TACKLING INEQUALITY
POLICY FRAMEWORK UPDATE

1 INTRODUCTION

1.1 It is NHS Greater Glasgow and Clyde’s core business to:

a) remove discrimination caused by social class, gender, disability, race, sexual orientation, age and faith;
b) tackle health inequality (the health gap) caused by social class, gender, disability, race, sexual orientation, age and faith;
c) respond effectively to the needs of marginalised groups such as homeless people.

1.2 In order to achieve this, we need to establish an Inequalities Sensitive Health Service (ISHS), the elements of which are defined by the 10 goals Framework.

2 NATIONAL CONTEXT

2.1 Since the Policy Framework was written the new Equality Act has come into force on the 1st October 2010. The overarching aim of the Act is to restate, simplify and, where appropriate, harmonise the various different pieces of equality legislation that have been produced over the last 40 years. It replaces current legislation, including the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, the Disability Discrimination Act 1995 and a number of sets of Regulations.

2.2 The Equality Act 2010 consolidates the 3 existing public sector equality duties into a new single equality duty. This new single duty covers the following protected characteristics; race, sex, disability, sexual orientation, religion and belief, age, gender reassignment and pregnancy and maternity. Our Equality Scheme 2010-13 was written to accommodate the Equality Act 2010 and since 2006 we have produced a single equality scheme. In addition we have included social class into our Equality Scheme as a way in which people experience discrimination and to reflect the social patterning of ill health in the NHSGGC area.

3 NHSGGC PLANNING CONTEXT

3.1 There is no change to the Policy Framework which should still be used as a planning guide. However since the Tackling Inequality Policy Framework was written the Corporate Inequalities Team have worked with the system to develop explicit actions which will ensure that we deliver the outcomes in the 2010-13 Equality Scheme as well as actions relating to reduce the Health Gap and address discrimination against marginalised groups.

3.2 The actions for 2012/13 are appended.
4 PROGRESS TO DATE

4.1 Key achievements over the course of 2011 are:

- Improvements in ethnicity monitoring
- All staff have been made aware of the Equality Scheme and their legal responsibilities
- HR Equality Monitoring Reports produced and made available on the staff intranet
- 72 frontline services have been subject to EQIA and subsequent improvement plans
- Equalities website traffic has increased by 65% in the past year. In February 2011 there were 2432 visits and 1836 unique visitors
- We have a core data set of measures for which can be disaggregated by SIMD.
- NHSGGC has been selected as a partner organisation to work with Stonewall Scotland's Good Practice Programme over the coming year to deliver 5 priority actions on sexual orientation. The 5 priority areas are - data collection, EQIA, staff awareness, service users engagement and staff engagement.
- A set of e-learning modules on the protected characteristics and marginalised groups has been developed to increase staff capacity on tackling inequality
- A range of work on employability and financial inclusion has been delivered locally to reduce the health gap between the richest and poorest

5 FURTHER PROGRESS REQUIRED

5.1 Some challenges remain in relation to the delivering the Equality Scheme Action Plan, most notably in ensuring that:

- Patient information in relation to all protected characteristics is collected and made available,
- Local EQIA programmes adequately assess areas of potential legal risk
- Significant new programmes relating to access are non-discriminatory
- Individual members of staff are adequately assessed for awareness of their legal responsibilities
- Revised interpreting service is delivered effectively and efficiently
- The workforce is representative of the diverse population served by NHSGGC

5.2 Significant challenges remain in tackling the Health Gap as inequalities continue to widen between the richest and the poorest. The impact of the recession, welfare reform and reduced public sector budgets is likely to make this worse over the coming years. The impact on patients could manifest in services particularly primary care and mental health.

