

**NHS Greater Glasgow and Clyde  
Equality Impact Assessment  
For Frontline Patient Services**

**GUIDANCE NOTES AND  
EQUALITY IMPACT ASSESSMENT TOOL**

**January 2011**

# **EQUALITY IMPACT ASSESSMENT**

## **1. Introduction**

The aim of this document is to provide members of NHS GG&C staff with the means to carry out Equality Impact Assessment (EQIA) of frontline patient services. In order to do this it contains:

- the reasons why EQIA is necessary
- the importance of EQIA for the health service and why NHS GG&C is committed to it
- an explanation of what EQIA sets out to achieve
- a description of the EQIA process that is being developed within NHS GG&C
- information about the implications of equality categories for health and health care
- a step-by-step guide to undertaking EQIA including the support that is available
- the EQIA tool
- additional useful information.

It is essential to read this entire document before completing the EQIA tool.

## **2. Why is EQIA necessary?**

The existence of equality legislation is a reminder that we do not yet live in a society that protects individuals and groups from discrimination, inequality and prejudice. The distribution of opportunities for good health and quality of life differ between people of different social classes, women and men, white populations and black and ethnic minorities, non-disabled and disabled people, heterosexual and lesbians, gay, bisexual and transgender people and across the life course. Religion also plays a part in denying some people opportunities.

There is a prevailing view that a fair society is one in which everybody is treated the same regardless of circumstances. Whilst superficially attractive, such an approach can mean that many people are actually denied equal access to goods and services. It is important therefore for organisations that are responsible for the provision of services to test out whether these services are able to meet a range of needs, thereby making them accessible and effective for all. Equality impact assessment is one means of doing this.

### **EQUALITY LEGISLATION aims to:**

- **Address unlawful discrimination**
- **Eliminate harassment**
- **Promote equality**
- **Ensure consultation and dialogue with a diverse community**

**Details about equality legislation are available in Appendix 1**

### **3. The importance of EQIA to NHS GG&C**

There is a growing body of evidence that shows the relationship between discrimination and poor health. Further there is evidence that shows that the way the health service is designed and operates means that, unintentionally, it discriminates in favour of those people who:

- have knowledge of the health care system and the confidence and assertiveness to use it;
- can communicate and be communicated with at several levels – i.e. have spoken English as the first language, who are literate and who have no sensory impairments;
- are familiar and comfortable with medical information;
- can travel easily to health care settings or for whom there are no physical barriers to getting into and journeying through our buildings;
- have health problems which fit one diagnostic category;
- have health problems, which are largely unrelated to life circumstances or discrimination as the result of personal identity.

Without a systematic assessment of the extent to which health services explicitly address these issues, there is a considerable risk that some people will not receive the kind of service they require to maximise the chance of a good health outcome. There is a further risk that this will also be unlawful.

NHS GG&C is committed to realising the aims of equality legislation as it recognises its significance in addressing health inequalities overall. In order to meet the requirements of the legislation, a unified Equality Scheme for 2010-13 has been produced (see [www.equality.scot.nhs.uk](http://www.equality.scot.nhs.uk) for more information). This identifies the need for effective scrutiny of policies, plans and service delivery to ensure that negative impacts on equality are identified and addressed using a formal EQIA process. It is however recognised that formal EQIA is only one part of an effective change process.

### **4. What does EQIA set out to achieve and what issues need to be taken into account?**

EQIA sets out to assess any organisational activity – policy, plans, project, service delivery, practice - in order to identify actions that can be taken to improve the ability of the activity to address discrimination and promote equality. A successful EQIA results in change, not just the recommendations for change. In NHS GG&C, the priority focus for testing EQIA has been within frontline patient services.

EQIA requires an explicit consideration of potential negative implications of the equalities categories (referred to in legislation as protected characteristics). These relate to:

- Sex
- Gender Reassignment
- Ethnicity
- Disability
- Sexual orientation
- Religion and belief
- Age
- Socioeconomic status and social class
- Potential additional marginalisation issue including:
  - homelessness
  - asylum seeking or refugee status
  - travelling community
  - prisoners and ex-offenders
  - ex-service personnel

Whilst each of these protected characteristics poses inherent difficulties for individuals, no-one is defined by one form of identity and individuals can often face multiple inequality and discrimination.

## **5. EQIA process that is being carried out in NHS GG&C**

An initial assessment within NHS GG&C showed there was no one complete EQIA tool that met all requirements, due to the complexity of the organisation. As a result, the Corporate Inequalities Team undertook an exercise to pilot and evaluate an EQIA tool and guidance for use with patient services. The pilot was also used to test out a facilitation process using specified facilitators.

As a result of the findings of the pilot, a revised version of the EQIA tool comprises part of this document.

The aims of the NHS GG&C EQIA process are:

- to identify existing good practice
- to identify potential negative impacts for the different protected characteristics
- to agree an action plan for introducing further good practice to address the identified negative impacts.
- To give services an opportunity to 'tell their story' of how actions have been taken to create better services for all

A centralised system for collating completed EQIAs and agreed actions has been put in place and will monitor the application of EQIA across the system to assess relevance and outcomes and distribution of EQIAs. This system is open to all via SharePoint to share learning. A further review will be carried out early in 2012 to ascertain whether further refinements of the tool are

required and the type and extent of ongoing support that needs to be put in place.

## **EQUALITIES CATEGORIES AND THEIR HEALTH AND HEALTH CARE IMPLICATIONS**

### **Sex**

Society has a set of gender expectations of women and men that differ for each sex. Currently, masculine characteristics are more highly valued than feminine characteristics and world-wide, this ascribes more power and wealth to men than to women. This in turn reinforces sets of behaviour, which have significant implications for the pathways into poor health.

