The Whittington Hospital NHS
NHS Trust

DRAFT

The Whittington Hospital

Single Equality Scheme

2008-2011

The Whittington Hospital will ensure that no service user or employee experiences less favourable treatment or care as a direct or indirect result of their race; gender; disability; age; religion or belief; sexual orientation and that there are robust policies in place to protect and safeguard patient and employee privacy and dignity

...the hospital of choice for local people

W

1. Foreword by Chair and Chief Executive

2. Introduction

- Aims of the Single Equality Scheme
- The Whittington Hospital's Strategic Objectives
- The Trust's Responsibilities

3. The legal framework

4. Consultation and involvement

5. Where we are now:

- monitoring patients
- workforce monitoring
- reviewing policies for adverse impact

6. The six strand approach

- Race Equality Scheme
- Disability Equality Scheme
- Age Equality Scheme
- Gender Equality Scheme
- Sexual Orientation Equality Scheme
- Religion/Belief Equality Scheme

7. Diversity awareness & training

8. Publishing information

9. Monitoring progress

10. How will the Trust promote this Single Equality Scheme?

11. Taking the Single Equality Scheme forward

Appendices

Appendix 1	Progress on current schemes
Appendix 2	SES action plan 2008 – 2011
Appendix 3	Monitoring data
Appendix 4	Definitions
Appendix 5	Key equalities legislation

1. Foreword

Welcome to The Whittington's Single Equality Scheme. This scheme forms part of our Board of Directors' commitment to equality both in terms of services and employment and covers race and ethnicity; gender; disability; age; religion and belief; sexual orientation.

The Whittington is committed to delivering equality to all our patients and staff and we believe that this single equality scheme will help us to achieve this. The Scheme sets out the context within which we deliver our services, reviews our recent achievements and sets out our plans for further improvements.

We recognise that the success of the scheme will only be achieved through the continued involvement of patients, staff, governors and staff. This will be an on-going process. Any comments on the Scheme would be very welcome.

Joe Liddane
Chairman

David Sloman
Chief Executive

2. Introduction

Valuing equality and diversity is about treating individuals fairly, supported by legislation designed to address unfair discrimination that is based on membership of a particular group. It is about the recognition and valuing of difference; creating a working culture and practices that recognise, respect, value and harness differences for the benefit of the organisation and the individual.

Equality and diversity are not inter-changeable but are inter-dependent. There is no equality of opportunity if difference is not recognised and valued.

Our Single Equality Scheme (SES) is an inclusive and comprehensive scheme covering both current and impending statutory duties regarding race, gender, disability, religion/belief, age, and sexual orientation (the "six strands").

This SES is intended to be more than a written plan in terms of its impact on the local population and our workforce. It includes current monitoring information, plans for expanding monitoring, details of progress to date and proposed action.

Much work has already been undertaken in the development and implementation of our race equality scheme; gender equality scheme and disability equality scheme. This experience will be used to support the development and implementation of the SES.

We have decided to move to a single equality scheme as an important step in our continued commitment to equality and diversity

Essential to the success of our SES are:

- board level commitment and support
- a firm link with the trust's strategic objectives, and our promises to patients and staff (see below)
- a clear action plan identifying responsibilities and timescales
- a way of measuring progress and outcomes.

Aims of the Single Equality Scheme

The main aims of our SES are to:

- ensure that consideration of equalities issues are at the mainstream of thinking and day-to-day practice across the trust
- reduce health inequalities and improve health outcomes for patients
- meet the current legal requirements concerning race, disability, age and gender
- ensure that trust policies and practices do not discriminate
- challenge discrimination against people who work here or use our services
- ensure equal access to services and work to enhance and improve service user choice and control
- provide a coordinated approach to meeting the requirements of forthcoming legislation on: religion/belief and sexual orientation
- raise staff awareness and understanding of these issues.

It is clear from the hospital's critical success factors listed below, that equality must be integral to the delivery of its services.

- *To deliver consistent standards of customer care*
- *To consistently meet agreed standards of clinical care*
- *To develop an up-to-date programme of education and research activities*
- *To improve our operational management to achieve resource efficiencies and service improvement*
- *To employ competent, motivated staff*
- *To promote the Whittington as the hospital of choice for local people, through being an integral part of the local community's health resource*
- *To reduce hospitalisation (admissions and length of stay)*
- *To provide a sustainable environment for the delivery of care and ancillary services*
- *To be financially robust*
- *To collaborate with other agencies in the provision of care*

The Hospital also has a *patient promise* and an *employment promise* – both of which have dignity and respect for the individual at the core.

Why is equality so important?

People have a right to live in a society built on fairness and respect without barriers related to age, race, gender, religion and belief, disability or sexual orientation.

In the workplace equality leads to better motivation and productivity. In service development and provision better healthcare based on need without prejudice should be a driving force.

What it means to be from an ethnic minority (national statistics 2004)

- Indian, Pakistani and Black African Women are four times more likely than White British women to be working as packers, bottlers, canners and fillers
- Pakistani and Bangladeshi Women in England and Wales reported the highest rate of "not good" health in 2001.
- Unemployment rates for people of non-White ethnic groups were generally higher than those from White ethnic groups. Among men, those from Black Caribbean, Black African, Bangladeshi and Mixed ethnic groups had the highest unemployment rates (between 13-14%) These rates were around three times the rates for White British men.
- Bangladeshi men were the most likely group to smoke cigarettes (44%)
- White Irish men and were more likely than any other ethnic group to drink in excess of government recommended guidelines. 58% of men and 37% of women from a White Irish background drank in excess of the recommended daily levels. All other minority ethnic groups were much less likely than the general population to have consumed alcohol in excess of the daily guidelines
- The lowest levels of GCSE attainment was among Black Caribbean pupils, particularly boys

- In 2003/04 pupils form Black Caribbean, Other Black and Mixed White and Black Caribbean were among the most likely to be permanently excluded from schools in England

What it means to be disabled

The legal definition of disability is:

"a physical or mental impairment which has a substantial and long term adverse affect on a person's ability to carry out normal day to day activities."

- There are just under 12 million disabled people in the UK (1 in 5 people)
- The prevalence of disability increases rapidly with age
- Approximately 75% of men and women aged 85 and over have a disability
- 20% of those with a disability are under 45
- Disabled people die younger than non-disabled people (for reasons other than their impairment), partly because of unequal access to health screening, assessment and treatment. One study found people with learning difficulties were 58% more likely to die before 50 than other citizens
- NACRO research showed that disabled people were four times as likely to have property stolen from them with the threat or use of violence and almost twice as likely to be burgled as non-disabled people

Disability demographic data on our local population

According to the 2001 Census, there are more than 8.7 million people in the UK with a disability. Of this number, more than 1.4 million live in London. Of the working age population, 6.9 million have a disability and about 810,000 of these people are in London. One in four people is directly affected by a close friend or family member with a disability. 17% of disabled people were born with their disabilities. 70% of disabled people develop their disabilities during their working lives.

Facts about Women and Men in Great Britain

These figures relate to 2005

Education and Training

- 59% of girls and 48% of boys gain 5 or more GCSEs grades A*-C or equivalent qualifications
- 43% of girls and 34% of boys gain two or more A levels or equivalent qualifications

Employment

- 46% of people in the labour market are women
- In the 16-64 age group, two-thirds of women and over three-quarters of men are in employment
- Nearly half of women (44%) and about one in ten men who work are part-time

Parents and Carers

- Of mothers of under fives, 52% were in employment, and two-thirds of those working as employees were part-time
- A mother with a child under the age of 11 is 40% less likely to be employed than a man
- Since there are almost 4.7 million under eights in England and just over a million places with childminders in full day care or in out of school clubs, there are four children for each place in these types of provision

Pay and Income

- Average hourly earnings for women working full-time are 18% lower than for men working full-time, and for women working part-time hourly earnings are 40% lower.

Political Life

- Only 18% of MPs are women
- 24% of UK MEPs are women

Men & women's health

Life expectancy at birth for both males and females has improved over the past century. The average life expectancy at birth of females born in 2004 in the UK was 81.1 years compared with 76.7 years for males. There is, however, a smaller gap in terms of the number of years they can expect to live in good or fairly good health. The average healthy life expectancy at birth for females in 2002 was 69.9 years compared to 67.1 years for males.

Chronic diseases like coronary heart disease, stroke, diabetes, back problems and arthritis are some of the most common illnesses to impair quality of life.

