



**Barts Health Equality and
Human Rights Impact
Assessment Report
March 2012**

brap

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About brap

brap is a think fair tank, inspiring and leading change to make public, private, and community sector organisations fit for the needs of a diverse society. brap offers progressive, tailored, and common sense solutions to equalities training, consultancy, and community engagement issues.

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Cover photo

Street art in Brick Lane.

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GLOSSARY

BME	Black and minority ethnic
CAG	Clinical academic group
CCG	Clinical commissioning group
CQC	Care Quality Commission
EDS	Equality Delivery System
EHRC	Equality and Human Rights Commission
EHRIA	Equality and human rights impact assessment
ESR	Electronic staff register
FBS	Full business case
GLA	Greater London Assembly
HRA	Human Rights Act
ICESCR	International Covenant on Economic, Social and Cultural Rights
ONS	Office for National Statistics
PSED	Public sector equality duty
VCO	Voluntary community organisation

EXECUTIVE SUMMARY

1. Introduction and background

This is a summary of the key findings of an equality and human rights assessment (EHRIA) analysing the merger of Barts and the London NHS Trust, Newham University Hospitals NHS Trust, and Whipps Cross University Hospital NHS Trust. The EHRIA was conducted by brap, an equality and human rights charity, between January and March 2012.

This is a data-rich report, and as such difficult to summarise. As part of the assessment, brap was asked to compile baseline data of inequalities as they relate to staff, local health conditions, and experiences of, and access to, care, as well provide an overview of the equalities implications of the merger. Since different sections will appeal to different people, depending on the information they're looking to extract, it may be useful to signpost readers to summaries of these sections as they appear in the report:

- staff data: pages 24-29
- health outcomes: pages 124-143
- patient experience: pages 144-150
- access to care: pages 151-155
- equalities implications of the merger: 190-204

Having said that, this executive summary provides a brief overview of the key equality considerations which the new organisation, Barts Health NHS Trust, may wish to consider going forward. For ease of reference, the recommendations are grouped under the key goals identified by the Equality Delivery System¹ since this might provide Barts Health with a useful head start in developing its response to the EDS. It is equally important, however, that Barts Health cross-reference its progress on equality against the requirements of the new public sector equality duties (introduced by the Equality Act 2010). For an overview of this, interested readers should see section IV.3.

2. Better health outcomes for all

Better health outcomes for all is the first goal of the EDS. It states that organisations should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results.

Overview of EHRIA findings

A review of the available data, conducted as part of this impact assessment process, found that it is often difficult to identify health inequalities within the Barts Health catchment area

¹ The EDS is a tool for NHS organisations to use to review their equality performance and to identify equality objectives and actions. It offers local and national reporting and accountability mechanisms. For more information go to: www.eastmidlands.nhs.uk/about-us/inclusion/eds

since the availability of local level data disaggregated by protected characteristic varies from borough to borough. Furthermore, while one or two boroughs may hold data relating to race, gender, or age, there is a particular paucity of data regarding the newer characteristics afforded protection by the Equality Act 2010: religion and belief, sexual orientation, and gender reassignment, for example.

Where local-level data does exist, it suggests that people from a Black background will be disproportionately affected by conditions such as chronic pulmonary disorder, tuberculosis, HIV and conditions that require admittance to psychiatric inpatient services. In contrast, 2008 figures from the Eastern Region Public Health Observatory suggest the incidences of coronary heart disease, cardiovascular disease, and hypertension will be more prevalent among White groups.

Given the paucity of local-level data (relating to the protected characteristics contained in the Equality Act) it may be useful to extrapolate from what is known about the demographic profile of the Barts Health catchment area. Greater London Assembly projections suggest the catchment area² will contain a majority Black and minority ethnic (BME) population, with people from a Bangladeshi background comprising the largest ethnic group, followed by Pakistanis and Black Africans. Nationally, levels of smoking are particularly high amongst Bangladeshis, with smoking-related conditions rising as a result. Prevalence of diabetes is also 13 times higher among children of a South Asian background.

Whilst the reasons for differential health outcomes are complex and multifaceted, it is apparent that some communities are slow to identify and respond to illness such as diabetes and cancer. Furthermore, some ethnic groups – such as those from Other White, Chinese, and African backgrounds – are less likely to access primary care through, for example, GP services which leads to a greater reliance on acute services when health problems come to a head.

Actions proposed by Barts Health

Promoting health improvement and reducing health inequalities will be one of Barts Health's four strategic outcomes, and as such will be embedded in the work of CAGs (such groups will, for example, be required to give the promotion of fairer outcomes due consideration in the development of their medium- and long-term plans). Furthermore, there are extensive plans for CAGs to liaise with local commissioners and patients when developing priorities, which will help ensure that the needs and views of local communities are reflected in decision making. This is in addition to plans to work with a range of North East London partners, such as GPs, primary care teams, and Health and Wellbeing Boards. Finally, the merger's Full Business Case also highlights plans to review the development of appropriate metrics used by CAGs to ensure delivering on health outcomes remains a central focus.

² Data relayed here is for a rough approximation of the Barts Health catchment area, encompassing the boroughs of Newham, Tower Hamlets, and Waltham Forest.

Proposed actions: things to consider

- a primary and obvious concern is the extent to which initial clinical strategic priorities can be influenced by considerations of health inequalities given the lack of local-level evidence (as it affects people with different protected characteristics).
- it is important the Trust considers what aspects of its proposed activities will be undermined if strong connections are not made with 'under the radar' groups. Currently, public health strategies and plans to promote access to primary care and expand community-based care may be hindered without a robust engagement strategy which avoids piecemeal or sporadic consultation
- the Trust should develop clear protocols around how CAGs engage with groups and how they demonstrate they have analysed and responded to local intelligence. There is the need to develop clear 'feedback loops' so people understand impact of consultation. Finally, these protocols should focus on the 'principles' of effective engagement, part of which is a recognition that participants' skills and the expertise they bring around equality and human rights is often more important than their demographic background
- expertise on individual health issues (and knowledge of local community groups) is dispersed across Barts and the London, Newham, and Whipps Cross. As roles combine or are made redundant, it is important that knowledge transfer procedures are conducted within a clear framework that picks up on local intelligence, lessons learnt from professional experience, and the intricacies of micro-level health issues. This is particularly significant given there are plans for knowledge transfer around issues of clinical importance but none for cross-cutting equality and human rights issues

3. Improved patient access and experience

This is the second goal of the EDS. It sets out a clear expectation that patients will be able to readily access services. Organisations are expected to promote positive experiences of care, during which patients' dignity is upheld.

Overview of EHRIA findings

Quantitative research clearly shows that, across the three pre-merged Trusts, people from Bangladeshi and Indian backgrounds are significantly more likely to say they were not always treated with dignity and respect compared to White British people. Similarly, one in five men report not always being treated with dignity and respect, a figure that rises to one in four women. In relation to specific facets of care such as receiving respect from doctors, young people are more likely to report poorer experiences than older people, people from Pakistani and African backgrounds poorer experiences than White British.

Feedback from consultation also revealed, anecdotally, particular incidents of poor experience which did not appear confined to a particular group. For example:

- stroke patients with mobility issues said nurses often left food and drink outside their reach
- some participants said nurses ignore patients who can't talk properly (such as stroke patients with speech problems)
- it was particularly common for people not to have privacy when discussing their treatment and/or condition
- examples were provided of nurses losing their temper with patients, in particular the elderly

With regard to access, patients at Whipps Cross from Pakistani and White Other backgrounds comprise the largest BME groups when looking at figures for admissions, outpatients, and A&E attendances. Within Newham, people from a White Other background are significantly more likely to attend A&E than their profile in the local community might suggest.

The results of various consultations suggest that those on lower incomes find it difficult to attend and keep appointments. Not only are transport costs currently very high, but many on lower incomes have co-morbidities which mean they have several appointments to attend and as such have to prioritise conditions. Travel also affected older and disabled people, some of whom said they would greatly benefit from a ring and ride service.

Given the importance placed on improving take-up of primary care, research was also briefly conducted into the number of people accessing GP surgeries in the boroughs of Newham, Tower Hamlets, and Waltham Forest. Generally speaking, White British people are less likely to visit GP surgeries than the make-up of local communities might suggest. Within Tower Hamlets, Indian and Pakistani people are less also likely to access GP services; within Newham, the same is true for people from Chinese, Pakistani, and Bangladeshi backgrounds; and within Waltham Forest this is the case for people from African backgrounds.

Poor experiences of GP services, across the three boroughs, were relayed by people from Bangladeshi backgrounds. A high number of people from Other White and Chinese backgrounds do not know how to contact an out-of-hours GP service. People aged 25- 34 are also more likely to have 'fairly poor' or 'very poor' experiences at GP surgeries.

Actions proposed by Barts Health

Improving patient access and experience is at the heart of the Full Business Case, which outlines the rationale and benefits of the merger.³ In particular, there are plans for Barts Health to commission specialist services (such as non-complex chemotherapy) closer to home. This is in addition to a number of specific strategies which aim to ensure patient experience considerations are mainstreamed into decision-making, including co-designing

³ The Full Business Case, December 2011 is available at: <http://tinyurl.com/chkqltt>

service change (particularly in areas where health inequalities are particularly large, such as diabetes); reflecting patient perspective in decision-making; learning from and acting upon feedback; and embedding patient experience responsibilities into each and every role. Systematic feedback from patients and carers will be included in the appraisal of senior clinical staff and any learning needs will be included in professional development plans.

Proposed actions: things to consider

- despite no significant changes in access for some residents – and improved access for others – there will still be accessibility issues going forward. As mentioned above, there are significant challenges faced by those in poverty and those without access to transport or who face mobility problems
- given the importance of improving access to care, it is important that clear and effective proposals around this are developed swiftly. For example, there are plans to establish an Equality and Human Rights Committee: it is legitimate to ask how people will be recruited to this and how the committee will access views of the most excluded in the catchment area. There is a risk that current gaps in reach of consultation processes will be replicated in the merged Trust
- in developing any future patient experience strategy, patient experience metrics will need to be disaggregated where possible by protected characteristics since the evidence clearly shows disparities in experience within particular groups (such as women, young people, and people from Bangladeshi and Indian backgrounds)
- it is also important that the development of patient experience measurements take into account those aspects of experience that are actually important to people. Evidence shows that some fundamental manifestations of dignity – acknowledging patients’ requests even if they can’t be met, leaving food out of people’s reach – are not being upheld
- it appears that fragmented care and gaps in informatics have led to a number of never events (Alzheimer’s patients being discharged without carers being informed, the wrong patients being approached for amputations, and so on). As greater emphasis is placed on tertiary and community-based care, and while care pathways are being redesigned, it is important plans are in place to tackle these issues ‘head-on’

4. Empowered, engaged and well-supported staff

This is the third goal of the EDS. It requires organisations to increase the diversity and quality of their staff’s working lives, supporting all employees to better respond to patients’ needs.

Overview of EHRIA findings

Collated data across the pre-merged Trusts suggests Barts Health may wish to explore further the representation of Asian (and in particular, Bangladeshi and Pakistani) staff, given the makeup of the surrounding community. Disabled staff are significantly underrepresented

in all three Trusts when compared to what is known about the local working age population. Black and Asian staff will be concentrated in bands 5 and 6. Men tend to be underrepresented in bands 2-6 but overrepresented in bands 8 and 9 and as consultants.

Levels of bullying and harassment identified by NHS Staff Surveys suggest that BME staff in all three Trusts are more likely to have experienced discrimination at work in the last 12 months compared to the national average. Although in many cases the number of disciplinarys in any given period is too small to draw robust conclusions, the general trend is for BME staff to be slightly more likely to be subject to disciplinary proceedings and more likely to raise a grievance when compared to their overall profile within the Trusts. Younger people (under the age of 30) are much less likely to raise a grievance than older colleagues. Age equality also appears to be a particular challenge in terms of promotion, with young members of staff more likely to receive promotion than older ones.

Consultation with staff in the different, pre-merged Trusts suggests that there are issues, within specific locations, of poor performance and a reluctance to challenge such performance if there is a risk of people raising equality-related grievances.

Actions proposed by Barts Health

The transition process will inevitably involve upheaval for existing staff, including redundancies, relocations, pay reviews, managerial changes, and so on. Barts Health has committed itself to conducting robust equality impact analyses of these procedures, in line with the requirements of the Equality Act. The new Trust will also provide guidance for CAGs on integrating equality and human rights into decisions affecting the workforce. Such guidance will include requirements to produce recruitment plans and provide equality and human rights training. Many longstanding personnel issues are expected to be tackled through organisational change resulting from the merger – for example, the recruitment and retention of talented management is expected to improve through the positioning of Barts Health as a dynamic, high-profile organisation at the cutting edge of research.

Proposed actions: things to consider

- staff buy-in into the merger process varies across location and between groups. It appears some staff feel the merger is being 'done to them' and not something they have ownership of. Others are not excited or motivated by the change since they are not convinced it will address longstanding workplace issues, such as unfair recruitment and promotion practices.
- there are particular methodological and procedural issues Barts Health will have to address in relation to the analysis of staff equalities data. For example, the pre-merged Trusts gather data using different groupings within particular categories, which makes comparison difficult. The standardisation of categories may simply be a procedural issue of deciding how to run information off the ESR. However, it may be useful to investigate what information is collected during, say, appraisals or once grievances have been raised

- connected with the above point, there is a need to address how data is collected in relation to *all* protected characteristics covered by equalities legislation. At the moment, monitoring around pregnancy and maternity and gender reassignment are patchy. (There may be sound legal and regulatory reasons why this is the case; however, it may be useful to explore whether these are opportunities for the Trust to be pre-emptive in dealing with people's sensitivities around data collection and monitoring.)

5. Inclusive leadership at all levels

Inclusive leadership is the final EDS goal. It covers how leaders and managers ensure everyone takes an active part in promoting equality.

Overview of EHRIA findings

Currently, across the three pre-merged Trusts the existing equalities infrastructure is extremely robust. The organisations' equalities reports show that each Trust has a sound grasp of the demographics and dynamics of their service users and workforce. However, feedback from consultation shows some staff members don't always feel equalities issues are properly resourced. This is most evident in the provision of equality training, which some people felt was cursory and not as in-depth as the topic actually warrants.

Actions proposed by Barts Health

Barts Health has outlined how human rights, equality, and diversity should be integrated into the work of clinical academic groups. There is a written statement outlining key areas CAGs should consider when planning their work, and it covers such topics as community engagement, the importance of equity and diversity to organisational culture, and the collection and use of data. The new organisation has stated its intention to ensure CAGs have an Equality Champion, staff receive equalities training, and that equality leads support CAGs in thinking through the impact of their decisions.

Proposed actions: things to consider

- it is important the Equality Champion is in a senior leadership position, to ensure the agenda has visibility, credibility, and 'stickability' (that is, it remains a priority when other issues emerge). Equality Champions will need to have sufficient training and a clear mandate so they can manage performance against equality targets.
- there are some significant gaps in health inequalities data disaggregated by different protected characteristics. Thus far different Trusts have used differing types of data depending on local availability. There is a risk that this will continue, making it harder to baseline progress on health inequalities across the catchment going forward
- a small number of staff described some of the drawbacks to previous equality training they had received (such as the use of an online programme that does not allow them to explore

issues in more depth). There is a risk that training of this type will not help to embed the seeds required to achieve organisational culture change of the type that is required

- the role of leadership in embedding cultural change on equality and human rights is not explored in much detail within the published documents pertaining to the merger. Procedural issues are described (which staff will have executive responsibility for decisions, for example); however, clear plans are required around what leaders will actually do to ensure equality and human rights is central to the organisational culture going forward.

6. Conclusions and recommendations

As the equality considerations outlined above show, there are a wide range of equality and human rights issues relating to the proposed merger. Listed below are a number of 'high-level' strategic themes and potential priorities for the merged Trust as it develops its own approach to progressing equality and human rights.

6.1 Acting on available data

There is a significant amount of available information that could inform the merged Trust's future strategy on equality and human rights. This report is only part of that equation: the 'Equality Impact Assessment: Completed Initial Screening Form of the Outline Business Case' (August 2011) and the 'Equality Impact Assessment, Initial Screen, Outline Business Case Summary and Recommendations Paper' (September 2011) are just two others. Given this weight of information, it would be all too easy for the Trust to become consumed by reviewing this data and conducting more work to gather further information before key decisions are made. However, a key challenge for the Trust – and one it will need to respond to quickly – is using what information is already available to develop clear aspirations and success measures around equality and human rights. Despite important gaps, a significant amount of data is already available: the Trust will need to move fast to avoid getting 'bogged down' attempting to close gaps it cannot currently avoid.

6.2 Challenging poor patient experience

All three Trusts have acknowledged they face challenges in improving patient experience. This research suggests younger people, particular ethnic groups, and women are more likely to say they are not treated with dignity and respect. As such, the new Trust may wish to consult with patients, carers, and staff to identify the behaviours which, if enacted at key moments along the care pathway, could help ensure patients' rights are protected. This type of approach can be used to develop 'patient promises' or a 'patient charter' which could be used by patients to hold the Trust to account if staff are behaving in a way that is below agreed quality benchmarks. It can also be used to identify the types of expectations placed upon patients themselves as they engage with the system.

It is also important CAGs think carefully about how 'difference' and 'diversity' is responded to. Whilst specific community groups may have specific requests, it will be important for CAGs to make proportionate and reasonable decisions about how the majority of people's rights are protected across the care pathway.

6.3 Devising equality objectives

The Trust will need to develop equality objectives to meet its obligations under the Equality Act 2010. A significant amount of data is already available to support the Trust to identify some of its key objectives around staff and service provision. The task for the Trust is to agree which of those inequalities it is best placed to do something about, and devise an approach and priorities that are 'proportionate' and 'reasonable'. The best equality objectives will be decided in part by an organisation's executive team and board members. Their endorsement is crucial to people taking the objectives seriously. It should also be developed in partnership with local people, local public agencies, and VCOs. This should be considered as a core component of a range of Trust work-streams (e.g., organisation development, clinical and patient experience strategy).

6.4 Improving equality-related data

There is a paucity of data on health inequalities disaggregated by protected characteristics. Long-term plans are therefore needed as a matter of urgency to develop more up-to-date, equality-specific evidence that can inform future care-planning over the decades to come.

6.5 Staff welfare

It is likely that the Trust has already made plans to consider staff welfare going into the merger process. It is essential that equality and human rights are integrated into work of this nature. There is a window of opportunity for staff recruitment, progression and anti-discrimination processes to be reviewed and to develop new processes which are seen as fair across the board. It appears there may be some challenges around staff performance, which relate in part to issues of inequality. Staff will need assurances to understand how the merged Trust will respond to long-standing problems of inequality and discrimination. A swift and anonymous internal staff survey could help to identify some of these challenges. Similarly, strong messages from senior leadership from the very beginning of Barts Health's inception (and repeated on a regular basis) could help to clearly express the Trust's vision for equality and human rights and how it is working to progress this vision.

I. INTRODUCTION

1.1 Background to this report

This report is the result of an equality and human rights analysis of the proposed merger of Barts and London NHS Trust, Newham University Hospitals NHS Trust and Whipps Cross University Hospital NHS Trust. It provides the proposed merged trust (Barts Health) with an opportunity to recognise and capitalise on the advantages of the potential merger in relation to equality and human rights. It also helps to identify potential negative effects. How can the merger be made more advantageous? How can previous patterns of inequality and discrimination be screened out in the future using the energy of creating a new organisation to drive improved practice, develop new standards and deliver better health outcomes for all?

The equality and human rights analysis builds on an initial equality impact assessment screening of the Outline Business Case already undertaken by the three Trusts to understand the equality implications of the merger. Given the health inequalities in the area, the Trusts have recognised that there will be potentially significant equality and human rights implications to the merger. They have also noted that the broad process of equality and human rights analysis must be on-going as the merger integration programme develops its work-streams and as the new organisation takes shape. This report is part of that process. The Trusts would like the equality analysis contained in this report to also help them in developing the future Equality Strategy of Barts Health and in undertaking on-going measurement of equality progress.

This report was written by brap, a national, innovative and no-nonsense equality and human rights charity. brap were commissioned to take an overview of the situation and advise on the equality and human rights implications of the merger as they relate to particular protected characteristics (as covered in the Equality Act 2010). Key requirements for this external support taken from the project specification are included below:

- reviewing and examining the findings of an initial Equality & Human Rights Analysis (EHRIA) of the Outline Business Case
- testing the conclusions and recommendations of that initial EHRIA with stakeholders;
- collecting baseline data covering the catchment area of the proposed merged Trust (population, health inequalities and staff equality data) – this was seen by the Project Steering Group as a priority
- undertaking an EHRIA with reference to the baseline data
- a description of the negative and positive impacts of the merger and the central issues that need to be addressed to mitigate the negative impacts

- a description of the communities and or stakeholders and or target groups within the baseline population data who would be most adversely or positively impacted by the merger and how these specific negative impacts will be mitigated
- steps that the merged trust can take to achieve compliance with its Public Sector Equality Duty in light of the conclusions of the analysis of baseline data and stakeholder consultation
- a mapping of the stakeholder groups and or community organisations within the merged trust's catchment area that need to be invited to participate in partnership working with the CAGs and proposals for initiating this process
- appendices providing the evidence base used;
- a directory of community organisations and other stakeholder organisations (as an appendix to the report).

1.2 Policy and legislative context

The NHS is facing one of the most changeable and challenging periods in recent times. NHS organisations are responding to the effect of broader public service funding cuts, restructuring and changes brought about by the Health and Social Care Bill. In terms of equality and human rights, all public bodies are required to comply with staged implementation of the Public Sector Equality Duty in 2012 (publication of information to show compliance with the Equality Duty by end of January and setting and publishing equality objectives by 6 April). NHS Trusts are being encouraged to adopt the Department of Health's Equality Delivery System which is an optional but recommended approach to managing and delivering on equality in healthcare in the future. Also in recent years a number of hospitals have faced high-profile public scrutiny relating to infringements of people's human rights (e.g. CQC's recent Dignity and Nutrition Review and the Frances Enquiry focused on Mid-Staffs Hospital). At the same time healthcare providers across the board are being asked to improve transparency and enhance their engagement with patients to drive quality improvement. In summary, healthcare providers are being encouraged (from a number of different angles) to improve their understanding and practice of engaging with patients and progressing equality and human rights.

It is in this social, legal and political context that Barts Health is embarking on this proposed merger. At a local level, as in many other poorer areas of the country, concerns have been raised by people from vulnerable groups about the equity, quality and impact of some existing healthcare services. The merger is seen as a key component in the North East London response to reducing health inequalities. There is a lot riding on the successful implementation of this merger and this report is produced to support future equality implementation in this regard.

1.3 Using this report

This report is divided into three main sections in line with the key requirements for this work:

- Part 1: Baseline review split into three parts – demography, staff, and health inequalities data
- Part 2: Results of consultation with stakeholders
- Part 3: Equality analysis: implications for the merger and for Barts Health future equality strategy

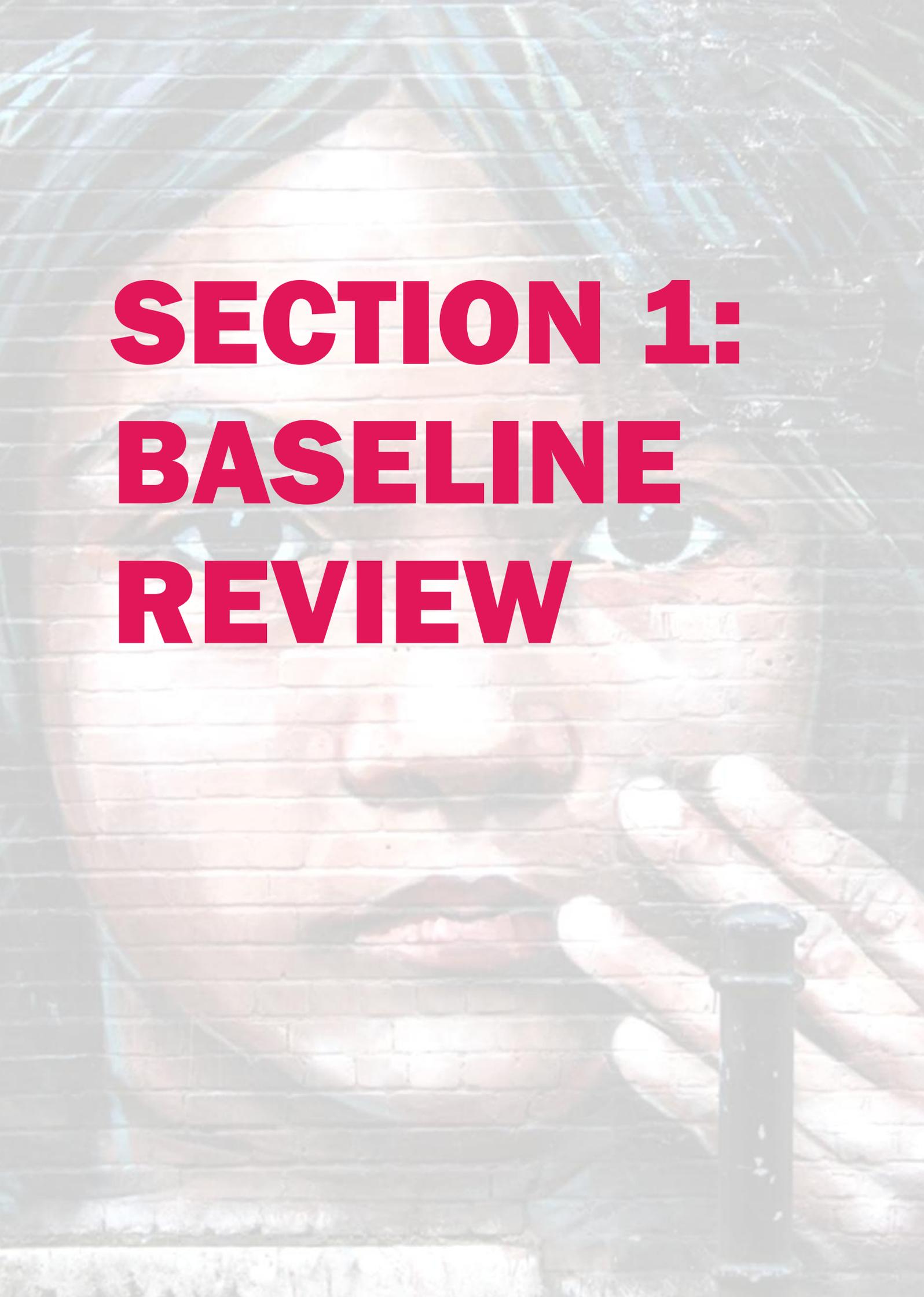
Each section of this report informs the overall equality and human rights analysis of the merger. However, they are written so that each can also be read separately.

1.4 About brap

brap is a think fair tank, inspiring and leading change to make public, private and voluntary sector organisations fit for the needs of a more diverse society. brap offers tailored, progressive and common sense approaches to equalities training, consultancy and community engagement issues.

In the past, brap has worked for organisations including the Department of Health, Macmillan Cancer Support, the Health Foundation, Heart of Birmingham PCT, Yorkshire and Humber Improvement Partnership, University Hospital Southampton NHS Foundation Trust, Birmingham South Central Clinical Commissioning Group, and many others.

The Human Rights Standard brap developed for Macmillan Cancer Support has been warmly welcomed by the Department of Health in its national cancer strategy. For more information visit www.brap.org.uk



SECTION 1: BASELINE REVIEW

II. STAFF EQUALITIES DATA: A BASELINE

1. INTRODUCTION

1.1 Aims of this section

The aims of this section of the baseline review are to:

1. collate in one place existing workforce data held by the three Trusts
2. establish, where possible, a baseline against which future activity can be measured
3. identify gaps in the collection of data within and across the three Trusts

1.2 How data was collected

The equality leads and HR colleagues within each of the Trusts arranged for brap to be sent relevant data. In addition, brap:

- reviewed the most up-to-date NHS staff surveys available at the time (2010)
- conducted two face-to-face surveys with staff to identify concerns and suggestions for areas of workforce equality that merit particular analysis. In the limited time available surveys included a drop-in stand at a staff engagement event for all 3 Trusts held on 26 January (8 people) and a focus group conducted with staff at Newham on 7 February 2012 (3 people)

After an initial review, Trusts were invited to send further data to fill 'gaps' that were evident between the three organisations. The cut-off point for receipt of information was 20 February 2012, five days before the submission of this report.

1.3 A health warning

The data here has been reproduced to help inform Barts Health's future approach to equality analysis. We recognise that issues around levels of disclosure and sample sizes mean it won't always be possible to draw robust conclusions from the information presented. For example, within their equality reports and other similar documents some Trusts have refrained from providing data relating to areas such as training or capability proceedings on the grounds that not enough information is available and analysis of these figures is not viable. However, for the purposes of this report we have reproduced some data where sample sizes are small or levels of disclosure low so that the Trusts can better understand the limitations of data going forward.

1.4 An overview of findings

Here's a quick summary of the findings. They relate to (a) staff equality issues and (b) methodological issues to consider.

1.4.1 Key equalities issues

- Workforce demographics

Individually, Trusts have identified areas of concern specific for their organisation (Barts and the London, for example, has raised the underrepresentation of Bangladeshi staff in the organisation, given the makeup of the local community). Disabled staff are significantly underrepresented in all three Trusts when compared to what is known about the local working age population (though this is likely to be due in part to low disclosure rates on disability). Collated data across the Trusts also suggests that the new organisation may wish to explore further the representation of Asian (and in particular, Bangladeshi and Pakistani) staff.

- Staff in band

Black and Asian staff are concentrated in bands 5 and 6. There are very few Black consultants (albeit data was only provided by one Trust). Men tend to be underrepresented in bands 2-6 but overrepresented in bands 8 and 9 and as consultants.

- Discrimination, bullying and harassment

Levels of bullying and harassment identified by the NHS Staff Surveys are well known within all three Trusts; and have, indeed, prompted joint research to uncover the reasons as to why this might be the case. For example, disabled staff in Newham are much more likely to have experienced bullying, harassment or abuse from staff in the last 12 months. Staff in all 3 trusts are more likely to have experienced discrimination at work in the last 12 months compared to the national average and this affects some groups more than others (e.g. Black and Minority Ethnic staff).

- Disciplinary and grievances

Although in many cases the number of disciplinarys in any given period is too small to draw robust conclusions, the general trend is for BME staff to be slightly more likely to be subject to disciplinary proceedings and more likely to raise a grievance when compared to their overall profile within the Trusts. Younger people (under the age of 30) are much less likely to raise a grievance than older colleagues.

- Promotion

Age equality seems to be a particular challenge in terms of promotion. As Whipps Cross note: 'younger members of staff are more likely to receive promotion than older ones',⁴ while

⁴ Whipps Cross (2011) Whipps Cross University Hospital NHS Trust HR Department Workforce (Equalities) Information Report January to June 2011

Barts and the London acknowledge the need to explore the opportunities available to older employees in light of the removal of the default retirement age⁵. The new, merged organisation may wish to explore how promotions are advertised and allocated.

1.4.2 Methodological issues

- Increasing levels of disclosure

Currently all three Trusts have low levels of disclosure around disability, religion and belief, and sexual orientation. This is a complex issue which all the Trusts have committed themselves to tackling. The new, merged organisation should be mindful of retaining knowledge about the particular reasons – perhaps connected to organisational culture – which explain why staff are reluctant to disclose information in this regard. That is to say, the work currently being undertaken by Trusts on this issue should not be lost.

- Standardising categories

At the moment, Trusts use different groupings within particular categories, which makes comparison difficult. Most obviously, this is the case with reference to the ethnicity categories used by Whipps Cross. Although basic demographic data is collected using specific categories, disaggregation on issues such as training provision and promotion is restricted to broad categories. Similarly, the groupings used by Newham to categorise people's ages do not allow comparison across the Trusts. The standardisation of categories may simply be a procedural issue of deciding how to run information off the ESR. However, it may be useful to investigate what information is collected during, say, appraisals or once grievances have been raised.

- Addressing 'gaps' in monitoring

It is difficult to state with certainty all the types of information that the three Trusts monitor. This is for a number of reasons. Primarily, however, it is because the data that was provided was, on the whole, taken from equality reports. This means the data had already been analysed by the Trusts and certain categories or issues filtered out. For example, Barts and the London clearly state in their equality report that information relating to training is not included given 'wide variations between the numbers of attendees on...courses'. Equally, Newham have limited the inclusion of data to priority areas for their organisation. The fact that organisations have not presented data obviously does not mean they do not hold it.

As part of the research process brap did give organisations an opportunity to provide additional data. While this prompted a great deal of extra information, some of the Trusts explained they would not be able to provide all the information that was requested within the timescales dictated by the project. Again, then, 'gaps' in this report are not necessarily an indication that an organisation does not monitor a particular issue or characteristic. It will be important for the new merged organisation to confirm this in due course with relevant HR departments as they plan combined workforce equality monitoring protocols.

⁵ Barts and the London (2012) Annual Equality Report

Having said this, we have included below an overview of some of the differences in monitoring we have noted from the data available to us. The table on the following page attempts to summarise the information that was shared as part of the research process.

As can be seen, no Trust appears to monitor information relating to staff gender reassignment or pregnancy/maternity status (although Barts and the London collects information on maternity leave). For this reason the table below does not include a column for these protected characteristics. This is an important gap to be filled, in light of the requirements of the Public Sector Equality Duty. In developing a proportionate response to this duty the merged Trust will need to consider how it can best demonstrate its ability to support staff and patients. So, for example, the Trust may decide not to collect information on gender reassignment in the way it does for other protected characteristics to avoid illegal 'outing' of transgender staff (or indeed patients).

With regards to the actual information that is monitored, the Equality and Human Rights Commission suggest the following as a starting point:

- applicants for jobs/roles, the number of people shortlisted, and the number of people subsequently appointed
- workforce profile – the number of people employed and their level within the organisation
- staff satisfaction levels
- the extent of disciplinary action⁶

In addition, given provisions in the Equality Act 2010 and the Equality Delivery System, it is best practice for healthcare organisations to monitor levels of equal pay.

Much of the above is monitored across all three Trusts. However, the new, merged organisation may wish to explore how levels of staff satisfaction are measured. Available NHS staff survey data on this topic (at least in the format brap researchers were able to access) may not allow for analysis at a sufficient level of granularity to identify key equality issues for the Trust (e.g. comparing staff satisfaction against staff band and ethnicity). In addition the new merged organisation may wish to review policies and processes for determining levels of equal pay and how up-to-date existing information is.

⁶ Equality and Human Rights Commission (2011) Good equality practice for employers: equality policies, equality training and monitoring. Available at: <http://tinyurl.com/7xqjvz>

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	Age	Disability	Ethnicity	Sex	Marital status	Religion and belief	Sexual orientation
Staff in post	data received from all Trusts	data received from all Trusts	data received from all Trusts	data received by all Trusts	data received by all Trusts	data received by all Trusts	data received by all Trusts
Staff in post by AFC banding	data received from Newham (bands 1-9) and Whipps X (bands 1-9, consultants and others)	data received from Whipps X	data received from Newham (bands 1-9) and Whipps X (broad categories only) (bands 1-9, consultants and others)	data received from Newham (bands 1-9) and Whipps X ((bands 1-9, consultants and others)	no data received	no data received	no data received
Disciplinary	data received from Newham and Whipps X	monitored by all Trusts	data received from all Trusts (Whipps X: broad categories only)	data received from all Trusts	- data received from Barts and the London - Whipps X confirmed that data is not monitored	data received from Barts and the London and Newham	data received from Barts and the London and Newham
Grievances	data received from Barts and the London and Whipps X Newham confirmed that data can be disaggregated this way	data received from Barts and the London and Whipps X Newham confirmed that data can be disaggregated this way	data received from Barts and the London and Whipps X (broad categories only) Newham confirmed that data can be disaggregated this way	data received from Barts and the London and Whipps X Newham confirmed that data can be disaggregated this way	- data received from Barts and the London - Newham confirmed that data can be disaggregated this way	- data received from Barts and the London - Newham confirmed that data can be disaggregated this way	- data received from Barts and the London - Newham confirmed that data can be disaggregated this way

Capability	- data received from Barts and the London only - Newham confirmed that data can be disaggregated this way	- data received from Barts and the London only - Newham confirmed that data can be disaggregated this way	- data received from Barts and the London only - Newham confirmed that data can be disaggregated this way	- data received from Barts and the London only - Newham confirmed that data can be disaggregated this way	- data received from Barts and the London only - Newham confirmed that data can be disaggregated this way	- data received from Barts and the London only - Newham confirmed that data can be disaggregated this way	- data received from Barts and the London only - Newham confirmed that data can be disaggregated this way
Promotion	data received from all Trusts	data received from all Trusts	data received from all Trust (Whipps X: broad categories only)	data received from all Trusts	no data received	data received from Barts and the London and Newham	data received from Barts and the London and Newham
Access to training	Barts and the London: No data received. However, it appears from equality report that data is monitored						
	Newham: At time of writing (February 2012) training information was still being analysed at the Trust						
	some data available from Whipps X	some data available from Whipps X	some data available from Whipps X (broad categories only)	some data available from Whipps X	no data from Whipps X	no data from Whipps X	no data from Whipps X
Detriments/ demotions	- data on downgrades received from Newham - data on detriments received from Whipps X	- data on downgrades received from Newham - data on detriments received from Whipps X	- data on downgrades received from Newham - data on detriments received from Whipps X (broad categories)	- data on downgrades received from Newham - data on detriments received from Whipps X	no data received	data on downgrades received from Newham	data on downgrades received from Newham
Equal pay	-	-	-	received	-	-	-

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				information from Whipps X pertaining to 2010			
Applicants	data received from all Trusts	data received from Barts and the London, Newham, and Whipps X (with 'not known' shown separately)	data received from Barts and the London, Newham, and Whipps X (broad categories)	data received from all Trusts	no data received	data received from Barts and the London and Newham	data received from Barts and the London and Newham
Shortlisted	data received from Barts and the London and Newham	data received from Barts and the London	data received from Barts and the London and Newham	data received from Barts and the London and Newham	no data received	data received from Barts and the London and Newham	data received from Barts and the London and Newham
Starters	data received from all Trusts	data received from all Trusts (Whipps X: 'not known' conflated with 'yes')	data received from all Trusts	data received from all Trusts	no data received	data received from Barts and the London and Newham	data received from Barts and the London and Newham

2. STAFF IN POST

This section outlines basic demographic data for the three Trusts. The data underlying the charts and their original sources can be found in appendix A.

2.1 Staff in post: overview

Data is organised around the nine protected characteristics covered under the Equality Act 2010.

2.1.1 Age

It is difficult to accurately draw comparisons between the three Trusts' staff age profiles, since all three use slightly differently cut-off points to determine age categories (see tables, 1.1.1a, 1.1.1b, and 1.1.1c in appendix A).

However, the categories used by Barts and the London and Whipps Cross are similar, so data for these two Trusts are combined in figure 2.1.1a (page 31). Some categories have been combined to facilitate this comparison (for example, the 65-69 and 70+ age categories used by Barts and the London are displayed as a single 65+ category to match the format used by Whipps Cross). Newham Trust is shown separately since its categorisation does not allow comparison.

Notwithstanding these variations, it is clear that within all three Trusts, the majority of staff are within the 30-50 age category. Staff in the 25-29 age group are slightly underrepresented when compared to the wider population in the area. Whipps Cross has a slightly older staff profile, with over a quarter of employees (25.5%) aged over 50, compared with 19.6% in Barts and the London and 21.7% in Newham. However, Whipps Cross does have a slightly older local population profile compared to the catchment area of the other two Trusts.

2.1.2 Disability

Whipps Cross presented disability-related data using slightly different categories to Barts and the London and Newham (see tables 1.1.2a and 1.1.2b in appendix A). Figure 2.1.2 below conflates data into the broadest available categories. It also merges data to present a breakdown for the new, merged organisation.

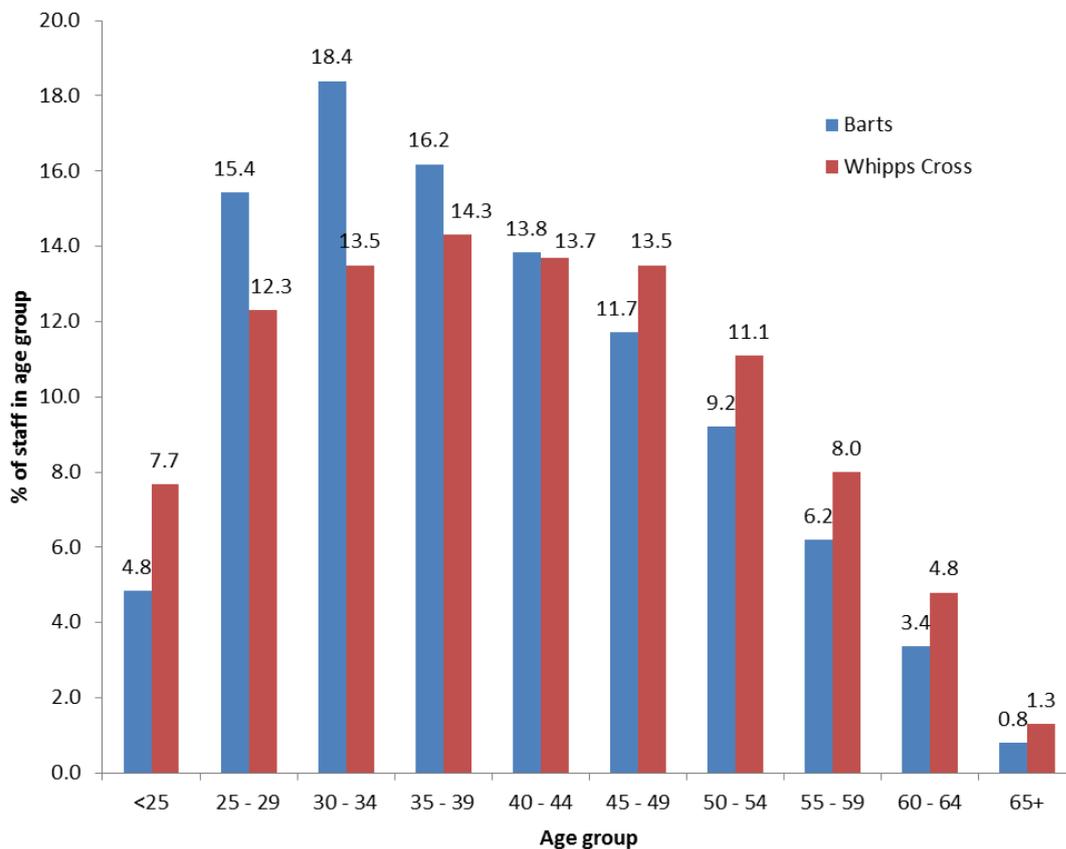
Figure 1.1.2: SIP by disability (all Trusts)

	No of staff		% of total staff	
	Disabled	Not disabled/not known	Disabled	Not disabled/not known
Barts and the London	53	8 444	0.62	99.38
Newham	36	2 240	1.58	98.42
Whipps Cross	45	3 561	1.25	98.75
Merged total	134	14 245	0.93	99.07

Available data about the percentage of the local working age population who are disabled is from 2009 (two years earlier than the data in the table above). However, presuming there are not significant changes in the local population over that two-year period, disabled staff are significantly underrepresented in the three Trusts compared to the local population. Figures from 2009 show 14.9% of people of working age in Newham were disabled, 16.8% in Tower Hamlets (catchment area of Barts and the London) and 15.7% in Waltham Forest (catchment area of Whipps Cross) (see Part 2 on demography for more information).

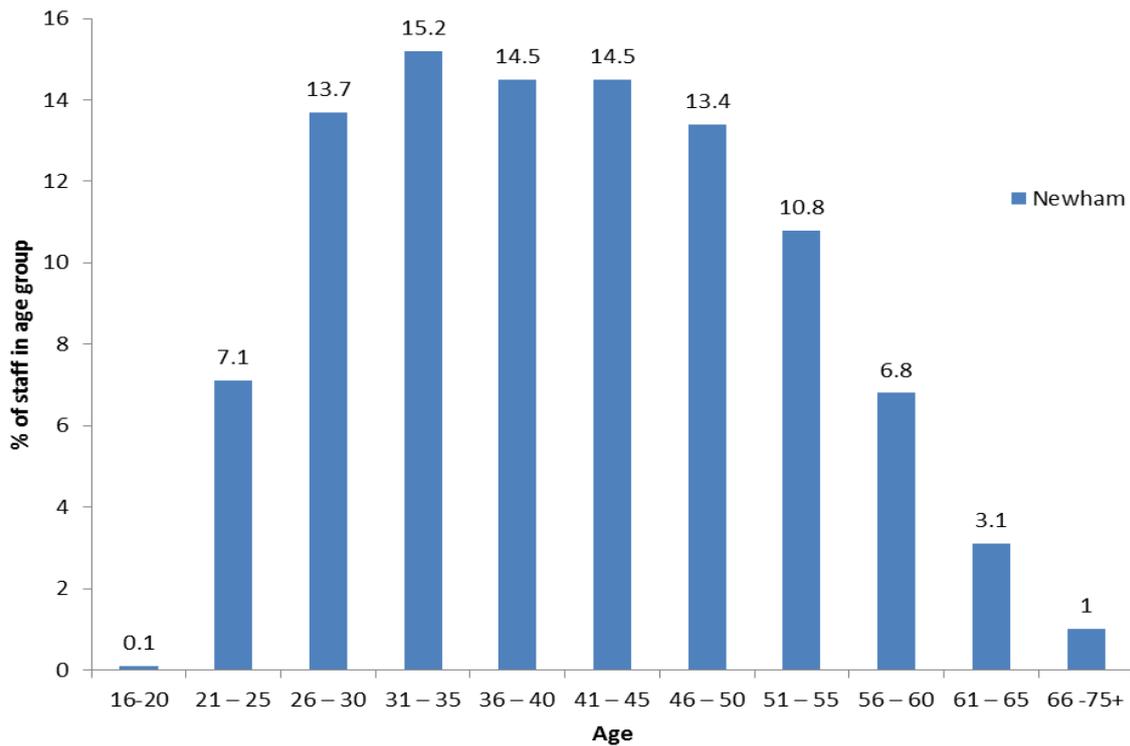
However, this discrepancy is also probably due in no small part to low levels of disclosure. All the three Trusts acknowledge that work needs to be done to improve staff disclosure rates on this issue.⁷ The paucity of data affects analyses of other indicators later in the report.

Figure 2.1.1a: Staff in post by age group (Barts and the London and Whipps Cross)



⁷ For example, Barts and the London NHS Trust (2012) Annual Equality Report; Newham University Hospital NHS Trust (2011) Annual Equality and Diversity Report 2011; and Whipps Cross (2011) Whipps Cross University Hospital NHS Trust HR Department Workforce (Equalities) Information Report January to June 2011

Figure 2.1.1b: Staff in post by age group (Newham)



2.1.3 Ethnicity

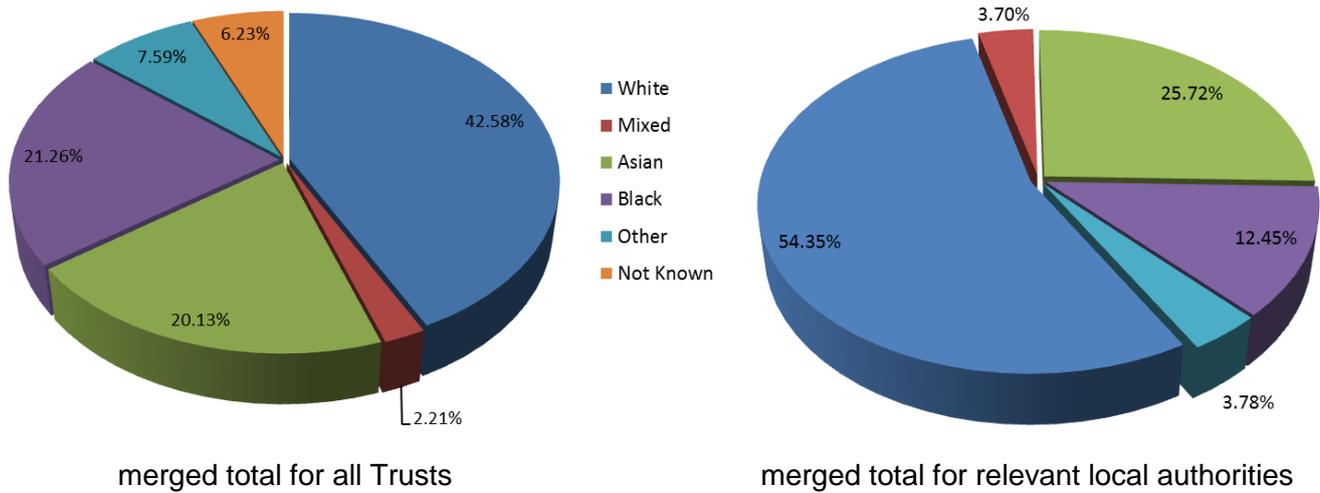
Although all three Trusts appear to collate data using categories derived from the NHS Staff Census, the headings under which information was provided to the researchers differed slightly (see tables 1.1.3c, 1.1.3d, and 1.1.3e in appendix A). In the figures below, data have been recalibrated so they conform to similar categories and comparisons can be made.

The simplest way to conflate data is under the six main ethnicity category headings used in the Census: White, Mixed, Asian, Black, Other, and Not known. Figure 2.1.3a provides a merged figure for the new organisation. Alongside this is a chart showing the ethnic composition of the area covered by Newham, Tower Hamlets, and Waltham Forest local authorities (broadly speaking, the communities served by the three Trusts).⁸

It appears that Asian staff in the three Trusts are underrepresented when compared with the surrounding area, forming 20.13% of the workforce despite being 25.72% of the community. Black people are overrepresented within the Trusts, forming 21.26% of the workforce and only 12.45% of the community.

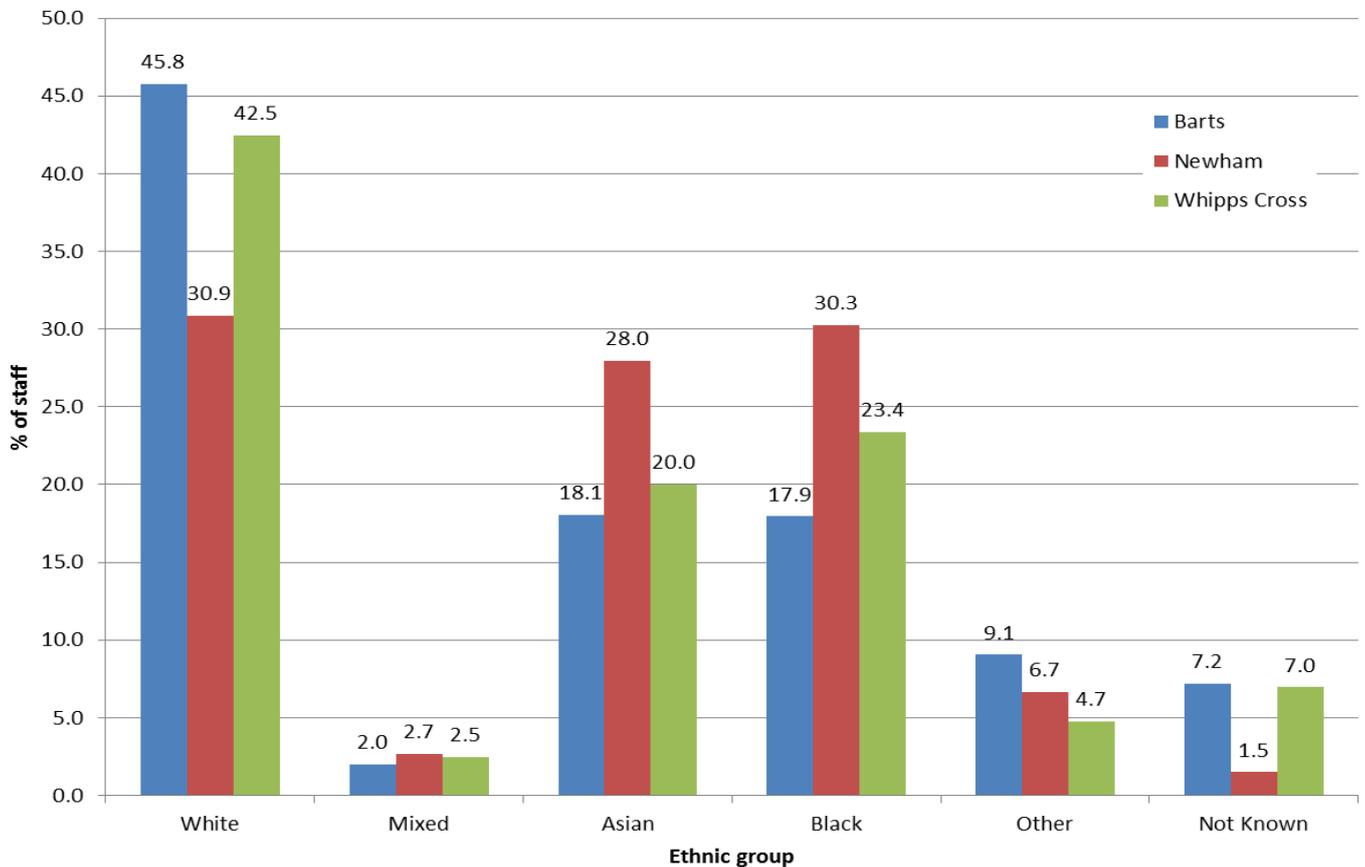
⁸ Data for the local population is taken from Office for National Statistics (2009) *Resident Population Estimates by Ethnic Group*. These estimates are ‘experimental’ statistics and have not yet received formal National Statistics status. For more information see: www.neighbourhood.statistics.gov.uk

Figure 2.1.3a: SIP by ethnicity (broad categories) (merged figure for all Trusts)



Identifying the identity of staff whose ethnicity is currently unknown (6.23%) will be an important task. Figure 2.1.3b suggests that this is currently more of an issue within Barts and the London and Whipps Cross (for whom, respectively, 7.2% and 7.0% of staff fall into this category), as opposed to Newham, where the figure is 1.0%

Figure 2.1.3b: SIP by ethnicity (broad categories) (all Trusts)



Obviously, this presentation of the data does not differentiate particular ethnic groups within each broad ethnic category. In the figures below more detailed analysis of particular ethnic categories is provided. Where there were 'unique' categories to a particular Trust, these have been recorded as the 'any other background' heading within the relevant major category. For example, people who have self-identified as 'Black Nigerian' are included below under 'Black or Black British - Any other Black background'. People who self-identified as 'White Greek' are included in 'White or White British – Any other White background'. Specific 'Mixed' delineations have been subsumed under 'Mixed background', which was the broadest relevant reported category. As can be seen from table 1.1.3e (appendix A), Whipps Cross provided extremely detailed information, the specificity of which is lost under 'Other specified' below.

Judging from figure 2.1.3c, the four most populous ethnic categories within the new, merged organisation will be White British (31.61%), Black African (12.62%), White Other (8.42%), and Indian (8.14%).

Currently, White Other makes up a significant proportion of staff at Barts and the London (8.8%) and Whipps Cross (9.0%) (see figure 2.1.3d, page 35). Equally, Indian staff comprise 14.7% of the workforce at Newham. Black African staff are also a significant grouping at Newham (23.2%) and Whipps Cross (13.2%).

Comparison of ethnicity of staff in terms of banding hierarchy is done in section 2.2.3.

Figure 2.1.3c: SIP by ethnicity (narrow categories) (merged figure for all Trusts)

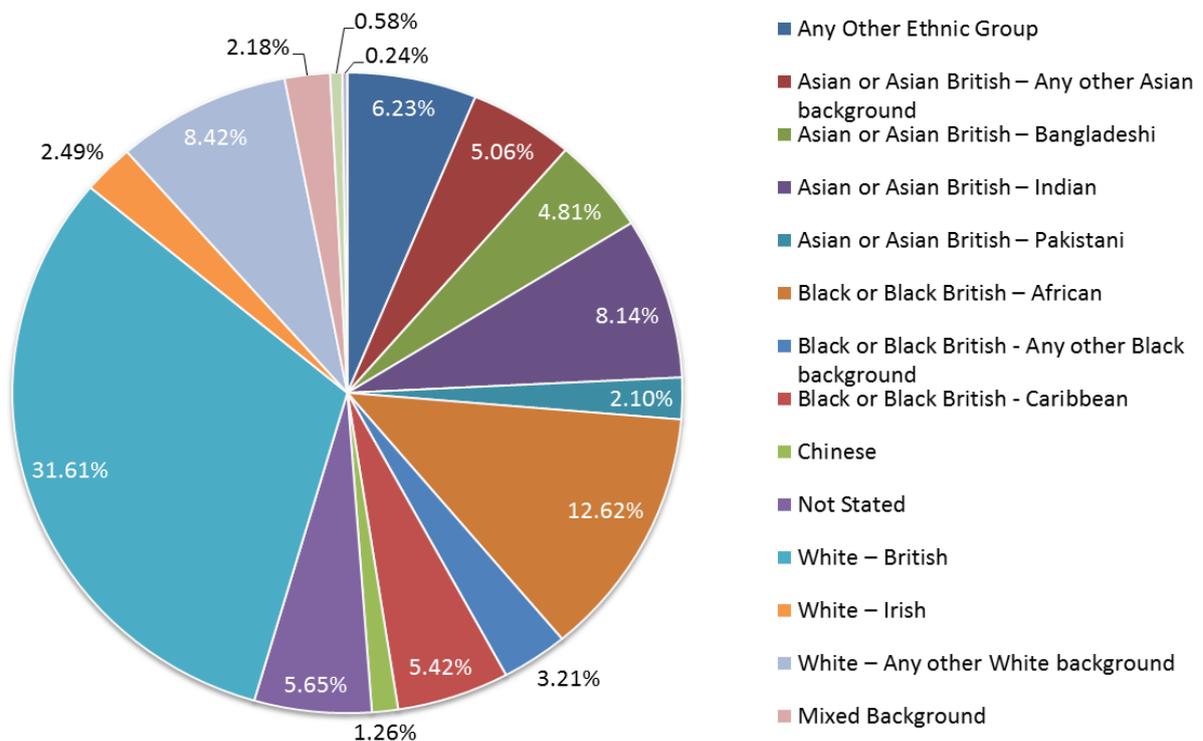
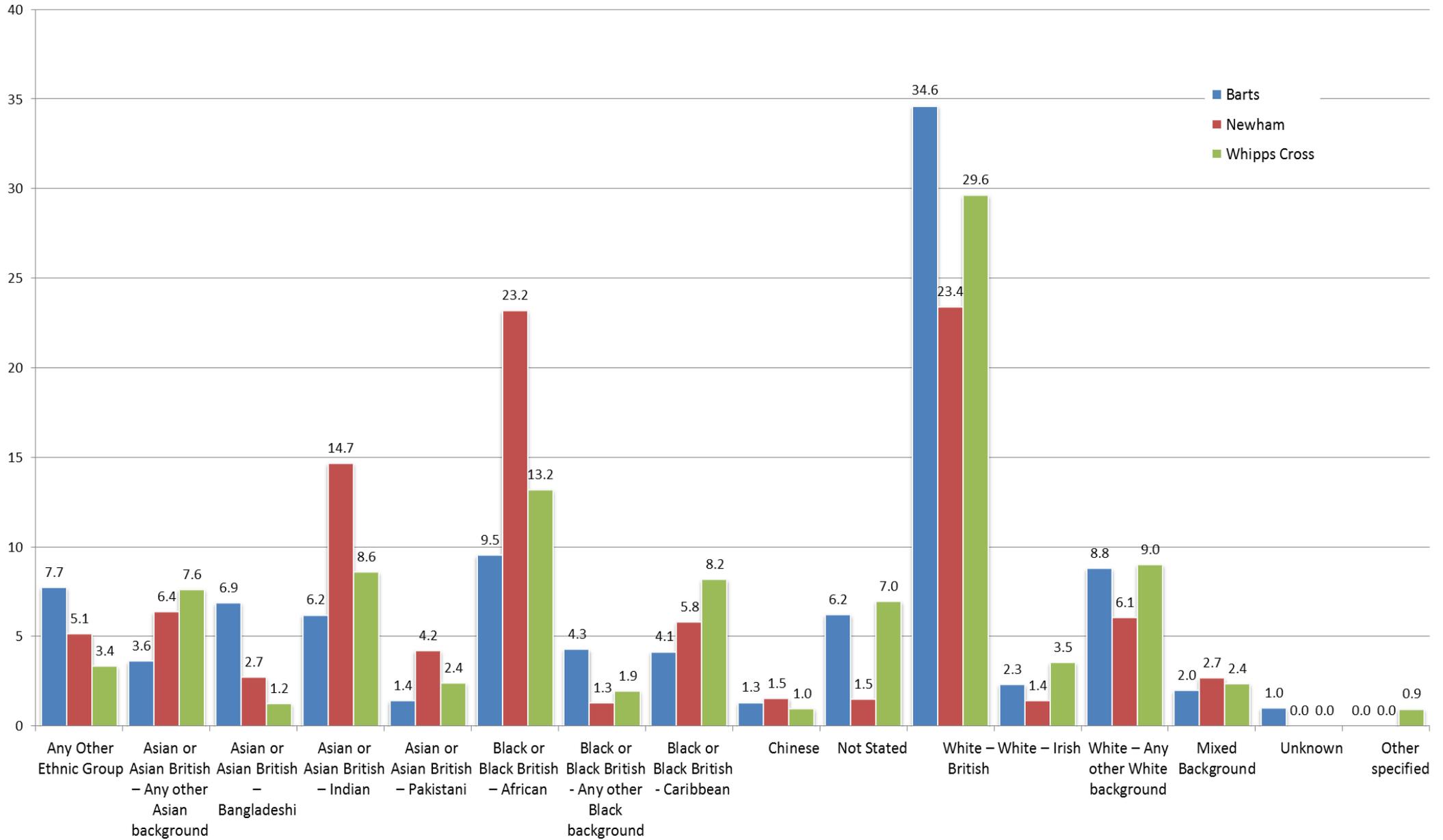


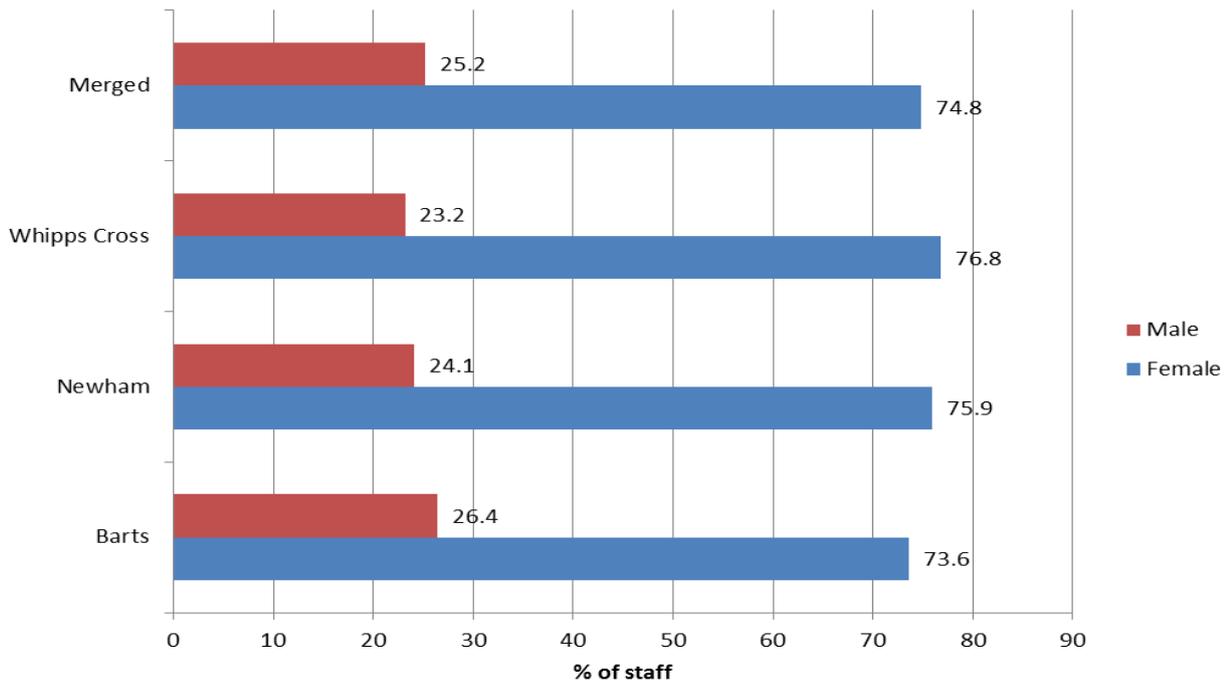
Figure 2.1.3d: SIP by ethnicity (narrow categories) (all Trusts)



2.1.4 Sex

All three Trusts have a similar staff sex breakdown, with women making up approximately three quarters of the workforce. Data have been combined in figure 2.1.4a below to give a sex breakdown for the new, merged organisation. Men are underrepresented when compared to the broader local population yet the staff sex profile is largely representative of the NHS workforce as a whole.

Figure 2.1.4a: Staff in post by sex (all Trusts)



2.1.5 Gender reassignment

No Trust currently monitors staff based on their transgender status. However, it is important to note that both the Equality and Human Rights Commission and the Department of Health have issued guidance stating that monitoring of people's gender reassignment status should proceed with extreme caution. Given the relatively small number of trans people in any given workforce, there is always the possibility that the disclosure of this information will lead to a witch-hunt. Instead, the emphasis should be on the preparedness of organisations to support trans equality for staff, something all the Trusts have committed themselves to.

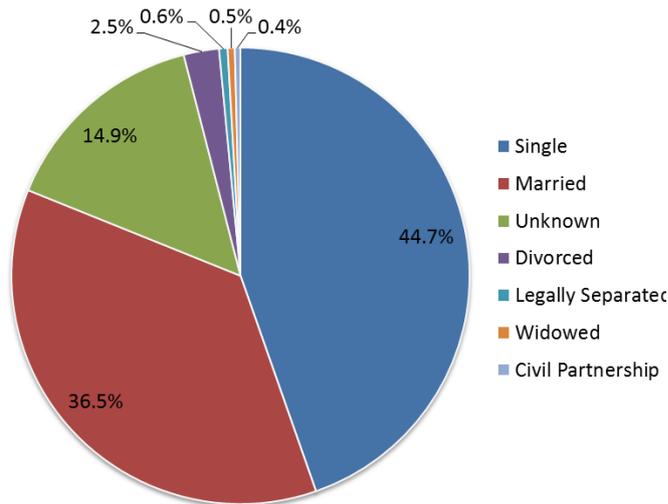
2.1.6 Marriage and civil partnership

As can be seen from table 1.1.6b (appendix A), Newham provided proportional figures for its Trust, which prevents the presentation of a merged total for the new organisation. Instead, figure 2.1.6 provides proportional data for each of the Trusts separately.

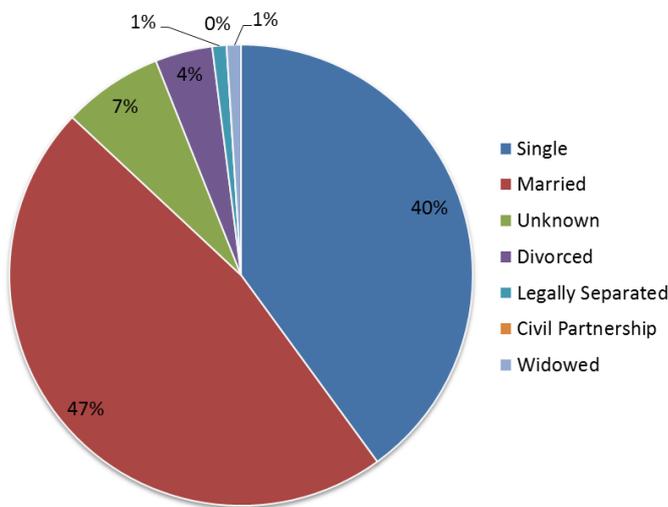
It appears that all the Trusts have a broadly similar composition to their workforce, with single people making up about 40% of the workforce in Barts and the London, Newham, and Whipps Cross (44.7%, 40%, and 39.0% respectively). Barts and the London appears to have

a lower proportion of married staff (36.5%) compared with Newham (47%) and Whipps Cross (42.7%). In this respect, it may be instructive to note its higher proportion of single employees and its high rate of staff whose status is unknown (14.9%). Indeed, within all three Trusts, the 'unknown' category is the third highest, which may be linked to a general apprehension around disclosing sexual orientation (see section 2.1.9).

