APPENDIX 1

ANNUAL EQUALITY REPORT 2013-14 - SUPPORTING EVIDENCE

1. INTRODUCTION

1.1. The specific duties deriving from the Equality Act 2010 Public Sector Duty require public bodies to publish relevant, proportionate information relating to demonstrating their compliance with the Equality Duty; and to set themselves specific, measurable equality objectives. Under the specific duties public bodies must publish information to show that they have consciously thought about the three aims of the Equality Duty as part of the process of decision-making. The three aims are:

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

The information published must include:

- information relating to employees who share protected characteristics (for public bodies with 150 or more employees); and
- information relating to people who are affected by the public body's policies and practices, who share protected characteristics (for example, service users).

1.2. The following appendix provides the information required on the Trust's access to Services, decision-making and engagement and workforce for the year from April 1 2013 to March 312014, as well as progress on its agreed equality objectives.

1.3 The Annual Equality Report will continue to be published on the Trust's intranet

and website and be made available on request in community languages and alternative formats to our patients, service users and stakeholders.

2. PROGRESS SINCE ANNUAL EQUALITY REPORT 2012-2013

2.1. The current report provides the access to key services and workforce profiling statistics for the period from April 1 2013 to March 31 2014.

2.2. Implementation of the Trust's equality objectives, in line with requirements of the Equality Act 2010 and the national NHS Equality Delivery System, continues to move forward. The Trust continues to be represented on the Outer North East London Equalities partnership group, to ensure regular face-to-face engagement with service users from protected characteristic groups.

2.3. The updated equalities monitoring guidance from NHS England, in line with the Equality Act 2010 Public Sector Duty, is still awaited. Following publication of this, consideration will be given to how best and appropriately to monitor take-up and satisfaction with the services provided by the Trust in relation to diverse protected characteristic groups. In the meantime the Trust has developed its own equalities monitoring form, which has met with approval from the leading employers' equality forums the Trust is a member of. This form is an appendix to the Trust's updated Equality and Inclusion Strategy and is now available for Trust-wide use, where appropriate. Equalities monitoring has been carried out on Trust Board Directors and will continue to be undertaken to ensure representation across protected characteristic groups.

2.4. Equality and Inclusion training continues to be delivered at induction, All in One Refreshers and embedded in other training delivered across the Trust. New equality and inclusion training has been designed and provided for operational staff by Training Officer Craig Noler in collaboration with training colleagues delivering equality and inclusion training and the Equality and Inclusion Team. A further

Equality and Inclusion module of the Trust's online Equality and Inclusion e-learning programme will be developed over the coming year. A briefing to the new Board of Trust Directors was delivered in June 2014 and further half-day workshops for staff and managers were delivered in June and July.

2.5. Briefings to project teams on the use of the Trust's Equality Analysis procedure continue to be provided by the Equality and Inclusion Team and equality analyses are published on the Trust's website.

2.6. The Trust's Staff Forums, the LGB Staff Forum, Deaf Awareness Forum and Enable continue to be supported in their work by the Trust, with the Chairs of each of the forums invited to meetings of the Equality and Inclusion Steering Group to discuss initiatives they have carried out and their aims and objectives for the coming year.

Over the previous year the Deaf Awareness Forum has participated in Deaf Awareness Week, Learn to Sign week and the annual Deaf Day at City Lit, undertaken a survey amongst England's NHS Ambulance Trusts to determine the level of activity within the deaf community and continued to raise deaf awareness amongst Trust staff . In an online video on YouTube and available on the Trust website one of the Trust's motorcycle paramedics Richard Webb-Stevens, who has hearing difficulties himself, uses British Sign Language in the film to inform deaf, hard-of-hearing and speech-impaired people how to use the emergency SMS service. Once registered, users can send a text message to request help from the ambulance, fire, police or coast guard. Richard appeared last year on the BBC programme See Hear and was interviewed about his work caring for patients with the motorcycle response unit. On behalf of the Deaf Awareness Forum he also undertakes outreach work to schools showing students the equipment he uses and talking about some of the emergencies he has dealt with. For his work Richard was recently recognized as an NHS hero. The Deaf Awareness Forum, set up by a colleague of Richard's, Mark Weller, two years ago, comprises a wide range of

volunteers from across the service in a wide range of occupations, from paramedics to office staff, working to increase deaf awareness among staff and forging links with London's deaf community.

The Trust's LGBT forum has been at the forefront of a wide range of high-profile initiatives, including the Trust's involvement in the Stonewall Health Champions programme, its annual applications to the Stonewall Workplace Equality Index and Health Equality Index. The forum is continuing its work with the first ever national LGB&T Ambulance Forum, which it launched, following extensive national consultation. In early 2013 the forum engaged with Trust staff on potential LGBT allies, staff confident and supportive of the LGBT community and their issues, and will be rolling out this initiative further, supported by Stonewall, over the coming year. The forum has a very visible presence each year at London Pride – in July 2013 the forum again had a large contingent including friends and families at the London Gay Pride event as well as attending Brighton Pride and other key LGBT events. The forum has also actively input into Trust policy, including the Positive Action Policy.

A new BME Forum has been launched (ADAMAS – Association of Diverse and Minority Ambulance Staff) and the Trust's Disabled staff/carers' forum (Enable) is being re-launched. Close collaboration between the forums is taking place, which includes the joint planning and staging of a Staff Forum day event at Waterloo, to be followed by further sessions at key Trust locations across London to raise staff awareness around the work of the forums, encourage new members and look at possible further staff diversity forum options.

2.7. Following its application to the 2014 Stonewall Workplace Equality Index, the Trust again featured as a Top 100 Employer, coming 19th, for the third year the top ambulance service in the country and in 2014 the second highest-performing NHS Trust.

2.8. In the 2014 Stonewall Healthcare Equality Index for health care organizations in the

UK, which focuses specifically on what organizations are doing to make their services accessible and equitable for their lesbian, gay and bisexual patients and communities across all protected characteristic groups, the Trust again featured as a top performer organization, coming joint fifth, again the highest- performing ambulance service in the country.

2.9. The Trust's work to implement its agreed equality objectives continues to progress. Objective 2 – "We will improve the process for capturing equalities data in the area of patient complaints to ensure that more than 50 percent of complainants have provided relevant details and begin to monitor trends in complaints from black and minority ethnic (BME) service users in 2012-13". Improvements to the process for capturing equalities data have been made and this work is ongoing, as reflected in the relevant section later in this report.

The training element of the Patient Transport Service Objective was also carried out, which should lead to the successful achievement of the overall Objective 1 - "We will ensure that the satisfaction rates with our Patient Transport Service are equitable for both women and men using the service and for all our service users, regardless of sexual orientation."

2.10. The Trust continues to be represented on the EDS Working Group, facilitated by North East London Foundation Trust, to ensure regular face-to-face engagement with service users from protected characteristic groups. Following publication by NHS England of an Easy Read version of the second version of the national Equality Delivery System, expected this year, the Trust will refresh its approach.

2.11. A new free mobile phone number and advice on how to use the Language Interpreting Service has been issued to staff.

3. GOVERNANCE

3.1. This section addresses the Trust's obligations under the Equality Act 2010 in regard to decision making.

3.2. During 2013/14 the Trust has continued to undertake equality analysis in line with the *Policy and Procedure for the Development and Implementation of Procedural Documents* TP01). The Governance & Compliance team co-ordinate the completion of policies and procedures and support the Equality & Inclusion Manager and other managers in ensuring that an equality analysis has been undertaken for each new or revised document as appropriate.

3.3. Front sheets for Trust Board and formal committee documents ask the author to identify whether an Equality Analysis had been undertaken and if so, whether any specific issues had emerged. Compliance levels remain variable; however assurance can be taken that any new or revised policy document taken to one of these committees will have a relevant and up to date equality analysis.

3.4. The Trust was awarded unconditional registration by the Care Quality Commission in April 2010 and continues to monitor progress against each outcome. The requirements do not specify a standard for equality & inclusion, but registration includes a section on equality, diversity & human rights asking how we ensure people's equality, diversity and human rights are actively promoted in our services and how these influence our service priorities and plans.

3.5. The CQC undertook a compliance review in March 2012 and found the Trust to be compliant with Outcome 1 *Respecting and involving people who use services*. Their judgement included the following: 'People's privacy, dignity and independence were respected. People who used the service were given appropriate information and support regarding their care or treatment.' The CQC found evidence that 'if a female patient wishes to be dealt with by a female

member of staff (for example, for cultural background reasons) staff will, where possible, try to accommodate this. Where a patient's first language is not English, staff will try to use people at the scene to interpret, balancing this against the need to ensure privacy and dignity.'

3.6. The Equality and Inclusion Steering Group reports to the Executive Management Team and the following directors are members of the group: Workforce, Finance, and Corporate Affairs.

4. FOUNDATION TRUST

4.1. Membership Strategy

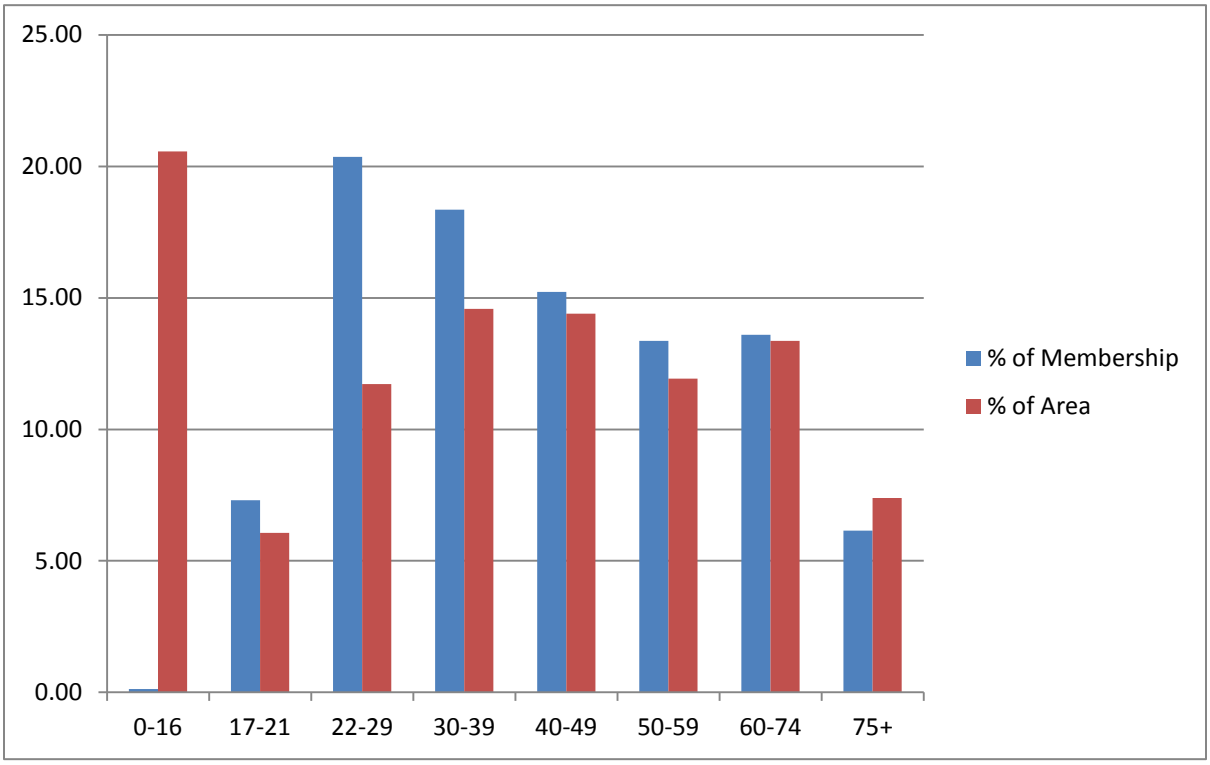
The Membership Strategy sets out the Trust's approach for growing, maintaining and developing an engaged and active public and staff membership. The strategy defines the membership community and sets out actions to help the Trust achieve its membership objectives. These objectives include achieving a membership consisting of the range of diverse communities of London's population and workforce and focusing on the development of our membership base and member-relations activities in order to achieve a representative membership. The document outlines how the Trust will evaluate its success in delivering the strategy and how it will continue to develop and benefit from an active and involved membership. The Membership Strategy is an appendix to the 5-year Integrated Business Plan and as such forms part of the application for NHS Foundation trust status. An Equality analysis has been carried out on the strategy.

4.2. Analysis of Membership

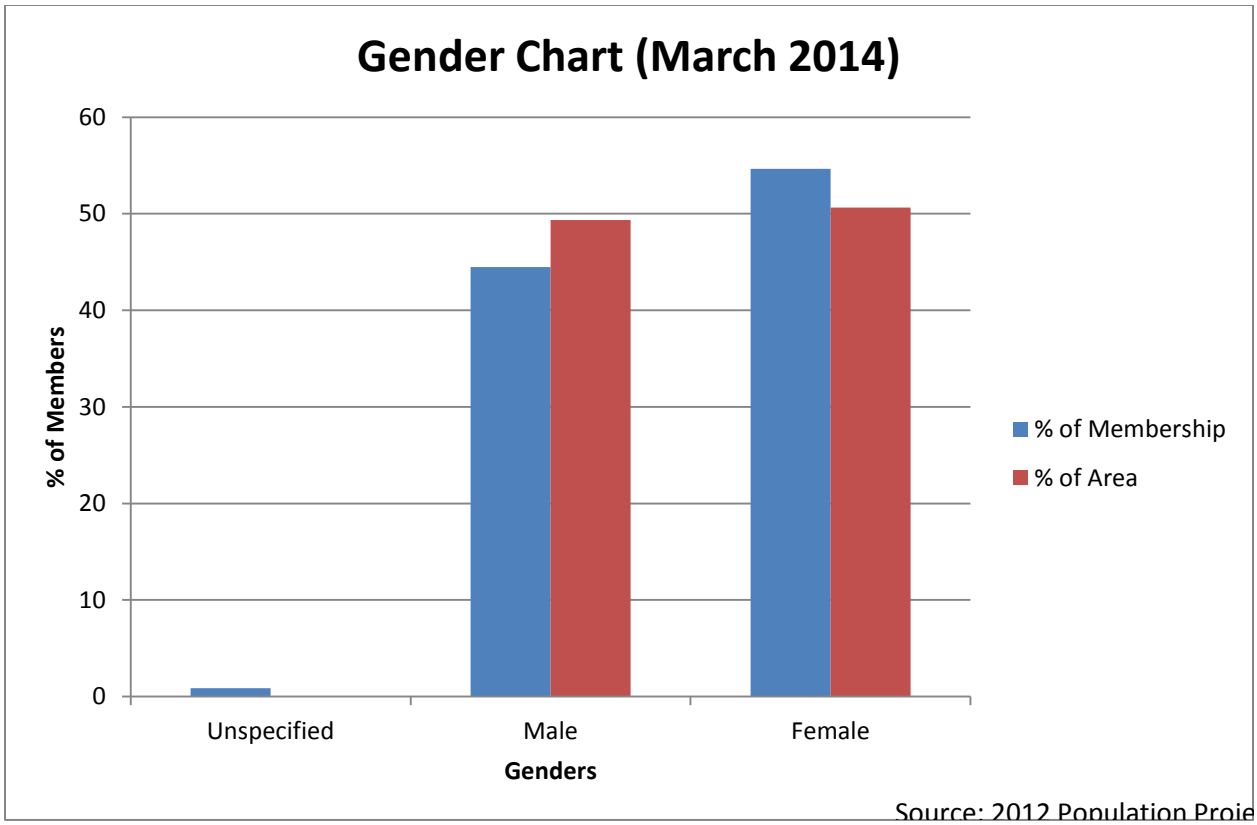
At 31 March 2014 the Trust had 8,995 public members. The Trust regularly and closely monitors the demographic profile of its public members to get a picture of how representative the membership is of the eligible population and to address any inequity in representation through recruitment. The following graphs

compare the public membership against the eligible population (London and surrounding counties) by age, gender, ethnicity and socio-economic grade. 8.1% (746) of our public members have indicated that they consider themselves to have a disability.

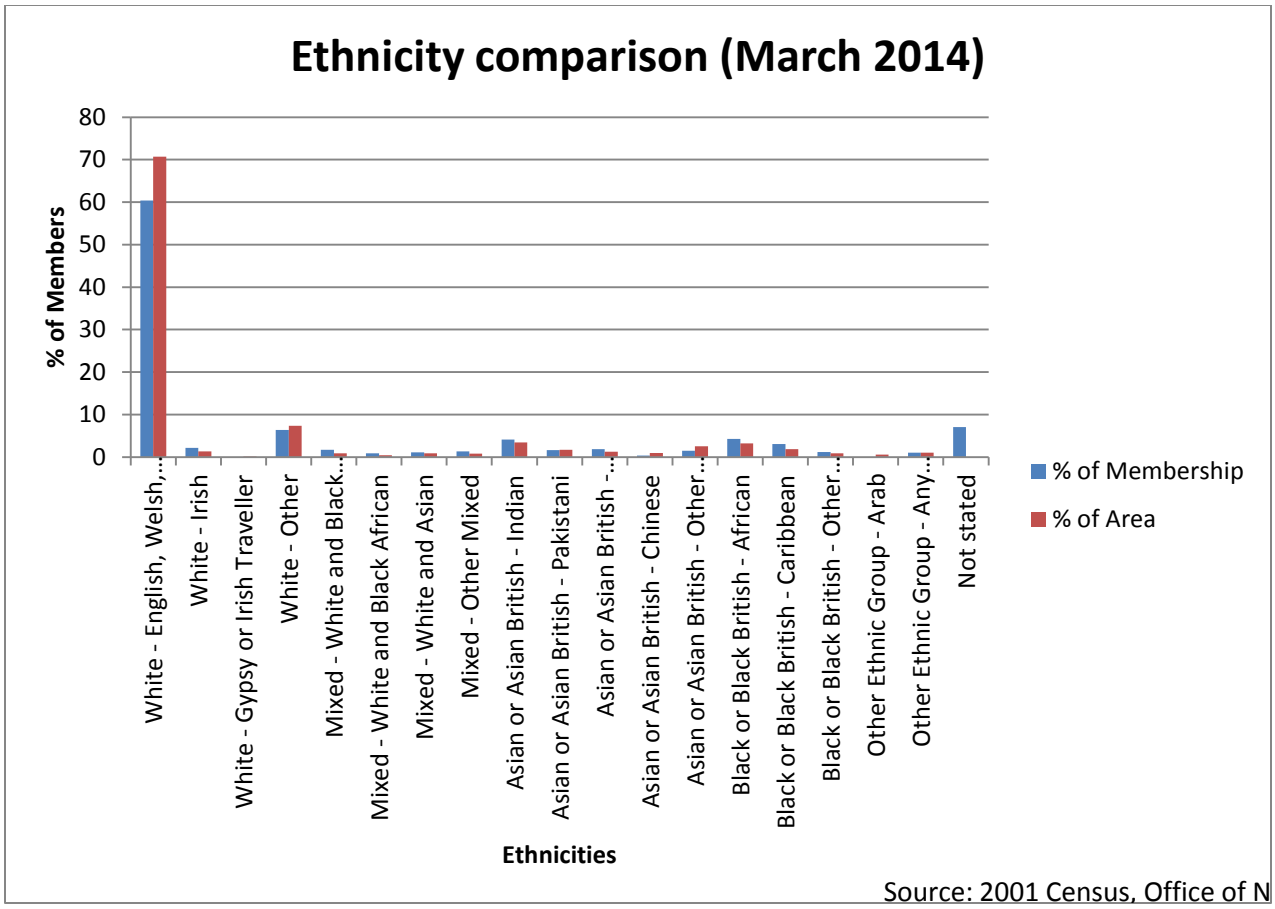
Comparison by age (March 2014)



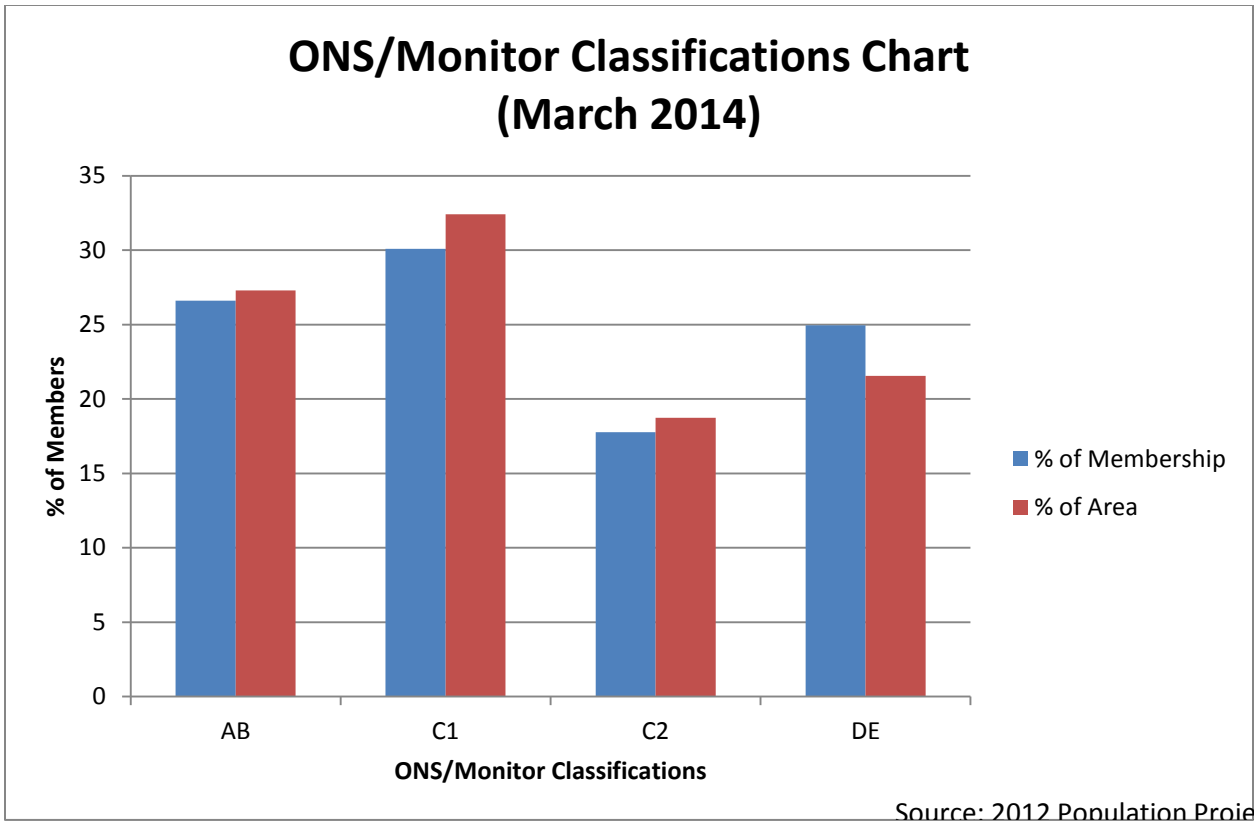
People aged 16 years and over are eligible to become members. The graph shows that the membership is representative of the area in almost all age categories and over- represented in the 22 – 29 age group. This is likely to be a reflection of the recruitment of members via the Trust current vacancies page of the website. The membership representation is slightly short in the 75+ category.



The graph above shows that the Trust is slightly under-represented in regard to male members but over-represented in regard to female members.



The chart shows the membership as being representative for almost all ethnic groups except for White - English, Welsh, Scottish, Northern Irish, British and ethnic group - Chinese. It should be noted that 7% of the membership have not stated their ethnicity.



The graph above shows that the membership is closely representative of the eligible population for social grade.

4.3. Membership engagement and involvement

All Trust members receive the Trust's newsletter Ambulance News four times a year. This is an important engagement opportunity for members to learn and understand more about the Service, how it works, key achievements and plans for the future. During 2013/14 the Trust held a programme of meetings and events for members. These included events on basic first aid for the family, mental health, cardiac care, understanding demand and a joint event with

University College Hospital London on trauma and long term conditions. More than 300 members have attended these events, which have provided an excellent opportunity for the Trust to showcase its work and gain a greater understanding of the views of the public.

4.4. NHS Foundation Trust Application

The Trust is aiming to become an FT in 2016.

5. ACTIVITIES AND SERVICES OF THE LONDON AMBULANCE SERVICE

5.1. This section demonstrates the Trust's delivery of its obligations under the Public Sector specific duties in regard to considering how the decisions it makes and the services it delivers affects people who share protected characteristics.

5.2. London Ambulance Service is the busiest ambulance service in the UK, serving over eight million residents in London and many more commuting into and visiting the capital. In line with the commitment in the Trust's Equality and Inclusion Strategy to "provide enhanced and world class health care to all our diverse patients and service users across all protected characteristic groups" and "to ensure patients and service users receive fair and equal access to our healthcare service " and that "everyone is treated with dignity and respect" the Trust has continued over this past year to look innovatively at ways of enhancing its

services.

5.3. Following the end of the three-year cycle of the Trust's first generic Equality and Inclusion Strategy, an updated strategy was produced including the Trust's key priorities for action, which were consulted on with a wide range of external and internal stakeholders. A separate report on this have been provided to the Executive Management Team, which will go to the Trust Board, and the updated strategy will be published on the Trust's website and made available widely, including in alternative formats and community languages, where required. An Easy Read version of the updated strategy will also be made available. The strategy will remain a living document with feedback welcome at any time and will be monitored on an annual basis with the involvement of our patients, service users, staff, Staff Diversity Forums, staff side representatives and other key stakeholders and formally reviewed at the end of three years in 2017.

5.4. **Mental Health**

The Trust is continuing to take forward a number of initiatives to improve the quality of care provided to mental health patients. These include incident and near-miss reporting, use of information, patient feedback and involvement, complaints, concerns and compliments, clinical audit, good leadership and management systems. The Mental Health Clinical Adviser is now working closely with the Clinical Audit Research Unit to help raise awareness by addressing it complex by complex.

The Patient Experiences Department continues to regularly seek assistance from the Trust's Clinical Adviser for Mental Health in relation to clinical advice regarding complaints containing a mental health component. Patient experience remains an important part of our learning from experience and helps us to improve on the quality of service we provide to our patients.

The Trust continues to engage with our patients through regular attendance at the Patients' Forum as well as keeping close links with patient representatives who form part of our mental health committee meetings.

The Mental health committee continues to run bi-monthly. It is now chaired by the Trust's Mental Health Clinical Adviser with the support of the Director of Nursing and Quality, who are both mental health trained nurses. The committee remains responsible for driving the Trust's Mental Health Action Plan which has been updated.

As a result of the Independent Police Commissioning Report work has been undertaken to draw up a Pan-London section 136 Action Plan. Members of the group tasked with doing this included the Chief Executive Officer group for the nine Mental Health Trusts with territorial responsibility for London, the Metropolitan Police and the London Ambulance Service. The action plan sets out the recommendations for each service in order to improve the patient experience of someone detained under section 136.

The Trust continues to progress with its mental health action plan. Following the launch of the Mental Health Alternative Care Pathways in May 2013 actions include monitoring the usage of the new pathways, identifying any issues our crews face when trying to use them and building in a review after one year.

The Trust's clinical Advisor for Mental health has started to deliver teaching

sessions for Clinical Paramedic Managers and Team Leaders as part of the “a time for change programme”. Sessions include the Mental Health Act and clinical risk assessment in mental health. Ongoing work to develop the skill set of the Clinical Hub staff continues with these staff having access to the Mental Health Clinical Advisor via email, phone or in person to assist with queries, complaints and general advice.

Joint working and collaboration on mental health issues continues within the Trust with attendance at external meetings including the Mental Health Partnership Board, Mental Health Trust /MPS meetings which are attended locally by complex AOMs; London AMHP leads network meetings and most recently attendance at a National Mental Health Lead meeting which will be held bi-monthly allowing the Trust to share good practice and network at a national level.

Training on mental health issues includes e-learning modules on an Introduction to Mental Health, Approaching people with Mental Health issues, Patient Consent, Depression, Post-Traumatic Stress Disorder, Self-Harm and Common Drug problems.

In addition to the in-house material developed, the Trust also provides staff access to e-learning material developed by the Social Care Institute for Excellence, which includes an introduction to mental health and older people, risks and protective factors in older people’s mental health, common mental health problems amongst older people, understanding depression in later life and services for older people with mental health problems. One of the Trust’s Clinical Involvement Officers has continued to work very closely with Oxleas Mental Health Trust in Bexley, including in mental health training with other key partners such as the Metropolitan Police Service and British Transport Police. Additionally the London Ambulance Service took part in a training video for the Metropolitan Police around the correct application of legislation for conducting Section 136 (removal from a public place). This video puts the views of service users at the centre of practice and presents a very realistic set of behaviour by the professionals involved with their care, including showing examples of good and bad practice.

The Trust continues to work with the Alzheimer’s Society and has become a

founder member of the Dementia Action Alliance. By joining the Pan-London Dementia Action Alliance and developing a short action plan, London Ambulance Service has become part of the national movement to improve the lives of people living with dementia.

5.5.Safeguarding

The Safeguarding Team provide a quarterly report on safeguarding activity and training within the Trust, which is shared both internally and externally with safeguarding partners. Highlights over the year 2013-14 have been:

- the development of a second edition of pocket communication guide to assist staff when communicating with patients with a learning disability or who are deaf; individual copies issued to all clinical staff;
- the development and issue of a safeguarding pocket book for all staff within the Trust to provide information on safeguarding children and vulnerable adults;
- safeguarding Training including information on female genital mutilation (FGM);
- Trust representation on NHS England working group for FGM;
- Trust work in partnership with NW London & NHS England and Buckinghamshire University on pressure ulcers education and processes;
- 120 staff attending first safeguarding conference, which covered a range of subjects including Child Abuse, FGM, Trafficking, Mental Health, Elder Abuse;
- safeguarding easy read leaflet produced for public and also available on Trust website.

The service has developed a monthly care home data report, which is shared internally with managers and externally with CCG's, CQC and social services -part

of recommendations from Winterbourne View. Local managers attend safeguarding boards and other multi agency events and meetings to safeguard vulnerable groups.

In the coming year attendance at multi-agency groups will continue, as will Core Skills Training including Learning Disability (developed with Mencap), Human Trafficking, Female Genital Mutilation, Pressure Ulcers, patient outcomes and Prevent work (radicalization awareness). The Trust is developing a pressure ulcer poster for use throughout UK Ambulance Trusts; a DVD (with subtitles) on the work of the Trust with patients with a learning disability will be published on the website and an application made re the Trust's care home report for a Health Service Journal award re its care home report.

5.6. Community Resuscitation

The Community Resuscitation Training Officer (CRTO) role has been defined as a community development and supporting role, raising awareness across London of the importance of life-saving skills, empowering with confidence a 'have a go' attitude aimed at making a difference to cardiac arrest survival rates in the capital. To achieve this, each diverse group offers unique challenges for understanding and inspiration. Projects which the Trust has been involved in include:

The Princes Trust

The Princes Trust, in partnership with the London Ambulance Service, seconded members of frontline staff onto a personal development course called Team Challenge. This was aimed at creating a relationship with groups of otherwise, hard to reach teenagers. Over 12 weeks they engaged in team building practical skills and community projects ending with a one week residential element. This exciting project was an ideal opportunity to capitalize on contacts made within the Princes Trust to introduce Heartstart training to young people.

