**EQUALITIES IN THE BUDGETING PROCESSES**

<table>
<thead>
<tr>
<th>Q</th>
<th>How were equalities issues taken into consideration in allocating budgets in 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The budgeting process in Tayside principally operates on an incremental basis. The Finance &amp; Resources Committee, which is a Standing Committee of NHS Tayside, consider issues in relation to Equality and Diversity through the range of detailed business plans and business cases that are presented to them for approval during the course of a financial year. If, after scrutiny and challenge by the Committee, they are approved, the financial implications are built into the financial planning assumptions for future years. Some business cases will require ultimately the approval of NHS Tayside Board given the level of investment/strategic direction sought. The Financial Planning process will consider the National uplifts together with the range of planned developments and also the level of efficiency savings required.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q</th>
<th>Was the approach taken for 2012/13 budget any different from that taken in 2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The above is the same financial planning process that has taken place in previous years.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q</th>
<th>Can you provide any examples of how equalities considerations influenced agreed budgets.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>In 2012/13 NHS Tayside has committed to continuing the Modern Apprenticeship Programme through the recruitment of a further 6 apprentices. The investment sought to provide opportunities for young people in Tayside to have vocational careers and paid work experience as part of the Apprenticeship Scheme. The impact contributing towards the socio-economic well being of Tayside and supporting an inclusive values driven culture within the organisation. Employment supports positive mental and physical wellbeing, and positive emotional wellbeing through the social networks and friendships the work environment provides. The NHS Tayside Healthcare Academy makes a key contribution to delivering on the inequalities agenda, with the continuation of the Apprenticeship programme providing long term benefits to the successful individual and the local economy.</td>
</tr>
</tbody>
</table>
## Equalities in Mainstream Services

<table>
<thead>
<tr>
<th>Q</th>
<th>Total budget for this service in 2011/12 and 2012/13.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td><strong>Outpatients</strong> The provision of Outpatient services across Tayside consumes approximately £65m per annum of the resources available to NHS Tayside.</td>
</tr>
<tr>
<td></td>
<td><strong>Elderly</strong> The assessment of the level of resources consumed by the elderly is informed through our work nationally as part of the Integrated Resource Framework. The sum committed is in excess of £220m per annum.</td>
</tr>
<tr>
<td></td>
<td><strong>Diagnostics</strong> The budget available for access to Diagnostic Services (Radiology &amp; Laboratories) is approximately £37m per annum.</td>
</tr>
<tr>
<td>Q</td>
<td>The impact (positive or negative) that this service has on equality groups.</td>
</tr>
</tbody>
</table>
| A | **Outpatients** • The referral management process can record any specific patient level information in relation to equalities. This should be provided by the referring clinician to support patient access to services based on the individuals needs. In addition to this, where a patient advises the booking staff of any particular requirements this is recorded on the patient administration system.  
  • The recording of ethnicity and religion is part of the outpatient, inpatient and daycase administration processes as it is mandatory to record patient's ethnicity (patients can choose whether they wish to provide this information). This information would then be available to services when planning future service provision.  
  • An Equality Impact Assessment was undertaken as part of the Outpatient Programme when considering the opportunities for improved access to outpatient services across NHS Tayside and the introduction of patient reminders. This proposal is yet to be finalised and presented at relevant forums within NHS Tayside.  
  • Staff Training: In March/April 2010 NHS Tayside took part in a Patients’ Equality Monitoring Training Pilot run by NHS Health Scotland. The purpose of this training was to increase the capability of NHS Staff to gather patient equalities information in a positive and sensitive as well as explaining how we were going to capture this data in Tayside. Sessions were held throughout Tayside and 45 members of staff attended these sessions and the attendees were then tasked with cascading the training within their own teams/department. Further sessions were also held where a presentation was given showing the changes that have been made in Topas to enable staff to collect ethnicity and religion and also to show staff the patient leaflet that had been produced. These sessions were also held throughout Tayside and were attended by 133 staff.  
  • Topas (NHS Tayside’s Patient Administration System): Topas has been updated to capture ethnicity and religion. Changes were |
also made to make it easier for out-patient reception staff and ward staff to capture this information.

- **Patient Leaflets:** A patient leaflet has been produced to explain to patients why we need to collect ethnicity and religion and what this data will be used for. The leaflets will be sent out to new patients with their appointment letters and we are asking patients to complete the questionnaire on the reverse of the leaflet and bring it back to their clinic appointment.

<table>
<thead>
<tr>
<th>Elderly</th>
<th>Please see attached Appendix 3.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NHS Tayside is currently working with Kavita Chetty, Scottish Government, on the Human Rights legislation around older people.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostics</th>
<th>Equality Partnership training for staff has been undertaken in the group in line with the organisation approach.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There are no particular Equality Assessments being undertaken within the Group.</td>
</tr>
<tr>
<td></td>
<td>Feedback is sought through Patient Experience in the group and any changes made to improve patient care.</td>
</tr>
</tbody>
</table>

**Q** The impact, if any, that budget changes have had on Equality Groups.

**A** There has been no impact on Equality Groups.

### Service Provision for Equality Groups

<table>
<thead>
<tr>
<th>Q</th>
<th>The total budget for this service in 2011/12 and 2012/13.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td><strong>Spiritual Care</strong></td>
</tr>
<tr>
<td></td>
<td>The available funding for Spiritual Care Services is approximately £0.5m per annum.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender-based Violence</th>
<th>Funding made available nationally to support Gender Based Violence was £15k.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>BBV/Sexual Health</th>
<th>Through the funding made available through the Effective Prevention allocation bundle, Sexual Health and Blood Borne Virus budgets are set at approximately £1.2m.</th>
</tr>
</thead>
</table>

**Q** The impact this service has on Equality Groups.

**A** **Spiritual Care**

Attached are both Spiritual Care Policy (Appendix 4) and Strategic Framework for Spiritual Care (Appendix 5) which shows the commitment of NHS Tayside to Equalities as far as Religion and Belief are concerned.

Within all new hospitals in NHS Tayside, such as the Susan
Carnegie Unit at Stracathro and all three sections of the new Murray Royal buildings there is a Quiet Spiritual Care Room which has, or will have when they are completed, all the Holy Books and artefacts necessary for the spiritual support of all the main belief and faith communities in the local area.

<table>
<thead>
<tr>
<th>Gender Based Violence</th>
<th>Covers seven areas:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Domestic Abuse</td>
</tr>
<tr>
<td></td>
<td>Forced Marriage</td>
</tr>
<tr>
<td></td>
<td>Human Trafficking</td>
</tr>
<tr>
<td></td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td></td>
<td>Honour Crims</td>
</tr>
<tr>
<td></td>
<td>Prostitution</td>
</tr>
<tr>
<td></td>
<td>Rape/Sexual Assault</td>
</tr>
</tbody>
</table>

The impact that this service has on equality groups:

- Early identification of vulnerable groups
- Early signposting and referral to support services
- Increased awareness of support available
- Encouragement to report incidents of abuse/assault/crimes
- Support for NHS employees at work through introduction of PIN Guidance and raised awareness
- Increased knowledge and needs assessment of numbers of vulnerable groups within these seven areas
- Establishment/development of protocols to ensure safe and appropriate services are put in place
- The establishment of targeted approaches and services based on need
- The development of service provision for transgender groups, groups with learning disabilities and low literacy skills
- Increased awareness of services for prisoners and their families
- Health inequality strategies have increased expectations that organisations target services at these particular vulnerable groups.

<table>
<thead>
<tr>
<th>BBU/Sexual Health</th>
<th>Blood Borne Virus (BBV) - HIV and Hepatitis B and C - disproportionately affect some of the most disadvantaged and marginalised groups in the population, including people who inject drugs, men who have Sex with Men and Black and Minority Ethnic communities.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In order to make sure that investment is appropriately targeted to meet population need, NHS Tayside has reviewed research on effective interventions as well as carried out local needs assessment with the key population groups affected by BBV. The recommendations from the needs assessments along with relevant national policy and specialist guidance on prevention,</td>
</tr>
</tbody>
</table>
treatment and care underpin ongoing investment decisions and service development. In recent years this has led to increased funding being directed not only to the priority population groups, but also towards earlier intervention, including in the early years of life and strength based approaches to reducing failure demand.

Publication of the Scottish Government’s Sexual Health and Blood Borne Virus Framework in 2011 and increasing recognition at a local level of the synergy and common outcomes led to the creation of an integrated Sexual Health and BBV MCN for Tayside. The integrated MCN is responsible for ensuring all of the outcomes detailed in the Sexual Health & BBV Framework are delivered for Tayside and additionally for delivery of Healthcare Improvement Scotland Sexual Health Standards, HIV Standards and Hepatitis C Quality Indicators.

NHS Tayside HIV service is currently being redesigned to ensure the service is accessible and has patient needs at its core and a needs assessment is near completion with ethnic minority groups and we will act on the recommendations from this.

<table>
<thead>
<tr>
<th>Q</th>
<th>The impact, if any, that any budget changes have had on Equality Groups.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>There has been no impact on Equality Groups.</td>
</tr>
</tbody>
</table>

## Mainstreaming Equalities

<table>
<thead>
<tr>
<th>Q</th>
<th>What specialist services or programmes have been, or are being, altered in the interests of mainstreaming?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>NHS Tayside’s Equality and Diversity Governance process allows for scrutiny and challenge on how Equality and Diversity is mainstreamed into the organisation. NHS Tayside at present has a Single Equality Scheme and Action Plan 2010-14 (Appendix 1) in place. This document shows how we mainstream and embed equality and diversity and human rights into the organisation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q</th>
<th>What monitoring is in place to ensure that the relevant Equality Groups continue to access an appropriate service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The Equality Act 2010 and the new Specific Duties that are now in place means we are reviewing and revising our governance arrangements and developing measures for improvement to help comply with the duties. This work will be aligned to the 3 Quality ambitions of The Healthcare Quality Strategy. We will build on the work that has been reflected within the Single Equality Scheme. NHS Tayside is working with our key leads to help identify outcomes for service delivery and workforce, we have already done some work on developing a Strategic Equality and Diversity Driver Diagram using the logic model. The Single Equality Scheme will show how we are working towards mainstreaming</td>
</tr>
</tbody>
</table>
services and what monitoring we have put in place.

Some of the work we have identified above will show how we are progressing towards mainstreaming.

Gerry Marr
Chief Executive
NHS Tayside
8 August 2012
Single Equality Scheme
And
Action Plan

2010 - 2014
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<td>Equality and Human Rights Commission (EHRC)</td>
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<td>Background</td>
<td>7 - 11</td>
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<td>Aim of Document</td>
<td>12 - 13</td>
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<td>Five Key Areas/Themes:</td>
<td>14 – 18</td>
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<td>• Leadership and Energising the Organisation</td>
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<td>• Access and Service Delivery</td>
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<td>• Demographic Profile</td>
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<td>• Community Involvement</td>
<td></td>
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<td>• Workforce and Employment</td>
<td></td>
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<td>Progress to date of Equality and Diversity in NHS</td>
<td>19 – 25</td>
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<td>Tayside</td>
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<td>Steps For The Future</td>
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<td>28</td>
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<td>Appendix</td>
<td>29 – 36</td>
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</tbody>
</table>
FOREWORD

In response to the new Equality Act NHS Tayside has developed its first Single Equality Scheme and Action Plan. In taking these steps we acknowledge publicly that when using our services, or if you are employed by us, it is unacceptable for individuals and communities to experience unfair discrimination and disadvantage because of your age, gender, race, disability, sexual orientation, transgender/transsexual and religion/belief. This will support NHS Tayside to create a culture which respects the rights and privileges of each individual and in which staff are fully valued for their diversity and the skills and knowledge they can bring to the health service in Tayside.

Over the last 7 years much work has been done on 3 equality schemes for Race, Disability and Gender to embed and mainstream these principles into our everyday activity. Opportunities have been taken where possible to learn from and work with our community planning partners and to share information and expertise.

NHS Tayside welcomes the moves to streamline equality legislation and to introduce a new single general duty on public authorities. We believe this will help us advance equality in NHS Tayside. The Government have placed on public authorities' specific duties as well as a general duty to make this duty effective.

Promoting equality is not one single person's role. It is the responsibility of all who take part in the planning and delivery of services regardless of where they sit in the organisation. A robust and focused Single Equality Scheme for the delivery of the general duty will help to drive institutional and cultural change and most importantly make a difference to people's lives.

NHS Tayside has zero tolerance to any form of discrimination and takes a personal and organisational responsibility to ensure there are policies and processes in place to tackle any level of discrimination in the organisation.

As Chairman and Chief Executive of NHS Tayside we give a personal commitment to this Single Equality Scheme and Action Plan. We believe that over time this will lead to measurable, evidenced outcomes and practical improvements in the day-to-day life and experience of people irrespective of their origin or background. We are determined to do this for all who are affected by our work be they patients, carers, staff or the wider public. Commitment of our staff will help us deliver on the outcomes and improvements and we will provide leadership, support and training to ensure success.
EQUALITY AND DIVERSITY STATEMENT

Over the last forty years the life chances and opportunities for people have considerably improved because of legislation. NHS Tayside welcomes the new Equality Act 2010 which will consolidate, streamline and bring equalities legislation into a single approach. This will allow NHS Tayside to continue to address inequality in relation to people whose needs are different because of personal and physical characteristics which are unique to each individual.

Managing diversity involves valuing people as individuals, employees, customers and clients. NHS Tayside is committed to equality and diversity in the provision of its services and in the employment of its staff. Our aim is to ensure that service users and staff receive equitable, fair, and consistent treatment irrespective of their origin and background. The NHS should be a service for everyone with equity of access and equity of treatment at its core.

Provision of healthcare should be personal and individuals should receive adequate information about their health needs and the choices available to them. These principles remain fundamental to the health service but the ongoing challenge is how to ensure that these principles continually and consistently translate into practices that can effectively deliver tailored services to our diverse communities and offer them choice.

NHS Tayside can maintain high levels of performance in everything that we do if we take a human rights based approach and build an explicit and focused commitment to Equality and Human Rights using the FREDA (Fairness, Respect, Equality, Dignity and Autonomy) principles.

We will recognise that individuals, communities and groups may be treated less favourably and/or disadvantaged because of:-

- Age
- Disability (including learning disabilities, physical disabilities, sensory impairment and mental health problems)
- Gender
- Race, Ethnic origin (including Gypsies and Travellers) or nationality
- Religion/Belief (including people who have no religion, faith or belief)
- Sexual Orientation
- Transgender

We also recognise that changing demographics puts different demands and expectations on the health service because of an ageing population, a lower birth rate, and migration especially from the European Union. More women than previously are now at work therefore impacting on the role of men and women in society. A shift in the Balance of Care from hospital to community care for disabled and older people, and civil partnerships which give gay couples the rights to adopt.

In order for us to meet these changes and promote equality we will challenge discrimination, harassment and inappropriate attitudes and behaviours. We will ensure that all of our policies, procedures and practices reflect this and that our staff are aware of their individual and organisational responsibilities. We will also take all opportunities to work in partnership with other organisations and our local community planning partners to have a multi agency approach to eliminate discrimination by working to a common agenda.

Equality and Diversity will be promoted by involving, consulting and engaging with staff, service users and the public with a commitment to shared values, unity, and
building open and honest relationships. NHS Tayside will ensure that all staff and service users are fully aware of the commitment of the organisation to provide and promote equality of opportunity, foster good relations between communities and people, and eliminate any disadvantage in accessing our services.

A commitment to work together to address the underlying health inequalities and to promote the benefits of equality and diversity across Scottish society is vital, not because the law requires us to do so but because it is the right thing to do. The moral and business case is unquestionable and the experience across NHS Scotland proves this through the value it adds to the organisation by delivering efficient, effective, and quality services that meet the needs of the communities we serve.

NHS Tayside will aim to deliver on the business, moral and legal case for equality and diversity. We will ensure that we embed and mainstream equality and diversity within our leadership, service delivery and employment practices. We will be an employer of choice and a responsible corporate body, working not only for the wellbeing of individual patients but also for the welfare of the workforce and the communities in which we are based.
EQUALITY AND HUMAN RIGHTS COMMISSION (EHRC)

The EHRC is a non departmental Government body in Britain which was established by the Equality Act 2006 and came into being on 1st October 2007. It has the responsibility for the promotion and enforcement of equality and non-discrimination laws in England, Scotland and Wales.

The EHRC has a general duty to work towards the development of a society where equality and rights are embedded

- People’s ability to achieve their potential is not limited by prejudice or discrimination.
- There is respect for and protection of each individual’s human rights (including respect for the dignity and worth of each individual)
- Each person has an equal opportunity to participate in society
- There is mutual respect between communities based on understanding and valuing of diversity and a shared respect for equality and human rights

The role of the Commission is to scrutinise all public bodies to ensure they are complying with the legal duties enforced on them by Equalities Legislation.
BACKGROUND

NHS Tayside is a teaching Board with an annual expenditure of £750m which employs approximately 14,000 employees. It serves a population of circa 400,000 people living in diverse urban and rural surroundings and with some of the highest health inequality in the country.

NHS Tayside provides many different health specialities, which include inpatient and outpatient services. The acute services are delivered from Dundee Dental School, Kings Cross, Ninewells Hospital and Medical School, and Perth Royal Infirmary. There are 3 Community Health Partnerships (CHPs) covering Perth and Kinross, Dundee City and Angus, which are each co-terminous with Local Authority boundaries. NHS Tayside also provides regional based Forensic services and provides acute health services to North East Fife. NHS Tayside has well-developed working partnerships with a range of other agencies including local authorities, local universities, colleges and schools, and voluntary organisations.

The Equality Act 2010

The Government is and always has been the champion of equality in public policy and in our democratic institutions. Equality is not just right in principle, it is necessary for:

- **Individuals**: everyone has the right to be treated fairly and to have the opportunity to fulfil their potential. To achieve this we must tackle inequality and root out discrimination
- **The economy**: a competitive economy draws on all the talents and ability – it’s not blinkered by prejudice; and
- **Society**: a more equal society is more cohesive and at ease with itself.

