Berkshire Healthcare
NHS Foundation Trust

Annual Equality Report 2017

How we meet the public sector duty

Stonewall DIVERSITY CHAMPION

Contents

1. Introduction

As a NHS Foundation Trust providing community and mental health services, Berkshire Healthcare needs to understand and respond to the needs of a wide range of people. We employ approximately 4,300 people and operate from over 100 bases, with most of our contacts with patients and service users in their own homes.

1.1 The Public Sector Equality Duty

The public sector equality duty is a general duty on public bodies and others that carry out public functions. It ensures that public bodies consider the needs of all individuals in their day to day work in shaping policy, in delivering services, and in relation to their own employees.

The equality duty has three aims. It requires public bodies such as Berkshire Healthcare to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people who share a protected characteristic and people who do not share it
- foster good relations between people who share a protected characteristic and people who do not share it.

The protected characteristics covered by the equality duty are:

- age
- disability
- gender reassignment
- marriage and civil partnership (but only in respect of eliminating unlawful discrimination)
- pregnancy and maternity
- race—this includes ethnic or national origins, colour or nationality
- religion or belief—this includes lack of belief
- sex
- sexual orientation.

The general equality duty is supported by two specific duties which require public bodies such as Berkshire Healthcare to:

- publish information to show their compliance with the equality duty
- set and publish equality objectives, at least every four years.

Our seven equality objectives are shown in Box 1 below.

Box 1
Equality Objectives agreed for the 2016 - 2020 Equality Strategy (published September 2016)

1. Increase representation of black and minority ethnic (BME) staff in (Agenda for Change) bands 7 and 8a-d, aiming for 20% representation at each of these grades. This reflects the Berkshire population demographic.

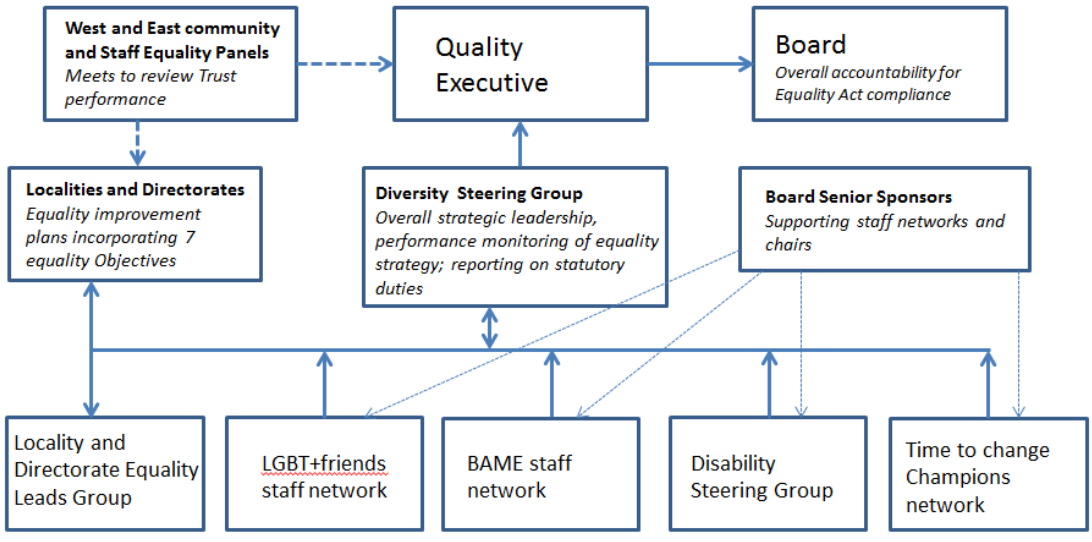
2. Ensure there is no difference in perceptions of equal opportunity in career progression between white and BME staff (as measured by our annual staff survey)
3. Reduce harassment and bullying as reported in the annual staff survey, in particular by BME staff. We are aiming to reduce experiences of harassment and bullying to lowest quartile rankings compared with other mental health Trusts in the NHS staff survey index. We also wish to achieve equity in reporting between BME and white staff
4. Deliver a more robust approach to making reasonable adjustments for disabled people – in particular implementation of the NHS Accessible Information Standard
5. Improve the well-being of disabled staff and reduce the proportion of staff experiencing stress related illness
6. Maintain Top 100 Workplace Equality Index Employer status and achieve a ranking in the top five health and social care providers by 2020
7. Engage with diverse groups in particular BME, Lesbian, Gay, Bisexual or Transgender (LGBT and disabled people to inform our understanding of their needs, with a view to ensuring good patient experience and equity of access in both mental and community health services.

