Gloucestershire Care Services NHS

NHS Trust

Advancing Equality, Embracing Diversity

Gloucestershire Care Services NHS Trust's equality annual report

January 2015

Understanding You

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This report can also be supplied in alternative formats on request.
Please contact: Lucy Lea - 0300 421 8364 - lucy.lea@glos-care.nhs.uk

1. Executive Summary: How are we doing?

1.1 Introduction

1. Gloucestershire is a broadly affluent and healthy place to live. However, we have a higher proportion of older people (over 65s) in the county than the country as a whole, and this age group is growing. Our ageing population has implications for care and employment. We will see rises in people with mobility issues, long-term conditions, dementia, hearing loss, and sight loss.
2. Our overall image as an affluent and healthy county can hide the fact that some of our communities face significant health and social inequalities, including some wards which are amongst the 20% most deprived in the country.
3. Social isolation is also a factor we need to pay heed to, especially as we are a largely rural county with a sizeable population of older people.
4. These demographics have an impact on what services we provide and how we provide care. There are communities and people with distinct needs who we should pay particular regard to. In particular, we need to consider those who are less likely to access or use services (in spite of perhaps being in greater need for healthcare and information), such as our Black and Minority Ethnic (BME), Eastern European, Gypsy and Traveller, transgender communities and people with learning disabilities.

1.2 Advancing equality and embracing diversity among service users

1.2.1 The issues we face

5. The majority of our services are used by people who are vulnerable and/ or have ongoing health problems. The exceptions are our Minor Injury Units, our Public Health Nursing Services, Sexual Health Services and our Healthy Living Services, all of which tend to be used by a broader cross-section of the population.
6. In our Community Hospitals, Integrated Community Teams, and Adult Specialist Services, most of our service users are older (many over 80). As a result, they are more likely to have disabilities, long-term conditions, hearing and/ or sight loss and have a higher prevalence of dementia.
7. This presents challenges in providing safe, effective care. These service users are at higher risk of falls, pressure ulcers, urinary tract infections and healthcare-acquired infections.

1.2.2 What are we doing well?

8. We have taken determined action on a range of types of harm over the past year and this appears to be making a difference for service users. We can report award-winning work to reduce pressure ulcers, drops in the numbers of falls and low levels of incidents of abuse, violence and harassment amongst patients.
9. Dedicated programmes around learning disabilities, dementia, end-of-life care and hearing loss are resulting in Trust-wide improvements to the care of people with very particular needs. These are discussed more fully in the body of the report.
10. We find high levels of satisfaction with our services amongst people who use them: of 14,404 people we asked in the year to October 2014, 97% would recommend the service they had used to family and friends.
11. This year we are able to report on many examples of efforts to take services and information out to communities who do not usually access them, such as Gypsy and Traveller communities, Trans people and Homeless people.
12. Most of our specialist services are used to – and good at – recognising and accommodating different needs, and they demonstrate an inclusive and proactive approach.

1.2.2 Where could we improve?

13. Initiatives to take services and information out to vulnerable communities are heavily reliant on the energy and enterprise of a few individuals. We have found little evidence of targeted work with some of our newer and growing communities, such as Eastern European communities. We also have few signs of an organisational approach to outreach activity to communities who struggle to access our services, and this is a gap the Trust will be looking to address.
14. In some of our other services, service users and colleagues describe having to 'make do': we are not always responding effectively to people with mobility issues, hearing loss, sight loss and communication difficulties. This was particularly noted with regards to reception areas and telephone contact with service users.
15. Early analysis of survey responses from our service users suggest disabled people rate 'service at reception' lower than non-disabled people. A small number of our complaints relate to colleagues not having the skills or understanding to respond appropriately to people with specific conditions or needs.
16. It is hoped that new initiatives in the Trust, including our new Engagement Framework, the Listening into Action programme, and Leading for Quality Care programme will help us better understand and respond to needs that are not met by mainstream approaches.

1.3 Advancing equality and embracing diversity among colleagues

1.3.1 What we know about our workforce

17. Echoing trends in the NHS as a whole, our workforce has an older age profile and a higher proportion of women than the population as a whole.
18. We also have a higher proportion of 'White British' people working with us than in the population of Gloucestershire, so are not representative of the county on the basis of race.
19. We have a similar proportion of people with disabilities as the Gloucestershire population as a whole. Our sickness absence rate is slightly above that of other community trusts nationally, and we find that stress is the most prevalent cause of sickness absence.
20. Our 2013 staff survey results suggest that colleagues with disabilities do not enjoy the same access to training and development opportunities and that they are more likely to report bullying and harassment from colleagues and from service users.
21. Gender pay gap analysis suggests we have gender pay equality in our workforce when we compare the median hourly rates of all men and all women. However, we find the proportion of men increases in the higher pay bands, so there is a higher proportion of men amongst our senior managers than there are in the lower pay bands.
22. Our recruitment and leavers data suggests we are reinforcing the majority ethnic, age, and gender groups within our workforce through who we recruit and who leaves the Trust.
23. 2013 staff survey data suggests that our colleagues are slightly more likely to experience bullying, harassment, and abuse than staff in other community trusts.

1.3.2 What are we doing to address these challenges?

24. Over 2014, we have been undertaking work to improve colleagues' experiences of working with the Trust, and to improve their sense of belonging. Listening into Action and a range of leadership programmes are examples of this. However, we recognise that it takes time and considerable effort to create a change in culture, particularly in a large and dispersed organisation.
25. In early 2015 we will be launching a new Core Values Framework to ensure that all colleagues within the Trust are clear on the expected values and behaviours required of them.
26. In the next year, we need a concerted effort from our colleagues across the Trust to embed these approaches. We also need to look for additional ways to increase the ethnic, age and gender diversity of our workforce,

root out unacceptable behaviours and nurture an inclusive culture which is welcoming of difference.

1.4 Conclusions and next steps

27. Since our last report we have made considerable progress in cementing an 'equality and human rights'-based approach into the workings of the Trust, including publishing an Equality & Human Rights policy, agreeing equality objectives and an accompanying implementation plan, and developing a new approach to analysing the impact of our activities on quality and equality.
28. We anticipate that our new Quality & Equality Impact Assessment process will introduce a rigorous, intelligent approach to assessing how our activities will affect people who use (or should use) and deliver our services. The heart of this process is ensuring we have a thorough understanding of who will be affected by changes we make. We anticipate that the information included in this report will support this process. It should help ensure we make sound, evidence-based decisions and deliver high quality services for the benefit of all our service users, colleagues and communities, especially the more vulnerable and those whose needs are easily overlooked.
29. However, we recognise that we have gaps in our understanding of how well we are meeting service users' and colleagues' needs and expectations. In particular we are missing information to enable us to determine differences by 'protected characteristics', which would help us understand whether some groups have poorer access, outcomes and experiences than others. We recommend that there is concerted, organisation-wide action to improve our data quality and completion. This will become a priority when we implement the NHS Equality Delivery System (EDS2), which is likely to become a mandatory requirement under the 2015 NHS Standard Contract.
30. A focus on identifying and meeting different needs will be supported by our work to help colleagues recognise, understand and accommodate the needs of the people they come across in their day-to-day work. This includes our End-of-Life, learning disabilities, Asset Based Community Development, and hearing loss programmes and the embedding of our new Core Values Framework.

2. About Gloucestershire Care Services NHS Trust

Gloucestershire Care Services NHS Trust provides a comprehensive range of coordinated health and social care services across the county. These services are delivered in community hospitals and in local communities, and include children's services, health visitors, community nursing, physiotherapy services, specialist services, and adult social care services that are provided on behalf of Gloucestershire County Council.

To support the people of the county, the Trust employs more than 2,600 staff including nursing, medical and dental staff, allied healthcare professionals, as well as support services, administrative and clerical workers. The Trust also manages approximately 800 social workers and reablement workers from Gloucestershire County Council, who mostly work within the Trust's Integrated Community Teams.

Over the year 2013-14, we recorded 1,173,142 service user contacts across Gloucestershire.

Our services are described below.

2.1 Integrated Community Teams

The Trust's Integrated Community Teams bring together occupational therapists, social workers, physiotherapists, community nurses and reablement workers into single teams, who work closely with local GPs and provide care to service users at home or close to home. As such, these Integrated Community Teams help people to be in control of their choices, and to maintain their independence safely and appropriately. A number of the Integrated Community Teams also provide access to:

- A Rapid Response service, which operates in Gloucester, Cheltenham, and Tewkesbury, with wider coverage across the county planned for 2015. The service operates 24 hours a day, 7 days a week, in order to provide assessment in the home for people who require urgent care within an hour and therefore avoid the need for hospitalisation;
- A high intensity service which supports people who have been stabilised by the rapid response team, and which can then provide high levels of support and monitoring during a person's recovery.

2.2 Community Hospitals

The Trust manages seven community hospitals across the county, namely: Cirencester and Fairford Hospital; North Cotswolds Hospital; Stroud General Hospital; Vale Community Hospital, Dursley; Tewkesbury Community Hospital; Dilke Memorial Hospital; Lydney and District Hospital. The community hospitals provide the following services:

- Community inpatient rehabilitation and palliative care beds;
- Outpatient services including a varied range of nurse led and therapy services and clinics;
- Minor Injuries Units which can save people from unnecessarily attending Emergency Departments, and which can treat a range of less serious conditions and ailments such as sprains, minor burns, and simple fractures and wounds;
- Out of Hours GP services including Primary Care Centres;
- X-ray facility managed by Gloucestershire Hospitals NHS Foundation Trust.

2.3 Specialist Services

Our specialist services provide care in community clinics and in people's own homes. They support service users who are managing long-term or complex conditions such as diabetes, enable people to be discharged from hospital with appropriate support, offer rehabilitation services, and provide palliative care to those managing life-limiting conditions. Our teams also provide education and hands-on training to care homes.

A summary of our specialist services is provided below: however, for more comprehensive information, please visit our website at www.glos-care.nhs.uk.

a) **Specialist Nursing:** expert care for people needing support with, for example, bone health, heart failure, respiratory conditions, tissue viability, motor neurone disease, Parkinson's disease and homeless healthcare.
b) **Therapy Services:** services such as podiatry, occupational therapy, physiotherapy services, and speech and language therapy.
c) **Community Dental Services:** NHS dental care for people in Gloucestershire who are unable to access treatment from a general dental practitioner, include those with mobility issues or specific learning needs.
d) **Sexual Health Services:** free and confidential information to those looking for support and advice relating to sexual health, including issues regarding contraception and pregnancy, sexually transmitted infections, sexual assault, emergency contraception and routine testing such as chlamydia testing. Teams are also offer support and care to those either living with

Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) or anyone caring for or supporting someone who is affected.

e) **Independent Living Services:** help people be cared for in their own homes whilst providing vital links to community-based services such as GPs and hospitals. They offer advice on equipment to promote safety and reduce risk if mobility is an issue, and also provide telecare and wheelchair services.

2.4 Children and Young People Services

The Trust offers a full range of NHS health services specifically tailored towards the needs of children and young people, and provides a coordinated approach for children's health. The Trust also delivers the universal services of health visiting, school nursing and the neonatal hearing screening service.

Wider services available include home safety checks, and children specific occupational therapy, physiotherapy and speech and language therapy. We also have a specific service dedicated to children in care. The children's respite care team can additionally help children to be cared for in a familiar home environment where their illness is ongoing.

2.5 Support Services

These clinical and care services are supported by a range of corporate functions such as human resources, finance, performance, governance and risk management. Additionally, the service user experience team provides a key point of contact for service users, their families and carers.

3. About this report

The principal aim of this report is to demonstrate how we have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations across and within our services. These are our duties under s.149 of the Equality Act 2010. Under the Act, we must have particular regard to nine ‘protected characteristics’: age, disability, gender reassignment, pregnancy/maternity, marriage/ civil partnership, religion/belief, race, sex, and sexual orientation.

A further aim of this report is to share progress against the Equality Objectives we published in July 2014. We also want to shine a light on some of our work over 2014 that we believe advances equality and embraces diversity.

We are publishing different types of information:

- Figures and explanations of our overall performance, regarding both services we provide and our employees’ experiences. Where possible we look at how these differ by ‘protected characteristics’, to see whether some groups have better/ poorer access, outcomes or experiences;
- Figures and explanations which relate specifically to inequalities and potential discrimination or harassment;
- Views from service users, carers and members of our communities from surveys, workshops and engagement sessions;
- Descriptions of how we address inequalities and potential discrimination or harassment through specific services and initiatives.

3.1 A note about the data

One of our main challenges with producing and analysing data on our service delivery is that different services use different systems. We have fairly good data around the protected characteristics of age, race, and sex. However, our data on the other protected characteristics requires further development.

Improving service user equalities data is a priority for the organisation. Over the past year, we have been introducing a new patient data system (SystmOne) for most services. We anticipate that this should improve data collection and make analysis easier. However, we have found that some data on service user’s protected characteristics has not been transferred from old systems, including ethnicity. Unfortunately this means that we have gaps in our service user ethnicity data as colleagues have to manually re-enter this.

Our workforce data is fuller and broader. We have an Electronic Staff Record (ESR) for each individual who works for us. The ESR system lets us record age, disability, marital status, maternity or adoption leave, race, religion/ belief, sex and sexual orientation. We do not currently collect data on gender reassignment amongst our staff. For the purposes of this report, we have conducted anonymised analysis of our workforce based on the data we have relating to 'protected characteristics'. In some cases, numbers are so small that there is a danger that individuals could be identified. We do not report data in these cases. Where there are fewer than 10 individuals in a particular category, we have not included them in the data charts.

3.2 Reporting periods

You will notice different reporting periods in this report. We have published a year's worth of data where possible, for example in relation to some of our workforce data. This data generally picks up where the previous report left off, i.e. September 2013.

It has not been possible to publish a year's worth of service user data, as the way our reporting systems are set up – plus several changes to information systems – makes it hard to report across two financial years. Service user data in this report therefore runs from April 2014 to September 2014. We are considering moving to a reporting schedule which ties in with the financial year to enable us to report on a year's worth of data.

Where possible, we will compare and contrast findings in this report with those in the previous report.

3.3 Statistical significance

None of the data in this report has undergone statistical analysis to establish significance. As a result, trends we note are indicative, but we cannot say whether they are statistically significant. As far as possible, we use a range of data sources to understand an issue and to add robustness to the findings.

3.4 A note about terminology

In this report we have used the following terms to refer to different ethnic groups:

- 'White British' – People who describe themselves as white and British;
- 'White non-British' – People who describe themselves as white, but not British. This will include people who are Irish, members of Gypsy and

Traveller communities, and people from Eastern European countries. In this report we usually report on this group separately because their needs and experiences are often different from 'White British' people and from more 'visible' ethnic minority groups;

- 'Black/ Minority Ethnic' (or 'BME') – People who from a 'visible' minority ethnic background. This may include mixed/ multiple ethnic groups, Asian/Asian British, Black/ African/ Caribbean/ Black British, and people from other Ethnic Groups.

4. About the communities we serve

Generally speaking, Gloucestershire is a healthy and affluent place to live relative to England as a whole. However, there are significant health and social inequalities between different parts of the county. There are also differences in the profile of our population by age, disability, race, religion and sex both within the county and compared to the national profile. A fuller description of the 'equality' profile can be found on the internet via this link: http://www.maiden.gov.uk/InstantAtlas/Equalities/summary.pdf.

4.1 Age and gender

- **More older people** than England as a whole[1];
  - And our age profile is older in our more rural districts – proportions of people aged 65+ in Cotswolds (23.3%), Forest of Dean (21.7%), Tewkesbury (21.1%) and Stroud (20.4%) all exceed national and county averages (16.4% of people in England and 19.4% of people in Gloucestershire are aged 65+);
  - Though Gloucester has the highest representation of children and young people (25%) and exceeds the national and regional average;
- **Slightly more women** (51%) **than men** (49%), reflecting national averages[2]
  - Though there are more women in the upper age ranges, as women have a longer life expectancy than men, for example 66.8% of people aged 85+ are women.

4.2 Disability

- A **smaller proportion of disabled people** than the English average (16.7% people in Gloucestershire have a long term limiting illness or disability, compared with 17.6% in England);
  - Though the proportion of people with disabilities is higher in the Forest of Dean than national average, at 19.6%[3];
  - The proportion of people with long term limiting illness dramatically increases with age: nearly half (49%) of people aged 65+ report this;

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[1] ONS (2012) 2011 Census - Table PP04 2011 Census: Usual resident population by single year of age, unrounded estimates, local authorities in England and Wales.

[2] ONS (2012) 2011 Census - Table PP05 2011 Census: Male usual resident population by single year of age, unrounded estimates, local authorities in England and Wales. ONS (2012) 2011 Census - Table PP06 2011 Census: Female usual resident population by single year of age, unrounded estimates, local authorities in England and Wales.

[3] ONS (2012) 2011 Census - KS301EW Health and provision of unpaid care, local authorities in England and Wales.

- And there are an estimated 8,667 people aged 65+ living with dementia in Gloucestershire, with a quarter of these people being 85-89.

- 1 in 10 residents who provide unpaid care to a friend or relative, equivalent to the proportion of unpaid carers in England as a whole[4];
- 2012 estimates suggest that there are at least 11,079 adults in Gloucestershire with a learning disability, of whom 2,274 have a moderate or severe condition. Additionally, there are at least 1,491 children with a moderate learning disability, and 162 with a severe learning disability[5].

4.3 Family and relationships

- There are **fewer people who are single or separated** – but **more people who are married, divorced or widowed** – when compared to the national average.
- Gloucestershire has **largest numbers of live births amongst the 25-34 year old age group**[6], continuing the national trend of later motherhood. There are notable regional variations:
  - Forest of Dean has the highest proportion of births amongst mothers aged 20 or under and exceeds the county and national average.
  - Cotswold has a higher representation of births to mothers aged 35-39 and 40+ than Gloucestershire and the country as a whole.

4.4 Ethnicity, Religion and Belief

- In Gloucestershire, **nearly 92% of people are White British**[7]. Our Black/ Ethnic Minority populations are considerably smaller (4.6%) than the national average (14.6%).
  - Gloucester has the highest proportion of people from a Black or Ethnic Minority (10.9%). However this is still considerably lower than the national average.
  - Forest of Dean has the lowest proportion of people from a Black or Ethnic Minority (1.5%).
  - People from a ‘white non-British’ background are under-represented when compared to the national average, but have higher representation in Cheltenham compared to Gloucestershire and England as a whole.

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[4] ONS (2012) 2011 Census - KS301EW Health and provision of unpaid care, local authorities in England and Wales.
[5] ONS (2012) 2011 Census - Long-term health problems by ethnic group by sex by age.
[6] NHS Information Centre Indicator Portal (2011) Live Births.
[7] ONS (2012) 2011 Census - KS201EW Ethnic group, local authorities in England and Wales.

- There are, however, notable variations in the ethnic profile of different age groups in Gloucestershire:
  - 9% of children aged 0-4 are not ‘White British', compared with 1% of people over 80.
  - The greater proportions of White non-British people are in the 20-29 age group (6.6%) and the 30-39 age group (7%).
  - Figure 1 below shows this in greater detail.

- In Gloucestershire, we have a **higher proportion of people who are Christian, have no religion or have not stated a religion** than the national average[8]. In contrast it has a lower proportion of people who follow a religion other than Christianity, which reflects the ethnic composition of the county.

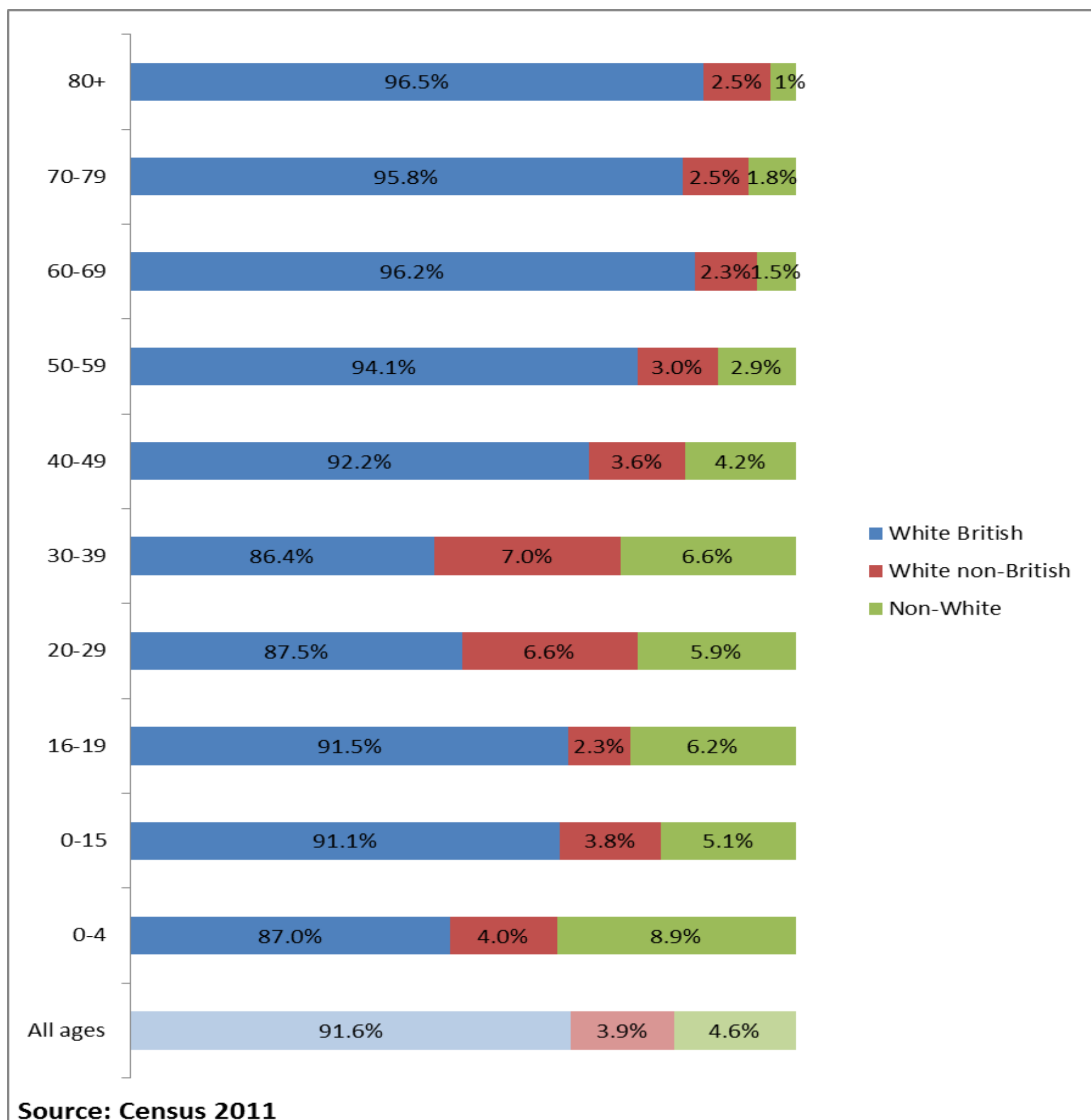

Figure 1: Ethnicity by Age in Gloucestershire

[8] ONS (2012) 2011 Census - KS209EW Religion, local authorities in England and Wales

4.5 Sexual Orientation & Gender Identity

There is no definitive data on sexual orientation or on gender identity at a local or national level, and we have no information to suggest that the profile by sexual orientation or gender identity is different to the national average. The best estimates of population figures at a national – and local – level are:

- Around 5-7% of the population aged 16+ are lesbian, gay or bisexual. This would mean somewhere between 24,500 and 34,300 people in Gloucestershire are lesbian, gay or bisexual[9];
- Between 0.6% and 1% of the UK's adult population experience gender variance to some degree, which would equate to between 2,900-4,700 people in Gloucestershire[10]. We know that Gloscats, the principal Transgender support network in Gloucestershire, has nearly 500 members.

4.6 Our vulnerable communities

Some of the communities we serve are more likely to experience social and health inequalities. This means they may find it harder – or be less likely – to use our services or they might have poorer health. They are also likely to find it harder to apply for and obtain jobs with us, or to remain in work with us if they do.

People on lower incomes, or those living in areas of deprivation, are more likely to experience poorer health and have lower life expectancy. Overall, levels of deprivation in Gloucestershire are significantly better than the national average. However, about 44,000 Gloucestershire residents (around 7% of the total population) live in areas that fall into the 20% most deprived in England.[11] These areas include Matson, Robinswood, Kingsholm and Wotton in Gloucester, and Hesters Way, St Pauls and St Marks in Cheltenham. Furthermore, about 14.7% (15,500) children in Gloucestershire live in poverty.

We also know that rural isolation can be a barrier to people accessing public services in Gloucestershire. Gloucestershire County Council has done some

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[9] Stonewall (2009) How many lesbian, gay and bisexual people are there?

[10] Gender Identity Research and Education Society (2011) The Number of Gender Variant People in the UK – Update 2011

[11] Understanding Gloucestershire 2013: A high level analysis of need in Gloucestershire, Gloucestershire County Council, December 2013. Based on Index of Multiple Deprivation (IMD) 2010.

analysis to identify communities at greatest risk of social isolation in the county[12]. They base this on people who:

- Are aged 65+ - retired
- Live alone
- Do not own a car
- Have a household income less than £20,000 a year
- Left formal education aged 18 or younger
- Do not use the internet
- Have experienced mental health difficulties – anxiety / depression
- Describe themselves as lonely with low levels of social contact

Analysis of households most vulnerable to social isolation shows that 7% of the total number of households in the County were likely to be the most vulnerable to isolation. The most vulnerable areas highlighted in the map below appear to be associated with the main urban centres and also the fringes of the more isolated market towns. There also appears to be a cluster of areas of moderate to higher vulnerability in the south west of Forest of Dean district and the north east of Cotswold district.