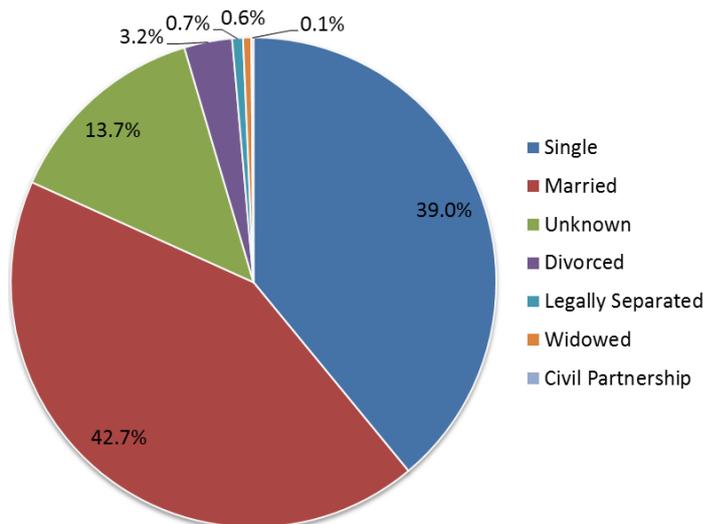
Figure 2.1.6: SIP by marital/civil partnership status (all Trusts)



Barts and the London



Newham



Whipps Cross

2.1.7 Pregnancy and maternity

No Trust currently appears to collect data relating to pregnancy and maternity (e.g. changes in role of people returning from maternity leave), although Barts and the London did include information on maternity leave.

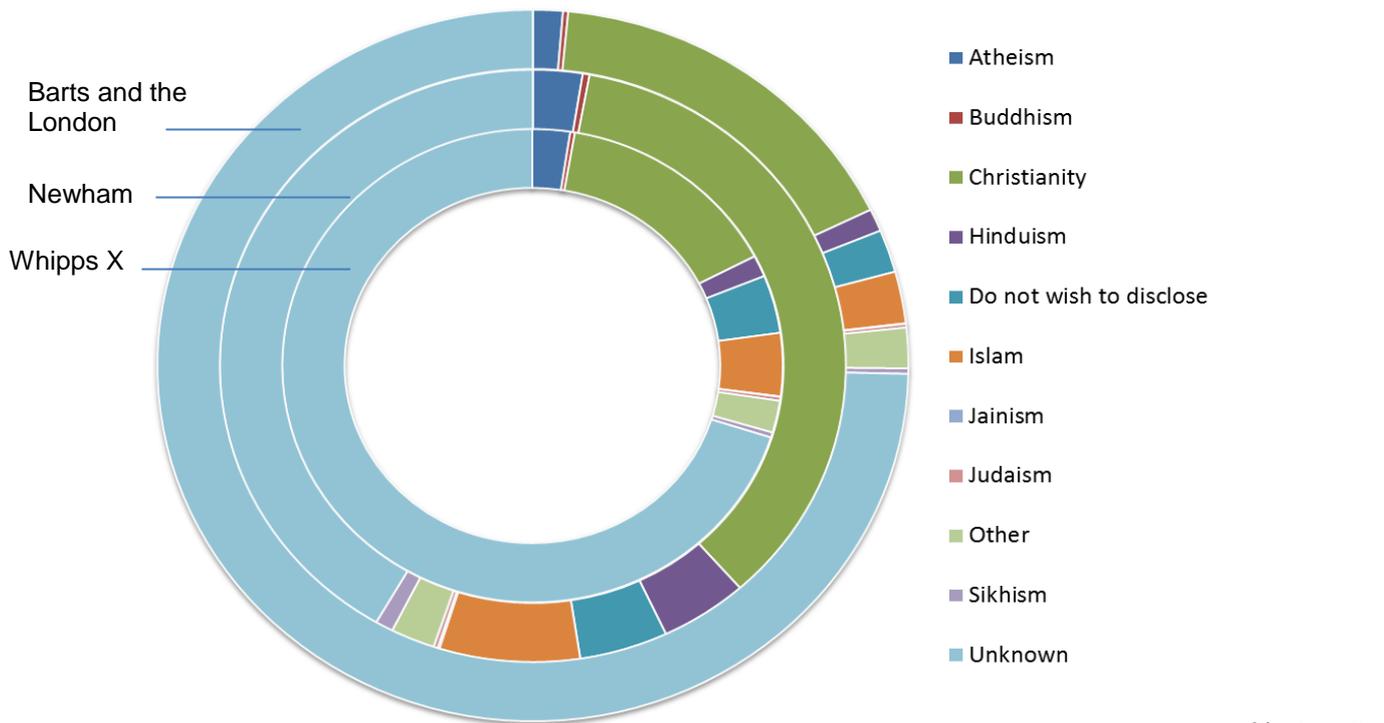
2.1.8 Religion and belief

As can be seen from figure 2.1.8a below, the most populated category within this characteristic is 'Unknown'. This will perhaps not surprise many: the need for targeted action to increase information disclosure around this issue has already been recognised by some Trusts.⁹

Having said this, combining the raw data contained in table 1.1.8 (appendix A), it appears the most practised religions within the new, merged organisation will be Christianity (18.37% of staff), Islam (4.28%), and Hinduism (1.84%), with 2.16% of staff subscribing to atheism and 3.55% consciously not wishing to disclose their religion/belief.

⁹ For example, Barts and the London NHS Trust (2012) op cit, In 2010 Newham, conducted a staff survey specifically to refine data in this area.

Figure 2.1.8a: SIP by religion and belief (all Trusts)



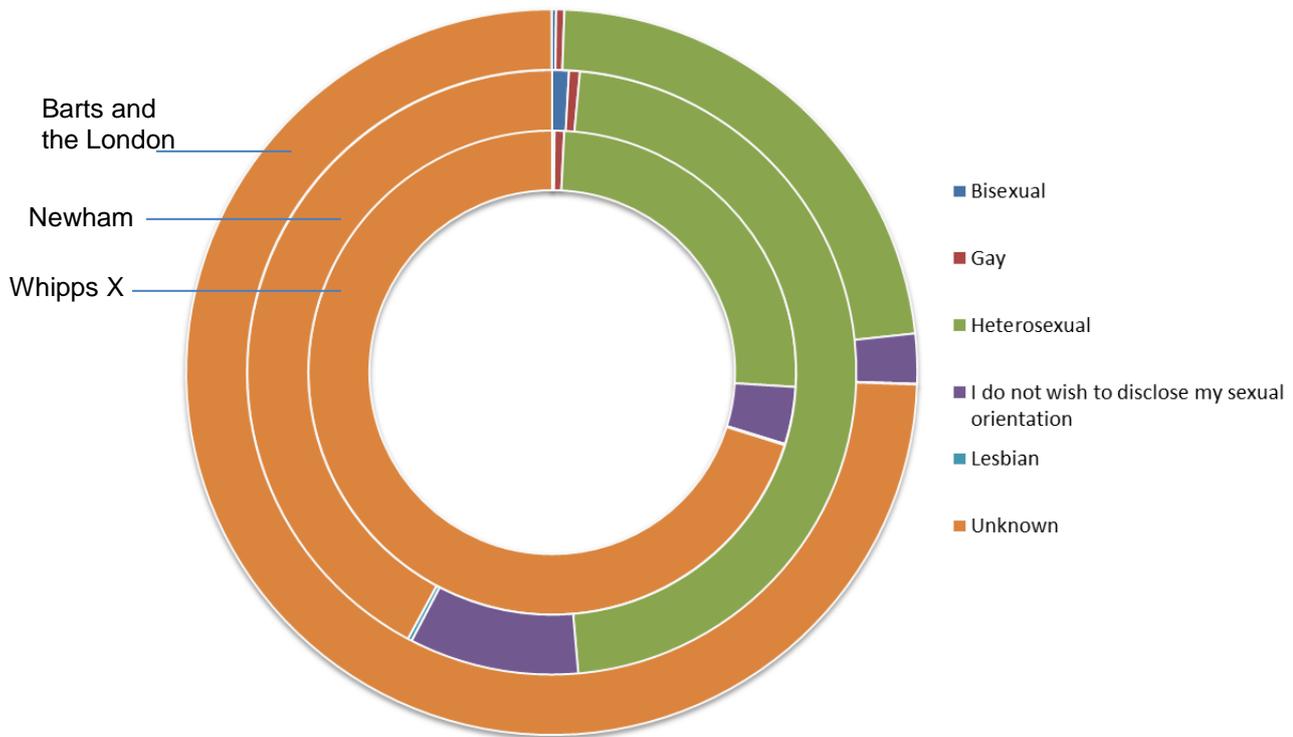
	% of staff										
	Atheism	Buddhism	Christianity	Hinduism	Not disclosed	Islam	Jainism	Judaism	Other	Sikhism	Unknown
Barts and the London	2.4	0.3	14.7	1.5	4	4.3	0	0.3	2.2	0.4	70.1
Newham	2.5	0.4	35.6	4.5	4.6	7.2	0.1	0.2	2.3	0.9	41.7
W Cross	1.3	0.2	16.3	1.0	1.9	2.4	0.0	0.2	1.8	0.2	74.6

Given the limitations associated with low levels of disclosure it is difficult to compare these figures to the most up to date information about the local population from the Annual Population Survey (2010). The Annual Population survey suggests that there are significantly higher proportions of people in all of the categories of religion and belief living in the local area when compared to the staff profile (e.g. 46% of Tower Hamlets are Muslim, whereas only 4.3% of staff in Barts and the London record themselves as Muslim).

2.1.9 Sexual orientation

Disclosure of information pertaining to sexual orientation is also limited: a situation all three Trusts are committed to tackling. Figure 1.1.9 below relays the data as it stands.

Figure 2.1.9: SIP by sexual orientation (all Trusts)



	Bisexual	Gay	Heterosexual	Not disclosed	Lesbian	Unknown
Barts and the London	0.2	0.6	25.2	3.8	0.1	70.1
Newham	0.9	0.6	47.2	9	0.2	42.1
W Cross	0.2	0.4	22.7	2.2	0	74.5

% of staff

While there is a paucity of reliable local data, some organisations claim between 5-7% of the national population is lesbian, gay, or bisexual.

2.2 Staff in post by AFC banding

Researchers did not receive staff data disaggregated by band from Barts and the London (though they did say they could provide this in the future). Newham provided data on staff banding disaggregated by sex and ethnicity. Whipps Cross provided information disaggregated by age, disability, ethnicity, and sex. As such data is organised around the protected characteristics which have been reported.

2.2.1 Age

Figure 2.2.1 on page 42 shows the proportion of age groups within different bands at Whipps Cross. There is a relatively even distribution of people from 35-59 across all bands. Not surprisingly younger people (24 years old or less) tend to be in lower bands within the Trust, though there is a relatively high proportion of 20-24 year olds in Band 5. People in the 'other' category tend to be much more likely to be 34 years old or less compared to staff from other bands.

2.2.2 Disability

As outlined in section 2.1.2, staff appear reluctant to disclose disabilities. This obviously has an effect on how informative subsequent analyses are. As such, figure 2.2.2 below simply reports the number of disabled people within particular bands.

Figure 2.2.2: No of disabled people in band (Whipps Cross)

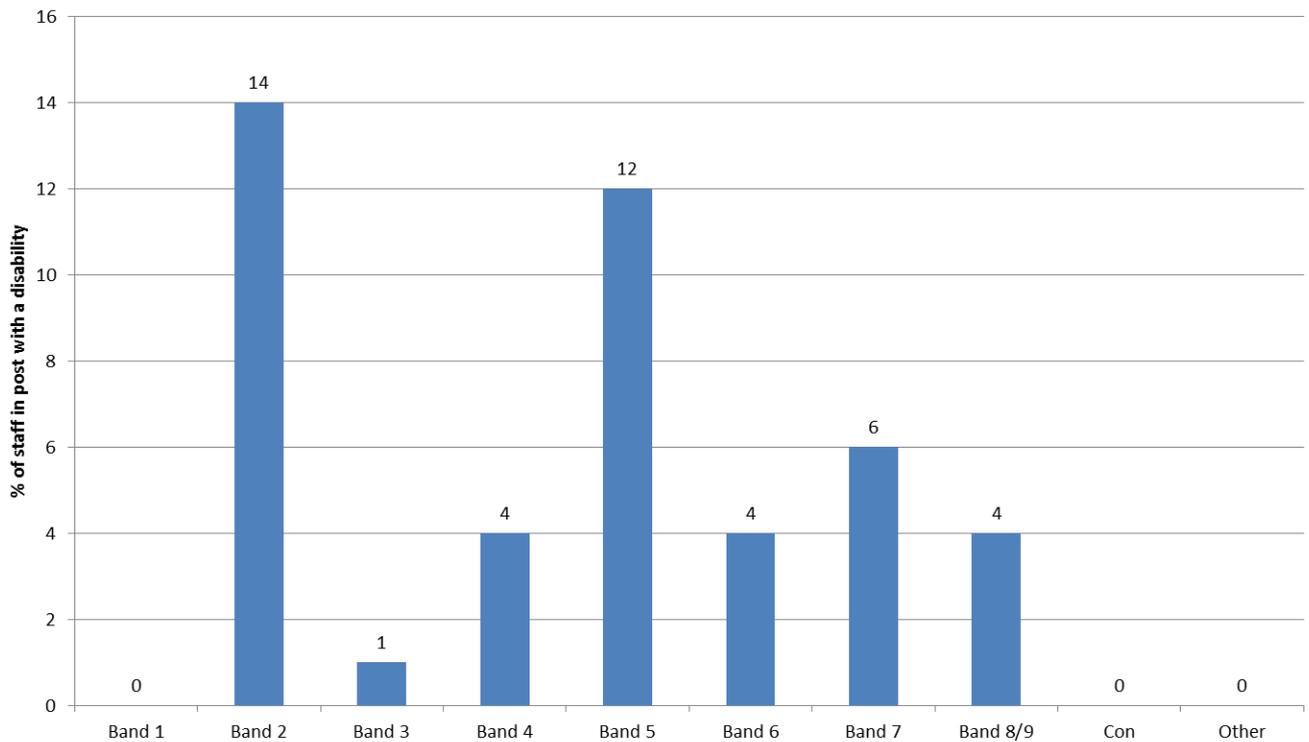
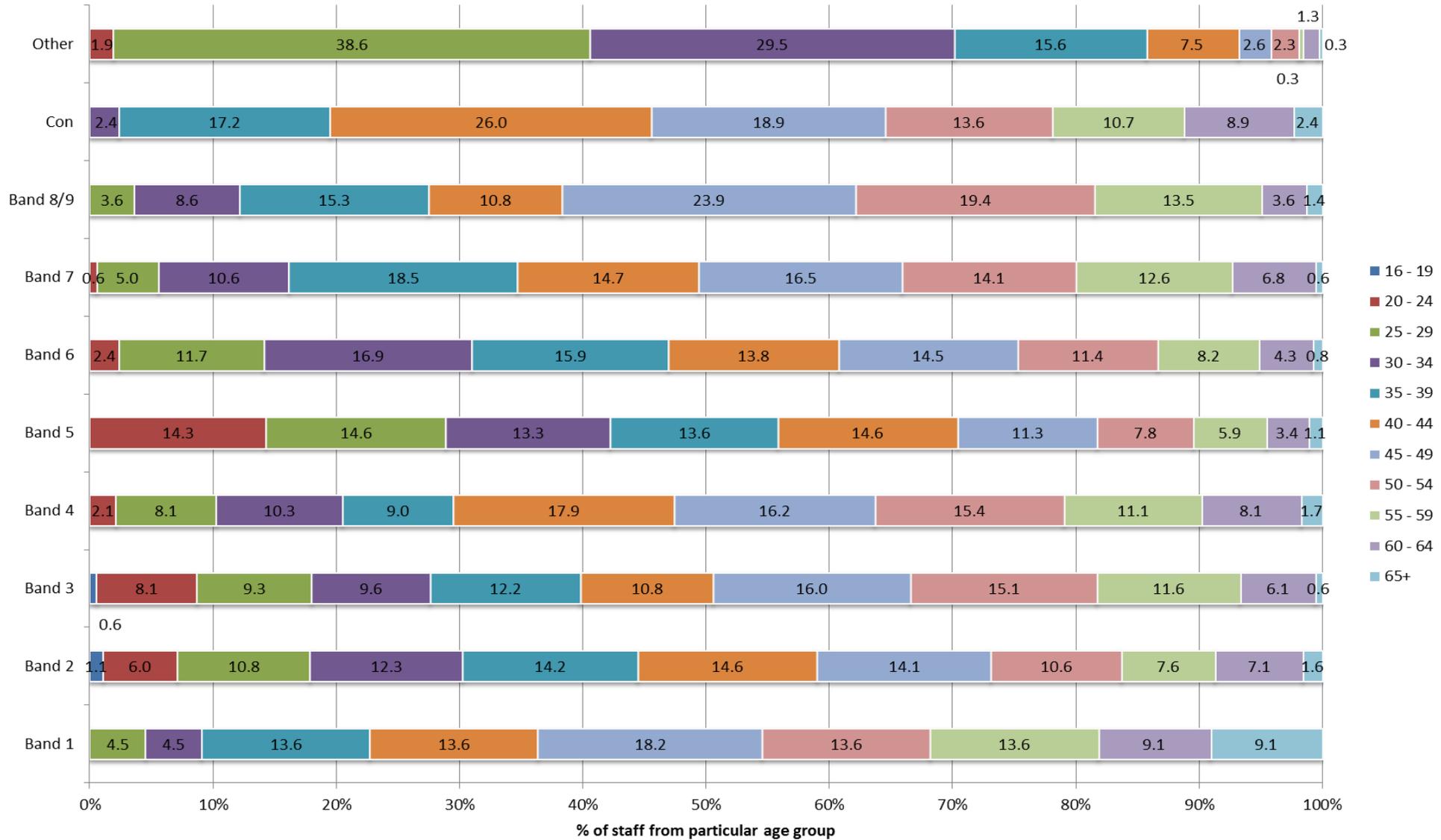


Figure 2.2.1: Staff in band by age (Whipps Cross)

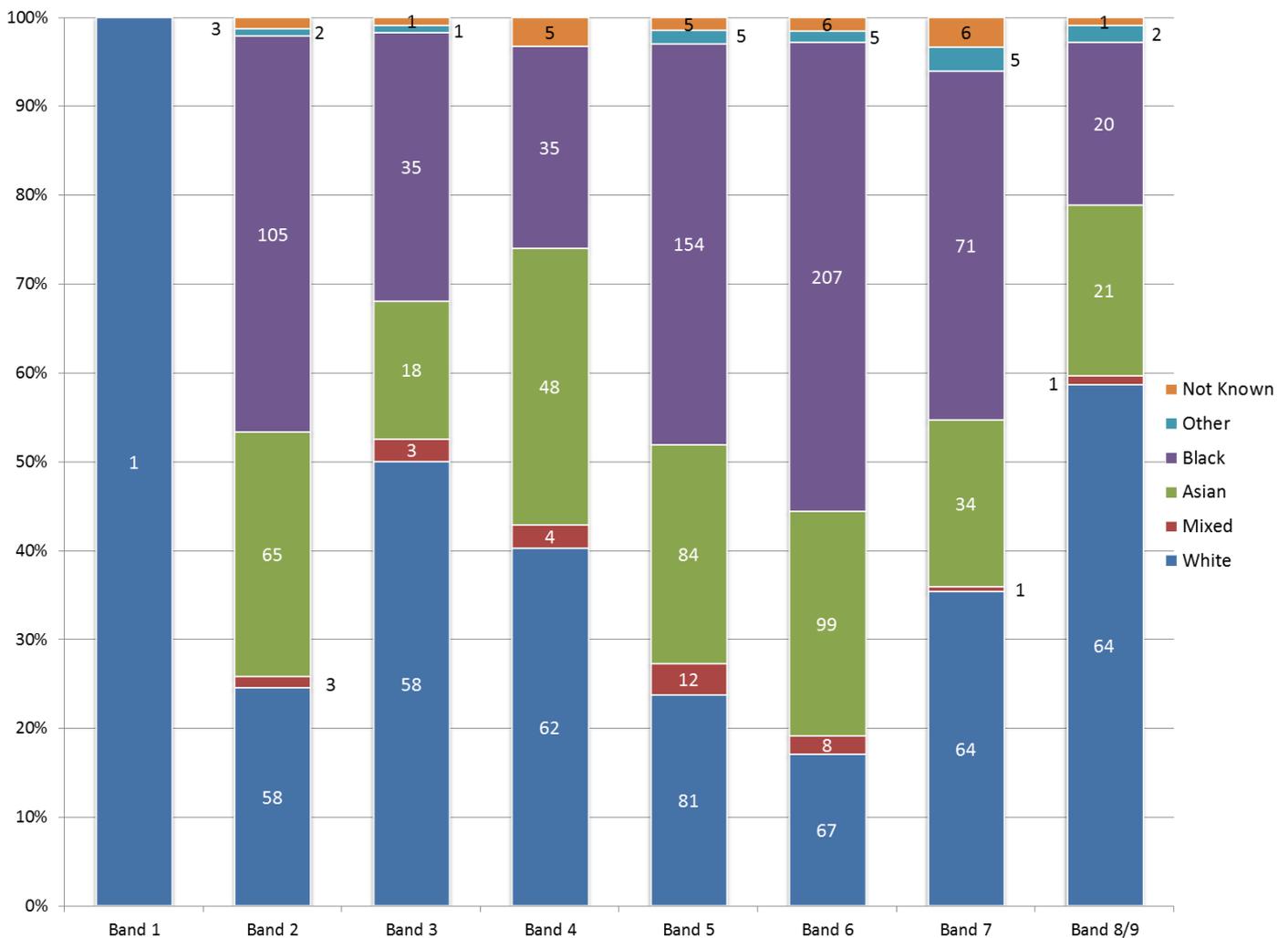


2.2.3 Ethnicity

As can be seen from table 1.2.3a in appendix A, Newham provided staff in band data using narrower, more specific categories to those provided by Whipps Cross. In the figures below, data from Newham have been standardised with the broad categories used by Whipps Cross to allow easy comparison. Furthermore, the data for bands 8a, 8b, 8c, 8d, and 9 have been conflated into a single category to match that provided by Whipps Cross (the broadest available category).

As figure 2.2.3a shows, there are lower proportions of Asian staff within bands 3 and 7 at Newham and a higher proportion within band 6 and 4. Similarly, there are high proportions of Black staff within bands 2, 5, and 6. Despite making up 30.9% of the workforce (see figure 2.1.3b), White staff make up nearly 60% of bands 8/9.

Figure 2.2.3a: Staff in band by ethnicity (Newham)

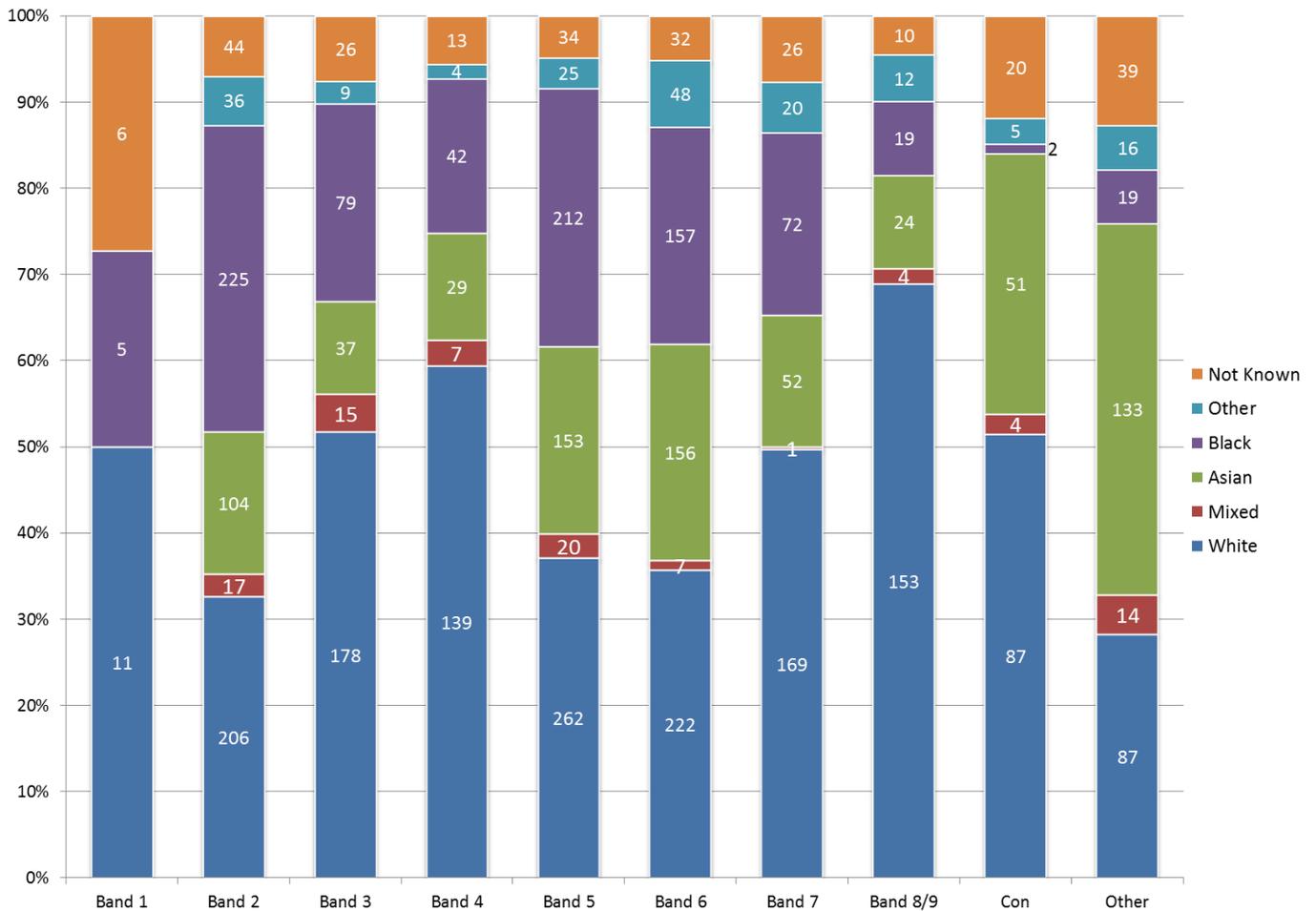


numbers are absolute figures showing the number of staff in band

Figure 2.2.3b similarly shows that despite comprising 42.5% of the workforce, White staff make up over 65% of bands 8/9 and over 50% of consultants. As the Trust notes in a recent

Workforce (Equalities) Information Report, there are higher proportions of Black and Asian staff in bands 2, 5, 6 than in other bands and grades. A significant proportion of consultants are Asian.

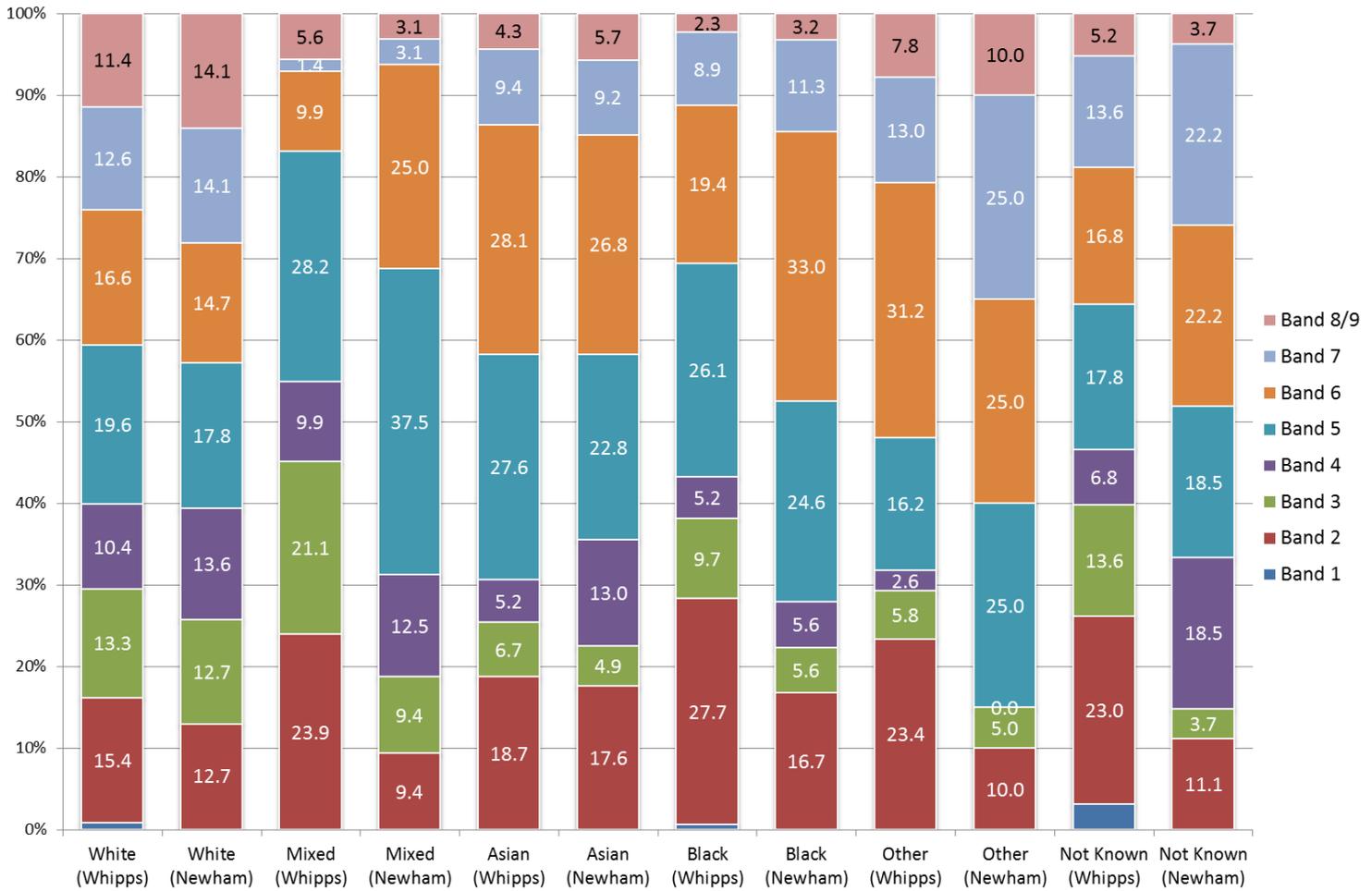
Figure 2.2.3b: Staff in post by ethnicity (Whipps Cross)



numbers are absolute figures showing the number of staff in band

Figure 2.2.3c allows an easier comparison of the position of different ethnic groups within Newham and Whipps Cross. It clearly shows that White staff within both Trusts are fairly evenly dispersed across all bands. The concentration of 'Mixed' staff at Newham in band 5 may be attributable to a small sample size (n=32).

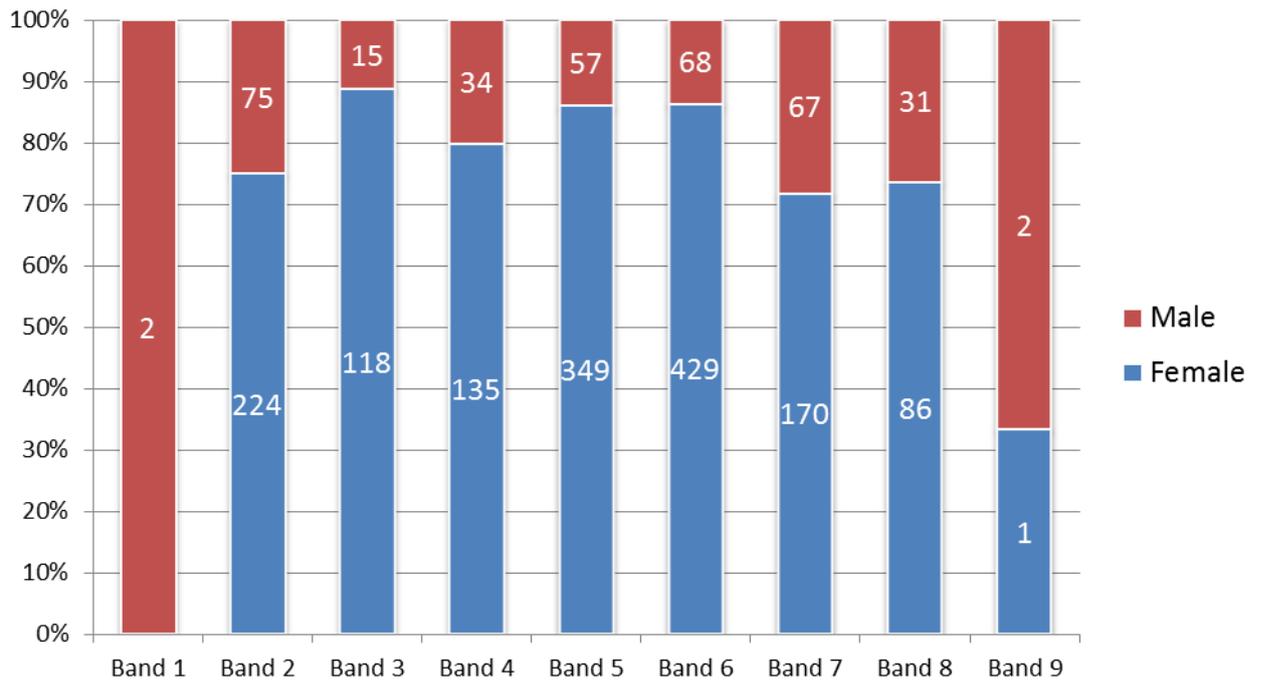
Figure 2.2.3c: Ethnicity by staff in post (Newham and Whipps Cross)



2.2.4 Sex

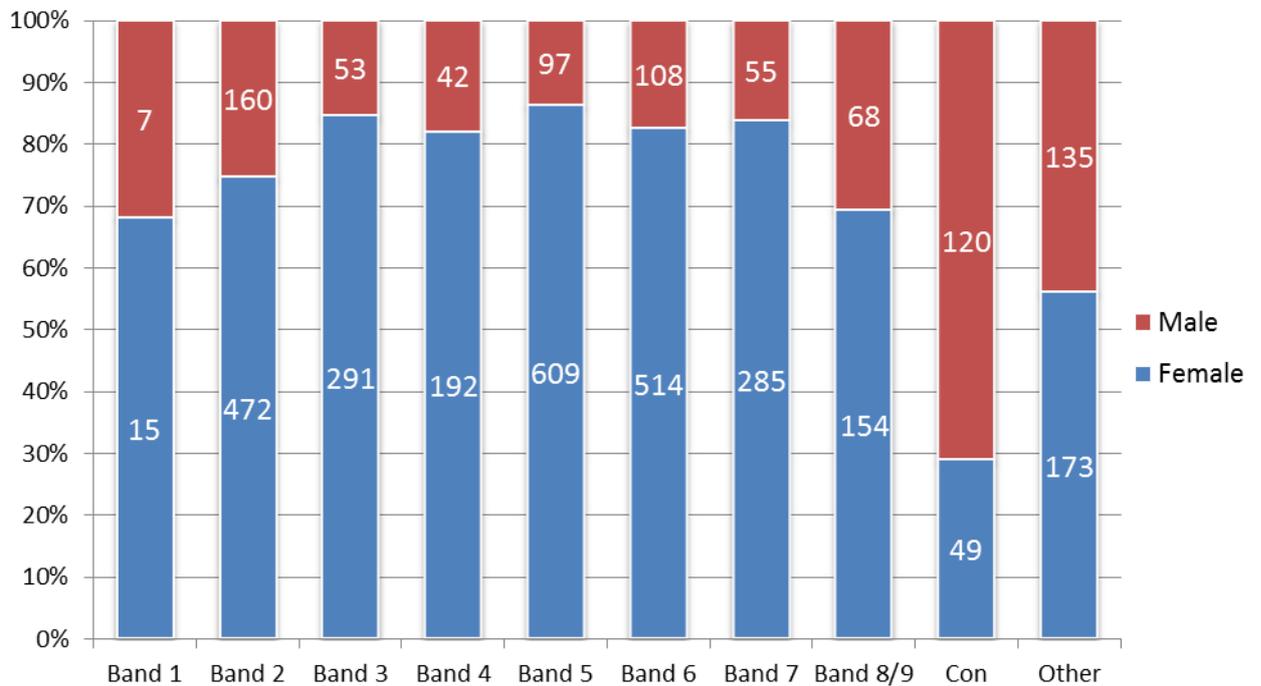
Discounting the highest and lowest bands (where sample sizes are very small), there are more women in Newham in bands 3, 5, and 6 than might be expected from the Trust's profile (see figures 2.2.4a and 2.1.4). Similarly, there are more women at Whipps Cross in bands 3, 4, 5, 6 than might be expected. Men are overrepresented in bands 8/9 (30.6% of band but only 23.2% of total workforce) and significantly overrepresented as consultants (of which they comprise 71.0%).

Figure 2.2.4a: Staff in band by sex (Newham)



numbers are absolute figures showing the number of staff in band

Figure 2.2.4b: Staff in band by sex (Whipps Cross)



numbers are absolute figures showing the number of staff in band

3. EMPLOYEE RELATIONS

This section uses a variety of indicators to explore employee relations within the three Trusts. The data underlying the charts and their original sources can be found in appendix B.

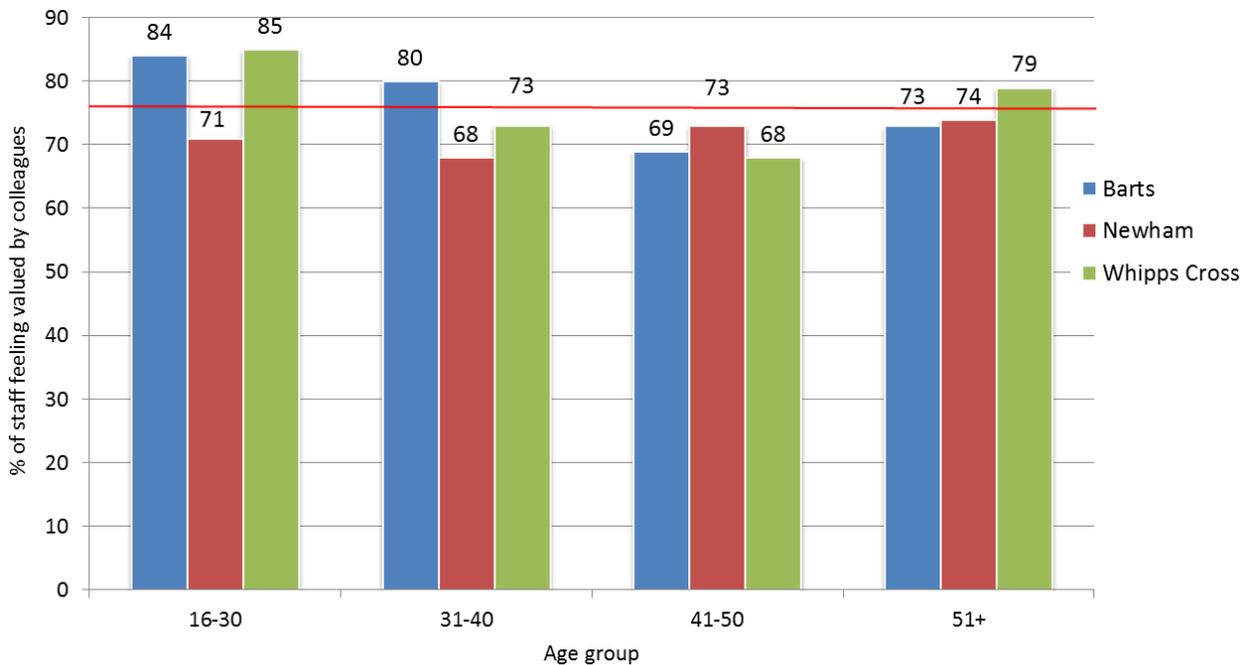
3.1 Feeling valued by work colleagues

This section uses data from NHS Staff Surveys to identify what percentage of staff at the three Trusts feel valued by their work colleagues. Data is only disaggregated by age, disability, ethnicity, and sex.

3.1.1 Age

Broadly speaking, feelings of being valued by work colleagues are fairly consistent across all Trusts and age groups. Newham appears to experience lower ratings compared with the other Trusts within the 16-30 and 31-40 age group; but the sample size within these categories is relatively small, making ratings particularly volatile. However, the lower cross-Trust ratings within the 41-50 age group may be significant and worthy of further investigation.

Figure 3.1.1: % of staff who feel valued by work colleagues by age (all Trusts)



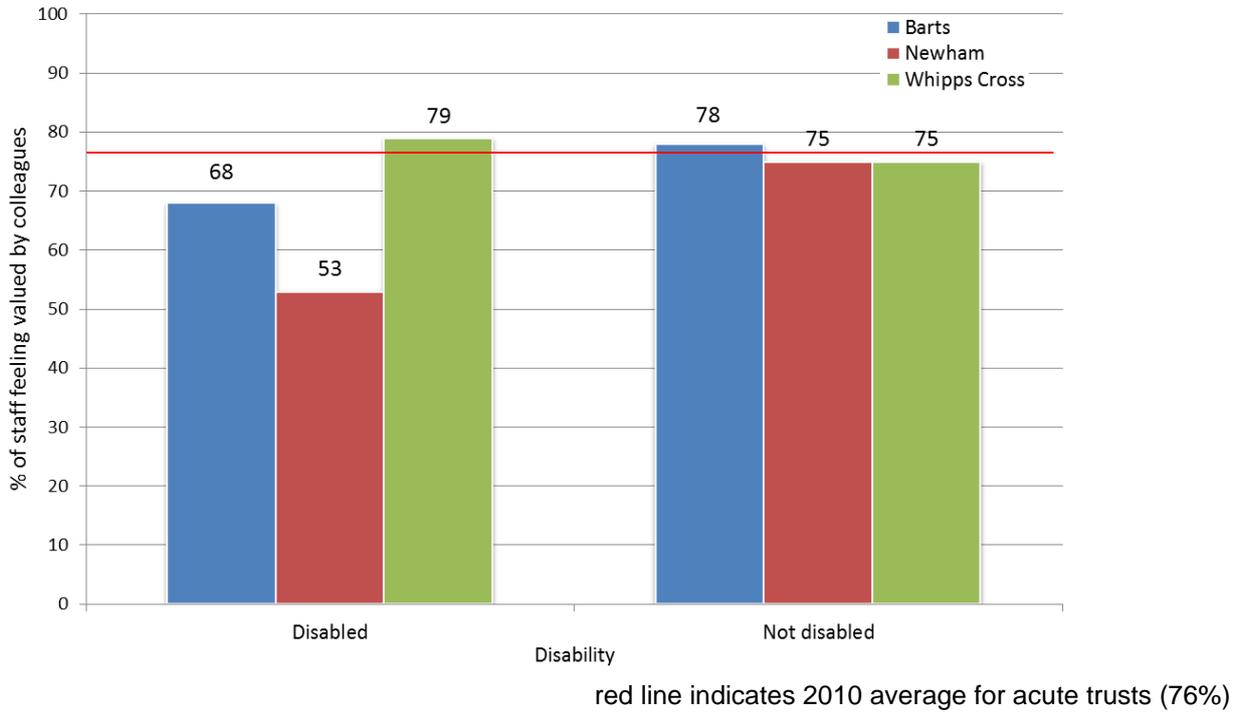
red line indicates 2010 average for acute trusts (76%)

3.1.2 Disability

Ratings across Trusts and disability status appear consistent, with the exception of the disabled staff members at Newham, nearly half of whom (47%) do not feel valued by their colleagues. It is interesting to compare this with other indicators in this section (such as

experiences of discrimination (section 3.2.2)) in which disabled staff members are similarly disadvantaged.

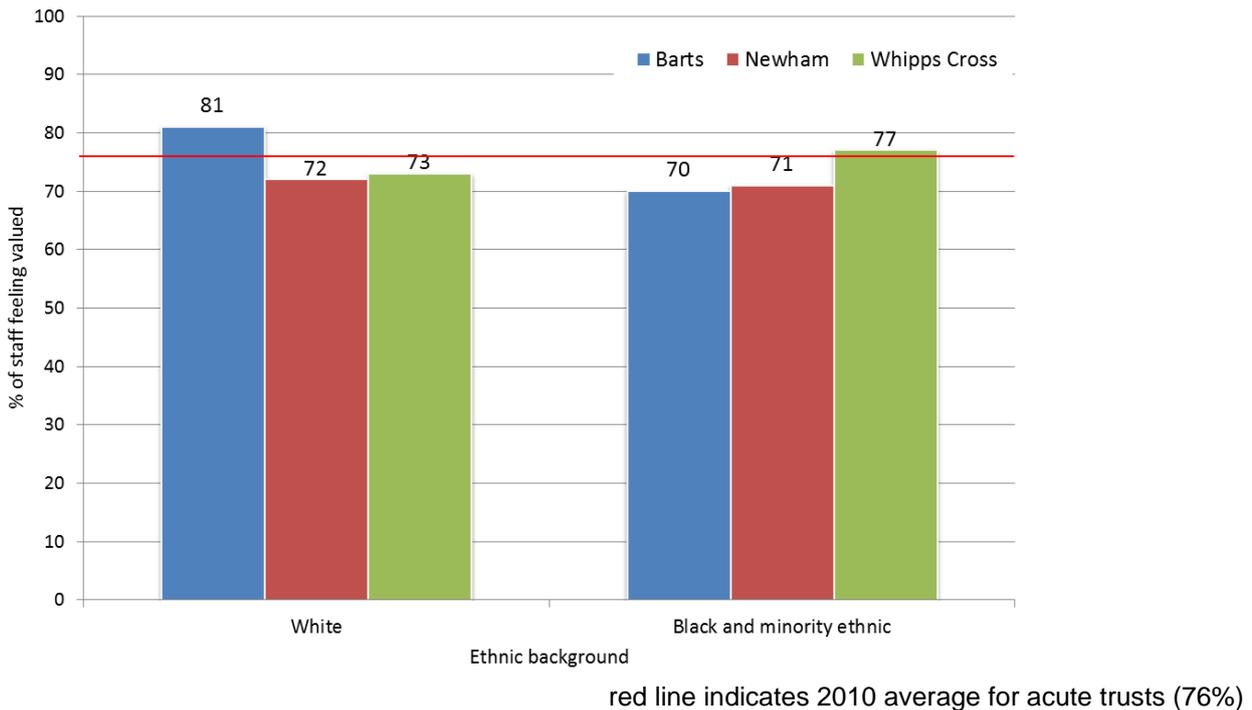
Figure 3.1.2: % of staff who feel valued by work colleagues by disability (all Trusts)



3.1.3 Ethnicity

Feelings of being valued by work colleagues are fairly consistent across all Trusts and ethnic backgrounds, and broadly in line with the national average.

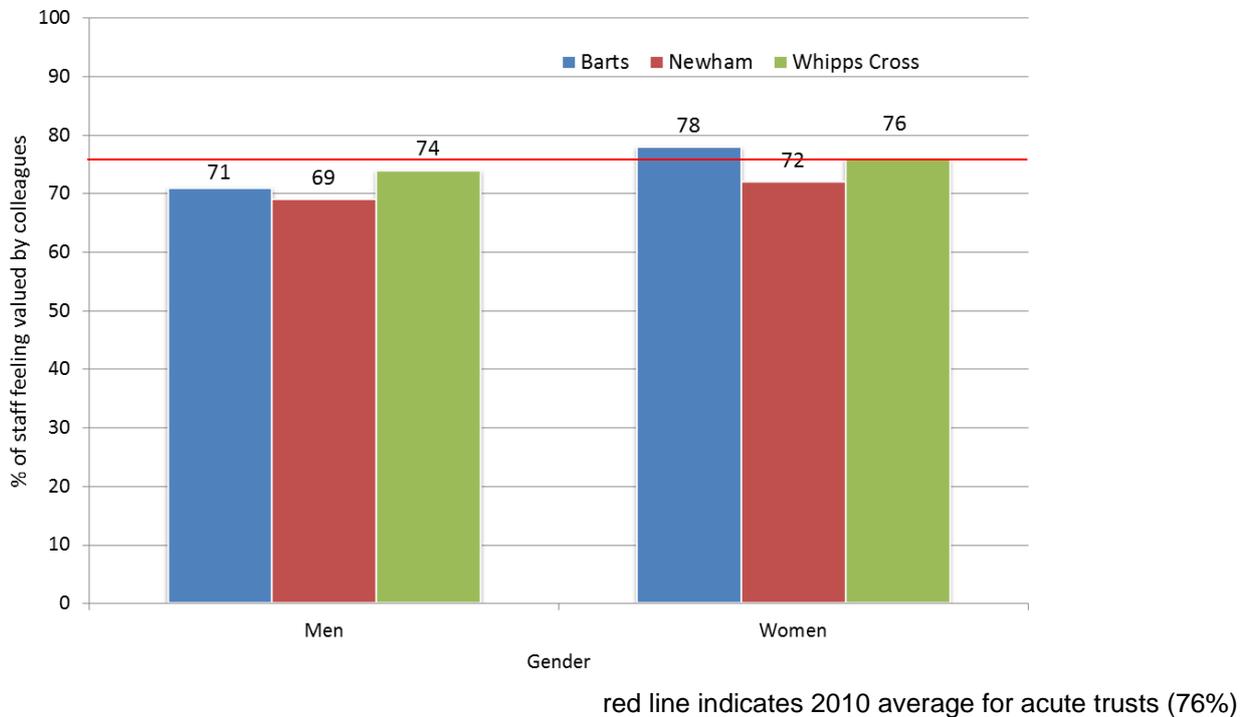
Figure 3.1.3: % of staff feeling valued by work colleagues by ethnicity (all Trusts)



3.1.4 Sex

Feelings of being valued by colleagues are fairly consistent across all Trusts and staff sex.

Figure 3.1.4: % of staff who feel valued by work colleagues by sex (all Trusts)



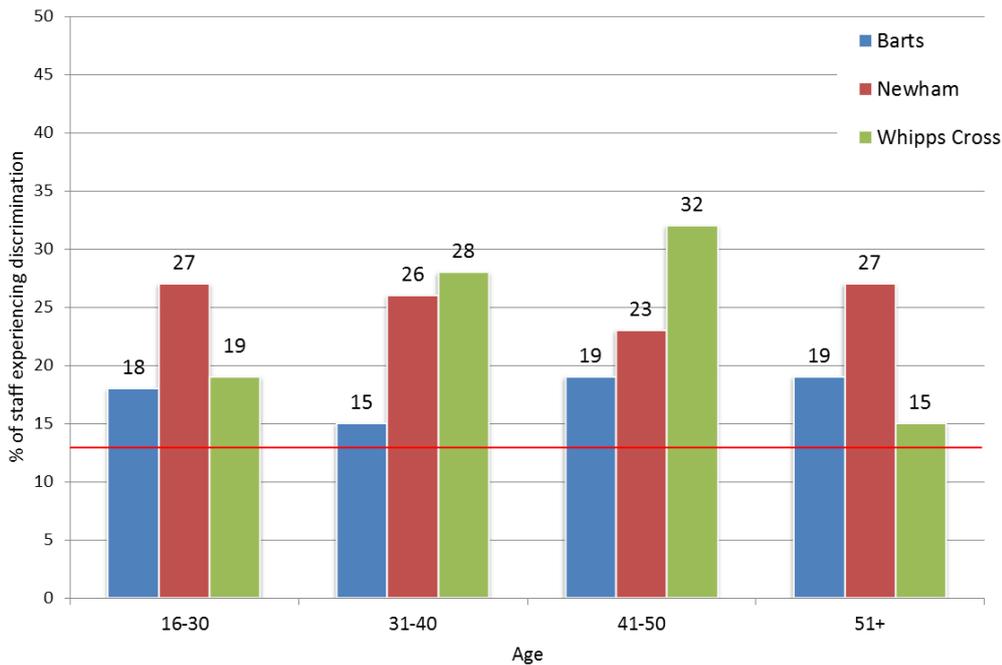
3.2 Experience of discrimination

This section outlines data from NHS Staff Surveys relating the percentage of staff who said they had experienced discrimination at work in the preceding 12 months. Data is only disaggregated by age, disability, ethnicity, and sex.

3.2.1 Age

In 2010, nationally, on average 13% of staff in acute Trusts said they had experienced discrimination in the preceding 12 months – a figure which may help contextualise some of the data below. Barts and the London’ ratings are broadly consistent with this average while Newham’s average of 25.8% is significantly higher. Whipps Cross also has a higher average, but this is predominantly because there are very high numbers of people aged between 31-40 (28%) and 41-50 (32%) experiencing discrimination.

Figure 3.2.1: % of staff experiencing discrimination at work in the last 12 months by age (all Trusts)

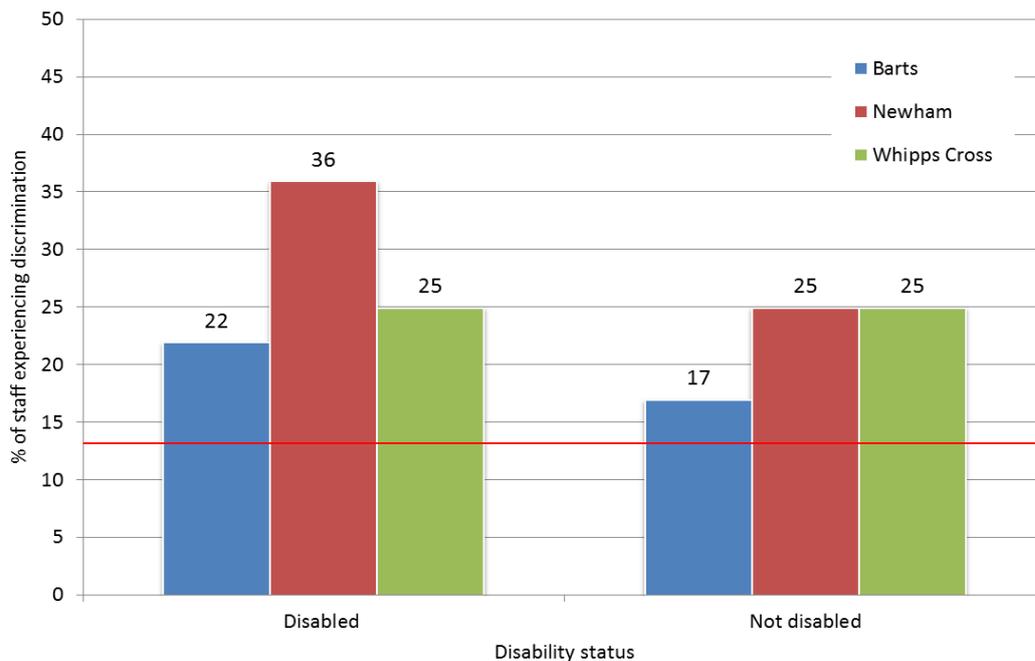


red line indicates 2010 average for acute trusts (13%)

3.2.2 Disability

Over a third of disabled staff members at Newham (36%) have reported experiencing discrimination in the last 12 months. Notwithstanding this outlier, the percentage of staff experiencing discrimination within the preceding 12 months appears consistent across Trusts and people’s disability status.

Figure 3.2.2: % of staff experiencing discrimination at work in the last 12 months by disability (all Trusts)

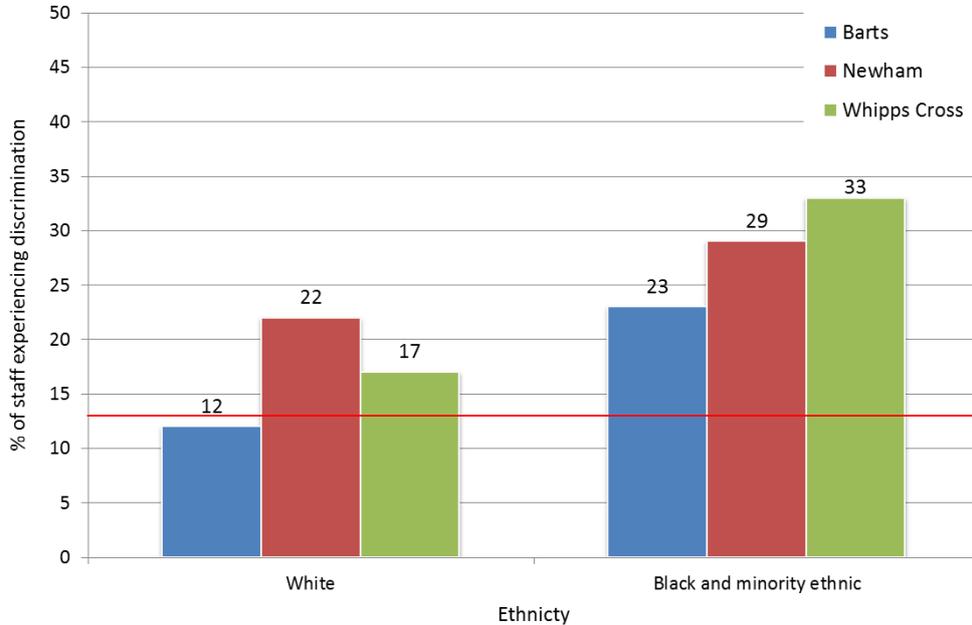


red line indicates 2010 average for acute trusts (13%)

3.2.3 Ethnicity

It appears BME staff members within Barts and the London and Whipps Cross are significantly more likely to experience discrimination than their White colleagues. Within Whipps Cross itself, one in three BME employees (33%) experienced discrimination in the preceding 12 months.

Figure 3.2.3: % of staff experiencing discrimination in the last 12 months by ethnicity (all Trusts)

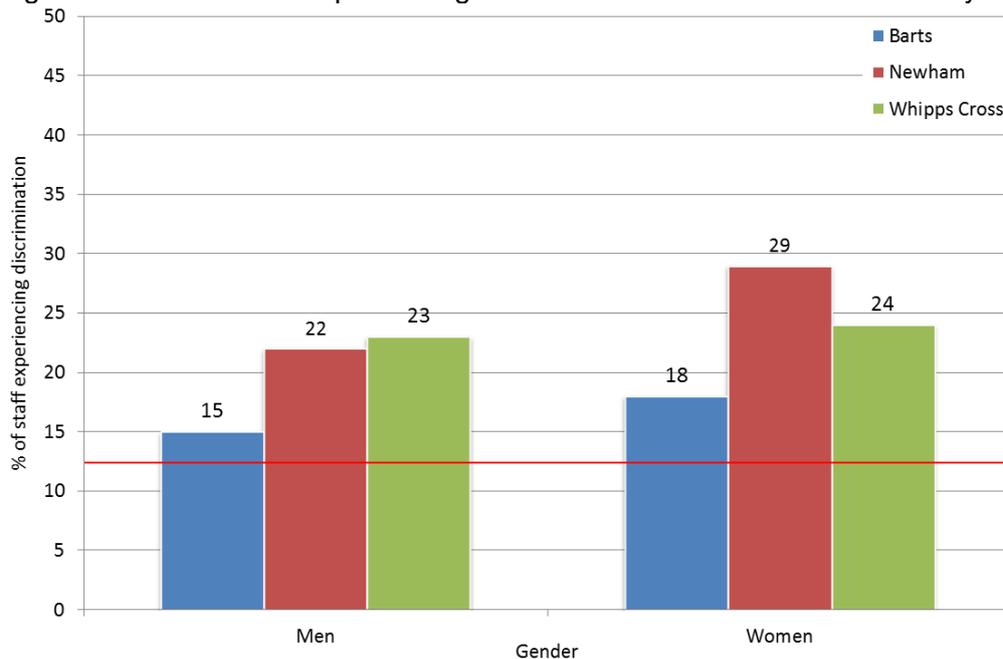


red line indicates 2010 average for acute trusts (13%)

3.2.4 Sex

Broadly, the prevalence of discriminatory experiences are fairly consistent across all Trusts and sexes (although significantly above the national average at Newham and Whipps Cross).

Figure 3.2.4: % of staff experiencing discrimination in the last 12 months by sex (all Trusts)



red line indicates 2010 average for acute trusts (13%)

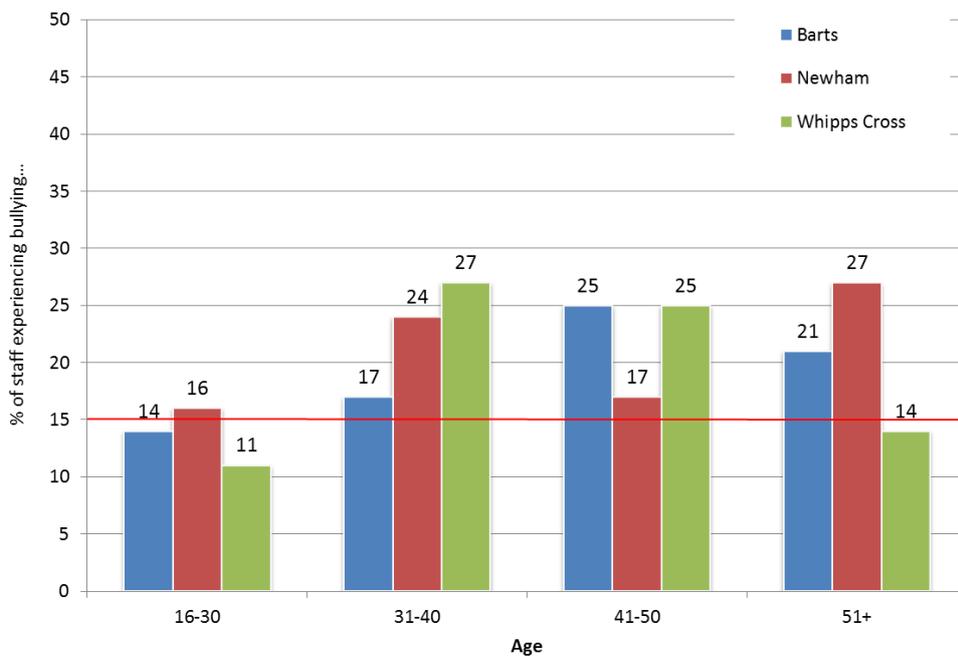
3.3 Experience of harassment, bullying, or abuse

This section outlines data from NHS Staff Surveys relating the percentage of staff who said they had experienced harassment, bullying, or abuse from staff in the preceding 12 months. Data is only disaggregated by age, disability, ethnicity, and sex.

3.3.1 Age

While experiences of bullying or harassment among the youngest, 16-30 age group are (comparatively) low across all the three Trusts, each organisation has particular age groups which experience a spike in incidences. In Barts and the London this is the 41-50 age group (25% of employees having experienced harassment, bullying, or abuse in the last 12 months); in Newham, the 50+ age group (27%); and at Whipps Cross the 31-40 age group (27%).

Figure 3.3.1: % of staff experiencing bullying, harassment, or abuse from staff in the last 12 months by age (all Trusts)

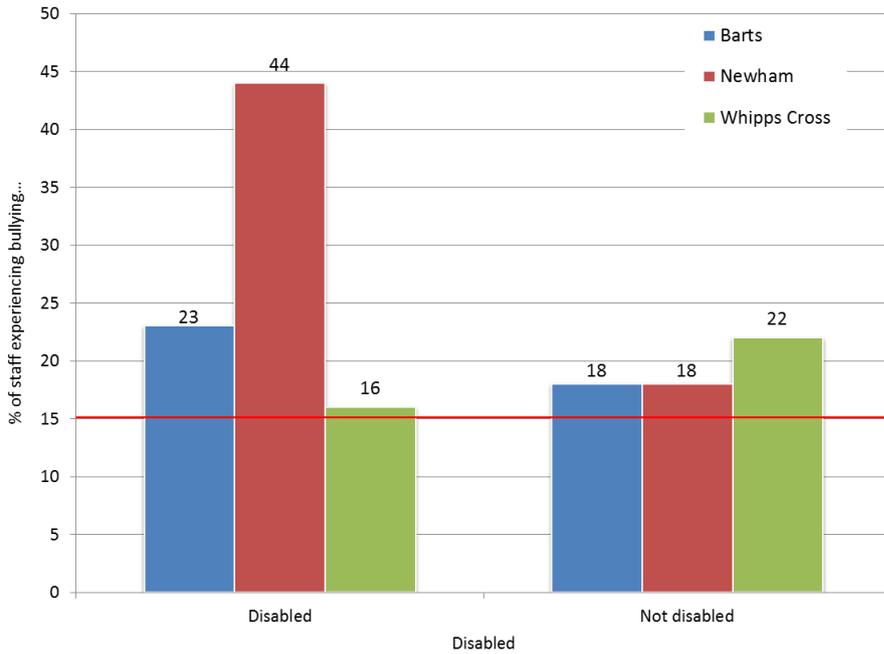


red line indicates 2010 average for acute trusts (15%)

3.3.2 Disability

Rates of staff reporting experiences of harassment or bullying are fairly consistent between Barts and the London and Whipps Cross and are not significantly affected by employees' disability status. Within Newham, staff are more than twice as likely to report bullying or harassment if they are disabled than if they are not (44% compared to 18%). Given the small sample size, it may be useful to express this in absolute terms: that is, out of 53 disabled people surveyed, approximately 23 said they had been subject to bullying or harassment.

Figure 3.3.2: % of staff experiencing bullying, harassment, or abuse from staff in the last 12 months by disability (all Trusts)

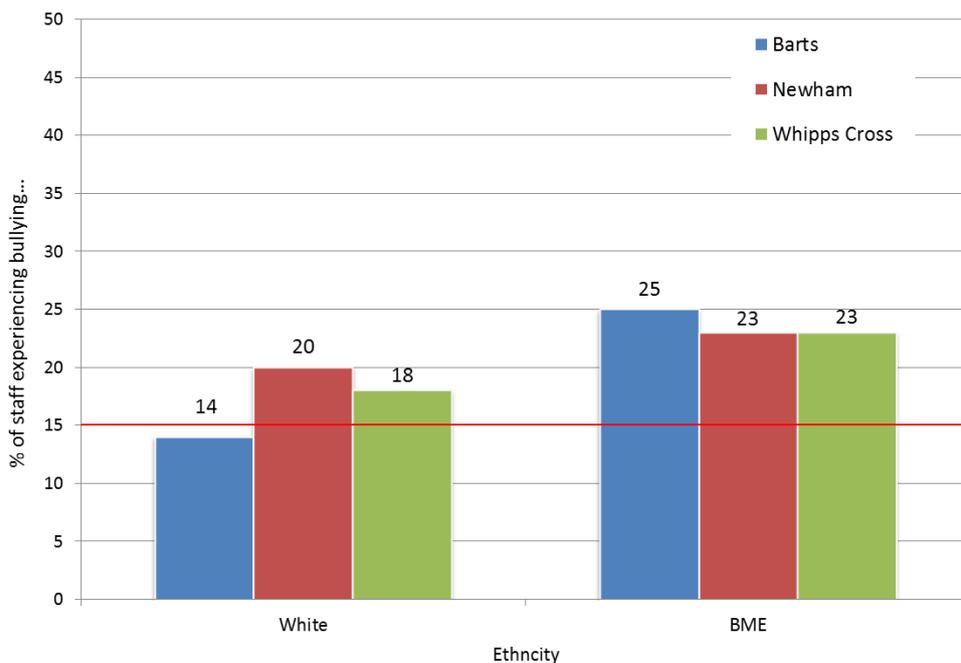


red line indicates 2010 average for acute trusts (15%)

3.3.3 Ethnicity

Notwithstanding White staff at Barts and the London reporting a lower than average experience of harassment and bullying, rates are all higher than the national average for 2010 (15%) regardless of organisation or ethnic background. Barts and the London in particular has a pronounced difference in the experiences of White and BME staff.

Figure 3.3.3: % of staff experiencing harassment, bullying, or abuse from staff in the last 12 months by ethnicity (all Trusts)

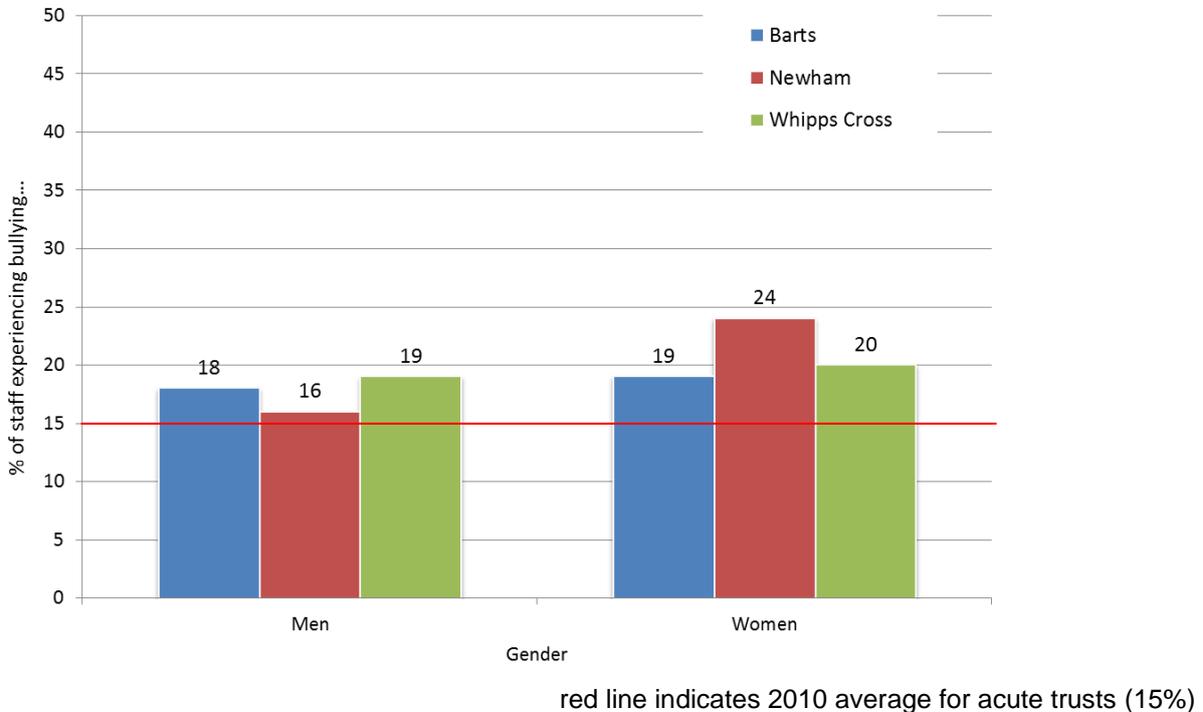


red line indicates 2010 average for acute trusts (15%)

3.3.4 Sex

Rates of harassment and bullying are broadly consistent across Trusts and sexes.