1.2 Our approach to governance on equality and inclusion

Our equality strategy 2016-20 ensures that we have systems in place across the organisation to consider equality for our workforce and regarding service delivery. The Diversity Steering Group, with Executive and Non-Executive membership, provides strategic leadership and performance monitoring to ensure that we fulfil our equality duty. The Diversity Steering Group is chaired by the Executive Director of Corporate Affairs.

The Trust also has 4 senior sponsors, 11 equality leads, over 100 equality champions, four staff networks, and three equality panels. Designated staff such as the Equality Manager and the Equality Human Resources Manager, Marketing and Communications, Workforce Information and Information analysts provide support. The diagram below shows our overall governance framework, enabling coordination of our work and monitoring of progress. NB. The Time to Change network is focussed on tackling mental health discrimination.

Figure 1: Berkshire Healthcare governance of equality and inclusion



1.3 Compliance with the equality duty

This summary report describes the progress we have made since the publication of the last Annual Equality Report in January 2016, highlighting key achievements and activity towards fulfilling our equality objectives. It also provides recommendations for next steps.

This report consists of four sections:

- A summary of our workforce and service user diversity
- A summary of our performance against the NHS Equality Delivery System, our benchmarking tool
- Actions taken to progress our equality objectives
- Recommendations.

The specific duties of the Act require the Trust to publish relevant and proportionate information relating to our workforce and service users. Detailed data tables for the period 1 April 2016 - 31 March 2017 are available to view on our website. In line with NHS data protection standards we cannot publish data that relates to less than five people.

This report covers all protected characteristic data we hold on job applications, short-lists, appointments, pay, turnover, harassment and disciplinary processes. This year we have also published data on the following services: mental health inpatients, crisis response and home treatment, community mental health services, Improving Access to Psychological services (IAPT), Memory Clinics, rehabilitation wards, community health services, hearing and balance services, Slough walk-in centre.

Following our equality strategy recommendation, we have changed our reporting time-frame this year to reflect the financial year, in this case 1 April 2016 – 31 March 2017, in line with all other Trust reports.

2. Data headlines

2.1 Berkshire demographic

Berkshire is a county of around 861,870 people (2011 Census), living in six local authority areas. In the East - Bracknell Forest, Royal Borough of Windsor and Maidenhead and Slough; in the West - Reading, Wokingham and West Berkshire.

According to the 2011 census, the population distribution is as follows: 50% women and 50% men; 25% of the population aged 0 – 19 years; 61% aged 20 – 64 years; 12% aged 65 – 84 years; 2% aged 85 years and over. 0.3% of the population have severe learning disability (Berkshire Learning Disability Register). 1.7% of respondents to the Annual Population Survey (2016) identify as lesbian, gay and bisexual. The most accurate assessment of British same sex experiences is the National Survey of sexual attitudes and lifestyles (2010) which estimates same sex experiences to be between 8-16% for women and 5-7% for men.

20% of the Berkshire population are from an ethnic minority background. When we refer to 'Black and minority ethnic' (BME) in this report we are counting only non-white ethnic minorities. In terms

of age bands, the proportion of minority ethnic people is significantly less for older age groups: 7.2% at 65-84 years and 3% for those aged over 85 years.

We have used the following summary categories in this report:

Summary ethnic categories	***2011 Census population estimate[1]***
White British	73.0%
White Other (including EU nationals, Irish, Gypsies & Travellers)	7.0%
Asian (Indian, Pakistani, Bangladeshi, Chinese, any other Asian)	13.0%
Black (African, Caribbean, any other Black background)	3.5%
Mixed	2.6%
Other ethnic group (Arab and any other ethnic group)	1.0%

Religion and belief	***2011 Census***
Christian	56.2%
Atheist	0.1%
Islam	6.5%
Hindu	2.7%
Other	27.7%
Not Declared	6.9%

2.2 Workforce data summary

2.2.1 Workforce diversity

The Trust employed 4,283 staff as at 31 March 2017. Workforce diversity is outlined below:

- 83.5% female and 16.5% (705) male
- 74.7% white, 21% (901) black and minority ethnic, 4.2% unknown ethnicity
- 4.8% (206) disabled staff
- 1.4% (62) lesbian, gay, bisexual or transgender; 80% heterosexual; 18.5% unknown sexual orientation
- 52.7% of our workforce identify themselves as Christian, 11.1% (474) Atheist, 3.2% (139) Muslim, 2.5% (07) Hindu, 8.8% other religious belief, 21.7% do not declare
- 5.1% were under 25 years, 20.9% were 25 – 34 years, 24.4% were 35 – 44years, 40.8% were 45 – 59 years, 8.8% were 60 years old and over.