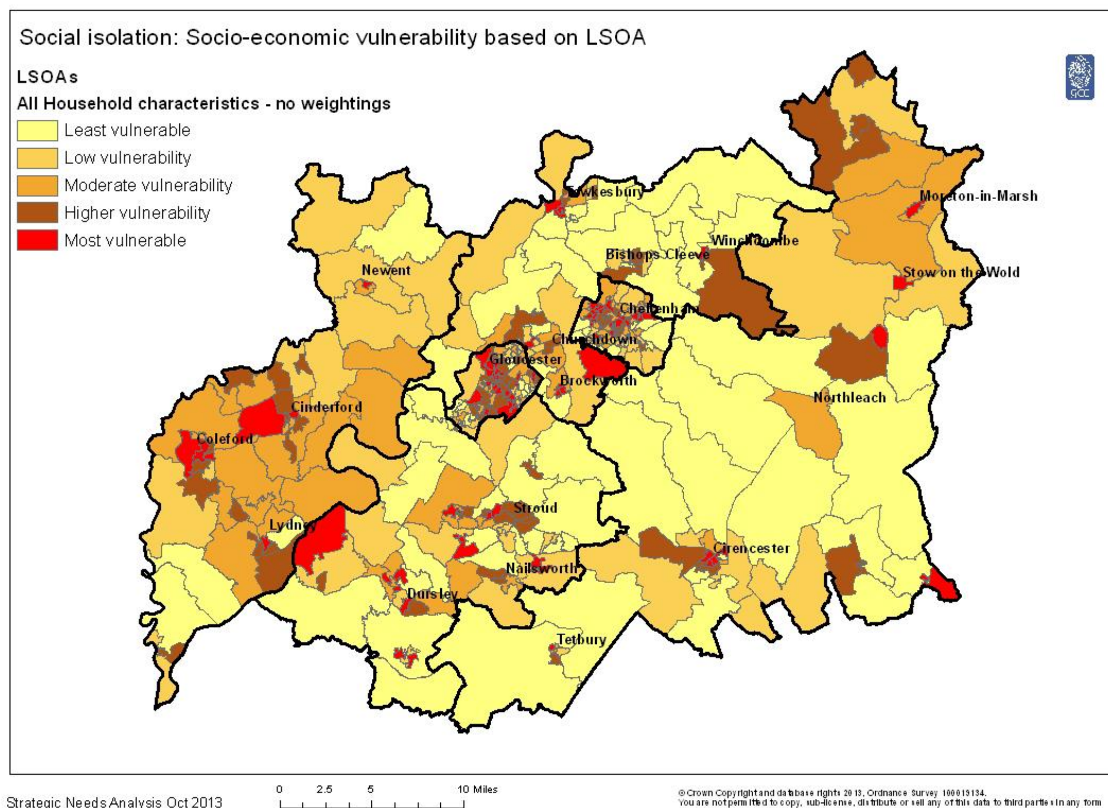

Figure 2: Vulnerability to social isolation in Gloucestershire

12 http://www.gloucestershire.gov.uk/inform/utilities/action/act_download.cfm?mediaid=61511

There is evidence to suggest that other groups who may be more prone to poor health outcomes include: the Gypsy and Traveller community, people with mental health issues, people with learning disabilities, people who are homeless and looked after children.

5. Advancing equality through our services

5.1 Introduction

In July 2014 Gloucestershire Care Services NHS Trust published its first Quality Account. The Quality Account seeks to demonstrate how the Trust is providing high quality care. Quality is defined as care that is safe, caring, effective, responsive and well-led.

Equality and quality are intricately linked: we can only say that our services are of high quality if we can show that they benefit all of our residents and communities. The following table shows the equality aspects of each of the five components of quality:

Quality components	Equality Aspects
Safe	• Preventing avoidable harm, with a particular focus on vulnerable people • Safeguarding vulnerable people/ groups • Protecting service users from abuse and harassment whilst in our care
Caring	• Understanding people's lives, needs and preferences and accommodating these wherever possible • Ensuring service users are treated with dignity and respect, and that we respect their privacy and autonomy • Tackling prejudice and reducing service users' fear that they may face prejudice whilst receiving care from us
Responsive	• Understanding people's lives, needs and preferences and accommodating these wherever possible • Ensuring waiting times are kept to a minimum, and those in greatest need are seen soonest (based on a holistic assessment of need) • Seamless care pathways and easy transitions • Providing opportunities for everyone to give us feedback on the services we provide • Responding as quickly as possible to concerns and complaints
Effective	• Ensuring our services are accessible and effective for everyone in Gloucestershire who needs them • Making the best use of our resources – and the skills and resources of others in the county – to provide the best care and support for people who need it • Reducing inequalities

Quality components	Equality Aspects
Well-led	• Ensuring decisions pay due regard to the needs of people who face inequalities, those who are vulnerable, and those who have extra or different needs • Ensuring that papers that come to Board and Committees identify equality-related impacts including risks, and say how these risks are to be managed • Fostering an inclusive culture and attitudes

In this section of the report, we will highlight findings from the Quality Account that show how we are advancing equality. You can find a copy of the 2013-14 Quality Account on our website or by contacting us[13]. We will also include further information and examples where appropriate.

5.2 Safe care for all

We know that some of our most vulnerable service users are at greater risk of certain types of harm. In particular, older people and people in poorer health are at greater risk of falls[14], pressure ulcers, urinary tract infections (UTIs) and healthcare acquired infections (HCAIs). These types of harm – especially avoidable pressure ulcers – can be an indicator of poor care.

Between 1st September 2013 and 31st August 2014, staff reported 3784 incidents in our care settings. These are categorised as follows:

Incident Type	Total incidents	% of total incidents
Personal Accident (Patient/Staff)	1379	36.4%
Clinical Incident	1051	27.8%
Estates, Staffing, Infrastructure, IT, Telecomms	379	10.0%
Security Incident	199	5.3%
Discharge, Transfer, Admission, Appointment	191	5.0%
Violence, Abuse or Harassment	191	5.0%
Communication	182	4.8%
Records, Information, Confidentiality	145	3.8%
Waste Environmental Incident	24	0.6%

[13] http://www.glos-care.nhs.uk/publications/what-are-our-priorities-and-what-are-we-doing or email contactus@glos-care.nhs.uk or call 0300 421 8100.

[14] Guidance on Falls Management issued by the National Institute for Health & Care Excellence (NICE) in June 2013 identified that people aged 65+ have the highest risk of falling, with 30% people aged 65+ and 50% people aged 80+ falling at least once a year.

Incident Type	Total incidents	% of total incidents
Vehicle Incident	23	0.6%
Fire Incident	19	0.5%
NHS 111 Incident	1	0.0%
Totals:	3784	

Figure 3: Incidents reported between 01/09/13 and 31/08/14 (Source: Datix)

Falls make up three quarters (75.3%) of all 'personal accidents' and account for over a quarter (27.5%) of all incidents reported in the year up to 1st September 2014.

Pressure ulcers make up nearly a fifth (18.6%) of all 'clinical incidents', accounting for 196 reported incidents in this period. This is a notable drop from the data presented in January 2014, when 42.7% of clinical incidents were down to pressure ulcers. This drop is partly down to a concerted effort to reduce the prevalence of pressure ulcers by improving the quality of care to our most vulnerable service users.

We have been putting considerable effort into reducing harm. In our Quality Account 2013-14, we shared some of the results of that effort:

- An 8% decrease in the number of service users who fall in community hospitals, which exceeded our in-year target;
- 89.6% service users assessed through the Safety Thermometer[15] were receiving harm-free care in 2013-14. This compared favourably with community Trusts nationwide which reported 89.1% harm-free care in the same period;
- A 17% reduction in acquired pressure ulcers;
- Innovations and Best Practice Award 2014 from the Community Hospitals Association (CHA) for outstanding work to improve the identification and early reporting of pressure ulcers.
- No cases of MRSA infection over the year. However, we did have 19 cases of C.difficile, which exceeded our tolerance of cases by 1 case.

Ties in with:
Equality Objective 1b: Reduce the number and severity of pressure ulcers amongst service users

[15] The NHS Safety Thermometer is a national tool that provides a way of us measuring and comparing our performance in four key areas of safety, namely falls, pressure ulcers, venous thromboembolism and urinary tract infections in service users with a catheter.

In the year up to 1st September 2014, there were 11 reported incidents of abuse, harassment, or violence directed at a patient. In a number of these cases the person responsible for the incident is thought to have dementia or cognitive impairment. In other cases, the context for the abuse, harassment or violence was conflict between family members.

Our approach to safeguarding is critical to ensure that the most vulnerable do not experience avoidable harm. Safeguarding is defined by the Care Quality Commission as the means to "protect people's health, wellbeing and human rights, and enable them to live free from harm, abuse and neglect". Those most in need of such protection are children, young people, and adults whose circumstances make them vulnerable. We are committed to a multi-agency approach to safeguarding, and are active in the Gloucestershire Adults and Children's Safeguarding Boards. In addition, over 2013-14 we placed emphasis on ensuring our colleagues received high quality training to give them the confidence to identify, report and manage safeguarding concerns. This work continues.

5.3 Caring services

Providing caring services entails treating people as individuals, with compassion, dignity and respect, while maintaining their rights to privacy and autonomy. Many of our service users are particularly vulnerable, and need us to take extra care or a different approach to make sure they feel well cared for.

Some examples of how we are striving to understand and meet different needs are included below.

5.3.1 Dementia care

The number of people living with dementia in Gloucestershire is rising: currently there are an estimated 8,500 people living locally with dementia. This figure is expected to increase by at least a further 2,000 people in the next 6 years alone. Similarly, over 70% of our county's hospital beds are already used by people with some degree of cognitive impairment, but this too will rise over time[16].

[16] Gloucestershire Care Services Quality Account 2013-14.

In our 2013-14 Quality Account, we reported on the work we have done to improve the care of people with dementia in our services:

- We supported and delivered dementia training to staff across the organisation. This included a training session with the Board. The quality of the training was rated highly, with positive feedback from participants.
- Our dementia link workers completed a nine month course, equipping them with the skills to raise the profile of dementia care, review environments and processes, and support service users and carers.
- Our recent refurbishment of the dental clinics at Redwood House, Stroud, created a dementia-friendly environment through, for example, colour contrast furnishings and fittings, as well as graphics-based signage.
- The refurbishment of wards at the Dilke Memorial Hospital also created a dementia-friendly environment including access control doors, a newly-laid out nurses' station with a seating area, colour contrast furnishings and fittings, and a reminiscence room to help encourage memories.

What's new?

The Trust has recently established a Dementia Best Practice Group. There has been a positive response to the setting up of this group and the first meeting took place in early November 2014. The meeting focused on lessons from the CQC 'Cracks in the Pathway' report published in 2014 and from the Dementia Friendly Environment work already undertaken in the Trust.

5.3.2 High quality care for people with learning disabilities

People with learning disabilities experience a range of health inequalities. For example:

- People with learning disabilities are 58 times more likely to die before the age of 50;
- Respiratory diseases affect 46-52% people with learning disabilities, compared to 15-17% of the general population;
- Epilepsy affects 22% people with learning disabilities, compared to 1% of the general population;
- Dementia affects 21.6% people with learning disabilities aged 65+, compared to 5.7% of the general population aged 65+.

We have a detailed action plan in place to improve our care of people with learning disabilities. Our achievements over 2013-14 include:

- 26% staff either completed a specially designed e-learning package or attended face-to-face training provided by the Learning Disabilities Training Team.

- 70 staff have now become champions for learning disabilities within their own areas of work.
- We hosted a multi-agency workshop in December 2013 in order to identify the range of actions that we need to undertake in order to offer a truly learning disability friendly service. The result of this workshop was the development of a robust quality implementation plan that seeks to:
  - Embed working partnerships countywide to ensure effective care across all health and social care pathways;
  - Establish a method to identify people with a learning disability on the Trust's main clinical IT system, so that staff can proactively recognise the need to make reasonable adjustments in their care delivery;
  - Introduce the systematic use of a reasonable adjustment tool within all clinical areas;
  - Update all relevant service user information leaflets into an easy-read format;
  - Further develop training opportunities across the Trust;
  - Facilitate improved service user and carer involvement.

Ties in with:
Equality Objective 1d: Respond effectively to gaps in the level of care provided to people with learning disabilities within Gloucestershire

5.3.3 End of life care

Providing high quality care at the end of someone's life is heavily reliant on understanding them as an individual – their culture, relationships, expectations, beliefs and preferences. This can be complicated by our reluctance to broach the subject of end-of-life: service users, their relatives and care givers can find it hard to know how to approach discussions in order to get a full understanding of someone's needs and preferences.

As set out in our Quality Account, over 2013-14 we made the following changes to improve experiences of end-of-life care:

- We worked collaboratively with all our partners across Gloucestershire to develop and implement a robust process to replace the Liverpool Care Pathway;
- We also worked with our partners to develop a complete care record which will better inform and measure coordinated care planning, service user and family involvement, and expression of care preferences;
- We provided extensive training, information events and other resources and support for staff in all settings, so as to facilitate best standards of

care. In particular, training sessions included information about spiritual and emotional care and support for service users, as well as their families and carers.

What's new?

The End of Life Best Practice Group had its first meeting in September 2014 where members spent the session identifying what was positive in respect of current care provision and what they felt needed improvement. The group has a wide variety of members from professions representing many of our care settings. The group welcomed the prospect of an external review of End of Life Care provided by Gloucestershire Care Services to be conducted by Dr Susi Lund, Nurse Consultant in End of Life Care. The group is in the process of developing an action plan based on this review.

Ties in with:

Equality Objective 1c: Improve patients' experiences of care in the last days of life.

Spotlight on: Compassion in end of life care on our wards

The team on Coln Ward in Cirencester was caring for a young man who was terminally ill and deteriorating rapidly. His last wish was to marry his partner, and Ward staff supported them to get engaged and married on the ward in a very short space of time to enable this to happen. The couple were surrounded by family and friends as they married on the Ward. Very sadly he died the next day, but with his final wish fulfilled.

The team were awarded the 'Compassion in Care' award in our 'Celebrating You' staff awards in June 2014.

"*Compliments and thanks to the Windrush Ward sister and all her staff for the care of our elderly, terminally ill mother prior to her death*"
Comment from relative of patient at Cirencester Hospital, Autumn 2013

5.3.4 ‘Understanding You’: training and awareness programme to promote understanding of different needs

The Trust is currently developing an innovative and engaging approach to raising awareness of the lives of people whose needs are not easily met by mainstream approaches. The aim of the programme is to share with our colleagues how different people and communities live their lives, and what that means for us when we provide care or work alongside them.

Our focus for 2014-15 is hearing loss. We are working in close partnership with the Gloucestershire Deaf Association to create a film-based piece of training which will replace our current mandatory refresher training on equality and diversity.

This is part of the ‘Listening into Action’ programme – a scheme to empower colleagues to work together to fast-track changes they want to see to improve the lives of service users and staff. The first training package is due to be launched in Spring 2015.

Ties in with:

Equality Objective 1f: Review settings, processes and communications materials to assess suitability for people with sensory loss. Focus for 2014-15 will be deaf people and people with hearing loss.

Equality Objective 4c: Introduce an annual equality & diversity training programme to promote better understanding amongst colleagues of the lives and needs of people who are different from the ‘mainstream’

5.3.5 Promoting dignity, respect, privacy and autonomy

Providing caring services means ensuring service users are treated with dignity and respect, and that we respect their privacy and autonomy.

In summer 2014, Patient Led Assessments of the Care Environment (PLACE) were undertaken in all seven Community Hospitals. We are pleased that our overall scores across the sites are above the national average, including for ‘Privacy, dignity and wellbeing’:

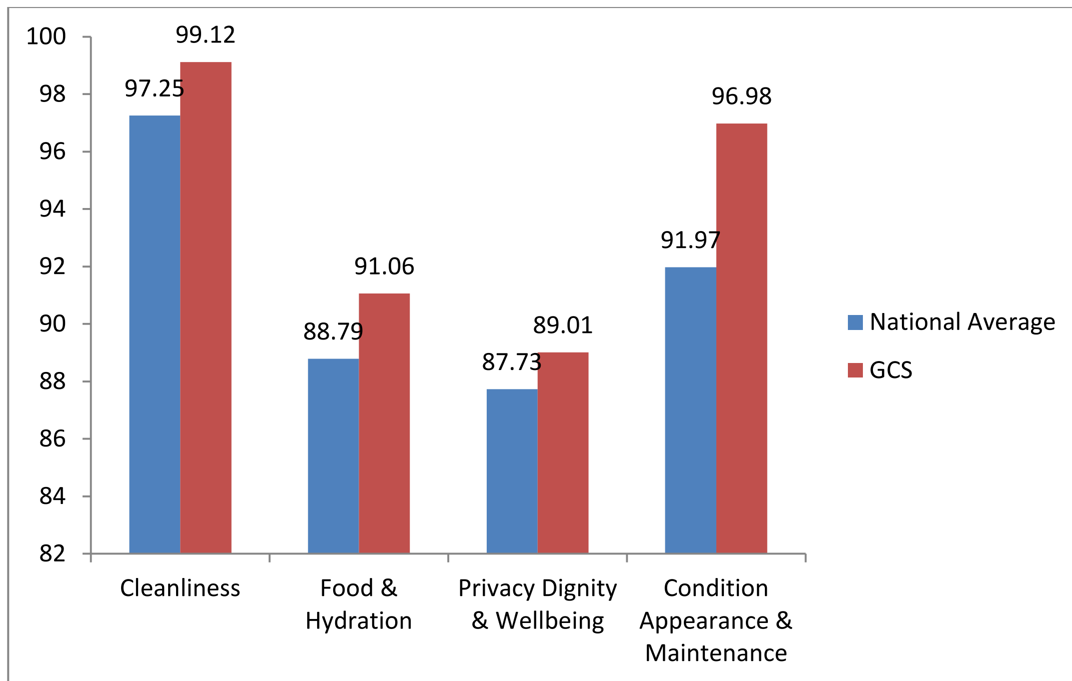

Figure 4: GCS PLACE scores compared with National Average, 2014

However, some sites fell just short of the national average on this factor, notably Lydney and the Dilke. For both sites, the 'Privacy, dignity and wellbeing' score was affected by the lack of separate treatment area for wound dressings which of course is not applicable for the new hospitals which all have single rooms.

We run surveys for all of our services to find out about service users' experiences. We have included more detailed information about the responses in Appendix D.

We ask our service users about the extent to which they feel they have been treated with dignity and respect. In all the surveys we ran across our services in the year up to September 2014, 99% rated our services as 'good' or 'excellent' at treating them with dignity and respect[17].

We have analysed a sample of 2817 of these responses by age (detailed data can be found at Appendix D). Our highest proportion of responses came from the over 75s age group (18.4% of respondents), and the lowest response rate was from 16-25s (9.2%), though there were still 259 respondents in this age group.

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[17] Patient surveys from all services, October 2013 – September 2014 (n=3087)

We have calculated a 'satisfaction' score for dignity and respect[18]. Out of a total possible score of 4, our services achieved an average score of 3.9 for all age groups. However, there are interesting variations between ages: generally, the satisfaction score increases with age – averaging 3.83 for people aged 16-24, rising to 3.93 for people aged 65-74, but then dipping to 3.86 for the 75+ age group.

This variation by age is also reflected in response to the survey question: "How likely are you to recommend this service to your family and friends if they needed care or treatment?" for all our services (Detailed data in Appendix D). The overall response amongst the 14,404 people answering this question is that 97% of respondents were extremely likely or likely to recommend services they had used.

Given that so few service users would not recommend our services, we calculated a 'likelihood to recommend' score for a sample of 3874 responses to this question to give an indication of any differences between age groups[19]. In this case, the average score given by service users was 4.83 out of 5. This shows a high level of satisfaction with our services overall. People aged 16-24 are least likely to recommend our services, with a score of 4.62 out of 5. Likelihood to recommend increases with age, and is greatest amongst people aged 55-64, where the score is 4.92 out of 5. Likelihood to recommend services dips to a score of 4.76 out of 5 for people aged 75+.

From this data, it is hard to explain the pattern of responses where satisfaction and likelihood to recommend increase with age, before dipping with people aged over 75. This is something we can explore further in 2015.

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[18] The score is calculated by attributing points to each of the values: 'Excellent' = 4 points, 'Good' = 3 points, 'Fair' = 2 points, 'Poor' = 1 point. We then calculate the total number of points for each value by multiplying the number of responses for each value by its equivalent number of points; for example 2566 people rate a service as 'Excellent', so 2566 x 4 points = 10,264 points. We repeat this for each of the values, then add all the points together, before dividing total number of points by the total number of responses. This gives us an average score out of 4.

[19] The score is calculated by attributing points to each of the values: 'Extremely likely' = 5 points, 'Likely' = 4 points, 'Neither Likely nor unlikely' = 3 points, 'Unlikely' = 2 points, 'Extremely unlikely' = 1 point. We then calculate the total number of points for each value by multiplying the number of responses for each value by its equivalent number of points; for example 2566 people rate a service as 'Extremely likely', so 3348 x 5 points = 16,740 points. We repeat this for each of the values, then add all the points together, before dividing total number of points by the total number of responses. This gives us an average score out of 5. PLEASE NOTE: THIS IS A DIFFERENT CALCULATION TO THE 'FRIENDS & FAMILY TEST' SCORE USED NATIONALLY.

Please note: Problems with data extraction mean analysis by ethnicity, disability and gender are not ready for this report, but we will commit to look at how responses vary (if at all).

"I was so worried about coming in today but you have been so kind and caring and taken all your time to explain procedures and health implications properly. Thank you"
Comment card received Summer 2014

"Most efficient, professional and compassionate service delivered in a very friendly and positive manner"
Comment card received Summer 2014

In the six months up until October 2014, we had no breaches of the 'same sex accommodation' standard. That is, all of our service users in in-patient beds in our community hospitals were cared for in wards that provided single sex sleeping accommodation and bathroom facilities for use by a single sex.

5.4 Responsive to a diversity of needs

5.4.1 Waiting times for services

Being responsive means keeping waiting times to a minimum, and seeing those greatest need soonest (based on a holistic assessment of need).

We have a large number of local and national targets relating to waiting times. You can find how we perform against these targets in Appendix C. By September 2014, we were meeting most of our 2014-15 targets for waiting times:

- All sexual health services exceeded waiting times targets;
- The vast majority of people using our Minor Injuries Units are seen, treated and discharged well within the expected time limits;
- The majority of children's services waiting times targets are being met;
- The majority of specialist services are meeting targets, with the exception of the Bone Health service.

Our Musculo-skeletal and Podiatry services are struggling to meet their waiting times targets this year. This is predominantly down to challenges we face with staffing. We require a high degree of specialism for our MSKAT service, which has recently been expanded. As a result, it can be difficult to find sufficiently qualified staff to provide the service, and we have moved some of our staff from 'core' podiatry and physiotherapy services to meet this need. However, pressures on 'core' services means that there is a shortage of sufficiently qualified staff to meet the need. We have a detailed action plan in place to help bring down waiting times.

Findings from our patient surveys over the year up to September 2014 show that 'waiting times' is the lowest scoring factor in patients' experiences (see Appendix D). However, it should be noted that 93% of patients still rate 'waiting times' as 'excellent' or 'good'.

5.4.2 Taking our services to communities who find it hard to access mainstream services

Some people and communities find it hard to access mainstream services. This may be because they do not know the services exist, because they struggle to get to them, or because they fear they will face prejudice and misunderstanding. In these cases, we believe that the best approach is usually to take our services and information to them, rather than expecting them to come to us. Building a trusting relationship is critical. In last year's equality report, we described the work of our Homeless Healthcare Team, who are based at the homeless shelter in Gloucester. In this year's report, we have included a couple of further examples of how we are doing this as 'Spotlights' below.

Spotlight on: Our work with Gypsy and Traveller Communities

One of the communities in Gloucestershire that struggles to use mainstream public services is the Gypsy and Traveller community. National data shows that this community experiences significant health inequalities, including substantially lower life expectancy, higher infant mortality and greater prevalence of long-term conditions. In the past year we have established links with several key members of the community, and have gained access to some of the larger traveller sites in Gloucestershire, taking 'healthy living' information to Traveller families. This work is continuing into 2015.

We also took the Gloucestershire 'Health Bus' to the Stow Fair – a major event for Gypsy and Traveller families from across the UK. Two of our Stop Smoking advisors attended, and we engaged people on a range of 'healthy living' topics such as smoking, alcohol awareness and healthy eating. We were met with a friendly and positive reception, and many of our visitors took our Easy Read materials away to share with friends and family.

Spotlight on: Our work with the Transgender Community

The Transgender (or 'Trans') community also experiences substantial prejudice, misunderstanding and health inequalities. Their fears of people's reactions may mean that they are less likely to use public services, and many Transgender people experience social isolation and mental ill-health. They also have some very different needs of health and social care services, for example in provision of intimate care and in sexual health advice and information.

Gloscats is a support and advice organisation in Gloucestershire, which represents the interests and provides practical and social support to people in the county who experience some degree of gender dysphoria. Over the past year, we have been involved several discussions between members of Gloscats and the public services around improving understanding and access in public services for Trans people.

We have also been working with the Trans community to improve their access to relevant and targeted information and support, on both healthy living and sexual health. In November 2014 one of our Healthy Living advisors attended a Gloscats meeting in order to share information and help attendees make healthy choices. From January 2015 we will be pulling together information sources for Trans people on sexual health, and looking at how we can make our Sexual Health Services feel welcoming and inclusive for Trans people and lesbian, gay and bisexual people.

Ties in with:
Equality Objective 1e: Develop targeted communications materials for communities with distinct communication and/or health needs (about our services and/or their health)

5.4.3 Responding to needs that are not met by mainstream approaches

Some people who use our services have extra or different needs that are not usually met through mainstream approaches. Examples include people with mobility issues, sensory impairments, and people who do not speak English/ speak English well.

We have a number of services that work almost exclusively with people who are vulnerable or have extra or different needs. Examples include some of our specialist services (who work with children and adults with long-term conditions, disabilities and challenging behaviour), our dental services (who see a lot of people who have learning disabilities, physical disabilities and dementia) and our independent living services. Our Integrated Community Teams are designed to wrap a tailored package of care around the individual, based on a holistic assessment of need. In a community event in October 2013, participants said they feel that our joined-up approach to providing holistic care is a real benefit[20].

However, we have anecdotal evidence that some of our services and functions find it harder to recognise, understand and respond to extra and different needs. In July 2014, we held a two-hour conversation with 24 colleagues on 30th July 2014. Participants were mostly reception and administrative staff who have patient/ service user contact (face-to-face and/or phone). Participants felt that our systems and processes do not always accommodate extra or different needs. Examples they gave included:

- Pressure at reception desk meaning that a patient with mobility issues had to stand and wait for receptionist to be free;
- There was no-one to guide patient with visual impairments to clinic;
- Patient with learning disabilities was not able to provide personal information (address and date of birth) when attending clinic without their key worker;
- Visually impaired patients relying on a carer/ relative to read letters;
- Deaf patients having to find carer/ relative to make phone calls for test results and appointments.

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[20] Your Care, Your Opinion event (29th October 2013).

Some colleagues felt that those who frequently did not attend appointments sometimes could not attend clinics due to disabilities or long-term conditions.

Receptionists and administrative staff also talked about communication difficulties, e.g. patients/ care home staff with strong accents or limited English, and hard-of-hearing patients. They say this can cause frustration on both sides.

Colleagues feel they are filling the gaps, and they find their own ways of trying to help, but admit these are not always effective/ right for the patient, e.g.

- Leaving desk/ phone unattended to walk patients to appointments;
- Finding porters/ other staff who speak other languages for last-minute translation;
  - Sometimes after appointments with consultants where service users have not understood what they've been told;
  - NB these staff said they found it hard to get emergency/ last minute interpreters, in spite of the Trust's translation and interpreting contract;
- Having to shout on the phone/ over the desk to patients who are hard of hearing.

Looking at our patient survey data, 'service at reception' scores lower than other factors we ask people about (see Appendix D). On average across all responses, it scores of 3.79 out of 4. Although this is still a relatively high score, when we look at a sample of these responses, people with disabilities are likely to give this factor a lower score[21].

What's new?

Our new approach to Quality and Equality Impact Assessments mean that each time we make changes to services, we explicitly consider how we will recognise and address the needs of people who will use this service. Colleagues are specifically directed to consider the implications of mobility, sensory impairments and communication needs.

Our 'Understanding you' campaign aims to provide colleagues with an in-depth understanding of people whose needs are not met by mainstream approaches and how they can best care for – and work alongside – these people.