Evidence shows that men are more likely to participate in risk-taking behaviour which leads to premature mortality and to use their power to commit acts of violence and abuse which affect themselves and women and children of both sexes. They are also less likely than women to participate in health improvement activity or to present to primary care in the early stages of illness. Where men have experienced abuse in childhood, this experience can manifest itself in a range of health and social problems in both childhood and adulthood but is often not identified as part of medical presentations.

Women still tend to have multiple social roles as employees, as carers and as the primary managers of households. This imposes stresses that can have physical and psychological implications and practical and cultural difficulties in accessing health care. Gender-based violence is an outcome of gender inequality and has a range of potentially severe physical and psychological effects for women, which are often not identified as part of medical presentations and can also affect opportunity and confidence in accessing health care.

In addition, genetic and physiological differences between women and men mean that there are differential pre-dispositions to certain diseases which require careful consideration when planning services to make sure that the needs of one sex or the other are not ignored. Where single sex services exist they need to take account of the impact of gendered behaviours on presenting problems.

### ***Gender Reassignment***

There is little understanding of deviation from the expectations of gender norms - you are born either male or female and subsequently behave like a woman or a man. However, *transgender* people report that their ascribed birth gender is not aligned with the sex they feel they are. Some may seek a gender change by transitioning to a sex that better fits their sense of self. Around 1 in 11,500 people are transgender and there is strong evidence trans people experience increased health risks and discrimination as a result of their transgender status. For more information please see NHS GGC's Transgender Policy at [www.equality.scot.nhs.uk](http://www.equality.scot.nhs.uk).

### ***Ethnicity***

Recent reports and investigations highlight the persistent imbalance of power between the white population, and black and ethnic minority groups. As a result, people from black and ethnic minority groups are often exposed to harassment and discrimination that can lead to differences in opportunities, differences in access to health care, treatment and outcomes and differences in access to health information. This is often invisible to organisations because there is limited monitoring of service use by ethnic group. The experience of racism can result in physical ill health as well as mental health problems but this experience is rarely investigated when people present to health care and therefore its significance is not considered or noted.

Access to health care can be affected by the extent to which services and recipients are able to communicate with each other about what they can offer and what they need. There is also manifest distrust of what are seen as white services by the black and minority ethnic communities.

In addition, genetic and physiological differences between different ethnic groups can pre-dispose some groups and individuals to certain diseases which require careful consideration when planning services to make sure that uptake is maximised. Heart disease and diabetes are examples of this.

### ***Disability***

Disability is often also negatively with a prevailing societal view that disabled people are somehow 'inferior'. Recent findings on disability hate crime show that more than two thirds of disabled people surveyed experienced victimisation in the previous two years, of which nearly a quarter had experienced physical assault. These experiences of inequality and discrimination have a profound affect on physical and psychological health.

Whilst there are many specialist services designed to address specific disabilities, particularly learning disability, access by disabled people to routine health services is often denied to them because their needs have not been taken into account. Disabled people are often invisible to services as there is no routine monitoring of their attendance. Access can also be affected profoundly by geography, mobility and insufficient attempts to communicate with people who do not have written or spoken English or who have literacy and comprehension issues.

People with mental health problems are considered as disabled under legislation and there is significant additional stigma and discrimination against people with mental illness. This can preclude people receiving non-judgemental care when using mainstream health services.

Some forms of disability also predispose individuals to particular health problems, which need to be taken into account when planning population approaches to good health. For instance, high levels of obesity are often experienced by some groups of people with learning disabilities.

### ***Sexual orientation***

Everyone has a sexual orientation, yet some people face discrimination because they are not heterosexual. Homophobic attitudes towards lesbians, gay men, bi-sexual people is still commonplace and like other forms of prejudice can have physical and psychological effects on individuals. This too is rarely identified in the course of presentations to health care. Research with young LGBT people in Glasgow found suicide ideation was 2-3 times higher than for heterosexual young people and the 'Live to Tell' report, 2003, found that 28% of young gay men had at some point deliberately injured themselves compared to only 2% of the general population.

People from the LGBT community often feel that they cannot disclose their sexual orientation for fear of discrimination when accessing health care. There is strong evidence to validate this fear with 40% of LGB people who disclosed their sexual orientation to health professionals reporting negative care experiences. This can affect the options for treatment or interventions offered and can have wider implications for their care and social support. There are a number of reports of same sex-partners not being accepted as next of kin and therefore denied information about partners who are patients. Reports also indicate gay couples are afraid to show emotional support for partners in inpatient care for fear of harassment and bullying.

### ***Religion and belief***

For some people, their religion is important to their health yet often the cultural and practical dimensions of religion are not assessed and taken account of when individuals attend for health care. This can be considered as a form of discrimination, can cause distress and as a result can have a negative impact on the effectiveness of diagnosis and treatment. In the same way that other examples of equality categories often remain invisible to health care organisations and therefore in the way that services are planned, there is lack of data on patients for whom religion is significant to their wellbeing.

In addition, strong views on any particular form of religion can lead to prejudice and discrimination against other beliefs – often referred to as sectarianism. This too can have an impact on the physical and psychological wellbeing of individuals.

There can also be assumptions that everyone has a faith of some description despite of a large percentage of people who consider themselves to be atheist. Any assumptions about faith can lead to experience of discrimination.

### ***Age***

Ageism can be very subtle but is pervasive throughout society: it can affect wellbeing, damage confidence and create exclusion. Throughout the life course, individuals are affected by the age group that they are in. The youngest and oldest groups in society are most likely to suffer discrimination or inequality in access, attitudes or treatment. Assumptions about lifestyle, cognitive ability and effectiveness of treatment are also common. At these two ends of the life course, access to health care is often mediated through others

thus potentially limiting opportunities for individuals to receive the type of health care that is important to them.

