1	2	0.05%
Any other Ethnic Group	4	3	7	0.18%
NOT KNOWN	**38**	**171**	**209**	**5.50%**
Not Stated	38	171	209	5.50%
TOTAL	**728**	**3,073**	**3,801**	**100.00%**

Employees:

Population by Ethnic Group (2011 National Census)					
	Doncaster	Rotherham	North Lincolnshire	North East Lincolnshire	Manchester
WHITE	95.3%	93.6%	96.0%	97.4%	66.6%
MIXED	0.3%	0.2%	0.1%	0.1%	1.8%
ASIAN	1.5%	2.1%	0.9%	0.4%	17.1%
BLACK	0.5%	0.4%	0.1%	0.1%	8.6%
OTHER	0.2%	0.3%	0.1%	0.1%	3.1%

The percentage of staff employed by the Trust who are of BME origin (including White Irish and White Other) is 5.5%, which is an increase of 0.1% compared to the same period in 2012.

The breakdown of staff employed in each locality of the Trust as at September 2013 is:

	Doncaster	Rotherham	North Lincolnshire
WHITE	95.6%	92.6%	90.9%
MIXED	0.5%	0.7%	0.3%
ASIAN	1.5%	1.9%	4.5%
BLACK	1.1%	0.7%	1.0%
OTHER	0.1%	0.5%	0.7%

The Trust has more or less maintained its BME representation as a percentage of total staff in most categories comparing 2012 and 2013 figures:

- White Irish 0.44% to 0.47% (+0.03%)
- White – Any other White Background 1.32% to 1.34% (+0.02%)
- Mixed – 0.51% to 0.55% (+0.04%)
- Asian 1.71% to 1.87% (+0.16%)
- Black 1.07% to 1.05% (-0.02%)
- Other 0.32% to 0.24% (-0.08%)

In relation to the staff who transferred out of the Trust in August 2013, the breakdown was as follows:

- White – Any other White Background 2 staff
- Mixed 1 staff
- Asian 4 staff
- Black 6 staff
- Other 1 staff

The largest impact on the Trust BME figures from the transfer can be seen in the other category due to the small numbers employed within the Trust and the Black category due to the high number who transferred out.

The highest percentage of BME new starters was in the Asian category (6.5%) which is a significant increase from the same period in 2012 (3.8%). 50% of the new starters in this category where medical staff in 2013 compared to 83% in 2012

The highest percentage of BME leavers was in the Asian category (2.5%) which is significant decrease from the same period in 2012 (4.7%). In 2013 this was due to medical staff leaving (external rotation). In 2012 this was due to 40% of medical staff leaving (external rotation) and the other 60% medical staff resignation.

In 2013 the Trust received 7476 applications of which 20% were from BME applicants and of the 2087 shortlisted, 18.5% were BME. Of the 199 new starters, 11% were from BME applicants.

In 2012 the Trust received 8226 applications of which 24.5% were from BME applicants and of the 646 shortlisted, 26% were BME. Of the 316 new starters, 9.5% were from BME applicants.

BME staff accessing training in 2012 and 2013 was 5.5% which is reflective of the overall workforce.

Within the Agenda for Change pay bandings the percentage of BME staff is as follows:

BME Staff percentage by Pay Band – Top 5				
Pay band	**Total (2013)**	**Total % (2013)**	**Total (2012)**	**Total % (2012)**
Band 8a	8	7.4%	7	6.3%
Band 6	40	5.6%	41	5.7%
Band 3	28	5.2%	30	4.5%
Band 5	37	5.2%	33	4.6%
Band 7	16	5.0%	15	4.6%

In relation to promotions, all of the internal promotions were White British apart from 1. However it should be noted that all internal vacancies are advertised on NHS Jobs for all staff to apply.

Within the employee relations section (disciplinary, grievance and harassment), there are no issues highlighted in relation to BME.

