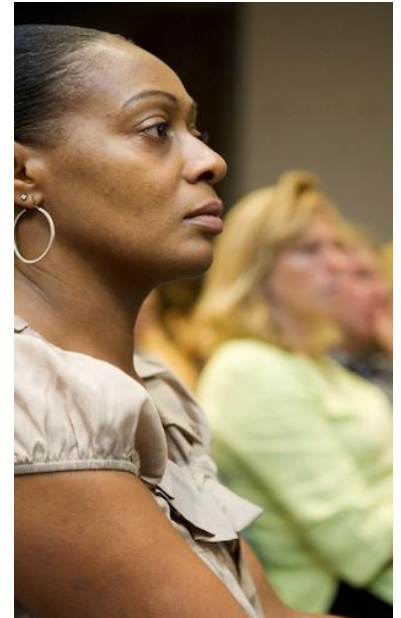
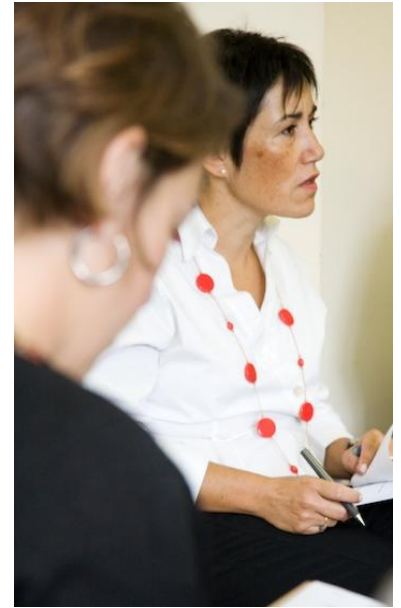


Single Equality Scheme 2010-2012



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SECTION 1 INTRODUCTION AND SUMMARY

1.1 Introduction from CEO



London's communities are becoming increasingly diverse. As a Trust we need to understand the opportunities and challenges this creates in order to deliver our services in the most effective and accessible way. We aspire to go beyond legal compliance in relation to equality and human rights legislation by reaching across all sections of society. This means thinking about the mental health issues of the local population, reflecting on the services we develop and deliver, and making sure that issues of equality and diversity are part of all of our planning and included in the way we conduct our daily business. Our Single Equality Scheme gives us an opportunity to do this for our staff, patients, students and service users in respect to ethnicity, religion or belief, age, disability, gender, sexual orientation and gender identity. Mental health

depends to a substantial degree on a sense of belonging and being accepted. Equity of access to services in turn depends on active engagement with local communities. The Trust is dedicated to delivering services and developing a culture that promotes equality and meets the mental health needs and expectations of local people; we want to work with our patients, students, staff and public to help us make changes to improve these services.

The Tavistock & Portman NHS Trust aims to support, develop and maximise the personal and professional potential of all its, service users and staff. The Trust recognises the impact of economic, political, social and ideological contexts in our society generally and the inequality which results from this for particular people and sections of the population. It recognises that inequalities based on race, socio-economic status, disability, culture, gender, religion, age and sexual orientation each may lead to emotional and psychological difficulties for individuals, but also that these intersect. In combination these multiple layers of inequality may seriously impair individual experiences of freedom, respect, identity and relationships. This contributes to mental health inequalities and suffering.

The Trust considers the elimination of discrimination, harassment and victimisation as central to the delivery of clinical services and training, We aim to address overt and covert processes which impede the delivery of full equalities and to back up our outcome monitoring with the aim of creating opportunities for a more global change in the our outlook over time.

We have achieved a lot in relation to race, disability and gender equality. We now welcome the opportunity to include age, religion or belief, sexual orientation and gender identity. This scheme sets out our long term commitment to equality, diversity and human rights and it will be regularly reviewed to ensure its relevance. We look forward to the work ahead and meeting the challenges we have set ourselves in this Scheme.

A handwritten signature in dark ink, appearing to read 'M Patel', written in a cursive style.

1.2 Introduction to the Trust

The Tavistock and Portman NHS Foundation Trust is a high performing mental health trust, specializing in Education and Clinical services, and in particular in Child and Adolescent Mental Health Services (CAMHS). The Trust has received an 'excellent' rating for the quality of its services, from the Healthcare Commission, for the last five years and the Trust's staff survey results are among the best in the country on many indicators. We have strong relationships with our commissioners and other partners and user satisfaction remains high.

The Tavistock Clinic has delivered exceptional mental health services to adults, young people, children and their families since the inception of the NHS, over 60 years ago. CAMHS is the largest part of our clinical business comprising 70% of patient services.

The Trust is a national provider of mental health education and training, across health, social care and education. It delivers around 70 courses locally, nationally and its international links relate to its excellent international reputation. The Trust enrolls in the region of 2700 students each year, including its CPD programme of workshops, short courses and study days. Our reach includes a wide professional audience, including commissioners, managers and service providers through our extensive conference programme. We run a developing range of leadership and management programmes as well as our consultancy services which influence the wider workforce.

The Trust is proud of its contribution to research and the evidence base for interventions in the areas of mental health and child development. We believe the research ethos of the Trust contributes to and supports our innovative approach to delivering clinical and academic services of the highest quality.

1.3 The Legal Context of introducing the Single Equalities Scheme

The Equalities legislation requires that the Trust prevents unlawful discrimination in regard to gender, religion/ belief, age, disability, race and sexual orientation and to promote equality and good relations between people. These general duties are underpinned by specific duties which include the publication of Equality schemes and setting of improvement targets and assessment of all policies, practices and procedures highlighting the way we conduct business. It is now anticipated that the Single Equality Bill, when enacted, will include a single equality duty for local authorities and other public bodies. Among other things, the current race and disability and gender equality duties will be replaced with a new single public sector duty, which is extended to cover gender reassignment, age, sexual orientation and religion or belief.

The new duty will require the public authorities to have regard to the following when exercising their public functions

- Eliminating discrimination, harassment, victimisation and any other conduct, prohibited by the Bill
- Advancing equality of opportunity between people who share a protected characteristic & people who do not share it
- Fostering good relations between people who share a protected characteristic and people who do not share it

The Tavistock & Portman NHS Foundation Trust has chosen to produce a Single Equality Scheme. This Scheme includes gender, race and disability as well as religion, culture, belief and sexual orientation which form part of future legislative requirements. The Scheme allows us to demonstrate how inequalities will be addressed proactively, recognising that they intersect. We indicate what we are currently undertaking and how we shall identify future directions and which inequalities apply most urgently in the context of finite resources within one of the smallest NHS Foundation Trusts.

1.4 Our Single Equality Scheme – making a difference

We want to identify our successes, the areas which need attention and carefully to consider what changes will really make a difference. We will do this by looking at quantitative data, direct feedback from patients, students, staff and benchmark against comparable organisations.

We intend to undertake many initiatives which address equalities, and not all are captured in this scheme. Here we identify a small achievable number of priorities. We do not believe overambitious or over detailed schemes are helpful. We want to put the effort and energy into identifying the right issues to prioritise and to make interventions that make the most difference. Our plans are thus intended to be specific, measurable, achievable, relevant and time-bound. The scheme will examine equality in 6 domains

1. Governance and Culture
2. Communications
3. Patient Services
4. Education and Training Services
5. The Trust Workforce
6. Buildings and environment

Each of our directors is responsible for integrating equalities clearly into their existing planning and reporting systems. Therefore reviewing progress on equality issues will be considered part of normal 'business'. There is an expectation that directors will include equalities in every part of their strategic

and operational thinking and planning. This will be within agreed priorities overseen by the Equalities Committee and approved and monitored by the Management Committee and the Board of Directors. The Equalities Committee will play a role in reviewing 'domain' plans.

In addition, we have developed a small number of Trust wide priority areas which will be actively overseen by the Equalities Committee.

1.5 Summary of Progress to Date and Priorities

1.5.1 Governance and Culture

Our priority is to increase the diversity of our governing bodies and those in leadership positions. We believe this in itself will bring equalities more centrally into our work and thinking. At present while our gender balance is good, we have too few staff from black and minority ethnic groups in leadership positions. We do not have sufficient information on the disability and sexuality of staff on our governing bodies to make a judgement about representativeness. As a Foundation Trust we are a membership organisation. Our members are reasonably representative of the local communities we serve (appendix G), the one area where there is a striking difference is in the younger age group 14-16. Therefore we are working towards increasing the number of members who are young people.

We know that managers and staff have a good understanding and most importantly a real commitment to equality issues. In many places equality issues are attended to and prioritised and there are many examples of good practice. However, there are areas of complacency and areas which are under-developed. Our aim is to ensure that we constructively challenge where there is a need to review and increase the focus on equalities.

Equality issues need to be more actively attended to in all areas and systematically integrated into existing planning and reporting processes, with nominated staff asked to review and galvanise equalities work. Consequently directors are expected to include equality issues in their planning and reviews as a matter of course and all service directorates have now nominated a member of staff to lead on equality issues. Sarah Wynn will lead on equalities in CAMHS, Sara Davidson will lead on equalities in our adult and specialist services and Trudy Klauber will continue to lead on equalities within education and training.

Trust Wide Priority

To ensure that our leadership consider and are fully informed of their role in equalities, that equality issues are effectively integrated into existing planning and review processes and to examine equalities in relation to our adult and specialist services. We also aim to increase the diversity of those in leadership

positions. The Equalities Committee will also consider how best to take forward debates on equalities within the Trust e.g. at Scientific meetings and with directorates.

1.5.2 Ethnicity

The primary focus over the past decade has been to increase ethnic diversity in our workforce, and service users - patients and students. We have good information about ethnic profiles. The ethnic profile of patients broadly reflects our catchment population. The diversity of our patient and student population is increasing e.g. growth from 12-15% for BME students in the past four years. We are reaching more patients from black and minority ethnic groups by locating CAMHS in Local Authority services and in the community (e.g. safeguarding, youth offending service, schools). The percentage of BME patients in these services is 51% compared to 28% at the CAMHS in our main bases. We have developed services for specific ethnic communities, including the Somali, Congolese and Bangladeshi residents of Camden and in dedicated refugee services. In education and training consultation on reading lists, feedback from BME students on their experience in such activities as cross cultural infant observation, inclusion of ethnic and cultural dimensions in work discussion and the impact on student experience of representing a visible distinctive ethnic minority in small seminar groups, have all had an impact.

This will continue to be a primary focus of our equalities work.

Trust Wide Priority

To increase the number of black and minority ethnic groups in leadership positions and representation in senior grades.

1.5.3 Religion

Race, culture and religion are linked and religion needs to be thought about in the context of ethnicity, cultural and spiritual life. Religion and culture clearly link with our work on race equality for many service users. We have not asked service users about religious belief and have no plans to begin data collection. The need to routinely collect this data is less important for a Trust which only provides outpatient services.

Trust Wide Priority

To examine alternatives for our existing, less than ideal, multi-faith prayer facilities for staff and students.

1.5.4 Disability

With regard to patient services, we have a specialist service for people with learning and complex difficulties, our CAMHS provision is integrated into Camden Local Authority's children's disability service and we also provide an autism service.

4 % of our students report a disability. In terms of hidden disabilities dyslexia is reported increasingly by students who along with all students are benefiting from a named disabled students' officer, staff who are committed to and trained in ensuring equality of access for all students and who are participating in an ongoing staff development programme on teaching methods, presentation of visual and written materials and lecture note summaries. The Tavistock and Portman Library is frequently praised for its services to disabled students which include monitors for visually impaired students and services such as scanning, photocopying and printing at 50% discount. The Library has modified large monitors to assist visually impaired students and the Lecture Theatre has a Hearing Loop. The Library staff understand the need to help students with dyslexia and dyspraxia on an individual basis to enable them to access research databases, order inter-library loans, and to work with any paid helpers in accessing printing and organising online and printed materials for course reading or in preparing dissertations and theses.

The Trust ensures we act fairly regarding recruitment and employment and have been awarded the two tick disability rating. We have actively promoted disability awareness in our mandatory in-service training days, for all staff. 1.8% of our staff have declared that they have a disability.

Most areas of the Trust are accessible by service users and staff with disabilities, including wheelchair users, and specific arrangements are put in place to ensure there is no disadvantage. Progress on making our buildings more accessible to people with disabilities continues, examples include renewal of signage and refurbishing the disabled toilet provision.

People First have been commissioned to work with the Trust to ensure that our information both paper and web based are appropriate for people with learning disabilities.

One area of weakness is the lack of systematic data collection on disability in our patient services and this will be a priority during the scheme.

Trust Wide Priority

To improve data collection in patient services and to create an environment where all staff with a disability feel able to declare this and receive appropriate support.