5.2.1 Discrimination also widens the health gap. For example the How Fair is Britain report \(^1\) showed that:

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• Low qualified British men with disabilities have seen their chances of working halved, from 77% to 38% from the 1970s to the 2000s
• Women aged 40 earn on average 27% less than men of the same age
• Disabled men experience a pay gap of 11% compared with non-disabled men, and disabled women experience a 31% pay penalty compared to non-disabled men

5.2.2 It is more important than ever that each part of the system and key service areas tackle the health gap by:

• Monitoring the health gap through routine reporting of disaggregated data on SIMD
• Showing evidence in development plans that this data has been used to plan services in a way which will reduce the gap
• Ensuring that EQIAs identify issues under ‘Social Class’ and take action to reduce social class discrimination in services
• Taking steps to tackle the inverse care law

5.3 Marginalised groups have been included into this Policy framework to ensure that we address the health needs of those who are vulnerable and have very poor health but are not covered by the Equality Legislation.

5.3.1 The groups we would like to highlight for focus for 2012 – 13 are as follow:

• People with literacy issues. Their needs to be specifically met through the application of the Accessible Information Policy.
• Asylum Seekers and Refugees. Their needs to be specifically met through application of the Interpreting Policy and inclusion in any programme of work addressing racism.
• Gypsy Travellers. The population profile of gypsy travellers to be included in any area population profiles and best practice gleaned from the Equally Well test site to be rolled out where appropriate.
• Ex-offenders and prisoners. Ex-offenders and prisoners to be specifically included in any financial inclusion programmes and in health improvement programmes.

5.3.2. The CIT will establish a specific work programme for the 2013 – 16 Policy Framework with regard to the addressing the needs of marginalised groups, establishing a profile of health need and population across all groups.

6. FINANCIAL AND WORKFORCE IMPLICATIONS

6.1 In line with the EHRCs Fair Financial Decision Making Guidance all cost saving decisions have been subject to a process to ascertain any systematic reduction in service for those with protected characteristics. This is a substantial body of work to ensure that any cost savings decisions that we make are fair and equitably applied. In

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2 “Those in greatest need often have access to the least health care”- Julian Tudor Hart, The Lancet, 1971.
the current financial climate this will continue to be the case. Any reduction in staff to non filling of posts should also be subject to this process to ensure that any depletion of service due to staff reduction do not unduly affect those with protected characteristics.

7 OWNERSHIP OF THE FRAMEWORK

7.1 The Policy Framework is led by The Corporate Inequalities Team in consultation with all CH(C)Ps, MHP and Acute Division.

7.2 The Tackling Inequality Policy Framework is relevant to all Planning Frameworks; however the following Planning Frameworks are seen as a priority with regard to its application as they are co-terminus with a protected characteristics group.

- The Mental Health Planning Framework
- The Disability, LTC, Older Peoples’ Planning Framework
- Child and Maternal Health Planning Framework
- Primary Care

Robert Calderwood
Chief Executive
NHS Greater Glasgow and Clyde
10 July 2012
**UPDATED OUTCOMES TEMPLATE**