Figure 3.3.4: % of staff experiencing harassment, bullying, or abuse from staff in the last 12 months by sex (all Trusts)



3.4 Disciplinary

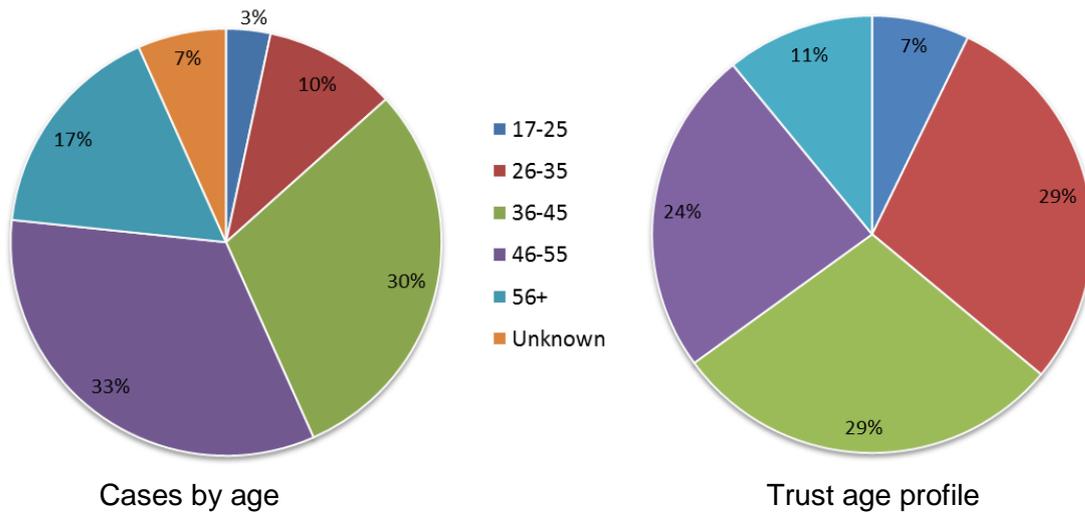
This section provides an analysis of disciplinary data from the three Trusts. It is important to note that the data covers different time periods and time periods of different lengths. The form in which data was presented did not allow standardisation. Appendix B provides more detail on the dates involved.

3.4.1 Age

Barts and the London did not provide disciplinary data disaggregated by age group. Newham and Whipps Cross used different categories.

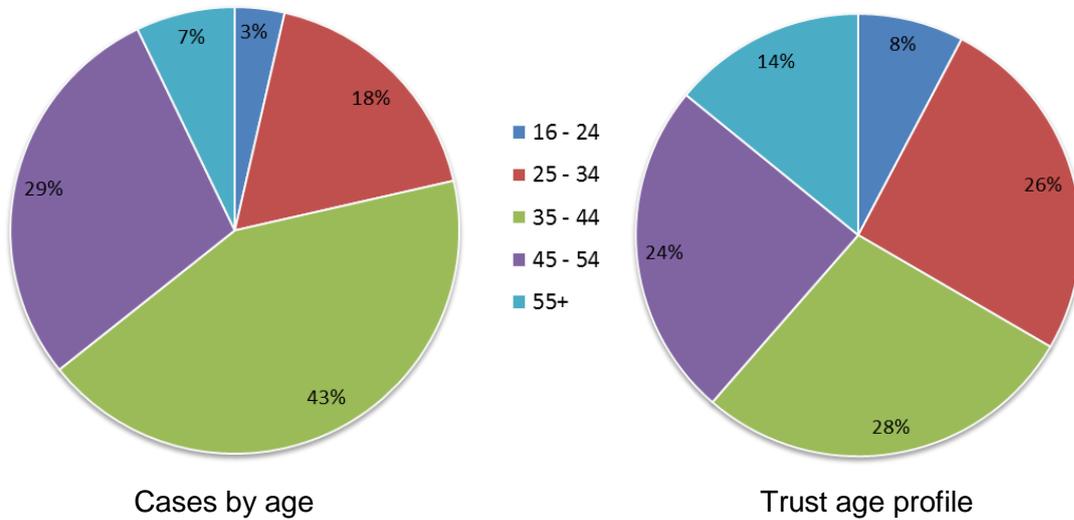
Within Newham, the majority of disciplinary cases were brought against people in the 36-45 and 46-55 age group. However, this appears to be in rough proportion with the number of employees within those age groups. See figure 3.4.1a below.

Figure 3.4.1a: Employees subject to disciplinary cases by age (Newham)



Whipps Cross appears to have a disproportionate number of people within the 35-44 age category being the subject of disciplinarys (43% of cases despite being 28% of the Trust workforce). Obviously, there are a number of reasons why this may be the case, not least because the relatively small sample size (n=28) can distort comparisons of this sort.

Figure 3.4.1b: Employees subject to disciplinary cases by age (Whipps Cross)



3.4.2 Disability

It is difficult to reach meaningful conclusions about the number of disabled employees facing disciplinarys given small sample sizes and the number of people not declaring their disability status. Purely for the sake of reference, then, absolute figures are presented below.

Figure 3.4.2: Disciplinarys by disability (all Trusts)

	Disabled		Not disabled		Not known		Total
	No	%	No	%	No	%	
Barts and the London	2	1	84	40	124	59	210
Newham	1	3	14	74	15	50	30
Whipps Cross	0	0	28	100	0	0	28

3.4.3 Ethnicity

The three Trusts used a variety of different ethnic categories to analyse the profile of people on disciplinarys (see tables 2.4.3a, b, and c in appendix B). Below, we present the data using the broadest categories that were provided.

The number of disciplinarys at Barts and the London and Whipps Cross appear broadly consistent with their respective Trust profiles, although – as Whipps Cross observe in their Workforce Report August 2011 – the “pattern is consistent with BME staff being more likely to be the subject of disciplinary procedures.” Within Newham, Asian and White staff appear less likely to be subject to a disciplinary, while Black staff are significantly more likely compared with their profile within the Trust.

Figure 3.4.3a: Disciplinarys by ethnicity (Barts and the London)

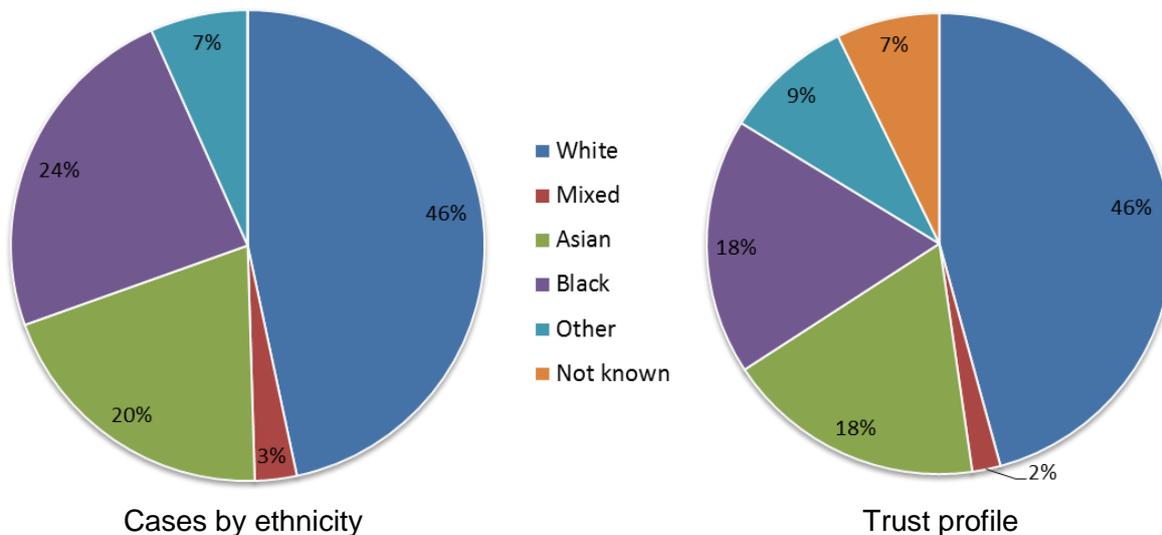


Figure 3.4.3b: Disciplinary by ethnicity (Newham)

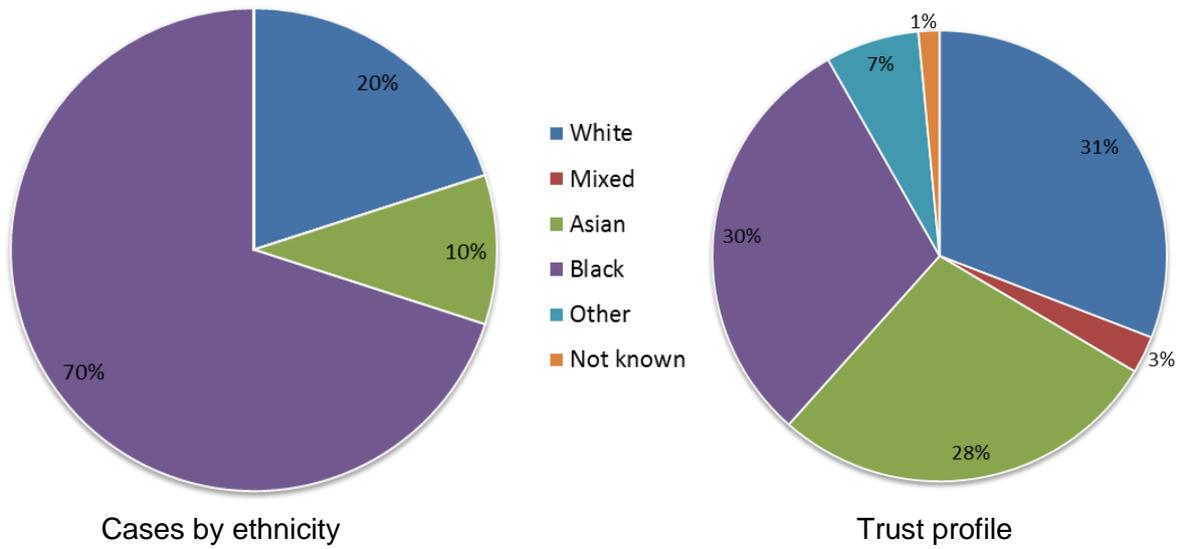
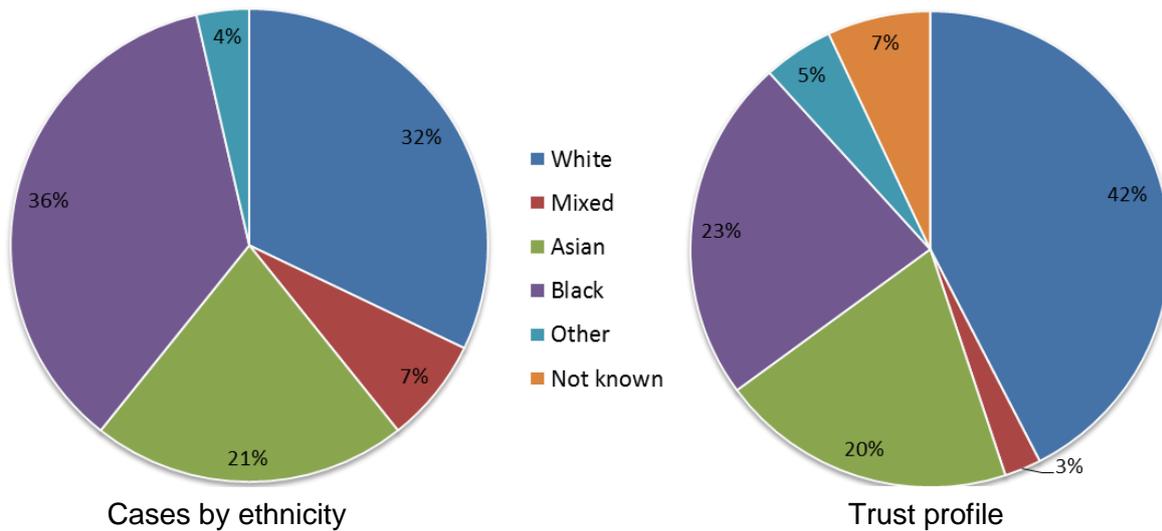


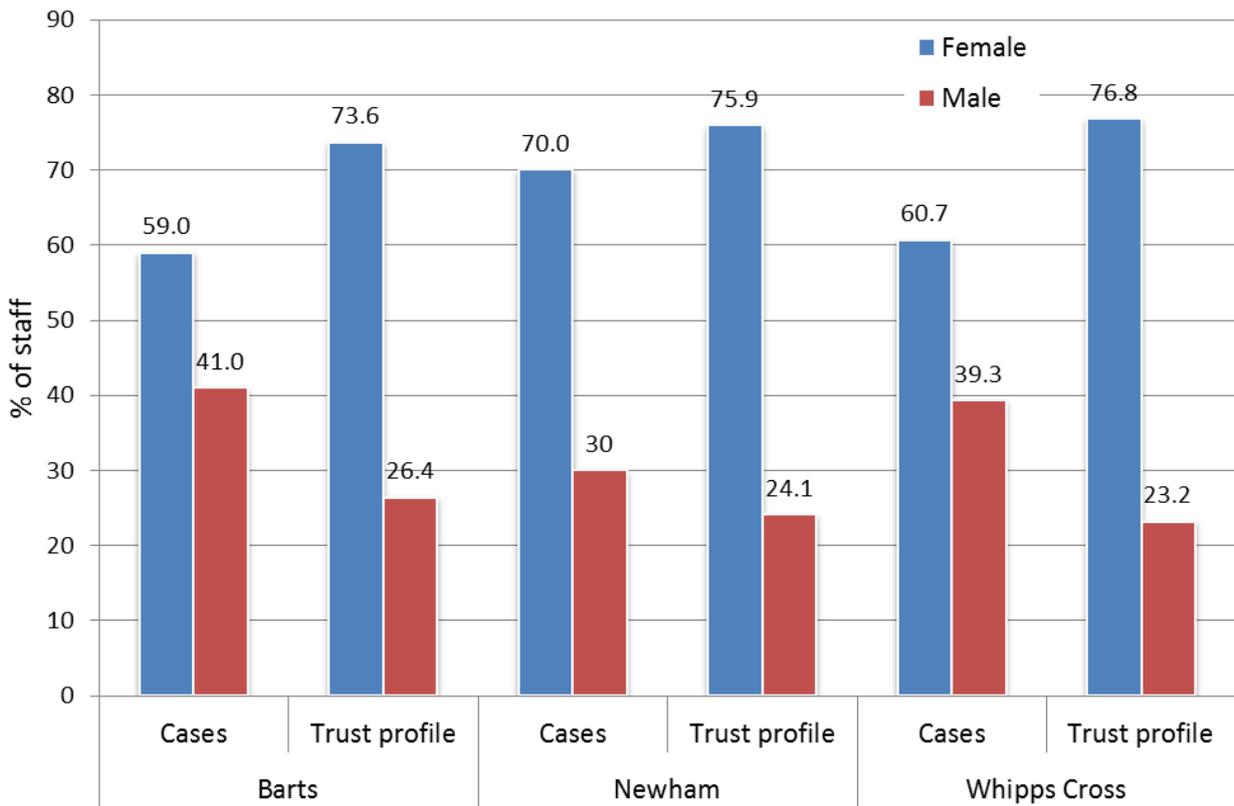
Figure 3.4.3c: Disciplinary by ethnicity (Whipps Cross)



3.4.4 Sex

The percentages of men and women facing disciplinarys within Newham and Whipps Cross appear broadly consistent with those organisations' staff profiles. Men at Barts and the London, however, appear to be much more likely to face a disciplinary than the Trust's profile might suggest (with men being the subject of 41.0% of disciplinarys despite only being 26.4% of the workforce).

Figure 3.4.4: Disciplinary by sex (all Trusts)



3.4.5 Religion and belief

Whipps Cross does not monitor disciplinary data by religion and belief. It wouldn't be expedient to draw substantive conclusions from the data provided by Barts and the London and Newham given the large number of people whose religious identities are unknown. Having said that, figures for disciplinary processes are broadly consistent with Trust profiles.

Figure 3.4.5a: Disciplinary by religion/belief (Barts and the London)

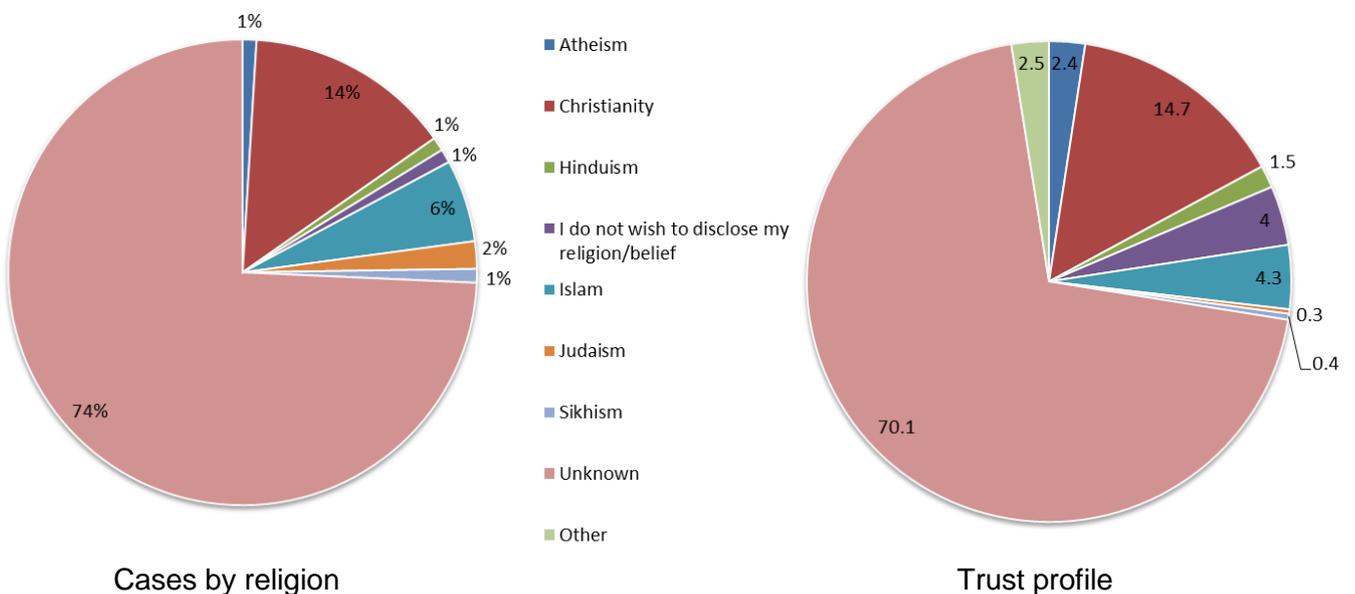
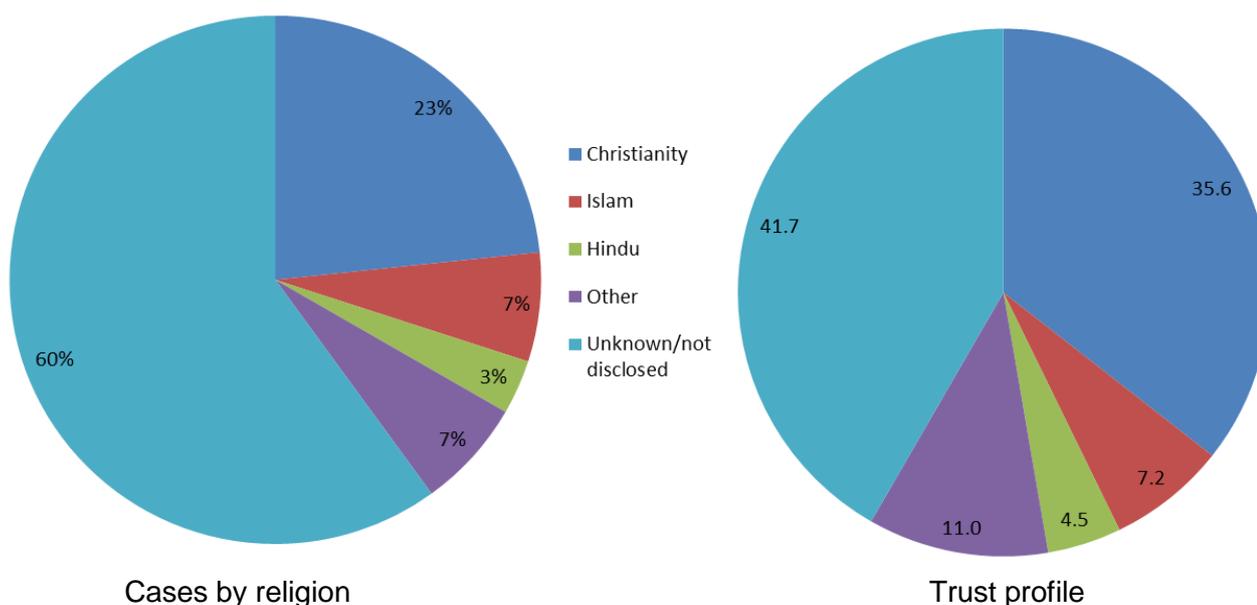


Figure 3.4.5b: Disciplinaries by religion/belief (Newham)



3.4.6 Sexual orientation

Whipps Cross does not monitor disciplinary cases by sexual orientation. The data provided by Barts and the London and Newham are distorted by a very large number of people refusing to disclose their sexual orientation. Absolute figures are presented in figure 3.4.6 for the sake of reference.

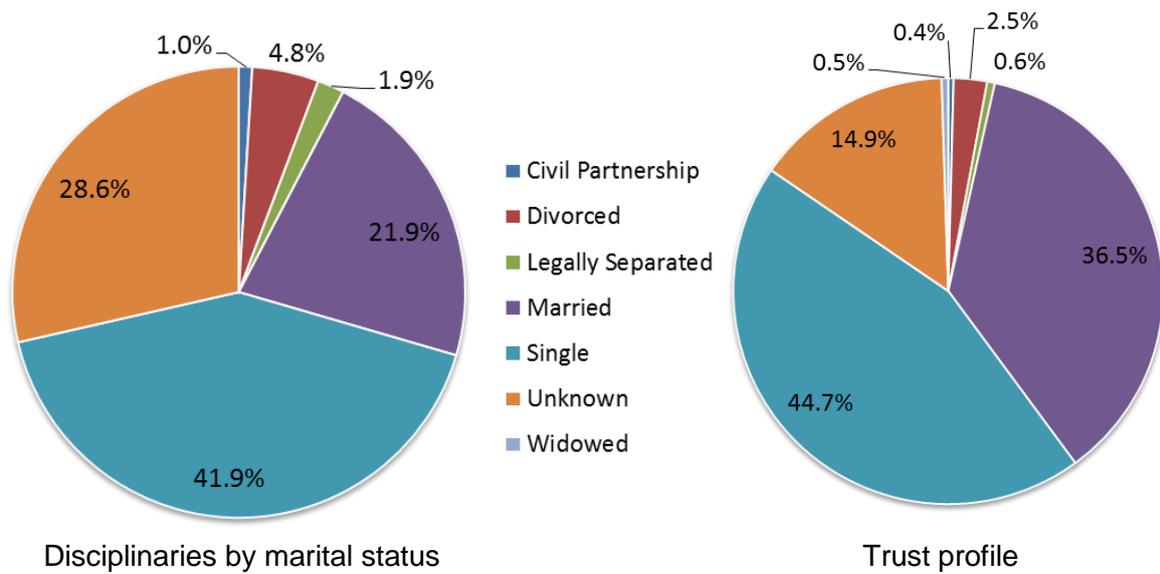
Figure 3.4.6: Disciplinaries by sexual orientation (Barts and the London and Newham)

	Barts and the London			Newham		
	No of cases	% of total disciplinaries	category as a % of Trust profile	No of cases	% of total disciplinaries	category as a % of Trust profile
Heterosexual	54	25.7	25.2	10	33	47.2
I do not wish to disclose my sexual orientation	2	1.0	3.8	3	10	9.0
Unknown	154	73.3	70.1	17	57	42.1
	210	100		30	100	

3.4.7 Marital status

Barts and the London was the only Trust to provide data on the marital status of people undergoing the disciplinary process. Married people appear less likely to receive disciplinaries than their Trust profile might suggest.

Figure 3.4.7: Disciplinary by marital status (Barts and the London)



3.5 Grievances

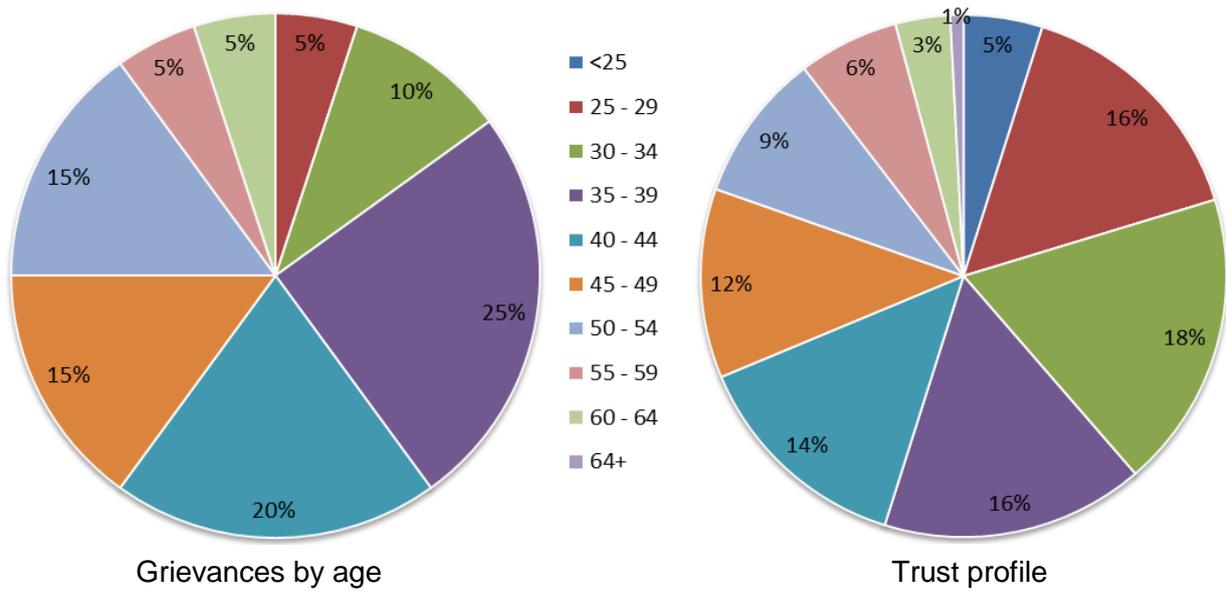
This section explores the profile of staff who raised grievances, disaggregated by protected characteristic. It is important to note that the data covers different time periods and time periods of different lengths. The form in which data was presented did not allow standardisation. Appendix B provides more detail on the dates involved.

Barts and the London and Whipps Cross provided details on the number of people raising grievances by different protected characteristics. It is important to note that the number of grievances – and therefore the sample size the figures below are based on – are relatively small: 20 grievances for Barts and the London and 17 for Whipps Cross.

3.5.1 Age

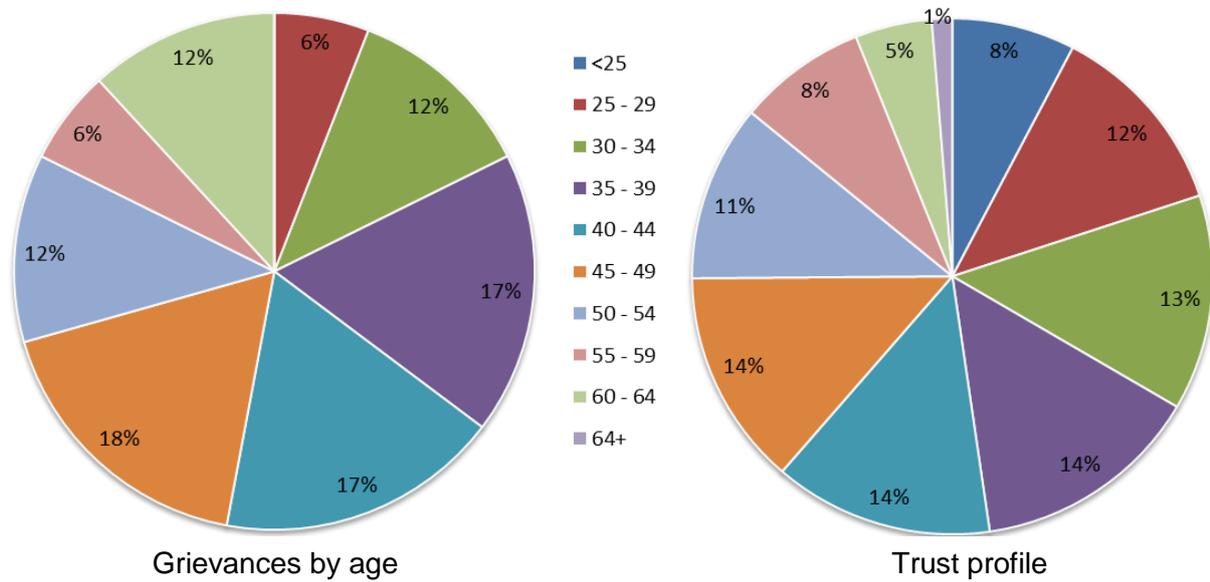
Within Barts and the London, it appears that employees aged 35-39 are significantly more likely to raise grievances than the Trust profile might suggest (the group raising 25% of all grievances despite being 16% of the workforce). Those in the 25-29 age group only raise 5% of grievances comprising 16% of the workforce. See figure 3.5.1a overleaf.

Figure 2.5.1a: Grievances by age (Barts and the London)



Within Whipps Cross, those aged 60-64 raise 12% of grievances despite comprising 5% of the workforce. At the other end of the scale, those under the age of 30 comprise 30% of the workforce but raise only 6% of grievances.

Figure 3.5.1b: Grievances by age (Whipps Cross)



3.5.2 Disability

Figures for the number of grievances raised by disabled employees are skewed by the large number of people whose disability status is unknown. Figure 3.5.2 outlines absolute figures under the broadest available categories.

Figure 3.5.2: Grievances by disability (Barts and the London and Whipps Cross)

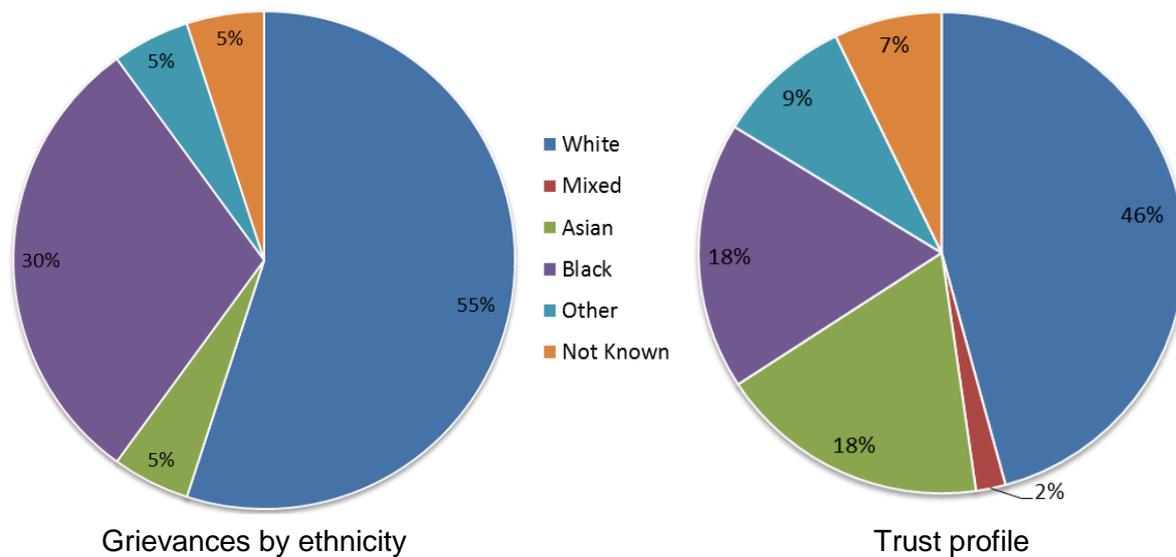
	Barts and the London		Whipps Cross	
	No of cases	% of total	No of cases	% of total
Disabled	1	5.0	1	5.9
Not disabled/NK	19	95.0	16	94.1
	20	100.0	17	100.0

3.5.3 Ethnicity

Table 2.5.3a in appendix A shows that Barts and the London provided ethnicity data using specific, narrow categories. Data is presented below using broad categories to match the format used by Whipps Cross.

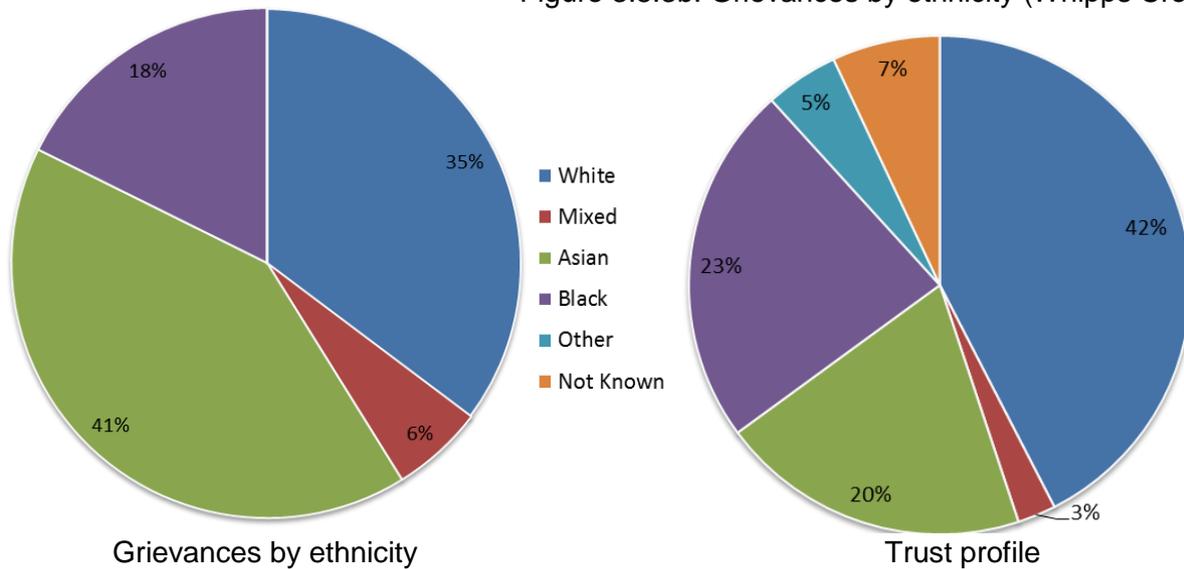
As can be seen from figure 3.5.3a, Black staff at Barts and the London are more likely to raise a grievance than the Trust profile might suggest (30% of grievances, compared with 18% of the workforce). Asian staff raise only raised 5% of grievances despite comprising 18% of the workforce.

Figure 3.5.3a: Grievances by ethnicity (Barts and the London)



In contrast, Asian staff at Whipps Cross raised 41% of the total number of grievances. They comprise just 20% of the workforce. However, given the caveat expressed at the beginning of this section about the small number of cases from which to draw conclusions, it is perhaps more prudent to simply remark that the data suggests BME staff are more likely to raise grievances than their White colleagues, see figure 3.5.3b below.

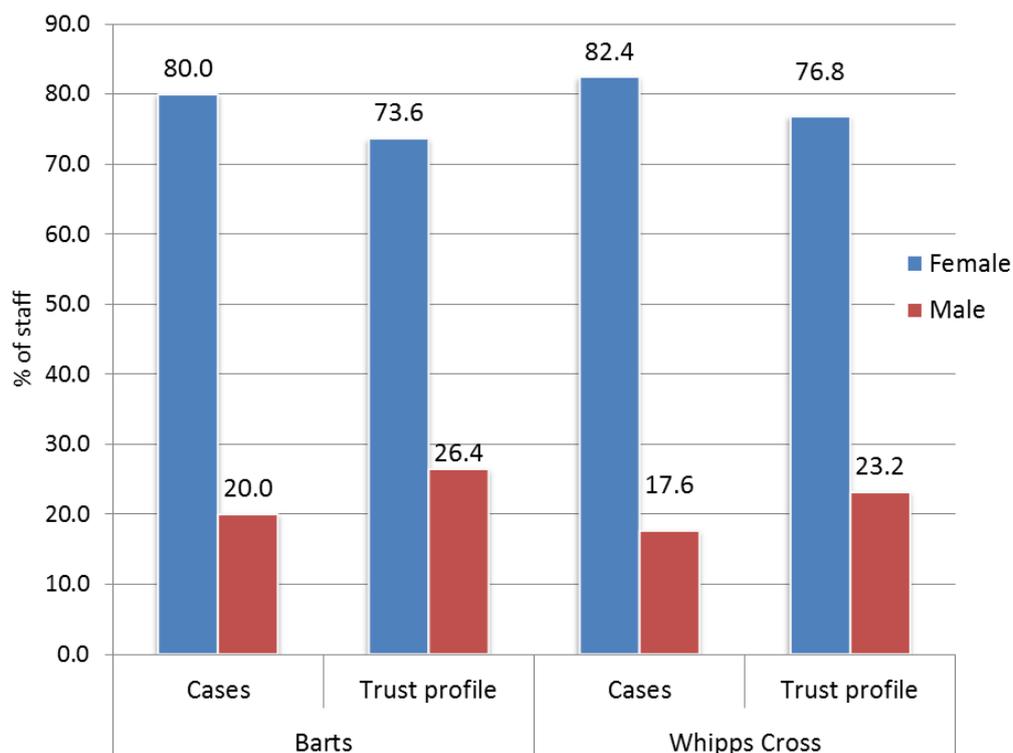
Figure 3.5.3b: Grievances by ethnicity (Whipps Cross)



3.5.4 Sex

Figure 3.5.4 shows that the number of grievances raised within Barts and the London and Whipps Cross is broadly consistent with respect to their respective sex profiles.

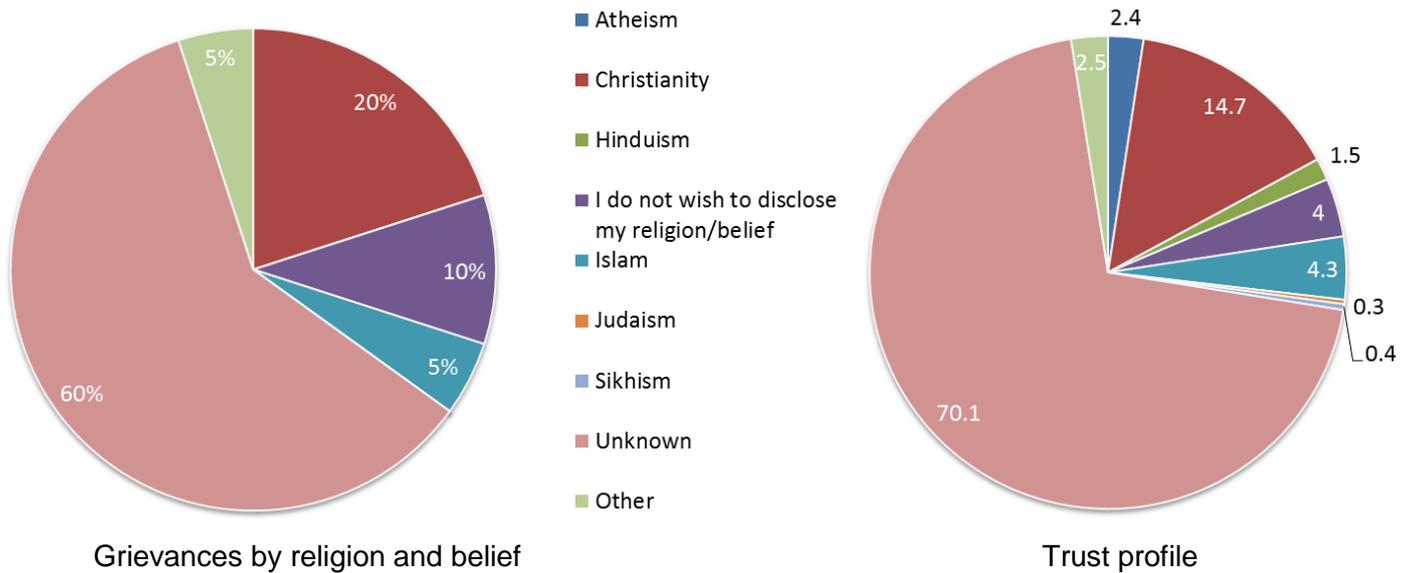
Figure 3.5.4: Grievances by sex (Barts and the London and Whipps Cross)



3.5.5 Religion and belief

Whipps Cross does not monitor grievance data by religion and belief. It wouldn't be expedient to draw substantive conclusions from the data provided by Barts and the London given the large number of people whose religious identities are unknown. However, the figures are included below for sake of reference.

Figure 3.5.5: Grievances by religion and belief (Barts and the London)



3.5.6 Sexual orientation

Whipps Cross confirmed that it does not monitor grievance cases by sexual orientation. For the sake of reference, absolute figures provided by Barts and the London are reproduced below.

Figure 3.5.6: Grievances by sexual orientation (Barts and the London)

	No of cases	% of total
Heterosexual	7	35
I do not wish to disclose my sexual orientation	1	5
Unknown	12	60
	20	100

4. TRAINING, PROMOTION, AND DEVELOPMENT

This section explores factors such as promotions and access to training opportunities. The data underlying the charts and their original sources can be found in appendix C.

4.1 Promotion

This section explores the profile of staff receiving promotions. It is important to note that the data covers different time periods and time periods of different lengths. The form in which data was presented did not allow standardisation. Appendix C provides more detail on the dates involved.

4.1.1 Age

Newham used slightly different groupings to Barts and the London and Whipps Cross, so figures for that organisation are presented separately (figure 4.1.1b).

Within Barts and the London and Whipps Cross, the 30-34 age group are most likely to be promoted (28.4% in Barts and the London; 29.8% in Whipps Cross); at Newham it's the 26-30 group (19.8%). Notwithstanding groups at either end of the age spectrum, Newham has a fairly even distribution of promotions. In their latest workforce report, Whipps Cross note that 'younger members of staff are more likely to receive promotion than older ones',¹⁰ while Barts and the London acknowledge the need to explore the opportunities available to older employees in light of the removal of the default retirement age¹¹ (see figure 4.1.1a).

4.1.2 Disability

Data related to disability is distorted by the low disclosure rate for this characteristic.

Absolute numbers are provided below for the sake of reference. The categories used are the broadest that were supplied (provided by Whipps Cross).

Figure 4.1.2: Promotions by disability (all Trusts)

	No of promotions		
	Barts and the London	Newham	Whipps Cross
Disabled	6	-	1
Not disabled/Not known	571	101	46
	578	101	47

¹⁰ Whipps Cross (2011) op cit

¹¹ Barts and the London NHS Trust (2012) op cit

Figure 4.1.1a: Promotions by age (Barts and the London and Whipps Cross)

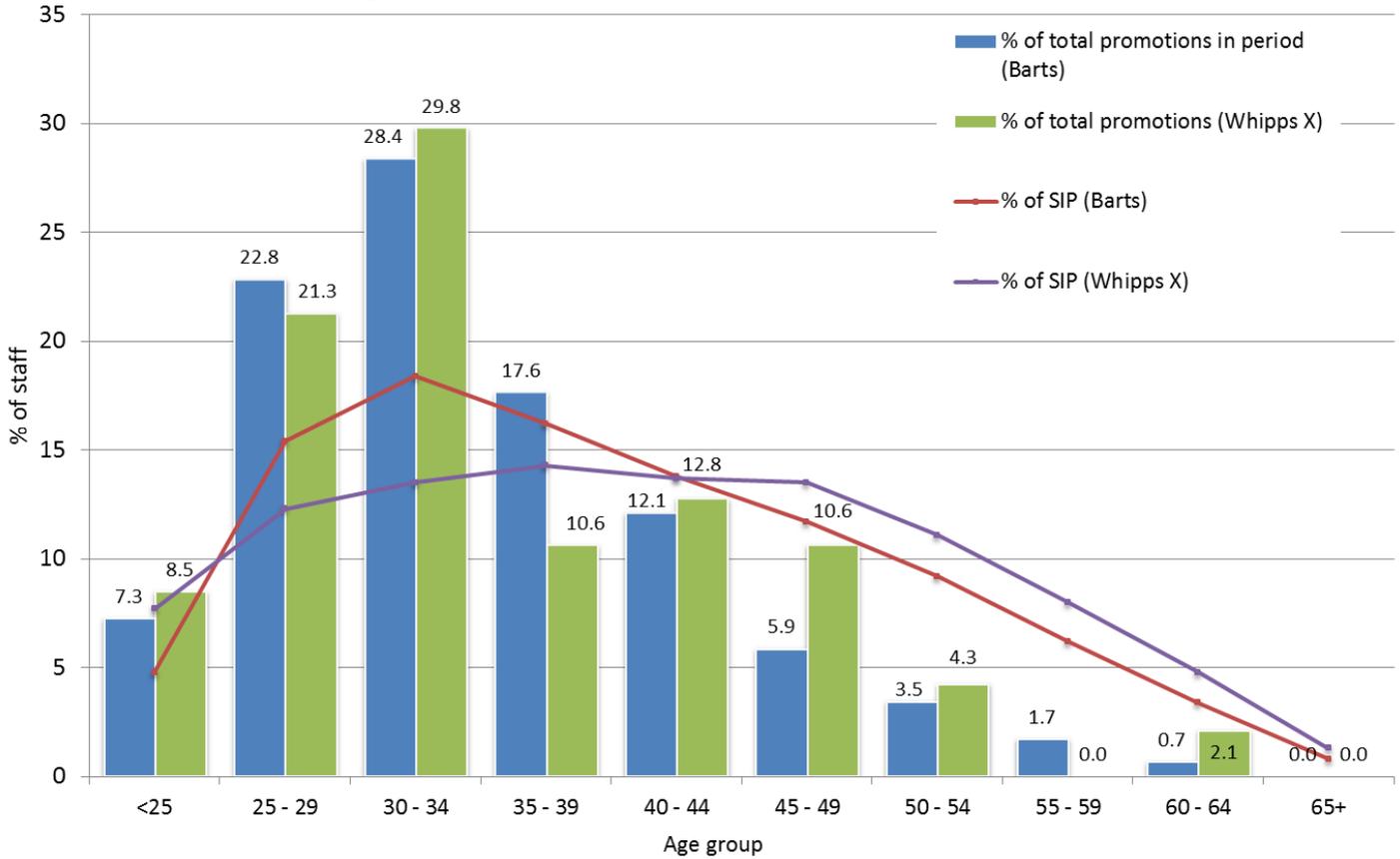
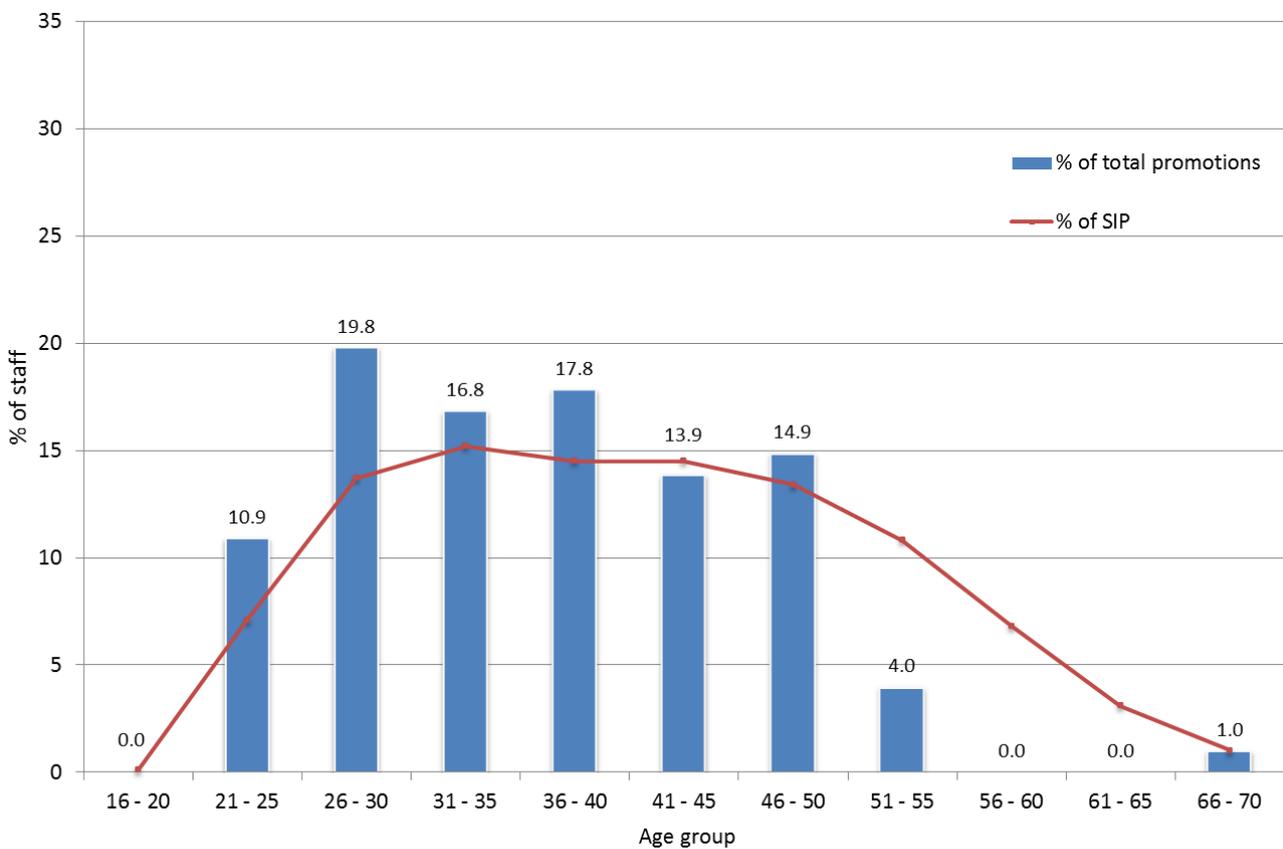


Figure 4.1.1b: Promotions by age (Newham)



4.1.3 Ethnicity

Tables 3.1.3a, b, and c (appendix C) show that the three Trusts used different groupings to categorise ethnicity. In figure 4.1.3a, below, data is shown under the broadest available categories. With Whipps Cross in particular, the number of promotions within the period is relatively low (Whipps Cross n=47) making distributions volatile. Bearing this in mind, it is perhaps safest to note only that promotions within Trusts are broadly in line with workforce profiles.

Figure 4.1.3a: Promotions by ethnicity (broad categories)(all Trusts)

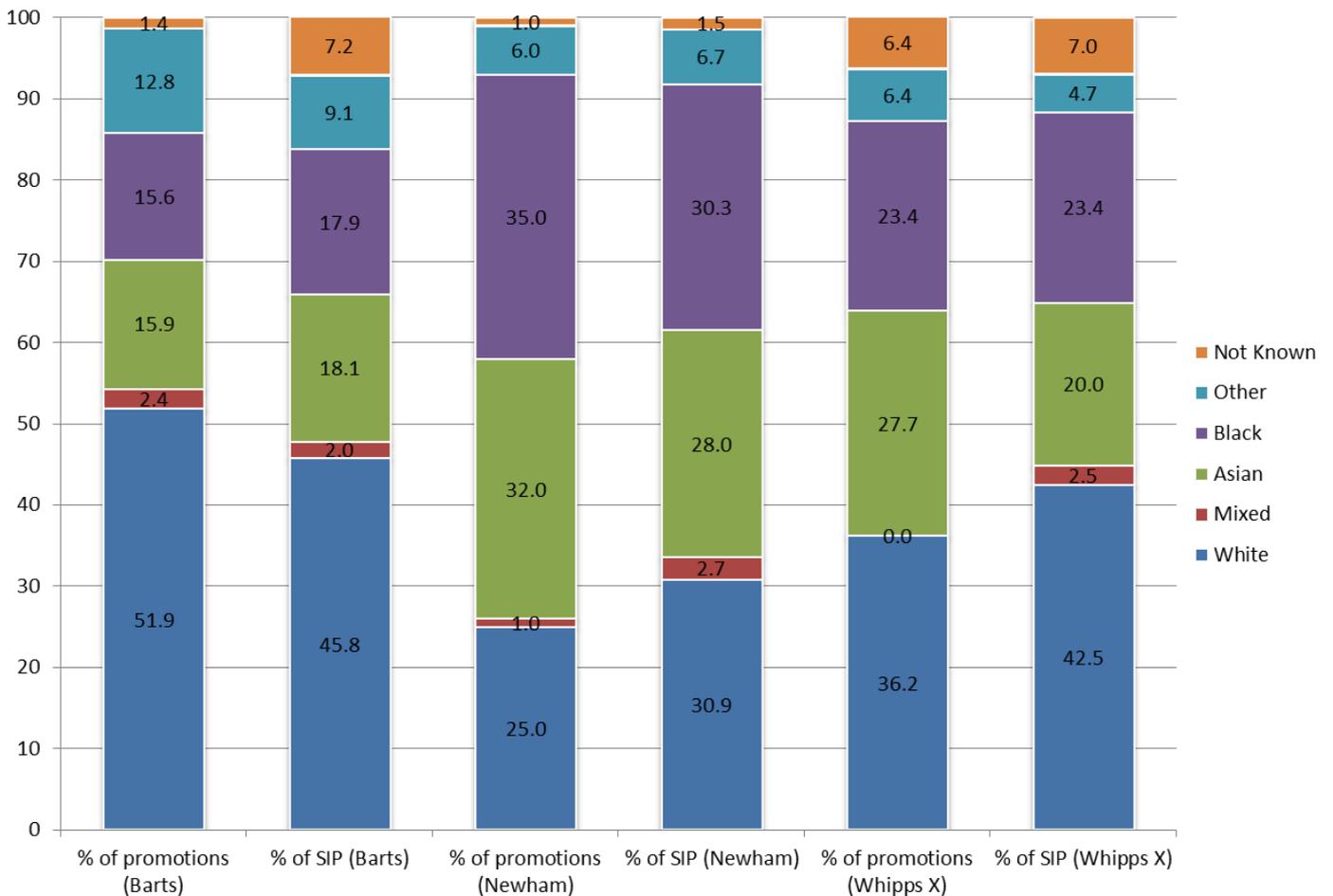
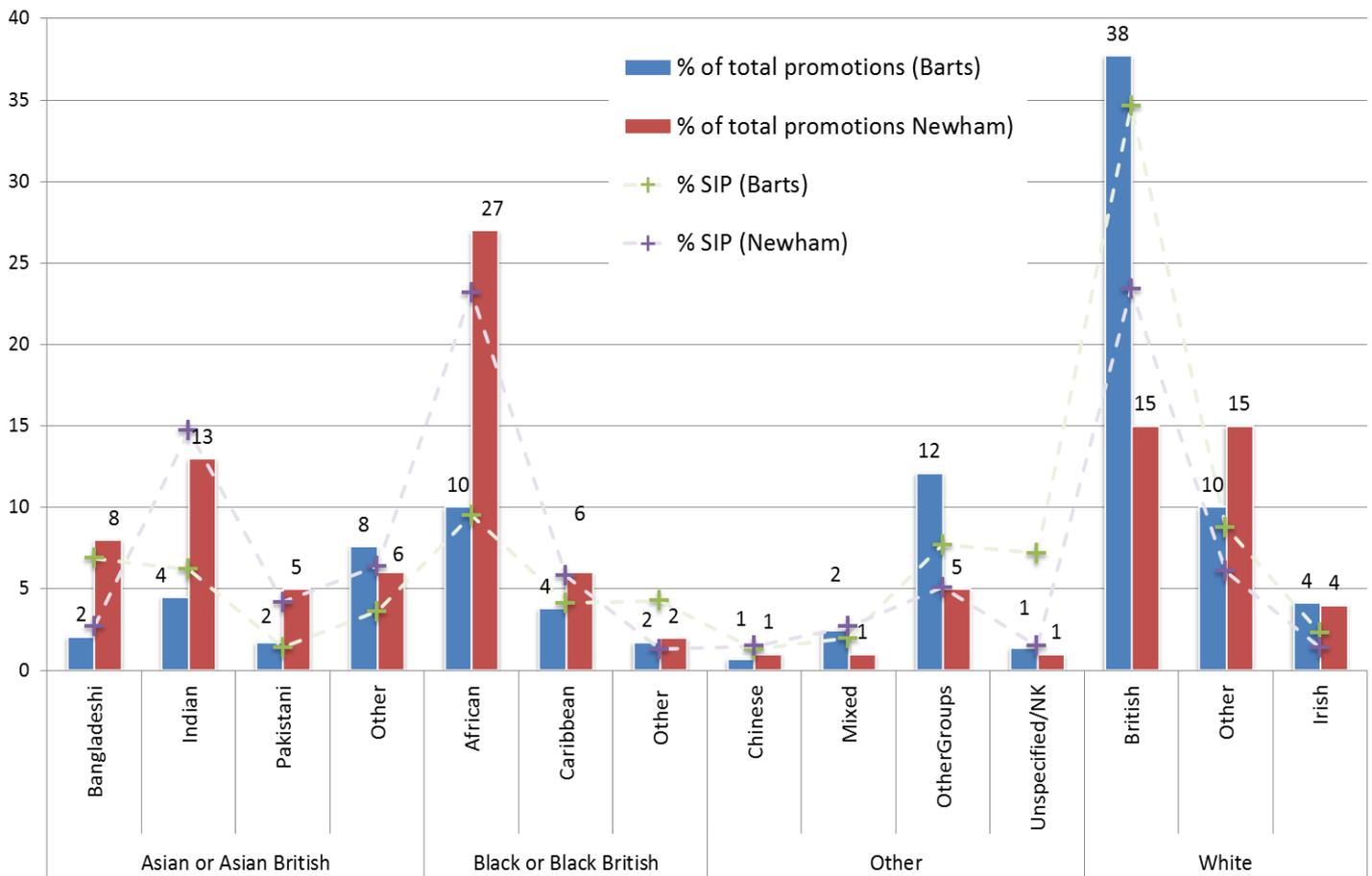


Figure 4.1.3b over the page shows promotions against narrower ethnic categories within Barts and the London and Newham. At Barts and the London, the most promotions occurred in the White ethnic category (38%), while at Newham it appears that the largest number of promotions occurred in the Black African category (27%). Within both Trusts a significant proportion of promotions were in the White Other category.

Bangladeshi staff at Barts and the London did not receive the number of promotions that might be expected given the Trust profile. At Newham, White staff are underrepresented in the promotion statistics.

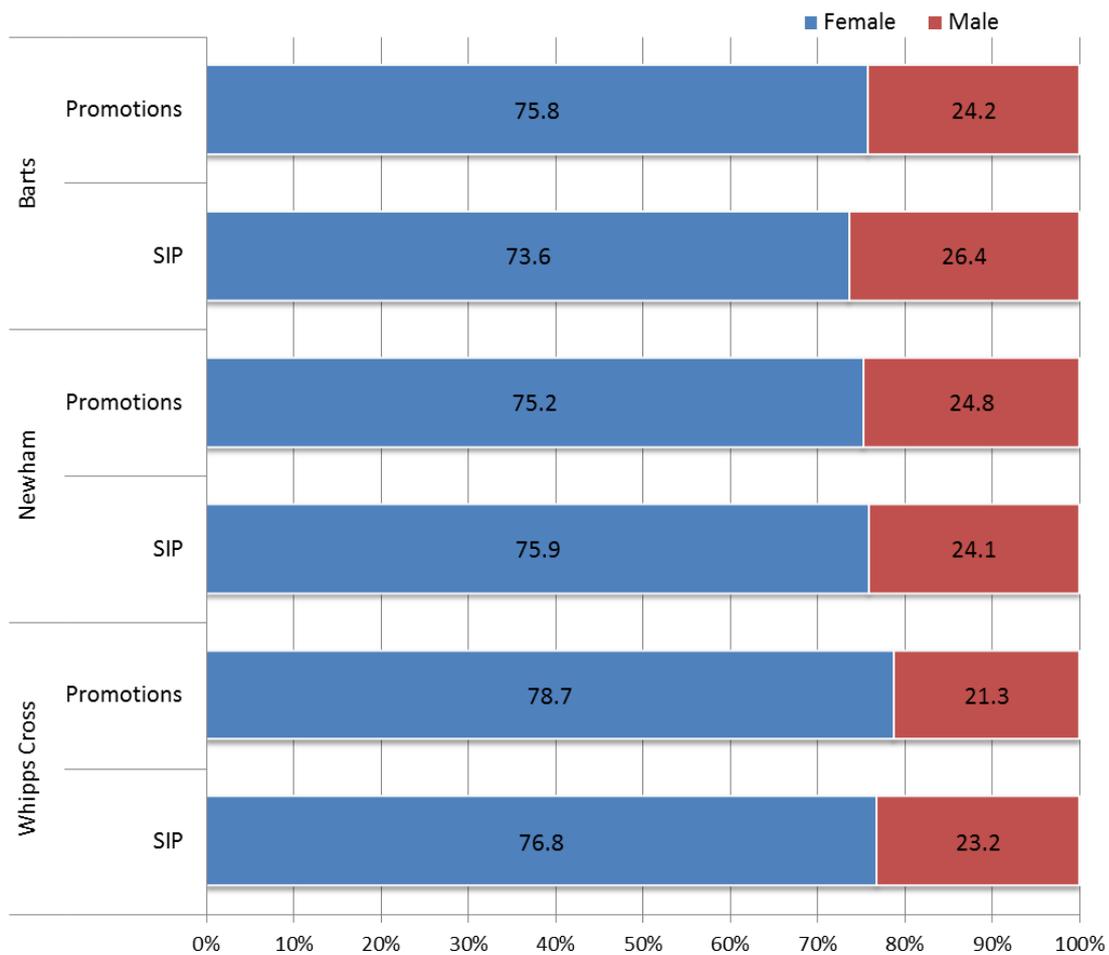
Figure 4.1.3b: Promotions by ethnicity (narrow categories)(BLT and Newham)



4.1.4 Sex

Rates of promotion between sexes appear broadly in line with Trust profiles (see figure 4.1.4).

Figure 4.1.4: Promotions by sex (all Trusts)



4.1.5 Religion and belief

Only Barts and the London and Newham provided data on the number of promotions by religion and belief. Within Barts and the London, the highest number of promotions occur in the category 'Unknown' (40.5%) and then 'Christianity' (30.8%). This last figure is significantly higher than the percentage of staff identifying themselves as Christian (14.7%) (see figure 4.1.5a).

At Newham, the two highest categories are again 'Christianity' (37.6%) and 'Unknown' (35.6%), figures which are broadly in line with the Trust's profile. People identifying their religion as 'Islam' received 14.9% of promotions despite comprising 7.2% of the workforce.

Figure 4.1.5a: Promotions by religion and belief (Barts and the London)

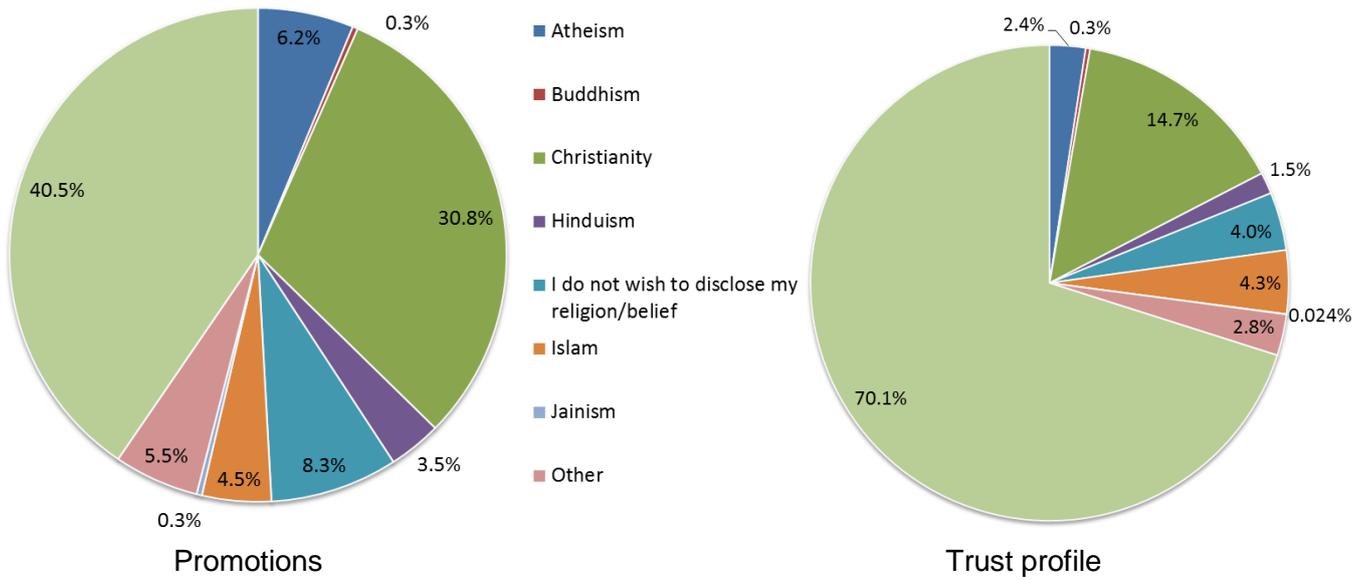
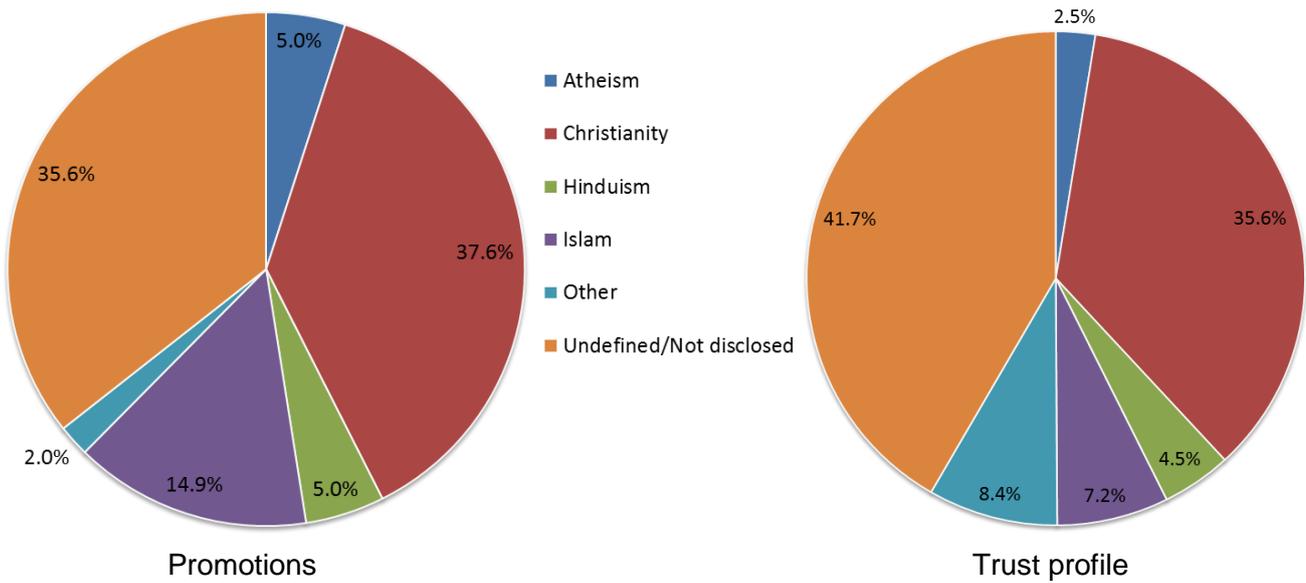


Figure 4.1.5b: Promotions by religion and belief (Newham)



4.1.6 Sexual orientation

Only Barts and the London and Newham provided data on the number of promotions by sexual orientation. Absolute figures are outlined below for reference.