Age

Age Range	Total	Total %
16 – 20	10	0.26%
21 – 25	148	3.89%
26 – 30	348	9.16%
31 – 35	365	9.60%
36 – 40	410	10.79%
41 – 45	521	13.71%
46 – 50	677	17.81%
51 – 55	688	18.10%
56 – 60	417	10.97%
61 - 65	186	4.89%
66 - 70	28	0.74%
71 and above	3	0.08%
Total	**3,801**	**100%**

As at September 2013, 5.7% of Trust staff were approaching, or at, pensionable age (age 61 or over). This is a slight increase of 0.4% from September 2012.

16 – 19 year olds accounted for 3.6% of job applications received by the Trust in the period, with 1.8% of shortlisted candidates falling into this age range. 16 – 20 year old staff in post has decreased by 0.14% (no staff under the age of 20 transferred out).

The highest percentage of new starters were in the 21-25 age range, however it should be noted that the Trust currently has more 61 – 65 year old staff than 21 – 25 year old staff.

With regard to staff currently in post, the largest age group is 51-55, which has changed from September 2012 (46-50). Staff in the age ranges over 50 have all decreased since September 2012. However it should be noted that 40% of the staff who transferred out in August 2013 were over the age of 50

Within the Agenda for Change pay bandings the highest number of staff within each pay Band is as follows:

Staff Age by Pay Band –		
Band	**Highest N^{o} Age Range 2013**	**Highest N^{o} Age Range 2012**
Band 9	56-60	56-60
Band 8d	41-45/46-50	41-45
Band 8c	46-50	46-50
Band 8b	46-50/51-55	46-50
Band 8a	46-50	46-50
Band 7	46-50	46-50
Band 6	46-50	46-50
Band 5	46-50	26-30/46-50
Band 4	51-55	51-55
Band 3	51-55	51-55
Band 2	51-55	51-55
Band 1	56-60	56-60

The change to the Band 5 profile from 2012 to 2013 is due to the number of staff in this age range transferring out of the Trust.

The highest number of promotions has changed from the 36-40 age range in 2012 to the 41-45 age range in 2013

Within the employee relations section (disciplinary, grievance and harassment), there are no issues highlighted in relation to Age.

Gender

It is not practical to benchmark Health and Social Care staff gender against local population data, as the NHS is a historically female dominated organisation. However, whilst only 19% of the Trust's workforce are male, 6.2% of staff in Agenda for Change pay bands 8a to 9 are men compared to 4% of women. This has changed slightly from 2012 – 5.9% of staff in Bands 8a to 9 were men compared to the same 4% of women.

Within the employee relations section (disciplinary, grievance and harassment), there are no issues highlighted in relation to Gender.

Disability

Headcount		
Disability	**Total**	**Total %**
Yes	136	3.58%
No	1910	50.25%
Not Declared	1728	45.46%
Unknown	27	0.71%
Total	**3801**	**100%**

The number of staff who have declared they have a disability has not changed from 2012.
In 2013 the Trust received 355 applications from applicants with a disability of which 99 were shortlisted (27.9%). Of the 99 shortlisted, 8 were offered positions and started with the Trust (8%).

In 2012 the Trust received 406 applications from applicants with a disability of which 30 were shortlisted (7.4%). Of the 30 shortlisted, 11 were offered positions and started with the Trust (36.5%).

In 2013, 8 staff with a disability left the Trust for the following reasons:

- 1 Dismissal (Conduct)
- 1 Retired (Age)
- 2 End of Fixed Term Contract
- 4 Resignation

There were no issues raised with the Trust in relation to disability discrimination for any of the leavers.

Within the Agenda for Change pay bandings the percentage of disabled staff is as follows:

Disabled Staff percentage by Pay Band – Top 5				
Pay band	**Total (2013)**	**Total % (2013)**	**Total (2012)**	**Total % (2012)**
Band 8b	2	6.9%	2	6.5%
Band 5	34	4.7%	29	4.1%
Band 8c	1	4.5%	1	4.7%
Band 4	11	3.9%	10	3.5%
Band 2	31	3.9%	27	3.0%

In relation to promotion, 1 member of staff (4%) with a disability was promoted which is in line with the Trust profile.