[1] Due to rounding upwards the ethnic breakdown adds up to 100.1%

- 44% of staff were married, 1.1% (49) were in a civil partnership, 22.6% (969) were single, 4.3% were divorced, 0.7% legally separated, 0.6% were widowed and 26.6% were of unknown status. Co-habiting partners are not recorded
- 41.4% of the workforce were part-time staff ; of these 92.7% were female.

The workforce profile has remained broadly similar for six years. This year there has been 0.6% increase in the proportion of male staff, a 1% increase in BME staff compared with last year. Efforts to encourage staff to review equality data held on their staff record this year led to a very small 1 – 2% increase in data completeness in data fields relating to sexual orientation, disability and religion and belief.

2.2.2 Recruitment and selection

In the financial year 2016/17 there were a total of 13,455 job applicants, 3,917 shortlisted applicants and 819 newly appointed staff. Applicant data is collected by NHS Jobs on gender, age, ethnicity, disability, religion and belief and sexual orientation.

- There was a change in success rates for minority ethnic short-listed candidates this year. Whilst white applicants were 1.2 times more likely to be shortlisted than minority ethnic applicants; once short-listed, ethnic minority applicants were 1.1 times more likely to be appointed. This is compares with 2014/15 when white candidates were 1.6 times more likely to be appointed from short-list than ethnic minority candidates.
- Female applicants were 1.2 times more likely to be shortlisted than male, and women were 1.1 times more likely to be appointed than male.
- Applicants aged 45 years or more were 1.4 times more likely to be shortlisted than those who were 44 years and under. Having been shortlisted, those who were under 44 years of age, were 1.1 times more likely to be appointed.
- Disabled applicants were equally likely to be shortlisted compared with non-disabled staff, but non-disabled staff are 1.5 times more likely to be appointed
- Christian applicants are 1.2 times more likely to be shortlisted and 1.1 times more likely to be appointed
- Staff who declare that they are LGBT are equally likely to be shortlisted compared with heterosexual staff; however, heterosexual staff are 1.4 times more likely to be appointed.

Figures comparing success rates for disability, sexuality, religion and belief are less reliable than other categories, as around a quarter of the data in these categories is not recorded.

2.2.3 Career development

In common with many other NHS trusts, ethnic minorities are under-represented in our workforce at senior grades. 74% of BME staff hold posts in job bands 1 – 6. Under-representation starts at Band 7 for clinical (16.7%) and 8a for non-clinical posts (11.5%).

2.2.4 Grade increase

369 internal candidates achieved a grade increase this year. Of these, 76.4% were white, and 20.6% were BME. This in line with the workforce average. More men achieved a grade increase compared to women; and more younger staff compared to older staff.

2.2.5 Continuing professional development

Continuing professional development (CPD) opportunities and/or training and development are linked to career progression. 564 staff in Bands 5 through to 9 had access to CPD training this year. White staff were 1.4 times more likely to receive CPD funded training than BME staff. The position has not changed compared with 2015/16.

2.2.6 Equal Pay

The majority of the Trust's posts are on the Agenda for Change pay banding system, which is designed, together with the policy on starting salaries, to reduce pay inequality between the sexes. Based on average hourly rates of basic salaries, the average pay gap between female and male staff on Agenda for Change was 6.9%, which is 1.7% lower than in the previous year. Men earned on average £15.81 per hour compared with the average for women of £14.72. When those who are not on Agenda for Change are included (medical doctors and directors), the gap increased to 19.6%; the average hourly rate for men was £19.07 and for women it was £15.34.

2.2.7 Disciplinary

There has been national concern for some years around levels of BME disciplinary cases in the NHS. Over the last 12 months, 53 staff were formally disciplined. This included closed and current cases. 35 (66%) were white staff, 17 (32%) were BME staff. BME staff were 1.73 times more likely to be disciplined compared to white staff.

2.2.8 Harassment and victimisation

In the 12 month period, there were six formal complaints brought under the Dignity at Work policy, which addresses allegations of harassment, bullying or victimisation. All six were brought by white staff.

