NHS Greater Glasgow and Clyde
Equality Impact Assessment Tool for Frontline Patient Services

Equality Impact Assessment is a legal requirement and may be used as evidence for referred cases regarding legislative compliance issues. Please refer to the EQIA Guidance Document while completing this form. Please note that prior to starting an EQIA all Lead Reviewers are required to attend a Lead Reviewer training session. Please contact CITAdminTeam@ggc.scot.nhs.uk for further details or call 0141 2014817.

Name of Current Service/Service Development/Service Redesign:

Older Peoples Beds

Please tick box to indicate if this is a : Current Service ☐ Service Development ☐ Service Redesign x☐

Description of the service & rationale for selection for EQIA: (Please state if this is part of a Board-wide service or is locally determined).

What does the service do?
Provides NHS Care for Older people

Why was this service selected for EQIA? Where does it link to Development Plan priorities? (if no link, please provide evidence of proportionality, relevance, potential legal risk etc.)
This work is subject to Rehabilitation and Assessment (RAD)templates aimed at bed reduction to meet population needs – all RAD Project Initiation Documents (PID) templates identify either no or positive impact on age and/or social class/socioeconomic issues. This EQIA is to ensure this planned reduction causes no disadvantage and where possible does address aspects of age discrimination and socioeconomic disadvantage.
It is assumed that the national NHS Continuing Care Guidance has been impact assessed
This reduction is planned against and to meet population need
Patient data will be reviewed to ensure there is no admission bias
Patient discharge data will be reviewed to ensure no subsequent care bias post discharge

Who is the lead reviewer and where are they based? (Please note the lead reviewer must be someone in a position to authorise any actions identified as a result of the EQIA)

Jan Whyte, Planning Manager

Please list the staff involved in carrying out this EQIA
(where non-NHS staff are involved e.g. third sector reps or patients, please record their organisation or reason for inclusion):

General Managers from all 3 RAD sectors took these plans to their local joint planning groups – most of these groups have CHP/CHCP members as well as local authority reps and PPF and PFPI representatives in attendance – therefore there has been wide representation involved,

	Lead Reviewer Questions	*Example of Evidence Required*	**Service Evidence Provided (please use additional sheet where required)**	**Additional Requirements**
1.	**What equalities information is routinely collected from people using the service? Are there any barriers to collecting this data?**	***Age, Sex, Race, Sexual Orientation, Disability, Gender Reassignment, Faith, Socio-economic status data collected on service users to. Can be used to analyse DNAs, access issues etc.***	Basic demographics specifically age, sex and postcode is collected on all inpatient admissions via the SMR 1 process Socioeconomic, Race and Gender reassignment data is not collected	Admissions data from the last 6 months to be reviewed and analysed to establish the ratio of admissions and readmissions by sex/gender
2.	**Can you provide evidence of how the equalities information you collect is used and give details of any changes that have taken place as a result?**	***A Smoke Free service reviewed service user data and realised that there was limited participation of men. Further engagement was undertaken and a gender-focused promotion designed.***	the data will be reviewed to ensure that there has been no impact on equalities groups of the service changes	
3.	**Have you applied any learning from research about the experience of equality groups with regard to removing potential barriers? This may be work previously carried out in the service.**	***Cancer services used information from patient experience research and a cancer literature review to improve access and remove potential barriers from the patient pathway.***	Service developments for older people and their carers have focussed on developments in communities and own homes as evidence shows that prolonged lengths of stay in hospital are not advantageous. As identified by the Joint Future report and all subsequent reports. Staff are aware of Gender Based Violence Policy and the potential impact on service users .Training and procedures are in place around Vulnerable Adults. Best practice in Dementia training available for staff and plans for new dementia ward being developed	
4.	**Can you give details of how you have engaged with equality groups**	***Patient satisfaction surveys have been used to make changes to***	Better together provides division wide and ward level data on service	