Everyone has a stake in creating a fair society because fairness is the foundation for individual rights, a prosperous economy and a peaceful society. Fairness and equality are the hallmarks of a modern and confident society. Over the past 40 years successive Governments have introduced laws both to create and to respond to change in society and to promote civil rights and equality. The Government has led the way from the first Race Relations Acts back in the 1960s to the important steps towards equality for women in the Equal Pay and Sex Discrimination Acts in the 1970s and from strengthening rights for disabled people in the 1990s to the introduction of civil partnerships in 2004. Fairness and commitment to equality has been at the heart of public policy for a more equal society.

This new Act is a historic piece of legislation that contains a range of new rights, powers and obligations to help the drive towards equality, including tackling the overarching inequality caused by where you are born and what your parents do for a living.

The Equality Act Strengthens Equality Law by:

1. Introducing a new public sector duty to consider reducing socioeconomic inequalities
2. Putting a new integrated Equality Duty on public bodies
3. Using public procurement to improve equality
4. Banning age discrimination outside the workplace
5. Requirement to publish gender pay gaps
6. Extending the scope to use positive action
7. Strengthening the powers of employment tribunals
8. Protecting carers from discrimination
9. Clarifying the protection for breastfeeding mothers
10. Banning discrimination in private members’ clubs
11. Strengthening protection from discrimination for people with a disability
12. Protecting people from dual discrimination. This could be due to direct discrimination because of a combination of two protected characteristics, e.g. Age and Race/Ethnicity.

WHAT THE EQUALITY ACT MEANS FOR DIFFERENT PEOPLE?

People from Disadvantaged Backgrounds

Inequality and disadvantage are not only associated with issues such as gender, age, disability or ethnicity. Overarching and interwoven with these is the persistent inequality that results from someone’s family background or where they were born. The Equality Act will require Government departments, local authorities and key health bodies to consider, in all the strategic decisions they make, how they will tackle the disadvantage some people face because of socio-economic deprivation.

Women

Women are on average paid around 22 per cent less than men but few employers would admit to it being an issue in their workplace. Transparency is the way forward, so the Equality Act will require public bodies with 150 or more staff to publish their gender pay gap.

In the private and voluntary sector employers with at least 250 employees will be required to publish details of their gender pay gap. This will be done from 2013 if insufficient voluntary progress has been made. The Act will also ban any pay secrecy clauses which conceal inequality.

The Equality Act will also protect pregnant women and new mothers from discrimination. This means that mothers can breastfeed their children in public without being asked to leave public premises such as cafes and shops.

The Act extends the permission for political parties to use all-women shortlists until 2030, helping to increase the number of women in Parliament.

Black and Minority Ethnic People

The Equality Act will help to make the workplace more diverse by tackling the employment gap for people from ethnic minority communities. This will be done by allowing employers to choose to take positive action to appoint a person from an under-represented or disadvantaged group in order to make their workforce better reflect the community they serve. This is a voluntary measure and will only be allowed if two candidates under consideration are as qualified as each other in terms of competence, aptitude, experience and overall performance during any interview or assessment.

People with a Disability

Schools will have to provide auxiliary aids and services for disabled pupils, for example special equipment and large-print books, where reasonable. Protecting people with a disability from discrimination in the recruitment process. The Act makes it unlawful for employers to ask job applicants questions about disability or health before making a job offer, except in specified circumstances. This
will prevent employers screening potential employees to avoid recruiting people with a disability.

Protecting carers from discrimination. The Equality Act will protect people who are, for example, caring for a disabled child or relative. They will be protected by virtue of their link to that person.

**People With Religious or Philosophical Beliefs**

The Equality Act puts a duty on public bodies to consider the needs of people with different religious and philosophical beliefs when designing and delivering services. This could include considering the need to offer halal and kosher meals as part of a meals on wheels service.

The Act carries forward existing laws protecting everyone from discrimination because of religion or philosophical belief, or lack of religion or belief. These protections are not just for minority groups – they extend to Christians, Muslims, Jews, Hindus and members of other religions, as well as humanists and atheists.

**People of All Ages**

In 2006 the Government banned age discrimination in the workplace. The Equality Act extends this protection beyond the workplace by outlawing unjustifiable age discrimination against people aged 18 and over where goods are bought and services provided, such as in shops, hospitals and when buying financial products. Beneficial age-based treatment such as free bus passes for over 60s will still continue and discounts for pensioners and age related group holidays will still be allowed.

The Act places a legal duty on public bodies to consider the needs of people of all ages when designing and delivering services. This will ensure that public bodies consider the needs of children, teenagers and younger and older adults.

A requirement for public authorities is to set equality objectives for people of different ages when developing and delivering services. These objectives will address some of the concerns expressed about the treatment of older people in health and social care services.

We have to recognise that some of the services we provide are legitimately designed to differentiate between people of different ages as a way of meeting their needs. There will always be positive reasons for treating people differently because of their age, for example, when providing concessionary travel for both younger and older people, services targeted at particular age groups.

It is important that when we develop the Single Equality Scheme that we ensure services for children are tailored in an age-appropriate way, because the age of a child is so closely related to his or her levels of development and need, also legislation protecting children is already in place and we would link into work that has already been done around children’s services. However there is evidence that some people experience unjustified discrimination in the provision of goods, facilities and services because of their age. There is also evidence that older people in particular are not always treated with dignity and respect.

When identifying our equality objectives for age we have to ensure that they are proportionate and addressing real equality issues in relation to age. To enable us to do this we will take into consideration some of the non-legislative guidance available on age:
The Scottish Executive (Scottish Government) publication, “All our Futures; Planning for a Scotland with an Ageing Population”

The Department of Health’s National Service framework for older people.

Opportunity Age - the Government’s strategy for an ageing society represents a comprehensive programme of action:

- End the perception of older people as ‘dependent'
- Ensure that life is healthy and fulfilling
- Ensure that older people are full participants in society

It is part and parcel of the normal operation of our society that we treat people of different ages differently, because people’s capacities, needs and aspirations change as they grow up and age. Different treatment often fulfils an important function such as promoting social integration, compensating for disadvantage, or enabling services to be delivered more effectively or efficiently. It is clear that there will always be a need for age-specific facilities and services.

Evidence also show that there will be instances where different treatment based on age leads to people of different ages experiencing unfair outcomes. Older people are more likely to suffer the negative effects of unfair attitudes and behaviours

**People who are Lesbian, Gay and Bisexual (LGB)**

The new Equality Duty means that public bodies will need to think about the needs of LGB people when designing and delivering services. This could mean a health centre running a promotional campaign to encourage more lesbians to attend clinics for cervical smear tests, or a workplace tackling homophobia in their organisation.

The Act removes the express prohibition within the Civil Partnership Act 2004 that prevents civil partnerships being registered on religious premises. This means that religious organisations that want to host civil partnership registrations on their premises will not be prevented from doing so, but no religious organisation will be forced to host a civil partnership if it does not want to do so. There will be full public consultation before this is put into effect.

**People who are Transgender**

The new Equality Duty will require public bodies to advance equality of opportunity for Transgender people. This could mean a local authority noticing that there are no support groups for people undergoing gender reassignment in that area and deciding to fund a charity to help reach out to the Transgender community and working with the local planning partners.

The Equality Act will revise the definition of ‘gender reassignment’ to make it clear that a trans person does not have to be under medical supervision to be protected from discrimination and harassment. It will also protect people who face discrimination because of their association with Transgender people, for example, as their partner.

The Act will also extend protection against gender reassignment discrimination to cover schools. This ensures that schools will have to be even more sensitive to the needs of children who have gender identity issues.
Everyone

The Act will bring in groundbreaking new protection from discrimination because of a combination of two protected characteristics. If a case goes to an Employment Tribunal it can be presented as a dual discrimination case where, for example, the case is of a black woman (ethnicity and gender) or a gay disabled person (disability and sexual orientation).

The Act will also encourage us to consider using public procurement as a way to improve equality, for example, by including requirements about apprenticeships or traineeships being offered to people from underrepresented groups as part of the contract conditions.

It will provide new protection if you experience discrimination because you are wrongly thought to have a protected characteristic, for example, a male job applicant who is rejected because the employer wrongly thinks he is a woman, because he has a name which is commonly used as a woman’s name, would be able to claim for sex discrimination.

The Act will extend the power of employment tribunals to make recommendations in discrimination cases that benefit the wider workforce as well as the individual claimant, to help employers improve their equality performance.

What Happens Next?

The provisions in the Equality Act will come into force at different times to allow time for people and organisations that are affected by the new laws to carefully prepare for them. It is planned that the Act will come into force as follows:

**October 2010:** Main provisions and specific duties of the Act.

**April 2011:** The integrated public sector Equality Duty, the Socio-economic Duty and dual discrimination protection.

**2012** The ban on age discrimination in provision of goods, facilities, services and public functions.

**2013** Private and voluntary sector gender pay transparency regulations (if required) and political parties publishing diversity data.
AIM OF THE DOCUMENT

Equality is about creating a fairer society where everyone is encouraged to participate and has the opportunity to fulfil their full potential. Diversity is about recognising and valuing difference for the benefit of the patient, carer, staff and public. This document sets out how we hope to do this and how the Single Equality Scheme and action plan will ensure that we embed equality and diversity in all that we do and mainstream it through our processes, policies, systems and functions.

The existing public sector equality duties on Race, Disability and Gender have helped to ensure that the delivery of services and the policies which inform them are responsive to people’s different needs and experiences.

The new Single Equality Scheme and Action Plan will set out how we will deliver on the General Duty and Specific Duties. The specific duties will be additional duties on public authorities to assist in the delivery of the general duty.

General Duty

- Promoting equality of opportunity
- Eliminating unlawful discrimination
- Fostering good relations across all protected characteristics

‘Protected characteristics’ means the different characteristics that people have that can lead to prejudice and discrimination - race, disability, gender, sexual orientation, age, religion or belief, pregnancy and maternity, and gender reassignment - which have been identified in the Equality Act as those for which there will be protection in law.

Specific Duties

- Tackling socio-economic deprivation and inequalities
- Public procurement to improve equality
- Banning age discrimination outside the workplace
- Equal pay
- Using positive action
- Protecting carers from discrimination
- Protecting people from dual discrimination
- Strengthening protection from discrimination for people with a disability

The Single Equality Scheme and Action Plan will fit in with the agreement between central and local government, our national performance framework, public sector reform and our focus on outcomes, efficiency and transparency.

The actions within the Action Plan will show how we propose to deliver on NHS Tayside priorities. The actions will be aligned to the local delivery plans, NHS Tayside priorities and objectives, our corporate objectives and national priorities. The actions will be specific, measurable and outcome focused with clear timelines and identified leads responsible for each action. Progress of the actions will be reviewed annually and reported through our existing governance arrangements for equality and diversity, and the Single Equality Scheme will be revised every 3 years.

The responsibility for Equality and Diversity rests with NHS Tayside Board’s Improvement and Quality Committee. Our performance in pursuing these objectives will be actively monitored by NHS Tayside Equality and Diversity Steering Group and our staff partnership structures. We will also work with our local planning partners across Tayside to ensure a multi-agency approach to diversity. The Director for Workforce is the Executive Lead and champion for the promotion of Equality and Diversity on behalf of NHS Tayside Board.
The 3 Existing Equality Schemes

NHS Tayside has 3 existing equality schemes in place for Race, Gender and Disability. As part of the new Equality Act, the 3 existing schemes will now be incorporated into a Single Equality Scheme, to cover all strands of diversity including religion/belief, age, sexual orientation, Transgender, race, gender and disability. This will allow NHS Tayside to have a more streamlined and single approach to equality, as people do not just fit into one physical characteristic but may fit into multiple strands.

Disability Equality Scheme (2009 - 2012)

We have revised our Disability Equality Scheme in December 2009, and within it identified how we propose to take forward actions for disability over the next 3 years. This is our second Disability Equality Scheme and much progress has been made since we published our first scheme in 2006. The actions identified for disability will now be incorporated into the Single Equality Action Plan.

Race Equality Scheme (2008 - 2011)

Our existing Race Equality Scheme was revised in November 2008 with a 3 year action plan. The actions which have not been completed in the Action Plan will be incorporated into the Single Equality Action Plan.

Gender Equality Scheme (2007 - 2010)

NHS Tayside will be required to revise its Gender Equality Scheme in 2010. The Gender Duty will now be addressed within the Single Equality Scheme and gender equality actions will form part of the Single Equality Actions.

Single Equality Scheme (2010 – 2014)

The Single Equality Scheme has been developed with a four year timeline. This is an exception to the normal three year Equality Schemes. The reason for this is that the Scottish Government may change or add to the specific duties in October 2010. We will then be required to implement these changes or additions by April 2011 at which point we will revise our Single Equality Scheme and then go back to a three year cycle (2011 – 2014).
Fair for All identified the following five key policy areas to help progress and improve on equality work. NHS Tayside will use these as a framework to enable us to deliver on OUR general and specific duties.

- Leadership and Energising the Organisation
- Access and Service Delivery
- Demographic Profile
- Community Involvement
- Workforce and Employment
LEADERSHIP AND ENERGISING THE ORGANISATION

NHS Tayside intends to demonstrate visible leadership which both acknowledges and challenges institutional discrimination by:-

- Being active in promoting equality of opportunity
- Eliminating unlawful discrimination
- Fostering good relations between people
- Raising the profile of equality and diversity throughout NHS Tayside

Additional duties in the form of specific duties will be placed on public authorities to help deliver on the general duty.

How will the organisation ensure that we are taking account of equality in our day to day work with reference to all of the equality strands covered by the general duty.

NHS Tayside will

- Provide clear leadership focused on achieving equality outcomes for Race/Ethnicity, Gender, Age, Sexual Orientation, Disability, Transgender and Religion/Belief in service delivery and employment
- Ensure strong Board Level commitment in achieving equality outcomes
- Provide a clear statement of intent that is forming the basis of ongoing actions and plans to deliver the change needed
- Will have measurable targets and outcomes which have been included in the Action Plan along with named accountable people at Senior levels
- Meet its key performance indicators for equality
- Ensure that equality objectives form part of our corporate plan
- Evidence that local delivery plans are considering the impact on the equality groups in relation to their service objectives
- Align equality objectives to performance management objectives
- Equality Impact Assess its policies/strategies, service improvements and service redesign in relation to all of the Equality strands

DEMOGRAPHIC PROFILE

As part of NHS Tayside’s Health Equity Strategy, evidence of the local demographic profiles has been produced. This will allow NHS Tayside’s Board to assess service delivery outcomes against statistics for the Tayside population make-up so that the Health Board is able to identify specific areas of need relating to Age, Disability, Gender, Race/Ethnicity, Religion/Belief, Sexual Orientation and Transgender.

The projected demographic and population changes will help Senior Managers, Practitioners, Clinicians, Specialist and frontline staff to meet the needs of different communities and patients and will help to target health care provision where there is a need. The demographic profiling will also help to identify the wider socioeconomic issues which contribute to health inequalities such as lifestyle, literacy, housing, employment and poverty.

ACCESS AND SERVICE DELIVERY

NHS Tayside actively engages in driving forward improvements to service delivery and access to meet the individual needs of patients and local communities. One of the ways that we are doing this is through regular monitoring and data collection on who is accessing our services. NHS Tayside will be collecting this information through monitoring forms which patients will be required to complete when they are
asked to attend hospital appointments. This monitoring data will help us to analyse the diversity of patients using our services to enable us to tailor those services to meet the needs of patients and address any issues.

Equality Impact Assessments will be carried out for service changes and policies to ensure equitable health/service outcomes for all communities and patients accessing our services. To enable us to Impact Assess we will be required to engage, consult and involve key stakeholders and community members.

COMMUNITY INVOLVEMENT

Guidance has been produced by the Scottish Government Health Directorate on Informing, Engaging and Consulting People in Developing Health and Community Care Services. The purpose of this guidance is to assist NHS Boards with their engagement with patients, the public and stakeholder on the delivery of local health care services.

The principles of the guidance will be applied when NHS Tayside proposes either a small or major service redesign or improvement. In other words NHS Tayside is required to take a consistent and robust approach in how we involve our communities, patients and public when we are considering and proposing new services or changes to existing services.

Health care and services should be provided in partnership with patients based on their needs, experiences and preferences which are responsive to Age, Gender, Race, Disability, Sexual Orientation, Religion/Belief, Transgender, Socioeconomic Status and Geographical Location. This will ensure that we are treating people with dignity and respect.

WORKFORCE AND EMPLOYMENT

Over the last three or four decades much has changed about the way unfair discrimination and exclusion are addressed. Diversity is gradually changing negative perceptions about difference causing problems and recognising that difference offers opportunities and brings in new ideas and perspectives about ways of doing things and answers many challenges.

This evolved way of thinking from equality to diversity to inclusion is taking place against the growing social and political importance of tackling unfair discrimination for moral, social and economic reasons. Public policy provisions, social interventions and business activities should be based on inclusion to reflect the needs, aspirations and expectations of an increasingly diverse society and diverse global market.

The main elements of a business case for managing diversity, improving performance and adding value to NHS Tayside are

- Good customer care and quality standards
- Corporate image, brand, ethics and values
- Recruitment and retention of talent
- Designing and delivering effective and efficient services
- Increasing employee creativity and innovation
- Being an employer of choice through effective people management and development
- Complying with legislation
- Corporate social responsibility
CHANGES THAT IMPACT ON THE MANAGEMENT OF THE WORKFORCE

1. The Social, Legal and Economic Landscape

Employee diversity and talent management and the introduction of new/changed legislation has brought the issues of equality, ethics and employee diversity to the forefront. Successive new legislation from both Europe and the UK has seen public sector organisations focusing on key areas like race and religious equality, inclusion of minority employee groups such as the disabled, ex offenders, and people with mental health problems, work-life balance issues, and the recruitment and retention of staff.