Arthritis and rheumatism are the most common types of chronic diseases in the UK and in both sexes prevalence increases with age. Women are more likely to suffer from arthritis and rheumatism than men.

Over the last decade the proportion of men and women aged 16 and over in England who are obese has been rising. In 2004 almost a quarter of both men and women were classified as such. Over the same period the proportions classified as overweight have remained fairly stable. Men are more likely than women to be overweight. In 2004, over two fifths of men were overweight compared with just over a third of women.

Men are almost twice as likely as women to exceed the recommended daily limits for the consumption of alcohol.

Young men are more likely than young women to take illicit drugs.

What it means to be from a sexual minority (not heterosexual)

- Experience of discrimination in society means LGB (Lesbian; Gay: Bisexual) people may be reluctant to disclose their sexual orientation to their GP because they anticipate discrimination
- Research suggest that LGB people are more likely to smoke than heterosexual people, and lesbians and bisexual women are more likely to smoke (and are likely to smoke more) than heterosexual people, or gay men
- Nine in ten lesbian and gay people think they would expect to face barriers to becoming foster parents because they are lesbian or gay
- More than a third of lesbian and gay people, including half of those over the age of 50, think they would be treated worse than a heterosexual if they were suspected of a crime.
- Nearly one in five lesbian and gave people have experienced homophobic bullying in the workplace during the last five years
- Homophobic bullying in schools is getting worse. Almost three in ten lesbian and gay people aged over 55 say they experienced homophobic bullying compared to more than half of those aged 25-34 and over six in then lesbians and gay students at schools in 2007, according to Stonewall's *School Report*

What are some of the issues facing people from minority religious groups?

- Membership of particular religious communities appears to have some bearing on health and well-being; the British Muslim community has worst reported health, followed by the Sikh population. For both groups, as well as for Hindus, females were more likely to report ill health whereas for Christians and Jews there was only minimal gender difference.
- Religious views on the beginning of life can influence attitudes towards reproductive medicine, abortion, contraception and neonatal care; views on old age and fulfilment of life can impact on decisions for allocation of resources for the elderly, on artificial nutrition and hydration of the terminally ill; views on dying, death and the afterlife can influence attitudes

towards telling truth to the dying, pain relief for the terminally ill, determining the moment of death, brain death, organ donations and care for the corpse.
- Since 9/11 and 7/7 many Muslims have reported an increase in harassment

The Trust's responsibilities

The Trust has a strong social responsibility to not only provide health services and advice to local people, but also to contribute actively to the local community by providing employment and business opportunities for the locality. As part of this, the Trust is fully committed to fulfilling its obligations under the Equality Act 2006. This is the first year that the Trust has developed and published a Single Equality Scheme to contribute to achieving this aim.

The Trust has a legal responsibility for ensuring that discrimination does not occur. The trust is liable (together with its managers and staff) for any act of unlawful direct or indirect discrimination by its staff committed during the course of their employment unless it can prove that it did all that was reasonably practicable to prevent that act.

The overall responsibility for achievement of this Equality Scheme lies with the Chief Executive on behalf of the Trust Board. The implementation of particular aspects of this policy is delegated to:

• Patient Care Services	Director of Operations
• Patient and User involvement and access to services	Director of Nursing & Clinical Development Director of Primary Care
• Employment	Director of Human Resources

All staff are responsible for delivering the scheme as it relates to their area of work. Individuals must co-operate with measures introduced by the Hospital to promote equality and prevention of discrimination.

The Single Equality Scheme will only be effective in promoting equality and helping us to meet our strategic objectives if:

- We recognise the importance of equality in achieving the Trust's wider objectives
- We focus on good outcomes not meticulous and exhaustive process
- We have ownership across the organisation
- Senior managers have commitment to achieving real improvements

The Trust's Single Equality Scheme is divided into three functional sections:

- Patient care services

- Patient and user involvement and access to information

- Employment

Each of these functions has been and will be reviewed by considering the following objectives:

- We will promote equality
- We will tackle discrimination
- We will support everyone to achieve their full potential
- We will work in partnership with patients and staff

Implementation of the Single Equality Scheme Action Plan will be monitored by the Equality Steering Group, which reports to the Executive Team.

3. The legal framework

Under the Race Relations (Amendment) Act 2000, public authorities including NHS trusts, have a **general duty** to:

- promote race equality
- eliminate unlawful discrimination
- promote good race relations between people of different racial groups.

The Act also gives public authorities **specific duties** to:

- prepare and publish a Race Equality Scheme (RES)
- assess functions and policies for relevance and priority
- arrange to:

  - monitor the impact of existing policies and functions
  - assess and consult on impact of proposed policies
  - publish results of assessment, consultation and monitoring
  - ensure access to information and services
  - train staff on their rights and responsibilities
  - undertake certain actions as employers.

Legislation covering disability discrimination came into force in December 2006, and gender legislation in April 2007, placing on public bodies the same duties in terms of eliminating discrimination, promoting equality, and producing a Disability Equality Scheme (DES) and a Gender Equality Scheme (GES).

Over recent years the notion of bringing together all the current statutory agencies (Commission for Racial Equality, the Disability Rights Commission and the Equal Opportunities Commission) working on the race, disability and gender equalities agendas has been crystallised through the Equality Act 2006.

In summary, all NHS organisations are required to:

- have in place a current Race Equality Scheme

- produce a Disability Equality Scheme by December 2006
- produce a Gender Equality Scheme by April 2007
- eliminate unlawful discrimination
- promote equality of opportunity
- reduce health inequalities
- prepare for future legislation which will require public authorities to take action to eliminate discrimination on the grounds of religion or belief, and sexual orientation.

Organisations are required to consult on the development of race and gender equality schemes. There is a specific legal requirement under disability legislation to involve people with disabilities in the consultation process.

Details of specific key legislation are at Appendix 5 with an outline of relevant definitions at Appendix 4.

4. Consultation and involvement

Consultation took place in the development of our previous gender and race schemes through focus groups with staff and patient groups.

The work on involving disabled persons in drawing up our previous action plan was undertaken partly in partnership with Islington Primary Care Trust and informs the development of this single equality scheme. We commissioned Disability Action in Islington to undertake some of the work for us and we also involved current service user groups and ran focus groups for staff. Disabled people involved in the discussion groups welcomed the process and the opportunity to report the barriers they face in securing health care.

Consultation and involvement are important to identify needs, find solutions and direct policy development. We have consulted with staff, service users and local groups in the development of our Single Equality Scheme.

Developing our Single Equality Scheme: Consulting staff

Staff have been involved in the drawing up of the single equality scheme. This consultation has included focus groups to which all staff were invited and also e-mails to all staff asking them to comment on issues.

Developing our Single Equality Scheme: Consulting patients and local groups

This process has entailed reviewing: comments, complaints and suggestions received by PALS and the complaints department; results of patient surveys; with local groups, by the PPI Forum and the patient panels

As we prepare for foundation trust status, we will be asking all of our FT governors for their views on our scheme. We will also seek the detailed views of approximately 50 of our members (chosen at random but with a mix of gender,

age, ethnicity and disability status). Their views will be gathered and will be incorporated into our action plans.

5. Where we are now

Patients' information for monitoring

It is important that monitoring information on patients attending the hospital are recorded. This allows us to ascertain whether there are some groups using our services less than other groups and then allows us to undertake investigations as to whether this difference is discriminatory. This helps us ensure equality of access to services.

- Information on patients' age, gender and ethnicity is routinely collected on the Trust's patient administration systems. Data regarding the religion/beliefs of patients is captured less regularly; patients' disability status and sexual orientation are not recorded.

- Data quality on ethnic group is a longstanding national target for all acute and specialist trusts, as information on patients' ethnicity is required to monitor the reduction in health inequalities related to ethnic diversity.

- The monthly Trust Maternity Report includes breakdowns by ethnicity and age and reports focus on various aspects of hospital activity in relation to patients' age, gender and ethnicity (including translation requirements).

- Previous reporting with regard to equality and diversity has included focus on the extent of ethnic data capture and waiting times by ethnic group to ensure fair access.

Workforce monitoring

Current workforce monitoring practices are well established - an analysis of current monitoring strands has been undertaken, the results of which are at Appendix 3. Monitoring of all job applicants by sexual orientation and religion/belief is also undertaken by our links to the NHS electronic recruitment service – NHS Jobs. One of our future actions in terms of recruitment will be to gather information on these two strands for current staff.

