Imperial College Healthcare **NHS**

NHS Trust

Annual Patient Equality and Diversity Report 2017/2018

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Contents

Alternative formats

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1. Introduction

Imperial College Healthcare NHS Trust (the Trust) is committed to the development of an organisational culture that promotes equality and celebrates diversity.

As a public sector organisation we have a legal obligation under the Equality Act 2010 to promote equality for the nine protected characteristics below:

- Age
- Disability
- Gender Identity* (see appendix 1)
- Marriage and civil partnership
- Pregnancy and maternity
- Race including nationality and ethnicity
- Religion or belief
- Sex
- Sexual orientation

The Trust is committed to meeting its duties under the legislation and believes that everyone who uses our services has the right to be treated with respect and dignity.

The Trust uses the national Equality Delivery System (EDS2) framework to report against. The EDS2 framework forms part of the NHS contract from April 2015.

This annual report reports on progress against our equality objectives that are based on the EDS2 framework. It gives details about how the Trust is meeting the public sector quality duty (PSED), as outlined in the Equality Act 2010.

This report focuses on the patient/ user perspective and should be read alongside the Annual Workforce Equality and Diversity report for the same time period.

The 2017/18 report builds upon existing work reported in the 2016/17 report. This report will focus on the patient focused objectives for 2017/18.

2. Background

2.1 PSED

The Public Sector Equality Duty was created by the Equality Act 2010. It contains two parts, the General Duty and the Specific Duty. Public Sector organisations are required to meet both.

2.1.1 General Duty

- Eliminate unlawful discrimination, harassment and victimisation and any other conduct that is prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

2.1.2 Specific Duty

Specific duties are legal requirements designed to help public bodies meet the general duty. These require the publication of:

- Equality objectives every four years
- Information to demonstrate compliance with the equality duty, at least annually

2.2 Equality Act

The Equality Act 2010 received Royal Assent on 8 April 2010 and the first phase was implemented on 1 October 2010. It replaces previous antidiscrimination legislation (such as the Race Relations Act 1976 and the Disability Discrimination Act 1995). It simplifies and strengthens the law, removing inconsistencies and making it easier for people and organisations to understand and comply with it.

The Equality Act also contains other provisions, including the concept of dual discrimination, an extended Public Sector Equality Duty, and a prohibition on age discrimination in services and public functions.

The Equality Act covers the nine protected characteristics as listed in section 1 above but extends some protections to groups not previously covered and strengthens particular aspects of equality law.

2.3 Equality Delivery System 2

EDS was designed by the NHS for the NHS, to deliver better outcomes for patients and better working environments for staff which are personal, fair and diverse. The EDS was refreshed on 4th November 2013 and renamed EDS2. The EDS2 has been streamlined, simplified and uses clearer language. As of April 2015 the EDS2 has become part of the NHS contract.

The EDS2 covers the nine protected characteristics (appendix 1). As well as the nine protected characteristics of the Equality Act 2010, other disadvantaged groups typically include but are not restricted to:

• People who are homeless

• People who live in poverty
• People who are long-term unemployed
• People in stigmatised occupations (such as sex workers)
• People who misuse drugs
• People with limited family or social networks
• People who are geographically isolated

The EDS2 contains four goals:
1) Better Health Outcomes
2) Improved patient access and experience
3) A representative and supported workforce
4) Inclusive leadership

There are 18 outcomes across the four goals. The EDS2 encourages local adaptation with a focus on local issues and problems to be used to achieve the goals and outcomes for the organisation and local communities. It prompts learning from and spreading good practice through focusing on situations where progress is being made and good practice can be shared.

On occasions organisations may wish to focus on a subset of the 18 outcomes where there is local support for doing so, and local evidence that indicates that a focus on particular outcomes will be beneficial.

The EDS2 highlights one factor for NHS organisations to focus on within the grading process, for most outcomes the key question is: *how well do people from protected groups fare compared with people overall?* The grading system continues to use Red, Amber, Green and Purple (RAGP) grading.

Red - Undeveloped if there is **no evidence** one way or another **for any protected group** of how people fare o**OR** if evidence shows that the **majority of people** in only **two or less protected groups fare well**

Amber- Developing if evidence shows that the **majority of people** in **three to five protected groups fare well**

Green - Achieving if evidence shows that the **majority of people** in **six to eight protected groups fare well**

Purple - Excelling if evidence shows that the **majority of people in all nine protected groups fare well**

EDS2 is not a self-assessment tool. Performance should be assessed and graded by NHS organisations in discussion with local people and the workforce.

