Royal Devon and Exeter NHS
NHS Foundation Trust

Equality Data Analysis - Summary Report

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1. Introduction

The NHS has a range of statutory drivers, which set the standard for our delivery of equality and diversity. They are as follows:

- the Equality Act
- the Public Sector Duty
- the Equality Delivery System
- the Care Quality Commission standards.

The Equality Act provides the basic foundation on which the other three drivers, listed above, stand.

The Public Sector Duty, as interpreted through the Equality and Human Rights Commission Guidance recommends that we report on a range of data, covering both staff and service users.

The Equality Delivery System is an internal NHS standard, designed to make sure we are complying with the Public Sector Duty.

The Care Quality Commission standards do not make any direct stipulations of the equality data we should be gathering, to give an overview of Trust performance in this area. The standards do, however, expect that equality should be embedded in all that we do.

If we focus on meeting the Public Sector Duty requirements, then we should automatically satisfy the expectations of the Equality Delivery System and the Care Quality Commission. The following tables show how we meet the Public Sector Duty recommendations for information publication.

The Public Sector Duty information recommendations include information which is beyond the immediate scope of this Data Report. For sake of completeness, we have included these elements in the tables which follow and shown where we publish the appropriate information.

a. Workforce data

Public Sector Duty expectation	How we meet it
The race, disability, gender, age breakdown and distribution of your workforce and whether they are full time or part time. Indication of likely representation on sexual orientation and religion or belief.	Section 2 Staff Profile. Our workforce is 75% female, so we have focused on gender as regards part-time/full-time working. We collect information on sexual orientation and religion/belief routinely.
Information about occupational segregation.	Section 2 Staff Profile.
Gender pay gap information and pay gaps for other protected groups.	Section 3 Gender Pay Gap and Pay Gaps for Other Protected Characteristics.
Length of time on grade and pay gap	Section 2

Public Sector Duty expectation	How we meet it
information.	Staff Profile We use "length of time on grade" as a tool to investigate a higher proportion than expected from a protected characteristic at one particular pay band. We consider this tool and our routine consideration of promotions covers similar ground to "pay gap information".
Success rate of job applicants.	Section 4 Appointments.
Part time and full time work by protected characteristic.	Section 5 Flexible Working
Take-up of training opportunities.	Section 6 Personal Development.
Appraisals	As above.
Return to work after maternity.	Section 7 Return from Maternity Leave.
Grievances (including about harassment) Disciplinary action (including for harassment).	Section 8 Employment Cases. This section covers all employment cases, not just grievances. Section 14 Staff Survey Equality Analysis Section f on “Experience of abuse, harassment, bullying and violence by protected characteristic” covers the harassment element of the requirement.
Dismissal	Section 9 Dismissal.
Other reasons for termination like redundancy and retirement.	Section 10 Retirement. Our Management of Organisational Change Policy makes provision for monitoring redundancy by equality category, should the need arise. We have had no compulsory redundancies in the last three years. Section 11 Retention and Stability.

Public Sector Duty expectation	How we meet it
Applications for promotion and success rates.	Section 12 Career Progression. Section 4 Appointments.
Return to work of employees with a disability, following sick leave related to their disability.	We do not, currently, separately record sick leave related to disability, but will consider doing so as part of our review of the Sickness Absence Management Policy, due for spring 2012. Section 13 Staff Sickness does, however, include disaggregation of sickness rates across the standard range of protected characteristics.
Quantitative and qualitative research with employees, e.g. staff surveys.	Section 14 Staff Survey Equality Analysis
Complaints about discrimination and other prohibited conduct from staff.	Section 14 Staff Survey Equality Analysis See, in particular, sections a-d.
An indication of any issues for transsexual staff, based on engagement with transsexual staff or equality organisations.	This is not directly covered in this Data Report. We have, however, consulted thoroughly on issues faced by transgender staff and intend publishing a webpage addressing those issues, during 2012.
Details and feedback of engagement with staff and trade unions.	Consultation arrangements and a summary of their outcomes are reported on our equality webpages.
Records of how you have had due regard to the aims of the duty in decision-making with regard to your employment, including any assessments of impact on equality and any evidence used.	The "actions" sections in this report shows how this evidence has directly impacted decision-making. The evidence in this report also informs our equality impact assessments, which are published on our website.
Details of policies and programs that have been put into place to address equality concerns raised by staff and trade unions.	Our equality action plan is published on our website.

b. Patient Data

Public Sector Duty requirement	How we meet it
Access to services	Section 15 Patient Numbers
Satisfaction with services	Section 14 Patient satisfaction
Complaints, including about discrimination	As above.
Patient outcomes, by equality category,	Sections 20 and 21
Details and feedback of engagement with service users.	Section 16 Patient Engagement This section looks at participation, by protected characteristic, in formally recognised patient engagement projects. The outcomes of our patient engagement activity routinely reported to the Board, separately to this report. Board papers are made available on our website. The equality dimensions of this engagement work are covered through discussion of the consultation arrangements in our webpages.
Quantitative and qualitative research with service users, e.g. patient surveys.	Section 17 Patient Satisfaction
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 "actions" sections in this report shows how this evidence has directly impacted decision-making. The evidence in this report also informs our equality impact assessments, which are published on our website.
Details of policies and programs that have been put into place to address equality concerns raised by service users.	Our equality action plan is published on our website.

c. Coverage of protected characteristics

Our evidence in this report covers the following protected characteristics:

- Age
- Disability
- Gender
- Race
- Religion
- Sexual Orientation.
- Pregnancy/maternity

We do not consider that local data analysis is an appropriate way of covering the needs of the two remaining characteristics, although we use our equality engagement work to understand their needs.

2. Staff profile (ESR 2011)

Staff are our most valuable asset in delivering care that meets patients' individual need.

We are best placed to meet that need when the profile of our staff matches that of the local community. (See a, below.)

The ethnic profile of the community we serve and our workforce is changing, so it is especially important for us to track our staff numbers by racial group. (See b, below.)

We have added a category for "age 65 and over", since the last Data Report. With the abolition of the Default Retirement Age, as of April 2011, we are likely to see an increase in staff who fall into the over 65 age bracket. It is therefore important to include this age group, in our diversity monitoring. This will provide an indicator as to the equity of our retirement policy, across staff group and pay band. Section 10 in this report monitors the equity of retirement, across the protected characteristics.

We have also added a separate profile of our Bank staff, who are those working with us to fill short-term gaps. Bank staff are also included in the broader staff profile.

We have looked at our staff profile through two sources.

The first is the Electronic Staff Record (ESR) which is a database of all staff (c. 6500 people) and their personal details.

The second is the staff survey (survey taken in 2010, results reported 2011). All staff were invited to participate and 47% responded.

Most of the community data, to which we compare our staff profile, is based on Office for National Statistics (ONS) data, for the years 2009/10. ONS data does not, however, cover every equality strand. Religion is therefore taken from the 2001 census data and the statistic for lesbian and gay people is from an official estimate made by the ONS in 2010.

a. RD&E staff compared with local community

Category	% of staff in the category 2011 according to ESR	% of staff in the category according to staff survey taken in 2010	Community data (Local Authority Area of Exeter)
Age up to 40	44%	38%[1]	60%[2]
Age 65 and over	2%	1%	15%
Having Disability	3% [3]	14% [3]	6%[4]
Male	25%	22%	50%[5]
Ethnic Minority	8%	7%	9%[6]
Minority religion	11%	Not covered	2%
Lesbian, gay or bisexual	1%	Not covered	1%[7]

Responses from the staff survey provide a broadly similar profile to data on ESR, with the exception of disability.[3]

Our staff profile is broadly the same as it was in 2010.

There have been two changes in the benchmarking, which have resulted in issues being highlighted, which were not evident last year.

This report uses a different method of age benchmarking. Last year's report looked at those aged 15-39 as a proportion of the population, as a whole, which was 43%. The analysis above reports those aged 15-39 as a proportion of the traditional working age population, which is, arguably, more appropriate benchmark for our workforce, which will also reflect the traditional working age of 16-64.

This change in benchmarking method highlights that our workforce is relatively aged, with a notably lower proportion aged under 40 than is the case for the working age population, as a whole. The NHS as a whole, however, has an older than average workforce, with 40% aged up to 40. RD&E therefore has a greater proportion of staff aged under 40 than is the case for the NHS nationally.[8]

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[1] The closest comparison in the staff survey is for people up to and including 40.
[2] This is based on those aged 15-39 inclusive and is the closest benchmark the source would allow to the age range taken from ESR, i.e. 16-39. The % shows those aged 15-39 as a proportion of those aged 15-64, the closest the source data allows to the traditional working ages.
[3] The staff survey has a loose question to identify "disability", which encompasses a broader group of people than the narrow legal definition of "disability", which ESR uses.
[4] This based on the % of Exeter working age people who declared themselves as "DDA disabled" in the Annual Population Survey.
[5] This is the % of males aged 16-64, i.e. the traditional working age.
[6] This is taken from a benchmark for the population as whole (i.e. all ages). The 9% has been rounded from 8.7%.
[7] ONS national estimate (2010) from Integrated Household Survey. Although this comes from an official source, it is disputed by some lgb groups.
[8] Data from The Health and Social Care Information Centre, accessed June 2011.

There has also been a sudden increase in the community benchmark for the working age population reporting a disability. This has risen from 4% last year to 6%.

b. Staff profile by Band and staff group

In the more detailed analysis which follows, note that:

- * indicates a number under 5, which has been hidden to protect the identity of the people concerned.
- The numbers of staff who have declared themselves as lesbian, gay or bisexual is under 5 in nearly all of the staff groups and pay bands below, so is not reported.
- The % column shows the % of staff in the particular staff group or band from the minority group in question.

The following tables show the staff profile (as above) by staff group and pay band:

Staff Group (ESR 2011)	Category											
	Age up to 40		Age 65 and over		Having Disability		Male		Ethnic Minority		Minority religion	
	Nos.	%			Nos.	%	Nos.	%	Nos.	%	Nos.	%
Add Prof Scientific and Technical	109	50%	6	3%	6	4%	76	35%	21	10%	11	13%
Additional Clinical Services	578	49%	18	2%	20	3%	210	18%	93	9%	74	14%
Administrative and Clerical	531	33%	45	3%	33	3%	331	21%	46	3%	78	10%
Allied Health Professionals	164	59%	*	*	6	3%	44	16%	17	6%	13	12%
Estates and Ancillary	270	36%	49	7%	18	4%	336	45%	70	10%	24	12%
Healthcare Scientists	83	38%	*	*	8	5%	93	43%	12	6%	5	11%
Medical and Dental	452	70%	*	*	*	1%	443	58%	141	20%	55	16%
Nursing and Midwifery Registered	735	44%	6	0%	27	2%	115	7%	124	8%	66	10%
Trust	2922	46%	134	2%	121	3%	1648	25%	524	8%	326	12%

Band (ESR 2011)	Category											
	Age up to 40		Age 65 and over		Having Disability		Male		Ethnic Minority		Minority religion	
	Nos.	%			Nos.	%	Nos.	%	Nos.	%	Nos.	%
1	163	39%	26	7%	13	6%	167	40%	46	12%	17	12%
2	637	42%	41	3%	31	3%	314	21%	106	8%	75	12%
3	228	37%	11	2%	10	2%	110	18%	22	4%	31	12%
4	194	37%	15	3%	10	3%	98	18%	14	3%	23	10%
5	750	53%	10	1%	24	3%	204	14%	129	10%	58	10%
6	302	39%	7	1%	15	3%	113	15%	28	4%	43	14%
7	106	30%	*	*	10	4%	86	24%	21	6%	9	6%
8+	58	26%	0	0%	*	1%	85	39%	11	5%	5	5%
Medical & Dental	438	59%	*	*	*	1%	434	58%	138	20%	54	16%
Trust[1]	2876	46%	110	2%	113	3%	1611	25%	515	8%	315	12%

This shows that ethnic minorities are noticeably under-represented in the following staff groups:

- Admin and Clerical
- Allied Health Professionals
- Healthcare Scientists.