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[21] NB these figures are indicative. We plan to carry out more analysis on our survey results by disability to gain a more robust understanding of the differences in experiences. You can find out more about how we calculate satisfaction scores on p.29.

Ties in with…
Equality Objective 4c: Introduce an annual equality & diversity training programme to promote better understanding amongst colleagues of the lives and needs of people who are different from the 'mainstream'
Equality Objective 1f: Review settings, processes and communications materials to assess suitability for people with sensory loss. Focus for 2014-15 will be deaf people and people with hearing loss

5.4.3 Inviting and responding to feedback on our services

A main focus for Trust colleagues and the Board continues to be listening to, and learning from, service users, carers and families. It is essential that we have robust processes to ensure that the public can easily contact us to share their views and experiences, and that we listen to and act on their feedback.

As well as running our patient surveys (see section 5.3.5: Promoting dignity, respect, privacy and autonomy), our Service Experience Team gathers, manages and analyses formal complaints, concerns and compliments about our services. The table below shows complaints, concerns and compliments we received between October 2013 and June 2014. It also shows our response rates to complaints:

Time period	Complaints	Concerns	Compliments	Complaints responded to within 25 days
Q3 (Oct-Dec) 2013	9	124	492	90%
Q4 (Jan – Mar) 2013	23	164	377	84%
Q1 (Apr – Jun) 2014	15	156	463	86%

Figure 5: Complaints, concerns and compliments Oct 2013 - June 2014

Because we receive few complaints, it can be hard to identify definite themes. However, there are some indicative themes when we look back at the complaints over the nine months. A number of complaints relate to quality of care. In the majority of these, the investigation finds that – while care may not have met a patient's or relative's expectations – it was up to the expected standard.

Communication is also a theme in complaints and concerns – either lack of compassion, or gaps in communication resulting in a poor transition between

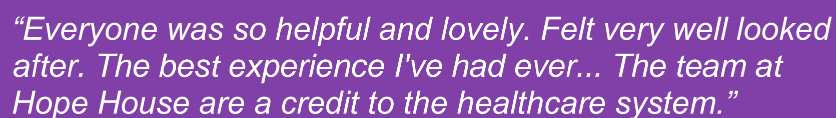
services/ care professionals or poorer quality care. In these cases, extra training and/ or supervision was put in place.

Three of these complaints over this period were found to be due to the care provider not having a sufficient appreciation of a specific condition (MS, Down's Syndrome, an unspecified learning disability). As a result, they did not necessarily provide appropriate care or communicate with the service user in the most effective way. In all cases, specific training was provided to enable our colleagues to provide effective, appropriate care for people with these conditions.

In two cases, service users complained that their privacy and dignity was not respected when they were weighed in public areas. In both cases, procedures have been changed, and there are now strict requirements that service users are weighed in private.

We respond to the vast majority of complaints within 25 days. Overall in 2013-14, we responded to 86% of complaints within this time period. Where we took longer than this, it was typically because a case was more complicated and/ or involved a wider number of people. During this period, we keep in close contact with complainants to keep them updated with progress.

The amount of compliments our colleagues receive vastly outweighs the number of complaints and concerns. The key themes in compliments we receive are the friendliness of our colleagues, their caring attitude, the efficiency and the high quality of care.



5.4.4 Engaging people in improving our services

We have recently published our new Engagement Framework. Its vision is:

"To engage and involve people from all backgrounds who are direct users of, or have an interest in, our services, in order to continuously improve the quality of care and treatment."

Currently as a Trust we have a number of methods to ensure that service users can shape our services and influence our decisions. These include:

- **Your Care Your Opinion Steering Group** – a forum with service users and representatives of local community organisations which encourages a dialogue, and identifies areas for joint working and for improvement;
- **Co-production with patients** – Service developments co-produced with service users, for example, work around multi-disciplinary teams in Stroud;
- **Patient stories at our Board meetings** – Service user stories are shared by a relevant clinician/team lead at the start of each Board meeting;
- **Site walkabouts** – The Trust non-Executive Directors and Chair conduct walkabouts across the whole organisation, as a result of which reports and action plans are developed and implemented;
- **Surveys and Friends and Family Test –** We currently collect feedback through annual surveys in each service, experience cards which are filled in upon discharge, and through the NHS Friends and Family test (FFT). We are moving to an integrated patient and service user experience measurement service run by CoMetrica, which will be rolled out across our services over the coming months. This system allows for real-time live reporting of feedback and results, which will enable us to continuously deliver service improvement. This new system will require minimum input from our staff, giving them more contact time with patients and service users.

What's new?

We are developing our engagement function in order to meet our engagement vision. We will be doing this in the following ways:

- **Consultations** with the public and colleagues to get feedback on ideas and changes to refine and improve proposals, and to identify possible alternatives for service delivery and/or improvement;
- **Reader's Panels:** Getting service users, families, carers and members of the public to review our information before it is printed;
- **Focus Groups** to explore issues in depth and to get qualitative information about service user and carer needs and views. For example, we are currently conducting focus groups on food and hydration amongst people who have used our services;
- **Staff engagement.** We are currently review how we involve our colleagues in developments and improvements. You can find out more about this in the 'Advancing equality in our workforce' section.

One or our core pledges published in our engagement framework is to: "Promote equality by ensuring we engage with people who represent the diverse communities we work within, and in particular make sure we are engaging effectively with those facing health inequalities."

An example of how we are doing this includes working with our BME communities to put on a targeted version of the exhibition we held for our Annual General Meeting. This will one way we are adapting the information we put out to meet the needs of specific communities.

Ties in with…
Equality Objective 3a: Publish a Communications & Engagement Strategy and implementation plan, which includes a systematic approach to involving external & internal stakeholders in decisions, including people with 'protected characteristics' and those in vulnerable groups

Equality Objective 1e: Develop targeted communications materials for communities with distinct communication and/or health needs (about our services and/or their health)

5.5 Effective for everyone

We strive to ensure that our services are accessible and effective for everyone in Gloucestershire who needs them.

Appendix B describes the profiles of people who used our services from April-September 2014 by their age, race and sex. When we compare this information with our county profile, it gives us an indication of how well the services are accessed by people from across our communities.

NB: it should be noted that this year we have gaps in our data around race: many of our services have changed the patient data system they use, moving over to SystmOne. When patient records were transferred to SystmOne, much of the patient data migrated automatically. However, ethnicity data was not transferred across. This means that our colleagues need to enter a service user's ethnicity manually from scratch. At the point of writing this report, not all patient records are complete. This is a priority for the organisation.

Ties in with:
Equality Objective 2a: Report biannually on the profile of users of all services provided by GCS NHST by age, gender, ethnicity and disability.

5.5.1 Who is using our services? Are they representative of the Gloucestershire population?

We provide a number of services where we would expect the users to be representative of our county population as a whole in terms of age, race and sex. These services include Health Visiting, Minor Injuries and Illnesses Units, our Musculo-Skeletal services (MSK) and Stop Smoking Services.

The profile of our service users for these universal services often reflects our communities. For example:

- We know the ethnicity of 5,466 people who used our **Health Visiting Services** between April and September 2014[22]. Of these, 16% were non-'White British', largely reflecting our the ethnic profile of under 5s in Gloucestershire (13% not 'White British'[23]);
- 91.3% of people using **Minor Injuries Units** were 'White British' (91.6% of the Gloucestershire population is 'White British');
- 90.3% of people using **Stop Smoking Services** were 'White British', and 63.7% were under 50.

With many of our services, we expect a more defined group of people to use them. This is because the need or the condition might be more common amongst certain ages (e.g. long-term conditions, dementia, falls, Parkinson's disease, mobility issues), ethnic groups (e.g. diabetes, HIV), or sex (e.g. osteoporosis/ bone health, contraception services).

For example, in this period, People over 80 years old make up 70% of our **community hospital** admissions and 62% of those seen by our **district nursing service**. As a result:

- More were female than male (as women have a longer life expectancy than men);
- More were 'White British' than in the Gloucestershire population as a whole (the proportion of people who are over 80 and 'White British' is higher than in the general population).

There is greater use of our **adult community services** by people aged over 65, and accordingly, larger proportions are 'White British' than in our population as a whole. This reflects the ethnic profile of this age group in

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[22] NB We do not know the ethnicity for 46% of people using the Health Visiting Service in this time period. We will be investigating the reason for this.
[23] Census 2011

Gloucestershire, where around 96% of people aged over 65 are 'White British'.

In most of these services, there are more women using them than men as there are more older women than older men in our population (55% of Gloucestershire residents aged over 65 are female). Analysis of our data shows greater demand on some services by one or other of the sexes:

- 72% of adults using our Speech and Language Therapy were over 65. However, only 51% of people using the service were female, suggesting there is a greater need amongst men.
- Everyone who used our **Bone Health service** was over 65, and 55% were over 80;
  - Most (85%) were female, largely because women are more likely to experience problems with their bones (osteoporosis) than men;
- 89% of people seeing our **Parkinson's Disease Nurses** were over 65, but more men used the service than women (53% were male);
- 61.5% of people using the physiotherapy service were male. This is similar to last year's usage, although there is a more even spread of ages using this service.

People using our sexual health services are quite different in make-up from our county population in terms of age, sex and race:

- They tend to be younger – over half of people using our contraception services are 25 or under;
  - Though our HIV service users have a slightly older age profile, and include more in the 50-64 age group;
- More women than men use our contraception services and psychosexual services – around 7 in 10 people using these services are female;
- Two thirds of people using our HIV services are male. This echoes national trends where 72% of new HIV diagnoses were male in 2012[24];
- Greater proportions of people who are not 'White British' use our sexual health services than make up our county population:
  - 26.6% come from BME groups (compared to 4.6% of the Gloucestershire population);
  - 13.6% come from White non-British groups (compared to 3.8% of the Gloucestershire population);
  - 38% of people newly diagnosed with HIV in 2011 were from BME groups[21].

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[24] Public Health England, Annual New HIV Diagnoses in UK

There are also indications in the data that our **Minor Injuries and Illnesses Units** (MIUs) we are reaching more communities who historically have found it harder to access healthcare. For example:

- Nearly one in four people using our MIUs are under 25 (39.5%). Only a fifth of people in Gloucestershire are under 25;
- More men than women use our **Minor Injuries and Illnesses Units** (54% men vs. 46% women);

However, echoing findings in last year's report, there are some notable differences by sex amongst children using some of our paediatric services:

- **Health Visitors'** patients are more likely to be recorded as female than male (70% female). This is because our information sometimes includes the parent/ carer's sex as well as the child's. Our health visitors predominantly have contact with the mother or a female carer;
- **Paediatric Occupational Therapy** patients are more likely to be male (66%). Studies demonstrate that there is a higher incidence of developmental co-ordination amongst boys than girls.
- **Paediatric Speech & Language Therapy** patients are more likely to be male (70%). Research into linguistics and speech disorders show that boys are more susceptible than girls.

Currently we do not have readily available information on our service users' disability status, gender identity, religion/ belief or sexual orientation. We will consider how to fill these gaps as part of our focus on data improvement in 2015.

5.5.2 Translation and interpreting – are we responding to demand?

According to the 2011 Census, 96.7% of Gloucestershire residents speak English as their main language, compared with 92% across England as a whole.[25]

Between April and September 2014, we commissioned 498.3 hours of face-to-face interpretation on behalf of people using our services. This compares with 294.3 hours of face-to-face interpretation in the same period last year. The main languages requested were Czech (120 hours), Polish (102.5 hours) and Slovak (53 hours). A more detailed chart showing interpreting activity across different languages can be found at Appendix E.

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[25] 2011 Census: Main language (detailed), local authorities in England and Wales

What's new?

In 2015 we will be re-tendering our Translation & Interpreting Services. During this process we will review the needs and preferences of our local communities and explore what changes we need to make to ensure the service is effective and responsive for service users and colleagues.

5.5.3 Making the most of community resources to benefit our service users

We recognise that – in order to be effective for everyone – we need to make the best use of people, expertise and knowledge beyond the boundaries of the Trust.

An aspect of this is sometimes called 'Asset Based Community Development' or ABCD. It as an approach which recognises that communities themselves often have the knowledge and resources to make lasting and effective changes, including in their health. It also encourages public sector (and other organisations) to direct people using their services to support available in their communities.

An example of this is the work we are doing with the Gloucestershire Deaf Association. We recognise their wealth of experience and expertise in meeting the needs of deaf and hard-of-hearing people, and are working with them to review our training and our interactions with service users. This will help our colleagues signpost support to hard-of-hearing service users they come into contact with. This will benefit those service users in their interactions with us, wider public services, and in life in general.

We are also training our staff in ABCD and developing toolkits for them to look to community resources to enable them to achieve better outcomes for their staff.

Ties in with:

Equality Objective 4b: Ensure staff work within a culture which is designed to routinely connect or re-connect communities & individuals to the resources and assets within their community as part of a person- and family- centred approach to care

5.6 Well-led – embedding equality principles and an inclusive culture

Our senior management team plays an important role in promoting an inclusive culture and ensuring our activities further equality. One of their key roles is to ensure that the Trust's decisions pay due regard to the needs of people who face inequalities, those who have extra/ different needs, and those who are vulnerable.

Over the past months, we have developed a new combined approach to gauging the impact of our activities on both quality and equality. The aims of this revised approach are to:

1. Provide increased visible assurance to the Trust Board and Committees that we have considered the impact of service change decisions on quality, equality and human rights;
2. Provide a robust assessment framework that moves away from a computer-based tick-box process and towards a more open, collaborative approach, that can be embedded within the Transformation and Change Team's own business case and programme management processes, but can also be used with Business as Usual change activity;
3. Bring a stronger focus to understanding who will be affected by changes to services and functions (both service users and colleagues), evidenced by profiles of the affected populations. This is fundamental to understanding how they will be affected, and how we may then need to adapt what we're doing to enable people to use and benefit from our services/functions;
4. Ensure that our impact assessment process is flexible enough to allow a level of analysis that is proportionate to the scale and impact of the change.

Ties in with…
Equality Objective 2b: Have a single equality and quality impact assessment process for policies, plans and strategies, with robust arrangements for scrutiny and accountability.

Other developments in the past year to support our Board and Committee members in their role in scrutinising decisions include:

- A Board development session in April entitled 'Small Group: Big Impact: How to manage minority needs in times of financial constraint'; and
- As a result of discussions in this session – changes made to all papers coming to Board and Committees to identify equality-related impacts.

Our Organisational Development Strategy sets out our aim to create "a supportive working culture, in which all Trust colleagues feel respected and valued, and which allows them to be productive, innovative and focused". To

support this aim, The Trust has developed a Core Values Framework to ensure that all colleagues within the organisation are clear on the expected values and behaviours that are required of them. The Core Values Framework will be embedded within induction, recruitment, appraisal and training, in order to achieve the culture described within our Organisational Development Strategy.

Ties in with:
Equality Objective 4a: Publish an Organisational Development Strategy and implementation plan, which includes plans to nurture a caring and open culture amongst our workforce.

6. Advancing equality in our Workforce

6.1 Introduction

Our aims with regards to equality and diversity in our workforce are that – regardless of personal characteristics, circumstances and background – everyone who works with us (or who may in the future):

- Is part of a **diverse workforce** where people are able to learn from each other and work together to respond creatively to the diverse challenges we face;
- Feels comfortable and content in the workplace, in **an environment free from discrimination and harassment**;
- Has the **opportunity to thrive and contribute**. There is equality of opportunity to progress at work and to access employment and development opportunities.

6.2 Diverse workforce

As at 1st September 2014, we employed 2674 staff, excluding bank staff. Below we describe the make-up of our staff by characteristics protected under the Equality Act 2010.

6.2.1 Staff profile by age

By age, our staff profile is older than the county profile. Most of our colleagues (61%) are aged between 40-59 years. In comparison, just over a third (35.7%) of working age people in Gloucestershire fall in this age range. Whereas a fifth (20.3%) of working age people in Gloucestershire are aged 17-29, only a tenth (10.2%) of our colleagues are in this age bracket. This is reflective of the ageing profile of the NHS as a whole.

However, our age profile has changed over the past year, with increases in the younger age groups. The chart below shows the proportions of colleagues in the different age bands in September 2014 compared to October 2013 and the county population.

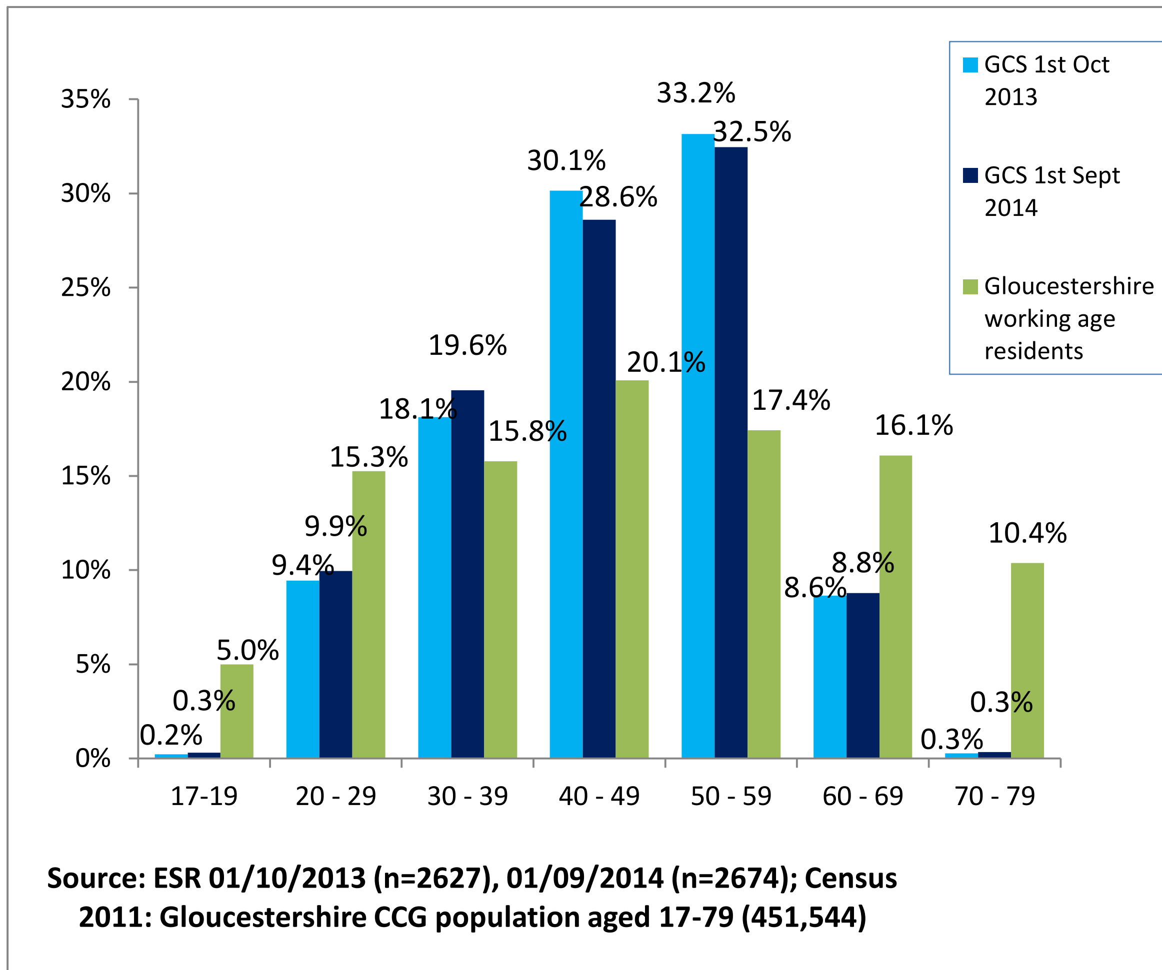

Figure 6: Age profile of staff September 2014 and October 2013 compared to working age adults in Gloucestershire

6.2.2 Staff profile by disability

17% of colleagues declared a long-standing illness, health problem or disability in our anonymous 2013 staff survey. This is comparable with other community trusts and with the Gloucestershire population as a whole, where 16.7% of people in Gloucestershire have a limiting long-term illness or disability.

As at 1st September 2014, 1.4% of colleagues are listed on our Electronic Staff Record (ESR) as having a disability, and 56.7% have no disability. However, based on ESR we do not know the disability status for 41.9% of our colleagues. By comparison, in our staff survey, less than 1% colleagues declined to declare their disability status. High rates of non-disclosure may because colleagues have actively declined to share their disability status with us, because colleagues have become disabled in the course of their

employment with us, or because the information was not initially recorded on legacy systems.

The low numbers of people listed on ESR as having a disability means we cannot conduct detailed analysis on the effect of colleagues' disability status on employment activities (such as training and performance management).

Our staff absence data shows that between 1st September 2013 and 31st August 2014, our sickness absence rate was 4.59%. This is slightly higher than other community trusts[26]. There are some notable differences based on occupation, age, and ethnicity. The table below demonstrates the differences based on occupational group and ethnicity (green indicates lower than average and orange indicates higher than average sickness absence rates):

Group	% Sickness absence rates
All staff	4.59
BME staff	3.41
Unregistered nursing staff	6.20
Registered nursing staff	4.49
Medical & Dental staff	5.48
Ancillary staff	5.85
Allied health professionals	3.20

Table 1: Differences in % Sickness absence in the year up to 1st Sept 2014

Generally speaking, staff in the youngest and oldest age bands are likely to have higher sickness absence rates. Staff aged 20-29 have the lowest sickness absence rates:

[26] On average, other community trusts experienced sickness absence rates of between 4.23% to 4.76% from September 2013 to June 2014 (July and August data was not available at the time of writing this report) Source: Health and Social Care Information Centre

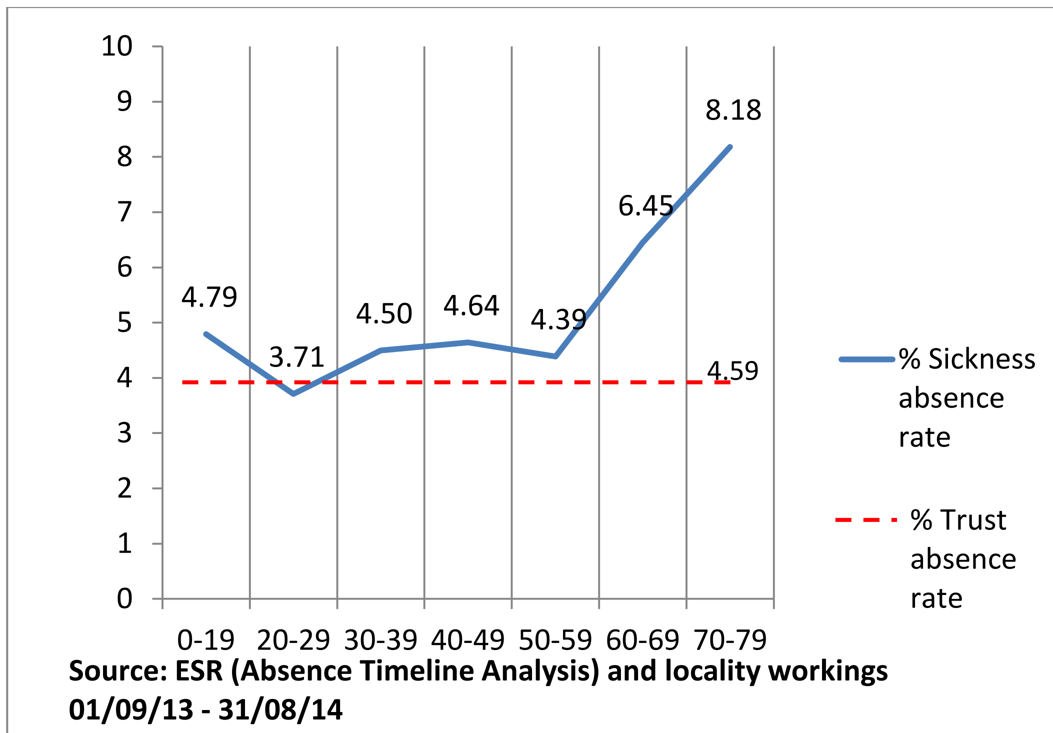

Figure 7: Sickness absence rates by age

From our staff absence data, we know that stress is the most common reason for staff being on sickness absence.

What are we doing about it?

The HR Department has been working closely with line managers in supporting them to manage individual long term sickness cases and progress has been made in this area. However, a recent review has identified that short term sickness management needs to be a priority for the Trust and action is being taken to ensure that managers are able to support staff but take action where absence is identified in excess of the Trusts agreed 'triggers'. HR Advisors are conducting sickness absence management workshops and feedback received to date has been extremely supportive of these sessions.

A detailed action plan has been developed which identifies a number of key actions that will be completed to ensure that sickness absence rates see a step change over the next 6-12 months. Further actions include:

- The development of a healthy workforce plan
- Further roll out of the Lighten up programme
- A review of the occupational health service and employee assistance programme
- A review of the Stress Management Policy and guidance supported by workshops for managers

6.2.3 Staff profile by gender reassignment

We do not ask colleagues or potential colleagues about their gender identity and whether their current gender is different from their sex at birth. We know that many people who experience gender dysphoria (or who live their lives in a different gender to their sex at birth) prefer to keep this to themselves.

Based on information collected by GIRES[27], 1% of people experience gender non-conformity to some degree. This would equate to around 27 of our colleagues.

GIRES recommend that organisations monitor gender identity and gender non-conformity, but only when they have established that they have a culture that supports transgender people and is free from potential discrimination. They recommend that organisations conduct attitude surveys towards gender non-conformity before monitoring. Further information on this can be found on the internet via this link:
http://www.gires.org.uk/assets/Workplace/Monitoring.pdf.

6.2.4 Staff profile by marital status

62.3% of our colleagues are married and 0.1% in a civil partnership. A quarter are not married or in a civil partnership. We do not know the marital status of 12% of our colleagues, either because they have chosen not to declare this, or because they have not been asked. There is very little change in these figures since 1st October 2013.

6.2.5 Staff profile by pregnancy/ maternity

As at 1st September 2014, 61 of our colleagues (2.1%) were on pregnancy or maternity leave. There is very little change in these figures since 1st October 2013.

6.2.6 Staff profile by race

As at 1st September 2014, nearly 95% of our colleagues describe themselves as ‘White British’, 3% are from BME groups, and 2% are ‘White non-British’. There have been small changes in the ethnic diversity of our workforce since 1st October 2013, with minor increases in the numbers and proportions of colleagues who are White but not British and who come from BME backgrounds.