1.5.5 Gender

Male patients are under-represented in our adult services, as in psychological therapies nationally. We believe that by delivering services in different settings we will increase accessibility for men. We will test out this hypothesis in our new City and Hackney Primary Care Mental Health

Service. We are also aiming to reach more men through our involvement in Big White Wall, an innovative online wellbeing service.

The majority of our staff are female (73%). In 2008, women were under represented on our Board of Directors. This is no longer the case and we have recently appointed a woman to the post of Trust Chair. Women are well represented in leadership positions within the Trust.

Most of our students are female (80%) and this reflects the gender composition of the mental health workforce.

Trust Wide Priority

Gender will not be an initial priority. The equalities committee will revisit gender profiles in the second year of the scheme.

1.5.6 Sexual Orientation

To date the Trust has not looked at equality of opportunity and access in terms of staff and service-users' sexual orientation. It is becoming evident through staff feedback in service training days and in response to consultation on the Single Equalities Scheme that this should become one of our priorities in the coming three years.

We are aware anecdotally that some gay and lesbian professionals hold the strong opinion that sexual orientation is an "unspoken" difference and that the Trust adheres to an earlier 20th Century view of homosexuality which was then seen as a perversion. This is *not* the view of the Board, Management or of the Trust's currently employed psychoanalytic practitioners. In terms of scientific meetings, public lectures and teaching, there is an increasingly proactive stance in challenging homophobia and misconceptions about the Tavistock and Portman. Modern psychoanalysis differentiates between relationships based on love, care and concern and those based on sadomasochistic interaction. Sadomasochism, cruelty and violence are perversions, not sexual orientation or same sex object choice.

In our Trust, discrimination on the grounds of sexual orientation is not tolerated. There is emerging evidence that lesbian, gay, bisexual and transgender people are at higher risk of some mental health problems.¹

We have not routinely collected information about patients or students' sexual orientation and we do not feel that at this time it would be

¹ Meads C, Pennant M, McManus J et al. (2009) *A Systematic Review Of Lesbian, Gay, Bisexual And Transgender Health in the West Midlands Region of the UK Compared to Published UK Research*. University of Birmingham, Department of Public Health and Epidemiology Report Number 71. West Midlands Health Technology Assessment Collaboration

appropriate to do so, although this will be considered for patients as part of the RiO deployment project. Recruitment through NHS jobs provides applicants with the opportunity to provide this information. This is a voluntary process. Recording of the workforce monitoring information is currently being improved through the implementation of the Electronic Staff Record (ESR).

Trust Wide Priority

Our priority is to gain more information about how people perceive our patient services, training and working at the Trust in relation to sexual orientation.

1.5.7 Age

The age profile of our CAMHS patients is similar to other CAMHS. The needs of young people (16-25 year olds) are often not met well by mental health services, and we believe our adolescent service provides an example of good practice for this age group. We are seeking to increase the proportion of our members who are between 14 – 21, as they are under represented at present. Our adult services see a reasonable proportion of over 60's (7%) but we intend to explore how we can increase access for the over 60s by developing services which link with physical illness. A high proportion of Trust staff are over 40 (68%) with 11% over 60.

Trust Wide Priority

To increase the number of young members of our Foundation Trust.

1.5.8 Socio- Economic Status (SES)

This scheme does not address socio- economic status directly, but we believe, as do our staff, that class is a dimension of equality that has to take centre stage and that it intersects with ethnicity and disability in particular. We intend the scheme to develop to include SES. Our initial aim is, with expert advice, to analyse the socio economic profile of our patient population and from there to identify what action needs to be taken. Feedback from staff indicated that locating more of our services 'in the community' and in other settings such as safeguarding and schools has significantly improved accessibility and that we are accessing a higher proportion of people from 'lower' SES.

Trust Wide Priority

To analyse the socio economic profile of our patients.

1.5.9 Information

Collecting and analysing information is key to identifying areas of potential inequality and in assessing progress. Data collection is good but will be further improved as outlined in this scheme. At present our focus on equalities has been to ensure equality of access and designing patient

services and training which meet the needs of different groups and individuals. We have not focussed on monitored outcomes in relation to equality issues. It is proposed that this is explored in the final year of the scheme, in 2012. It should be noted that we have focused on outcomes for staff and are actively looking at increasing the diversity of our senior staff group in particular.

Trust Wide Priority

To examine outcome data in relation to equality issues in the third year of the scheme.

1.6 CONSULTATION

Consultation about the single equality scheme began in 2008. Approximately 50% of staff discussed the scheme at two INSET days. Formal consultation, including 3 consultation workshops, took place in October 2009 and included our joint staff committee, all staff and Board of Directors (Executive and Non Executive), Patient Public Involvement Committee, Equalities Committee and Management Committee. The scheme was also circulated to external agencies like SCOPE, Nafsiyat, PCT Commissioners, Stone wall and was placed on Trust's Internet for wider reach.

1.6.1 How the Consultation process influenced the Scheme

There was general support for the scheme and the priorities it outlines. The scheme and associated programmes has been modified to take into account the following themes that were raised

- The need for the Trust to make unambiguous statements about sexual orientation.
- Socio economic status to be included in the scheme.
- A greater emphasis on disability e.g. in the staff section.
- The need to attend to transparency, openness and improved communication within the Trust.

Summary of the discussion points is attached as Appendix H.

Section 2 CULTURE AND GOVERNANCE

2.1 Organisational Culture

The Tavistock & Portman is a small, organisationally compact NHS mental health trust that specialises in providing outpatient psychological therapy clinical services and training public sector staff to work in ways that emphasise the centrality of relationships, human systems and organisational context. A large majority of clinical staff are very highly trained with long experience. These factors make for a rather distinctive organisational culture that is highly valued by all staff – clinical and non-clinical. Staff groups like to 'own' their own change processes and tend

to value organisational self-determination. This gives rise both to particular strengths and distinctive dynamics where change is driven, or partly driven, by external forces and imperatives. From experience over the last ten years, successful internal change processes in the area of equalities entail:

- Clear and strongly mandated leadership that engages both clinical and non-clinical staff with equal respect
- Change processes that emphasise consultation, dialogue, negotiation and local ownership
- Change processes that successfully bridge national legislative and policy requirements, and local specialist knowledge of mental health equalities issues
- Timely but forceful challenges to areas of organisational resistance to change, which respect the fact that genuine change is often incremental and 'molecular'

Staff will often speak in terms of the need for change in the area of equalities to be 'organic'. In the last ten years, there has been notable progress in particular inequality domains, where leadership has respected some of the above factors, senior management has mandated key processes, and adequate resources have been available to support staff leading change. On the whole, staff in the Trust are cautious about declaring their commitment to equalities work, but given the opportunity to do so, it is evident that there is widespread commitment and enthusiasm for this work.

2.2 Governance

It is important that equalities is a central consideration of our governing bodies. We also believe that this is aided by our Governing bodies being representative of our local communities.

2.3 Members and the Board of Governors

As a Foundation Trust, we are a membership organisation. Members elect the public governors of our Board of Governors, who in turn appoint the Trust Chair and Non Executive Directors. Our Board of Governors has a key role in informing the development of the Trust Strategy. At present our membership is reasonably representative of the population in terms of ethnicity, with a higher proportion of female members (77% where gender is known), with low and decreasing number of young people (14-16 and 17-21 age groups). At present we do not collect or report on disability (Appendix G). The Trust is amending its Membership Application Form to request this information, although disclosure will not be mandatory. This data will be collected as of January 2010, and going forward we will be able to monitor the disability profile of our members, but there are currently no plans to ask the existing membership to disclose this information. Students automatically become members on enrolment unless they opt out, and do not have to complete a Membership Application Form. However, information

on disability is already captured in the student registration process. For staff, this information is captured at the time of application and/or appointment.

The priority is to recruit more members in the younger age groups and the Trust is talking to the local youth council about ways of ensuring relevance to this age range.

The Board of Governors still have no members who are from black and minority groups. We encouraged people from these groups to put themselves forward for the November 2009 election for governors. Lessons learnt with regard to the board of governor elections will be reviewed by the Board of Directors.

2.4 Board of Directors

Our Board of Directors has 12 members. Two board members are from black and minority ethnic groups. When the Trust's gender equality scheme was published in 2008, the gender imbalance was noted. Now the profile has changed, 42% of board members are now female.

2.5 Management Committee

The Management Committee is the Trust Executive Committee whose role is to advise the Chief Executive on all aspects of the Trust's management. It has 9 members. The balance between men and women is good. No members are from black and minority ethnic groups. The number of black and minority staff in leadership positions is being addressed across the Trust (see Section 6).

2.6 Equalities Committee

The Trust's Equalities Committee, has significant Director level membership i.e. Director of Service Development, Dean, Trust Director, Director of Governance and Facilities, a non executive Director. There are also two governor members, a Human Resources Manager and staff side representative. The equalities committee is responsible for leading, coordinating and monitoring the Trust's action in the areas of equality and diversity i.e. race, gender, disability, religion, sexuality, socio economic status and human rights across the training, clinical and HR functions. The aim is not only to ensure the Trust complies with legislation and external assessments e.g. Care Quality Commission compliance with National Standards, but also to define the Trust's aspirations in this area and identify how they may best be executed. The committee also considers equality issues which raise concern, examples could include overseeing further investigation of differences in opportunity or experience.

2.7 How are equality issues currently considered and addressed at a Trust wide level?

Our Annual Plan clearly states our commitment to equalities. "One of the themes

of our annual plan is equity of access and equality in all areas of our activity". We monitor our equalities work through our annual assessment of compliance with healthcare standards relating to equalities work and subject all our policies to equality impact assessments, an increasing number of services/functions are also formally assessed in this way. Data on equalities is also considered by the Board of Directors (e.g. in relation to workforce statistics).

2.8 Priorities

Whilst there is a high degree of commitment to equality issues among management committee members, there is a need to become more familiar with current legislation, issues (e.g. move to the equality commission), current debates and appropriate language and contemporary thinking in the area of equalities. Equalities training will therefore be commissioned for the Board of Directors and Management Committee.

We also plan to monitor membership of Trust committees, reviewing appointment processes to identify how we can promote the opportunity to be involved in the Trust's decision – making processes to under represented groups.

Section 3 COMMUNICATIONS

We need to ensure that we clearly communicate our commitment to equalities, our successes and our plans. Our website has recently been redesigned and the feedback is that it is successful in representing strong images of a multi cultural organisation with clear statements of the Trust's commitment to greater diversity.

Consultation with staff has revealed that they feel there is a lack of information about 'how we are doing' in the area of equalities and what our plans are. In response to this we have therefore created an equalities section on our intranet, which includes data, reports, our equality schemes and minutes of the equalities committee.

We are developing a children's website together with children from Camden schools where there is diversity in the populations across the borough. One of the main themes of the site is 'difference'.

All our leaflets have been redesigned with images that more accurately reflect our service user population.

The Trust's Learning and Complex Disability Service has recently begun a consultation project to obtain feedback on our patient services accessibility from disabled users, for example using posters and materials that are less verbal.

SECTION 4 PATIENTS SERVICES

The Trust has a national and international reputation for the range and quality of its outpatient mental health services to children, and families, adolescents and adults. The Trust aims to draw on its research strength, clinical innovation and partnerships to provide new services and new ways of delivering care.

4.1 Information

4.1.1 Quantitative Data

We routinely collect information on patient's ethnicity and data quality is reasonable with only 22% of our patients ethnicity not known or not given. We analyse this information each year identifying groups which may not be equally accessing services and considering how we can improve access. In 2009 we will begin to routinely collect information on whether patients have a learning disability or a physical disability in our CAMHS and will be extending routine data collection to all services as part of the RiO deployment in 2010. This will enable us to assess accessibility and outcomes in relation to disability more systematically. We routinely collect information on gender and age, but have no plans to extend this to sexual orientation or religion.

4.1.2 Patients' Views

We conduct an annual patient survey, ideally we would analyse the results to see if people from different groups experience the services they receive in different ways. However the combination of the small sample size/ return rate (in 2008/9 97 responses from a sample of 522 patients) and high rates of patients not completing the equalities monitoring form mean that it is not possible to do this. The Trust receives an exceptionally small number of complaints (08 in 2008/9); therefore it is not meaningful to subject these to an equality analysis.

Children are rarely given a collective voice about the services they receive. The Trust has developed a children's survey, we are not aware of a similar initiative elsewhere.

Case Example: Children's Survey

We have set up a regular children's survey that was designed in consultation with primary school children. Initially we involved 12 child patients and 12 local school children. Over 60 % of our current child patients have completed the children's survey in the waiting room. The main aim was to get better feedback on children's experience of attending our services, and to use this feedback to improve communication and services. Our experience is that children really appreciate being asked

directly what they think about our CAMHS. As a result of this survey we had made a number of changes to our services such as installing blinds in the waiting room to better control the temperature, getting donations for a wider range of magazines. Results are translated to a child friendly poster in the waiting room, with clear indications about what we have changed in response to feedback. The most important aspect of child involvement was ensuring the children had access to the results of the research and could see the changes made as a direct result of their involvement. We felt that it would not be possible to understand what attending our services was like for children with out directly involving them.