3. Governance

The Equality and Diversity Steering Committee is jointly chaired by the director of nursing and director of people and organisation development. The members include representation from each clinical division and corporate services. The Committee meets each quarter and progress against EDS2 objectives are reported here.

Progress against the Equality objectives is reported to the Equality and Diversity Steering Committee and annually through the Equality Reports, including the Workforce Race Equality Standard report.

4. Demographic profile and Patient Data

4.1 Overview

The Trust has used the most recently published data about the local population of the three boroughs where its hospitals are based. We noted small increases to the local population numbers with the largest increase in Westminster (6%). The local population continues to significantly increase during the day as more people come into the area to work than actually live in the area. The data that is published will not capture this group of people.

People who visit the boroughs during the day may use our emergency services; this number would also include those temporary and transient visitors who pass through the boroughs from our major airports and railway stations.

Tab.1

| Local authority	Population data
Hammersmith and Fulham *2015 data	185,004
Kensington and Chelsea*2018	158,000
Westminster* 2016 data	247,614
Total	590,618

In 2017-18, the Trust had over 1 million patient contacts across all of our services.

The Trust data used in this paper will be based on patients who used our services in 2017/18.

4.2 Ethnicity

In 2017/18 we noticed little change in the ethnic mix of our patients when compared with the previous year (figure 1). There continues to be a significant number who do not wish to disclose their ethnic group.

White people make up 40% of the patient population.

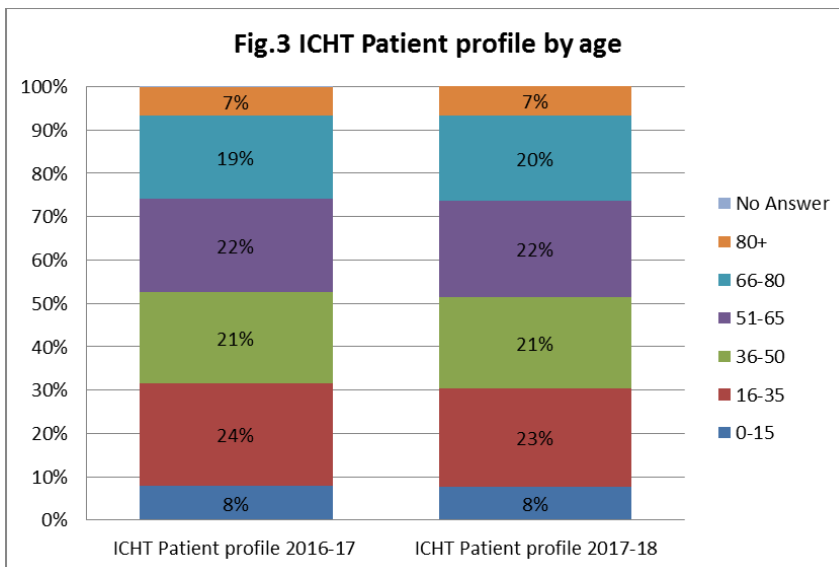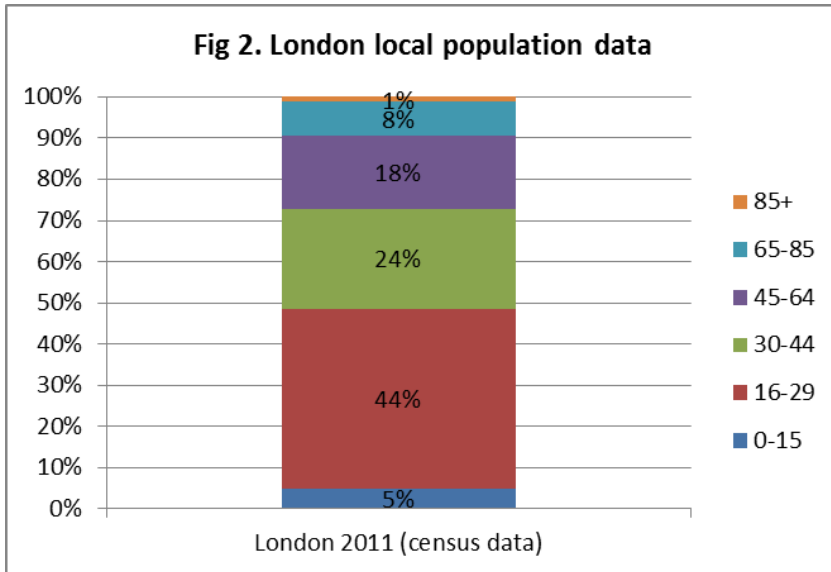Fig.1 London local population and Trust patient profile
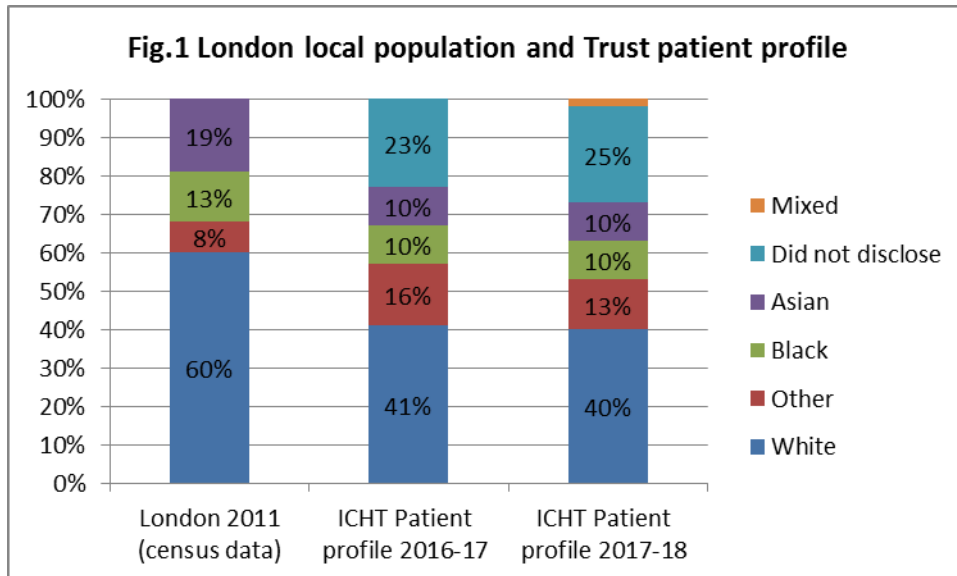
4.3 Age