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[27] The Gender Identity Research and Education Society

This chart shows the ethnic profile of our colleagues in 2013 and 2014 compared to that of working age residents in Gloucestershire as a whole:

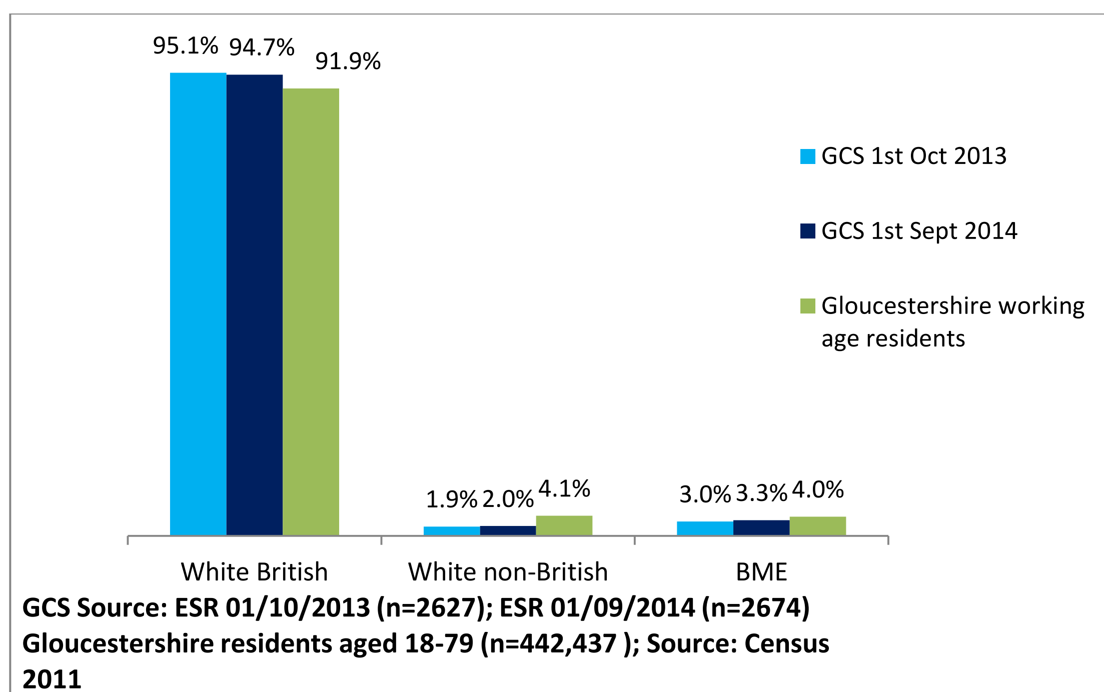

Figure 8: Ethnicity profile of staff in 2013 and 2014 compared with County profile

We are conscious that our staff profile does not fully reflect the county profile in terms of race. This follows a pattern in community trusts nationally, where 89% describe themselves as 'White British'[28], compared to 81% of the population of England[29].

There are a number of possible reasons for this:

- Our staff profile is older. A third of our workforce is aged 50-59. 94% of this age group county wide is 'White British'.
- The vast majority of our jobs require occupational registrations and/ or qualifications (or relevant equivalents). People who were born outside the UK are less likely to have the relevant occupational registrations and qualifications required of many of our posts.
- We require a high level of spoken English from our front-line staff (as per national requirements), as communication is a vital component of our work. This may exclude some people.

[28] NHS Staff Survey 2013
[29] Census 2011

Nonetheless, the figures on the race profile of our successful job applicants (see section 6.4.2) suggest that further analysis and work is needed to understand and address the mismatch in our staff profile compared to the county profile.

6.2.7 Staff profile by Religion/ Belief

The breakdown of colleagues' religion/ beliefs is as follows:

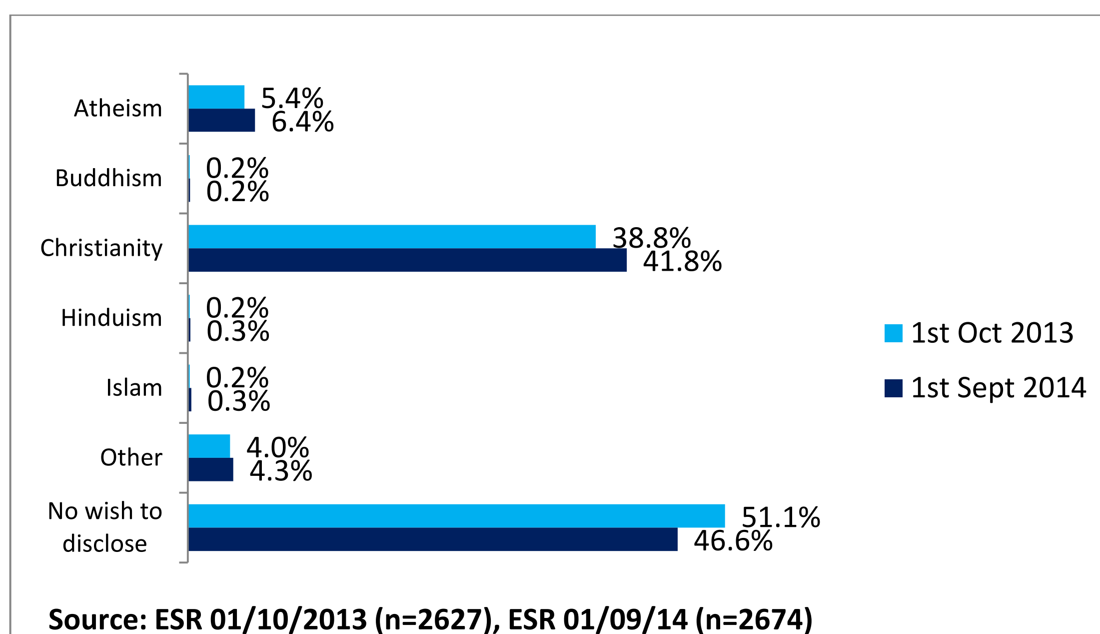

Figure 9: Religion/ Belief profile of staff in 2013 and 2014

Nearly half of our colleagues have chosen not to disclose their religion/ belief on ESR, though our disclosure rates are increasing. Of those who have disclosed their religion/ belief, the majority are Christian (42%). 62% of respondents to our latest staff survey (n=437) identified themselves as Christian. This is comparable with other NHS community trusts (63%[30]) and Gloucestershire as a whole (63.5%[31]).

6.2.8 Staff profile by sex

91.2% of our colleagues are female and 8.8% are male. Historically, caring professions have been more likely to attract women than men, and this is demonstrated in the NHS as a whole, where 78% of staff are female[32]. In community trusts as a whole, 89% of the workforce is female[33].

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[30] National NHS Staff Survey 2013
[31] Census 2011.
[32] National NHS Staff Survey 2013
[33] National NHS Staff Survey 2013

6.2.9 Staff profile by sexual orientation

55.6% of colleagues listed on ESR have declared themselves as heterosexual/ straight. However, nearly half have not disclosed their sexual orientation.

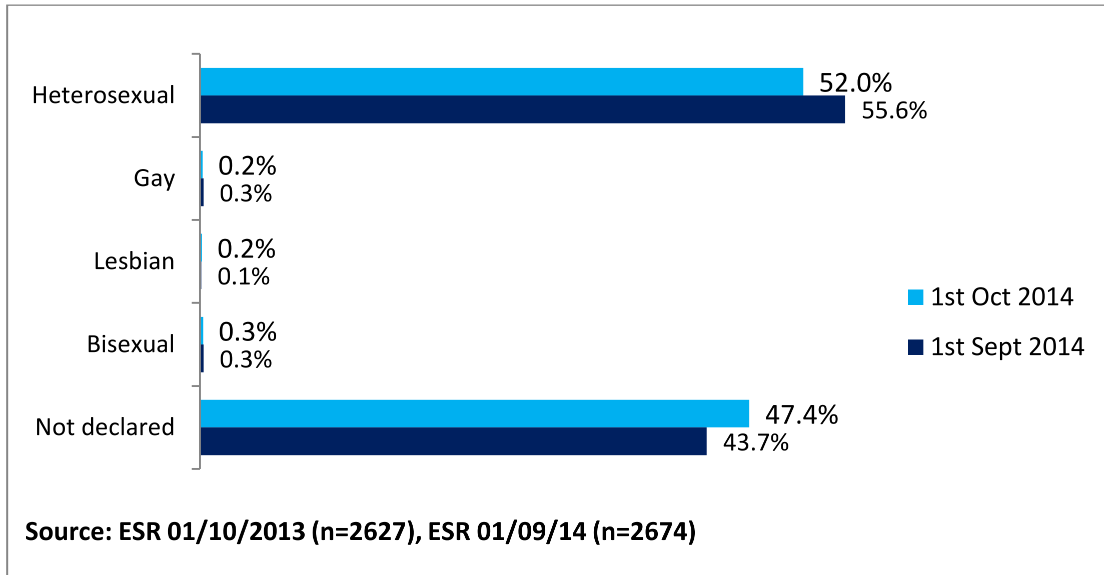


Figure 10: Staff profile by sexual orientation Oct 2013

In our latest (anonymous) staff survey in 2013 (n=437), 93% said they were heterosexual, 1% said they were a gay woman/ lesbian and 5% did not wish to say.

6.2.10 Improving disclosure rates

There are a number of possible explanations for why so few of our colleagues have disclosed their sexual orientation, religious belief and disability status. Firstly, many of our colleagues have been with the organisation – and predecessor organisations – for many years. It is possible that their characteristics were not captured at the point when they were recruited. Secondly, it is possible that colleagues do not understand why it is important for us to collect information they might regard as 'personal'. Thirdly, colleagues may be unwilling to disclose this information because they have concerns that the data will not be stored securely, or that they may face prejudice if they share it with others.

What's new?

Our 2014 figures show slight increases in the proportions of staff who have shared their religion/ belief, sexual orientation and disability status compared with our 2013 data. However, we need to dramatically improve disclosure rates if we want to do meaningful analysis to understand whether colleagues face disadvantages because of their personal characteristics (e.g. in access to training, promotion, and in regards to grievance and disciplinary action). In 2015 we plan to undertake a data validation exercise amongst all our staff, asking them to check and update the information we hold about them on the Electronic Staff Record.

6.3 An environment free from discrimination and harassment

6.3.1 Equality & Diversity Training

We strive to provide an environment free from discrimination and harassment for all our colleagues. All colleagues are required to complete Equality, Diversity and Human Rights training. The course aims to challenge prejudice, and help colleagues understand the value of diversity and how to challenge discrimination. 66% of our colleagues are listed on our training system as being up-to-date with their equality and diversity training. Our most recent staff survey shows us that 42% of colleagues said they had received equality and diversity training in the last 12 months, compared to a national average of 67% in other community Trusts[34]. There are a couple of reasons for this disparity. Firstly, we currently require colleagues to complete equality and diversity training once every three years. Secondly, we have a number of other training courses that advance equality and promote diversity by focusing on vulnerable people and people who face health inequalities, such as dementia awareness, learning disabilities training, and safeguarding training. However, we believe that colleagues do not recognise this as 'equality and diversity' training when they are answering the staff survey.

What's new?

From Spring 2015 colleagues will complete annual equality training updates (instead of once every three years). We are also radically changing the style and approach of the training: the new programme will be an engaging and practical look at the lives of people whose needs are different from the

[34] NHS Staff Survey 2013

mainstream. The voice of service users will be at the heart of the training, which will be designed in collaboration with local community groups.

The 2015 training will focus on hearing loss. We are working closely with the Gloucestershire Deaf Association to develop a creative, touching and pragmatic piece of training. Its aim is to give colleagues an insight into the lives of people with hearing loss and to provide practical guidance on what they can do to support them when providing care and in the workplace. The training will be available on our intranet to can be completed individually, or as a group, for example in team meetings.

Ties in with:
Equality Objective 4c: Introduce an annual equality & diversity training programme to promote better understanding amongst colleagues of the lives and needs of people who are different from the 'mainstream'
Equality Objective 1f: Review settings, processes and communications materials to assess suitability for people with sensory loss. Focus for 2014-15 will be deaf people and people with hearing loss

6.3.2 Discrimination, bullying and harassment?

To understand how well we are providing an environment free from discrimination and harassment, we look at staff survey data and reported incidents of bullying and harassment. We can look at breakdowns of these findings by age, sex and disability. Unfortunately, the numbers of BME colleagues answering the survey are too small to enable subgroup analysis on the basis of ethnicity. We can also look at information on how much our colleagues are paid, and see whether there appear to be any discrepancies based on colleagues' age, sex or race.

Our staff survey conducted in November 2013 asked colleagues about equal opportunities and discrimination. On the whole, our colleagues feel we are a fair employer:

- 91% believe the Trust provides **equal opportunities** for career progression or promotion (equivalent to community trusts nationwide);
- 8% had experienced **discrimination** at work in the past 12 months (equivalent to community trusts nationwide).

The survey also asked about their experiences of physical violence, harassment, bullying or abuse over the past 12 months. We found that:

- 13% had experienced **physical violence** from patients, relatives or the public, compared to 9% of staff in community trusts nationally;
  - And 30% of nurses and 38% of healthcare assistants had experienced physical violence.
- A third (33%) had experienced **harassment, bullying or abuse** from patients, relatives or the public;
  - Compared with a quarter (26%) of staff in community trusts nationwide;
  - And half (50%) of staff with disabilities had experienced harassment, bullying or abuse, compared with 31% of non-disabled colleagues.
- 22% had experienced **harassment, bullying or abuse** from staff, compared to 20% of staff in community trusts nationally;
  - This rises to 35% of colleagues with disabilities, compared to 19% without disabilities.

Between 1st September 2013 and 31st August 2014, colleagues reported 191 incidents of violence, harassment or abuse by patients or visitors in the Trust. Staff were affected in 180 of these incidents. The incidents were categorised as follows:

Verbal/written abuse	103
Actual Physical Assault	49
Threat of physical violence	23
Sexual harassment	3
Racial harassment	2
Grand Total	**180**

Table 2: Reported incidents of violence, harassment or abuse against staff (Source: Datix, 01/09/13 to 31/18/14)

In a number of the physical assault cases by service users, dementia is noted as a contributory factor. In the verbal abuse cases, some involve patients' relatives verbally abusing staff, and some involve patients abusing staff. Sometimes this is because they do not believe they/ their relative is receiving the right care and in some cases patients are abusive because they have dementia, mental ill-health or are in pain.

In the year up to the end of August 2014, we had few reported cases of abuse, harassment or assault on the basis of colleagues' personal characteristics. We had three recorded incidents of sexual harassment – two related to inappropriate comments, and the third to inappropriate touching. All three were recorded as 'low' grade incidents. These cases were dealt with by reporting the incidents centrally and to managers, and alerting others involved in the patients' care of the risk.

There were also two recorded incidents of racial harassment in this period. Both were incidents of racist verbal abuse. In one of these cases, dementia was thought to be a contributory factor.

What are we doing about this?
We have a task force looking at this issue, made up of colleagues from our Community Hospitals, Human Resources, Communications, and the Security Management Service. They will lead on the development of guidance and advice and help embed this in the teams affected by abuse and harassment from patients.

Ties in with:
Equality Objective 4d: Introduce guidance and advice to support staff who face violence, abuse, and harassment from patients, relatives or the public, especially where this arises from patients who have a cognitive impairment.

6.4 Opportunity to thrive

We review the extent to which our colleagues feel able to thrive and contribute regardless of who they are by looking at our pay and conditions, recruitment data, access to training, survey data, and data on who has left the organisation, and why.

6.4.1 What do our colleagues say about working with the Trust?

Since April 2014 the Trust has undertaken the staff friends and family test (FFT) on a quarterly basis. We are not currently able to analyse the results by protected characteristics, but in 2015 we plan to review whether to include monitoring questions in the FFT surveys.

Between April and September 2014, 4 out of 5 colleagues (80%) would recommend Gloucestershire Care Services as a place to receive care and only 3% would not recommend the Trust for care. This compares favourably with Trusts nationally: on average 76% of staff would recommend their Trust as a place to receive care and 8% would not recommend their Trust. The results of quarter one and two are summarised in the tables below:

	Total Responses Qtr. 1	**Qtr1 %**	**Total Responses Qtr. 2**	**Qtr2 %**
Extremely likely	174	31	127	28
Likely	279	49	238	52
Neither likely or unlikely	93	16	75	15

Unlikely	13	2	9	2
Extremely unlikely	6	1	9	2
Don't know	8	1	10	1
Total	**573**	**100**	**468**	**100**

Table 3: How likely are you to recommend the Trust to friends and family if they needed care or treatment?

However, our colleagues were less likely to recommend Gloucestershire Care Services as a place to work in quarter one compared with Trusts nationally:

- 53% of our staff recommend the Trust as a place to work and 21% do not recommend it;
- An average of 62% of NHS staff nationally recommend their Trusts as a place to work and 19% do not recommend them.

	Total Responses Qtr. 1	**Qtr. 1 %**	**Total Responses Qtr. 2**	**Qtr. 2 %**
Extremely likely	86	15	66	14
Likely	217	38	162	35
Neither likely or unlikely	136	24	135	29
Unlikely	76	13	62	13
Extremely unlikely	49	9	35	8
Don't know	4	1	8	1
Total	**568**	**100**	**468**	**100**

Table 4: How likely are you to recommend the Trust to friends and family as a place to work?

Reasons cited for recommending the Trust as a place to work include team, environment and rewarding work. Reasons for not recommending it include poor communication, low morale, staffing levels/ workload, high levels of change, stress, lack of support from management and pay & conditions. Both the positive and negative themes are similar to the feedback received from the 2013 national NHS Staff Survey and Investors in People review.

The overall response rate for quarter one was 17% and for quarter two was 14%. By comparison, the highest completion rate nationally for community and mental health Trusts was between 4% and 20%[35].

What are we doing about this?

To address the issues identified above the Trust has developed an Organisational Development (OD) Strategy and a separate Workforce Strategy each being supported by a detailed implementation plan. The three

[35] As reported by Quality Health, based on Trusts using Quality Health to administer the Staff FFT.

priorities from the OD strategy for 2014/5 are the Listening into Action programme, investment in leadership and the Core Values Framework.
In January 2014 the Trust launched the **Listening into Action** programme which is a tool widely used in the NHS to change the culture within an organisation. The Trust has undertaken a range of activities under this programme which include:

- A pulse check to obtain a base line of how it feels to work for the organisation
- Five big conversation events (attended by over 300 staff) to understand what gets in the way of providing the best care possible
- Implementing ‘quick wins’ identified during the big conversation events
- Supporting 13 teams across the organisation to make changes
- A “pass it on event” to allow the 13 teams to pass on what they have learnt from the change process.

During 2014/15, the Trust has invested over £160k in **leadership programmes** for middle managers. Since the Trust was formed in March 2013, 179 colleagues have participated in leadership programmes, including Leading for Quality Care (led by the Royal College of Nursing), Leading an Empowered Organisation and NHS Leadership Academy programmes (Mary Seacole, Elizabeth Garrett Anderson & Nye Bevan)

The Trust has developed a **Core Values Framework** to ensure that all colleagues within the organisation are clear on the values and behaviours that are expected of them. By embedding the framework within induction, recruitment, appraisal and training, it will support the Trust to achieve the culture as described within our Organisational Development Strategy.

6.4.2 Equality in pay and conditions

Our pay band analysis shows that women are more likely than men to be employed in the lower pay bands in the Trust: 87% of women are in Agenda for Change (AfC) pay bands 1-6, compared with 69% of men. The remainder are in AfC bands 7-9, or are on different pay structures (as medical specialists or ‘other’). The chart below shows the increasing proportions of men in the higher pay bands:

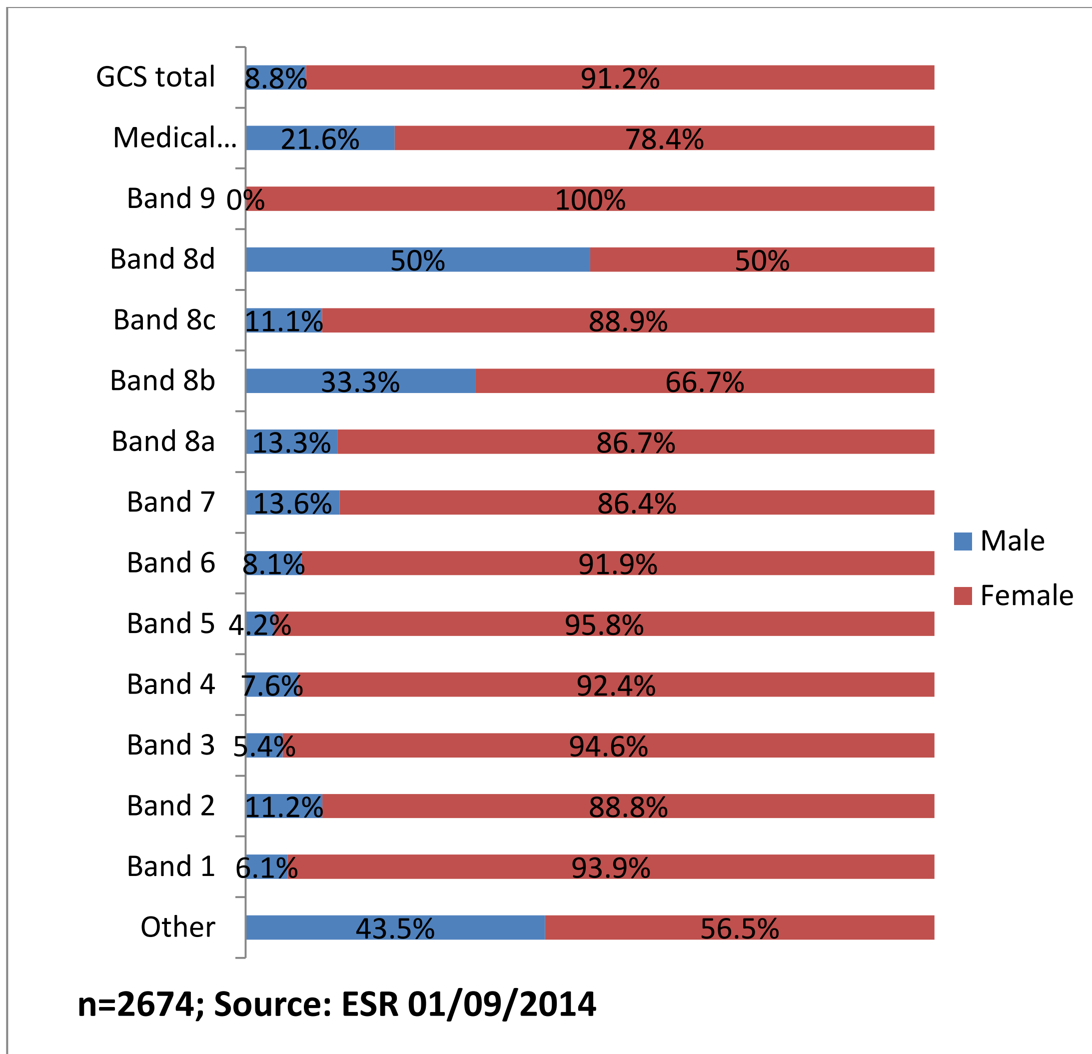


Figure 11: Gender by pay band

We have conducted gender pay gap analysis following the formula set out by the Equality & Human Rights Commission[36]. This calculation seeks to establish whether we pay men and women equally for equal work.

Based on this, we have no gender pay gap when comparing colleagues' pay across all of our staff. There is a pay gap when comparing all full-time colleagues' pay, which suggests that – on average – amongst full-time workers, women get a higher hourly rate than men. The analysis shows that women working part-time receive a lower hourly rate than men working full-time. The EHRC recommends this analysis as it is more likely that women are

[36] The full-time gender pay gap is calculated by dividing the median hourly earnings of female full-time employees by the median hourly earnings of male full-time employees, showing this as a percentage and subtracting the figure from 100 per cent. Thus a 0 per cent figure would indicate that for a particular category, there is no gender pay gap.
http://www.equalityhumanrights.com/uploaded_files/research/Briefing_papers/bp_6_final.pdf

employed in part-time roles and historically part-time hourly rates have been lower than full-time hourly rates for equivalent work.

	GCS NHST	UK
Full-time gender pay gap: women F/T as % of men F/T	-4.03%	9.6%
Part-time women's pay gap: women P/T as % of men F/T	3.82%	38.8%
Women (all) as % of men (all)	0%	19.7%

Figure 12: Median hourly earnings of GCS NHST employees (Source: ESR, November 2014) compared to median hourly earnings of UK employees (Source: ECHR Gender pay gaps Briefing Paper 6, 2012)

These pay gaps are substantially smaller than the national pay gaps and they are smaller than the pay gaps we reported last year.

6.4.3 Equality in recruitment and retention

All our posts are advertised on NHS Jobs, and occasionally we use more targeted channels for inviting applications. NHS Jobs handles all of our applications. This includes monitoring the 'protected characteristics' of applicants. It is important to note that colleagues who shortlist applications do not see information on an applicant's name, age, sex, ethnicity, or religion. We run a 'Guaranteed interview' scheme for applicants who declare a disability, whereby we offer them an interview as long as they meet the minimum criteria.

Between 1st November 2013 and 31st October 2014[37] our recruitment activity was as follows:

	Applied	Shortlisted	Appointed
Number of applicants	8841	2796	418

When we break down these figures by age, race, religion and sex, it appears that these factors are linked with the likelihood of being shortlisted or appointed.

In terms of age, applicants under 30 were less likely to be shortlisted and appointed than older applicants (see chart below). Around a fifth (20.8%) of our applicants over this period were under 24. 12% of the total people

[37] A note on the reporting period: This data comes from NHS Jobs. NHS Jobs introduced a new website and database in 2014, and this only allows us to access one year's worth of data. As a result, the reporting period is a little later than other workforce data in the report.

appointed come from this age group. This is possibly because although nationally, unemployment is higher amongst younger age groups, they are less likely to have developed the experience and skills necessary for some of our posts.