On an ongoing basis we keep equality/BME engagement as a standing item on our agenda for the Patient and Public Involvement Committee meetings to ensure that we consider developments in this area.

4.1.3 Staff feedback

Staff views were gained through INSET days in 2008 and 2009. For example, staffs' experience is that our outreach services have a vital role in improving access and it is a priority in this scheme to expand these further.

4.2 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) AND YOUNG ADULTS

Child and Adolescent Mental Health services (CAMHS) are delivered by our Child and Family and Adolescent Department and Camden CAMHS. This work comprises a balance of generic and more specialised service provision. CAMHS make up the majority (70%) of our services

Children, young people and families are seen from the pre-natal period up to the child's school-leaving age. The adolescent service sees young people between 16 and 21 years of age although work may also take place with parents and other family members. The cases are often complex and there is an increasing emphasis on outreach work supporting colleagues in neighbouring boroughs.

We also have a number of specialist CAMHS:-

Tavistock Children's Day Unit, Gloucester House

The Day Unit offers a service for primary school children with complex and extreme behaviour difficulties who are unable to attend mainstream or special education. The Unit aims to support both general child development and educational progress and incorporates a multidisciplinary child and adolescent mental health team with a full education curriculum. The unit is registered as an independent school with OFSTED.

Monroe Family Assessment Centre

The Monroe is an assessment and treatment centre for families, often with children under five, who are at risk of, or have experienced, abuse or neglect. It

receives referrals from local authorities and the courts. It also offers a limited number of treatment places, consultation and training to other services.

Gender Identity Service

This specialist service provides assessment, advice and treatment for children and adolescents who have problems of sexual identity. It is the only service of its kind in the UK, and during the course of 2008/09 was authorised for national commissioning.

4.2.1 Our approach to Equalities in CAMHS and the young adult services provided by the Adolescent Department

We see CAMHS as part of a wider service for children, families and young people, much of which is provided by local Councils. Therefore we see our role as working in partnership with other agencies to reduce inequalities. Consequently we are active members of local children's partnership structures in Camden, Barnet and Haringey. We are also members of the single point of referral schemes, which works to reduce inequalities of access to CAMHS services across the borough.

Our CAMHS have a track record in identifying populations who are not equally accessing services and who are in need, working with the community and other agencies to identify what type of services can best meet these needs and then developing appropriate services. Examples include Integrated Early Years, Asian services, the work of the South Camden Community Team, MALT and the Refugee Team's work with the Somali Congolese and Afgani communities.

Case Example: Habari (Peace of Mind)

Through reviewing our services and looking at local needs we realised that there was a significant Somali Community in Camden, whose young people and families had many needs and weren't accessing our services.

We worked with all the Somali community organisations to find out what we could do. With funding from the Children's Fund we established a new service, which was designed in conjunction with the community. Somali staff were employed and trained as mental health workers. The service has been such a success that we have been able to incorporate it into the Refugee team, and use the model to begin engaging the Congolese community.

We have also designed our services, in collaboration with commissioners and other children's service, to address the needs of many vulnerable groups either by developing specific services at our main base, such as the Monroe Family Assessment Service and our refugee team, but also by integrating CAMHS staff into services such as Mosaic (Camden's service for children with disability), the Youth Offending Team, Children's Centres and

schools in Camden.

Case Example: Adolescent Department

Our approach to being sensitive to diversity on an individual patient level is illustrated by the adolescent departments approach. Since its inception, the Adolescent Department has attempted to achieve a high level of sensitivity to diversity, developing services that are as accessible as possible for young people. This includes offering self-referral, and very brief interventions. Working with young people between the ages of 14-30 years necessarily involves sensitivity to the young person's perception of themselves (their identity), of where they think they come from, and which groups they feel they belong to. Adolescents often feel judged and discriminated against, whatever their background ('adolescent' itself can be a pejorative term, implying immaturity) and so staff work hard to support those who have additional concerns about how they will be perceived and received.

4.2.2 Socio-Economic Disadvantage

In 2008, we opened our South Camden Service at St Pancras Hospital and the Crowndale Centre. The aim is to increase access by locating more of our services in community bases where more of the deprived wards are located. In particular Integrated Early Years Services, commissioned by the local authority, have a remit to offer universal services throughout the borough, which are also targeted at hard-to-reach groups, eg teen-parents, fathers, BME communities, mothers with post-natal depression. Community CAMHS use links and partnerships with voluntary agencies to reach people who traditionally have been wary of mental health services.

Case Example: The Integrated Early Years Service

The Integrated Early Years Service is running a Webster-Stratton Parenting group for teen-parents in conjunction with a project worker from Coram, in Kilburn, near to several teen-parent hostels. They provide lunch and help with transport, to maximise group members accessing the help offered.

Case Example: MALT (multi-agency referral service)

Based in a Social Services Family Centre, the service delivers specialist services to high need children and families, many of whom are under Child Protection Procedures or in Care Proceedings. The core task of the team is to deliver specialist programmes of mental health work to children and families referred by social workers in the Local Authority; and to offer specialist advice to the Local Authority safeguarding and social care teams, regarding decisions made in the best interests of the child.

In normal circumstances few of these children and young people access mental health services, particularly when care proceedings are underway. These children are at high risk of poor outcomes on all of the 'every child matters' indices. The work often includes parenting programmes (individual

or group) or family work and occasionally individual work with children and young people. Treatment is preceded by focused assessments aimed at seeing if it is appropriate to carry out further work. Initial pieces of work are also aimed at assessing the emotional wellbeing and identification of mental health problems in children, and treatment if appropriate (although often MALT will refer to specialist CAMHS teams around Camden if longer term work is required).

We believe that our services contributed to some of the high praise received in the recent Camden JAR (2007) 'highly effective multi-agency actions that improve outcomes for particularly vulnerable groups'. 'outstanding comprehensive CAMHS with a single point of access'

4.2.3 Disability

All our assessments involve consideration of the potential areas of disability, from sensory impairment to neurological impairments, such as dyslexia, to developmental disorders/ autistic spectrum disorders. Additional assessments, such as psychological tests will be used when indicated, to identify areas of difficulty, which may previously have been undetected. When a level of disability requires additional resources, we liaise with other services within the Trust, such as the Learning and Complex Disability Service, to offer a more specialist service. Work can also be undertaken in other settings, such as a school, when the physical demands of attending the main clinics are too great.

Whilst we aim to make all our services accessible to people with physical and learning disabilities we also have a number of specialist services.

Case Example: Mosaic (Camden Local Authority)

MOSAIC CAMHS (formerly Greenland Rd CAMHS, Special Needs) came into being in January 2004 in response to the Children's National Service Framework which stressed the need for disabled children to have access to CAMHS services as readily as any other group of children in the community. It is part of Camden MOSAIC, the Integrated Service for Disabled Children. It is jointly commissioned by NHS Camden and the Local Authority, and managed by the Local Authority. MOSAIC CAMHS is a multi-disciplinary mental health team containing Child psychotherapists, Clinical Psychologists, Family Therapists and a Child Psychiatrist, which offers multi-disciplinary assessments of children and families with a range of disabilities –sensory, physical, learning and social communication –ranging from mild to profound. Our focus is on supporting and promoting the mental health and well-being of children and families, whilst taking into account the primary disability and its impact on development, functioning and relationships.

We offer a range of treatment modalities, to ensure that families are not expected to fit our preferred ways of working - rather we try to adapt to their needs and wishes. We work closely with other groups within the integrated service and offer an outreach service to special schools in the borough, liaising with our colleagues in Educational Psychology to ensure the best use of resources and a cooperative division of labour.

We use interpreters where needed, for BSL or other languages and ask our colleagues, including those in the voluntary sector to help us to engage hard-to-reach families, which might include families where one or both parent has a learning disability.

Where appropriate we refer cases to other teams within Camden CAMHS services, acknowledging that children with disabilities do not always need a 'specialist service' but are entitled to access mainstream CAMHS services like any other group of children and young people.

Case Example: Learning and Complex Disability Service

This team works with children, adolescents and adults with disabilities, including borderline learning disabilities which are not clearly defined, as well as those who have suffered brain injury, sensory or other neurological difficulties. Those who suffer from emotional difficulties such as depression, anxiety, relationship complications or behavioural problems as a result will find this service very useful.

Case Example: Autistic Spectrum Disorders

We have a dedicated service for children on the autistic spectrum and their families. We have built up considerable experience in working with families, helping them to understand their children and the impact their child has had on their whole family, as well as with individual psychotherapy with the child. Our approach has been developed over the last twenty years through both research and clinical experience, and our service is dedicated to properly thinking about the whole family's needs not just the child. We have in the past facilitated a strong users' group of families, who organised conferences and raised public awareness. They are happy to be called on to provide testimony about our work. We are also exploring setting up a service for adults with autism, which would address a current inequality in our service provision.

4.2.4 Gender

The adolescent service has received increasing numbers of requests for male clinicians, particularly black male clinicians – where it is thought that a black male would be helpful for the young person/family concerned. Our service also seems less accessible to white male than white female patients.

Case Example: Young Black People's Consultation Service

This enables young black people to see a black member of staff. This has been successful for certain groups, though providing a service that Bangladeshi young people can access remains an area of concern (1% of attendees are Bangladeshi young people, against a population comparator of 8.8%). This is an area for further investigation.

The gender profile of people accessing the Young People's Consultation Service (a self-referral only, brief consultation service for young people aged 16 to 30) shows that in the last five years 35% of service users were male, and 65% were female. This is in line with the profile of service users overall. It was noticeable, however, that of young black people referring themselves to the service in the last five years, 56.6% were male, and 43.4% female. This would seem to indicate that having a flexible service targeted at young black people, improves the normally poor uptake by young men.

Our CAMHS teams on the other hand, see a higher proportion of male patients than female. Putting these figures in context, a comprehensive survey carried out by the Office for National Statistics in 1999 ('Mental health of children and adolescents in Great Britain') found that 7.6% of 5-15 year old girls and 11.4% of 5-15 year old boys had a mental disorder of some type. To put this another way, 60% of those with mental disorders were boys and 40% were girls, which is reflected closely in the gender profile of under 18 year old service users in the Trust.

4.2.5 Ethnicity

In our CAMHS, the ethnic breakdown of our patients is relatively similar to that of our catchment area and indeed has not changed with any significance over the last 4 years. There are some variances in the level of white (+4%), Mixed (+4%) and Asian (-6%) patients however, although the general trend is reverting towards the comparator figure, albeit rather slowly.

We have been concerned about the under representation of Asians and Black Africans in our patient population. The improving trend of the last few years has reversed this last year away from the comparator. However, in some services based in community settings such as the Multi Agency Liaison Service (MALT) and Integrated Early Years service (IEYS) the patient population served is greater in terms of Ethnicity than the comparator in the catchment area and these patients do not yet appear in our analysis of ethnicity of patients. The plan is to ensure this information is captured on local database as outlined in the action plan. The inclusion of several outreach teams onto carenotes/RiO as shown in National CAMHS Mapping revealed that more patients from black and minority ethnic groups are seen in the outreach services than the Tavistock Clinic itself. The percentage of BME patients in these services is 58% compared to 42% at the CAMHS in our main bases.

Case Example: Haverstock School

We ran a group for 15 black young men in Haverstock School, Years 10- & 11 who are at risk of exclusion, during their critical GCSE years (2008-2009).

Case Example: Black Minority Ethnic Specialism (BME)

This service is aimed at young black and minority ethnic people and their families with mental health needs. Staffed by professionals who are themselves from minority communities or who have specialist cultural knowledge of these communities, these professionals work at the Trust as well as in schools to promote cultural competency across our services.

Case Example – Refugee Team

This team includes a Somali psychotherapist and a Congolese Development worker who is fluent in French. In order to increase accessibility, initial contact is often made by phone, through home visits or through schools, working particularly with SENCOs (special educational needs coordinators). Following assessment, treatment may be offered at the clinic or in school. Where appropriate the team holds cases conjointly with other CAMHS teams e.g. South Camden Team, LCDS. We have a longstanding partnership with a number of voluntary and statutory agencies including British Somali Cultural Centre, VAC, Camden Council's School Improvement Service and Ethnic Minority Achievement Service. Development work with other agencies has included a SENCO conference. Development work with the Congolese community includes research into the emotional needs of Congolese children in Camden in the context of educational experience (May 2009), a conference on Congolese children's experiences and achievements in Camden schools (June 2009) and bespoke parenting training programmes. We are engaged in similar initiatives, in partnership with education and integrated early years, with the Somali and Afgani communities. These include focus groups, educational forums and parent training.