Intellectual Disability (Learning Disability) and special needs schools

Involvement with special needs groups began at St Georges Hospital Tooting. Initially, Heartstart training was taking place over four regular sessions. Within these sessions came the idea to train as many teachers as possible at schools specialising with learning disabilities across the South East of London. In association with Merton Mencap, came the opportunity for CRTOs to begin training staff at Cricket Green School (special needs school for children 4-18) in the vital skills of emergency life support and defibrillator familiarisation.

Following the success of this scheme, the head of the group at St Georges invited a CRTO to become a member of the *Health and Wellbeing* committee of the Special Olympics GB 2013, The Special Olympics is a global movement of people with intellectual disabilities, which aims at creating inclusion and a sense of community to all, regardless of ability or disability. At the 2013 Special Olympic GB Summer Games, the CRTO, representing the LAS and the BHF, began a specially adapted programme for all the athletes, their families and coaches in Heartstart training including how to operate a defibrillator. The CRTO is currently working with Baroness Hollins and the BHF, on a publication of a picture booklet to teach anyone with intellectual disabilities CPR and defibrillator use.

Neasden Temple

Located in Neasden, north London the 'Neasden Temple', as it is popularly known, is a sacred house of God and a place of daily worship for the Hindu community. As well as a visitor attraction, it also has an active sports hall which hosts 8,600 school and group visits annually. It is a unique meeting place encompassing all faiths and cultures. While actively running health awareness days, a doctor serving this community, found that most of the congregation were reluctant to visit their own GP and were falling behind the general population with regard to their own health and care. They also found that none of the regular residents, amounting to thousands, had ever had any form of first aid or resuscitation training. Through the health care professionals who worship in the Temple, made up mostly of doctors and dentists within the community, it was decided to change the mind set ensuring these essential skills were proactively taught to everyone. Here was the ideal place to

implement the Train the Trainer scheme which now ensures regular Heartstart and defibrillator awareness sessions. The Heartstart and defibrillator awareness sessions are also taught by theses trainers, to the older children at a nearby faith school guaranteeing that a new generation within the community have an understanding of health care and life saving techniques.

Black and Minority and Ethnic Groups (BME)

The British Heart Foundation has an established BME manager who arranges partnership working with the CRTO team ensuring inclusion for all black minorities and ethnic groups' access to training sessions. Historically, these groups are notably reluctant to seek medical or health advice and lifesaving skills had been virtually non- existent. The aim was to provide informal and interactive courses in local community centres and halls. These are now well established and well attended. The CRTO team have developed their own skills further by adapting teaching methods, learning and respecting cultural differences, overcoming language barriers creatively and building lasting relationships with diverse communities.

Hearing impaired

CRTOs are represented at the LAS Deaf Awareness Forum (DAF) and actively support all communications and training within the hearing impaired community. As well as attending the Staff Development Programme, which features a specific module on British Sign Language and awareness, they work in partnership with public education to deliver CPR and defibrillator training at open days to specific groups with all levels of hearing impairment. Spearheading DAF is a motorbike Paramedic, who is hearing impaired, has been trained as a Heartstart trainer and now regularly teaches deaf groups in emergency life support. Recently, around 100 people attended a deaf conference at City Lit College in London and were given lifesaving skills and communication advice on calling 999.

Hatzola

Hatzola is the Hebrew word for rescue and is the name given to its International

Ambulance Service .Hatzola ambulance service evolved in North London in 1979 when the local Orthodox Jewish community had concerns with the Trust regarding perceived late attendances to emergency calls, some delicate issues around cultural insensitivities within their defined boundaries, and the general dedicated care that that a locally run ambulance service could potentially bring.Hatzola is broadly a charitable service, which raises funds from regular donations within its own community. (Although there are schemes in Golders Green and Stamford Hill, they are run separately only sharing the control centre). It is run voluntarily by the local Jewish community to help the entire surrounding neighbourhood. Specially trained volunteers are on call from home, waiting for an emergency, which they respond to on blue lights in their own cars. There are also two fully equipped ambulances available for clinical support and transport to hospital. When facing a medical crisis, the patient or family contact a normal landline number, which connects them to a robust network of people at home answering the call for help. Once the details have been given, they are relayed by radio to two responders who are alerted to the patient. Once on scene they assess the patient and are able to triage, treat or call for additional resources such as the ambulance service. It has been a successful working partnership with the Trust keeping regular contact and sharing events and information. Over recent times, through regular contact with CRTO, they have become aware of the community first responder scheme, operated by the Trust, and are keen to create a closer working relationship. So, there is now a training structure which involves developing their volunteers to the same FPOS basic level. This relationship is bridging gaps and, as a result of collaboration and support from the First Response team, is very successful in serving the needs of the local community Sunday to Thursday from 9 am to 9pm.

5.7.Patient and Public Involvement and Public Education

The PPI Committee continued to meet quarterly and also reported to the Learning From Experience Group. In the year 2013-14 962 patient involvement and public

education events/ activities were recorded on the database; Trust staff attended or took part in 717, approximately 60 events or activities per month, which meant that ca. 75% of requests were able to be met. This activity is largely carried out by staff from across the Service usually in their own time. This demonstrates a high level of commitment to this work from Trust staff and is a good example of staff engagement as well as public engagement.

Public education events and activities have included school and college visits, cub and scout groups, Junior Citizen schemes, career and job fairs, first aid training, gang and youth violence events, and health and safety days. We have taken part in health events, including some for deaf people, and given talks to “over 50s” and “over 60s” groups. With Stonewall we ran a patient involvement event to find out about the experiences and views of lesbian, gay and bisexual service users.

The community resuscitation training team continues to undertake Heartstart training courses, train the trainer courses and defibrillator training. There have also been a number of Community First Responder recruitment open evenings.

Events for Foundation Trust members included one on the achievement of the 2012-13 CQUINs and another on long term conditions. In June we invited members to learn more about our plans for the future, and in July we held an event for more than 50 Foundation Trust members, where they learned basic first aid techniques including CPR, how to use a defibrillator, how to put someone in the recovery position and how to help someone who is choking. We have also held member events on cardiac care, trauma, and mental health. The mental health event (“Mind Matters”) included presentations from the Croydon charity Hear

Us. They told the 40-strong audience about how they were diagnosed with different illnesses, including schizophrenia and depression, as well as their experiences of calling for help from the ambulance service.

The findings of last year's non-conveyed CQUIN (patient and staff surveys) were presented to the LAS Patients' Forum at their May meeting, and to the PPI Committee and Learning from Experience Group. The LAS Patients' Forum have also learned about a variety of subjects and plans from directors and other Trust senior managers; topics have included the Trust's plans for winter sustainability, the modernisation programme, infection control, trauma, commissioning and the Trust's clinical audit and research activities. The Clinical Audit & Research Unit (CARU) is now in the process of establishing a patient and public involvement group, so that patient engagement is embedded in their future clinical audit and research projects.

Regular basic life support sessions continue to be run in the Children's Centres in Tower Hamlets. Other health promotion events include a binge drinking event, knife crime awareness events (including one chaired by Reverend Desmond Tutu), and a talk to patients with dementia and their carers. We have also undertaken talks about the London Ambulance Service to other healthcare professionals and police cadets, church groups, deaf groups (including a visit to a deaf school) and the British Legion women's group.

There are seven Community Involvement Officers based in different parts of London, who are responsible for patient and public engagement, as well as staff engagement and partnership working in their local areas. This year they have been focusing on a range of activities including mental health awareness sessions, alcohol and knife crime awareness, Appropriate Care Pathways, Safeguarding and

external liaison e.g. with CCGs. They have also contributed to discussions about the future of their role in the new Trust strategy. Their public education visits have included providing first aid training and emergency awareness sessions for children with severe learning disabilities, the Greenwich Blind Independence Group, a BME women's group. Visits included every age group from nursery age to pensioner forums/care homes. One of the Community Involvement Officers was asked to talk at the "Bexley Big Health Check Forum" in November 2013. The day consisted of different agencies talking about Health services in Bexley and gaining an understanding of how the groups they were talking to have experienced them. The day was for people with learning disabilities, their family members, carers and professionals and was very well received.

A local initiative was set up by Croydon Community Involvement Officer to improve the engagement activities between frontline staff and patients experiencing health illnesses. A relationship was formed with a Croydon-based mental health charity "Hear Us" and the Service was invited to take part in a project called the Reach Out Challenge. The programme run by Hear Us aimed to reduce the stigma surrounding mental illness by bringing together people with lived experience of the condition and the staff in front line organizations coming into contact with them, such as the ambulance service, hospital, council and fire brigade. Over the course of five sessions lasting up to three hours volunteers from the project visited Croydon ambulance station to take part in a series of conversations with our staff.

As a result of the work carried out with Hear Us as part of the Reach Out Challenge, a good relationship has been built with the group, and they have become involved in a number of events and projects throughout the Service including eight mental health awareness sessions for Emergency Operations Centre call takers at Waterloo and Bow (mentioned previously), presentations by members of Hear Us to the Trust Board in January 2013 and to the Foundation Trust "Evening with us" event on February 27 2014. The feedback from Hear Us and Trust staff was highly positive and a very solid relationship founded between both. Staff enjoyed the one-

to-one conversations with volunteers and found the sessions a valuable, unique experience. The volunteers also benefitted from engaging with our staff and their worries and concerns were eased. A report on this project was produced - – **“**Mental health awareness project – Engaging staff and patients 2013-14.”

Targeted work is also carried out with young people between the ages of 10 -16, as this age group is considered as the most vulnerable to be drawn into group offending and gangs. The Community Involvement Officer leading on this area of work is involved in a number of projects in different boroughs around the consequences of knife crime. He works with a number of external agencies including the police, youth offending services, pupil referral units, youth charities and schools and colleges. One of the bigger projects is in the borough of Enfield – “Gangs – Making the Right Choices.” This project is delivered in a number of primary schools in the borough – year 6 (10-year olds). The police deliver a session on “Joint Enterprise” and the fact that they can be arrested from the age of 10. Sessions are also delivered by the Community Involvement Officer regarding the consequences of a knife crime from a medical perspective e.g. living with a life-changing injury. An ex-gang member who describes how he got involved in a gang at the age of 10 and how it took him years to get out also assists with these sessions.

During the year we also attended the Learning Disability Partnership Board in Lambeth and attended a women’s group in Hounslow, also for people with learning disabilities. We have been involved in hard-hitting road safety campaigns such as Driven by Consequences in Bromley and Safe Drive, Stay Alive in north and west London boroughs. We have also held training sessions for care home staff to increase their awareness of the LAS.

At the end of May 2013 we held a community health fair in New Addington, which was extremely successful, with over 440 visitors attending. In addition to a number of Trust stands and old and new vehicles on display, 31 other organisations

attended to give free information and advice. Members of the public could learn CPR and find out about healthcare options in the area. The Mayor attended and was extremely positive about the event, having spent an hour and a half talking to all the stall-holders. There were also activities for children including face painting, a magician and a teddy-bear hospital. We held a similar event in October, in the St. Helier area.

A Safeguarding conference was held in early June, and included two patients talking about their personal experiences. One talked about her experience of having survived sexual abuse, and the other about his experience of mental illness. Their sessions were very moving and received excellent feedback in the evaluation of the event.

An Appropriate Care Pathway (ACP) Action Plan has been agreed by the Learning from Experience Group and is being led by the Head of PPI and Public Education. The action plan includes the recommendations arising from previous discussions at Learning from Experience Group and also the recommendations from the survey of non-conveyed patients carried out last year. Key learning points from this work are:

- in order for staff to use ACPs, they need accurate information, the ability to make referrals, appropriate training and support, and for the use of the ACP to be made easy for them; there is high usage of ACPs which are co-located with Emergency Departments;
- There is a clear need for leadership within the Trust on the development, review and maintenance of ACPs;
- Issues around coding need to be addressed; in particular, the mental health pathways need attention, as many of them will shortly be out of date as systems change, and the coding needs to be consistent;

- We need to work with commissioners to establish new ACPs, review the use of existing ones and raise issues and problems wherever appropriate (e.g. staff not accepting Trust patients where this has been agreed)
- Part of the process for setting up an ACP needs to be around the staff at the ACP knowing about the process as well as Trust staff. The information we provide both to staff and patients needs to be up-t0-date and accurate
- Local training sessions and support around using ACPs needs to be provided at station/complex level
- Many of the issues identified could be addressed by the creation of an ACP Co-ordinator (or similar) post. This person could lead on most of these developments, supported by others who have an interest; there is a high level of staff commitment and interest in resolving these issues.

We ran a public education staff development programme in November 2013 with 15 participants. Over five days they learned key skills and increased their knowledge on a variety of topics which will help them make the most of their public education activities. The National Ambulance Service Patient Experience Group worked with the CQC and Picker to develop a national Hear & Treat survey. The telephone surveys were carried out during the winter months, and the results will be available in July 2014. This should provide some comparison between patients' experiences of hear and treat services across the country. We also provided advice to a researcher at St. George's Hospital about a research proposal on non-conveyed/hear and treat patients, possibly focusing on vulnerable patients, and/or those whose first language is not English. If this research is approved, it will take place during 2014.

The Patient & Public Involvement and Public Education Team transferred from the Corporate Services Directorate to the Nursing & Quality Directorate in August. As part of the Trust's restructure, the Media Resources Unit (including responsibility for

the historic collection) transferred to Communications in December.

We continue to have patient representation on many of our committees and groups, including hearing patients' stories at the Trust Board. We are now in the process of recruiting a patient representative for the Trust's Quality Committee.

5.8. Emergency Bed Service

In the delivery of its services, the Trust's Emergency Bed Service(EBS) deals mostly with Health Care Professionals, dealing with patients at one remove. Often the patient's details are unclear or the patient to be moved may not have been decided upon at the time the enquiry is taken. For that reason it has been the view of EBS Managers historically that there was no benefit to recording either ethnicity or disability in the operation of these services.

The ex-utero service is provided to premature babies and the in-utero to women in the later stages of pregnancy: gender and age profiling has not been thought relevant in these services.

EBS does have patient contact in the delivery of its services to District Nursing clients. The dataset collected for those patients has been agreed by the commissioners of those services and does not include age, gender or disability.

In provision of the Safeguarding service, where EBS collect and forward child protection and vulnerable adult referrals, service improvements this year have meant that from February 2014, protected characteristics (age, gender, ethnicity, religion or belief, sexuality, gender re-assignment, physical or mental disability as well as other characteristics indicative of vulnerability) are, or can be recorded.

5.9. Patient Transport Service

Patient Transport Services (PTS) is responsible for the transport of patients to their non-emergency appointments at a range of clinical care facilities.

Transport is provided to patients who are disabled, with mobility difficulties, where their medical condition may deteriorate on route, or where failure to provide transport would restrict their ability to access healthcare. The eligibility of patients to access this transport is assessed by a medical clinician at a GP's surgery or at a hospital or other NHS facility with an appropriate booking made with the London Ambulance Service.

In 2013-14 the Trust's PTS service delivered 153,436 journeys. All aspects of a patient's booking through to delivery of service are captured on the Meridian Planning system. Bookings, and therefore details about each patient, are provided by their treatment centre or GP surgery. Although the Trust requests monitoring details about patients from each treatment centre or GP surgery, the data provided is dependent on the individual making the booking. These individuals are not employed by the Trust. In the past 4 years the Trust has encouraged its customers to adopt a system of e-booking which would force capture of the monitoring data. Although this service is limited within the existing customer base, take up over the last 12 months has been encouraging. Of the 153,436 journeys completed last year 24% were registered using e-bookings.

Work is still on going to capture NHS Numbers for all patients and we have been relatively successful again in this piece of work.This field was made mandatory on our e-booking system during the last 12 months. A call back process has been adopted in our transport operation centres where staff ring the treatment centre or GP back for bookings received by fax or email without the patient's NHS Number recorded. There were 88% correct NHS numbers recorded for FY 2013-14, compared to 82% FY 2012-13. We expect to see this trend continue; however, access to this data is limited to the person making the booking.

PTS will continue to work with customer Trusts to seek assistance to capture equalities information in a more consistent manner.

The data collected below shows an increase from the previous years; unknown age is down to 18% from 24% with unknown ethnicity down slightly to 85% from 88%. Patient gender remains at 3% unknown.

Patient Gender	JA	%
F	88411	57%
M	60608	40%
UK	4417	3%
Grand Total	**153436**	**100%**

Patient Age Profile	JA	%
0-20	702	0%
21-30	834	1%
31-40	1284	1%
41-50	4219	3%
51-60	7411	5%
61+	110813	72%
UK	28173	18%
Grand Total	**153436**	**100%**

Ethnicity Of Patient	JA	%
A - White British	15571	10%
B - White Irish	701	0%
C - Any other White Background	1471	1%
D - Mixed White & Black Caribbean	212	0%
E - Mixed White & Black African	40	0%
F - Mixed White & Asian	31	0%
G - Mixed Any other White Background	70	0%
H - Asian or British Asian Indian	716	0%
J - Asian or British Asian Pakistani	362	0%
K - Asian or British Asian Bangladeshi	159	0%
L - Asian or British Asian Any other background	421	0%
M - Black or Black British Caribbean	1803	1%
N - Black or Black British African	459	0%
P - Black or Black British Any Other Background	321	0%
`R - Other Ethnic Groups Chinese	163	0%
S - Any other Ethnic Groups	603	0%

Z - No Information Available	130333	85%
Grand Total	**153436**	**100%**

Again the statistics above show that from the data collected there are slightly more users of PTS services who are women than rather than men. We saw a 7.5% increase in patient journeys from 2012-13 but the percentage split between men and women remain within 1% of last year's split. As in previous years, it is predominantly older patients who rely on the service to access healthcare (a 5% increase in records). There are fewer journeys year on year where the age is unknown, which shows that the service is improving its ability to capture this element of data.

Of the 15% of data captured the majority of patients recorded were of white British ethnicity. However, it is difficult to draw any clear conclusion from this, given that 85% of records had no information.

The Trust will need to continue to engage with its customers more, both to collect the data in the first instance, but also to work with them to consider any issues over access of services where inequality may be identified and needs to be addressed.

The results of the latest surveys over two large hospital Trusts and three community service Trusts reflect the patient demographic recorded in patient journey data noted above.

The gender data from the surveys returned supports the journey data that women are more users of the service.

Question 27 – Is the user of the service...?

GENDER		
Male	48	32%
Female	95	64%

No response recorded	5	3%
Total	148	100%

The department has clearer ethnicity data than that provided from the patient journey data; however the ratios are similar to those who provided above.

Question 28 – How would describe your ethnic background?

ETHNICITY		**% against overall response**
White		
British	105	71%
Irish	8	5%
other white background	1	1%
Total White	114	77%
Mixed		
White/Black	0	0%
White/Asian	0	0%
White/Black African	0	0%
other mixed background	0	0%

Total Mixed	0	0%
Asian/British Asian		
Indian	2	1%
Bangladeshi	0	0%
Pakistani	3	2%
Other Asian background	3	2%
Total Asian / British	8	5%
Black/British black		
Caribbean	15	10%
African	4	3%
other black background	2	1%
Total Black ; Black British	21	14%
Chinese/Ethnic other		
Chinese	2	1%
Ethnic other	1	1%
Total Chinese / Other Ethnicity	2	1%
No Response Recorded	3	2%
Ethnicity Total	145	98%

With regard to sexual orientation, of the source group in the survey 12% would prefer not to say, whereas of those who gave a specific response 64% said that they were heterosexual.

Question 29 – Which of the following best describes how you think of yourself?

Sexual Orientation	Responses	% Answered Questions
Heterosexual	94	64%
Gay man	0	0%
Gay woman (Lesbian)	0	0%
Bisexual	4	3%
Other	4	3%
I would prefer not to say	18	12%
No response recorded	28	19%
Total	**148**	**100%**

The greatest response the department received on the surveys for religion or belief reflected a 66% Christian demographic response. The next largest group responding said they had no religious belief.

Question 30 – Please indicate your religion or belief?

Religion or Belief	Responses	% Answered Questions
Christian	98	66%
Hinduism	1	1%
Sikhism	1	1%
Muslim	1	1%
Humanism	1	1%
Jainism	1	1%
Other	10	7%
None	16	11%
Do not wish to disclose	14	9%
No response recorded	5	3%
Total	**148**	**100%**

75% of survey respondents felt their illness to be a long-standing one or a disability; this is around the percentage for 2012-13, which was 76%.

Question 31 – Do you have a long-standing illness, health problem or disability?

Disability	Responses	% Answered Questions

Yes	111	75%
No	9	6%
Do not wish to disclose	8	5%
No response recorded	20	14%
Total	**148**	**100%**

Key challenges in delivering patient surveys is that they are labour intensive and are still reliant on the four Customer Relations Managers finding time to undertake this task.

5.10.CLINICAL TELEPHONE ADVICE

CTA continued to refer a significant amount of patients to Alternative Care Pathways and more appropriately attend their individual clinical need and personal circumstances. The department also continued to reduce the number of inappropriate admissions to hospital by offering, for example, self-care advice at home.

Collecting equalities data places significant demands on those who collate such information locally. There are over one million staff in the health service, and a further one million in social services, of whom perhaps 30% are employed by Local Authorities. There are about eleven million Hospital Episode Statistics (HES) records each year, for inpatients alone (outpatients would at least double this). Getting equalities data for all these groups and activities (and where necessary, checking and updating records) is as a result a major undertaking.

Ethnicity data was collected by the Psiam software, but this has not been captured by management information. As such, exact data could not be reported immediately. To address future data collection requirements, CTA had been capturing ethnicity data since 16th September 2008 and this was a required field

within their Clinical Decision Support Software PSIAM. The benefits of capturing this information by the team has allowed the London Ambulance Service to provide even more appropriate patient care and outcomes for our patients.

Ethnicity Monitoring became part of the Quality Assurance process for CTA and the Psiam Quality Improvement case evaluation form allowed the monitoring and measuring of the effectiveness of the data, which was appropriately scored under the Pre-Triage phase of the audit form. Although this information was captured and CTA staff were able to see and search individual patient records to view ethnicity information, they were still not able to report on the data captures, and were awaiting IM&T installation of the latest version of PSIAM to facilitate this. The disability question existed within PSIAM, but was not being applied. Because of the difficulties in producing this data and the lack of data covering ethnicity, there is no basis for a sensible comparison with the figures, also incomplete, from the previous report. The PSIAM product had come to the end of its commercial shelf life and was no longer being developed or supported by the manufacturer at the end of our current licence period in December 2013. The use of PSIAM was also limited to registered health care professionals. At the time of its inception, the Trust chose to introduce, by way of a local agreement, a process which allowed for our Medical Director to take full clinical accountability for the actions of all those non-registered Emergency Medical Technicians who operated the system. It was evident that this situation could not be sustained in the long term and had the licence not been coming to an end would need to have been reviewed in light of the Francis report anyway. CTA closed on the 3rd December.

Nationally, the provision of Hear and Treat services by UK ambulance services is carried out by either state registered Paramedics or Nurses. In February 2014 an options paper was presented to the Executive Management Team to look at a suitable replacement for the PSIAM software. The decision was made to adopt the Manchester Triage System (MTS), currently in use by the Clinical support advisors within EOC, who are all registered Paramedics. MTS is also in use within five of the ten UK ambulance services and has been developed to work in healthcare systems

across Europe. MTS moves away from set questioning in favour of allowing a more experienced and qualified professional to provide a more autonomous clinical assessment of the patient's presenting symptoms.

5.11.PATIENT EXPERIENCES

Complaints

1060 complaints were recorded during 2013/14. This includes 50 cases where a referral was made by another health and social care professional but deemed to be on behalf of the patient.

Ethnicity

17% of cases recorded ethnicity data about the complainant (Table 1) against 13% in 2012/13. Only 7% of cases were recorded citing the patient involved (Table 2) against 19% in 2012/13. Sometimes this was the same person.

Table 1 - Complainant

Ethnicity of complainant	Number
Not stated	878
White British	84
No details	64
Black Caribbean	7
White Irish	6
Black African	6
White other white	4

Other Ethnic	3
Mixed White and black Asian	2
Indian	2
Pakistani	2
Mixed white and black Caribbean	1
Bangladeshi	1
Total	**1060**

Table 2 - Person/Patient involved

Ethnicity of Person (Patient)	**Number**
Not stated	981
No details	78
White British	1
Total	**1060**

Table 3 **–** complainant by gender

Gender where recorded (complainant)	**Number**
Male	397

Female	578
Not stated	14
No information recorded	71
Total	**1060**

Table 4 **–** patient by gender

Gender where recorded (patient)	**Number**
Male	337
Female	416
Not stated	2
No information recorded	305
Total	**1060**

Table 5 **-** Age range of patient/complainant

The dataset for the case management system have been updated to reflect the forthcoming migration to the web version. Alternative fields have been added for the collection of the age ranges and only those are now available, so 15% of age data was recorded where a completed equalities monitoring form was received.

Age range of patient/complainant	Number in this range
0-15 (1)	21
16-24 (2)	33
25-34 (3)	32
35-44 (4)	36
45-54 (5)	56
55-64 (6)	38
65-74 (7)	42
75-84 (8)	60
Prefer not to say	6
Not stated	736
Total	**1060**

There were 83 cases (7%) of ages recorded from the PRF information. 566 Equalities Monitoring Forms were sent to complainants (49% of complainants) of which 162 (40%) were returned.

Table 6 - Religion or belief

Where recorded from the returned Equalities Monitoring forms, the following responses were noted.

Religion	Number in this range
Not stated	901
Christianity	81
No religion	44
Islam	9
Prefer not to say	9
Other	7
Judaism	6
Jainism	2
Hindu	1
Total	**1060**

Table 7 - Sexual Orientation

Where recorded from the returned Equalities Monitoring forms, the following was recorded.

Sexual orientation	Number in this range
Not stated	901

Heterosexual	132
Prefer not to say	15
Not stated	7
Bi Sexual	3
Gay man	2
Total	**1060**

Most complaints are received by telephone and email, with relatively few letters sent to the Chief Executive. The Department has improved the recording process so that, where the gender of the enquirer is immediately known, this is recorded at source, for example by the Duty Officer who receives the initial telephone call to the department. The Department does not however undertake equalities monitoring at this stage, as complainants are often very distressed, upset and angry and experience has shown that seeking to explore monitoring at this point often meets with a hostile reaction. Indeed, it is not uncommon to receive 'complaints about complaints' where equalities monitoring is itself the subject of the complaint.
Staff continue to be reminded about the importance of collecting gender and ethnicity data. Every complainant is also sent a monitoring questionnaire and the self-completed data received is entered into the case management system. Unfortunately, this still has a poor response rate, which is a common experience across health and social care.
Although sometimes cited as an aggravating factor, there is no evidence to suggest that there is any discrimination in service delivery.
Extensive information about the department is available on the Trust's website at: http://www.londonambulance.nhs.uk/talking_with_us.aspx#servicecomplaints

Monitoring is also regularly undertaken in relation to the cohort of patients who make frequent and repeated 999 calls, managed using a care plan approach by the Patient Centred Action Team:
http://www.londonambulance.nhs.uk/health_professionals/caring_for_frequent_callers.aspx

With regard to the implementation of our equality objective around complaints: "We will improve the process for capturing equalities data in the area of patient complaints to ensure that more than 50 percent of complainants have provided relevant details and begin to monitor trends in complaints from black and minority ethnic (BME) service users in 2012-13, while this was implemented for 2012-13 and increasing amounts of data are being obtained, this is still disappointingly slow, but as is the case across the health and social care economy, complainants are seemingly reluctant to provide this data.

Improving the amount of data we receive can only be achieved by increasing the resourcing available to the department. However, the same low returns are experienced across the health and social care economy.

5.12. PATIENT PROFILING

In the year 2013-14 a total of 1,096,812 incidents were recorded from April 1 2013 to March 31 2014. Of these a total of 550,976 were from women (50.23%); in the previous year this was 544,192. 521,328 were from men (47.53%); in the previous year this was 515,000. For 24,508 (2.27%) no gender was stated; in the previous year no gender was stated for 28,119 incidents, so this is a slight improvement. The BME communities with the highest numbers of incidents raised were: Black or Black British Caribbean (25,576 – 2.3%), followed by Black of Black British – African (24,912 – 2.2%) then Other ethnic groups – any other ethnic group (20,878 – 1.95%). In the previous year incidents were raised predominantly by the Black or Black British Caribbean community, then by people from Any other ethnic group then Black or Black British African.

A high number of incidents were not identifiable by ethnicity 582,607(53.1%); in the previous year this was 522,113; as before, the ethnicity data cannot be validated. The most prevalent age ranges were 21-30 (159,89914.57%), followed by 81-90 (137,204 – 12.5%) then 31-40 (127,042 – 11.58%), followed closely by 71-80 (125,450 – 11.43%). This parallels the statistics in the previous year for the most prevalent age ranges, which were were 21-30 (147,667 – 13.57%), followed by 81-90 (124,267 – 11.4%) then 31-40 (115,768 – 10.64%) followed closely by 71-80 (115,394 – 10.6%).

A revamp of the Patient Report Form is pending the publication by NHS England of Health of its updated equalities monitoring guidance; this will include further protected characteristic groups, as required by the Equality Act 2010. In the meantime categories for Physical Disability and Learning Disability and Mental Capacity have been added to the form.

Briefing for staff will follow the implementation of the NHS England guidance, which should then hopefully enable the recording of more comprehensive and robust patient data. Additional funding is likely to be required to cover the cost of a redesign of the scanning system to capture the additional data or for additional data entry staff to capture this manually.

6. LONDON AMBULANCE SERVICE NHS TRUST WORKFORCE DIVERSITY PROFILE

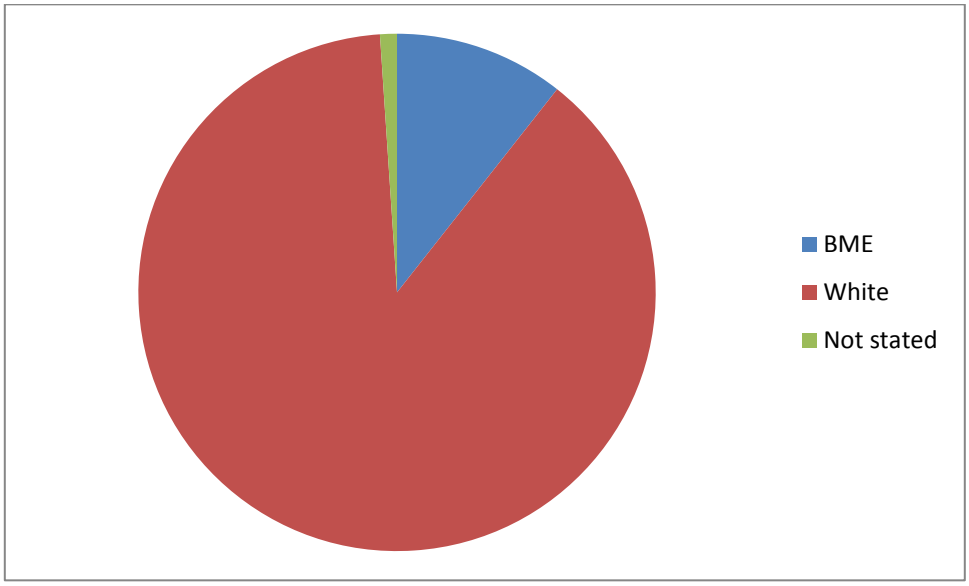
6.1.The following section addresses the Trust's obligations under the Equality Act 2010 Public Sector Duty specific duties to consider how its activities as an employer affect people who share different protected characteristics.