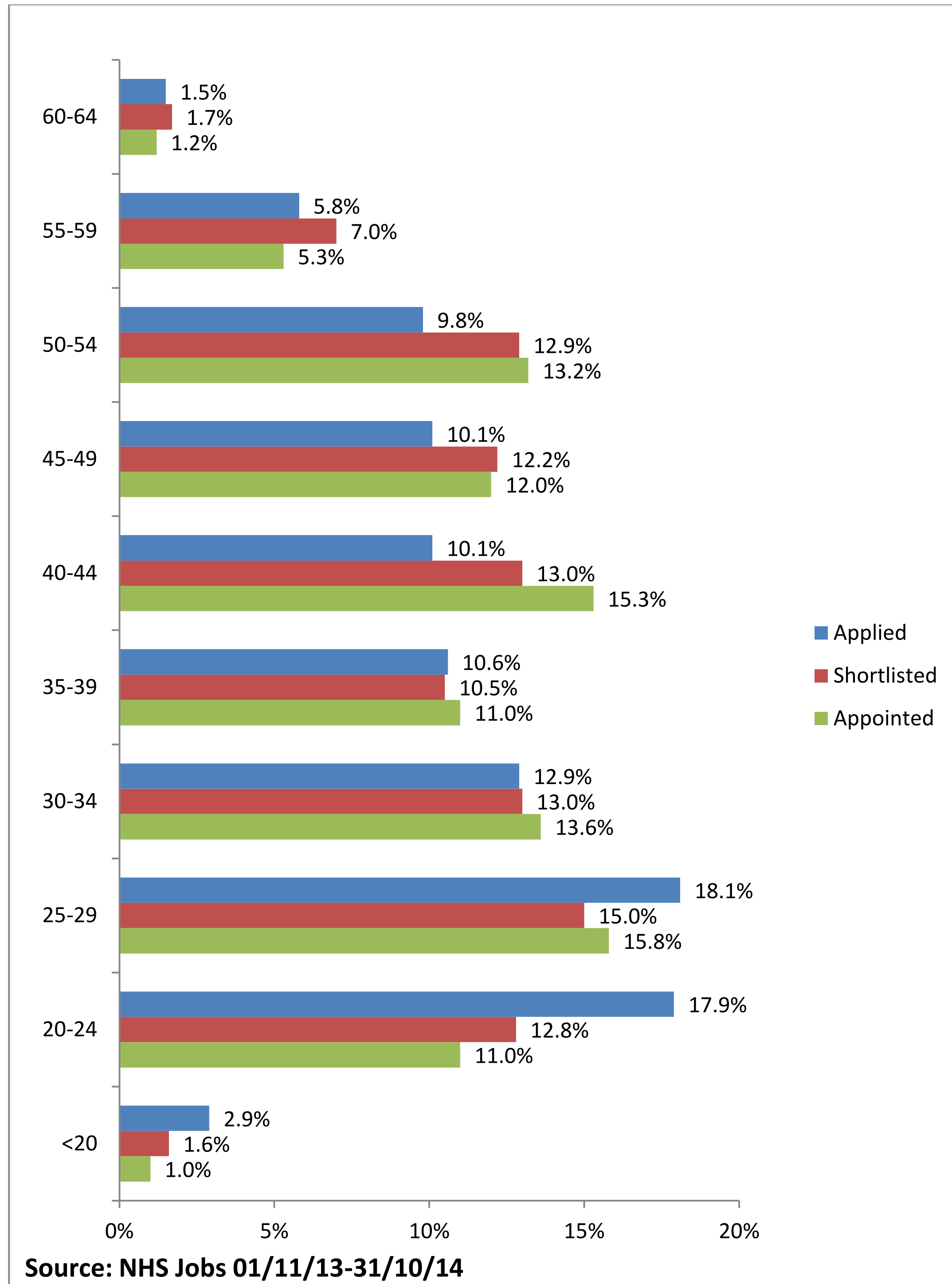


Figure 13: Recruitment by age

Ethnicity also accounts for differences between successful and unsuccessful candidates over this period. Just over three quarters of applicants (76.4%) described themselves as 'White British', but 'White British' people make up 89% of those appointed. People applying who describe themselves as BME or 'White' but not British are less likely to be shortlisted or appointed:

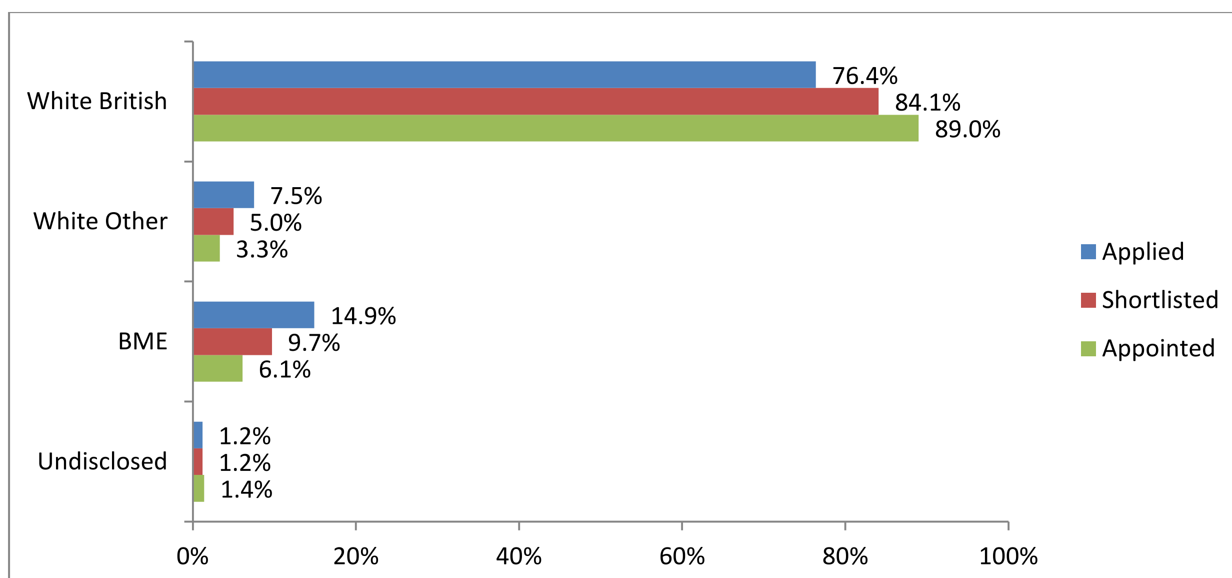


Figure 14: Recruitment by Race

This can partly be explained because all our posts are advertised on the NHS Jobs website, which can be accessed from across the globe. People applying from outside the EU (who are also more likely to be from BME groups) are less likely to have the right to work in the UK, and are therefore automatically screened out at the shortlisting stage. We require a high standard of spoken English in many of our roles, as communication is central to high quality care. This may account for some people from BME groups being shortlisted but not appointed.

This may also explain why an applicant's religion can affect their likelihood of being shortlisted and appointed. Figures for this period show that Christian and Atheist applicants were slightly more likely to be appointed, and Hindu and Muslim applicants were slightly less likely to be appointed. These figures are indicative, not statistically significant, but they do reflect previous data. It may be our Hindu and Muslim applicants are more likely to come from outside the EU. If so, they are less likely to have the right to work in the UK, and not shortlisted on this basis.

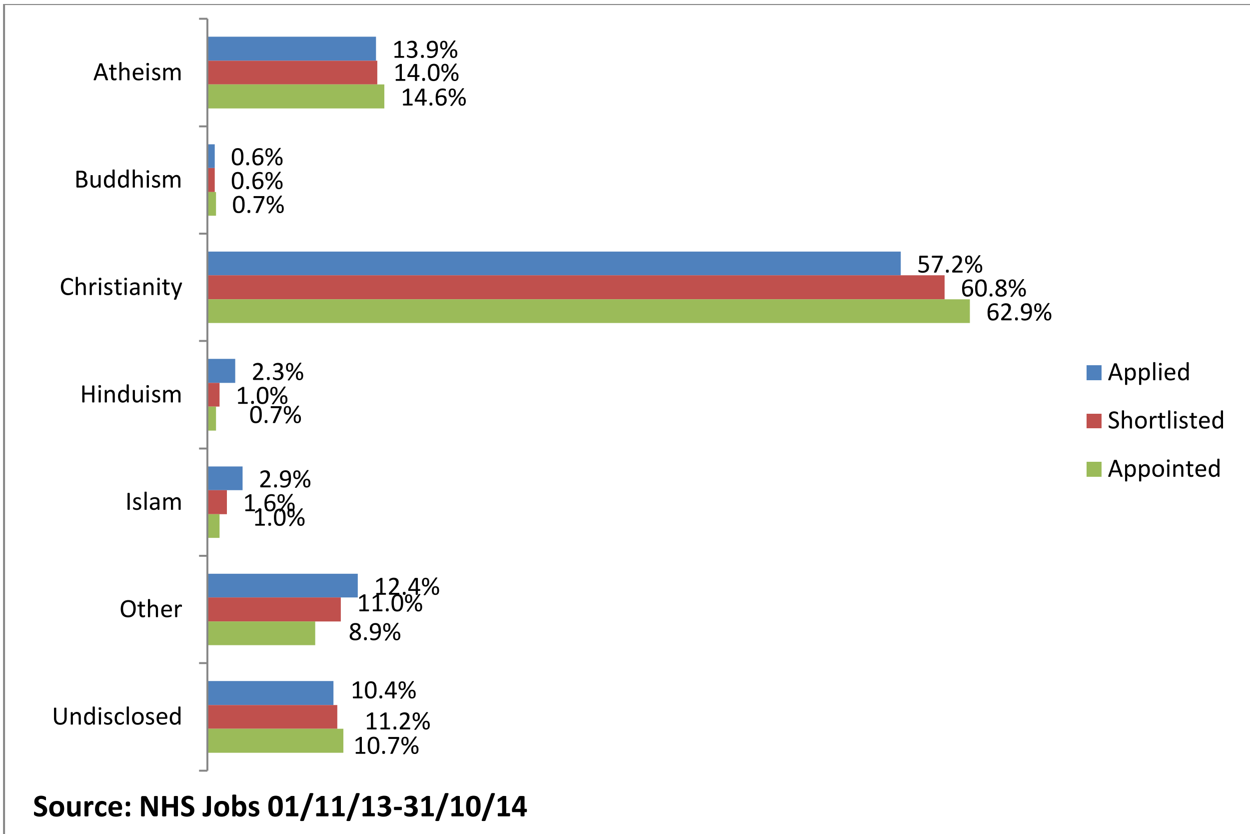


Figure 15: Recruitment by Religion

Our recruitment figures for this period also show that people are more likely to be shortlisted and appointed to jobs if they are female, echoing last year's figures:

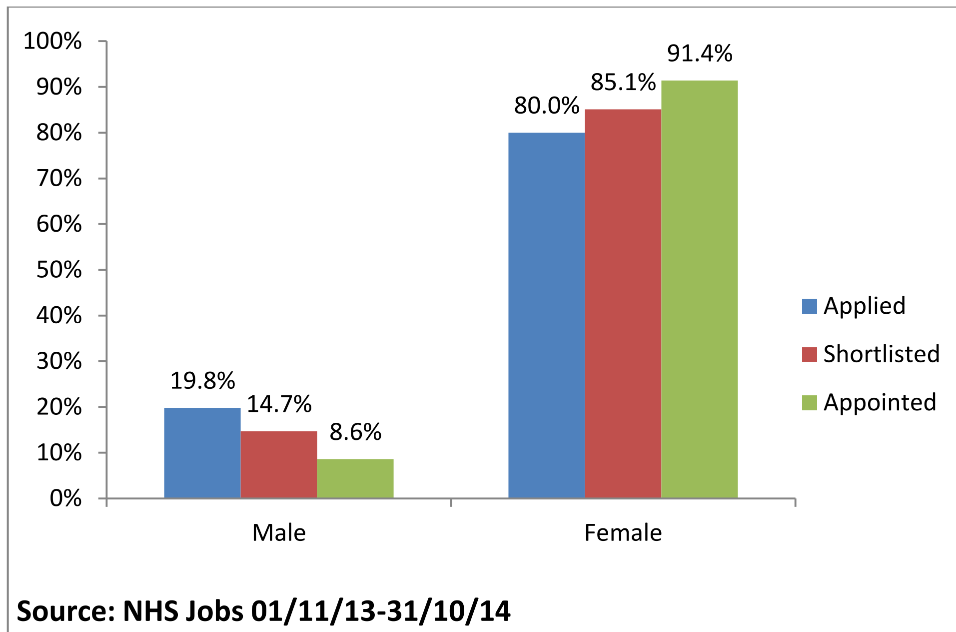


Figure 16: Recruitment by Sex

Recruitment data for November 2013 to October 2014 shows some differences based on disability and sexual orientation. However, the figures are not large enough for us to determine their significance. In comparison, in our last report (published January 2013), we found no notable differences on these characteristics. We have included this year's data on disability and sexual orientation in Appendix E.

The recruitment data on age, race, religion and sex echoes findings we published last year. It is important for us to further investigate the underlying reasons for these trends, particularly as they reinforce the demographic make-up of our existing workforce.

These trends are also reinforced by data we hold on leavers.

Between 1st September 2013 and 31st August 2014, 556 people left the employment of Gloucestershire Care Services. The reasons for leaving – and proportions in each of these categories – are as follows:

Reason	**Number**	%
Voluntary Resignation	344	61.9%
Retirement	96	17.3%
Bank Staff not fulfilled minimum work requirement	80	14.4%
End of Fixed Term Contract	24	4.3%
Dismissal - Capability	5	0.9%
Redundancy - Compulsory	5	0.9%
Death in Service	2	0.4%
Grand Total	**556**	100.0%

Figure 17: Reasons for leaving GCS NHST

We have analysed the leavers by age, race and sex. By age, the highest proportion of leavers – making up a fifth of all leavers – was in the 20-39 age group, though this is one of the smaller age groups in the Trust as a whole. This is in contrast to last year's leavers figures, where a quarter of leavers were aged 30-39. This year, our retention of this age group appears better. We would expect a higher number of leavers amongst the older age bands, and this is consistent with last year's data.

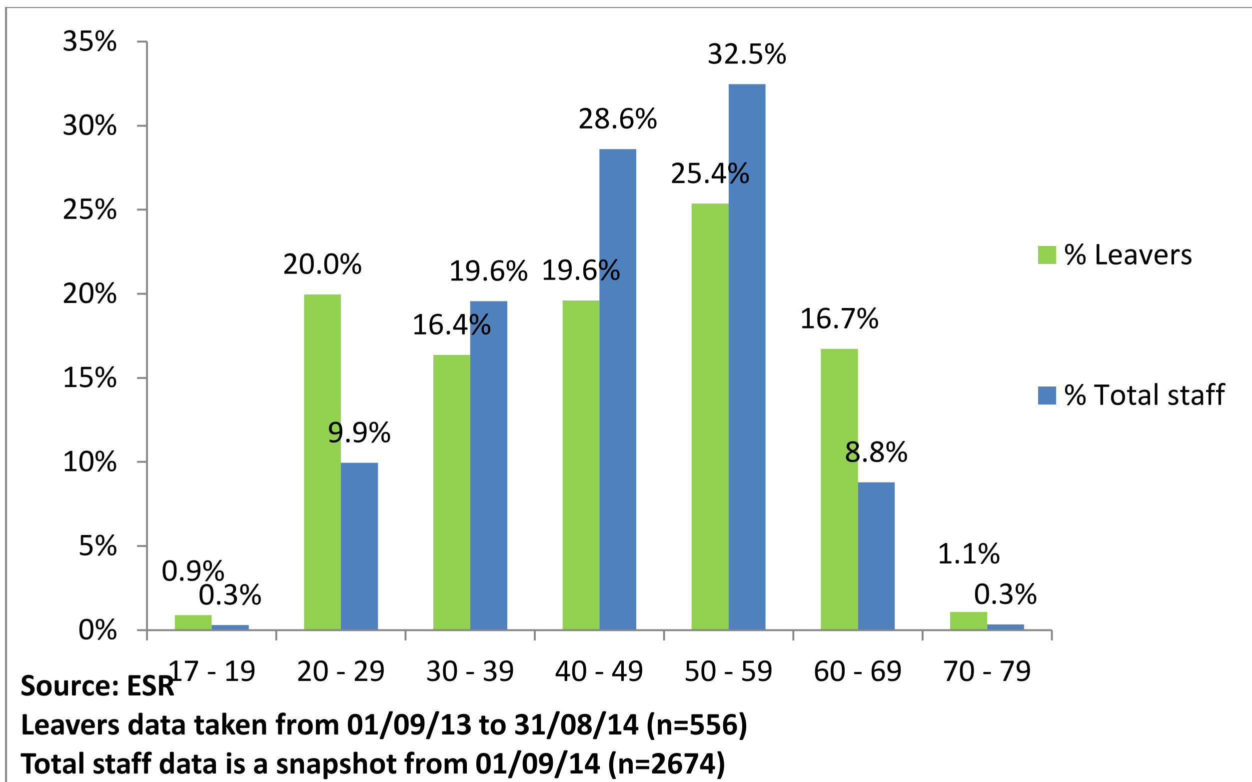


Figure 18: Age groups of leavers compared to total staff

We also had a higher proportion of men leaving the organisation than there are in the organisation as a whole, as shown in the chart below. This echoes the data we published last year.

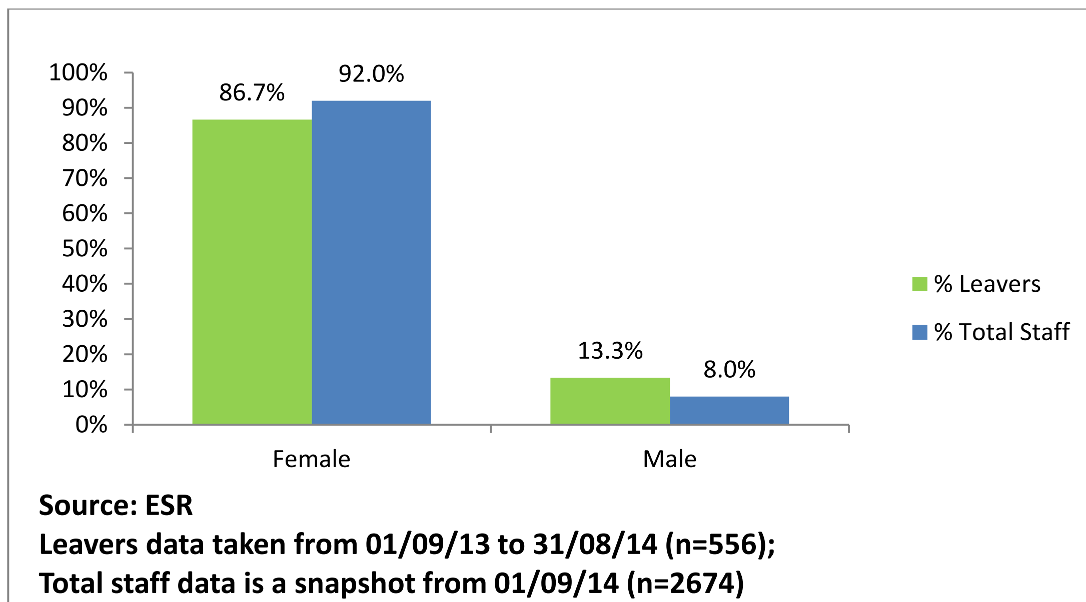


Figure 19: Sex of leavers compared to total staff

Analysis of leavers by race shows that we had a higher proportion of leavers from BME backgrounds than we have in the organisation as a whole. However, the difference appears to be less than it was between April and September 2013. The numbers are too small for us to draw firm conclusions, but we hope that this is indicative of improved retention of BME staff.

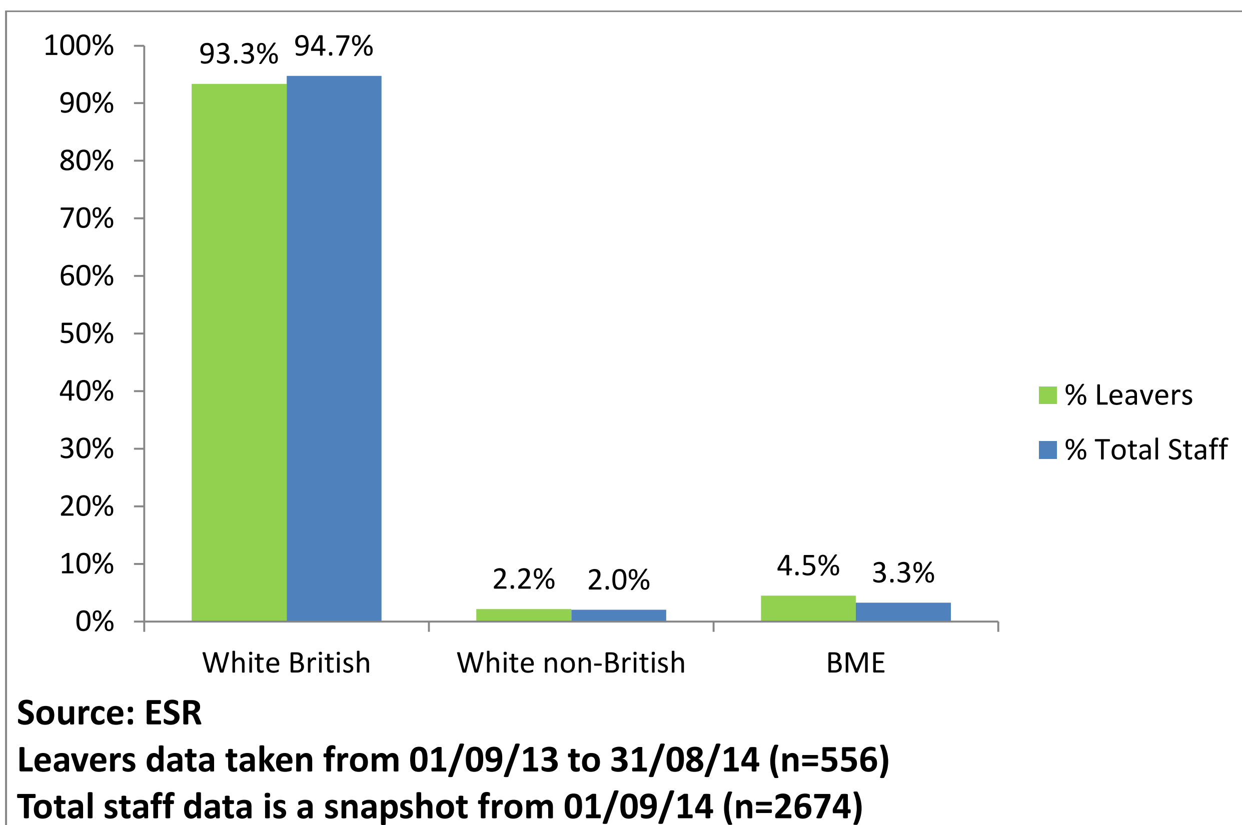


Figure 20: Ethnic groups of leavers compared to total staff

6.4.4 Equality in training and development

2443 (91%) of our existing staff attended at least one training course in the year up to September 2014[38]. This is a 33.8% increase on the figures we reported last year (for April-September 2013).

We have analysed access to staff training by age, race and sex (note: the levels of non-disclosure on disabilities, religion/ belief and sexual orientation mean that figures are too low to allow meaningful analysis of training data by these characteristics). Based on the training records we hold centrally, there are no notable discrepancies in access to training on the basis of age, race or sex. Detailed figures are provided at Appendix F. However, results from the

[38] It is important to note that a member of staff may well have attended more than one course, but that this data only shows one 'Training' episode per member of staff.

2013 staff survey do show some variation between different groups of staff with regards to training, education and personal development:

In the last 12 months…	Community Trusts	GCS	Full-time	Part-time	Maintenance/ Ancillary	Allied health professionals	Healthcare assistants & support staff	Nursing and health visiting
Received job-relevant training or development	82%	81%	84%	77%	47%	84%	60%	84%
Had an appraisal	87%	82%	81%	84%	64%	91%	59%	80%
Had a well-structured appraisal	38%	33%	34%	32%	18%	33%	15%	35%

Table 5: Staff survey responses by staff group (2013)

It should be noted that we cannot say whether the differences are statistically significant, as the numbers are too small. However, there are some indications that:

- Maintenance/ Ancillary staff and Healthcare Assistants/ Support Staff appear less satisfied with their training and development than staff as a whole. It should be noted that these staff tend to be in lower paid jobs;
- Colleagues are less likely to receive job-relevant training and development if they are part-time;
- Colleagues are more likely to have an appraisal if they work within the Allied Health professionals, though they are no more likely to feel it is well-structured.

There are also some differences on the basis of age, sex and disability[39]:

In the last 12 months, I received…	Community Trusts	GCS	Men	Women	Disabled	Non-disabled	Age 18-30	Age 31-40	Age 41-50	Age 51+
Job-relevant training/ development	82%	81%	77%	82%	75%	82%	90%	87%	80%	77%
An appraisal	87%	82%	83%	83%	73%	86%	78%	83%	81%	85%
A well-structured appraisal	38%	33%	38%	33%	27%	35%	42%	32%	32%	33%

Table 6: Staff survey responses by demographic group (Nov 2013)

The indications here are that:

- Men seem slightly less likely to have received job-relevant training, but are more likely to feel they have had a well-structured appraisal;
- Colleagues who identify as disabled are less likely to have had job-relevant training or an appraisal, and are less likely to feel their appraisal was well structured;
- Access to job-relevant training appears to decline with age;
- Over 51s say are more likely to have an appraisal than staff as a whole, and colleagues aged 18-30 are less likely to have an appraisal. However, the younger staff are more likely to feel their appraisal was well-structured.

[39] Please note: the number of responses from BME colleagues is too low to enable us to undertaken analysis on the basis of race.

6.5 Opportunity to contribute: staff engagement

We have a range of different approaches to involve our colleagues in the direction and activities of the Trust:

- Meet the Chair and Chief Executive Sessions – presentations with the chair and chief executive
- Team Brief – a regular internal bulletin which goes to all colleagues
- Staff Forums – nine forums currently exist, covering each locality area as well as children and countywide services, where topics are identified and raised by colleagues.
- Staff Council – Members of each of the staff forums are elected by their colleagues to sit on the Trust's staff council. The staff council is chaired by a Non-Executive Director thereby ensuring strong links to the Board.
- Listening into Action – Listening into Action is a new way of working which empowers staff within the NHS to achieve better outcomes for patients, colleagues and stakeholders. Listening into Action is a grass roots movement that shifts how the NHS should lead and operate.
- Staff survey – We run an annual staff survey, which enables colleagues to express their views anonymously. We are able to analyse anonymous views by a range of characteristics to compare the experiences of different groups of staff.
- The Joint Negotiating & Consultative Forum that is held at least bi-monthly where terms and conditions of employment are negotiated and discussed. The following trade unions are represented at this forum: Unison, Unite, Chartered Society of Physiotherapy, Royal College of Nursing, BDA, SCP, and BMA.

What's new?

We are currently reviewing our model for staff engagement, reassessing the channels that are currently used, and looking at possible alternatives and improvements.

A working group has been set up to review our staff engagement model. The group is working jointly with human resources to ensure that all colleagues across the Trust have the opportunity to contribute to this work.

7. Looking back, looking forward

The Trust has a dedicated Equality & Diversity function to drive this agenda forward. Over 2014 we focused on establishing an equality and human rights approach in the founding frameworks of the Trust. Our achievements include:

1. Developing **equality objectives** in collaboration with our staff, service users and members of our communities. These was based on the evidence contained in the January 2014 'Advancing Equality' annual report.
2. Developing an **equalities governance framework** to structure future work and monitor progress against our equality objectives.
3. Setting up a short-life **Equalities Steering Group** to embed a focus throughout the Trust on addressing inequalities and meeting the needs of different people, and ensuring that there are systems and processes in place to make this happen.
4. Introducing more stringent requirements for **equality analysis** of our activities, and greater scrutiny in decision-making, including:
    a. Creating a combined quality and equality impact assessment process and embedding this in our service change process;
    b. Ensuring decision makers are confident in their ability to scrutinise decisions from an equalities perspective, for example by running a session with the Trust Board on scrutinising decisions for equality implications.
5. Publishing an **Equality & Human Rights Policy** to ensure staff and service users know what they can expect – and what is expected of them – with regards to equality and human rights. You can find our policy alongside this report on our website;
6. Developing and running **Equality & Human Rights training** sessions at induction and with individual teams, including starting to develop a new and engaging training programme as part of the Listening into Action programme (the 'Understanding You' team project).

Appendix A describes our equality objectives for 2014-16 and the progress we have made in achieving them.

Over 2015, we will continue our work to entrench an equality and human rights approach into our functions and decision-making. In particular, we will be rolling out and embedding our new combined approach to assessing the impact of our plans and activities on quality and equality. We will be training staff to use it to ensure services are developed in a way that ensures high

quality for all who will use them, paying particular attention to people who experience inequalities, are vulnerable and have extra needs.