The 2011 census uses different age brackets to the data that the Trust collects, so cannot be directly compared. We have therefore presented this data as two separate charts overleaf (fig.2 and 3).

The age structure in each of the three boroughs is different from England, with a much larger working age population and a smaller number of children and older people.

Hammersmith and Fulham have the largest young-working age of the three boroughs and the smallest proportion of older people. In the 2011 census that 89% of the tri-borough population were aged 65 years and younger and 61% aged 16-50 years.

The largest percentages of people who use our services are aged between 16- 65 years. This is spread quite evenly across these age brackets. The age profile of our patients in 2017-18 is very similar to last year.

Fig 2. London local population data

London 2011 (census data)

Legend:
- 85+
- 65-85
- 45-64
- 30-44
- 16-29
- 0-15

Values (bottom to top): 5%, 44%, 24%, 18%, 8%, 1%

Fig.3 ICHT Patient profile by age

ICHT Patient profile 2016-17: 8%, 24%, 21%, 22%, 19%, 7%

ICHT Patient profile 2017-18: 8%, 23%, 21%, 22%, 20%, 7%

Legend:
- No Answer
- 80+
- 66-80
- 51-65
- 36-50
- 16-35
- 0-15

4.4 Sex

There is no difference between the local residents in terms of sex across the boroughs. Hammersmith & Fulham reported a slight increase in females in 2015 to 51%.

When considering our patient population, there are slightly more women than men who use our services, although this remained unchanged in 2017-18.