Reviewing policies for adverse impact

Under current equalities legislation covering race, disability, age and gender, the trust is required to review all functions and policies for race, disability, age or gender impact. As part of our Single Equality Scheme we aim to identify relevant functions and policies, and assess whether policies could adversely affect any of the six equality groups, and take steps to eliminate or reduce adverse impact.

This action is important because policies do not affect everyone in the same way. By making sure at an early stage of development that the policy will not have

unfavourable effects on some groups or by taking steps to mitigate these effects, we can make sure services meet the needs of our patients and increase public confidence in our services.

Most policies that involve and affect people have the potential to affect different groups of people in different ways. Therefore all policies should be screened as part of the process of policy development to test their relevance to the three elements of the general duty.

A framework for assessing the impact of policies on the six equality groups has been agreed. A toolkit has been developed to support staff in carrying out impact assessments. All new trust policies should have an impact assessment carried out before they can be approved. Existing policies continue to be prioritised and systematically reviewed to test whether they impact adversely on any of the equality groups.

Equality Impact assessments are published on our external website.

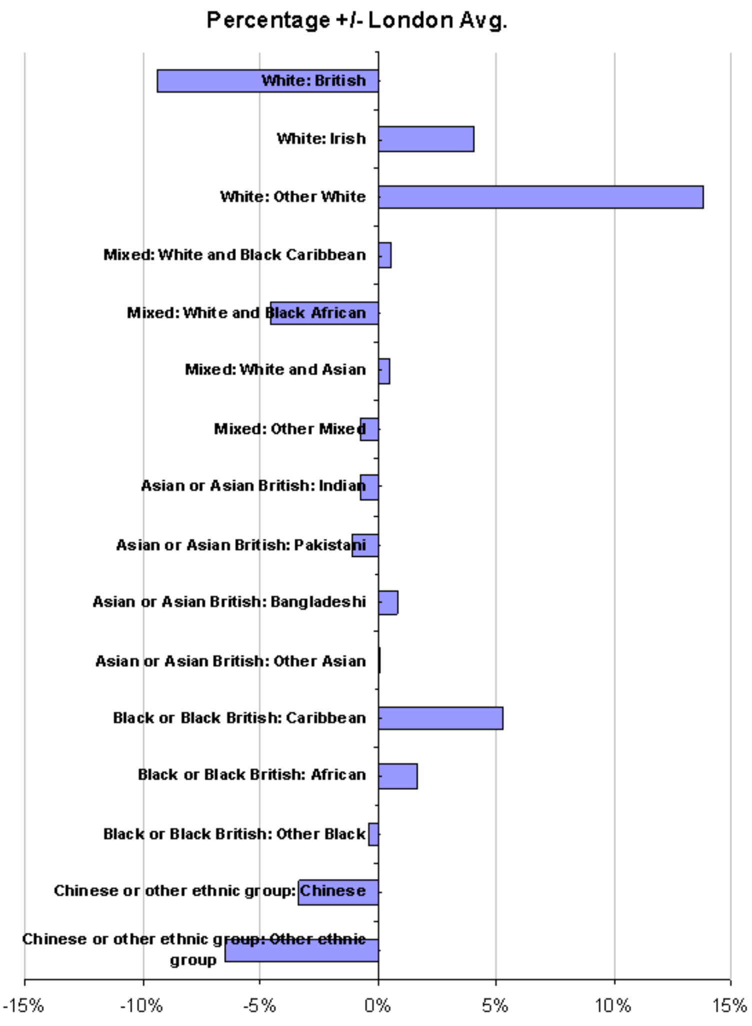
6. The “Single Equality Scheme” Approach

Race Equality Scheme

The Trust already has in place a Race Equality Scheme (RES) and action plan for 2005-2008. An outline of the current composition of the local population is shown in Figure 1.

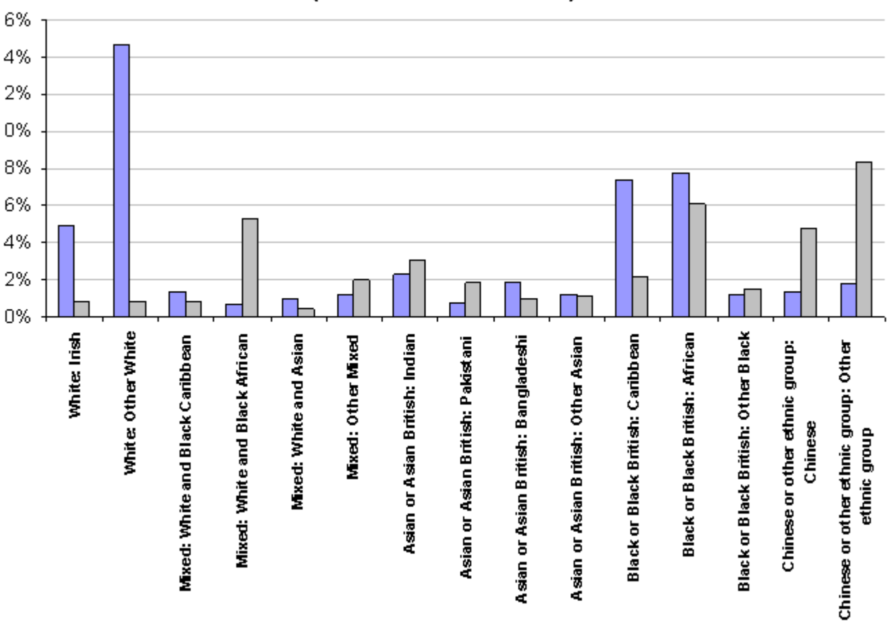
Demographic data on our local population – Census Data 2001

Figure 1



Ethnic Group	Percentage	London Avg (%)	% +/- London Avg.
White: British	50.4%	59.8%	-9%
White: Irish	4.9%	0.8%	4%
White: Other White	14.6%	0.8%	14%
Mixed: White and Black Caribbean	1.4%	0.9%	1%
Mixed: White and Black African	0.7%	5.3%	-5%
Mixed: White and Asian	1.0%	0.5%	1%
Mixed: Other Mixed	1.2%	2.0%	-1%
Asian or Asian British: Indian	2.3%	3.1%	-1%
Asian or Asian British: Pakistani	0.8%	1.9%	-1%
Asian or Asian British: Bangladeshi	1.8%	1.0%	1%
Asian or Asian British: Other Asian	1.2%	1.1%	0%
Black or Black British: Caribbean	7.4%	2.1%	5%
Black or Black British: African	7.7%	6.1%	2%
Black or Black British: Other Black	1.2%	1.6%	0%
Chinese or other ethnic group: Chinese	1.4%	4.8%	-3%
Chinese or other ethnic group: Other ethnic group	1.8%	8.3%	-7%

Office for National Statistics (Census - 2001)
W06 Ethnic group, 2001 (Coverage: England - Region and LA)



Considerable effort has been put into improving the recording of ethnic monitoring data on patients. Out-patient receptionists and ward clerks have been trained on how to capture the information, explaining to patients why we need this information, raising staff awareness, and reporting progress and data to various trust groups, including the trust board and the SHA.

We have explored various options for providing information to patients whose first language is not English. Where data shows evidence for doing so, we have translated information into relevant languages. In other instances we have produced information in a pictorial format.

Interpreting services have been reviewed to improve provision of interpreting for patients. It currently has 5 in-house interpreters covering 8 languages. They all carry bleeps and are available at short notice. There are 40 sessional interpreters who cover 28 languages. These interpreters also offer an out-of-hours service.

Further work has been undertaken with the Patient Partnership information forum to establish a support group for pregnant women from ethnic minorities with HIV/AIDS

A policy impact assessment toolkit has been developed and is now being rolled out across the trust to test whether trust policies have an adverse effect on certain races.