They are also notably over-represented at Bands 1 and 5, as well as in Medical and Dental. The over-representation at Bands 1 and 5 is further explored in section d, below.

c. RD&E staff numbers by racial group (ESR)

	2008	2009	2010	2011	% change since 2008
Asian	101	176	178	178	102%
Black	34	47	59	55	139%
White not British Isles	113	172	209	225	200%
Mixed	18	25	31	33	120%
Other	13	15	23	29	123%
Ethnic Minority	279	435	500	520	143%
White British Isles	4867	5281	5648	5751	36%
Trust (known race)	5146	5716	6148	6271	41%

[1] The numerical totals do not match those in the previous table, as the numbers of staff who are unknown varies, according to whether we are analysing by pay band (as in this table) or staff group (as in the previous table).

% Ethnic Minority	5.4%	7.6%	8.1%	8.3%	73%

The growth in ethnic minority staff since 2008 has been significant and has been most noticeable across the "White not British Isles" category.

d. Ethnic Minority staff profile by band (ESR 2011)

Band	% of the Band who are Ethnic Minority (2011)
1	12%
2	8%
3	4%
4	3%
5	10%
6	4%
7	6%
8	5%
Medical & Dental	20%
Trust average	8%

We would expect that the proportions above would be broadly in line with the Trust average. Where the figure is above Trust average, this highlights where ethnic minority staff are over-represented.

This results above show over-representation of ethnic minority staff at Bands 1 and 5, as well as Medical and Dental. The Medical and Dental jobs are often seen as the most senior, Band 1 is the basic entry band and Band 5 is the entry point for professionals.

Within Band 1, ethnic minority staff are over-represented in the Estates and Ancillary Staff Group, covering roles in Laundry, Catering and Housekeeping and some Portering roles.

At Band 5, ethnic minorities are over-represented in the Nursing and Midwifery staff group.

We have analysed the length of stay for staff at Band 1 and Band 5 and compared the length of stay in post for ethnic minority and non-ethnic minority staff. In doing this, we looked at the staff group in each band where there were most ethnic minority workers.

The results were as follows:

Band	Staff group	Length of stay in post for ethnic minority staff	Length of stay in post for non-ethnic minority staff
1	Ancillary and Estates	89	108
5	Nursing and midwifery registered	160	106

This shows that the ethnic minority Band 5 nurses have a notably longer length of stay in their post than would be expected. This is not due to any difference in age, or retention patterns for this staff group, as the average age and retention rate for both the ethnic minority and the non-ethnic minority nurses at Band 5 are broadly similar.

Our analysis also shows the following about the Band 5 ethnic minority nurses:

- Within this group, 41% have an Asian ethnicity, 27% are White ethnic minority and 19% have Black ethnicity.
- Most of them are in Medicine, with a slightly higher proportion of them in this directorate than is the case for the non-ethnic minority Band 5 nurses.
- The Asians have an average time in post of 201 weeks and those with a Black ethnicity 150 weeks, but the white ethnic minority nurses' average is 91 weeks.

e. Profile of Bank staff

The following profiles are of Bank staff, only.

Staff Group	Nos. of staff in the Staff Group 2011 (ESR)	% of Bank staff in the Staff Group 2011 (ESR)
Additional Clinical Services	219	58%
Administrative and Clerical	72	19%
Nursing and Midwifery Registered	85	23%
Trust	376	6%

The Bank staff are in three staff groups, predominantly in Additional Clinical Services. They make up a relatively small proportion (6%) of staff in the Trust.

Category	Nos. of Bank staff in the protected characteristic 2011 (ESR)	% of Bank staff in the protected characteristic 2011 (ESR)	Trust
Age up to 40	376	49%	44%
Age 65 and over	16	4%	2%
Having Disability	*	2%	3%
Male	41	11%	25%
Ethnic Minority	24	8%	8%
Minority religion	29	15%	11%
Lesbian, gay or bisexual	*	1%	1%

The profile of Bank staff by equality category is either broadly the same as for the Trust as a whole, or is in line with the figures for the three staff groups in which they work.

Pay Band	Nos. of staff in the Band 2011 (ESR)	% of Bank staff in the Band 2011 (ESR)	Trust
1	0	0%	6%
2	235	63%	23%
3	23	6%	9%
4	27	7%	8%
5	79	21%	22%
6	12	3%	12%
7	0	0%	5%
8	0	0%	3%
Medical & Dental	0	0%	11%

Bank staff are skewed towards Band 2, which is to be expected given the nature of temporary work and that the staff group in which most of them work is also skewed towards Band 2.[1]

Actions

- We are actively developing our Apprenticeship delivery, which should contribute to encouraging more younger staff to join us.
  Recruitment is currently slowing, as a way of meeting our efficiency targets, so any wider recruitment initiative to encourage younger entrants would not be appropriate.

[1] 71% of Additional Clinical Services staff are at Band 2.

- Continue with promotion of discrete race awareness training, in view of the increasing proportion of staff who are ethnic minority.

- Consult with relevant stakeholders to consider whether there is any need for a career development initiative to support ethnic minority Band 5 nurses.

3. Gender Pay Gap and pay gaps for other characteristics (ESR 2011)

a. Gender pay gap

Measuring the gender pay gap is an important way of showing whether men and women have equal pay. Gender pay gap analysis looks at broad patterns of pay and can suggest structural issues, for example, whether women's careers are progressing as well as men's. This type of headline analysis cannot in itself It prove whether individual men are being paid more than individual women to do the same job.

A gender pay gap usually arises because:

- men and women are paid different rates for jobs of equal worth
- women are stereotyped into lower paid jobs
- women find it harder to progress up the career ladder
- women enter their pay band at a lower point than men.

We believe Agenda for Change has addressed the first point, above, for the NHS.

The table below uses the standard national reporting method to show our gender pay gap. It shows the average[1] hourly rate for basic salary by staff group:

Staff Group	Female	Male	Variance
Add Prof Scientific and Technical	£13.06	£13.06	0%
Additional Clinical Services	£8.38	£8.11	-3%
Administrative and Clerical	£9.63	£13.06	26%
Allied Health Professionals	£17.48	£14.13	-24%
Estates and Ancillary	£7.47	£7.90	5%
Healthcare Scientists	£16.09	£17.48	8%
Medical and Dental	£17.95	£36.84	51%
Nursing and Midwifery Registered	£14.13	£14.13	0%
All Staff	£11.60	£13.06	11%

The Office for National Statistics reports the national gap, over the whole economy, as being 20% in 2010.[2] The figure for RD&E is, therefore, well below the national average and has fallen very slightly since last year, when it was 12%.

This Trust's two largest gender pay gaps are for the Administrative & Clerical and Medical & Dental staff groups.

Last year's data report shows that for the former staff group this is due to it embracing two very different subgroups, namely administrative jobs in pay bands 1-4

[1] In line with official sources, it uses the median average – see for example the Office for National Statistics Report at http://www.statistics.gov.uk/pdfdir/ashe1108.pdf
[2] Office for National Statistics website http://www.statistics.gov.uk/cci/nugget.asp?id=167 November 2009, accessed September 2010.

(which are predominantly female) and more specialised managerial roles at band 5 and above, which are less often female.

As regards Medical & Dental staff, last year's report showed that a significant contributory factor to the issue at RD&E is the under-representation of women at consultant grade, which is a national issue.

Overall, the Trust is able to recruit satisfactorily to consultant posts, so there is no pressing need to open up new sources of labour supply for these jobs. We have, however, reviewed the recommendations of national research into this issue, to ensure that, as far as we can influence it, the environment we offer female medical staff is broadly in line with national best practice.

b. Pay gaps for other protected characteristics

During the last year, NHS organisations have been encouraged to measure the pay gaps for other protected characteristics. Nationally, the pay gap is also monitored between full-time and part-time staff, so we have replicated this below.

This Trust's results are as follows, using the same methods as for the gender pay gap information, above:

Age	Under 40	40+	Variance
	£12.06	£12.06	0%

Disability	With disability	Without disability	Variance
	£11.15	£12.56	-11%

Race	Ethnic minority	Not ethnic minority	Variance
	£13.06	£12.06	8%

Religion	Minority religion	Not minority religion	Variance
	£11.60	£11.60	0%

Sexual orientation	Lesbian, gay or bisexual	Not lesbian, gay or bisexual	Variance
	£10.64	£11.42	-7%

Part time / full time	Part time	Full time	Variance
	£12.06	£12.06	-0%

The only minority groups showing a negative variance are those with disabilities and staff who are lesbian, gay or bisexual.

Measuring pay gaps for these protected characteristics is not well embedded, so there is a lack of well-evidenced benchmarks. The EHRC research report *Pay gaps across the equality strands* (2009)[1] echoes this uncertainty, but makes the following comments, across the strands:

- younger workers are generally disadvantaged, compared to prime age workers
- there is a substantial pay gap for disability, but estimates vary widely, from 6% to 26%
- there is a gap of 5% for full-time workers who are ethnic minorities
- most minority religions are disadvantaged by a pay gap
- the evidence as regards sexual orientation is uncertain
- pay is usually lower for part-time work.

It is pleasing to note that our two pay gaps for minority groups are both small, when compared to available benchmarks.

[1] Available at http://www.equalityhumanrights.com/uploaded_files/research/14_pay_gaps_across_equalities_review.pdf (accessed 3 August, 2011).

4. Appointments 2010-11 (NHS Jobs and Staff Survey)

a. NHS Jobs

This information helps us gauge whether our selection process is treating all types of people equally. The data covers both external candidates and those applying internally, for example, existing staff seeking promotion.

It shows the proportion of all candidates at each stage of the selection process, from the various equality strands.

In theory, we would expect the proportion to be broadly the same at each stage of the selection process. Where the proportions shrink progressing through the process, then this suggests an equality gap.

For applicants with a disability, we have a Guaranteed Interview Scheme, which means that they are automatically shortlisted if they meet the minimum job requirements. Candidates who are shortlisted through this Scheme may not be the best people for the job, so this would contribute to the drop in the proportion of people with a disability between shortlisting and appointment.

	% applying	% shortlisted	% appointed	% status unknown at application
Male	34%	23%	21%	0%
With disability	3%	5%	3%	1%
Ethnic minority	34%	14%	7%	1%
Age 16-29	47%	38%	40%	0%
Age 50+	11%	15%	14%	0%
Religious minority	26%	14%	12%	10%
Lesbian, gay or bisexual	3%	3%	2%	8%
People with court conviction	1%	1%	0%	34%

The analysis above shows the following:

- There has been a notable increase in the proportion of applicants who are ethnic minority – from 21% last year to 34% in 2010/11.
- The equality gaps suggested above are less than they were last year for almost every group, apart from ethnic minorities and religious minorities.
- There may be some overlap between these groups, in that people who are in one group may also be in the other. This issue could therefore represent the same people failing to progress through our selection process.
- The increased equality gap for ethnic minority people could be due to increased difficulties in obtaining work permits.