Fig.4 London Profile and Trust profile by gender
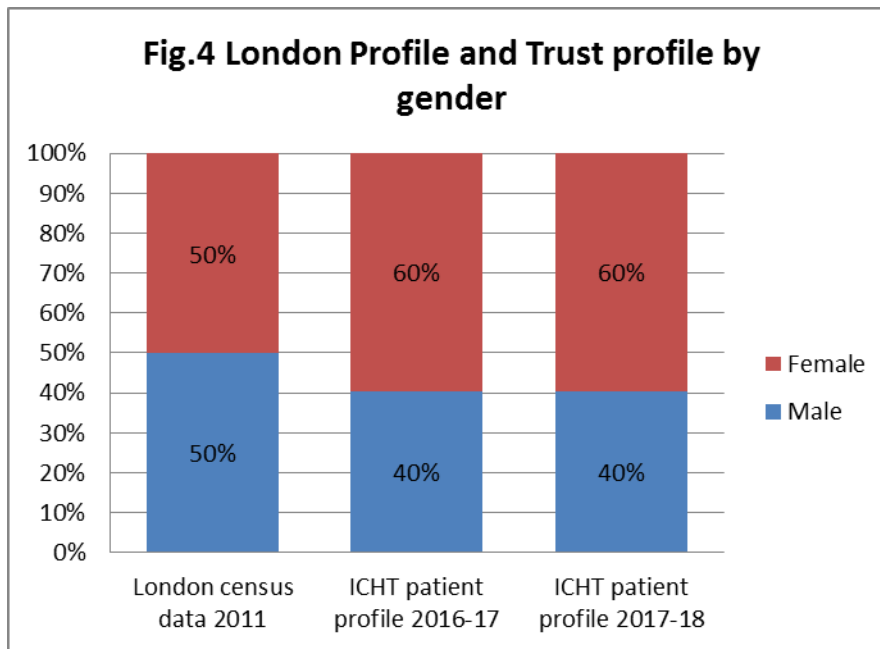
4.4 Additional information re: local population

The Trust does not capture information against all of the nine protected characteristics (appendix 1). We tried to include additional information in the past through the Friends and Family Test data but patients were reluctant to disclose this as shown in the significant number of people who did not disclose their ethnic group.

We have reintroduced additional demographic questions into the FFT survey for 2018/19. These include religion; additional sex categories and we have refined the disability question as the previous question had resulted in an over reporting in this area. We will closely monitor this to see if it has an impact on our response rates and to see if we receive any feedback from patients about this.

The demographic data we collect through the electronic patient records has not changed.

Our patient data is similar to our local community for age and gender. When comparing ethnic groups, it would appear the local population has more white people; however the Trust data has significant number who selected 'other' or did not disclose, so it is difficult to understand if this is a real difference or not.

The nature of the local population presents challenges for both commissioners and healthcare providers, as the population increase by two-thirds during the day and these people will not be captured in local population demographics, therefore the profile of the local population may significantly change during the day.

5. Feedback from patients

5.1 Friends and Family Test (FFT)

All NHS organisations are required to ask patients a question referred to as the Friends and Family Test (FFT). This question asks people who use the services if they would be likely to recommend the Trust to family member or friend if they needed similar treatment. The response is reported as a percentage likely to recommend.

We have looked at our patient population and the profile of those who complete the FFT. White people are overrepresented in the FFT data; however more people were prepared to disclose their ethnic group when completing the FFT than when they attended outpatients department or were admitted to hospital. This may be a reflection of their health and well-being at the time.

People aged 51-65 years were over represented in the FFT feedback and women were marginally under represented.

We found that there was little difference between the ethnic groups in terms of whether or not they would recommend the service. The only group that scored slightly lower were those who identified as mixed multiple ethnic backgrounds and used our A&E services. More people who attend A&E do not disclose their ethnic group.

The most significant differences were between people aged 16-50 years who used our outpatient services who would be less likely to recommend our services when compared with other age groups. This may be due to waiting times and work commitments.

5.2 Complaints

People aged 36-50 years were more likely to complain than other age groups. Women were more likely to complain than men; however more women use our services so proportionality the numbers were similar (65% of complainants were women and 60% of our local population are female).

White people were more likely to complain but again this was consistent with more white people using our services, we noted that we only have data for 15% of complainants.