Although the age of individuals presenting to health care is collected routinely, this data is rarely disaggregated and used to inform local service planning and day-to-day service delivery issues. The absence of this monitoring can contribute to a lack of consideration of the implications of the needs of a specific age group especially older people.

### ***Socioeconomic status and social class***

There is a gradient of opportunity across social classes and this is reflected in the distribution of poor health. Social class as measured by wealth, income, occupation, status, power and education is central to the experience of inequality and health outcomes.

A key indicator of class inequality is poverty, which can materially and psychologically affect health. Poverty is also distributed differentially across equality categories. Women are more likely to experience poverty than men, even in areas of disadvantage. One in three children in poverty has a disabled parent and the rate of poverty for Pakistani children is 60% compared to 25% amongst white children.

An understanding of the effects of social class on health and its relationship to other forms of inequality is important to the delivery and distribution of health care. People who experience poverty are often blamed and marginalised by society and this is often reflected in people's experience of health services. Poverty can also make accessing health care difficult if due consideration is not paid to basic access requirements like location of buildings.

### ***Potential additional marginalisation***

Some people experience a set of social circumstances, which can add extra difficulties in accessing health care or maximising treatment opportunities. They may also be affected by the attitudes of staff. For people without a permanent address as the result of homelessness or being a member of a travelling community, there are the practical difficulties of communication about appointments and continuation of care. For asylum seekers and refugees, particular issues for services can be addressing severe isolation, health implications of persecution / torture in their own country, language barriers and poverty. For asylum seekers, homelessness may be an issue if application for permanent stay is denied. Due in part to sensationalised media coverage, asylum seekers and refugees are often stigmatised and have to live with the experience of negative attitudes and prejudice. It would be naïve to think these attitudes are not held by some members of NHSGGC staff, and particular attention must be paid to ensure these beliefs do not impact on the consistency of high quality patient care. Particular issues around privacy and confidentiality are key if prisoners or people involved in the criminal justice system use services. In mainstream services, people with substance misuse problems may experience difficulties in having their needs met due to staff attitudes. For all these issues, services need to consider any specific actions arising from 'additional marginalisation'.

## **STEP BY STEP GUIDE TO SUCCESSFUL EQIA OF PATIENT SERVICES**

Effective EQIA of patient services involves consideration of the patient journey in relation to **getting in, getting through and getting out** of the service. Ideally, all three stages should be considered but it is possible to carry out an EQIA on individual component parts of the journey.

### **STEP 1: Identify the service for EQIA**

Following a review of planning arrangements within NHSGGC, it was agreed that EQIAs identified within the organisation should relate directly to appropriate planning priorities. This supports NHSGGC in evidencing relevance and proportionality. This does not exclude EQIAs that have been planned prior to the new set of arrangements or EQIAs that are required as a response to identified need within specific service areas.

The following are a suggested check list when identifying priorities for EQIA:

- Clear links to respective Development Plan priorities
- If a particular service is being redesigned or developed, then it is good practice to start scheduling in a process of EQIA.
- If there is a higher/lower uptake of patients from some groups using the service, it may then be possible to investigate the reasons behind this, for example, the uptake of mental health services by members of BME communities. Statistics show that the uptake is low within this group.
- Evidence that a particular community has a higher incidence of a disease e.g. South Asian communities and diabetes.
- High incidence of complaints associated with a particular group.
- Evidence of perceived discrimination by the service.

### **STEP 2: Identify the Lead Reviewer**

In order to undertake an EQIA it is essential to have a **Lead Reviewer**. This person will be the key contact point for the EQIA and be involved in setting up the necessary infrastructure to support the EQIA process. The Lead Reviewer needs to have overall responsibility for ensuring the service being assessed meets its legislative requirements in terms of equality, and will be in a position to ensure that any actions agreed are sanctioned by the organisation and followed through on. They will also lead on the 6 monthly reviews to identify progress against agreed actions.

### **STEP 3: Seek advice and support, if required.**

Learning and Education will provide quarterly training sessions for Lead Reviewers starting in March 2011. Additional support will be provided through dedicated clinic time from the Corporate Inequalities Team. If support is required before March 2011, additional guidance will be available from the Corporate Inequalities Team (Alastair Low – 0141 2014817). To find out more about the Quarterly Lead Reviewer Training sessions please contact [CITAdminTeam@ggb.scot.nhs.uk](mailto:CITAdminTeam@ggb.scot.nhs.uk).

#### **STEP 4. Decide on who should be involved**

Successful EQIA processes require a number of people to be involved. For a typical NHS service there are several key practitioners involved in the patient journey. For example this could include receptionists, clerical officers, medical records staff, allied health professionals, consultants, practice nurses, service manager etc. For every service, this will be different. All of these staff will have different experiences of patients and thus ideas on how barriers can be identified and removed and equality promoted. Patients or their representatives also bring an essential perspective on how the service is experienced, and therefore should be involved in the discussions if possible. The Lead Reviewer should consult various members of staff about who is appropriate to be involved.

#### **STEP 5. Establish the EQIA group and consider what evidence is available.**

Before the first meeting, participants should have read the Guidance document and be familiar with the EQIA Tool and associated process and the Lead Reviewer should have attended a quarterly training session. The group also need to consider relevant evidence on equalities categories in relation to their service. This should include consideration of local and national information on differential uptakes, morbidity and mortality, and satisfaction rates. Services that have created engagement programmes with patients will find it useful to draw on this to inform the process

<b>See Appendix 2 for weblinks with further good practice information</b>
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#### **STEP 6: Complete the form in draft form**

The EQIA group needs to meet further for at least 2 hours, in order that actions are based on consideration of evidence, current good practice and existing negative impact.

In completing the EQIA tool, please follow the instructions given below:

***Name of Current Service/Service Development/Service Redesign*** – complete the name of the service and tick the appropriate box to indicate if this is a current service, service development or service redesign. You will also be asked to explain why this service/policy etc. has been chosen for EQIA. If this links to a strategic priority as described in a relevant development plan please state this.