4.2.6 Sexual Orientation and Gender Identity

Examples of work in this area are outlined below.

Gay/Lesbian Adoption Group.

The Fostering, Adoption and Kinship Care Team has been running groups for carers and adoptive parents for several years. The experience of the team is that a significant number of adopted children live with lesbian/gay parents but the group leaders felt that for the parents of these children there might be some issues that could not be talked about in a mixed group. They invited the parents to attend a support group for lesbian/gay parents three times per year. This has been warmly welcomed. The feedback from the groups will be evaluated.

Gender Identity and Dysphoria Services

The use of the pronouns 'he' and 'she' and addressing individuals by their chosen name is a sensitive issue for the service users who attend the GIDS. In our day to day clinical work we discuss this issue with young people and their families who attend our service. In some cases family members refer to the young person using pronouns and a name which reflects their birth sex, contrary to the young person's wishes. We work to achieve a consensus about how we refer to the young person attending our service. In the past the young people we work with have experienced difficulties in relation to changing their title and name. In a number of cases letters were sent to individuals using the name and title they had entered the service with. Subsequently they had transitioned and changed their name. The letters caused some upset amongst our service users. A system has been put in place to ensure this does not happen in the future. When a young person changes their name this is reflected in 'care notes' and on their paper file. We give the chosen names to reception for young people attending appointments to prevent the distress associated with the use of a title or name that does not correspond to the individual's perceived gender identity. This practice extends outside the Tavistock. We run a regular adolescent liaison clinic in conjunction with endocrinologists at UCLH. Clinicians from the Tavistock attend these clinics and ensure that the endocrinologists are updated with any name changes.

The GIDS are about to seek service users' experience of attending the Tavistock and our service in order to better understand their needs and ensure that they do not feel discriminated against.

4.2.7 Age

The age profile of our CAMHS patients is similar to other CAMHS (0-18), although through the adolescent department, we are able to work with young people who are in transition between CAMHS and Adult services. We believe this to be particularly important in ameliorating longer- term mental health problems. We also have particular expertise in peri-natal and under 5's work.

4.2.8 Priorities

Our priorities are

- To identify an equalities lead to ensure that equality issues are actively addressed in all areas of our work
- To try to better meet patient preferences for therapists, particularly in relation to race gender and religion, by highlighting this issue at the point of allocation,
- To use targeted advertising to attract and then train/recruit more staff from minority groups,

- To increase the scope and coverage of our community outreach work, in particular to target hard-to-reach communities, and take services to them,
- To act on the Camden Community Child and Adolescent Mental Health Services Evaluation Report 2009, in particular to improve service delivery to primary schools across Camden.
- To improve data collection from our community teams and projects, in order to monitor our progress in improving access.

4.3 ADULT DEPARTMENT

Generic adult psychological therapy services are also delivered across two directorates, Adult and Adolescent (the latter service is included above). Within these directorates we deliver a broad range of interventions, including psychodynamic psychotherapy with individuals and groups, CBT (both generic and trauma focused), IPT, CAT, couples therapy, including work with parents, and family work. The Trust also delivers a primary mental health service in City and Hackney.

Clinical work is monitored through a network of supervision and clinical discussion based in the units; it is a part of this culture that we look out for evidence of discrimination.

4.3.1 Disability

In terms of the Department's clinical work, we are delivering a service to disabled people. The whole of our approach is about recognising the specific and unique form of disability of our patients, this will most commonly manifest in psychological and social terms including relationship problems and social isolation. We are also on the look out for problem of mental function (learning disability, autistic spectrum disorders and cognitive impairment) but we have recognised that there is a growing need that crosses the border into physical illness and disability. As indicated elsewhere the Trust has a specialist Learning and Complex Disability Service which spans the age range.

The new IT system, RiO will allow us to gain proper information about the level of such disability in the services we provide. Our view is that there ought not to be anything that precludes any disability from access to our psychological services; for example we have been developing techniques of working with interpreters in our refugee service that means we have the skills necessary to work with patients with speech or hearing disabilities.

Case Example: Body Image

We have a reputation for work with eating disorders and we've recently developed a service that attends to various forms of body dysmorphia (i.e. unhappiness about one's body). In addition there is a particular form of

eating problem that we expect to see more of; obesity. Within the generic clinical service we are beginning to see patients who have problems with obesity; these patients, because of the physical nature of their problems, can create difficulties for the Trust in terms of the environment. For example access to rooms and chairs that can accommodate them. This is an area that we are addressing.

Case Example: Medically Unexplained Physical Symptoms (MUPS)

The department has just won a bid to deliver psychological and consultation services to the GP practices in City and Hackney. This patient group includes MUPS patients and we have designed the service with the problem of stigma in mind; these patients usually feel that they do not have a psychological problem and feel humiliated if they are referred to a psychological clinician; we have designed our intervention to remain within the domain of physical medicine but enabling us to take up the problems that the patient's symptoms have created for their relationships and social and work lives. We are currently negotiating with the Royal Free to deliver the same service there.

4.3.2 Ethnicity

Racial and ethnic origin/identity presents certain challenges for the department. The most significant of these are that Black (both Caribbean and African) communities do not access our services as much as the statistics would predict that they should. We have given this a great deal of thought and have drawn the conclusion that one of the main reasons for this is the perceived profile of the Trust and particularly of the Adult Department. We are seen as essentially identified as delivering psychoanalytical psychotherapy, which is perceived as a white, middle class treatment. We have created plans to address this.

The shorter term approach: we have re-branded the department and we have been able to demonstrate our new brand in the service we are delivering at City & Hackney. Essentially we now offer a range of psychological therapies. Although these still include our core intensive treatments delivered as either group or individual psychoanalytic psychotherapy, we also offer a range of brief therapies and, in the Primary Care Setting we provide case-work and supportive group work. We will link directly with the ethnic minority communities to form partnerships so that the patients from these communities will see us providing a service that is valued by their own voluntary sector services.

Case Example: Using Interpreters

In the trauma unit we see patients who require interpreters. This is a unique service in the world of psychoanalytic psychotherapy because the conventional wisdom is that clinicians cannot work effectively if they have to work through interpreters. We have developed a protocol which includes

spending time developing working relationships with the interpreters. We offer teaching on the Trauma course of working with refugees and asylum seekers. We also offer external teaching events to a variety of organisations.

The 'Short Course Intervention' (tailor made training developed in consultation with managers) which is a specific technique on the boundary between consultation and training that we offer to teams and organisations in trouble. We have developed a very good reputation with services for or run by staff from ethnic minorities. (It is one of our action points to start to collect statistics of the ethnic profile of our clients). This was the base from which we developed the first ever psychoanalytic and cross cultural training (see below).

The longer term approach for the Department: we recognise that one way to alter the mindset of those who do not refer to us is to engage black professionals in our psychotherapy trainings and to enable those who are already on our training to think about the impact of culture. In 2005 the Adult Department created and ran a Cross Culture and Psychoanalytic Short Course for Tower Hamlets Social Service Department. This was the first time such a course had been designed or run and it produced a very useful source of information from which the department has been able to benefit in designing other initiatives.

The most important such initiative was for the psychodynamic psychotherapy training (D58). We designed a final year (that has to be completed in order to qualify as a psychotherapist) which is a cross cultural and psychoanalytic training; it is called D59. This experience helped us to design a cross culture module for the consultant level psychoanalytic Psychotherapy training, M1. Our longer term aim is to draw black trainees into the trainings so that we demonstrate to their communities that we are not simply a white, middle class service.

4.3.3 Gender

Women are more likely to experience common mental health problems such as depression and anxiety – around 20 per cent of women at any one time compared with about 12.5 per cent of men². Men however have higher rates of suicide and addictions.

We believe that we and other psychological therapy services are seeing about similar proportions of men and women patients.

² NHS Information Centre (2007) *Adult Psychiatric Morbidity in England, 2007: results of a household survey*

Profile of Adult Department Service Users 2006-07

Gender	Female No. %	Male No. %	Not known No. %	Not specified No. %	TOTAL
All Service Users	732 68.5 %	337 31.5 %	0 0	0 0	1,069

The figures as above are not at all surprising; historically this has been put down to the fact that women are more able and more likely to access medical help; they use their GPs more often than men and are constantly more well represented in mental health provision until measures are taken of people in hospital under section. In the same way men with mental health problems are hugely over-represented in prisons and addiction services.

The adult department is developing a primary care service in City and Hackney. We are interested in exploring the hypothesis that we may be able to provide a service that men feel more able to access in this setting.

4.3.4 Sexual Orientation

It would be a commonplace to say that most people in the psychological therapies world would expect that we would have a lower than normal representation of homosexual patients because the (false) belief is that the psychoanalytic approach is prejudiced against homosexuality. In fact our reputation has grown in terms of our work with gay and lesbian patients so that we believe that we might well be seeing more than the expected percentage of these patients.

4.3.5 Age

Although we believe that older adults who are looking for psychological services are able to access the adult department through the usual channels, we believe that there is a wider population whose presentation to health services appears to be, or is assumed to be physical, who actually have problems that we can help. We are actively engaging with the Alzheimer's Society to see how a partnership will make us more accessible to this group of prospective patients and we shall pursue further opportunities for partnership with other third sector agencies.

4.3.6 Priorities

The priority is to formally bring equalities into planning of the adult department and it will be an agenda item at every monthly executive meeting. Race and ethnicity is the other main priority, the aim is to change the profile of the department from that of a white, middle class service into something that is clearly in the vanguard of multi cultural enterprises, increase the number of trainees from black and minority ethnic groups and to increase our awareness of the racial identities of the clients who purchase particularly our short courses.

4.4 PORTMAN CLINIC

The Portman Clinic is an outpatient forensic psychotherapy clinic, part of the Tavistock and Portman NHS Foundation Trust, London. It works with patients who suffer as a result of their delinquent, criminal or violent actions, or whose sexual behaviour damages themselves or others. Such patients are those who are also cared for by forensic psychiatry, antisocial personality disorder services and the criminal justice system. Based on an accumulated understanding of the relationship between emotional states and the body, the Clinic also offers a service to members of the transgender community - transvestites and transsexuals. In addition, the Portman Clinic provides teaching and clinical and organisational consultancy to clinicians, their supervisors and service managers around the UK who manage forensic and anti-social personality disordered patients in the community or within secure institutions. In addition the clinic provides risk assessment reports and court reports for both family court and criminal court proceedings.

In the region of 85% of patients seen in the Clinic are referred as a result of the arrangements contained in the London Specialist Commissioning Contract.

The remaining 15% (approximately) of patients are referred via very small specialist contracts with out of London commissioners but most come through Named Patient Agreements (NPAs) whereby the prospective patient's local PCT negotiates the funding for that particular patient's assessment and if appropriate treatment. This process can be lengthy and the funding often needs to be renegotiated at short intervals which complicates the patients need (often) for longer term involvement with the Clinic.

Given the nature of the patients who attend the Clinic – they have histories of criminality, violence and/or sexual violence – they are very likely to arouse hostile feelings in the community and as a result are likely to be discriminated against, often unknowingly by much service provision. The Clinic therefore offers assessment and treatment to patients who may find it difficult to be accepted for treatment elsewhere or who are offered only short term treatment. Equally, given the nature of these patients' behaviours (delinquent, violent, perverse) it is likely that even when they become aware of needing help embarrassment, shame and guilt are likely to be complicating factors and the open access offered by the

Specialist Contract allows some such patients to come to the Clinic without needing to go and see their GPO or other professional.

4.4.1 Gender

The gender distribution of Clinic patients is skewed towards male patients. In the last audit (2007-08) the distribution was 88% male and 12% female. This figure is not significantly different from that in previous audits, in 2002-03 the figures were 90% and 10%, and in 2001-02, 84% and 16%. This compares with the figures for the prison population which in 2005 were that 94% of prisoners are male and 6% female. (Appendix F)

The comparison between the gender mix of Portman Clinic patients and that of the prison population offers a partially helpful comparison. The figures for both the Clinic and the prison population are influenced by the fact that females are less likely than men to be antisocial in their expression of their conflict and distress or to present with paraphilias (i.e. problems in relation to disturbing or aggressive sexual behaviours). Hence the preponderance of men referred to and treated by the Clinic. The commissioners of the Clinic's clinical services require that the Clinic sees perpetrators of sexual and non-sexual violence and criminality and these are much more likely to be males. Hence it is inevitable that the majority of patients seen in the Clinic will be male. The difference in the gender distribution between the figures for the prison population and the Clinic is partly explained by the fact that because females tend to act out their conflict and distress through an attack on themselves rather than on another person, they are more likely to come to the notice of social care and psychiatric services than the criminal justice system and are therefore more likely than males to seek or be referred to psychological treatment. For example women are disproportionately represented in eating disorder services.