- Lesbian gay or bisexual people and males are still not progressing through the process as expected, but the rate at which they do so has improved since last year.
- People with disabilities are now making better than expected progress through the process, which is a significant improvement on what was the case last year.
- We have started to track performance for "people with court conviction", this year.

  Many of our posts require a CRB check, so it is possible that people with court convictions are not being appointed because of concerns arising through the CRB process.

b. Staff survey

This includes a question as to whether staff believe the Trust provides equal opportunities in career progression or promotion.
The results by protected characteristic are shown below:

	% agreeing that the Trust provides equal opportunities in career progression or promotion
Age (16-30)	93%
Age (51+)	92%
Staff with a disability	85%
Staff without a disability	94%
Females	94%
Males	89%
Staff who are ethnic minority	77%
Staff who are not ethnic minority	93%
National average (acute and specialist)	89%

Only two results, above, are lower than the national average and there are no notable equality gaps for any groups.

Action

- During 2010-11 there was conducted in-depth equality monitoring of the Trust's recruitment process, which has led to a detailed action plan to address issues arising.
  We will continue to implement that plan, subject to levels of recruitment.

- We will investigate the causes of the anomaly for ethnic minority applicants by tracking their progress through the system at individual level.

- Investigate the extent to which applicants are rejected due to issues arising during the CRB process and whether this could account for the low proportion of people with court convictions who are appointed.

5. Flexible working (ESR 2010/11)

One important way of helping staff achieve a good work-life balance and meet caring obligations is to offer flexible working patterns.

Part-time hours is one option to achieve flexible working, so we have considered the proportion of staff who are part-time in each pay band, according to ESR. This is set alongside the proportion of staff in each band who are female, as they are most likely to request part time working, to fulfil caring duties.

The staff survey complements this, as it shows how staff rate us for the availability of the full range of flexible working options and our overall commitment to helping them achieve work-life balance.

a. Part time working (ESR 2011)

Band	% who are part time	Nos. who are part time	Nos. who are female	Part time as % of female staff	Total in Band	% female
1	42%	134	192	70%	322	60%
2	44%	504	907	56%	1157	78%
3	44%	250	469	53%	569	82%
4	31%	154	407	38%	490	83%
5	44%	577	1123	51%	1315	85%
6	47%	348	631	55%	744	85%
7	31%	111	275	40%	361	76%
8+	18%	40	134	30%	217	62%
Medical & Dental	17%	105	260	40%	623	42%

This data shows, as would be expected, that the incidence of part-time working declines at the two higher bands.
It also declines at Band 4, which is often the highest pay band for staff who are not professionals and again from Band 7.
There is no corresponding decline in the proportion of females at Band 4, although this is the case at Band 8.

Bank staff are not included in this data as they are, by definition, flexible workers.

Survey data (taken in 2010)

- Our survey result for use of flexible working remained static, but is slightly above national average.
- Looking at use of flexible working options by equality group, the only notable variations are that females make greater use of flexible working options (as would be expected), but that ethnic minorities are less likely to access these.

The variation for ethnic minorities could be because the proportion of females (who make higher use of flexible working) is lower among ethnic minority staff (66%) than for the Trust as a whole (75%).

- RD&E is average, for commitment to work-life balance.

The detailed results from the staff survey are as follows:

	% using flexible working options	Trust commitment to work-life balance
Age 16-30	52%	3.39
Age 51+	60%	3.32
With a disability	60%	3.33
Without a disability	64%	3.41
Female	65%	3.4
Male	53%	3.41
Ethnic minority	48%	3.68
Not ethnic minority	64%	3.39
Trust overall	64%	3.39
National sector average	63%	3.38

6. Personal development (ESR 2010-11 and staff survey taken in 2010, analysed in 2011)

This examines whether all staff are able to access personal development fairly.

a. Training activity

The data looks at all recorded training activities and shows the proportion of all activities that were undertaken by each category of staff. It excludes essential learning, as this should be undertaken by all staff, regardless.

We would expect that the two proportions would broadly match, for each category in the table below.

	% of training activities for this group (2010-11)	% of this group in Trust (2010)
Age up to 40	40%	42%
With disability	2%	3%
Male	19%	25%
Ethnic Minority	9%	7%
Religious minority	11%	11%
Lesbian gay or bisexual	1%	1%

The only notable gap is for male staff.

The under-representation of males (and implicit over-representation of females in training activity) can be attributed to the gender profile by staff group, with males tending to work in those staff groups where training activity is low and females in the groups where it is highest. For example, Nursing and Midwifery is a staff group with a low proportion of males, yet it is the one with the highest proportion of training activity. (This staff group has 50% of training activity, compared to 26% of staff and is 93% female.)

b. Access to appraisal

This is covered by the staff survey and by ESR.

The staff survey asks whether respondents have received an appraisal within the last 12 months. The results by protected characteristic are as follows:

	% saying they have had an appraisal in the last 12 months
Age 16-30	85%
Age 51+	80%
With a disability	76%

	% saying they have had an appraisal in the last 12 months
Without a disability	83%
Female	82%
Male	78%
Ethnic minority	87%
Not ethnic minority	81%

There are no notable equality gaps in this evidence.

We can also measure access to appraisal via ESR. The following table analyses by protected characteristic those who have had an appraisal and compares this with the profile by protected characteristic of all staff who are eligible for an appraisal.[1]

	% with in date appraisal	% in Trust who are eligible for appraisal
Age under 40	37%	38%
With a disability	2%	2%
Female	81%	79%
Male	19%	21%
Ethnic minority	7%	8%
Religious minority	11%	8%
Lesbian, gay or bisexual	2%	2%

There are no notable equality gaps in this evidence.

[1] Those who are not eligible include those on long term leave, career breaks and new starts with less than 12 months service.

7. Return from maternity leave (Payroll records 2010/11)

This indicates how well we are re-engaging women after maternity leave. We aspire that all should return, but recognise this will not always be at the same grade.

Our most recent analysis of 167 women who were due to return from maternity leave in the year from 1st June 2010 shows that:

- 92% had been retained one month after the date that their maternity leave was due to end
- None of these returned to a lower pay band than that at which they left.

We are not aware of any formal benchmark for return rates, however a specialist equality journal quotes a best practice case study which achieved a 97% return rate.[1] It is not clear from the source, however, how the benchmark was calculated, in particular whether any allowance was made for whether returners were still in post after one month.

[1] See Equal Opportunities Review 191:7-11 on the Financial Services employer, Citi.

8. Employment cases (ESR 2010-11)

The following analysis is based on all cases on ESR opened during 2010/11.

Employee relations cases are analysed to establish whether we have a disproportionate number of staff involved by disability, gender, racial or age status. An imbalance, where there is a notably higher proportion in the "% … in this type of case" column, can indicate potential discrimination for that minority group.

The cases involving capability with an underlying health issue have been excluded from the analysis of the result below for staff with a disability, as staff with a disability will inevitably be over-represented in this category of case, due to the common link between disability and health issues.

	No. of all employment cases about someone from this group	% of all employment cases about someone from this group	% in workforce from this group
Age up to 40	38	41%	42%
With a disability	6	12%	3%
Males	25	27%	25%
Ethnic Minority	6	7%	8%
Religious minority	9	26%	11%
Lesbian gay or bisexual	*	*	1%

The proportion of people with a disability and who are religious minority involved in these cases is higher than expected. This was not the case last year, or the year before.

Although the numbers involved are small the degree of the anomaly for both people with a disability and religious minorities is large.

Of the 9 cases involving religious minority staff, 6 were capability and 3 disciplinary.

Of the 6 cases involving people with a disability, 3 were for disciplinary reasons and 3 for capability linked to performance.

The anomaly for religious minority staff is a one-off in this particular analysis, not having occurred in the previous two years. The issue for staff with a disability is, however, one of many anomalies arising for this protected characteristic and is therefore addressed in the action below.

There was no sexual harassment reported this year.

Survey data (taken in 2010)

- We are above average for the proportion of staff saying that we take effective action towards violence and harassment.
- There was no notable variation in the above question across the equality strands covered in the survey, namely age, disability, gender and race.

Action

- Continue with work to understand the experience of staff with a disability and support them.
- Conduct case studies of the three staff with disabilities who were subject to disciplinary action to see whether there could be any link to their disability. This has been done and there was no obvious link. One made a harassment complaint (although this was not upheld), another was for "bad behaviour", the third for poor attendance and time-keeping.

9. Dismissals (ESR, 2007-11)

Dismissals are relatively rare (there were 14 in 2010-11) so the following table considers dismissals over a 4 year period, which widens the sample to 67 people.

	% of staff dismissed (2007-2011), by equality group	% in workforce by equality group[1]
Age up to 40	49%	44%
With a disability	12%	3%
Males	45%	25%
Ethnic Minority	7%	7%
Religious minority	7%	11%
Lesbian gay or bisexual	6%	1%

The data above shows a notably greater than expected proportion of dismissals among staff with a disability, males and LGB people.
It is possible that the figure for staff with a disability is inflated, because they are liable to be dismissed on capability grounds, due to their disability making it no longer possible for them to work. Excluding those dismissed on capability grounds, however, there are still 10% of dismissals coming from staff who have disabilities.
The numbers of LGB people and staff with disabilities involved in the figures above are, however, both very small, so that the results will be volatile and not a reliable indicator of any issue. For example, had a 1 less LGB person been dismissed, there would have been no issue for this staff group at all, in the data above.
Whilst the number of males dismissed is much larger (30), it is still relatively small when spread over four years and would not, in itself, warrant any further action without other data evidence suggesting issues in our treatment of male staff.

[1] The staff profile has remained broadly stable for the period 2007-11, apart from the % who are ethnic minority, which has grown. The benchmarks are therefore from the latest staff profile, apart from the ethnic minority figure, which is an average for the period 2007-11.

10. Retirement (ESR, 2011)

With the abolition of the Default Retirement Age as of 1st April 2011, we anticipate that there will be an increase in staff who are working past the age of 65, as retirement becomes more flexible.

We therefore intend monitoring our retirement patterns by reporting the staff aged 65 or over and showing their distribution across pay bands and staff groups.

The information below was gathered in April 2011 and will therefore provide a starting point from which to identify any medium-term changes in the profile of our workers aged 65 or over.

It shows the distribution of our staff aged 65+ across pay bands and Staff Groups, alongside a comparison with the distribution of all Trust staff.

a. Profile of staff aged 65+ by pay band

Pay Band	Nos. of staff aged 65+	Distribution of staff aged 65+	Distribution of all Trust staff
1	26	22%	6%
2	41	35%	23%
3	11	9%	9%
4	15	13%	8%
5	10	8%	22%
6	7	6%	12%
7	4	3%	5%
8+	0	0%	3%
Medical & Dental	4	3%	11%

This shows that staff aged 65+ are more likely to be in Bands 1-4.

b. Profile of staff aged 65+ by Staff Group

Staff Group	Nos. of staff aged 65+	Distribution of staff aged 65+	Distribution of all Trust staff
Add Prof Scientific and Technical	6	5%	3%
Additional Clinical Services	18	14%	18%
Administrative and Clerical	45	34%	24%
Allied Health Professionals	1	1%	4%
Estates and Ancillary	49	37%	11%
Healthcare Scientists	4	3%	3%
Medical and Dental	4	3%	11%
Nursing and Midwifery Registered	6	5%	25%

This shows that our staff aged 65+ are more likely to be in the following staff groups:

- Additional Professional, Scientific and Technical
- Administrative and Clerical
- Estates and Ancillary.