Figure 4.1.6: Promotions by sexual orientation (BLT and Newham)

	Barts and the London			Newham		
	No of promotions	% of total promotions	category as a % of Trust profile	No of promotions	% of total promotions	category as a % of Trust profile
Bisexual	2	0.3	0.2	2	2.0	0.9
Gay	14	2.4	0.6	1	1.0	0.6
Heterosexual	290	50.2	25.2	57	56.4	47.2
I do not wish to disclose my sexual orientation	38	6.6	3.8	7	6.4	9.0
Lesbian	0	0.0	0.1	0	0.0	0.2
Unknown	234	40.5	70.1	34	33.67	42.1
	578	100		101	100	

4.2 Access to training

Not all Trusts provided information on staff access to training. In their Equality Report 2012, Barts and the London note that:

The data available for staff training does not enable meaningful analysis of the level of training attended by the protected characteristics. Although the data enables some analysis this analysis cannot be relied upon as wide variations exist between the numbers of attendees on these courses. Given this context it would be erroneous to attempt a comparison of statistics in reference to the protected characteristics as the total figures for each of the courses demonstrate a very high level of variance

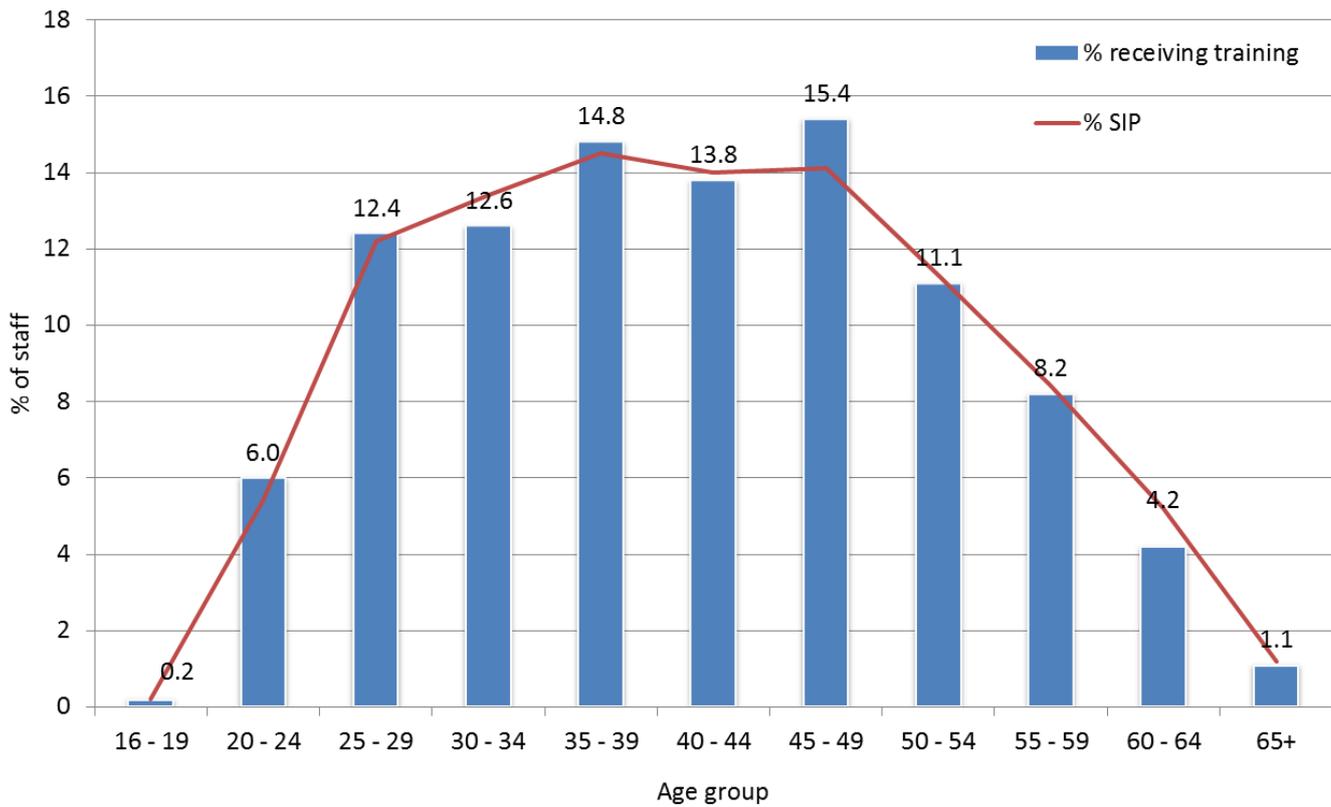
At the time of writing (February 2012), Newham was compiling its training data for inclusion in its Equality Report.

The following data therefore relates solely to Whipps Cross. The data shows the number of staff who have been in receipt of training within the six months January to June 2011.

4.2.1 Age

The proportion of different age groups receiving training appears broadly in line with the Trust's profile (figure 4.2.1).

Figure 4.2.1: Receipt of training by age (Whipps Cross)



4.2.2 Disability

Absolute figures relating the number of people receiving training by disability status are reproduced below for reference.

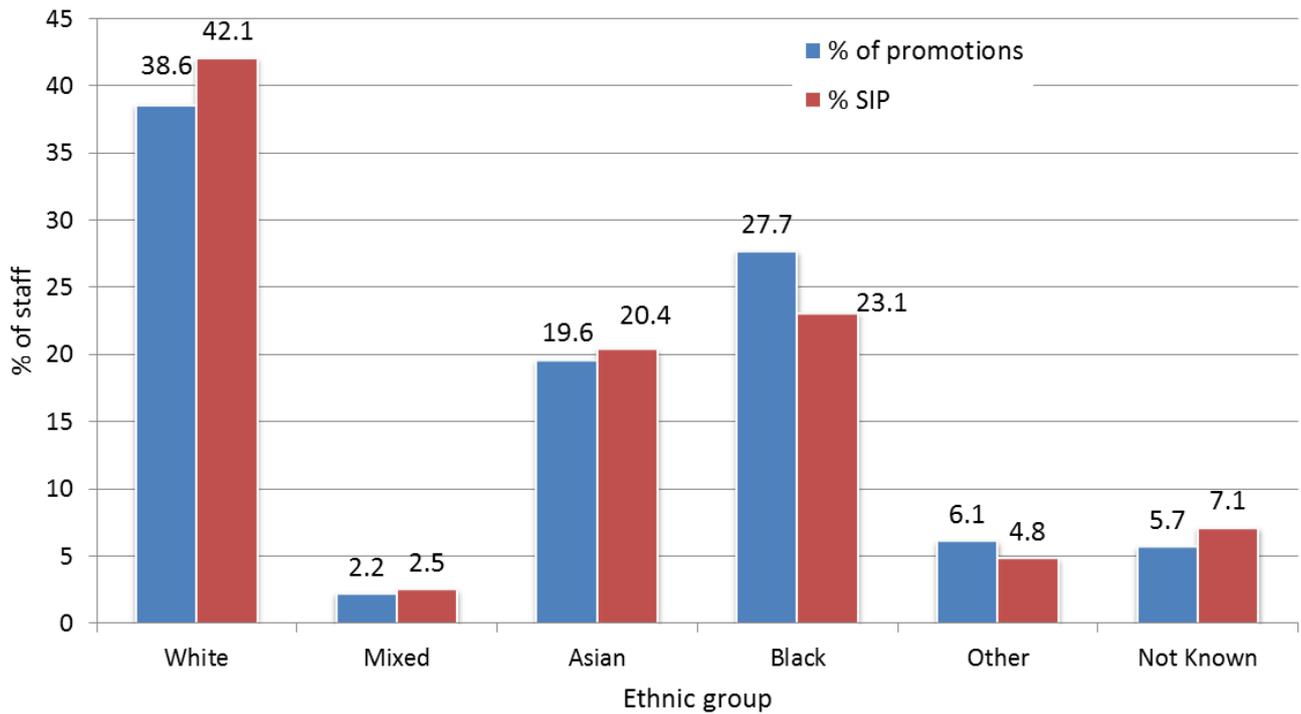
Figure 4.2.2: Receipt of training by disability (Whipps Cross)

	No receiving training	% receiving training	% of Trust profile
Disabled	28	1.6	1.3
Not disabled/NK	1684	98.4	98.7
	1712	100.0	100.0

4.2.3 Ethnicity

Broadly, the proportion of different ethnic groups receiving training appears in line with the Trust’s profile (figure 4.2.3); notwithstanding a slightly higher percentage of Black staff receiving training (27.7% compared to 23.1% of workforce) and a lower percentage of White staff receiving training (38.6% compared to 42.1% of workforce).

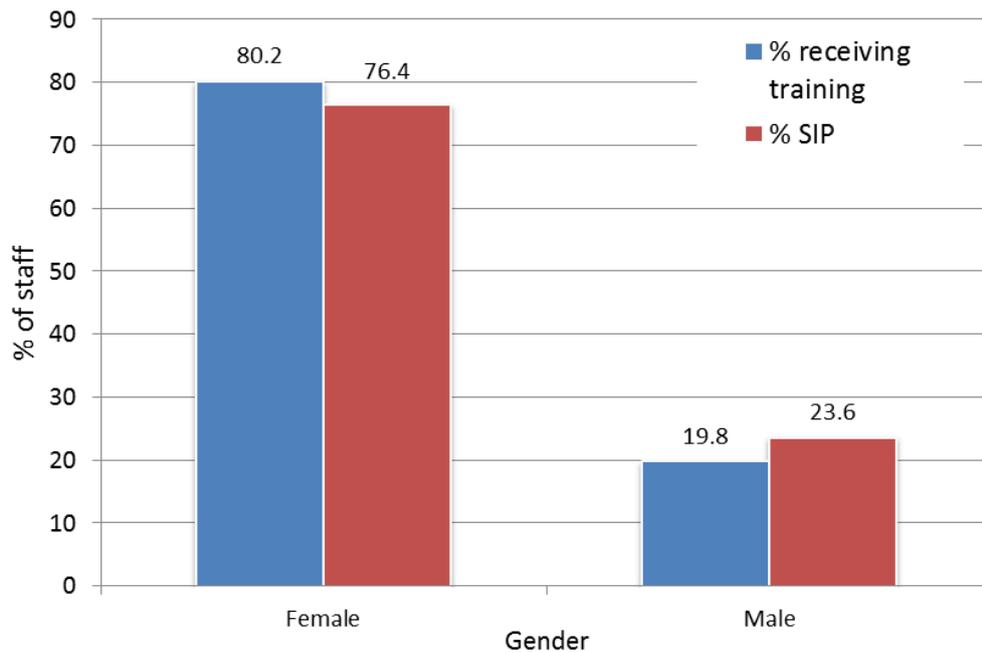
Figure 4.2.3: Receipt of training by ethnicity (Whipps Cross)



4.2.4 Sex

Men at Whipps Cross are perhaps slightly more likely to receive training than the Trust profile might suggest (figure 4.2.4).

Figure 4.2.4: Receipt of training by sex (Whipps Cross)



4.3 Detriments and demotions

This section relays information from two different datasets. Whipps Cross collate, and have presented, data relating to detriments experienced by different staff members. Staff falling into this category are:

staff who either fail to pass through an Agenda for Change gateway, consultants on the new contract who have incremental progression withheld, and staff who are downgraded or dismissed due to capability¹²

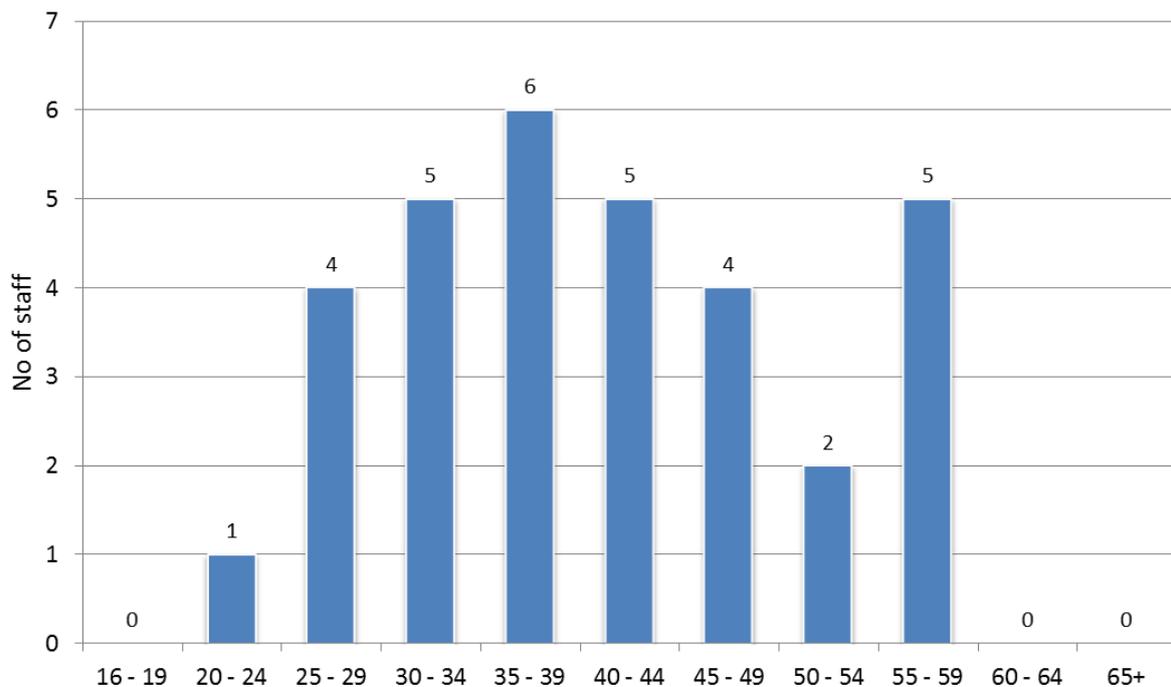
Newham provided information on the number of staff demoted. While the category used by Whipps Cross is obviously wider, the two sets of data are here provided together for the sake of convenience.

It is important to note that the number of cases in each data set is small (for Newham, n=32; for Whipps Cross, n=9). Additionally, the data applies to time periods of different length (see appendix C).

4.3.1 Age

Within the period in question, six people within the 35-39 age group were demoted at Newham (figure 4.3.1a). Worthy of further investigation, however, is the spike in the number of people in the 55-59 age group who were demoted.

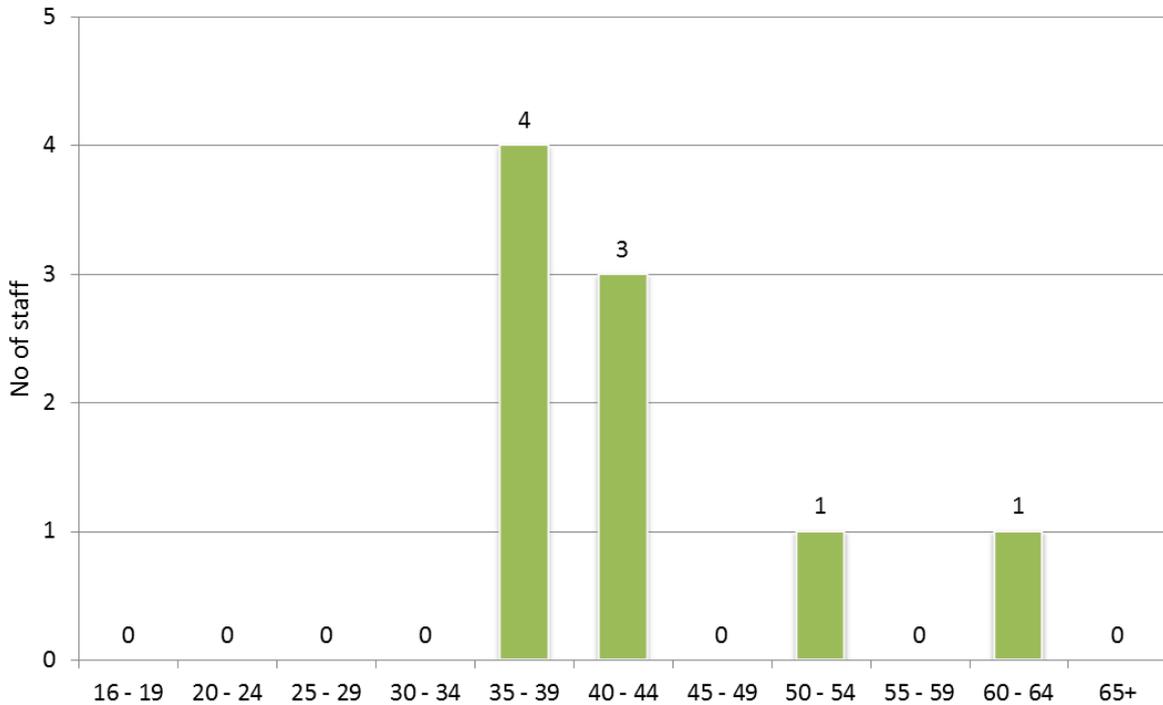
Figure 4.3.1a: Demotions by age (Newham)



¹² Whipps Cross (2010) Whipps Cross University Hospital NHS Trust HR Department Workforce (Equalities) Information Report April – June 2010

At Whipps Cross, four people in the 35-39 age group were demoted and three in 40-44 age group (figure 4.3.1b below).

Figure 4.3.1: Detriments by age (Whipps Cross)



4.3.2 Disability

Figure 4.3.2 below shows the number of disabled people receiving detriments or demotions in Newham and Whipps Cross.

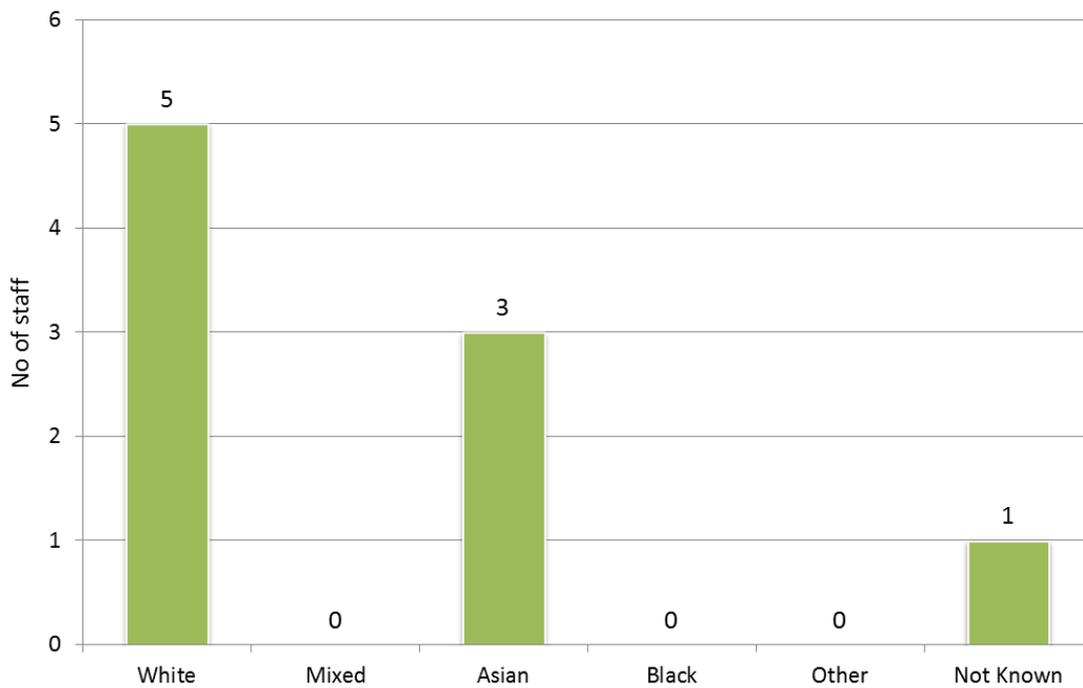
Figure 4.3.2: Demotions and detriments by disability (Newham and Whipps Cross)

	Newham		Whipps Cross	
	No of demotions	% of total demotions	No of detriments	% of total detriments
Disabled	2	6.25	0	0.00
Not disabled/NK	30	93.75	9	100.00
	32	100.00	9	100.00

4.3.3 Ethnicity

The data provided by Newham did not allow analysis of demotions. At Whipps Cross, five White employees received detriments, as did three Asian employees (figure 4.3.3).

Figure 4.3.3: Detriments by ethnicity (Whipps Cross)



4.3.4 Sex

Within Newham, 15.63% of demoted employees were men (five out of a total of 32). At Whipps Cross, out of the nine people receiving detriments three were men.

Figure 4.3.4a: Demotions by sex (Newham)

	No of demotions	% of total demotions
Men	5	15.63
Women	27	84.37
	32	100.00

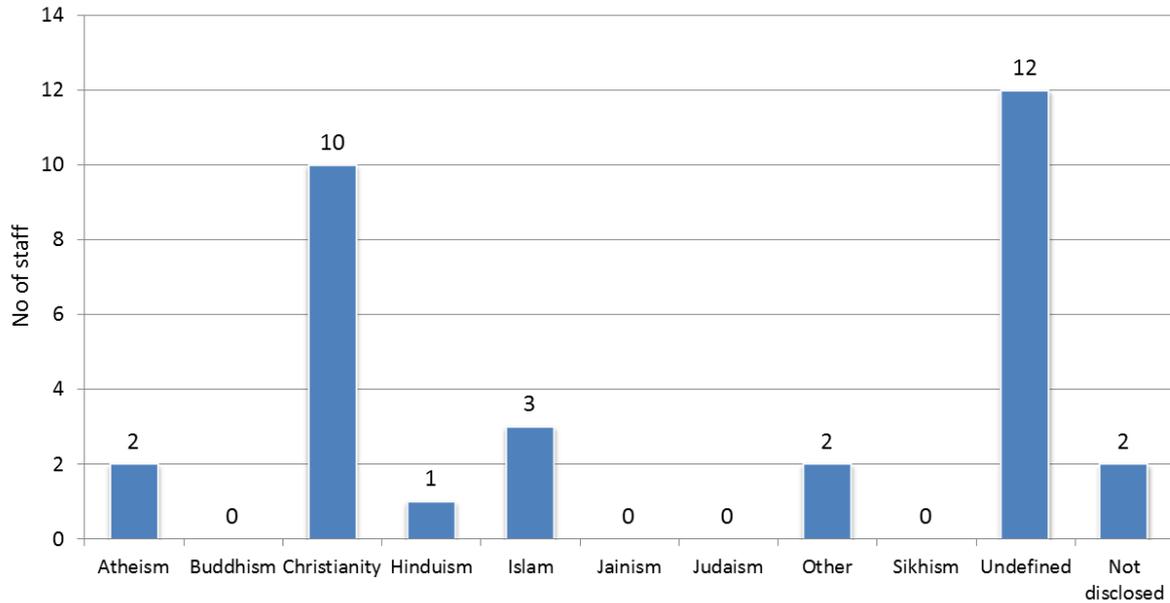
Figure 4.3.4b: Detriments by sex (Whipps Cross)

	No of detriments	% of total demotions
Men	3	33.33
Women	6	66.66
	9	100.00

4.3.5 Religion and belief

Whipps Cross did not provide information on the religion/belief status of people receiving detriments. At Newham, 12 people experiencing demotion did not reveal their religion/belief, 10 fell into the 'Christianity' category, and three into the 'Islam' category.

Figure 4.3.5: Demotions by religion and belief (Newham)



4.3.6 Sexual orientation

Whipps Cross did not provide information on the sexual orientation of staff receiving detriments. The sexual orientation of staff undergoing demotion at Newham is outlined below.

Figure 4.3.6: Demotions by sexual orientation (Newham)

	No of demotions	% of total demotions
Bisexual	0	0
Gay	0	0
Heterosexual	15	46.9
I do not wish to disclose my sexual orientation	4	12.5
Lesbian	1	3.1
Undefined	12	37.5
	32	100

5. RECRUITMENT

The data underlying the charts in this section and their original sources can be found in appendix D.

This section contains information on variables including the number of applicants in a given time period and the number of subsequent starters. Given the potential for these indicators to show fairness along the recruitment pathway it makes sense to display them together. As such this section has a slightly different structure to the proceeding ones.

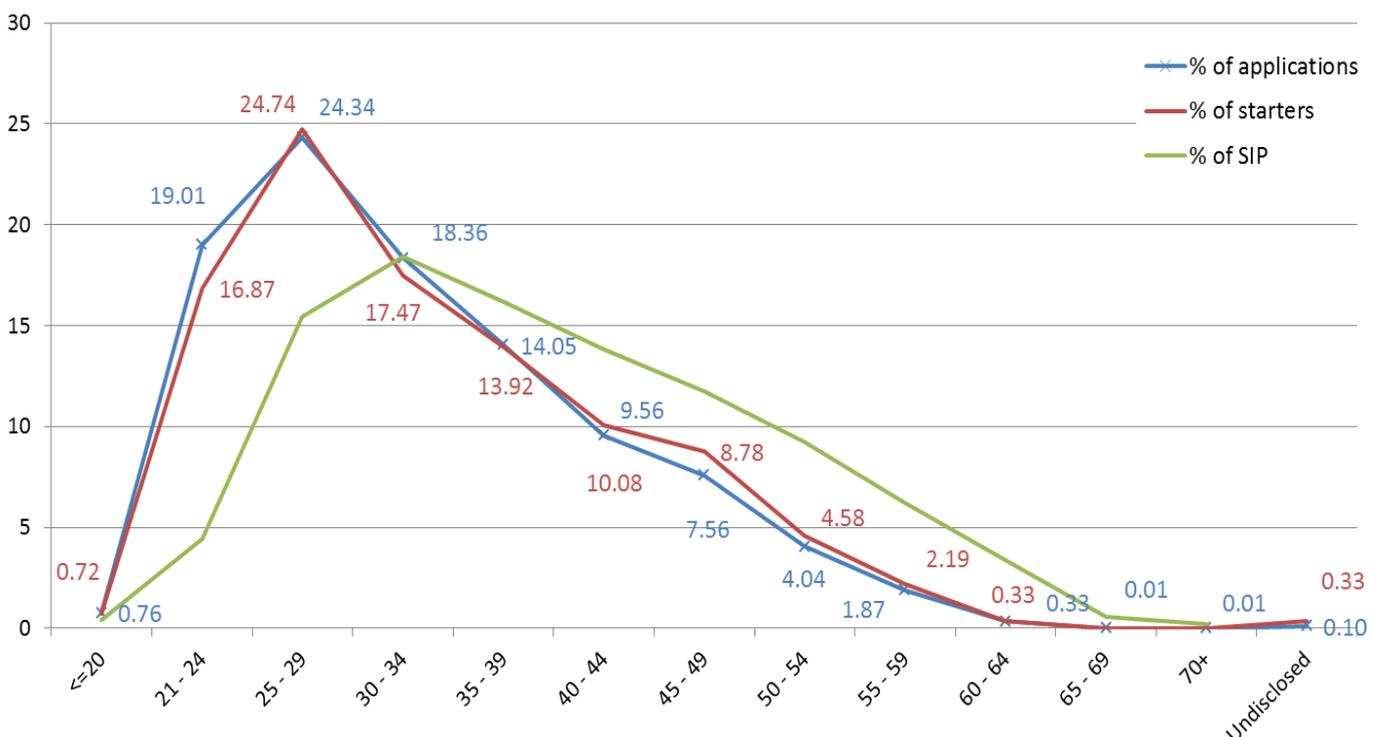
Barts and the London provided information on: the number of applicants for available posts, those who were shortlisted, and the subsequent number of starters. Newham provided information on: the number of starters. Additional information was provided on the number of applicants and the number of people shortlisted. However, researchers were not able to include this information within the project timescales. Whipps Cross provided information on: the number of applicants and the subsequent number of starters. The data received is laid out comprehensively in appendix D. The sections below relay salient information.

5.1 Age

5.1.1 Barts and the London

The 21-24 and 25-29 age groups applied for the most jobs and constituted most of the starters within the time period. Nobody over 65 was recruited. Despite slight variations, the rate of appointment follows the rate applications quite closely.

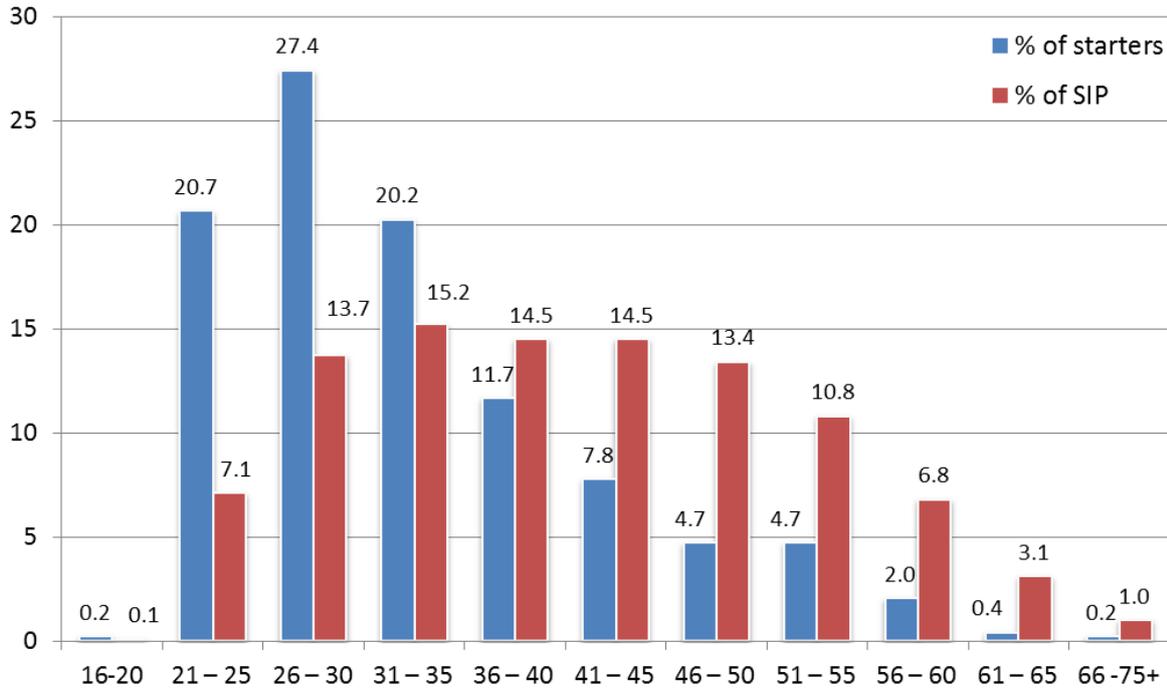
Figure 5.1.1: Applicants and starters by age (Barts and the London)



5.1.2 Newham

Within the period, the highest proportion of starters at Newham fell into the 21-25 (20.7%) and 26-30 (27.4%) age categories. This intake was not in proportion to the Trust’s existing staff profile (see figure 5.1.2).

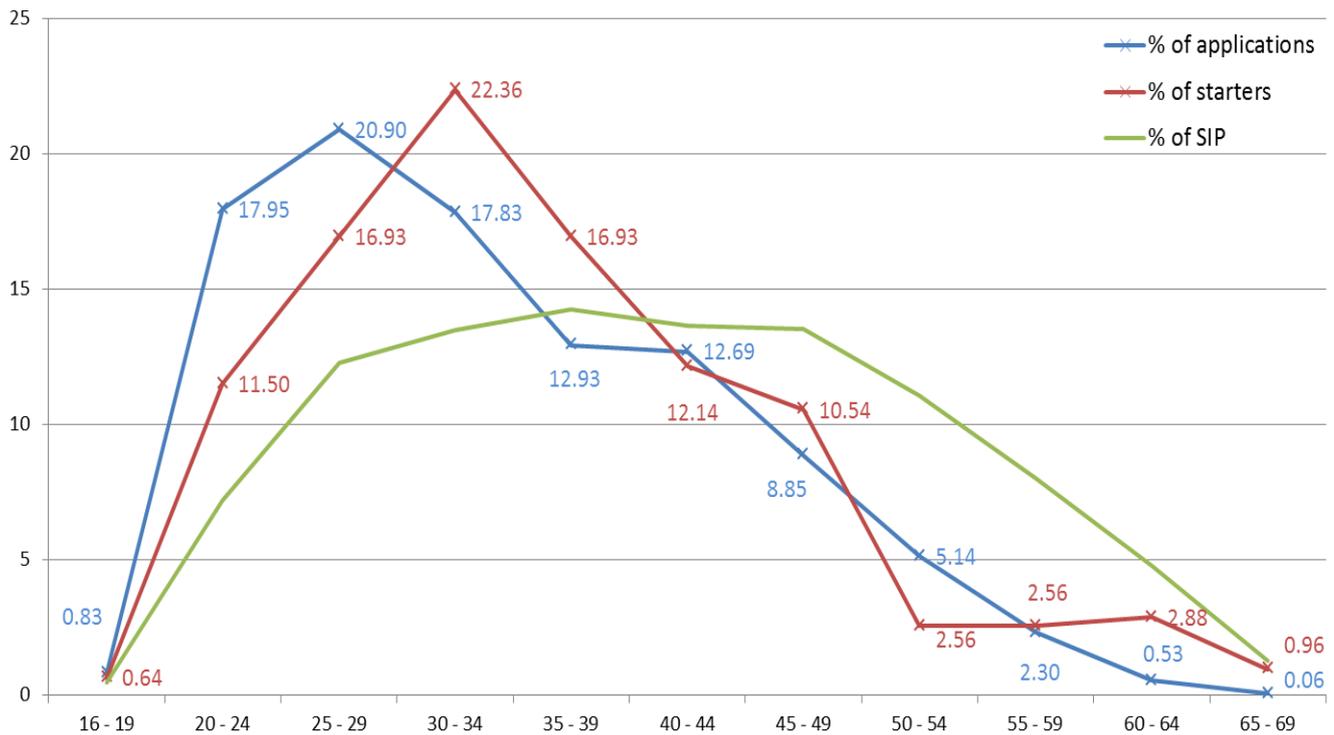
Figure 5.1.2: Starters by age (Newham)



5.1.3 Whipps Cross

The 30-34 age group contained the most starters in the period (22.36%). The success rate – the discrepancy between the rate of applications and the starter rate – is quite volatile, with applicants under the age of 30 being less successful than those aged 30-40; and applicants between 45-49 more successful than those aged 50-54 (see figure 5.1.3).

Figure 5.1.3: Applicants and starters by age (Whipps Cross)



5.2 Disability

5.2.1 Barts and the London

The percentage of disabled people filling posts at Barts and the London (3.0%) was slightly higher than the proportion of disabled people applying for posts (2.8%). Indeed, the success rate for disabled applicants (2.79%) was broadly the same as that for non-disabled people (2.60%).

Figure 5.2.1: Applicants and starters by disability (Barts and the London)

	No of applicants	% of total applicants	No of people	% of total starters
Disabled - Yes	753	2.80	21	3.00
Disabled - No	25888	96.40	681	96.30
Undisclosed	220	0.80	5	0.70

5.2.2 Newham

Figures relating to the disability status of starters at Newham are outlined below.

Figure 5.2.2: Starters by disability (Newham)

	No of starters	% of starters
Disabled: Yes	1	0.21
Disabled: No	249	51.44
Not known	234	48.3

5.2.3 Whipps Cross

Levels of disclosure around disability status are much higher with regard to the submission of applications (99.5%). Out of the 68 disabled people applying for positions, five (7.4%) were successful, although there may be more falling into the 'Not known' category (see figure 5.2.3b).

Figure 5.2.3a: Applicants by disability (Whipps Cross)

	No of applicants	% of total applicants
Disabled	68	4.0
Not disabled	1618	95.5
Not Disclosed	8	0.5

Figure 5.2.3b: Starters by disability (Whipps Cross)

	No of starters	% of total starters
Disabled	5	1.6
Not disabled/NK	308	98.4

5.3 Ethnicity

5.3.1 Barts and the London

As shown in figure 5.3.1a, the highest number of applications were received from people from a Black African background (6081 applications compared to 5157 from White British people). This is completely out of proportion to the number of Black African people in the local community.¹³ Similarly, there were more applications from people from Indian and White Other backgrounds than might be expected given the profile of the local community. The Bangladeshi and White British communities were underrepresented in the applicant figures.

Figure 5.3.1b shows that White British people have an extremely high success rate: accounting for 41.0% of starters despite submitting only 19.2% of applications. In contrast, the category 'Black African' has a low success rate (12.7% of starters, 22.6% of applicants), as does 'Indian' (8.1% of starters, 11.9% of applicants) and 'Other White' (8.8% of starters, 11.6% of applicants).

¹³ Population figures for Tower Hamlets are taken from Office for National Statistics (2009) op cit.

Figure 5.3.1a: Applications and local population by ethnicity (Barts and the London)

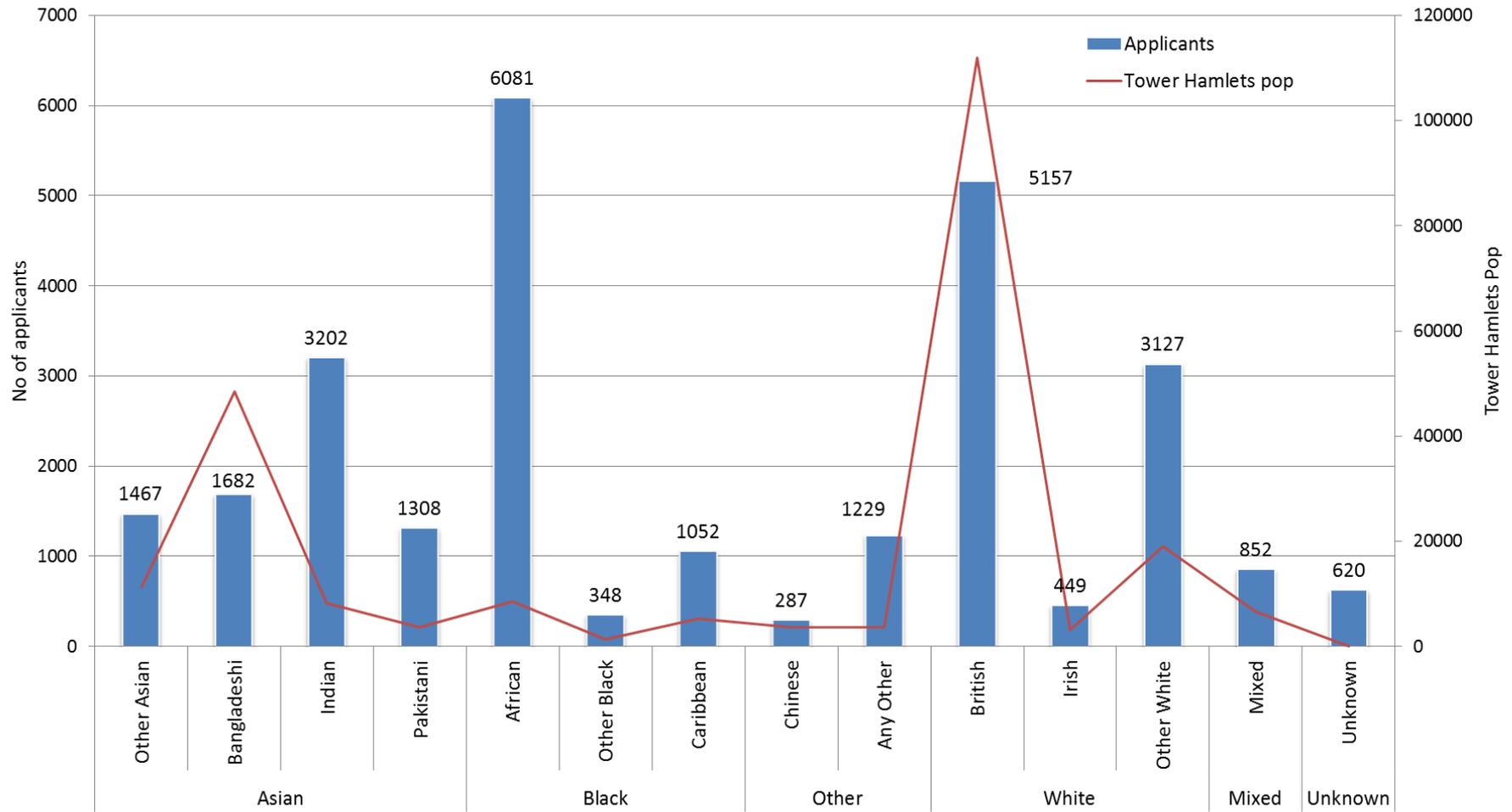
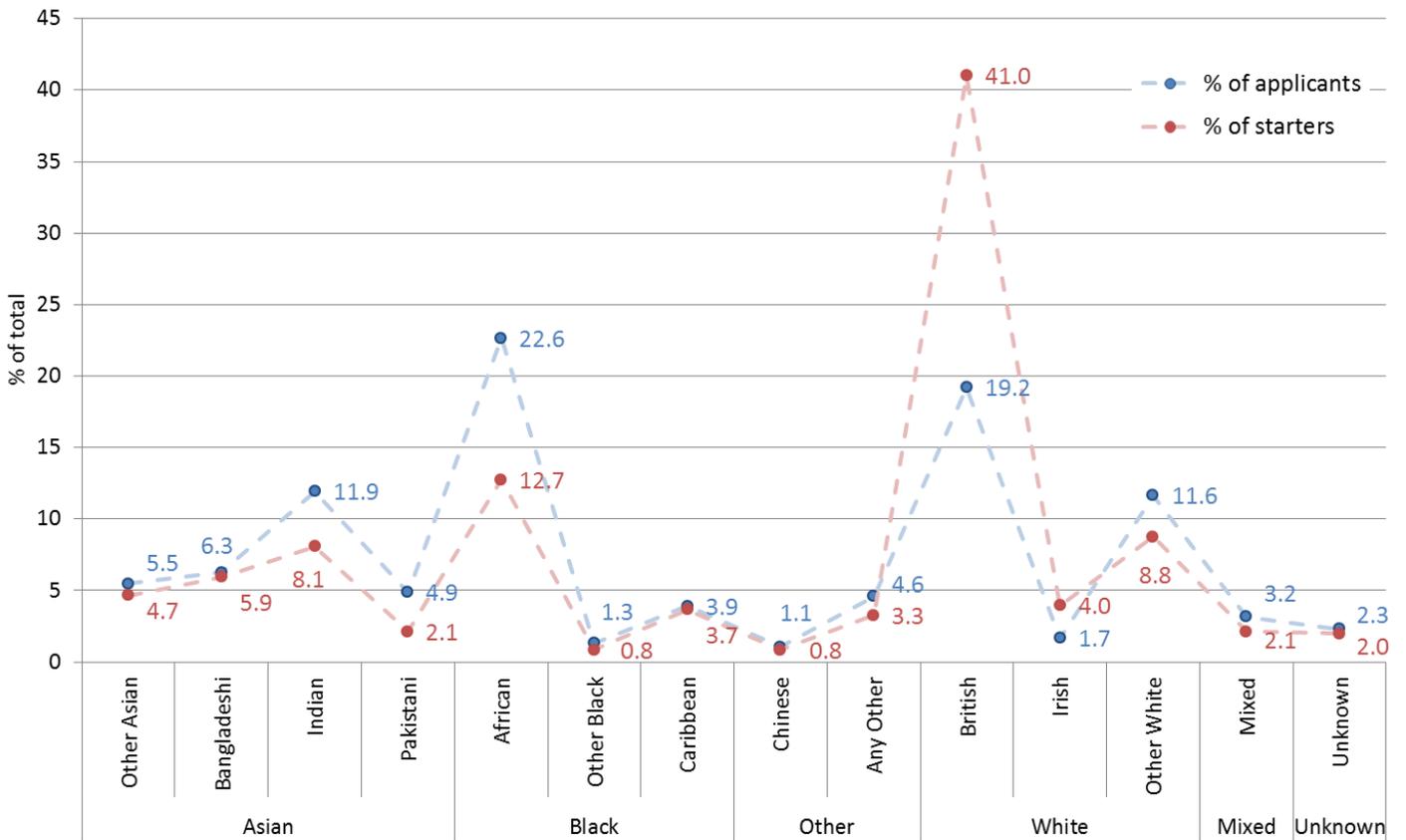


Figure 5.3.1b: Applicants and starters by ethnicity (Barts and the London)



5.3.2 Newham

The largest proportion of new starters at Newham came from the 'White British' (25.8%) and 'Indian' (15.1%) categories. People from a Black African background comprised only 13.9% of starters despite being 23.2% of the workforce. See figure 5.3.2.

5.3.3 Whipps Cross

The number of applications Whipps Cross received from people from Asian and Black backgrounds far outweighed what might be expected given the profile of the local community¹⁴ (see figure 5.3.3a).

¹⁴ Population figures for Waltham Forest are taken from Office for National Statistics (2009) op cit. Here, 'Asian' and 'Black' refer to the broad categories against which data was disaggregated.

Figure 5.3.2: Starters by ethnicity (Newham)

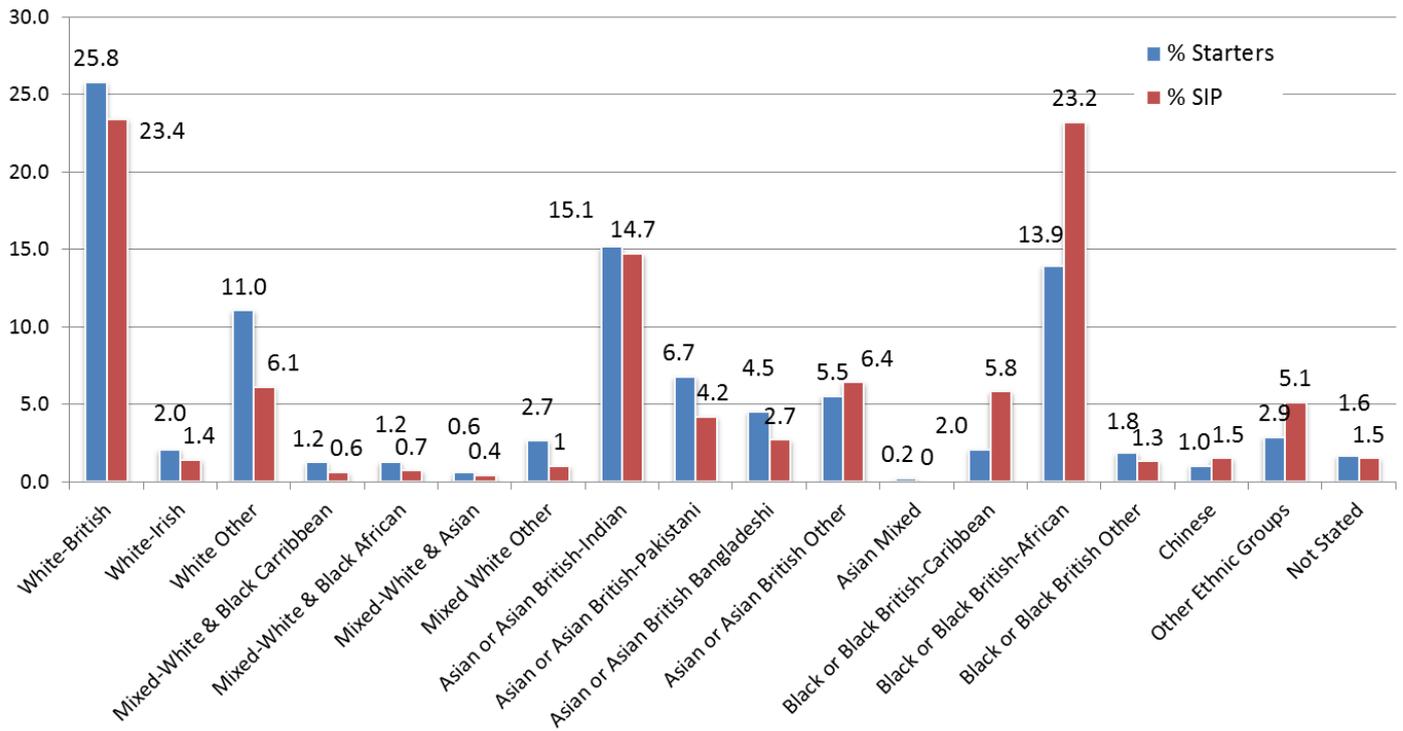
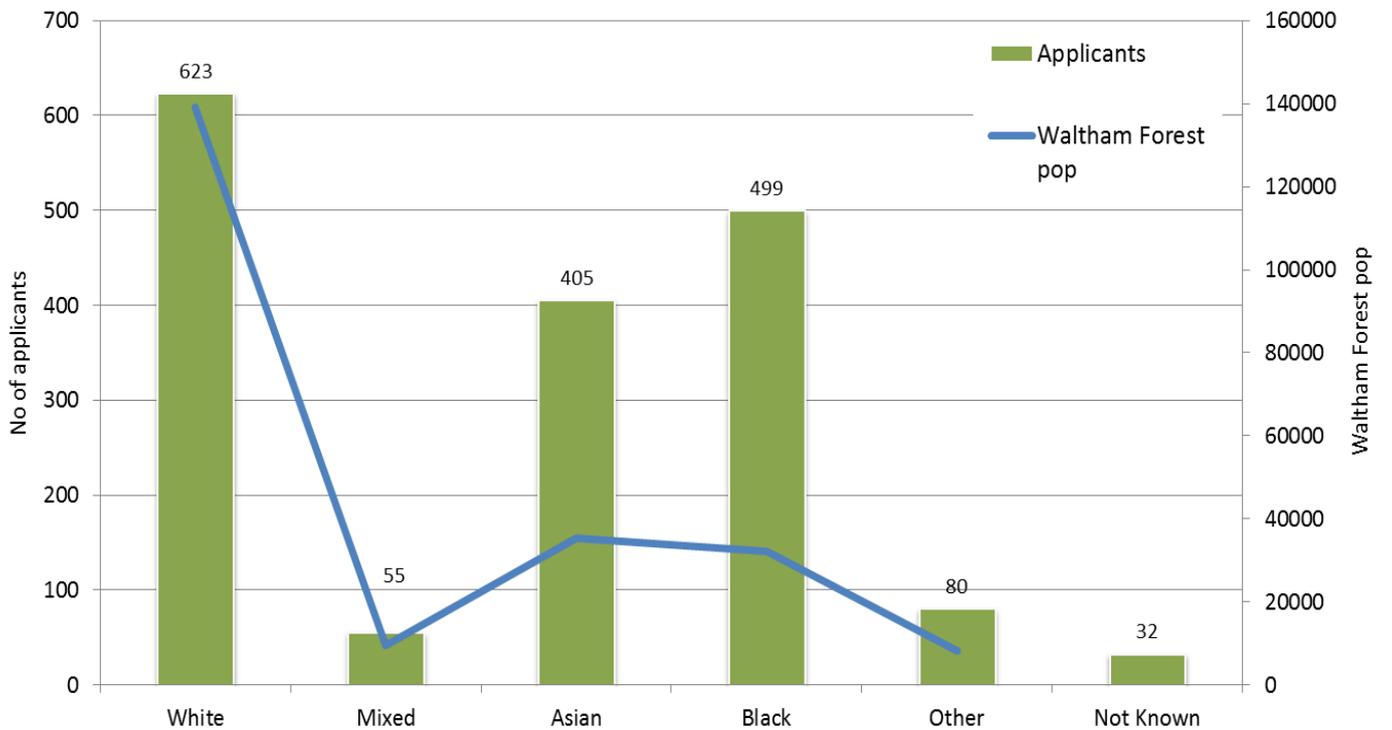
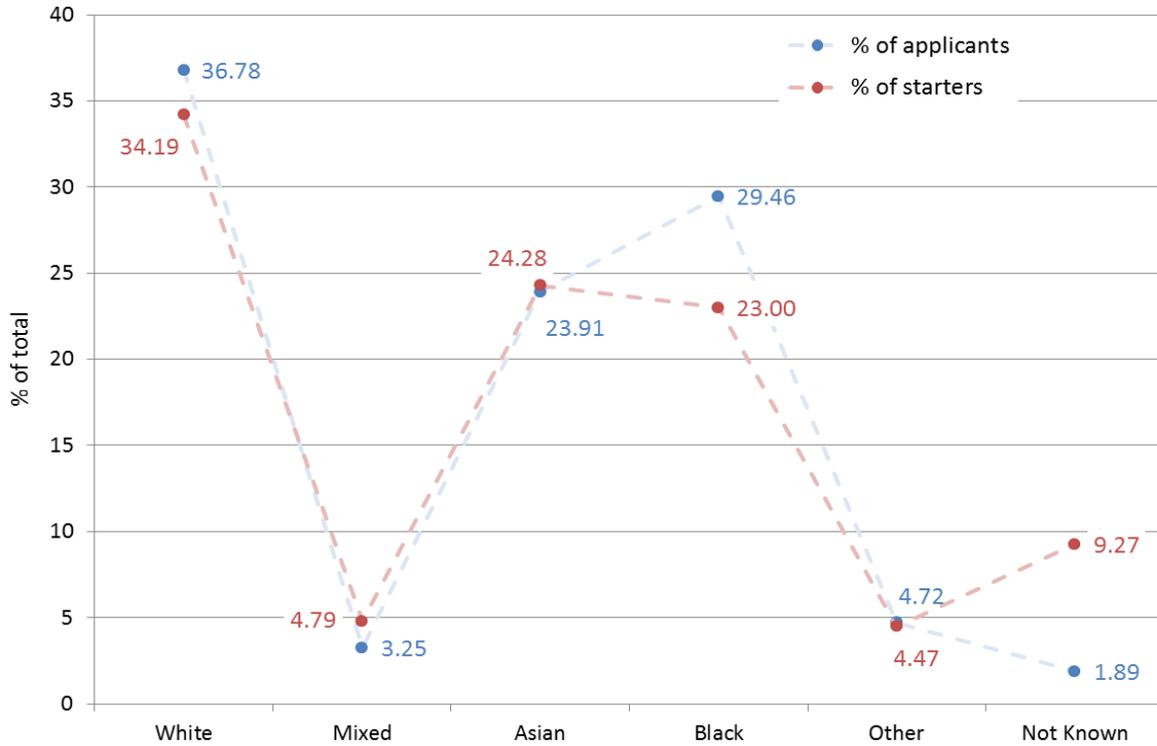


Figure 5.3.3a: Applicants and local population by ethnicity (Whipps Cross)



The rate at which staff from different ethnicities are appointed to roles is broadly in line with the rate at which applicants apply for them. An exception to this is the 'Black' category, which comprised only 23.0% of starters despite submitting 29.5% of applications.

Figure 5.3.3b: Applicants and starters by ethnicity (Whipps Cross)

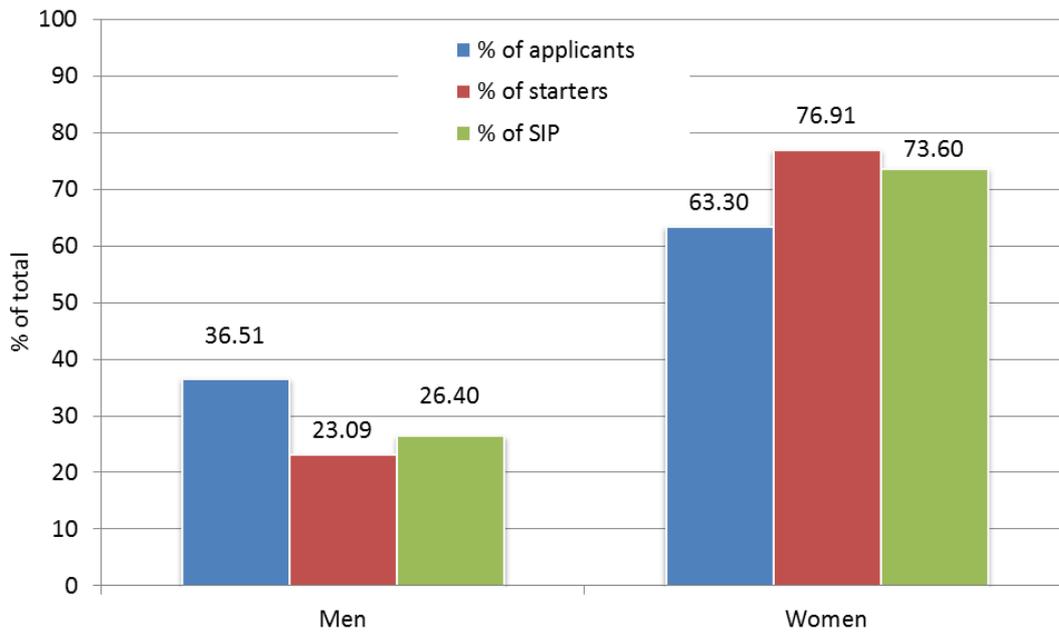


5.4 Sex

5.4.1 Barts and the London

Men tended to have a lower success rate than women, comprising 23.1% of starters despite submitting over a third of applications (36.5%).

Figure 5.4.1: Applicants and starters by sex (Barts and the London)



5.4.2 Newham

Figures for the percentages of new starters at Newham are below.

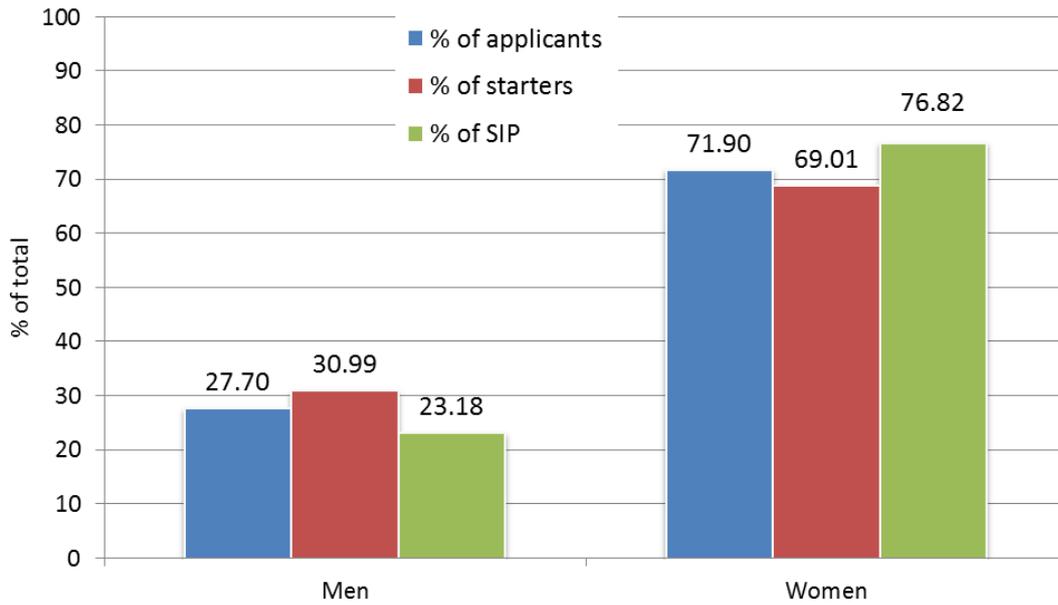
Figure 5.4.2: Starters by sex (Newham)



5.4.3 Whipps Cross

Women at Whipps Cross made up 69% of starters, submitting about 72% of applications.

Figure 5.4.3: Applicants and starters by sex (Whipps Cross)



5.5 Location

Given the importance Barts Health will have as a local employer, Whipps Cross provided data on the number of its employees who live locally. As figure 5.5 below shows, a third of staff (32.2%) live with two miles of the Trust, whereas 40.9% live within 2-8 miles.

Figure 5.5a: proximity of staff to Trust (Whipps Cross)

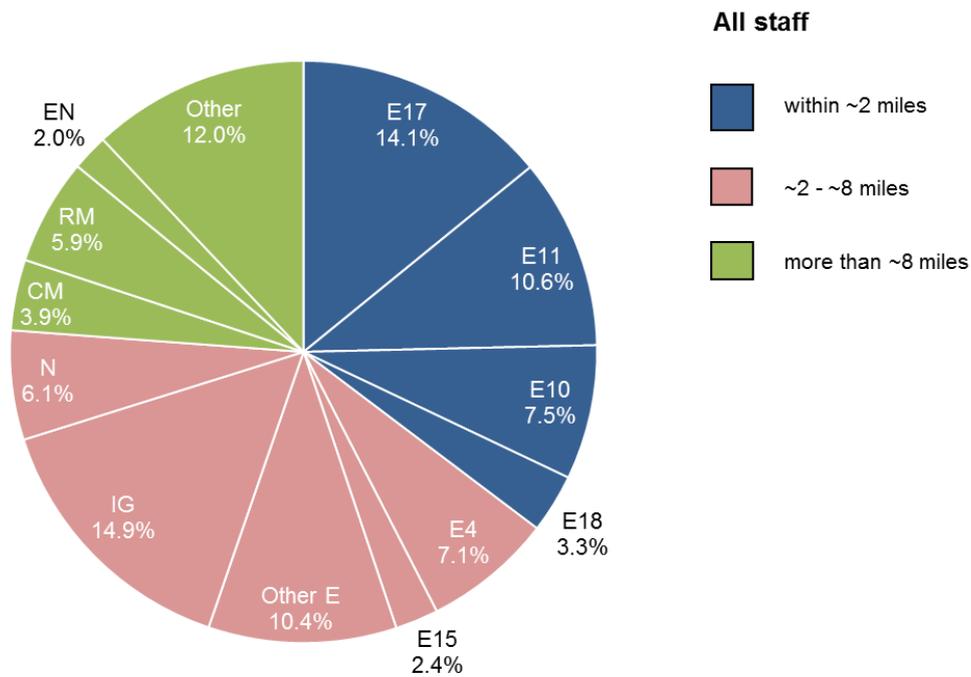
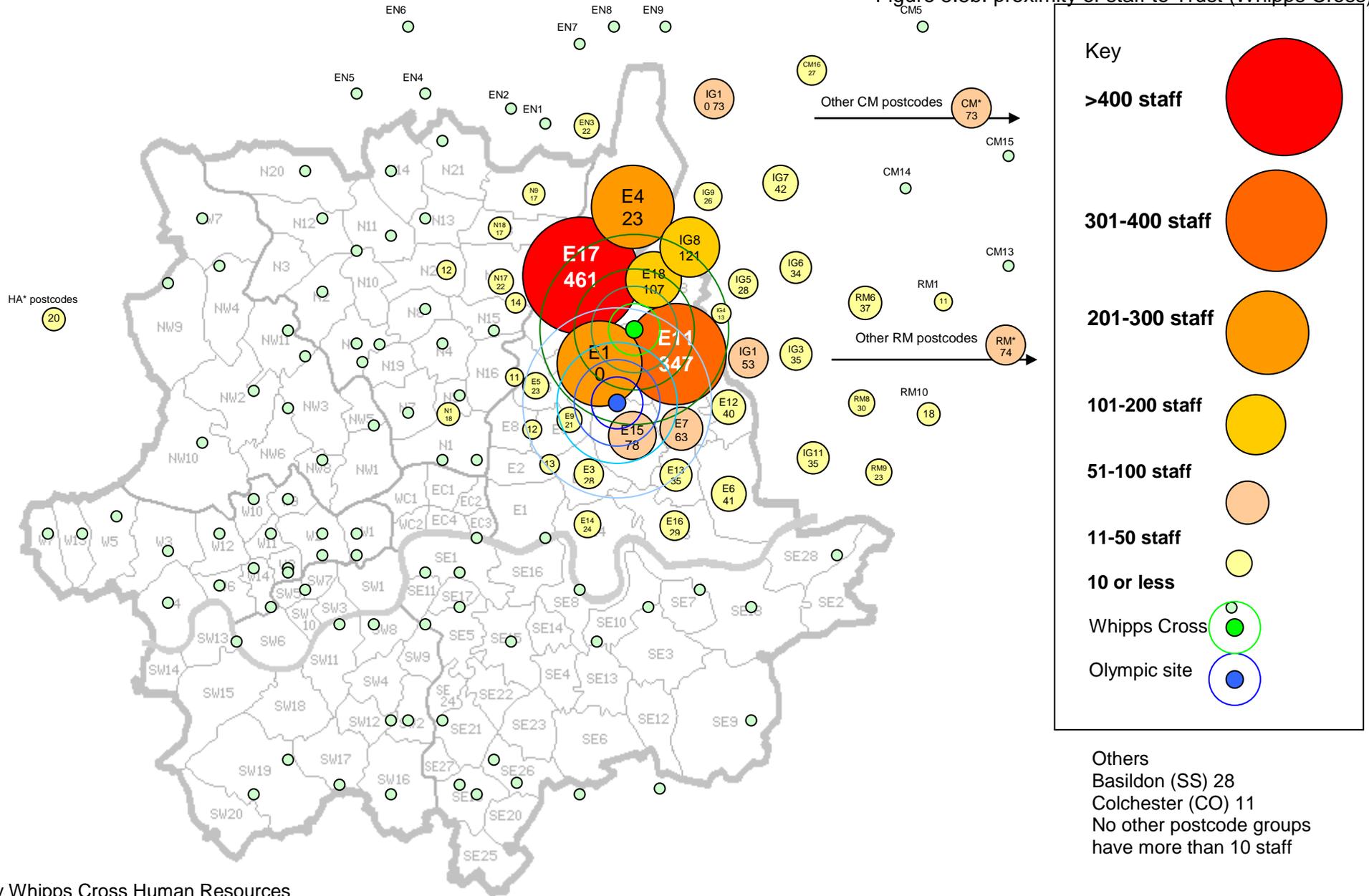


Figure 5.5b: proximity of staff to Trust (Whipps Cross)



provided by Whipps Cross Human Resources

III. LOCAL DEMOGRAPHICS: A BASELINE

1. Introduction

This report provides up-to-date demographic data relating primarily to Newham, Tower Hamlets, and Waltham Forest: the three boroughs in which the merging hospitals are situated. Where feasible, this section also relays information relating to Bart Health's specific catchment area (see section 2.1 for a definition). However, for a variety of reasons (which are explained further on) this is not always possible. As such, the final section of this chapter contains a list of websites where useful ward level data can be found (see section 17).

In part A, focus is placed on information about people from different protected characteristics as covered in the Equality Act 2010. Each sub-section relates to each protected characteristic (age, disability, sex, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion and belief and sexual orientation). Part B contains other relevant contextual information about the catchment area (e.g. deprivation, unemployment, child poverty and homelessness).

When gathering data, priority was given to evidence sources that were broadly comparable across all three boroughs. Whilst more detailed information was sometimes available at a borough level,¹⁵ if this could not be compared to the other two boroughs it was not included.

Part A: Protected characteristics overview

2. Age and sex

At a Glance...

- there is a broadly equal proportion of men and women in all boroughs for most age groups (although this does begin to change in the 75+ age group, with more women compared to men)
- when figures for the three boroughs are combined, people in the 25-34 age range are the largest group, though this is predicted to flatten out over the next twenty years as the proportion of people in the 60+ age groups grows

The most up-to-date evidence on the age and sex profile of the three largest local authorities in question is provided by Greater London Assembly (GLA) 2011 round of demographic projections (released January 2012). Projections for 2011 are provided so that these can be compared to 2011 census data when these are made available (release likely to be summer 2012). Also included are projections for 2031 to show predicted change in age/ sex profile.

¹⁵ See for example, Mayhew Harper Associates (2010) *Counting with confidence: The population of Waltham Forest*

As figures 2a-d below show, there is a broadly equal proportion of men and women in all boroughs for most age groups. However, this begins to change in the 75+ age group, with more women compared to men at that age. Tower Hamlets and Newham have relatively more people in the 25-34 age range in 2011 though this is predicted to become less pronounced in 20 years' time. When figures for the three boroughs are combined, people in the 25-34 age range are the largest group, though this is predicted to flatten out over the next twenty years as the proportion of people in the 60+ age groups grows.