4.4.2 Disability

The Clinic's assessment and treatment services are not affected by issues of prospective patients' physical disability. There is only limited wheelchair access into the Portman Clinic – there is manageable access through the back of the building - but this is largely overcome by arranging to see such patients in rooms in the Tavistock Centre next door which does have wheelchair access.

4.4.3 Ethnicity

The range of the Clinic's patients' ethnicity, compared to the last census (2001), shows that the Clinic sees a greater proportion of white patients than the proportion of Asian or Asian British, or Black or Black British people in the general London population. The one exception to this is in

relation to people of mixed ethnic background where the Clinic sees a slightly higher proportion than in the general London population.

The reasons for the skewed figures is partly related to the fact that that black and Asian people are more likely to find themselves taken into the criminal justice system rather than to be offered social care or therapeutic treatment. This is a complex issue for the Clinic to respond to given that it is a specialist service and dependant on referrals from other professionals in the community.

The Clinic's teaching, trainings and CPD programmes are open to anyone in the professional and related community who is interested to participate. Organisational and clinical consultancy to teams and institutions is delivered to whatever teams the host service puts forward for the intervention.

SECTION 5 EDUCATION AND TRAINING SERVICES

The Trust has a strong reputation in mental health training for professionals who work in health, education, social care, mental health and CAMHS. We provide professional trainings and post-qualification professional development opportunities. Our core professional trainings are in psychiatry, psychology, social work, adult, child, and forensic psychotherapies. Courses and CPD events are aimed at professionals interested in working more effectively with their clients, students or patients in education, social care, mental health and CAMHS work of all kinds. We have created new and expanding opportunities for professional development and applied lifelong learning for individuals, teams and services. Strong university links support accredited postgraduate and professional doctorate teaching.

5.1 Core Professional Trainings

The Trust delivers higher specialist (ST3 and ST4) medical training in child and adolescent psychiatry, and adult and forensic psychotherapy. The Trust is acknowledged by the London Deanery as its most highly consistent performer in relation to standards for medical education.

Core professional and other advanced psychotherapy training for non-medical NHS and social care professionals is at professional doctorate or master's level. These include adult, child and systemic psychotherapy, educational psychology, and social work.

Our Continuing Professional Development (CPD) programme (launched April 2007) responds positively and flexibly to the evolving learning and development needs of the mental health and social care workforce. We provide short, targeted courses in areas of work highlighted through consultation with current commissioners, past students, workforce developments and requests from Trusts, local authorities and other organisations. The CPD programme has expanded rapidly.

5.2 The general approach to equality

The Trust seeks to have a proactive approach to equality and this is embedded in all aspects of our practice. In recent years a key priority of the Trust in education and training has been to increase the diversity of our student population, so that it more accurately reflects the service user profile. Support for disabled students, including those with hidden disabilities, along with equity of access, is another key priority. We have evaluated our student profile in order to set targets for increased diversity in recruitment. In 2007/08 we undertook a race equality impact assessment on our marketing and PR which has informed our student recruitment strategy in 2008/09.

Education and training plays an important role in creating a more inclusive society. The Trust promotes the equality agenda in E & T by informing, influencing and advising all staff, in consultation with training and clinical service users and employers, in monitoring the way it conducts its business.

5.3 Student Feedback

Annual generic student feedback exercise, regular feedback from black and minority ethnic students' feedback and individual course feedback, students' complaints monitored for equality issues.

As a training and education provider we have worked hard at making our facilities accessible to disabled students, in particular, a number of facilities have been made available in the library such as accessibility wizard on all computers, assistance from friendly staff, audio-recording of selected psychoanalytic texts, Braille on request, cheaper photocopying etc. The academic Directorate has a Disability Officer who can put students in touch with his counterparts in the Universities the Trust is affiliated with (UEL and Essex in particular).

5.4 Ethnicity

Our BME student numbers have grown from 12%-15% in academic year 2008/09. We have reconvened BME student groups as a central forum for engagement with students. The convener meets the Dean regularly to provide feedback which influences all aspects of our strategy development.

(Data source: Appendix E).

Ethnic (and social) diversity:

More than 10 years ago the Trust appointed two part-time training development consultants with responsibility for recruitment and understanding and improving the experience of BME students. Their task was to support the Trust in improving the ethnic diversity of its student population, and to work with what course tutors and others in exploring the relatively invisible ways in which BME students and those from lower socio-economic groups were subject to relative exclusion in

terms of curriculum content and the dynamics of lectures and seminars. One consultant remains in post and is line-managed by the Dean. Her work includes convening BME student groups at different times during the week in term time so that they are able to feed back their experience which is open to discussion to support equity of access. The meetings with the Dean feed at a senior level into the development of an equitable training and education strategy. These groups will continue. The Trust has also held popular forums for staff and student groups to view and discuss films and listen to guest speakers (Thinking Space) on ethnic diversity and cultural topics.

The Trust has raised its profile in its commitment to greater diversity in the following ways.

1. African psychology seminars
2. Specific courses on black leadership in white organisations, BME issues in CAMHS, cultural competence and supporting workers in brief counselling services for black and mixed-heritage young men.]
3. Student recruitment policy has been developed through a range of media and, in particular, through our new website. Early student feedback indicates that the new site represents strong images of a multicultural organisation, with clear statements of the Trust's commitment to greater diversity. Some advertising is focused to BME press and networks. This element is part of a wider marketing and PR strategy.
4. Equality Impact Assessments (EIAs) have been carried out on sample course publicity and documentation, and in future all publicity will have an EIA.

We collect student ethnic monitoring data routinely.

5.5 Gender

Our male/female split is stable and reflects broadly similar proportions to the rest of the NHS and social care and the mental health workforce in particular. In 2008/09, 80% of our student population was female. (Data source: Appendix E).

5.6 Disability

Recently significant work has been undertaken in this area. In 2008 we began ensuring that disability awareness training was available to all directorate staff and to all organising tutors or representatives from their course teams. The focus was on the disabled students' experience, and in particular on improving accessibility through changing teaching materials, particularly for students with dyslexia who form the largest group of students with a disability in the Trust. Supporting students' preparation of summative assessment assignments was also discussed. The Trust has also appointed a course administrator as training disability lead. He holds responsibility for ensuring that information is available to students and that

course teams are aware of disabled students' needs. The disability lead also provides the co-ordination which is essential for providing thorough and cohesive support to students.

The Directorate of Education and Training (DET) collects data on disability. 3% of students in 2007/08 and 2008/09 declared a disability. (Data source: Appendix E).

The Trust, through DET, has taken the initiative to promote and enhance student experiences from enquiry and application through to final assessment.

1. The directorate has committed itself to improving disabled students' experience by ongoing training of teaching and administrative staff and providing guidelines on equality of access to interview, improving communication, ensuring adaptation of teaching materials and support in the preparation of written assignments. It has continued to train staff in these matters (July & September 2009) and will complete its draft disabled student policy by the beginning of October 2009.
2. An agreement on collaboration with our major university partner ensures that students have access to affordable assessment of learning disabilities, in order that they can access support from the university, the Trust and through a disabled students allowance where appropriate. We aim to audit progress by the end of the academic year 2009-10 (AP)
3. The Trust has also appointed a course administrator as training disability lead. He holds responsibility for ensuring that information is available to students and that course teams are aware of disabled students' needs

5.7 RELIGION

Currently the Trust does not hold student data in relation to their religious background or belief.

SECTION 6 STAFF GROUP

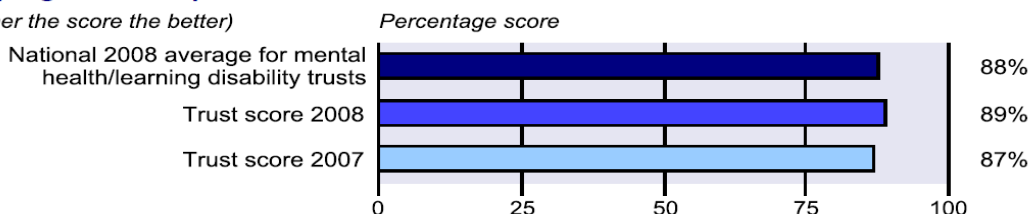
The Trust recognises that staff are its most important asset and are crucial to the delivery of quality healthcare, education and training. The Trust's clinical and training staff group is multi-disciplinary, with psychiatrists, psychologists, child psychotherapists, social workers, family therapists and nurses all taking leading roles in the Trust's activities.

The Trust is committed to the Continuous professional development of its staff and continually ensures that it maintains a highly skilled and well trained workforce by providing staff with a wide range of development opportunities. The Trust recognises the contribution of its staff to its success and the impact of a highly motivated staff group on the smooth running of the organisation, and therefore continually strives to ensure that the working lives of its staff are as successful and rewarding as possible. To achieve this, the Trust not only provides opportunities for training and development but

also provides its staff with supportive policies and support mechanisms, including a wide range of flexible working options to suit individual needs. This ensures that staff can enjoy a good work life balance and have full opportunities to reach their maximum potential while at work. Key finding (36) of the National Staff Survey, is reproduced below.

KEY FINDING 36. Percentage of staff believing trust provides equal opportunities for career progression or promotion

(the higher the score the better)



89% of staff at the trust said that the Trust acts fairly with regard to career progression or promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.

- The trust's score of 89% was average for mental health/learning disability trusts in England.
- It has not changed significantly since the 2007 survey, when the trust scored 87%.

6.1 Employment Consultation Functions

The Trust remains committed to partnership working through both the formal joint consultative process and also informal meetings and sub-groups with staff-side colleagues. Communication with staff is key in ensuring open dialogue exists across the organisation. Discussion forums, Newsletters, briefing sessions and various other methods of ensuring staff are given the opportunity to influence the work of the Trust through discussion and consultation are in place with new methods of communication continually being introduced. The Trust values all contributions from staff in the delivery of its services and is committed to treating its staff with dignity and respect, while also ensuring there is active promotion of equality of opportunity for all in the workplace. All of the Trust's employment policies are subject to full consultation and equality impact assessed to ensure no staff group is disadvantaged. The Board of Directors continue to maintain an awareness and understanding of the views of staff. The Director of Human Resources presents workforce statistics data to the Board members on an annual basis. This paper is a public document and available on our website.

The other Quality of working life indicators

The staff survey this year (2008) has been altered from the previous format and is now structured around the four pledges contained in the NHS constitution with the inclusion of two additional themes. For the purposes of the scheme, additional theme (Theme 2) arising out of the staff survey is important and will be pursued as detailed in the Action Plan (Appendix A). The work of the Sub Group - Race equality in Employment, set up within

the auspices of the Equalities committee will be addressing this theme.

6.2 Staff group and approach to Equality

6.2.1 Ethnicity

The Trust aims to recruit and develop a diverse workforce at all levels.

When advertising for vacancies, our advertisements promote the advantages of working for a Trust that values diversity. Ethnic monitoring is managed and monitored for the following areas:

- Applicants for jobs
- Staff involved in grievances
- Disciplinary procedures
- Complaints
- Performance review procedures
- Staff who cease employment

The staff data as March 2009 {Appendix B (i)} indicates that our Turnover has dropped to 4.6% in this period as a percentage of total employed personnel. Out of the 24 leavers 15 people gave their reason as being the end of a fixed term contract, whilst for 6 it was voluntary resignation. The 24 leavers represented WTE of 16.7. From the data, it does not appear that staff from a particular ethnic group is particularly disadvantaged Appendix B (ii).

6.2.2 Equalities in Employment sub group

The Trust's Equalities committee has established a Race Equality in Employment sub group. The role of the Sub-Group is to develop measures to promote workforce diversity, inclusion and equality at all levels of the organisation. The sub group has a defined remit which is to examine the data relating to composition of the workforce in relation to recruitment, training and career opportunities and management of employee relations, responding to management concerns about the under representation of black and minority ethnic groups in senior management and leadership positions. It is a short life working group, meeting for 12 months in the first instance. The work of the sub group is being lead by the Trust Director, who chairs the meetings of the sub group. The initial core membership of the sub-group included an HR manager and the former Director of Research and Development. After consultation with a number of colleagues across the Trust, the Chair extended an invitation to all staff to widen the representation of staff within the group. The Committee now includes members from non clinical functions and clinical areas across a range of bands within the Trust and has formed an active, committed work group.

The sub-group was given two main tasks to consider. Firstly, to develop a complete picture of the workforce in relation to ethnicity in order to provide a basis on which to develop an action plan aimed at promoting equality in the workforce in relation to ethnicity and secondly, to examine whether or not there was evidence of racial discrimination leading to greater number of staff from ethnic minorities being involved in disciplinary procedures or leaving the Trust not of their own volition.