6.2. Workforce Profile

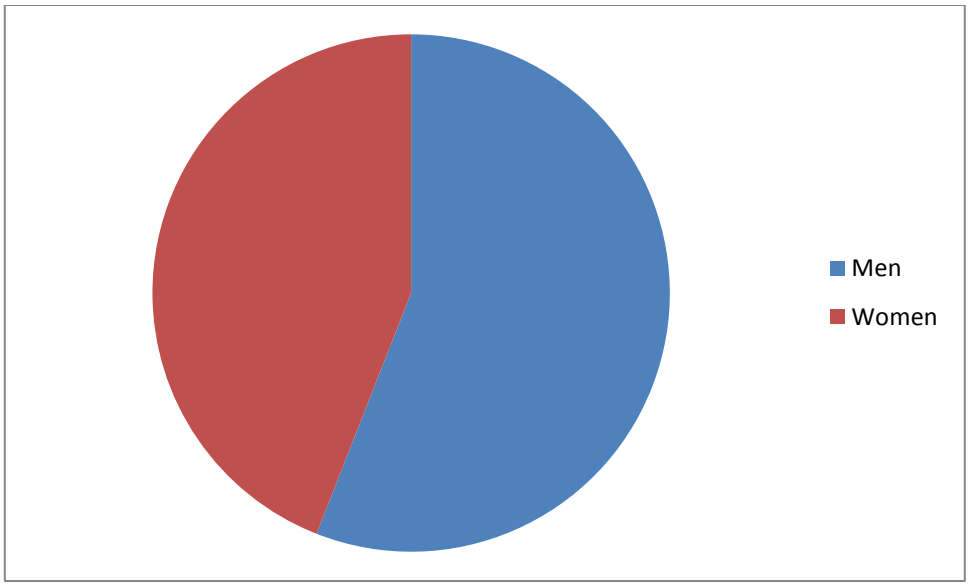
In the last Annual Equality Report, covering the period from April 1 2012 to March 31 2013, the Trust's workforce comprised 9.3% BME Staff and 43.2% female with

0.5% declaring themselves to be disabled, although the percentage of those not wanting to declare was 80.4% In the year from April 1 2013 to March 31 2014 the Trust's workforce comprised 10.6% BME, an increase on last year and 44% female, a slight increase on last year and 56% men, with workforce representation still being below the respective 2011 Census estimates of 40.2% for BME people and 50.7% for women respectively. The percentage of staff declaring themselves as disabled was 1% with 74.8% not declaring either way (the Census 2011 total for residents of London reporting limiting long-term illness, the closest indicator to disability, as there are no specific census data on this was 14.2%). The majority of staff were in the age range 41 -50 (31.37%), followed by 31-40 (28.06%) and 21 – 30 (21.29%).

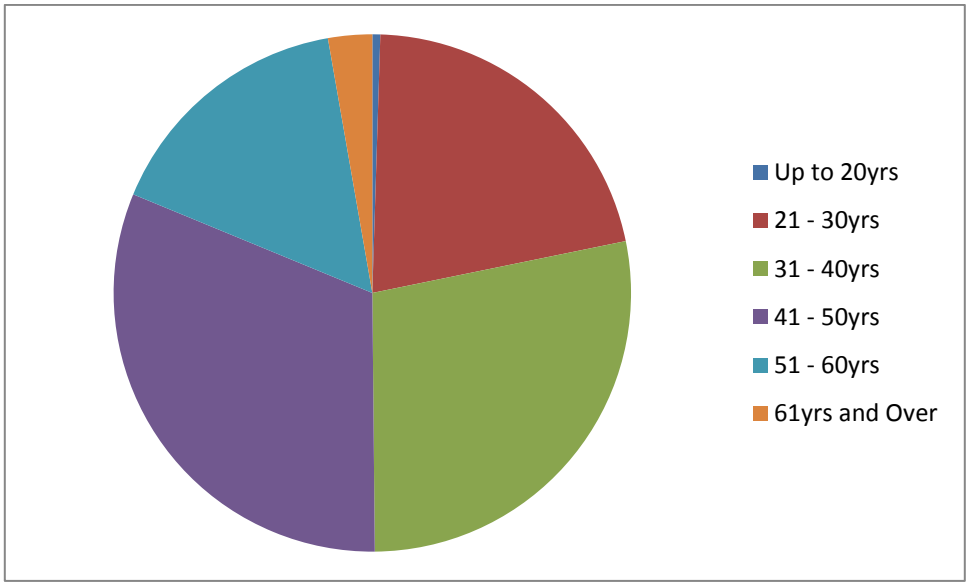
STAFF IN POST BY ETHNICITY



STAFF IN POST BY GENDER



ALL STAFF BY AGE

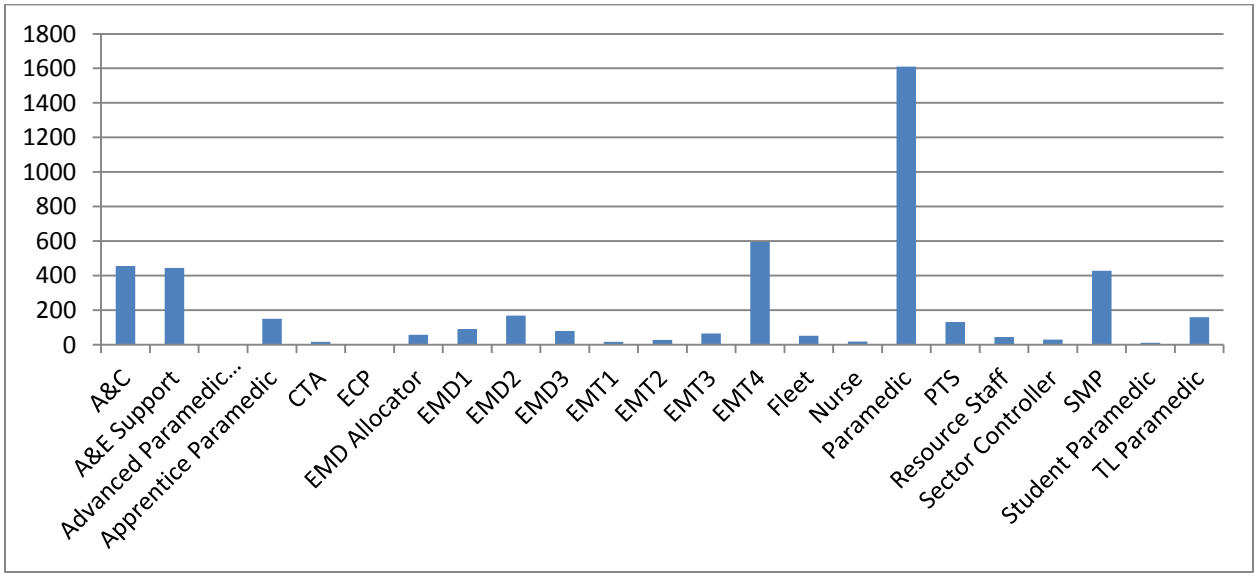


6.3. LONDON AMBULANCE NHS TRUST STAFF DIVERSITY PROFILE 2013 -

14

ALL STAFF BY GRADE AND RANK

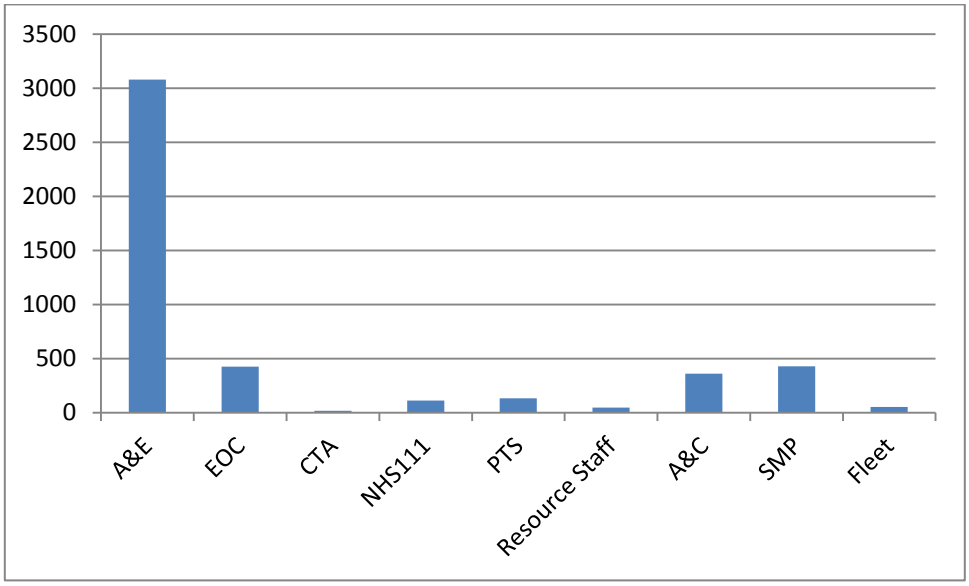
The highest number of Trust staff were Paramedics (1611 - 34.6% of all staff), followed by EMT4 (594 - 12.77 %) and A&C (455 - 9.78%). In the previous year similarly the highest number were Paramedics, followed by EMT4, then SMP.



ALL STAFF BY STAFF GROUP

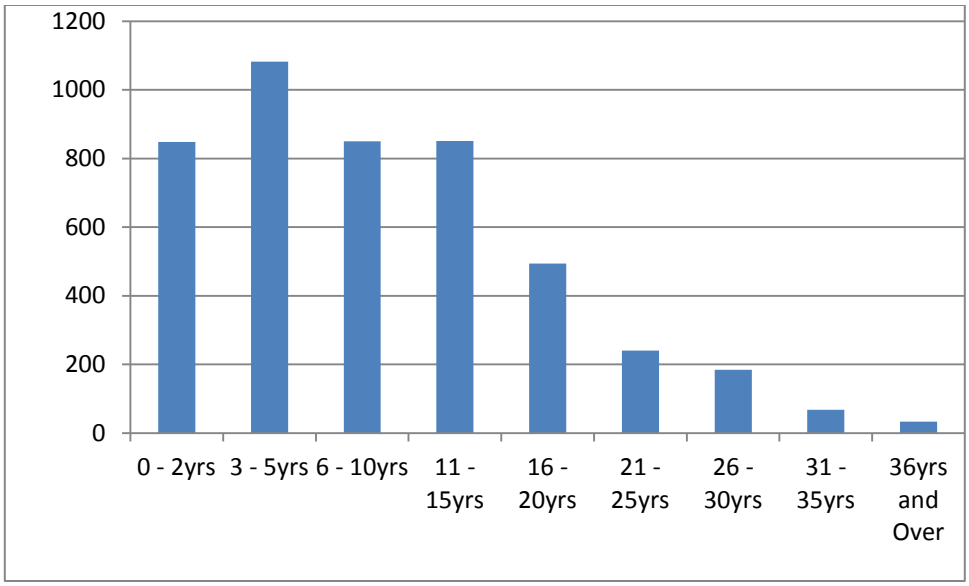
As the chart below shows, the largest number of staff were employed in A&E (3079 - 66.2%), followed by SMP (428 - 9.2%) and EOC (425 -9.1 %). This mirrors the

previous year, in which the largest number of staff were again employed in A&E (3131 – 67.8% of all staff), followed by SMP (428-9.3%) and EOC (419 – 9.8%).



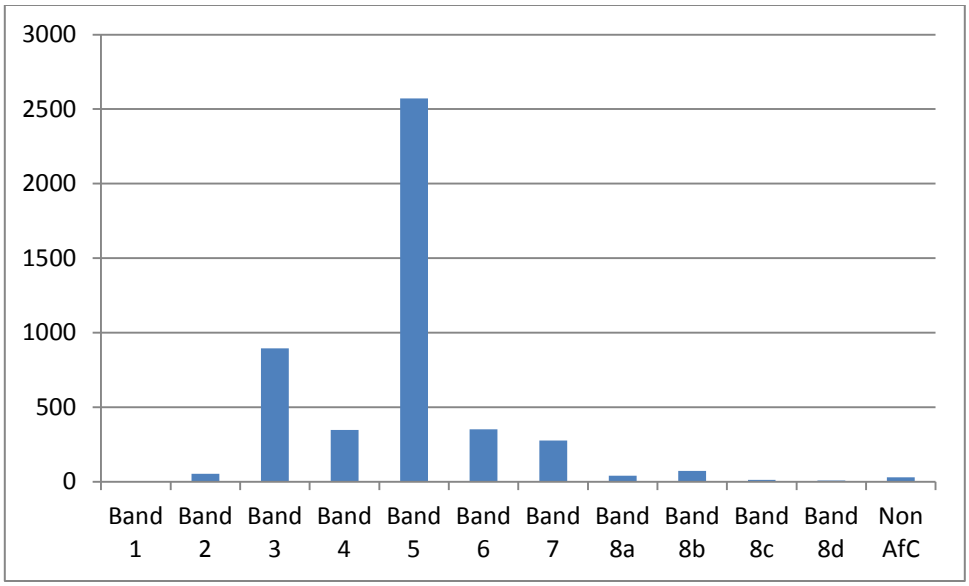
ALL STAFF BY LENGTH OF SERVICE

As shown by the chart below, the highest number of staff have been with the Trust between 3-5 years (1082 – 23.3% of all staff), followed by 11-15 years (851 –18.3 %), then 6-10 (850 – 18.27 %) and 0-2 years (848 – 18.23%). In the previous year most staff had been with the Trust between 3-5years (25.9%) followed by 6-10 years (21.6%), then 11-15 years (16 %).



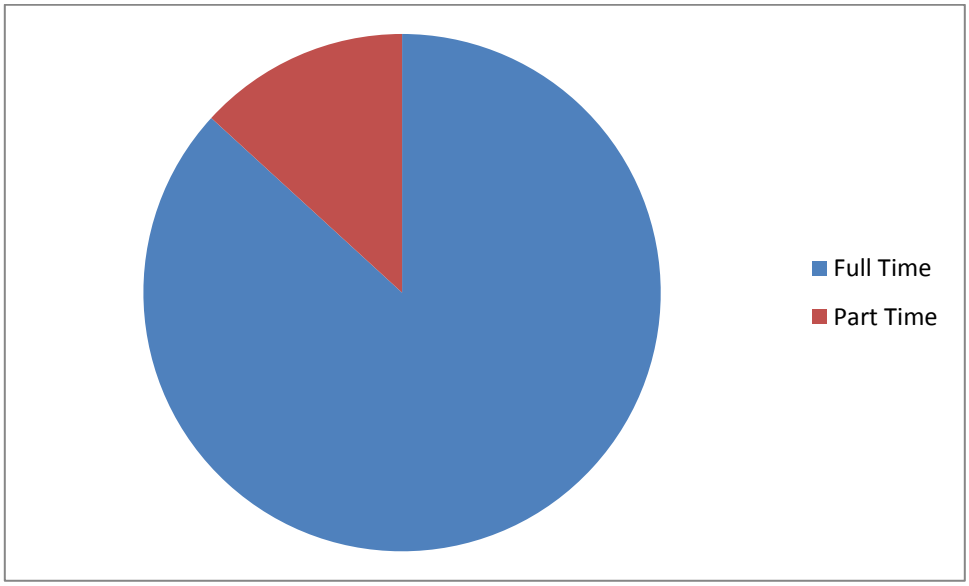
ALL STAFF BY PAY BAND

As the chart below shows, by far the highest number of staff are in Band 5 (2571 - 55.29% of all staff), followed by Band 3 (895- 19.24%), then Band 6 (351 - 7.54%). In the previous year most staff were in Band 5 (59%), followed by Band 3 (13.8%) then Band 4 (9.1%).



ALL STAFF BY EMPLOYMENT CATEGORY

In 2013-14 the majority of staff were employed in full-time positions (4036-86.8%),with (614 – 13.2%) employed in part-time positions. In the previous year there were 87.7% full-time staff and 12.3% part-time.



6.4. RECRUITMENT

The Recruitment Team continued to improve the recruitment process by adapting to the new version of NHS jobs and streamlining our application process, thus reducing the time it takes to process and short list applications and improving the candidate experience. In this last year an application was made for a sponsorship license to sponsor migrant workers to harder to recruit roles. This application was accepted by the Border Control Agency. The allocation of certificates we have been given for the next financial year is 100.

During this period of time external recruitment was mainly focused on A&E support recruitment and University recruitment. The A&E support recruitment was given to recruitment with some very challenging deadlines owing to the course dates already being agreed. Advertising mainly focused on NHS jobs but there was a creative advert campaign and adverts placed in various media such as the metro, local London papers and websites. Due to short timescales, the advertising was mainly focused on tried and tested methods which would attract large volumes of applicants.

The university recruitment focused on ca.100 students in their final year of paramedic science degree who have worked for the organisation on placements. There was also in addition a small number of applicants from other universities who had not worked previously with the organisation. For these students, it is the university's decision on how and where to advertise to attract potential applicants and not something the Trust can influence. A larger recruitment campaign will be completed next year for graduates from other universities due to the success of the smaller campaign. However, there will still be the same limitations, as the universities will already have attracted students on to their paramedic science degree programme.

Looking at the diversity statistics for 2013-4, it would seem that the majority of our applicants' sexual orientation was heterosexual - 87%of all applicants. This remained constant with last year's figure. There was a further reduction in those preferring not to say from 6 % in 2012-3 to 5.5 % in 2013-4. Therefore, it would seem that applicants are continuing to feel more able to inform us about their sexual orientation. There has again been a slight increase in numbers applying who are gay men - 3.4 % in 2013-4 compared to 2.8 % in 2012-13, gay women 1.8% in 2013-14 and bisexual people 1.5% in comparison to 2012-13 when there were 1.7% gay women and no bisexual applicants.

In reviewing our diversity statistics for gender, the percentage of female applicants has decreased to 39 % in 2013-4 from 47 % in 2012-3. Further work may be needed to review whether more should be done to encourage female applicants.

The main belief stated is still Christianity at 51 % in 2013-14 compared to 48 % in 2012-3. The second highest belief is Atheism at 15 % in 2013-14 compared to 13.3 % in 2012-13. The third highest is "other" and "prefer not to say" at 9 % compared with Islam being third in 2012-13 at 9.9 % Further work is needed to engage with those from different religious backgrounds such as Sikhism and Judaism, who are not applying for roles within the Trust.

The pattern of applicants from BME background remains similar with certain groups not engaging with the recruitment process - for example, there are low numbers of applicants from the Chinese community - 0.4 % of all applicants and Pakistani community - 2.2 % of all applicants. Applicants from African background are our largest BME applicant group with 7.3%. It would appear the biggest hurdle is the short listing for a number of BME applicants such as 70 % of Indian applicants and 67 % of African applicants failing short listing, compared to 45 % of British applicants failing short listing. The total percentage of BME applicants is 29.6% (as compared to 40.6% in 2012-13). Work is being undertaken with Communities into Employment and Training (CITE), a community sector organization, specifically

targeting BME and other under-represented groups, so this will hopefully improve the employment chances of this group in future.

4.4 % of applicants were disabled as compared to 12-13 when this was 3.1%.

A breakdown by protected characteristic groups of new starters to the Trust is provided later in this report.

The Trust continues to profile itself in a wide range of equalities media; however, it is also recommended that profiles of individuals in different positions across the Trust representing certain sections of the community are displayed in key careers publications with a suitable budgetary resource being identified.

6.5. LEAVER PROFILE

In the year from April 1 2013 to March 31 2014 a total of 494 staff left the Trust. The majority of those leaving were from A&E (330- 66.8% of all staff), followed by EOC (53 - 10.7%), then A&C (41 -8.29%). In the previous year the majority of staff leaving were in A&E (60.5%), then EOC (13.5%), then SMP (10.6%).

6.6. PROMOTIONS

From April 1 2013 to March 31 2014 a total of 139 staff were promoted (defined as moving from a role in one AFC pay band to another role in a higher pay band). In the previous year it was 289 staff. Breakdown by protected characteristic groups is provided later in the report.

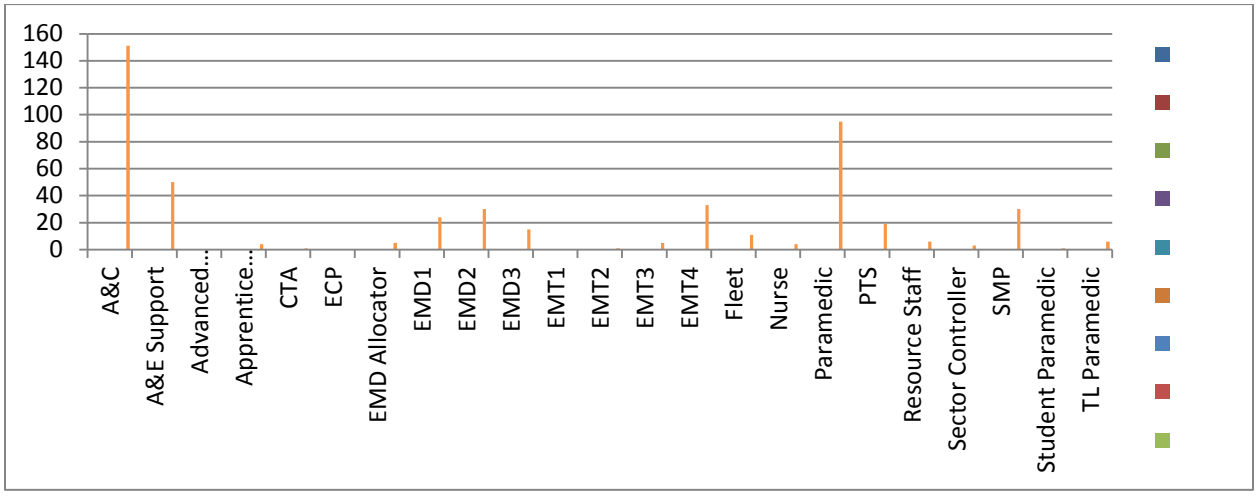
It is currently not possible to report on the equalities statistics for internal applicants who have been unsuccessful for a promotion, as individuals are not presently asked to confirm if the position they have applied for is a promotion or not. The Recruitment Team is therefore unable to distinguish the promotions from the lateral moves; this would take significant resourcing to complete.

6.7. LAS PROFILE BY ETHNICITY

From 2013 to 2014 the representation of BME staff in the Trust was 494 (10.6%) of the total workforce. In the previous year the percentage was 9.3%. However, the results of the 2011 national census indicate that BME people make up 40.2% of the residents of London, so more work will need to be undertaken to increase their representation in the Trust's workforce and, in line with the Trust's Positive Action Strategy, the Trust has begun to work again with Communities into Employment and Training (CITE), a voluntary sector organization to target and encourage potential BME recruits and others from under-represented protected characteristic groups.

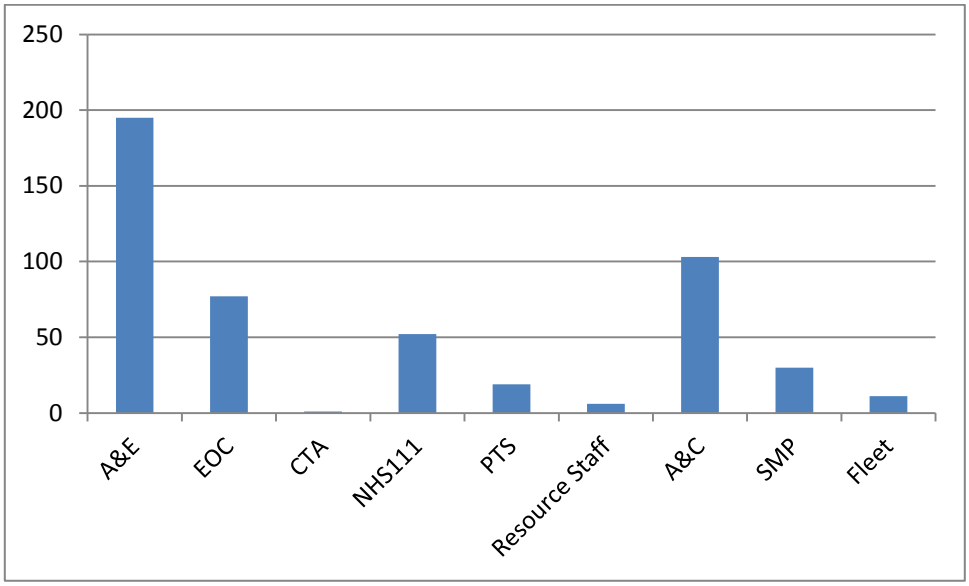
STAFF IN POST BY GRADE AND RANK BY ETHNICITY

As the chart below shows, most BME staff are A&C (151-30.5%), followed by Paramedic (95-19.2 %), then A&E Support (50 -10.1%). In the previous year the highest representation was in A&C (24.2%), followed by Paramedic (20.56%), then EMT4 (8.64%).



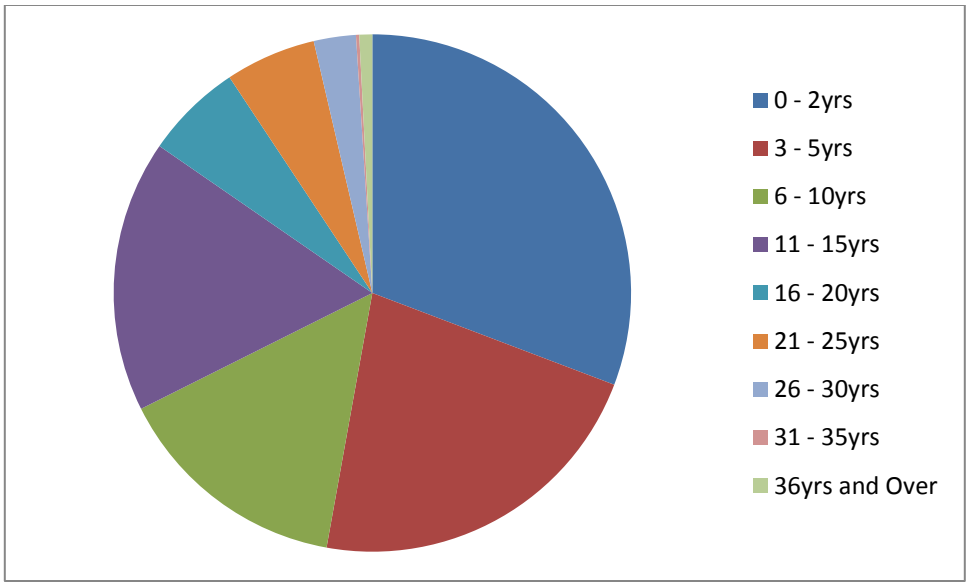
BME REPRESENTATION BY STAFF GROUP

In 2013-14 the highest representation of BME staff was in A&E (195 – 6.3% of all staff in that staff group), followed by A&C (103 – 28.5%) and EOC (77 - 18.1%). In the previous year the representation was similar with most BME staff being in A&E (6% of all staff in that staff group), followed by A&C (28.49%) and EOC (16.2%).



LENGTH OF SERVICE OF BME STAFF

As the chart below shows, in the year 2013-14 the highest number of BME staff had been with the Trust between 0-2 years (152 – 17.9% of all staff), followed by 3-5 years (109 - 10%) and 11-15 years (84 - 9.8 %). In the previous year the highest length of service for BME staff was 3-5 years (10.3%), followed by 6-10 years (8.7%) and 11-15 years (10%).



BME REPRESENTATION BY PAY BAND

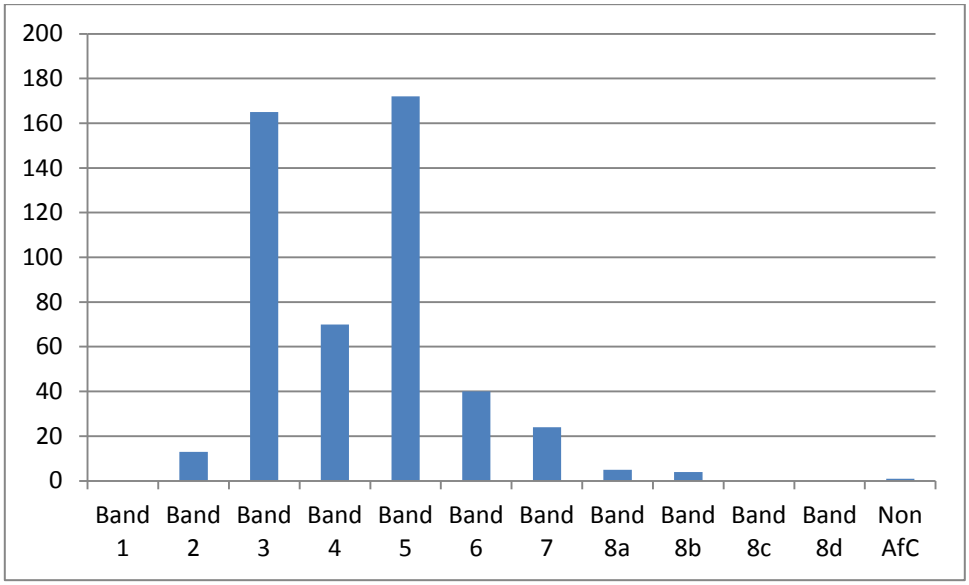
The former Healthcare Commission's report "Tackling the challenge – Promoting race equality in the NHS in England" (March 2009) estimated that BME staff represented 16% of the total workforce, with fewer than 10% of senior managers being BME staff.

As the chart below shows, in 2013-14 BME staff were most represented at Band 5 (172 – 6.69% of all staff), followed by Band 3 (165 – 18.4%) then Band 4 (70 - 347%). In the previous year most BME staff were at Band 5 (177), followed by Band 3 (91) then Band 6 (34). This is partly similar to the pay band profile of the overall Trust workforce, which has highest representation at Band 5, followed by Band 3 then Band 6.

34 BME staff were in senior management grades (7.85% of all staff at senior management grades) below the representation of BME staff in the Trust (10.6%) and 6.8 % of all BME staff in the Trust.