Figure 2a: Age-sex distribution in Newham, 2011 and 2031

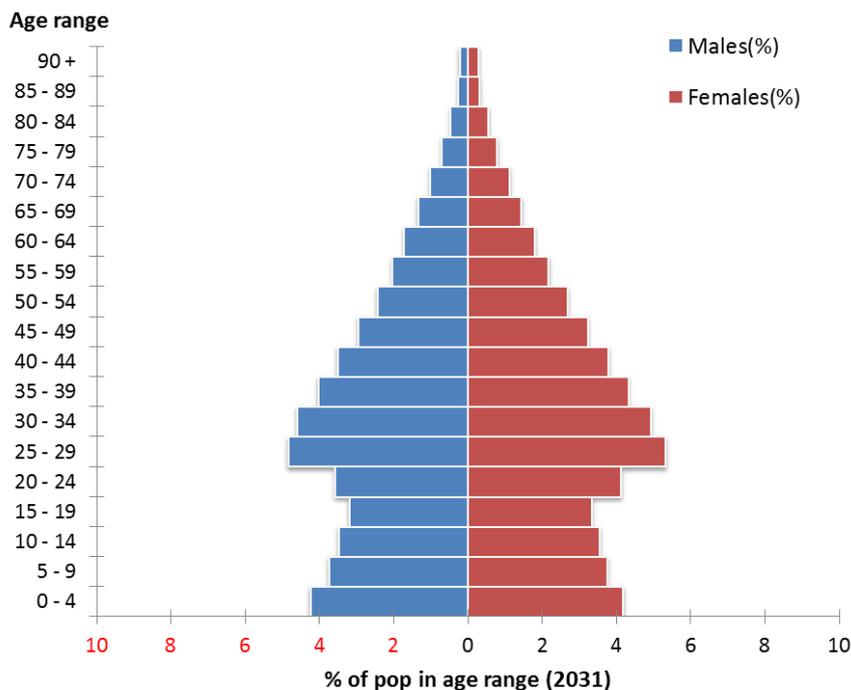
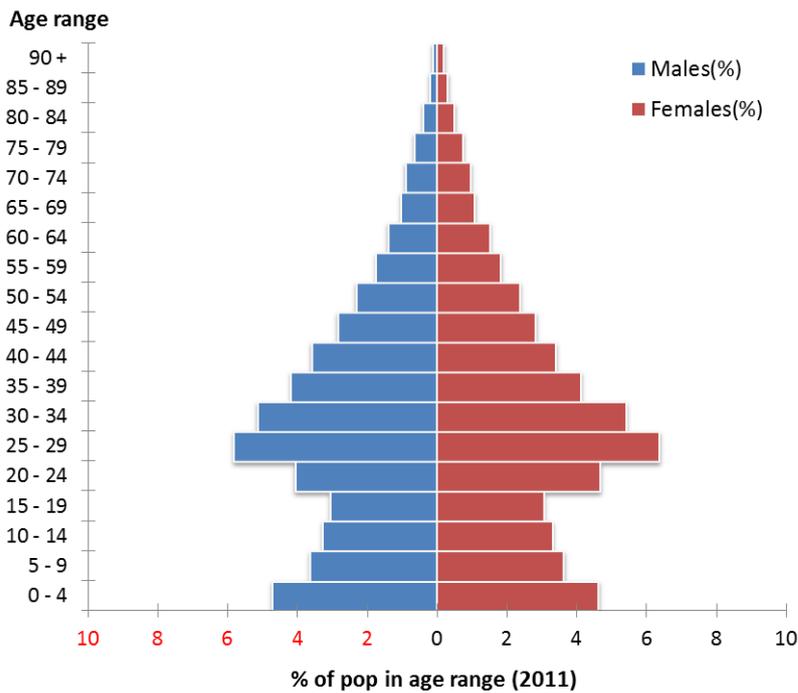


Figure 2b: Age-sex distribution in Tower Hamlets, 2011 and 2031

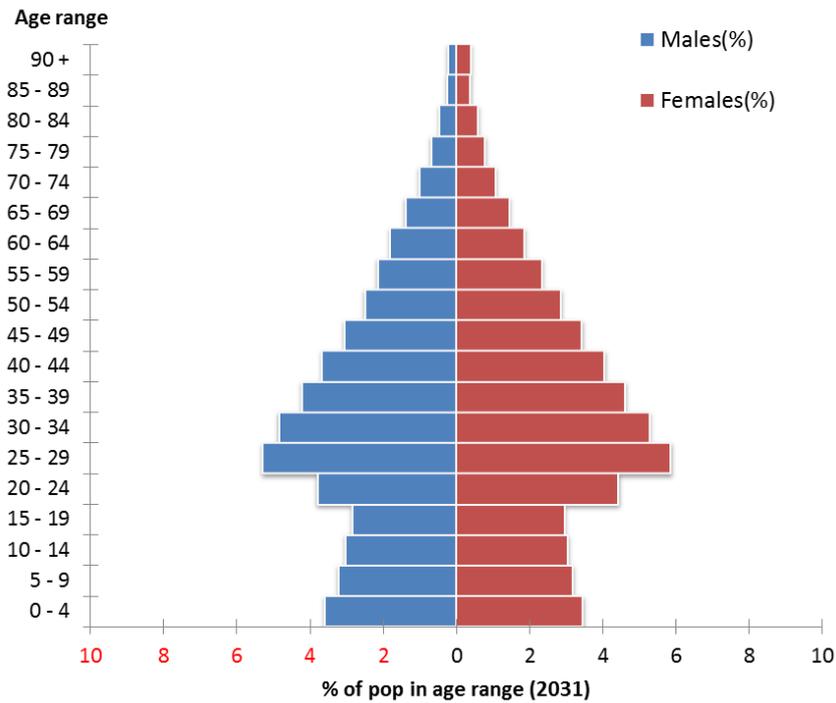
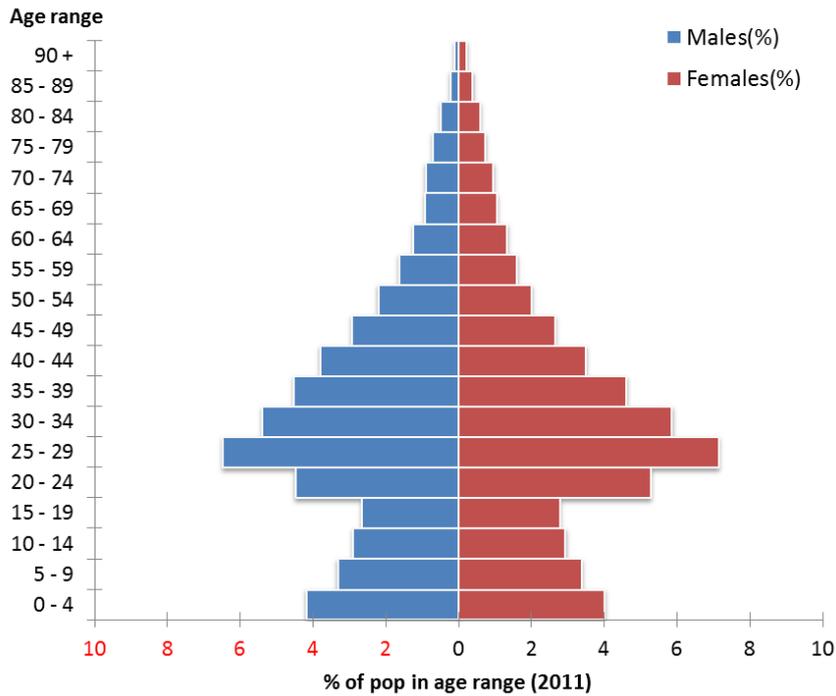


Figure 2c: Age-sex distribution in Waltham Forest, 2011 and 2031

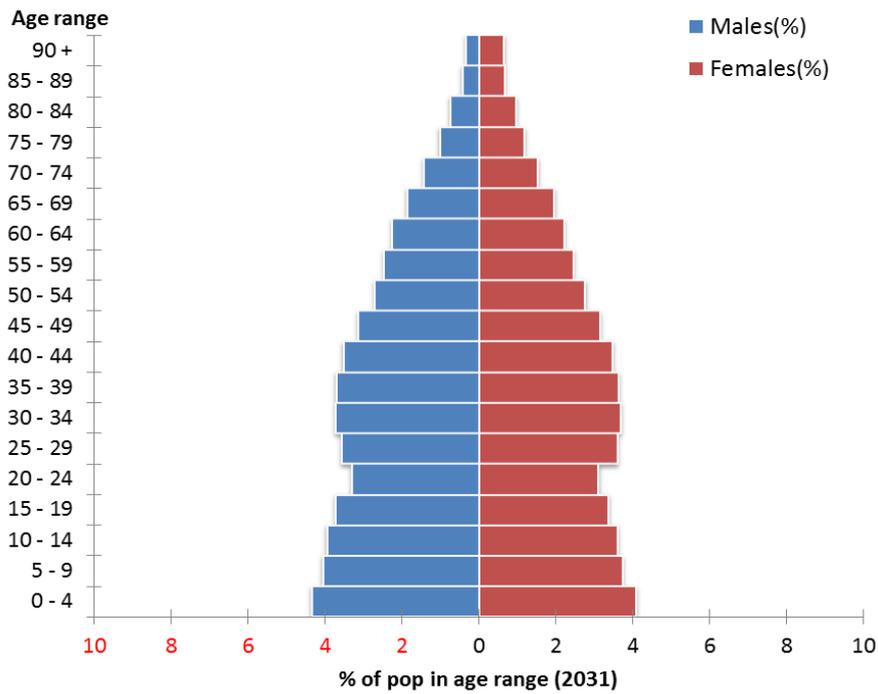
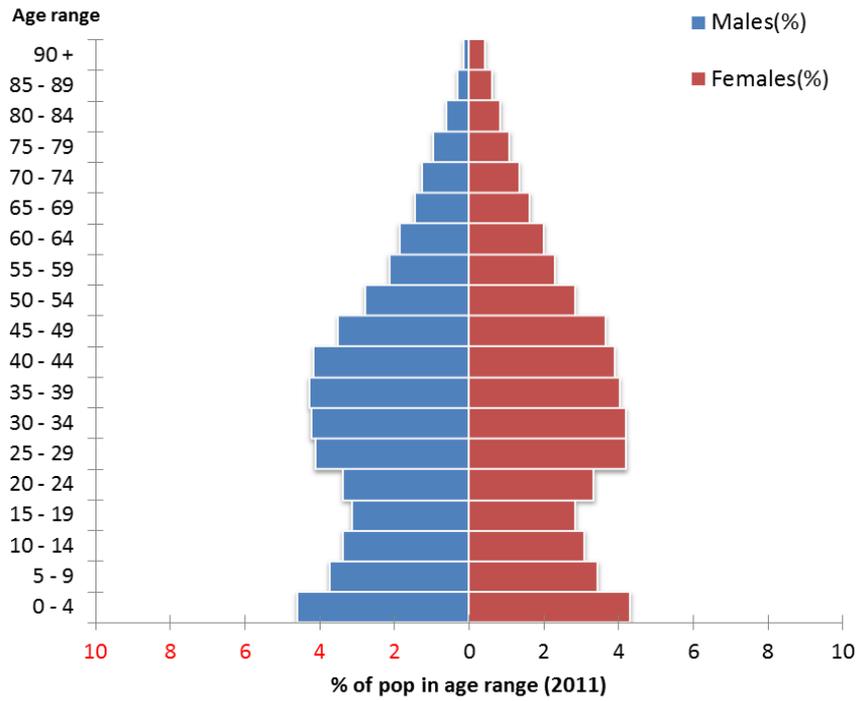
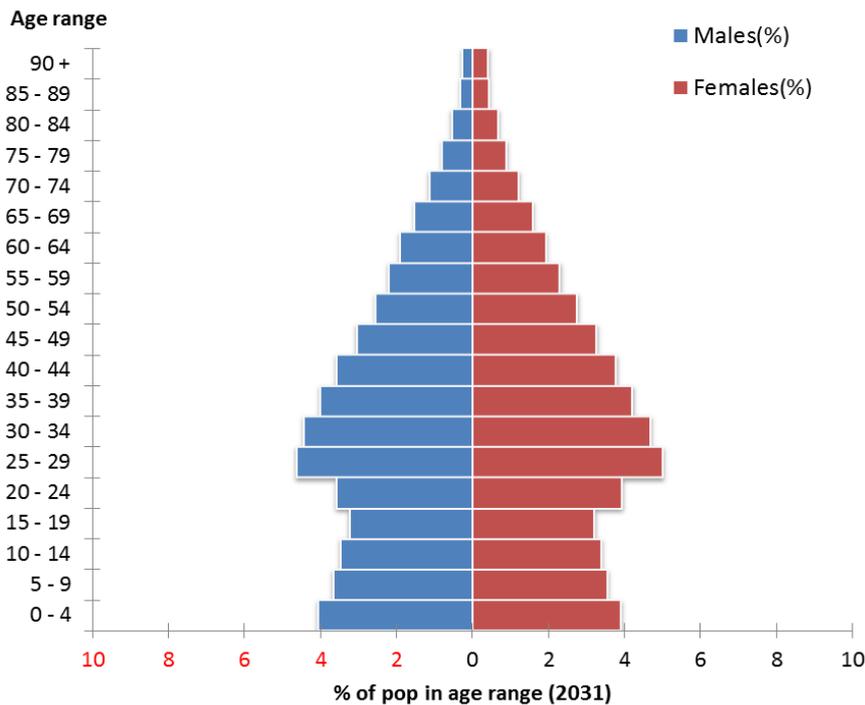
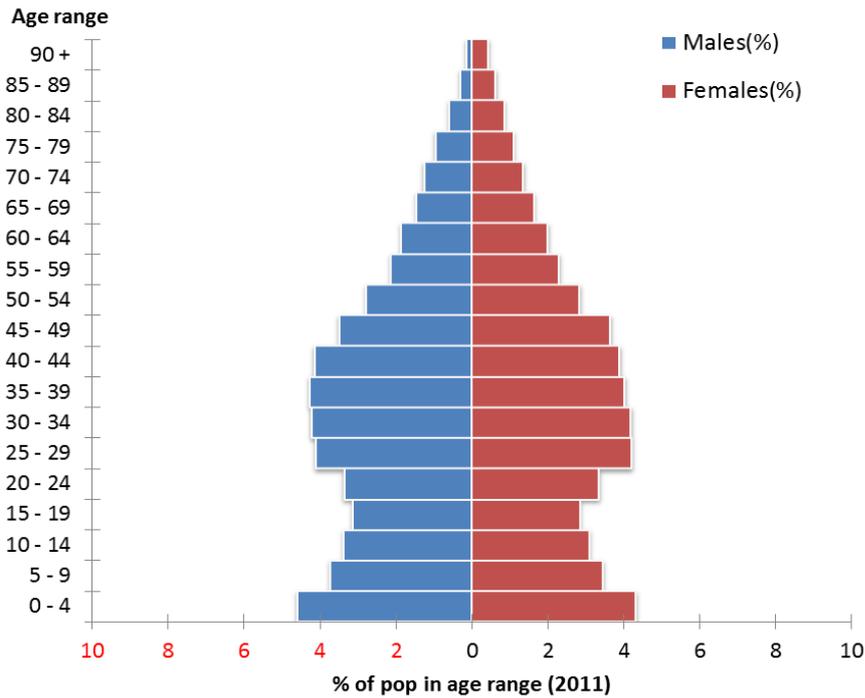


Figure 2d: Age-sex distribution in combined area, 2011 and 2031 merged

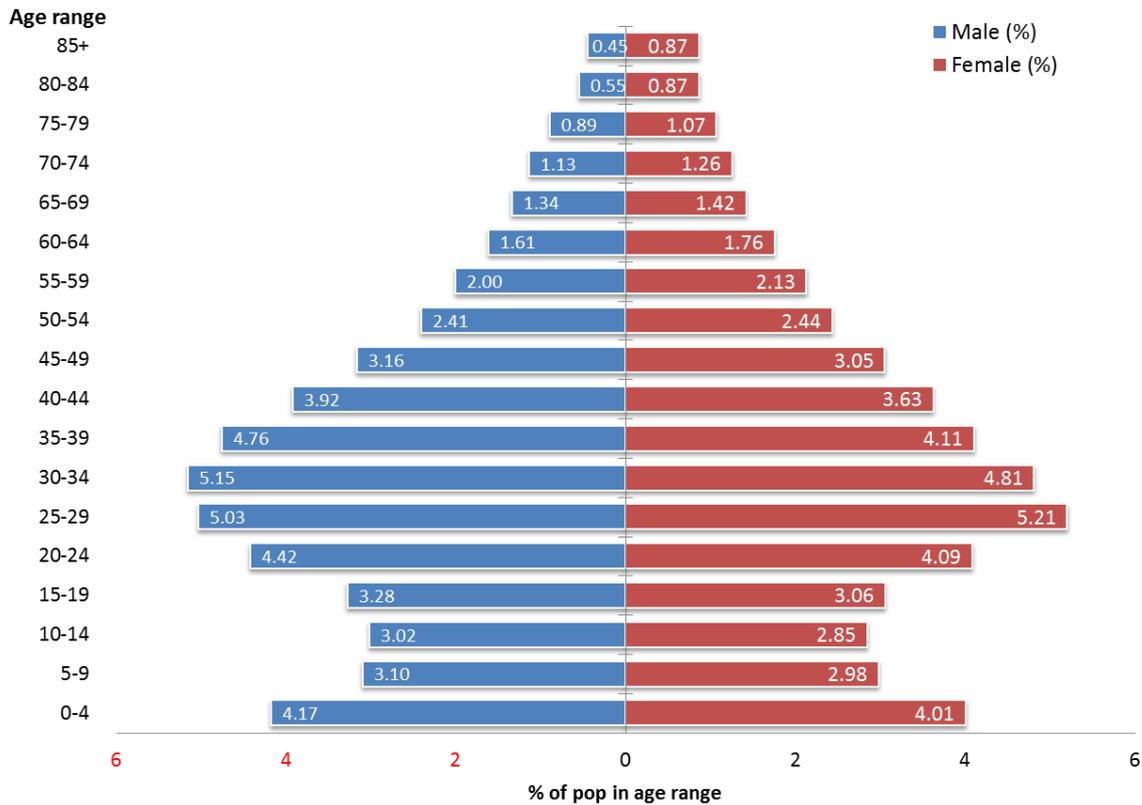


Source: GLA, 2011 Round of Demographic Projections - SHLAA
 Data sole copyright of the © Greater London Authority, 2011

The actual catchment area for the new, merged organisation is slightly bigger than the area covered by the three local authorities listed above. As such, figure 2e below provides a sex and age profile of the area covered by the boroughs of City of London, Newham, Tower Hamlets, Waltham Forest, selected wards in Redbridge and selected wards in Epping

Forest. The particular wards were supplied by Whipps Cross and can be seen in table 2d (appendix E).

Figure 2e: Age-sex distribution in catchment area, 2007



Source: Mid-2007 Population Estimates for 2009 Wards in England and Wales by Quinary Age and Sex and Selected Ages (Revised): Office for National Statistics© Crown Copyright 2011

It is important to note that figure 2e is based on a different dataset to the preceding figures since Epping Forest does not come under the purview of the Greater London Assembly. For this reason, projections for 2031 are not available.

3. Race

At a Glance...

- outside of White British, the largest ethnic categories in Newham are 'Indian' (9.7%) and 'Black African' (9.5%); in Tower Hamlets, 'Bangladeshi' (20.6%); and in Waltham Forest 'White Other' (6.8%) and 'Pakistani' (6.7%)
- there will be a higher rate of population growth for BME people in Newham and Waltham Forest in the next 20 years
- Newham has the highest proportion of adults who do not speak English at home, whereas Tower Hamlets has the highest proportion of pupils whose first language is not English

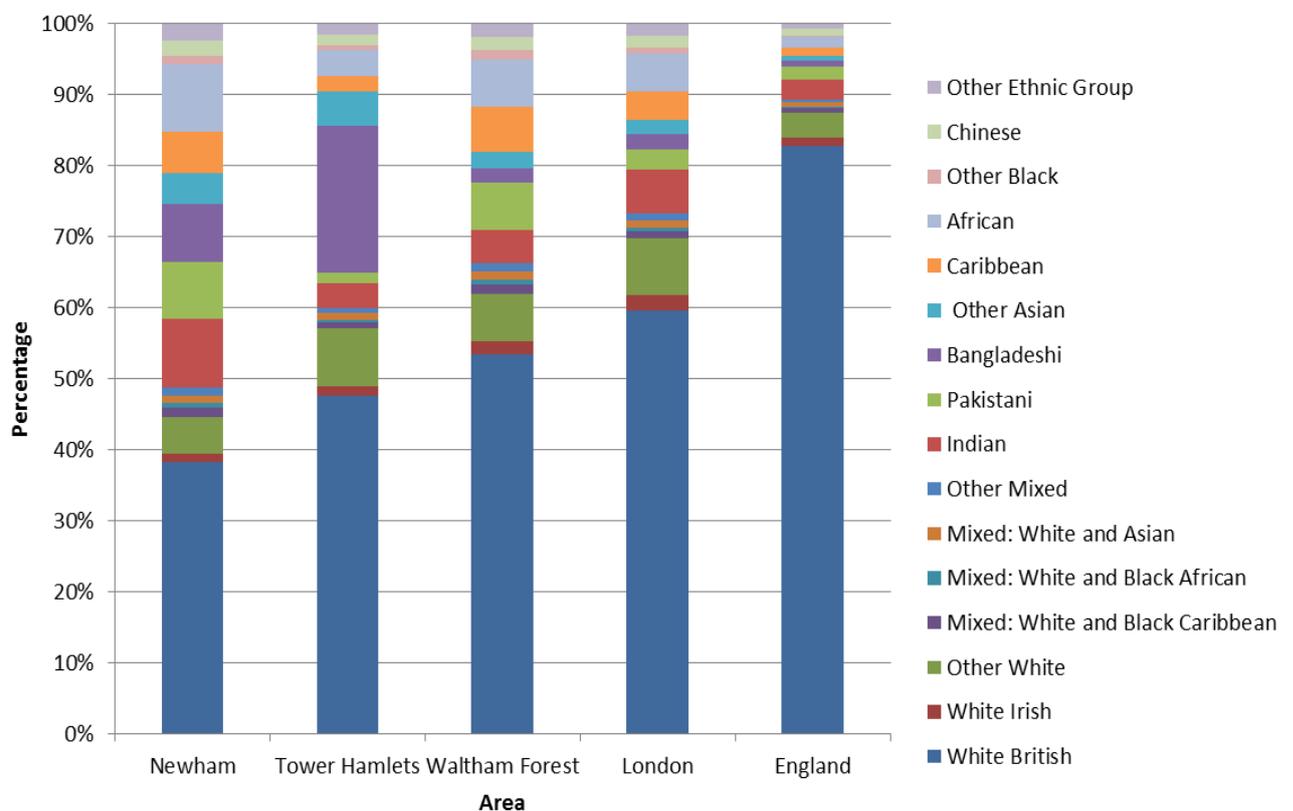
- Newham has seen a significant increase in the number of overseas nationals coming to live and work in the area since 2002

There is a range of comparable data available to give an indication of ethnicity across the three boroughs. In the absence of Census 2011 results, the most up-to-date projections are provided by GLA. These results can be considered alongside results of the Annual Population Survey conducted by the Office for National Statistics which is less up to date but uses different and more detailed ethnic categories. Also included in this section is information about the language habits of local people and information about overseas nationals settling in the area to find work.

3.1 Current demography

Figure 3.1 below shows the ethnic composition for each borough. As can be seen, all of the three boroughs are more 'diverse' than the London and national aggregates. Outside of White British, the largest ethnic categories in Newham are 'Indian' (9.7%) and 'Black African' (9.5%); in Tower Hamlets, 'Bangladeshi' (20.6%); and in Waltham Forest 'White Other' (6.8%) and 'Pakistani' (6.7%).

Figure 3.1: Proportion of population by ethnicity, 2009



Source: ONS (2011) from Annual Population Survey 2009¹⁶

¹⁶ Note that at the time of writing 2009 APS figures were the most up to date. Ethnicity estimates in the Annual Population Survey (APS) have been withdrawn for the April 2010 to March 2011 survey period and are not included in the estimates for the July 2010 to June 2011 period published on 18 Jan 2012. In 2010 changes

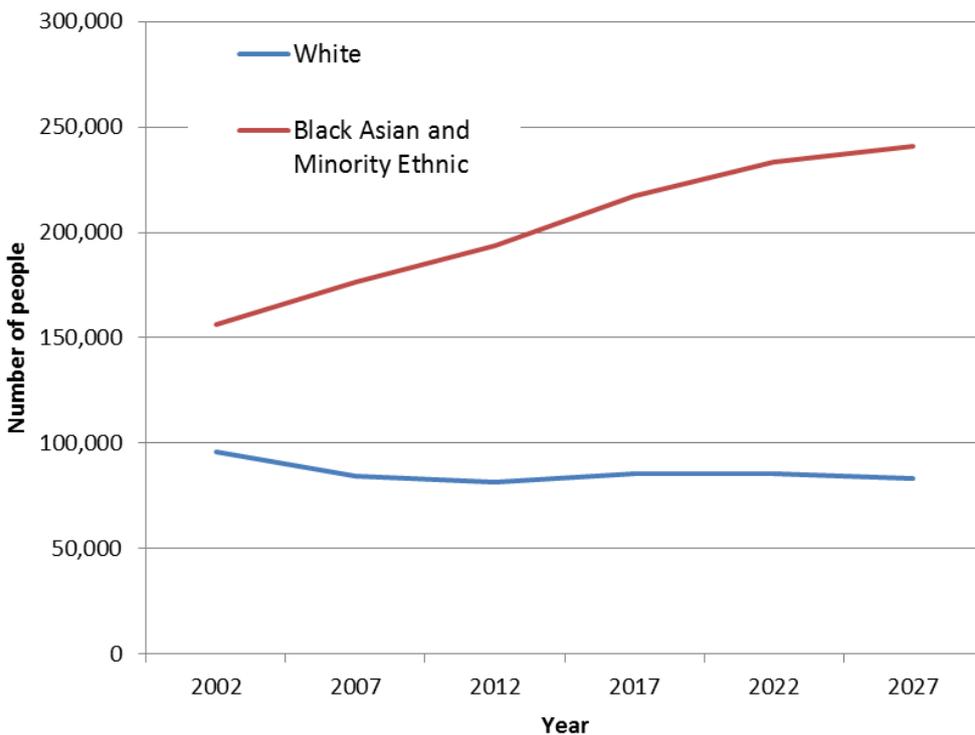
Providing data relating to Barts Health’s specific catchment area is difficult. Unfortunately, at time of writing (March 2011) the results of the 2011 Census are still a few months away from being published. This means the only reliable survey of ethnicity data at a ward level is the 2001 Census. Given the importance of this data to Barts Health’s future equalities planning it seems inappropriate to relay decade-old information. As such, readers are directed to the list of useful websites in section 17 which will no doubt relay up-to-date and accurate information as soon as it is available.

3.2 Population projections

The four charts below provide high-level population projections for ‘Black and Minority Ethnic’ (BME) groups¹⁷ compared to ‘White’ ethnic groups. They show that there will be a higher rate of population growth for BAME people in Newham and Waltham Forest. Since 2002 there have been more BAME people in the three boroughs combined compared to people from White ethnicities. This is due to the larger number of BAME people in Newham (both Tower Hamlets and Waltham Forest are projected to have slightly higher levels of people from White ethnicities up to 2027).

Figures 3.2a-d: Projected population change by ethnicity, 2002-2027

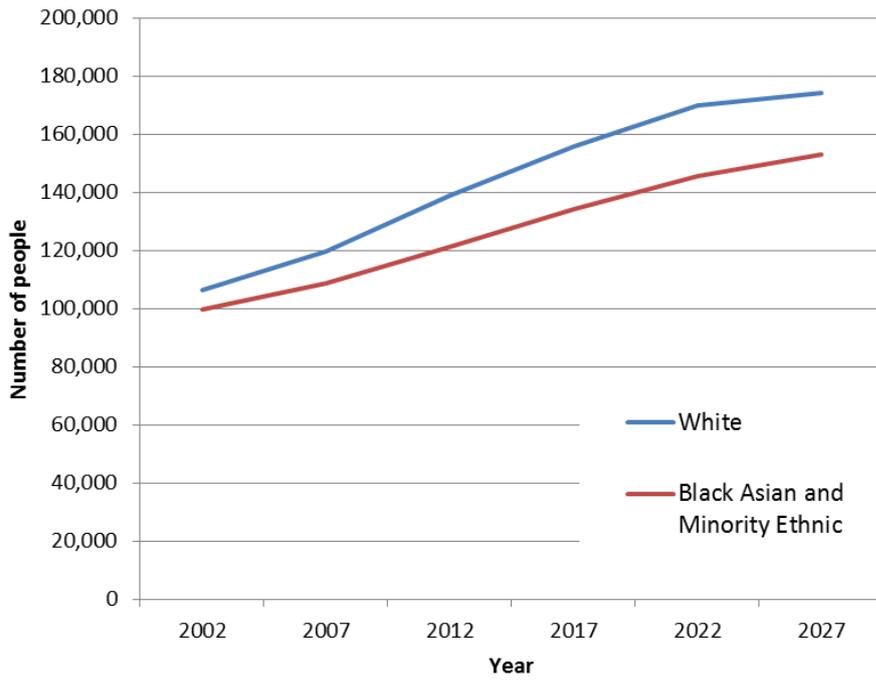
a: Newham



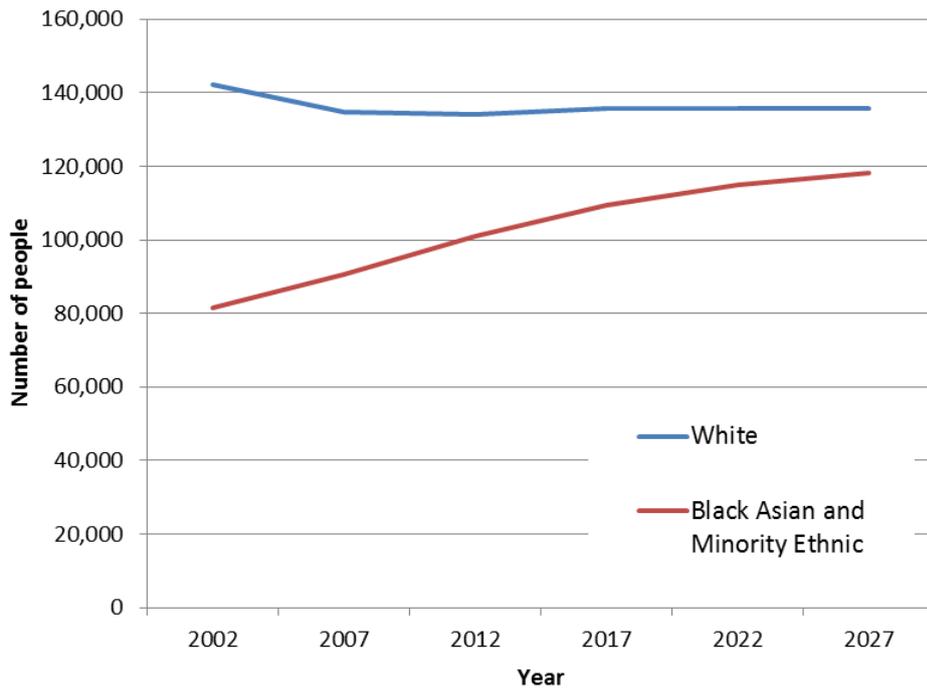
were made to the ethnicity questions asked in the APS. These changes have caused problems with producing a consistent time series of estimates for a number of the variables published on Nomis.

¹⁷ Note that there are differences in the way that different agencies describe ‘Black and Minority Ethnic’ people. Sometimes they are described as Black, Asian and Minority Ethnic (BAME). For example, the GLA describes this category as BAME. There is currently no accepted definition. For this report, we have referred to this category as ‘BME’ – except where an agency (and associated data) refers to ‘BAME’ people. This has been done to ensure our analysis is consistent with the data provided by those agencies.

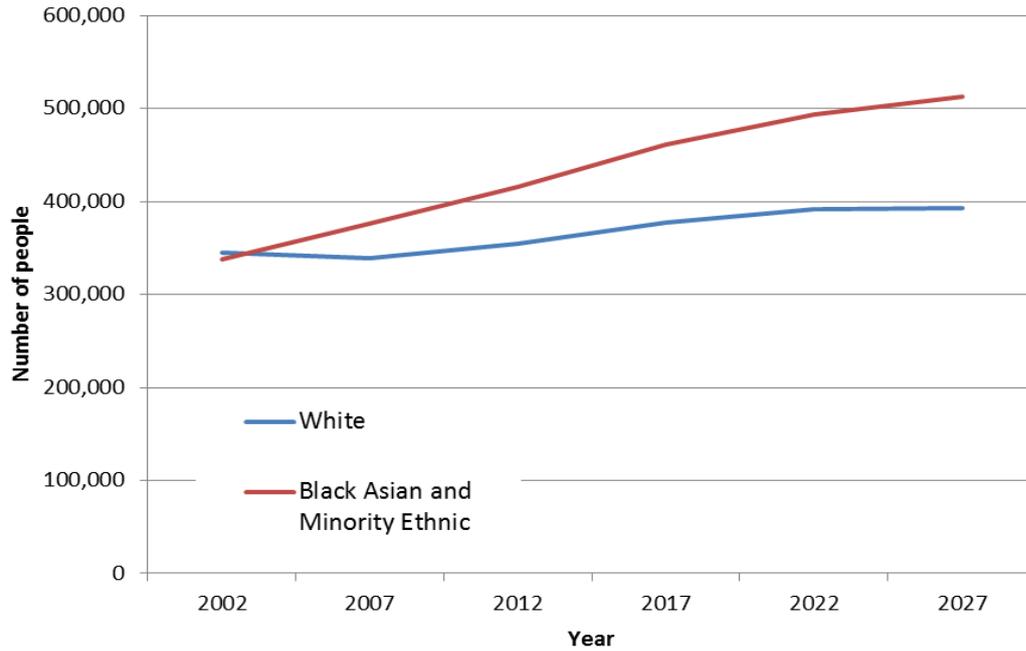
b: Tower Hamlets



c: Waltham Forest



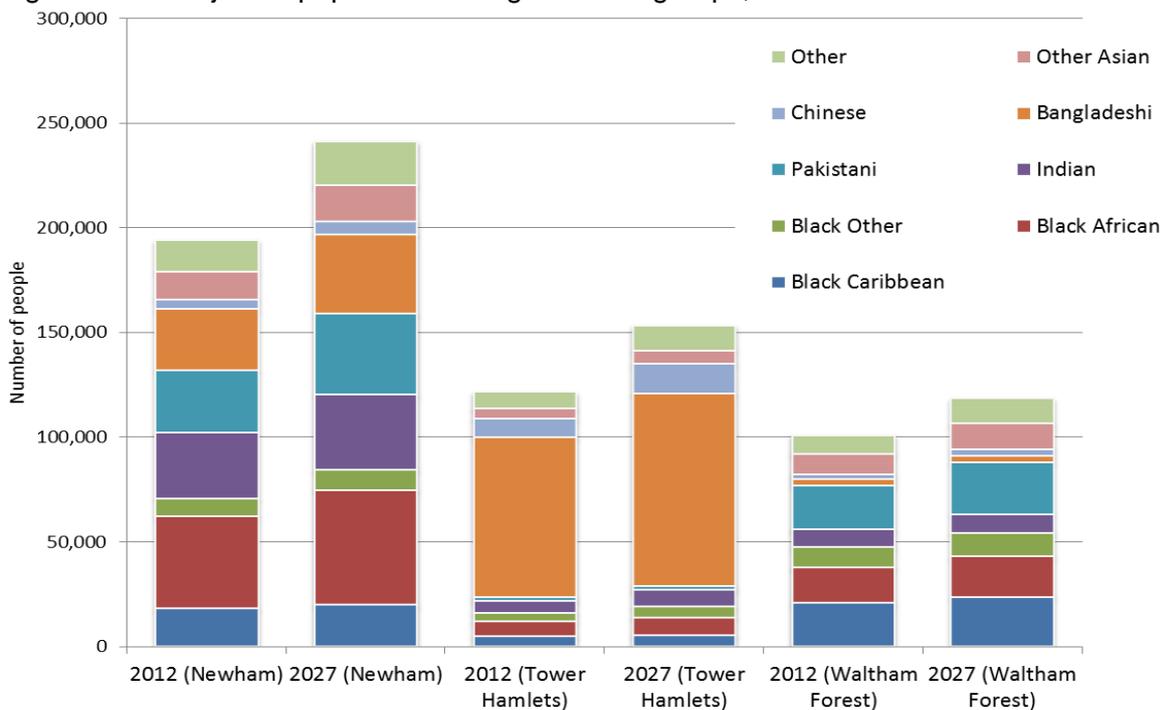
d: Merged figures



Source: GLA, 2010 Round Borough Level Ethnic Group Projections
Data sole copyright of the © Greater London Authority, 2011

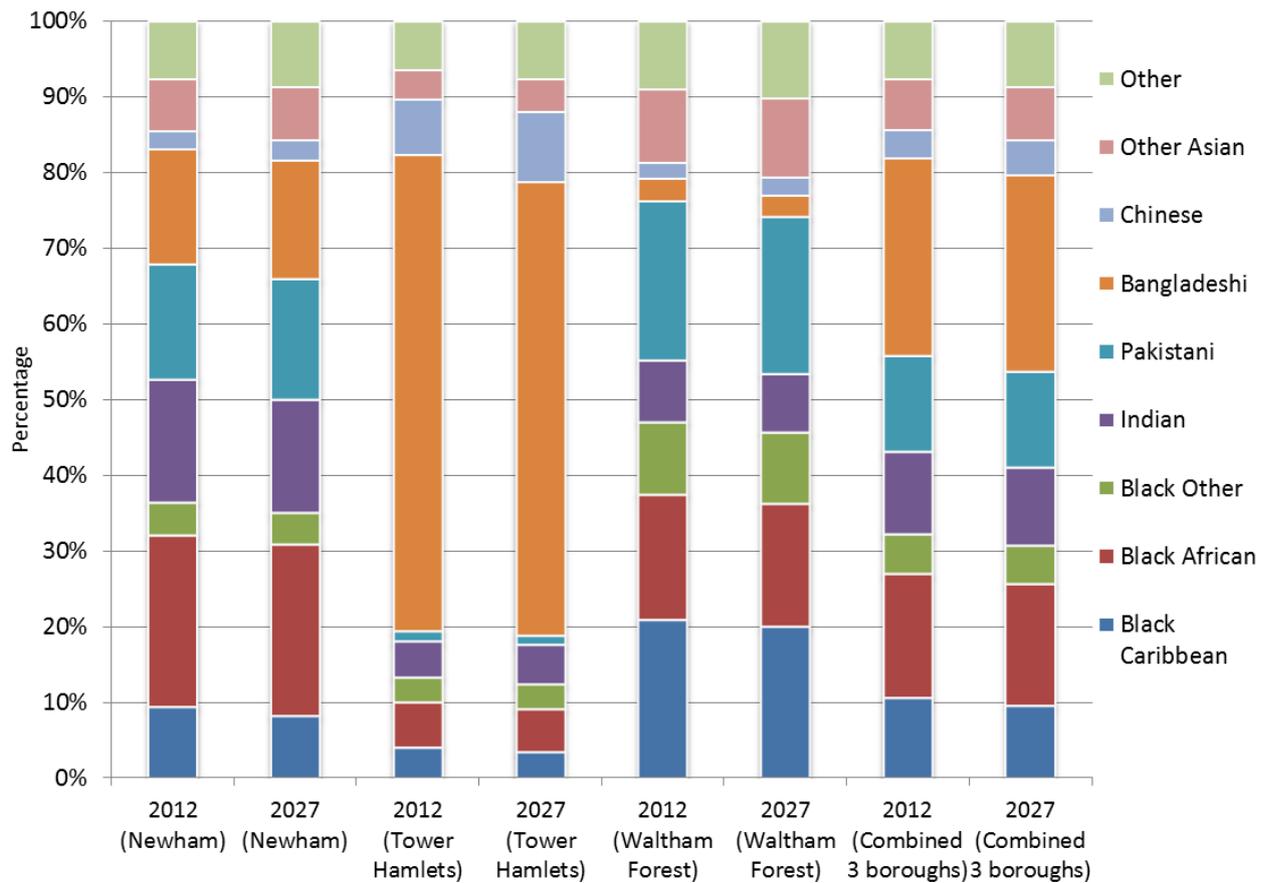
The two charts below provide a more detailed breakdown of that increase in the BAME population (they do not include information about people from 'White' ethnicities). Figure 3.2e includes details about population size and increase. Figure 3.2f provides a description of the proportion of people from particular ethnicities (including a projected proportion for the three boroughs combined).

Figure 3.2e: Projected population change of BME groups, 2012-2027



Source: GLA, 2010 Round Borough Level Ethnic Group Projections
Data sole copyright of the © Greater London Authority, 2011

Figure 3.2f: Compositional change in borough ethnicities, 2012-2027



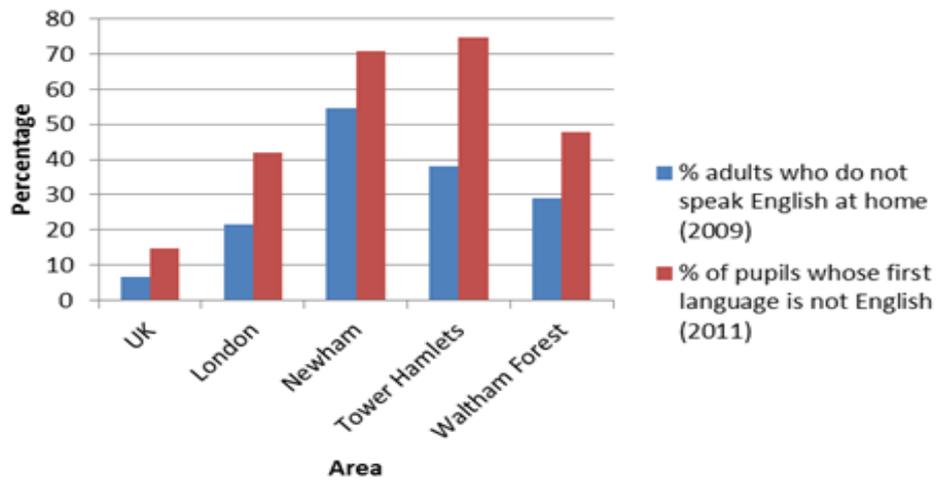
As figure 3.2f shows, the relative proportion of people from particular BAME groups within each area will remain largely the same between 2012 and 2027. Combined projections for all three boroughs show that Bangladeshi people are the largest BAME group, followed by Black African and Pakistani people.

It should be noted that a significant drawback to the GLA projection data – at least in the format we were able to secure - is that it does not provide specific details of people from ‘mixed’ ethnicities. ‘Mixed’ ethnicities are included as part of the broader ‘other’ category. For example, ‘Black other’ includes ‘Mixed: White and Black Caribbean’, Mixed: White and Black African as well as ‘Other Black’. (The Annual Population Survey does distinguish Mixed ethnicities as separate categories see figure 3.1a.)

3.3 Local language habits

The following chart provides additional information about language habits of the local population. It shows that, when compared to London and the UK, all three boroughs in the catchment area have a higher proportion of adults who do not speak English at home and pupils whose first language is not English. Newham has the highest proportion of adults who do not speak English at home, whereas Tower Hamlets has the highest proportion of pupils whose first language is not English.

Figure 3.3a: Proportion of adults not speaking English at home (2009) and pupils whose first language is not English (2011)

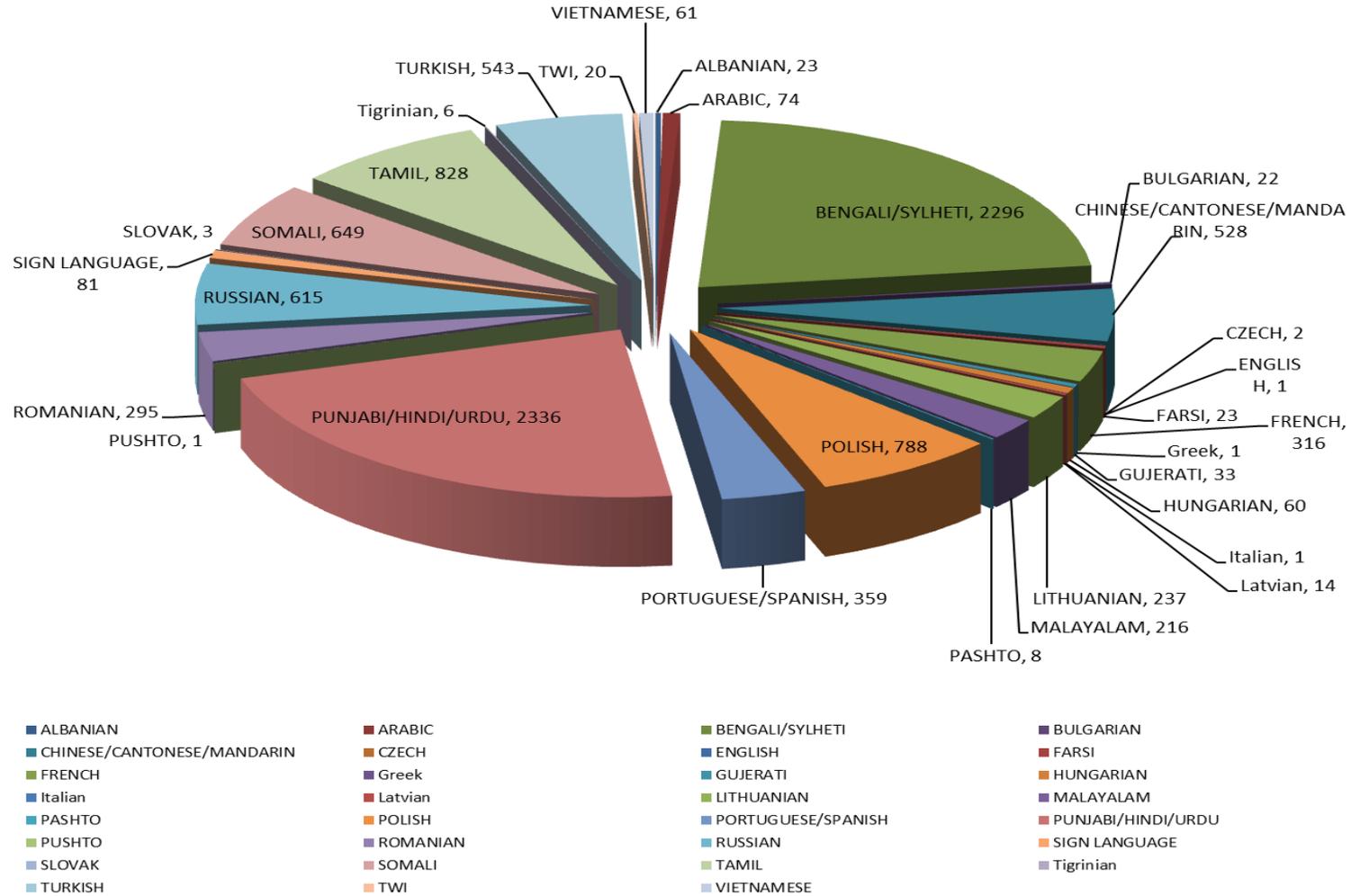


Source: Labour Force Survey 2009

Source: Department for Education 2011

Newham University Hospital Trust also provided researchers with a snapshot of language support for patients over a 6 month period. Although this information was not requested or supplied from the other two Trusts, this snapshot from Newham provides a perspective on the level and breadth of language support required for patients. See figure 3.3b over the page.

Figure 3.3b: Language Support for Patients for a period of six months from 1st April 2011 to 30th September 2011 (Newham)

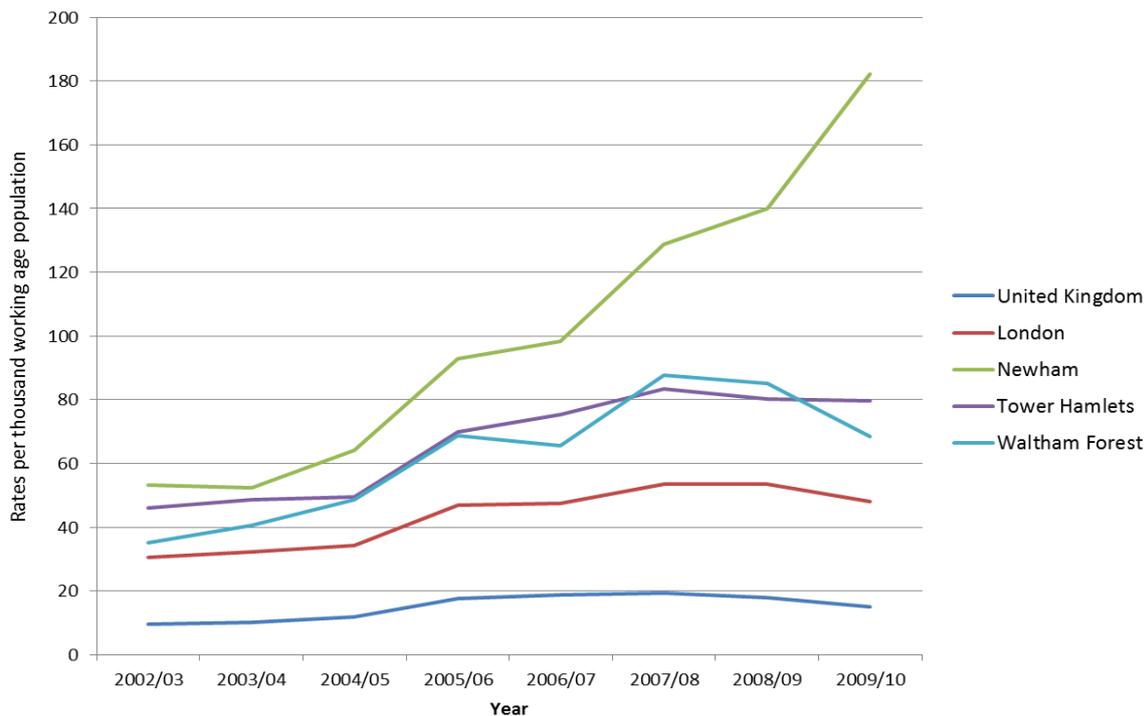


Source: Newham University Hospital Trust 2011

3.4 Migrant populations

Data on National Insurance number registrations can't be used as a basis for estimating migrants currently resident in the area because the data doesn't record de-registrations or how long migrants intend to stay). However, National Insurance numbers are a first step for employment and for claiming benefits so they can provide useful information about migrants who have come to work in a particular area (although it should be noted that person may live in one area and work in another). With these caveats in mind, the following graph shows how in recent years only Newham has seen a significant increase in the number of foreign nationals coming to live and work in the area.

Figure 3.4: National Insurance number registrations to overseas nationals



Source: DWP 2010

4. Disability

At a Glance...

- there were approximately 77,000 disabled people in the three boroughs in 2009
- a relatively high proportion of people of working age are disabled in Tower Hamlets (16.8%)
- 1,200 people were registered as blind or partially sighted across the three boroughs in 2008
- the prevalence of people with learning disabilities in the three boroughs is largely

proportionate to the London average (0.32)

- the number of people with all types of travel related disabilities is predicted to increase over the next 20 years
- there were approximately 6,650 wheelchair users across the three boroughs in 2010

Comparable data is available on a range of disabilities across the three boroughs.

According to the most recent figures, a relatively high proportion of people of working age are disabled in Tower Hamlets. There were approximately 77,000 disabled people in the three boroughs in 2009 (see below).

Figure 4a: Working age population who are disabled, 2009

Area	Number of working age population who are disabled (2009)	Percentage of working age population who are disabled (2009)
Newham	23,300	14.9
Tower Hamlets	27,500	16.8
Waltham Forest	24,500	15.7
London	835,600	15.7

Source: ONS 2011 (Annual Population Survey 2009)

A recent report by the Office for Public Management for Inclusion notes that in London as a whole Black Caribbean, Bangladeshi and Pakistani people are most likely to be disabled.¹⁸ Disabled people in London are younger than disabled people across the UK – 45.3% of disabled people in London are under 55 years of age compared with 40.7% of disabled people across the UK. In London, disabled people are twice as likely (12%) to be divorced compared to non-disabled people (6%). They are also almost three times more likely to be widowed than their non-disabled counterparts (13.5% and 4.8%, respectively).

The most up to date incapacity benefit data we were able to access demonstrates that in May 2011 there were some 35,180 people claiming employer support allowance/ incapacity benefit across the three boroughs. The rate of incapacity benefit claims is higher than the London average, particularly in Tower Hamlets and Newham.

¹⁸ Office for Public Management (2011) *Deaf and Disabled People in London: Summary Statistics*, Inclusion London. The statistics in this paragraph taken from this report were in turned derived from the Annual Population Survey 2009.

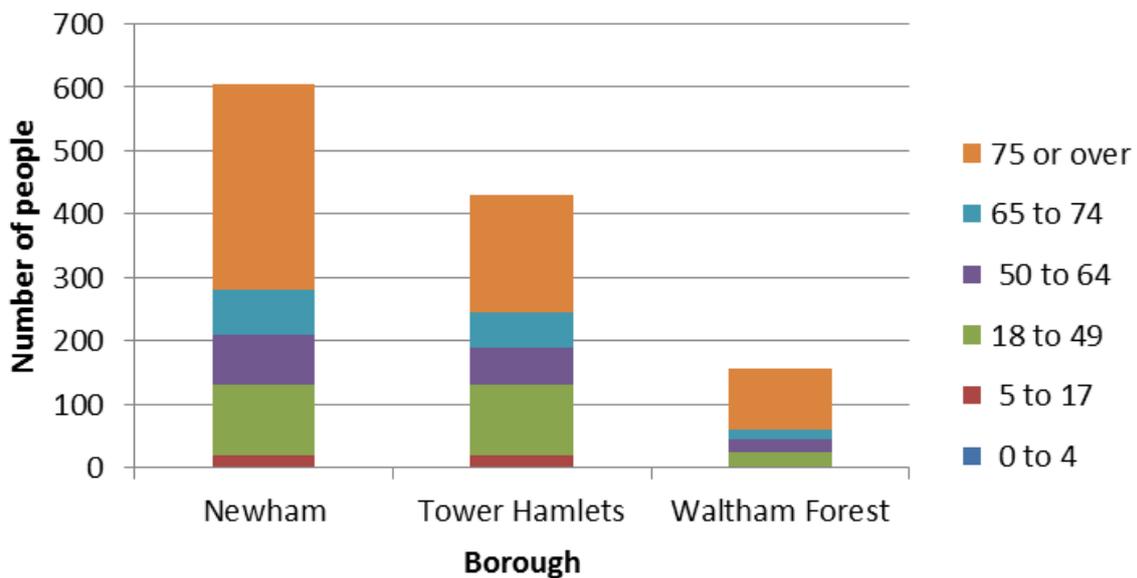
Figure 4b: Number of ESA/ incapacity benefit claimants, 2011

Area	Number of Incapacity benefit claimants in May 2011	Incapacity benefit rate May 2011
Newham	12,910	6.6
Tower Hamlets	12,200	7.0
Waltham Forest	10,070	6.6
London	314,710	5.8

Source: DWP (2011)

The most recent information about people registered as blind or partially sighted is from 2008. In all areas the majority of people registered are from the 75 or over age group. There were 1,200 people registered as blind or partially sighted across the three boroughs in 2008.

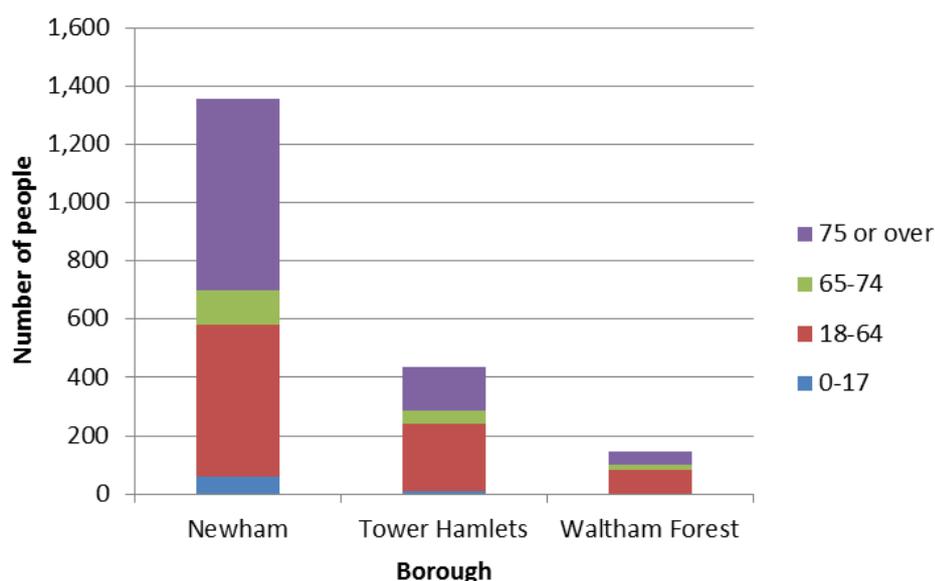
Figure 4c: Number of people registered blind or partially sighted, 2008



Source: NHS Information Centre 2008

In 2010 there were 1,930 people registered as deaf or hard of hearing across the three boroughs. In Newham, the majority of these were from the 75 or over age group. In Tower Hamlets and Waltham Forest the majority of these were from the 18-64 age group.

Figure 4d: Number of people registered as deaf or hard of hearing, 2010



Source: NHS Information Centre 2010

The following table outlines the number of people on the learning disabilities register in the period 2010-11. The prevalence of people on the register is largely proportionate to the London average.

Figure 4e: Number of people on the learning disabilities register, 2010-11

Location	Number on learning disability register	Learning Disabilities (unadjusted prevalence %)
England	188819	0.43
London	22091	0.32
Newham	818	0.31
Tower Hamlets	643	0.31
Waltham Forest	780	0.35

Source: NHS (2011) GP Survey results

Figures generated by Transport for London based on their 'Dial a Ride' service help in understanding the level of people with 'travel related' disabilities. The number of people with all types of travel related disabilities is predicted to increase over the next 20 years. There were approximately 6,650 wheelchair users across the three boroughs in 2010. The number of people with walking difficulties in 2010 in the same area was approximately 24,850. The number of people with other travel related disabilities in 2010 was an estimated 22,110.

Figure 4f: Projected number of wheelchair users, 2010-2031

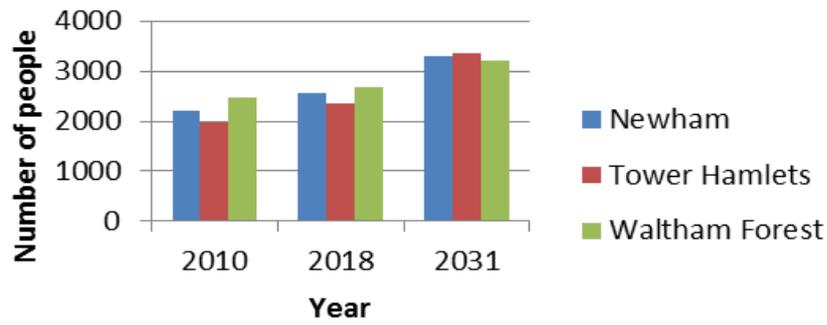


Figure 4g: Projected number of people with other travel related disabilities, 2010-2031

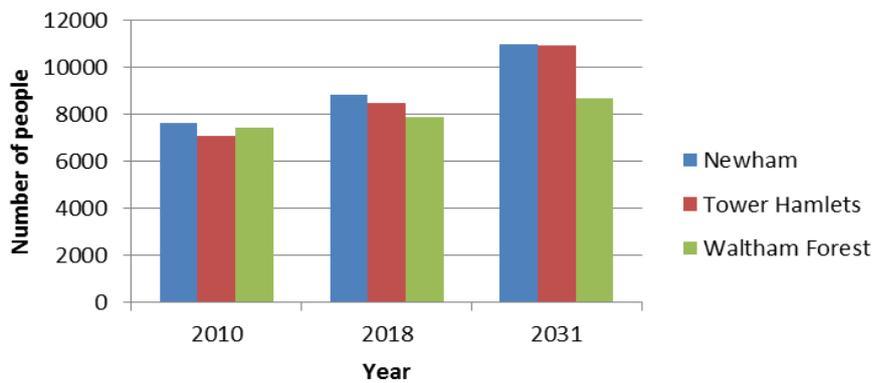
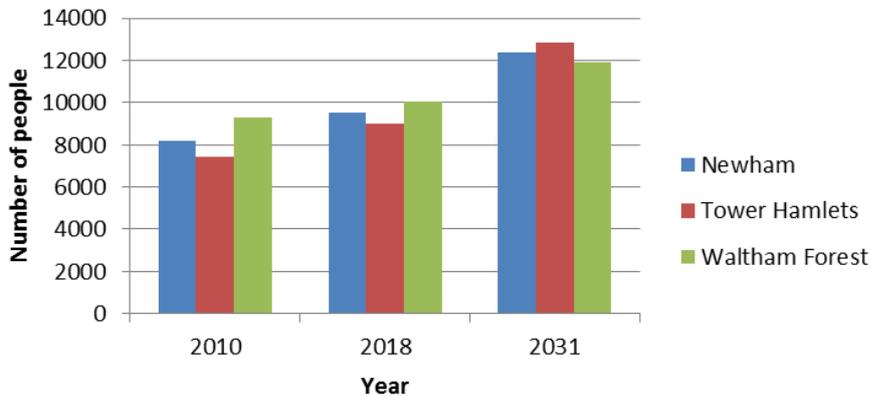


Figure 4h: Projected number of people with walking difficulties



Source: TfL, Committee report 'Accessibility of the Transport Network', 2010. Note that 2010 are actual figures (2018 and 2031 projected)

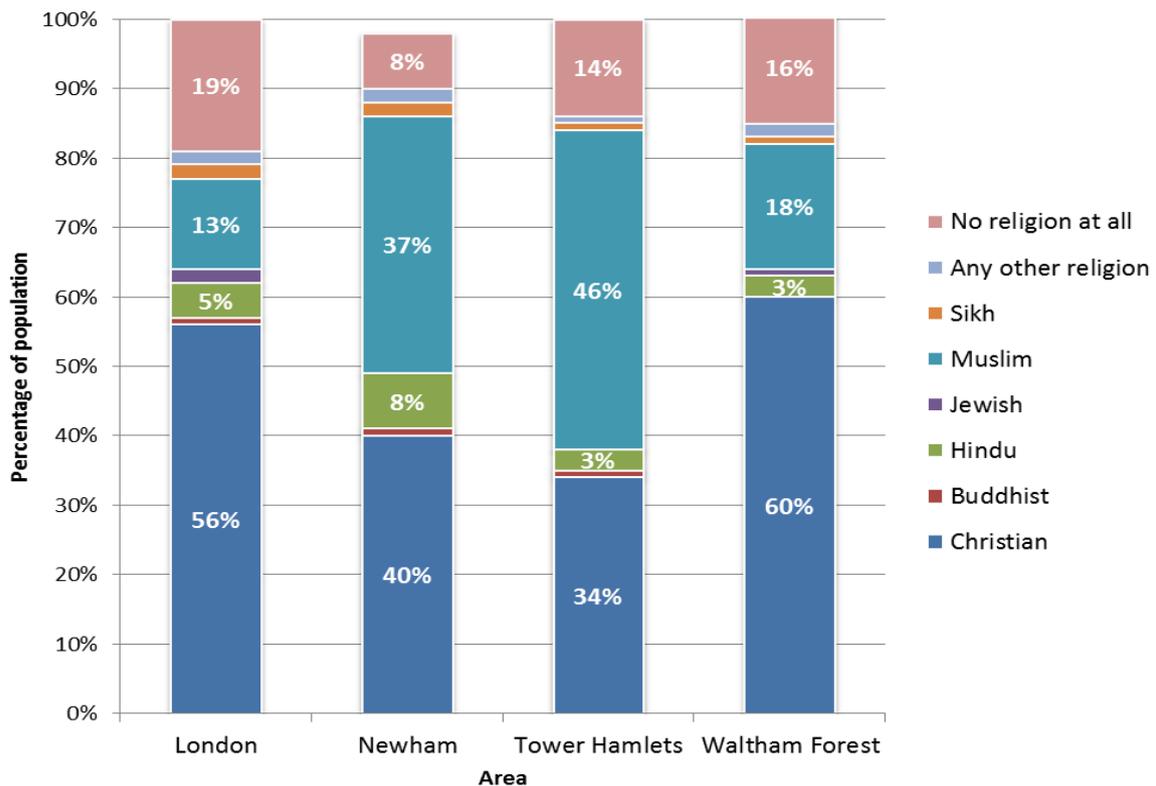
5. Religion and belief

At a Glance...

- there is a relatively higher proportion of Muslims in Newham and Tower Hamlets and a higher proportion of Hindus in Newham compared to London as a whole

As the below chart demonstrates, there is a relatively higher proportion of Muslims in Newham and Tower Hamlets and a higher proportion of Hindus in Newham compared to London as a whole. There is a relatively lower proportion of people with 'no religion at all' across all three boroughs. The proportion of people with particular religions in Waltham Forest is broadly in keeping with the London average. It should be noted that this source of data does not capture the degree to which people have specific non-religious beliefs such as humanism or secularism (non-religious belief is also an element of this protected equality characteristic).

Figure 5: Percentage of population by religion and belief, 2010



Source: ONS 2010 (Annual Population Survey 2010)

6. Sexual orientation

At a Glance...

Locally available data from the Integrated Household Survey suggest that the percentage of LGB people in Tower Hamlets is broadly in line with the national average (1.5%), and the percentage in Newham and Waltham Forest is lower. However, there are challenges with this data set. Many studies suggest that there are between 0.3% and 3% LGB people in the national population, whilst others estimate this figure to be higher (5-7%).

Identifying the number of lesbian, gay, and bisexual (LGB) people in the population is notoriously difficult. A recent report from the Office for National Statistics, for example, highlighted the absence of reliable national and local data.¹⁹

A commonly used estimate for the number of LGB people at a national level is 5 to 7 per cent. This is taken from the government's Impact Assessment of the Civil Partnership Act 2004, which in turn used a wide range of research sources.

More up-to-date estimates can be derived from the Citizenship Survey 2009/10 (2.3%), and the British Crime Survey 2009/10 (2.2%).

Local data is available from the UK Data Archive from the Integrated Household Survey and these are replicated below.

Figure 6a: Sexual Identity by Borough, April 2009 to March 2010 (percentage*)

	Heterosexual/ Straight	Gay/ Lesbian	Bisexual	Other	Don't know/ Refusal	No response
Newham (Male)	47.4	unavailable	0.4	0.6	1.5	50.1
Newham (Female)	59	unavailable	0.4	0.5	3	37.1
Newham (Total)	53.5	unavailable	0.4	0.6	2.3	43.3
Tower Hamlets (Male)	54.7	3	0	0.8	1.7	39.8
Tower Hamlets (Female)	57.2	0.6	0.4	0.2	1.6	40
Tower Hamlets (Total)	56	1.7	0.2	0.5	1.6	39.9
Waltham Forest (Male)	56.3	0.5	0.3	0	2.1	40.9
Waltham Forest (Female)	62.8	0.4	0.9	0.7	1.5	33.7
Waltham Forest (Total)	59.8	0.5	0.6	0.4	1.8	37

Source: ONS (2012) from Integrated Household Survey 2009-2010

¹⁹ Office for National Statistics (2010) *Measuring Sexual Identity: an evaluation report*. Available at: <http://tinyurl.com/7nabdt5>

Figure 6b: Sexual Identity by Borough, January-December 2010 (percentage)

	Heterosexual/ Straight	Gay/ Lesbian	Bisexual	Other	Don't know / Refusal	No response
Newham (Male)	47.7	0	0.7	0.9	1.8	48.9
Newham (Female)	54.2	0.4	0.2	0.2	3	42.1
Newham (Total)	50.9	0.2	0.5	0.5	2.4	45.6
Tower Hamlets (Male)	52.9	1.9	0	0.6	1.9	42.6
Tower Hamlets (Female)	52.6	1.1	0.6	0	1.5	44.2
Tower Hamlets (Total)	52.7	1.5	0.3	0.3	1.7	43.4
Waltham Forest (Male)	54.6	0.6	0.2	0	2.7	41.9
Waltham Forest (Female)	59.6	0.6	1.1	0.4	1.3	37.1
Waltham Forest (Total)	57.2	0.6	0.7	0.2	2	39.4

Source: ONS (2012) from Integrated Household Survey 2010

*Note that percentages are calculated by discounting under 16 respondents who were not asked the question/ under the age of consent

These figures can be compared to Integrated Household Survey data from a broadly similar period (though not exactly the same), figure 6c.

Figure 6c: Sexual Identity by Region, April 2010 to March 2011

	London	UK
Heterosexual / Straight	90.6	94.0
Gay / Lesbian	1.8	1.0
Bisexual	0.7	0.5
Other	0.6	0.4
Don't know / Refusal	5.5	3.6
No response	0.7	0.7

Source: ONS (2011) from Integrated Household Survey 2010-2011

As can be seen, estimates of gay and lesbian people in Newham and Waltham Forest are significantly below the London and national average. However, the sample sizes involved in borough-wide data are so small and level of response so low that local level estimates like this are potentially unreliable.