Monitoring data on patients 2007

OP – all attendances, excluding therapies and pre-clerking
IP – all admissions

Figure 2

Ethnic Origin	Outpatients	Inpatients	A&E	Total
White British	75,484	16,420	28,956	**120,860**
White Irish	8,728	1,789	2,673	**13,190**
Any other White	26,000	6,753	12,315	**45,068**
White and Black Caribbean	790	248	371	**1,409**
White and Black African	563	152	97	**812**
White and Asian	440	142	129	**711**
Any other mixed	1,530	391	1037	**2,958**
Indian	4,454	973	1,228	**6,655**
Pakistani	1,177	313	247	**1,737**
Bangladeshi	3,065	595	778	**4,438**
Any other Asian	3,392	789	1,464	**5,645**
Black Caribbean	14,070	2,801	5,012	**21,883**
Black African	13,518	3,101	4,812	**21,431**
Any other Black	3,156	780	2,803	**6,739**
Chinese	1,741	351	503	**2,595**
Any other ethnic	19,058	4,849	12,704	**36,611**
Not stated	27,794	3,948	5842	**37,584**
Uncoded	3,616	546	2	**4,164**
	208,576	**44,941**	**80,973**	**334,490**

Workforce issues

Ethnic composition of staff compared with the local population 2007

Figure 3

Ethnic origin	% of workforce	% managers (band 7 and over)	% in local population[1]
Mixed White & Black Caribbea	0.3%	0.2%	1.3%
Mixed White and Black African	0.3%	0.2%	0.7%
Mixed White and Asian	0.3%	0.0%	0.9%
Mixed Other	0.9%	0.2%	1.2%
Asian or Asian British Indian	5.3%	4.4%	1.6%
Asian or Asian British Pakistani	0.6%	1.4%	0.5%
Asian or Asian British Bangladeshi	0.7%	0.4%	2.4%
Asian or Asian British other Asian	8.5%	2.3%	0.8%
White British	33.5%	50.2%	56.8%
White Irish	7.0%	12.4%	5.7%
White other	7.9%	7.5%	12.9%
Black/Black British Caribbean	9.7%	5.0%	4.9%
Black/Black BritishAfrican	11.9%	5.6%	6%
Black/Black British Other	1.8%	0.8%	1%
Chinese	2.0%	3.7%	1.7%
Other ethnic group	4.3%	3.5%	1.5%
Not stated	4.8%	2.3%	

The above ethnic monitoring data demonstrates that the workforce employed at the hospital well reflects the local population in terms of ethnicity. For example, staff defining themselves as Black/Black British, Black African/Black British Other comprises approx 24% of our workforce, compared with 12% in the local community. Similarly staff defining themselves as Asian/Asian British Indian/Pakistani/Bangladeshi or Other Asian are approx 15% of our workforce, compared to 5% of the local population.

However the overall picture changes when the analysis of employees' seniority by ethnicity is reviewed in relation to the local population. Work on addressing this issue has been done in the past – this work continues.

It is clear that the composition of senior management/supervisory posts continues to require actions to ensure that potential applicants, either within the hospital or externally, are given every opportunity to enter the workforce at a senior level.

[1] *Islington LA census data 2001. This is a different population pool from that used for patient analysis (which uses the patient catchment area of Islington and Haringey). Target population for recruitment purposes can at times be local, national or indeed – for certain posts - international*

We have in place the following policies: Equal opportunities; Bullying and Harassment; Knowledge & Skills Framework – KSF

Agreed competencies are used for recruiting and appraising staff to reinforce an equalities approach. All staff are required to achieve at least a minimum level in equalities issues.

The hospital is now a member of Camden Employment Action Steering Group. There is also an ambassador scheme in place, working in conjunction with local schools and colleges, to encourage applicants from the local community to work at the Whittington – or in the wider NHS.

We now have a well-established local Black and Ethnic Minority leadership (BEL) programme.

Disability Equality Scheme

Census data 2001 on health-related and disability issues

Figure 4

	Islington	London	England
All People (Persons)	175,797	7,172,091	49,138,831
Good Health (Persons)	119,552	5,078,978	33,787,361
Fairly Good Health (Persons)	37,300	1,499,198	10,915,594
Not Good Health (Persons)	18,945	593,915	4,435,876
Economically inactive: Permanently sick / disabled (Persons)[1]	9,380	242,408	1,884,901

Involving disabled people

Disabled people were involved in drawing up the action plan for our original disability equality scheme (2007-2010). This was undertaken partly in partnership with Islington Primary Care Trust. We commissioned Disability Action in Islington to undertake some of the work for us and we also involved current service user groups and ran focus groups for staff. Disabled people involved in the discussion groups welcomed the process and the opportunity to report the barriers they face in securing health care.

Participants in the process wanted to assist local health providers to address these barriers in a meaningful and sustainable way through the Disability Equality Duty.

What are some of the things we have done so far?

We have been talking to our patients and their representatives for a number of years and have listened to their views.

- We interviewed a number of patients with physical disabilities and their carers, to explore the problems they face when they visit the hospital or stay overnight.

- We ran a number of half-day disability awareness courses for our staff. We prioritised certain staff for this training as they have the most contact with disabled people: emergency department; pharmacy; outpatients; maternity; appointments, and the wards.

- We asked staff from the awareness courses to come to a discussion session to look at how they could make their departments more disabled friendly. They came up with a number of solutions.

- We asked patients for their views through national surveys of patients
- We asked staff for their views through national staff attitude surveys
- We asked patients for their views through our patient panel meetings

What did we do about what we were being told?

The Whittington hospital has done a number of things:

- We have a very large rebuilding programme and our new hospital has good disabled access with lifts, ramps, hearing loops and better street access
- We are working on a computer system to be able to record disabled people's needs on their electronic records so our staff know what assistance they may need.
- We have introduced large print appointment letters for the eye department
- We have increased the number of patient information leaflets that are on audio tape
- We have successfully piloted taped consultations and will roll this out further. This would give patients a tape recording of their discussion with their doctor
- We have put seats into most corridors
- Panic buttons have been placed in disabled toilets
- We have drafted a new leaflet outlining services offered by the hospital for disabled patients
- We are training staff on disability awareness and basic sign language
- We have improved our patient and user involvement strategy and strengthened our patient panel meetings
- We have launched a large Hospital project on treating others with dignity and respect
- We provide BSL support for patients
- We have recruited a patient and user involvement manager – this person will have responsibility for disability issues
- We have developed patient information packs and have given these to all our wards

- We have reviewed our car parking arrangements and offer free parking to visitors with long-term conditions attending the hospital for treatment

- We have improved the support to disabled staff and introduced employment policies on rehabilitation and adjustments to work.

- We have joined in with the national NHS jobs service – this allows us better to monitor job applicants and new employees in terms of disability

- We have had presentations to managers by job centre specialists on employing disabled people

Workforce issues

The workforce statistics on the number of disabled staff is limited. All staff were recently asked to confirm their personal details for us as we moved towards a new electronic staff record system. 20 people in this exercise stated that they had a disability. This is clearly an understatement.

A range of support mechanisms for employees and their managers is in place. This includes access to occupational health services and OASIS. There are also policies dealing with disability in the workplace

As a good employer, it is important that managers support their staff who have a disability or who become disabled whilst working here. This support needs to be backed up with sound HR policies and practices if for example someone in our workforce becomes disabled and needs help to continue in employment.

We are a "Two Ticks" employer. The government supported scheme shows our commitment to good practice in employing disabled people. It also enables disabled people to know that we will be positive about their abilities.

On-going disability awareness training for staff remains a priority as described above. The customer care session during the general orientation programme has been updated to include guidance on disability awareness.

Age Equality Scheme

Age equality is concerned with responding to differences between people that are linked to age, and with avoiding preventable inequalities between people of different age groups. It is underpinned by human rights frameworks such as the Human Rights Act 1998, the United Nations Convention on the Rights of the Child and the United Nations Guiding Principles for Older Persons. These frameworks promote key principles such as dignity, autonomy, fairness and participation for all including people of different ages. Age equality and human rights are also key principles in the Standards for Better Health and in National Service Frameworks such as the NSF for Older People and the NSF for Children, Young People and Maternity Services. In the field of employment, the Employment Equality (Age) Regulations 2006 make it unlawful to discriminate against someone on grounds of their age in the context of employment or training.

Demographic data on the local population (census 2001)

Figure 5

		Islington	London	England
All People (Persons)	**Count**	138,340	3,805,655	22,376,120
Less than 20 years old (Persons)	**Count**	2,851 **2%**	120,518	1,126,061
20 to 29 years old (Persons)	**Count**	38,887 **28%**	944,847	4,486,880
30 to 39 years old (Persons)	**Count**	45,376 **33%**	1,143,851	5,972,510
40 to 49 years old (Persons)	**Count**	28,402 **20%**	828,408	5,240,955
50 to 59 years old (Persons)	**Count**	17,655 **13%**	589,413	4,314,052
More than 59 years old (Persons)	**Count**	5,169 **4%**	178,618	1,235,662

Workforce age monitoring – Whittington statistics 2007

Figure 6

Age	%	Headcount
Under 20	0.2	4
20-29	18.2	403
30-39	30.6	678
40-49	26.5	587
50-59	19.2	425
Over 59	5.5	121

Our workforce therefore is slightly older on average than the Islington population.