	to get a better understanding of needs?	*service provision.*	satisfaction, engagement process on service change such as Stobhill / GRI , Lightburn and Blawarthill involves older people and a wide range of stakeholders. Community engagement and SHC collect equalities data on those involved in the change	
5.	If your service has a specific Health Improvement role, how have you made changes to ensure services take account of experience of inequality?	*A service for teenage mothers includes referral options to smoking cessation clinics. The clinics are able to provide crèche facilities and advice on employability or income maximisation.*	LTC Money Advice Service in place in Glasgow hospitals with financial inclusion services providing 'in-reach' to stroke wards as part of a wider LTC approach across stroke, heart and resp. Service offers immediate information/advice and a follow up on discharge or referral on to local financial inclusion service as required.	
6.	Is your service physically accessible to everyone? Are there potential barriers that need to be addressed?	*An outpatient clinic has installed loop systems and trained staff on their use. In addition, a review of signage has been undertaken with clearer directional information now provided.*	EQIAs have been conducted on inpatient, day hospital and outpatient settings and no physical barriers identified. All services have developed to be able to allow access to all who could use these services and have addressed a range of barriers to services for people with physical and mental disabilities.	Specific pilot work planned to provide an environment more suited for people with cognitive impairment
7.	How does the service ensure the way it communicates with service users removes any potential barriers?	*A podiatry service has reviewed all written information and included prompts for receiving information in other languages or formats. The service has reviewed its process for booking interpreters and has briefed all staff on NHSGGC's Interpreting Protocol.*	Staff are aware of the interpreting service , of advocacy services and core pieces of information are being reviewed to ensure it complies with the accessible information policy. Individual patient histories will support identification and assessment of service users communication needs)	

8.	Equality groups may experience barriers when trying to access services. The Equality Act 2010 places a legal duty on Public bodies to evidence how these barriers are removed. What specifically has happened to ensure the needs of equality groups have been taken into consideration in relation to:			
(a)	Sex	*A sexual health hub reviewed sex disaggregated data and realised that very few young men were attending clinics. They have launched a local promotion targeting young men and will be testing sex-specific sessions.*	Separate bed areas are available for patients of different genders	
(b)	Gender Reassignment	*An inpatient receiving ward has held briefing sessions with staff using the NHSGGC Transgender Policy. Staff are now aware of legal protection and appropriate approaches to delivering inpatient care including use of language and technical aspects of recording patient information.*	Staff are aware of the policy	
(c)	Age	*A urology clinic analysed their sex specific data and realised that young men represented a significant number of DNAs. Text message reminders were used to prompt attendance and appointment letters highlighted potential clinical complications of*	The services provided are needs led but predominantly for older people and average age on admission is over 80 Inpatient stays are supported by all NHSGGC policies and procedures for older people. All patient input is provided to meet personal need on	

		non-attendance.	an individual patient basis as required. Raising the profile of engaging with carers is ongoing.	
(d)	Ethnicity	*An outpatient clinic reviewed its ethnicity data capture and realised that it was not providing information in other languages. It provided a prompt on all information for patients to request copies in other languages. The clinic also realised that it was dependant on friends and family interpreting and reviewed use of interpreting services to ensure this was provided for all appropriate appointments.*	The service is part of the acute divisions plans to collect more comprehensive ethnicity data . Members of staff are aware of the NHSGGC Interpreting Protocol and services etc and of cultural issues in relation to care of the elderly	
(e)	Sexual Orientation	*A community service reviewed its information forms and realised that it asked whether someone was single or 'married'. This was amended to take civil partnerships into account. Staff were briefed on appropriate language and the risk of making assumptions about sexual orientation in service provision. Training was also provided on dealing with homophobic incidents.*	No specific issues highlighted There is awareness of the need particularly with an older client group that the zero tolerance approaches to homophobia and inclusion of same sex partners in care management where appropriate equally applies to the older population.	
(f)	Disability	*A receptionist reported he wasn't confident when dealing with deaf people coming into the service. A review was undertaken and a loop system put in place. At the same time a review of interpreting arrangements was made using*	physically frail with auditory, visual and cognitive impairment and services have additional supports and policies in place to address these needs e.g. Falls prevention, MUST nutritional tools, dementia awareness. Care of the elderly	