There has also been an increase in parental rights, such as, enhanced maternity and paternity leave and an increase in maternity benefits. While these have introduced additional employee rights and benefits, they have stimulated heated discussion adding to the complexity of managing diversity at work. Questions have been raised on the impact of these changes on the rights and choices of groups who are not covered by the legislation, such as employees without carer responsibilities, who in the workplace cover periods of carer absence.

Researchers in employee engagement have noticed shifts in values and beliefs and in each individual’s perception of what motivates and stimulates them at work and in their personal lives. There is an increase in the importance of ethics and corporate social responsibility in managing the business of the 21st century which has added another dimension to how businesses and organisations conduct themselves and manage their employees.

There have also been changes in the political society that we live in, and religion and cultural differences have led to intolerance. Some events, like the destruction of the World Trade Centre, have had lasting effects on the way we do business globally and sparked changes in the mindset of individuals and organisations’ ethics and values. Some of these changes are irreversible and their consequences have an impact on society in general and the workplace specifically.

2. Corporate Social Responsibility

As mentioned earlier the increase in the importance of ethics and Corporate Social Responsibility has added a new dimension on how organisations manage their employees. Corporate imaging plays a vital role in an organisation and maintaining an acceptable corporate image is as important as the quality of the services it provides and also how it treats its employees. Compliance with legal obligations is a key issue for managing risk, but compliance is essentially defensive. Workforce needs to promote positive behaviours and relationships in the workplace. The psychological contract offers a good framework for managing people by ensuring that there is trust, fairness and transparency between an employer and employee. The way an employer treats its employees, manages diversity, employee representation and development reflects on the ethics of an organisation.
3. **Staff Governance Standard**

The Staff Governance Standard sets out what each NHS Board in Scotland must achieve in order to improve continuously in the fair and consistent management of staff. The standard is explicit in that all legal obligations are met, including all NHS employers comply with current employment legislation and that all policies and agreements are implemented. The Standard requires that NHS Tayside must demonstrate that staff are:

- Well informed
- Appropriately trained
- Involved in decisions which affect them
- Treated fairly and consistently
- Provided with an improved and safe working environment

The aim of NHS Tayside is to be an employer of choice and to manage talent within a diverse workforce. To enable us to do this we have to ensure that corporate responsibility, human rights and equality are at the heart of the way we manage our employees. Equality of opportunity and elimination of unlawful discrimination are at the centre of our employment practices and policy development.
PROGRESS TO DATE WITH EQUALITY & DIVERSITY IN NHS TAYSIDE

Over the last 8 years NHS Tayside has made much progress with Equality and Diversity through the delivery and implementation of our existing Equality Schemes for Race, Gender and Disability. We have progressed equality and diversity actions in each of the 5 key policy areas.

Energising the organisation

- Regular Board Development Events have taken place over the last couple of years to discuss with the Board their leadership responsibilities on equality and diversity.
- NHS Tayside has a Document Control Policy in place for the development, implementation and review of organisational policies and strategies. This document has guidance on how to carry out Equality Impact Assessments (EQIAs) of policies, strategies and service improvement.
- The Document Control Policy states that there will be an identified Executive Lead for all policy areas who will have the responsibility for Governance and Quality Control for EQIA.
- NHS Tayside has an Equality and Diversity statement of intent on its public site.
- All NHS Tayside reports now have a mandatory section called Impact Assessment and Informing, Engaging and Consulting.
- NHS Tayside’s procurement process now has equality and diversity processes integrated into the e-Tendering system.
- NHS Tayside is a Stonewall Diversity Champion. We participate in the Workplace Equality Index benchmarking against other public and private organisations to show that we are moving towards Lesbian, Gay, Bisexual and Transgender (LGBT) inclusive employment practices.
- NHS Tayside now has 110 Equality and Diversity Champions who are trained to challenge inappropriate behaviours and reinforce positive attitudes to equality and diversity.
- Corporate Induction programme for all staff groups highlights Equality & Diversity legislation and provides information on how to access NHS Tayside policies relevant to Equality & Diversity.
- All Induction Co-ordinators are trained “Equality and Diversity Champions”.

Demographic Profile

- NHS Tayside’s population profile is now completed and available on our intranet and internet site.
- Support and advice is ongoing by the information services manager to groups and individuals as required re demographics and the rapidly changing population of Tayside so that service delivery can be planned accordingly to meet the needs of the population.
- Demographic information is also used to identify health inequalities for specific groups of people within communities and reflected in the Health Equity Strategy.

ACCESS AND SERVICE DELIVERY

Race/Ethnicity and Religion/Belief

- Interpretation and Translation Services are now available at point of contact across NHS Tayside and GP surgeries. Every service user who cannot speak English has access to Interpretation services. Family members being used as interpreters are discouraged.
• A flag up system has been developed for patients who require an interpreter when using NHS Tayside services. For patients whose first language is not English a sticker will be added to the patient’s case notes that will inform staff that the patient requires an interpreter for their appointment.
• Language Line Services now provide interpreters in nearly 120 languages, and a telephone service which is easy to access. Any patient requiring face to face interpretation will be assessed accordingly. NHS Tayside has a Service Level Agreement with Dundee City Council for face to face interpretation.
• Staff awareness and training has been provided in how to use and access interpretation and translation services.
• A project manager has been appointed to look at the effectiveness of the service and to make improvements if required.
• Translation, interpretation and communication support services are now in place for people whose first language is not English and for those requiring communication support, such as BSL and Guide Communicators.
• A culturally competent catering service is in place. An ethnic catering menu is now available for patients and staff from ethnic minority groups who require specific cultural meals. The menus are available in different languages.
• Religion and culture information documents are now available for staff on the website. NHS Tayside’s Spiritual Care Forum (advisory to the Spiritual Care Department) has representation from the different faith communities and belief groups. The Spiritual Care Department holds a directory of contact numbers of faith communities who can be contacted for advice, or when a member of their community requests them to visit in hospital.
• Quiet places for reflection and worship are now available for in-patients of all faiths. There are ablution facilities available in some of these quiet areas.

Disability

• Within children’s services there is multidisciplinary training.
• NHS Tayside Carers Strategy training group has a very active involvement of users/carers in delivering training.
• The Consultant Nurse for Learning Disabilities supports staff to ensure they have the appropriate level of skills and knowledge for them to care for any person who comes into their care with a learning disability.
• Staff have had awareness sessions on how to access information regarding interpretation services for deaf patients.
• A Service Level Agreement is being developed with Deafblind Scotland for guide communicators.

Information access

• Information about health services can be made available in a range of formats on request.
• We have consulted and engaged with members of the deaf community via Tayside Deaf Forum and had an open meeting with the deaf community in order to make improvements to the services we provide through new Service Level Agreements.
• Patient information leaflets can be made available in a variety of translated languages including Braille.
• Content of leaflets provided by departments are quality controlled by designated persons within nursing and patient services department.
• NHS Tayside is testing an electronic system for deaf patients within secondary care through TOPAS (Tayside Out-patient Administration System)
Care planning

- There is a Fast-track system for children with complex needs who have frequent admissions and at discharge, families are advised to phone the ward if they have any concerns.
- For children or adults with learning disabilities specific health needs are identified in records, care plans and Personal Life Plans (PLP)
- Children’s health needs are included in care plans and Personal Life Plans are developed in conjunction with Barnardos where applicable.
- Single shared assessments are in place for patients with learning disabilities. Particularly good practice in relation to this area of work with children is ASPIRE (A Shared Personal Information Record) for pre-school children with very complex disabilities in Dundee.
- Carers or family members are involved in care plans by assisting in completing the All About Me document. Carers are encouraged to bring this in with the patient on admission.
- Joint Co-ordinated Support Plan reflects likes/dislikes of children.
- Admission and nursing documentation takes into account additional needs of disabled people.
- To ensure that additional and complex needs are considered thoroughly in discharge planning, there is Joint Tayside Discharge Planning Protocol. Case conferences take place to ensure that additional and complex needs are considered.

Physical Access

- The Operations Directorate have an on-going focus on where disability equality issues require to be addressed in conjunction with issues around access to facilities, particularly for disability groups.
- A disabled and changing places facility/toilet is now available on level 7 at Ninewells Hospital.
- Estates department have had a general allocation included within the maintenance budget to ensure issues around disability discrimination and access are addressed and changes if reasonable can be carried out.
- Significant work has been carried out with the car park contractor at Ninewells (Vinci Park UK Ltd) and this includes - an increase in the number of disabled parking bays, free parking permits for certain patients and relatives on a compassionate basis, free of charge scooter mobility service at Ninewells, which won a National Award for Innovation and a free of charge courtesy bus service between the outlying car parks and the main hospital entrances.
- NHS Tayside Wheelchair Users Group has been set up to improve services for wheelchair users. A Wheelchair Service Improvement Plan has been developed in line with the National Wheelchair Project and this will now be implemented. A Wheelchair User Forum has been set up which will help to implement the improvement plan.
- NHS Tayside has 20 mini buses which are equipped with wheelchair lifts for disabled clients for outings and appointments.

Communication

- A multilingual speech and language therapist is available for therapy sessions for children.
- Access to Medical Records and Complaints available in Boardmaker symbols. Communication needs are identified and met for children and adults.
Individuals with learning disabilities may bring with them PAMIS Passports/All About Me documents which highlight specific communication difficulties.

Children’s communication needs are identified through speech and language therapy assessments

Posters in all general hospitals/GP Practices informing staff of Learning Disabilities Liaison Service.

Other communication aids that are available are: DisDat Document (on intranet), Let's be Patient DVD, a hospital communication book in all secondary care wards, pictorial menus and communication cards within children’s services.

Tip Cards, developed by Fair For All Disability on how to communicate with disabled people are in place in acute service areas and CHPs.

Gender

NHS Tayside is focusing on the different needs of men and women and their expectations of what health services can deliver.

NHS Tayside’s local delivery plans will have to evidence how they are meeting the needs of equality groups within their service delivery priorities. This will be addressed through carrying out EQIA.

P&K CHP has expanded its Healthy Community Collaborative activity which is an inclusive process to address the needs of local populations and to encourage communities to influence service provision.

The Single Shared Assessment process is designed so that people’s service preferences are met within the care environment in both hospital and community settings.

Fat Busters class for men has been provided and Winning Weigh Class for women, as part of the healthy living initiative in Perth & Kinross.

The Unmet Needs Project in Dundee was funded for 18 months to target people most at risk of Coronary Heart Disease.

In Angus targeted work was done around a structured exercise programme for cardiac rehabilitation for men and women.

Mental Health services in Angus have been doing some focused work around the national Choose Life programme to promote mental health issues as well as suicide prevention. This is particularly targeted at young males to help facilitate them getting back into training and employment.

NHS Tayside has an established Gay Men’s Health service which is focused on HIV prevention. The Gay Men’s Health Co-ordinator also provides training around challenging homophobia, discrimination and social exclusion, and provides leadership on Lesbian, Gay, Bisexual and Transgender issues for NHS Tayside.

Age

NHS Tayside has an Older People’s Strategy. Within the strategic Framework there are four themes: Staying at Home, Being part of the Community, Quality Dementia Care, and Better Experience of Acute Care.

Community Planning Partners working together towards an integrated approach to care for all communities.

NHS Tayside Engagement and Involvement of Children and Young People Action Plan.

NHS Tayside also has a Carer’s Information Strategy.

Within Dundee, NHS Tayside is a member of the Equality and Diversity Partnership which also has members from The Celebrating Age Network who we work closely with, as well as representatives for all the other Equality Strands.
• Policy on Single Sex Accommodation: when an older/younger person requires hospital care it must be provided in an environment and in a way that promotes dignity, independence, choice and wellbeing.

• Child Protection Policy: All children whatever their age, culture, disability, gender, race, religion or sexual identity have the right to protection from abuse. This policy sets out the standards that all NHS Tayside staff have to adhere to.

• Protected Mealtimes Policy: To protect mealtimes from unnecessary and avoidable interruptions, providing an environment conducive to eating, enabling staff to provide support and assistance with meals, especially for elderly/vulnerable groups.

• Food Fluid and Nutrition Care in hospital: NHS Tayside will ensure that all patients at greatest risk of malnutrition will be assessed and cared for equally. Older people are more at risk of malnutrition.

• Young People’s Health Team has issued Client Satisfaction Surveys which have influenced the shape of services, e.g. timings of service to young people in Blairgowrie changed to meet their needs.

• Provision of mobile scooters for people who may have mobility problems.

• Better signage within hospitals for people who may be sight-impaired, mostly elderly

• Information is available in a format that is easy to read.

• Angus CHP has been working on promoting dignity and respect for Older people in Angus, labelled Look Closer – I’m Still ME!.

• Following publication of the Report from the UK Inquiry into Mental Health and Wellbeing in Later Life (Age Concern/Mental Health Foundation, 2006), Angus Older People’s Planning Partnership received funding support from NHS Health Scotland’s Health in Later Life Programme to take forward the Report’s recommendations at local level.

• A public consultation and engagement event held in Carnoustie in 2007 resulted in a commitment to introduce a multi-agency staff training programme and produce a range of awareness-raising materials to promote dignity and respect for older people in Angus.

• The Angus Gold 50+ Project has been key to the development of this work which complements the Scottish Government’s ‘See the Person, Not the Age’ initiative and forms part of a longer-term campaign to tackle wider issues of age discrimination and elder abuse. This work includes any issues or barriers that may arise around gender and old age.

• Training for Staff on Caring for the Older Person and Dementia Training.

COMMUNITY INVOLVEMENT

• NHS Tayside is working with our Local Authorities, Police, Fire and Rescue and Lifelong Learning in Perth & Kinross, Dundee and Angus. This work is being carried out in partnership and each of the partnerships have developed a community engagement strategy which lays down clearly how we engage and involve our communities in decisions that affect them.

• NHS Tayside has a database of community groups with whom we can engage with around BME issues.

• NHS Tayside works with the Fire and Rescue Service, Police and Dundee City Council through the Dundee Equality and Diversity Partnership in order to support the community engagement partnership.
Informing, Consulting and Engaging:

- NHS Tayside has mature patient focus public involvement (PFPI) structures which ensure that patients, carers and the public are routinely involved in contributing to policy, strategy and service developments and planning.
- Community Health Partnerships engage with their Public Partnership Groups and virtual forums as a matter of course. This includes men, women, young and old people.
- Patients across hospital settings in Tayside are invited to comment on their episode of care by describing what has worked well, not so well and what could have been done to improve their experience. Comments and actions taken by staff are displayed on notice boards within wards.
- Specific pieces of work include the development of the Single Sex Accommodation Policy which was developed in partnership with male and female patients / public.
- NHS Tayside Older People’s strategy involved members of the public in identifying its priorities.
- Young people and community youth workers have contributed to the development of a youth health forum. Issues already highlighted include sexual health.
- All reports that are presented to the Board and its standing committees must include details of how patients and the public have been involved and the contribution they have made to developments and measures for improvement. Reports must also include details of impact assessment to ensure that individuals are not disadvantaged because of their age, ethnicity, gender, religion or faith, disability or sexual orientation.
- Governance structures around PFPI include the Equality and Diversity Steering Group and the PFPI Operational Group with a role and remit to ensure that systems and processes are in place to enable patients and members of the public to be actively involved in the planning and delivery of NHS Tayside services and which reports to the NHS Tayside Improvement Panel. The Improvement and Quality Committee oversees the reporting of progress of Patient Focus Public Involvement.
- In recognising that community engagement was a significant part of a mutual ‘NHS’ a short life Community Engagement Strategic Working Group has been convened with membership from across Tayside including local authority partners, to pull together the various strands of engagement and to provide reassurance to the Improvement and Quality Committee that all age groups were covered in community engagement.
- Within P&K CHP, New VOICE tool is about to be used for the joint older people’s strategy. This is to effectively plan inclusive consultation methods and identify barriers to inclusion such as gender/transgender issues.
- The REACH project which is being funded by the Big Lottery is to help build confidence and support for BME people to engage and get involved more with policy development and influence NHS Tayside policy by actively participating within engagement structures in NHS Tayside.
- As part of the development of the Single Equality Scheme NHS Tayside has engaged with the communities and people of Tayside through a Community Engagement Event in March 2010. The feedback from the event has been written up and shared with the people who attended on the day.( appendix 1)
WORKFORCE AND EMPLOYMENT

- An Equality and Diversity Training Strategy.
- NHS Tayside has 110 Equality and Diversity Champions whose role is to challenge inappropriate behaviour and reinforce positive attitudes to dignity at work issues and diversity.
- We have trained managers who have a responsibility for recruitment and selection of staff on employment legislation and discrimination and they have a Certificate to Recruit.
- We have also trained managers who have a lead for policy development and service improvement on how to carry out Equality Impact Assessments and also to impact assess their departmental strategies and local action plans.
- There is guidance and good practice for managers on recruitment and selection.
- There is guidance and good practice for managers on employing people with a disability.
- We have systems and processes in place to monitor the diversity of our employees, in relation to recruitment and selection, training uptake, tracking system for grievances that are lodged in relation discrimination and harassment on grounds of age, disability, race/ethnicity, religion/belief, transgender, sexual orientation and gender.
- NHS Tayside has set up an LGBT employee network, one of the first in NHS Scotland with support from Stonewall
- NHS Tayside has in place employment policies to address equality and diversity issues.
  - Equal Opportunities Policy
  - Dignity at Work Policy
  - Flexi-time Policy
  - Retiral Policy
  - Grievance Policy
  - Carer Leave
  - Paternity Leave
  - Breastfeeding and Returning to Work Policy
  - Staff Discipline Policy
  - Employment on People with a Disability Policy
  - Recruitment Policy
  - Domestic Abuse Policy
STEPS FOR THE FUTURE:

We will ensure our services are high quality, continually improving, efficient and responsive to local people and community needs.

The Government’s aim is to have a healthier Scotland and to enable us to do that we have to improve the quality of healthcare experience for everyone.

A national outcome of the Scottish Government is, “that we have tackled the significant inequalities in Scottish society”.

**Why is this national outcome important and how does it relate to the work that is going to be taken forward as part of the Single Equality Scheme and Action Plan?**

Scottish Government has recognised and made clear in their National Performance Framework, that, “Although outcomes are generally improving for most people in Scotland, they are not improving fast enough for the poorest sections of our society, including those who face barriers because of their race, gender, age, disability, sexual orientation, religion/belief or if you are transgender”.