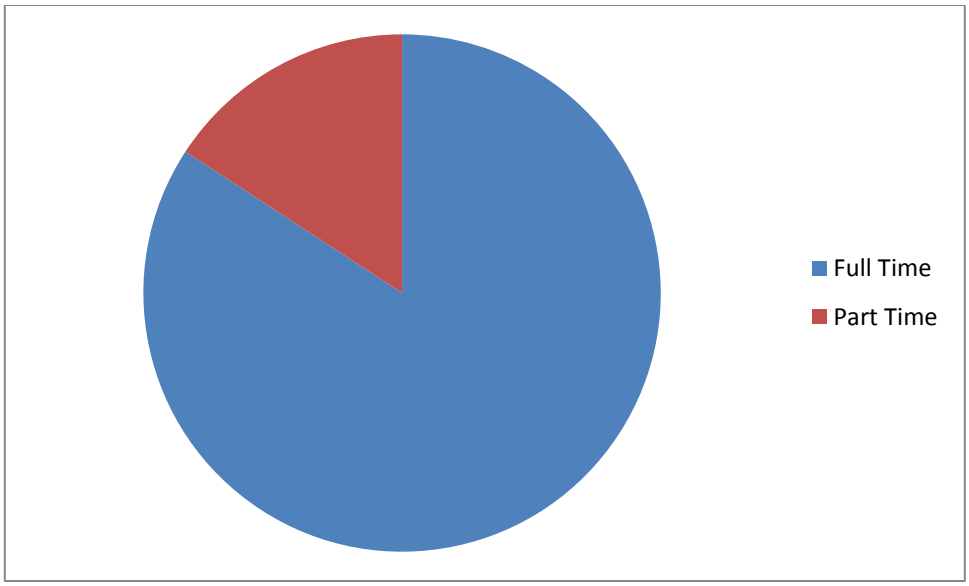
The overall representation of BME staff in the Trust is still below the estimated overall representation in the NHS (10.6% in comparison to an estimated 16% in the NHS-wide workforce, with the representation in the Trust at Senior Management

Grade of 7.85% BME virtually comparable with the NHS-wide percentage of fewer than 10% of senior managers being BME staff.
In the previous year 37 BME staff were in senior management grades (8.5% of all staff at senior management grades, so this year's statistics represent a slight decrease in representation at this level.



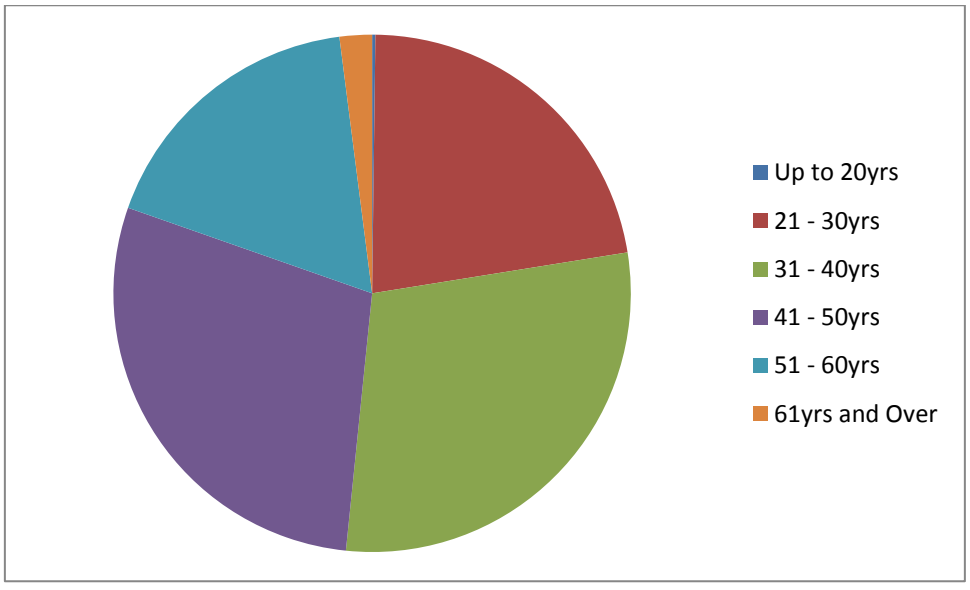
BME STAFF IN POST BY EMPLOYMENT CATEGORY

In terms of employment type, 416 BME staff were full-time (10.3% of the total number of staff employed in that category and 78 part-time (12.7%). In the previous year 377 BME staff were full-time (9.3% of the total number of staff employed in that category and 51 part-time (8.96%).



STAFF AGE RANGE BY ETHNICITY

In 2013-14, as the chart below shows, the majority of BME staff were in the age ranges 31-40 (11% of all staff), followed by 41-50 (9.7%) and 51-60 (11.6%). This compares with the previous year when the majority of BME staff were in the age ranges 31-40 (9.62%), followed by 41-50 (8.9%) and 21-30 (8.7%).



STARTER PROFILE

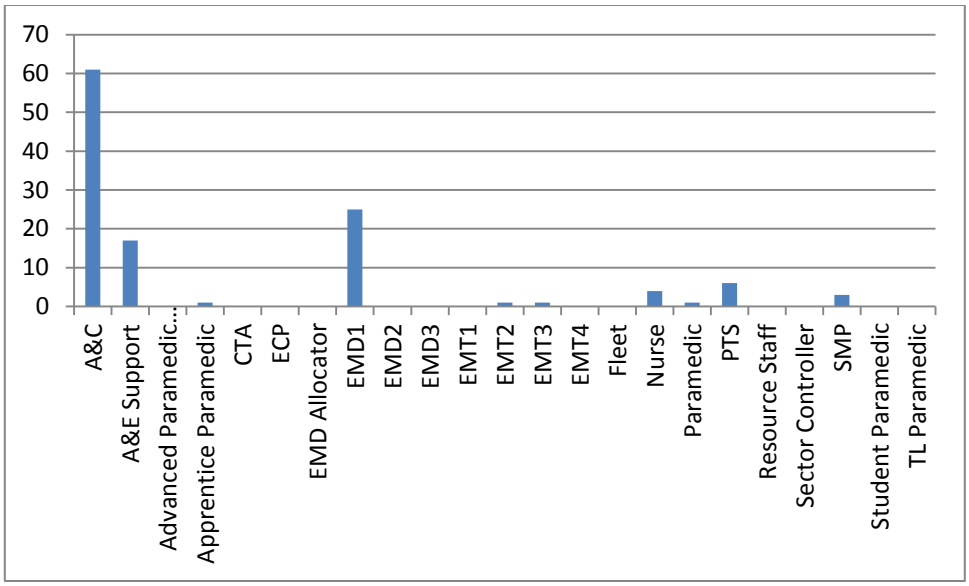
In the year 2013-14 a total of 120 BME staff started with the Trust (23.3% of the total number of new starters). In the previous year 38 BME staff joined (11.98% of the total number of new starters). This is a significant step forward in addressing under-representation in the Trust. With the new opportunities this year for recruitment comes also the opportunity to make strides into further increasing the representation across our workforce of people from our black and ethnic minority communities. Working with voluntary organizations which have expertise in targeting BME and other under-represented communities, as well as innovative advertising through local radio networks and other minority media, and providing appropriate Trust staff wherever possible at career fairs/community events etc. should greatly assist the Trust in this aim.

BME STARTERS BY PAY BAND

As the chart below shows, the majority of BME people starting with the Trust came in at Band 3 (91 – 26% of all starters), followed by Band 6 (9 - 32.1%) and Band 4 (6 – 15.78%). In the previous year the highest prevalence of BME new starters was at Band 3 (18), followed by Band 5 (11) then Band 4 (6).

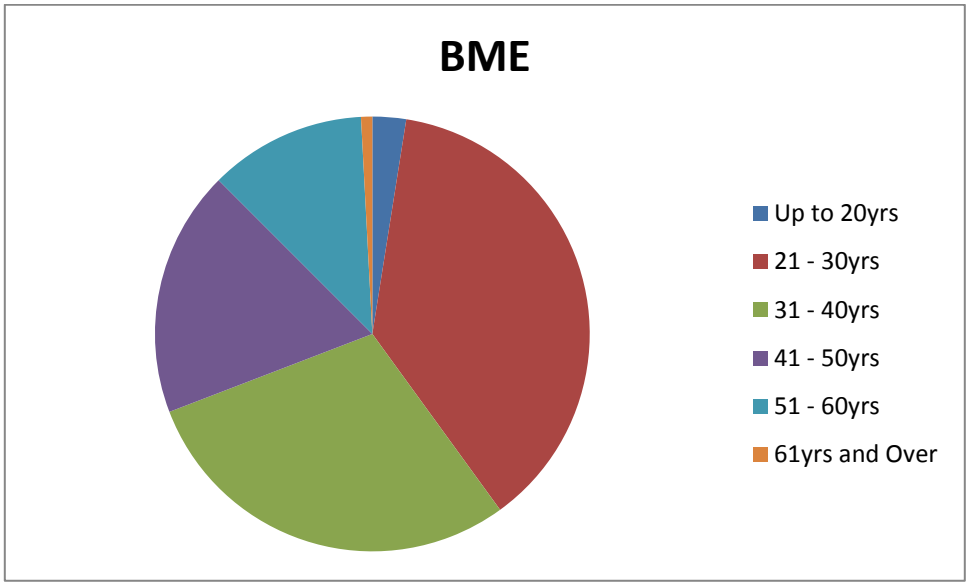
BME STARTERS BY GRADE AND RANK

As the chart below indicates, the highest number of BME new starters came into the Trust as A&C (61 - 48%), followed by EMD1 (25 – 29.4%) then A&E Support (17 – 9.49%). In the previous year the representation by grade and rank was highest at EMD1 (18), followed by A&C (9) and Apprentice Paramedic (4) and EMT (4) jointly.



BME STARTERS BY AGE

As the chart below indicates, the most prevalent age range for BME new starters was 21-30 (45– 20.8% of all new starters), followed by 31-40 (35 - 31.5%) then 41-50 (22 – 22.4%). In the previous year the most prevalent age ranges were 21-30 (23), followed by 31-40 (12) and up to 20 (1), 41-50 (1) and 51-60 (1).

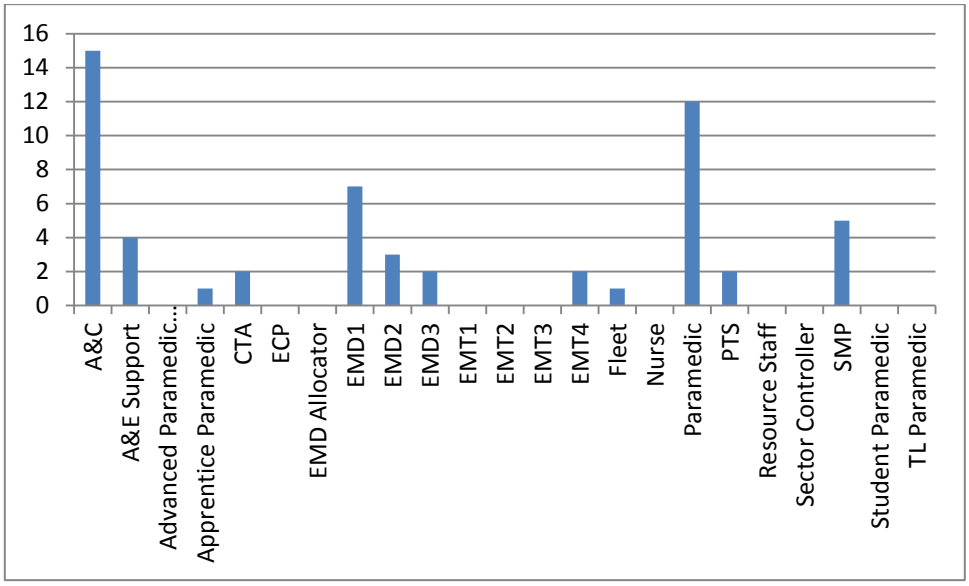


LEAVER PROFILE

In the year 2013-14 a total of 56 BME staff left the Trust (11.3% of all leavers); in the previous year 49 BME staff left the Trust.

As the chart below shows, most BME leavers were A&C (15 – 32.6% of all leavers), followed by Paramedics (12 – 18.3%) then EMD1 (7 – 36.8%). In the previous year most BME staff left were A&C, followed by EMD1 and Paramedics **.**

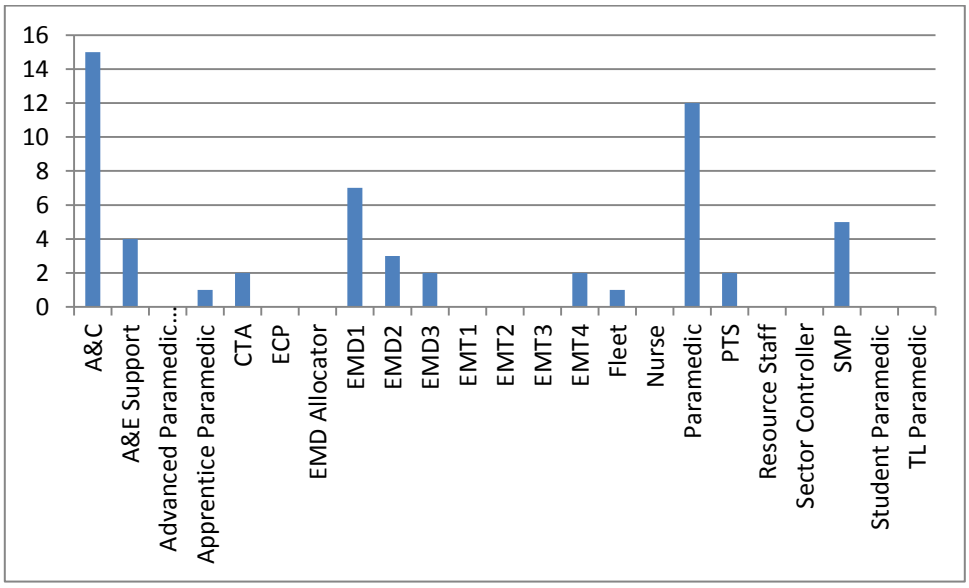
BME LEAVERS BY GRADE & RANK



BME LEAVERS BY STAFF GROUP

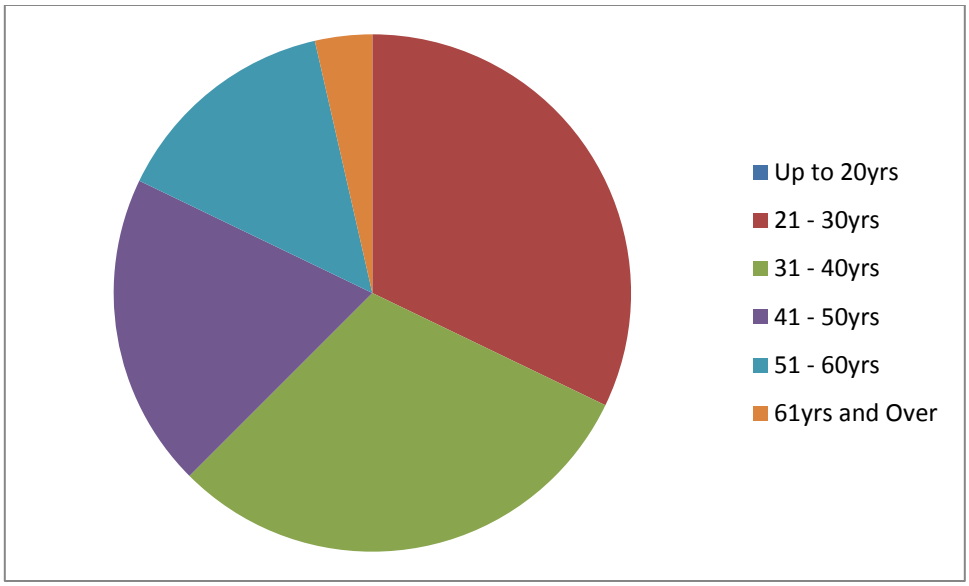
As the chart below shows, most BME leavers were from A&E (19 – 5.75% of all leavers in that staff group), followed by EOC (12 – 22.6%) then A&C (41- 29.2%0.

In the previous year most BME leavers were in the staff groups A&C, followed by EOC and A&E.



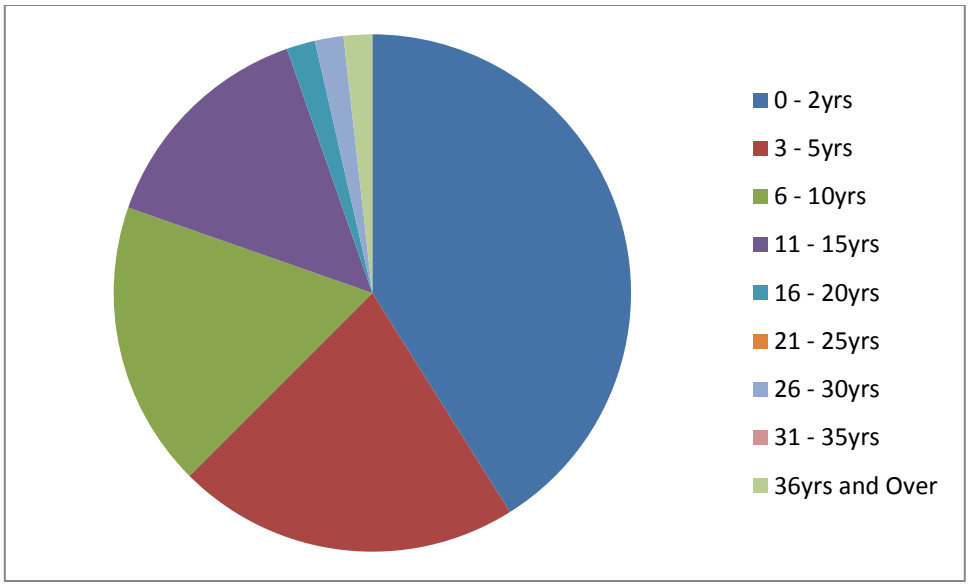
BME LEAVERS BY AGE RANGE

In the year 2013-14, as the chart below shows, the most prevalent age for BME leavers was 21-30 (18- 12.4% of all leavers in this age range), followed by 31-40 (17 – 5.8%) then 41-50 (11 – 10.2%). In the previous year it was 31-40, followed by 21-30 then 41-50 and 51-60 jointly.



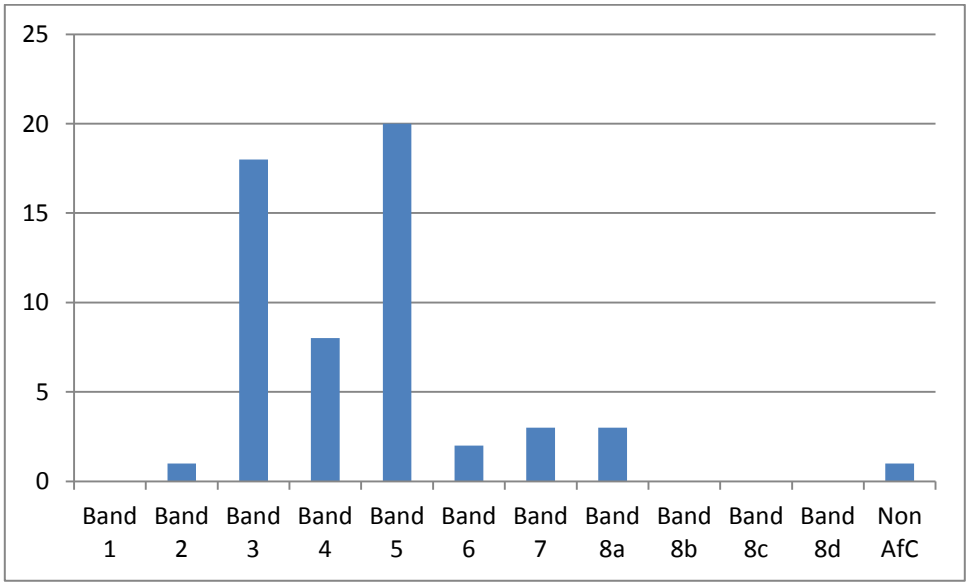
BME LEAVERS BY LENGTH OF SERVICE

In 2013-14, as shown by the chart below, the majority of BME staff leaving the Trust had a length of service of between 0-2 years (23 – 23.4% of all staff leaving with that length of service), followed by 3-5 years (12 – 8.4%) then 6-10 (10 – 11.6%). That mirrors the most prevalent length of service of BME leavers in the previous year.



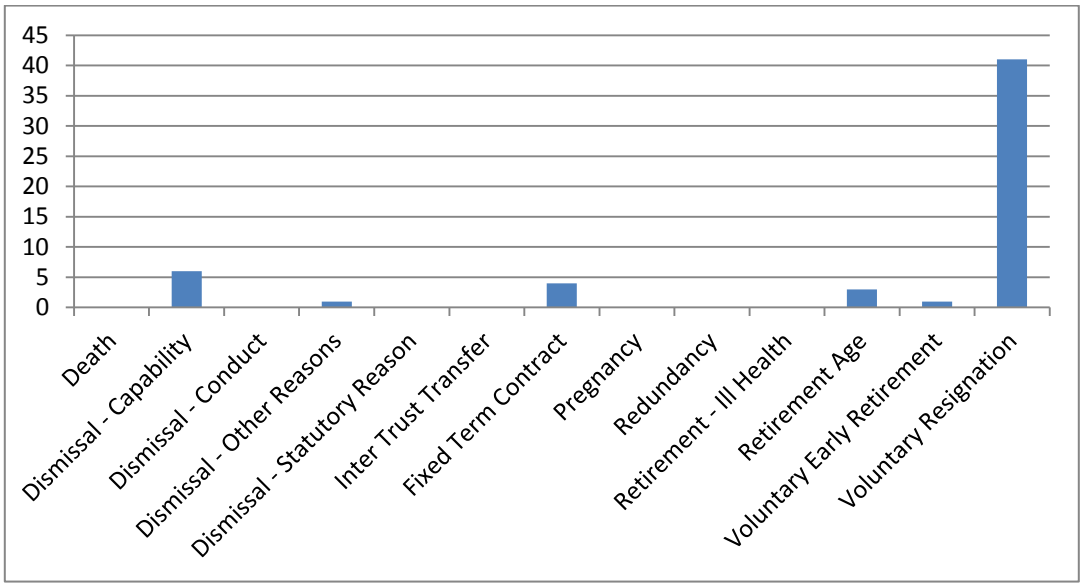
BME LEAVERS BY PAY BAND

In 2013-14 as the chart below indicates, the majority of BME leavers were in Band 5 20 -6.5% of all leavers in that pay band), followed by Band 3 (18- 21.6%) then Band 4 (8 - 25.8%). In the previous year the majority of staff leaving were in Band 3, followed by Band 5 and Band 4.



BME LEAVERS BY REASON

In 2013-14 the reason for most BME staff leaving was Voluntary Resignation (41 – 11.3% of all staff leaving for that reason), followed by Dismissal-Capability (6 – 27.2%) then Fixed Term contract (4 – 44.4%). In the previous year the main reasons for BME staff leaving were Voluntary Resignation, followed by Inter Trust Transfer, Dismissal other reasons and Fixed Term contract jointly.



PROMOTIONS

11 (7.9%) of all promotions in the year 2013-14 were for Black and Minority ethnic staff, which is below the current representation of BME staff in the Trust, although above the percentage in the previous year, which was 5.9%.

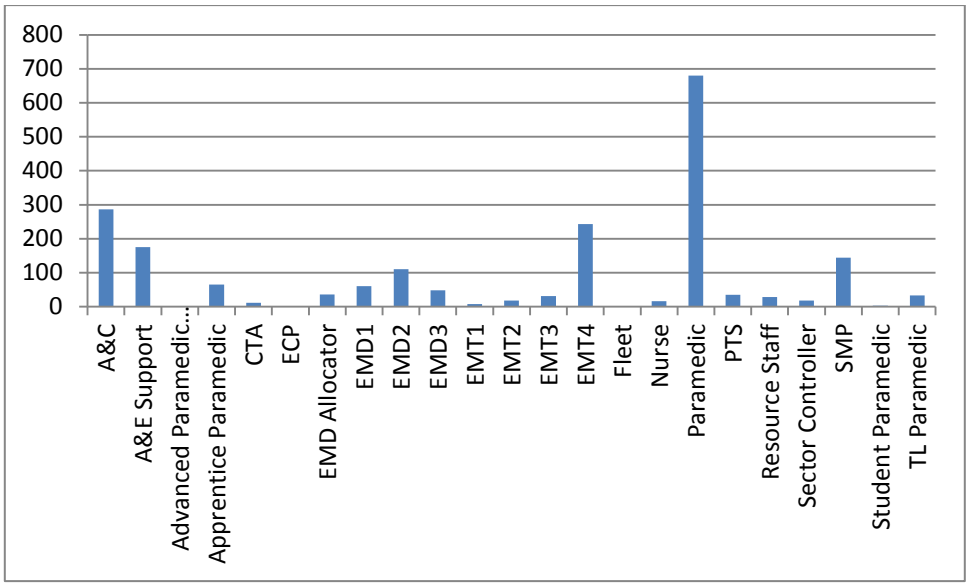
6.8. LAS PROFILE BY SEX

In the year from April 2013 to March 31 2014 the Trust's workforce comprised 2048 women (44 %) and 2602 (56%) male staff. This is virtually the same gender balance as the previous year, when representation in the Trust was 43.2% female and 56.8% male. Representation of women in the Trust workforce is still lagging behind the Census 2011 London female resident percentage of 50.7%.

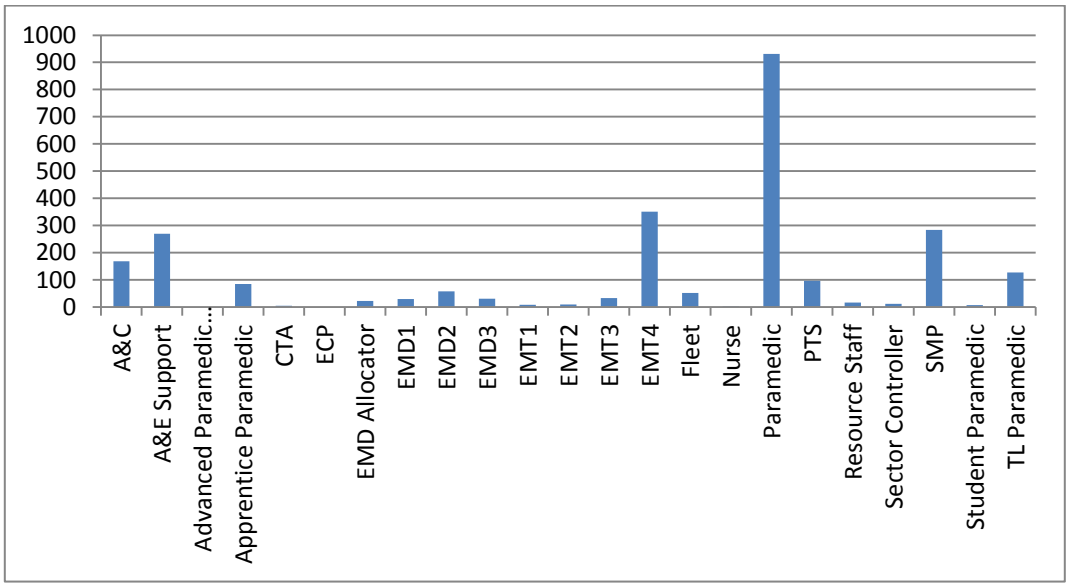
REPRESENTATION BY STAFF GRADE/RANK

With regard to representation by staff/grade rank, most women staff were represented as Paramedics (680 – 42.2%), then A&C (286 – 62.8%), then EMT4 (243 – 40.9%). In the previous year representation was highest at Paramedic, then EMT4, then A&C. In comparison the male representation for the year 2013-14 by staff grade/rank within the Trust is highest as Paramedics (931 – 57.7%), followed by EMT4 (351 – 59%), then SMP (284 – 66.3%), the same prevalence as the previous year.

WOMEN IN POST BY GRADE AND RANK

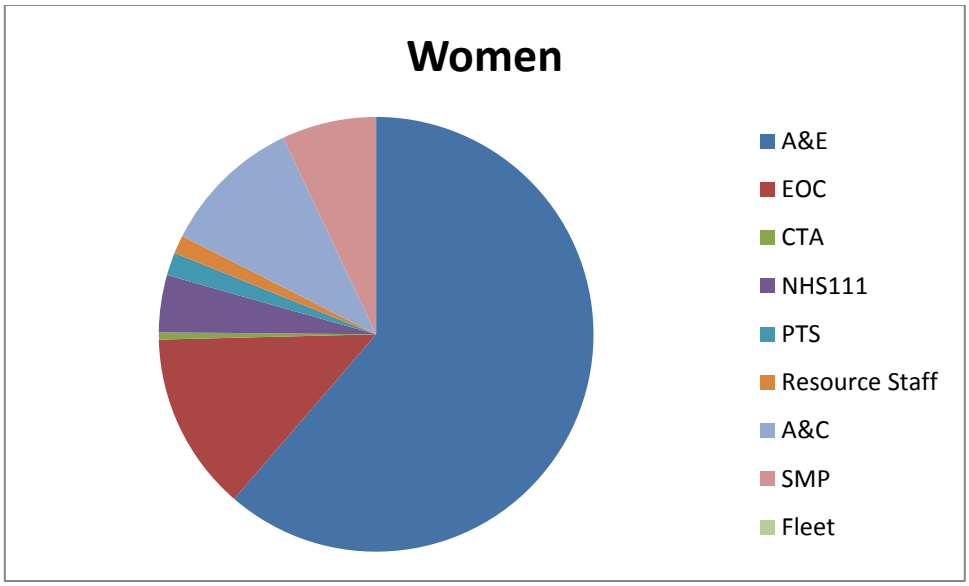


MEN IN POST BY GRADE AND RANK

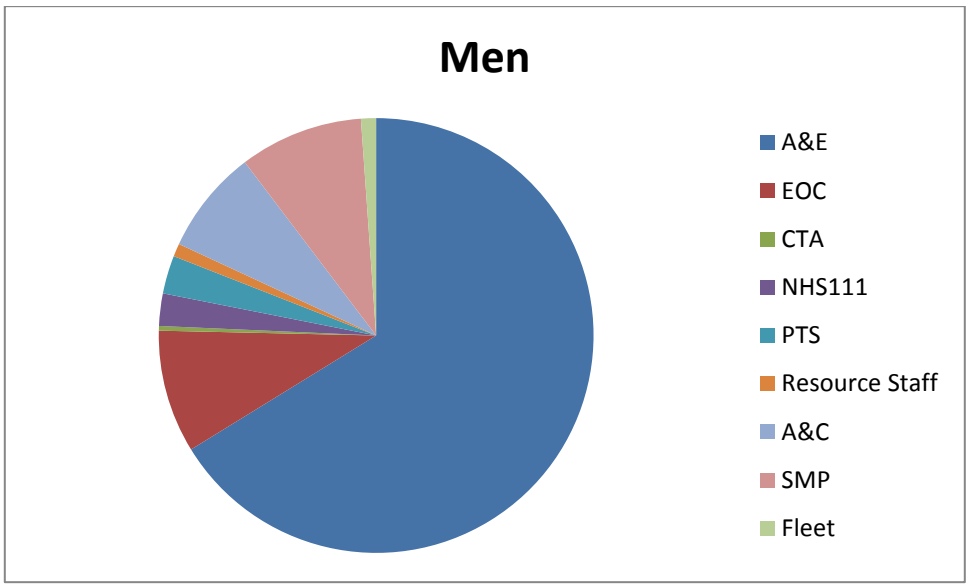


REPRESENTATION BY STAFF GROUP

In the year 2013-14, as the chart below indicates, the highest representation of women by staff group was in A&E (1256 - 40.7% of all staff in that staff group), followed by EOC (272 - 64%) and A&C (215 – 59.5%), the same order of prevalence as in the preceding year.