2.2.9 Turnover

Over the reporting period, 776 staff left the Trust, giving an average turnover rate of 17.6%. The turnover rate for men (18%) was slightly higher than for women (17.5%). The turnover rate for BME staff varied from a low of 14.6% for Black staff, to a higher rate of 17.9% for Asian staff. For White staff the turnover rate was 17.2%.

The turnover rate varied across the age bands. The highest rate was for those under 25 years old (31.7%). The turnover rate was 23.3% for those aged 25 to 34 years and 22.1% are aged 60 years plus. The LGB turnover reduced this year to 17.7% (it had been 34% in 2016). The turnover for disabled staff was 17.1%.

Box 2: Launch of the Black Asian Minority Ethnic (BAME) Staff network

In June 2016 the Trust launched its Black Asian Minority Ethnic staff network with a conference at the Hilton Hotel Reading. Numbering over 100 staff the network now has an active organising committee with links to all directorates. The network held an Awayday, organised Black History Month celebrations and held its second conference on 31 March 2017. There has been a focus on role modelling throughout, and the network is making a real contribution to the achievement of our goals.

2.3 Service Delivery

The Trust provides over 100 services, and in order to provide a good overview, the data analysis in this section is focussed on key mental health and community services including: mental health inpatients, community mental health, crisis response, Improving Access to Psychological Therapy (IAPT), rehabilitation services, and generic community health services.

2.3.1 Age

We provide universal health visiting to families of children aged 0-5 years and a range of other services targeted at children and young people, adults and older people. We also provide a number of services open to all age groups. Some of these are disproportionately used by older people as a result of disability or ill health in older age. For example, rehabilitation services, diabetic retinopathy screening, memory clinics, hearing and balance. Activity at our walk-in services such as the Slough Walk-In centre, a minor injury and illness service, is broadly in line with Slough's younger demographic.

Box 3: IAPT reaching out to older people

Improving Access to Psychological Services, which was originally designed to meet the needs of working age adults, has been adapting its service provision to meet the mental health needs of older people. It has seen a 2% (418) increase in its service offering to people over 65 years compared with the period reviewed by the last report. 8% of IAPT service users are now aged 65 plus compared with 13.5% of the Berkshire population. This brings the total number of over 65s seen by the service this year to 1,322. The service has also provided services to 20 people over the age of 90 years.

2.3.2 Gender

Patterns of service access by gender are in line with previous years, with women slightly outnumbering men as adult service users in many key services. Women's service usage increases with age. For example in our inpatient rehabilitation[2] services, 62% of those service users aged over 85 years were women. This also mirrors the higher prevalence of disability among women of this age. There are proportionately more men using hearing and balance services aged 85 than might be expected - this may be explained by the higher prevalence of hearing loss among men.[3]

Historically men have been over-represented in tertiary mental health services and under-represented in primary mental health services. This pattern continues this year. Men comprise 56% of mental health inpatient service users aged 20-64 years of age, 42% of community mental health service users and 33% of Improving Access to Psychological Therapy service users.

2.3.3 Ethnic minorities

Data quality

One of the main problems in assessing equality of access according to ethnic background has been recording of accurate data. We have had modest success in improving our data in this area and this is being addressed through locality equality improvement plans. Data from mental health inpatients and Improving Access to Psychological services continues to be exemplary (with un-coded or 'not

[2] These services cover Henry Tudor, Jubilee wards in the East and Oakwood, Donnington, Highclere, Ascot and Windsor wards in the West.

[3] From the age of 40 onwards a higher proportion of men than women develop hearing loss. This may be because men and more likely to be exposed to industrial noise. (Reference Action on Hearing Loss website.)

stated' data rates of 1.7% and 5.2% respectively). Community mental health service ethnicity data capture has improved from 16% 'not stated' data in 2014/15 to 10% in 2016.

Over the past three years steps have been taken to address ethnicity data gaps in community health services generally. 19.4% of community health ethnicity data is now 'not stated', an improvement of 5% compared to 2014/15. Capturing ethnicity data from services where the user group is older continues to prove difficult. Corporate initiatives have focused on our main patient data base Rio. Improving ethnicity data quality in other smaller patient databases remains a challenge.

Mental health

An area of national concern over the past 20 years is the over-representation of people from a Black background (i.e. people from an African, African-Caribbean and other Black background) in mental health inpatient services. Data from the Mental Health Foundation shows that in England people from a Black background are 3 to 5 times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia. In Berkshire, people from a Black background comprise 5.6% (58) of the mental health inpatient population in 2016/17 – this compares with 3.5% of the population according to the 2011 census.