These estimates are all considerably lower than that arrived at by the government in its impact assessment of the Civil Partnership Act. Research conducted in 2009 suggests that the higher government estimate be treated with caution.²⁰ It points out that most surveys estimate the percentage of LGB people in the population to be between 0.3 and 3 per cent.

²⁰ Betts, P. (2008) *Developing survey questions on sexual identity: UK experiences of administering questions on sexual identity/orientation*: Office for National Statistics

Against this, however, a number of organisations – including Stonewall – continue to use and publicise the 5-7% figure.

7. Gender reassignment

At a Glance...

No local data is available on the size of the transgender population in the catchment area for the proposed merged Trust. Issues of low disclosure and a lack of data gathering systems mean that estimating the size of this population can be challenging. However, national research suggests this could be as high 1% of people living in the catchment area.

Reliable estimates of the size, growth and geographic distribution of transgender people have historically been difficult to gather. Not only are national surveys on the subject few and far between; but a perceived risk associated with revealing gender variance prevents people from doing so.

In 2009, GIRES – the Gender Identity Research and Education Society – commissioned research into the prevalence of gender variance in the UK.²¹ The report, and a subsequent 2011 update,²² found that in 2007:

- the prevalence of people seeking medical care for gender variance was 20 per 100,000. This equates to 10,000 people across the UK, of whom 6,000 had undergone transition
- of the above, 80% were assigned as boys at birth (and are now trans women) and 20% as girls (and are now trans men)
- the prevalence of people presenting for treatment of gender dysphoria was 3.0 per 100,000 people over 15 in the UK. This equates to 1,500 people

With regard to this last point, GIRES estimate that the rate of prevalence increased to some 12,500 people by 2010. This represents an 11% per annum since 1998. GIRES suggest that with this level of increase, organisations should assume that 1% of their employees and service users may be experiencing some degree of gender variance. At some stage, around 0.2% may undergo transition.

²¹ Reed, B et. al. (2009) *Gender variance in the UK: Prevalence, incidence, growth and geographic distribution*: GIRES

²² GIRES (2011) *The Number of Gender Variant People in the UK: 2011 Update*, GIRES

8. Marriage and civil partnership

In 2010, the ONS estimated that 48.9% of the over-16 population was married, 7.21% were widowed, and 9.21% divorced.²³ In 2011, the ONS reported that the provisional number of civil partnerships in the UK in 2010 was 6,385, an increase of 1.9% since 2009. As relayed in section 6, there is no reliable figure for the number of LGB people in the country, which makes estimating the proportion of LGB people in civil partnerships tricky.

Table 8a and 8b below show the marital status at time of the last census and number of civil partnerships (2006-8) respectively.

Figure 8a: Marital status by borough, 2001

	Newham	Tower Hamlets	Waltham Forest	London	England
All People	243891	196106	218341	7172091	49138831
Single (never married)	138326	117089	118017	3808066	21763102
Married (first marriage)	67909	51162	63364	2138738	17069491
Re-married	5842	3841	7162	247533	2885186
Separated (but still legally married)	7357	4866	5344	167760	941911
Divorced	12750	9912	12737	423736	3219984
Widowed	11707	9236	11717	386258	3259157

Source: ONS, Census 2001

Figure 8b: No of civil partnerships in borough, 2006-08

	2006			2007			2008 ^p		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Newham	53	38	15	39	30	9	23	18	5
Tower Hamlets	136	123	13	74	62	12	62	53	9
Waltham Forest	90	53	37	53	33	20	38	16	22
London	4,019	3,058	961	2,110	1,545	565	1,729	1,271	458

Source: ONS, 2009 taken from GLA datastore

9. Pregnancy and maternity

Table 9a includes information on teenage conceptions. It suggests that there has been some variability in the rate of teenage conception between 2006 and 2009. In 2009 both Newham and Tower Hamlets had a higher teenage conception rate than the London average. Table

²³ ONS (2010) *Marital Status population projection, 2008-based*. Available at: <http://tinyurl.com/7hswxex>

9b suggests that fertility rates in Newham and Waltham Forest have remained consistently higher than the London average.

Figure 9a: Teenage conceptions under 18, 2006-9

		Newham	Tower Hamlets	Waltham Forest	London
2006	Number	242	158	191	5,709
	Rate	48.6	44.1	48.4	45.6
	% leading to abortion	51	63	56	61
2007	Number	219	156	210	5,691
	Rate	45.0	46.1	53.0	45.7
	% leading to abortion	45	74	65	63
2008	Number	226	109	195	5,508
	Rate	48.3	33.5	50.5	44.6
	% leading to abortion	50	53	66	61
2009	Number	220	132	206	4,977
	Rate	50	41	55	41
	% leading to abortion	54	66	61	61

Under 18 rates are per 1000 female population aged 15-17.

Source: Teenage Pregnancy Unit 2011 via GLA datastore

	2006			2007			2008			2009		
	Live births	GFR ¹	TFR ²	Live births	GFR ¹	TFR ²	Live births	GFR ¹	TFR ²	Live births	GFR ¹	TFR ²
Newham	5,523	90.4	2.56	6,053	97.7	2.71	5,963	97.6	2.70	6,003	103.0	2.87
Tower Hamlets	4,152	70.2	1.83	4,144	69.4	1.80	4,230	67.1	1.75	4,337	66.1	1.73
Waltham Forest	4,185	76.8	2.23	4,449	83.7	2.44	4,582	87.4	2.55	4,533	87.3	2.54
London	120,883	65.4	1.84	125,505	68.3	1.91	127,651	69.3	1.95	129,245	69.5	1.95

1 The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15-44.

2 The Total Fertility Rate (TFR) is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lifespan.

Source: ONS 2010

Part B: Additional contextual data

A number of vulnerable groups are not covered by equality law as a 'protected characteristic'. This sub-section provides contextual information about other characteristics of the local population and socio-economic context that merit further consideration as part of an equality and human rights analysis.

10. Looked after children

There is a relatively high rate of children who are looked after in Newham.

Figure 10: Rates of looked after children, 2011

Area	Rates of looked after children per 10,000 children aged under 18 years (2011)
England	59
London	61
Newham	74
Tower Hamlets	63
Waltham Forest	56

Source: Department of Education (2011)

11. Concentration of deprivation

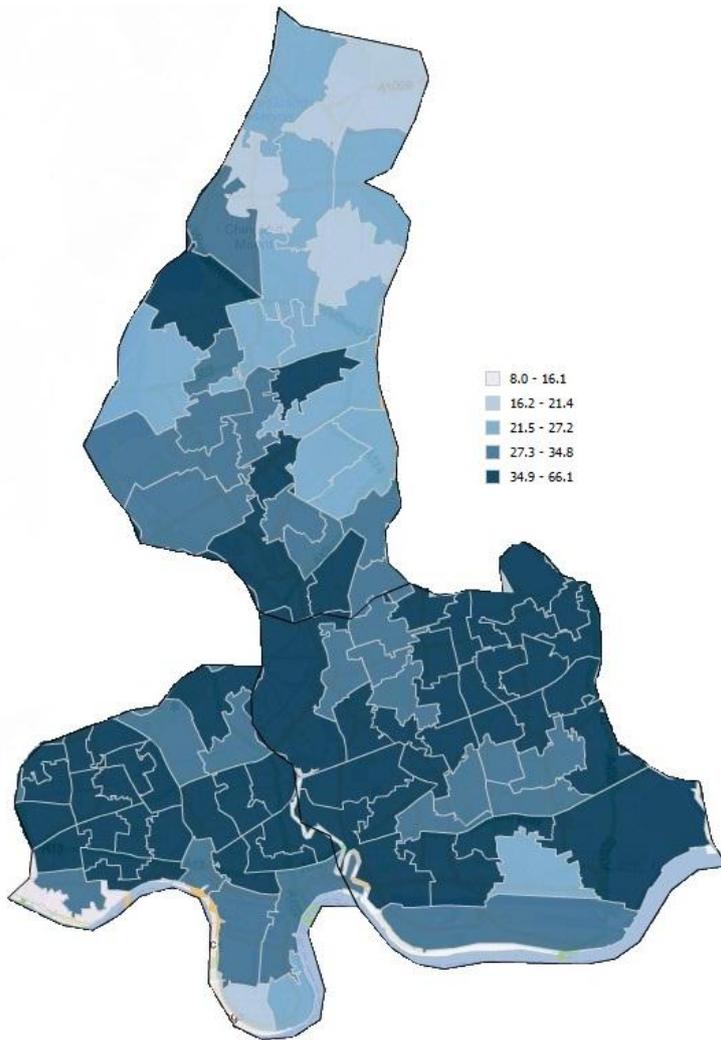
There are significant socio-economic inequalities within each borough and in comparison to the rest of London. Figure 11 on page 114 demonstrates those clusters of the catchment area where there are relatively high level of households below 60% of the median income (after housing costs) 2007/8

More recently, GLA have calculated deprivation in wards within London based on Department for Communities and Local Government Indices of Deprivation 2010. This shows that nine of the 25 most deprived wards (based on the 'extent' measure) were in Newham and Tower Hamlets. These included:

- Canning Town North- Newham (Rank 4th)
- Canning Town South - Newham (Rank 5th)
- East India and Lansbury - Tower Hamlets (Rank 7th)
- Bromley-by-Bow - Tower Hamlets (Rank 10th)
- Little Ilford - Newham (Rank 11th)
- Weavers - Tower Hamlets (Rank 14th)
- Stratford and New Town - Newham (Rank 17th)
- Mile End East - Tower Hamlets (Rank 19th)
- Forest Gate South – Newham (Rank 23rd)

Source: GLA Calculations based on the Department for Communities and Local Government, Indices of Deprivation 2010

Figure 11: Levels of households below 60% of median income, 2007-08



Source: ONS, taken from GLA 2012 MSOA Atlas

12. Homelessness

As figure 12 shows, in 2009 there were 17,282 homeless people seeking and securing accommodation across the three boroughs. Newham has a relatively higher level of recorded homeless people for that period.

Figure 12: Households accommodated by local authority, 2009

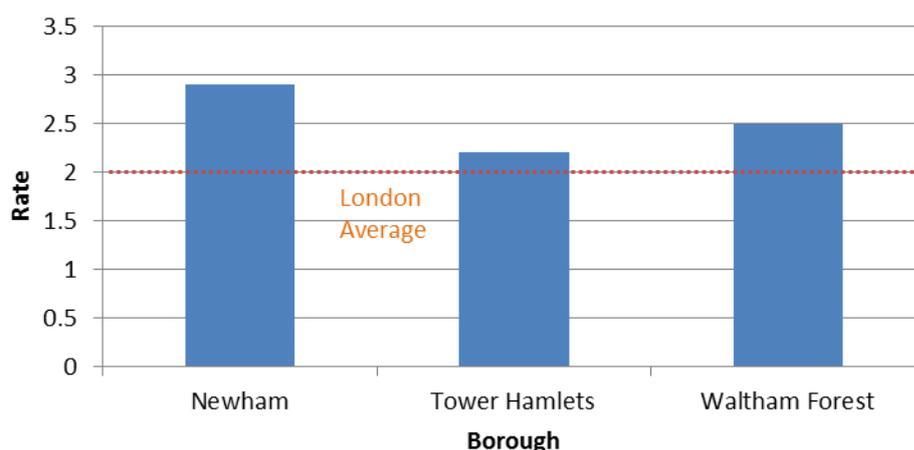
	Newham	Tower Hamlets	Waltham Forest
Households accommodated by the authority-Bed and breakfast including shared annexe-as at 31st March-2009	42	143	0
Households accommodated by the authority-Hostels including women's refuges-as at 31st March-2009	0	3	38
Households accommodated by the authority-LA/HA stock-as at 31st March-2009	51	354	101
Households accommodated by the authority-Private sector leased-as at 31st March-2009	2868	1923	1241
Households accommodated by the authority-Others-as at 31st March-2009	1521	0	356
Households accommodated by the authority-Total in TA-as at 31st March-2009	4482	2423	1736
Households accommodated by the authority-Duty Owed but no accommodation secured -as at 31st March-2009	0	0	14

Source: DCLG (2009)

13. Lone parents

In May 2011, there were 4,600 lone parents claiming benefits in Newham; 3,920 in Tower Hamlets; and 3,850 in Waltham Forest. There was a relatively higher rate of lone parents in all of the three boroughs and in Newham in particular.

Figure 13: Rate of lone parents, 2011



Source: DWP (2011) Rates are as a percentage of all people aged 16-64 from ONS mid-year estimates

14. Jobs Density

Jobs density describes the number of jobs in an area divided by the resident working-age population of that area. For example, a job density of 1.0 would mean there is one job for every resident of working age. Figure 14 shows that Newham and Waltham Forest have relatively low jobs densities compared to Tower Hamlets and to the London average. It should be noted, however, that the high density in Tower Hamlets partly reflects jobs available in the financial district in Canary Wharf.

Figure 14: Jobs density by area, 2009

Area	Jobs density in 2009
London	0.88
Newham	0.50
Tower Hamlets	1.26
Waltham Forest	0.46

Source: ONS May 2011, from Labour Force Survey

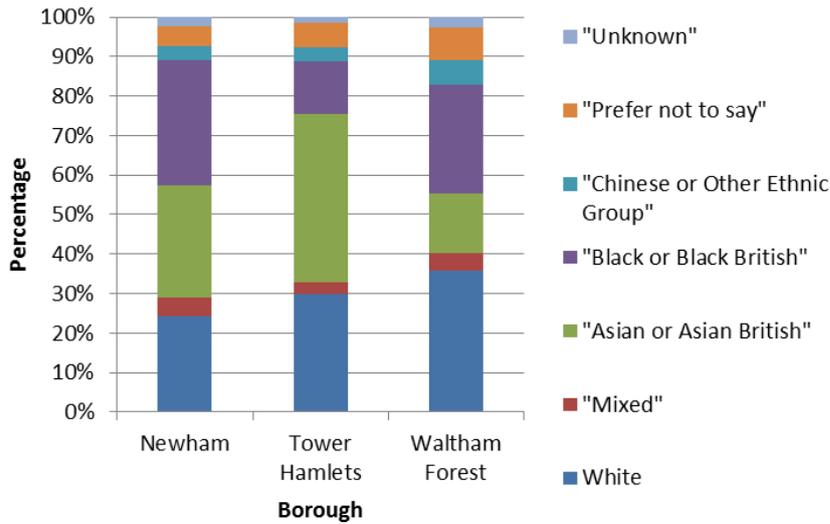
15. Unemployment

The highest levels of unemployment in London are in Tower Hamlets where around 9% of working-age adults are unemployed. The second highest levels of unemployment in London are in Newham at 8.5%. Waltham Forest has the 7th highest rate of unemployment in London at around 7.1%. This compares to a London average of approximately 6%.²⁴ It is clear the three boroughs face significant challenges associated with unemployment.

In December 2011, there were 11,485 Jobseeker Allowance claimants in Newham; 11,110 in Tower Hamlets; and 9,950 in Waltham Forest. As figure 15a below shows, claimants were more likely to be from BME groups in each of the boroughs. When this is compared to figure 15b, it can be seen that the JSA claimant rate for people from BME backgrounds was disproportionately high when compared to their proportion of the population two years previously.

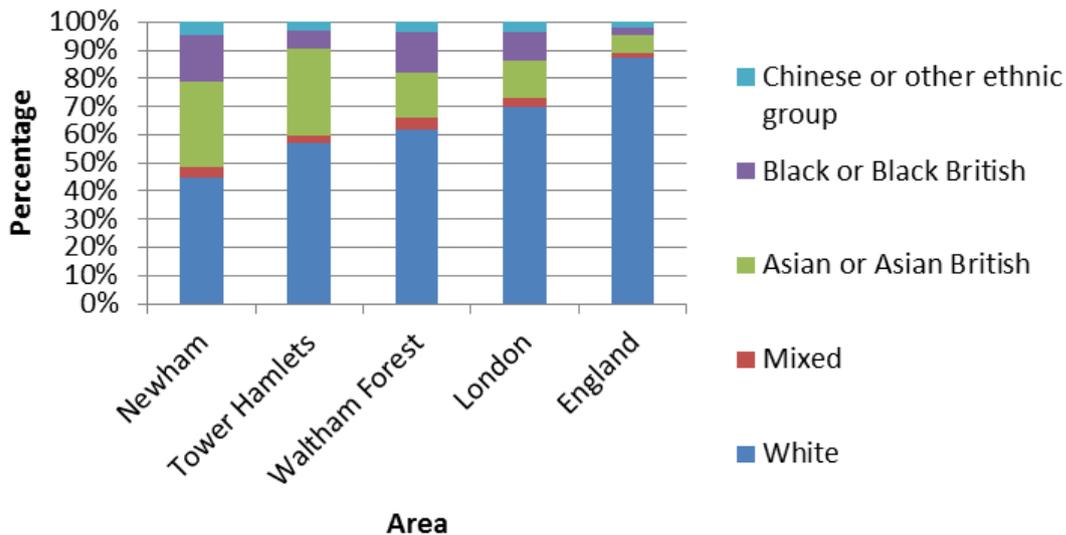
²⁴ Figures are taken from the Annual Population Survey 2011, NOMIS. They are averaged rates between 2008-2010

Figure 15a: JSA claimants by ethnicity, 2011



DWP (2011) via NOMIS, JSA Claimants Q3 2011-12

Figure 15b: Proportion of population by ethnicity, 2009



Source: ONS (2011) from Annual Population Survey 2009²⁵ - ethnic groups have been aggregated to correspond as far as possible with DWP ethnic categories used for JSA claimant data. APS 2009 data used as more up to date GLA projections do not include 'mixed' ethnic group category.

²⁵ Note that at the time of writing, ethnicity estimates in the Annual Population Survey (APS) have been withdrawn for the April 2010 to March 2011 survey period and are not included in the estimates for the July 2010 to June 2011 period published on 18 Jan 2012. In 2010 changes were made to the ethnicity questions asked in the APS. These changes have caused problems with producing a consistent time series of estimates for a number of the variables published on Nomis.

Individual ward profiles are also available on more locally run websites:

- City of London
(all wards)
http://www.cityoflondon.gov.uk/Corporation/LGNL_Services/Council_and_democracy/Councillors_democracy_and_elections/ward_boundaries.htm#muscat_highlighter_first_match
- Epping Forest District Council
(relevant wards: Buckhurst Hill East; Buckhurst Hill West; Chigwell Row; Chigwell Village; Grange Hill; Lambourne; Loughton Alderton Loughton Broadway; Loughton Fairmead; Loughton Forest; Loughton Roding; Loughton St John's; Loughton St Mary's)
www.eppingforestdc.gov.uk/community/mini_observatory.asp
- Newham
(all wards)
www.newham.info/profiles
- Redbridge
(relevant wards: Bridge; Church End; Monkham; Roding; Snaresbrook; Wanstead)
www2.redbridge.gov.uk/cms/the_council/about_the_council/about_redbridge/research_and_statistics/ward_profiles.aspx
- Tower Hamlets
(all wards)
<http://thisborough.towerhamlets.gov.uk/>
- Waltham Forest
(all wards)
www.walthamforest.gov.uk/index/community/wf-statistics/bp-ward-profiles.htm

17.2 General information

GLA datastore

www.data.london.gov.uk

Office for National Statistics

www.ons.gov.uk

London Health Observatory

www.lho.org.uk

IV. HEALTH INEQUALITIES: A BASELINE

1. INTRODUCTION

1.1 Background

A key aim of the merger is to develop a stronger response to health inequalities. CAGs have already begun to identify some of the key priorities in addressing health inequality for Barts Health and these are supported by related evidence in each clinical area. The Full Business Case identifies some of the most significant health inequalities (between different parts of the catchment area and when comparing the catchment area to other parts of the country). These are repeated below for ease of reference:

Figure 1.1: Selected measures of health for north east London population, as outlined in the Full Business Case

Indicators	Notes	Newham	Tower Hamlets	Waltham Forest	England Average
Life expectancy (males)	1	76.2	76.0	77.1	78.3
Life expectancy (females)	1	80.5	80.9	81.6	82.3
Infant deaths	2	5.3	4.4	4.7	4.71
Deaths from smoking	3	251.0	306.5	229.6	216
Early deaths: heart disease and stroke	3	116.9	113.6	90.3	70.5
Early deaths: cancer	3	118.1	141.4	113.2	112.1
People diagnosed with diabetes	4	7.0	6.1	5.9	5.4
New cases of TB	5	120	63	47	15

Key:

	Significantly worse than the England average
	Not significantly worse than the England average
	Significantly better than the England average

Notes

- At birth 2007 - 2009
- Rate per 1000 live births 2007 - 2009
- Per 100,000 population aged 35 +, directly age standardised rate 2007-2009
- % of people on GP registers with a recorded diagnosis of diabetes 2009/10
- Crude rate per 100,000 population 2007-2009

Source: Association of Public Health Observatories, Health Profiles, July 2011

A lot of evidence is available on different health inequalities across the catchment area. This was a rapid review to collect the most suitable information that could be used as an equality and human rights baseline by Barts Health going forward. It required a rapid assessment of the *level* of relevant information currently available on health inequalities for each of the protected characteristics covered by the Equality Act 2010. It also involved identifying *key patterns* of health inequality as they affect people with protected characteristics. In addition to acting as a baseline for Barts Health, the remit provided to brap made it clear that collected information would also be used to inform an Equality and Human Rights Impact Assessment of the Full Business Case for the merger.

1.2 Approach

With this in mind, it was agreed with the Steering Group that the rapid review would focus solely on health inequalities disaggregated by protected characteristics. Clearly, this differs from common national definitions of 'health inequalities' (which refer principally to differences in health outcomes as experienced by people in different parts of the country). Evidence that related most closely to the clinical focus of CAGs was also given priority in the review (e.g., cancer, cardiovascular, diabetes and behavioural risk factors like smoking).

Given the relatively short timeframe available and barriers faced in accessing relevant datasets, the review mainly covered publicly available documents where health inequalities had already been analysed and assessed (e.g. local Joint Strategic Needs Assessments and Public Health reports). This meant that in some cases data was only available for one locality within the catchment area and not for others. Where this happened, it is noted as part of the review to help Barts Health to identify any gaps in locally available data and to identify where data on health inequality is being used to good effect and could be replicated elsewhere. Where data was available in larger publicly accessible datasets (e.g. GP Patient Survey or COPD prevalence modelling) data was analysed across the catchment area. Also, inpatient and outpatient survey data was requested from the Picker Institute and permission received from each Trust to use that data. Patient survey data is used to better understand and baseline human rights-related issues within the Trusts (e.g, right to privacy, dignity and respect).

Given the relatively sparse availability of local health inequalities data for some protected characteristics (e.g. sexual orientation, gender reassignment and religion and belief), information is also included (where easily available and relevant) about regional, national, international health inequalities as they relate to those groups. Although a crude proxy for detailed local information, national evidence can be used in conjunction with what is known about the local demographic profile to help understand the potential health inequalities experienced by those traditionally excluded groups locally.

1.3 Availability of data: an overview

Explorations of health inequality data in London have been conducted before. In 2008 a significant programme of work was undertaken to develop a Health Equity Profile for London. As part of this, a scientific review identified the availability of routine datasets or indicators by different dimensions of inequality and for different protected characteristics. A summary table from the report is reproduced below.

Routine Data or Indicators	Age	Deprivation	Disability	Ethnicity	Faith	Gender (sex)*	Geography	Socio-economic status	Sexual orientation
Demographic	✓	✓	✓	✓	✓	✓	✓	✓	X
Life expectancy	N/A	X	X	X	X	✓	✓	X	X
Mortality	✓	X	X	X	X	✓	✓	X	X
GPs/population	∞	X	X	X	X	✓	✓	X	X
Other primary care staff/population	X	X	X	X	X	X	✓	X	X
48hr GP access (sample survey data only)	✓	✓	X	✓	X	✓	✓	X	?
Registered/ resident population	X	X	X	X	X		✓	X	X
Avoidable admissions	✓	X	X	¥	X	✓	✓	X	X
Access to stop smoking services	✓	X	X	✓	X	✓	✓	X	X
Maternity data	✓	X	X	#	X	N/A	✓	✓	X
Prevalence of stroke, TIA and hypertension	✓			∞	X	✓	✓	X	X
% hypertension controlled	∞	X	X	∞	X	∞	✓	X	X

Notes:

✓ routinely recorded

X no routine data collection.

*Male/female, not transgender

∞ Data collected at practice level, but not reported for routine datasets

¥ Incomplete recording and reporting of data at hospital level.

Mother's country of birth only, not actual ethnicity, nor ethnicity of father or infant.

Source: Husbands, S., Chau, K., Health Inequalities and Equality Impact Assessment of 'Healthcare for London: consulting the capital', Scientific Annex I Health Equity Profile (2008)

Clearly the table above shows significant gaps in available data that was routinely recorded in 2008. Conducting our review in 2012, brap has identified additional information that will be of use to Barts Health in future planning and measuring progress on health inequalities. However, as the rest of this section shows, the extent to which data gaps exist in relation to particular protected characteristics is still significant.

1.4 Structure of findings

Findings are organised in relation to three broad areas:

- i) **Health outcomes:** this is the largest section and is organised in relation to key service areas and conditions. Where local data benefits from additional regional or national data to provide context, or where local data is particularly sparse, regional and/or national data has been included to support Barts Health to conduct further enquiries
- ii) **Experience of healthcare:** information from inpatient and outpatient surveys are used to examine performance on key aspects of patient experience (focusing in particular on issues that relate to human rights and CQC Essential Standards of Care). GP Patient Survey results are also used to provide an indication of patterns in experience of local primary care.
- iii) **Access to healthcare:** information from patient admission results are compared to demographic profiles of the population. GP Patients Survey results (levels of registration for people with particular protected characteristics) are used to assess levels of access to local primary care

2. INEQUALITIES IN HEALTH OUTCOMES

Appendix F provides more detailed information about available data for each of the health issues/ conditions covered below. This section offers a quick overview of where data was available on health inequalities, how up-to-date that information is, and a headline summary of what that evidence was saying. A simple Red, Amber, Green system is used to identify where local data was available, with colours meaning the following:

- green: data available for all three boroughs/PCT areas of Newham, Tower Hamlets and Waltham Forest
- amber: data available for one or two boroughs/PCT areas
- red: data not available for any borough/ PCT area

The overview is outlined as a summary table, pages 124-143.

Key: Newham (N), Tower Hamlets (TH), Waltham Forest (WF)

Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
Prevalence of Smoking	Age						
	Disability		TH	2009	Yes	2011	Tower Hamlets – More than twice amount of people with severe mental illness smoke compared to average local population. National – confirms patterns in Tower Hamlets
	Pregnancy and maternity						See smoking during pregnancy below
	Race		N TH	2008 2009	Yes	2004	Newham – High for White British/ Eastern Europeans. Low smoking rates for Pakistani, Bangladeshi, Indian women. Tower Hamlets – High smoking levels for Bangladeshi males and White women.
	Sex		N TH	2008 2009	Yes	2008	Newham – Men twice as likely to smoke Tower Hamlets – 34% of males current smokers compared to 20% of females National – Men slightly more likely to smoke (21% compared to women 20%)
	Sexual orientation				Yes	2004	National – Adult Gay smoking prevalence is twice that of adult heterosexuals
	Gender Reassignment, Religion and Belief				None found		
Chronic Obstructive Pulmonary Disorder (COPD)	Age				Yes	2007	Prevalence and mortality increases with age. Age is a predictor of risk of re-admission following hospitalisation for severe COPE exacerbation.
	Disability		TH	n/d	Yes	2006	Tower Hamlets – People with disabilities significantly more likely to have COPD compared to the rest of the population (severe mental illness, deaf, blind, housebound).

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Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
							National – Similar patterns but much higher national average prevalence in 2006.
	Race		N TH WF	2008			All boroughs: Data for all boroughs available via ERPHO modelling data. Estimates of prevalence in these boroughs higher than predicted national average for all boroughs (and all ethnicities except white in Tower Hamlets). More up to date data from Tower Hamlets suggests prevalence is lower than predicted in 2008 and with different patterns (e.g. white ethnic group more likely to have COPD in Tower Hamlets). This may be due to different definitions of COPD being used. Need to review usefulness of ERPHO data.
	Sex				Yes	2012	National: Sex differences in risk of COPD reported in previous studies are influenced by the definition used for COPD. When using a statistically driven definition, no independent sex difference was found and there was no evidence of an increased susceptibility to COPD among female compared with male smokers
	Gender Reassignment, Pregnancy and Maternity, Religion and belief, Sexual Orientation					None found	
Asthma	Age		TH	n/d JSNA 2010- 11			Tower Hamlets – Under-diagnosis in adolescents. Black Caribbean children 6 times more likely than White/ Asian peers to be admitted for emergency asthma treatment.
	Disability		TH	2009			Tower Hamlets – People with disabilities more likely to have asthma (severe mental illness, deaf, blind, housebound)

Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
	Race		N TH	1999 n/d JSNA 2010- 11	Yes	1998, 2005, 2010	<p>Newham – Groups most affected are Black Caribbean, Irish, Chinese boys and Black Caribbean, Irish girls (broadly in line with local population)</p> <p>Tower Hamlets – Black children 0-4 years old with asthma 6 times more likely to be admitted than South Asian/ White peers. Black ethnic group adults most likely to be admitted in all age groups, Asian ethnic group more likely than White.</p> <p>National – In UK as a whole, South Asian people 3 times more likely, African Caribbean 2 times more likely to require emergency admission for asthma compared to White population.</p>
	Sex		TH	n/d JSNA 2010- 11			<p>Tower Hamlets – Asthma affects more males in childhood but more females in adulthood</p>
	Gender Reassignment, Pregnancy and Maternity, Religion and belief, Sexual Orientation					None found	
Tuberculosis	Race		N TH WF	2002 2009 2008	Yes	2009	<p>Newham – Higher number of TB cases in people from Indian ethnic origin and a recent rise in cases from African patients</p> <p>Tower Hamlets - Significantly higher number of TB cases amongst Bangladeshi patients, followed by Black African then White</p> <p>Waltham Forest – Black African, Pakistani and Indian communities have highest rates of TB</p>
	Age, sex				Yes	2011	<p>Just over half of all cases in 2010 were male (57%). Sixty per cent were 15 to 44 years old; those aged 45 to 64, 65 and over, five to 14 and under five years accounted for 21%, 15%, 3% and</p>

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Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
							2% of cases respectively. In England, the rate in UK-born children under five years of age, an indicator of recent transmission, was 3 per 100,000 Source: HPA, Tuberculosis in the UK 2011 Report (2011)
	Gender Reassignment, Pregnancy and Maternity, Religion and belief, Sexual Orientation				None found		
Diabetes	Age		N	2007	Yes	2009	Newham – Young people in Newham are more likely to have diabetes than nationally (1.67 per 1,000 of local population aged 0-17 years old). National - Prevalence is highest between 45-74 year old age group.
	Disability		TH	2009	Yes	2006	Tower Hamlets – People with disabilities (mental illness, learning difficulties, deaf, blind, housebound) much more likely to have diabetes
	Race		N TH	n/d (JSNA 2010) 2007/8	Yes	2004	Newham - Doctor diagnosed diabetes 4 times more prevalent in Bangladeshi men, 3 times more prevalent in Pakistani/ Indian men, 5 times more prevalent in Pakistani women and 3 times more prevalent in Bangladeshi/ Black Caribbean women compared to general population. Tower Hamlets – 42% of Bangladeshis over 65 years old have diabetes compared to 20% of White population National – In 2004 Children of South Asian ethnicity were 13 times more likely to be diagnosed with diabetes (and increased prevalence of childhood obesity).

Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
	Sex		N	2010			Newham – see above data on ethnicity/ gender National - The frequency of diabetes in England is higher in men than in women. However, women with diabetes are at relatively greater risk of dying than men with diabetes - in comparison with women and men who do not have diabetes.
	Gender Reassignment, Religion and belief, Sexual Orientation				No		
HIV	Race		N TH WF	2008 2009 2008	Yes	2010	Newham – 65% of people infected were Black African Tower Hamlets – 68% of people infected were from White ethnic group compared to 14% Black African. 64% of HIV cases in Black Africans diagnosed late compared to 38% of HIV in men who have sex with men diagnosed late. Waltham Forest – Amongst males, majority diagnosed with HIV were white. Amongst females majority diagnosed were Black African.
	Gender reassignment				Yes	2007	A 2007 Department of Health document claimed, “a US study found (MTF) trans women to have the highest incidence of HIV infection of any risk group; however, HIV infections are not a major risk factor in the UK, mainly because sex work or recreational drug use is not usual in UK trans cultures.”
	Sexual orientation		TH	2009	Yes	2007	Tower Hamlets – 70.5% of HIV cases in Tower Hamlets are in men who have sex with men. In 2009 38% of people with HIV in this group were diagnosed late. National – 5.4% of men who have sex with men aged 15-44 were infected with HIV.

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Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
	Age, disability, pregnancy and maternity, religion and belief sex				None found		
Coronary Heart Disease (CHD)	Age				Yes	2010	National - CHD increases with age. This is a non-modifiable risk factor. In recent years CHD death rates have been falling more slowly in younger age groups.
	Disability		TH	n/d (JSNA 2010-11)	Yes	2006	Tower Hamlets – Significantly higher proportion of people who are deaf, blind or housebound have CHD compared to local population. National – Approximately 40-50% of people with Down’s syndrome have a congenital heart defect. People with schizophrenia more likely to be diagnosed with CHD under age of 55
	Race		N TH WF	2008	Yes	2011	All boroughs - ERPHO projections suggest higher rate in all ethnic groups for Newham compared to national average and higher rate in Black ethnic group compared to national average in Tower Hamlets. Though more up to date data suggests that in Tower Hamlets ethnic distribution for heart failure reflective of make-up of older population. National – CHD more common among some ethnic minority groups (e.g. people from Indian sub-continent).
	Sex				Yes	2008	National - 1 in 5 men and 1 in 7 women die from CHD. Women in manual employment are 5 times more likely and men 3 times more likely to die from CHD compared to others in higher managerial and professional employment
	Gender Reassignment,					None found	

Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
	Pregnancy and Maternity, Religion and belief, Sexual Orientation						
Cardio-vascular Disease (CVD)	Age and Sex				Yes	2010	Prevalence of CVD is higher in men (all ages) and higher in men (aged 75 and less) and higher in women (aged 75+).
	Race		N TH WF				ERPHO projections suggest higher or equal rate in all ethnic groups for Newham compared to national average and higher rate in Black ethnic group compared to national average in Tower Hamlets. Though more up to date data suggests that in Tower Hamlets the white population has significantly higher mortality rates than other ethnic groups for cardiovascular disease (under 75 years - males and females). The findings are particularly interesting given the high levels of cardiovascular disease amongst the South Asian population and high smoking prevalence amongst Bangladeshi males in Tower Hamlets.
	Disability, Gender Reassignment, Pregnancy and Maternity, Religion and belief, Sexual Orientation,				None found		
Hypertension	Age and Sex				Yes	2010	National - Overall, the prevalence of hypertension (at least $\geq 140/90$ mm Hg or on treatment for hypertension) in those aged over 35 was 32% in men and 27% in women. The prevalence significantly increased with age in both sexes: about 33% of men and 25% of women aged 45-54 years have hypertension; about 73% of men and 64% of women aged ≥ 75 years or older have hypertension.

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Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
	Disability		TH	n/d JSNA 2010-11	Yes	2002	Tower Hamlets – A significantly higher number of people with severe mental illness, deaf, blind, or housebound have hypertension compared with the local population.
	Race		N TH WF				ERPHO projections suggest lower rates for White and Asian ethnic groups in all areas, and higher rates for Mixed and other ethnic groups in Newham and Black ethnic groups in Tower Hamlets. Though more up to date data suggests that in Tower Hamlets the prevalence is lower than predicted in 2008 (though this newer evidence does suggest prevalence is highest amongst Black ethnic group – which is consistent with ERPHO projections).
	Gender Reassignment, Pregnancy and Maternity, Religion and belief, Sexual Orientation,				None found		
Stroke and Ischaemic Heart Disease	Age and Sex				Yes	2006	National - In 2004 Women were more likely to die from stroke compared to men. Most deaths were in older age groups (particularly 75+).
	Disability		TH	2009	Yes	2006	Tower Hamlets – 2.0% of people with learning difficulties have had a stroke compared to 0.4% of total local population. Significantly more people who are housebound have had a stroke compared to local population. National – those with severe mental illness and depression more likely to have a stroke compared to general population.
	Race		TH	n/d – JSNA 2010-	Yes	1999	Tower Hamlets - White ethnic group (0.73%), Black ethnic group (0.74%), Asian ethnic group (0.48%), Other ethnic group (0.26%).

Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
				2011			National - Black Caribbean men have a much higher prevalence of stroke - the risk is almost two thirds higher than the general population. Indian men also have a higher risk of stroke.
	Gender Reassignment, Pregnancy and Maternity, Religion and belief, Sexual Orientation,						
Mental health	Age and Sex				Yes	2002	National - More girls than boys experience depression, experience eating disorders and engage more in suicide ideation and attempts than boys; but boys engage in more high-risk behaviour, commit suicide more frequently than girls. In adulthood, depression and anxiety is more prevalent in women, while antisocial behaviour and substance misuse is higher in men. There are no statistical differences in the number of men and women experience the more severe types of mental ill-health, but men experience earlier onset of schizophrenia while are more likely to experience acute bipolar depression.
	Disability		N TH	2011 n/d JSNA 2010-11	Yes	2011	Tower Hamlets - 9.91% of people with learning difficulties in Tower Hamlets experience depression, compared to 7.40% of the total population. 7.75% of people with learning difficulties in Tower Hamlets have a serious mental illness compared to 0.80% of the total population. National – Prevalence of psychiatric disorders is 36% among children with learning disabilities, compared to 8% among children without learning disabilities.

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Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
	Gender reassignment				Yes	2007	National - People undergoing or who have undergone gender reassignment experience stigma and discrimination that may contribute to poorer mental health. A survey of 872 trans people the – UK’s largest such survey –found that 34% (more than one in three) of adult trans people have attempted suicide.
	Race		N TH WF	2011	Yes	2007	All boroughs – Large inequalities in admissions to adult psychiatric inpatient services in all 3 boroughs. Newham - admission rate 1.4 times higher for white ethnic groups and 2.6 times higher for black ethnic groups (compared to national average). Tower Hamlets – admission rate 15% higher for all ethnic groups and 4.5 times higher for black ethnic groups (compared to national average) Waltham Forest – admission rate two times higher for black ethnic groups (compared to national average) National – BME people more likely to receive diagnosis of mental illness than White British – however prevalence in the community shows smaller ethnic differences.
	Religion and belief				Yes	2004	National – a recent systemic review of health inequalities found that “Available evidence does not suggest significant and systematic differences in indicators of common mental disorder, such as GHQ12, between religious groups”
	Sexual orientation				Yes	2008	National - Gay men and lesbians report more psychological distress than heterosexuals a range of indicators. LGB people are at significantly higher risk of mental disorder, suicide ideation, substance misuse and deliberate self-harm

Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
							(NIMHE 2007) compared to heterosexual people, and face higher levels of discrimination by professional mental health professionals.
Lifestyle (obesity, physical activity, alcohol, drugs, carer responsibilities)	Age and Sex				Yes	2011 and 2009	National - In 2009, almost a quarter of adults (22% of men and 24% of women aged 16 or over) in England were classified as obese (BMI 30kg/m ² or over). In 2008, among adults aged 16 and over, overweight or obese men and women were more likely to have high blood pressure than those in the normal weight group; high blood pressure was recorded in 48% of men and 46% of women in the obese group, compared with 32% of overweight men and women and 17% of men and women in the normal weight group. In 2009/10, almost a quarter of adults (24.3% of respondents) in England reported that they had taken part in sport on 11 to 28 days within a four week period. In 2009, around 1 in 5 children aged 5 to 15 consumed five or more portions of fruit and vegetables a day (21% of boys and 22% of girls). This has increased from 5 years ago where the corresponding figures were 13% and 12% in 2004. Since 1998, there has been a general increase in drinking over recommended weekly limits, especially for women. Among men aged 16-24 drinking over weekly limits has decreased alongside overall consumption since 2000. In the UK, women are less likely than men to drink and women who do drink consume less than men.
	Disability				Yes		People with learning disabilities are much more likely to be either underweight or obese than the general population. Fewer adults with learning disabilities who use learning disability services

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Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
							smoke tobacco or drink alcohol compared to the general population. Over 80% of adults with learning disabilities engage in levels of physical activity below the Department of Health's minimum recommended level, a much lower level of physical activity than the general population (53%-64%).
	Race		N TH WF	n/d JSNA 2010 2009 n/d JSNA 2012- 13			<p>Newham - Obesity is more prevalent within Black Caribbean, Black African and White groups, including East Europeans. Obesity levels in children have not been improving significantly over the last 3 cohorts surveyed. White ethnic groups are over represented among young people referred for drug treatment. Referrals of Black and Asian ethnic groups are under-represented compared to population.</p> <p>Tower Hamlets – Significant differences in fruit and vegetable consumption by ethnicity. Only 2% of Asian men, 3% of Black men and 12% of White men reported eating five a- day. The Asian population was the least likely to reach the 5-a-day target. This is similar to The Health Survey for England 2004. Migrants more likely to be drinkers than non-migrants (and to engage in more 'risky' drinking). No evidence to show any statistically significant differences in physical activity between ethnic groups/ genders within ethnic groups. A much higher proportion of Asian community provide unpaid care compared to other ethnic group, Chinese/ mixed heritage people have lowest proportion of people providing unpaid care.</p> <p>Waltham Forest – Highest prevalence of obesity in children by ethnicity is White British (18.3%),</p>

Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
							followed by Pakistani (17.1%). White ethnic group is largest group of young people accessing specialist treatment for substance misuse, underrepresentation from Black and Asian backgrounds compared to local school population.
	Sexual orientation				Yes	2006 2010	US studies find a higher prevalence of overweight and obese women among lesbian and bisexual women compared to all other sexual orientations groups, suggesting a higher risk of morbidity and mortality among this group – but general research tends to attribute predisposing factors to mental health related drivers such as the stress of coping with homophobic attitudes towards LGB people generally.
	Gender Reassignment, Pregnancy and Maternity, Religion and belief,				None found		
Cancer	Age				Yes	2006-2008	Cancer is primarily a disease of older people, with incidence rates increasing with age for most cancers. More than three out of five (63%) cancers are diagnosed in people aged 65 and over, and more than a third (36%) are diagnosed in the elderly (aged 75 and over) (Source: Cancer Research UK website)
	Disability		TH	n/d JSNA 2011- 12	Yes	2011	Tower Hamlets – People with disabilities (learning disabilities, deaf, blind, housebound) significantly more likely to have cancer compared to rest of the local population. National - Overall, the proportion of people with learning disabilities who die from cancer in the UK is lower than the general population although

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Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
							people with learning disabilities and people with schizophrenia have proportionally higher rates of gastrointestinal cancer. Women with schizophrenia are 42% more likely to develop breast cancer.
	Race		N TH WF	2009-10 2009-10 2009-10	Yes	2002-6	<p>Percentage of Women Aged 53-64 Screened for Breast Cancer 2009/10:</p> <p>Newham PCT: 61.6% (out of 13,325 eligible women);</p> <p>Tower Hamlets PCT: 67.3% (out of 8,300 eligible women);</p> <p>Waltham Forest PCT: 70.8% (out of 13,895 eligible women)</p> <p>Tower Hamlets – there is a weak correlation between lower male life expectancy and higher cancer mortality in Bangladeshi residents. People in most deprived areas and BME people had lowest awareness of cancer symptoms and lifestyle risk factors.</p>
	Sex		TH WF		Yes	2007-9	<p>Newham - The crude overall mortality rate due to cancers for Newham populations stands at about 25% for both men and women, although for all people that die before the age of 75 in Newham, more women die from breast and lung cancers, while the leading cause of death for men are cardiovascular diseases.</p> <p>Tower Hamlets – Some ethnicity/ gender specific information on cancer awareness. For example, Low level of breast awareness, particularly Asian women; barriers to seeing a GP were embarrassment and fear (more Asian women),</p>

Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
							worry about wasting doctor's time (more white women) and transport difficulties (older women). Waltham Forest - Prostate cancer – poor awareness in men. Lower incidence in sexually active males of older ages National - Most common cancers for males are prostate, lung and colorectal, and for women are breast, lung and colorectal. The incidence rate for lung cancer was 35 per cent higher in males than in females (60 and 39 cases per 100,000 respectively), and the incidence rate of colorectal cancer was 36 per cent higher in males than females (58 and 37 per 100,000 for males and females respectively). Breast cancer in females had the highest overall incidence rate (124 cases per 100,000). This was 17 per cent higher than the cancer with the highest incidence in males – prostate cancer (103 cases per 100,000).
	Sexual orientation				Yes	2008	Over one in twelve lesbian and bisexual women aged between 50 and 79 have been diagnosed with breast cancer, compared to one in twenty of women in general. Three in ten lesbian and bisexual women check their breasts for lumps or changes every month and half every few months. Four in five lesbians over the age of 50 have had a breast screening test, which is similar to women in general.
	Gender Reassignment, Pregnancy and Maternity, Religion and belief				No data found		
Fertility	Disability				Yes	2011	National - Women with learning disabilities have markedly different patterns of contraceptive use to

Barts Health Equality and Human Rights Impact Assessment Report

Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
							women in the general population with greater use of long term methods such as depot injection, oral contraceptive, intrauterine device or sterilisation and significantly less use of barrier methods. Evidence suggests that women with learning disabilities are not given sufficient information or fully involved in decisions about contraception. Furthermore there is evidence that women are prescribed contraception even when they are not sexually active or are past child bearing age.
	Race		N TH	2010 n/d JSNA 2010- 11			<p>Newham - Newham had the highest birth rate in the country and it was expected to increase by approximately 17% by 2012. The total period fertility rate for women of Bangladeshi ethnic group is an average of 3.5 children, women of Pakistani ethnic group an average of 3 children, women of black African ethnic group an average of 5 children. Women of mixed race, white or black Caribbean ethnic groups have much lower averages of between 1-2 children. This is compared to an England average of just below 2. Approximately a third of all women accessing maternity services require language translation support. This is provided either by the woman's own family or from the bilingual health advocacy team (BHAT).</p> <p>Tower Hamlets - Fertility in the Bangladeshi community is significantly higher than in the non-Bangladeshi community and appears to be independent of deprivation.</p>
	Sexual orientation				Yes	n/d	National - Stonewall research suggests that LBT women are more likely to experience

Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
						2004	discrimination and reduced access to healthcare services, at all three levels: perinatal, during birth and post-natal. Independent research found documents the various categories of poor outcomes for lesbian, gay and bisexual people in relation to choices on motherhood and parenting, supporting earlier broader research on related issues.
	Age, gender reassignment, pregnancy and maternity, religion and belief, sex				No data found		
Infant mortality	Disability				Yes	n/d	National - Mother's mental illness thought to increase the chances of infant mortality by up to 20 time
	Race		N TH	2007 2010			Newham - Infant mortality statistics could be broken down into several groups as follows: 40% Asian; 20% African; 20% White (10% white British and 10% White Other); 20% Other. Tower Hamlets - Incidence of infant mortality over 28 days >1 year between 2008-2010 was: Bangladeshi (36.5%), White British (9.6%), Other minority ethnic groups (28.9%), Ethnically mixed/ not known/ not stated/ blank (25%).
	Age, gender reassignment, pregnancy and maternity, religion and belief, sex, sexual orientation				No data found		

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Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
Breast feeding	Race		WF	2010-11			Waltham Forest - Highest breastfeeding prevalence were Black African (87.3%), Indian (81.1%), Black Other (78.2%) and Asian Other (76.8%). The ethnic groups with the lowest prevalence of breastfeeding were White and Black African Caribbean (50.7%), White British (57.8%) and Pakistani (64%). The Chinese and White Irish group had very low prevalence (44.4% and 57.1%) but the numbers of babies in these groups were very small.
	Age, disability, gender reassignment, pregnancy and maternity, religion and belief, sex, sexual orientation				No data found		
End of life care	Age				Yes	2011	National - The majority of deaths in the UK occur in acute hospitals, and older people are particularly likely to die in this setting. Research participants identified various barriers to palliative care provision for older people, including attitudinal differences to the care of older people, a focus on curative treatments within hospitals and a lack of resources. Participants also reported differing understandings of whose responsibility it was to provide palliative care for older people, and uncertainty over the roles of specialist and generalist palliative care providers in acute hospitals
	Disability				Yes		Disability - People with learning disabilities with cancer are less likely to: be informed of their diagnosis and prognosis; be given pain relief; and less likely to receive palliative care

Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
	Race				Yes	2011-12 2012-13 2004 2007	<p>Tower Hamlets and Waltham Forest – Both acknowledge that they do not have sufficient information to understand whether there is an unmet need for palliative / end of life care among ethnic minority patients.</p> <p>National - Historically in the UK, it appears that ethnic minorities have not had access to specialist palliative care as much as would be expected according to their percentage in the population. The reasons for this are not fully understood, but include low referral rates and lack of knowledge of services</p>
	Religion and belief				Yes	2000 2002 2009	<p>National - There is evidence that the religious needs of some South Asians and Black Caribbeans have not been well catered for. However, hospices have been shown to be sensitive to the religious and cultural needs of minority patients, and patients and families are largely happy with the care received.</p>
	Sex				Yes	2011 2006	<p>National - US research similarly finds that gender, more than severity of illness, age and co-morbidities, had a profound influence on end-of-life care and decisions. Another American study similarly finds varied sex-related poor outcomes for end-of-life citizens in Michigan, USA, including cultural barriers, lack of choice and discrimination.</p>
	Sexual orientation				Yes	2011 2012	<p>National - Research by NCIC documents that LGBT people fear they will face discrimination and lack of understanding when seeking access to end of life palliative care and related services, with 70% near end of life LGBT people reporting the use of inappropriate language.</p>

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Health issue/condition	Protected characteristic	Local data			Regional/national/international data		What the evidence is saying
		Availability	Areas covered	Year	Available	Year	
							Stonewall's extensive research documents the challenges faced by LGBT people in later life, including discrimination, abuse, challenged personal support systems, and recommends response measures for various agencies.

3. INEQUALITIES IN EXPERIENCE

This section is in two parts. Part A explores patient experience in in- and outpatient care. Part B looks at people's experience of GP surgeries.

Part A: Patient experience

This part of the report explores patient experience, based primarily on findings from the NHS Inpatient Survey 2010 and the Outpatient Survey 2011.

A full list of responses is contained in appendix G. This short section provides an overview of particularly significant findings. As such, not all protected characteristics are explored in each area: anyone looking for a comprehensive baseline should consult the appendices.

In addition to containing particularly interesting findings, the questions below have been chosen because they are useful indications of whether patients' human rights are being upheld. For anyone interested, this is explained in a bit more depth below; however, you can jump straight to the findings without losing any understanding of the issues involved.

Using patient experience measures to understand progress on human rights

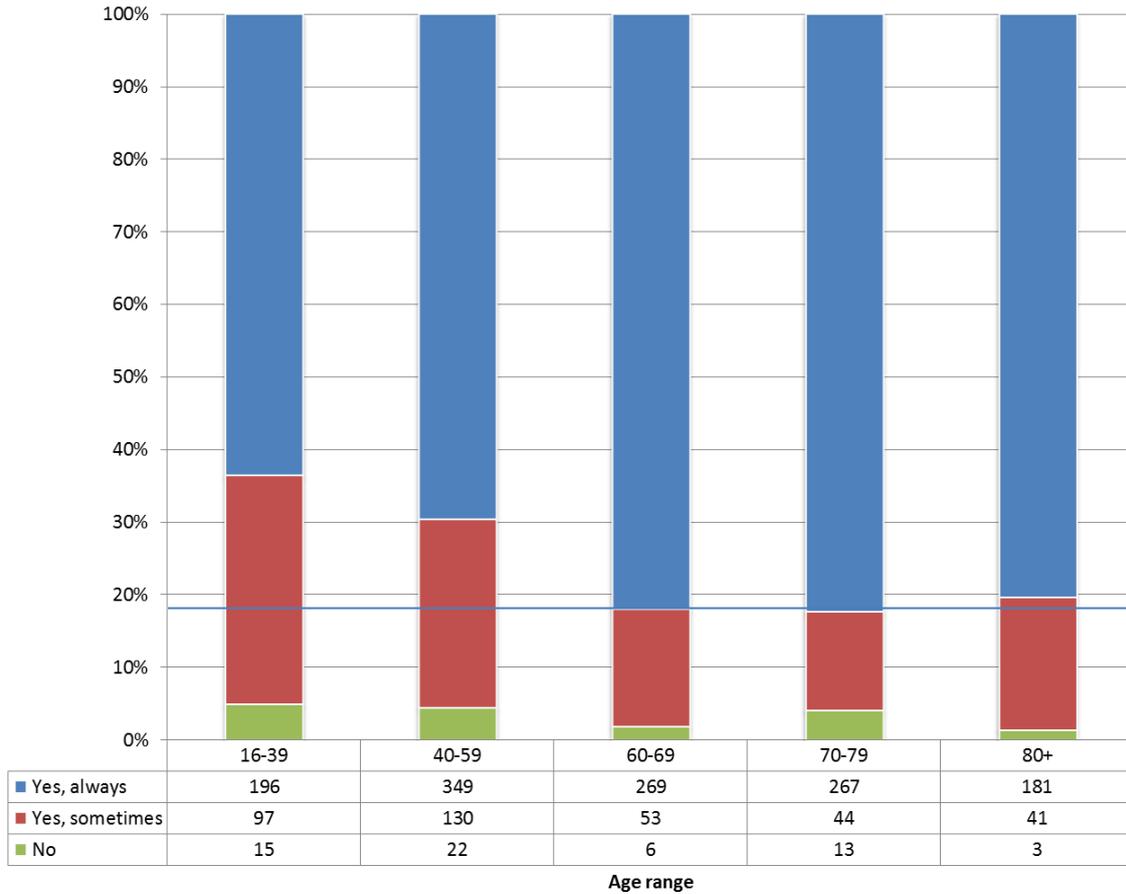
Since 2008 brap has been at the forefront of using human rights to improve the provision of healthcare. On behalf of Macmillan Cancer Support, we developed a human rights standard, which clearly shows professionals how human rights are practically relevant to their day-to-day roles. The standard has been warmly welcomed by the Department of Health. As part of the process of devising the standard, brap consulted with over 400 patients, carers and staff. They relayed to us that it was often the 'little things' that made a huge difference to their experience of care – things like being called by the right name or not being talked about as if they weren't there. As such, the exhibition of these behaviours can serve as a useful proxy as to whether human rights principles – respect, dignity, privacy – are being upheld. This project also explored whether patient survey questions could be used to understand progress on human rights. Some of the most relevant human rights related metrics from the inpatient and outpatient surveys are included below.

3.1 Overall experience of being treated with dignity and respect

3.1.1 Age

Generally, younger people across the three Trusts are more likely to report not always being treated with dignity and respect (see figure 3.1.1a below).

Figure 3.1.1a: % of people who, overall, felt they were treated with respect and dignity whilst in the hospital/at the Outpatients Department by age (2010/11) (merged total for all Trusts)



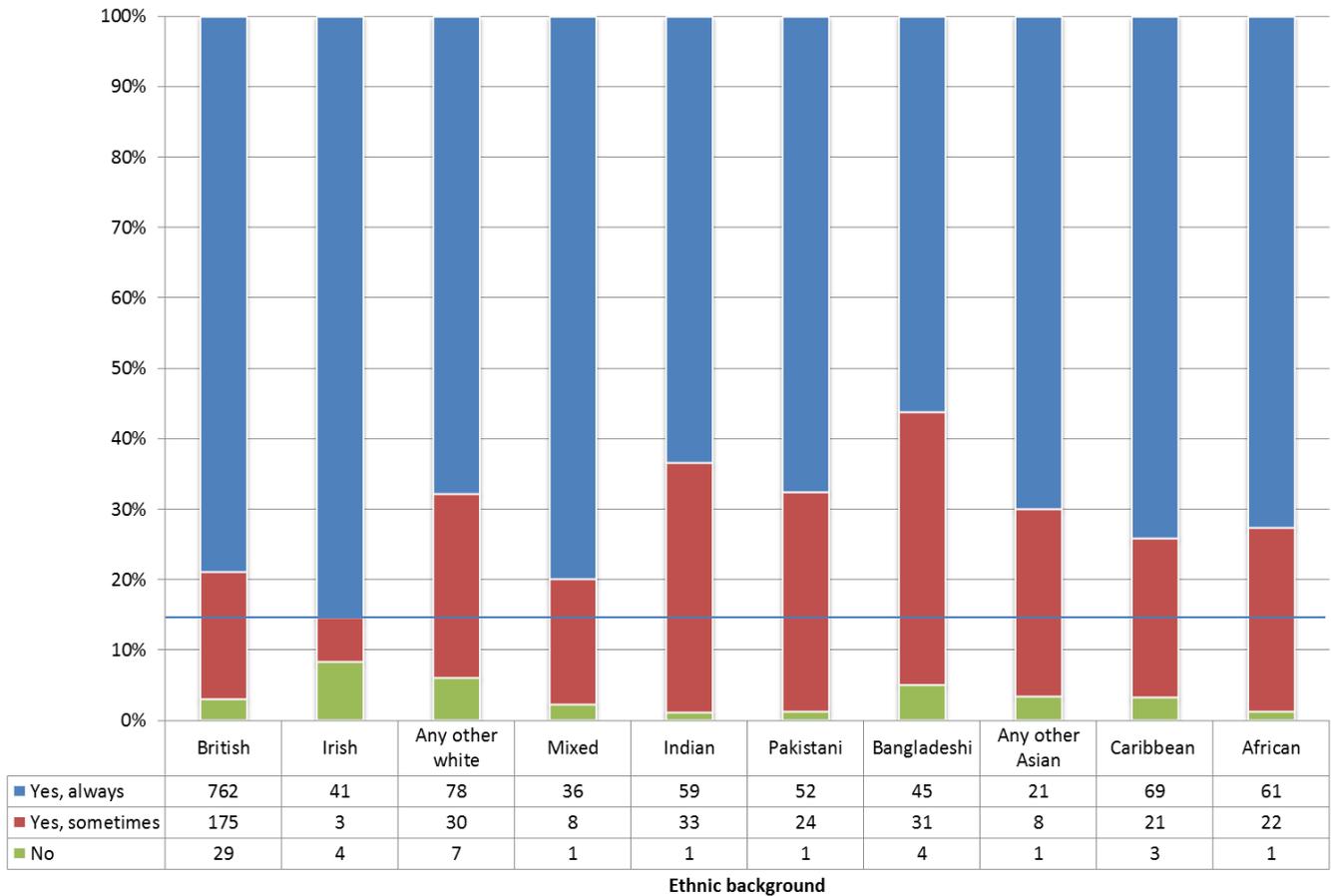
Over a third of people (36.36%) aged 16-39 said they weren't always treated with dignity and respect, 30.34% of people aged 40-59 and 17.59% of people aged 70-79.

This pattern is discernible within the three Trusts individually. It should also be noted that within the 70-79 aged range there is a significant number of inpatients at BLT (7.94%) and outpatients at Newham (21.5%) who say they were not treated with dignity and respect.

Ethnicity

As figure 3.1.1b below shows, people from Bangladeshi and Indian backgrounds were more likely to say they were not always treated with dignity and respect. People from Irish and White British backgrounds were most likely to say they were.

Figure 3.1.1b: % of people who, overall, felt they were treated with respect and dignity whilst in the hospital/at the Outpatients Department by ethnicity (where n>15) (2010/11) (merged total for all Trusts)



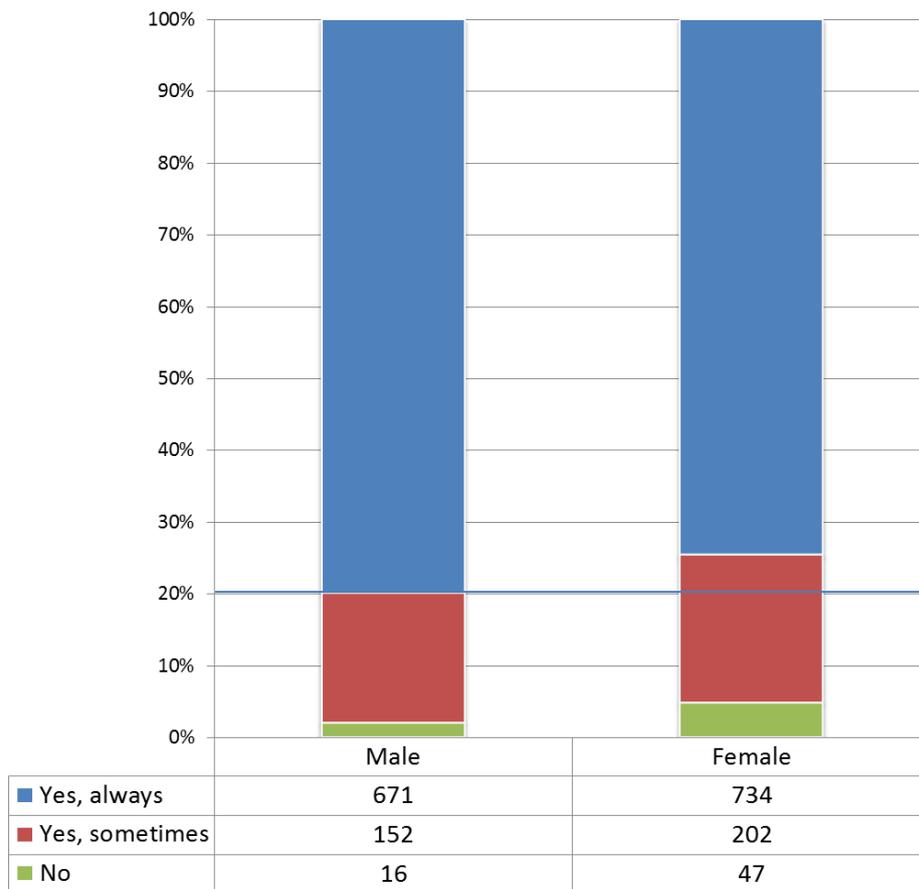
Within BLT (whose surrounding area has by far the largest Bangladeshi population) 43.48% of Bangladeshis claimed they were not always treated with dignity and respect. In contrast, the high proportion of Indian people claiming to have been treated in this way can be accounted for by the experience of outpatients at Whipps Cross and both in- and out-patients at Newham.

It is important to note that the figures can be skewed by relatively small sample sizes. However, it is clear that BME patients are more likely to report not always being treated with dignity and respect than White patients.

Sex

Across the three Trusts, one in five men (20.02%) report not always being treated with dignity and respect, a figure that rises to one in four (25.33%) in relation to women (see figure 3.1.1c). Particularly significant is the proportion of women categorically stating they were not treated with dignity and respect – 4.78% (compared with 1.90% of men).

Figure 3.1.1c: % of people who, overall, felt they were treated with respect and dignity whilst in the hospital/at the Outpatients Department by gender (2010/11) (merged total for all Trusts)



This pattern is discernible within the three Trusts individually and does not appear to be concentrated in one organisation or type of care.

3.2 Respect from doctors

brap research shows that patients find doctors talking in front of them as if they weren't there particularly dismissive and demeaning. As such it serves as useful indication of the extent to which patients feel they are being respected.

Age

Generally, younger patients were more likely to report that doctors, at least sometimes, talked in front of them as if they weren't there. In BLT, 47.9% of people aged 16-35 said this happened to them, compared with 32.3% of people aged over 66. In Newham, this figure was 54.5% (compared with 38.7%); and in Whipps Cross, 51.4% (compared with 34.0%).

Ethnicity

Merging the results of both in- and out-patient surveys, it appears that people from Pakistani backgrounds are most likely to say doctors (and other staff) talk in front of them as if they

weren't there at least sometimes. Over half (56.1%) of Pakistani respondents reported this, compared with 23.9% of White British people. People from Bangladeshi (45.1%) and African (42.4%) backgrounds are the next most likely groups to witness this behaviour (notwithstanding groups with a particularly small sample size).

This general pattern is consistent with the picture within individual Trusts. See tables 4, 7, and 12 in appendix G.

3.3 Privacy when discussing treatment

Patients often relay to brap the importance of having the space to receive information and – crucially – to react to it without fear of being overheard or judged. Maintaining privacy when discussing patient conditions and treatment is therefore a crucial part of the communication process.

Ethnicity

It appears that within individual Trusts, particular groups are not always granted privacy when discussing their condition/treatment to the same extent as others. The following is based on a conflation of in- and outpatient data:

- BLT: 14.92% of African and 7.14% of Caribbean respondents said they did not receive privacy when discussing their condition/treatment, compared to 5.28% of White British respondents. In absolute terms, this corresponds to five cases out of 49, most of which occurred in inpatient care
- Newham: 9.09% of Pakistani and 8.33% of Bangladeshi respondents said they did not receive privacy when discussing their condition/treatment, compared with 4.74% of White British respondents. In absolute terms this corresponds to five cases out of 57, all of which relate to inpatient care
- Whipps Cross: 24.00% of African and 12.12% Caribbean respondents said they did not receive privacy when discussing their condition/treatment, compared to 5.01% of White British respondents. In absolute terms, this corresponds to ten cases out of 58, which occur in both in- and outpatient care

For more information, see tables 9 and 13 in appendix G.

3.4 Involvement in treatment

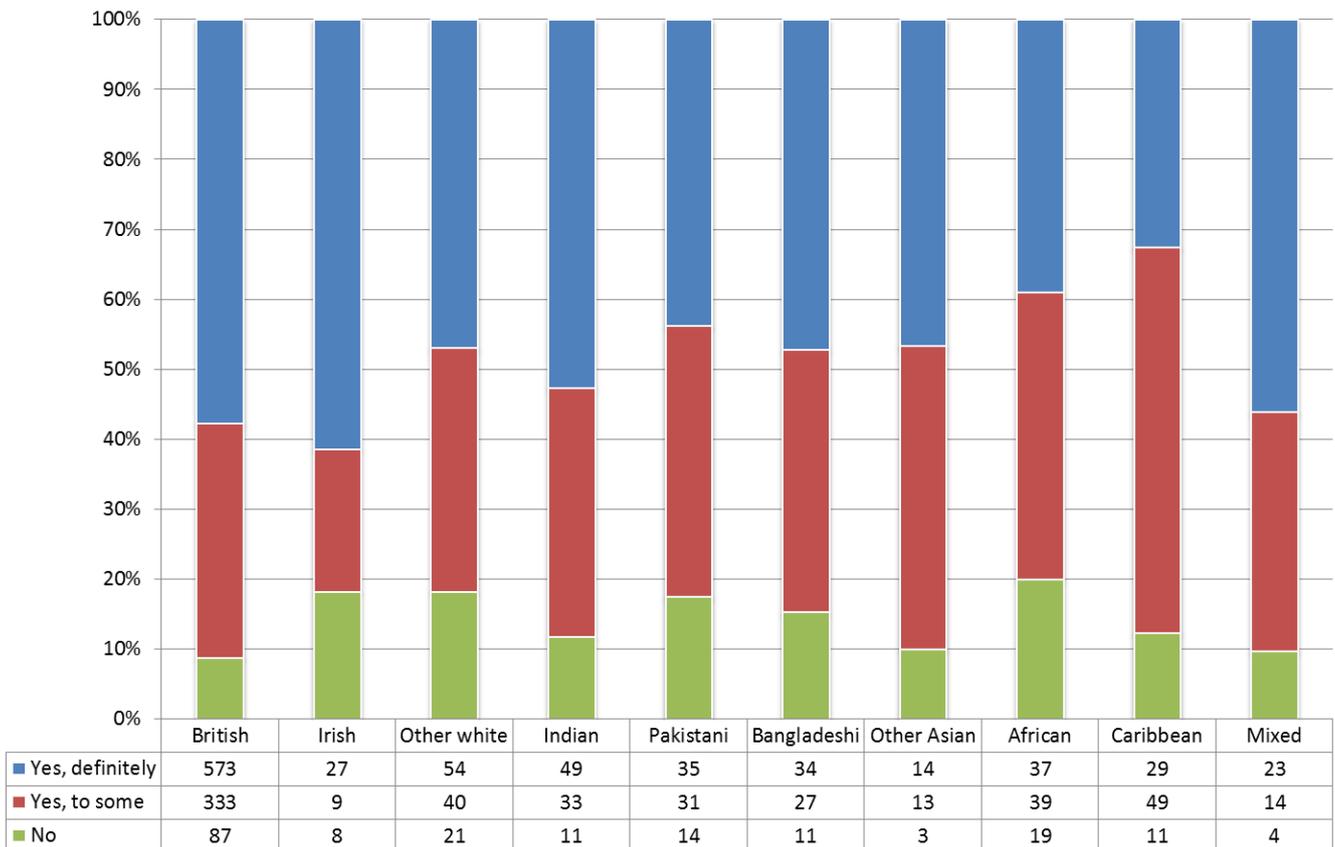
Patients feel better if they are more engaged in their treatment plan. Often this means understanding what treatment options are available and discussing an appropriate course of action. This allows patients to prepare for the treatment and have a better understanding of potential consequences. The extent to which people are involved in the decisions about their care is therefore an important indicator of the autonomy they are afforded.