Current workforce monitoring practices will be extended to include information by age on:

- those who request training and those who receive training
- those who are involved in disciplinary and grievance hearings
- those who leave the trust
- harassment and bullying complaints and outcomes

The staff survey will also be used as a source of information.

Some of the things we have already done in relation to age:

- Revised retirement guidelines for both staff and managers have been reviewed
- Staff wishing to work beyond 65 are allowed to do so unless there is an issue not related to their age which prevents this
- There was no upper age limit for foundation trust members – and at the lower end of the scale people were entitled to be nominated from age 14

Gender Equality Scheme

The Gender Equality Duty has been introduced by the Government in recognition of the fact that women and men have different needs in relation to many public service areas, and that in both the workplace and as service users they can experience unfair and unequal outcomes.

Demographic data on the local population (Census 2001)

Figure 7

		Islington	London	England
All People (Persons)	**Count**	175,797	7,172,091	49,138,831
Males (Persons)	**Count**	84,229	3,468,793	23,922,144
Females (Persons)	**Count**	91,568	3,703,298	25,216,687

Service issues

It is vitally important that we consider the different needs of women and men when developing our policies and delivering services to the public. Gender is a major factor in health care because of the vast differences in susceptibility to different conditions between men and women, and because of the different ways in which men and women access health services. Analysis of available data is necessary to discover who is using the service, and the levels of satisfaction of different services by men and women. Information may also highlight the fact that, for instance, disabled women, or men from a particular

ethnic group, are dissatisfied with a particular aspect of a service, or do not use it.

For instance, men in general do not access primary health care as often as women; they tend to wait until symptoms are serious or can no longer be ignored. This leads to late diagnosis, and poor health, and in the long run costs the health service more money.

Employment services

Breakdown of current workforce at Whittington Hospital in terms of gender (2007 workforce data)

2007

Figure 8

	Male staff (headcount)	Female staff (headcount)	Total
Total staff by gender	597 (27.5%)	1576 (72.5%)	2173
Band 7 and above	69 (20.4%)	270 (79.6%)	339
Part-time staff	57 (9.5%)	352 (22.3%)	409

Equal Pay

As part of the Gender Equality Duty, public authorities need to develop and publish a policy on developing equal pay arrangements between men and women. For the Whittington NHS Trust this duty has been met by the implementation of Agenda for Change. The Agenda for Change Job Evaluation Scheme was developed nationally by the NHS and equal pay experts were involved in all aspects of the project. Well established local equal opportunities monitoring of the workforce will continue and monitoring at early implementer sites concluded that there was no evidence to suggest that the relative change in the ranking of jobs resulting from Agenda for Change was dependant on either the gender or ethnicity in those jobs.

Other Workforce Issues

The following initiatives have been put in place as part of the trust's "Improving Working Lives" programme to support the achievement of a work/life balance:

- childcare advice and support
- expectant mothers and carers forum
- childcare vouchers
- carers leave

- flexible working advice
- policy and procedure development

Further development of these areas of activity will form part of the Single Equalities Scheme Action Plan.

Other things we have done in relation to gender:

- Flexible working options are available to both men and women
- Ensure all pregnant workers are consulted on their health and safety needs and receive a written risk assessment which is reviewed regularly
- We have a policy to prevent and deal with sexual harassment. The policy is regularly reviewed and actively promoted to all staff to ensure that they are aware of the policy and understand what it means
- Specific clinics are provided related to gender – e.g. female genital mutilation

Sexual Orientation Equality Scheme

What is "sexual orientation"?

Everyone has a sexual orientation. Sexual orientation means the general attraction a person feels towards people of one sex or another (or both). Most people are generally attracted to people who are the same sex as them (lesbian or gay), people who are the opposite sex to them (heterosexual or straight) or people of both sexes (bisexual).

The majority of women and men are heterosexual or "straight" and they are attracted to the opposite sex. Other women and men –HM Treasury Actuaries estimate it to be six per cent – are attracted to people of the same sex or both the same and opposite sex.

Sexual Orientation (Census 2001)

Figure 9

		Islington	London	England
All People Aged 16 and Over in Households (Persons)	**Count**	140,058	5,632,491	38,393,304
Living in a same-sex couple (Persons)	**Count**	1,180 **0.84%**	21,366	75,746

As the first stage in determining action to be taken, workforce monitoring practices will be extended to include information by sexual orientation on:

- the current workforce
- those who apply for training and those who receive training
- those who are involved in disciplinary and grievance hearings
- those who leave the trust
- harassment and bullying complaints and outcomes

Religion and Belief Equality Scheme

Impact of religion or belief on healthcare

We live in a society with an ever widening and diverse mix of religions and beliefs, which NHS organisations need to take into account when developing both services to the public and employment policies. Even within established religions there are various branches and regional variants with different traditions of interpretation, rituals and practices, moral guidelines and laws. There are also levels of personal compliance ranging from nominal to strict observance.

In Britain, Christianity is the main religion, nominally covering 72% of the total population. It includes the Church of England, Church of Scotland, Church in Wales, Roman Catholic Church and other Protestant and Christian denominations. Muslims are the second largest group, covering 3% of the total population and 52% of the non-Christian religious population, followed by Hindus with 1% of the total population and 18% of the non-Christian religious population.

Employers should be aware that the Regulations on religion and belief extend beyond the more well known religions and faiths to include beliefs such as Paganism and Humanism. The Regulations also cover those without religious or similar beliefs

Future legislation will make it unlawful to discriminate against someone on the grounds of their religion or belief. Some of these issues are already being addressed under the umbrella of the Race Equality Scheme.

Religion and our local population
Census Data 2001

Figure 10

	Islington		London	England
All People (Persons)	175,797		7,172,091	49,138,831
Christian (Persons)	95,305	**54%**	4,176,175	35,251,244
Buddhist (Persons)	1,840	**1%**	54,297	139,046
Hindu (Persons)	1,751	**1%**	291,977	546,982
Jewish (Persons)	1,846	**1%**	149,789	257,671
Muslim (Persons)	14,259	**8%**	607,083	1,524,887
Sikh (Persons)	590	**1%**	104,230	327,343
Any other religion (Persons)	719	**1%**	36,558	143,811
No religion (Persons)	41,691	**24%**	1,130,616	7,171,332
Religion not stated (Persons)	17,796	**10%**	621,366	3,776,515

In-patients are already asked to state their religion (if they have one), which is recorded on PAS. Although this information is not complete it does indicate the most commonly stated religion or belief. The most frequently stated are shown in the table below.

Figure 11

	ED	OP	IP	Total
% patients with recorded religion/belief	**32%**	**46%**	**48%**	**43%**
Christian	14942	58667	12749	**86358**
Muslim	5288	13424	3088	**21800**
Jewish	307	2578	660	**3545**
Hindu	382	1855	400	**2637**

Key:
ED: Emergency Department
OP: Outpatients
IP Inpatients

;:

Workforce monitoring for religion and belief:

As the first stage in determining action to be taken, workforce monitoring practices will be extended to include information by religion and belief of:

- the current workforce
- those who apply for training and those who receive training
- those who are involved in disciplinary and grievance hearings
- those who leave the trust
- harassment and bullying complaints and outcomes.

We do not as yet record religion and belief statistics for our current workforce. However there is a staff policy in place on time off for religious observance in recognition of the diversity of our workforce.

The chaplaincy team has been extended to include representatives of all the main faiths seen at the Whittington.

Some of the things we have done in relation to religion and belief:

- we have a well established spiritual care department
- we have a multi-faith room
- we have developed polices on time off for religious festivals and time off for religious observance

Some religions have strong views concerning sexual orientation. However, everyone has the right to be treated with dignity and respect in the workplace whatever their sex, race, colour, disability, age, religion or sexual orientation. This is the overriding premise of our equality agenda and the hospital will take a robust view when this principle is not adhered to. There can be no justification for discrimination

7. Diversity and awareness training

The trust provides specific training on equality and diversity issues for all staff. There is also training on recruitment and selection – which encapsulates equality good practice for managers who recruit staff. Diversity and equality issues are embedded in other courses run by the trust.