People who have least access to income, employment and good housing also experience higher levels of ill health; often have less physical and psychological resilience to meet challenges and less power and influence to effect change. Poverty and inequality not only diminish opportunity and life experience, they detract from Scotland’s economic success and wellbeing as a nation. Tackling inequalities, therefore, remains a major challenge for the Government and for us as a health provider.

The Single Equality Action Plan has identified actions for us to take forward to tackle some of these significant issues. We have already made in-roads into tackling inequality by having processes and systems in place that promote equality of opportunity and eliminate barriers to service delivery for equality groups. We have a lot more work to do and we hope the scheme will influence our way forward.

The Single Equality Scheme is not a stand alone document and has to be influenced by and work in partnership with key national priorities and initiatives and NHS Tayside local delivery plans and strategies.

Some of the national and local drivers will be:

- HEAT Targets and Local Delivery Plans which address needs of equality groups.
- Equally Well Recommendations: Communication Support and Patient Data collection.
- Gender Based Violence national priority action plan.
- NHS QIS recommendations for Learning Disabilities.
- Equal Pay Legislation.
- Informing, Engaging and Consulting national framework.
- Single Outcome Agreements
- Better Health, Better Care
- A Force for Improvement – Workforce response to BHBC
The key in achieving the outcomes from the Action Plan is to ensure that we are identifying the impact of our services and policies on equality groups, by ensuring there are mechanisms in place to engage meaningfully with equality groups to influence their health service, aiming towards a mutual health service where everyone participates. Our health Equity Strategy refers to it as “communities in control”.

As part of the development of the Single Equality Scheme and Action Plan, NHS Tayside engaged with equality groups from local communities in Tayside. We had a one day event which was split into a morning and afternoon session. The morning session was for all equality groups and the afternoon session was specifically focused on people with disabilities.

The event was well received and the feedback was positive, here are a few examples of some of the comments we received,

“There appeared a sincerity in implementing this with NHS Tayside”

“Afternoon single group session very helpful, summary of feedback very good”

“While all initiatives discussed were relevant and important, I am aware and concerned that they are all dependent on resources and may be altered through cuts in services by government”

We will identify actions that need to be included in the single equality action plan. We have communicated to all of the participants with feedback from the event and how we propose to move forward.

NHS Tayside will work in partnership with our local authority partners and voluntary organisations and in harmony with our communities. We will understand the changing needs of our diverse communities and be more responsive in the policies we develop and the services we provide. We will promote and advance equality and challenge discrimination and prejudice.

**Publication and Monitoring**

- All 3 existing Equality Schemes on Race, Disability and Gender are published and available to the public through NHS Tayside internet site.
- All annual reviews of NHS Tayside’s Equality Schemes are also published and available on NHS Tayside intranet site.
- Regular updates and reports on Equality and Diversity are submitted to the Improvement and Quality, and Staff Governance Committees.
- NHS Tayside has a legal obligation to monitor its workforce on diversity and these monitoring figures are published on NHS Tayside website.
- Equality Impact Assessments are now published and available on NHS Tayside Website.
- Single Equality Scheme and Action Plan will be published on our website.
- The Single Equality Action Plan will be reviewed annually.
Publication and Access

The Single Equality Scheme and Action Plan can be found on our website, see web address below, or alternatively if you would like a copy please write to us on the address below.

Santosh Chima
Diversity and Inclusion Manager
NHS Tayside
Kings Cross
Clepington Road
DUNDEE
DD3 8EA
Telephone:- 01382 596950

Existing Equality Schemes and Annual Reviews on Race, Gender and Disability can also be accessed through our website.

Website: [http://www.nhstayside.scot.nhs.uk](http://www.nhstayside.scot.nhs.uk)

**Alternative Formats:** This annual report can also be produced in a hard copy in Easy Read version, LARGE PRINT or other formats and languages on request.

If you would like a copy of any of the partners Equality Schemes please request by contacting them direct as detailed below.

**Links to partner Equality Schemes:**
- Dundee City Council - [http://www.dundee.city.gov.uk/dundeecity/uploaded_publications/publication_329.pdf](http://www.dundee.city.gov.uk/dundeecity/uploaded_publications/publication_329.pdf)
- Tayside Police - [www.tayside.police.uk](http://www.tayside.police.uk)
- Tayside Fire & Rescue - [https://www.taysidefire.gov.uk/Uploads/9D017D3A-4C09-4230-9652-7EDEBF81A546.pdf](https://www.taysidefire.gov.uk/Uploads/9D017D3A-4C09-4230-9652-7EDEBF81A546.pdf)
- Perth & Kinross Council - [http://www.pkc.gov.uk](http://www.pkc.gov.uk)
Community Engagement Event

Single Equality Scheme

What?
NHS Tayside organised an engagement event and invited people from local communities in the 3 geographical areas of Tayside. The event started off with a presentation about the new Single Equality Bill. We took this opportunity to invite along an external speaker (Graeme Tarbet) who explained the work he does with Talking Newspapers (Audio tapes for the blind).

The rest of the time was allocated to involving the participants in a workshop.

Why?
We were required to engage with various groups and communities within Tayside and what their views were on what NHS Tayside were doing well for their particular needs and where they felt we needed to improve or develop services further.

Who?
Information and invitations were distributed widely throughout Tayside working with our local planning partners to ensure we included groups covering the 7 diversity strands.

Where?
It was decided by the Single Equality Planning Group that as there was to be only one Community Engagement Event it would be appropriate to hold the event in Dundee which is the central location in the 3 geographical areas of Tayside (Angus, Dundee and Perth & Kinross). A full day was booked at Ardler Complex in Dundee which met the needs of our diverse participants.

The Way Forward
The feedback from the workshops will be communicated to all participants and incorporated into our Single Equality Scheme on how we propose to take actions forward.
Dear Participant

SINGLE EQUALITY SCHEME, COMMUNITY ENGAGEMENT EVENT,
25 MARCH 2010

First of all I would like to thank you for taking time out from your busy schedule to attend the Community Engagement Event on 25 March 2010. It was a pleasure to meet with you personally, to seek your views and opinions about your health service and to engage with such a diverse audience.

As promised I am writing to inform you of how your input and participation at the event will be taken forward by NHS Tayside.

I have attached/sent out the feedback from the four groups. The morning session consisted of 3 groups. There were a mix of people from all equality strands – Age, Race/Ethnicity, Sexual Orientation, Disability, Gender and Religion/Belief. The afternoon session was specifically for people with a disability and their carers.

As you can see we have identified all of the issues under the four key questions. From this we will be able to identify key areas that NHS Tayside could take forward and other key areas which will be passed onto our local planning partners.

WHAT IMPACT HAS THIS EVENT HAD ON THE DEVELOPMENT OF THE SINGLE EQUALITY SCHEME?

The Single Equality Scheme has been developed in line with the new legislation and our general and specific duties. One of the duties in the development of the Scheme was that we have meaningful engagement with Equality Groups to identify things that we had done well, things that we needed to improve on and things that we need to progress with.

This will help to identify any issues, concerns or barriers to service delivery and access for Equality Groups. The feedback from the Engagement Event will then be collated and analysed to identify priorities/actions that we will address in the Single Equality Scheme and Action Plan.

THE WAY FORWARD

We will identify key themes and issues under these headings so that we can prioritise those -

- which are local to NHS Tayside
- which are issues for GP services
- which need to be fed back to NHS 24
- which are Local Authority issues.

This work will be taken forward over the next couple of months so that we can identify the priorities that need to be addressed, what is already being addressed and issues that have been tackled and we have achieved an outcome on.

This will be done through the Single Equality Planning Group and with our Key Service Managers across the organisation. There may be a further opportunity to involve some of you on key issues that have been identified and require further
involvement and engagement with yourselves. This will be taken forward as an action in the Single Equality Scheme Action Plan.

A copy of the Single Equality Scheme and Action Plan will be available on our website from July 2010.  www.nhstayside.scot.nhs.uk

Regards

Santosh Chima

Santosh Chima
Diversity & Inclusion Manager
NHS Tayside
Group 1

At the AM Session there were 3 groups with 4 questions to answer.

Q1 **Are there any barriers which prevent you from using our services?**

- Transport/Information around transport available.
- Identify to visually impaired NHS staff to recognise that we acknowledge who we are to everyone.
- Nutrition
- Provision of information – e.g. size of print – how placing/where
- Communication – “Just Ask Us” (service users)
- Understanding your needs

Q2 **What is important to you as a service user?**

- Dignity & Respect
- Individuals (“We Are”)
- Good Practice
- Good Patient Experience
- Staff Attitudes
- Create a healthy environment
- Training
- Listening
- Diversity in staff at all levels

Q3 **How can we tell you of the development of new services?**

- Utilise Community Groups
- GP Surgeries
- Use of technology
- Local radio

Q4 **How do we tell you about the progress with our action plan?**

- GP Surgery televisions
- Health Centres
- Local places of Worship
- Businesses/Libraries
- Need to identify where to place information locally
- Information correct – no jargon

**Challenge**

How do we (NHS) feed out the appropriate information?

Specific points of context for information

Realising we are all individuals

- Different needs
- Want good patient experience
- Information/Communication
- Ask us what we want and in a format that meets our needs
- Listen to us
Group 2

Q1 Are there any barriers which prevent you from using our services?

COMMUNICATION
- Literacy and Language
- More interpreters (female interpreters for female patients)

GENDER SPECIFIC SERVICES
- Muslim women accessing services who may require same gender health professionals
- Health Inequalities for Gypsies/Travelling Community are still very prominent and these people cannot access services in the same way.

SIGNAGE
- Consistent Message (e.g. not just one poster in one area)
- Poor services can enable future barriers (young mothers – LGBT users)
- Loss of personal contact for older people because of advancing technology

Q2 What is important to you as a service user?

COMMUNITY INFRASTRUCTURE
- Promote Self Help
- Promote Volunteers
- “Communities in Control” (community links from diverse groups with health services) e.g. BUDDY SYSTEM
- Be mindful of “Age”
- Champions
- Volunteer
- Champions from communities/contacts e.g. LGBT champions

DEVELOP “MENS”/“WOMENS” CLINICS – Holistic approach to care
- Open Door
- No Embarrassment
- -Community Based/Outreach e.g. Adopt Community Heart Model?
- Get Rid of Assumptions/Labels
- Staff Need More Development – diverse workforce

Q3 How can we tell you of the development of new services?

OPEN COMMUNICATIONS
- Community
- Flyers/Posters (eye catching – inviting – easy read)
- Places of Worship
- Surgeries/Pharmacies
- Libraries
- Local Authority Offices
- Schools

Q4 How can we tell you about the progress with our action plan?

- Use Word of Mouth
- Find the Networks – 3 Geographical Areas – Community Forums
- Voluntary Action
- Volunteer Centre
- Continue to use existing Distribution Lists
- Link with local authority E & D Groups
• Social Networking Style Site/Page
• Carry out process of mapping existing communication structures
• Develop All Inclusive One Stop Shop
Group 3

Q1 Are there any barriers which prevent you from using our services?

Lack of preventative information
- Ready access to GP – having to phone at 8am if looking after someone who needs lots of help
- Continuous phone calls (times to phone/access)
- Receptionist training (improve communication skills – protection of GPs – how can they assess someone’s needs?)

NHS 24 (out of hours)
- Frontline interaction of staff – improved communication skills
- Phone numbers and how to access (should be easily accessible)
- Cultural understanding/training for all staff

Acute Hospitals
- Nursing staff in acute hospitals not able to relay vital information from medical staff – patients may not be able to do this themselves if elderly or disabled
- Discharge planning protocol access – carers should be involved
- People who have no visitors – Advocates – Volunteers
- Mobility issues
- Dignity and Respect for Patients

Q2 What is important to you as a service user?
- Dignity and Respect – elderly and cultural issues
- Poor communication skills (nursing staff too busy)
- Mixed messages given from different Health Professionals (Attitudes)
- Time slots for meals not patient focused – elderly patients may not eat if not supported
- Information access – easy read leaflets – where to find information – how do you know what questions to ask and what services are available

Q3 How can we tell you of the development of new services?
- Information leaflets (there are no easy read formats)
- One stop shop to find information and easily accessible, not necessarily in hospital
- Help with knowing what questions to ask
- What services are available in different locations
- Concerns re future services – keeping informed

Q4 How can we tell you about the progress with our action plan?
- Follow up meetings
- Campaigns

Other Main Points
- Appropriate food for those elderly people in hospital long term
- Holistic care for people in hospital and before discharge
Group 4

The PM Session consisted of 1 group focusing on disability.

Q1 Are there any barriers which prevent you from using our services?
Q2 What is important to you as a service user?

The above 2 questions were asked and the following key issues were identified around barriers and priorities as service users.

- Listening to Carers
- Service to fit the person
- Communication
  - Frontline Staff
  - Abbreviations
  - Jargon
- Access
  - Appointment Times
  - Distance to Travel etc
- Literature
  - Density of Print
  - Easy Read
- Signage
- Assistance Point
- Waiting Times
- Carers needs/Help
- Flagging Systems – I.T.
- Domiciliary Auditory Services
- Loop Systems
- Stocks and Equipment Supplies – Location
- Frontline Staff Communication
- Staff Attitudes
- Inequity of Service (e.g. people with learning disabilities do not have the same access to physio services)
- Status of Carers
- Transitional Issues
- Information – Equipment etc
- Support (Family) ADHD

Q3 How can we tell you of the development of new services

- Media (Radio, Journals etc)
- Shopping Centres
- Cafes
- Signposting

Q4 How can we tell you about the progress with our action plan?

- Feedback survey through various mediums

Comment from a PPG Group Member

Today’s event has opened my eyes in that the PPGs in NHS Tayside are not reflecting our communities and public because they are made up of retired middle class people – there is no diversity in the PPGs, more diversity in today’s event than in PPGs. The PPG membership requires to be revisited.
# NHS Tayside
## Single Equality Scheme
### Action Plan
#### 2010 – 2014

<table>
<thead>
<tr>
<th>Equality Groups</th>
<th>Implementation Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>✓ - Action completed</td>
</tr>
<tr>
<td>Gender</td>
<td>😊 - Action on course for completion</td>
</tr>
<tr>
<td>Disability</td>
<td>🕒 - Progress made but slippage on planned timescale</td>
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<tr>
<td>Race</td>
<td>✗ - Little or no progress achieved</td>
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<tr>
<td>Religion/Belief</td>
<td>🗣 - Change to action originally planned</td>
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<tr>
<td>Sexual Orientation</td>
<td>📦 - Further information required</td>
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<tr>
<td>Transgender</td>
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</tbody>
</table>
### Leadership and Energising

#### The Organisation

**Aim - Human Rights based Approach**

<table>
<thead>
<tr>
<th>Objective 1</th>
<th>Action What are we going to do?</th>
<th>Outcome What will success look like?</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership and Energising the Organisation</td>
<td>An executive or Board member to have lead responsibility on human rights action to achieve improved outcomes for patients and their carers.</td>
<td>NHS Tayside Board will name an executive or Board member to take responsibility for Human Rights action and show leadership at local and national level.</td>
<td>Director for Workforce</td>
<td>Sept 2010</td>
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<tr>
<td></td>
<td>To build a culture based on the FREDAX (Fairness, Respect, Equality, Dignity and Autonomy) principles.</td>
<td>NHS Tayside Board will use explicit human rights language, such as accountability, empowerment, participation, non-discrimination, when developing strategy and policy and can evidence this approach, especially when focusing on vulnerable groups.</td>
<td>NHS Tayside Board Secretary</td>
<td>2010 - 2014</td>
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<td>1.2</td>
<td>To identify key areas where a 'human rights-based approach' to healthcare is relevant where human rights issues may arise and what these issues may be.</td>
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<td>Putting Human Rights based approach at the centre of service priorities and service delivery, (policies and practices) especially for vulnerable groups</td>
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<td></td>
<td>Local Delivery Plans will evidence how a human rights approach using the FREDA principles have been used to deliver better outcomes for patients and carers</td>
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<td></td>
<td>Develop a greater understanding of what a human rights framework means for healthcare.</td>
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<td></td>
<td>Service managers will be able to incorporate the FREDA principles into delivery of healthcare.</td>
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<td>CHP General Managers</td>
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<td></td>
<td>Director of Public Health</td>
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<td>Director of Health Strategy</td>
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<td></td>
<td>Jun 2012</td>
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<td>All</td>
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<table>
<thead>
<tr>
<th>1.3</th>
<th>To raise awareness and give information on human rights approach to healthcare.</th>
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<tbody>
<tr>
<td></td>
<td>Human Rights training is incorporated into future Equality and Diversity training and awareness and into Board Development events</td>
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<tr>
<td></td>
<td>Senior managers have completed Human Rights training and this can be evidenced through their objectives. This will allow the Board and Senior Managers the skills and tools to enable them to assess that we are moving towards a culture based on the FREDA principles.</td>
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<td></td>
<td>Head of Knowledge and Skills</td>
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<td></td>
<td>Jun 2010</td>
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<table>
<thead>
<tr>
<th>1.4</th>
<th>Encourage all staff to value themselves in the work they do in supporting others</th>
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<tbody>
<tr>
<td></td>
<td>Develop a Spiritual Care Strategy which sets out five strands of Spiritual Care – acute, bereavement, community, staff and volunteering.</td>
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<td></td>
<td>All staff will have respect for themselves in the work they do and so provide best value of care to all they have responsibility for.</td>
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<td></td>
<td>Head of Spiritual Care</td>
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<td>2011</td>
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<td>All</td>
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</table>
### Objective 2: Governance

#### Action

**What are we going to do?**

- The Equality and Diversity Steering Group will lead on Equality and Diversity work and will receive reports on the annual review of the Single Equality Action Plan.

- The Staff Governance Committee will receive annual reviews of the employment actions of the Single Equality Action Plan and the Improvement and Quality Committee on the Service delivery and Access actions.