Ethnicity

Looking at conflated in- and outpatient data for all three Trusts, it appears that people from African and Caribbean are much more likely to say they are not always as involved in discussions about their treatment as they would like to be. 67.42% of Caribbean people said this was the case, compared to 61.05% of African people and 42.30% of White British people. This pattern is discernible within individual Trusts, and does not appear to be concentrated in any one organisation or type of care.

When looking at groups who categorically state they were not satisfactorily involved in discussions about their treatment, people from an African background still feature prominently (20.00%). Interestingly, however, the next two most disadvantaged groups are White Other (18.26%) and White Irish (18.18%). See figure 3.4.1a below.

Figure 3.4.1a: % of people who were as involved in decisions about their treatment and care as they would like to be by ethnicity (2010/11) (merged total for all Trusts)



Part B: Experience of GP surgeries

3.5 Overview of experiences

This part of the report provides a very brief overview of people's experiences of GP surgeries by various protected characteristic. Data is taken from the GP Patient Survey April 2010-March 2011.

This information is included since people's experience of GP surgeries directly affects their propensity to access such services. Since a stated aim for the new organisation is to reduce the pressure on acute services, it may be useful to explore barriers preventing access to primary care.

As such, this section looks at three factors: people's overall experience of GP surgeries, knowledge of how to contact an out-of-hours GP service, and the convenience of GP opening times. Given the timescales involved in this project it was not feasible to retrieve data on all these factors by all protected characteristics. For an overview of the data that has been collected, see appendix G.

For ease of reference it may be convenient to list some of the key factors that emerge from the data:

- merged figures for the three PCT areas in question show Bangladeshi (9.0%), Other White (6.7%), and Pakistani (5.8%) patients are more likely to report 'fairly poor' or 'very poor' experiences at GP surgeries. These experiences are fairly evenly distributed across the three PCTs (with certain exceptions; for example data on Pakistani patients is not recorded within Tower Hamlets PCT since the sample size is so small).
- across the three PCT areas, people aged 25- 34 are more likely to have 'fairly poor' or 'very poor' experiences. Within individual PCT areas, between 6-9% of people in this category report this type of experience.
- a high number of people from Other White and Chinese backgrounds do not know how to contact an out-of-hours GP service. The figure for is particularly high (81%) for the Chinese community within the Tower Hamlets PCT area.
- a high number of people from Chinese and Other Asian backgrounds feel that GP surgery opening times are not convenient. A significant number of people from Other White, Pakistani, Bangladeshi, and Other Ethnic backgrounds say they do not know whether opening times are convenient or not. Whether this reflects an uncertainty within those communities about what people can reasonably expect from services may be a useful topic to further explore.

4. INEQUALITIES IN ACCESS TO HEALTHCARE

This section explores patient access to the services provided by individual Trusts.

The data used was provided by individual Trusts and therefore varies in the protected characteristics covered and the types of care covered. A comprehensive overview of all the information is provided in appendix H. Below we recount the main trends and findings.

The section begins with an overview of access to GP surgeries, since this is important contextual information for the local area (given plans to reduce pressure on acute services in the future). This data is taken from the GP Patient Survey, and therefore covers protected characteristics including religion or belief and sexual orientation.

Since the focus here is on access, and not just service user profiles, figures are often placed within the context of local community demographics. For convenience, these are taken to be the prominent boroughs of Newham, Tower Hamlets, and Waltham Forest. For more detailed information on actual catchment areas, see the Demography section (section III).

4.1 Access to GP surgeries

Data showing the number of people accessing GP surgeries is available from the GP Patient Survey. A comprehensive overview of data is provided in appendix H. A summary is provided below.

Generally speaking, White British people are less likely to visit GP surgeries than the make-up of local communities might suggest. Within Newham, for example, White British people make up 27.0% of people accessing GP services despite being 38.8% of the local population. In Tower Hamlets, these figures are 44.4%, compared with 47.6%; and in Waltham Forest, 45.9%, compared with 53.4%.

In contrast, certain groups are more likely to access GP services, given their profile in the local community. For example:

- Newham: people from an Indian background are 11.7% of people accessing GP services despite being 9.8% of the population. For people from an African background the figures are 11.3% and 9.7 respectively
- Tower Hamlets: people from a White Other background are 11.6% of people accessing GP services, despite being only 8.1% of the population. For people from a Bangladeshi background, the figures are 20.1% and 20.6% respectively
- Waltham Forest: people from a White Other background are 12.5% of people accessing GP services, despite being only 6.8% of the population. For people from a Caribbean background, the figures are 7.3% and 6.3% respectively

These discrepancies may be a result of lower access by particular groups, but it is also important to note that they may also be a result of drawbacks to the projected population figures we have used to estimate total population of each borough.

In each of three PCT areas, women are more likely to visit their GP than men. Women are also more likely to visit a GP than the composition of local communities might suggest:

- Newham: 55.1% of people accessing GP services are women; however, women comprise 51.1% of the local population
- Tower Hamlets: 54.6% of people accessing GP services are women; however, women comprise 51.0% of the local population
- Waltham Forest: 57.5% of people accessing GP services are women; however, women comprise 50.0% of the local population

4.2 Patient populations

Within the timescales dictated by the project, Barts and the London were unavailable to provide an equalities profile of their patient population.

Within Newham, people from a White Other background are significantly more likely to attend A&E than their profile in the local community might suggest (11.4% of attendees; 5.3% of the local population). It may be useful to compare this figure with the high number of people from a White Other background who said they had poor experiences of GP surgeries and were unaware of GP opening times (see section IV.3.5).

This discrepancy is also observable within the inpatient population, of whom people with a White Other background comprise 10.9%.

Women make up 63% of all inpatients at Newham and 72% of all outpatients.

Within Whipps Cross, people from Pakistani and White Other backgrounds comprise the largest BME groups when looking at figures for admissions, outpatients, and A&E attendances – 8.2% (this is compared with the Pakistani community comprising 6.7% of the Waltham Forest population, and people from a White Other background 6.8%). White British people are generally underrepresented in these figures, comprising 47.0% of the patient profile, but 53.4% of the Waltham Forest population.

Women make up 60% of the patient profile.

The information relating to ethnicity is summarised on the following pages.

Figure 4.2a: no. of people accessing GP services compared with total borough population by ethnicity (Tower Hamlets)

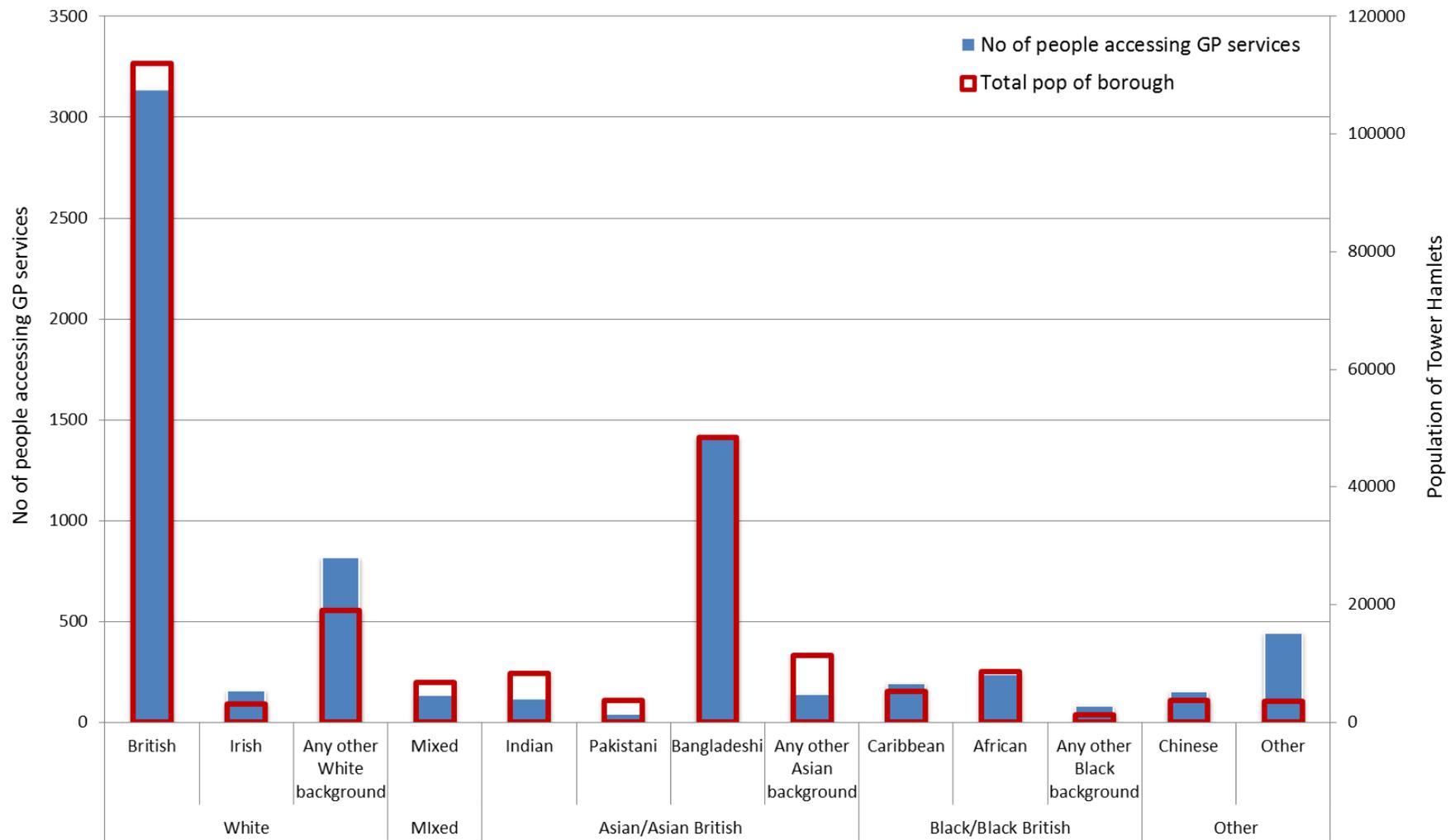


Figure 4.2b: no. of in/outpatients and A&E attendances compared with GP surgery visits and total borough population by ethnicity (Newham)

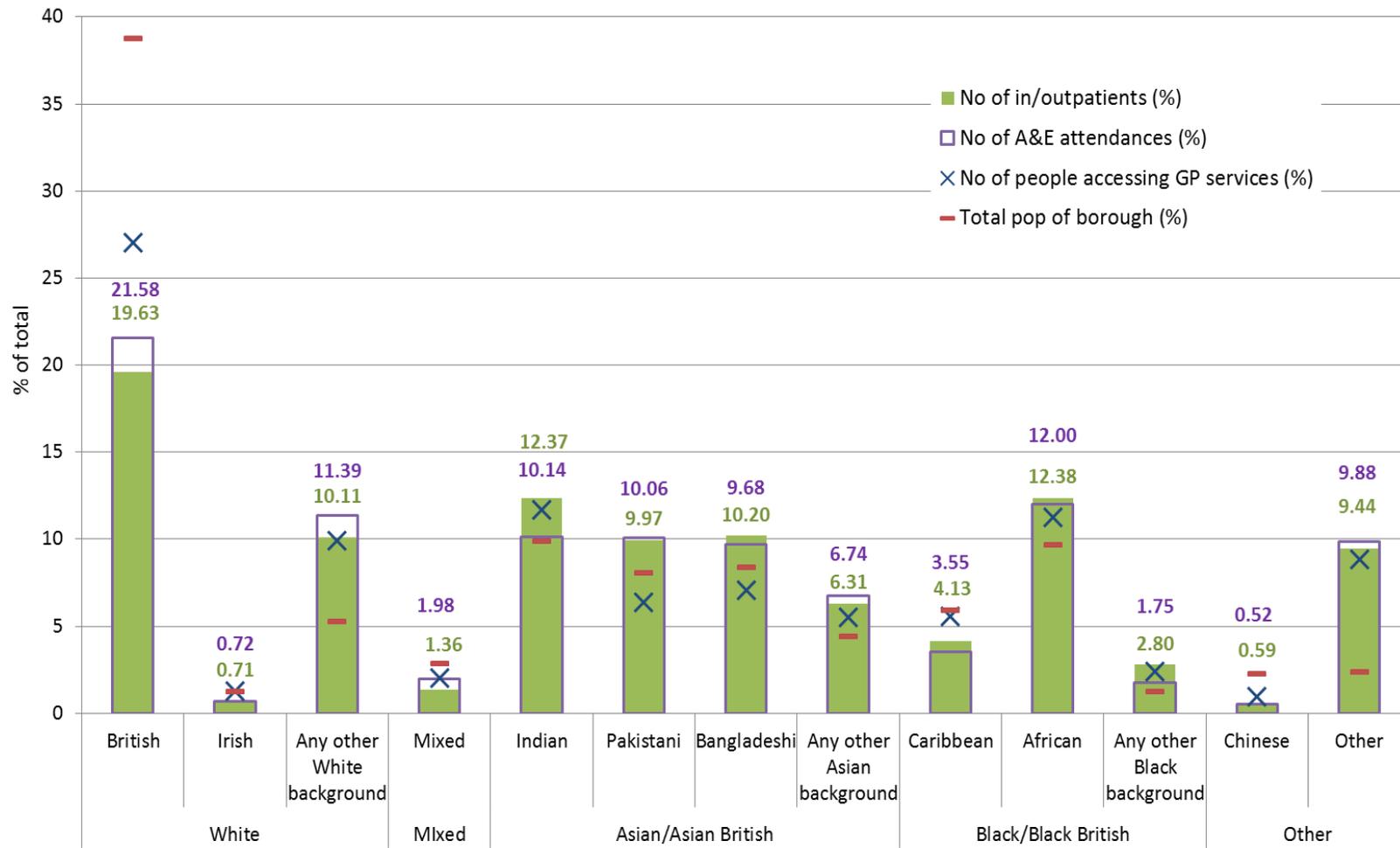
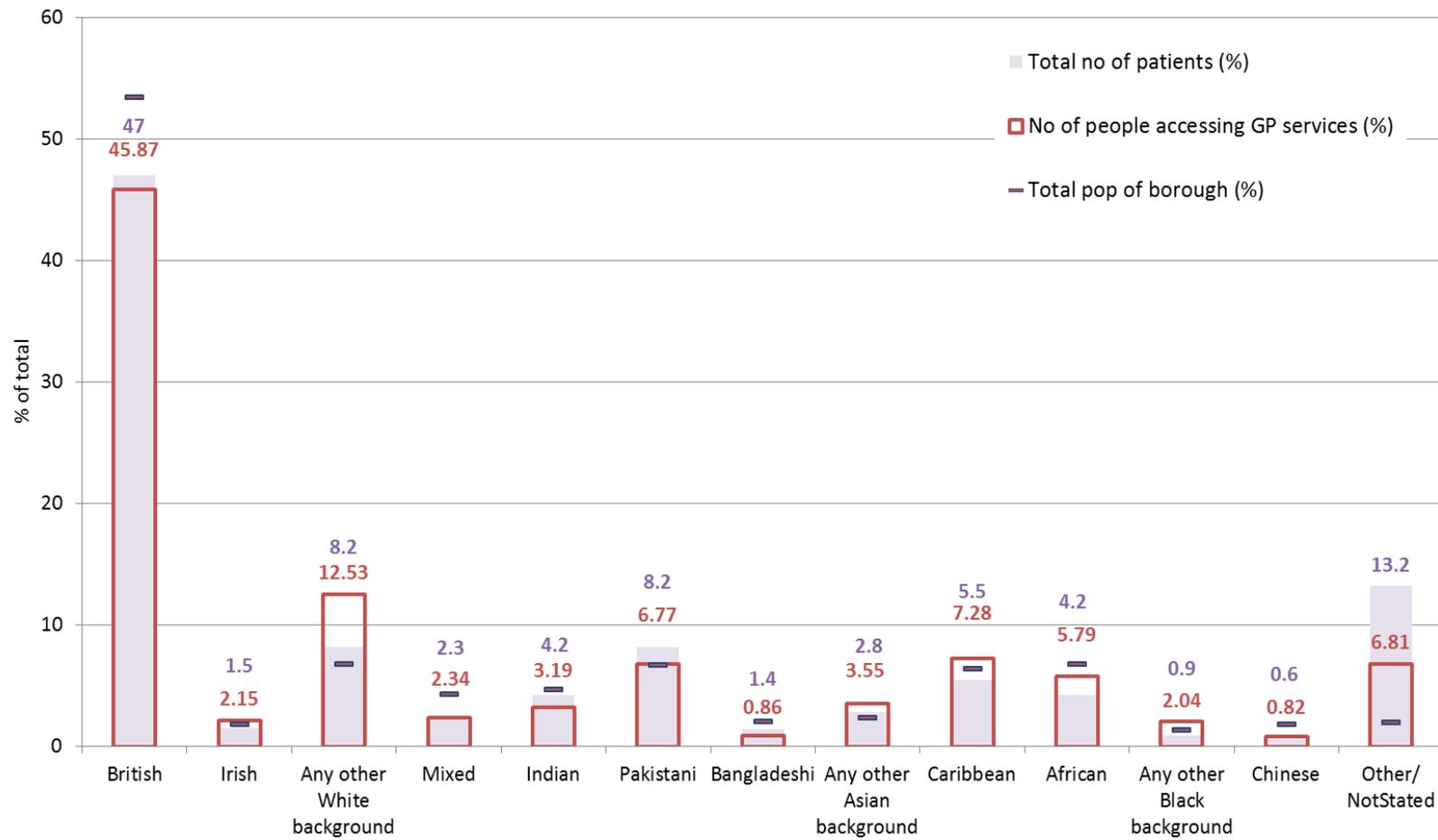
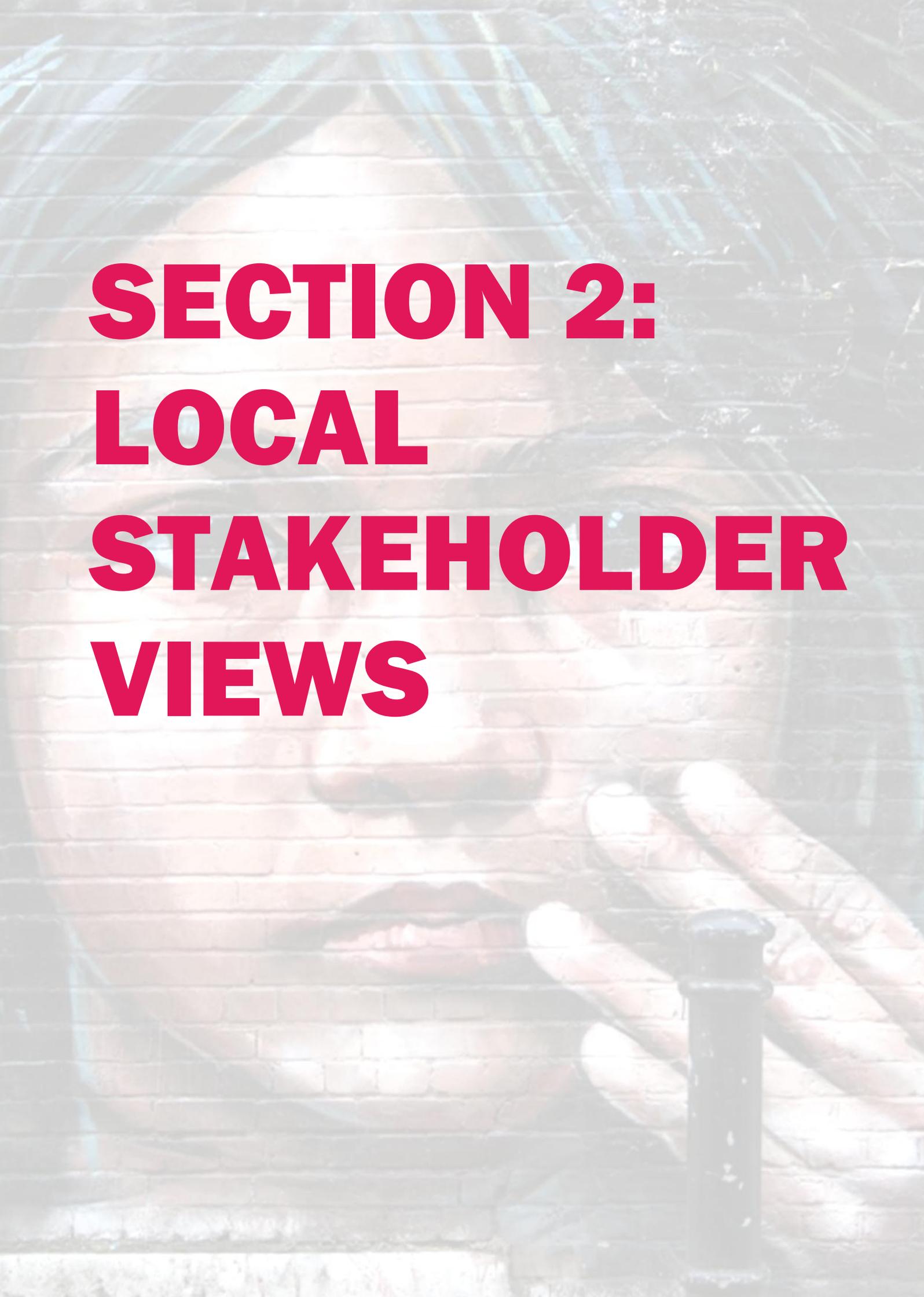


Figure 4.2c: no. of in/outpatients and A&E attendances compared with GP surgery visits and total borough population by ethnicity (Whipps X/Waltham Forest)





**SECTION 2:
LOCAL
STAKEHOLDER
VIEWS**

V. LOCAL STAKEHOLDER VIEWS

1. INTRODUCTION

As part of the base-lining exercise brap were asked to do two main things:

- engage with local stakeholders to test the conclusions and recommendations of an initial EHRIA undertaken by the Trusts.
- map stakeholder groups/ community organisations within the merged trust's catchment area to understand who needs to be invited to participate in partnership working with CAGs and proposals for initiating the process.

2. APPROACH

A limited amount of time was available to identify and undertake engagement with stakeholders (5 days) and it was agreed emphasis should be placed on groups with particular protected characteristics (where Trusts had experienced barriers to engagement in the past). These were lesbian, gay and bisexual, transgender and disabled people. Given the short timeframe, it was also agreed brap should attend, where possible, staff consultation events already planned by the trusts. A list of consultation sessions we attended is provided below:

- consultation with approximately 50 older people (organised in conjunction with Community Resource Centre, Plaistow on 19 January 2012)
- focus group with eight LGBT people (organised in conjunction with ELOP at their offices in Walthamstow on 30 January 2012)
- focus group with 11 disabled people (organised in conjunction with London Disability Law Service at their offices in Whitechapel on 21 February 2012)
- staff group with three Newham staff (organised in conjunction with Newham University Hospital Trust)
- staff consultation at a 'stand' during a staff conference for all three Trusts engaging eight staff members (organised in conjunction with Barts Health merger team at West Ham Football Club on 26 January 2012)

The approach to gathering data differed across each session, but generally involved a brap member of staff running a facilitated discussion to explore:

- level of awareness about the proposed merger
- understanding of health inequality as experienced by people with particular protected characteristics (community group sessions)
- understanding of inequality experienced by staff (staff group sessions)

- views about the broad findings/ recommendations of the initial Equality and Human Rights Impact Assessment (EHRIA). These needed to be simplified and summarised considerably to aid discussion in groups.
- views about potential positive and negative effects of the merger as these affect people with different protected characteristics
- views about current approaches to engagement between the public/VCS and local NHS Trusts on issues of equality and human rights

An online survey covering similar issues was disseminated to local community groups in the area (mainly via local VCS networks such as the 'HEAR Network' which is a group of equality focused VCOs in London). Where respondents required hard copies, these were posted to them and two local organisations helped to collect these (Newham Age UK and Disability Law Service). In total 18 responses were received (three via hard copy).

Requests were made to all three Trusts (e.g. via Patient Quality/Experience staff) for: relevant consultation evidence in the field of equality and human rights; details of upcoming consultation events; details of existing community organisation databases used by the Trust to consult with local people; complaints data disaggregated by protected characteristics. In the timeframe available we only received detailed information from Newham who put us in touch with Newham LINKS, who had a wealth of consultation evidence. These included:

- African Caribbean End of Life Care Consultation (28 people, 1 November 2010)
- African End of Life Care Consultation (29 people, 9 November 2010)
- Chinese End of Life Care Consultation (39 people, 24 March 2010)
- Pakistani End of Life Care Consultation (28 people, 1 November 2010)
- White British Older People End of Life Care Consultation (44 people, 26 March 2010)
- Asian Women's Breast Screening Event (20 people 12 December 2008)
- Migrant Health Access Project Evaluation (21 people in focus groups run by Refugee and Migrant Forum August 2011)
- Enter and Views Visit to Renal Unit (to assess quality of care 21 October 2010)

We also reviewed details of Quality Accounts 2010-11 sent by Whipps Cross.

This previous consultation information was reviewed in order to understand key issues of equality and human rights as they affect people from the merged trust catchment area.

3. WHAT WE FOUND

This section is in two parts. The first part recounts the experiences of patients (based on the consultation information outlined above). The second part, section 3.2, explores staff views.

3.1 Views of local people (service provision and engagement)

Section 3.1.1 below outlines results from each of the consultation events facilitated by brap. Section 3.1.2 lays out results from an online survey set up to gather views from the local community. Section 3.1.3 concludes by relaying the results of previous consultation events held in the area.

3.1.1 Focus Groups

Tower Hamlets: Disability Law Service

Focus group with 11 disabled people (organised in conjunction with London Disability Law Service at their offices in Whitechapel on 21 February 2012)

Awareness of the merger

None of the participants knew that the merger was happening and everyone wondered why this was the case, particularly given the frequent use of hospital services by some of the participants. People felt that communication was lacking and that there would be benefits to improving communication around the merger.

Views on the initial EHRIA

Participants agreed in particular with points about the gaps in involvement/ consultation with disabled people to identify need. The majority of participants also felt that a key concern that had been missed is the lack of 'joined up care' and how this can affect vulnerable and traditionally exclude groups disproportionately.

Patient experience/health inequalities

This led to a much broader discussion about examples of health inequalities experienced by people in the catchment area. A number of participants who had been using hospital services for some time talked about good relationships with their consultants and how consultants had gone 'the extra mile' to ensure the system responded to the patient's needs. However, the majority of experiences described involved examples of areas for improvement and a lack of joined up services. These are summarised below:

- One respondent said she had previously had a stroke (so she knew what it felt like), suspected that she had had another one, and ended up waiting at Newham for 6 hours to see a doctor. She said as she was waiting she was going blind and by the time she was seen she had lost her hearing in one ear. A key problem from her point of view was

that professionals were very uncaring, no one listened and filling out forms is seen as more important than people.

- A respondent who was admitted to Barts and London was in hospital waiting for an operation. Two nurses came along to give her an injection. She questioned this, as she knew she wasn't due to have her operation until later on that day - but they insisted that they were right. She became very assertive and it was only when staff asked her name that they realised that they had the wrong notes!
- "I felt like an object, not a human being"
- A key concern from the whole group was how the merger will help those who are more vulnerable: standards of care are bad – experiences are poor – so how will the merger address these issues? Many don't believe that standards will improve and see this very much as a cost-cutting exercise with patients, especially disabled people and other vulnerable groups, taking the brunt of cuts in services as savings are made
- There was genuine fear that what were already harrowing experiences of care would be made worse. Respondents wanted a direct response from the merged trust on how the merger will specifically help those with disabilities [brap researchers said we would ask the Trust to respond to this question and email a response directly to DLS]
- Many respondents said that the 'human side' of care was missing; another person said "they have forgotten their nursing skills."
- Respondents identified a range of complaints that they knew about, staff not caring sufficiently and lack of joined up care even in the same hospital. Some had made complaints themselves and they had little faith in the complaints system and also suspect that a larger hospital will make getting answers to complaints even worse.
- One respondent began fighting for his rights when his daughter was in hospital: his view is that you have to be in the know and be prepared to fight for your rights. He clearly knew a lot about his rights – but others pointed out that those who are ill and vulnerable haven't always got the time to fight!
- Another respondent described her waiting experience. Again, she had spent six hours waiting to be seen, and only got somewhere when she started to complain by swearing and speaking loudly. She felt that the lack of care and poor treatment forces patients to behave in ways that are rude
- A number of respondents described feeling disempowered and unable to understand and navigate the healthcare system. There was a concern that if this is true with smaller Trusts, there is a risk that having a 'bigger system' will make it even harder for patients to navigate through.

Summary

A number of respondents described being 'lost in the system'. Many disabled people are regular users of the healthcare system, yet when services are not sufficiently joined up, it is those with less resources and capacity that can fall through the gaps. A lot of concerns related to general issues of respect and dignity and ensuring staff behaviour is appropriate. Given the lack of awareness about the merger amongst this group (some of whom are well-established members of other public consultative forums on disability), it would seem worthwhile for the merged trust to do more to assure regular users (e.g. vulnerable older people, disabled people, those with long term limiting illness) that their views will be heard and responded to as the merger develops.

Newham: Community Resource Centre, Plaistow

Consultation with approximately 50 older people (organised in conjunction with Community Resource Centre on 19 January 2012)

Awareness of the merger

Across all respondents only three had heard about the merger. When asked if they wanted to be kept up to date/informed about the merger, only two people said yes. When pressed for more information they described this as a general interest (to receive leaflets, etc) rather than a commitment to be more involved in consultation.

Views on initial EHRIA

As a group, people were more interested in discussing their general experience of care, rather than discussing, in the level of detail required, the implications of the initial EHRIA.

Patient experience/health inequalities

Participants were asked to indicate whether they had a generally negative or positive experience at their local hospital by holding up green or red cards. Approximately half held up green (positive experience) and half red (negative). When asked about why they had held up green cards, two people said it was because staff were generally nice and friendly. However, few people with positive experiences fed back on this question. Many more people fed back on negative experiences. Summarised examples are included below:

- one woman had had two operations at a hospital and had woken up during both. She seemed genuinely scared about going back there
- another woman went in for routine, asthma-related tests. She was being prepared for an anaesthetic and expressed surprise, given that she was only there for tests. It transpired that staff had her down for a leg amputation
- after having a bath, one particularly elderly woman asked for a towel. The nurse snapped

that there weren't any and threw her a pillow case, which she had to use to dry herself

- a couple of participants said that nurses ignore patients who can't talk properly (e.g., patients who have speech problems following a stroke)
- food is an issue: it isn't all that nice, there's no choice, and more than one person said that they had been served lukewarm food before. One person said he lost three stone during the course of his visit
- stroke patients with mobility issues said nurses often left food and drink outside their reach
- cleanliness: more than one person said they had caught infections during their time at Newham
- someone said they had had to take a bath which was 'covered in grime'
- referral and waiting times was raised as an issue generally. However, as a specific example, someone claimed that a stroke patient had been waiting for 3½ months for the physiotherapy he needed. The resource centre itself had tried taking this up with the hospital, but hadn't heard back
- an issue was raised by a worker at the resource centre: the hospital doesn't inform – or is bad at informing – care agencies when a vulnerable patient is being released. A typical example was the case of a man with Parkinson's and Alzheimer's who was discharged from the hospital on a Friday. He didn't eat properly or take his medicine until a care worker came to his house on the Monday.
- complaints: only one person who had received poor treatment complained; others thought this was a waste of time. That person complained to a PALS representative. When asked, only four/five people had heard of PALS
- transport: a few people talked about transport and getting to Newham. They would like some kind of ring and ride service

Summary

There are clearly some challenges faced by this cohort, some of which have been raised through other national studies in other parts of the country (e.g. the CQC's Dignity and Nutrition Review). A particular challenge picked up by our researchers was the feeling of disempowerment and an inability/lack of desire to challenge the system when older people faced poor experiences of care. For example, the lack of faith in using the complaints system and lack of knowledge about the PALS service. This may be an issue worth exploring further, alongside more general concerns about lack of joined-up services, information management and infringements of patient rights.

Waltham Forest: ELOP

Focus group with eight LGBT people (organised in conjunction with ELOP at their offices in Walthamstow on 30 January 2012)

Awareness of the merger

Of the eight people engaged, five had heard about the merger (a lot of those attending are involved in community work of some kind and had heard about the merger through this). For most people this was the first time they had been consulted about it. When asked, the general feeling was that people would like to be kept *informed* about the merger, but not necessarily *involved* with it.

Views on the initial EHRIA

This was introduced to the group via prompts from the EHRIA relating to key areas such as community engagement and health inequalities data and issues of patient access. Participants agreed that there is a significant paucity of data on health inequalities as experienced by LGBT people in the catchment area. In fact, ELOP noted that they had presented data for the local JSNA which had been rejected because it wasn't local. However, they pointed out that there is a significant challenge here as there isn't local data available because health services aren't collecting it. In terms of additional issues to be considered by the new organisation as a priority they identified the following.

Health inequalities:

- mental health issues caused by alienation, distress, etc. There are also knock-on effects of this, such as greater incidences of drug and alcohol abuse and higher rates of smoking
- sexual health issues
- for lesbians in particular: fertility issues because more and more lesbians are choosing to have children
- cancer: lesbians are less likely to present with symptoms following previous poor experiences
- treating older LGBT people will increasingly become an issue

Policy, staff training, procedures:

- clear training in relation to understanding the needs of LGBT people BUT not tick-box, half hour training – developing a real understanding of patient experience. Understand that 'cultural' values do not trump human rights
- more monitoring and collation of data – and staff who are comfortable asking people if they are LGBT
- have same-sex partners recognised as next of kin
- tackle heterosexist assumptions
- greater emphasis on joined-up services

Patient experience/health inequalities

Key experiences described by participants in the focus group are summarised and recounted here:

Positive/no experience of healthcare:

- a couple of people hadn't really had to use Whipps Cross or their local GP and when they had, they'd had a generally positive experience
- Barts and the London has a specialist blood clinic for children – this is great because it means children don't have to queue with adults (they can be very nervous, 'hysterical'). Whipps Cross doesn't have this facility
- somebody's partner received fantastic treatment at Whipps Cross when she went in for meningitis

Direct prejudice:

- one participant recounted that a nurse was physically taken aback when she remarked that she was a lesbian. The nurse was so shaken she was unable to finish the procedure she was conducting properly. The patient felt "ashamed" and felt the experience to be completely "unpleasant"
- one woman's partner wasn't allowed into the maternity unit when she was giving birth because staff didn't recognise her as a 'legitimate' partner
- one participant went to his GP in relation to his dyspraxia and Asperger's. On finding out that he is gay, his doctor sent him for an MRI scan and said he shouldn't be teaching
- a hospital refused to accept a patient's same-sex partner as his next of kin. Staff there continually asked him for the details to fill in a form, despite him repeatedly giving his partner's information
- there is a local GP that refused to treat a lesbian patient after she came out

Heterosexist policies/procedures:

- during a booking appointment [the first official check-up after pregnancy] a nurse was completely confused as to how to deal with a lesbian couple. In particular she wondered aloud how to direct a standard question about domestic violence (standard procedure being to ask the man to leave)
- when one participant's son had a biopsy, the hospital refused to accept her partner had parental responsibility – which meant she couldn't sign a particular form. The participant pointed out that at such moments, having arguments about rights is the last thing you want
- generally, there appears to be an assumption of heterosexuality – most obviously in the way that, when partners are referred to, they're gendered. That means the doctor/nurse has to be corrected to which the common response is surprise, which itself is offensive and demeaning

- there is a particular issue around lesbians going for smear tests: the questions you get asked show there's a basic assumption of heterosexuality, eg: if you are actively having sex, are you using contraception? Sometimes this gets pushed: the nurse asks if you may be pregnant and if you say no, she'll ask how you can be so certain. In this way, patients eventually have to reveal their sexual orientation.

Specifically trans prejudice:

- feeling that even if healthcare is getting more gay-friendly, it certainly isn't more trans-friendly. One participant recounted a conversation with GIREs during which she'd been told that some trans people had been told to fully transition or they'd have their hormone therapy stopped. Another participant had also heard of trans people who had been refused hormone treatment because it was viewed as 'cosmetic' [it is not clear whether these comments relate to any of the three merging Trusts]

General poor treatment (not necessarily LGBT-related):

- one participant with Asperger's was prescribed Lyrica, which is known to have adverse effects on people with that condition. He was on the medication for two years and suffered hallucinations
- one participant recounted how his grandmother's GP misdiagnosed hip problems as just old age, when actually she needed a hip replacement. When she was being treated, doctors and nurses talked to her as if she was deaf. Nurses also refused to let her use a commode at night, and made her walk to the toilet
- treatment of older people generally raised as an issue in healthcare
- one woman had her baby placed in her arms after having an early Caesarean. She couldn't move properly so she couldn't put him down, but she was left completely alone with him. Eventually used the phone to call home and ask them to phone hospital switchboard. Still traumatised at the thought she could have killed her baby by dropping him

Access:

- one participant outlined that the opening hours for mainstream sexual health services can mean they are inaccessible for working people. A friend of his wanting to access such a service eventually went to the 'West End, to a gay place because they're a bit more accessible'

Complaints:

- very few participants raised complaints with the Trusts in question about the treatment they received except in exceptional circumstances (such as when a partner was not allowed into the maternity ward). The most common reason for this is that usually being in hospital is the time when you are least likely to want to get embroiled in debates and arguments – there are usually bigger issues at stake. Another reason was the perceived complexity of the process

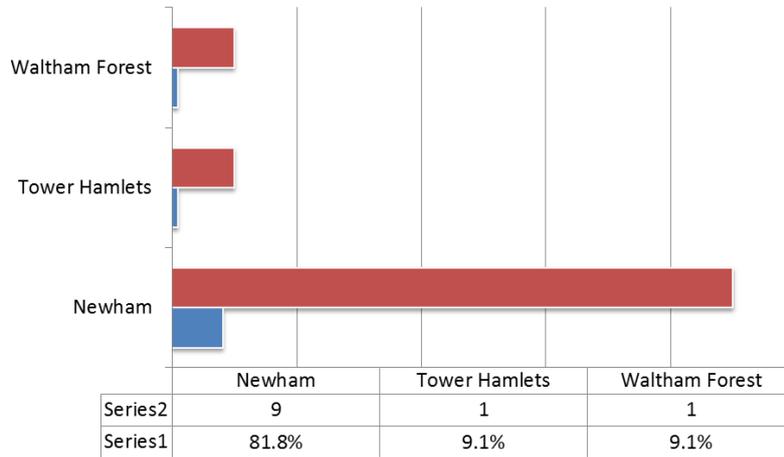
Summary

As with other cohorts, the group identified a number of the barriers experienced by patients when they want to challenge examples of poor care. Few were willing to use the complaints system and a number reported not wanting to challenge the hospital at a time when they are vulnerable and their mind is on other things. There was clearly a desire across the cohort to share knowledge, skills and evidence to help address barriers faced by LGBT. It appears local healthcare providers may have missed opportunities to engage in a meaningful way with groups like this (and voluntary and community sector organisations like ELOP) in the past.

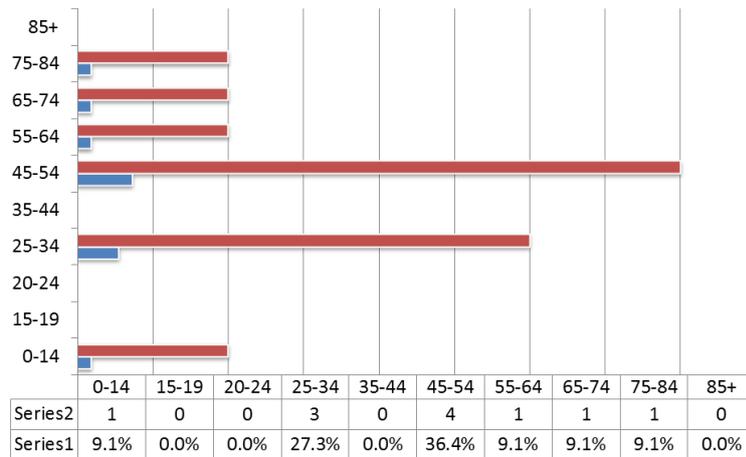
3.1.2 Online survey responses

18 responses were received. Of these, roughly two thirds of people indicated personal details that would help in understanding equality implications of the answers. The profile of respondents is outlined below

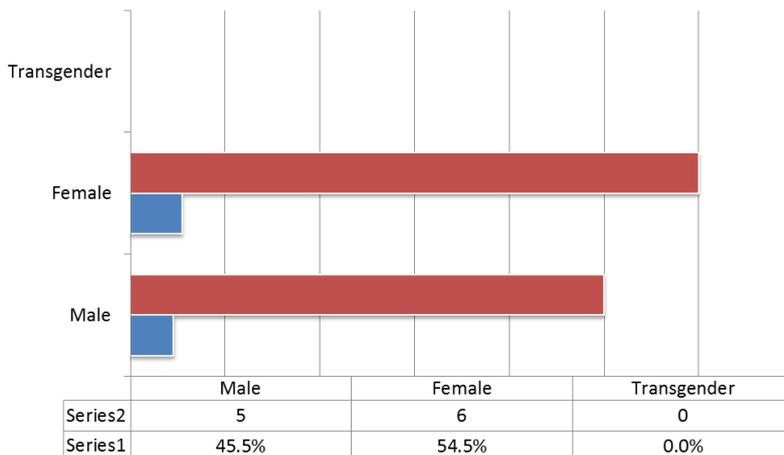
Location



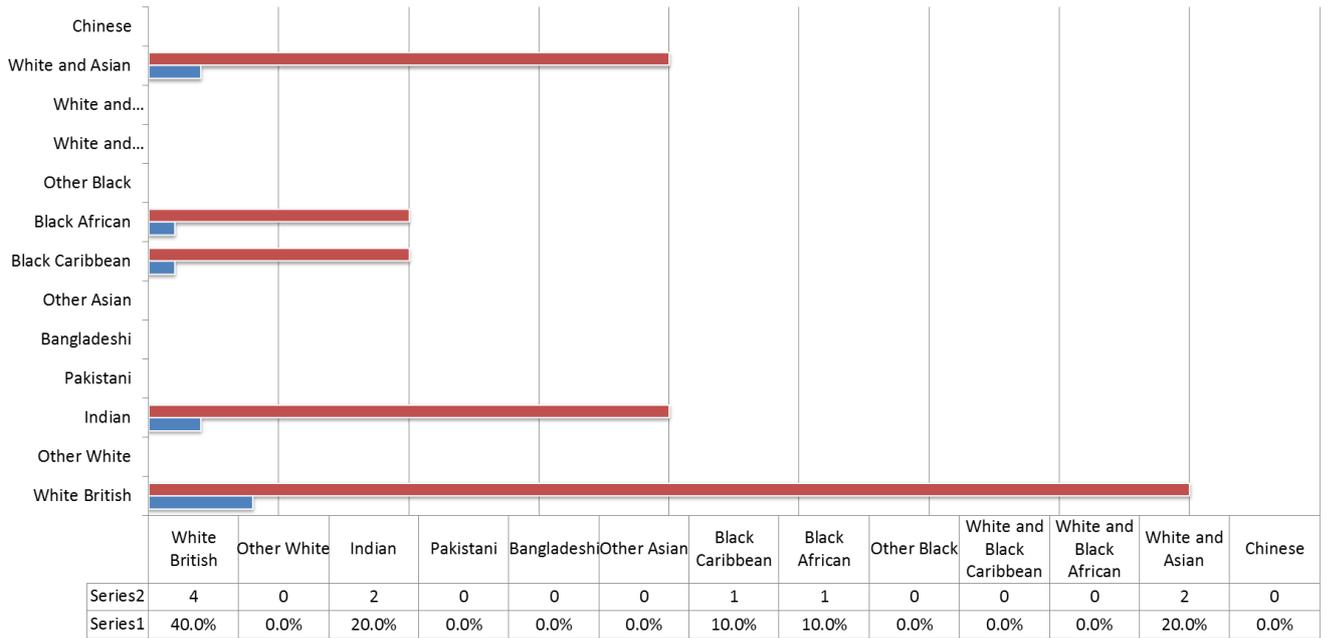
Age



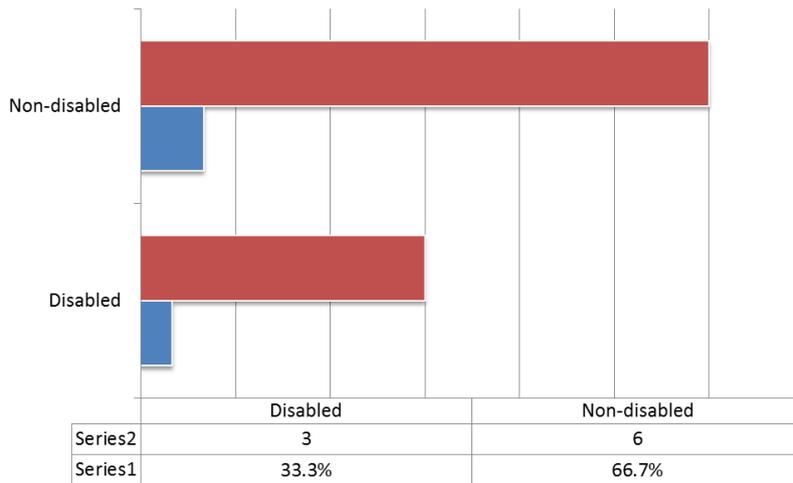
Gender



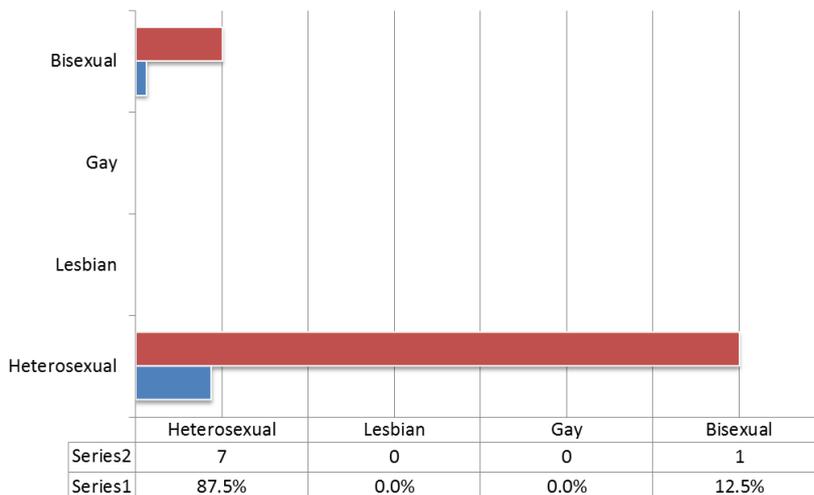
Ethnicity



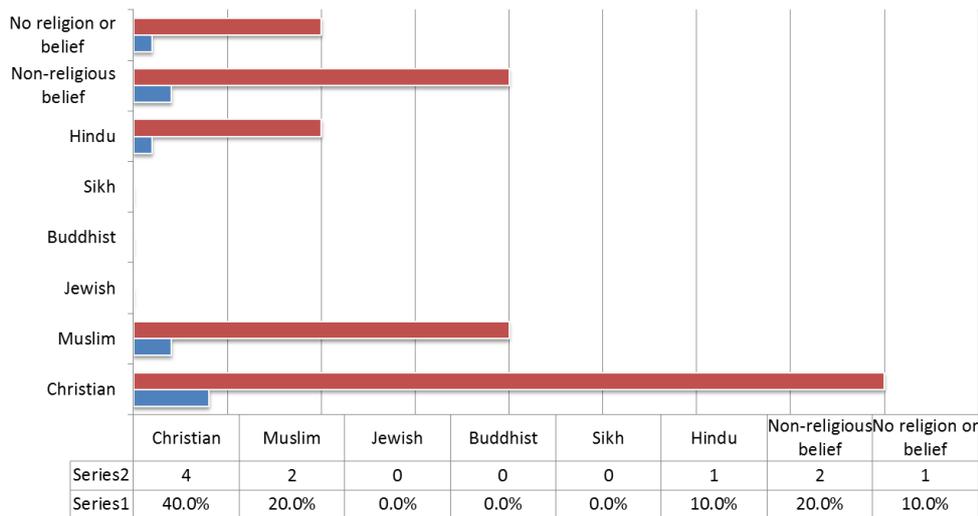
Disability



Sexual orientation



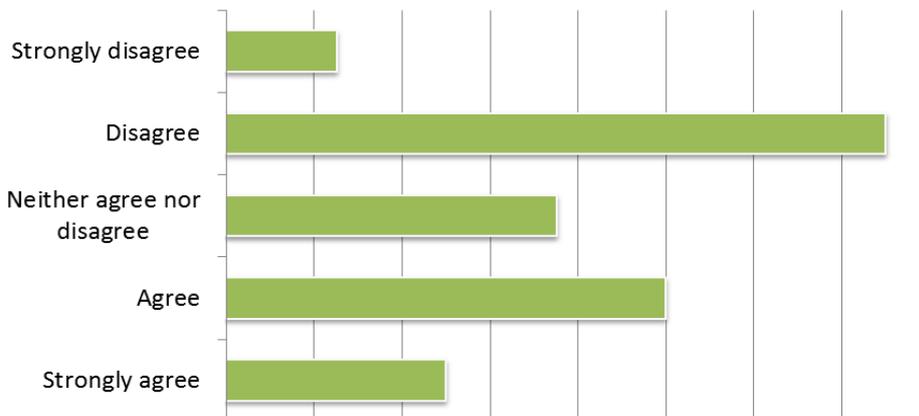
Religion and belief



Given the relatively low numbers involved in the sample, answers were not disaggregated and then analysed in relation to respondents from particular protected characteristics. Instead, broad answers from the total sample are included below.

Access to hospital services

Slightly more people disagree with the statement that ‘people have the same level of access to hospital services in their local area’.



Strongly agree	12.5%	2
Agree	25.0%	4
Neither agree nor disagree	18.8%	3
Disagree	37.5%	6
Strongly disagree	6.3%	1

When asked which types of people find it harder to access and use local hospital services when compared to the majority of the population, only six respondents answered this. Responses are as follows:

Group	Much Harder to Access	Harder to Access
Minority ethnic people	2	2
Disabled people	4	1
Lesbian, gay or bisexual people	1	1
Transgender people	2	2
People with particular religions or belief	1	1
Older people	1	2
Younger people	1	1
Women	1	0
Men	1	0
People living in poverty	1	2

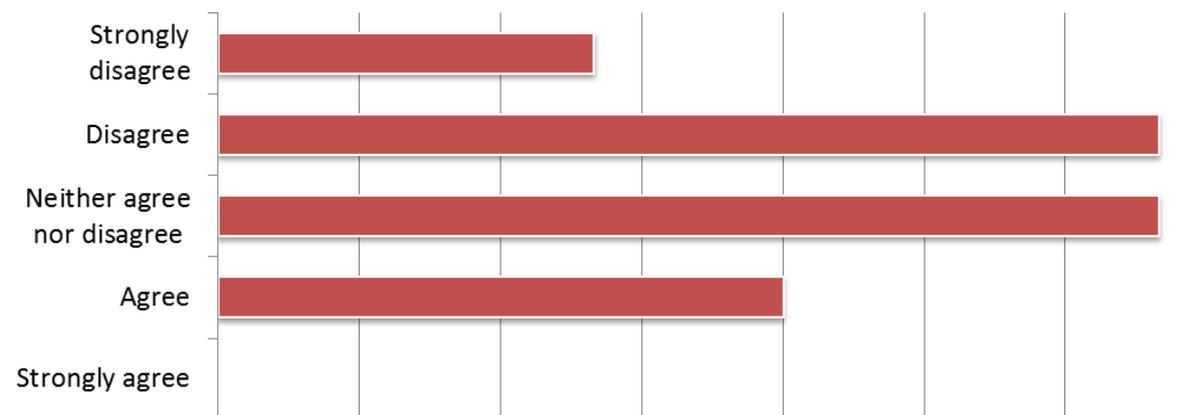
As a follow up question, respondents were asked if they thought it is harder for some people to access and use hospital services to please explain why. Some of the answers are included below:

- If you're homeless, where can an appointment be sent to? Disabled people and disabled children voices are not heard or valued. GPs do not address people with mental health needs issue. Language barriers for European and Ethnic Minorities. Islamophobia for Muslim communities.
- People in poverty may find it harder to see their GP. Travel, for some, is expensive and could deter people from attending appointments
- People with particular disabilities often need particular types of additional care when they are discharged but this isn't always provided. Also difficult to access services (transport, mobility, insufficient adjustments). Transgender people and minority ethnic people aren't always treated with dignity.
- People from minority ethnic backgrounds encounter racism and stereotyping; they may also encounter language barriers, barriers related to religion, cultural differences, lack of understanding of the 'system' especially if they are newly arrived, refugees etc.
- Disabled people face a wide range of barriers including:
 - availability and ease of transport
 - lack of disability awareness amongst staff at all levels, stereotyping (example a blind person asking to be shown the Ear, Nose And Throat Department but being taken to the eye clinic instead because they have a visible problem with their sight)
 - assumptions that disabled people do not work, live alone, etc
 - lack of guidance available (eg porters) so having to wait for hours to leave the building after an appointment
 - lack of accessible information eg appointment letters in different formats
 - lack of awareness of mental health and learning disability amongst staff

- lack of awareness of deafness and hearing impairment
- physical barriers in buildings; inaccessible lifts, for example with no audio messages re floor numbers, etc;
- disabled people are likely to have less disposable income for transport but there is a lack of flexibility with appointment times, etc
- Older people may face barriers but this can depend on a range of factors such as economic circumstances, level of health, level of understanding of hospital system, level of confidence, hearing and visual impairment, lack of mobility, ageism and possibility that they will not receive treatment a younger person would, assumptions and stereotypes, frailty and ability to carry out personal care such as eating, bathing, etc unaided
- LGBT people may similarly encounter prejudice, misconceptions, assumptions, stereotyping; people may encounter difficulty with religious practices, lack of awareness

Quality of services

Most people disagree with the statement “people all receive the same quality of services when they engage with my local hospital”.



Strongly agree	0.0%	0
Agree	20.0%	3
Neither agree nor disagree	33.3%	5
Disagree	33.3%	5
Strongly disagree	13.3%	2

When asked which types of people (if any) might be likely to experience a poorer quality of service in their local hospital when compared to the majority of the population, seven respondents answered this as follows:

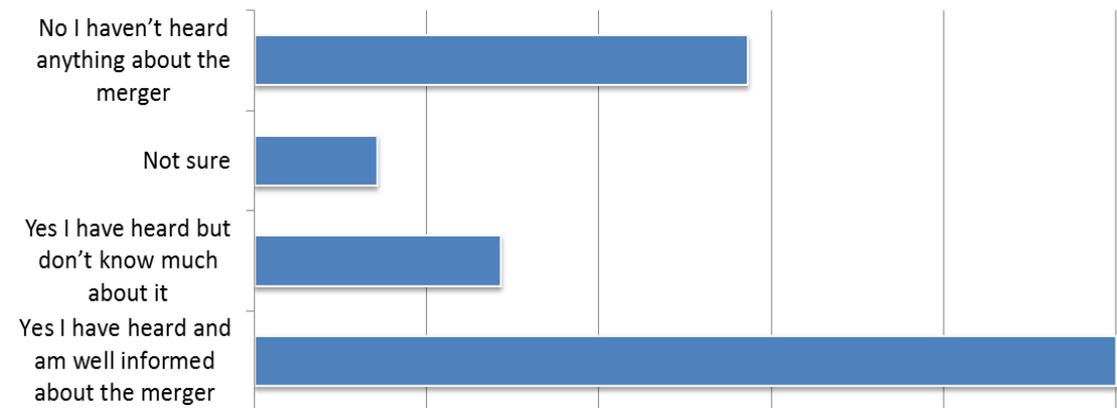
Group	Much Harder to Access	Harder to Access
Minority ethnic people	2	3
Disabled people	3	2
Lesbian, gay or bisexual people	1	2
Transgender people	2	2
People with particular religions or belief	1	0
Older people	2	2
Younger people	1	0
Women	1	1
Men	1	0
People living in poverty	2	2

As a follow up question, respondents were asked if they thought that some people are more likely to experience poorer quality services and to please explain why. Some of the answers are included below:

- I feel that it is attitudinal barriers as well as language. Also the hospital haven't the proper resources due to government cutbacks. Patients haven't the energy to speak up
- As before, lack of dignity and respect experienced by some people, particular ethnic minorities, disabled people and transgender
- Because (1) they are unable to explain their need (2) no children to demand better service for their elderly parents (3) Agency staff have no commitment to their temporary employer
- Consultants are not listening to your problems. If a person is the same religion as a patient, he seems to receive a slightly better service from that particular consultant. If you are Muslim you will definitely receive a better service and others will receive a poorer service.
- Some people will get better treatment than others mainly because of some staff's biased views
- People living in poverty can also experience stereotyping and poorer service flowing from their situation

Awareness of the merger

More people were well informed about the merger (benefits and disadvantages) than weren't.



Yes I have heard and am well informed about the merger	50.0%	7
Yes I have heard but don't know much about it	14.3%	2
Not sure	7.1%	1
No I haven't heard anything about the merger	28.6%	4

Similarly, more of the sample felt that their local NHS Trust engages well with local people to hear their views about how to improve local services. Yet there was still a sizeable minority of people who didn't feel this way. When asked if their local NHS trust engages well with local people to hear their views about how to improve local services responses were as follows:



Strongly agree	21.4%	3
Agree	28.6%	4
Neither agree nor disagree	21.4%	3
Disagree	28.6%	4
Strongly disagree	0.0%	0

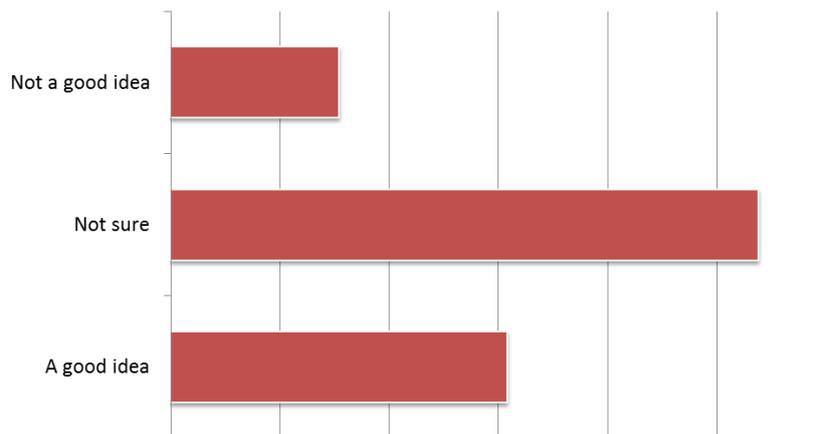
Of those who didn't feel their Trust engages well with local people (four respondents), two thought disabled people weren't engaged with as much as others and two people thought people living in poverty aren't. When asked for more detail about why they thought these groups weren't engaged as much as other people they said:

- it means pulling resources from other parts of the hospital
- there are a number of different types of disability, not sure if they get a the chance to consult with a range of people – probably the usual suspects

Respondents were asked what if anything could be done to improve the approach local NHS Trusts take when consulting and engaging with local people. Responses included:

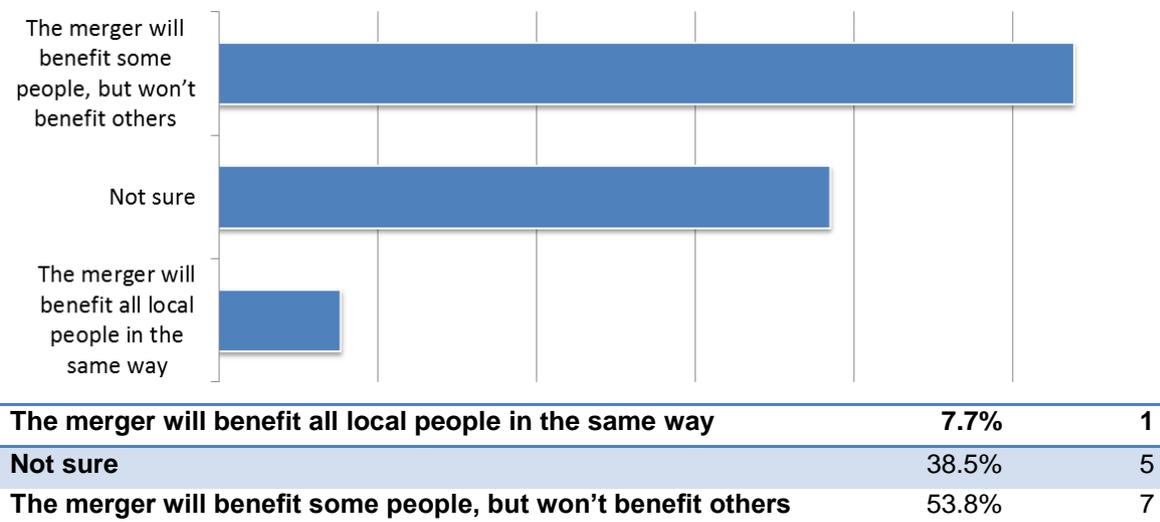
- have meetings to explain to public the merger in terminology they understand. Also to have regular meetings inviting service users with access needs
- advertise public meetings more obviously; have material printed in many languages, have interpreters present
- sometimes it's just ticking the box - people need to feel their views are valued
- send out letters to locals, again if change is happening every three years it is a waste of resources as what happened over the last ten years
- more openness and share the views with local members of public
- nothing - I think that we are well consulted
- consult larger numbers of people from more diverse backgrounds, allow more time for consultations, not take decisions before consulting, make it easier for people to take part

Respondents were asked, from what they know about the merger, whether they thought it was a good idea or not. Most people were not sure:



A good idea	30.8%	4
Not sure	53.8%	7
Not a good idea	15.4%	2

Respondents were also asked, from what they know about the merger, whether they thought it would benefit people in the same way. Most people thought the merger will benefit some people, but won't benefit others:



As a follow-up to this question, respondents were asked to explain in more detail who they thought wouldn't benefit from the merger and why. Five people answered the question:

- disabled people will be the ones who get very confused with this change. Also the minority groups, especially if they feel safe in one hospital
- travelling away from one's area won't be easy for some - expense, difficulty in using public transport, getting to early appointments on time
- local patients because funding will be consumed by reorganisation and the companies involved in setting up the merger. Possibly three years later there will be a repeat of the same thing
- people on the edges of society
- people who live close to one hospital but have to go to a different hospital because the different hospital specialises in their issue

General comments were also invited about what the Trusts need to take into account when deciding on the merger and how to proceed. These are included below:

- explain to service users in a format that is accessible to all communities that it won't affect their health care in any way: files won't be lost, treatment will be the same/better
- it is important the Newham hospital is not in any way downgraded by the merger
- it seems like it's going ahead anyway, so I think we need to have a frequent update for local communities to discuss who is benefitting/ not benefitting
- you have not allocated sufficient time for the last change to produce fruitful change yet
- I think it's an OK idea but you have to think of the way things will change maybe asked the public for their views before you proceed

- people should not be disadvantaged by having to travel longer distances away from their local area to access a particular clinic or service; communications with patients must be clear and arrangements for transition orderly and not confusing

Summary

Results are from a relatively low sample size and not statistically significant, yet some interesting issues emerged. In particular, the majority of people surveyed felt that people do not receive the same quality of services from their local hospital. Similarly a slight majority of people felt that people do not have the same level of access to local hospital services. Some useful qualitative information about specific barriers by people with particular protected characteristics is included (particularly in relation to disability, race and additional information in relation to socio-economic status of service users). Those surveyed appear to be well-informed about the merger, yet a number of respondents had suggestions about how engagement with traditionally excluded groups could be improved.

3.1.3 Additional consultation already undertaken in the area

As described above, we reviewed evidence made available by Newham Links and Whipps Cross (Quality Accounts).

Newham

Specific information was available around end of life care, breast screening, migrant access to health, general respect and dignity in healthcare. Summarised findings from these consultation activities are included below:

Newham African Caribbean end of life care consultation – Nov 2010

- Strong emphasis on community care – care in the home, as opposed to hospital care.
- Lobbying for support services at home also – as opposed to hospital care
- Supportive and professional staff very important
- Concerns about not losing independence and being able to make decisions throughout the process.
- Hygiene was mentioned (not getting good care in hospital) – respect and dignity from staff
- Many people felt that professionals didn't take account of African Caribbean needs – but having looked through the paper, I think that it would be very challenging for needs to be dealt with in a hospital setting – quite an unrealistic set of demands.
- Some inference that clinical staff need to respect African Caribbean people more – and don't understand their culture. Big push for home care – some recognition that home may not be set up to care for people who are ill adequately. Lack of understanding about burial cultural issues – 'nine nights'.

Newham African End of Life Care Consultation – November 2010

- The majority said their preferred place to be during their end of life was at home
- People were concerned that their pain was managed and well controlled
- Need for more awareness about Islamic end of life practices
- Importance of family

Newham White British End of Life Care consultation – December 2010

- Key theme of dignity and emotional wellbeing
- Also an issue about freedom of choice
- Also wanted to be at home when they died
- Wanted to be treated as a person – helped by family, not strangers
- Info about financial support
- Continuity of care – if supported by carers

Newham Carers End of Life Care Consultation – November 2010

- Need more preparation for death
- Asian people's needs are not met
- Death needs dignity and respect
- Those dying require more choice.

Newham Chinese End of Life Care consultation – March 2010

- Most of this group said they would like to die in a hospice
- Many wanted to go back to China to die – didn't want to die in the UK
- Wanted access to Buddhist Monk, financial services, so that wills could be made, interpretation and translations services.

Newham Pakistani End of Life Care – March 2010

- Service providers not informing the community about hospices – assumption that they will be cared for by their family
- Death not readily discussed in the community – people felt that it should be
- Need for religion to be respected

Asian Breast screening event – 2008

- Attended by 30 women – very few had had breast screening – but seemed well informed about breast cancer. Reasons for non-attendance: people feeling shy, not wanting to be naked in front of strangers; participant needed someone to attend appointments with them, but this was not always possible.

Migrant project – Newham – August 2011

- High numbers of migrants already registered with GPs (82% of those surveyed)

- Correlation between length of residency in the UK and GP registration - newer people are unlikely to register
- 20% found registration with GPs more challenging
- Connections via friends, family or community group, helped people understand that they had an entitlement to register.
- Barriers to registration – lack of appropriate documentation – proof of identity asked for at time of registration

Exploring Respect and Dignity in Newham: User Consultation – January 2011

- Includes examples of infringements of patient rights. Includes some strong, practical examples of ‘small changes’ that can be made which will have a big impact on service users experiences of respect and dignity

Summary

When comparing views about healthcare requests across this wide cohort, interesting there was little evidence of healthcare needs that related to people from *only* one ethnic group and that were ‘culturally specific’ in this sense (though there were some – e.g. Islamic burial practices). Instead, there were more common issues that were raised. These related, in particular, to issues of dignity and respect and lack of patient voice in the system. Some common issues are summarised below:

- The issue of choice: this came out across all consultation, perhaps suggesting that people didn’t always know what they were able to choose, or that decisions were made for them.
- Following on from the above, while most people wanted home or community care, importantly some would choose a hospital or a hospice if they thought it was best for them or their family
- Cost of hospital appointments
- Dignity/respect came across strongly
- Lack of basic cultural knowledge – some groups appeared to value this
- Cultural boundaries remain unchallenged (eg, women not attending breast screening)
- Appears that interpretation support is not regularly available – and it should be
- No clear complaint procedure
- Waiting time delays and no facilities to support a four-hour wait (renal unit consultation)
- Some stereotypical requests (‘African meals with African drummers’). There appears little recognition that consultation with a particular group of people may not be representative of all people from that group. Furthermore, there appears little appetite to explain to patients that proportionate service responses may need to be made based on available resources/interests of other patients
- Some suggestions that staff needed to understand what respect and dignity *really* meant – treating people as a whole person, treating you with care, courteous attitude, accepting of differences (colour/culture was often mentioned)

Whipps Cross

Whipps Cross Quality Accounts for 2010-11 highlight a number of issues, particularly related to protection of patients' human rights and meeting the CQC Essential Standards of Care. Key headlines are outlined below:

Involvement in decisions

"We know from concerns raised through our Patient Advice and Liaison Service (PALS) and from the complaints we receive that patients and their relatives do not always feel that they have been adequately involved in decisions about their care and treatment...In particular with Women's Health, many women felt that their birth plan had not been considered or adhered to, disempowering them at an important time in their life."

"Using hand held devices for real time feedback to provide benchmark data, the Trust surveyed 270 patients in the first quarter of 2010. 54% of patients reported that they had 'definitely' been involved in decision making. In the final quarter of 2010, 201 patients were surveyed and the results had improved to 86%. The Trust is striving to ensure that patient involvement in treatment decisions is at the centre of its improvement programme."