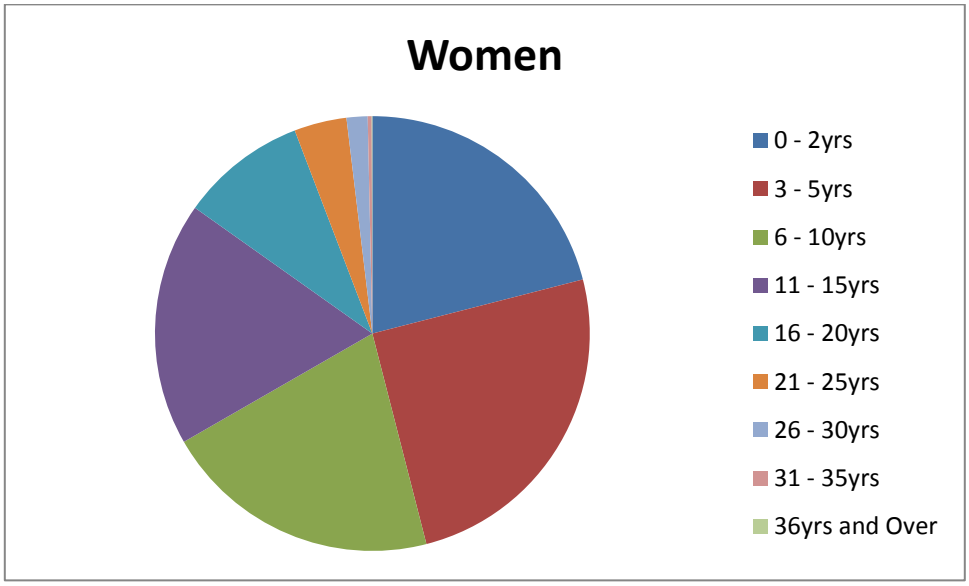
For men, as the chart below shows, the highest representation was in A&E (1823 - 59 % of all staff), followed by SMP (284 – 66.3%) then EOC (153 - 36 %), the same as in the preceding year.



More action needs to be taken to enable representation by women in different grades and occupations throughout the Trust.

LENGTH OF SERVICE BY SEX

In the year 2013-14 most women in the Trust's workforce had been employed between 3-5 years (512 – 47.3% of all staff with that length of service), followed by 0-2 years (430 – 50.7 %) and 6-10 years (424 – 49.8%). In the previous year the most prevalent length of service for women was 3-5 years, followed by 6-10 and 11-15.

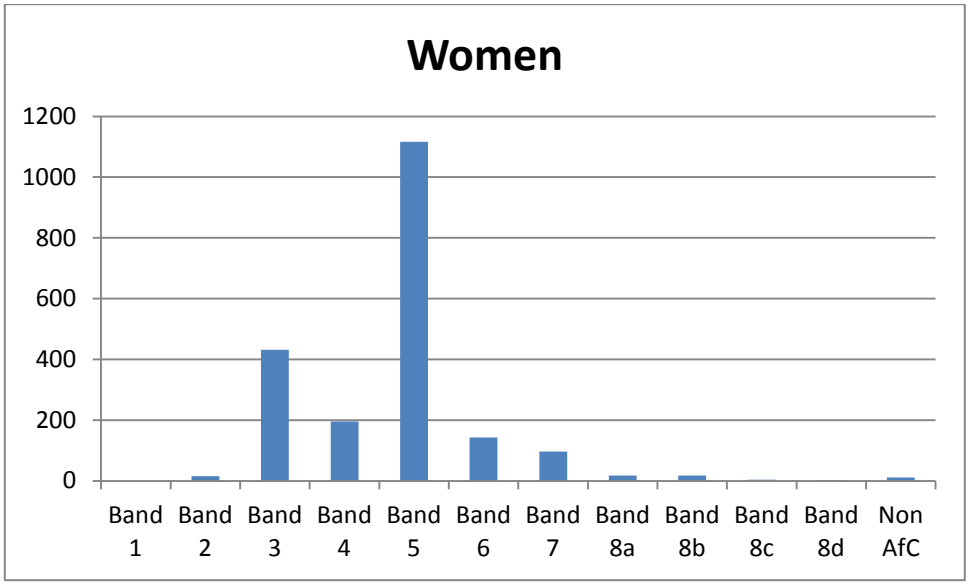


Most men employed in the Trust had been employed with the Trust between 3 - 5 years (570 -52.6% of all staff with that length of service), followed by 11-15 years (480 -56.4%) then 6-10 years (426 – 50.1%). In the previous year most men had been with the Trust for between 3 and 5 years, followed by 6-10 years then 11-15 years.

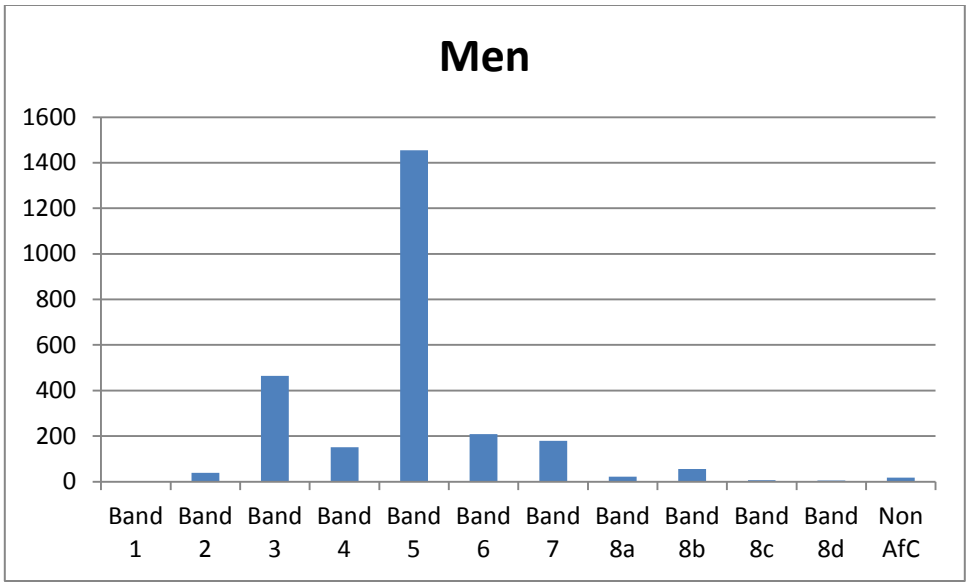
PAY BANDS BY SEX

In the year 2012-13 the majority of women were paid at Band 5, followed by Band 3 and Band 4, with only 7 % of women being paid at senior grade level. In the year

2013-14 the majority of women were paid at Band 5 (1116 -43.4 %), followed by Band 3 (431 -48.1%) and Band 4 (196 -56.4%) . Only 7.17% of women - an increase of .1% on the previous year - were at senior management grade level. Women make up 33.9% of all staff in senior management posts in the year 2013-14.



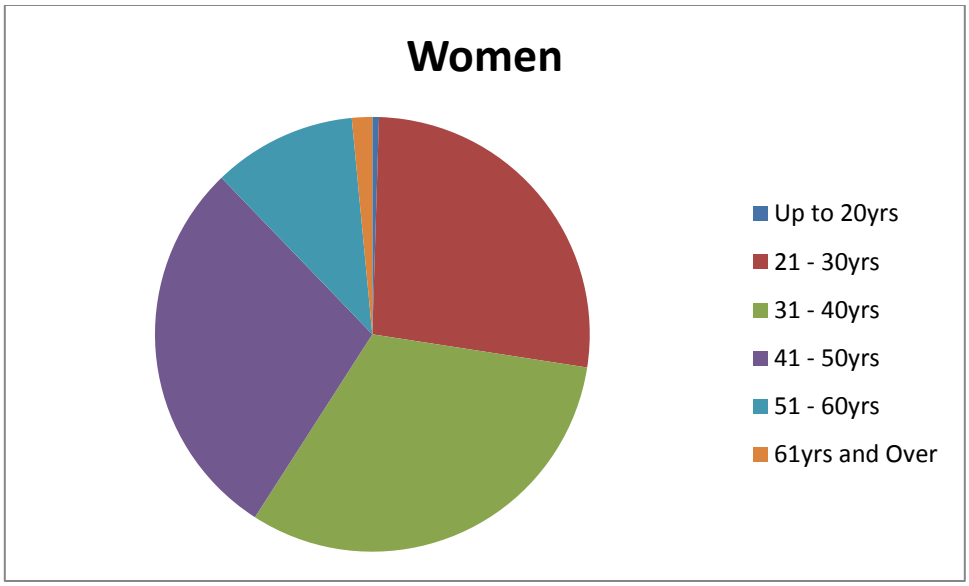
In comparison, as the chart below shows, most men were at Band 5 (1455 - 56.5% of all staff at that grade), followed by Band 3 (464 - 51.8%), then Band 6 (208 - 59.2%). 66% of senior management positions were held by men (10.99% of all men employed), which is considerably higher than the Census 2011 London made resident population statistic of 49.3%. In 2012-13 most men were also at Band 5, followed by Band 3 then Band 6, with 55% of senior management positions being held by men.



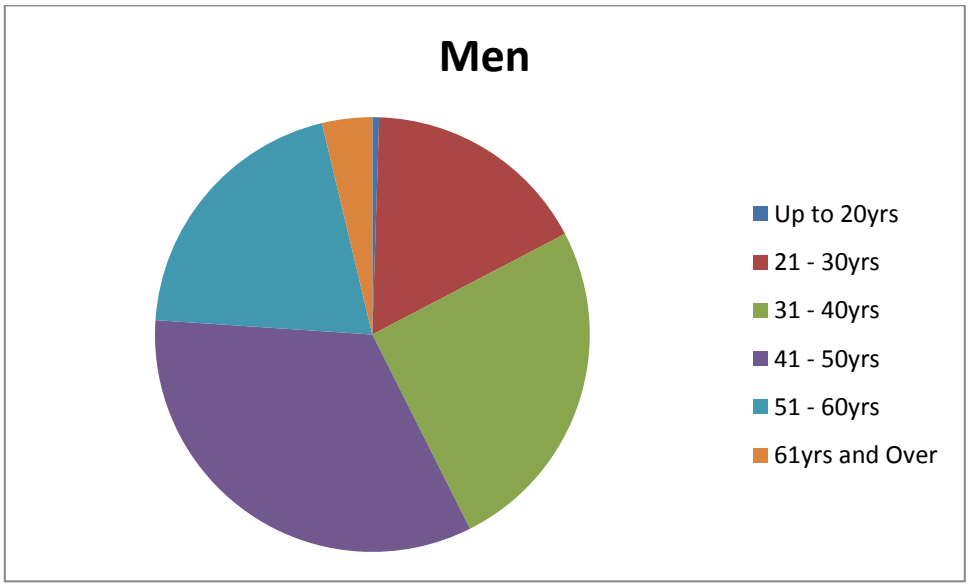
Given that women make up 44% of the overall Trust workforce, more work needs to be done to increase representation of women at senior management level, which could include coaching and mentoring as well as targeted recruitment, wherever external advertising occurs, to encourage women to apply for higher-graded posts within the Trust. In a time of ongoing austerity training initiatives will carry considerable weight in addressing this under-representation.

STAFF AGE RANGE BY SEX

In 2013-14 the majority of women in post are in the age ranges 31-40 (648 - 49.6% of all staff in that age range), followed by 41- 50(588 – 40.3%) then 21-30 (552 – 55.7%). In the previous year the majority of women were between 31-40, followed by 21-30 then 41-50.

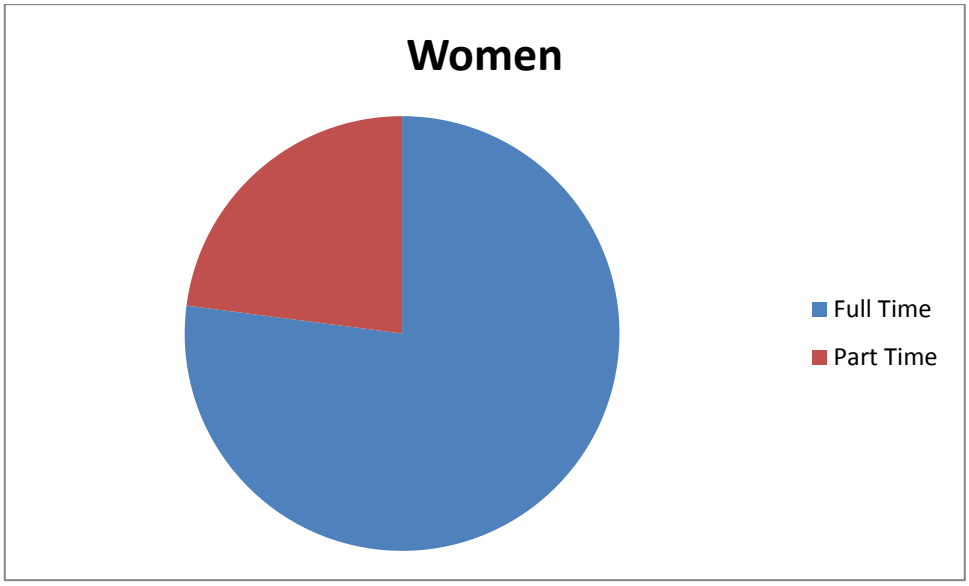


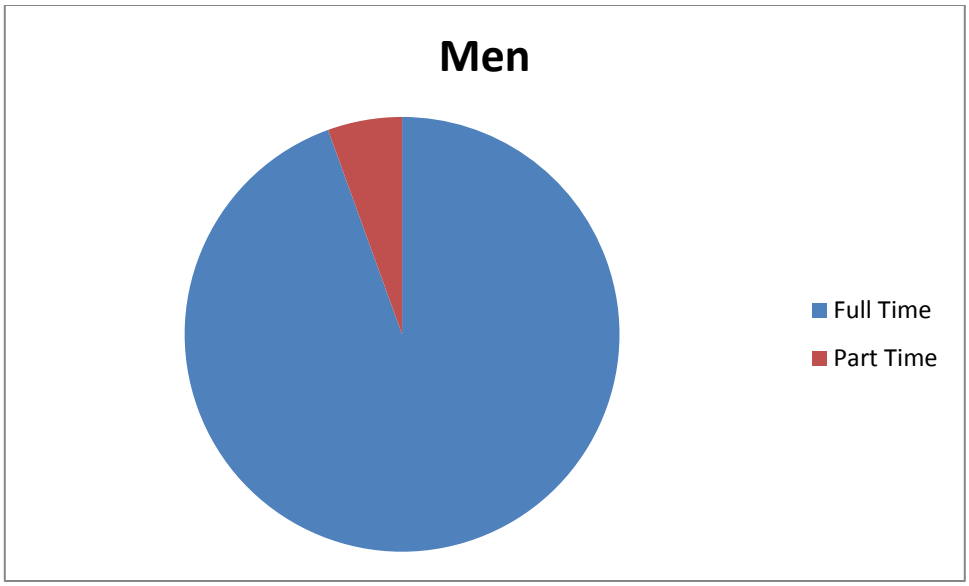
The majority of men are in the age ranges 41-50 (871 -59.6%), followed by 31-40 (657 50.3%) then 51-60 (526 – 70.6%). In the previous year the age profile for men was the same.



STAFF IN POST BY EMPLOYMENT CATEGORY

In 2013-14 the majority of women were in full-time employment (1578 - 39% of all full time employed staff) with 470 staff in part-time employment (76.5-% of all part-time staff. In comparison 2458 men in post are in full-time employment (60.9 % of all full time employed staff) with 144 in part-time employment (23.45%).





In the previous year 1590 (39.2%) of women and 2459 (60.7%) of men were in full-time employment with 407 (71.52%) and 162 (28.47%) of men in part-time employment.

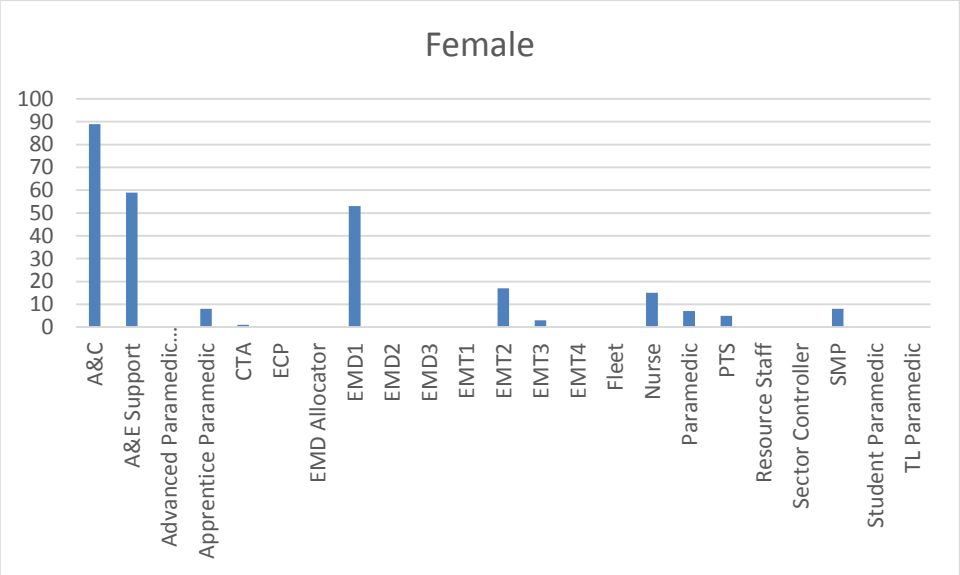
STARTER PROFILE

In the year 2013-14 there were a total of 515 new starters to the Trust, of whom 265 (51.5 %) were women and 250 (48.5%) men. In the previous year 84 (54.3%) were women and 82 (45.7%) men.

STARTER GRADE/RANK PROFILE BY SEX

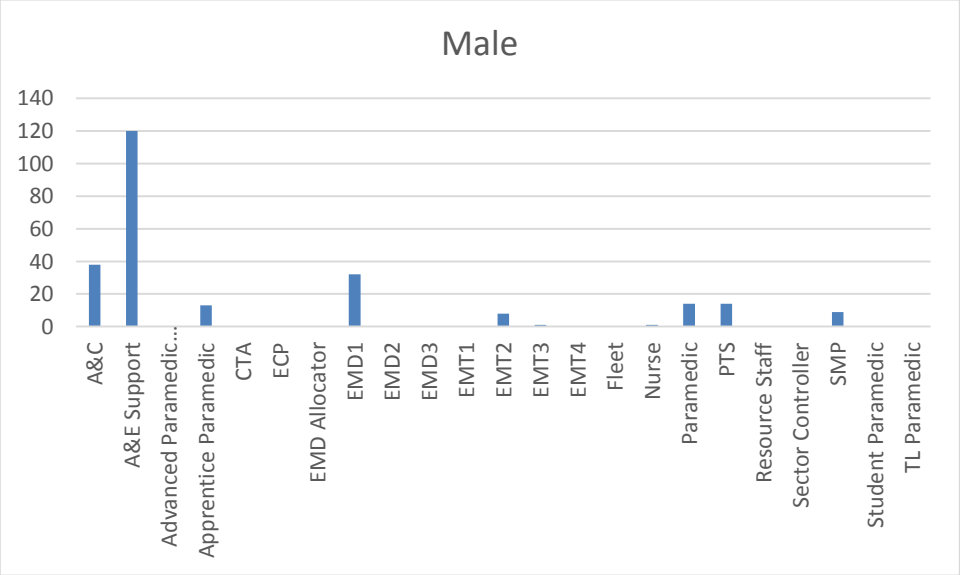
In 2013-14, as the chart below shows, the majority of women starting with the service started as A&C (89 - 70% of all starting in that grade/rank), followed by A&E Support (59 – 32.9%) then EMD1 (53 – 62.3%). In the previous year the majority of women started as EMD1, followed by Apprentice Paramedic then EMT2.

FEMALE STARTERS BY GRADE AND RANK



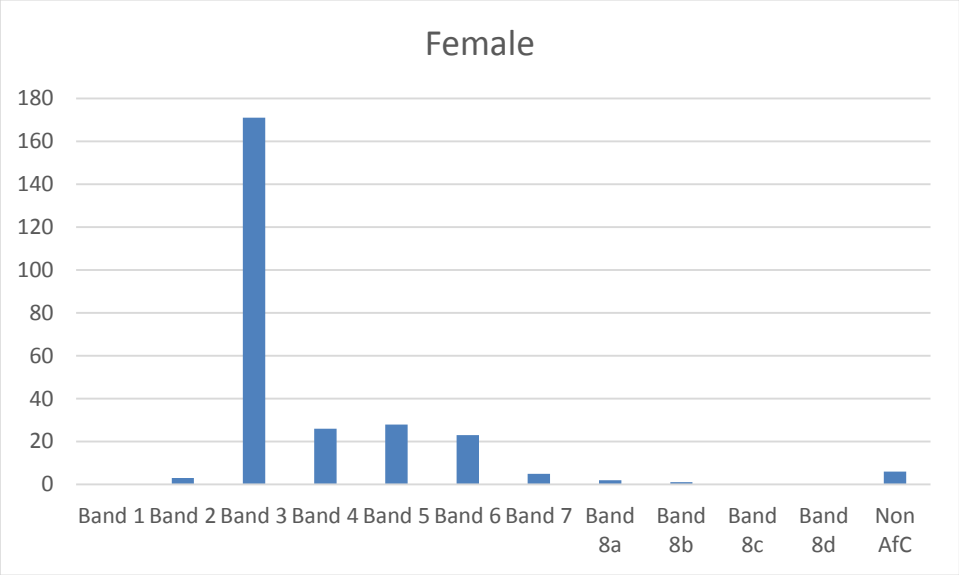
MALE STARTERS BY GRADE AND RANK

The majority of men starting with the service started as A&E Support (120 - 67% of all staff starting in that grade/rank), followed by A&C (38 – 29.9 %) then EMD1 (32 – 37.6%). In the previous year the majority of men started as Apprentice Paramedic, followed by EMT2 then EMD1.

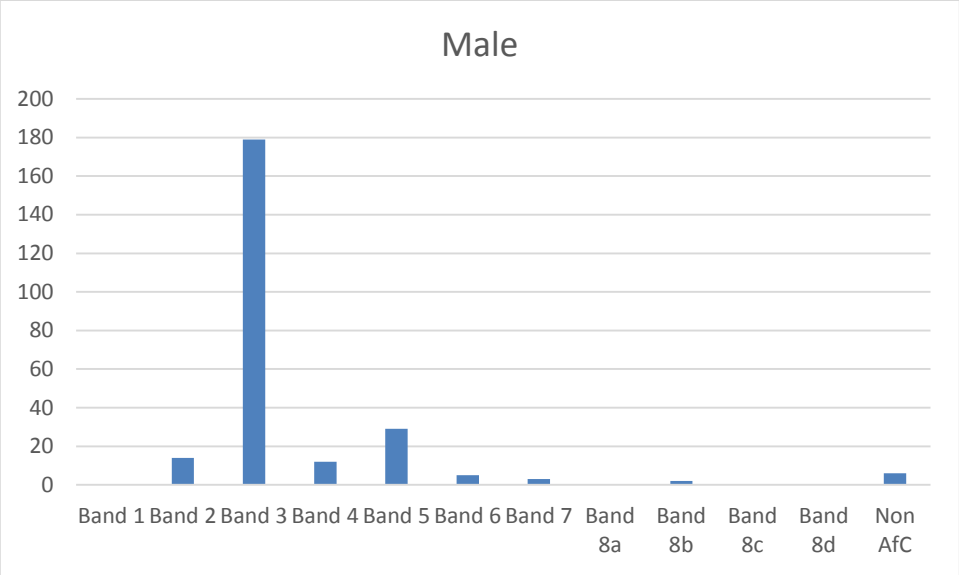


STARTERS BY PAY BAND BY SEX

In the year 2013-14, as the chart below shows, the majority of women starting with the Trust started at Band 3 (171 – 48.8% of all new starters at that pay band), followed by Band 5 (28 – 49.1%) then Band 4 (26 – 68.4%). In the previous year most women started at Band 5, followed by Band 3 then Band 4. 14 women started in senior management grades (56 % of all new starters at that grade). In the previous year it was 4 (50% of all new starters then).



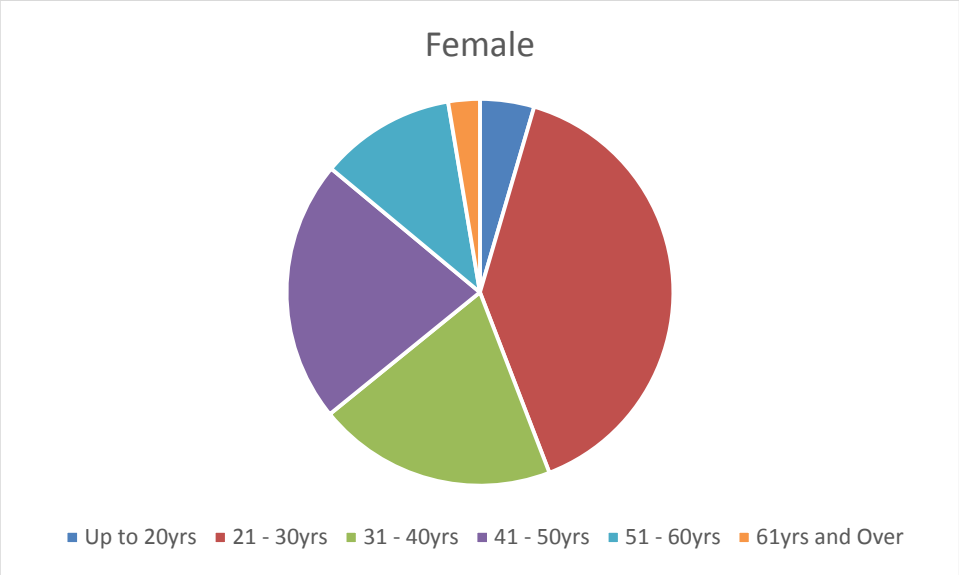
In the year 2013-14 the majority of men starting with the Trust started on Band 3 (179 – 51.1% of all staff starting in that pay band), followed by Band 5 (29 – 50.8%) then Band 2 (14 – 82.3%). In the previous year the majority of men starting were at Band 5, followed by Band 4 then Band 3. The number of men starting in senior management grades was 11 (44% of all new starters at that level). In the previous year this was 4 (50% of all new starters at that level).



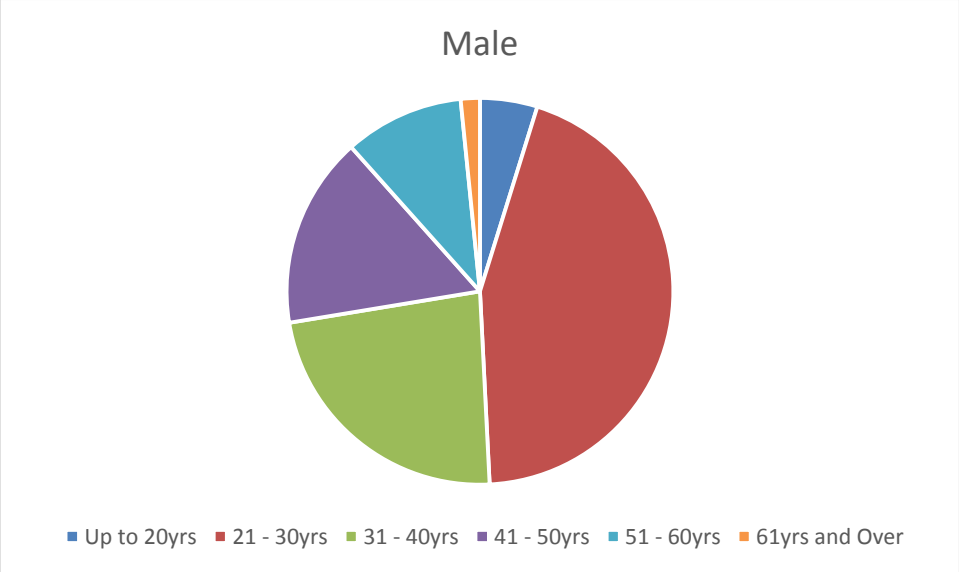
STARTERS BY AGE RANGE

The majority of staff starting with the Trust in the year 2013 - 14 were in the age range 21 - 30 (216 - 41.9% of all new starters), followed by 31 - 40 (111 - 21.5%) then 41 - 50 (98 - 19%). In the previous year the majority of staff starting in the Trust were in the age range 21 - 30, followed by up to 20 then 31 - 40.

As the chart below shows, women starting with the Trust were predominantly in the age ranges 21 - 30 (105 -20.3%), followed by 41 - 50 (58 – 11.2%) then 31 - 40 (53 – 10.2%). In the previous year women were predominantly in the age ranges 21-30, then up to 20 then 31-40.



For men starting with the Trust, as the chart below shows, the most prevalent age ranges were 21 - 30 (111 – 21.5% of all new starters), followed by 31 - 40 (58 - 11.2%) then 41 - 50 (40 – 7.7%). In the previous year the most prevalent age range of men starting with the Trust was 21 - 30, followed by up to 20, then 31 - 40.



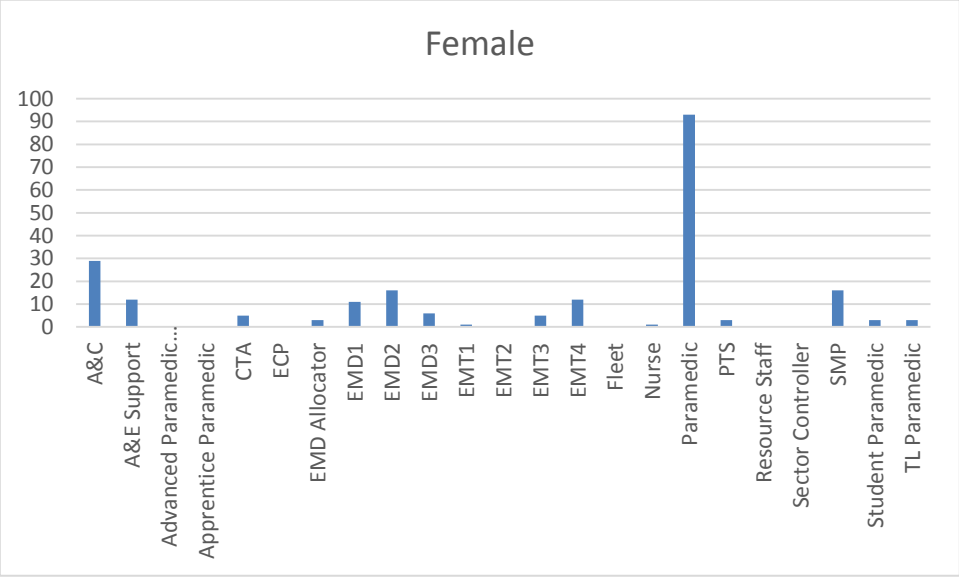
LEAVER PROFILE

In the year 2013-14 a total of 494 people left the Trust, of whom 219 (44.3%) were women and 275 (55.6%) men. In the previous year a total of 443 people left the Trust, of whom 199 (44.9%) were women and 244 (55.1%) men. In the coming year more work will be undertaken to improve the exit interview process, to identify reasons for staff leaving and improve retention.