11. Retention and stability (ESR, 2010-11)

Good employers aim to retain staff. High retention rates give stability to the workforce, contribute to increased performance and cut replacement costs.

Conversely, low retention can suggest something amiss in our management of staff. If we have lower than expected retention for any one equality category, this could mean we are not managing that group of staff as well as we might.

This analysis excludes:

- retirement due to reaching retirement age, as until the recent law change there has been an expectation that staff would retire at 65, so the fact that they do so is not a reflection on the Trust's ability to retain staff.
- staff reaching the end of fixed term contracts
- those who retire due to ill health (when considering the disability data) as there will inevitably be a higher proportion of people with a disability in this category.

The first table looks at leavers from January 2010 until February 2011. This reflects more recent history at the Trust, but is a smaller sample (446 leavers).

The second table analyses all leavers from January 2007 until February 2011 (2079 staff). This has the advantage of a large sample, but the disadvantage of a wide timeframe so reflecting what was happening at the Trust over 4 years.

The staff profile by equality category has remained broadly stable, so the tables below use the 2011 workforce profile figures as a benchmark. The proportion who are ethnic minority has grown, however, so the benchmark for the % who are ethnic minority in the workforce is an average for 2007-2011.

We would expect the two proportions in the columns below to be broadly the same, although the younger workforce is more likely to be mobile and so have a lower retention rate.

	Profile of staff who left (2010-11), by equality group	% in workforce, by equality group
Age up to 40	59%	44%
With a disability	5%	3%
Males	21%	25%
Ethnic Minority	11%	8%
Religious minority	20%	11%
Lesbian gay or bisexual	2%	1%

	Profile of staff who have left (2007-2011), by equality group	% in workforce, by equality group
Age up to 40	60%	44%
With a disability	3%	3%
Males	25%	25%
Ethnic Minority	9%	7%
Religious minority	14%	11%
Lesbian gay or bisexual	2%	1%

The following groups have noticeably lower retention in both of the above tables:

- Those aged up to 40.
- Ethnic minorities.
- Religious minorities.

In addition, the following staff groups are shown in the first table as notably more likely to leave than would be expected:

- staff with a disability
- lesbian, gay or bisexual staff.
-

Many of these anomalies could, however, be explained by other characteristics of the staff above, other than their protected characteristics.

We have a relatively high proportion of leavers at Band 2, Band 5, in Medical & Dental and Nursing & Midwifery.

There are a relatively high proportion of staff aged under 40 at Band 5 and in Medical & Dental and a relatively high proportion of ethnic minority staff in these two areas as well as at Band 2. There is also a relatively high proportion of lgb staff at Band 2.

Staff aged under 40 are likely to be more mobile in their careers, so where there is a higher proportion of younger staff in a protected characteristic, this could explain lower retention. The Trust average age is 42, but the average age for ethnic minority staff is 38, for minority religions it is 37, for lesbian, gay and bisexual staff it is 35.

This factor is not contributing to the low retention among staff with a disability as their average age is 46.

Consequently the higher proportion of leavers from ethnic minorities, religious minorities, lesbian, gay or bisexual staff and those aged under 40 could be because they are more likely to be working in the bands and/or staff groups, or at an age where there is higher turnover rather than due directly to discrimination.

Action

- Continue with support measures for staff with disabilities.

12. Career progression

a. (ESR 2010-11)

We want to encourage all staff to achieve their best for the Trust, which will include giving a fair opportunity for all to progress in their careers.

This section uses ESR data on staff who have been promoted and survey results, to help gauge how fair we are achieving this.

This data looks to see if the staff from the various equality groups are gaining promotions as we would expect. It excludes Medical and Dental staff, as their career progression cannot be readily tracked.

It compares the proportion of all promotions who are from the staff group with the proportion of that staff group in the workforce.

We would expect the two proportions be roughly the same, for each staff group.

Bank staff are excluded from this data, as their short-term working pattern means they do not fit in analysis of long-term career progression.

Excludes Medical & Dental staff		
	% of promotions who are from this group (2010-11)	% of this group in Trust (2010-11)
Age up to 40	56%	42%
With disability	3%	3%
Male	16%	20%
Ethnic Minority	6%	7%
Religious minority	8%	11%
Lesbian gay or bisexual	1%	1%

Last year the differences were notable for lesbian, gay or bisexual people and for people with disabilities, but these gaps are no longer present.

b. Staff survey (taken in 2010)

Relevant indicators from staff survey are:

- RD&E is in the top 20% of Trusts of a similar type for staff believing it provides equal opportunities in career progression or promotion.
- The results for this question do not vary significantly by age, disability, gender or ethnicity at RD&E.

Action

- The numbers of religious minorities involved are small, so we do not consider specific action for this group to be appropriate.
  Our actions to promote fairness in our recruitment and selection process, however, should contribute to equality in the area of promotions.

13. Staff sickness

This analysis examines the sickness rate (expressed as time off sick as a percentage of total time available).

	Sick Rate
Age under 40	3.3%
Age over 40	3.8%
Age over 65	3.6%
Female	3.9%
Male	2.5%
With a Disability	6.0%
Without a Disability	3.2%
Ethnic Minority	2.9%
Not Ethnic Minority	3.6%
Lesbian, Gay or Bisexual	6.0%
Not Lesbian, Gay or Bisexual	3.2%
Trust Average	3.2%

The only notable variations are for staff with a disability and those who are lesbian, gay or bisexual.

The variation among those with a disability is not unexpected, as disabilities can often contribute to sickness.

Action

- Examine staff survey satisfaction rates for LGB respondents, during 2011, as a follow-up to the high sickness rate is noted for this staff group, which could indicate satisfaction/morale issues.

- Publish webpages aimed at staff, covering the theme of sexual orientation, as a way of improving our support to lesbian, gay or bisexual staff.

14. Staff survey equality analysis

a. Overarching indicators

Our overarching indicators from the survey, covering equality, have improved pleasingly, over the last year.

Reported discrimination nationally has almost doubled, from 7% in 2009 to 13% in 2010, but our Trust has seen a smaller increase, from 6% to 10%. Last year, we were average for this indicator, but now we are in the best 20% of Trusts.

	RDE	National (acute and specialist)
2010	10%	13%
2009	6%	7%

Our rating for acting fairly as regards career progression and promotion has improved slightly (up 1% point to 93%) and the national benchmark fallen (down 1% point to 89%), with the result that we have moved from being above average to being within the best 20% of Trusts.

	RDE	National (acute and specialist)
2010	93%	89%
2009	92%	90%

b. Overview by protected characteristic

i. Age

Reporting of discrimination on grounds of age has almost doubled between 2009 and 2010, from 28 to 51 people, representing 1.1% and 2.0% of respondents.

The reporting of discrimination, whether or not age-related, by our youngest staff (aged 16-30) has risen significantly, from 1 person to 8, which is from 2% to 11% of respondents in this age group. There is a higher proportion of younger staff (14%) than Trust average (11%) in the Medical & Dental staff group, so the increase in discrimination among this staff group may be linked to the above average decline in satisfaction for Medical & Dental staff as a whole (-4%).

The relative staff satisfaction indicators based on age of staff have remained broadly stable.

ii. Disability

The relative dissatisfaction of staff with a disability has been repeated for a third year. There are 10 key findings which are notably more negative, for this staff group and none which are notably more positive.

Although the number of key findings improving for staff with disabilities (14) is in line with overall Trust performance (13), the number deteriorating (22) is worse than the Trust as a whole (15).

There is some evidence to suggest a national issue, whereby staff with disabilities have lower satisfaction rates in the NHS staff survey than those who do not have disabilities.

Discrimination reported on the theme of disability has fallen very slightly from 0.7% in 2009 of respondents to 0.6% in 2010, representing 18 people in 2009 and 15 in 2010.

In contrast, the incidence of reported discrimination (whether or not disability-related) among staff with a disability has almost doubled, from 9% (5 people) in 2009 to 16% (12 people) in 2010.

We remain well above national average for the implementation of reasonable adjustment, with 84% of staff who report a disability and who require reasonable adjustment saying that the adjustments have been made, compared to a national average of 70%. Implementing reasonable adjustments is one of the most significant things we can do to improve the experience of our staff with disabilities.

iii. Gender

Females are much more dissatisfied than males this year and reporting of discrimination on the theme of gender has increased, noticeably. Female staff are also twice as likely to report discrimination in 2010 (10% of respondents, 38 people) as they were in 2009 (5% of respondents, 16 people).

This may be linked to a notable downturn in overall job satisfaction for Nurses (down 5% from 2009 to 2010, compared to a Trust average decline of 2%). Nurses are a large and predominantly female staff group, so results for this staff group will be highly influential on the overall results for female staff (over 30% of female staff are in this group).

iv. Race

Reported discrimination on the grounds of race has increased, up from 17% in 2009 to 25% in 2010, although by noticeably less than the almost two-fold overall increase in discrimination, nationally, which is up from 7% in 2009 to 13% in 2010.

In contrast, the experience of discrimination among our black ethnic minority staff has fallen, down from 27% in 2009 (6 people) to 16% (4 people) in 2010 and among our white staff, it has risen marginally from 6% (23 people) to 8% (36 people).

There are also 3 less instances than last year where black ethnic minority staff are notably more positive on a key finding than their white counterparts, although comparison of their satisfaction levels still suggests a positive working experience, as there are 6 key findings where they are notably more positive, compared to 4 where they are notably more negative. This could be due to a notable dip in overall job satisfaction since 2009 for both Medical & Dental and staff and Nurses (down 4% and 2%), which are the two staff groups at our Trust with the highest proportion of ethnic minorities. (These two groups account for over 50% of our ethnic minority staff.)

Action

- Continued action to improve the welfare at work of staff with disabilities, including formal consideration of a staff conversation or online survey around disability issues, subject to our overall strategy for staff engagement work, promoting work experience placements for learners with disabilities and review of impact of disability intranet pages.
- Continue promotion of race awareness training to address the level of discrimination on grounds of race, review impact of webpage for ethnic minority staff and the effectiveness of mentoring support.
- Review female satisfaction and the experience of discrimination among female staff, as compared to male, next year to see if females remain more dissatisfied.
- Review discrimination among the 16-30 age group next year, to see if this year's findings are repeated.

c. Rates of reporting discrimination by protected characteristic – theme of discrimination.

This reports by theme of discrimination, not by who is experiencing it. For example, a white British person might report discrimination on the grounds of race and show in table iv, below, but this would not be a reflection on the experience of our ethnic minority staff.

There are no national benchmarks for this data.

This data uses the Full Census results, so has the largest available number of respondents.

One theoretical weakness in the race indicator is that some staff will have answered the discrimination question, but without giving their racial background. They could therefore appear in the "numbers reporting discrimination" column, but not in the "respondents" column. The impact of this should be negligible, as only 2% of respondents failed to complete their racial information in 2011 and this factor will have been present in each year's results in the tables, below.