At its first meeting, the Sub-Group looked at data relating to the composition of the workforce, noting that within the clinical workforce and within senior non-clinical grades Black and Minority Ethnic staff are significantly under-represented. As this was a matter of concern to the sub-committee we decided to draw up plans to investigate the issues further. All managers of central functions and heads of clinical disciplines were asked to provide the following information, supported by HR, with a commentary.

1. A breakdown of staff by salary band or grade and ethnic origin.
2. A commentary on the data, including reference if appropriate to the composition of the labour market for each particular staff group, descriptions of the main career pathways within the discipline or function, including how and when staff are eligible to move upwards, and how opportunities are advertised. For clinical disciplines, information was also requested on the impact of major Trust training programmes (M1, M10 etc) on figures e.g. whether the profile of the students on those trainings influence the make up of the discipline's workforce.
3. Following on from 2. a commentary about the appointments that have been made in each discipline or function in the past two years, making specific reference to race equality, so far as possible mentioning whether people from Black and minority ethnic groups were interviewed or appointed for particular roles.
4. Initial thoughts on what action managers or heads of clinical disciplines or the Trust could take to increase diversity within each particular discipline or function, mentioning any barriers or difficulties that they think they or the Trust will need to overcome in making progress. Managers/heads of discipline were also asked to highlight any particular training needs that they or their staff had in relation to race equality and diversity e.g. issues in recruitment interviewing, building and developing diverse teams.

The data has now been collected and a report is being compiled which will

be made available on the intranet. As the data has been coming in, it has been discussed at the Race Equality in Employment sub-group meetings and has provided a fruitful basis for discussion. It is clear that the data requires careful consideration as whilst it has been collected on the basis of staff ethnicity, many other factors such as social class will interact with ethnicity in determining eg career progression. Once the data is integrated, we plan to take discussion out to the wider staff group in ways which will include staff groups from across the Trust in developing plans to tackle inequalities where they exist and to reassure staff of the fairness of our systems and procedures where the evidence supports this being the case.

The work of the sub group will be included in the agenda for INSET day in 2010.

The implementation of agreed actions for addressing issues within the group will be overseen by more senior groups in the Trust including the Clinics Committee, Management Committee and Equalities Committee itself.

The work has been included in the Action Plan appended to the Scheme (Appendix A).

6.3 Gender

Staff Headcount by Gender, indicates that majority of our workforce is female both for Clinical and non clinical staff groups. {Appendix C & C (i)}. If we look at the breakdown of staff by band, representation of female groups is higher across all bands. We have two female and four male Non executive Directors. The imbalance in the profile of the Trust's Non-Executive Directors (NEDs) appears to be a cause for concern, especially in an organisation with a predominantly female staff, and whose membership is also predominantly female. However, this should be interpreted within the context that Trust employs staff who are best qualified for the role requirements regardless of their gender. This is reflected in the NHS overall. The Trust encourages healthy work life balance and our employment policies are reflective of this philosophy. We have recently appointed a female to the post of Trust Chair who will run the office for the period of 3 years. The Trust achieves economic parity between men and women through workplace practices and has also implemented the Agenda for Change Terms and Conditions of employment and Medical Consultant Terms and Conditions. Equal access to employment and development opportunities is afforded to both men and women by adhering to Trusts Equal Opportunities Policy.

6.4 Age

The Trust has a balanced workforce profile across all age groups (Appendix D). Our recruitment and retention policies are geared towards attracting and retaining talent irrespective of age. The Trust continues to work

towards new ways of working along side reforms like Agenda for Change which means that there is greater emphasis and recognition of skills and competencies people bring to the role and eliminating any bias related to age. The changing nature of the way we conduct our business will require our workforce to have transferable skills and flexible working styles irrespective of their age groups. Developing our staff through appraisal, PDP's ensures that our staff is adequately trained through out their career with the Trust.

6.5 Disability

The structure and requirements of our policy framework lend themselves to increasing awareness of the importance of confidentiality, raising acceptance of people with disabilities in the workplace, increasing supervisor awareness of reasonable adjustments requirements and facilitating rehabilitation process.

The Trust maintains the Two Ticks "Positive about Disabled People" status and continues to find new ways to take positive action where appropriate with regards to disability. There is a written policy in place i.e. Sickness Absence that articulates the possible intersection of the disability non-discrimination requirements under the Disability Discrimination Act (DDA) with management of disability and sickness absence and rehabilitation. The Trust is continuously reviewing the Equality and Diversity agenda to ensure any changes in legislation are included in the agenda.

We have 9 staff members with declared disability. We have support packages for staff who have declared their disability. We liaise with SCOPE and Access to work. The advisors from these organisations contact our staff member and their line manager to make recommendations about the best support for them. Once a decision on the best support package is reached, Jobcentre plus approve the request and the Trust buys the necessary equipment and contributes a certain amount towards the purchase of the support package.

We hope that positive working practices and flexibility, together with training initiated at INSET days will encourage staff to disclose their disability on the basis that they will be supported in the workplace. It is also our intention to have a formal structure appropriate to supporting disabled staff by having regular meetings with them at Trust's instigation, should they wish to take up. This would also help us to assess their support needs at a given time as these may change over time.

We do not have many disabled staff (we are only able to record details of those who have declared disability). Both formal and informal feedback on support available is positive.

Involvement of people with disability (ies) for more informed decision-making: increase disabled people involvement. We meet with the disabled staff both formally and informally.

1. **Two Ticks:** In employment, work towards improved practices in relation to recruitment, training, development and retention of staff
2. **Building accessibility:** improve building accessibility for disabled people (whether patients, students or staff members)

6.6 Sexual Orientation and Religion/ Belief

At the time of making an NHS application the potential candidates are given the opportunity to provide this information. This is a voluntary process.

6.7 Training in Equalities

From the 2008 Staff Survey, the Trust was identified as a having excellent scores in the provision of diversity training.

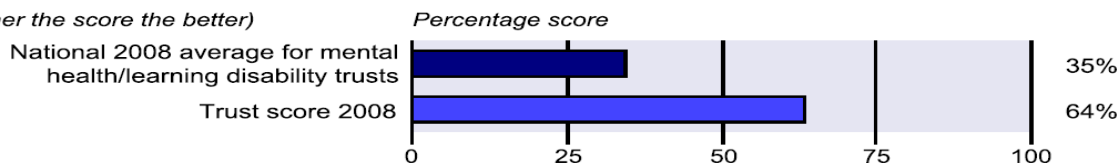
The Trust provides regular equality and diversity training at Mandatory INSET sessions. Annual updates on equality training are provided for all staff. Disability Awareness sessions are also provided to managers.

Key Finding 35 of the National Staff survey is reproduced below:

ADDITIONAL THEME: Equality and diversity

KEY FINDING 35. Percentage of staff having equality and diversity training in last 12 months

(the higher the score the better)



64% of staff at the trust said that they had received equality and diversity training (the definition of which included training on the awareness of age, disability, gender, race, sexual orientation and religion) in the last 12 months.

- The trust's score of 64% was in the **highest (best) 20%** of mental health/learning disability trusts in England.
- This question was not asked in this format in 2007.

SECTION 7 TRUST'S BUILDINGS AND ENVIRONMENT

As part of the Disability Equality Scheme the Trust has had a programme of improving accessibility of the existing buildings including renewal of signage throughout the Trust and updating the disabled toilet provision.

During the last summer the main reception area was redesigned to improve the overall patient experience. Prior to the commencement of the work there was an extensive period of consultation so that staff, patients and visitors could comment on initial proposals. Following the consultation period, the Trust endeavoured to ensure that

everyone felt their needs and requirements had been considered and incorporated in the design wherever appropriate and possible. Compliance with the Disability Discrimination Act regarding the use of colours, access arrangements and provision of hearing loops was an integral part of the scheme.

The Trust has a Design Advisory Group, which looks at the overall design strategy for the Trust, which includes representation from staff, governors and the Patient and Public Involvement Committee. The Trust will ensure that there is wide consultation about changes concerning the buildings and environment during the ongoing plans to improve facilities for the benefit of all.

SECTION 8 ACTION PLAN

The Trust will develop a 3 year plan (2009 –10) of how we intend to promote and implement this scheme and mainstream this into our functions and policies.

The action plan will have clear objectives towards promoting single equality with steps to achieve it and realistic timetables for meeting the objectives. It will also include responsibilities for implementing the action plan and give a clear indication of specific outcomes it hopes to achieve.

Information gathered from involvement and consultations with all stakeholders, should dictate the priority actions to make improvements towards identifiable disparities in service which have become evident from involving disabled people.

Action Plan is attached as **Appendix A.**

SINGLE EQUALITY SCHEME - ACTION PLAN (2009-2010)

Accountability	Action	Timescales	Success Measures (Visible & Evidence based information)	Equality Strands						Progress / Outcome	Other Comments
				Gender	Age	Sexual orientation	Religion/Belief	Race	Disability		
Governance											
PPI Communication lead	Recruit more younger age group members	Next Election	Increase in the number of young members		✓						
Director of HR	Monitor disability profile of Membership	March 2010	Have more robust information. Based on current data available, it would seem that the average return rate for supplying such data is around 60%. It is hoped that this would improve. Knowing 60% of new members disability status by March 2011								
Director of HR	Monitor membership of Trusts committees; consider reviewing appointment processes in line with the revised recruitment policy; How to promote the opportunity to be involved in Trusts decision-making to	June 2010	Checking for potential inequality; promoting opportunities for under-represented groups.					✓			Feedback from all departmental heads required on an ongoing basis

Accountability	Action	Timescales	Success Measures (Visible & Evidence based information)	Equality Strands						Progress / Outcome	Other Comments
				Gender	Age	Sexual orientation	Religion/Belief	Race	Disability		
Chair Equalities Committee with HR	To organise training event for the Management committee on equality issues	March 2010	Training takes place								
Director of HR	To review lessons learnt re Governor elections with specific recommendations about how best to improve diversity of board of governors.	March 2010	Lessons learnt. Paper discussed with Board of Directors with follow up plan agreed								
Gender											
Chair Equalities Committee	Equalities Committee to consider in 2011		Agenda item for Equalities Committee for 2011								
Sexual Orientation											
Chair Equalities Committee	Trust wide meetings on sexual orientation on existing perceptions and what action should be taken to address this	March 2010	Meetings takes place with follow up action agreed								
Religion											
Director of Governance and Facilities	To examine alternatives for our existing, less than ideal, multi-faith prayer facilities for staff and students	July 2010	Alternatives considered to improve provision				✓				
Socio Economic Status											
CAMHS Equalities Lead	To undertake an analysis of the socio economic profile of	April 2010	Trust can better assess the Socio-								

	patients.		Economic profile									
Accountability	Action	Timescales	Success Measures (Visible & Evidence based information)	Equality Strands						Progress / Outcome	Other Comments	
				Gender	Age	Sexual orientation	Religion/Belief	Ethnicity	Disability			
Information												
Chair of Equalities Committee	The Equalities Committee to agree how to progress evaluating outcomes with regard to equality issues	February 2012	Plan in place to assess outcomes	✓	✓	✓	✓	✓	✓			
Training and Education												
Dean of Postgraduate Studies	Equality Impact Assessments to be carried out on all publicity materials.	Process in place by July 2010	Audit/review	✓	✓	✓		✓	✓	Pilot completed in September 2009	Results of pilot will be fed into training marketing and general training strategy	
Dean of Postgraduate Studies	Finalise Training Disability Policy	November 2010	Completed policy						✓	Already in draft form and consultation with organising tutors and course administrator is in progress. New paperwork will be		

											created for staff by end January 2010	
Accountability	Action	Timescales	Success Measures (Visible & Evidence based information)	Equality Strands						Progress / Outcome	Other Comments	
				Gender	Age	Sexual orientation	Religion/Belief	Ethnicity	Disability			
Dean of Postgraduate Studies	Explore possibility of an SLA for disabled students with UEL	April 2010	Decision made regarding SLA for disabled students							✓	The Asst. Director has met with disability leads at UEL	
Dean of Postgraduate Studies	Develop a more rounded equality strategy, integrating the race and disability policies.		Equality strategy in place for training					✓	✓		Evaluation of Race Impact Assessment under way	
Dean of Postgraduate Studies	Amend student complaints policy	To be completed by July 2010	Completed policy	✓	✓	✓	✓	✓	✓		Under way	
Dean of Postgraduate Studies	Explore possibility of developing an equality policy on sexual orientation	To begin in Oct 2010	Review of consultation results.			✓					Consultation with students will commence Oct 2010.	
Staff Group												
Director of HR	Improve in house monitoring systems for data recording	Dec 2010	Accurate & updated information	✓	✓	✓	✓	✓	✓			