#### Outcome

**What will success look like?**

- There will be a clear audit trail of progress with Equality and Diversity.
- There will be clear and robust governance process in place for monitoring and evaluation to evidence a continuous improvement approach with equality.
- This will be audited through the Board Committee reports and minutes.

<table>
<thead>
<tr>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversity &amp; Inclusion Manager</td>
<td>2010 – 2011</td>
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<tr>
<td>2.2</td>
<td><strong>To assess the effectiveness of the arrangements in place for equality and diversity.</strong></td>
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<td></td>
<td>To revisit the governance arrangements for Equality and Diversity in light of the changing landscape and context of equality legislation and national priorities.</td>
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<td></td>
<td>A Continuous Quality Improvement (CQI) approach to equality and diversity in response to key priorities and is able to clearly demonstrate this through the governance process.</td>
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<td></td>
<td>To work with service managers to ensure that they have measures in place to monitor and evidence progress</td>
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<tr>
<td>Diversity &amp; Inclusion Manager</td>
<td>Dec 2010</td>
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<table>
<thead>
<tr>
<th>2.3</th>
<th><strong>In the delivery of their objectives senior managers are able to reflect the FREDA principles.</strong></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>NHS Tayside Board will be given guidance on how to deliver and incorporate the FREDA principles into the principles for decision making and delivery of objectives.</td>
</tr>
<tr>
<td></td>
<td>This will allow equality objectives to be identified for all Senior Managers and management teams within the organisation and will be evidenced through the annual reviews of the Local Delivery Plans.</td>
</tr>
<tr>
<td>CHP Service Managers Acute Service Managers</td>
<td>Apr 2010 – Apr 2011</td>
</tr>
</tbody>
</table>
### Objective 3: Procurement

**Action**
- Any new supplier of services to state and show evidence that they have equality embedded into their policies and practices and if they do not, it is a condition of their contract that they must introduce equality into their policy and practice.

**Outcome**
- Procurement arrangements will show that contractors and partners demonstrate and evidence a commitment to equality.
- Tenders from organisations unable to demonstrate a positive approach to promoting equality will be unsuccessful.
- Using public procurement to improve equality by including requirements about apprenticeships or traineeships being offered to people from under represented groups as part of the contract conditions.

<table>
<thead>
<tr>
<th>Action</th>
<th>Outcome</th>
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<tr>
<td>Any new supplier of services to state and show evidence that they have equality embedded into their policies and practices and if they do not, it is a condition of their contract that they must introduce equality into their policy and practice.</td>
<td>Procurement arrangements will show that contractors and partners demonstrate and evidence a commitment to equality. Tenders from organisations unable to demonstrate a positive approach to promoting equality will be unsuccessful. Using public procurement to improve equality by including requirements about apprenticeships or traineeships being offered to people from under represented groups as part of the contract conditions.</td>
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<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
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<tbody>
<tr>
<td>Head of Procurement</td>
<td>Jun 2010 - Jun 2012</td>
<td>All</td>
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</tbody>
</table>
3.2 Procurement and contractor compliance

Where a contractor is carrying out a public function on behalf of NHS Tayside, we will be required to build relevant gender equality considerations into the procurement process. Gender equality applies for those functions which are carried out through procurement as well as directly by NHS Tayside. Head of Procurement and Diversity & Inclusion Manager 2010 - 2011 Gender
<table>
<thead>
<tr>
<th>Objective 4</th>
<th>Action</th>
<th>Outcome</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity Leadership Skills</td>
<td>Diversity Management integrated into Board development plans and leadership training and development.</td>
<td>Increased diversity confidence and understanding amongst senior level leaders who are able to demonstrate this through performance management. Managers able to measure evidence during Appraisals.</td>
<td>Head of Leadership and Management Development Head of Knowledge and Skills</td>
<td>Jun 2010 - Jun 2011</td>
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</tbody>
</table>
### Aim – Equality & Diversity Impact Assessment Financial Decisions

<table>
<thead>
<tr>
<th>Objective 5 Core Budgets and Staff Resources</th>
<th>Action What are we going to do?</th>
<th>Outcome What will success look like?</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Equality Impact Assessment of financial plans to help with financial planning processes</td>
<td>All cost saving financial planning decisions are subject to EQIA.</td>
<td>This will ensure there are no disproportionate effects on different equality groups as the result of financial decisions made. Core budgets and staff resources may be used differently to tackle inequality.</td>
<td>Director of Finance</td>
<td>Jun 2010 - Jun 2011</td>
<td>All</td>
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</tbody>
</table>
# Access and Service Delivery

## Aim - Equalities Monitoring and Profiling

<table>
<thead>
<tr>
<th>Objective 1</th>
<th>Action</th>
<th>Outcome</th>
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<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td><strong>Ethnicity data collection</strong></td>
<td>To develop an action plan to improve the collection of data on Age, Gender, Disability, Race/Ethnicity, Sexual Orientation, Transgender and Religion/Belief.</td>
<td>TOPAS (Tayside Outpatients System) will be able to record patient information by equality groups. This will be done in two phases: Phase I will allow us to record patient information on Age, Gender, Race/Ethnicity and Religion/Belief. Phase II will include recording information on Disability, Sexual Orientation and Transgender.</td>
<td>Data Quality Manager</td>
<td>Nov 2009 - Mar 2010</td>
<td>Age Gender Race/Ethnicity Religion/Belief</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Diversity and Inclusion Manager</td>
<td>Mar 2010 - Nov 2010</td>
<td>Sexual Orientation, Disability and Transgender</td>
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<td>Nov 2010 - Nov 2012</td>
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<tr>
<td>1.2 Develop an Equalities Monitoring and data collection training programme for staff</td>
<td>Work with NES (NHS Education Scotland) to deliver a national pilot training programme for Equalities Monitoring and Data collection.</td>
<td>Targeted staff are aware of the importance of collecting data and feel confident and equipped to do so through an appropriate training and education programme.</td>
<td>Head of Knowledge and Skills Data Quality Manager</td>
<td>Mar 2010 - Jul 2010</td>
<td>Age Gender Race/Ethnicity Religion/Belief</td>
<td></td>
</tr>
</tbody>
</table>
### Aim - Delivery of Clinical Service Priorities

<table>
<thead>
<tr>
<th>Objective 2</th>
<th>Action</th>
<th>Outcome</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity Impact Assessment Local Delivery Plans</td>
<td>Each of the service managers will have identified their service priorities for the next year and the ones that will require to be Equality Impact Assessed. Equality Impact Assessments will be carried out by involving, consulting and engaging with staff who provide those services and service users who use those services.</td>
<td>Service plans will clearly demonstrate how they promote equality and eliminate discrimination by addressing any disadvantage or adverse impact for equality groups. Clinical services for Cancer, Diabetes, Coronary Heart Disease/Stroke, Sexual Health, Mental Health, and Learning Disabilities will assess and manage patient’s experiences of inequality and discrimination in line with priorities for service development.</td>
<td>CHP General Managers Acute Services General Managers for Access, Surgery and Medicine</td>
<td>Apr 2010 - Apr 2011</td>
<td>All</td>
<td></td>
</tr>
</tbody>
</table>
### Objective 3
**Systems and Processes in Place to Tackle and Address Gender Based Violence**

<table>
<thead>
<tr>
<th>Action</th>
<th>Outcome</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
</tr>
</thead>
</table>
| Year 1 and year 2 (Oct 2008 – Oct 2010) 4 key deliverables:  
- National Employee Policy on GBV  
- Introduction of Routine Enquiry  
- Dissemination of good practice guides  
Multi agency collaboration to prioritise participation on child/adult protection and health and homelessness partnerships and review links with other key partners. | There will be a National Employee Policy on Gender Based Violence which will have been Equality Impact Assessed.  
Systems and processes will be in place for Routine Enquiry of abuse in the 3 priority settings.  
Priority staff groups will have Good Practice Guides on GBV.  
There will be evidence of partnership working across Tayside. | Director of Nursing at NHS Tayside Board | Oct 2010 | All | To comply with the action plan timelines |
### 3.2
NHS priority service areas have been identified for year one:
- Mental Health
- Maternity
- Addiction and substance misuse

<table>
<thead>
<tr>
<th>Training for trainers programme to be implemented in those areas.</th>
<th>To build capacity and sustainability. Give staff the skills, knowledge and abilities to address/tackle Gender Based Violence in the priority settings.</th>
<th>Head of Knowledge and Skills</th>
<th>Feb 2010</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training for staff on gender based violence in the 3 priority areas.</td>
<td>Head of Knowledge and Skills</td>
<td>Oct 2010</td>
<td>All</td>
<td></td>
</tr>
</tbody>
</table>
### Aim – Improve Service Delivery & Access for Learning Disabilities

<table>
<thead>
<tr>
<th>Objective 4 NHS Tayside Plan for Learning Disabilities</th>
<th>Action What are we going to do?</th>
<th>Outcome What will success look like?</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
</tr>
</thead>
</table>
| 4.1 Develop an Action Plan to address the quality indicators that were not met in the NHS QIS assessment. | Robust systems and processes in place for people with learning disabilities  
1. We are able to meet all of quality indicators  
2. Promoting inclusion and well being  
3. Meeting general health care needs | Service will meet the individual needs of the clients/patients and ensure that there are systems and processes in place to address and meet each of the quality indicators. | Executive lead for Learning Disabilities | 2010 - 2011 | Learning Disabilities | |
| 4.2 Care planning for people with learning disabilities | All admission and discharge documentation contains information on the specific needs of the clients and ensuring that they are individualised. | All care plans will be developed by utilising the new nursing documentation and with input from the multidisciplinary team. Where available the All About Me or PAMIS passport can assist when documentation is being completed. | Nurse Consultant for Learning Disabilities | 2010 | Learning Disabilities | |
| 4.3 Implementation of the NHS Tayside Wheelchair Service Improvement Plan |
|---|---|
| **Wheelchair users** will be part of the group and will help in delivering the key priorities in the Improvement plan to improve wheelchair users and seat services for the disabled people.

A Wheelchair User Forum will be established to support in the delivery of the priorities and also to raise and address issues with wheelchairs and access issues. | **Wheelchair users** will be able to identify and feedback what improvement has happened and what else needs to be done through the forum. | **Consultant Clinical Scientist/Head of AT Services** |
| 2009 – 2012 | Disability |
### Aim - Communication and Information Access

<table>
<thead>
<tr>
<th>Objective 5 Interpretation and Translation Service</th>
<th>Action</th>
<th>Outcome</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.1</strong> Equally Well Recommendation 63 is Accessible Communications. Meet the Communication support and Language needs of our communities and service users</td>
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<tr>
<td>Interpretation and Translation Operational Group will take forward any issues and improvements to the service. NHS Tayside will regularly consult and engage with users of the service to ensure we are complying and providing a quality service.</td>
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<td>This will be an efficient and effective service which is quality assured.</td>
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<td>Director of Nursing</td>
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<td>Jan 2012</td>
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<tr>
<td>Disability and Sensory Impaired Black Minority Ethnic Communities</td>
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<tr>
<td><strong>5.2</strong> Access to information is available in a format that meets the needs of the diverse communities</td>
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<tr>
<td>Patient Information Group will address any issues and take forward work around patient information.</td>
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<tr>
<td>There is evidence of an increase in information produced in an accessible format.</td>
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<tr>
<td>Head of Safety Governance and Risk Management</td>
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<td>2010 - 2011</td>
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<tr>
<td>Disability Sensory Impaired BME Communities</td>
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</tbody>
</table>
### Objective 6
Development and Implementation of the Health Equity Strategy

<table>
<thead>
<tr>
<th>Action</th>
<th>Outcome</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Ensure that health improvement delivery takes account of the needs of the socio economically deprived and equality groups.</td>
<td>All CHP’S will develop local HES action plans to address health inequalities. The Health Equity Strategy makes explicit how health improvement activity addresses inequality and disadvantage. NHS Tayside can demonstrate how the health improvement framework priorities are tailored to meet the needs of the equality groups.</td>
<td>Director of Public Health</td>
<td>Jun 2011</td>
<td>All</td>
<td></td>
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<tr>
<td>6.2 Social Responsibility and Inclusion is inbuilt into health improvement and service provision.</td>
<td>Invest in goods and services in a way which tackles poverty and discrimination. Corporate Social Responsibility activity will be aligned to the local CHP Health Equity Strategy Action Plans and the Single Equality Scheme Action Plan.</td>
<td>CHP General Managers Diversity &amp; Inclusion Manager</td>
<td>Jun 2011</td>
<td>All</td>
<td></td>
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</tbody>
</table>
### Objective 7
**Equality Impact Assessment**

<table>
<thead>
<tr>
<th>Action</th>
<th>Outcome</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
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</thead>
</table>
| **7.1** Equality Impact Assess policies, functions and service improvement planning framework.  
Planning frameworks are in line with inequalities guidance and are subject to EQIA. | Policy development and service improvement planning will take account of any inequalities and barriers that may inadvertently impact on equality groups. 
The Committee/Forum where the policy is being approved has to ensure that the policy has a completed EQIA before approval. | CHP Service Managers Clinical Service Managers and Policy Leads | Ongoing | All |
| **7.2** To develop an Equality Impact Assessment Policy  
A policy development group will be set up to take this work forward. | This will allow the EQIA process to be reviewed and revised regularly. | Diversity & Inclusion Manager | 2011 | All |
| **7.3** All policies assessed as relevant to the public duty by carrying out EQIA  
The Safety Governance & Risk Management monitor and review all policies. An action framework is in place to support the EQIA system. | All policies flagged up 3 months prior to review date. Policy breaches are regularly reported to the Delivery Unity/Health & Safety Management Group and the Strategic Risk/Health & Safety Management Group. | Head of Safety Governance and Risk Management | June 2010 | All |
## Aim – Transgender Policy

<table>
<thead>
<tr>
<th>Objective 8 Develop Transgender Policy</th>
<th>Action What are we going to do?</th>
<th>Outcome What will success look like?</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td>8.1 Policy to be developed with key stakeholders and transgender people</td>
<td>A policy group will be set up to take this work forward.</td>
<td>Staff are aware of the transgender policy and know who to contact for further information.</td>
<td>Diversity &amp; Inclusion Manager</td>
<td>2011</td>
<td>Transgender People</td>
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<tr>
<td>8.2 Develop a training plan and communication plan for the implementation of the policy.</td>
<td>An audit is done of the frequently used services by transgender people so that a targeted training programme can be delivered for staff in those services.</td>
<td>Transgender specific training has been delivered to staff who require it.</td>
<td>Diversity &amp; Inclusion Manager</td>
<td>2011 – 2012</td>
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</tbody>
</table>
## Aim – Implementation of Older People’s Strategy

<table>
<thead>
<tr>
<th>Objective 9</th>
<th>Action What are we going to do?</th>
<th>Outcome What will success look like?</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
</tr>
</thead>
</table>
| Effective Delivery of Improved Services for Older People | Deliver on the 10 key priorities within the Older People’s Strategy under the 4 key themes:  
- Staying at Home  
- Quality Dementia Care  
- Being part of the community  
- Better experience of Acute Care | The priorities will be implemented primarily through the local Community Planning Partnership in Angus, Perth & Kinross and Dundee  
Older People’s Service development plans will be developed for each locality. | Will improve the health care, support and well being of older people.  
Will allow NHS Tayside to shift the Balance of Care to provide care that is more in line with the modern needs and to ensure we are using the resources effectively and efficiently in the long term. | Commissioner for Older People | 2010 – 2014 | All | |
| Equality Impact Assess current approach to delivery of Older People’s Services | The 4 key themes will be Equality Impact Assessed. | Any inequality, barriers and issues of discrimination for equality groups are identified and addressed to ensure equal access to services. | Commissioner for Older People | | All |
9.3 NHS Tayside will be part of a Scottish Government pilot to test out a Health Inequality approach to Equality Impact Assessment using a nationally developed toolkit.

| The key theme that will be involved in this pilot is Dementia Care. A Health Integrated Equality Impact Assessment will be carried out on Dementia Care Services. Learning and good practice from this pilot will help with consistency to equality impact assessment. A national toolkit will be developed from this pilot to be used across NHS in Scotland. | Assistant Commissioner for Older People and Diversity & Inclusion Manager | Nov 2010 | All |

All
<table>
<thead>
<tr>
<th>Objective 10</th>
<th>Action</th>
<th>Outcome</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
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<tbody>
<tr>
<td>Effective delivery of services for children and young people</td>
<td>To implement the CAMHS framework for promotion, prevention and care. To develop Early Strategy and Parenting Strategy</td>
<td>To increase the number of opportunities to intervene in children and young people’s lives at an earlier stage, in line with the National Early Years Early Intervention Strategy</td>
<td>Deputy Child Health Commissioner</td>
<td>Jun 2011</td>
<td>All</td>
<td></td>
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<tr>
<td>10.1 Early Intervention</td>
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<tr>
<td>10.2 Preventative Health Services</td>
<td>To develop preventative health services in communities, for communities, by fully engaging with them from an early stage</td>
<td>There will be a reduction in Teenage Pregnancy We will reduce the impact of substance misuse on children and young people through parental or own use</td>
<td>Deputy Child Health Commissioner</td>
<td>Jun 2011</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>10.3 Vulnerable Children and Young People</td>
<td>Ensure a multi-agency approach to the development of Child Protection Services</td>
<td>There will be accessible, appropriate, fair and equitable services for vulnerable children and young people</td>
<td>Deputy Child Health Commissioner</td>
<td>Jun 2011</td>
<td>All</td>
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<tr>
<td>Ensure appropriate and timely services are available to <strong>Looked After Children</strong> and young people</td>
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<tr>
<td>Implement and Monitor the National Delivery Plan</td>
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<tr>
<td>Continue to address the health inequalities that impact upon children and young people in line with Equally Well.</td>
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<tr>
<td>10.4 Engagement and Involvement of Children and Young People</td>
<td>Integrate and embed engagement and involvement action plans across NHS Tayside.</td>
<td>There will be engagement of children and young people in the planning and development of services in an open, honest and realistic manner.</td>
<td>Deputy Child Health Commissioner</td>
<td>Jun 2011</td>
<td>All</td>
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</table>
## Community Involvement