In the following tables, "discrimination rate" refers to numbers reporting discrimination by the particular theme as a proportion of the number of respondents.

i. Age (as a % of all staff surveyed)

	Respondents	Nos reporting discrimination by age	Discrimination rate
2010	2594	51	2.0%
2009	2578	28	1.1%
2008	2348	18	0.8%

ii. Disability (as a % of all staff surveyed)

	Respondents	Nos reporting discrimination by disability	Discrimination rate
2010	2594	15	0.6%
2009	2578	18	0.7%
2008	2348	15	0.6%

iii. Gender (as a % of all staff surveyed)

	Respondents	Nos reporting discrimination by gender	Discrimination rate
2010	2594	31	1.2%
2009	2578	21	0.8%
2008	2348	9	0.4%

iv. Race (as a % of all non-British staff surveyed)

	Bme (non British) respondents	Nos reporting discrimination by race	Discrimination rate
2010	183	45	25%
2009	203	35	17%
2008	184	37	20%

v. Religion (as a % of all staff surveyed)

	Respondents	Nos reporting discrimination by religion	Discrimination rate
2010	2594	7	0.3%
2009	2578	7	0.3%
2008	2348	5	0.2%

vi. Sexual orientation

	Respondents	Nos reporting discrimination by sexual orientation	Discrimination rate
2010	2594	5	0.2%
2009	2578	14	0.5%
2008	2348	4	0.2%

- Discrimination on grounds of sexual orientation and disability have fallen, but it has risen on the grounds of gender, age and race.
- Given that the national trend shows a significant increase in discrimination reporting (almost double) it is encouraging that our gender and race discrimination rates have not risen by that much and that discrimination rates in two areas have fallen.
- The increase in gender discrimination is matched by an increasing dissatisfaction for females, when compared to males, in the analysis in section 4, following.
- The rise in reporting of age discrimination is not matched by any significant negative change in the satisfaction, by age group, in section 4, following.

  The above data does not show whether this is discrimination reported on the grounds of older age or younger age, although there is a sharp rise in discrimination reported among those aged 16-30.

  This may be due to our enforcement of retirement at 65, prior to the abolition of the Default Retirement Age. Were this so we would, however, expect an increase in the reporting of discrimination among staff aged 51+, but this is not the case (see table ii, below).

d. Rates of reporting discrimination by protected characteristic - staff who are reporting the discrimination.

This indicator looks at the experience of discrimination by staff in the available equality categories.

Its focus is therefore different from the indicator reported above, which looked at the theme of the discrimination, rather than who is experiencing it.

The difference between the theme of discrimination and the person experiencing it can be quite significant. For example, in this source (the sample survey), 16% of staff with disabilities say that they experienced discrimination at work (page 41), whereas the answer to question 18c (page 63) shows that no staff reported discrimination based on disability. This would suggest that either the 16 percent of staff with disabilities who reported discrimination did not go on to complete question 18c properly, or they all experienced discrimination on grounds other than their disability.

This indicator uses the CQC Sample Survey and so has a smaller sample than that used above.

This indicator shows the experience of discrimination among staff, by equality group, as follows:

i. Age 16-30

	% of staff in this group reporting discrimination	Numbers of staff in this group reporting discrimination
2010	11%	8
2009	2%	1

ii. Age 51+

	% of staff in this group reporting discrimination	Numbers of staff in this group reporting discrimination
2010	8%	13
2009	7%	8

iii. Staff with a Disability

	% of staff in this group reporting discrimination	Numbers of staff in this group reporting discrimination
2010	16%	12
2009	9%	5

iv. Male

	% of staff in this group reporting discrimination	Numbers of staff in this group reporting discrimination
2010	7%	7
2009	13%	12

v. Female

	% of staff in this group reporting discrimination	Numbers of staff in this group reporting discrimination
2010	10%	38
2009	5%	16

vi. White (includes non-British white staff)

	% of staff in this group reporting discrimination	Numbers of staff in this group reporting discrimination
2010	8%	36
2009	6%	23

vii. Ethnic minority

	% of staff in this group reporting discrimination	Numbers of staff in this group reporting discrimination
2010	16%	4
2009	27%	6

e. % who report a disability/health issue, who require a reasonable adjustment and say adjustments have been made.

	RDE	National (acute)
2010	84%	70%
2009	88%	Not available

f. Experience of abuse, harassment, bullying and violence by protected characteristic

The staff survey has 5 questions which help us measure how well we are protecting staff from abuse, harassment, bullying and violence.
They are as follows:

A % experiencing physical violence from patients/relatives in last 12 months
B % experiencing physical violence from staff in last 12 months

C % experiencing harassment, bullying or abuse from patients/relatives in last 12 months
D % experiencing harassment, bullying or abuse from staff in last 12 months
E Perception of effective action from employer towards violence and harassment[1]

The comparative results against these questions are as follows:

	A	B	C	D	E
Age 16-30	8%	3%	8%	11%	3.59
Age 51+	3%	1%	11%	12%	3.56
With a disability	5%	0%	16%	19%	3.54
Without a disability	11%	1%	9%	12%	3.58
Female	6%	1%	12%	13%	3.58
Male	4%	0%	6%	10%	3.57
Ethnic minority	0%	4%	12%	8%	3.68
Not ethnic minority	5%	0%	11%	13%	3.58

The data above would suggest the following:

- Staff rate the effectiveness of the action taken by the Trust towards violence and harassment evenly, across the protected characteristics.
  Our Trust average score on this measure (3.58) compares favourably with the national sector average (3.55).
- Performance is broadly balanced as regards age.
- The experience of those with a disability tends towards the notably negative.
- The experience of females tends towards the notably negative, although this is to be expected with reference to abuse from patients/relatives, due to the preponderance of females in front-line roles.
- The experience of ethnic minorities tends towards the positive.

g. Relative satisfaction, by protected characteristic

i. Balance between much more positive and much more negative responses

The following summary shows much more and much less positive responses in each equality category.

Category	Much more positive responses in 2010	Change since 2009	Much less positive responses in 2010	Change since 2009
Age 16-30	3	-3	7	-2
Age 51+	10	0	5	0
Male	10	+7	0	-2

[1] The higher the score on this question, the better the perception.

Category	Much more positive responses in 2010	Change since 2009	Much less positive responses in 2010	Change since 2009
Female	1	-3	10	+8
Disability	0	-3	10	+2
Ethnic minorities	6	-3	4	0

- The results for staff aged 51+ have remained positive and those for younger staff have remained broadly stable since last year.
- Results for males have moved significantly towards the more positive since 2009, although this is mirrored by a similar increase in less positive responses from females.
- The results for ethnic minorities are slightly more positive than they are negative, but are more evenly balanced than the overwhelmingly positive picture of the last two years.
- The results for those with a disability have deteriorated and are still notably skewed towards the less positive.

  ESR analysis of staff with a disability shows that greater proportions of them are male (34%) than in the Trust as a whole and they are notably over-represented in the Healthcare Scientist, Additional Professional Scientific and Technical and Estates and Ancillary staff groups.

  Males have seen a notable improvement in relative satisfaction (see above) and the Scientific and Technical and Maintenance and Ancillary groups in the staff survey have both seen notable increases in overall satisfaction (+4% and +16%, compared to a Trust average of -2%). Given that staff with a disability are over-represented in these areas, it is all the more noteworthy that relative satisfaction for staff with a disability has fallen.

The following table shows where the ratings on the same Key Finding were much less positive in 2011 and at least one of the two previous years:

Category	No. of Key Findings (KFs) which were much less positive in 2011 and at least one of the two previous years	Areas	No. of Key Findings (KFs) which were much less positive in all three years analysed	Areas
Age 16-30	2	% suffering work-related injury in last 12 months. % experiencing physical violence from patients/relatives in last 12 months.	1	% experiencing physical violence from patients/relatives in last 12 months.
Age 51+	0		0	

Category	No. of Key Findings (KFs) which were much less positive in 2011 and at least one of the two previous years	Areas	No. of Key Findings (KFs) which were much less positive in all three years analysed	Areas
Male	0		0	
Female	1	% suffering work-related stress in last 12 months.	1	% experiencing harassment, bullying or abuse from patients.
Disability	7	% receiving well structured appraisals % suffering work-related injury in last 12 months. % suffering work-related stress in last 12 months. % experiencing physical violence from patients/relatives in last 12 months. % feeling pressure to attend work when unwell, in last three months. % reporting good communication between senior managers and staff. % experiencing discrimination at work.	2	% suffering work-related injury in last 12 months. % suffering work-related stress in last 12 months.
Ethnic minorities	2	% experiencing physical	0	

Category	No. of Key Findings (KFs) which were much less positive in 2011 and at least one of the two previous years	Areas	No. of Key Findings (KFs) which were much less positive in all three years analysed	Areas
		violence from staff % experiencing discrimination at work		

- Staff with disabilities are the group for which there is most recurrence of issues.

  Many of these could be addressed, in theory, through effective reasonable adjustment and support, although we already perform much better than the national average as regards making of adjustments, according to the staff survey.

  It is perhaps arguable that this level of imbalance in satisfaction rates is inevitable, given the difficulties that often accompany having a disability.
- There is no discernible trend in issues causing dissatisfaction for female members of staff. The only recurring areas of dissatisfaction can easily be explained by female staff being in predominantly patient centred roles.
- The numbers of ethnic minority staff who reported suffering physical violence from staff are very small.

ii. Balance between results which have improved since the last staff survey and those which gave got worse

	Number of issues which have improved since the last staff survey	Number of issues which have got worse since the last staff survey
Age 16-30	18	17
Age 51+	24	9
Male	32	2
Female	17	17
Disability	14	22
Ethnic minority	20	16
Trust overall (full census)	13	15

- All of the above categories have seen more issues improving than is the case for the Trust as a whole.
- People with disabilities have seen noticeably more issues worsen than is the case for the Trust overall.

- The issues where the result for staff with a disability has worsened, without worsening for the Trust overall, are as follows:
  - % of staff feeling satisfied with the quality of work and patient care they are able to deliver
  - % of staff agreeing that their role makes a difference to patients
  - quality of job design
  - % of staff working extra hours
  - % of staff using flexible working options
  - % of staff receiving job-relevant training, learning or development in last 12 months
  - % of staff experiencing physical violence from patients/relatives in the last 12 months
  - % of staff experiencing harassment, bullying or abuse from staff in last 12 months
  - Perceptions of effective action from employer towards violence and harassment
  - Impact of health and well-being on ability to perform daily work or activities.

iii. Further Analysis – relative satisfaction for female staff

There has been a noticeable negative swing in relative satisfaction for female staff.

The key findings where they have notably less positive ratings than their male counterparts are as follows:

- % suffering work-related injury
- % suffering work-related stress
- % witnessing potentially harmful errors, near misses
- % experiencing physical violence from patients/relatives
- % experiencing physical violence from staff (numbers are extremely small)
- % experiencing harassment, bullying or abuse from patients[1]
- % experiencing harassment, bullying or abuse from staff
- % feeling pressure in last three months to attend work when unwell
- % reporting good communication between senior management and staff
- % experiencing discrimination at work in last 12 months.

iv. Further Analysis – overall job satisfaction by staff group

There has also been a notable downturn in job satisfaction (as measured by Key Finding 32, job motivation) for Nurses. Nurses show the biggest downward change in this indicator and are the staff group where there are most females, which might account for the downturn in satisfaction levels for female staff.