LEAVERS BY GRADE AND RANK BY SEX

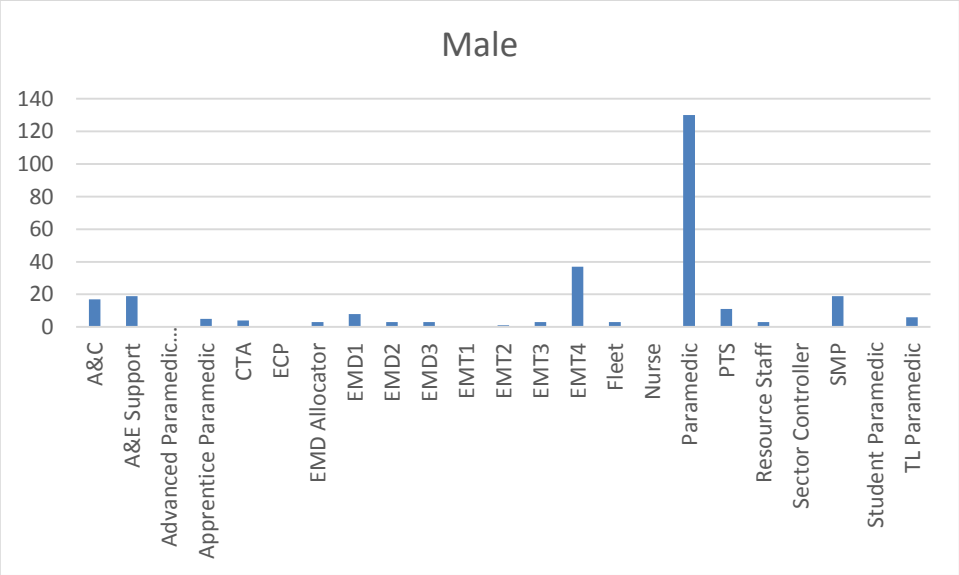
FEMALE LEAVERS BY GRADE AND RANK

As the chart below indicates, the majority of women leaving the Trust were Paramedics (93 – 41.7% of all leavers), followed by A&C (29 - 63%) then EMD2 (16 – 84.2%) and SMP (16 – 45.7%). In the previous year the majority of women leaving the Trust were Paramedics, followed by A&C then EMT4.



MALE LEAVERS BY GRADE AND RANK

As the chart below shows, the majority of men leaving the Trust were Paramedics (130 – 58.2%), followed by EMT4 (37- 75.5%) then A&E Support (19 – 61.2%) and SMP (19 – 54.2%). In the previous year the majority of men leaving the Trust were Paramedics, followed by SMP then EMT4.



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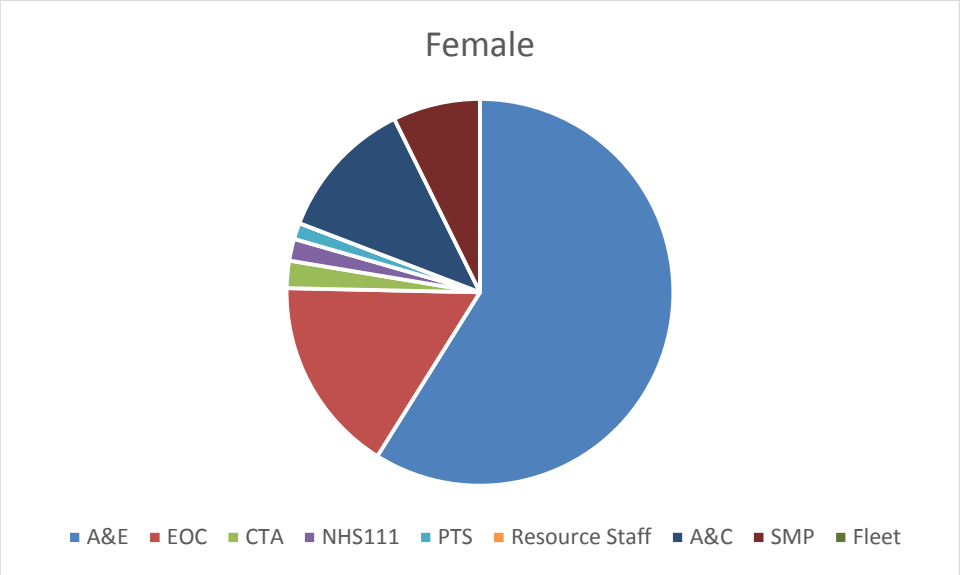
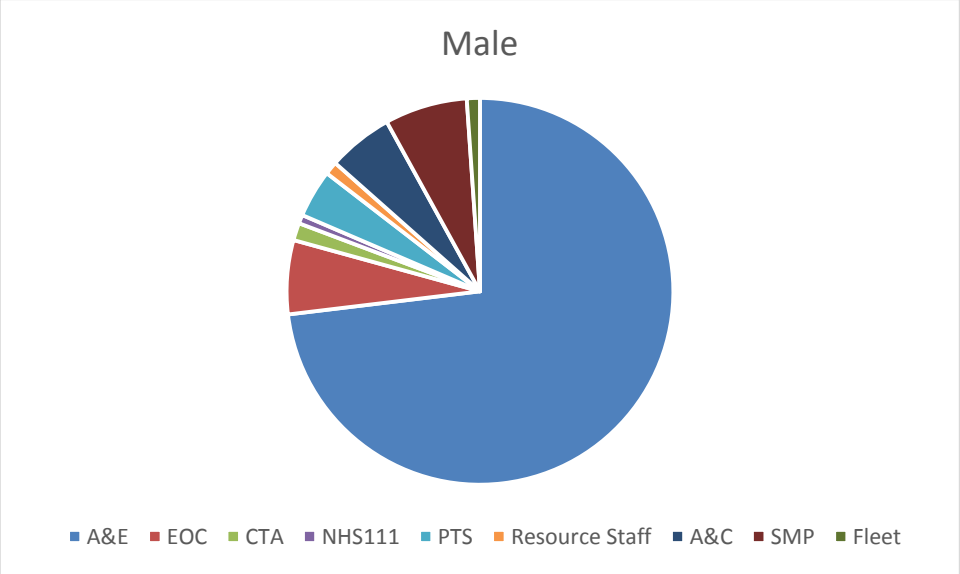
LEAVERS BY STAFF GROUP BY SEX

As the chart below shows, in the year 2013-14 the majority of women leaving the Trust were predominantly from A&E (129 - 39% of all staff leaving in that staff group), followed by EOC (36 – 67.9%) then A&C (26- 63.4%). In the previous year the majority of women left from the same staff groups in order of prevalence.



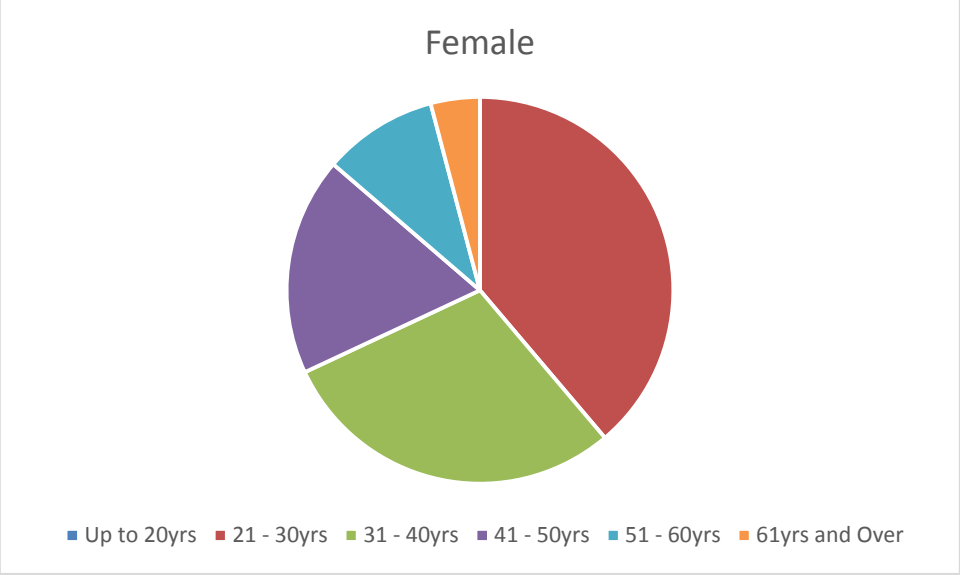
In the year 2013-14 the majority of men leaving the Trust were from A&E (201 – 60.9%), then SMP (19 – 54.2%) then EOC (17- 32%). In 2012-13 the majority of men left from the same staff groups in order of prevalence.



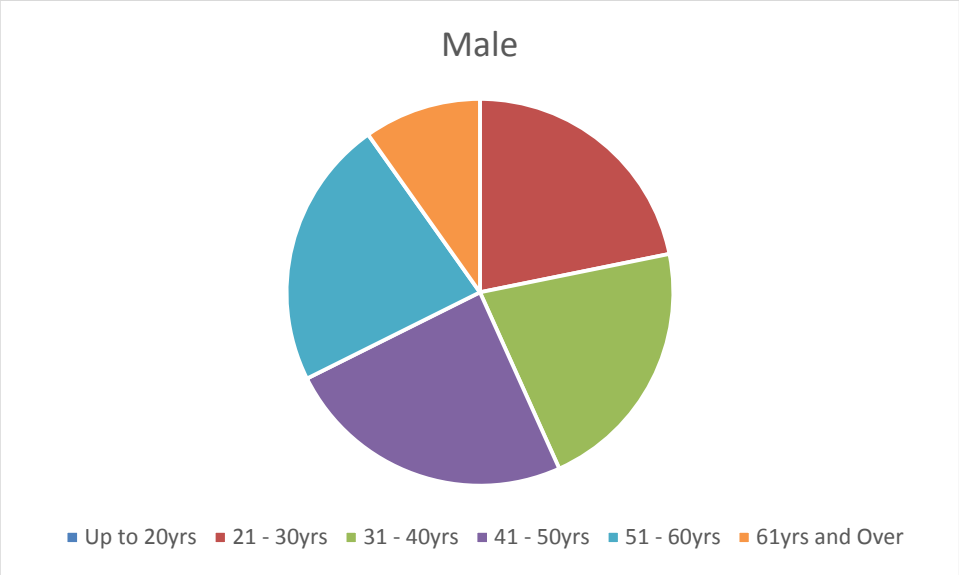
STAFF LEAVING BY AGE BAND

In 2013-14 the majority of staff leaving the Trust were in the age bands 21-30 (145 – 29.3% of all leavers), then 31-40 (123- 24.8%) then 41-50 (107 -21.6%). In the previous year the majority of staff were in the age bands 31-40, followed by 21-30 then 41-50.

In the year 2013-14, as shown below, the majority of women leaving the Trust were in the age bands 21-30 (85 – 44.8% of all leavers in that age band), followed by 31-40 (64 -52%) then 41-50 (40 – 37.3%). In the previous year the majority of women leaving the Trust were from the same age bands in the same order of prevalence.



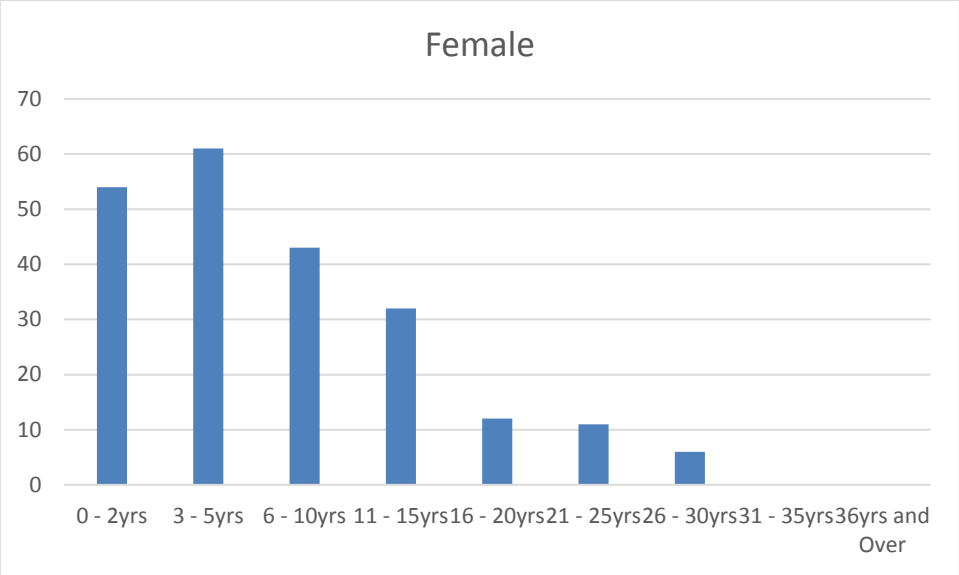
In the year 2013-14 as shown below, the majority of men leaving the Trust were in the age bands 41-50 (107- 62.6% of all staff leaving in that age band), followed by 51-60 (62 – 74.6%) then 21-30 (60 – 41.3%). In the previous year the majority of men leaving the Trust were in the age bands 31-40, then 21-30 then 41-50 and 51-60 jointly.



LEAVERS BY LENGTH OF SERVICE BY SEX

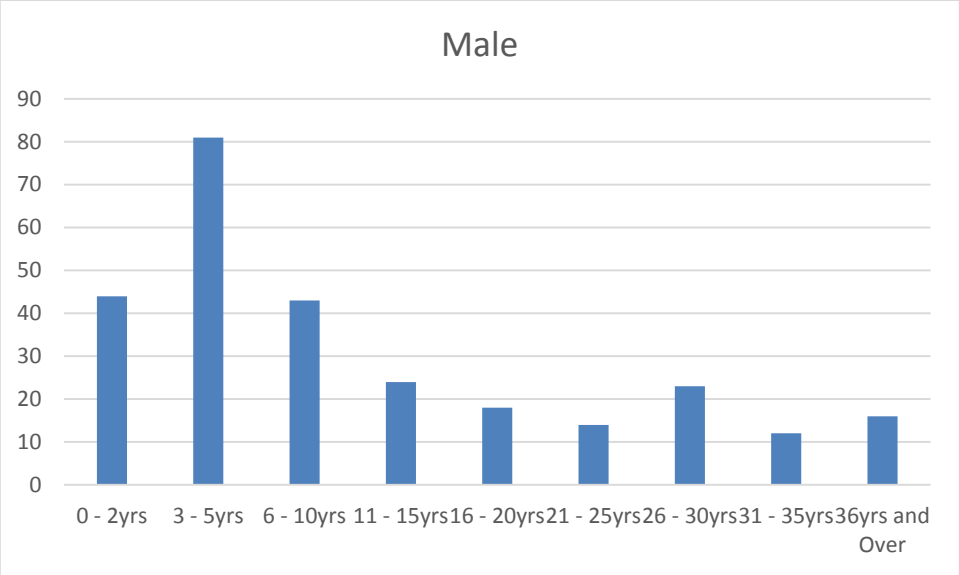
FEMALE LEAVERS BY LENGTH OF SERVICE

As the chart below shows, the majority of women leaving in 2013-14 had length of service of 3-5 years (61 – 42.9%), followed by 0-2 years (54 – 55.1%) then 6-10 years (43 -50%). In the previous year the majority of women leaving the Trust had length of service between 0-2 years, followed by 3-5 years then 6-10**.**



MALE LEAVERS BY LENGTH OF SERVICE

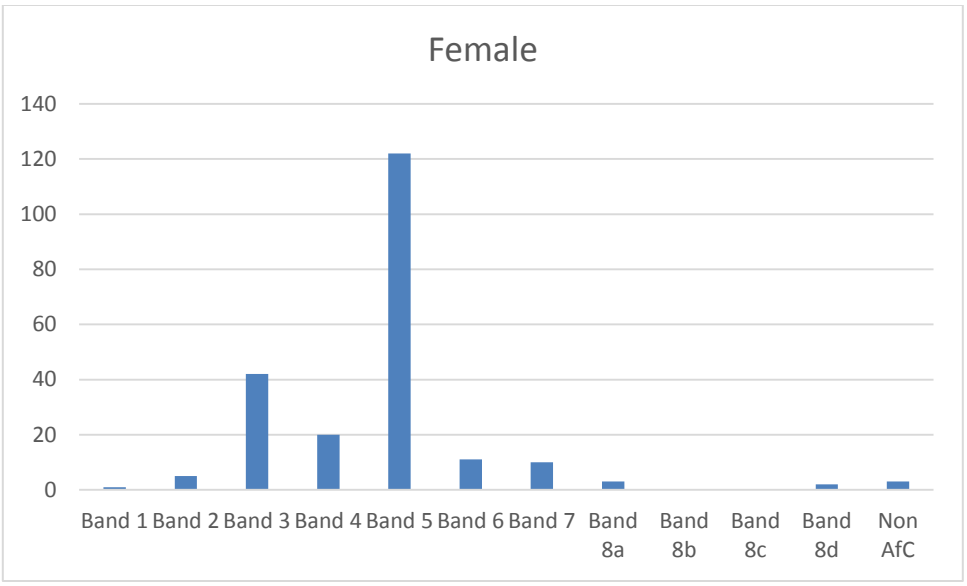
As the chart below shows, the majority of men leaving the Trust had length of service of 3-5 years (81 - 57%), followed by 0-2 years (44 – 44.8%) then 6-10 years (43 - 50%). In the previous year the majority of men leaving the Trust had the same length of service in order or prevalence.



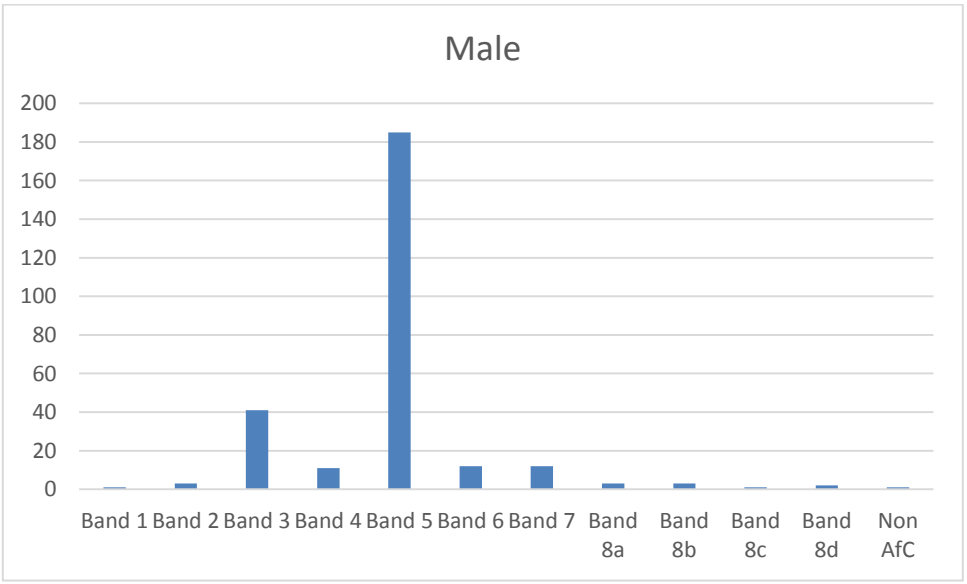
LEAVERS BY PAY BAND BY SEX

FEMALE LEAVERS BY PAY BAND

In the year 2013-14, as the chart below shows, the majority of women leaving the Trust were in Band 5 (122 – 39.7% of all staff leaving in that pay band), followed by Band 3 (42 – 50.6%) then Band 4 (20 – 64.5%). In the previous year the majority of women leaving were in Band 5, followed by Band 3 then Band 6.

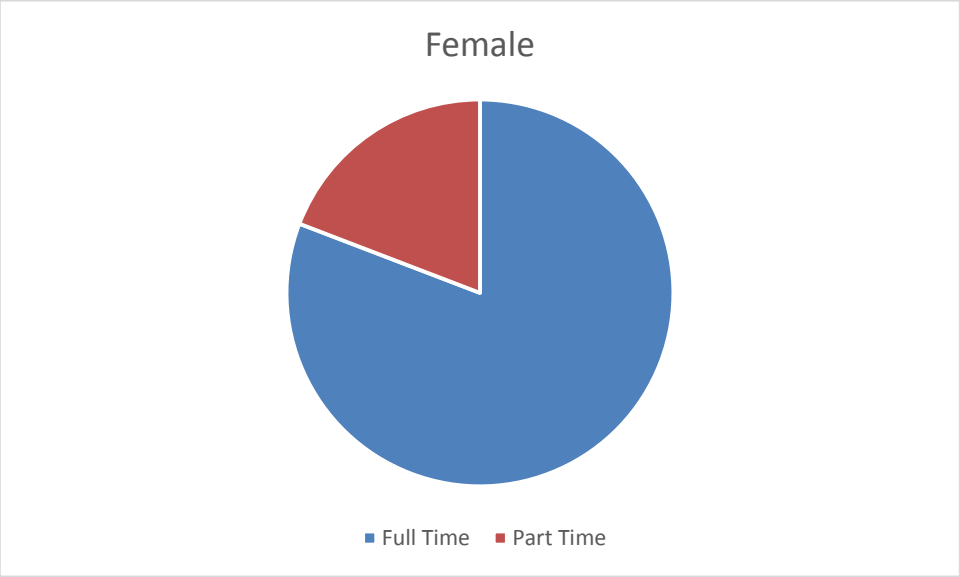


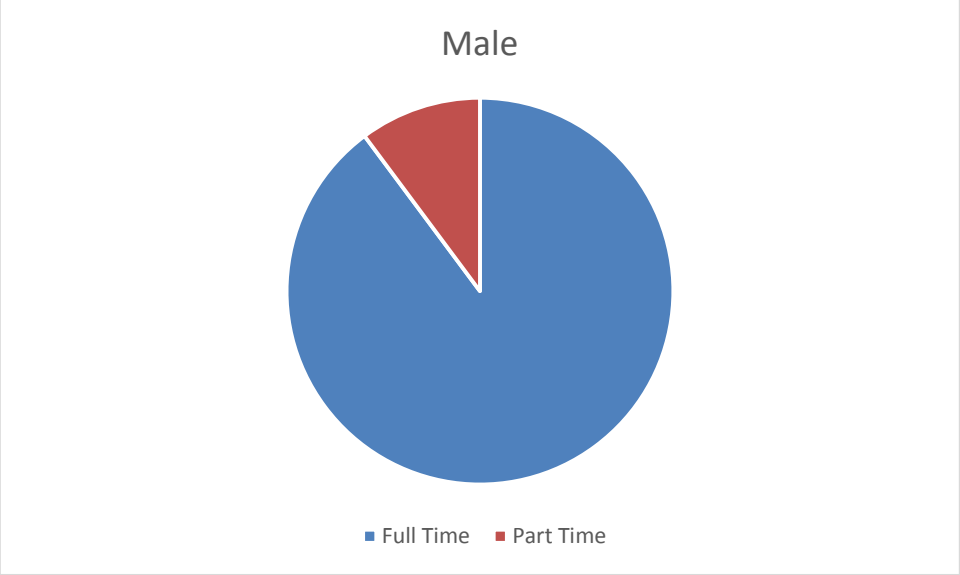
In the year 2013-14, as indicated by the chart below, the majority of men leaving the Trust were in Band 5 (185 – 60.2% of all staff leaving in that grade), followed by Band 3 (41 – 49.3%) then Band 6 (12 – 52.1%) and Band 7 (12 – 54.5%). In the previous year the majority of men leaving followed a similar pattern - Band 5, followed by Band 3 then Band 7.



LEAVERS BY EMPLOYMENT CATEGORY

In 2013-14 out of a total of 494 staff leaving the Trust 424 (85.8%) were full-time and 70 (14.17%) part-time. Of the women leaving the Trust, 177 were in full-time employment (41.7 % of all staff leaving in that employment category), while 42 (60%) were part-time. Of the men leaving the Trust 247 (58.2% of all staff leaving in that employment category) were full-time and 28 part-time (40%). In the previous year women made up 40.37% of full-time staff leaving, men 59.6%, while women made up 69.56% of part-time staff leaving and men 30.43%.

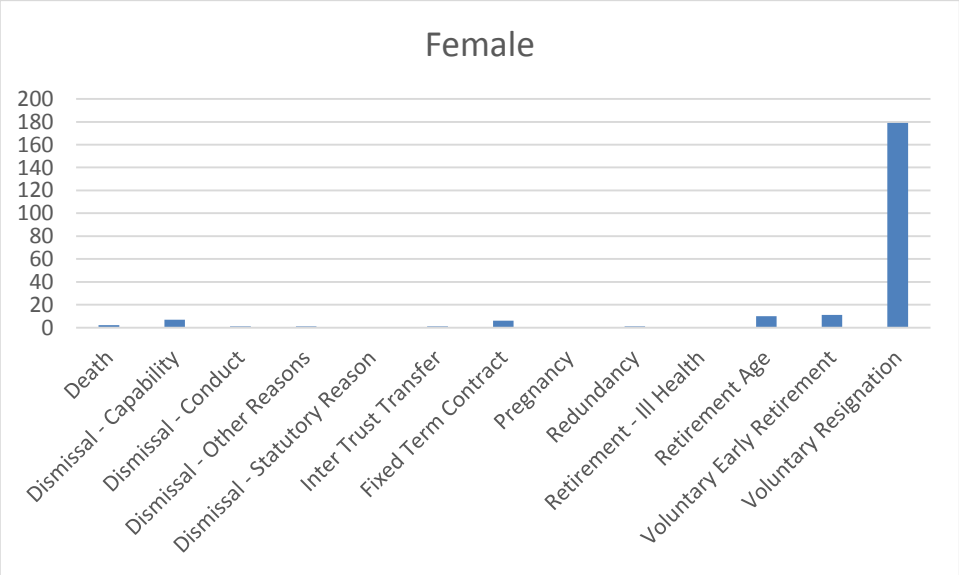




LEAVERS BY SEX – REASONS FOR LEAVING

In the year 2013-14, as the chart below shows, the majority of women leaving the Trust left on the following reasons – Voluntary Resignation (179 – 49.58% of all staff leaving on those grounds), followed by Voluntary Early Retirement (11 – 42.3%) then Retirement Age (10 – 17.2%). In the previous year the majority of women leaving left on Voluntary Resignation, followed by Retirement Age then Dismissal Capability.

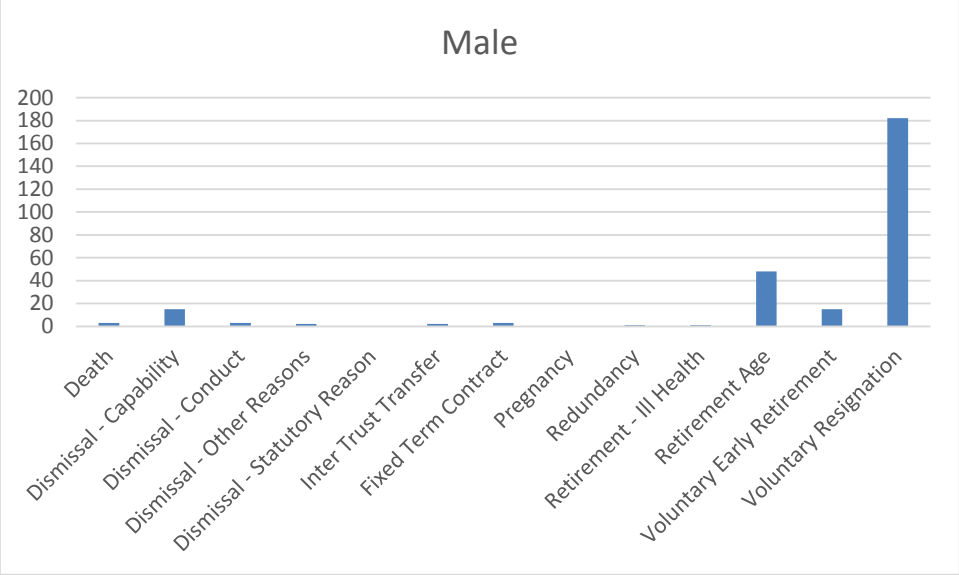
REASONS FOR WOMEN LEAVING THE TRUST



In 2013-14, as the chart below demonstrates, the majority of men leaving the Trust left on the grounds of Voluntary Resignation (182 – 50.4% of all staff leaving on those grounds), followed by Retirement Age (48 – 82.7%) then Dismissal-Capability (15 – 68.1 %) and Voluntary Early Retirement (15 – 57.6%). In 2012-13 the majority

of men leaving the Trust left for similar reasons - Voluntary Resignation, followed by Retirement Age then Dismissal Capability.

REASONS FOR MEN LEAVING THE TRUST



PROMOTIONS BY SEX

In 2013-14 the total number of promotions was 139, of which 62 (44.6%) were for women and 77 (55.39%) for men. In terms of overall representation of staff, the percentage of women being promoted is around the overall representation in the Trust (44%), but still behind the Census 2011 female estimated representation in the capital of 50.7%. In the previous year the total number of promotions was 289, of which 133 were for women and 166 for men.

6.9. PROFILE BY DISABILITY

As the chart below shows, the number of staff declaring themselves to be disabled was very low (47 - 1% of the total Trust workforce, in comparison with the Census 2011 total for residents of London reporting limiting long-term illness – 14.2%, the closest indicator to disability, as there are no specific census data on this). In the previous year 22 staff had declared themselves to be disabled, so this is a slight increase in number.