### Aim - Community Engagement

<table>
<thead>
<tr>
<th>Objective 1 Consultation, Engagement and Involvement</th>
<th>Action What are we going to do?</th>
<th>Outcome What will success look like?</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td>1.1 Involve, engage and consult with service users and the public in the planning and delivery of services and service change. Ensure that individuals and groups who can identify with the issue of discrimination associated with Race, Gender, Disability, Age, Religion/Belief, Sexual Orientation, Social Class/Socio Economic Deprivation and Transgender are an integral part of the engagement process</td>
<td>Engagement and patient feedback, action plans and reports will demonstrate that equality groups and individuals are included in community and patient involvement, activity, taking cognisance of community engagement standards.</td>
<td>Views of all communities will contribute to service improvement and development.</td>
<td>Public Involvement Manager, CHP PFPI Leads</td>
<td>2010 - 2011</td>
<td>All</td>
<td></td>
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<td></td>
<td>Patient experience and complaints by equality groups will be addressed through clinical governance</td>
<td>The number of complaints in relation to equality groups will be monitored and reported regularly</td>
<td>Complaints and Advice Manager, Clinical Governance Leads</td>
<td>2010 - 2011</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Implementation and Delivery of the 3 year REACH Project for BME communities.</td>
<td>To support the project team and meet with them regularly for project updates and progress</td>
<td>The Project will compliment existing public engagement work being carried out by CHPs within NHS Tayside. Will build confidence and capacity within the BME communities for them to have a voice in participating in the policy decision making process.</td>
<td>Associate Director for Workforce</td>
<td>2009 - 2012</td>
<td>Race / Ethnicity</td>
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<tr>
<td>1.3</td>
<td>Advocacy Strategy to be developed by April 2010</td>
<td>EQIA strategy to identify any gaps/adverse impacts/barriers.</td>
<td>The strategy would include views and input from local minority communities, local advocacy providers will monitor referrals in relation to local communities.</td>
<td>Public Health Voluntary Sector Manager</td>
<td>2009 - 2012</td>
<td>Race / Ethnicity Disability Older People</td>
</tr>
</tbody>
</table>
## Demographics

### Aim - Demographic Profile

<table>
<thead>
<tr>
<th>Objective 1</th>
<th>Action</th>
<th>Outcome</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td>1.1 To develop a population profile and update it as and when data/evidence becomes available</td>
<td>Analysis of the disaggregated data to identify demographic/health patterns for use in planning processes.</td>
<td>People designing service delivery will understand where and how to access demographic information to inform decisions about service delivery and to address any inequality in health care provision for the equality groups.</td>
<td>Health Intelligence Manager</td>
<td>2010 - 2011</td>
<td>All</td>
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</tbody>
</table>
# Workforce and Employment

**Aim – Equality & Diversity Employment Monitoring**

<table>
<thead>
<tr>
<th>Objective 1</th>
<th>Action</th>
<th>Outcome</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
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<tbody>
<tr>
<td>Collection of Employment and Monitoring Data</td>
<td>An analysis of the workforce profile data is done and annually reported to NHS Tayside Staff Governance Committee.</td>
<td>The collection of equality and diversity monitoring data will improve</td>
<td>Associate Director of Workforce</td>
<td>Jun 2011</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>1.1 To improve the availability of employment information on a disaggregated basis</td>
<td>Consider the use of positive action to improve any barriers to employment for equality groups</td>
<td>NHS Tayside will have a diverse workforce which is reflective of the make up of local population and the communities that we serve.</td>
<td>Head of Employment Services</td>
<td>Jun 2011</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>1.2 From the data address any remaining barriers that may exist in recruitment and retention.</td>
<td>Take steps to remove any barriers and promote equality of opportunity.</td>
<td>NHS Tayside will be able to identify who benefits and who does not suffer as a result of application of process.</td>
<td>Associate Director for Workforce (Employee Experience)</td>
<td>Jun 2011</td>
<td>All</td>
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<tr>
<td>1.3 Measuring progress in equality of opportunity through monitoring</td>
<td></td>
<td>We will be able to capture better data on training opportunities</td>
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<tr>
<td>• Number of staff in post</td>
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<tr>
<td>• Applicants for employment</td>
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<tr>
<td>• Training and promotion</td>
<td>To implement e-KSF</td>
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<td>• Who receives training.</td>
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</table>
## Aim - Equal Pay

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<thead>
<tr>
<th>Objective 2 Equal Pay Audits</th>
<th>Action</th>
<th>Outcome</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
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<tbody>
<tr>
<td>2.1</td>
<td>To develop an equal pay action plan</td>
<td>Develop an equal pay action plan</td>
<td>Head of Pay and Productivity</td>
<td>Jun 2011</td>
<td>All</td>
<td></td>
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<tr>
<td></td>
<td>NHS Tayside will carry out an Equal Pay Review to tackle any pay gap for equality groups.</td>
<td>We will identify any causes of unequal pay and change any policies or practices that have, or continue to contribute to unequal pay.</td>
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<td></td>
<td>Identify key actions to deliver on equal pay.</td>
<td>Publish Equal Pay data and information at regular intervals.</td>
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<tr>
<td>2.2</td>
<td>Equal Pay Statement</td>
<td>Review and revise the existing Equal Pay Statement in line with guidance from Scottish Government Workforce Directorate.</td>
<td>Head of Pay and Productivity</td>
<td>Jun 2011</td>
<td>All</td>
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<tr>
<td></td>
<td>To review and revise the existing Equal Pay Statement in line with guidance from Scottish Government Workforce Directorate.</td>
<td>An Equal Pay Policy which will develop steps towards achieving equal pay</td>
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</table>
### Aim - Promotion of Positive Attitudes and Behaviours

<table>
<thead>
<tr>
<th>Objective 3 Employee behaviour</th>
<th>Action What are we going to do?</th>
<th>Outcome What will success look like?</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Compliance with PIN guideline for Dignity at Work</td>
<td>Implementation of the Dignity at Work Toolkit</td>
<td>Number of Bullying and Harassment grievances will decrease</td>
<td>Head of Workforce for Acute Services</td>
<td>2010-2011</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>3.2 Equality and Diversity Champion’s role will be promoted.</td>
<td>Equality and Diversity Champions will act as a support and contact for Dignity at Work Issues. They will signpost and challenge inappropriate behaviour and reinforce positive attitudes to Equality and Diversity</td>
<td>Equality and Diversity Champions</td>
<td>Diversity &amp; Inclusion Manager</td>
<td>2010-2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3 Staff are well informed and trained appropriately on their legal responsibilities.</td>
<td>A learning and education plan is in place including annual targets to increase the numbers of staff trained on equality issues. Equality and Diversity Training will be aligned to the Knowledge and Skills Framework and Core competency 6 (Equality &amp; Diversity) E-KSF will be able to collect data on training.</td>
<td></td>
<td>Head of Knowledge and Skills</td>
<td>2010-2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equality and Diversity Training plan is implemented and training monitored.</td>
<td>Evidence is provided by the Equality and Diversity Training group of progress and the number of people trained in the organisation.</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
## Aim – Staff Policies to Meet the Needs of Equality Groups

<table>
<thead>
<tr>
<th>Objective 4</th>
<th>Action What are we going to do?</th>
<th>Outcome What will success look like?</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality Impact Assessment of all employment policies</td>
<td>Carry out equality impact assessment on all new policies. Publish all equality impact assessments and evidence any adverse impact on equality groups. Address any barriers that may be identified for any of the equality groups or change the policy to ensure that we are meeting the general duty.</td>
<td>All employment policies will be non-discriminatory. Employment policies will be equally accessible to all.</td>
<td>Policy Leads</td>
<td>Ongoing</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>4.1 To ensure equality of opportunity for all employment policies</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4.2 Develop a Disability Leave Policy</td>
<td>A policy group with key stakeholders will take this piece of work forward and ensure that the policy will address and recognise the particular difficulties that are faced by disabled employees.</td>
<td>This will ensure that NHS Tayside will make specific provision for special leave in appropriate circumstances for employees who are disabled or care for a disabled person.</td>
<td>Head of Staff Governance</td>
<td>Jun 2011</td>
<td>Disability</td>
<td></td>
</tr>
</tbody>
</table>
## Aim – Involving Staff Who Are Lesbian, Gay, Bisexual and Transgender

<table>
<thead>
<tr>
<th>Objective 5</th>
<th>Action</th>
<th>Outcome</th>
<th>Corporate Lead</th>
<th>Timescale</th>
<th>Equality Groups Affected</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGBT Staff/Employee Network</td>
<td>Structured involvement of people who are LGBT and who work for NHS Tayside.</td>
<td>NHS Tayside will give LGBT staff time and support to be involved in the network. Communicate to all the workforce of the LGBT Network to encourage membership. This will give LGBT staff a support network where they can support each other and share views and experiences. The Network in time will be used as a reference group for consultation on policy practice and development to ensure we are being inclusive for LGBT staff.</td>
<td>Diversity &amp; Inclusion Manager</td>
<td>Jun 2011</td>
<td>Sexual Orientation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stonewall membership and part of the Stonewall Champions Programme.</td>
<td>Complete the Equality Workforce Index annually. To be part of the Stonewall Recruitment Guide for Employees and advertise NHS Tayside as an employer who is LGBT Inclusive. This will allow NHS Tayside to be benchmarked against other Stonewall members who are part of the Champions Programme to let us know how inclusive we are and how we can improve. NHS Tayside will be seen as an employer of choice and our corporate image will be promoted as an employer who is inclusive and treats all its employees with dignity and respect irrespective of who they are.</td>
<td>Diversity &amp; Inclusion Manager</td>
<td>Jun 2011</td>
<td>Sexual Orientation</td>
<td></td>
</tr>
</tbody>
</table>
EQUALITY & DIVERSITY IMPACT ASSESSMENT GUIDANCE FOR NHS TAYSIDE

1. Background

Partnership for Care committed us to extend the principles set out in Fair for All ensuring that our health services recognised and responded sensitively to the individual needs, background and circumstance of people’s lives. The NHS Reform (Scotland) Act 2004 turned this into specific duties to promote public involvement and equal opportunities.

The Race Relations (Amendment) Act 2000 requires us to make arrangements of assessing and consulting on the likely impact of policies and functions on the promotion of race equality. A similar requirement is necessary for an amendment to the Disability Discrimination Act. The Disability Discrimination Act 2005 now places a duty on all public authorities, when carrying out their functions, to have due regard to the duty to promote disability equality. The Equality Act 2006 places a duty on us to ensure that when developing policies/strategies when delivering services to men and women, including transsexual people, they are not disadvantaged and take action to address any adverse impact.


Those members of staff normally involved in policy development should use the Equality Impact Assessment toolkit. It cannot be completed by one person and it is essential that the process as outlined in the toolkit is followed. This will ensure that a clear understanding of the specific issues/barriers/discrimination faced by one or more equality groups is addressed.

3. Specialist Support Within NHS Tayside

The Diversity & Inclusion Manager should be contacted for guidance in relation to race/ethnicity, gender, age, religion/belief, disability, transgender, or sexual orientation and when Equality Impact Assessments have been completed.

3.1 NHS Tayside Intranet

The NHS Tayside Staffnet Equality & Diversity Webpage provides a range of information on Equality & Diversity and relevant legislation.

4. Health Intelligence

There will be a clear requirement when preparing policies etc to have reliable data on areas such as demographic and/or disease specific information on the population of Tayside which could include quantitative databases and qualitative reports.

Assistance with this information can be sourced from contacting the Health Intelligence Manager, NHS Tayside. Information is also available on the NHS Tayside Intranet via the following pathway: Directorates/Directorate of Change & Innovation/Social Inclusion/Health Inequalities

5. Public Involvement & Consultation

Involvement and consultation is a key part of impact assessment. To discuss this further and/or to seek further guidance please contact the Public Involvement Manager, NHS Tayside.

6. Supplementary Information and Resources

There is a legal requirement to publish Equality and Diversity Impact Assessments on our external website www.nhstayside.scot.nhs.uk
Completing an Equality and Diversity Impact Assessment (EQIA)

The process enables you to screen policies and functions for potential impact on the equality target groups and other relevant groups. It is part of the development and planning process of any piece of work.

The EQIA is intended to highlight potential health and well-being impacts on equality groups, based on the knowledge and understanding of the stakeholders who participate. This then helps to identify any ways in which the policy or service improvement/redesign should be changed, to address any adverse impact or barriers to equality groups/communities and socio-economically deprived/poverty groups.

First the Impact Assessment Team identifies the different group/groups that may be affected by the policy or service redesign. It is important to include people who have a good understanding of the policy or service, as well as people with knowledge of the equality target groups and other stakeholders. You may need to have more than one group to cover the relevant interests and perspectives.

Population Groups

Specific consideration should be given to the following groups:

- Minority ethnic population (including refugees, asylum seekers & gypsies/travellers)
- Women and men
- People in religious/belief groups
- Disabled people
- Older people, children and young people
- Lesbian, gay, bisexual and transgender people
- People with mental health problems
- Homeless people
- People involved in criminal justice system
- Staff
- Socio economic deprivation groups

Not all of these groups will be relevant. Define the relevant groups for the specific policy or service improvement/redesign and add them to the Impact Assessment form.
### EQUALITY AND DIVERSITY IMPACT ASSESSMENT

<table>
<thead>
<tr>
<th>Name of Service Improvement / Redesign, Policy or Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Location Area of Service Improvement / Redesign, Policy or Strategy</td>
</tr>
<tr>
<td></td>
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<tr>
<td>What are the main aims of you Service Improvement / Redesign, Policy or Strategy?</td>
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<tr>
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<tr>
<td>What are the intended outcomes from the proposed Service Improvement / Redesign, Policy or Strategy?</td>
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<tr>
<td>Review Team – Who is assessing or considering the assessment?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Names and Titles of Team Members</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

When completed please attach to the policy prior to endorsement/approval at the relevant committee.

**MUST BE COMPLETED IN ALL CASES**
<table>
<thead>
<tr>
<th>Item No</th>
<th>Considerations</th>
<th>Detail Impact and Identify Groups Affected</th>
<th>Document the Evidence Which Supports This</th>
<th>What Further Actions Require to be Taken?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Which groups of the population will be affected by the policy/strategy/service redesign</td>
<td></td>
<td>Research you need to carry out in order to understand the impact more clearly. If not applicable please give reason why.</td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>Will it impact on the whole population?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1.2     | If not which groups of the population do you think will be affected by this function/policy?  
- Minority ethnic population (including refugees, asylum seekers & gypsies/travellers)  
- Women and men  
- People in religious/faith groups  
- Disabled people  
- Older people, children and young people  
- Lesbian, gay, bisexual and transgender people  
- People with mental health problems  
- Homeless people  
- People involved in criminal justice system  
- staff | | | |
<table>
<thead>
<tr>
<th>Item No</th>
<th>Considerations</th>
<th>Detail Impact and Identify Groups Affected</th>
<th>Document the Evidence/Research</th>
<th>Actions Taken/To be Taken</th>
</tr>
</thead>
</table>
| 2.      | **What impact will the policy/strategy/service redesign have on lifestyles?**<br>For example will the changes affect:  
- Diet & nutrition  
- Exercise & physical activity  
- Substance use: tobacco, alcohol or drugs  
- Risk taking behaviours  
- Education & learning or skills  
- Other | | | |
<table>
<thead>
<tr>
<th>Item No</th>
<th>Considerations</th>
<th>Detail Impact and Identify Groups Affected</th>
<th>Document the Evidence/Research</th>
<th>Actions Taken/To be Taken</th>
</tr>
</thead>
</table>
| 3.      | Does your function/policy consider the impact on the communities? Things that might be affected include:  
  - Social status  
  - Employment (paid/unpaid)  
  - Social/family support  
  - Stress  
  - Income |                                                                         |                                            |                            |                           |
<table>
<thead>
<tr>
<th>Item No</th>
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<th>Document the Evidence/Research</th>
<th>Actions Taken/To be Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.</td>
<td>Will the proposal have any impact on:</td>
<td></td>
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<tr>
<td></td>
<td>- Discrimination</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Equality of opportunity</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Relations between groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Will the function/policy have an impact on the physical environment?</td>
<td>For example will there be impacts on:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Living conditions</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Working conditions</td>
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<td></td>
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<td>- Pollution or climate change</td>
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<td></td>
<td></td>
<td>- Accidental injuries/public safety</td>
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<td></td>
<td></td>
<td>- Transmission of infectious diseases</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>- Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item No</td>
<td>Considerations</td>
<td>Detail Impact and Identify Groups Affected</td>
<td>Document the Evidence/Research</td>
<td>Actions Taken/To be Taken</td>
</tr>
<tr>
<td>---------</td>
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<td>---------------------------------------------</td>
<td>---------------------------------</td>
<td>--------------------------</td>
</tr>
</tbody>
</table>
| 6.      | **Will the function/policy affect access to and experience of services?**  
For example  
- Healthcare  
- Social services  
- Education  
- Transport  
- Housing | | | | |
| 7.      | **Consultation**  
1) What existing consultation data do we have?  
- Existing consultation sources  
- Original consultations  
- Key learning  
2) What consultation, if any, do you need to undertake? | | | | |
<table>
<thead>
<tr>
<th>Item No</th>
<th>Considerations</th>
<th>Detail Impact and Identify Groups Affected</th>
<th>Document the Evidence/Research</th>
<th>Actions Taken/To be Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td><strong>In relation to the groups identified</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• What are the potential impacts on health?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Will the function/policy impact on access to health care? If yes - in what way?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Will the function/policy impact on the experience of health care? If yes – in what way?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item No</td>
<td>Considerations</td>
<td>Detail Impact and Identify Groups Affected</td>
<td>Document the Evidence/Research</td>
<td>Actions Taken/To be Taken</td>
</tr>
<tr>
<td>---------</td>
<td>----------------</td>
<td>------------------------------------------</td>
<td>-------------------------------</td>
<td>---------------------------</td>
</tr>
</tbody>
</table>
| 9.      | **Have any potential negative impacts been identified?**  
• If so, what action has been proposed to counteract the negative impacts? (If yes state how)  
For example:  
• Is there any unlawful discrimination?  
• Could any community get an adverse outcome?  
• Could any group be excluded from the benefits of the function/policy? (consider groups outlined in item 3)  
• Does it reinforce negative stereotypes? (For example, are any of the groups identified at item 3 being disadvantaged due to perception rather than factual information?) |                           |                               |                           |
<table>
<thead>
<tr>
<th>Item No</th>
<th>Considerations</th>
<th>Detail Impact and Identify Groups Affected</th>
<th>Document the Evidence/Research</th>
<th>Actions Taken/To be Taken</th>
</tr>
</thead>
</table>
| 10.     | **Data & Research**  
  - Is there need to gather further evidence/data?  
  - Are there any apparent gaps in knowledge/skills? |                                  |                               |                           |
| 11.     | **Monitoring**  
  - How will the outcomes be monitored?  
  - Who will monitor?  
  - What criteria will you use to measure progress towards the outcomes? |                                  |                               |                           |
| 12.     | **Recommendations**  
  State your conclusion of your Impact Assessment |                                  |                               |                           |
<table>
<thead>
<tr>
<th>Item No</th>
<th>Considerations</th>
<th>Detail Impact and Identify Groups Affected</th>
<th>Document the Evidence/Research</th>
<th>Actions Taken/To be Taken</th>
</tr>
</thead>
</table>
| 13.     | Is a more detailed assessment needed?  
          • If so, for what reason? |                                            |                               |                           |
| 14.     | Completed function/policy  
          • Who will sign this off?  
          • When? |                                            |                               |                           |
| 15.     | Publication                                                        |                               |                           |
## Conclusion Sheet for Equality Impact Assessment

<table>
<thead>
<tr>
<th>Positive Impacts</th>
<th>Negative Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Note the groups affected)</td>
<td>(Note the groups affected)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Information and Evidence Required</th>
</tr>
</thead>
</table>

From the outcome of the Equality Impact Assessment what are your recommendations? (refer to questions 10 -13)

This conclusion sheet should be attached to the relevant committee report.