Key Finding 32 Job satisfaction	2009	2010	Difference	% change
All Nurses	3.55	3.38	-0.17	-5%
Medical & Dental	3.67	3.51	-0.16	-4%

[1] This is the only one which was also notably more negative last year.

Allied Health Profs	3.43	3.41	-0.02	-1%
Scientific & Tech	3.36	3.51	0.15	4%
Admin & Clerical	3.53	3.5	-0.03	-1%
Central Functions	3.41	3.42	0.01	0%
Maintenance / Ancillary	3.06	3.56	0.5	16%
Trust	3.85	3.79	-0.06	-2%

15. Patient numbers (Patient Administration System, PAS, 2011)

a. Patient profile by protected characteristic

A service provider such as our Trust is not directly responsible for the patients referred to it and is therefore limited in the extent to which data analysis on patient access (as seen through patient participation patterns) is within our control. Nevertheless, it is still valuable to conduct this analysis so that we can understand any changes to the profile of the patients we serve.

Direct benchmarking of patient demography statistics with the local community is difficult, as the equality characteristics of patients in a large acute trust will inevitably be different from those of the local community. For example, older people are much more likely than younger ones to use our services, so our patient numbers will be skewed significantly, when compared to the local community, towards the older age ranges. A further area of difficulty is that there is no easily accessible data for a local community which is coterminous with the Trust's patient catchment area. The benchmark below is the Exeter LA area, which is somewhat narrower than the geographical area served by the Trust and has a younger age profile.

It is, however, useful for us to track patient demographics over time, so we can gauge any growth areas and be satisfied that our service delivery is in line with these.

Patient demographics are recorded on an on-going basis on PAS (our central IT system managing patient data), which enables us to monitor any changing trends. PAS includes data on patient age, gender, religion and ethnicity.

Data on disability is due to be collected as of Autumn 2011.

Data on sexual orientation and any transgender status is not currently being collected. We aim to assess the effectiveness of our service towards these protected characteristics through other means.

The table below shows the equality profile of our patient "population" from 2007 to 2010.

Equality Strand		RD&E 2007	RD&E 2008	RD&E 2009	RDE 2010	Exeter[1]
Gender	M	44%	43%	44%	44%	49%[2]
	F	56%	57%	56%	56%	51%
Age	0-17	13%	12%	12%	12%	21%[3]
	18-64	51%	52%	51%	53%	63%[4]
	65+	36%	36%	37%	38%	15%
Race	White British	98%	98%	97%	97%	91%

[1] All benchmarks are from the ONS and are for 2009 unless otherwise stated.
[2] The gender benchmarks are for "all people".
[3] Benchmark is for ages 0-19.
[4] Benchmark is for ages 20-64.

Equality Strand		RD&E 2007	RD&E 2008	RD&E 2009	RDE 2010	Exeter[1]
	Ethnic minority	2%	2%	3%	3%	9%[1]
Religion	Christian [2]	83%	84%	83%	83%	69%
	Other Religion	1%	2%	1%	2%	2%

Data on gender, age, and ethnicity includes both inpatient and outpatient statistics, however, the religion statistics only include inpatient data as this information is not recorded for outpatients.

There are some interesting differences between the RD&E's patient demographics and the Exeter benchmark.

As would be expected, the RD&E has a higher rate of patients in the 65+ age bracket than the Exeter population.

The proportion of patients who are ethnic minority is much lower than in the local community. It is hard to tell how significant this is, as identifying a community benchmark for patient ethnicity is especially problematic. Our patient body is skewed towards the elderly age groups, whereas the ethnic minority people tend to be in the younger age groups. There is no easily accessible community benchmark which would enable us to allow for this. The latest Joint Strategic Needs Assessment work does not tackle the issue of ethnic minority access to hospital services from a data perspective, but has made recommendations as regards the needs of migrants and gypsies and travellers, which we have already actioned.

The proportion of Christians is different perhaps due to the relatively high proportion of patients who preferred not to disclose this information, or the relatively high proportion of older patients, who are from an age group which is more likely to identify as Christian than average.

Overall, there is only one significant trend, with most equality strands remaining fairly stable. This is the steady increase in activity for patients aged over 65, 2% overall, with a 1% rise in outpatient activity, but a 3% rise for inpatients. The latter figure represents an increase of over 12,000 episodes per year, between 2007 and 2010.

There is a slight increase in the proportion of patients who are ethnic minority, although we cannot attribute this to any specific racial group.

b. Racial profile of local population and associated health needs

The Primary Care Trust (PCT) leads on the analysis of the local population and the identification of their health needs.

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[1] The ethnicity benchmark for our members is 3%, based on the ethnic profile of the communities from which they come, which is a wider area than the Exeter local authority benchmark. If we assume our patient come from roughly the same geographical area as our members, then the appropriate benchmark would be 3%, which matches the ethnic profile of our patients.

[2] This was reported last year as a % of all attendances; this year we have reported on the % of all with known religion.

Our PCT takes a mainly qualitative approach to identifying the needs of ethnic minority groups and has not published any new work in this area, since our last data Report.

Action

- Develop a Trust equality objective with a focus on ensuring a good experience of RD&E for patients aged 65+.

- Continue with engagement work, to understand the needs of ethnic minority patients and respond to those specific needs already identified.

- Continue with training to make staff more race-aware, as the mismatch between the proportion of staff (8%) and patients (3%) who are ethnic minority can cause cultural tension.

16. Patient engagement (Involving People Database)

Involving People Projects are an important mechanism we use to involve patients and their carers in assessing the quality of experience they have of our service. During the year 2010-11 these projects have covered a diverse list of almost 40 service areas and themes ranging from cancer patient discharge to patient letters. We have analysed the equality profile of the service users who have been involved with us in these projects during 2010-11, to see how closely they match the profile of our patient population.

The results are as follows:

	% of those participating in Involving People projects from this group	% of our patient population from this group
Aged 70+	29%	30% (estimate)[1]
Having a Disability	23%	Data not yet available[2]
Male	46%	44%
Ethnic minority	5%	3%

There was also involvement from the transgender strand in our Involving People Projects activity. This has not been shown above as less than five people were involved and reporting numbers that small can breach the confidentiality of the individuals concerned.

We are especially pleased at the healthy representation of ethnic minority people, in the Involving People Projects.

[1] This is a crude estimate, achieved by a pro-rata reduction of 20% in the proportion of patients who are aged 65+.
[2] The Employers Forum on Disability estimates that there are 10 million people with disabilities in the UK http://www.efd.org.uk/disability/disability-facts. This equates to roughly 16% of the UK population. In the absence of a benchmark covering our patients, there is therefore grounds for optimism that the 23% engagement rate of people with disabilities in our involving people work is healthy.

17. Patient satisfaction (surveys and complaints 2010-11)

a. National patient surveys

i. National Inpatient Survey 2010

This was a national survey covering 8 key elements of patient experience in the in-patient journey, such as the hospital and ward, your care and treatment and the nursing service. It took place between October and December 2010 and surveyed 521 patients (63% response rate, compared to a national average of 50%).

The inpatient survey differentiates responses by age, gender and, potentially ethnicity. At RD&E, however, there were not enough ethnic minority respondents for the national survey to publish our results.

We have identified 3 questions which are especially important for overall quality of care and for the issues considered in this report. The results are shown below, by age and gender.

Question	Answer	All ages	Age 65+	Male	Female
Overall, did you feel you were treated with respect and dignity while you are in the hospital?	Yes, always	86%	91%	88%	84%
Overall, how would you rate the care you received?	Excellent	53%	58%	57%	48%
Did you want to complain about the care you received in hospital?	Yes	7%	5%	5%	8%

The only notable variations by equality group are:

- Patients aged 65+ are noticeably less likely to want to complain about the care received.
- Females are noticeably more likely to want to complain.

Whilst females are less satisfied than males across all three indicators examined, the only notable difference for females concerns the question on complaining about the care received in hospital. The percentages involved here are small, so it is likely that the results on this indicator will be volatile.

Action

- We will review next year's survey, to see if there are any areas in which females are notably less satisfied than their male counterparts and if they remain more likely to want to complain.

ii. National Outpatient Survey

There was no National Outpatient Survey taken in 2010.
There were no notable equality anomalies in our results last year, which were reported in the last equality Data Report.

b. Nursing Quality Assessment Tool (NQAT) 2009-11

In July 2009 the Nursing Quality Assessment Tool was developed to incorporate the 11 Essence of Care benchmarks and the Royal College of Nursing Observations of Care into an electronic survey with 173 quality measures. This survey includes a real time patient survey, a documentation audit and a clinical observation to provide a standard measure for the quality of nursing care.

Between July 2009 and June 2011, 883 patients were surveyed about their experience in the hospital and the quality of care they received. Information on patient age, gender, disability and ethnicity is collected and monitored for any significant trends. The number of ethnic minority respondents was low (31) but at 4% of all those of known race, is higher than the proportion of patients who are ethnic minority and has been included in the analysis.

The full analysis is too extensive to be published here, but is available on request. The vast majority of indicators show broadly equal levels of satisfaction, however those where there is a notable equality variation are shown below:

- People with disabilities are noticeably more likely than those without a disability to say that they always received sufficient help in eating their meals.
- Patients aged over 40 are more likely than other age groups to have been bothered by sharing ward facilities with those of the opposite sex, but the reverse is true for those under 40.
- Patients aged 16-29 are much more likely to report that their family or people close to them have been able to talk to a matron when they have wanted to.
- Patients aged 30-39 are noticeably less likely to say that the ward or hospital room they are in is clean.
- Patients aged 40-49 are noticeably less likely to say that they have been offered a choice by staff in how to maintain their personal hygiene.
- The same age group are noticeably less likely to say that they have always received sufficient help in eating their meals.
- Patients aged 50-59 are noticeably less likely to say that they always received sufficient help in eating their meals.
- Patients aged 60-69 are noticeably less likely to say that they were asked if they have any spiritual, religious or faith needs on admission.

The only anomalies occurring for more than one group are as follows:

Anomaly	Group affected
More likely to be bothered by sharing facilities with other sex.	All age groups over 40.
Less likely to have received sufficient help in eating their meals.	Patients aged 40-49 and 50-59.

NQAT also showed that ethnic minority patients were less likely than their white counterparts to receive the spiritual care leaflet. The variation here was not notable, with 20% of white British and Irish patient saying they received the leaflet, but 16% saying this was the case among ethnic minority patients.

Action

- Mixed sex accommodation has been phased out, so there is no need for an action to address the issue of sharing facilities with the other sex.

- Ask the Patient Experience Group (our new body for consulting about patient experience) to consider action to raise awareness of the support in eating required by patients aged 40-60.

- Review next year's results, to see if the issue about ethnic minority people being less likely to be offered the spiritual care leaflet is repeated.

c. Patient and Visitor Feedback Cards

Patient and Visitor Feedback Cards are in place in every inpatient and outpatient area in the hospital. Since October 2009 until March 2011, 503 responses have been received. The response rate will increase as these cards become more widely embedded across the Trust.

These cards ask the 3 key quality questions: ‘Have you felt safe’, ‘Have you felt cared for’, and ‘Would you recommend this hospital to your friends and family’ as well as leaving space for patient/ visitor comments to enable greater qualitative analysis of patient/ visitor experience.

Last year, we reported on the results for all three questions by the available protected characteristics. The equality analysis for all three questions yielded broadly the same results. As the results were broadly the same for each question, the analysis below has been simplified and concentrates on the final question (as to whether they would recommend this hospital) as it gives a good overall judgement of the patient's perception of us.