Within the employee relations section (disciplinary, grievance and harassment), there are no issues highlighted in relation to Disability.

Sexual Orientation

Staff in Post Sexual Orientation as at 30 Sep 2013		
Headcount		
Sexual Orientation	**Total**	**Total %**
Lesbian	11	0.29%
Gay	13	0.34%
Heterosexual	1983	52.17%
Bi-Sexual	4	0.11%
Undisclosed	1777	46.75%
Undefined	13	0.34%
Total	**3801**	**100%**

(Currently there is no national benchmarking information to compare to Trust date)

The profile of the Trust in relation to sexual orientation has remained the same compared to 2012.

In 2013 the Trust received 206 applications from applicants who declared they were either Gay, Lesbian or Bi-Sexual (2.7%) compared to 239 applications (2.9%) in 2012. In 2013, 52 (25%) were shortlisted compared to 16 (6.7%) in 2012. Of the 52 shortlisted, 2 (3.8%) were new starters compared to 4 new starters (25%) in 2012.

In 2013 the following staff resigned from the Trust

- 1 Gay
- 1 Lesbian
- 1 Bi-sexual

There were no issues raised with the Trust in relation to discrimination for any of the leavers.

In relation to promotion, 2 members of Lesbian/Gay staff (8.3%) were promoted which is significantly over the Trust staffing profile percentage.

Within the employee relations section (disciplinary, grievance and harassment), there are no issues highlighted in relation to Sexual Orientation.

Religious Belief

Staff in Post by Religious Belief Compared to National Census					
	Trust Staff Percentage		National Census Percentage		
Religious Belief	**2012**	**2013**	**Doncaster**	**Rotherham**	**North Lincs**
Buddhism	0.3%	0.3%	0.2%	0.2%	0.2%
Christianity	35.7%	38.5%	65.9%	66.5%	66.0%
Hinduism	0.3%	0.4%	0.3%	0.2%	0.3%
Islam	0.5%	0.4%	1.7%	3.7%	1.8%
Judaism	0%	0%	0%	0%	0%
Sikhism	0.1%	0%	0.4%	0.1%	0.3%
Other	5.1%	5.7%	0.3%	0.2%	0.2%
Undisclosed	51.5%	47%	6.9%	6.6%	7.1%

As can be seen from the table above, the profile of the Trust in relation to religious belief as changed very little from 2012.

In 2013 the Trust received 420 applications from applicants who indicated their religious belief was non-Christian (5.6%) – not including other or undisclosed. Of those, 130 were shortlisted (31%) and 7 joined the Trust as new starters (5.4%)

In 2012 the Trust received 649 applications from applicants who indicated their religious belief was non-Christian (7.9%). Of those, 63 were shortlisted (9.7%) and 10 joined the Trust as new starters (15.8%).

In 2013 the following staff resigned from the Trust

- 2 Buddhism (1 x redundancy – 1 x resignation)
- 2 Hinduism (1 x End of fixed term contract – medical staff – 1 x resignation)
- 1 Islam (End of fixed term contract – medical staff)

There were no issues raised with the Trust in relation to discrimination for any of the leavers.

Within the employee relations section (disciplinary, grievance and harassment), there are no issues highlighted in relation to Religious Belief.

4.1.2 Staff Accessing Training

The Trust has a Learning and Development Centre which publishes a catalogue of both internal and external training available to staff each year. Nomination forms are completed by staff and their manager and then forwarded to the appropriate administrator for that course. Attendance on courses is monitored through the central Electronic Staff Record system. Staff wishing to obtain a recognised qualification are able to apply for support for funding via the Trust Qualification Based Sponsorship panel to ensure a fair approach.

The data in relation to staff accessing training in relation to all of the protected characteristics approximately reflects that of the Trust profile.

Mandatory Equality and Diversity Training on Induction and monthly updates for existing staff.

Gender Reassignment Awareness training was provided for staff during May / June and July of 2013. It is planned to hold more workshops in 2014 recognising the excellent

evaluation of the courses and the need expressed by staff attending the Mandatory Equality and Diversity training.