Rates of Crisis Response and Home Treatment and community mental health service usage by people of a Black background are in line with population averages but may not reflect need. People from a Black background are also slightly under-represented as IAPT service users (2.7%) and have lower than average treatment completion rates of 55% compared with the average of 62%.

People from an Asian background comprised 9.6% of mental health hospital admissions this year (a 3% rise) though this was just 10 more people compared to the 2014/15 headcount. A similar proportion used Crisis Response and Home Treatment (8.5%), community mental health (9%) and IAPT (9.3%). Completion rates for IAPT treatment were 53% for Asian compared to the average of 62%.

Memory clinics appear to be under-used by minority ethnic communities with only 7% of service users from minority ethnic backgrounds. However, analysis by age band shows that in fact, ethnic minorities are using these services in line with the demographic. 7% of service users over 65 years are from a minority ethnic background compared with 7.2% of the population aged 65 years plus; 3.9% of service users over 85 years are from a minority ethnic background compared with 3.02% of the population at this age.

Community health

Overall, ethnic minority usage of generic community health services appears in line with expected levels. Ethnic minorities appear to be slightly under-represented (up to 2%) in services with an older service user population such as rehabilitation wards. Although service usage was not analysed, patient experience data for both health visiting and community nursing demonstrated high levels of satisfaction with the overall service by all ethnic and religious groups.

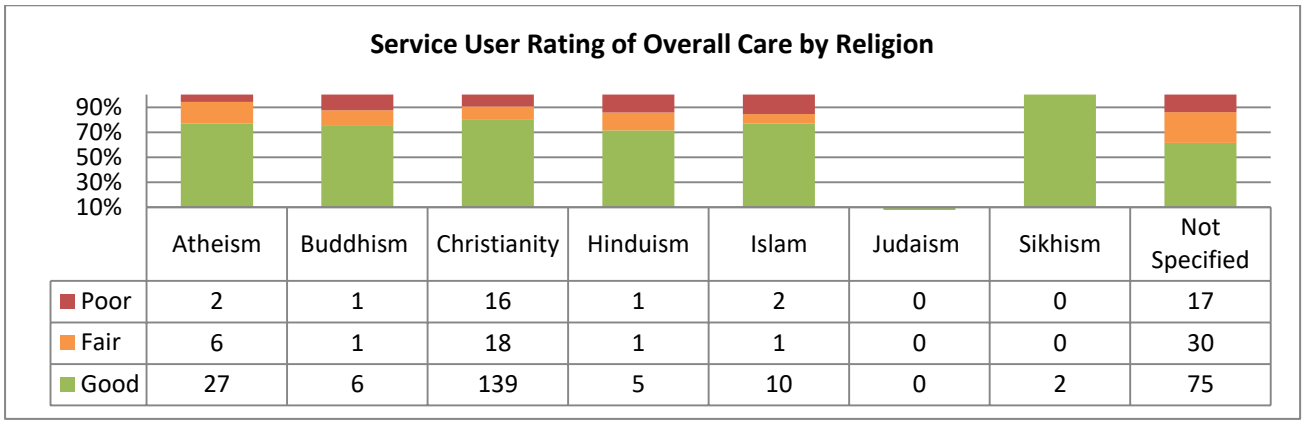
2.3.4 Religion and belief

Religious belief data is collected inconsistently as it is not a mandatory data requirement. The most reliable data in this area is from IAPT where 52% of service users declared they had no religious belief, 26% were Christian, 3% were Muslim, 1.4% were Hindu, 1.6% were Sikh, 0.2% were Jewish. 1.8% declined to disclose. Treatment completion rates for people of different religious beliefs were

in line with average. There were slightly lower rates compared to the average for people from a Muslim background (58%).

Mental health inpatient services (Prospect Park Hospital) collect patient data on religion and belief and provides a multi-faith chaplaincy. 66% of the 360 inpatients who undertook the patient experience survey filled out the data on religion and belief.

The results are presented below.



	Atheism	Buddhism	Christianity	Hinduism	Islam	Judaism	Sikhism	Not Specified
Poor	2	1	16	1	2	0	0	17
Fair	6	1	18	1	1	0	0	30
Good	27	6	139	5	10	0	2	75

2.3.5 Disability

Disability codes are rarely used at the Trust since many of our patients attend specific services dealing with long-term or disabling conditions. Following the implementation of the NHS Accessible Information Standard in July 2016, 2,058 records were established by staff to record the communication needs of disabled service users. The highest rate of completion was in Wokingham locality (25%), the lowest was in North West Reading (7% of the total records). This new data forms a baseline to compare performance year on year.