		NHSGGC's Interpreting Protocol to ensure staff understood how to book BSL interpreters.	requires individual needs assessment processes and responses as required such as accessing BSL support for deaf patients, mobility aids and caregiver information for people with dementias.	
(g)	Faith	*An inpatient ward was briefed on NHSGGC's Spiritual Care Manual and was able to provide more sensitive care for patients with regard to storage of faith-based items (Qurans etc.) and provision for bathing. A quiet room was made available for prayer.*	Wards have the Spiritual care manual and use the chaplaincy service. Each patient is asked about their spiritual care needs and information is given on quiet areas for prayer or reflection as required by patients and their carers	
(h)	Socio – Economic Status	*A staff development day identified negative stereotyping of working class patients by some practitioners characterising them as taking up too much time. Training was organised for all staff on social class discrimination and understanding how the impact this can have on health.*	People from deprived areas are more likely to be admitted to hospital and need greater support on discharge. Person centred Discharge planning in partnership with Social Work Services ensures these needs are met. For Living and Dying Well reporting an analysis of post codes and economic data informed the need for higher levels of services required for the increased population health need in the most deprived areas.	Maintaining a spread of beds will allow better access to people from areas of high deprivation
(i)	Other marginalised groups – Homelessness, prisoners and ex-offenders, ex-service personnel, people with addictions, asylum seekers & refugees, travellers	*A health visiting service adopted a hand-held patient record for travellers to allow continuation of services across various Health Board Areas.*	Homeless people are supported by a specialist team to ensure that they do not have to stay in hospital for a prolonged period due to their social circumstance	There is potential to identify good practice – consideration of a case study on patient pathway when the change has

				been made.
9.	Has the service had to make any cost savings or are any planned? What steps have you taken to ensure this doesn't impact disproportionately on equalities groups?	*Proposed budget savings were analysed using the Equality and Human Rights Budget Fairness Tool. The analysis was recorded and kept on file and potential risk areas raised with senior managers for action.*	Cost savings are targeted and will be linked to efficient and effective use of beds. Beds reductions will be delivered by ensuring that patients are not delayed in hospital. Hospital stays encourage dependence in older people, have associated health risks and for those with cognitive impairment can exacerbate confusion. Ensuring that patients are discharged as soon as they are fit and supported by discharge planning is best practice	This current review is to ensure doesn't impact disproportionately on equalities groups
10.	What does your workforce look like in terms of representation from equality groups e.g. do you have a workforce that reflects the characteristics of those who will use your service?	*Analysis of recruitment shows a drop off between shortlisting, interview and recruitment for equality groups. Training was provided for managers in the service on equality and diversity in recruitment.*	Workforce cannot represent age spread of patient group Staff will be redeployed in accordance with Board policy so no staff will lose their jobs and so that personal circumstances are respected	
11.	What investment has been made for staff to help prevent discrimination and unfair treatment?	*A review of staff KSFs and PDPs showed a small take up of E-learning modules. Staff were given dedicated time to complete on line learning.*	Staff have eksf / pdp and are completing mandatory training as well as additional adult protection training All managers attended equality training.	

If you believe your service is doing something that 'stands out' as an example of good practice – for instance you are routinely collecting patient data on sexual orientation, faith etc. - please use the box below to describe the activity and the benefits this has brought to the service. This information will help others consider opportunities for developments in their own services.

Actions – from the additional requirements boxes completed above, please summarise the actions this service will be taking forward. (This box needs completed)	Date for completion	Who is responsible?(initials)
Cross Cutting Actions – those that will bring general benefit e.g. use of plain English in written materials		
Specific Actions – those that will specifically support protected characteristics e.g. hold staff briefing sessions on the Transgender Policy		

Ongoing 6 Monthly Review Please write your 6 monthly EQIA review date:

Review admission and discharge data by gender before reduction and after reduction

Lead Reviewer: Name Jan Whyte
EQIA Sign Off: Job Title Planning Manager RAD
Signature
Date 14TH June

Quality Assurance Sign Off: Name Alastair Low
Job Title Planning Manger
Signature
Date 23rd January 2012

Please email a copy of the completed EQIA form to EQIA@ggc.scot.nhs.uk, Corporate Inequalities Team, NHS Greater Glasgow and Clyde, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, G12 0XH. Tel: 0141-201-4560. The completed EQIA will be subject to a Quality Assurance process and the results returned to the Lead Reviewer within 3 weeks of receipt