The Trust will continue to enhance staff's knowledge and understanding of the importance of equality issues by:

- Continuing to provide training in induction programmes to new staff
- Continuing to provide equality and diversity training to staff and managers which includes information on relevant legislation and individual duties under this legislation
- Continuing to provide disability awareness training for staff
- Providing specific training for supervisory and management staff to enhance their ability to optimise the benefits of employing a richly diverse workforce

In addition a number of staff have been trained as staff harassment advisors. Detailed guidance and support mechanisms have been developed for them and their role is regularly publicised within the Trust.

8. Publishing information

Trusts are required to publish and make available their equality schemes and other relevant information such as ethnic monitoring data, results of policy impact assessments, examples of good practice on making services more responsive to the needs of ethnic minority groups, and using ethnic monitoring data to improve services. Ethnic monitoring data is now on the trust's intranet and website and is updated quarterly.

The Trust website includes completed impact assessments and will contain ongoing updates on the Trust's Single Equality Scheme action plan.

The public website contains comprehensive information on accessing services, patient information leaflets, and how to book an interpreter.

9 Monitoring Progress

The Trust Board will annually monitor the progress on this Single Equality Scheme. The Hospital equality and diversity steering group will undertake quarterly monitoring on behalf of the Trust Board.

10 How will the Trust promote this Single Equality Scheme?

The Trust will raise awareness of this Single Equality Scheme by providing:

- Information, in a variety of accessible formats, for patients and users of the hospital's services
- Information for each member of staff
- Inclusion in staff induction programmes and staff induction handbook
- Information, in accessible formats, to prospective job applicants
- Information to its public and patient members

Information will be available in the following ways:

- Patient/user and staff leaflets
- Hospital website
- Hospital intranet
- Staff newsletter: Link
- Hospital's annual report
- Hospital's membership information

The Trust's Single Equality Scheme will also be published through its public Trust Board documents.

11. Taking the Single Equality Scheme Forward

The Equality and Diversity Steering Group will take the strategic lead in relation to the SES, with operational responsibility for developing and implementing detailed action plans resting with the appropriate directors

Appendix 1

Here are some of the things we said we would do in our previously published race, gender and disability schemes and what progress we made:

What we said we would do	What we did
Ascertain the current provision for single sex accommodation in our service	Single sex accommodation compliance audited – all areas complying April 2008. Two further single sex wards created
Install tactile paving and crossovers and dropped kerbs	Additional dropped kerbs and tactile pavements installed 2006-2007 and 2007-2008
Review disability access under the Highgate Wing priority works	DDA compliant lift installed in Highgate Wing
Install automatic doors to Jenner and Highgate Wing	Installation underway – to be competed by May 2008
Identify the key physical barriers which currently make it difficult for disabled people to access health care provision	Our website is being developed to provide information on access issues for visitors
Undertake and publish Equality Impact Assessments	Assessments undertaken and published – EIA group established to take further work forward
Involve the local community in the running of the hospital	Have recruited approx 4000 local residents as members – these members are from a diverse range and well reflect local population in terms of ethnicity; disability. This consultation/communication channel will be strengthened with our foundation trust application and our foundation trust board of governors
Ascertain number of day surgeries for after hour appointments	New day surgery unit hours of opening extended. Also single sex recovery areas.
Publicise access to complaints support and existing modes of communication for making a complaint	Complaints leaflets have been distributed around the hospital. Information on how to make a complaint is now on our internet site. Complaints can be in writing; telephone; face-to-face or by e-mail

What we said we would do	**What we did**
Set up and run “here to Help” service	Volunteer befrienders have now been introduced on the wards; meet and greet guides daily at main entrance – If wheelchair required this can be booked in advance
Publicise BSL interpreting service throughout the trust	All medical staff given information on how to access all interpreters – to include BSL- information also on intranet. Good use made of BSL interpreter
Review all employment policies	We reviewed – or are reviewing – all policies to ensure there is no imbalance in terms of race; disability or gender. This work will continue
Undertake regular staff focus groups	We held focus groups on the drawing up of our equality schemes. We also held a number of focus groups in drawing up our *Employment Promise.* This promise places great importance in equality and dignity in the workplace
Review, update and publicise the *Discrimination, harassment and victimisation in employment* policy	Policy up-dated and used – Following further comments policy has been revised again and is out to consultation (April 2008)
Introduce local BEL programme to meet better individual local needs	First course delivered successfully and with good feedback – second course now running
Set up patient focus groups	Focus groups related to patient promise run in December – future patient involvement to come through our foundation trust membership
Develop patient surveys – to help to identify potential areas of inequality/poor standards	Survey on-going in outpatients – again looking at patient promise
Improve links with patient involvement activities in local PCTs	*Health foundation co-creating health* project – 3 year programme involving patients and clinical staff – working with our 2 PCTs

Appendix 2

Single Equalities Scheme Action Plans 2007 – 2010

Action Plans will be reviewed annually by the equality and diversity group. Action plans will also develop following on-going consultations with patients/community groups/staff and other interested parties

Patient Care Services

Objectives	Current Status	Action to be taken	Responsibility	Timescale	Race	Gender	Disability	Age	Religion/ Belief	Sexual Orientation
1. Identify complaints pertaining to discrimination in sexual orientation, race, religion and disability and address any trends	Trends not collated at present	Patient Relations to establish database Issues to be discussed at senior nurses and GM meetings quarterly Identify any staff education needs relating to discrimination Include breakdown in HMB and TB reports	Director of Nursing and Clinical Development	By Sept 2008 for database establish-ment and then on-going	√	√	√	√	√	√
2. Ensure that no patient is discriminated against in terms of respect of their privacy and dignity	Patient surveys Visible Leadership	Monitor complaints via Patient Relations data base Regular monitoring of adherence to privacy and dignity policy by visible leadership Use data from patients survey to address any issues relating to privacy and dignity Monitor comments from NHS Choices	All Directors	Sept 2008	√	√	√	√	√	√
3. Ensure that no patient is discriminated against in respect of their age.	Little monitoring of issues by age	Increase availability of single sex wards. Relaunch steering group for care of older people. Action plan in place for 2008/09	DW	June 08 July 08					√	

Objectives	Current Status	Action to be taken	Responsibility	Timescale	Race	Gender	Disability	Age	Religion/ Belief	Sexual Orientation
4. Easily accessible information for staff pertaining to cultural differences, religion and disability	Limited information currently available	Intranet guidance for staff to identify and manage the variance between different cultural groups. These groups should be identified from the national patient and staff surveys Local resource files to be available for staff, bank and substantive, relating to SES issues Local orientation to address discrimination issues SES information to be included in induction packs	Director of Nursing and Clinical Development All Directors Director of HR	Sept 2008 December 2008 December 2008	√		√		√	
5. Accessible information for patients	Some communication leaflets are available different languages. There are some areas with hearing loops	Ensure there are core leaflets available in patient areas in common local languages, as determined from patient data Ensure hearing loops are available in clinical key areas (OPD) Make visible the interpreter services the Trust offer on a daily basis	Director of Operations	Sept 2008	√		√			
6. Proactive approach to patients feedback relating to SES	Information relating to leads for focus groups needs to be made available	Ensure the issues discussed at patient focus groups relating to the SES subsections are fed back to the head of nursing and that appropriate actions are taken	Director of Operations	August 08	√	√	√	√	√	√

Objectives	Current Status	Action to be taken	Responsibility	Timescale	Race	Gender	Disability	Age	Religion/ Belief	Sexual Orientation
7. Increase knowledge and understanding about the health and inequalities experienced by local people from all groups. Priorities to be influenced by the health needs of all groups. Evidence based strategies and plans to be used to reduce inequalities	Issues of health inequalities for some different groups in place (e.g. thalassaemia)	To undertake research on health inequality issues coming from national and regional studies and to take steps to address these inequalities (e.g. *Born Equal*- The London Health Observatory Report) Link to national work undertaken by e.g. Men's Health Forum/Age Concern	Director of Operations	On-going	√	√	√	√	√	√
8. Review information received from consultation and draft further actions			All directors	On-going						
9. Continue with patient services work identified in other equality schemes ensuring action plans have been carried out and those not completed are reviewed/ ensure future actions are dealt with	Action plans in race; disability and gender schemes	• Review actions outlined in gender; disability and race equality schemes – and carry forward those actions not yet completed	As appropriate	On-going and linked to other scheme actions	√	√	√			