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<tr>
<th>REVISED OUTCOMES</th>
<th>ESSENTIAL ACTIONS</th>
<th>PERFORMANCE MEASURES</th>
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<tr>
<td>a) Tackling Discrimination- Equality Scheme Actions</td>
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<tr>
<td>Goal 1: All planning processes explicitly use disaggregated data.</td>
<td>- Show evidence of the use of available data on race, gender, disability, age, sexual orientation, social class, faith to meet the needs of inequality groups.</td>
<td>- Number of EQIAs for health improvement and service redesign. - Number of leaflets produced in accessible formats. - Number of staff trained in equality and diversity. - Increase in collection of ethnicity data. - Increase in numbers of services using Inequalities Sensitive Practice including sensitive enquiry for gender based violence.</td>
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<td>Goal 2: Each part of NHSGGC demonstrates that equality groups are part of all public and patient involvement activity.</td>
<td>- Audit PPF activity and develop plans to increase equality group engagement.</td>
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<td>Goal 3: Each part of NHSGGC can demonstrate how health improvement Framework priorities are tailored to meet needs of equality groups.</td>
<td>- Show evidence of EQIA of Health Improvement programmes.</td>
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<td>Goal 4: Each Partnership has risk management systems that prevent unlawful discrimination. Evidence from DNAs by equality groups is used to improve access to targeted services.</td>
<td>- Continue commitment to review risk management to prevent unlawful activity. - DNA data to reflect protected characteristics and SIMD where possible.</td>
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| There is evidence of innovative solutions to address the challenges of disabled people in using services | - A plan to disseminate examples of good practice is in place.  
- A plan is in place to communicate interpreting protocols to staff.  
- A process for monitoring and reporting demand is in place.  
- A process for monitoring use of new accessible information in priority settings is in place.  
- A plan for ensuring routine assessment of communication and language support needs of all patients in place.  
- EQIAs plan produced and implemented. |
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<tr>
<td>Each part of NHSGGC demonstrates compliance with interpreting protocols and how demand will be met on an annual basis.</td>
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<td>There is evidence of an increase in information in accessible formats.</td>
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<td>Service plans resulting from new planning and policy arrangements clearly demonstrate how they will promote equality and remove discrimination using EQIA where appropriate.</td>
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<td>Goal 5:</td>
<td>- Mental Health, Addictions, Children’s services will implement training and plans on GBV across selected services.</td>
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<td>Each part of NHSGGC can demonstrate an increase in the number of services using inequalities sensitive inquiry in GBV and inequalities sensitive practice.</td>
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<td>Goal 6:</td>
<td>- Evidence in Financial Plan that cost savings have been EQIAed to prevent potentially unlawful decisions.</td>
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<td>All cost saving financial planning decision are subject to EQIA.</td>
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<th>Goal 8:</th>
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<td>Evidence is provided of how system is meeting the Learning and Education Plan and targets.</td>
<td>- Agree numbers and staff to be trained. Record staff attendance at training on equality issues. Set targets for staff completing appropriate e learning modules.&lt;br&gt;- Include staff training on inequality issues where appropriate.&lt;br&gt;- Include the promotion of positive attitudes to equality groups in communications and make examples of good practice available for the equalities website.</td>
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<td>Each part of the system can demonstrate implementation of a plan to promote positive attitudes to equality groups.</td>
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<th>Goal 9:</th>
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<td>Action to support engagement with the social economy sector has increased local employment and training opportunities for equality groups.</td>
<td>- Ensure local procurement increases social benefit and eliminates discrimination.</td>
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<td>Partnership activity with income inequality, e.g., referral pathways on financial inclusion and employability increased.</td>
<td>- Plans to implement Policy Framework on Employability, Financial Inclusion and Responding to the recession in place.</td>
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### b) ADDRESSING THE GAP

| Each part of the system has measured the health gap and taken steps to reduce it. | Disaggregated data on socio-economic status is used to measure the gap and the gradient in health outcomes. This data is used to develop plans on reducing the gap. Build on current resource allocation models for CH(C)Ps to align need and resources through developing appropriately resourced services in line with patient need (addressing the inverse care law) Design health improvement objectives to make a contribution to closing the gap Performance indicators on closing the gap will be embedded in to all major programmes of work Ensure that EQIAs identify issues under ‘Social Class’ and take action to reduce social class discrimination in services | - Increase in the collection of disaggregated data by socio-economic status - Reduction in number of DNAs in lower socio-economic groups - Further reallocation of resources in favour of deprived areas - Focus resources n deprived areas - Number of referrals to employability and financial inclusion advice and outcomes - Reporting on recession indicators - Reporting on indicators - Evidence of the health gap is presented in planning frameworks and development plans - Progress on HEAT targets in reducing the health outcome gap - Evidence of planning based on data disaggregated by SIMD |
c) MARGINALISED GROUPS

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<tr>
<th>Activity</th>
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<tr>
<td>Apply the Accessible Information Policy specifically to those with literacy issues</td>
<td>- Uploaded resources on AIP electronic directory</td>
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<td>Apply the Interpreting Policy to Asylum Seekers and refugees specifically</td>
<td>- Interpreting uptake per area</td>
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<td>Establish the population profile of gypsy travellers in each area</td>
<td>- Qualitative analysis of Asylum Seekers / Refugees experience</td>
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