***Brief description of the above*** – it is essential before completing the rest of the EQIA tool to identify what aspect of the service is being assessed e.g. Radiotherapy Services in the Beatson Oncology Unit. Please state the purpose of the service and indicate whether the service is regional or local. Please remember that your EQIA may be read by a range of interested partners and that not all of them will be familiar with the service, so clear explanation and avoidance of jargon is essential.

**Who is the lead reviewer and where based?** – it is crucial to identify the lead person for the EQIA process as a contact point for any questions around the impact assessment.

**List those involved in carrying out the EQIA** – for staff, record their staff grouping and for others record whether they are patients, carers or the organisation they represent. Do not record individual's names. A file note of the names and contact addresses of all those involved in the EQIA process should be kept for future involvement in the review processes.

### **The Questions**

You will be asked to consider a range of questions covering equalities issues including those areas listed below. Remember, the EQIA is really a snap shot of what you are doing now. You shouldn't think of this as a test to be passed. Some of the most positive EQIAs will involve staff thinking a bit more deeply about possible barriers and then making formal commitment to address these in the EQIA action plan. Wherever possible, answer the questions with examples of current practice.

- Is **Patient Data** currently collected and disaggregated in relation to the equalities categories? Are there challenges to collecting this data?
- How is patient data used to inform service provision? Do you have any examples of how reviewing patient data has led to changes being made?
- Has any existing research been used to inform the way the service is delivered to people with protected equality characteristics? For instance cancer services may have used the recent NHSGGC research looking at Cancer and Inequalities to change the way some aspects of the service are delivered. This could also include any patient satisfaction surveys that are undertaken or a review of complaints that have been made.
- Do assessments of the **Communication and Language Support** needs of patients take place routinely? Do members of staff know how to book interpreters and if the service provides written information, can it offer this in different formats? Are there loop systems in place?
- Are the health implications of the **experience of inequality, discrimination or marginalisation** taken into account at different points in the patient's journey?
- Are there arrangements in place to address the **practical difficulties** of inequality or marginalisation?
- Is the experience of inequality, discrimination or marginalisation **recorded in the patient's notes**?

- Are **referrals** made systematically to appropriate agencies to provide support in relation to inequality, discrimination or marginalisation?
- Is there a programme of **learning and education for staff** to improve knowledge and practice in relation to inequalities categories?

Wherever possible services are asked to provide examples of practice to evidence how potential barriers have been removed. It is intended that examples illustrating good practice will be made available on NHSGG&C's equality in health website ([www.equality.scot.nhs.uk](http://www.equality.scot.nhs.uk)) and on an appropriate good practice repository on SharePoint.

### ***Impact assessment – Additional Requirements***

The next part of the form requires an assessment of additional requirements. This relates firstly, to gaps in practice and secondly, to remaining 'negative impacts'. Assessment of 'additional requirements' is not straightforward and requires consideration of the overall ways in which the service might be treating individuals or groups less favourably than others. This includes where there is likelihood that some individuals or groups are potentially denied a service because their needs are not made explicit or where the actions of the service reinforce inequality, discrimination or marginalisation.

One example of negative impact would be when epidemiological evidence shows that a specific group or community carries the burden of a specific health problem yet they are under-represented in the uptake of appropriate services. Another example would be when patients raise issues of discrimination such as racism as being important for their health and this is ignored by staff. The information on 'Equalities Categories' (Pages 5-8) provides further examples. Appendix 2 provides key web links for those wishing to explore further examples.

### ***Impact assessment – Actions***

This section of the EQIA form is based on the gaps between 'Evidence Provided' and 'Additional Requirements' and requires a set of actions to be identified. Actions need to be allocated both a date for completion and a person responsible for taking the action forward.

This section is split into two separate parts:

- **Cross cutting actions:** actions which address identified barriers for all or most equality categories/additional marginalisation – for instance review of patient information in terms of plain English will provide benefits for a range of patients/service users, as would a review of opening times.
- **Specific actions:** actions, which are specific to particular equality categories or additional marginalisation.

These actions will then form the focus of ongoing 6 monthly review processes. It is important to note that change will be incremental over time and that not everything should be attempted within the first year.

### **STEP 7 Complete the final version of the form and secure agreement for actions**

This step allows for review and reflection on the form by the EQIA Group and others if necessary. The Lead Reviewer should request feedback and finalise the form on the basis of the comments before re-circulating.

The Lead Reviewer is required to secure agreement for a programme of implementation of recommended actions from senior management.

**Signing off the document** - the Lead Reviewer should sign and date the form and write down the date of the 6 month review date. Where required by internal governance, the form may be signed off by an appropriate director or representative of a governance committee.

### **STEP 8 – Return the completed form for quality Assurance**

The completed form should then be submitted to the Corporate Inequalities Team Administration ([CITAdminTeam@ggc.scot.nhs.uk](mailto:CITAdminTeam@ggc.scot.nhs.uk)) where it will be quality assured by a rotating pool of trained reviewers. This process should take no longer than 2 weeks from time of receipt. The quality assuring officer will either approve the EQIA for publishing and so send the Lead Reviewer confirmation, or highlight additional issues to be considered and return the original tool with a Quality Assurance report for amendment. Once complete this should be returned to the above address for checking and publishing.

All completed forms will be published on the NHSGG&C Equality and Health website ([www.equality.scot.nhs.uk](http://www.equality.scot.nhs.uk)) in line with legislative responsibilities and will also be available on SharePoint.

### **STEP 9**

As your 6 monthly review date draws closer the Lead Reviewer will be sent a reminder to complete the update and return to the above e-mail address.