Results of the community mental health patient experience survey were also reviewed. These showed that 13.4% (23) of the 171 disabled service users surveyed were not completely satisfied with information provided to them in the course of their treatment. 2% disagreed that they had been given all required information.

The Trust continues to provide British Sign Language interpretation for BSL speakers whenever required. A small number of Braille requests were also received this year.

2.3.6 Sexual orientation

IAPT, Prospect Park Hospital and our sexual health services collect information on the sexual orientation of their service users.

Mental health inpatient data shows that 2% (22) of inpatients were gay or lesbian, 1.4% (14) were bisexual, 0.3% defined as 'other' and 1.6% (14) preferred not disclose their status. Although numbers are very small and not statistically significant, on average LGB and bisexual patients appeared more likely than heterosexual patients to rate the service overall as fair or poor – 44% compared to 21% in our mental health inpatient experience survey.

Improving Access to Psychological (IAPT) services work with the LGBT community is one of the Trust's successes. 4% (599) of the IAPT service users identified as lesbian gay or bisexual this year;

1.2% (178) were gay, 1% (152) were lesbian and 1.8% (269) were bisexual. Overall this is a 2% (200) increase in LGB IAPT service users compared with 2014/15. This level of declaration is higher than the average of 1.7% as recorded by the Annual Population Survey which may indicate that patients feel safe in declaring their sexual orientation to their IAPT counsellor. However, IAPT treatment completion rates are a few percentage points lower for LGB service users than for heterosexuals.

2.3.7 Interpretation services

To promote equality and ensure people who use our services are not discriminated against in clinical assessment and care planning, we provided around £106,000 of interpretation services for people whose first language is non-English or who are hard of hearing/deaf. This is a £16,000 increase on the levels reported in 2014/15 due to increased demand.

2.3.8 Patient experience

Patient experience data is collected for six protected characteristics. However, although they provide valuable insights, numbers of respondents with protected characteristics are often small. Minorities are significantly under-represented in all samples. Where pertinent, results have been noted in the sections above. Consideration will be given to potential use of qualitative methods such as focus groups or group interviews to learn more about patient experience from the perspective of those with protected characteristics. A more conventional survey design may not be appropriate to capture useful information from these respondents.

2.3.9 Complaints

202 formal complaints were made this year. 12.4% or 25 were from ethnic minorities, of these 4% were from 'other white' minorities. 46% of complaints data on ethnicity was not available.

3. NHS Equality Delivery System

The Equality Delivery System was introduced by the NHS in England to assist NHS organisations in complying with the public sector duty: it is the NHS's equality benchmarking tool. It drives improvements and strengthens the accountability of services to patients and the public.

Equality Delivery System grades are agreed at panel meetings where detailed evidence is reviewed. Our last panel meetings took place in Spring and Summer 2016. Each of the outcomes listed below are graded against a range of criteria. Grades are awarded at four levels: Underdeveloped - Red; Developing - Orange; Achieving – Green; Excelling – Purple. The Trust has yet to grade on EDS Goals 4.1 and 4.2 which covers Inclusive leadership and equality impact assessment. EDS guidance recommends these areas for peer review.

Box 4 Taking steps to embed inclusive leadership Trust leaders have taken significant steps to increase their leadership profile on diversity this year. Julian Emms, Chief Executive Officer (CEO), delivered the key note speech to the equality conference on his vision for inclusivity by 2020 and showcased the Trust's new staff diversity video. David Townsend, Chief Operating Officer, delivered a speech on unconscious bias to 200 senior leaders at the September Trust leadership forum. A number of executive directors became senior sponsors of staff networks and many have undertaken reverse mentoring with members of the LGBT&friends staff network. Board members participated in a workshop on diversity and inclusion in February 2017.

Our progress against the Equality Delivery System goals and outcomes is shown in the table below.

Goals and Outcomes of the EDS2 Toolkit			2013	2014/15	2016	Priority
Goal 1 **Better Health Outcomes**	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities			*Not graded this year*	
	1.2	Individual people's health needs are assessment and met in appropriate and effective ways				
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed				✓
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse				
	1.5	Screening, vaccination and other health promotion services reach and benefit all communities				
Goal 2 **Improved Patient Access and Experience**	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds.				✓
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care				✓
	2.3	People report positive experiences of the NHS				
	2.4	People's complaints about services are handled respectfully and efficiently.				
Goal 3 **A represent-ative and supported workforce**	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels				✓
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to fulfil their legal obligations				
	3.3	Training and development opportunities are taken up and positively evaluated by staff				
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source				✓
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives				
	3.6	Staff report positive experiences of their membership of the workforce/health and wellbeing				
Goal 4 **Inclusive Leadership**	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations				
	4.2	Papers that come before the Board and other major committee identify equality-related impacts including risks, and say how these risks are to be managed	*New outcome*	*Not graded*	*Not graded*	✓
	4.3	Middle managers and other line manager support their staff to work in culturally competent ways within a work environment free from discrimination.				