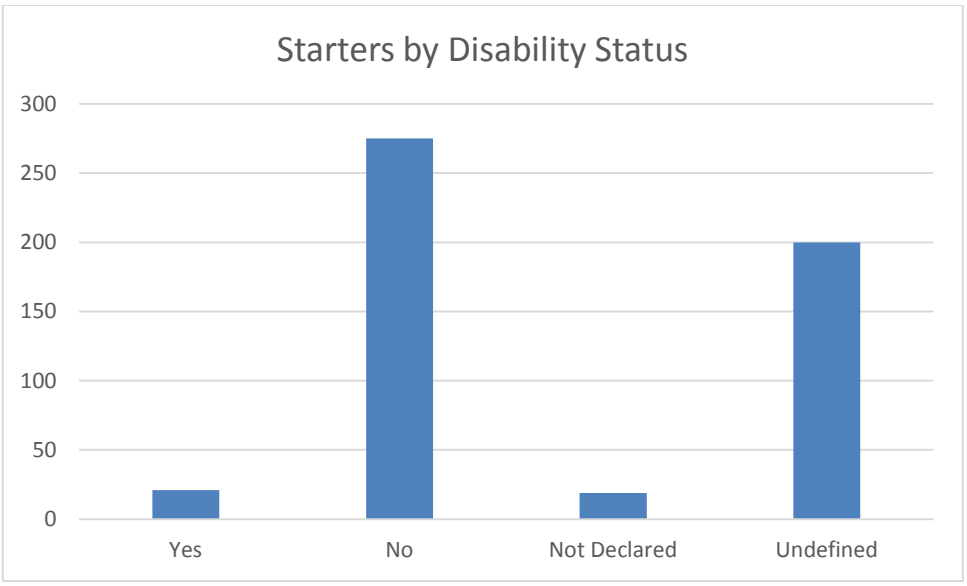
However, in this past year a very high number of staff were still not declared or undefined (3481- 74.8 %) with 1,122 staff (24 %) defining themselves as not disabled, which will need to be addressed through future changes to the national ESR system or through an internal Staff Data Refresh, undertaken at regular intervals, as well as through work with our Disabled Staff/Carers Forum (Enable) to increase confidence in self-reporting.

DISABLED STAFF IN POST

STARTER PROFILE

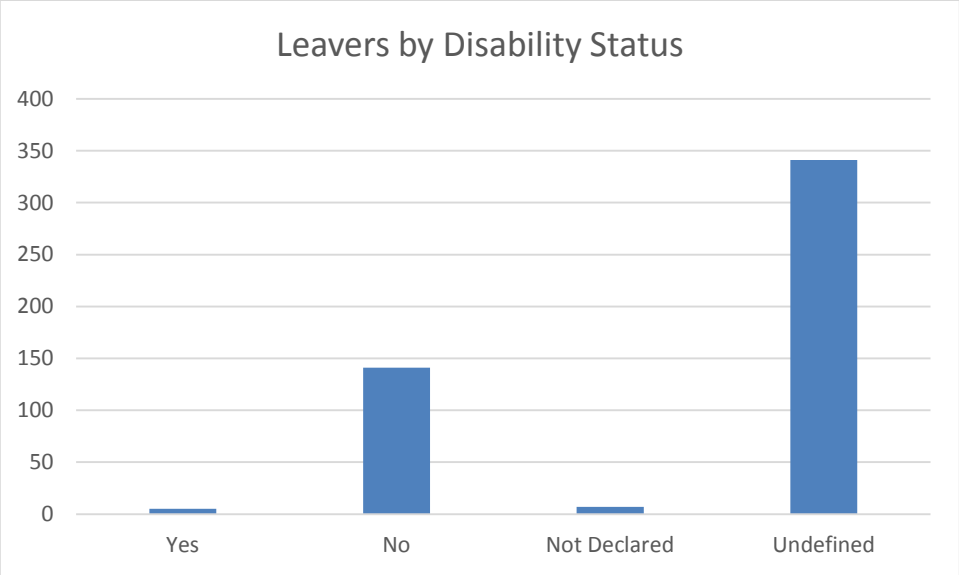
Of 515 new starters to the Trust, 21 people (4%) self-identified as disabled,

275 (53.3%) said they were not disabled, while 219 (42.5%) did not declare either way. The Trust's membership of the leading UK Employers' Forum on disability (the Business Disability Forum), its commitment to being a Two Ticks Employer, as well as support for Enable – the Disabled Staff and Carers' Forum - and the Deaf Awareness Forum, should help to encourage new staff to self-identify as disabled and reduce the high number of new starters not declaring. In the previous year 5 people self-identified as disabled, 185 said they were not disabled and 127 did not declare either way.



LEAVER PROFILE

As the chart below shows, of the 494 staff leaving the Trust, 5 (1%) said they were disabled, 141 (27.3 %) said they were not disabled and 348 (67.5%) did not declare either way. In the previous year 1 leaver said they were disabled, 97 said they were not and 345 did not declare either way. For administrative reasons no further breakdown of disabled staff is currently available; this will need to be addressed in future reports.

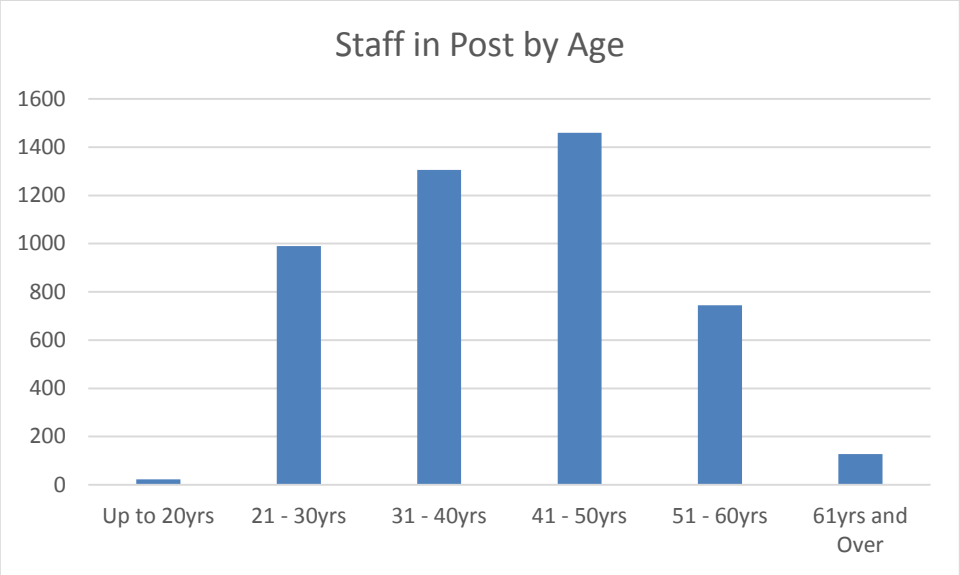


PROMOTIONS

In the year 2013-14 5 (3.59%) disabled staff were promoted, 50 staff (35.97%) were promoted who said they were not disabled and 84 staff (60.4 %) were promoted who did not declare either way. In the previous year one member of staff who self-identified as disabled was promoted.

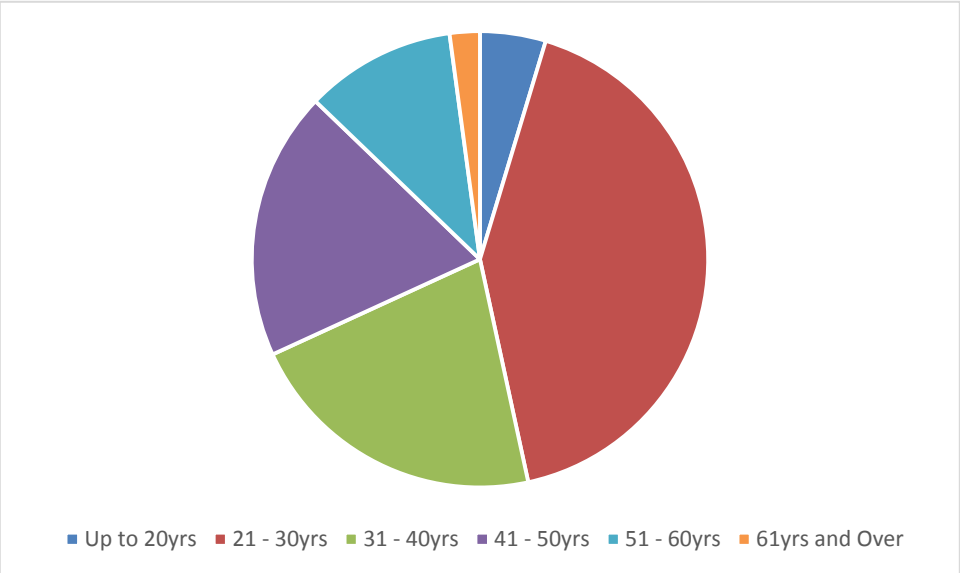
6.10. WORKFORCE PROFILE BY AGE

As the chart below shows, in the year 2013-14 the majority of Trust staff (1459 - 31.37%) were in the age ranges 41-50 followed by 31-40 (1305 - 28%) then 21-30 (990 – 21.89%). This age profile mirrors that of the previous year.



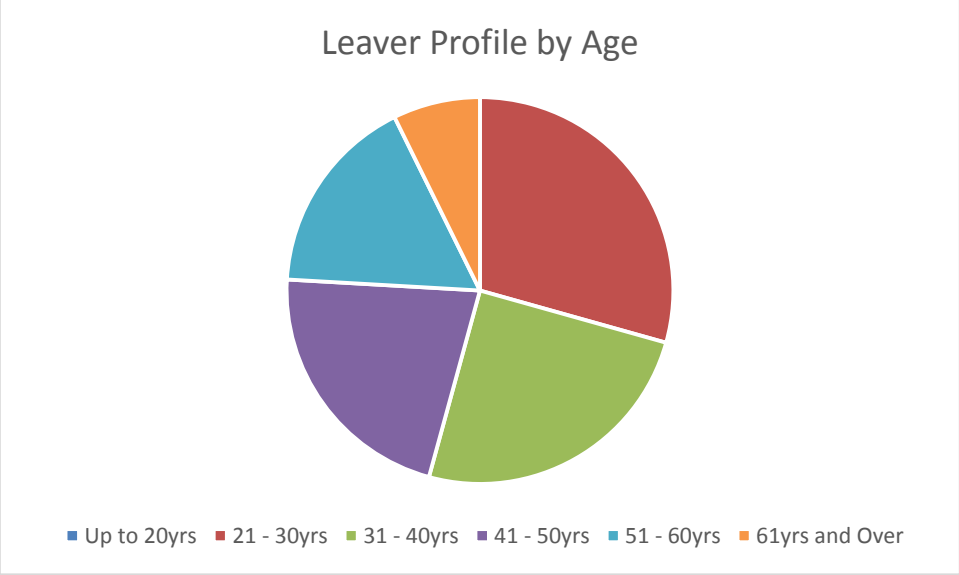
As shown by the chart below, the majority of Trust staff (216 – 41.94% of all new starters) were in the age ranges 21 - 30, followed by 31-40 (111 – 21.55%) then 41-50 (98 - 19%. In the previous year the majority were in ranges 21-30, followed by up to 20, then 31-40.

STARTER PROFILE BY AGE



LEAVER PROFILE

As shown by the chart below, the most prevalent age range of staff leaving the Trust was 21 - 30 (145 – 29.35% of all staff leaving the Trust), followed by 31-40 (123 – 24.89%) then 41-50 (107 – 21.65%). In the previous year the profile was 31-40, followed by 21-30 then 41-50.



PROMOTIONS

In this past year the most prevalent age ranges in which staff were promoted were 21-30 (53 – 38.1%), followed by 31-40 (45 – 32.37 %) then 41-50 (34 – 24.46%). This mirrored the previous year's trend, in which again the most prevalent age ranges for promotions were 21-30, followed by 31-40 then 41-50. This appears to

show that there continues to be visible equality of opportunity for promotion within the Trust regardless of age.

6.11. EMPLOYEE RELATIONS ACTIVITY

For 2013-14 in total, records show that the Disciplinary procedure was instituted 66 times (last year figures in parenthesis throughout – 118); Grievance 9 (15) times; and Managing Attendance 349 (504) times. The figure for Managing Attendance includes people for whom capability in terms of their health was the key issue. Twenty-two (8) cases were initiated during the period under the Capability Performance procedure.

The Disciplinary Procedure was instituted with a total of 66 staff, 46 men (69.7% (63.6%)) and 20 women (30.3% (36.4%)). Ten cases (15.7% (16.9%)) were BME staff. No members of staff (0.0% (0.0%)) were in the age band 20 or under; fourteen (21.2% (17.8%)) in band 21-30; sixteen (24.2% (35.6%)) in band 31-40; nineteen (28.8% (35.6%)) in band 41-50; eight (12.1% (11.0%)) in band 51-60; and two (3.0% (0.0%)) over 60 years.

The Disciplinary Procedure was instituted with two (one) members of staff who self-identified as disabled persons.

In one (five) case disciplinary allegations related to bullying and/or harassment.

Eight (31) women (34.8% of a total of 23 (72.1% of a total of 43)) and four (17) BME staff (17.4% (85.0%)) received warnings or were dismissed as a result of the Disciplinary proceedings. No member of staff was in the age band 20 or under; eight in band 21-30; five in age band 31-40; four in band 41-50; two in band 51-60; and none over 60 years.

The Grievance Procedure was instituted by a total of 9 (15) staff, 5 (8) women and 4 (7) men, of whom one (three) (11.1% (20.0%)) were BME staff. No members of staff self-identified as disabled persons.

One (one) member of staff were in age band 21-30; three (three) were in age in band 31-40; four (seven) in band 41-50; one (two) in band 51-60; and none (one) over 60 years.

Four (one) grievances were related to bullying and/or harassment.
Of the grievances submitted, none (one) was upheld. Three cases were resolved through discussion.
The Managing Attendance Procedure (MAP) was formally instituted (i.e. the member of staff was issued with a warning or dismissed) with 349 (504) members of staff in total; 157 (45.0% (50.8%)) women; 192 (55.0% (49.2%)) men; 30 (8.6% (6.2%)) BME staff.
No members of staff (0.0%) either self-identified as a disabled person or were declared by the Occupational Health department to be treated as protected by legislation.
Three (0) members of staff (0.9% (0.0%)) were in age band 20 or under; 50 (14.3% (17.5%)) in band 21-30; 87 (24.9% (33.4%)) in band 31-40; 140 (40.1% (34.7%)) in band 41-50; 51 (14.6% (14.1%)) in band 51-60; 8 (2.3% (1.6%)) were over 60.
The Capability Performance Procedure was instituted with 22 (8) members of staff; fifteen male and seven female; two in the age band 21-30; one in the age band 31-40; eleven in the age band 41-50; five in band 51-60 and two over 60.
In the year 2013-14 there were a total of 6 (15) claims lodged in the Employment Tribunal, three of which were by women. No claimants were in age band 21-30; two in band 31-40; two in band 41-50; and one in band 51-60 and one over 60.
No (one) claims were made by BME members of staff, all were by White British.
No claims for discrimination on the grounds of race were made; three (five) claims were made for discrimination on the grounds of disability.

Analysis

On all fronts, the activity has significantly diminished and this is against the trend of previous years. The historical increases in reported activity were likely to be due to improved reporting mechanisms and, now that these are mature and effective, a truer picture of declining discontent emerges. A historical data table is below.

	08/09	**09/10**	**10/11**	**11/12**	**12/13**

	08/09		09/10		10/11		11/12		12/13	
	No.	%	No.	%	No.	%	No.	%	No.	%
Disciplinary Procedure	**36**		**51**		**64**		**95**		**118**	
Male	22	61.2	36	70.6	34	53.1	58	61.0	75	63.6
Female	14	38.8	15	29.4	30	46.9	37	39.0	43	36.4
BME	0	0	7	13.7	8	12.5	11	11.6	20	16.9
Disabled	0	0.0	0	0.0	0	0.0	0	0.0	1	0.8
Grievances	**17**		**16**		**34**		**33**		**15**	
Male	13	76.5	8	50.0	21	61.8	15	45.5	7	46.7
Female	4	23.5	8	50.0	13	38.2	18	54.5	8	53.3
BME	3	17.6	4	25.0	3	8.8	2	6.0	3	20.0
Disabled	1	5.9	1	6.3	0	0	0	0.0	1	6.7
Managing Attendance	**48**		**403**		**613**		**661**		**504**	
Male	26	54.2	233	57.8	33	55.3	34	52.6	24	49.2

	08/09		09/10		10/11		11/12		12/13	
					9		8		8	
Female	22	45.8	170	42.2	274	44.7	313	47.4	256	50.8
BME	11	22.9	16	4.0	16	2.6	54	8.2	31	6.2
Disabled	0	0.0	7	1.7	5	0.8	8	1.2	0	0.0
Capability Performance	0		**2**		**2**		**1**		**8**	
Male	0	0.0	0	0	1	50.0	0	0.0	4	50.0
Female	0	0.0	2	100.0	1	50.0	1	100.0	4	50.0
BME	0	0.0	1	50.0	0	0	0	0.0	1	12.5
Disabled	0	0.0	0	0	0	0	0	0.0	0	0.0
Age (all activity)			**472**		**713**		**790**		**647**	
20 or under		0.0	5	1.1	2	0.3	6	0.8	0	0.0
21 - 30		9.6	58	12.3	122	17.1	155	19.6	113	17.4

	08/09		09/10		10/11		11/12		12/13	
31 - 40		41.2	166	35.3	231	32.4	239	30.3	200	30.9
41 - 50		33.3	183	38.7	232	32.5	265	33.5	229	35.4
51 - 60		14	60	12.6	111	15.6	112	14.2	86	13.3
Over 60		2.6	0	0	15	2.1	13	1.6	11	1.7

6.12. RETURN TO WORK FOLLOWING MATERNITY LEAVE

In 2013-14 a total of 144 women took maternity leave. Of those 76 have since returned to work, with 58 still on maternity leave and 10 leaving the service. In the previous year 111 women had taken maternity leave, with 60 returning to work with the service and a total of 6 leaving the service. Of the 45 still on maternity leave at the last report 37 returned to work in the Trust, with six then leaving the service.

6.13. ACCESS TO FLEXIBLE WORKING

There was no question around access to flexible working in last year's national NHS survey, so data for this last year is not available. Consideration will need to be given to including questions on this in future surveys or finding alternative ways

to gain feedback.

6.14. STAFF ENGAGEMENT

In 2013 1793 staff responded to the National NHS Survey, giving a response rate of almost 40%. This year only the problem score data was broken down by protected characteristic groups; responses provided below.

22 - Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?

All Staff	n	%
Yes	645	37.0
* No	436	25.0
Don't know	663	38.0
Problem Score: 25.0%	1744	

23a - In the last 12 months have you personally experienced discrimination at work from patients/service users, their relatives or other members of the public?

All Staff	n	%
* Yes	383	22.2
No	1345	77.8
Problem Score: 22.2%	1728	

23b - In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?

All Staff	n	%
* Yes	202	11.7
No	1518	88.3
Problem Score: 11.7%	1720	

23c - On what grounds have you experienced discrimination?

Staff experiencing discrimination in last 12 months	n	%
Ethnic background	203	42.0
Gender	201	41.6
Religion	33	6.8
Sexual orientation	80	16.6
Disability	28	5.8
Age	124	25.7
Other (please specify)	91	18.8
(Total number of respondents)	483	

A breakdown by protected characteristic groups of the response to Question 22 in the survey “Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual

orientation, disability or age revealed that with Trust average of 25% this question was answered in the affirmative by:

- 27% of men and 22% of women
- 25% heterosexual staff, 21% gay men, 25% gay women, 32% bisexual people, 50% other with 26% preferring not to say;
- 18% of staff aged 16-30, 24% of 31-40, 27% of 41-50 and 28% of those aged 51 and up;
- 22% of staff with no religion, 25% Christian, 18% Buddhist, 27% Hindu, 41% Muslim, 27% any other religion, with 32% preferring not to say – no data was received from anyone who was Jewish or Sikh;
- 37% of staff who said they were disabled, 22% who said they were not disabled;
- 24% white, 21% mixed, 38% Asian/Asian British, 29% Black/Black British, 35% Chinese and other.

Any issues of concern in regard to the protected characteristic groups will be explored further with the Trust's Staff Diversity Forums. The overall survey results, provided by the Service's contractor Picker, will be used to develop action plans at both complex and Service-wide levels.

We are looking very closely at the survey results, along with feedback received through other routes such as the temperature check surveys, "change one thing" suggestions scheme and webinars on specific key Trust matters to identify actions we can take to make staff experience better. The temperature check is a very short and entirely anonymous staff survey with the questions specially designed to allow the Trust to track the progress of our key engagement initiatives in areas which staff have consistently told us are important to them. The survey is open for two weeks, three times a year, to gather regular snapshots of staff opinion. We are also implementing an "Ask the Top Team" initiative.

Since the launch of “Ask the Top Team” in August 2013, a wide range of senior managers in the Trust have responded to 29 questions from staff across the Service. The questions and responses are published in the Routine Information Bulletin, the Trust’s intranet and on the Listening into Action facebook page once a week. Topics covered so far include uniform issues, overtime and staff morale.

Over the past year key highlights of the Listening into Action programme have been drop in sessions with local management, complex Facebook groups and more recognition for staff. In May 2013 over 250 members of staff attended “Big conversation” events where they got together to talk about the issues that make it difficult for them to carry out their jobs. Key themes from the events then informed seven engagement projects: communications, 111 feedback, refreshments at hospitals, Medical Priority Dispatch System, learn about each other, recognition of excellence and Health Care Professional (HCP) education and development. Each of these projects had specific members of staff working on trialling and implementing new ideas to improve the way things work in the Trust. Planning is now in progress for year 2 of the programme.

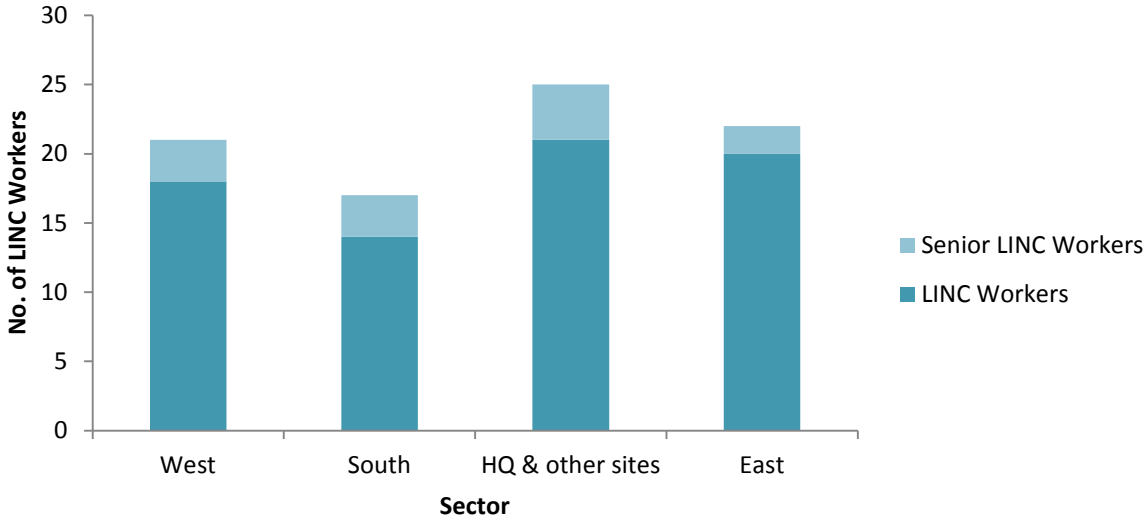
6.15. LINC WORKER SERVICE

The LINC Network forms an integral part of the Staff Support Services available to all London Ambulance Service Staff. The Staff Support Services include Employee Assistance Advice, work based Counselling, Trauma Risk Management, the Benevolent Fund, specialist Trauma Psychotherapy and 24 hour access to a network of trained LINC and Senior LINC Workers.

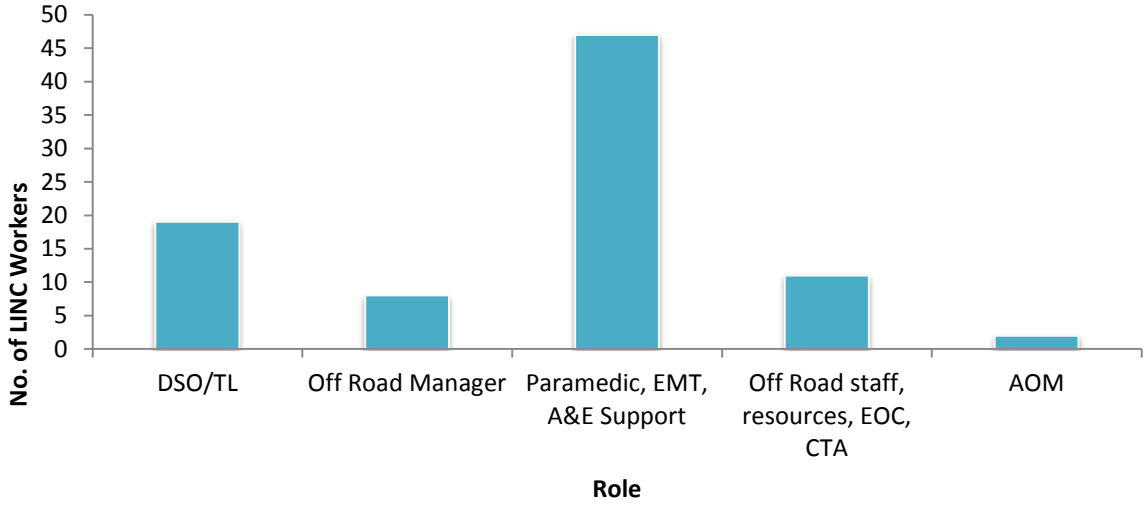
LINC (Listening, Informal, Non-judgemental, Confidential) is an established and trusted Peer Support Network, staffed by volunteers from across the Trust. LINC Workers undergo thorough assessment and training before joining the network. They provide a confidential listening and referral service, either face to face or via the telephone. In addition to this, Senior LINC Workers man a 24 hour on call service.

LINC has been developed and designed to harness individual strengths and to promote a resilient workforce. It is managed by the LINC & Wellbeing Manager and currently comprises 85 LINC Workers and 14 Senior LINC Workers. Nine LINC Workers are currently on sabbatical and so not currently included on the list of LINC Workers available to staff. During the recruitment process, efforts are made to ensure that we recruit from all areas of the LAS, incorporating all roles. The graphs below demonstrate that the LINC Network is reflective of the workforce demographic as a whole, enhancing accessibility for all staff.

Location of LINC Workers



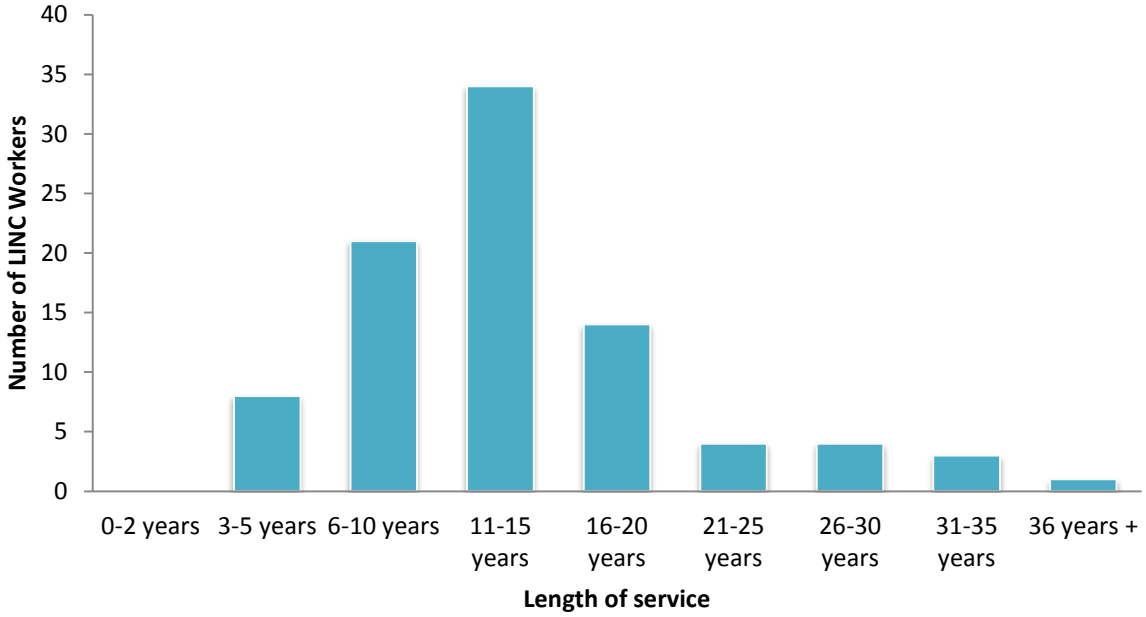
Distribution of LINC Workers by role



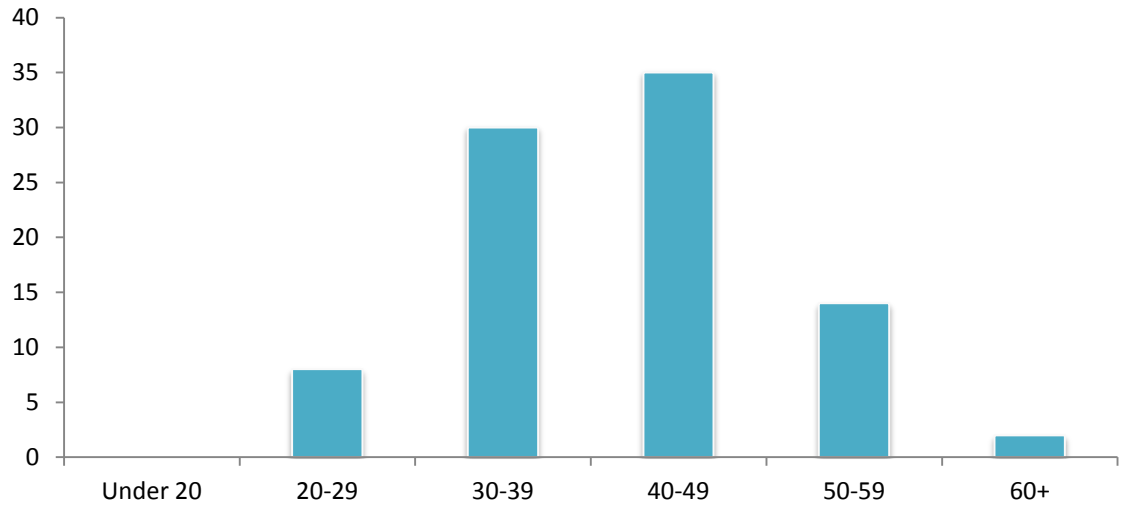
The distribution of LINC Workers by role is reflective of the LAS as a whole, with the majority working as Paramedics. In the year from 1 April 2013 to March 31 2014 the LINC Network comprised 8% BME staff (just below this last year's Trust's profile of 10.6%) and 54% female (considerably higher than the Trust profile of 44%). This has not changed significantly since last year.

LINC Workers by Length of Service

The following graph shows that the majority of staff within the LINC Network have between 11 and 15 years of experience. This is fairly representative of the Trust as a whole – in the last year 11-15 years' service was the second most prevalent length of service - however worthy of note is that the LINC network has far fewer members with 3 – 5 years of service – 9% in comparison to last years' overall Trust figure of 26%. (This length of service is the most prevalent one for 2013-14 - 23.3%). This is likely to change after this year's recruitment drive.