### **STEP 8 – Implementation of recommended actions and review after six months**

A six month review is crucial to assess the extent to which the implementation plan is on track and to do this the EQIA Group should be reconvened, progress considered and noted on the six month review form.

The specific tool for 6 monthly reviews is available on NHSGG&C Equality Diversity website ([www.equality.scot.nhs.uk](http://www.equality.scot.nhs.uk)). However, a copy of the tool with a prompt will be forwarded to Lead Reviewers in advance of the expected return date.

**END**

This documentation has been produced as the result of the work of EQIA Review Group, comprising representatives of the Corporate Inequalities Team, Learning and Education and Acute Services



	<b>Lead Reviewer Questions</b>	<b>Example of Evidence Required</b>	<b>Service Evidence Provided (please use additional sheet where required)</b>	<b>Additional Requirements</b>
1.	<b>What equalities information is routinely collected from people using the service? Are there any barriers to collecting this data?</b>	<i>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.</i>		
2.	<b>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?</b>	<i>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.</i>		
3.	<b>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.</b>	<i>Cancer services used information from patient experience research and a cancer literature review to improve access and remove potential barriers from the patient pathway.</i>		
4.	<b>Can you give details of how you have engaged with equality groups to get a better understanding of needs?</b>	<i>Patient satisfaction surveys have been used to make changes to service provision.</i>		
5.	<b>If your service has a specific Health Improvement role, how have you made changes to ensure services</b>	<i>A service for teenage mothers includes referral options to smoking cessation clinics. The clinics are</i>		

	take account of experience of inequality?	<i>able to provide crèche facilities and advice on employability or income maximisation.</i>		
6.	Is your service physically accessible to everyone? Are there potential barriers that need to be addressed?	<i>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.</i>		
7.	How does the service ensure the way it communicates with service users removes any potential barriers?	<i>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.</i>		
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	<i>A sexual health hub reviewed sex</i>		

		<i>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.</i>		
(b)	<b>Gender Reassignment</b>	<i>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.</i>		
(c)	<b>Age</b>	<i>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 non-attendance.</i>		
(d)	<b>Ethnicity</b>	<i>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</i>		

		<i>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.</i>		
(e)	<b>Sexual Orientation</b>	<i>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.</i>		
(f)	<b>Disability</b>	<i>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 NHSGGC's Interpreting Protocol to ensure staff understood how to book BSL interpreters.</i>		

(g)	Faith	<i>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.</i>		
(h)	Socio – Economic Status	<i>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.</i>		
(i)	Other marginalised groups – Homelessness, prisoners and ex-offenders, ex-service personnel, people with addictions, asylum seekers & refugees, travellers	<i>A health visiting service adopted a hand-held patient record for travellers to allow continuation of services across various Health Board Areas.</i>		
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?	<i>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.</i>		

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?	<i>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.</i>		
11.	What investment has been made for staff to help prevent discrimination and unfair treatment?	<i>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.</i>		

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.

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**Actions – from the additional requirements boxes completed above, please summarise the actions this service will be taking forward.**

	<b>Date for completion</b>	<b>Who is responsible?(initials)</b>
<b>Cross Cutting Actions – those that will bring general benefit e.g. use of plain English in written materials</b>		
<b>Specific Actions – those that will specifically support protected characteristics e.g. hold staff briefing sessions on the Transgender Policy</b>		

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

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Lead Reviewer:  
EQIA Sign Off:

Name  
Job Title  
Signature  
Date

Quality Assurance Sign Off:

Name  
Job Title  
Signature  
Date

Please email a copy of the completed EQIA form to [CITAdminTeam@ggc.scot.nhs.uk](mailto:CITAdminTeam@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.

## Appendix 1: Requirements from equality legislation

The body of legislation on Race (Race Equality Duty), Disability (Disability Equality Duty) and Gender (Gender Equality Duty) has identified both General and Specific Duties with which public organisations have to comply.

The **General Duties** for all three areas of legislation lay down that public bodies require to have 'due regard' to the need to eliminate unlawful discrimination and harassment and to promote equality of opportunity. The RR(A) also includes a duty to 'promote good relations between persons of different racial groups'. In the Disability Equality Duty (DED) this duty is to 'promote equality of opportunity between disabled people and other people'. The DED further includes a duty to:

- promote positive attitudes towards disabled people;
- encourage participation by disabled people in public life;
- take steps to meet disabled peoples' needs, even if this requires more favourable treatment.

The **Specific Duties** apply to major public bodies primarily and are designed to set out the steps that should be taken in meeting the General Duty, the key requirements of which are:

- The development of a specific Equality Scheme in relation to each aspect of inequality.
- Consultation with stakeholders and employees in drawing up the equality schemes for race and gender. In relation to disability, the legislation is considerably stronger, requiring the active involvement of disabled people in drawing up the Equality Scheme.
- Publication of the equality schemes and associated action plans.
- Publication of how the organisation will assess the impact of its policies and practices for equality across the three areas and the outcomes of these.
- Monitoring of progress and production of annual reports.
- Review of each scheme every three years.
- Monitoring of employment procedures and practices. In relation to gender, a policy on developing equal pay arrangements between women and men must be developed and published.
- One of the provisions of the **Equality Act 2006** is the merger of the three existing commissions i.e. the Commission for Race Equality, the Disability Rights Commission and the Equal Opportunities Commission. In 2007, they became one body – the Equality and Human Rights Commission – which has responsibility for assessing the extent to which organisations have fulfilled their legislative duties.

There is also new legislation on sexual orientation. The Equality Act (Sexual Orientation) Regulations 2007 protects individuals from direct or indirect discrimination on grounds of sexual orientation, in provision of goods,

facilities, services, education, disposal and management of premises and exercise of public functions. There is also European legislation on age and religion and belief discrimination in employment.

The **Equality Act 2010** is currently out for consultation in terms of what Public Sector Duties may include. Until this has been clarified, arrangements as per the Equality Act 2006 remain in place.