Fig.5 Profile of the total patient population and complainants by age
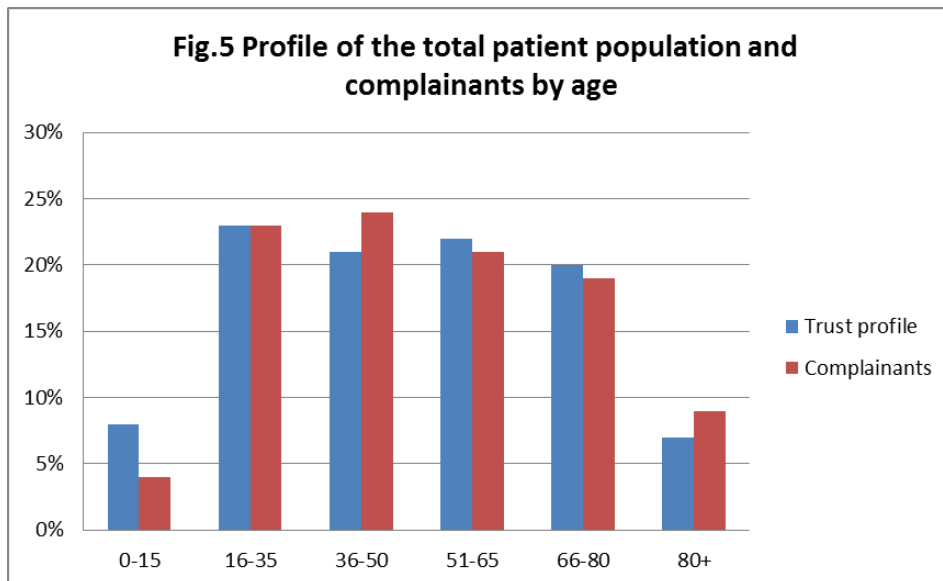
6. Summary of Progress against the Equality Objectives 2017/18

6.1 Patient focused Equality Objectives

In 2017/18, the Trust decided to focus on the protected characteristics age and gender identity*. Age is identified as one of the protected characteristics under the Equality Act 2010.

*The Trust acknowledges that under the Equality Act 2010 the term Gender Reassignment is used to identify one of the nine Protected Characteristics; however the Trust believes that the surgical intervention that some people may choose is only one option for addressing gender dysphoria that not everyone transitioning will seek.

The Trust recognises that the surgery itself does not change someone's gender identity so avoids the term reassignment surgery. The Trust also recognises that surgery is not necessary to confirm anyone's gender identity. In the context of this protected characteristic, the Trust will use the preferred term Gender Identity.

In 2017/18, we specifically focused on the outcomes overleaf from the EDS2 framework.

Tab.2

Goal No.	Goal	Outcome	Protected characteristic being considered
1	Better health outcomes	1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed	Age
2	Improved patient access and experience	2.3 Patients and carers report positive experiences of the NHS, were they are listened to and respected and their privacy and dignity is prioritised	Gender Identity*

6.2 Protected characteristic- Age

In 2017/18, the Trust decided to focus specifically on young people who were approaching an age when they may be preparing to move from children's to adult services.

Adolescents or young people (classified as those aged between 10 and 19) account for over 12 per cent of the UK's total population (Census 2011);an increasing number of whom have long term conditions and complex health needs.

Shaw et al (2004) describe how the lack of 'discrete provision for transfer of care' between paediatric and adults services leave young people feeling 'dumped, cut off and abandoned'.

Transition, (in the context of age) is defined as 'the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centred to adult-orientated health care systems' (Blum et al 1993).

The Trust recognises that our current transitional care services for young people are ad-hoc. There are examples of excellent practice but this is often disease specific and we do not have a consistent approach or model. For example our HIV services work together across paediatrics and adults and have gained an international reputation for their work.

In 2017/18, an Adolescent Interest Group was established, consisting of paediatric and adult clinicians. This group currently meets monthly and is reviewing our adolescent services including proposing the development of a 'virtual' adolescent service. This will ensure adolescents receive the holistic, developmentally appropriate support they need in all clinical settings.

An important part of this work has been raising the profile of Adolescent care and the group has been working hard to do this. In January 2018, a young person (aged 18 years) attended our public Trust Board to share their experience of transitioning to

adult services. This patient's story was positive; however the learning illustrated the need to ensure that all young people have such a positive experience.

In March 2018, the Trust 'signed up' to be part of an international Global Teen Health Week. This consisted of a number of events focusing on teenage specific health related matters such as sexual health and drugs. During the week, the Adolescent Interest group hosted a number of interactive information stands at the main entrance of one of our sites. This week generated a lot of interest from staff and public.

Building upon this, we held an Adolescent themed Schwartz Round. Schwartz rounds are an important opportunity for our staff to come together and share and reflect upon a subject and to encourage reflective discussion amongst the audience. Schwartz rounds were developed after a terminally ill patient (Kenneth Schwartz) identified the importance of staff welfare and how having a 'safe' place to openly discuss their feelings can help them to deal with their emotions and continue to deliver compassionate care.

The Trust has a well-established quality improvement programme. This uses a range of different tools and techniques to try and make small improvements to the quality of the services we deliver and then to share and spread these good practices to other wards or departments. One of the ways in which we do this is through big rooms. Big Rooms bring together staff who have an interest in a subject and through coaching and support great ideas are born and developed. This is a supported programme and teams are required to apply to become a 'big room'.