Objectives	Current Status	Action to be taken	Responsibility	Timescale	Race	Gender	Disability	Age	Religion/ Belief	Sexual Orientation
10. Ensure no patient is discriminated against in respect of their weight	No monitoring at present.	• Access to large size equipment – hoist, chairs, beds. • Specialist nurse for bariatric services	Director of Operations				√			

Patient and Public Involvement and Consultation

Objectives	Current Status	Action to be taken	Responsibility	Timescale	Race	Gender	Disability	Age	Religion/ Belief	Sexual Orientation
1. Develop a strategy to ensure a more coordinated and systematic approach to regularly involving local groups in the SES	Not in place at present	• Use the public/staff group governors and the Foundation Trust membership. • Set up Focus Groups with a programme of topics that will enable us to use their feedback to monitor satisfaction. • Identify changes needed.	Director of Primary Care	Work to begin Sept 2008	√	√	√	√	√	√
2. Patient surveys to include questions which address equality issues.	Some surveys have been carried out by various clinical areas	• Action plan to be written to cover national inpatient survey for 2007. (Full results awaited) • Annual inpatient survey to be carried out in autumn 2008 will provide information on patient satisfaction about services.	Director of Primary Care	Sept 2008	√	√	√	√	√	√
3. Ensure spiritual care facilities meets the needs of patients and staff	Separate chapel and multi-faith room. Some dissatisfaction with provision	• Survey of staff, patients & visitors about facilities. • Action plan to be in place in response to survey.	Director of Nursing & Clinical Development	May 2008			√		√	
4. More information on the Trust's website about how to get involved, and more opportunities to do this via email.	Not sufficient information on web site at present	• Publish the Trust's email and website addresses more widely i.e. on appointment letters, in leaflets. Ensure website feedback is collected, collated and given to appropriate groups. • Explore feasibility of patient & public feedback on website	Director of Primary Care	Sept 2008	√	√	√	√	√	√

Objectives	Current Status	Action to be taken	Responsibility	Timescale	Race	Gender	Disability	Age	Religion/ Belief	Sexual Orientation
5. Feed back to local people and patients the progress that has been made and issues to be tackled.	Currently some feedback via local papers and the Link.	• Feed back via the website, newsletters etc. Patient feedback re these issues to be built into future surveys.	Director of Primary Care	On-going	√	√	√	√	√	√
6. Draft action plan based on issues coming from the consultations above			Director of Primary Care	Once consultation is underway	√	√	√	√	√	√
7. Continue with patient and public involvement work identified in other equality schemes – ensuring actions are carried out and those not completed are reviewed/ensure future actions are dealt with	Action plans in race, disability and gender schemes	• Review actions outlined in gender; disability and race equality schemes – and carry forward those actions not yet completed	Director of Primary Care	On-going and linked to timescales in other schemes	√	√	√			

Employment

Objectives	Current Status	Action to be taken	Responsibility	Timescale	Race	Gender	Disability	Age	Religion/ Belief	Sexual Orientatio n
1. Review all employment policies to ensure all are fair and equitable in terms of religion/belief and sexual orientation (as was done for other strands at time)	Policies are reviewed on an on-going process and have been amended as necessary.	• Review all employment polices to ensure fair and equitable • Draw up timetable for more thorough review and updating of policies on a rolling basis	Director of HR	June 2008 and continuing					√	√
2. Provide equal opportunities training for managers in relation to applying employment policies	Build on current training delivered	• Seminar from Trust's solicitors • Deliver workshops for managers	Director of HR	May 2008 ongoing	√	√	√	√	√	√
3. Continue to provide equal opportunities training for all – to ensure 6 strands are covered – to ensure issue of bullying and harassment are also included	Training currently provided	• Need to review number of sessions and content • Link equality training to KSF outlines	Director of HR	On-going	√	√	√	√	√	√

Objectives	Current Status	Action to be taken	Responsibility	Timescale	Race	Gender	Disability	Age	Religion/ Belief	Sexual Orientatio n
4. To examine results from each annual staff attitude survey and identify areas of work to do to ensure all staff feel valued and respected	Staff attitude survey results already fed through the organisation	• Ensure managers discuss results of survey at relevant departmental meetings and have local action plans in place to identify issues within their area – action plans to be forwarded to the Director of HR	Director of HR and all managers	At time of each survey	√	√	√	√	√	√
5. Involve staff - through the JCC - in suggesting policy development in equality and diversity field	New polices are taken through this forum already	• More partnership discussion on proposed new policies	Director of HR	On-going	√	√	√	√	√	√
6. Monitor current staff in terms of religion/belief and sexual orientation	Monitoring done at recruitment stage but not for current staff	• Publicity/information campaign to inform staff of why need to collect data • Data collection exercise • Benchmark data collected and then monitored through the equality and diversity group • Examine monitoring data of recruits in terms of sexual orientation/religion (as we do with race etc) to see if there are any areas which may give cause for concern	Director of HR	Work to commence July 2008					√	√

Objectives	Current Status	Action to be taken	Responsibility	Timescale	Race	Gender	Disability	Age	Religion/ Belief	Sexual Orientatio n
7. Provide staff with information on different world religions and outline issues for these religions in terms of care received e.g. blood transfusion; death	Training was provided but some time ago – need to reintroduce	• Identification – through department of spiritual and pastoral care – of different religions/beliefs and the drawing up of awareness sessions for staff – open to all but with particular emphasis on those staff delivering direct patient care – perhaps with involvement of local community groups in the design/delivery of the awareness raising • Revise information manual	Director of Nursing and Clinical Development	Work to commence September 2008					√	
8. Introduce a mentoring scheme to encourage upward movement in the organisation	No formal mentoring schemes in place	• Identification of potential mentors • Mentoring training if required • Publication of scheme • Matching of mentors and mentees	Director of HR	By March 2009	√	√	√	√	√	√
9. Evaluate current black & ethnic leadership (BEL) programme	Current BEL programme now in second year	• Review participants comments • Review current position in organisation compared to before undertook BEL • Run further course subject to evaluation	Director of HR	By end of current course (Dec 2008)	√					
10. Ensure equality impact assessments take place in relation to revised and new policies	Several impact assessments already published – need to ensure more are done	• Continue to monitor through the EIA group • Provide training on EIAs for more managers	Director of HR	On-going	√	√	√	√	√	√

Objectives	Current Status	Action to be taken	Responsibility	Timescale	Race	Gender	Disability	Age	Religion/ Belief	Sexual Orientatio n
11. Introduce additional monitoring of training once ESR implemented	Training up-take/access not	• Ensure monitoring of training to identify if any groups may be suffering disadvantage	Director of HR	Once ESR in place and working well	√	√	√	√	√	√
12. Improve on current links with local schools and colleges/community to encourage applicants from all sections of the community	Current links somewhat patchy	• Review staff ambassador scheme to ensure working well • Identify local community groups where e.g. talks on working in the NHS can be given	Director of HR	Work to commence June 2008	√	√	√	√	√	√
13. To continue with employment services work identified in other equality schemes – ensuring action plans are carried out and those not completed are reviewed/ensure future actions are dealt with	Action plans in race, disability and gender schemes	• Review actions outlined in gender; disability and race equality schemes – and carry forward those actions not yet completed	Director of HR	On-going and linked to other scheme actions	√	√	√			

Appendix 3

Workforce Monitoring Data

Current strands of workforce monitoring

	Race	Disability	Age	Gender	Sexual Orientation	Religion/ Belief
Workforce	Y	Y	Y	Y	N	N
Recruitment	Y	Y	Y	Y	Y	Y
Disciplinary Outcomes	Y	N	N	P	N	N
Grievance Outcomes	Y	N	N	N	N	N
Staff Leavers	P	P	N	P	N	N
Training & Development	P	P	N	P	N	N

Work will be undertaken to ensure that all strands are met. This will be helped by the introduction of our electronic staff record.

Analysis of data we do hold has started.