## **Appendix 2: Good practice websites**

The following websites are very good for key information around good practice around equalities issues.

- NHSGG&C Equality and Health website ([www.equality.scot.nhs.uk](http://www.equality.scot.nhs.uk)) will provide key information on each of the different equality categories, the key health issues related to equality categories and good practice examples from NHSGG&C and beyond.

The website has links to NHSGG&C Equality Scheme; all Equality Scheme action plans and the annual monitoring report; NHSGG&C Equality Impact Assessment Guidance, Tools and Evaluation report.

- The Equality and Human Rights Commission ([www.equalityhumanrights.com](http://www.equalityhumanrights.com)) is the governing body for equalities legislation implementation. NHSGG&C has to provide annual reports to the Commission on its implementation of its Equality Scheme.

The website includes legislative and good practice information on the rights of workers and service users and responsibilities of public sector employers.

- The Scottish Government Equality Unit website (<http://www.scotland.gov.uk/Topics/People/Equality>) provides information on the national context for action on equalities issues and provides many national statistics about equality strands in relation to government activities.

- The UK Government Equality Website ([www.equalities.gov.uk](http://www.equalities.gov.uk)) provides information on non-devolved, UK-wide legislative considerations.

- The Scottish Human Rights Commission ([www.scottishhumanrights.com](http://www.scottishhumanrights.com)) provides information relating to human rights legislation. While an EQIA will not necessarily consider full human rights implications, there will often be overlap between the requirements laid down by equality legislation and Human Rights Articles.

**Appendix 3  
Sample Completed Tool**

**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](mailto:CITAdminTeam@ggc.scot.nhs.uk) for further details or call 0141 2014817.

**Name of Current Service/Service Development/Service Redesign:**

Physiotherapy Outpatient Services South Glasgow Sector

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

**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?**

Outpatient physiotherapy services operate from 2 community sites based in South Glasgow. The service runs on a self-referral drop-in bases (first come first served) between 10am and 12pm and 2pm and 4pm with later opening on Thursday evening till 7pm. The service is open to anyone and delivers one-to-one sessions of approximately 40 minutes per patient where initial diagnosis checks take place and depending on the outcome, will offer further referrals or self-help fact sheets/exercises. Both sites use a main consultation room with curtain partitioned rooms.

**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.)**

The service has been operational now for 4 years and in that time has not been subject to any review. It was felt appropriate that an EQIA should be undertaken at this time in advance of a wider review of community-based services as detailed in the Glasgow CHP Development Plan.

**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)**

Bill Murray – Head of Community Services

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):

3 FT staff-grade physiotherapists, 1 Receptionist – staff attended from both community venues.

	<b>Lead Reviewer Questions</b>	<b>Example of Evidence Required</b>	<b>Service Evidence Provided (please use additional sheet where required)</b>	<b>Additional Requirements</b>
1.	<b>What equalities information is routinely collected from people using the service? Are there any barriers to collecting this data?</b>	<i>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.</i>	The service collects patient information on age, gender and disability routinely.	Requirement to expand minimum data collection for protected characteristics.
2.	<b>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?</b>	<i>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.</i>	Patient data is not currently analysed to any extent.	Time needs to be set aside to review patient data collected to date to identify any user patterns or gaps in service delivery/patient groups accessing the service.
3.	<b>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</b>	<i>Cancer services used information from patient experience research and a cancer literature review to improve access and remove potential barriers from the patient</i>	When the service was originally designed an extensive literature review was undertaken to identify best practice in relation to accessing community-based services. This	None

	<b>in the service.</b>	<b>pathway.</b>	information was sensitised to take account of potential barriers experienced by patients from Equality groups (as was).	
4.	<b>Can you give details of how you have engaged with equality groups to get a better understanding of needs?</b>	<b><i>Patient satisfaction surveys have been used to make changes to service provision.</i></b>	<p>In 2008 we enlisted the help of the local development worker to raise the profile of the service within the local BME population. Staff had previously stated that numbers coming through appeared to be small given the location of the service.</p> <p>We regularly review the patient satisfaction slips, though there are no identifiers on the forms so we are unsure what comments relate to specific protected characteristics. As a result of the suggestions though we have managed to acquire larger chairs with better support, a range of information leaflets for the waiting area and an evening drop in clinic on Thursdays.</p>	<p>We'll need to support this work with evidence of attendances. We will expand the patient data capture so we have robust figures to review attendances.</p> <p>We will add further details to the satisfaction forms to allow us to investigate trends by equality group/protected characteristic.</p>
5.	<b>If your service has a specific Health Improvement role, how have you made changes to ensure services take account of experience of inequality?</b>	<b><i>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.</i></b>	The service's main focus is better back care through awareness and understanding. We ensure that all our health literature is available in a range of languages and large print. We have extended opening hours	None

			as per patient feedback and as we have no fixed appointments are flexible in terms of timing. We are aware that back care and back issues may be dependant on a number of factors –manual work, diet, age etc and make sure that every consultation asks about causal factors sensitively.	
6.	<b>Is your service physically accessible to everyone? Are there potential barriers that need to be addressed?</b>	<b><i>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.</i></b>	The services are on the first floor of both buildings but there are lifts from the ground floor. The front door is accessible from the car parks via a ramp. The reception area and both treatment rooms have loop systems and there is clear signage throughout the building. There are two accessible toilets on site, both clearly designated. Patients are given a numbered ticket on arrival. When ready, the number is displayed on a screen and a tanoy announcement made.	The front door to the building isn't automatic and is quite heavy to open. People coming to the South Street Clinic by public transport need to get off the bus around a quarter of a mile away. This does create problems for some people. We need to make service users aware of this.
7.	<b>How does the service ensure the way it communicates with service users removes any potential barriers?</b>	<b><i>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</i></b>	All members of staff use plain English when talking with patients and avoid clinical jargon. Written information is in plain English and available in other languages and formats. Exercise sheets use pictorial representations rather than	Because we are a drop-in service it's impossible to arrange appointments with interpreters. Normally people who don't have English as a first language bring