**MUST BE COMPLETED IN ALL CASES**

Manager’s Signature       Date
Older People Services

NHS Tayside has a 10 year Tayside Older People’s Strategic Framework (2008 – 2018). One of the key themes in this framework that we are required to deliver on is Dementia Care.

The service area that NHS Tayside identified to be worked through a health integrated impact assessment was Dementia Care. The workshop helped identify the potential and the differential impacts on different equality groups when accessing dementia services.

The strategy was written at a time of reasonable levels of investment and expectations of the same or even more.

Whilst there is a presumption that health improvement, tackling inequality and anti-discrimination practices are built in to the Plan; it is hoped the HIIA process will allow unintended consequences and indirect impacts to be drawn out.

Rationale and Aims of Policy

The NHS Tayside Dementia Care Plan aims to provide specialist services in the Tayside region for people with dementia including:

1. Raising awareness about dementia:
   - Community Engagement
   - Awareness raising and training care staff

2. Early identification and intervention:
   - System of Assessment
   - Care planning

3. Post diagnostic counselling and providing support for people who care for those with dementia:
   - Joint Agreements
   - Specialist brain case service
   - Support for care homes
   - Home support
   - Psychological therapies
   - Services for people in general hospitals
   - Services for young people with dementia

Population Groups Considered

<table>
<thead>
<tr>
<th>Population</th>
<th>Potential Differential Impacts of the policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older People</td>
<td>Potential positive impacts for all dementia patients if the policy is delivered equally across Tayside, dealing with issues of rurality, deprivation and isolation. Potential positive impacts if planned awareness-raising and engagement activities help to reduce stigma around dementia.</td>
</tr>
</tbody>
</table>
Potential differential impacts for some dementia patients as access to services is variable across Tayside which is compounded by mobility and transport problems for the very elderly. Also, funding commitments for dementia across the three local authorities are variable in Tayside and therefore the potential for inconsistency. The Plan should therefore take this contextual issue into account.

Positive impact on people with dementia if the policy is carried through and they are able stay at home longer (particularly on early diagnosis), rather than being rushed into hospital or care home.

Potential negative impacts if stigma over seeking a diagnosis (partly because of fear of legal issues and losing certain powers/assets e.g. driving licence) is not tackled.

The focus in the strategy on the individual needs of the patient will allow more appropriate use of resources and better direction for investment, rather than simply putting people into care regardless of their specific circumstances.

There are often problems in making the transition from adult to older people's services (> 65 yrs). E.g. changed support networks, introduction of new medical professionals who are unfamiliar to the patient, perception that differences in quality of care & range of services available to older people.

<table>
<thead>
<tr>
<th>Children and young people</th>
<th>Children and Young People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness-raising activities targeted at children could empower children (as future older citizens) to access dementia services in later life.</td>
<td></td>
</tr>
<tr>
<td>There will be indirect positive impacts for children if their grandparents are better able to connect with services. Better access to services for people with dementia may result in fewer children having to adopt an informal caring role.</td>
<td></td>
</tr>
<tr>
<td>There are differences in need and perspective within the older people's group (between 65 and 85), which means that campaigns may need to be targeted accordingly (e.g. from a 65 year old still in work to an older person who is housebound).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Women, men and transgender</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are differences in incidence of dementia (i.e. more women than men) because women generally live longer. There does not appear to be an increased prevalence in women once greater lifespan is taken into account.</td>
<td></td>
</tr>
<tr>
<td>The numbers of Older frail women may have been underestimated in the original estimates of prevalence. Potential negative impacts if older frail women with dementia are missed and therefore not receiving the appropriate care.</td>
<td></td>
</tr>
<tr>
<td>Older women living with dementia are more likely to live on their own (often widowed) and subject to isolation. The Plan should therefore take this contextual issue into account.</td>
<td></td>
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</tbody>
</table>
The plan aims to provide more support to carers. Women are more likely to be carers. Therefore, potential positive impacts on women, and in particular older women, who are informal carers as a result of this targeted support.

Potential positive impacts on women as they are more likely than men to access health services in general.

Potential to use women to assist in awareness-raising activities and to identify behaviour change in men to enable early diagnosis.

**Men**
Negative impact on men if issues around getting men earlier into diagnosis and services are not tackled.

Potential positive impacts on men if the current focus in the NHS on men’s health and tackling inequalities results in more men taking care of themselves and accessing services earlier. If this change is realised, there is a longer-term possibility that men will live longer and therefore experience a raised profile for dementia as a group.

**Transgender**
No intrinsic issues for transgendered people around dementia (and the population >65 is low), apart from the general marginalisation of such people and therefore a potentially lower likelihood of accessing services.

The proposed individualised packages of care should benefit this group.

**All genders**
Potential positive impacts if Dementia Action Plan considers gender-specific elements to awareness-raising campaigns, as appropriate.

<table>
<thead>
<tr>
<th><strong>Disabled people</strong></th>
<th>Younger onset (&lt;65) dementia appears to relate, at least partially, to people with learning disabilities.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dementia for people with learning disabilities is linked to certain genetic disorders (for instance, Down’s Syndrome can lead to Alzheimer’s, particularly as people are living longer) – although such people are likely to be in a system of care already, so it may be more of an adaptation of services than a big change.</td>
</tr>
<tr>
<td></td>
<td>There was a query over whether dementia has the legal status of a disability in terms of DDA, given that it brings with it specific issues in relation to information, communication, and mobility.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>People with long term medical conditions</strong></th>
<th>The same public health messages for stroke, heart disease and cancer relate to lowering the risk of dementia (e.g. in relation to alcohol and obesity) – although care should be taken not to appear to blame people for their lifestyle choices if they do get dementia; these messages will contribute to lowering risk.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There could be a potential negative impact on people with long term conditions who move from very specific care to older people’s services i.e. their level of care may drop.</td>
</tr>
</tbody>
</table>
Many carers may themselves have a long term condition, and this could increase the pressure of caring. The Plan should therefore take this contextual issue into account.

**People with Mental Health problems**

There is no conclusive evidence that people with mental health problems have a greater risk of dementia, although a higher risk profile for cardio-vascular disease and stroke may imply a raised risk of dementia.

Potential positive impacts of the Plan on people with mental health problems who will benefit from earlier diagnosis of dementia (as with the rest of the population). However, whilst there are relatively good adult services for people with severe and enduring mental health problems, older people’s services are more geared to dementia support.

In the light of the above, it was proposed that people over 65 should still have their mental health cared for in a non-age based manner when they also enter dementia services.

**Minority Ethnic People**

The issues for BME groups are not about prevalence of dementia, but about access and cultural attitudes.

There are taboos in certain communities against going into care and a strong emphasis on the family taking responsibility for care at home. However, there may be differing and diverging expectations amongst different generations of BME communities in this respect, which means that services cannot always assume that family care will be the norm.

Some South Asian groups are at raised risk of diabetes and cardio-vascular disease, so this could lead to a greater risk of dementia.

The demographics of immigration mean that there will be a growing number of people from BME communities who are >65 as relatively young generations of migrants move into old age.

There are issues in relation to communication, as with other areas of policy, and a general concern about having to rely on family members for translation (Within NHS Tayside it is best practice not to rely on family interpreters and to use interpreting services wherever possible. Similarly, people within BME communities may have varying expectations of services and preparedness to seek them.

**Gypsy Travellers**

Potential negative impacts for gypsy travellers are similar to those raised above in terms of the traditional focus on family-based care, which can lead to people coming for diagnosis and support later than they should be doing.

**Refugees and Asylum Seekers**

There are relatively few refugees and asylum seekers in Tayside, they will experience similar issues to other BME populations in relation to access and language, perhaps also with an increased mistrust of services.
| People with different religions or beliefs | There are issues of respect and appropriateness which relate to some faiths, in particular Islam, which are similar to other issues for BME communities in general.  
Spiritual care services are offered across NHS Tayside, so the principal issue relates to ensuring that staff in general have the right attitudes towards all patients and are aware of the potential significance of faith for some patients.  
Being a member of a faith group can be protective for mental health, so there may be some slight differences in risk factors for dementia too, and members of faith groups may have a greater tendency to support one another than the general population if people are housebound or need assistance when they have dementia.  
Historically, some care homes in Tayside have been established and run by the main Churches.  
Potential positive impacts if outreach work can be done through pastoral groups. |
| Lesbian, gay and bisexual people | There are no specific prevalence issues, but staff can be expected to have the same prejudices as the general population and dementia care will be no different in that respect.  
It is known that LGB people are less likely to access services for fear of disclosure and homophobia – however, this is less of an issue than only a few years ago, so it may be that changes will occur and more ‘out’ people will appear in care homes. Again, staff attitudes may need to be challenged.  
The programme may have a positive impact on LGB people if care is provided at home as often there is a stigma around LGB people in care homes.  
There could be assumptions made about informal carers being husband or wife, which could result in discrimination or reinforcing stigma. |
| People living in poverty / people of low income & People in different social classes | Differences in education and status may lead to inequalities in expectation, preparedness to access services, and ways of communicating need and preferences (as in other parts of the health care system).  
NHS Tayside is developing an inequalities strategy to address such issues, and it was felt that services should be geared to need rather than respond to those who have more information and appear to be more articulate.  
On balance, the less healthy lifestyles associated with income inequality and lower social status will carry a potentially higher risk level for dementia. However, as life expectancy is lower in more deprived communities; there may be correspondingly lower levels of dementia within these communities. |
<table>
<thead>
<tr>
<th>Group</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Homeless people</strong></td>
<td>There are general health issues for this group in terms of nutrition, alcohol, and accessing services; although data is missing on whether there is a greater prevalence of dementia.</td>
</tr>
<tr>
<td><strong>People involved in the criminal justice system</strong></td>
<td>Nothing formal is known in relation to dementia and people from this group, although occasionally someone with dementia is convicted of a criminal offence. The main issue for the prison population relates to mental health.</td>
</tr>
<tr>
<td><strong>People with low literacy</strong></td>
<td>There are obvious issues of communication and access to information for this group which are similar to those noted above.</td>
</tr>
<tr>
<td><strong>People in remote, rural and/or island locations</strong></td>
<td>There are rurality issues in Tayside, which require risk to be managed and access to services (including transport and potential mobility of services themselves) to be considered. (The potential for unrealistic campaigns to preserve under-used services in rural settings was also acknowledged).</td>
</tr>
<tr>
<td></td>
<td>The current tight budget pressures may mean that more rural services are required to be redesigned because they have lower throughputs by their nature.</td>
</tr>
<tr>
<td></td>
<td>Lack of nearness to family support can also be a difficulty in rural parts of the region, although there may also be tighter-knit communities in rural areas. Rural communities often rely on the community (e.g. pastoral care) rather than family members.</td>
</tr>
<tr>
<td><strong>Staff</strong></td>
<td>The group wished to see a strong level of ‘buy-in’ from the top of the organisation and the Scottish Government to supporting dementia services, so that all staff would also recognise the importance of this area. The goal would be to create a ‘dementia-friendly’ NHS.</td>
</tr>
<tr>
<td></td>
<td>Equality of respect and care for people with dementia and their carers across all services will require attitudes and beliefs to change. Potential negative impact on health if staff find it challenging and stressful to achieve this change in attitude.</td>
</tr>
<tr>
<td><strong>Carers</strong></td>
<td>Potential positive impacts if individual case management takes carers’ needs into consideration; the policy should improve this further.</td>
</tr>
<tr>
<td></td>
<td>Women are more likely to be carers than men (see ‘Women, men and transgender’ section above).</td>
</tr>
<tr>
<td></td>
<td>Carers may often be old and frail themselves and have health problems and this could compound the pressure of caring.</td>
</tr>
<tr>
<td></td>
<td>Carers themselves will often have a good understanding of the person and their context, though they will have had no training in dementia care, and this is a resource which can be built upon by formal services (cf expert patient concept for the expert carer).</td>
</tr>
</tbody>
</table>
### All patients with dementia

Potential negative impact on patients with dementia if skills training is not provided for all staff to recognise the signs of dementia. Training should not be restricted to specialist services but should be in general hospital and community settings. (Generally, the time spent on dementia issues for most professionals in non-specialist services is tiny).

Potential negative impact on patients with dementia if skills training is not properly incorporated into graduate (clinical and non-clinical) training.

All populations will benefit from a shift in perspective to living with dementia, rather than suffering from it.

### Others

The group wished to make the point that inequalities within dementia services are dwarfed by those between dementia services and other ones.

### 5. Potential Impacts on Equality and Health

The group identified the following potential impacts of the policy on equality, and on health.