Further work is planned to enable staff to access eLearning on workbooks as an attractive method of training.

4.1.2 Pay

Staff employed by the Trust are predominately paid on Agenda for Change pay bands ranging from 1 to 9. There are staff who are paid on Medical pay scales and staff who transferred into the Trust on existing Social Services pay scales; these make up the data in the 'other' column.

Analysis of the data in relation to the protected characteristics does not appear to show any immediate issues in relation to staff in pay bands 1 to 8a/b. From pay band 8c to 9 there appears to be little or no staff identified with non-white ethnic category, classified as disabled or non-Christian. This may be due in part to the low numbers of staff employed in these pay bands and the number of staff still classified as 'unknown' in relation to these fields on ESR.

4.1.3 Promotion

As indicated previously all vacancies within the Trust are advertised through NHS Jobs. This ensures that all staff within the Trust are offered the same opportunity to apply for positions and ensures that effective monitoring can be undertaken via the Applications and Short-listing data on NHS Jobs.

4.2 Patients / Service Users

We aim to provide a high quality service to our patients so it is important that we continually improve our service as a result of feedback from patients.

We welcome feedback whether it is to say ‘thank you’ for a positive experience, or you feel that we could have done better.

Our Patient Experience Team has the responsibility for our PALS (Patient Advice and Liaison Service), compliments, formal complaints and results from our surveys.

Equality / Diversity and the work of CQC

The CQC guidance about compliance: Essential Standards of Quality and Safety states that ‘Providers should in every aspect of their work, consider the needs of each person using a service against 6 key strands of diversity (now 6 of 9 protected characteristics)

- Race
- Age
- Gender
- Disability
- Sexual orientation
- Religion and Belief.

When the Essential Standards were agreed the Equality Legislation on ‘gender’ also covered gender reassignment where it is now recognised as a separate protected characteristic in the Equalities Act 2010.
As the CQC also needs to comply with this act the CQC inspectors will also be looking at the provider response to the needs of Transgender people. However, in line with a paper issued by a: gender ‘Evidence Gathering in respect of Transsexual People, the Trust will not carry out ‘headcount’ monitoring of transsexual people simply to report how many trans employees or service users they might have, but only to ask individuals to declare their trans status indirectly where it is considered to be contributing to an individual’s treatment and therefore a good reason for asking such questions.

Interpreter Information

Telephone Interpreters

April 1 2013 - January 17 2014

Language	Serviced Calls
Albanian	6
Arabic	3
Czech	13
Farsi (Persian)	1
Hindi	1
Hungarian	2
Kurdish (Sorani)	7
Latvian	1
Lithuanian	10
Mandarin	19
Polish	80
Punjabi	7
Romanian	9
Russian	10
Slovak	25
Tamil	1
Thai	1
Turkish	19
Twi	3
Urdu	1

Face to Face Interpreters

April 1 2013 – January 17 2014

Summary

Language Pair	Number Of Appointments
English - Albanian	9
English - Arabic	22
English - Bengali	3
English - British Sign Language	76
English - Bulgarian	1
English - Cantonese	1
English - Czech	81
English - Farsi	19
English - Farsi (Persian)	1
English - French	13
English - Gujarati	1
English - Hindi	4
English - Hungarian	9
English - Italian	1
English - Kurdish	5
English - Kurdish (Sorani)	25
English - Latvian	12
English - Lithuanian	27
English - Mandarin	23

English - Mirpuri	14
English - Pashto	0
English - Polish	224
English - Portuguese	1
English - Punjabi	101
English - Romanian	4
English - Russian	44
English - Slovak	117
English - Somali	4
English - Tamil	7
English - Thai	1
English - Tigrinya	1
English - Turkish	30
English - Urdu	104
English - Vietnamese	12