		<i>Interpreting Protocol.</i>	text.	relatives or friends to interpret. See ethnicity field for additional actions
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	<i>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.</i>	We record the gender of patients coming to both drop-ins. Both sites have a mix of male and female staff so patients can chose if they feel more comfortable with a male or female treating them. In the past all conversations happened in the curtained bays but we have created a quiet room on both sites following sensitive disclosures made by patients. At the time it was inappropriate to continue the discussions and staff asked patients if they would like to move to one of the offices to chat. In this way we have been able to provide a listening ear, help and support to	We don't analyse data and need to set aside time to do this. We think that there are more female patients coming into the service than male though men seem to require more onward referrals. We need to be more proactive about offering the choice of male or female workers to the patients. We also had a couple of disclosures of abuse by female patients last year (see age box also) when

			<p>women who have experienced violence including signposting women to the Routes out of Prostitution serve.</p> <p>Treatment bays are partitioned by curtains to protect a patient's privacy while undergoing therapy.</p>	<p>staff enquired about the cause of their discomfort. We need to get a copy of the NHSGGC Gender Based Violence Plan and circulate to staff to make sure staff know what to do. We think there may be training available which we will follow up organise further discussions through departmental meetings.</p>
(b)	<b>Gender Reassignment</b>	<p><b><i>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.</i></b></p>	<p>We have worked with transgender patients in the past. We don't have any specific protocols in place and this has been a learning curve for us. However, talking to trans patients about the how they want to be addressed and any things we needed to know to help with their care meant staff are comfortable and confident. After our first trans patient, a couple of colleagues asked if they could come to the Transgender Support Group at the Sandyford. The questions and answers have led to us being far more confident about recording patient details etc.</p>	<p>We need to get a copy of the NHSGGC Transgender Plan and circulate to staff. It might be worth having a session with the team on this.</p>

(c)	Age	<p><b><i>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 non-attendance.</i></b></p>	<p>A large number of people we see are older. We realised that some members of staff were treating older people in a fairly stereotyped way – talking loudly though there was no reported hearing issue and making other assumptions about the context of their lives (see sexual orientation). We had a session with the staff last year around ensuring dignity and respect which included working with older people. We know that there may be some mobility issues associated with older age – particularly with older women suffering from osteoporosis. We have developed a range of materials covering this available in plain English and large print and have clear referral routes into other services. We have a number older men who complain about back problems that may be linked to prostate issues and again have been able to support referrals into other services.</p> <p>We have been involved in some cases of 'elder abuse' through sensitively enquiring about causal</p>	<p>We need to take some time out to look at the patient data in terms of age and access. There may be implications for the upcoming service review.</p>
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			<p>issues. This has led to multi-disciplinary/agency working to protect the individual in question. We are hopeful that a service-wide protocol will be in place by August 2012 and are using our service experience to help inform this document.</p> <p>We collect patient information on age.</p>	
(d)	<b>Ethnicity</b>	<p><b><i>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.</i></b></p>	<p>We have done some development work with the local BME population to raise the profile of the service. This included providing leaflets in other languages in community centres, local shops and places of worship. Following the promotion we did observe an initial increase in numbers attending but this created some difficulties in terms of interpreting during patient discussions. Normally a friend or member of the family would accompany them to interpret, but this meant both people having to wait up to an hour and a half before being seen.</p>	<p>We have recently circulated the NHSGGC Interpreting Protocol to staff but this has raised issue about using interpreting services in what is an unplanned drop in service. We have committed to look at the possibility of getting a language line account set up so we are not reliant on friends and family members. Staff have been issued with language identifier cards so will know what language to book in</p>

				advance of the discussions.
(e)	<b>Sexual Orientation</b>	<i>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.</i>	Members of the team on both sites attended a dignity and respect course and are aware of not making assumptions about sexual orientation. This was partly because we received a complaint from a patient about an assumption made relating to the sex of his partner. It can be easy when working with an older patient group to make assumptions but team members now use the term 'partner' whenever discussing relationship status. This taught us quite a bit about other assumptions we may make when discussing issues with patients.	We don't collect sexual orientation data & need to consider this as part of the overall data review process.
(f)	<b>Disability</b>	<i>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 NHSGGC's Interpreting Protocol to ensure staff understood how to book BSL interpreters.</i>	The building is fully accessible and there are induction loops in reception and treatment areas.  We often work with people with Learning Disability and their carers who may accompany them. Through training, we know to always talk directly to the individual and not the carer.	Possible issues with South Street front door.

			<p>We have had experience of working with deaf patients on one of our sites, though they have taken a friend to sign for them. As above we make sure we talk to the patient directly during any discussions.</p> <p>We haven't had any blind people use either site, but are aware of the Assistance Dog Policy. We can provide some information in audio format though this is limited to one leaflet on back care only.</p>	
(g)	Faith	<p><b><i>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.</i></b></p>	<p>Most of our work does not require an individual to remove clothing and the gender mix of staff means that people can ask for either a male or female therapist. We don't have a prayer room as such, but as patients might be required to wait for some time to be seen, we have made the quiet rooms available for prayer if required.</p> <p>Being in a high BME area, we were aware that some members of staff were making assumptions about people's faith – mainly assuming that BME people attending were</p>	<p>We don't record faith and need to review this as part of a wider patient data collection review.</p>