The Adolescent Interest group submitted an application and were approved. This work will commence in June 2018 and we are hopeful it will bring together all relevant parties with a specific focus on developing a 'virtual adolescent service'. This means that in the first instance, the service will not have a geographical location or base but will be formed so that the team can be contacted and be responsive to supporting young people.

6.3 Protected characteristic- Gender Identity

Last year we had received a complaint from a patient re: gender recognition. The Trust committed to developing a policy that would outline how we would implement the Gender Recognition Act in the first instance. The Gender Recognition Act (2004) outlines people's rights to be recognised in law as the gender they identify with, not the gender they were assigned at birth.

A working group was gathered to co-design this new policy, including clinical staff from our gender recognition services; legal team and service users. The policy was developed together and published in 2017.

As part of the launch of this new policy, we shared a patient story at our public Trust Board, highlighting how it feels to be misgendered (incorrect use of pro-nouns,

calling a female person male). This story highlighted that there is still much work to be done to embed this policy into practice and to improve patient experience.

There is still much work to be done on this protected characteristic, especially in terms of embedding this into practice.

6.4 Patient stories

Patient stories are 'told by individuals from their own perspective and in a healthcare setting they can provide us with an opportunity to understand their experience of the care they have received – what was good, what was bad and what could be done to improve their experience' (NHS Improvement 2017).

We try to include some patient stories to reflect the work we are doing around Equality and Diversity. As stated above in 2017/18 we have listened to 2 such stories at our public Trust Board.

In addition, we have heard from patients who represent people who are of different genders and ages and from different ethnic groups. We have heard from 2 patients from BAME backgrounds in 2017/18.

7. Patient focused priorities for 2018/19

7.1 Patient priorities for 2017/18

Following an internal review of progress against EDS2 outcomes and utilising patient feedback, it was agreed that we should continue to focus on the EDS2 outcomes included in the table below as further work is needed in these areas.

Tab.3

Goal No.	Goal	Outcome	Protected characteristic being considered
1	Better health outcomes	1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed	Age
2	Improved patient access and experience	2.3 Patients and carers report positive experiences of the NHS, were they are listened to and respected and their privacy and dignity is prioritised	Gender Identity*

Based upon these outcomes, our priorities are:

- To embed the Gender Recognition Policy.
- To develop the virtual transitional care services for adolescents and young people

In addition we will continue to:

- Develop Accessible Information in easy read format and to monitor the effectiveness of systems in place to meet the needs of patients with specific communication needs as outlined in the Accessible Information Standard.

- To continue to embed our services for people with learning disabilities

Appendix 1- Protected Characteristics as defined by the Equality Act 2010

Nine protected characteristics as defined by the Equality Act 2010

Age - Refers to a person having a particular age (for example, 32 year olds) or being within an age group (for example, 18-30 year olds). This includes all ages, including children and young people.

Disability - Includes significant and lengthy conditions that are physical as well as not seen, such as those relating to sight, hearing, speech, learning and mental health. Also includes HIV and cancer and other types of diseases.

Gender reassignment* - This is the process of transitioning from one gender to another, whether proposing to undergo, undergoing or having already undergone a process (or part of a process) to reassign biological sex.

Marriage and civil partnership- Marriage being a union between a man and a woman and civil partnership being legal recognition of a same-sex couple's relationship. Civil partners must be treated the same as married couples.

Pregnancy and maternity -Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth and this includes treating a woman unfavourably because she is breastfeeding.

Race- Refers to a group of people defined by their colour, nationality (including citizenship), ethnic or national origins. Includes Asian, Black, Chinese, Mixed and Any Other Ethnic Group, as well as White British, Irish, Scottish and Welsh, Romany Gypsies and Irish Travellers.

Religion or belief Religion means any religion, including a reference to a lack of religion. Belief includes religious and philosophical beliefs including lack of belief (for example, Atheism).

Sex - Someone being a male or a female. Assigned at birth.

Sexual orientation - This is whether a person's sexual attraction is towards their own or opposite sex or to both. Includes people that are gay (men who are attracted to men), lesbian (women who are attracted to women) and bisexual (people attracted to both sexes).

*The Trust acknowledges that under the Equality Act 2010 the term Gender Reassignment is used to identify one of the nine Protected Characteristics; however the Trust believes that the surgical intervention that some people may choose is only one option for addressing gender dysphoria that not everyone transitioning will seek.

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