The Age profile of the LINC Network



Skills and Knowledge Training

The LINC Network is not only designed to ensure support is available to staff, but also that LINC Workers themselves have 24 hour access to support and advice. The design of LINC as a comprehensive and supportive network helps to ensure that LINC Workers retain their skills, enhance their knowledge and do not work in isolation. This training and support is delivered through a series of educational Forums and compulsory clinical supervision.

LINC Forums

Attending LINC Forums is compulsory. We run four Forums per year, covering subjects such as Communication skills, Understanding Self-Harm, boundaries and ethics, LGBT and understanding job roles within the Trust. Forums are educational, informative and encourage networking between the LINC Workers; on average, 25 LINC Workers attend each Forum.

Clinical Supervision & LINC 1-2-1's

1-2-1's are in place to ensure that LINC Workers have the opportunity to meet the LINC Manager on an individual basis. They serve a variety of purposes, including a welfare check, an opportunity to discuss any problems, sharing of ideas, identification of any training needs and to check on the LINC Workers' attendance of the mandatory Supervision and training sessions.

Each LINC Worker is allocated a Supervisor. Each Supervisor is a qualified and experienced Counsellor with specialist training in Supervision and they provide four sessions a year, three group sessions and one individual. The purpose of Clinical Supervision is to provide time for the LINC Worker to talk through their LINC experiences and seek expert guidance and support.

Returns

All LINC Workers are required to complete 'returns' – anonymous feedback on the work they have done. The analysis of these statistics allows us to notice trends and identify problem areas. Between April 1 2013 and March 31 2014, there have been 533 LINC Contacts recorded by LINC Workers on their returns. 94% of the staff who utilised the LINC network were road staff (497).

The following charts show a breakdown of the returns received by role and by reason for contact.

People Accessing LINC by Role	Number of staff
Paramedic	180
EMT	144
Student Paramedic	26
A&E Support	27
VRC	1
EOC	33
Resources	6

Op Manager	28
CTA	5
Admin	24
Other	38
PTS	1
HR	11
Estates	4
HART	1

Reason for Access	Number of staff
Family/Relationship	123
Chronic stress	112
Health	40
Harassment/bullying	11
Job dissatisfaction	39
Problems with Management	22
Distressing call/incident	46
Bereavement	48
Major incident	32
Difficulty with peers	16
Psychological issues	13
Restructuring	12
Assault	7
Other	12

Of those who accessed LINC between April 1 2013 and March 31 2014 2% were BME staff and 57% female; 100% stated they were not disabled; of those who were prepared to say (72% of total) 93% were heterosexual and 7% were gay; of those who were prepared to say (55% of total), 48% stated that they had a religion with the majority (90%) stating Christianity and the rest Islam. On average 28 LINC workers completely their monthly returns (32%), a figure the service is aiming to improve.

Leavers

46 LINC Workers have left the network in total since it began, most due to resignation from the Trust. 10 LINC Workers stepped down from the LINC network in 2013 and 8 in 2012.

The Staff Counselling Service

The London Ambulance Service currently employs six external Counsellors, who provide six sessions of therapy for our staff from their private therapy practices.

The Staff Counselling Service is well utilised. We have improved ease of access to it over the past year, with a specific referral telephone line, direct referral email address and improved, safe and efficient communication templates between the Staff Support Team and the Counsellors.

LINC Workers play a vital role in ensuring those people that need additional support in the form of counselling are referred. In fact, 41% of counselling referrals came via a LINC Worker between April 1 2013 and March 31 2014.

After analysing the statistics and feedback from the Counselling referral forms and client monitoring forms, we changed them to ensure we captured more information and were in a better position to analyse trends and identify areas of need in the process. The new ‘start of therapy’ and ‘end of therapy’ forms have been in use for six months now and feedback is positive.

Client Monitoring Statistics

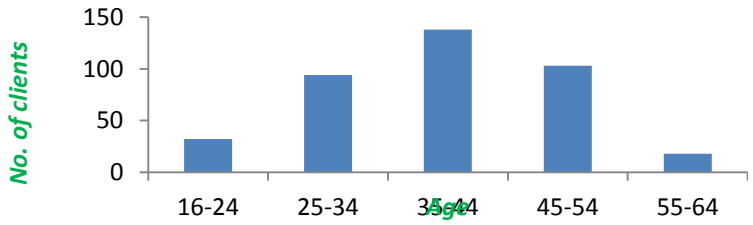
The following is a breakdown of those members of staff referred for Counselling between April 1 2013 and March 31 2014.

Gender

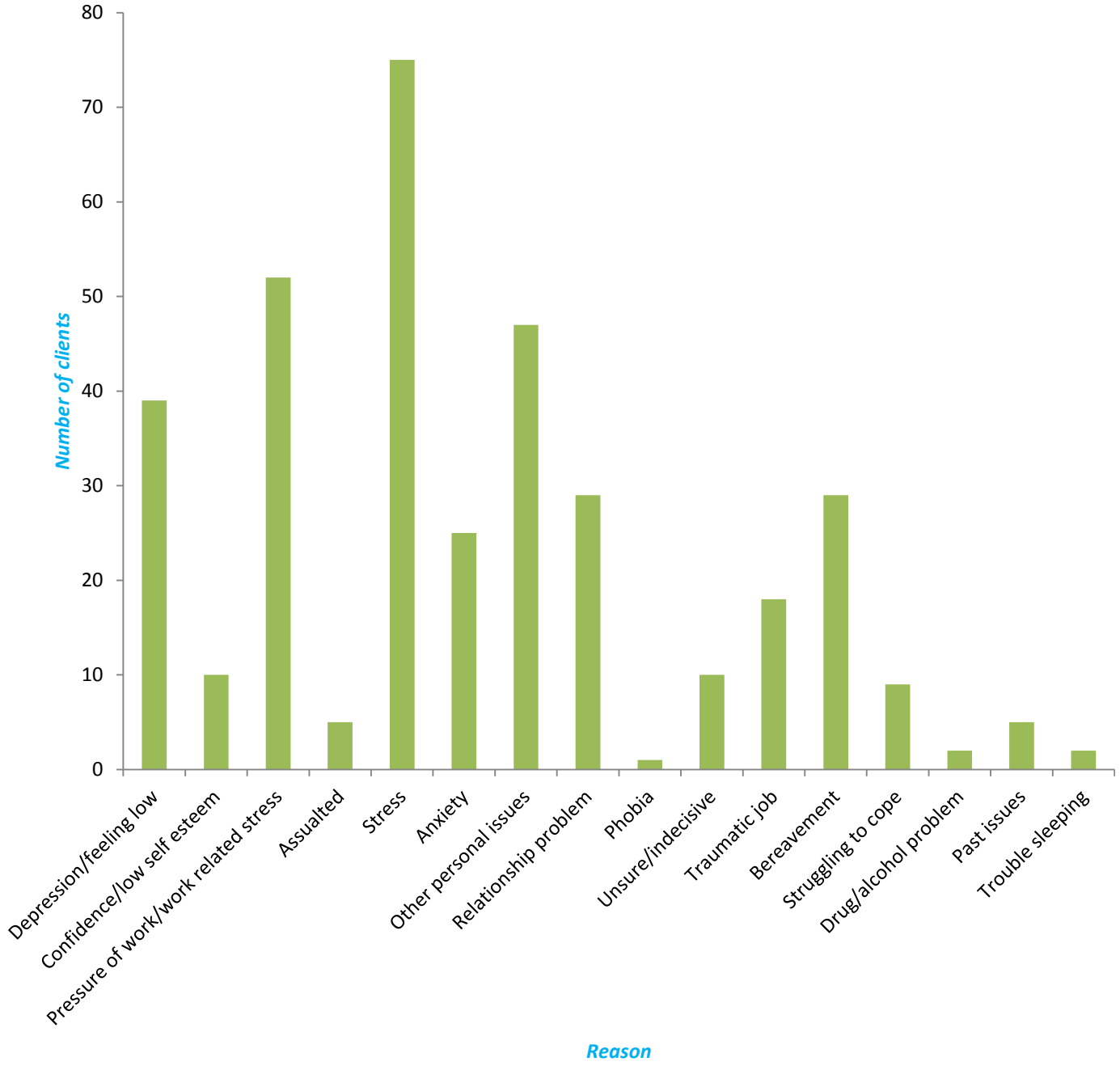
- 69% of clients referred for Counselling were women.
- There are no statistics available to assess whether this figure is in line with the norm in London or the UK

Age

Although it is difficult to be accurate as the Trust age ranges for monitoring are different, as the table below shows, the data does appear to reflect the Trust as whole. The staff survey shows 23.1% of staff between 21-30, 31.7% of staff between 31-40 and 28.6% between 41-50. This is also consistent with the 2013-14 workforce profile, which shows representation between 21-30 to be 21.29%, 31 – 40 to be 28.06% and 41 – 50 to be 31.37%.

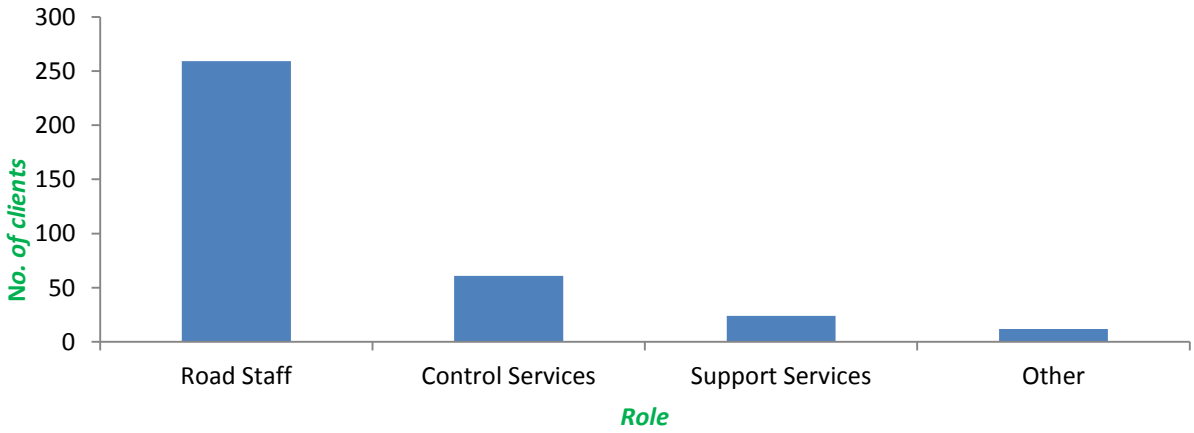


Reason for Counselling



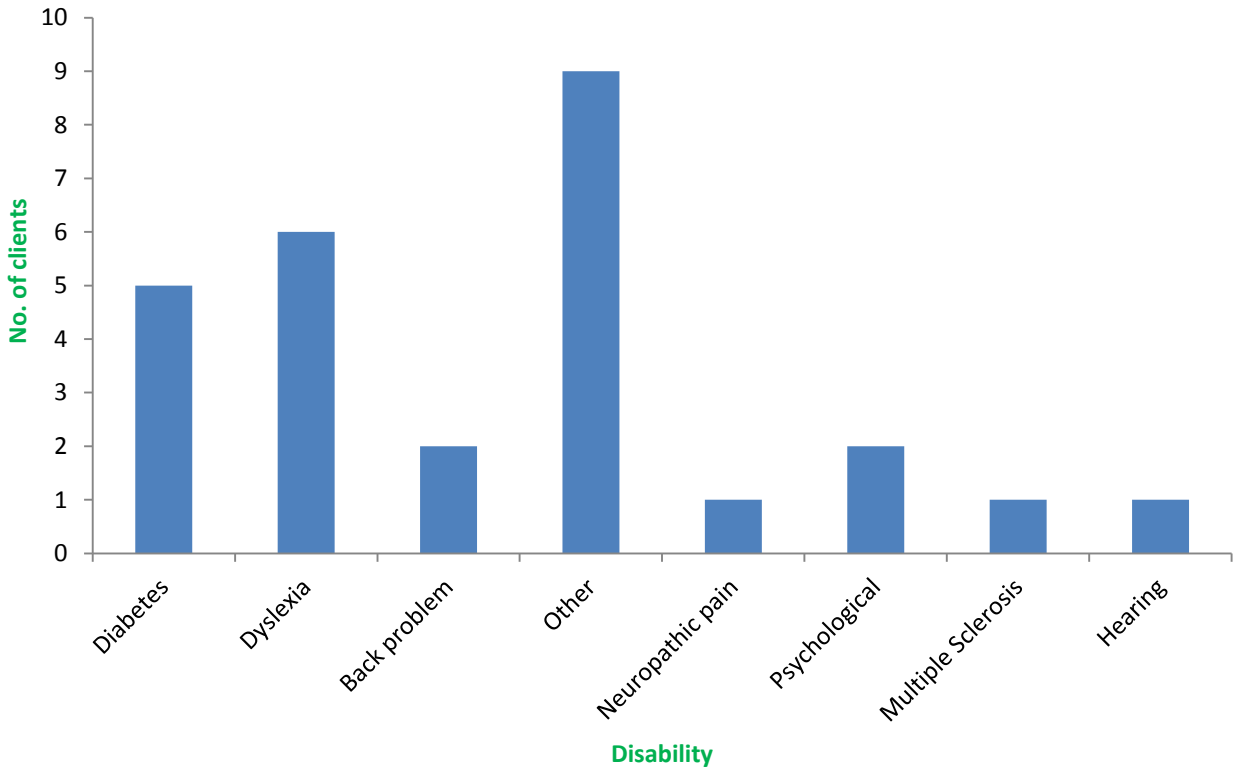
- These results reflect the information gathered from LINC returns, which show the most common reasons for staff to access a LINC Worker to be cumulative stress and relationship problems.
- They also indicate that 34% of clients accessed counselling as a result of stress. 1% of those were from a BME group and 60 % were female.

Where do the clients work?



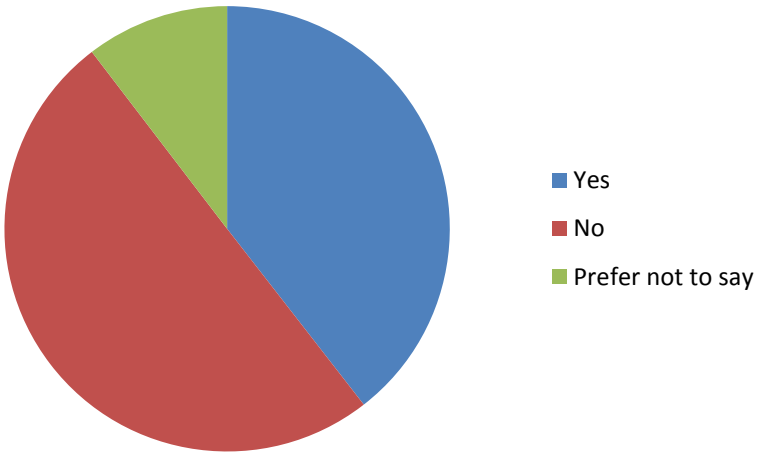
- 92% of the Clients work full time, the rest part time.
- This is reflective of the workforce as a whole (86.8% of all staff are full-time with 13.2% part-time)

Types of Disability

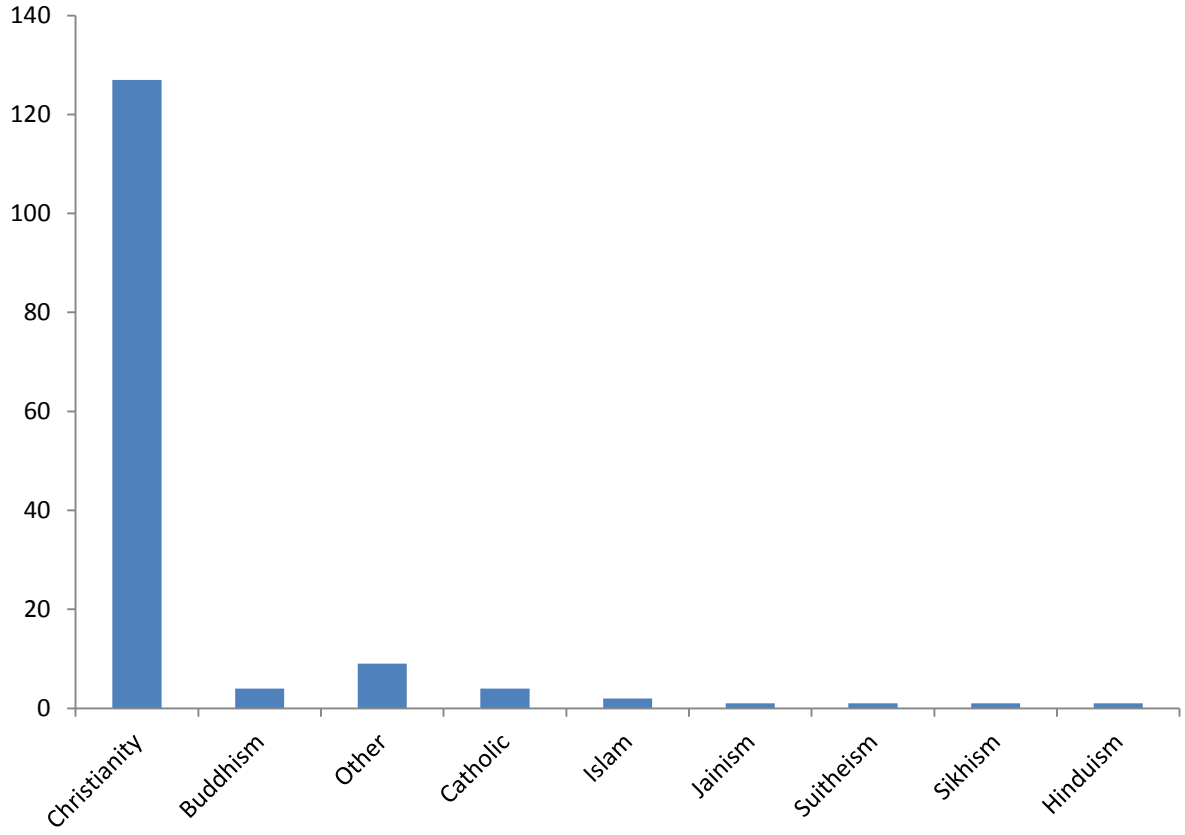


Religion or belief?

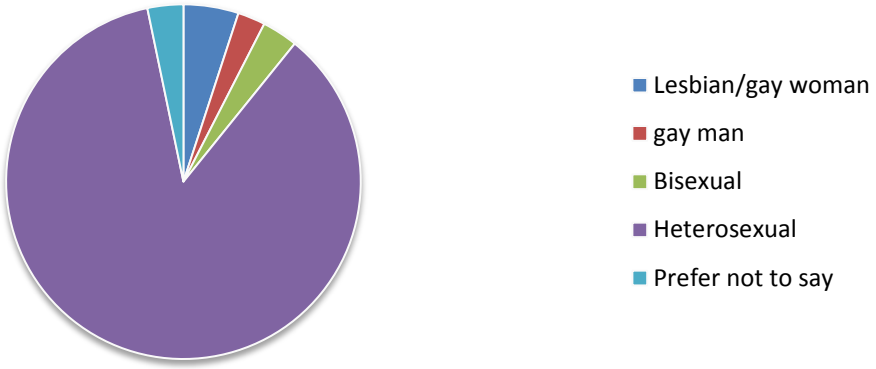
39% of the clients who responded to the client monitoring form, stated that they had a religion. A further breakdown of their religious beliefs is available below.



Type of Religion

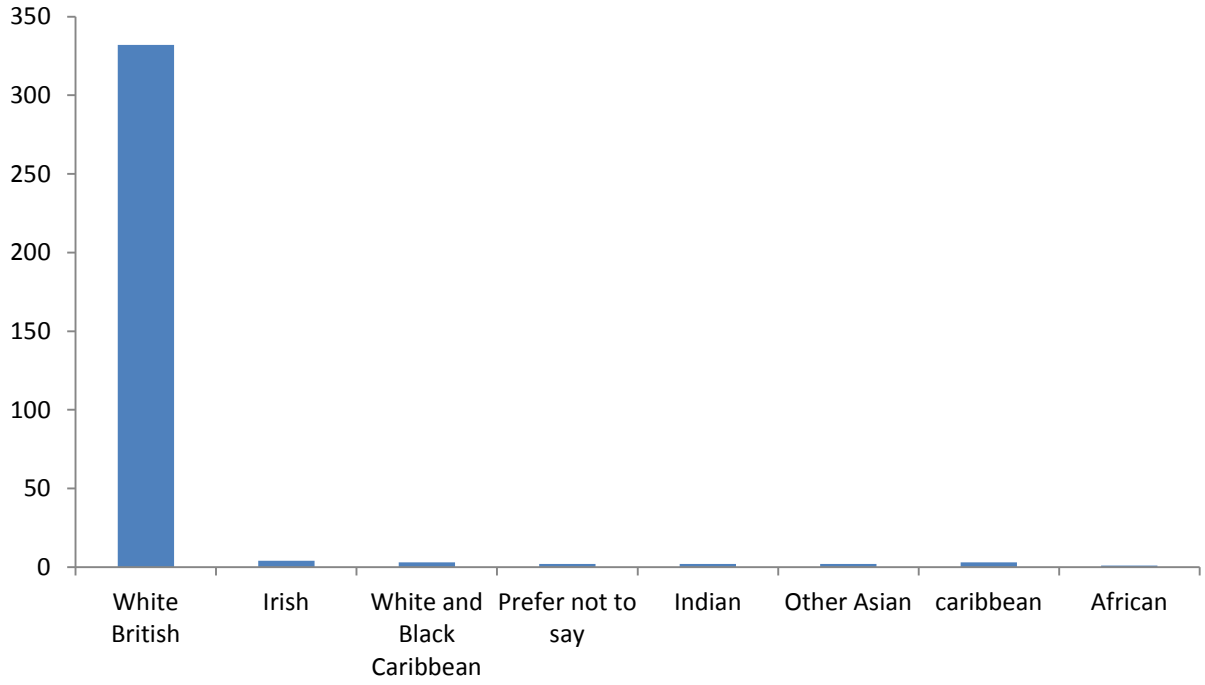


Sexual Orientation



- 100% of the clients answered no to the question ‘are you planning, undergoing or (having) undergone a process (or part of a process) of gender reassignment?’

Ethnic Origin



- Over 99% of the clients describe themselves as White British

- This is substantially higher than the staff profile as a whole – 10.6% of LAS staff describe themselves as BME

Actions for the Future

- We are taking steps to improve the LINC 'returns' process to ensure we increase the amount we receive in order to be able to monitor trends and predict future needs/problems. We are currently trialling a new process via Survey Monkey which is proving to be a success.
- There is currently a significant lack of public information and statistics detailing those who access Counselling, in the workplace or otherwise. As a result comparisons between the LAS client profile and those of other organisations cannot be drawn. Perhaps doing this as an annual exercise will highlight trends, most importantly in what needs staff have and what brings them to Counselling. As information becomes more available in the public domain, with the drive towards evidencing Counselling results, we will strive to keep up with this trend and can begin to draw comparisons and learn from them.
- We have four LINC forums planned for this year, to enable enhanced communication within the network , training and information sharing and problem solving
- We are in the process of recruiting new LINC Workers and will run two four day LINC Worker training courses in October of this year with the aim of having approximately 30 newly trained LINC workers by the end of the year
- As the Trust's workforce as a whole gets younger, we aim to reflect that change by encouraging younger members of staff to apply for and join the LINC network. This has been achieved so far via word of mouth and next year we will have the opportunity to see if the network has changed to be more in line with the age profile of the trust as a whole.
- We are working towards enhancing LINC Workers involvement in the general wellbeing of staff and encouraging staff to take a more proactive approach to their

own mental, emotional and physical health. We are achieving this through sharing of Wellbeing information in the monthly LINC Lowdown. We are also training LINC Workers, new staff and Management in recognising stress and managing symptoms.

- We have changed our client monitoring forms to enhance the information we capture and to compare more easily with the LAS Annual Equality report and will re-evaluate the change after it has been in place for one year.

6.16.LEARNING & DEVELOPMENT

LEARNING & ORGANISATION DEVELOPMENT INTIATIVES 2013-14

Participants

In 2013/14 there were 331 applicants for the open programme courses (shown immediately below) which were either facilitated or administered by the Learning and Organisation Development Team, L&OD; of these 25 applicants cancelled of their own accord (7.5%).

HR Suite -

- Recruitment & Selection – 2 courses ran; 17 delegates attended, 6 delegates cancelled

Microsoft IT Courses -

34 courses ran;73 delegates attended,1 delegate cancelled;

- Excel 2007 Levels 1-3: 14 courses ran; 30 delegates attended, 0 delegates cancelled
- Word 2007 Levels 1-2: 6 courses ran;16 delegates attended, 0 delegates cancelled
- Visio 2007 Levels 1-2: 2 courses ran;1 delegate attended, 0 delegates cancelled

- Outlook 2007 Levels 1-2: 2 courses ran;12 delegates attended,0 delegates cancelled
- Project 2007 Levels 1-2: 4 courses ran; 4 delegates attended, 0 delegates cancelled
- PowerPoint 2007 Levels1-2: 4 courses ran; 6 delegates attended, 0 delegates cancelled
- Access 2007 Level 1: 1 course ran, 1 delegate cancelled
- Managing Your Time with Outlook 2010: 1 course ran; 3 delegates attended

Equality & Inclusion for Managers & Staff:

- 1 Managers' session ran;10 delegates attended, 1 delegate cancelled
- 1 Staff session ran; 8 delegates attended, 0 delegates cancelled

Managing Safety & Risk for Managers:

- 6 sessions ran; 32 delegates attended, 5 delegates cancelled. 8 courses were cancelled

Fire Marshall Awareness:

- 7 sessions ran; 38 delegates attended, 6 delegates cancelled. 6 courses were cancelled

All in One Refresher:

- 4 sessions ran; 25 delegates attended,1 delegate cancelled

PDR Training:

- 11 courses ran;103 delegates attended, 5 delegates cancelled. 3 courses were rescheduled

In response to course and participant cancellations, key stakeholders were sent regular attendance and cancellation information. L&OD records identified all cancellations and the associated rationale and actions.

Dimension	2013-14	2013-14%	2012-13	2012-13 actual

				numbers
Classes Offered	83	100	148	100%
Classes cancelled	17	20%	28 (only 9 of which were L&OD courses)	18.9 % (of which 6.1% were L&D courses)
No. who applied for training	331	100%	608	100%
Attendance	306	92%	339	100%
Women attending	165	54%	276	50.6%
Men attending	141	46%		
Known BME attending	Not available	Not available	87	16%
Known Bands 1 – 4	60	19%	n/a	n/a
Known Bands 5 – 9	246	81%	n/a	n/a
Known Disability*	Not available	Not available	n/a	n/a

Summary of Support Given to Students with Specific Learning Needs (2013-14)

Screening Undertaken	
No of students with previous diagnosis of Dyslexia / Special Learning Needs	1
British Dyslexia Association Adult Checklist completed	4
LADS+ screening tool completed	4
LADS+ Low probability identified	2
LADS+ Moderate probability identified	2
LADS+ High probability identified	0
Support Given in Training Centre	
Study / Revision advice given	4
Extra times in Exams	n/a
Reader provided in exams	n/a
Scribe provided in exams	n/a
Handouts given prior to any theory session	n/a
Exams and handouts printed on coloured paper	n/a

Referral to Educational Psychologist	0

As fewer courses have been delivered over the past year, there have been less referrals for dyslexia screening. However, everyone who was screened and assessed was given comprehensive advice about studying and sitting exams.
Of those screened, only one student was actually on a paramedic course. As she was assessed as low probability, no special measures were put in place and she was subsequently advised on how to study effectively. We have also been seeing more Trust staff on an 'informal' basis, who are often simply curious as to whether they display any dyslexia traits. However, as no tangible support has been provided for these staff members, they have not been included in the statistics outlined above.

Updated Equality and Inclusion Training for Operational Staff

Equality and Inclusion training provided for operational staff was overhauled to include areas of updated practice. This is now available to all new entrants to an operational role. A programme of support ensured the trainers were able to facilitate the session which has now been successfully delivered to a number of courses throughout the year.
The session was designed by Training Officer Craig Noler in collaboration with training colleagues who deliver our diversity training, alongside members of the equality and inclusion team. It utilises an interactive workbook, which asks the student to follow a fictitious member of operational staff as they experience a day in the life of an ambulance crew member, when viewed from an equality and inclusion perspective.
The student explores some of their own attitudes, behaviours and strategies around equality and inclusion, especially around bullying and harassment, while they are encouraged to access legislation and guidance from the service's intranet, thus signposting them for the future. This process is supported by the facilitator, and it

additionally refers to systems such as staff support and e-learning via LASlive. The aim in developing this session was that it would be pertinent to the role and that it equipped the student with the skills and confidence to not only challenge and support behaviour as necessary, but also to be able to access support as required.

Future Plans

In recognition of current difficulties associated with the capture of equalities monitoring information, work is progressing in the further introduction of the Oracle Learning Management (OLM) system within the Department. This represents a significant Trust development, with wide-ranging benefits expected from establishing a centralised learning management provision which is integrated within the Electronic Staff Record (ESR).

The department's aim is to utilise the reporting mechanisms within OLM to produce a detailed analysis of staff attendances on Clinical Education & Standards programmes, which reflect the nine protected characteristics. Although this project has been further delayed by staffing issues during 2013, the Department plans to further integrate OLM over the coming months and achieve full Equality reporting by late 2014.

It is anticipated that this will be achieved by undertaking a comprehensive review of all Departmental processes and associated staffing levels. We plan to utilise the forthcoming Departmental restructure for such purposes, thereby creating the necessary capacity to utilise OLM to its maximum benefit.

7. CONCLUSION

Over the year 2013-14 much progress has been made by the Trust both in regard to enhancing the care it provides to its patients and service users as well as in improving its policies and employment practices. The Trust again gained a place in the Top 100 Employers of the 2014 Stonewall Workplace Equality Index, coming 19th, in a highly competitive field of private, public sector and government organizations. Although the main focus of the index is to measure improvement in regard to LGB people, the benchmarking also provides general external scrutiny of

the Trust's policy and procedure to ensure that it is providing its services, organizing its engagement and decision making and enhancing its employment and training in a way which is accessible, welcoming and inclusive of all protected characteristic groups. The Trust also attained fifth place in the Stonewall Health Equality Index and in both indexes was the leading ambulance service in the country. A whole range of exciting initiatives aimed at improving the Trust's performance in its have been taking place and have been outlined above

8. RECOMMENDATIONS

To ensure that the Trust continues to be proactive in its approach on equality and inclusion, it is recommended that the ensuing actions from the priorities set out in the update of the Trust's Equality and Inclusion Strategy form the template for future equality and inclusion work, including the implementation of the Trust's equality objectives, in accordance with the Equality Act 2010 and national Equality Delivery System.