			<p>Muslim. On a couple of occasions patients had corrected staff who asked about difficulties attending the Mosque. We now ask if the issue is impacting on any aspect of social life or other community activities they may be involved with.</p>	
(h)	<b>Socio – Economic Status</b>	<p><b><i>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.</i></b></p>	<p>Both sites are in areas of multiple deprivation, with high rates of poverty and associated poor health. Many of the people we see will have other co-morbidity issues that relate to the stress of every day life and we spend additional time asking about other services they are attending or might want to be supported to attend.</p> <p>We ask all patients if they are eligible for refunds for travel expenses to the clinic and can ensure out of pocket expenses are covered. A member of staff from each site attended an income maximisation workshop and has briefed other team members on discussing these issues with patients. Often patients will be entitled to home aids that would help with their condition but are</p>	<p>We have patient post-codes on the patient notes but haven't analysed them as a group to see where the bulk of our users are coming from.</p>

			unaware of how to access these supports.	
(i)	<b>Other marginalised groups – Homelessness, prisoners and ex-offenders, ex-service personnel, people with addictions, asylum seekers &amp; refugees, travellers</b>	<b><i>A health visiting service adopted a hand-held patient record for travellers to allow continuation of services across various Health Board Areas.</i></b>	We have worked with travellers in the past and were able to provide self-help information to take away and also details of services in other health board areas. We are not aware of any asylum seekers or refugees accessing the service. We have had experience of people with addiction issues using the service. Sometimes the addiction issue has stemmed from pain management of the condition and we are able to work with the client regarding both the physiotherapy element and options for addictions support. As mentioned earlier we have worked with women involved in prostitution and there tends to be an addiction issue apparent in those cases. We have also worked with some ex-service personnel who have required physiotherapy for recurring injury treatment. This has also crossed over in one case to working	We need to make sure that we have links with asylum seekers and refugee agencies so the service is promoted to this group.

			with homeless support agencies and supporting referral to a local addictions service.	
9.	<b>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?</b>	<i>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.</i>	As part of the pending review, the option of moving to one single site as an efficiency saving will be discussed. We will review service data and apply the budget fairness tool to inform any decision. We will also undertake a range of community engagement activities to gain a sense of community views.	Ensure that through re-design, a new service will not disproportionately disadvantage anyone with a protected characteristic.
10.	<b>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?</b>	<i>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.</i>	Our staffing group on both sites is comprised of four therapists (total of 8) of which 5 are female and 3 male. This is quite unusual as physiotherapy tends to have a mainly female workforce. We have a range of ages of staff but despite our location in a high BME area we do not have any BME workers. We hope that through working with the community, people may thin of physiotherapy as a possible career option in the future.	None
11.	<b>What investment has been made for staff to help prevent discrimination and unfair treatment?</b>	<i>A review of staff KSFs and PDPs showed a small take up of E-learning modules. Staff were given</i>	Both staff teams have attended Equality and Diversity training and a range of other patient-centred	Investigate GBV training for teams and create time for staff to discuss the

		<b><i>dedicated time to complete on line learning.</i></b>	service sessions. We have embarked on a rota of completing the appropriate e-learning modules. Staff are also encouraged to meet with community groups to explain the service and gain a better insight into user needs.	Transgender Policy.
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**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.**

In applying the EQIA we realised that many of the aspects of our working routine appear to go beyond what some might describe as standard or routine delivery. We take time with patients to make sure that their needs are being met. Creating a safe quiet space for sensitive discussions has meant staff are less frustrated at having to avoid certain issues. We actively encourage staff to engage with community groups and have learnt much from this in terms of better understanding patient needs or simply reassuring staff that we’re doing the right thing. We have worked hard to make sure we are aware of other services that might be able to provide support and help to vulnerable patients, be it Routes out of Prostitution, the Thrive counselling service for male survivors of sexual abuse or income maximisation services. To this end we see ourselves as an integrated service within a wider patient/person journey rather than an isolated stand alone service.

We do need to review things like our data collection systems and hope to further enhance patient experience through a more robust system in future.

**Actions – from the additional requirements boxes completed above, please summarise the actions this service will be taking forward.**

	<b>Date for completion</b>	<b>Who is responsible?(initials)</b>
<p><b>Cross Cutting Actions – those that will bring general benefit e.g. use of plain English in written materials</b></p> <p><b>Review of data capture option for all protected characteristics</b>  <b>Access the Budget Fairness tool and start process for application</b>  <b>Amend Patient Satisfaction Slips in line with data capture review</b>  <b>Draw up community engagement action plan as part of the review process</b></p> <p><b>Make sure all promotion material for the clinic highlight public transport access routes and potential issue with South Street distance from bus stop.</b></p>	<p>February 2010  March 2010  March 2010  February 2010    October 2009</p>	<p>Bill Murray  Bill Murray  Anne Slessor  Anne Slessor    Alex Right</p>
<p><b>Specific Actions – those that will specifically support protected characteristics e.g. hold staff briefing sessions on the Transgender Policy</b></p> <p><b>Contact Facilities Team regarding front door issues at South Street.</b>  <b>Circulate Gender Based Plan to teams and organise a team session to discuss implications</b>  <b>Identify appropriate training – Liaise with local GBV Lead</b></p> <p><b>Circulate a copy of the Transgender Policy to teams and session (combine with GBV meeting)</b>  <b>Establish opportunities for using Language Line in the clinics – Bill to speak to Jac Ross corporate lead for communication</b>  <b>Make connections with Asylum Seeker and Refugee Team to promote the service</b></p>	<p>September 2009  September 2009  September 2009    September 2009  November 2009    February 2010</p>	<p>Anne Slessor  Alex Right  Alex Right    Alex Right  Bill Murray    Bill Murray</p>

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

February 2010

Lead Reviewer:	Name	Bill Murray
EQIA Sign Off:	Job Title	Head of Community Services
	Signature	
	Date	21 <sup>st</sup> August 2009

Quality Assurance Sign Off:	Name
	Job Title
	Signature
	Date

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