Last year, there was insufficient participation by ethnic minorities to report the findings for this group. We have included their responses on this occasion. The number of responses from ethnic minorities is still relatively low (13, compared to 450 for British and Irish people) although, pleasingly, the proportion of known ethnic minorities participating is broadly in line with the proportion of patients who are ethnic minority (3%).

The comment cards ask about transgender status and we have analysed the feedback from those who identifies transgender. The numbers who do so, however, are too small to be reported below.

The table below gives a breakdown of responses for those who said they would definitely recommend this hospital to their friends and family.

	Aged under 60	Aged 60+	Without a disability	With a disability	Female	Male	British / Irish	Ethnic Minority
% who would definitely recommend this hospital	73%	91%	83%	89%	79%	82%	84%	85%

- Patients aged 60+, those who are ethnic minority and those with a disability are all more likely to recommend this hospital than their relevant comparator groups.
- Patients aged 60+ are notably more likely to do so.
- There was some transgender participation in this activity, although the number responding is too small to be reported above.
  The very small response from this group was indicative of dissatisfaction.

d. Patient complaints

We have conducted an initial analysis of the 401 patient complaints for the year from 31st March 2010, by the available equality categories, which are age, gender, religion and ethnicity. (We have recently started collecting data by disability, but did not have enough of this data to support analysis during this period.)
This information is compared below with the % of all patient episodes (both inpatient and outpatient) across the same equality categories.
Where the % of complaints from patients in an equality category matches the % of patients in that category, this would suggest that patients in that category have equal satisfaction levels and equal ability to access the complaints system. The results were as follows:

	% of complainants in category	% of episodes in category
Aged 65+	39%	38%
Female	56%	56%
Male	44%	44%
Religious minority	3%	2%
Ethnic minority	2%	3%

The notable variations in the table above are as regards religion and ethnicity. There are notably more complaints than we would have expected from patients who are from a minority religion and notably fewer than expected from ethnic minorities.

The numbers of complainants from religious minorities (7) and ethnic minorities (6) are both small, consequently it is likely that year on year results will be volatile. In the year analysed, had there been 2 fewer complainants from religious minorities and 3 more who are ethnic minority then the degree of variation would not have been notable.

This year's evidence as regards ethnic minorities is also ambivalent, in that it could indicate either that our ethnic minority patients are more satisfied than those who are not ethnic minority, or that they are not accessing the complaints system adequately.

We have informally analysed the subject matter of complaints by equality category. This has shown that patients aged over 65 are notably more likely to generate complaints about discharge processes, as is highlighted in the following table:

	% of complainants from the age group which were about discharge
Aged 65+	15%
Aged under 65	5%

Action

- Review whether the anomalies as regards religious minorities and ethnic minorities are repeated in next year's analysis.
- Within the overall review of discharge information which has already been planned, give particular attention to the needs of patients aged 65 and above.
- Use recent complaint from a transgender patient to further understand issues facing this patient group and respond accordingly.

e. National Cancer Survey (2010)

This Data Report is a Trust-wide document and, as such, would not normally include results specific to one area of patient care, such as the National Cancer Survey. The National Cancer Survey, however, is the only data-based evidence which enables us to focus specifically on patients who are lesbian, gay or bisexual. The results from this survey are therefore included here, as they give us some measure of the satisfaction of our lesbian, gay or bisexual patients, compared to those who are heterosexual.

The survey data appears reliable as regards its capacity to quantify lesbian, gay or bisexual patients. The rate of unknowns as regards sexual orientation is relatively low (11%) and the proportion of survey respondents who reported themselves as lesbian, gay or bisexual (2%) is slightly higher than the benchmark from ONS for the community as a whole (1%).

Lesbian, gay or bisexual patients therefore appear well represented, within the survey.
In the survey, 758 respondents declared their sexual orientation, of whom 13 have been classified as lesbian, gay or bisexual. (For the purpose of this analysis, we have classified those who declare their sexual orientation as "other" as lesbian, gay or bisexual.)

The analysis of the survey results, presented below, tends to be at headline level, rather than exploring individual issues of comparative satisfaction. This is because, while recognising the limitations of this method, we are taking the service-specific results of this survey as suggestive of the overall satisfaction of our patients who are lesbian, gay or bisexual.

The results below are based on the questions in the survey which are directly relevant to patient satisfaction, rather than those elicited factual information.

The tables below show that our lesbian, gay or bisexual patients tended to have a more positive experience than the heterosexual patients. These results measure the responses to the most positive option in the survey questions about satisfaction. The first table shows whether satisfaction for lesbian, gay or bisexual patients was higher or lower, the second shows whether it was notably higher or lower (i.e. where the difference was noticeable, as opposed to marginal).

Number of questions where lesbian, gay or bisexual patients indicated higher satisfaction	Number of questions where lesbian, gay or bisexual patients indicated lower satisfaction
40	18

Number of questions where lesbian, gay or bisexual patients indicated notably higher satisfaction	Number of questions where lesbian, gay or bisexual patients indicated notably lower satisfaction
9	6

Both tables above indicate an overall positive experience for lesbian, gay or bisexual patients, compared to heterosexual patients.

Our general consultation evidence, taken from work with lesbian, gay or bisexual people, generally, or in the health service nationally, has suggested that issues can arise over the inclusion of same-sex partners in care and the dignity with which the lesbian, gay or bisexual patient is treated.

The table below shows the results of those questions which are relevant to the issues highlighted in the consultation work, namely inclusion of partners and patient dignity:

Question	% choosing the most positive response available	
	Heterosexual	Lesbian, gay or bisexual
When you were first told that you had cancer, had you been told you could bring a family member or friend with you?	73%	50%
If your family or someone else close to you wanted to talk to a doctor, have they had enough opportunity to do so?	73%	75%
Were you treated with respect and dignity by the doctors and nurses and other hospital staff?	86%	100%

The evidence in the above table on the key issue of partner involvement is ambivalent. The first question affecting this issue shows a lower level of satisfaction by lesbian, gay or bisexual patients, whereas the second one shows the reverse.

The result for the final question shows that there is no issue as regards the way in which our staff treat lesbian, gay or bisexual patients with respect and dignity.[1]

[1] Dr. Julie Fish, of De Montfort University, when presenting the national results from this survey at an SW SHA conference on 28 June, 2011, indicated that this was not the case nationally.

Actions

The above evidence does not necessitate any actions, however, as a matter of good practice, we wish to pursue the following:

- Amend the Clinical Integrated Document (CID), which controls the gathering of information on admission of inpatients, to reflect civil partnership.

- Review the patient pathway through the Trust and consider where we need to check that our service delivery is inclusive of patients who are lesbian, gay or bisexual.

18. Reasonable adjustments for patients with a disability

We have implemented a system of flagging patients' specific requirements related to any disability at the bedside, to enable staff to make any required "reasonable adjustments".
Through NQAT, we track the extent to which this system is in place and there is documented evidence available to show that action has been taken.
The results of our auditing for the year to September 2011 show that the system is in place 87% (84% last year) of the time and that an assessment is completed and notes flagged (where required) 72% of the time (54% last year).

Actions

- We will consult with service users to ensure that the questions we ask in monitoring this area remain appropriate.

19. Patient Communication support

This section analyses usage patterns for the various means of communication support available to patients.

This service meets the needs of two distinct groups of patients. Firstly, it supports communication for ethnic minority patients who have difficulty in communicating in English and secondly it supports those who need sign language interpretation because of a hearing impairment.

a. Support to ethnic minorities

Ethnic minority patients receive most language support through either face to face activity, or, secondarily a telephone interpretation service.
As the table below shows, the overall trend in sessions for both services combined is upward, with a 52% increase since 2007-08.

Year	Number of bookings
2007-08	375
2008-09	581
2009-10	593
2010-11	725

This increase has broadly kept pace with the increase in the percentage of ethnic minority patient episodes since 2007. Our patient numbers data is measured by calendar year, so the period which is broadly equivalent to that shown in the table above is for the calendar years 2007-2010, where we have seen an increase from 6766 episodes to 11059, a 63% increase.

The table below shows the preferred language of those using both services between 1 April 2010 and 31st March 2011:

Language	Total interpretation / translation bookings	As percentage of total
Polish	299	41%
Arabic	77	11%
Farsi	67	9%
French	46	6%
Lithuanian	26	4%
Dari	25	3%
Mandarin	26	4%
Bengali	18	2%
Vietnamese	14	2%
Russian	13	2%
Kurdish	14	2%
Turkish	11	1%

Language	Total interpretation / translation bookings	As percentage of total
Cantonese	13	2%
Punjabi	1	0%
Thai	8	1%
Portugese	8	1%
Hindi	6	1%
Czech	6	1%
Bulgarian	5	1%
German	5	1%
Hungarian	6	1%
Slovak	4	1%
Urdu	2	0%
Spanish	5	1%
Pashto	2	0%
Korean	1	0%
Romanian	1	0%

This shows that Polish, Arabic and Farsi are the most common languages and would suggest that we might wish to investigate whether there are any particular cultural needs with regard to healthcare that could be common among speakers of these languages. If these patients require the interpretation service, that would suggest that they may appreciate cultural sensitivity on our part more than other ethnic minority patients who have functional English and so do not need this service.

Our current analysis does not show usage of face to face interpretation by Trust department, but we have this information for the telephone interpretation service. This shows that Child and Women's Health accounts for over 50% of the usage of the telephone service. The table below shows the most popular languages requested in Child and Women's Health:

Language	Number of calls	Number of calls as % of total calls made to this service
Polish	54	43%
Arabic	33	26%
Lithuanian	14	11%
Farsi	6	5%
Bengali	5	4%
Dari	3	2%
Kurdish	3	2%

Latvian	2	2%
Mandarin	2	2%
French	1	1%
Portuguese	1	1%
Russian	1	1%
Thai	1	1%
Urdu	1	1%

The top two are the same as in the analysis for all interpretation and translation activity, shown above.

Action

- Consider whether there are particular cultural needs among speakers of Polish, Arabic, Farsi and possibly Lithuanian which would need supporting during healthcare, in particular the care delivered by Child and Women's Health.

b. Support to hearing impaired people, through BSL

The Trust is putting in place a process to gather information on patients' disabilities, including whether they are hearing impaired. When this data is available, we will be able to match trends in our provision of BSL support with the number of patients who have hearing impairments.
The table below shows the numbers of BSL sessions by Directorate:

Directorate	Number of sessions	% of total
CWH	77	39%
Medicine	37	19%
Specialist surgery	34	17%
Gen Surgery	18	9%
Diagnostics	15	8%
Orthopaedic	11	6%
Critical Care	1	1%
Nursing	1	1%
Prof Servs	1	1%
(blank)	1	1%
Grand Total	196	100%

By Directorate, the biggest users of face to face BSL support is Child and Women's Health, which would suggest that we need to be particularly sensitive to the needs of hearing impaired people in this service area.

Action

- Review support of hearing impaired people in Child and Women's Health to see if there is any transferable good practice from there which could be spread more widely in the Trust and (given their large usage of BSL support) whether there is national good practice which could be implemented in Child and Women's Health.

c. Information in alternative formats

We have the capacity to provide documentation in Braille, but this service is rarely used.

Action

- Consider whether the availability of information in Braille needs better advertising, in the context of our re-launch of patient information.