Dignity and respect when being examined or receiving care

"Between April 2010 and March 2011, out of 779 patients whose feedback was collected via our hand held tracker devices, 636 (82%) stated that they had been treated with privacy and dignity when being examined or receiving care. When asked whether they were given enough privacy when discussing their condition or treatment, 595 (76%) said this was the case."

Being listened to by staff

"The Care Quality Commission (CQC) carried out a routine unannounced review visit in December 2010, when CQC inspectors visited our elderly care wards, the Emergency Department and Maternity Unit. In their report following the visit, the CQC stated that: "Patients who spoke to us overwhelmingly felt that medical and nursing staff listened to them. Patients felt that they could speak to staff."

Other essential standards

"In March 2011, the CQC carried out an unannounced inspection visit at Whipps Cross into standards of care for elderly patients, as part of their review of standards following the publication in February 2011 of the Parliamentary and Health Service Ombudsman's report *Care and Compassion?* which is based on ten independent investigations into complaints about NHS care for people over the age of 65 across England. The inspection measured performance against two of the CQC's essential standards:

- People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run.
- Food and drink should meet people's individual dietary needs.

The inspection report found that the Trust was meeting both these essential standards. The CQC did raise minor concerns with our provision of food and drink to meet individual and cultural dietary needs. These concerns centre on providing sufficient choice of meals and ensuring that the choices patients make are always acted upon by ward staff.”

Summary

Quality Accounts contain some useful headline figures on patient experience. This can be helpful in understanding performance in protecting and promoting human rights of patients (e.g. dignity, respect, right to privacy). Yet, the Accounts do not provide disaggregated information by protected characteristics.

3.2 Staff consultation

brap undertook two small staff consultations in the time available. Details of these are included in this section.

Barts Health Staff Conference

Conference ‘stand’ at event for staff from all three Trusts (27 January 2012 at West Ham United Football Club). Eight staff contributed their views. Staff were not asked which Trust they work for to ensure anonymity, the cohort included clinicians, a community outreach worker and corporate staff.

Views on initial EHRIA

Given the nature of the engagement (short amount of time with respondents at a conference stand) researchers did not have an opportunity to introduce recommendations from the initial EHRIA. Instead, general questions on equality and human rights and implications of the merger were used to prompt discussion. Responses for each of these questions is included below.

Are staff are currently treated fairly?

Initial responses suggest that staff from a BME background may face unfair treatment in a number of areas:

“BME staff – particularly those from overseas – face disciplinaries more often and the punishments are more severe. There are disparities in promotion opportunities too. This is also true for clinicians.

“There are differences in how much flexibility people are given in relation to carers/attending children’s events, etc.”

“I am a BMA rep and see all the grievances that people have. I’ve seen posts go vacant for two years because they didn’t want to give it to BME person. I’ve been at the Trust for almost ten years and things are definitely improving though.”

People were divided on the root causes of such discrimination; although one response summarised the feelings of many:

“I think there is an issue about resources – diversity training is simple, online, and ‘rubbish’. This is because the Trust doesn’t want to spend too much money on it.”

However, it is important to note that there were participants from a BME background who had generally positive experiences. Such participants often suggested that, when it comes to promotion and development, the onus falls on BME people to show they are capable of accepting greater responsibilities:

“There are good opportunities at my Trust. BME people have to take a bit more responsibility for themselves – they have to act and talk professionally; there are some people who talk like they do on the streets. They should be aware that they’re representing their community.”

Support to ensure potentially excluded patients are treated fairly

Many staff openly claimed that their organisations did not always deliver fair and accessible treatment of everyone. Particular issues were highlighted around levels of linguistic competence:

“There is still a problem with dealing with patients who speak a foreign language. The area around our hospital is so diverse – Algerians, Moroccans, and so on – that you get a new language every day.”

“It’s difficult sometimes with overseas patients because of language problems. If you go to a particular hospital you can sometimes see White wards and BME wards, because nurses separate the patients out this way [to deal with language and cultural issues].”

As before, participants suggest that training around equalities issues was an important means of promoting best practice. However, the capacity of staff to 'go the extra mile' was also raised:

"I think what we do is 'colour-blind' and that we don't treat people differently, but to be honest we must do, society does. We do need help to make sure we treat people fairly, but where's the time? We're all pushed and don't get released for development like this."

Specific equality and human rights issues for Barts Health to address

The phrasing of this question appeared to elicit responses that illuminate many of the comments about staff equality issues above. For example, some respondents claimed that:

"There's a need for fairer, more open and accountable promotion process."

"Diversity of executives and especially the board should reflect the diversity of the local community. Why doesn't it? It's a long story"

"The Trust is afraid to challenge bad practice because its worried about discrimination cases – who wants a tribunal? [The Trust's] culture needs to focus on performance."

Other respondents talked about the diversity of needs with local communities. Partly this was about raising awareness in communities:

"There are big problems with diabetes and heart disease. Also cancer. This is about awareness."

And partly about raising awareness with the Trusts themselves:

"My role is to connect with local community groups, religious organisations, etc. I am retiring soon and as far as I know there isn't an equivalent post in other Trusts. So what will happen to community development work? Raising awareness needs someone on the ground, but will the new organisation have this role? There aren't always resources available in this area."

In addition to the above, there were some general issues raised throughout the conference as a whole that are relevant to equality and human rights policy going forward. These include:

Issues around staffing

- Clinical staff will be unaffected by merger. However, corporate staff (finance, HR, IT) will face redundancies – is there any equality issue here?
- Pay weighting – currently there are inner and outer London allowances. How will this be managed when everyone works for one organisation?
- Transport is an issue for staff too – will they be required to move around sites?

Issues affecting patients

- Transport for patients between all the different sites is a huge issue – can the new organisation do something about this?
- Responding to the diversity of the population will be a big problem – the new organisation will have to build a representative workforce, and also provide effective, community-centred care
- The new organisation should focus on public health and not just primary/acute health
- It is important to build on Whipps Cross' experience of revolutionising patient care

Summary

Although opportunities for detailed discussion were limited at this event and a small group of people were consulted, we did get a sense that staff experience of inequality and discrimination can differ depending on which part of a Trust people work in. Staff were equally keen to discuss staff inequality issues as they were issues of patient equality.

Newham Staff Consultation

7 February 2012, three staff present

Views about the merger and initial EHRIA

It was felt that the merger alone will not solve health inequalities. It needs a planned approach from a number of other parties (including health). All three said that they were not reassured by what they had been hearing about the merger. One respondent said, "it's less like a merger and more like a takeover: even the name is 'Barts Health'." For that respondent it felt like Newham is having to acquiesce to Barts and the London, particularly in relation to employment: "all the senior appointments are from Barts." This raises concerns about equality and fairness going forward.

It is important to note, however, that another respondent said they could understand why the Barts name had been kept as it is prestigious and well known. Participants all felt there is no 'best' hospital and that all have different elements of expertise.

Health inequalities issues for patients

Retaining the body of expertise that has developed over the years was cited as an important factor in the delivery of fair and effective patient care:

“I’m a nurse, and as such I know that there is often value placed on quantitative information, especially in relation to some condition. But Newham has collected very relevant qualitative data and has a really good understanding of its population. I’m not saying that we can’t do more. There are some good examples of projects I have been involved in where having a better understanding of the community really made a difference to the services on offer.”

There was also a sense that the merger provided an opportunity for the new organisation to reevaluate how equalities practices are implemented:

“I do think we can do much more to change what we do to fit with the needs of patients within our community though. Many of the groups that we see have very poor health literacy and this is compounded by a lack of English literacy. They do not understand how to employ many of the preventative health measures that we are promoting to the population at large. They can live perfectly well inside their own bubble – until they have a health episode which requires them to interact with the system. Most people would find it hard to navigate themselves around the health system, and for those with little health literacy it is a nightmare. They tend to interact with the system in the same way as they did when they were back home – they need a ‘health navigator’.”

The issue of poverty and social class also reemerged, as staff highlighted concerns about the accessibility of services for those on lower incomes:

“We are currently analysing the results of a project to understand more about who does not attend appointments we are only just getting the preliminary data. We have found that there is a band of poorer white communities that circle Newham – these are the people who are most likely not to attend. Finances tend to be the main reason for non-attendance. Many of our patients have co-morbidities - they often have several appointments to attend, at different hospitals or different conditions. I know of examples where people have made decisions about which appointment they should attend - based on what they perceive to be their needs at the time. Routine appointments - such as check-ups for diabetes, do suffer under this type of decision making. However it is often these type of routine appointments which pick up on issues before they occur. We have more A&E usage - people just go from crisis to crisis.”

Staff Inequalities

A lot of the emphasis in development of the merger has been on patients and their well-being which staff felt was appropriate. Indeed, there appeared to be a general sense that staff were resigned to unfairness in the workplace:

“There isn't any equality for staff - you just have to get used to this, I've been here 20 years.”

“It is clear that as far as promotion is concerned there is no equality: but this isn't just Newham, it's reflected throughout the NHS. It's very much part of the culture. I'm not saying it's right, but Newham does mirror the status quo. As far as Newham is concerned there is a general acceptance of this situation across the organisation.”

Summary

Clearly this was a very small sample, yet we gathered some rich information. A strong trend, which does not seem unique to Newham, is an element of 'resignation' to inequality in the workforce. In particular a lack of progression for BME staff was seen as the 'Achilles heel' of the NHS and seen as present in all hospitals. Expectations were low about the ability of a merged Trust to respond to the challenge, though there was hope that it would be possible. It was also clear that some staff feel they are getting the 'raw end' of the deal and are being 'taken over' by another Trust. The effect of this on staff morale and implications for recruitment/ promotion into merged Trust jobs will need to be monitored closely from an equalities perspective.

3.3 Mapping local community organisations

3.3.1 Approach

A request was sent to all Trusts for details of their current community engagement database to ensure this is consolidated and not lost during the merger process. We received responses from Newham in particular, we were unable to access detailed information from Patient Experience/ Patient Quality staff in Barts and London and Whipps Cross, though Whipps Cross did supply a copy of their Quality Accounts which includes a list of some of the groups regularly consulted as part of the Quality Accounting process.

In addition to this, brap also undertook desk-based research and compiled lists of community groups we encountered through our focus groups with local communities. A copy of the database we have produced for use by the merged Trust going forward is included as a separate Excel spreadsheet (made available to Lead Commissioner for this work).

3.3.2 Reach of existing consultation processes

More work is required in mapping community organisations and understanding gaps in reach of existing database used by Whipps Cross and Barts and London in particular. Of the information provided by Newham (a community organisation database), there were 25 contacts listed. Some provided support to a range of people (e.g. Beckton Community Centre), whereas others were clearly targeted in their support for specific groups (e.g. Gujarat Welfare Association). Those clearly focused on supporting people with particular protected characteristics were mainly targeted at specific ethnic/language groups, older people and learning disability. There were gaps in contact information for groups covering other protected characteristics (e.g. religion or belief, sexual orientation, gender reassignment, pregnancy and maternity and other types of disability).

Of those provided by Whipps Cross in the Quality Accounts, there were clearly organisations included that potentially support a wide range of vulnerable and traditionally excluded groups (e.g. LINKS). Given the speed of this review, we were unable to test this assumption (though in other parts of the country there have been concerns raised about equality and access to established patient forums like this). In reviewing the list, there are gaps in reach in terms of organisations focused specifically on sexual orientation, gender reassignment, gender and pregnancy and maternity.

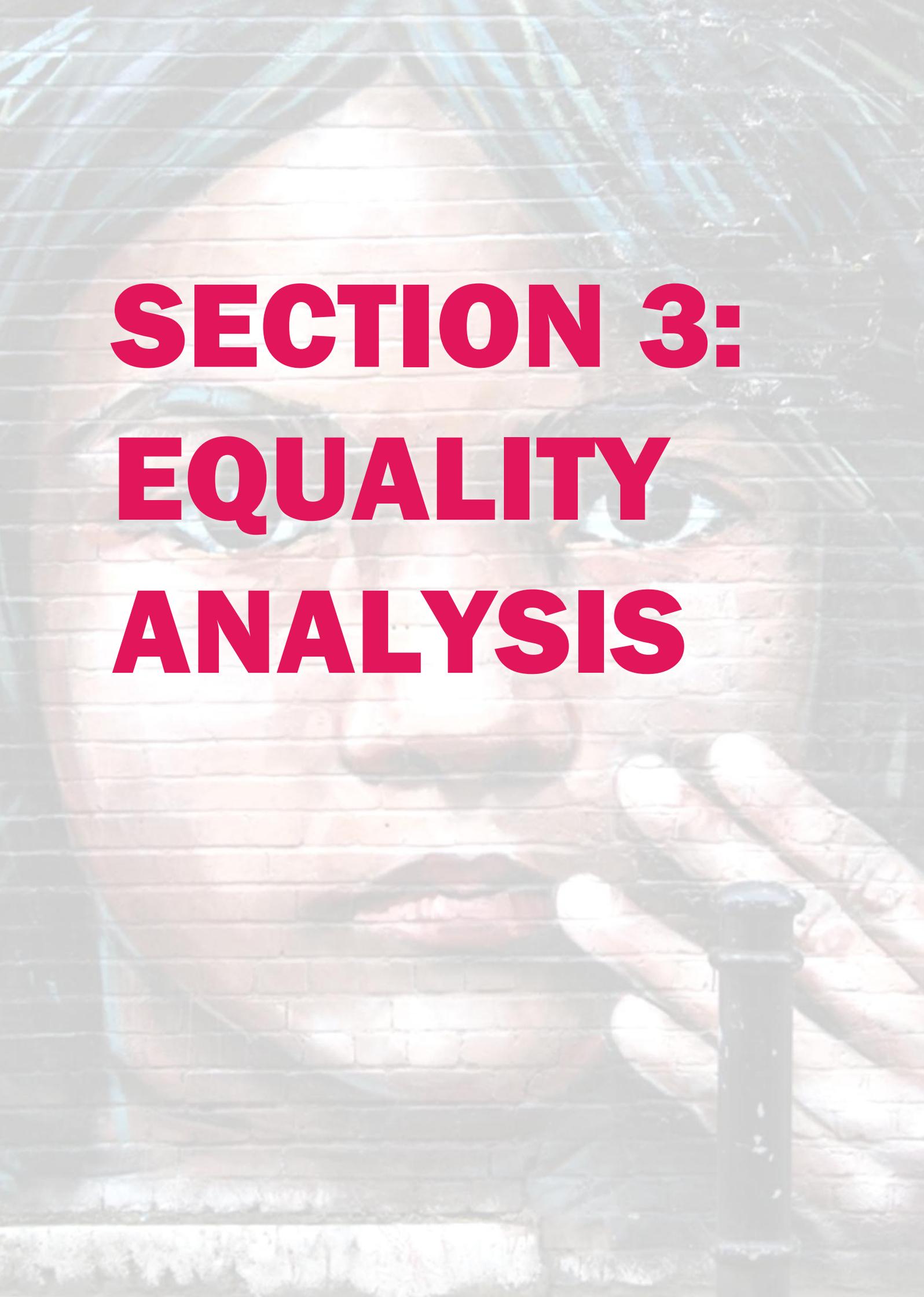
Summary

Reviewing this information alongside the above focus group and survey results, it appears that there are a number of missed opportunities where Trusts have not engaged with voluntary and community organisations and local forums that have clear expertise in particular areas of equality and human rights. This lack of communication is an issue that will need to be addressed. Through working in partnership with organisations like ELOP (Walthamstow) and Disability Law Service (Whitechapel) in conducting this research, we found that there are a number of highly committed individuals and voluntary and community organisations that have expertise to share, but are at risk of feeling cast aside during this merger process.

As plans for the merged Trust progress, it will be worthwhile for the Trust to invest time and resources in engaging with groups covering all protected characteristics. This will require the Trusts to think 'outside the box' on who they engage with too. Some VCOs may not have a specific 'health' mandate, yet their users and staff can be extremely knowledgeable on issues around patient experience and access. One of the people interviewed during the staff conference on 27 January 2012 (see section 3.2 above) mentioned he undertook community outreach. He was concerned that there aren't similar roles in the other two Trusts. He is due to retire soon and is concerned that this type of role may be lost going forward with the merged Trust. Clearly investment may be required to strengthen this type of activity in the future, but as a starting point the Trust will need to implement further work to embed this baseline review (gathering information from all Trusts when staff have time to contribute) and

to identify its key aims and expectations around community engagement/ service user involvement in the future.

What this future work might look like is considered in the final 'Equality Analysis' section of this report.



**SECTION 3:
EQUALITY
ANALYSIS**

VI. AN EQUALITY AND HUMAN RIGHTS IMPACT ASSESSMENT

1. Introduction

This final section includes an equality analysis of the proposed merger in the light of evidence included in the previous two sections (the Baseline Review and Local Stakeholders Views). In particular, brap were asked to:

- examine the impact of the merger on health inequalities in North East London and on the three arms of the public equality duty in relation to protected characteristics as defined by the Act
- describe the negative and positive impacts of the merger (and who these will affect) and central issues that need to be addressed to mitigate the negative impacts
- identify steps the merged trust can take to achieve compliance with its PSED in light of conclusions of analysis of baseline data and stakeholder consultation
- focus on equality *and* human rights

In addition to this, following discussion with the project working group, brap were informed that the merged Trust is likely to pursue the (non-mandatory) Equality Delivery System (EDS) for the NHS in the future. The three Trusts have not used the EDS this year and are waiting for the proposed merger to happen before initiating work on this. Although this has yet to be confirmed, the EDS is likely to help shape the equality and human rights related work of the merged Trust going forward.

2. Approach

The brief for this equality and human rights analysis is a relatively complex one. It requires analysis to focus on both equality and human rights. It also needs to be useful for the merged Trust going forward (helping them to respond to the Public Sector Equality Duty and potentially the NHS EDS). A bespoke approach to undertaking the analysis was required and this is described below:

- **EDS Goals** were used to structure the scope of this equality analysis as it was felt the four broad goals provided sufficient scope to cover issues encountered through our research and were relevant to the equality and human rights implications of the merger. Within those four broad EDS goals there are an additional 18 detailed outcomes that were also used to guide enquiry (though the equality analysis below does not refer to these more detailed outcomes specifically). This approach was chosen to provide the Trust with a useful 'head start' in developing its future response to the EDS. It would help signpost the merged Trust to key equality and human rights issues relevant to each EDS goal.

It should be noted that the EDS has some alignment with the Public Sector Equality Duty and can help organisations in their response to equality legislation too – but it is not a substitute for responding to those duties. It is also important to stress that the equality analysis below is not a substitute for the more detailed work that would be required to develop the EDS in Barts Health (which would require more consultation and ‘grading’ activities to baseline current performance).

- **Positive and negative implications of the merger** were assessed in two main ways:
 - Using information from stakeholders directly describing potentially positive or negative effects of the merger in relation to equality and human rights
 - Using other evidence on existing patterns of health inequalities, staff inequalities and inequalities in engagement and consultation with local people. Considering this information alongside what is known about the merger process (taken mainly from the Full Business Case). This allowed brap to assess where the merger had the potential to compound or reduce existing inequalities and human rights infringements. Where groups with particular protected characteristics are potentially affected disproportionately this is signposted.
- **Implications for compliance with the Public Sector Equality Duty** was assessed by firstly, examining existing inequalities and potential future inequalities as the merged Trust develops and then secondly, considering the implications of these for the merged Trust’s ability to comply with the Public Sector Equality Duty. Clearly, this is different to an assessment of whether the merged Trust itself (and all of its associated policies and publications will be compliant with the Act).
- **Implications for protection and promotion of human rights** was assessed by firstly, examining existing evidence about protection of human rights and potential future protection of human rights as the merged Trust develops and then secondly, considering the implications of this for the Trust’s statutory responsibilities in relation to the Human Rights Act.

3. Equality and human rights analysis

The following equality and human rights analysis should be read in conjunction with the previous initial screening equality impact assessment of the Outline Business Case and associated documentation. This documentation includes a number of recommendations which were not necessarily responded to in the Full Business Case. Key issues from this previous work are not replicated in the following analysis, but are equally important to plans for the merger in the future.

EDS Goal 1: Better Health Outcomes for All

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation/opportunities for merged Trust	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
<p>1a) CAGs have set clinical strategic priorities</p>	<p>CAGs have a clear mandate for responding to health inequalities. The Full Business Case (FBC) includes useful and targeted guidance for CAGs and stresses the importance of leadership in embedding the process of equality in analysis in policy development.</p>	<p>Lack of evidence on health inequalities (as it affects people with different protected characteristics) means that this may not have fully influenced development of initial clinical strategic priorities.</p> <p>Data of this type is included in a summarised form as an appendix in the FBC. Most focus in the main body of the report is given to 'health inequalities' in terms of geography (comparing different parts of the catchment area to each other and to national averages). There is a risk that this will be the dominant approach to thinking about health inequality as CAGs develop. Health inequality, as it affects different groups, runs the risk of being seen as an 'add-on' and 'ghettoised' in the work of CAGs. The current lack of available data disaggregated by protected characteristics may serve to compound this.</p> <p>Also it is not clear from FBC how inverse care law will be addressed fully. Those in most need can be the least likely to be able to access and receive services. There is a risk that this will not be considered in a 'routine' way as part of CAG decision-making processes on health inequality because there are gaps in data about who needs services most and who is unable to receive them (disaggregated by protected characteristics).</p>	<p>Mainstreaming issues of equality (in terms of protected characteristics and other areas like poverty) into broader work on health inequalities is critical to success. In the FBC, Trust Equality and Human Rights Leads have started to identify how they can support CAGs to achieve this. These plans will need to be developed further and sufficient resource provided to support specialist input (and sufficient authority/ leadership support to ensure equality and human rights advice is acted upon).</p>	<p>Having due regard to need to advance equality of opportunity involves considering need to remove/ minimise disadvantage and meet needs of people with protected characteristics. So far, there is not much evidence of how this has been done in developing CAG clinical strategic priorities. FBC includes proposals for how this will be done more thoroughly in the future with support from Equality Leads.</p> <p>Fostering good relations involves tackling prejudice and promoting understanding between people who share a protected characteristic and others. A lack of public understanding about how clinical priorities are developed (particularly when they favour one particular group) can lead to competition between</p>	<p>Risk of infringement of Article 14 of the Human Rights Act (prohibition of discrimination) as it relates to other articles (e.g. Article 3: prohibition of torture, inhuman and degrading treatment).</p> <p>The UK Government is obliged under the ICESCR to 'progressively realise' economic, social and cultural rights (including right to health). This means public bodies should always be seeking to improve protections in this field.</p>

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation/opportunities for merged Trust	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
				<p>groups and poor relations. FBC includes plans for improving transparency/ community engagement – but not clear how groups with particular protected characteristics will be involved.</p>	
<p>1b) Centralised approach to clinical strategy (via CAGs) – plans to work with commissioners to ensure local priorities reflected</p>	<p>Clear plans to engage with commissioners at a local level – opportunity to ensure services reflect broad strategic priorities for North East London (e.g. closer to home care)</p>	<p>Potential risk that commissioners, will find it harder to influence the merged Trust, particularly on issues of local importance as decision-making on service priorities in merged Trust is centralised via CAGs. The merger may make it harder for CCGs from different localities to come together and agree shared quality standards/ service priorities with Barts Health (e.g. in relation to equality and human rights).</p>	<p>Opportunity for merged Trust to develop and publicise clear principles that will govern relationship with all commissioners and other local providers in relation to equality and human rights (in the form of a ‘Compact’ or similar). For example, a draft Schedule 7 could be developed as part of a particular service contract in partnership with commissioners to implement training/ improvement plans on delivering better equality and human rights outcomes for patients. This can then be developed into a Schedule 2 contract with firmer outcomes/ quality measures linked to equality and human rights performance.</p>	<p>Having due regard to the need to advance equality of opportunity includes encouraging people with protected characteristics to participate in public life or in other activities where their participation is low. The merged Trust will need to demonstrate how it is doing this through its work with other partners (e.g. CCGs and Health Wellbeing Boards) and how the merged Trust is open, transparent and accountable to local people (whom some of these agencies represent).</p>	<p>None identified</p>

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation/opportunities for merged Trust	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
<p>1c) Centralised approach to clinical strategy (via CAGs) – role of patient involvement in setting priorities</p>	<p>There are plans to increase patient engagement and membership on key quality and improvement groups both at corporate and service (Clinical Academic Group) level</p> <p>Clear opportunities to address some of the gaps/inequalities in patient engagement to inform service improvement.</p>	<p>Yet our work with local stakeholders has revealed the importance of 'local' relationships between decision-makers and advocacy groups on equality and human rights. In the past Trusts have missed opportunities in engaging with groups like this that have relevant expertise. If decisions are further centralised there is a risk this will be further compounded as these groups become further 'below the radar'. The merged Trust will not achieve the right level of accountability/transparency in relation to equality and human rights issues in this respect.</p> <p>It is important that existing inequalities in access to patient/ local involvement mechanisms are not replicated in the merged Trust. This affects patients and community groups focusing on a range of protected characteristics (we noted particular gaps in reach of Trusts in relation to disability, sexual orientation, gender reassignment, religion and belief, pregnancy and maternity, gender).</p> <p>In addition, we noted a sense of apathy and resignation to inequalities amongst some groups and that their views would not be listened to (e.g. older people). There is a risk that CAGs will replicate this trend if they do not consider issues of transparency and accountability to local people fully.</p> <p>There is a risk that the Trust will engage in a sporadic way with a wide range of protected characteristic groups. There is a need for a clear strategy on who needs to be engaged and why.</p>	<p>Important for CAGs to develop appropriate engagement mechanisms that focus not only on 'background' of individuals and community groups, but also on the 'skills' and expertise they bring around equality and human rights. CAGs will need to liaise with equality specialists and other staff (e.g. community outreach and patient experience) to understand how best to gather the views of these groups</p> <p>Need for clear protocols around how CAG engages with groups and how it demonstrates it has analysed/responded to local intelligence. Need to develop clear 'feedback loops' so people understand impact of consultation.</p> <p>Need for clear CAG strategy around patient engagement on equality issues that focuses on who, why, when and how engagement should take place.</p>	<p>As above – duty to advance equality of opportunity includes service user engagement in decision-making. There are currently gaps in detail about protocol CAGs and the Trust as a whole will take in ensuring traditionally excluded groups are engaged more fully. Similarly there are gaps in detail about how the Trust intends to demonstrate it is accountable, transparent and open to challenge from local people on equality and human rights issues.</p>	<p>None identified – other than those that relate to differential patient experience/health outcomes (as per above).</p>

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation/opportunities for merged Trust	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
<p>1d) Integration Action Plan – Year spent mainly on integration issues, Year 2 clinical and patient experience improvements.</p>	<p>Important that the first year required to ensure integration goes smoothly.</p>	<p>There is a risk that in the first year of the merger, the speed of change on service improvement will not be adequate to address some of the significant gaps in care we have noted through the baseline review. In particular, there were a number of ‘never events’ due to instances of fragmented care and gaps in informatics (e.g. the wrong patient being approached for an operation to amputate her leg when she was in the hospital for routine tests). There are significant health inequalities that affect particular groups when compared to the national average (e.g. CHD and ethnic minorities). Similarly, there are more routine service improvement/ quality improvement issues identified in the review that need to be undertaken as a matter of urgency to protect patients’ human rights (e.g. dignity and respect issues, food being left out of people’s reach, lack of communication with follow-on care providers).</p> <p>Risk that there will be a loss of performance as merger may distract from delivery of operational targets. In areas where significant inequalities exist already (in terms of health outcomes) there is a risk that this will be compounded by lower performance overall. How will the Trust enhance its performance in areas of health inequality that affect high risk groups?</p>	<p>CAGs to consider baseline review information above alongside additional service performance data that is held ‘in-house’ to review clinical priorities as they affect people with particular protected characteristics. Potential to develop clear corporate quality guidelines and associated ‘patient promises’ that are communicated to patients covering issues that may infringe a person’s human rights.</p> <p>FBC suggest this will be mitigated by appropriate resourcing of business as usual. Important that issues of Trust performance that affect differential health outcomes are prioritised. This will involve research to understand causes underlying health inequalities.</p>	<p>Duty to eliminate unlawful discrimination refers to service provision as well as employment and training. This means that the Trust should have considered whether health inequalities (outcomes, experience and access) are in any way a result of discrimination on the part of Trust staff. For example, are particular service provision policies indirectly discriminating against particular groups? Are there examples (from complaints data for example) of where Trust staff have harassed service users?</p>	<p>There is a risk that some potential infringements of patients’ human rights (e.g. Article 3: inhuman and degrading treatment) are going unnoticed and that the Trust will not respond to these quickly enough. These are issues also monitored by CQC (essential standards of care).</p>
<p>1e) Plan/ execute review model and development of appropriate</p>		<p>Our review has identified significant gaps in available data on health outcomes disaggregated by protected characteristics. Also have identified variation across Trusts / across the catchment area in how that type of evidence is captured and analysed to inform service</p>	<p>CAGs to assess evidence in this report and add additional data if available. Develop appropriate metrics that use available data on</p>	<p>As part of specific duties, Trust is obliged to publish information on its equality performance in relation to service provision. There are</p>	<p>As above (1a)</p>

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation/opportunities for merged Trust	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
<p>metrics used by CAGs to ensure delivering on health outcomes remains a central focus.</p>		<p>improvements. This will make it much more challenging for CAGs to develop appropriate metrics for health outcomes at a merged Trust level. It is particularly important that this issue is addressed given significant level of health inequalities within the catchment.</p>	<p>health inequalities (between protected characteristics).</p> <p>In the interim, potential to establish a six month 'call for evidence' involving local VCOs that focus on equality to provide appropriate evidence (e.g. qualitative data).</p> <p>Initiate work to influence more coherent collection of data and use of similar categories (e.g. types of disability recorded) across different parts of the catchment (working with partner agencies). At a Trust level, need for this data should inform the informatics strategy/ approaches to electronic patient recording going forward.</p> <p>Consult on how to gather more effective evidence on health inequalities as they relate to different protected characteristics (with local VCOs, patients, NHS staff).</p>	<p>limits to the extent of this information in Equality Reports for all three Trusts. Although there is no statutory guidance and a lack of case law on 'how much' evidence is appropriate in the context of the Equality Act, there is a compelling argument for the merged Trust to baseline its performance on health inequality in the area and to seek to understand the impact of its actions on addressing that health inequality over time. This should be included as part of the information it shares with the public on equality progress.</p>	
<p>1f) FBC identifies plans</p>	<p>Opportunity to work with other</p>	<p>Baseline review has emphasised importance of partnership with a wide range of providers in each area.</p>	<p>Merged Trust influencing strategy/ relationship with</p>	<p>The Trust has a duty to foster good relations in the</p>	<p>None identified</p>

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation/opportunities for merged Trust	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
<p>to work with range of partners in North East London (GPs, Primary Care Teams, Health and Wellbeing Boards)</p>	<p>partner agencies (housing, employment, criminal justice, social care) to address some of the systemic causes of health inequalities. 'Health' is being seen in a wide/ holistic sense by Barts Health. The merged Trust is positioning itself to play significant role in addressing inequality in North East London as a whole.</p>	<p>Needs to be clearly stated that a key aim of this will be to address health inequalities as they affect people with particular protected characteristics. We are aware that initial focus of CAGs will be on babies, cancer, diabetes, tuberculosis. Yet our review also identifies a number other key areas where health inequalities exist – and where patient experience/ human rights performance could be improved.</p> <p>FBC does not refer in much detail to the relationship the Trust will establish with voluntary and community sector providers (secondary/ tertiary care) and equality focused advocacy groups. This relationship will also be very important to develop as these groups tend to have strong access to traditionally excluded/ vulnerable groups identified through this baseline review. These groups are often also aware of the some of the public attitudes/ perceptions of unfairness relating to mainstream healthcare provision. They are often well informed on gaps in access/quality of care.</p>	<p>local agencies needs to be driven by desire to address health inequalities (including those experienced by people with protected characteristics).</p> <p>Need for a strong voluntary sector engagement strategy focusing on gathering local intelligence to help address health inequalities and respond to local expectations around equality, fairness and human rights.</p>	<p>local area. This includes helping to tackle prejudice and promote understanding between people who share a protected characteristic and others. As part of this work, the Trust has a responsibility to engage a range of equality focused groups to ensure they are kept informed about the Trust's plans. They are also encouraged to ensure that community groups like this are all clear about how resources have been used and decisions made by the Trust. – Given the gaps in reach of some of the existing consultation/ engagement approaches identified in the baseline review, this will be an area the Trust may want to review in more detail in the future.</p>	
<p>1g) Merged Trust will be the largest local employer/ significant procurer of</p>	<p>Opportunity to improve health inequalities by enabling more equitable access to employment</p>	<p>Baseline review identifies significant inequalities in relation to employment, promotion, retention, bullying and harassment (in relation to a range of protected characteristics – e.g. sex, age, and race). If these patterns are replicated in the new Trust, there will be less potential to influence health inequalities through the Trust's role as an employer.</p>	<p>As below – need for better collection of staff data and strong actions to improve recruitment and promotion practice (including training for frontline staff, managers and leaders).</p>	<p>From day one, Trust will need to have a strong commissioning protocol in place with regard to equality and anti-discrimination. Public bodies cannot delegate</p>	<p>Potential infringement of Article 8: right to respect for private and family life (if merger compounds existing inequalities</p>

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Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation/opportunities for merged Trust	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
goods and services	across the Catchment. Opportunity to influence commissioned providers to adopt more equitable / human rights focused practice in service provision		Need to develop clear vision for equality and human rights in the Trust and to translate this into service level agreements/contracts/ quality measures for providers.	responsibility. They are responsible for ensuring that any third parties exercising functions on their behalf are capable of complying with the Equality Duty and do so in practice.	and staff redundancies/staff consultation on working patterns not handled well).

EDS Goal 2: Improved Patient Access and Experience

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
<p>Emphasis on plans to respond to North East London commissioning strategy (increased access to primary care/ more outpatient and community based care)</p>	<p>Strategy will reduce pressure on acute services (particularly useful given increases and changes in demographic profile). This strategy will also help with service integration across health economy/ patients will benefit from care closer to home – less risk of late diagnosis, etc.</p>	<p>When this strategy is considered alongside what is currently known about patterns of health service use by traditionally excluded and vulnerable groups a number of risks/ negative implications emerge. Firstly, the baseline review notes there are residents who are ‘below the radar’ of primary care providers or residents that do not know how to contact/ access primary care services (e.g. Other White, Chinese, African people much less likely to know how to contact out of hours GP). Also the review identified people living in poverty who can’t afford to keep all appointments. These people often rely on acute services when health problems come to a head. This has implications for effectiveness of care pathway development and ensuring seamless support for service users.</p> <p>Secondly, in some cases (e.g. diabetes) particular groups of people are less likely to identify health problems early enough. There is a risk that this behaviour will be replicated. The ‘closer to home’ approach has potential to reap benefits, but relies on strong commissioning of community-based and high-quality services – which emphasises the importance of preventative/awareness activity.</p>	<p>FBC does indicate intentions of merged Trust to work closely with GPs and influence pathways of care. Important that equality and human rights implications of ‘closer to home’ strategy are considered fully. The strategy may reduce costs, but there are longstanding issues of poverty and health service usage patterns which need to be considered.</p> <p>Trust should feed into commissioning specifications, particularly given its knowledge around vulnerabilities/ quality of service required by community/ home-based care providers.</p>	<p>None identified for the Trust, though Trust can influence others to ensure they do not infringe rights of patients (e.g. influencing quality standards for other local providers)</p>	<p>None identified for the Trust, though Trust can influence others to ensure they do not infringe rights of patients (e.g. influencing quality standards for other local providers)</p>
<p>Improved access to specialist services (particularly for residents in Waltham)</p>	<p>Improved access for people in these parts of the catchment. FBC identifies that people in Newham will still be within 30 minutes-drive of between five and</p>	<p>Despite no significant changes in access for some residents/ improved access for others, there will still be accessibility issues going forward. Our review identified significant challenges faced by those in poverty and those without access to transport/ that face mobility problems.</p>	<p>The Trust may already have lobbied local transportation services to improve access/ lower costs for its service users. However, it may be important for the Trust to communicate it has done</p>	<p>In advancing equality of opportunity, the Trust needs to show it has listened to the views of traditionally excluded groups around access to services (even if it is to</p>	<p>None identified.</p>

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
<p>Forest and Newham). No planned service reconfiguration</p>	<p>eight providers of elective care.</p>	<p>Disabled people and older people that we spoke to described the need for better transport support (e.g. ring and ride). Where services are already provided, knowledge of those services differed across cohorts.</p> <p>Though no service reconfiguration is currently planned as part of the merger, should this be required there are gaps in reach around engagement/ consultation of traditionally excluded groups (as described above)</p>	<p>this to local people. This would demonstrate Trust has heard what local people living in poverty and with mobility issues are saying about access to services. Merged Trust may also need to consider any reasonable adjustments required due to changes in service offer.</p>	<p>say that the Trust has decided not to respond to a particular issue). Similarly Trust may need to make reasonable adjustments to respond to inequality in access.</p>	
<p>Focus on providing world class leading edge patient-centred healthcare</p>	<p>FBC clearly recognises there is much room for improvement on issues of patient experience across all three Trusts and sets out plans to respond to that. For example: co-designing service change; reflecting patient perspective in decision-making; learning from and acting upon feedback; embedding patient experience responsibilities into each and every role. Systematic feedback from patients and carers will be included in the appraisal of senior clinical staff and</p>	<p>FBC does not detail specific intentions to improve access of the most vulnerable and traditionally excluded groups in decisions about their care. There will be an Equality and Human Rights committee, yet it is not clear how people will be recruited to this and how the committee will access views of the most excluded in the catchment (e.g. how will patient advisors feed into this?) There is a risk that current gaps in reach of consultation processes will be replicated in the merged Trust.</p> <p>FBC refers to development of a draft patient experience strategy. FBC does not however include many more details on how patient experience will be measured. Baseline review identified a number of significant disparities in the experience of patients with particular protected characteristics (e.g. young people, women, Bangladeshi people, Indian people were all more likely to say they weren't always treated with dignity and respect). This type of information was not readily available in published Equality Reports or Quality Accounts. If this information is not publicly</p>	<p>In developing the patient experience strategy, patient experience metrics will need to be disaggregated where possible by people with different protected characteristics. These metrics will also need to pick up key issues of human rights infringements. Emerging work by CQC and others (e.g. Macmillan Human Rights Standard) that brap has supported identifies core behaviour-based patient experience metrics (from patient surveys and from additional data-gathering exercises) that can be used to assess progress on key aspects of human rights protection</p>	<p>Patient experience is an important aspect of delivery of services. Trust is duty-bound to publish information that demonstrates compliance with the equality duty at least annually. Progress in addressing disparities in patient experience as they affect people with protected characteristics is important aspect of the Trust's progress against the duty (eliminating unlawful discrimination and advancing equality of opportunity). This type of information needs to be published and regularly reviewed.</p>	<p>Potential infringements of Article 3: prohibition of inhuman and degrading treatment and Article 8: respect for private and family life. This relates to staff behaviour in both an in-patient and out-patient setting. Particular groups are more likely to experience a lack of dignity and respect and this has implications for</p>

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
	<p>any learning needs will be included in professional development plans. There are some concrete plans outlined for co-design activities in areas where health inequalities are particularly large (e.g. diabetes care pathway).</p>	<p>discussed with those groups affected there is a significant risk progress will be stymied.</p> <p>Baseline review emphasises the importance of also engaging voluntary and community sector organisations/ secondary and tertiary health and social care providers to understand gaps in mainstream acute provision. For example, a community resource centre described how they were not informed that a patient had been released and that patient went without food for a weekend until their care worker found them on the Monday. Local intelligence like this is critical to helping address gaps in care and gaps in information sharing. Similarly, many VCOs provide community-based, holistic care and are able to provide examples of how mainstream services could achieve better patient experience results/ opportunities for partnership to improve impact of acute provision. The FBC does not include any plans for developing a VCS engagement strategy to ensure this sharing of intelligence could happen. This may have negative implications for service improvement to address health inequalities going forward.</p> <p>Baseline review identified a number of examples of ‘never events’ that left patients feeling genuinely scared about returning to the hospital. Similarly, patients recounted examples of being treated without the type of care and compassion they felt they deserved. Trust will need to set out how it plans to address this ‘head on’ if this to be improved in the future.</p>	<p>(e.g. right to privacy, dignity, autonomy and respect).</p> <p>As the merged Trust develops, there will be opportunities to develop service-specific patient reported experience measures that respond to some of the health inequalities/ human rights issues identified in the baseline review. Importance of liaising with local VCOs too in developing these.</p> <p>Opportunity to develop staff behaviour-based ‘patient promises’ that respond to patient concerns about human rights infringements.</p>		<p>Article 14: prohibition of discrimination.</p>

EDS Goal 3: Empowered, Engaged and Well Supported Staff

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
<p>Transition process, reduction in staff pay costs and streamlining/redundancies</p>	<p>Cost savings which can help financial viability and sustainability of organisation – allowing it to continue to provide care to local people.</p> <p>Talent management approach being taken to retain staff and there are opportunities for promotion.</p>	<p>Baseline review identified some feelings of unfairness; that is, some staff feel the merger is being ‘done to them’, it’s a takeover of their Trust. Related to this are concerns about unfairness of promotion and much longer standing perceptions of unfairness and inequality around the recruitment and promotion of staff (the baseline review identified evidence of this particularly for BME staff but did not consult specifically on other issues/protected characteristics).</p> <p>This creates significant risks around loss of talent and maintaining staff support through the process. Particularly when a number of members of staff don’t feel the merged Trust will be any better equipped to respond to staff inequalities (staff inequality is seen as the ‘Achilles Heel’ of all NHS institutions). It also creates risks around the impact of poor motivation on staff performance and resulting patient experience.</p> <p>The baseline review identified existing challenges around low performance and a reluctance to challenge performance if there is a risk of people making grievances related to discrimination/ harassment. There is a risk that this will be replicated in the merged Trust and amplified by redundancy situations.</p>	<p>Important to communicate plans clearly around transition and redundancy process. Useful to initiate staff satisfaction survey (even if one is not due) to understand staff feelings on this issue. This will help to respond to areas of discontentment and avoid allowing feelings to ‘fester’.</p> <p>Clear opportunity to make a ‘fresh start’ and establish the type of organisational culture that talks openly about staff inequality and responds swiftly and effectively to discrimination and inequality.</p> <p>Need for strong performance management processes that managers feel confident in using. Need for additional training and support on this.</p> <p>Need for training for managers on responding to inequality, discrimination and harassment experienced by staff they support.</p> <p>Clear messages required in relation to rights of frontline staff and managers in merged Trust and where they can get support and advice on equality and human rights issues.</p>	<p>Merger will affect Trust’s ability to respond to its duties (e.g. eliminating unlawful discrimination). The Trust may already have plans to consider staff welfare going into the merger process and it is essential that equality and human rights are integrated into work of this nature. There is a window of opportunity for staff recruitment, progression and appointment processes to be reviewed and to ascribe new processes which can be seen as fairer across the board. Important for Trust to demonstrate that it has considered equality objectives in light of the impact of merger on staff equality. For example, NHS East London and City has included responding to implications of the impending staff transition process as a specific equality objective.</p>	<p>Article 8 Right to privacy and family life: important to ensure staff transition process is done in an equitable and transparent way – and that the effect on people’s privacy and family life is considered.</p>

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
<p>Plans for knowledge transfer outlined in FBC</p>	<p>Includes clear strategy for knowledge transfer (e.g. pre-exit audit checks and handover)</p>	<p>Our baseline review revealed that it can, at times, be challenging to access information that relates to data and protocols around staff inequality, health inequality, patient experience, community engagement, etc. Equality Leads and the project steering group facilitated access to relevant information, yet occasionally brap researchers found rich pockets of relevant data held by particular members of staff that other colleagues were not necessarily aware of.</p> <p>The FBC outlines plans for knowledge transfer around issues of particular clinical importance (e.g. infection prevention and control). Yet there is a risk that knowledge transfer around other cross-cutting themes such as equality, human rights, and community engagement will not be prioritised.</p> <p>All Trusts currently do not collect information in relation to gender reassignment and pregnancy and maternity. There are particular sensitivities involved in collecting information on trans-status which is not clearly acknowledged by all Trusts (neither are there clear plans for how the Trusts will demonstrate their ability to support trans staff). Also, there are some differences in the level of information Trusts collect and analyse in relation to other protected characteristics (see section II).</p>	<p>This report helps to baseline existing information in the field of equality and human rights in the Trust, but it is by no means exhaustive. It will be important for the merged Trust to consider how knowledge transfer is ensured around cross-cutting themes like equality and human rights.</p>	<p>Implications for Trust's ability to meet general and specific duties going forward (e.g. Trust needs to know where specific information is kept relating to equality is kept. It also needs to access information about impact of previous approaches to progress equality and human rights in the past across the three Trusts).</p> <p>The Trust will need to collect employee information on <i>all</i> protected characteristics in the future to comply.</p>	<p>None identified</p>

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
<p>Advice for CAGs on need to improve recruitment and selection practice</p>	<p>Will help to ensure leadership is responding to areas of concern</p>	<p>Recruitment and selection are both important, but baseline review identifies significant issues around bullying, harassment, victimisation and staff relations too. There are inequalities in all three trusts on one or more of these issues (e.g. in relation to race) and this has a significant impact on staff morale and performance. A core aim of the merger is to improve staff motivation and performance and addressing bullying and harassment will be an important part of that equation. Also bullying and harassment cases can have large impact on credibility of Trust and financial costs (e.g. end of 2011-2 employment tribunal cases which resulted in compensation payments of £4.4 million and £1 million).</p>	<p>Specific and high-profile plans (backed by Senior Leadership) required to address issues of discrimination (bullying, harassment, victimisation) across the merged Trust. This could include examples of what discrimination 'looks like', who to report it to, where to get support from. It could also include support for managers on how to respond to different types of discrimination (as described above). There is also a broader issue to be addressed around how time and resources are created for managers to conduct appropriate supervision and performance management activities in the Trust.</p>	<p>Eliminating unlawful discrimination is a general duty. The Trust will need to show how it intends to address this across the new organisation. Plans are already underway to conduct cross-Trust research on this issue.</p>	<p>Employers who do not aim to prevent bullying and harassment outside the context of discrimination (covered by protected characteristics – e.g. obesity) may be in breach of the Human Rights Act (Article 3: degrading and inhuman treatment). HRA also relates to harassment in that it provides right to respect for private and family life (Article 8)</p>

EDS Goal 4: Inclusive Leadership at All Levels

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
<p>FBC recognises that Newham and Whipps Cross (in particular) face significant workforce pressures (recruitment, retention of staff and dependence upon temporary/ agency staff).</p>	<p>Multisite approach to staff deployment will help to address some of the workforce pressures. This has the potential to improve staff motivation and respond to some of the inequalities in staff deployment.</p> <p>Integrated HR systems will help to monitor progress on responding to these workforce pressures and to understand who is disproportionately affected by them across the Trust.</p>	<p>Merged Trust in April 2012 will still have workforce pressures and high numbers of temporary/agency staff. This will raise a number of challenges around how Trust staff are inducted around the equality and human rights/ performance/patient experience expectations of the merged Trust. High turnover of staff and a lack of motivation has the potential to lessen the impact of induction and training on these issues.</p>	<p>Rolling induction/training programme on equality and human rights/patient experience obligations of staff (e.g. quarterly). This will help to ensure people who miss a ‘yearly’ equality and diversity training session still have an opportunity to participate.</p>	<p>Although there are no specific duties to ensure all staff receive training, the Trust must demonstrate that it has taken all necessary steps to meet the general duties. This will include ensuring that staff are sufficiently skilled and knowledgeable to respond to inequality and to avoid unlawful discrimination. Induction can be a useful place to initiate process of training and awareness-raising on this issue.</p>	<p>None identified. though knowledge of staff will affect ability of Trust to ensure it is complying with Article 14 of the Human Rights Act (prohibition of discrimination).</p>
<p>As merged Trust develops CAGs advised to each nominate an equality champion to embed equality analysis in policy development</p>	<p>If implemented, the Equality Champion will be a person with clear responsibility for progressing this agenda. Evidence suggests that unless very senior leadership have responsibility for equality and human rights, there is little likelihood of the</p>	<p>The advice outlined in the Appendix of the FBC is to be considered by CAGs. There is a risk that some of this advice may not be followed.</p> <p>In addition, Equality Champions will need to have sufficient training and a clear mandate so that they can manage performance against equality targets. Similarly, others will need to have a mandate to hold equality champions to account.</p>	<p>This will be much easier for Equality Champions to do if equality practice and associated targets are ‘mainstreamed’ and integrated into broader organisational objectives. If these actions sit outside the mainstream, they become harder to champion and harder to influence others to progress.</p>	<p>The Equality Duty encourages a range of people within an organisation to have responsibility for meeting legislation. The FBC already clearly indicates a range of places within the organisation where responsibility will lie for equality and human rights.</p>	<p>None identified.</p>

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
	<p>agenda 'sticking' when competing agendas emerge.</p>				
<p>CAGs to lead on developing clinical priorities and strategy for Trust</p>	<p>Clear approach to clinical leadership informed by specialists from all Trusts.</p>	<p>The FBC recognises that it will be important to retain clinical support during the transition/integration process and the role of CAGs will be critical in maintaining that momentum. It was not clear from the FBC how people were recruited to the CAG structure and whether this runs the risk of replicating existing inequalities in the system. The baseline review identified inequalities in recruitment of clinical staff.</p>	<p>Need for transparency about how decisions have been made to recruit to particular positions within the merged Trust structure.</p>	<p>All positions (including CAG) to be considered in same way in relation to Equality Act 2010 duties.</p>	<p>None identified.</p>
<p>As merged Trust develops CAGs advised to focus on equality and diversity in strategic planning (e.g. in care pathway development)</p>	<p>If implemented, will help to ensure negative impact of policy/strategy on particular groups is considered fully and responded to appropriately.</p>	<p>The advice outlined in this Appendix of the FBC is to be considered by CAGs. There is a risk that some of this advice may not be followed.</p> <p>CAGs may require support to collate, analyse and respond to health inequalities data and information on progress against human rights and patient experience/CQC essential standards of care. CAGs may not require support on this, but there is a risk that assumptions will be made about existing skills and knowledge on this agenda. FBC focuses on need to improve performance of merged Trust on health equality and puts role of CAGs centre-stage in responding to and navigating health inequalities. This</p>	<p>Assessment of any support needs CAG may have in terms of responding to health inequalities data (disaggregated by protected characteristics) and strategic planning. Possibility to run joint sessions with E&D Leads and Public Health professionals to ensure CAGs are fully supported to consider equality and human rights implications of care-planning.</p> <p>CAGs to work with Public Health experts to understand the limits of current data sets and to influence future collection and analysis of that data by Public Health Partners.</p>	<p>It is important that those responsible for implementing general duties (including CAGs) are fully cognisant of those duties and their role in meeting them.</p>	<p>None identified.</p>

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
		<p>could be a high risk strategy if CAGs need additional support to understand equality and human rights implications of their strategies.</p> <p>There are some significant gaps in health inequalities data disaggregated by different protected characteristics. Thus far different Trusts have used differing types of data depending on local availability. There is a risk that this will continue, making it harder to baseline progress on health inequalities across the catchment going forward.</p>			
<p>As merged Trust develops CAGs advised to implement a number of actions to improve engagement with diverse groups in the catchment</p>	<p>If implemented will help to ensure: relevant community groups identified; partnership opportunities to address health inequalities identified; accessibility of community engagement processes improved.</p>	<p>The advice outlined in the Appendix of the FBC is to be considered by CAGs. There is a risk that some of this advice may not be followed.</p> <p>More detail will be required going forward around how the CAGs respond to some of the equality related advice in the FBC. For example, how will CAGs “identify, publicise and make accessible a number of avenues for service user groups to communicate with and receive feedback from CAGs”.</p> <p>The FBC does not constitute a clear plan of action for how existing inequalities in access to consultation processes (described above) will be mitigated.</p>	<p>CAGs to develop a clear process for engaging groups on issues of equality and human rights to help CAGs with a range of issues (e.g. care pathway development, patient experience and quality measurement, gathering evidence on differential health outcomes). Some initial proposals for initiating this process are included below in section 4</p>	<p>The duty to advance equality of opportunity includes encouraging people with protected characteristics to participate in public life or in other activities where their participation is low. The Merged Trust will need to set out how it intends to do this as part of a clear strategy (we have not identified one so far that refers directly to equality and human rights).</p>	<p>None identified.</p>
<p>As merged</p>	<p>If implemented, CAGs</p>	<p>The advice outlined in the Appendix of</p>	<p>Support for CAGs to include work on</p>	<p>Public duties stress</p>	<p>Employers who do</p>

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
Trust develops, CAGs advised on their role in promoting equality and diversity in workforce and partners	<p>will play a role in: developing processes for equitable recruitment; opportunities for clinical innovation; supporting rotational opportunities for junior doctors; inclusion of staff in talent management; equitable approaches to succession planning; working with Public Health partners and innovating to address health inequalities.</p> <p>Equality Leads to support CAGs to improve equality of recruitment (via training and advice)</p>	<p>the FBC is to be considered by CAGs. There is a risk that some of this advice may not be followed.</p> <p>While Equality Leads have been identified as support for CAGs in responding to inequalities in recruitment, there may be potential gaps in support on other areas of workforce equality (e.g. harassment, bullying and victimisation).</p>	<p>the Equality Act and Human Rights Act. This should include explanations of different types of discrimination covered by the Act and the role of leadership in supporting managers and frontline staff to eliminate discrimination.</p>	<p>important role of leadership in ensuring actions to eliminate unlawful discrimination are carried out effectively. There are plans to support CAGs to do this – training may be required to support this process.</p>	<p>not aim to prevent bullying and harassment outside the context of discrimination (covered by protected characteristics – e.g. obesity) may be in breach of the Human Rights Act (Article 3 – degrading and inhuman treatment). HRA also relates to harassment in that it provides right to respect for private and family life (Article 8).</p>
As merged Trust develops, CAGs advised to develop an organisational culture which has the ethos and values of equity and diversity at its	<p>Clear statement of intent around the need for equality and diversity focused organisational culture.</p> <p>Equality and diversity training for leadership and frontline staff will clearly help in embedding some of the</p>	<p>The advice outlined in this Appendix of the FBC is to be considered by CAGs. There is a risk that some of this advice may not be followed.</p> <p>The limited number of staff that we spoke to described some of the drawbacks to previous equality training they had received (e.g. use of an online programme that does not allow them to explore issues in more depth). There is</p>	<p>Significant opportunity to place equality and human rights at the centre of a new organisational culture. The organisation already has clear plans to address health inequalities in North East London and this is a significant ‘hook’ that can be used to energise staff and create new principles and values for the merged Trust.</p> <p>The Trust has significant ‘weight’ (major</p>	<p>Those exercising the public body’s functions need to be aware of requirements of the Equality Duty. Important to understand level of awareness within CAGs and to respond to gaps in knowledge as matter of urgency.</p>	<p>None identified.</p>

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
<p>heart.</p> <p>Equality training for CAG staff will help to ensure this happens.</p>	<p>principles upon which a strong organisational culture can be built.</p> <p>HR and OD workstreams both recognise the importance of culture change and resources identified to support this process.</p> <p>FBC identifies CEO as having primary responsibility for equality and human rights which sends a strong message on importance of this agenda.</p>	<p>a risk that training of this type will not help to embed the seeds required to achieve organisational culture change of the type that is required.</p> <p>Also the review identified a number of concerns that patients have about the level of care and compassion shown by staff (and associated infringements of human rights through poor staff behaviour). This is also reflected in patient experience results from inpatient/ outpatient surveys (affecting particular groups). Thus in addition to embedding principles of 'equality and diversity', organisational culture change also needs to address some of the <i>human rights</i> concerns that patients have.</p> <p>The role of leadership in embedding cultural change on equality and human rights is not explored in much detail in the FBC. Procedural issues are described (e.g. which staff will have executive responsibility for decisions and who will be recruited to focus on this brief/ who they will report to/ who will receive training etc.) Yet clear plans are required around what leaders will actually do to ensure equality and human rights is central to the organisational culture going forward. It is not clear what the Trust's vision and</p>	<p>employer, service deliverer and procurer) in the local area. Opportunity to develop ambitious plans on health inequality and influence partners to do the same.</p> <p>Leadership will need to both 'walk the walk' and 'talk the talk.' Strong statements on the importance of equality and human rights need to be backed up by strong actions (e.g. punishing discriminatory activity, rewarding good practice and exemplifying good equality practice in their own decisions and actions). It will be important for Senior Management 'repeat' messages on equality and human rights regularly (e.g. every month) to ensure it is reinforced in meetings/ corporate messages.</p> <p>Differences in approaches to equality</p>	<p>Equality and human rights focused organisational culture is an important foundation upon which a range of the general duties can be implemented.</p>	

Merger issue	Positive implications of the merger	Negative implications of the merger	Mitigation	Implications for compliance with Public Sector Equality Duty	Implications for protection and promotion of human rights
		<p>aspirations for equality and human rights will be. Without them there is a risk the merger will miss an opportunity to embed these values and ways of working from the outset.</p>	<p>and human rights between the three Trusts need to be acknowledged and successes/ drawbacks of those approaches discussed openly to help identify what is most likely to motivate staff on this agenda going forward (not more of the same – if the same doesn't work well).</p>		

4. Conclusions and recommendations

Hopefully, it will be apparent from the above equality analysis and baseline review that there are a wide range of equality and human rights issues relating to the proposed merger. In this final concluding section, we suggest a number of 'high-level' strategic themes and potential priorities for the merged Trust as it develops its own approach to progressing equality and human rights.

Historically, equality approaches have generated large, unwieldy action plans, the results of which are commonly known: people spending more time going through the documentation than they do taking action! The new equality duty requires organisations to produce a small number of SMART targets. Devising these will be extremely useful in helping the Trust think through priority areas which can really support its core business objectives going forward. Our view would be for the Trust to prioritise some of the following actions to help them develop equality and human rights strategy that is right for the new organisation:

4.1 Act on what you know

There is a significant amount of available information that could inform the merged Trust's future strategy on equality and human rights in a number of different places. This report is only part of that equation. We would point to the 'Equality Impact Assessment: Completed Initial Screening Form of the Outline Business Case' (August 2011) and the 'Equality Impact Assessment, Initial Screen, Outline Business Case Summary and Recommendations Paper' (September 2011) as particularly useful documents. Both contain insightful information on health inequalities as they affect particular groups and also robust recommendations that should be considered in developing any future equality and human rights strategy. In addition, each separate Trust has its own annual Equality Report and is in the process of developing associated equality objectives (as is NHS East London and the City). All this is not to mention the wide range and types of health inequality data collected and analysed in different parts of the catchment area identified in section IV.3.

This is a lot of information for the merged Trust to consider. The sheer weight of data available is, in part, a product of the size of an organisation and catchment area of this type. It would be all too easy for the Trust to become consumed by reviewing all of this data and conducting more work to gather further information before key decisions are made.

However, a key challenge for the Trust – and one it will need to respond to quickly – is using what information is already available to develop clear aspirations and success measures around equality and human rights. Despite important gaps, a significant amount of data is already available: the Trust will need to move fast to avoid getting 'bogged down' attempting to close gaps it cannot currently avoid.

4.2 Improving patient experience and human rights protection

All three Trusts have acknowledged they face challenges in improving patient experience. This project has identified a number of challenges for the new organisation in relation to equality and human rights. Particular groups of people (younger people, ethnic minorities, and women) are more likely to say they are not treated with dignity and respect. The baseline review recounts stories from a minority of people who feel they had their human rights infringed and people who were genuinely fearful of returning to receive care due to poor experiences and significant threats to their health and safety.

It would be tempting to follow this up by consulting specifically with people only from each of these protected characteristics to understand why they feel they are not being treated with dignity and respect. There are significant benefits to doing this. Yet the rapid baseline review in this report has shown how there can be a number of common themes that, if addressed across all frontline staff behaviour, would have an impact on patient experience and protection of human rights for a wide range of traditionally excluded groups. For example, a common theme that came out across a broad range of (specifically ethnic group) consultation sessions on End of Life Care conducted by Newham LINKS was the need for 'patient choice' and autonomy. Patients felt that they did not always have a say in their treatment and that services could be improved by making choices explicit to people.

As care pathways are further developed, there will be opportunities for CAGs to work with local people to identify relevant aspects of staff behaviour that could be improved in order to deliver more compassionate and responsive care. We would encourage CAGs to think carefully about how 'difference' and 'diversity' is responded to. Whilst specific community groups may have specific requests, it will be important for CAGs to make proportionate and reasonable decisions about how the majority of people's rights are protected across the care pathway. It may be proportionate to respond to particular inequalities in a targeted way (for example, the provision of specific language support or adjustments for disabilities), but sometimes *mainstream* change across the whole system will be a more effective and proportionate use of resource, and will benefit a wider range of people.

One way to approach this would be to trial a similar approach to the one taken by Macmillan Cancer Support in their Human Rights Standard for Cancer Care. The standard was developed by brap following consultation with over 400 patients, carers, and staff to identify the eight key 'moments that matter' in a particular care pathway. Staff behaviours were identified that, if followed, would help to ensure patient rights are protected in those moments that matter (examples include: making sure that important conversations are held in a private space; ensuring food is not out of patients' reach; and making sure that patients have an opportunity to discuss and influence their care in a way they understand). There was a high degree of convergence and agreement around what those 'moments' should look like across people from a range of protected characteristics and across professionals. By ensuring staff are equipped to deliver against a standard that responds to issues like this,

quality of provision and patient experience is increased across the whole care pathway for all. This approach also helps to respond to the needs of vulnerable/excluded groups not covered by equality law (such as homeless people).

This type of approach can be used to develop 'patient promises' or a 'patient charter' that patients and staff have had a chance to influence (either at a care pathway level or at a wider Trust level). It can be used by patients to hold the Trust to account if staff are behaving in a way that is below agreed quality benchmarks. It can also be used to identify the types of expectations placed upon patients themselves as they engage with the system (e.g. patients agreeing that when they use Trust services they will communicate any concerns they have with staff).

Clearly this would not be a substitute for focused work to address inequalities in patient experience. Yet, a rights-based approach to addressing patient inequality has the potential to reap significant benefits and put Barts Health 'ahead of the game' with regards to any future government equality strategy.

4.3 Developing equality objectives

The Trust will need to develop equality objectives to meet its obligations under the Equality Act 2010. A significant amount of data is already available to support the Trust to identify some of its key objectives around staff and service provision. The task for the Trust is to agree which of those inequalities it is best placed to do something about, and devise an approach and priorities that are 'proportionate' and 'reasonable'. A proportionate objective will be one where the Trust can make a strong argument for why it has chosen a particular objective and that it has considered all less-discriminatory alternatives to any decision made. It will rarely be possible to respond to all issues of inequality – and all issues raised by local groups. It is important to demonstrate why particular objectives are being chosen and why they are most likely to have the largest impact on those most in need of support. A 'reasonable' objective will be one where the decision has considered the relative cost and anticipated impact of interventions to address inequality.

The preceding Equality Analysis (and, indeed, these conclusions and recommendations) will hopefully help the Trust consider what the content of those equality objectives should be. The best equality objectives will be decided in part by an organisation's executive team and board members. Their endorsement is crucial to people taking the objectives seriously. It should also be developed in partnership with local people, local public agencies, and VCOs. This should be considered as a core component of a range of Trust work-streams (e.g., organisation development, clinical and patient experience strategy). For more support in developing Equality Objectives see www.brap.org.uk/index.php/resources-publications-342/equality-act-publications-567.

4.4 Engaging with local people

Effective and fruitful engagement with local people will be critical to the new organisation for a number of reasons. The Full Business Case emphasises the central role of patient involvement in driving service improvement in the future and recommends that CAGs create opportunities for engagement of traditionally excluded groups in care pathway development. In addition, and from a purely equalities-driven perspective, this report has identified inequalities in access to patient engagement mechanisms across the catchment area (section IV.3).

As part of the brief for this work we were asked to outline some basic proposals for how CAGs might develop engagement mechanisms of the type mentioned above. Whilst below we outline a simple approach to engagement and co-design for particular care pathways, it is important to say it is crucial that CAGs, patients, and community groups play a central role in agreeing appropriate engagement mechanisms that will respond to their differing needs and expectations. Since the outline below lacks this crucial ingredient, we present this approach with a view to it being discussed with Equality Leads and others to develop more robust plans in the future.

Example of approach to community engagement for co-design and development of a care pathway

Step 1

What is already known about health inequality/effective equitable practice in healthcare:

- establish whether useful information is already available on health inequalities disaggregated by people from different protected characteristics at a local level (and if not local, a regional or national level)
- establish whether useful information is already available on 'what works' in addressing those health inequalities

Step 2

Rationale for engaging with community groups and outcomes required:

- based on Step 1, consider where more evidence is required and where it would be useful to test assumptions in existing evidence
- consider and respond to local people's requests to become more involved in decisions about their care
- identify key stakeholders it would be most useful to talk to and the type of information that would be particularly useful to generate
- identify the type of role community groups and patients can play (e.g. how much influence can they have? what are individual CAGs particularly looking for input on? what resources and time are available for engagement activities?)

Step 3

Designing appropriate engagement mechanisms:

- consider the type of information required and appropriate engagement mechanisms to gather it (e.g. survey, focus group, conference)
- consider the preferred engagement style of the target groups (including access issues)
- identify where additional community outreach will be required to reach people with expertise around particular protected characteristics who have not been accessed previously
- develop clear marketing and advertising to explain the purpose of any engagement and – importantly – its parameters and expected outcomes (what will be done with the feedback? what is the benefit of people participating?)

Step 4

Undertaking engagement activity:

- conduct outreach to identify relevant groups and local people
- run surveys/focus groups/consultations/etc as appropriate
- establish terms of reference with the group and communicate plans to share the outcomes of consultation and what is done with the information
- identify potential service changes and how performance/patient experience and quality should be measured (eg via patient reported experience measures or similar)

Step 5

Analysis of engagement activities/decision-making/pathway development:

- identify key issues as they affect people with particular protected characteristics
- identify pathway design to address health inequalities (if required) and share these plans widely with local stakeholders
- outline plans for implementation of pathway and opportunities for local people to feed into a quality assessment and/or review the pathway's impact

Step 6

Monitoring effectiveness of pathway design in addressing health inequalities:

- encourage local people to contribute their views on the effectiveness of the care pathway (for example, through surveys which allow the disaggregation of responses by protected characteristic)
- establish a community reference group, including people with relevant experience and expertise, to contribute to the evaluation activities (e.g. 'mystery shopping')
- identify key learning to influence the next stage of the care pathway development

Step 7

Back to Step 1!

4.5 Improving equality-related data

A paucity of data on health inequality data disaggregated by different protected characteristics is something that affects a large number of localities across the country. Barts Health is no different in that respect. It is clear, though, that in spearhead areas like North East London the potential impact of not understanding patterns of inequality and discrimination can be higher and affect more vulnerable people. As stated above, a balance needs to be struck. A lack of data cannot be an excuse for inaction. However long-term plans also need to be initiated as a matter of urgency to develop more up-to-date, equality-specific evidence that can inform future care-planning over the decades to come. Other agencies such as the London Health Observatory and North East London Health Equality Partnership have already done much to establish the case for change and to support agencies to improve their responses to this subject. It will be important the merged Trust learns from this and leads the way, using its significant local presence (and resources) to influence other agencies to improve recording and analysis of evidence of this type.

In relation to staff data, it is clear from section II that each of the three separate Trusts adopts slightly different approaches to collecting staff equality data. Furthermore, there are particular issues surrounding the collection of data in relation to certain protected characteristics – gender reassignment and pregnancy and maternity being the most obvious. The new Trust should be pre-emptive in tackling these issues; for example, it should be able to show how 'ready' it is to support equality for trans staff and patients without monitoring data in the traditional sense. This will require a sensitive and proportionate response to monitoring. As a general point, the merged Trust should also be ready to show why it has chosen a particular approach to equality monitoring and to explain this clearly to staff and patients (e.g. why data is being collected and how it is being used).

4.6 Staff welfare

The FBC identifies a number of procedures it will follow to ensure staff are not 'left behind' as the proposed merger goes forward. This includes a range of talent management and consultation activities. It is likely that the Trust has already made plans to consider staff welfare going into the merger process. It is essential that equality and human rights are integrated into work of this nature. There is a window of opportunity for staff recruitment, progression and anti-discrimination processes to be reviewed and to develop new processes which are seen as fair across the board. We know that there are challenges around staff performance and these relate in part to issues of inequality. Staff will need assurances to understand how the merged Trust will respond to long-standing problems of inequality and discrimination. A swift and anonymous internal staff survey could help to identify some of these challenges. Similarly, strong messages from senior leadership from day one of the merged Trust (and repeated on a regular basis) could help to clearly express the Trust's vision for equality and human rights and how it is working to progress this vision.