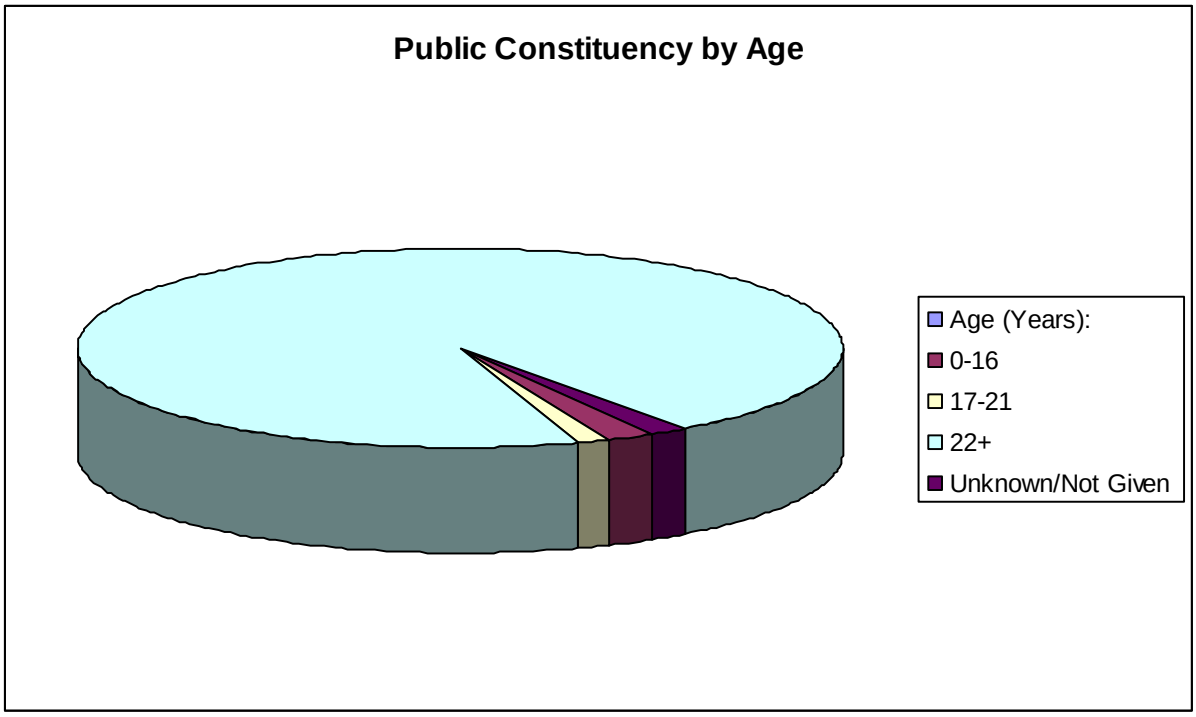
4.3 Trust Membership

Analysing **public** membership provides us with an indication of how representative our membership is. The key points to consider are as follows:

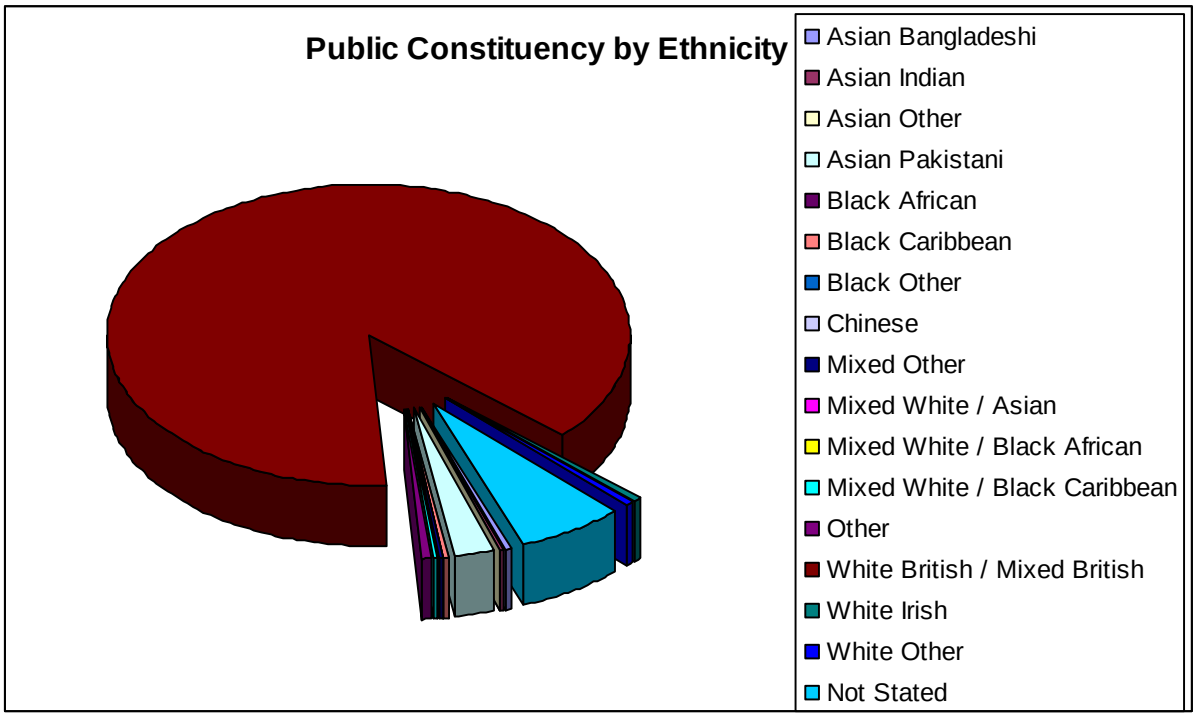
- The membership is geographically focused in Rotherham and Doncaster in line with the range of services provided in these locations in comparison with those in North and North East Lincolnshire.
- Ethnicity profile shows membership to be well represented in the black and minority ethnic groupings.
- The gender ratio is weighted towards females whereas the eligible membership is more equally balanced.
- The socio economic profile demonstrates that our membership is 'more affluent' than the eligible membership indicates.

Analysing our **patient** constituencies we can conclude that there is a need to focus our efforts of recruitment on the specialist services and community services areas to ensure service users, patients and carers have a voice and that we have benefit from their experience and knowledge.