- Consider how we can track the uptake of Easy Read literature.

20. Patient safety (2010/11)

a. "Patient incidents"

Sources: Patient Incidents Report (2010/11) and Patient Administration System

One of the key data indicators the Trust uses to monitor patient safety is patient incident reporting, where we record all notifications of incidents which could lead to harm to patients.

The table below shows the proportion of patients for whom incidents have been notified, broken down by the available protected characteristics, as well deprived postcode areas. This is set alongside the proportion of patients from each group in question among our patient body, as a whole.

Our postcode analysis, here and in the subsequent section, looks at our patients who come from postcode areas which are categorised within the 10% most deprived, nationally. This data comes from the English Indices of Deprivation 2010.[1] In looking at social deprivation, it is common for the public sector to concentrate on the 10% most deprived postcodes.

	% patients from this group in reported "patient incidents"	% of all patients who are from this group
Aged 65+	51%	38%
Female	57%	56%
Male	43%	44%
Ethnic Minority	3%	3%
Religious Minority	2%	2%
From 10% most deprived postcodes	2%	1%

The notable variation in the table shown above is for patients aged 65 or over, who are involved in a reported "patient incident".

To some extent the result for patients aged 65+ is to be expected, as those aged 65 or over are more likely to be vulnerable to mishaps (for example, slips, trips or falls). We are, however, being proactive in our efforts to improve safety for this age group, for example through intentional rounding and raising awareness of good practice in preventing slips, trips or falls.

Whilst we may never totally redress this data anomaly for patients aged over 65, we would aim to see it shrink, over time.

Action

- Develop a Trust equality objective with a focus on ensuring a good experience of RD&E for patients aged 65+.

[1] http://www.communities.gov.uk/publications/corporate/statistics/indices2010 accessed July 2011.

- Continue to monitor the equality indicator for patient safety, with regard to those aged 65 and over, as an indicator of how well we are improving patient safety for this age group.

b. National Inpatient Survey (2010)

The following question from the national survey is especially relevant to patient safety:

> "Did you feel threatened during your stay in hospital by other patients or visitors?"

This source allows us to analyse our results by age, gender and race, although the number of ethnic minority respondents was too small for our results to be published by ethnicity.

We can also compare our overall performance with the national norm.

The results are shown below:

	RDE overall	National Overall	RDE Male	RDE Female	RDE aged 65+
% who felt threatened, according to response to question above	2%	3%	2%	2%	1%

This shows that our overall performance is slightly better than the national average and that there are no notable equality gaps.

21. Patient health and wellbeing - emergency readmissions (2010/11)

The Trust reports routinely on patients who experience an emergency readmission for a condition for which they have been treated by us within the last 30 days.

For the purpose of this report, this data provides an overall headline measure of patient health and well-being. Where a patient features in this report, this suggests that our contribution to that particular patient's health and well-being may not have been all that we would have wished.

The table below gives the profile of the patients who featured in the standard report on emergency admission, by all available protected characteristics and by postcode deprivation:

	% patients from this group among "emergency readmissions"	% of inpatients who are from this group
Aged 65+	53%	43%
Female	50%	52%
Male	50%	48%
Ethnic Minority	2%	3%
Religious Minority	2%	2%
From 10% most deprived postcodes	2%	2%

The only notable gap is for patients aged 65 and over.

To some extent, this is to be expected, as those aged 65 or over are more vulnerable to conditions which need repeated readmission and the health of those in deprived areas is known to be relatively poor.

Whilst we may never totally redress this data anomaly for patients aged over 65, we would aim to see it shrink, over time.

Action

- Review this data annually, with particular attention to the result for patients aged 65 and over as an indicator of the effectiveness of our actions to improve patient health and well-being for these groups.
- Pay particular attention to the needs of patients aged 65+ in our review of discharge arrangements.

22. Representativeness of key decision making bodies (2011)

Sources: ESR for Executive and Board (2011), Membership data base for Governors and Membership (2011), also *Membership Profiling Report* by Membership Engagement Services (2011).

Decision making bodies can sometimes work better when their profile matches those for whom they make decisions.

This section looks at the extent to which the profile of our key decision making bodies (Executive, Board, Governors and Membership) matches that of the Trust workforce and the Exeter area, across the key equality categories.

The Trust data is from ESR and the Exeter data uses the latest information from the Office for National Statistics.

	Executive	Board	Governors	Membership	Trust staff (ESR)	Exeter area	*Membership Profiling Report* benchmark[1]
% aged under 40	0%	0%	0%	7%	44%	60%	45%
% known to have disability	0%	0%	12%	16%	3%	4%[2]	Not reported
% who are female	71%	14%	38%	55%	75%	51%[1]	51%
% known to be ethnic minority	0%	0%	0%	3%	8%	9%[3]	3%

This data shows notable under-representation of younger people among Governors and members. There are no known ethnic minority people among Governors, the Executive and the Board, although if we accept the 3% benchmark then statistically, given the small numbers involved at Governor, Board and Executive level, we would not necessarily expect that there would be representation of ethnic minority people.

A development session with younger people during the year using a workshop helped the Trust better understand the motivations of young people to become members and how the membership offer may need to be adapted to recruit more younger people.

Action

- Focus on recruiting new members from among young people and, in further pursuit of diversity, from among people living deprived postcode areas.

[1] The benchmarks coming below are based on the catchment areas of our members live in and therefore reflect a wider accurate geographical area than the “Exeter area” benchmark. This benchmark is the more accurate for gauging the representativeness of membership.
[2] Uses Exeter population aged 16+.
[3] Uses Exeter population as a whole.

Progress report on actions identified in 2010 Data Report

Staff equality:

- **Identify how to reach out to local ethnic minority community with key messages about the Trust, including information on career and volunteering opportunities.**

  We have, however, engaged extensively with one ethnic minority community group, as part of our consultation on patient equality.

- **Develop work experience placements for people with disabilities, to increase their employability.**

  We have formalised arrangements since last year, opened out two new placements and increased the throughput of learners.

  Although the growth has been slow, this activity has been high impact in terms of the benefit to the individual learners. It has made the teams of staff working with those learners more disability-aware, which has knock-on benefits for both patients and colleagues with disabilities.

- **Develop apprenticeship delivery.**

  There is now a process to consider recruiting apprentices into vacancies as a matter of course.

  The educational infrastructure has been successfully developed and aligned to service need.

  As at November 2011, we have in post 16 apprentices.

- **Use webpages to showcase externally how the Trust promotes diversity.**

  We have published webpages on disability, race and religion as well as one promoting our equality work among staff, in general terms.

  It is too early, as yet, to gauge the impact of this work.

- **Continue to encourage managers to attend recruitment and selection training.**

  We have since ceased our formal recruitment and selection training course, due to the downturn in recruitment activity mentioned above.

- **Continue with specialist equality training for Recruitment Team, to include a new session on disability awareness and possibly one on ethnicity.**
- **Conduct Human Rights training with Recruitment Team.**

  The training on disability awareness has been delivered and sessions on race awareness and human rights training have been written.

- **Audit the progress of people from minority groups through the application process.**
- **Monitor interviews more closely for those groups of applicants with lower than expected success rates, including:**

- **composition of interview panels where candidates from the priority groups are being interviewed.**
- **attendance at interview**
- **possible tokenism among interview candidates with a disability.**
- **review our use of pre-employment questions about health and disability.**

o **Identify, as appropriate, any "serial applicants" from minority groups (i.e. those who apply repeatedly for jobs without success) and offer them personal support.**

o **Raise the profile of existing equality monitoring within the Recruitment Team, which includes:**

- **observation of interviews, on a sampling basis**
- **recording the take up of Guaranteed Interview Scheme and reasonable adjustments during interview**
- **sampling the shortlisting and interview notes.**

All of the above issues were considered within an in-depth monitoring exercise, observing and examining our recruitment and selection activity, from an equality perspective.

We have produced an action plan as a result and are part way through implementing it.

We are particularly pleased to note the improvements in the recruitment data considered in this year's Equality Data Report.

o **The Trust is publishing a new policy on flexible working. We will review how this affects both the uptake of flexible working and female access to higher pay bands.**

We have published a new policy, but there has been no improvement, as yet, in the uptake of flexible working.

We will be raising awareness of flexible working options through IaN.

o **Design and implement staff engagement activity with staff who have disabilities, to understand what might be contributing to their ratings of the Trust, as shown above.**

o **We will raise the issue of promotion in our engagement activities with employees who have disabilities.**

Our engagement activity specifically on the theme of disability has so far been informal and focusing on work with key individuals. We have not identified anything specific which would affect the likelihood of people with disabilities to secure promotion, other than the general lack of self-confidence and low morale which can accompany working with a disability.

The issue of whether and how to engage in more formal and higher profile engagement activity has been kept under review, pending the development of our staff engagement strategy.

o **We will include the issue of ethnicity in our broader consideration of the inclusiveness of our involvement and engagement work. (Under way.)**

We have continued to engage with key individuals as regards ethnicity within staff equality and have increased ethnic minority representation had both the

Diversity Leads Forum and the Joint Staff Consultative and Negotiating Committee.

- **Consider the career development needs of ethnic minority staff at band 1-5 and whether a training intervention might address them.**

  We have undertaken further data work, reflected in this report, which has suggested there might be an issue for Band 5 nurses.

  Consultation work with another local Trust has identified a potential course of action.

  This issue has been carried forward for further consideration into this year's Equality Data Report.

- **Continue with work to support ethnic minority staff.**

  We have increased the representation of ethnic minority staff at the Diversity Leads Forum, to good effect.

  Close engagement with operational HR casework has resulted in a significant success for one individual supported, as well as much learning which has been incorporated into our race awareness training.

  Regional and national development initiatives have been promoted to our ethnic minority staff and several have shown an interest, although none have been successful in their applications for places, as yet.

  The implementation of the action plan in response to our work looking at equality in recruitment has already produced some materials which are particularly appropriate for ethnic minorities.

  Delivery of race awareness training started this year, ranging from a 10 minute session for senior managers to a full half day course.

  One staff member has taken up the Executive's offer of mentoring for ethnic minority staff.

Patient equality:

- **Research and develop collection of evidence on religion and sexual orientation.**
- **Develop consultation mechanisms, with particular attention to religion, sexual orientation and ethnicity.**

  We have consolidated learning from personal consultation, desk research and attendance at regional events promoting understanding of health and workplace issues for lesbian, gay and bisexual people.

  We have produced a summary of relevant issues, for further consideration and which has informed staff training on issues facing this patient group.

  We have also obtained some survey evidence on the satisfaction of lesbian, gay and bisexual patients.

  We have undertaken extensive engagement work with a local ethnic minority community group, which has identified the issues they feel face our ethnic minority patients. These have been summarised for further consideration and are already being used in race awareness training for staff.

  The Chaplaincy has broadened their relational networks, by appointing an Imam as an honorary chaplain and established a network of members of

other faiths with whom they can consult, as necessary. As a result of their enhanced engagement work, they have identified the need to upgrade the chapel facilities for Muslims, Hindus and Roman Catholics.

- **Work through Health Equality Forum to consult with the Primary Care Trust, Devon Partnership Trust and user representatives to understand patient equality issues.**

  The Health Equality Forum has only met once since the publication of our last report, due to the restructuring of our patient engagement arrangements.

  This meeting provided us with some valuable comment on our equality priorities, which is being fed into the new structure for patient engagement.