There will be several developments nationally and locally that will have an effect on our work in this area in the coming year:

1. The NHS **Equality Delivery System** (EDS2)[40] is likely be become a mandatory requirement for all NHS Trusts through the NHS Standard Contract from April 2015. The Trust Development Authority has specified that all NHS Trusts on the Foundation Trust 'pipeline' must implement EDS2. The Trust is well-placed to adopt it EDS2, and in 2015 we will work with colleagues and community representatives to establish how to implement EDS2 in a way that is meaningful and adds value for colleagues, service users, and our communities.
2. NHS England is also likely to introduce a new **National Workforce Race Equality Standard** as part of the Standard Contract. The Standard aims to tackle the lack of black & minority ethnic (BME) representation at senior levels in the NHS, and to galvanise cultural and organisational change. It will be underpinned by commissioning and regulatory action, and aims to address national inequalities BME staff face in the NHS, including adverse outcomes throughout recruitment and promotion, access to non-mandatory training, over-representation in disciplinary procedures, bullying and harassment.
3. Our **Translation & Interpreting Services contract** is up for renewal in 2015. This will involve reviewing current provision, and assessing local need (based on service user and staff feedback).
4. We will be moving towards **annual updates for Equality & Diversity training**. Currently colleagues are required to complete updates every three years. Once the new training programme is launched, all colleagues will be obliged to complete annual updates.

Alongside these pieces of work, we will be driving forward work to meet our equality objectives. Towards the end of 2015 we will begin the process of identifying new priorities to reduce health inequalities, provide high quality care to our most vulnerable communities and meet extra needs.

[40] This is a framework of 18 outcomes for service users and staff against which Trusts work with their local communities to assess their performance for people with 'protected characteristics'. Find more about EDS2 here: www.england.nhs.uk/ourwork/gov/equality-hub/eds/

8. Glossary of terms

BME	Black/ Minority Ethnic. Refer to the note about terminology on p. for further information on this.
'Disadvantaged groups'	Sometimes called 'marginalised', 'hard-to-reach' or 'seldom-heard' groups, these are people who experience inequalities in health, healthcare and employment, but who are not specifically protected by the Equality Act. They can include homeless people, sex workers, people who misuse substances, people with low socio-economic status, and people living in rural isolation.
ESR	Electronic Staff Record. An NHS system for capturing and analysing information about our colleagues.
GCS or GCSNHST	Gloucestershire Care Services NHS Trust
'Local interests' or 'Local interest group'	Patients, the public, voluntary sector organisations, members of the community, staff and staff-side organisations who have an interest in what we do.
'n='	The base/ total number on which we have calculated percentages
NHS	National Health Service
NHS Gloucestershire	The Primary Care Trust for Gloucestershire. NHS Gloucestershire has both commissioning functions and care providing functions (under Gloucestershire Care Services).
'Protected characteristics'	The nine characteristics protected under the Equality Act 2010: age, disability, gender reassignment, pregnancy/ maternity, marriage/ civil partnership, religion/ belief, race, sex, and sexual orientation

Gloucestershire Care Services NHS

NHS Trust

Advancing Equality, Embracing Diversity:
Gloucestershire Care Services NHS Trust's Equality Annual Report

Appendices

January 2015

Understanding You

9. Appendices

Appendix A: Progress against Equality Objectives

Ref.	Equality Objective	Progress update
Aim 1: Address the health and care of people with extra or different needs by providing targeted, personalised support and information		
1a	Work proactively with GP Practices to administer a case management framework to identify individuals who are most at risk of losing their independence, e.g. being admitted to hospital, or residential/ nursing care	We have been working with commissioners and GP Practices to develop a model for identifying people who are at risk of losing their independence. This will be a proactive case management approach. The case management model has been agreed and we have a list of individuals who will benefit from this approach. We have trained Integrated Community Team (ICT) staff in approaches to promote resilience and independence. We are piloting the approach with two ICTs. By early 2015 we will evaluate the pilot and roll it out across the county.
1b	Reduce the number and severity of pressure ulcers amongst service users	Our approach to achieving this objective is to improve the quality of reporting of pressure ulcers, train colleagues in the recognition, recording and care of pressure ulcers. We are also conducting detailed investigations of pressure ulcers to establish whether they were avoidable, and what could have been done to avoid them if so. In these cases, our Tissue Viability Team will target expertise and support to improve skin inspections. So far we have held a pressure ulcer awareness and management

Ref.	Equality Objective	Progress update
		study day in conjunction with industry. 80 nurses from around the county attended. We have conducted audits on pressure ulcers in our care settings to enable the Tissue Viability Team to take a targeted approach. In Q2 we achieved a 35% reduction in pressure ulcers compared to Q1.
1c	Improve patients' experiences of care in the last days of life	Our plan for achieving this objective is to ensure people are informed of their diagnosis, and their choice relating to their preferred place of death is recorded and implemented where possible. We commissioned an external review of practices across our services which took place in Summer 2014. To address the findings of the review, we have set up an End of Life Best Practice Group. We are currently conducting an audit of patients in our Community Hospitals needing palliative/ end of life care to establish the extent to which this is happening. We are also running monthly training and development sessions for colleagues to equip them with the skills and confidence to begin difficult conversations and provide appropriate care to people in the last days of their life.
1d	Respond effectively to gaps in the level of care provided to people with learning disabilities (LD) within Gloucestershire	We have established a Learning Disabilities Steering Group, and recruited service users with learning disabilities as members. We have a detailed action plan, and are progressing well against this. Some of our recent actions include: • Identifying potential to flag learning disabilities on the patient record system SystmOne. • Developing and distributing a 'Reasonable Adjustments' tool to

Ref.	Equality Objective	Progress update
		teams via our Learning Disabilities Champions, and drafted an audit to gauge the success of implementation. • Selecting an initial 10 leaflets from our services for translation into EasyRead. • Developing a bid for funding for a Learning Disabilities Liaison Nurse for 2015. • Setting up more face-to-face training dates for Learning Disabilities champions.
1e	Develop targeted communications materials for communities with distinct communication and/or health needs (about our services and/or their health)	We are involved in a range of outreach projects, taking healthcare and health information to groups with distinct needs. For example, attending Stow Fair, workshops with homeless people, the older Chinese community, the Hindu Elders, and more. We have begun discussions with some of our service leads on how we can take a targeted approach to specific communities, e.g. Stop Smoking Services to the Eastern European communities. We are planning an exhibition about our services specifically designed for a BME audience. This will take place in Spring 2015.
1f	Review settings, processes and communications materials to assess suitability for people with sensory loss. Focus for 2014-15 will be deaf people and people with hearing loss	We have been working with the Gloucestershire Deaf Association to develop training for all staff on how to best care for and work with people with hearing loss. We have developed an outline for the training and in 2015 will be working with particular staff groups who can improve the experiences of people with hearing loss (e.g. reception and administrative staff). We are also taking advice on addressing other areas of practice.

Ref.	Equality Objective	Progress update
Aim 2: Ensure decisions are based on sound evidence of their potential impact on people affected, with particular regard for people who are vulnerable or who have characteristics protected under the Equality Act 2010		
2a	Report biannually on the profile of users of all services provided by GCS NHST by age, gender, ethnicity and disability	This report includes data on the profile of service users by age, ethnicity and gender. In spring 2015, we will be undertaking a review of our data and launching initiatives to improve the quality and completeness of patient and staff data.
2b	Have a single equality and quality impact assessment process for policies, plans and strategies, with robust arrangements for scrutiny and accountability	A draft combined approach to assessing the impact of our activities on quality and equality was presented at the Trust's Board meeting on 25th November. It is due to be finalised in December 2014. It has been piloted with several teams responsible for service transformation projects, and has been well received. Board and Committee papers now include an equality statement. The Board has received training on equality scrutiny.
Aim 3: Enable people to influence decisions which affect them, with particular regard for people who are vulnerable or who have characteristics protected under the Equality Act 2010		
3a	Publish a Communications & Engagement Strategy and implementation plan, which includes a systematic approach to involving external & internal stakeholders in decisions, including people with 'protected characteristics' and those in vulnerable groups	We published our Communications & Engagement Strategy in March 2014. The Strategy includes a commitment to improve its dialogue with members of the Gloucestershire public who represent people with protected characteristics, people who have extra or different needs, and people who traditionally experience social and health inequalities. The implementation plan is going to the Communications and Engagement Committee for comment in December 2014.

Ref.	Equality Objective	Progress update
Aim 4: Support our colleagues to provide the best service they can so we can provide the best care to our diverse communities		
4a	Publish an Organisational Development Strategy and implementation plan, which includes plans to nurture a caring and open culture amongst our workforce	The Strategy was published in December 2013 and sets out how the Trust plans to nurture a culture 'in which all Trust colleagues feel respected and valued, and which allows them to be productive, innovative and focused'. A workforce plan and an organisational development plan have been developed.
4b	Ensure staff work within a culture which is designed to routinely connect or re-connect communities & individuals to the resources and assets within their community as part of a person- and family- centred approach to care	We have worked with commissioners and community partners to design and deliver a multi-disciplinary professional development programme for staff. We are focusing on 3 localities in the county to pilot this work. So far, 40 staff have completed the programme. Each staff member attending the course will complete a monthly reflective log over October, November, and December 2014. A further 20 staff will complete the programme by March. Their reflections will shape our plan to roll the approach out to the rest of the organisation and will help us demonstrate to patients and staff the benefits of links with learning site community builders.
4c	Introduce an annual equality & diversity training programme to promote better understanding amongst colleagues of the lives and needs of people who are different from the 'mainstream'	This work is a 'Listening into Action' programme, led by a small group of staff from across the organisation and sponsored by the Director of Service Delivery. So far, we have worked closely with the Gloucestershire Deaf Association to scope out an innovative and engaging training programme on hearing loss.
4d	Introduce guidance and advice to support staff who face violence, abuse, and harassment from	We have established a 'taskforce' made up of members of Community Hospitals, Human Resources, Communications, and our

Ref.	Equality Objective	Progress update
	patients, relatives or the public, especially where this arises from patients who have a cognitive impairment	Security Management teams to look at this issue. They are due to meet in December 2014 to agree the best approach.

Appendix B: Profiles of Service Users by Age, Race and Sex

B.1: Total numbers of service users (April-September 2014)

Services	No. patients
Adult Community Services	
Adult Speech and Language Therapy	1549
Podiatry	12430
Adult Occupational Therapy Services	1767
Adult Physiotherapy	9306
District Nursing Service	18534
Community Hospitals & MIIUs	
Community Hospitals Admissions	1748
Minor Injury & Illnesses Units	37089
Specialist Services	
Parkinson's Nursing service	389
Diabetic Nursing service	503
Bone Health Service	890
MSK Service	1725
Stop Smoking Service	2144
Sexual Health Services*	
Contraception Service	9960
HIV Service	353
Psychosexual Service	85
Children’s services	
Health Visitors	10178
Paediatric Physiotherapy	1312
Paediatric Occupational Therapy	354
Paediatric Speech and Language Therapy	1147
Number of children in Reception with height and weight recorded	6193
Number of children in Year 6 with height and weight recorded	5826

Source: GCS NHST Performance & Information Team (April-Sept 2014)

* Sexual Health Services – we are awaiting verification of these figures from the Performance team.

** Please note: in the following charts we have not reported the data where there are less than 10 service users in a particular group.

B.2 Service user profiles by age

District Nursing Service
0.5%
3.9% 8.6% 25.3% 61.7%

Adult Physiotherapy
0.3%
6.0% 28.4% 29.8% 28.1% 7.4%

Adult Occupational Therapy Services
0.7%
7.2% 12.2% 26.4% 53.3%

Podiatry
5.6% 3.5% 12.4% 19.2% 32.5% 26.9%

Adult Speech and Language Therapy
2.1%
8.4% 17.2% 32.9% 39.2%

ENGLAND
18.9% 11.8% 34.8% 18.1% 11.8% 4.6%

GLOUCESTERSHIRE
17.9% 10.9% 32.7% 19.8% 13.3% 5.4%

<16
16-25
26-49
50-64
65-79
80+

Sources:
Service User data provided by GCS NHST Performance & Information Team (April-Sept 2014)
Gloucestershire & England data from Census 2011