Workforce Monitoring Information – Employee Relations (2007-08)

Ethnic composition of staff raising formal grievances compared to the overall workforce

Ethnic origin of staff raising grievance	***No of staff raising formal grievance***
White British	3
Black/Black British Caribbean	4
Black/Black British African	2
Asian or Asian British other Asian	1

Composition of staff involved in formal disciplinary action compared to the overall workforce

Ethnic origin of staff involved in formal disciplinary action	Ethnic background of people within workforce issued with written disciplinary warning	Ethnic background of people within workforce dismissed
Mixed White & Black Caribbean		
Mixed White and Black African		
Mixed White and Asian		
Mixed Other		
Asian or Asian British Indian	2	1
Asian or Asian British Pakistani		
Asian or Asian British Bangladeshi		
Asian or Asian British other Asian	1	3
White British	4	3
White Irish		1
White other		1
Black/Black British Caribbean	4	3
Black/Black British African	1	2
Black/Black British Other		
Chinese		
Other ethnic group		

There were no staff made redundant in 2007-08

Appendix 4

Definitions

Direct Discrimination takes place when one person or group of people are treated less favourably than other people on the grounds of their race, sex, disability, sexual orientation, religion or belief, marital status, age, creed, colour, nationality, national origin or ethnic origin. This includes discrimination on the grounds of perceived characteristics whether or not that perception is correct. It can also be directed against someone because they associate with or defend someone of a particular group, even though they are not a member of that group themselves.

Indirect Discrimination takes place when a criterion, provision or practice is applied which adversely affects, or favours, one particular group more than another and cannot be shown to be a proportionate means of achieving a legitimate aim (and so is not justified).

Examples are:

- insisting on an unnecessary physical requirement which might discriminate against women or people with disabilities;
- using marginally relevant employment experience such as minimum time spent in a particular occupation rather than facts about performance in a range of tasks.

Harassment can take many forms. It may, for example, be directed in particular against women and black people and towards people because of their disability, sexual orientation, religion or belief, age or some other characteristic (whether actual or perceived). It may involve action, behaviour, comment or physical contact which is found objectionable or which causes offence; it can result in the recipient feeling threatened, humiliated or patronised; and it can create an intimidating work environment. It can also be directed against people because they choose to associate with or defend someone of a particular group, even though they are not a member of that group themselves.

Victimisation occurs when action is taken against a person because they have or intend to make a complaint or allegation under equal opportunities legislation, or have given or intend to give evidence related to such proceedings.

.

Appendix 5

Key Equalities Legislation

- **The Equal Pay Act (as amended) 1970**

The Equal Pay Act gives an individual a right to the same contractual pay and benefits as a person of the opposite sex in the same employment, where the man and the woman are doing:

- Like work; or
- Work rated as equivalent under an analytical job evaluation study; or
- Work that is proved to be of equal value.

- **The Sex Discrimination Act (as amended) 1975**

The SDA (which applies to women and men of any age, including children) prohibits sex discrimination against individuals in the areas of employment, education, and the provision of goods, facilities and services and in the disposal or management of premises.

- **The Human Rights Act 1998**

The Human Rights Act came fully into force on 2 October 2000. It gives further effect in the UK to rights contained in the European Convention of Human Rights. The Act:

- makes it unlawful for a public authority to breach Convention rights, unless an Act of Parliament meant it could not have acted differently;
- means that cases can be dealt with in a UK court or tribunal; and
- says that all UK legislation must be given a meaning that fits with the Convention rights, if that is possible.

Article 2	Everyone has the right to life
Article 3	No one shall be subjected to … degrading treatment
Article 5	Everyone has the right to … security of person
Article 8	Everyone has the right to respect for their private and family life, home and correspondence
Article 9	Everyone has the right to freedom of thought, conscience and religion … subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, public order, health, morals, or the freedoms of others
Article 10	Everyone has the right to freedom of expression (subject to the same requirements as Article 9), but the exercise of those freedoms carries duties and responsibilities to the rights of others
Article 14	Prohibition on Discrimination. The enjoyment of the rights and freedoms set forth in the convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin

- **Employment Equality (Religion or Belief) Regulations 2003**

These regulations outlaw discrimination (direct discrimination, indirect discrimination, harassment and victimisation) in employment and vocational training on the grounds of religion or belief. The regulations apply to discrimination on grounds of religion, religious belief or similar philosophical belief.

- **Employment Equality (Sexual Orientation) Regulations 2003**

These regulations outlaw discrimination (direct discrimination, indirect discrimination, harassment and victimisation) in employment and vocational training on the grounds of sexual orientation. The regulations apply to discrimination on grounds of orientation towards persons of the same sex (lesbians and gay men) and the same and opposite sex (bisexuals).

- **The Gender Recognition Act 2004**

The purpose of this Act is to provide transsexual people with legal recognition in their acquired gender. Legal recognition will follow from the issue of a full gender recognition certificate by a Gender Recognition Panel. In practical terms, legal recognition will have the effect that, for example, a male-to-female transsexual person will be legally recognised as a woman in English Law. On the issue of a full gender recognition certificate, the person will be entitled to a new birth certificate reflecting the acquired gender and will be able to marry someone of the opposite gender to his or her acquired gender.

- **The Civil Partnership Act 2004**

This Act creates a new legal relationship of civil partnership, which two people of the same-sex can form by signing a registration document. It also provides same-sex couples who form a civil partnership with parity of treatment in a wide range of legal matters with those opposite-sex couples who enter into a civil marriage.

- **The Disability Discrimination Act 1995**

This Act prohibits discrimination against disabled people in the areas of employment, the provision of goods, facilities, services and premises, and education; and provides for regulations to improve access to public transport to be made.

- **The Race Relations Act 1976 (as amended by the Race Relations (Amendment) Act 2000)**

The Race Relations Act (RRA) makes it unlawful to treat a person less favourably than another on racial grounds. These cover grounds of race, colour, nationality (including citizenship), and national or ethnic origin.
The Race Relations (Amendment) Act outlawed discrimination (direct and indirect) and victimisation in all public authority functions not previously covered by the RRA, with only limited exceptions. It also placed a general duty on specified public authorities to promote race equality and good race relations. There are also specific duties for listed organisations including the production of Race Equality Schemes.

- **Disability Discrimination Act 2005**

This Act makes substantial amendments to the Disability Discrimination Act 1995 (see above). The 2005 Act places a general duty on public authorities to promote disability equality and to have due regard to eliminate unlawful discrimination. Those listed bodies within the public sector will also be subject to specific duties of the 2005 Act. The specific duties provide a clear framework for meeting the general duty and include the requirement to produce a **Disability Equality Scheme**. The Disability Equality Duty for the Public Sector came into force in December 2006.

This will mean that DH and all NHS bodies will have to have in place by December 2006 disability equality schemes demonstrating how they intend to fulfil their general and specific duties under the Act. This will include:

- a public authority should involve disabled people in the development of the scheme
- the scheme should include a statement of:
    - the way in which disabled people have been involved in the development of the scheme
    - the authority's methods for impact assessment
    - steps which the authority will take towards fulfilling its general duty (the "action plan")
    - the authority's arrangements for gathering information in relation to employment, and, where appropriate, its delivery of education and its functions
    - the authority's arrangements for putting the information gathered to use, in particular in reviewing its action plan and in preparing the next Disability Equality Scheme
- A public authority must, within 3 years of the scheme being published, take the steps set out in its action plan (unless it is unreasonable or impracticable for it to do so) and put into effect the arrangements for gathering and making use of information.

- A public authority must publish a report containing a summary of the steps taken under the action plan, the results of its information gathering and the use to which it has put the information.

The first scheme must be published by 4 December 2006 and will have to cover the following three years and this must be a living document, regularly monitored and reviewed.

- **Employment Equality (Age) Regulations October 2006**

The Age Regulations will implement the age strand of the EU Employment Directive 2000, which prohibits discrimination on specified grounds in work and vocational training. The Age Regulations will apply to all workers and to people who apply for work. In addition they will cover access to vocational training. The Age Regulations will prohibit direct and indirect age discrimination, harassment and victimisation.

- **The Equality Act 2006**

The Equality Act received Royal Assent on 16 February 2006. The Act's main provisions include:

  - the **creation of the Commission for Equality and Human Right**s (CEHR) which replaces the existing three equality commissions. The new Commission would give individuals suffering from discrimination easier access to support and provide employers and service providers with improved advice and information in a one-stop-shop. The purpose and functions of the CEHR are outlined in the Act and the new Commission will be operational from October 2007 (with the Commission for Racial Equality joining in 2009)

  - **to make unlawful discrimination on the grounds of religion and belief and sexual orientation** in the provision of goods, facilities and services, education, the use and disposal of premises, and the exercise of public functions; and

  - to create a **duty on public authorities to promote equality of opportunity between women and men ('the gender duty')**, and prohibit sex discrimination in the exercise of public functions. This will also include a specific duty on public bodies to produce a Gender Equality Scheme. The Gender Duty will came into force in April 2007.