Priority areas have been agreed for re-grading by panels in 2018. These relate to improving transitions between services, access to services, information and involvement in decisions about care, fair employment and reducing harassment and bullying. These priorities have been integrated into locality equality improvement plans and the HR Equality Delivery System plan.

4. Public Sector Equality objectives

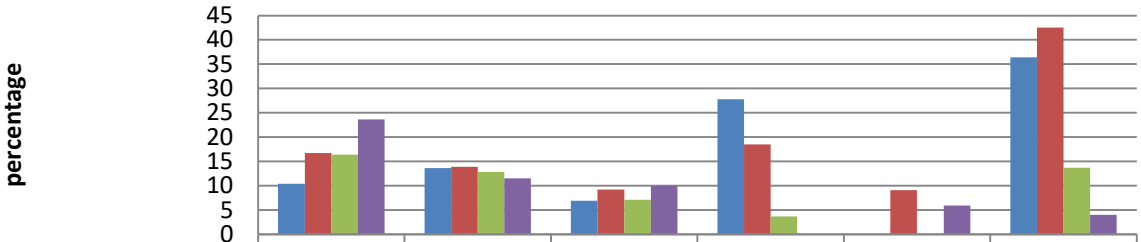
The Trust's equality objectives for the period 2016 - 2020 were agreed by the Board in September 2016. These were introduced to over 100 Equality Champions by Julian Emms, CEO, at the Trust's first equality conference on 13 October 2016.

The first phase of the strategy implementation involved nominating equality leads, conducting audits and setting local key performance indicators. Following consultation in Spring 2017, the Trust is launching an employment focused programme – *Making it Right* to address issues of fairness in employment raised by the NHS Workplace Race Equality Standard. This programme pledges: fair recruitment for all; career progression for all; zero tolerance of bullying and harassment; prioritising staff health and wellbeing; and all are valued and feel included. The pledges will be delivered through a series of internal development centres for BME staff. Health and wellbeing modules will prioritise the needs of disabled staff.

Objective 1: Increase representation of black and minority ethnic (BME) staff in (Agenda for Change) bands 7 and 8a-d, aiming for 20% representation at each of these grades.

Since the last Equality report (September 2015 data), there has been a 7.2% increase in representation of BME staff in Band 7 non-clinical managerial jobs (now 23.6%) and a 6.3% increase in Band 7 clinical managers (16.7%). There is now some BME representation (9.1% clinical and 5.9% non-clinical) at Band 8d where previously there was no representation.

Figure 2: % of BME clinical and non-clinical staff September 2015 – March 2017



	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Other
Sep-15 Clinical	10.4	13.6	6.9	27.8	0	36.4
Mar-17 Clinical	16.7	13.9	9.2	18.5	9.1	42.5
Sep-15 Non-clinical	16.4	12.8	7.1	3.7	0	13.7
Mar-17 Non-clinical	23.6	11.5	10	0	5.9	4

Action taken: *Locality and Directorate Equality improvement plan targets were set in April 2017 based on detailed local audits of current performance. Equality leads worked with the Workforce Race Equality Standard (WRES) project lead and the Equality HR Manager to address deficits. A number of training and awareness interventions on the topic of 'unconscious bias' took place in 2016/17.*

Objective 2: Ensure there is no difference in perceptions of equal opportunity in career progression between white and BME staff (as measured by our annual staff survey)

According to the October 2016 Staff survey, 90% of white staff believe the Trust provides equal opportunities for career progression compared with only 68% of BME staff. Our data shows that White staff are more likely to access continuing professional development opportunities at work. However, this year short-listed BME candidates were slightly more successful at interview compared with White candidates.

Action taken: *We have taken steps to include BAME Staff Network members in recruitment processes, and provided unconscious bias training. Our internal development programme 'Making It Right' is designed to address barriers and perceptions of unfairness. This launches mid-2017.*

Objective 3: Reduce harassment and bullying as reported in the annual staff survey, in particular by BME staff.