Figure 21: Adult Community Services – service user age profiles

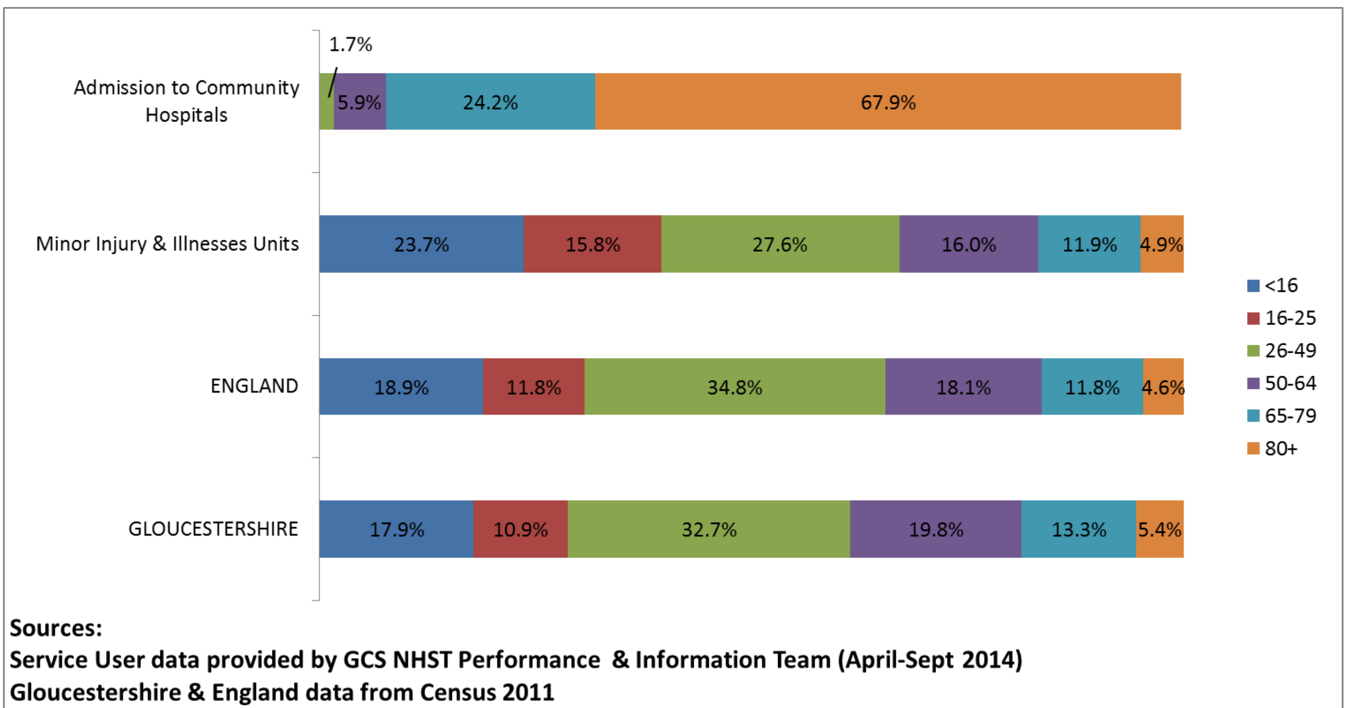


Figure 22: Community Hospitals and MIIUs - service user age profiles

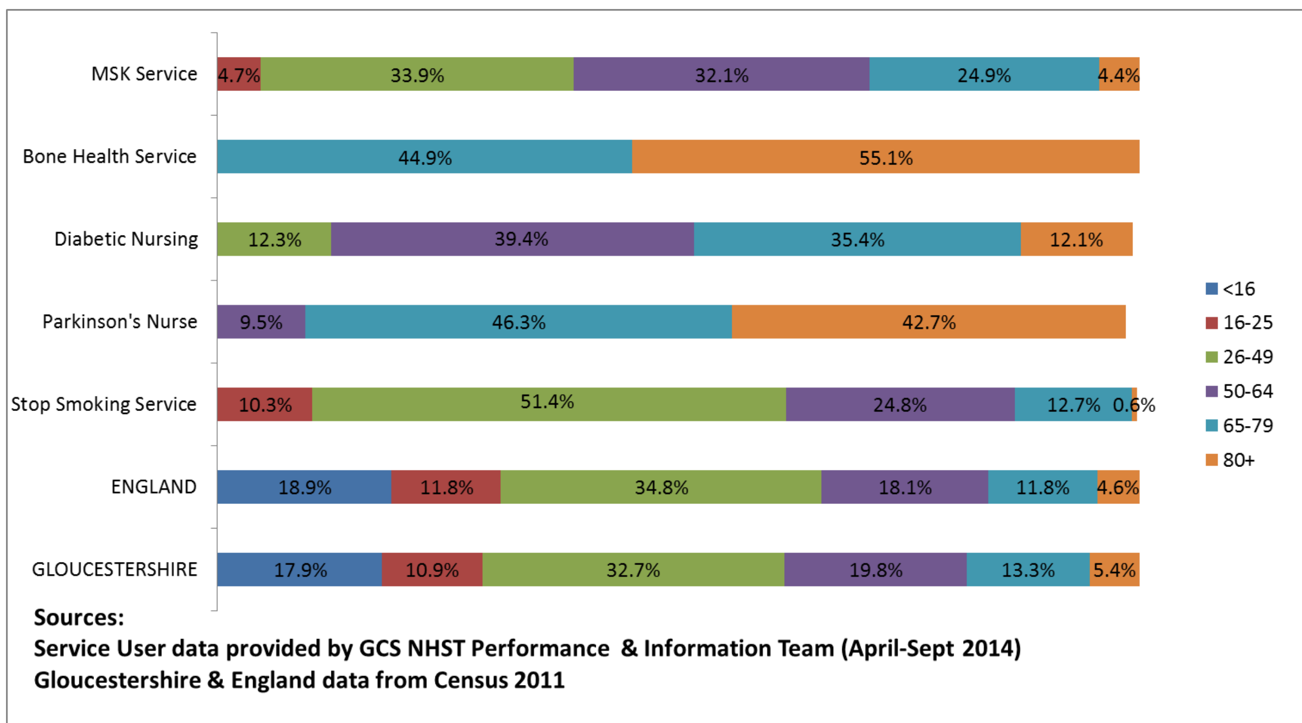


Figure 23: Specialist services - service user age profiles

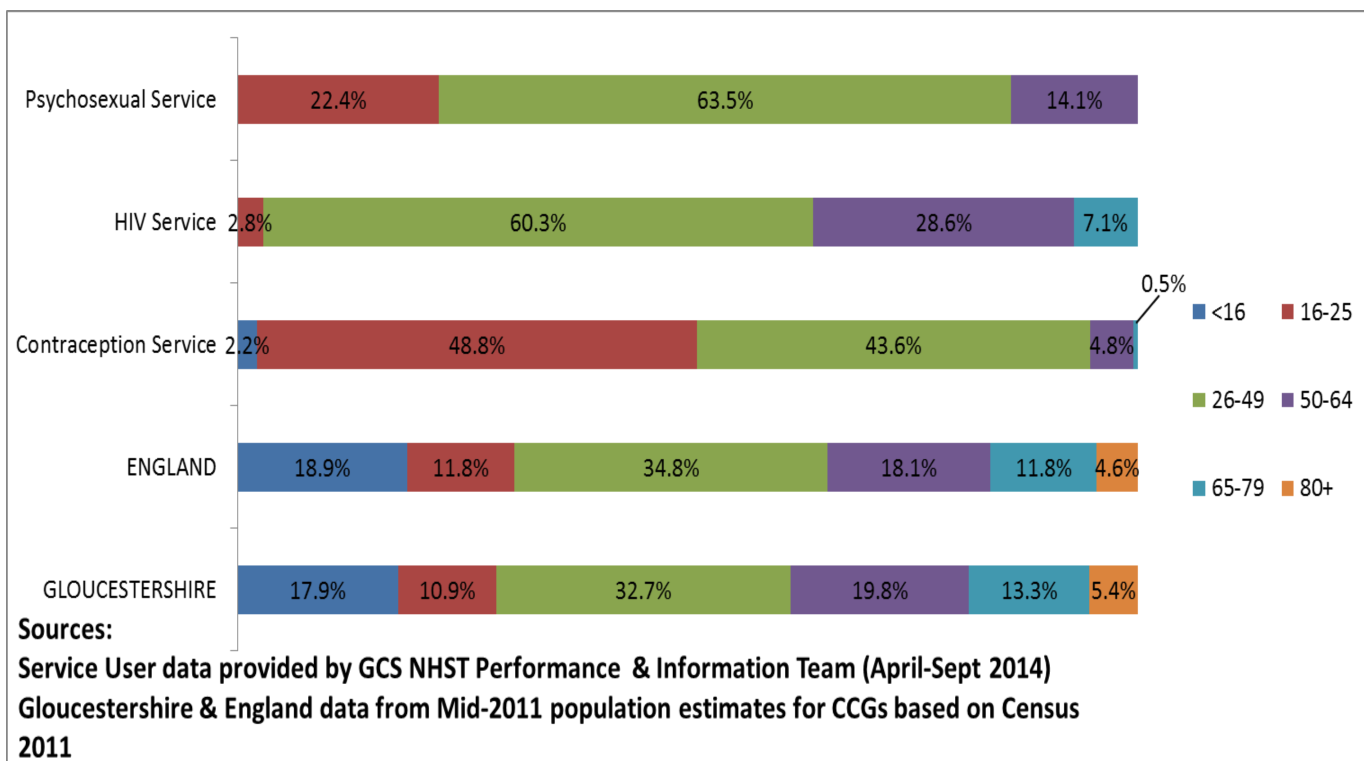


Figure 24: Sexual Health Services - service user age profiles

B.3 Service user profiles by race

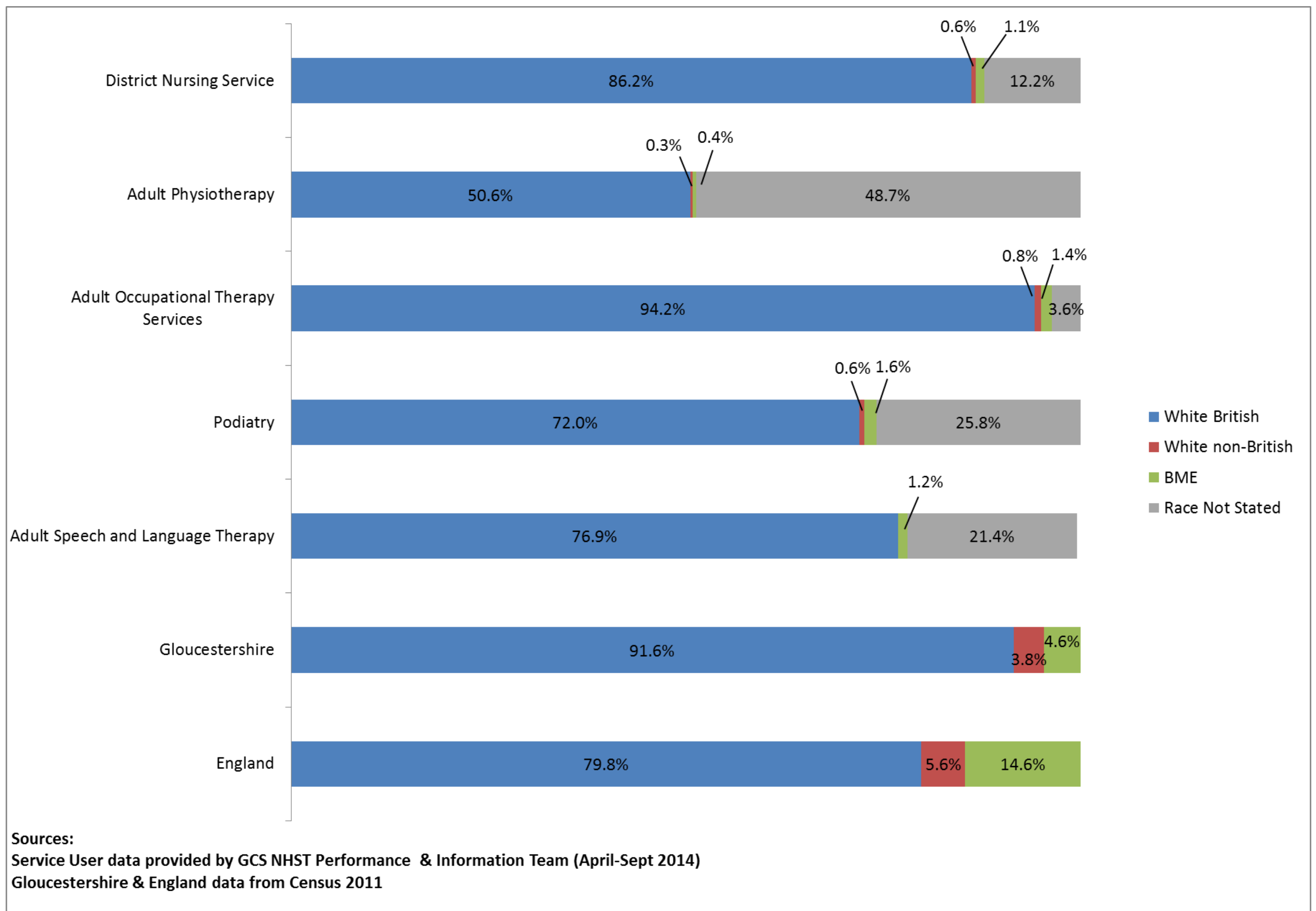


Figure 25: Adult Community Services: service user race profiles

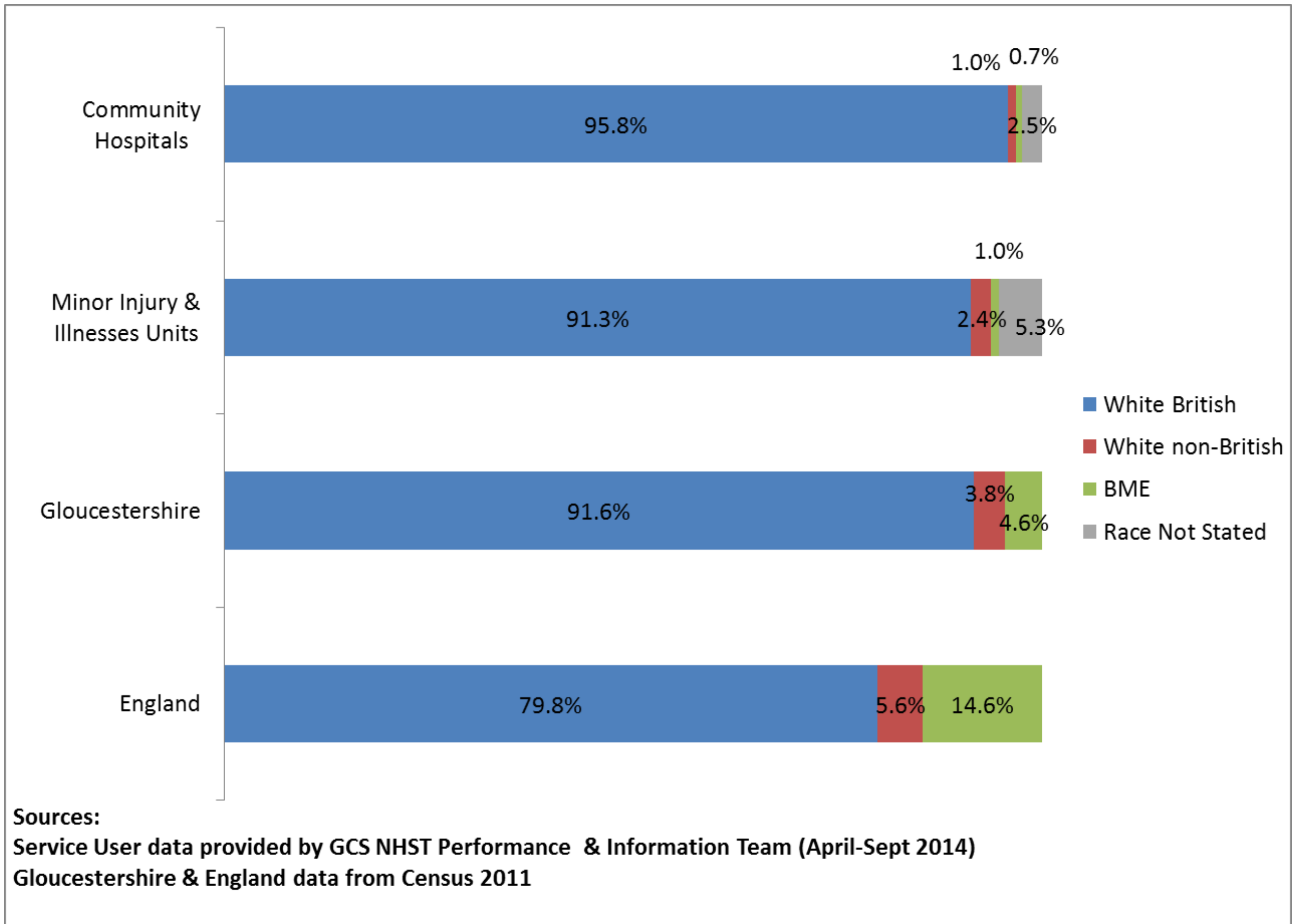


Figure 26: Community Hospitals and MIIUs - service user race profiles

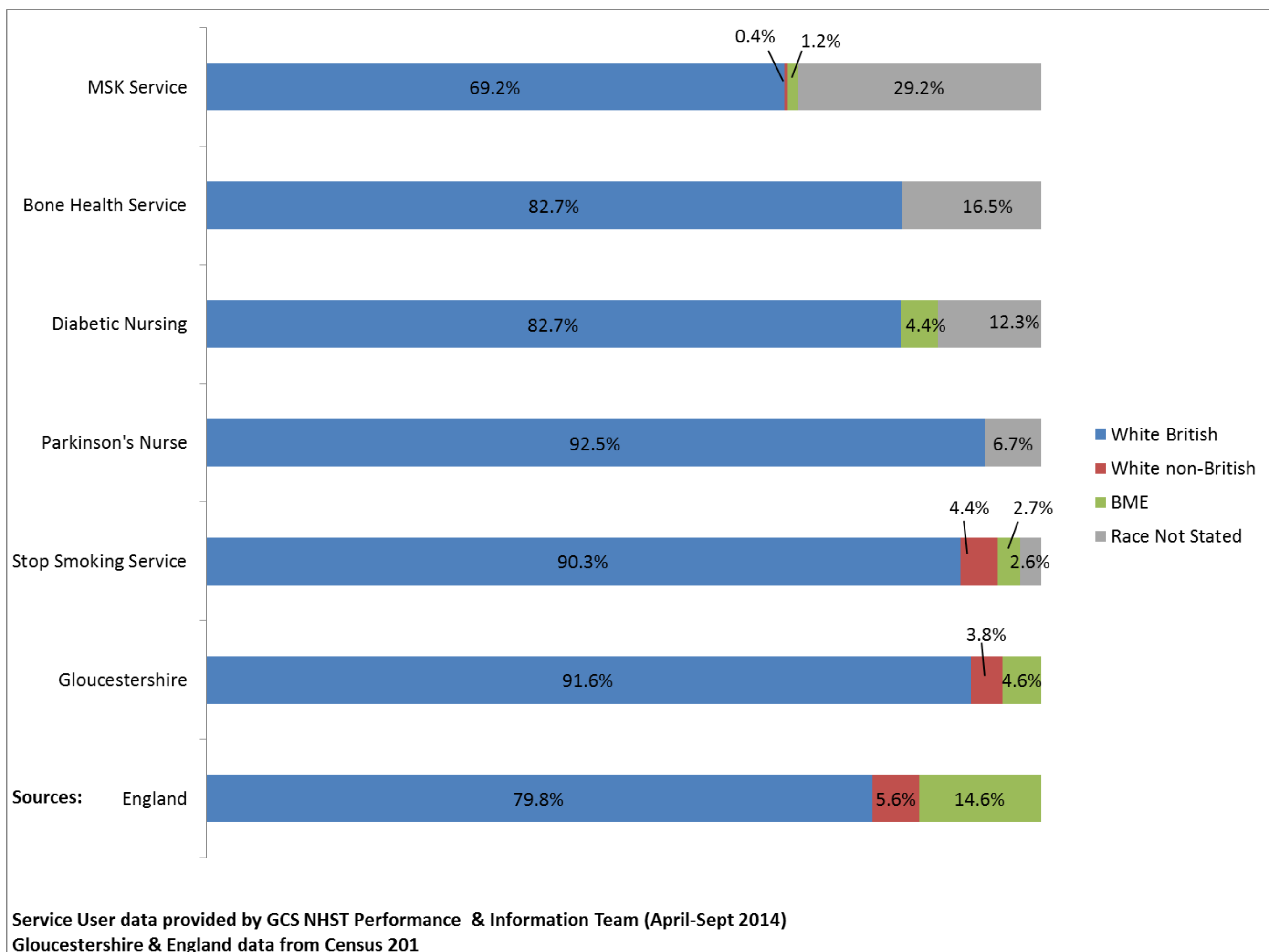


Figure 27: Specialist Services - service user race profiles

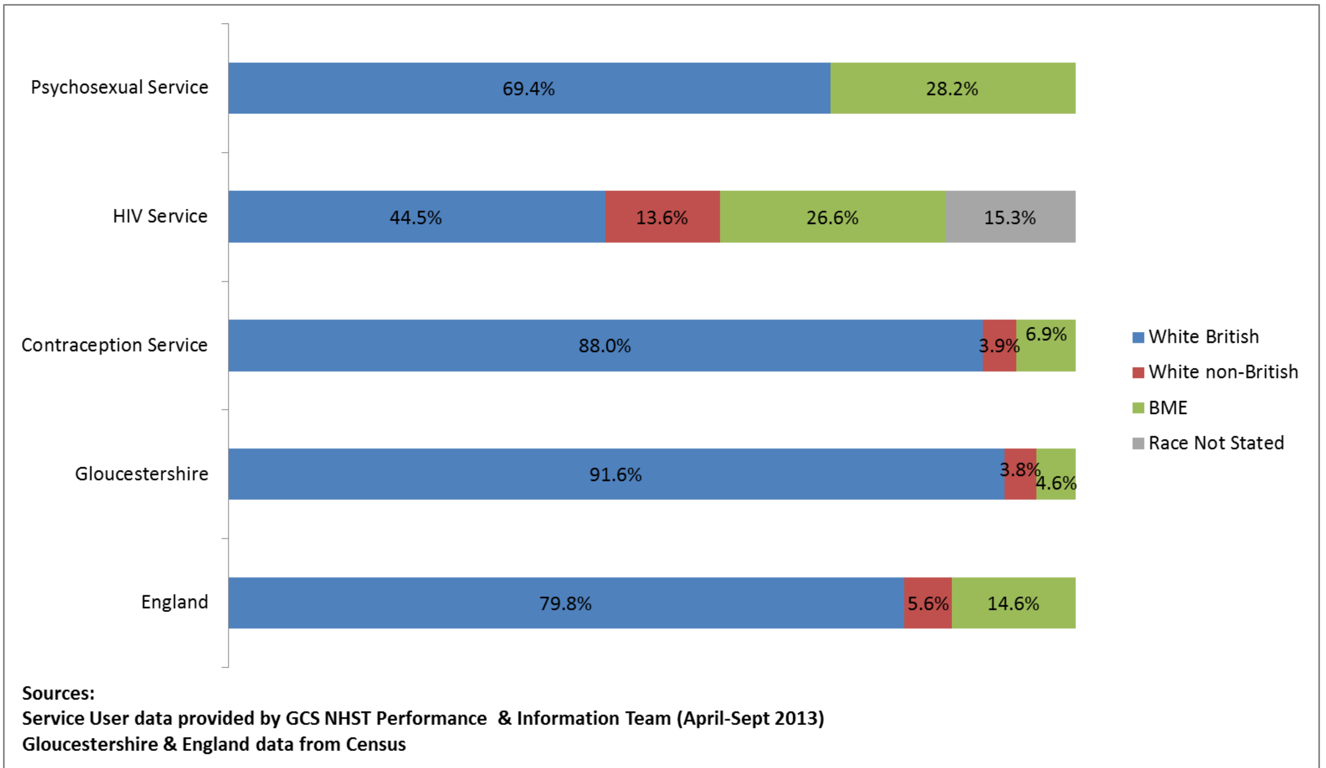


Figure 28: Sexual Health Services - service user race profiles

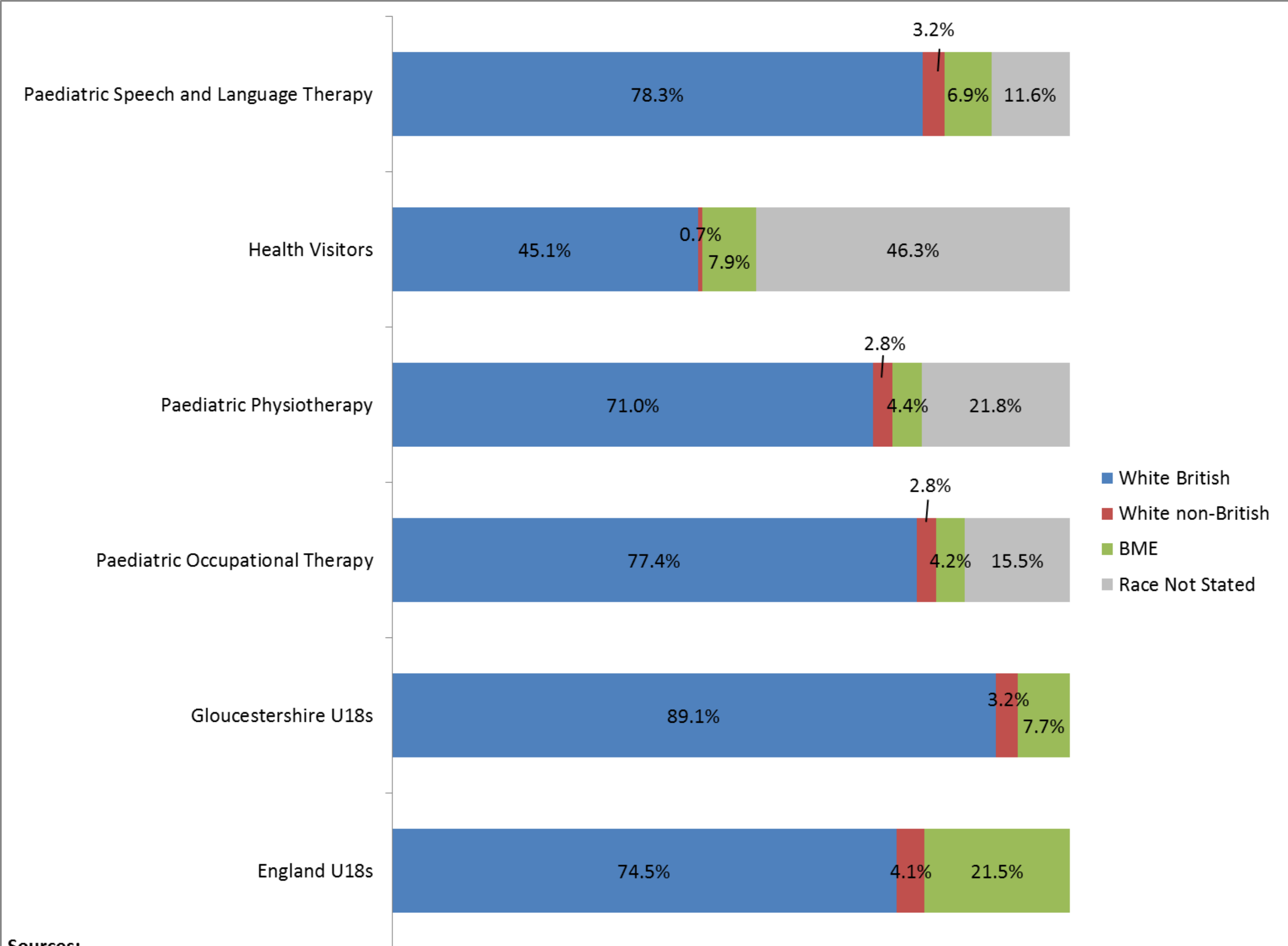


Figure 29: Children's Services - service user race profiles

B.4 Service user profiles by sex

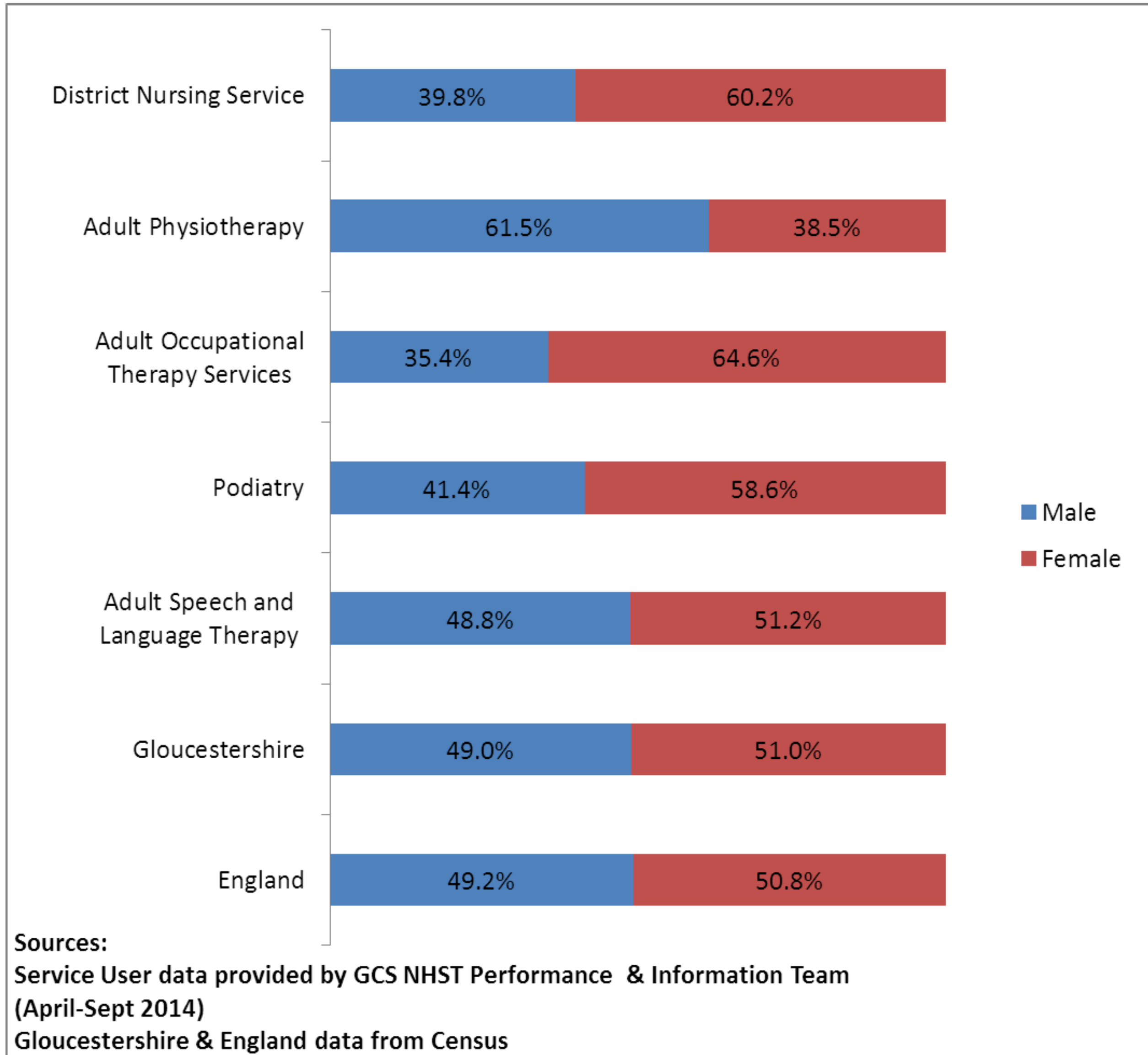


Figure 30: Adult Community Services - service users by sex

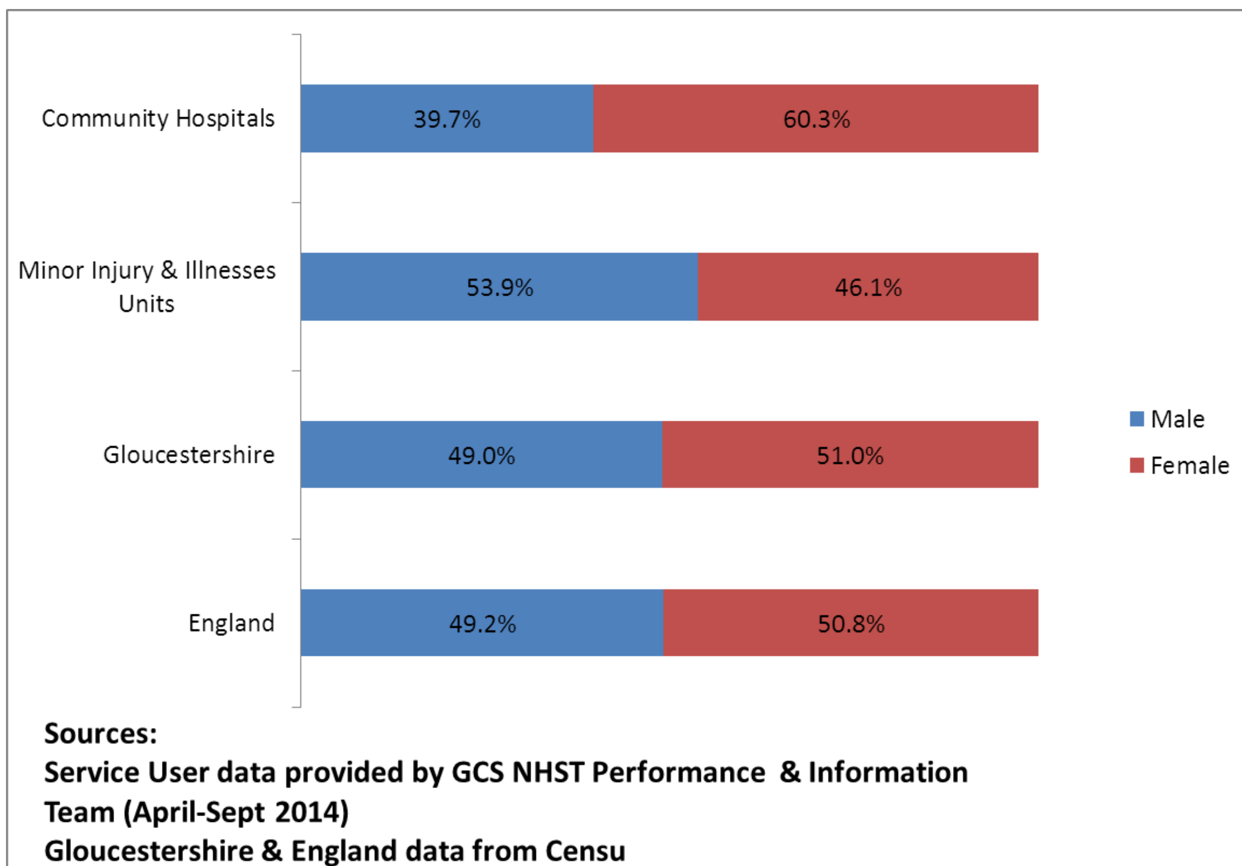


Figure 31: Community Hospitals and MIIUs - service users by sex

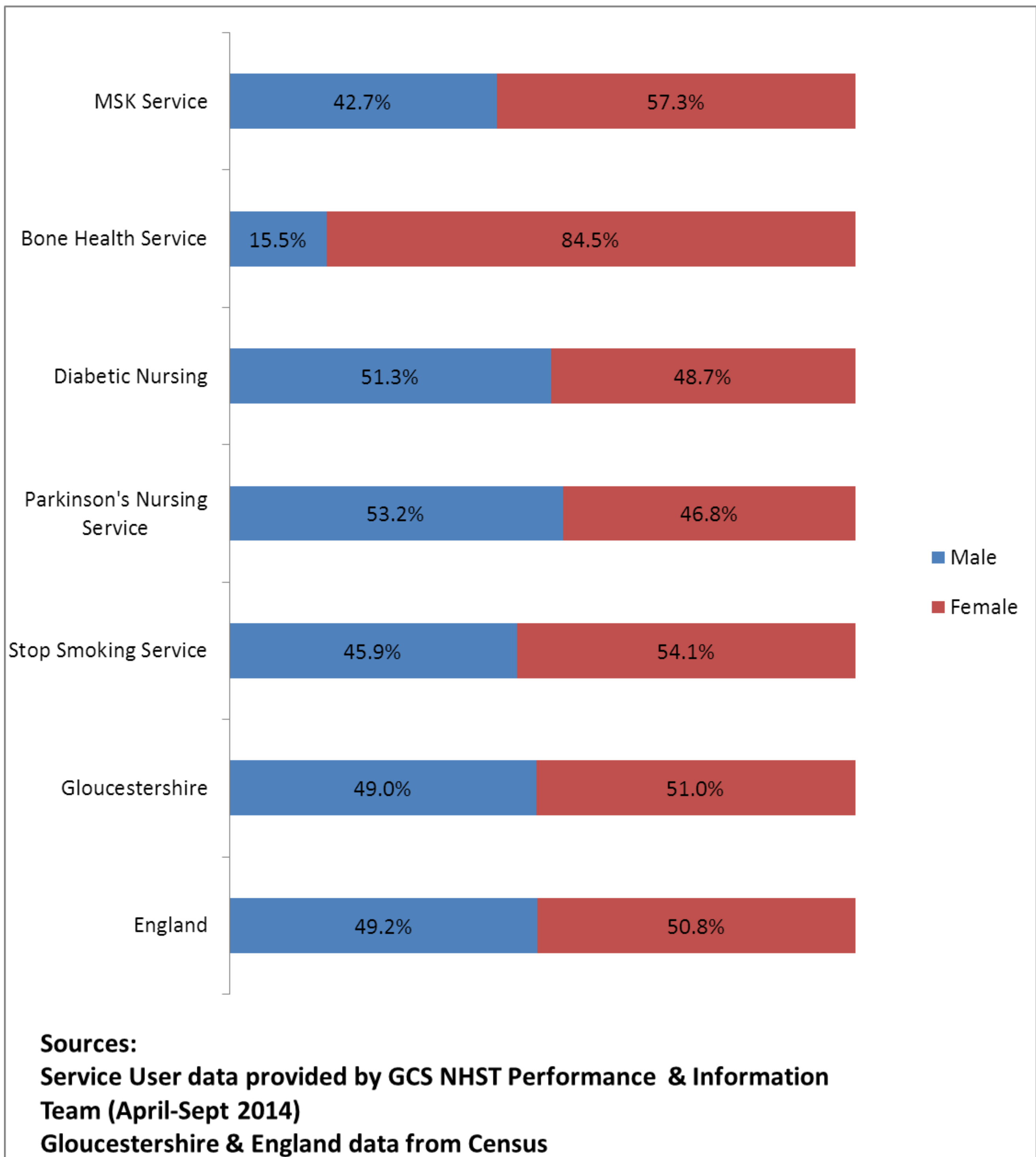


Figure 32: Specialist Services - service users by sex

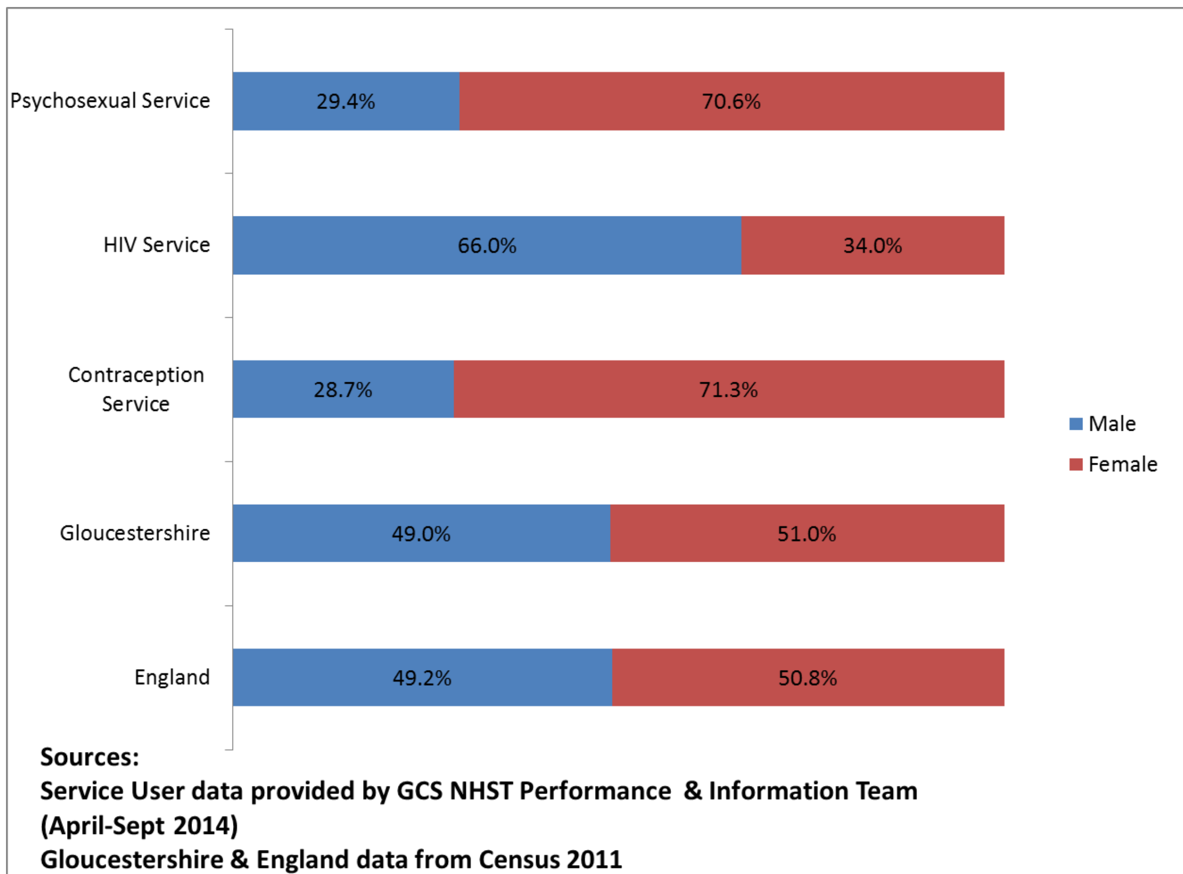


Figure 33: Sexual Health Services - service users by sex

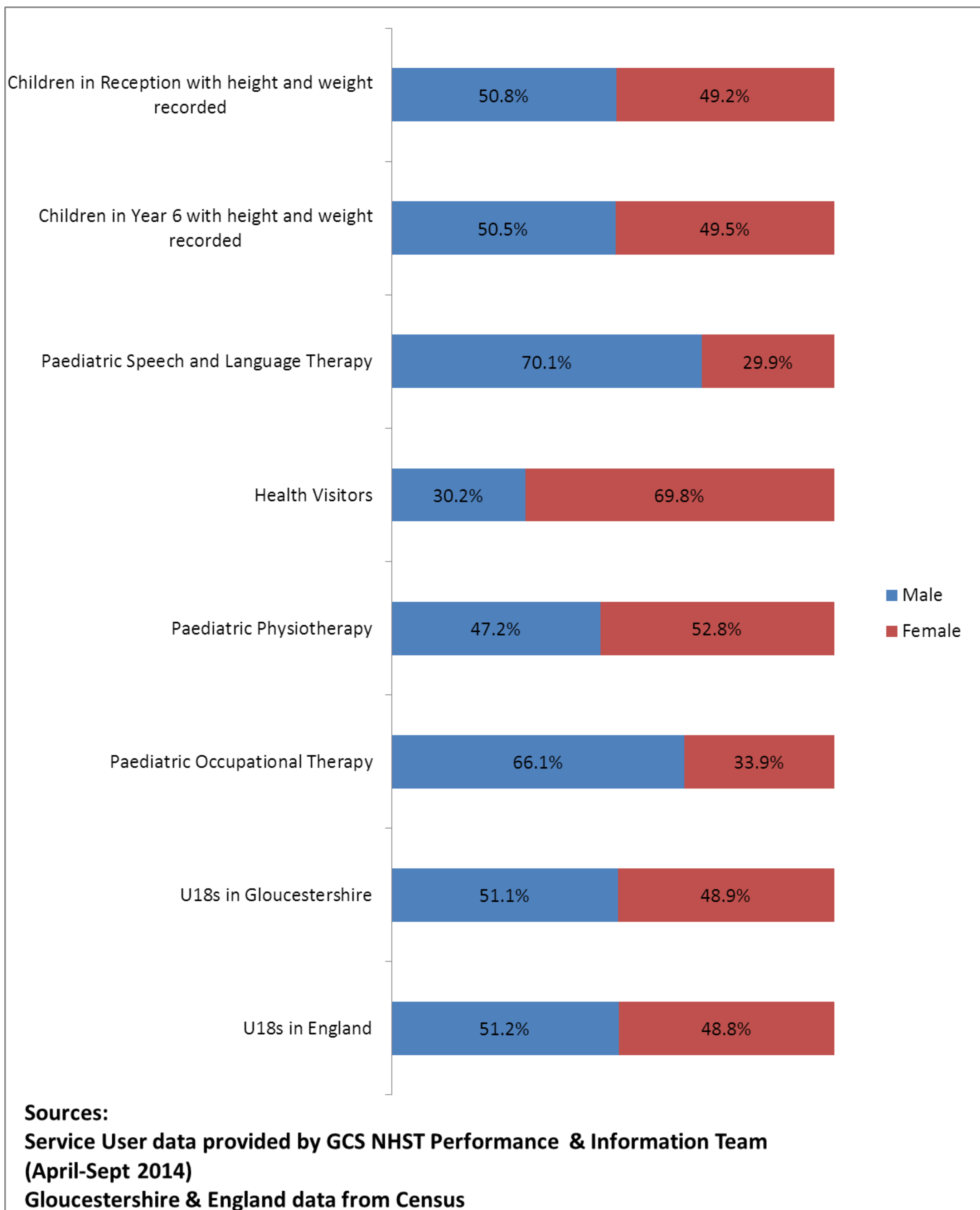


Figure 34: Children's Services - service users by sex

Appendix C: Waiting times for services

These tables show actual waiting times for services and how they compare with local and national targets.

Source: Locality performance reports Sept 2014

Service	Target	2013/14	2014/15 YTD[41]
Adult community services			
Integrated Community Teams physiotherapy service	Target % treated within 8 Weeks	95%	95%
	Actual	97%	95%
Musculo-skeletal Physiotherapy	Target average wait (weeks)	2.0	2.0
	Actual	2.2	3.1
	Target % treated within 8 Weeks	95%	95%
	Actual	97%	96%
Musculo-skeletal Clinical Assessment and Treatment (MSKCAT) Service	Target % treated within 8 Weeks	95%	95%
	Actual	98%	72%
	Target % of referrals on to secondary care	<30%	<30%
	Actual	5%	4%
	Target % wait from referral for routine patients does not exceed 4 weeks	4.0	95%
	Actual	3.2	42%
	Target % wait from referral for urgent patients does not exceed 2 weeks	2.0	95%
	Actual	1.7	60%
Podiatry	Target average wait (weeks)	2.0	2.0
	Actual	2.3	3.7
	Target % treated within 8 Weeks	95%	95%
	Actual	98%	88%
Speech and Language Therapy	Target % treated within 8 Weeks	95%	95%
	Actual	99%	97%
Occupational Therapy	Target % treated within	95%	95%

[41] YTD = Year to Date, i.e. April-Sept 2014

Service	Target	2013/14	2014/15 YTD[41]
Adult community services			
Services	8 Weeks		
	Actual	100%	99%

Service	Target	2013/14	2014/15
Specialist services			
Parkinson's Nursing - % treated within 8 Weeks	Target	95%	95%
	Actual	100%	100%
Diabetic Nursing - % treated within 8 Weeks	Target	95%	95%
	Actual	99%	97%
Bone Health Service	Target % treated within 8 Weeks	95%	95%
	Actual	95%	87%
Combined Specialist and Non-Specialist wheelchair Service	Target average wait (weeks)	2.0	2.0
	Actual	1.0	1.0
Occasional Wheelchairs	Target % treated within 8 Weeks	95%	95%
	Actual	100%	100%

Sexual Health Services			
Service	**Target**	**2013/14**	**2014/15**
GUM	Target % offered to be seen within 48 hours	100%	100%
	Actual	100%	100%
	Target % actually seen within 48 hours	95%	95%
	Actual	99%	98%
Contraception Service	Target % treated within 8 Weeks	95%	95%
	Actual	99%	99%
HIV Service	Target % treated within 8 Weeks	95%	95%
	Actual	100%	100%
Psychosexual Service	Target % treated within 8 Weeks	95%	95%
	Actual	83%	100%

Children's Services			
Service	**Target**	**2013/14**	**2014/15**
Diagnostic test results – children's services	Target % of patients waiting less than 6 weeks from referral for a diagnostic test	>99%	>99%
	Actual	100%	100%

	Target % of screens of well babies completed by 5 weeks in community sites	>95%	>95%
	Actual	98.8%	99.3%
Newborn hearing screening	Target % screens completed by 5 weeks (community sites)	>95%	>95%
	Actual	98.8%	99.3%
Newborn Bloodspot test	Target % of result by 17 days of age	95%	95%
	Actual	96.8%	TBC
Health Visiting	Target % of Children who have a two-year review by 32 months of age	>93.4%	>93.4%