	and analysis of employee relation cases.		available from electronic records								
Accountability	Action	Timescales	Success Measures (Visible & Evidence based information)	Equality Strands						Progress / Outcome	Other Comments
				Gender	Age	Sexual orientation	Religion/Belief	Ethnicity	Disability		
Director of HR	To produce information on training uptake across the Trust for the Board on an annual basis as part of our Key Performance indicators.	June 2010	Issues arising from the data report will be discussed bi-monthly at the staff training committee	✓	✓	✓	✓	✓	✓	To Obtain information for improved decision making in training provision Increased knowledge of equality issues	
Director of HR	Raise visibility and awareness around Disability support issues by appointing a "Disability Officer" for staff	June 2010	Enhance Staff Awareness and engagement by having a designated Disability Officer						✓		
Trust Clinical Director/HR Director Work of the Sub – group convened under	Raise visibility and awareness of equality and diversity within the Trust. In particular, consider workforce and employment relation practices	June 2010	Findings of this subgroup to be presented to the Equalities committee					✓		Enhanced Trust wide awareness on recruitment, promotion and training opportunitie	

the auspices of the Equality Committee									s and on employee relation matters		
Accountability	Action	Timescales	Success Measures (Visible & Evidence based information)	Equality Strands						Progress / Outcome	Other Comments
				Gender	Age	Sexual orientation	Religion/Belief	Ethnicity	Disability		
Adult Department											
Director of Adult services	We are aware that the department's commitment to diversity and equality should be reflected in the work of the Department Executive. To that end we have instituted a quarterly fixed item on the Executive agenda to monitor Equalities issues but also to link these to 'Quality'	Ongoing	Adult department issues considered by the adult department will be considered in a more systematic manner as part of an active agenda		✓	✓	✓	✓		Enhance awareness of Equality Agenda	
Director of Adult services	All new developments in training and clinical work will be required to include and equality impact assessment. This will be monitored in the Clinical development meetings by the Clinical Lead and in	Ongoing	Adult department issues considered by the adult department will be considered in a more systematic manner as part of an active agenda	✓	✓	✓	✓	✓		Enhance Equality Agenda	

	the Training Committee by the Vice Dean (or her replacement).										
Accountability	Action	Timescales	Success Measures (Visible & Evidence based information)	Equality Strands						Progress / Outcome	Other Comments
				Gender	Age	Sexual orientation	Religion/Belief	Ethnicity	Disability		
Director of Adult services	We are committed to change the profile of the Adult Department from that of a white, middle class service into something that is clearly in the vanguard of multi-cultural enterprises.	September 2012	Profile change					✓			
Director of Adult services	We shall continue our aim of attracting members of ethnic minorities to join our psychotherapy training streams. We do this through our basic level training work, S5 and D65 which draw a student base that is predominantly BME. The figures are held in the DET data base about student	October 2010	We expect an ongoing increase in activity by October 2011					✓			

	demographics.											
Accountability	Action	Timescales	Success Measures (Visible & Evidence based information)	Equality Strands						Progress / Outcome	Other Comments	
				Gender	Age	Sexual orientation	Religion/Belief	Ethnicity	Disability			
Adolescent Department												
Director of Adolescent services	We shall increase our awareness of the ethnic and racial identities of the clients who purchase particularly our short courses (for example the Short Course Intervention and D65, the front line training for nurses).	Dec 2009	Greater accessibility and reach for our courses					✓				
Director of Adolescent services	User Involvement Project to Identify Barriers to Bangladeshi Young People Accessing Services	June 2010	Barriers identified					✓		Enhanced awareness of issues facing Bangladeshi Community		
Director of Adolescent services	Increase 'Thinking Space' Activities.	September 2010	Think space activities increased	✓	✓	✓	✓	✓	✓	As a learning forum looking at		

											race, culture and diversity in mental health	
Accountability	Action	Timescales	Success Measures (Visible & Evidence based information)	Equality Strands						Progress / Outcome	Other Comments	
				Gender	Age	Sexual orientation	Religion/Belief	Ethnicity	Disability			
Director of Adolescent services	Improve Use of Technologies to Increase Access.	June 2010	Recent focus groups have identified that young people now prefer to be contacted by text messages and emails. This may be a more discrete and sensitive way to arrange appointments, compared with letters going to the family home	✓	✓	✓	✓	✓	✓	The aim is to investigate how different methods of communication could improve access to different groups		
CAMHS												
CAMHS Director	Identifying a SES lead to be an advocate for equality issues within CAMHS Directorate	November 2009	Greater availability and equality proposals actively addressed	✓	✓	✓	✓	✓	✓	Appointed October 2009		
CAMHS Director	SES Lead will work with intake teams to identify	February 2010	Teams to document in case notes when	✓								

	preferences for therapists at point of referral, and match where possible.		matching occurs. Patient satisfaction may increase								
CAMHS Director	Increasing the availability of therapists from minority groups by targeted advertising/ training/ recruitment	Ongoing	Staff group more diverse	✓				✓	✓	✓	
Accountability	Action	Timescales	Success Measures (Visible & Evidence based information)	Equality Strands						Progress / Outcome	Other Comments
				Gender	Age	Sexual orientation	Religion/Belief	Ethnicity	Disability		
CAMHS Director	Increasing community clinics in more accessible areas and appropriate settings in line with Camden Community CAMHS evaluation review 2009	July 2010	Greater accessibility for our services in particular improved coverage for all primary schools in Camden	✓	✓	✓		✓	✓		
CAMHS Director	Ensure that Data relating to gender, disability and ethnicity is captured from outreach services	2010	Improved data collection	✓	✓	✓		✓	✓		
CAMHS Director	Consult users to find out what would make our disabilities services more accessible	2010	Improved documentation and accessibility and patient satisfaction						✓		

Appendix B

Ethnic Profile of Staff in Post on 31st March 2009

Ethnic Code	Ethnic Description	Band 1-3	Band 4-5	Band 6-7	Band 8	Band 9	Medical	Non-Executive Directors	Teacher	Total
A	White – British	8	52	60	111	10	19	4	4	268
B	White – Irish	1	4	1	5		6		1	18
C	Any other White background	0	18	28	33		12			91
D	White & Black Caribbean	1		3						4
E	White & Black African				1					1
F	White and Asian			1				1		2
G	Any other Mixed background	1	1	1			1			4
H	Asian – Indian	2	2	4	4		3			15
J	Asian – Pakistani	1	1	2			1	1		6
K	Asian – Bangladeshi		1		1		1			3
L	Any other Asian background	1	1	2	3		2			9
M	Black – Caribbean	2	11	4	7					24
N	Black –African	8	6	6	3					23
P	Any other Black background		1							1
R	Chinese			1	1					2
S	Any other Ethnic group	2	2	1	4		0			9
U	Not known	1	2	4	3		1			11
Z	Not Stated	1					2			3
	Total	29	102	118	176	10	48	6	5	494

Ethnicity Data cont Appendix B (i)

Ethnicity of Staff in Post on 31st March 2009 shown in comparison to the ethnicity of London, Census of 2001			
Ethnic Code	Ethnic Description	Trust %	London %
A	White - British	54.3	59.8
B	White - Irish	3.6	3.1
C	Any other White background	18.4	8.3
D	White & Black Caribbean	0.8	1
E	White & Black African	0.2	0.5
F	White and Asian	0.4	0.8
G	Any other Mixed background	0.8	0.9
H	Asian - Indian	3.0	6.1
J	Asian - Pakistani	1.2	2
K	Asian - Bangladeshi	0.6	2.1
L	Any other Asian background	1.8	1.9
M	Black - Caribbean	4.9	4.8
N	Black -African	4.7	5.3
P	Any other Black background	0.2	0.8
R	Chinese	0.4	1.1
S	Any other Ethnic group	1.8	1.6
Z	Not Stated	2.2	0
	Not Known	0.6	0
	Total	100	100

Ethnicity Data cont Appendix B (ii)

Ethnicity of Leavers, over period Oct 08 – Mar 09				
Ethnic Code	Ethnic Description	Number of leavers	Total employed over period	Leavers as % of total employed
A	White - British	14	282	5.0
B	White - Irish	1	19	5.3
C	Any other White background	7	98	7.1
D	White & Black Caribbean		4	0.0
E	White & Black African		1	0.0
F	White and Asian		2	0.0
G	Any other Mixed background		4	0.0
H	Asian - Indian		15	0.0
J	Asian - Pakistani	1	7	14.3
K	Asian - Bangladeshi		3	0.0
L	Any other Asian background		9	0.0
M	Black - Caribbean		24	0.0
N	Black -African		23	0.0
P	Any other Black background		1	0.0
R	Chinese		2	0.0
S	Any other Ethnic group		9	0.0
Z	Not stated	1	12	8.3
	Undefined		3	0.0
	Total	24	518	4.6

Gender Profile of Staff

Staff Breakdown by Gender and Discipline Headcount as at 31 st March 2009			
Staff	Male	Female	Total
Clinical	80	227	307
Non-Clinical	55	132	187
Total	135	359	494

Appendix C (i)

Breakdown of staff by Band as at 31st March 2009

	Band 1-3	Band 4-5	Band 6-7	Band 8	Band 9	Medical	NED	Teacher	Total
Male (number)	13	19	25	49	4	21	4	0	135
<i>(% of total male staff)</i>	9.6%	14.1%	18.5%	36.3%	3.0%	15.6%	3.0%	0.0%	100.0 %
Female (number)	16	83	93	127	6	27	2	5	359
<i>(% of total female staff)</i>	4.5%	23.1%	25.9%	35.4%	1.7%	7.5%	0.6%	1.4%	100.0 %
Total	29	102	118	176	10	48	6	5	494

Age Profile of Trust Staff

Age Profile of Trust staff by grade, as at 31st March 2009									
Age Group	Band 1-3	Band 4-5	Band 6-7	Band 8	Band 9	Medical	NED	Teacher	Total
<20									
20-29	4	21	14			2			41
30-39	6	34	31	21		19	1	3	115
40-49	8	24	44	55	2	13	1	1	148
50-59	3	16	26	70	7	9	2	1	134
60+	8	7	3	30	1	5	2		56
Total	29	102	118	176	10	48	6	5	494

PROFILE FOR STUDENT AT THE TRUST

*Academic Year 2007/2008 – TOTAL STUDENT POPULATION – 2003

ETHNIC ORIGIN		DISABILITY		GENDER		NATIONALITY	
White	1232	No Known Disability	1494 (75%)	Female	1609 (80%)	European	330 (16%)
TOTAL WHITE	1232 (62%)			Male	394 (20%)	Home	1633 (82%)
				TOTAL GENDER	2003	Overseas	40 (2%)
Black or Black British -Caribbean	46	Blind/Partially Sighted	2			TOTAL NATIONALITY ALL STUDENTS	2003
Black or Black British -African	40	Deaf/Hearing Impairment	10				
Other Black Background	7	Wheelchair User/Mobility Difficulties	3				
TOTAL BLACK	93 (5%)	Mental health Difficulties	1				
		An Unseen Disability e.g. Diabetes, Epilepsy, Asthma	12				
Asian or Asian British - Indian	28	A Specific Learning Difficulty e.g. Dyslexia	13				
Asian or Asian British - Pakistani	8	Multiple disabilities	1				
Asian or Asian British Bangladeshi	3	A disability not listed above	1				
Chinese	13	TOTAL DISABILITY	43 (2%)				
Other Asian Background	18						
TOTAL ASIAN	70 (3%)	Information not sought	2				
		Not Known	62				
Mixed – White & Black Caribbean	11	Other	4				
Mixed – White & Black African	7	No Data Provided	398				
Mixed – White & Asian	4	TOTAL NOT DEFINED	466 (23%)				
Other Mixed Background	18						
TOTAL MIXED	40 (2%)						
Other ethnic background	39						
Total – OTHER ETHNIC BACKGROUND	39 (2%)						
TOTAL BME	242 (12%)						
Not Known	66						
Information refused	5						
No Data Provided	458						
TOTAL NOT DEFINED	529 (26%)						

* Numbers have been rounded up for purpose of reporting.