In the 2016 NHS staff survey, 26% of BME staff reported experiencing harassment and bullying from a colleague, compared with 18% of white staff. The gap was similar in the 2015 survey. During this period no formal harassment claims were raised by BME staff.

Action taken: *The 'Making It Right' programme will address harassment channels and a new HR Equality Manager was appointed by the Trust in March to handle harassment complaints. The new BAME staff network now acts as a first point of contact for BME staff.*

In 2016, the Trust stepped up its efforts to address hate crime against staff and patients. Mandatory recording of incidents of a racial and sexual nature is now required by our incident database DATIX.

14% of overall assaults to patients and staff recorded in the financial year involved a racial or sexual element. A number of hate crime awareness champions were trained.

Objective 4: Significantly improve the well-being of disabled staff and a reduction in the proportion of staff experiencing stress related illness

Our recorded sickness absence due to stress related illness was a fifth (0.87%) of total sickness absence (4.0%) for 2016/17 and is reducing. Stress related sickness absence has reduced from 25.3% of days lost through sickness absence in 2015/16 to 21.6% in 2016/17. The staff survey also showed a small (4%) reduction in stress experienced by respondents.

In terms of disability, 52% of disabled respondents felt stress due to work and 32% of non-disabled staff also experienced stress. 27% of disabled survey respondents felt that they did not have adequate reasonable adjustments in place. A third of disabled respondents felt support from their immediate line manager was lacking.

Action taken: *In March 2017, the Trust established a Disability Steering Group chaired by the Director of Finance. The group is currently engaging with disabled staff prior to developing and implementing an action plan. The 'Making It Right' also programme targets wellbeing of staff with a disability. The Trust continues to offer stress reduction workshops and monitors sickness absence monthly through the Performance Assurance Framework. The Time to Change (anti-mental health stigma) champions organise the Trust's mental health awareness day - Time to Talk.*

Objective 5: Take a more robust approach to making reasonable adjustments for disabled people – in particular implement the NHS Accessible Information Standard.

2,058 patient records specifically recording reasonable adjustments were established in 2016/17.

Action taken: *Our accessible information standard was launched in July 2016 and new patient data codes were created to capture service user data. The standard has been publicised widely and is promoted by local equality leads.*

Objective 6: Maintain the Top 100 Workplace Equality Index Employer (WEI) status with a ranking in the top five WEI health and social care providers by 2020

The Trust was ranked 122 out of 439 entrants in the 2017 Stonewall Workplace Equality Index (WEI). We remain in the top quartile of health and social care providers and are ranked 11 out of 48 health and social care providers this year, compared to position 13 in 2016.

Action taken: *In May 2016, the Trust established the Thames Valley LGBT employers good practice network with Reading University to spread good practice across the region. Work to produce clinical guidance for staff working with transgender service users and changes to the patient database to facilitate appropriate recording of transgender service user status was undertaken in 2017. This was launched with the post-card entitled 'Mr Ms Mx'. A task and finish group is in place to meet the requirements of the 2018 WEI Index. This focuses on LGBT career development, training, LGBT staff network activities, role modelling and leadership.*

Objective 7: Engage with diverse groups in particular BME, LGBT and disabled people to inform our understanding of their needs, with a view to ensuring good patient experience and equity of access in both mental and community health.

In spring 2016, our Equality Delivery System (EDS) panels awarded us an average of 100% Green (Achieving) for the EDS Goal 'Patient Access and Experience'.

Action taken: *Objective 7 is devolved to locality improvement plans and guided by the Equality Delivery System service priorities. In the West, a community engagement lead post was established to engage with local BME groups across the region, in particular to improve take up of primary and secondary mental health services. Such engagement is also part of an initiative to address the over-representation of people from a Black background in mental health inpatient services. In the East, the focus is on improving the patient experience of those with hearing impairments and improving transitions across services. The Trust's LGBT&Friends network continued to engage with the LGBT community – transgender speakers were invited to address the plenary at the Trust's equality conference.*

5. Recommendations

Board members are asked to consider:

5.1 A time-frame for peer review of Goal 4 of the Equality Delivery System in order to be fully compliant. It is proposed that this is incorporated in the Board Equality and Inclusion workshop planned for July 11th 2 2017.

5.2 Board assurance of equality impact assessment in relation to strategic planning to ensure that strategy is inclusive from the outset. This is also a potential action to be considered at the Board workshop.

5.4 Any additional action that may support the achievement of our equality objectives and reinforce our ethos of fairness as an employer.