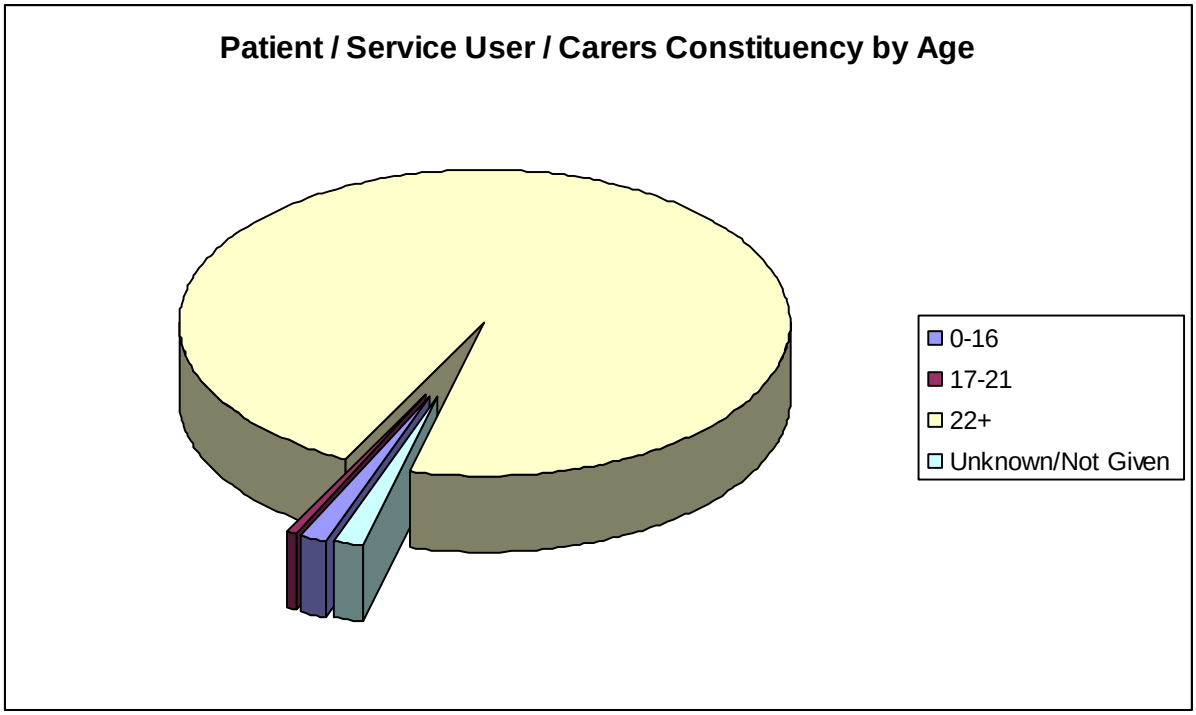
Public Trust membership by Age



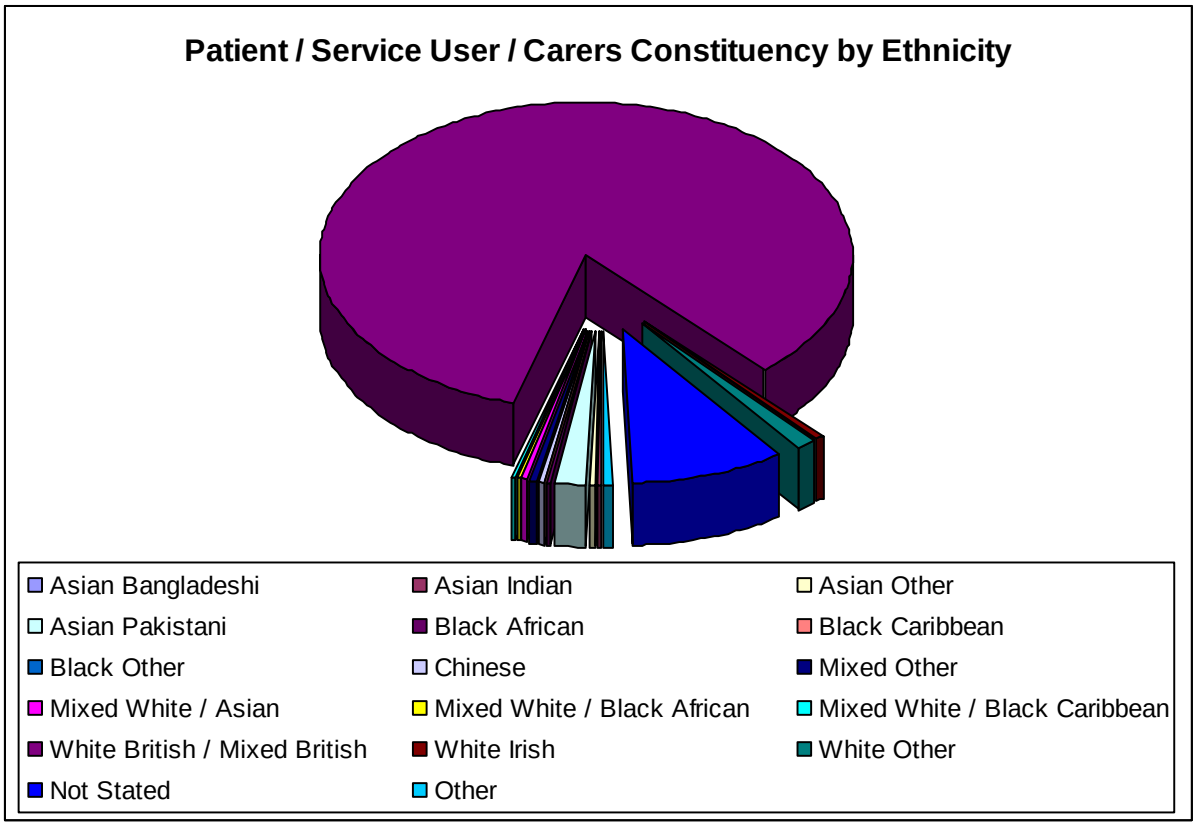
Public Trust Membership by Ethnicity



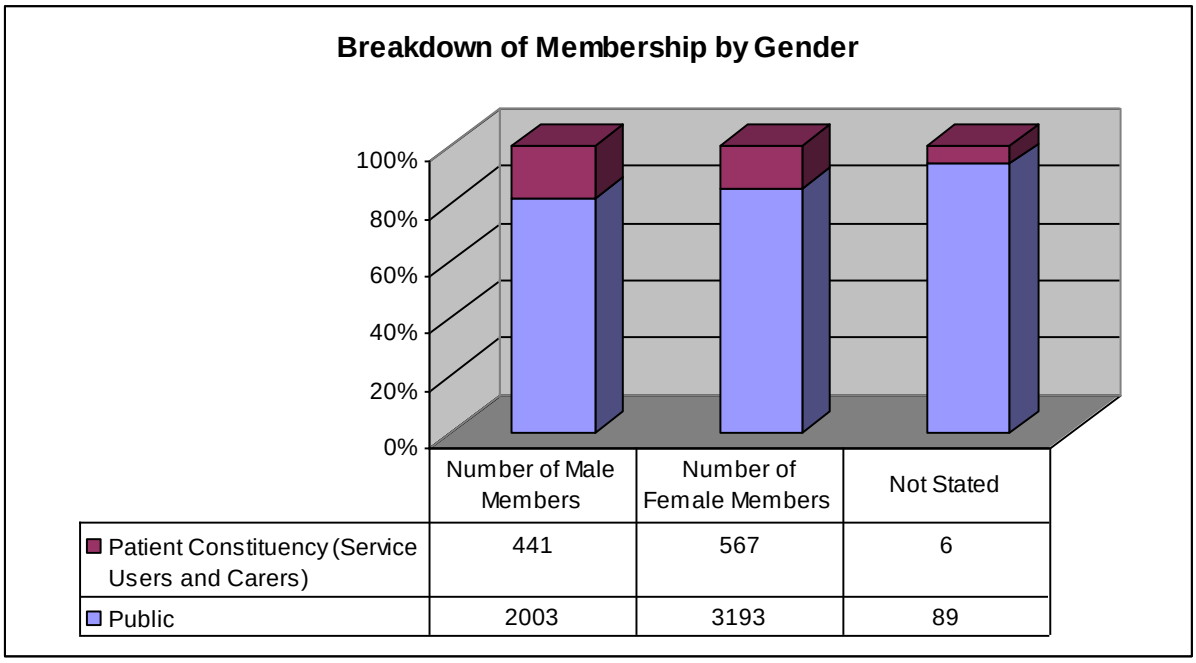
Patient / Service User / Carer Membership by Age



Patient / Service User / Carer Membership by Ethnicity



Breakdown of Membership by Gender



	Number of Male Members	Number of Female Members	Not Stated
Patient Constituency (Service Users and Carers)	441	567	6
Public	2003	3193	89

5 Workforce

Engagement and education with the workforce on equality issues is an on-going and evolving process.
Feedback from staff on equality issues affecting the workforce or patients/service users is channelled into the Trust's governance arrangements through the Equality Diversity and Human Rights steering group.
Results from staff surveys are also analysed and any learning in respect of equality issues is disseminated.

As an organisation we chose to survey all relevant staff, rather than only sampling the minimum number as stipulated in the staff survey guidance. The overall response rate for the organisation was 59% for the full sample and 59% for the core sample. The 59% response rate will be reported by the Care Quality Commission (CQC). Compared to last year's response rate, the response rate has increased by 3%, increasing from 56%. The increased response rate is very positive given the survey closed earlier this year.

5.1 Patients / Service Users / Carers

Local Engagement

The involvement of Local Communities is the ethos that underpins everything we do. We actively seek to involve patients and the public (and those who represent them) in our decision making, ensuring we engage with community and patient representative groups so that our services reflect local needs and are fair and equal.

The Trust has a well-established dialogue with service users and carers through the User Carer Partnership Council which continues to meet bi-monthly.