PROFILE FOR STUDENT AT THE TRUST

* Academic Year 2008.09 – TOTAL STUDENT POPULATION – 1889

ETHNIC ORIGIN		DISABILITY		GENDER		NATIONALITY	
White	1209	No Known Disability	1449 (77%)	Female	1509 (80%)	European	290 (15%)
Other White background	1			Male	380 (20%)	Home	1499 (79%)
TOTAL WHITE	1210 (64%)			TOTAL GENDER	1889	Overseas	93 (5%)
		Blind/Partially Sighted	3			No Data Provided	7 (11%)
Black or Black British – Caribbean	60	Deaf/Hearing Impairment	10			TOTAL NATIONALITY ALL STUDENTS	1889
Black or Black British – African	48	Wheelchair User/Mobility Difficulties	6				
Other Black Background	12	Mental health Difficulties	3				
TOTAL BLACK	120 (6%)	An Unseen Disability e.g. Diabetes, Epilepsy, Asthma	17				
		A Specific Learning Difficulty e.g. Dyslexia	24				
Asian or Asian British Indian	29	A Disability Not Listed Above	8				
Asian or Asian British Pakistani	13	TOTAL DISABILITY	71 (4%)				
Asian or Asian British Bangladeshi	5						
Chinese	13	Information Refused	2				
Other Asian Background	22	Not Known	31				
TOTAL ASIAN	82 (4%)	No Data Provided	336				
		TOTAL NOT DEFINED	369 (20%)				
Mixed – White & Black Caribbean	10						
Mixed – White & Black African	9						
Mixed – White & Asian	6						
Other Mixed Background	18						
TOTAL MIXED	43 (2%)						
Other ethnic background	38						
Total – OTHER ETHNIC BACKGROUND	38 (2%)						
TOTAL BME	283 (15%)						
Not Known	35						
Information refused	4						
No Data Provided	357						
TOTAL NOT DEFINED	396 (21%)						

- Percentage numbers have been rounded up for purpose of reporting

Ethnic Analysis 2008/09 - All patients who attended (Ethnicity Recorded)

Ethnic Category	Adolescent			Adult			Child & Family			Portman			GIDU			N&S Camden			Trust Totals	
	Nos.	%	Comp	Nos.	%	Comp	Nos.	%	Comp	Nos.	%	Comp	Nos.	%	Comp	Nos.	%	Comp	Nos.	%
WHITE	273	65.5%	57.8%	613	79.5%	76.7%	465	69.0%	57.8%	211	85.4%	71.2%	91	85.8%	76.9%	259	58.6%	54.5%	1912	72.0%
White - British	209	50.1%	46.2%	417	54.1%	55.9%	349	51.8%	46.2%	191	77.3%	59.8%	83	78.3%	72.6%	185	41.9%	42.8%	1434	54.0%
White - Irish	11	2.6%	1.7%	30	3.9%	5.2%	8	1.2%	1.7%	5	2.0%	3.1%	3	2.8%	0.7%	6	1.4%	1.6%	63	2.4%
White - Any other white background	53	12.7%	10.0%	166	21.5%	15.6%	108	16.0%	10.0%	15	6.1%	8.3%	5	4.7%	3.7%	68	15.4%	10.2%	415	15.6%
MIXED	42	10.1%	8.5%	36	4.7%	2.6%	85	12.6%	8.5%	10	4.0%	3.2%	10	9.4%	4.7%	68	15.4%	8.5%	251	9.4%
Mixed - White and Asian	5	1.2%	1.9%	7	0.9%	0.7%	16	2.4%	1.9%	3	1.2%	0.8%	2	1.9%	1.3%	10	2.3%	2.0%	43	1.6%
Mixed - White and Black African	6	1.4%	1.4%	7	0.9%	0.4%	8	1.2%	1.4%	1	0.4%	0.5%	0	0.0%	0.6%	12	2.7%	1.4%	34	1.3%
Mixed - White and Black Caribbean	13	3.1%	2.6%	8	1.0%	0.5%	23	3.4%	2.6%	3	1.2%	1.0%	3	2.8%	1.7%	20	4.5%	2.4%	70	2.6%
Mixed - Any other mixed background	18	4.3%	2.5%	14	1.8%	0.9%	38	5.6%	2.5%	3	1.2%	0.9%	5	4.7%	1.1%	26	5.9%	2.7%	104	3.9%
ASIAN OR ASIAN BRITISH	30	7.2%	14.1%	39	5.1%	8.3%	33	4.9%	14.1%	10	4.0%	12.1%	2	1.9%	9.1%	50	11.3%	18.4%	164	6.2%
Asian - Indian	8	1.9%	2.9%	16	2.1%	3.5%	9	1.3%	2.9%	4	1.6%	6.1%	0	0.0%	3.8%	7	1.6%	1.5%	44	1.7%
Asian - Pakistani	5	1.2%	0.9%	3	0.4%	0.7%	3	0.4%	0.9%	3	1.2%	2.0%	2	1.9%	2.1%	3	0.7%	0.6%	19	0.7%
Asian - Bangladeshi	4	1.0%	8.8%	4	0.5%	2.9%	9	1.3%	8.8%	1	0.4%	2.1%	0	0.0%	2.1%	30	6.8%	15.1%	48	1.8%
Asian - Any other Asian background	13	3.1%	1.4%	16	2.1%	1.2%	12	1.8%	1.4%	2	0.8%	1.9%	0	0.0%	1.2%	10	2.3%	1.2%	53	2.0%
BLACK OR BLACK BRITISH	62	14.9%	16.3%	51	6.6%	8.2%	76	11.3%	16.3%	10	4.0%	10.9%	3	2.8%	7.6%	54	12.2%	15.3%	256	9.6%
Black - Caribbean	25	6.0%	3.7%	23	3.0%	3.0%	26	3.9%	3.7%	6	2.4%	4.8%	0	0.0%	2.7%	12	2.7%	2.1%	92	3.5%
Black - African	28	6.7%	11.2%	13	1.7%	4.7%	35	5.2%	11.2%	3	1.2%	5.3%	0	0.0%	4.1%	28	6.3%	12.1%	107	4.0%
Black - Other Black background	9	2.2%	1.4%	15	1.9%	0.4%	15	2.2%	1.4%	1	0.4%	0.8%	3	2.8%	0.9%	14	3.2%	1.1%	57	2.1%
OTHER ETHNIC GROUP	10	2.4%	3.4%	32	4.2%	4.2%	15	2.2%	3.4%	6	2.4%	2.7%	0	0.0%	1.6%	11	2.5%	3.2%	74	2.8%
Chinese	0	0.0%	1.3%	5	0.6%	1.8%	5	0.7%	1.3%	2	0.8%	1.1%	0	0.0%	0.7%	2	0.5%	1.1%	14	0.5%
Other Ethnic Group	10	2.4%	2.1%	27	3.5%	2.4%	10	1.5%	2.1%	4	1.6%	1.6%	0	0.0%	0.9%	9	2.0%	2.1%	60	2.3%
Trust Total (Excluding Missing)	417			771			674			247			106			442			2657	

Patient figures are based upon a unique count of attended patients (patients only counted once) for the Financial year 2005/06

Comp (Comparator) - is based upon the 2001 Census and uses the following for each department: -

- Adolescent & Child & Family based on North Central London under 18s
- North & south Camden based on Camden 0-17's
- Adult based on North Central London 18 and over
- GIDU used London + S.East figures for under 18s
- Portman based on London figures for all ages
- LCDS and Monroe have been merged into C&F figures

Trust Patient Caseload 2008/2009 - Gender Split

		Male	%	Female	%	Total
Non-Adult Services	Adolescent	197	41%	286	59%	483
	Child & Family	540	64%	305	36%	845
	N. Camden	225	58%	165	42%	390
	S. Camden	147	54%	124	46%	271
	Gender Identity*	70	53%	63	47%	133
	Learning Disabilities	39	62%	24	38%	63
	Monroe	21	54%	18	46%	39
	Sub-Total	1239	56%	985	44%	2224
Adult Services	Adult	296	32%	615	68%	911
	Portman	256	83%	52	17%	308
	Sub Total	552	45%	667	55%	1219
Trust Total		1791	52%	1652	48%	3443

* - Gender Identity has 3 patients where gender was not assigned.

Trust Patient Caseload 2008/2009- Age Breakdown

		Age Breakdown								Total		
		0 - 5	%	5 - 10	%	10 - 15	%	16 - 21	%		21 Plus	%
Non-Adult Services	Adolescent	12	2%	48	10%	117	24%	224	46%	82	17%	483
	Child & Family	92	11%	466	55%	234	28%	27	3%	26	3%	845
	N. Camden	82	21%	154	39%	117	30%	26	7%	11	3%	390
	S. Camden	34	13%	91	34%	102	38%	35	13%	9	3%	271
	Gender Identity	2	1%	29	21%	49	36%	56	41%	0	0%	136
	Learning Disabilities	2	3%	9	14%	14	22%	13	21%	25	40%	63
	Monroe	21	54%	14	36%	4	10%	0	0%	0	0%	39
	Sub-Total	245	11%	811	36%		0%		0%		0%	2227
		0 - 21	%	21 - 40	%	21 - 60	%	61 plus	%		Total	
Adult Services	Adult	1	0%	467	51%	383	42%	60	7%		911	
	Portman	43	14%	139	45%	119	39%	7	2%		308	
	Sub-Total	44	4%	606	50%	502	41%	67	5%		1219	

CURRENT PUBLIC MEMBERSHIP FOR 2008/2009

Public Constituency	Number of members	Eligible membership
Age (years):		
0–16	2	42,882,883
17–21	53	
22 +	3,315	
Unknown	1,123	
Ethnicity:		
White	2,396	42,882,883
Mixed	110	
Asian or Asian British	196	
Black or Black British	251	
Other	58	
Unknown	1,482	
Gender:		
Male	894	42,882,883
Female	3,023	
Unknown	576	

Completed Equality Impact Assessment (EQIA)

<p>Form one – initial screening</p> <p>1. Name of policy, function, or service development being assessed: Single Equality Scheme</p>
<p>2. Name of person carrying out the assessment: Shilpi Sahai, Human Resource Manager</p>
<p>1. Please describe the purpose of the policy, function or service development:</p> <ul style="list-style-type: none"> • Eliminate unlawful discrimination • Promote equality of opportunity • To ensure that the public authority legislative requirements are met • To ensure that the six strands of diversity are included in planning for the service functions • Present a 3 year action plan for achieving equality and diversity within the Tavistock and Portman Foundation Trust
<p>4. Does this policy, function or service development impact on patients, staff and/or the public? Response: Yes Staff (directly) & patients & public (indirectly)</p>
<p>5. Is there reason to believe that the policy, function or service development could have an adverse impact on a particular group or groups? Response : NO</p> <p>If YES, which groups may be disadvantaged or experience adverse impact? Age – especially younger and older people NO Disability – people with impairments NO Gender – women, men, transgender people NO Race – people of different ethnic groups NO Religion and belief – people of different faiths and beliefs NO Sexuality – especially lesbian, gay, and bisexual people NO</p>
<p>6. If you answered YES in section 5, how have you reached that conclusion? (Please refer to the information you collected e.g., relevant research and reports, local monitoring data, results of consultations exercises, demographic data, professional knowledge and experience)</p> <p>The Single Equality Scheme addresses equality issues in relation to Race, Gender, Disability, Age, Sexual Orientation and Religion/ Belief. The equality target groups both external and internal stakeholders are all covered by the policy</p>

7. Sources of Consultation and Data Evidence that informed the development of the Scheme

The scheme was widely distributed to local agencies and community groups i.e. Stonewall, Nafsiyat, SCOPE and was made publicly available for consultation through the Trust public website. Staff group was consulted both individually and through their Trade Union representatives.

Gender: Do you have enough information? (Population data , researched indicators)
Yes – these have been attached to the scheme as Appendix C and F

Race: Do you have enough information? Yes – The data has been attached as Appendix B, E, F

Disability: Do you have enough information? No – Appendix E ,
If answered No, then how do you propose to include this information in future – RIO Project and updating patient and staff monitoring information forms

Sexual Orientation: Do you have enough information? No
If answered No, then how do you propose to include this information in future – updating patient and staff monitoring information forms

Age: Do you have enough information? Yes, Appended as D & F

Religion & Belief: Do you have enough information? No
If answered No, then how do you propose to include this information in future – Revising and Updating patient and staff monitoring information forms and through RiO

Section 9 References

The Scheme has been framed in accordance with the following UK legislation and guidance (this is not an exhaustive list):

- Sex Discrimination Act, 1975 (as amended)
- Sex Discrimination (Gender Reassignment) Regulations 1999
- Race Relations Act, 1976
- Race Relations Amendment Act, 2000
- Disability Discrimination Act, 1995 (as amended)
- Employment Equality (Religion or Belief) Regulations, 2003
- Employment Equality (Sexual Orientation) Regulations, 2003
- Employment Equality (Age) Regulations, 2006
- Human Rights Act, 1998
- Health and Safety at Work Act 1974
- Health & Safety at Work Regulations, 1999
- Protection from Harassment Act, 1997
- Civil Partnership Act, 2004
- Public Interest Disclosure Act (Whistle Blowing), 1998
- NHS Employers (<http://www.nhsemployers.org/>)