	Actual	95.3%	96.9%

Waiting times in Minor Injuries Units

Target		**2013/14**	**2014/15**
% seen and discharged within 4 Hours	Target	95%	95%
	Actual	99.8%	99.8%
Number of breaches of 4 hour target	Actual	56	57
Number of hours spent waiting on a trolley in the MIU	Target	<12 hrs	<12 hrs
	Actual	0	0
Total time spent in MIU	Target	<4 hrs	<4 hrs
	Actual	01:49	01:59
Time to initial assessment for patients arriving by ambulance	Target	<15 m	<15 m
	Actual	00:10	00:11
Number of handovers between ambulance and MIU taking more than 30 minutes.	Target	0	0
	Actual	0	0
Time to treatment in department (median)	Target	<60 mins	<60 mins
	Actual	00:23	00:26

Appendix D: Responses to patient surveys

Overall responses to service user survey questions

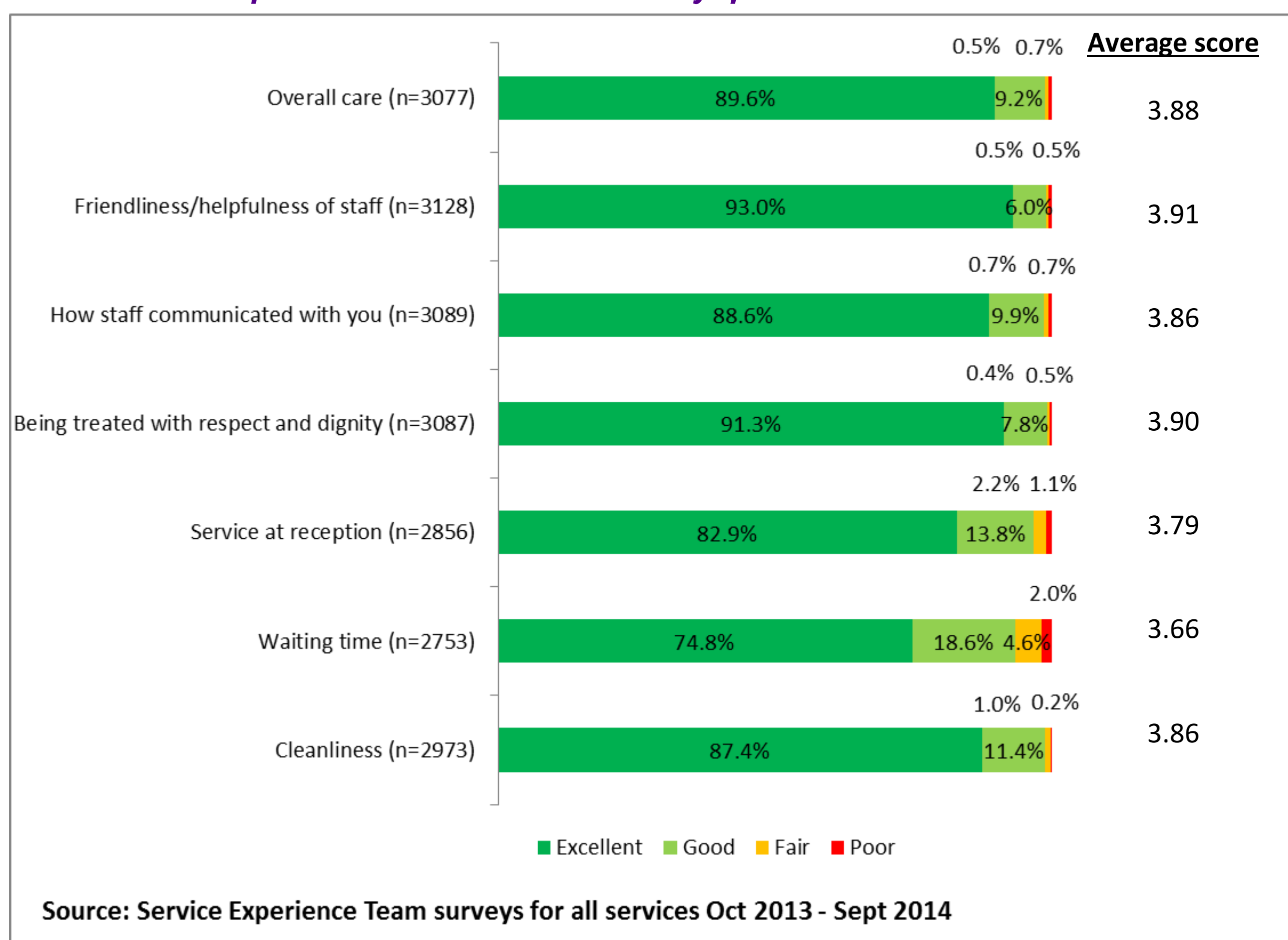


Figure 35: Experiences of service users (Source: Service Experience Team surveys for all services Oct 2013 – Sept 2014)

How likely are you to recommend this service to friends or family if they needed similar care or treatment?	Number of responses	% responses
Extremely likely	12058	83.7%
Likely	1905	13.2%
Neither Likely nor unlikely	178	1.2%
Unlikely	82	0.6%
Extremely unlikely	68	0.5%
Don't know	113	0.8%
Total	14404	100%

Figure 36: Likelihood to recommend services to family and friends if they needed similar care or treatment (Source: Service Experience Team surveys for all services Oct 2013 – Sept 2014)

Responses to service user survey questions analysed by age

	Total	16-24	25-34	35-44	45-54	55-64	65-74	75+
Excellent	91.1%	88.0%	91.6%	91.3%	93.0%	86.5%	93.9%	87.1%
Good	8.0%	9.3%	7.1%	7.6%	6.2%	6.7%	5.5%	12.3%
Fair	0.4%	0.8%	0.5%	0.8%	0.3%	0.0%	0.0%	0.4%
Poor	0.5%	1.9%	0.5%	0.2%	0.5%	0.0%	0.7%	0.2%
N/A	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
Satisfaction score	3.90	3.83	3.89	3.90	3.92	3.93	3.93	3.86
Total number of respondents	2817	259	392	472	371	346	458	519
Age group as a % of total		9.2%	13.9%	16.8%	13.2%	12.3%	16.3%	18.4%

Figure 37: "To what extent did you feel you were treated with dignity and respect?" analysed by age (n= 2817; Source: Service Experience Team surveys for all services Oct 2013 – Sept 2014)

Likelihood to recommend	**Total**	**16-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75+**
Extremely likely	86.4%	72.8%	82.5%	86.5%	90.6%	92.7%	91.2%	84.7%
Likely	12.0%	23.6%	15.7%	12.7%	8.5%	6.9%	7.9%	11.5%
Neither Likely nor unlikely	0.7%	3.0%	0.7%	0.4%	0.2%	0.2%	0.2%	1.5%
Unlikely	0.3%	0.0%	0.5%	0.0%	0.3%	0.2%	0.4%	0.9%
Extremely unlikely	0.2%	0.0%	0.5%	0.2%	0.2%	0.0%	0.0%	0.4%
Don't know	0.3%	0.5%	0.2%	0.2%	0.3%	0.0%	0.2%	1.1%
Likelihood score	4.83	4.68	4.79	4.84	4.88	4.92	4.89	4.76
Total number of respondents	3874	368	600	806	662	490	478	470
Age group as % of total		9.5%	15.5%	20.8%	17.1%	12.6%	12.3%	12.1%

Figure 38: "How likely are you to recommend this service to friends or family if they needed similar care or treatment?" analysed by age (n=3874; Source: Service Experience Team surveys for all services Oct 2013 – Sept 2014)

Appendix E: Use of Face-to-Face interpreting services

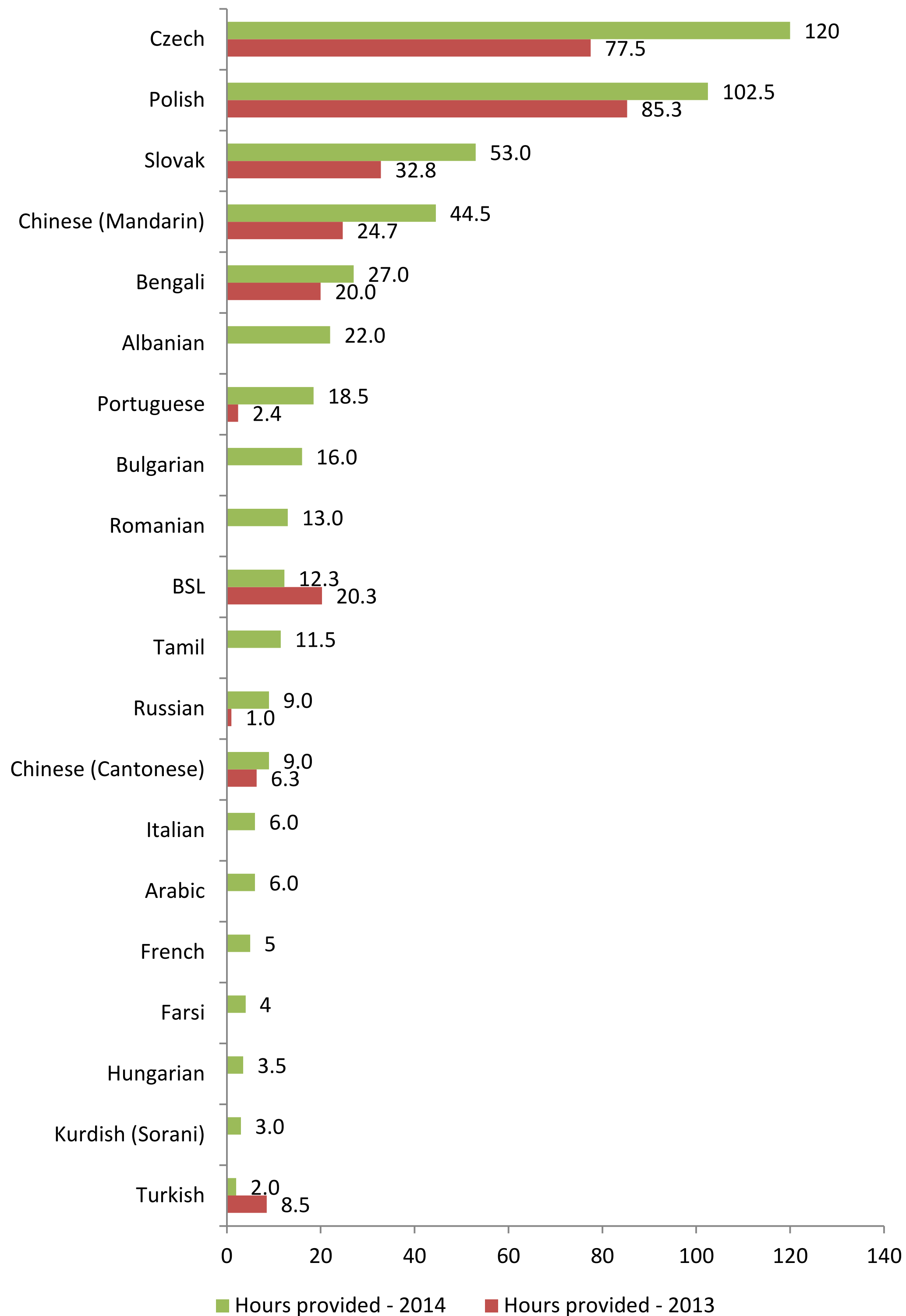


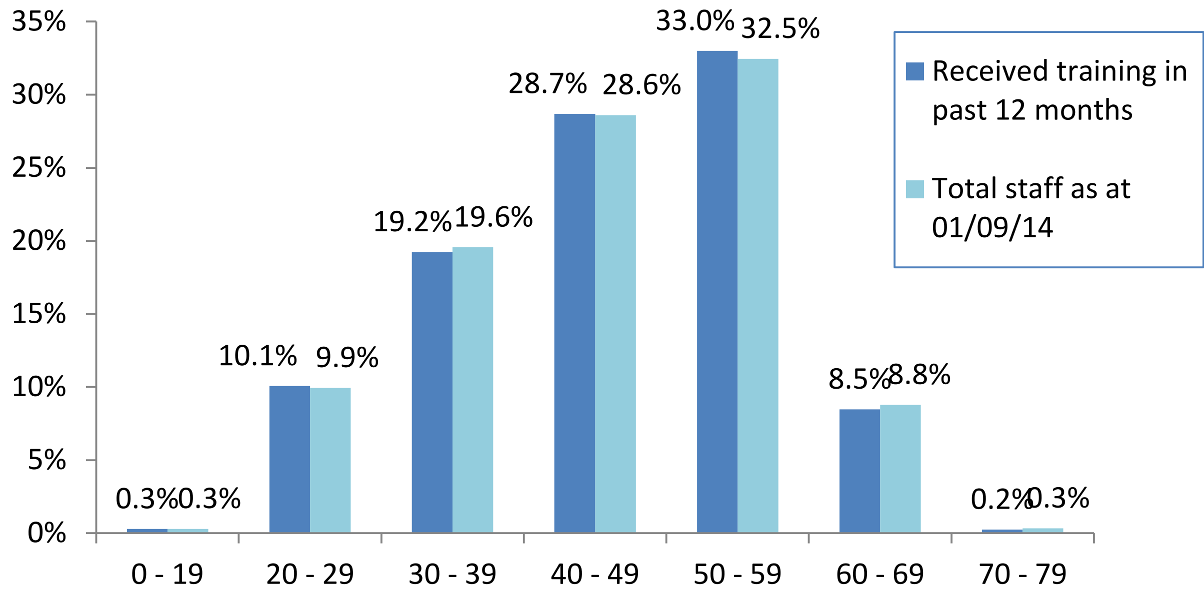
Figure 39: Face-to-face interpreting usage comparing April-Sept 2013 and April-Sept 2014 (Source: Prestige Network Ltd)

Appendix F: Recruitment data by protected characteristics

	Applied	Shortlisted	Appointed
Numbers	8841	2796	418
Disability	5.4%	4.9%	3.8%
No disability	94.6%	95.1%	96.2%
Heterosexual	91.4%	92.8%	92.1%
Gay	1.0%	1.2%	1.9%
Lesbian	0.6%	0.5%	0.5%
Bisexual	0.8%	0.6%	0.2%
Undisclosed	6.1%	4.9%	5.3%

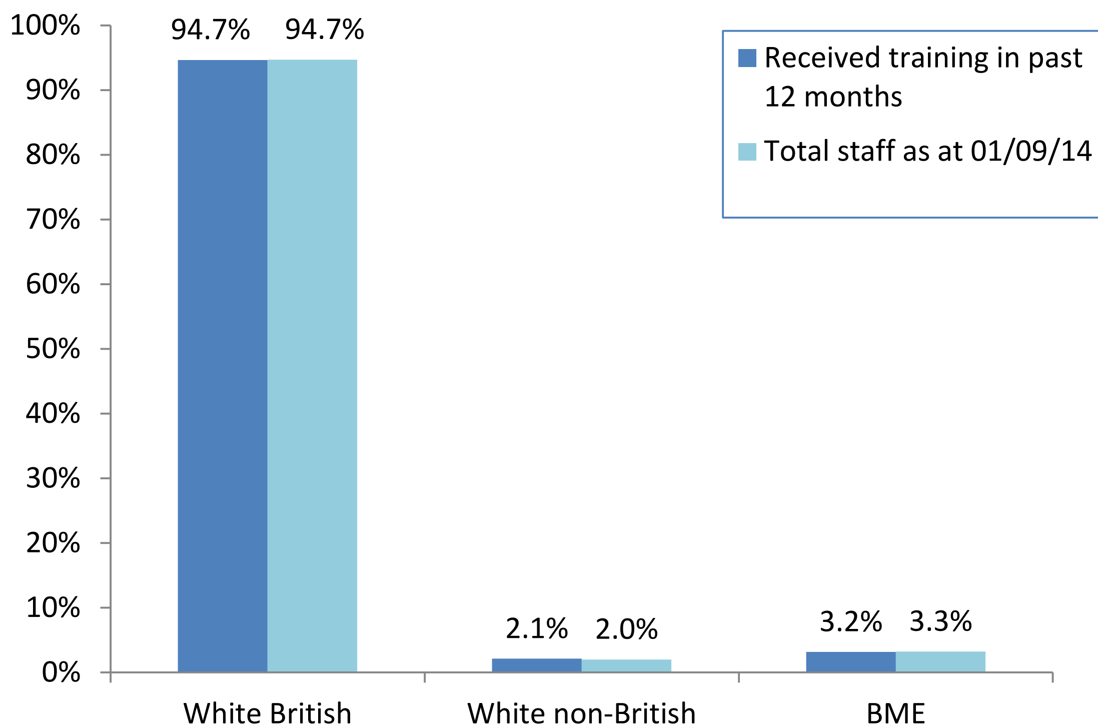
Figure 40: Recruitment by Disability and Sexual Orientation
(Source: NHS Jobs 01/11/2013 – 31/10/2014)

Appendix G: Access to training by protected characteristics



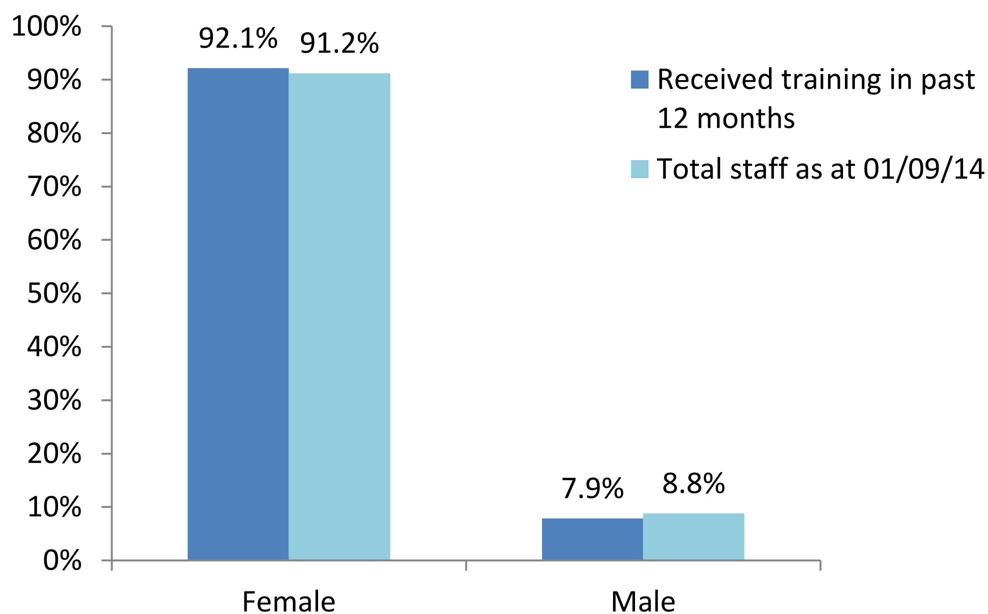
Source: ESR
Received training in past 12 month (01/09/13 - 31/08/14) (n=2443)
Total staff as at 01/09/14 (n=2674)

Figure 41: Access to Training by age



Source: ESR
Received training in past 12 month (01/09/13 - 31/08/14) (n=2443)
Total staff as at 01/09/14 (n=2674)

Figure 42: Access to training by Race



Source: ESR
Received training in past 12 month (01/09/13 - 31/08/14) (n=2443)
Total staff as at 01/09/14 (n=2674)

Figure 43: Access to training by Sex