<table>
<thead>
<tr>
<th>Key Areas of impact</th>
<th>Potential impacts of the policy &amp; how the impacts may arise</th>
<th>Affected populations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equality</strong></td>
<td>The area of post-diagnostic support was felt to be very prominent in terms of apparent inequalities in the system – for instance, people with vascular dementia get a different approach to medication and follow-up compared to people with Alzheimers (the latter are more likely to receive a diagnosis from a psychologist( Clinical and neuropsychologists tend to report their findings rather than make diagnoses), whereas people with vascular dementia are more likely to be diagnosed in hospital and then discharged without all the supports in place). The revised Dementia Plan should address this issue.</td>
<td>People with pure vascular dementia tend to be relatively uncommon ( ?3% at post mortem)</td>
</tr>
<tr>
<td>Referral criteria can exclude some people in mental health services, which are focused more on certain severe cases – whilst this is an unintended form of discrimination, it is now more likely with current finances that such services will look to more complicated and disturbed behaviour and miss those with relatively less complicated dementia issues.</td>
<td>People with certain mental health problems and dementia</td>
<td></td>
</tr>
<tr>
<td>Key Areas of impact</td>
<td>Potential impacts of the policy &amp; how the impacts may arise</td>
<td>Affected populations</td>
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<td>---------------------</td>
<td>-------------------------------------------------------------</td>
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</tr>
<tr>
<td></td>
<td>Concern that the long-term vision of the national and local policies may be lost if budgetary pressures mean that a ‘lowest common denominator’ approach is adopted.</td>
<td>Whole population</td>
</tr>
<tr>
<td></td>
<td>The elderly abuse agenda is low down on the public and policy agendas – issues around vulnerable adults bring major potential problems in relation to harassment, abuse and fraud. The Plan should take reasonable measures to prevent and address abuse or there should be signposting to relevant policies and practice documents.</td>
<td>Vulnerable adults</td>
</tr>
<tr>
<td></td>
<td>Potential positive impacts in terms of better inter-generational attitudes and tackling stigma, with greater emphasis in the strategy on community engagement.</td>
<td>Whole population</td>
</tr>
<tr>
<td></td>
<td>Potential negative impacts in shifting patients from acute hospital wards (in Ninewells) to community settings that may not be geared up to manage these patients. There was a suggestion that should this scenario arise that it might constitute a form of unequal service.</td>
<td>People with dementia</td>
</tr>
<tr>
<td><strong>Lifestyle</strong></td>
<td>There should be potential positive impacts on the lifestyles of people with dementia. Dietary issues are raised in the strategy and this will relate both to obesity and diabetes in the general population and links to dementia, as well as feeding and physical activity within care settings (where malnutrition and lack of exercise can also be a problem for older people).</td>
<td>Patients with dementia</td>
</tr>
<tr>
<td></td>
<td>Carers’ dietary issues are not addressed in the Plan (there is a carers’ group which can look at such matters).</td>
<td>Carers</td>
</tr>
<tr>
<td></td>
<td>Care homes are regulated by the Care Commission and any issues arising will be addressed by the Care Commission.</td>
<td>People with dementia residing in care homes</td>
</tr>
<tr>
<td>Key Areas of impact</td>
<td>Potential impacts of the policy &amp; how the impacts may arise</td>
<td>Affected populations</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Social Environment</td>
<td>There are no higher rates of smoking or alcohol intake amongst dementia groups than the general population, but there is greater incidence of these for people from deprived areas in any case.</td>
<td>People with dementia living in deprived areas</td>
</tr>
<tr>
<td></td>
<td>There are no major sexual health issues around dementia, although there may be ones around sexuality, as previously noted.</td>
<td>LGB People with dementia</td>
</tr>
<tr>
<td></td>
<td>For education and learning, the Plan should raise awareness and enable people to be more informed. There was a feeling that there is a responsibility on some key groups to be better informed – eg staff from private care homes, which are publicly funded. There is nothing in the Care Commission to address this and the group wished to see this matter addressed more robustly.</td>
<td>Staff Education Providers</td>
</tr>
<tr>
<td></td>
<td>The Plan will benefit the social status of older people as it aims to change attitudes and ensure that they are more valued and not seen as a burden.</td>
<td>Older people</td>
</tr>
<tr>
<td></td>
<td>There are major disadvantages for carers in terms of employment and income, especially (if as a result of earlier diagnosis/early intervention actions) there are increased numbers of carers for people with relatively early onset dementia. The Plan’s proposed support for carers should consider employability support or there should be signposting to relevant employability initiatives.</td>
<td>Carers</td>
</tr>
<tr>
<td></td>
<td>The Plan will promote support for people with dementia within the community. This will enable people with dementia to keep and enjoy their assets, rather than going into a care home.</td>
<td>People with dementia</td>
</tr>
<tr>
<td>Key Areas of impact</td>
<td>Potential impacts of the policy &amp; how the impacts may arise</td>
<td>Affected populations</td>
</tr>
<tr>
<td>---------------------</td>
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</tr>
<tr>
<td></td>
<td>In respect of crime, people with dementia have similar issues to other vulnerable adults in terms of potential abuse (which can be financial, psychological or by neglect). The Plan should take reasonable measures to prevent and address abuse or links should be made to relevant policies (e.g. community safety, social services).</td>
<td>People with dementia</td>
</tr>
<tr>
<td></td>
<td>The strategy should promote the involvement of community and family networks in the care of patients with dementia. This should impact positively on dementia patients, although there are differences across both geography and between communities in terms of capacity and preparedness to help.</td>
<td>People with dementia Informal Carers Social networks: Families &amp; Friends</td>
</tr>
<tr>
<td></td>
<td>Living conditions: improvements in the built environment are needed to ensure that enough homes are adapted or that new build homes address accessibility from the start. The revised Dementia Plan should take this contextual issue into consideration and link to local housing and regeneration strategies.</td>
<td>People with dementia Informal Carers Families</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>Working conditions: the Plan should better support people who work in care homes and other service settings.</td>
<td>People with dementia</td>
</tr>
<tr>
<td></td>
<td>Pollution – nothing much here, although more people cared for at home may have implications for energy usage/car use (and corresponding effects on household budgets, esp. in colder winters).</td>
<td>People with dementia Informal Carers Families</td>
</tr>
<tr>
<td></td>
<td>Injuries – there is a risk of falls for all elderly frail people, with an increased risk for people with dementia linked to certain psychotropic medications.</td>
<td>Older people with dementia</td>
</tr>
<tr>
<td></td>
<td>Infectious disease – uncertain impacts, although the Plan should mean that people spend less time in hospital and therefore are less exposed to hospital-acquired infections.</td>
<td>People with dementia</td>
</tr>
</tbody>
</table>
Key Areas of impact | Potential impacts of the policy & how the impacts may arise | Affected populations
--- | --- | ---
| Generally speaking, if the Plan is successful, then other non-specialist services will have greater numbers of people using them, but without any additional resources, as people are able to stay at home. | Whole population

Services | There could be issues around services for rural residents and transport as services are likely to move away from smaller, more isolated communities. | People with dementia in rural/isolated communities

The above points emphasise the need to get the right planners and services together, as well as engage with the public, to think through the consequences of putting the Plan into action in the context of diminishing public sector budgets. | People with dementia Staff Service providers

6. Potential Impacts on Human Rights

The group identified the following potential Human Rights impacts.

<table>
<thead>
<tr>
<th>Article</th>
<th>Potential Relevance</th>
<th>Affected populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life (Article 2, ECHR)</td>
<td>Potential positive impacts if end of life care becomes part of advanced care planning - which will therefore benefit from earlier diagnosis. There will be different needs potentially for different groups (eg BME communities). Potential positive impacts if earlier diagnosis could address issues such as proxy appointment or legal issues at an early stage, thereby avoiding issues of who takes decisions (usually an NHS professional or the family). The Plan should potentially lower the risks of abuse. Through this programme more palliative care will be provided at home and more people enabled to die at home and be able to make end of life decisions.</td>
<td>People with Dementia BME People with different religions Vulnerable people Carers/advocates Families</td>
</tr>
<tr>
<td>Freedom from ill-treatment (Article 3, ECHR)</td>
<td>The Plan should support greater dignity and care for people with dementia, particularly with its focus on care within the home (this is an aim also recognised in the national Plan).</td>
<td>People with Dementia</td>
</tr>
</tbody>
</table>
If fewer people are in residential care as a result of the Plan, there is potentially a greater risk of harm (eg in relation to feeding) if resources are not maintained.

See ‘Equality’ and ‘Social Environment’ and ‘Life’ Sections above on issues of abuse and neglect.

<table>
<thead>
<tr>
<th>Liberty (Article 3, ECHR)</th>
<th>People with Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential negative impacts on people who are in locked care homes and who may not have been out of the building for a long while. There remain difficult issues to distinguish between restriction and deprivation of liberty for vulnerable people.</td>
<td>Staff</td>
</tr>
<tr>
<td>Greater awareness of human rights and vulnerable adults issues for staff is needed.</td>
<td>Employers</td>
</tr>
<tr>
<td>How people can appeal a decision on welfare guardianship was also a concern.</td>
<td>People with Dementia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fair hearing (Article 6, ECHR)</th>
<th>People with Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are likely to be relatively small numbers of people with dementia who can remain in employment and they will be covered by existing employment law.</td>
<td>Employers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Private &amp; family life (Article 8, ECHR)</th>
<th>People with dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive impacts on promoting the right to family life - Care for people will take place more within specific settings (mainly the home), rather than being automatically being transferred to general settings like a hospital. Conversely, there may be a potential negative impact on a carer’s right to a family life, if caring responsibilities (within the home) increase.</td>
<td>Informal carers</td>
</tr>
<tr>
<td>People with learning disabilities are most likely to have these rights disrupted or infringed, respite care can bring these issues to the fore for people with dementia as well as carers.</td>
<td>Families</td>
</tr>
<tr>
<td>There is a general problem of ageism within society and a misperception that all older people end up in care homes (an image of people always having something done to them, rather than being active in society). The actions</td>
<td>People with learning disabilities and dementia</td>
</tr>
<tr>
<td></td>
<td>Carers</td>
</tr>
<tr>
<td></td>
<td>Older people with dementia</td>
</tr>
</tbody>
</table>
different stances on what constitutes informed consent, whether it can be given, and what differences there are between opt-in and opt-out approaches.

<table>
<thead>
<tr>
<th>Freedom of expression (Article 10, ECHR)</th>
<th>Access to appropriate information and to speech &amp; language therapy and interpreters is important (and it was observed that many people with dementia and English as a second language will revert to their first language).</th>
<th>People with dementia and communication difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freedom of assembly (Article 11, ECHR)</td>
<td>The right to socialise may be compromised especially for those in residential care along with the right to forms of representation. The Plan should take reasonable measures to promote this right.</td>
<td>People with dementia</td>
</tr>
<tr>
<td>Property (Article 1)</td>
<td>There are known to be issues in relation to people's assets when they have dementia.</td>
<td>People with dementia</td>
</tr>
</tbody>
</table>

**Draft summary human rights impact analysis – Further work to be progressed with Kavita Chetty Scottish Government**

The right to a private home and family life (Article 8 of the ECHR) is the key right engaged in several aspects of the implementation of this strategy, in particular the right to a home life, family life, physical and mental integrity, well-being, autonomy, capacity and right to participate in decision making are central human rights considerations.

Participation in decision making and legal capacity are key to the realisation of an individual's rights and is core to the implementation of the Dementia Care Plan. The three pillars of this strategy, awareness raising, early identification and intervention and post diagnostic counselling and support should all assist in strengthening the exercise of this right. However, these positive impacts rely upon staff taking a rights based, functional rather than status based approach to assessing capacity and supported decision making, which must be built into the policy implementation.

In relation to home life and participation in decision making, the Care Plan, promoting early identification, intervention and planning, will facilitate the development of user led contingency plans in the event of a loss of capacity for decision making and should have a positive impact on assisting people with dementia to spend longer living at home as opposed to in residential care.

The family life as well as the psychological well-being of individuals is also at stake in the implementation of this policy. It has been recognised that social isolation affects many older persons who may be at risk of developing dementia as well as carers. In particular older women who may out-live their partners or are carers are vulnerable to these impacts. Access to services and social contact will be essential.
to the full realisation of this right for those with limited social contact or opportunity to engage in the social, political or cultural life of the community.

The physical and mental well-being of people through implementation of this policy may also be positively impacted where the quality and appropriateness of services is improved through care planning processes. However, if the key professionals and staff working with service users are not taking a rights based, person centred approach to service delivery this may be compromised and medical or service led models may persist. The awareness raising and training of staff should therefore be underpinned by human rights, ensuring issues of capacity and dealing with risk are dealt with in a rights compliant way and rights based concepts such as proportionality, or minimum interference with an individual’s rights to achieve desired outcomes, must be well understood.

The autonomy and capacity of individuals may also be enhanced through early diagnosis allowing increased participation in decision making, supported decision making and engagement with service providers in directing support packages. The policy should also allow for advance planning of decisions in the event of limited capacity for decision making. Where carers are being relied upon to support decision making they must also be adequately supported and informed of their obligations or the principle of autonomy and capacity for decision making may be compromised in practice.

### Population Groups Considered

<table>
<thead>
<tr>
<th>Population</th>
<th>Potential Differential Impacts of the policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Older People</strong></td>
<td>Potential positive impacts for all dementia patients if the policy is delivered equally across Tayside, dealing with issues of rurality, deprivation and isolation.</td>
</tr>
<tr>
<td></td>
<td>Potential positive impacts if planned awareness-raising and engagement activities help to reduce stigma around dementia.</td>
</tr>
<tr>
<td></td>
<td>Potential differential impacts for some dementia patients as access to services is variable across Tayside which is compounded by mobility and transport problems for the very elderly. Also, funding commitments for dementia across the three local authorities are variable in Tayside and therefore the potential for inconsistency. The Plan should therefore take this contextual issue into account.</td>
</tr>
<tr>
<td></td>
<td>Positive impact on people with dementia if the policy is carried through and they are able stay at home longer (particularly on early diagnosis), rather than being rushed into hospital or care home.</td>
</tr>
<tr>
<td></td>
<td>Potential negative impacts if stigma over seeking a diagnosis (partly because of fear of legal issues and losing certain powers/assets e.g. driving licence) is not tackled.</td>
</tr>
<tr>
<td></td>
<td>The focus in the strategy on the individual needs of the patient will allow more appropriate use of resources and better direction for investment, rather than simply putting people into care regardless of their specific circumstances.</td>
</tr>
<tr>
<td></td>
<td>There are often problems in making the transition from adult to older</td>
</tr>
</tbody>
</table>
| **children and young people** | **Children and Young People**  
Awareness-raising activities targeted at children could empower children (as future older citizens) to access dementia services in later life.  
There will be indirect positive impacts for children if their grandparents are better able to connect with services. Better access to services for people with dementia may result in fewer children having to adopt an informal caring role.  
There are differences in need and perspective within the older people’s group (between 65 and 85), which means that campaigns may need to be targeted accordingly (e.g. from a 65 year old still in work to an older person who is housebound). |
| **Women, men and transgender** | **Women**  
There are differences in incidence of dementia (i.e. more women than men) because women generally live longer. There does not appear to be an increased prevalence in women once greater lifespan is taken into account.  
The numbers of Older frail women may have been underestimated in the original estimates of prevalence. Potential negative impacts if older frail women with dementia are missed and therefore not receiving the appropriate care.  
Older women living with dementia are more likely to live on their own (often widowed) and subject to isolation. The Plan should therefore take this contextual issue into account.  
The plan aims to provide more support to carers. Women are more likely to be carers. Therefore, potential positive impacts on women, and in particular older women, who are informal carers as a result of this targeted support.  
Potential positive impacts on women as they are more likely than men to access health services in general.  
Potential to use women to assist in awareness-raising activities and to identify behaviour change in men to enable early diagnosis.  
**Men**  
Negative impact on men if issues around getting men earlier into diagnosis and services are not tackled.  
Potential positive impacts on men if the current focus in the NHS on men’s health and tackling inequalities results in more men taking care of themselves and accessing services earlier. If this change is realised, there is a longer-term possibility that men will live longer and therefore experience a raised profile for dementia as a group.  
**Transgender** |
No intrinsic issues for transgendered people around dementia (and the population >65 is low), apart from the general marginalisation of such people and therefore a potentially lower likelihood of accessing services.

The proposed individualised packages of care should benefit this group.

**All genders**
Potential positive impacts if Dementia Action Plan considers gender-specific elements to awareness-raising campaigns, as appropriate.

<table>
<thead>
<tr>
<th><strong>Disabled people</strong></th>
<th>Younger onset (&lt;65) dementia appears to relate, at least partially, to people with learning disabilities.</th>
<th>Dementia for people with learning disabilities is linked to certain genetic disorders (for instance, Down’s Syndrome can lead to Alzheimer’s, particularly as people are living longer) – although such people are likely to be in a system of care already, so it may be more of an adaptation of services than a big change.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There was a query over whether dementia has the legal status of a disability in terms of DDA, given that it brings with it specific issues in relation to information, communication, and mobility.</td>
<td></td>
</tr>
<tr>
<td><strong>People with long term medical conditions</strong></td>
<td>The same public health messages for stroke, heart disease and cancer relate to lowering the risk of dementia (e.g. in relation to alcohol and obesity) – although care should be taken not to appear to blame people for their lifestyle choices if they do get dementia; these messages will contribute to lowering risk.</td>
<td>There could be a potential negative impact on people with long term conditions who move from very specific care to older people’s services i.e. their level of care may drop.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Many carers may themselves have a long term condition, and this could increase the pressure of caring. The Plan should therefore take this contextual issue into account.</td>
</tr>
<tr>
<td><strong>People with Mental Health problems</strong></td>
<td>There is no conclusive evidence that people with mental health problems have a greater risk of dementia, although a higher risk profile for cardio-vascular disease and stroke may imply a raised risk of dementia.</td>
<td>Potential positive impacts of the Plan on people with mental health problems who will benefit from earlier diagnosis of dementia (as with the rest of the population). However, whilst there are relatively good adult services for people with severe and enduring mental health problems, older people’s services are more geared to dementia support.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In the light of the above, it was proposed that people over 65 should still have their mental health cared for in a non-age based manner when they also enter dementia services.</td>
</tr>
</tbody>
</table>
| Minority Ethnic People | The issues for BME groups are not about prevalence of dementia, but about access and cultural attitudes.  
There are taboos in certain communities against going into care and a strong emphasis on the family taking responsibility for care at home. However, there may be differing and diverging expectations amongst different generations of BME communities in this respect, which means that services cannot always assume that family care will be the norm.  
Some South Asian groups are at raised risk of diabetes and cardiovascular disease, so this could lead to a greater risk of dementia.  
The demographics of immigration mean that there will be a growing number of people from BME communities who are >65 as relatively young generations of migrants move into old age.  
There are issues in relation to communication, as with other areas of policy, and a general concern about having to rely on family members for translation (Within NHS Tayside it is best practice not to rely on family interpreters and to use interpreting services wherever possible). Similarly, people within BME communities may have varying expectations of services and preparedness to seek them. |
| Gypsy Travellers | Potential negative impacts for gypsy travellers are similar to those raised above in terms of the traditional focus on family-based care, which can lead to people coming for diagnosis and support later than they should be doing. |
| Refugees and Asylum Seekers | There are relatively few refugees and asylum seekers in Tayside, they will experience similar issues to other BME populations in relation to access and language, perhaps also with an increased mistrust of services. |
| People with different religions or beliefs | There are issues of respect and appropriateness which relate to some faiths, in particular Islam, which are similar to other issues for BME communities in general.  
Spiritual care services are offered across NHS Tayside, so the principal issue relates to ensuring that staff in general have the right attitudes towards all patients and are aware of the potential significance of faith for some patients.  
Being a member of a faith group can be protective for mental health, so there may be some slight differences in risk factors for dementia too, and members of faith groups may have a greater tendency to support one another than the general population if people are housebound or need assistance when they have dementia.  
Historically, some care homes in Tayside have been established and run by the main Churches.  
Potential positive impacts if outreach work can be done through pastoral groups. |
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td>Lesbian, gay and bisexual people</td>
<td>There are no specific prevalence issues, but staff can be expected to have the same prejudices as the general population and dementia care will be no different in that respect.</td>
</tr>
<tr>
<td></td>
<td>It is known that LGB people are less likely to access services for fear of disclosure and homophobia – however, this is less of an issue than only a few years ago, so it may be that changes will occur and more ‘out’ people will appear in care homes. Again, staff attitudes may need to be challenged.</td>
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<td></td>
<td>The programme may have a positive impact on LGB people if care is provided at home as often there is a stigma around LGB people in care homes.</td>
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<td>There could be assumptions made about informal carers being husband or wife, which could result in discrimination or reinforcing stigma.</td>
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<tr>
<td>People living in poverty / people of low income &amp; People in different social classes</td>
<td>Differences in education and status may lead to inequalities in expectation, preparedness to access services, and ways of communicating need and preferences (as in other parts of the health care system).</td>
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<tr>
<td></td>
<td>NHS Tayside is developing an inequalities strategy to address such issues, and it was felt that services should be geared to need rather than respond to those who have more information and appear to be more articulate.</td>
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<td></td>
<td>On balance, the less healthy lifestyles associated with income inequality and lower social status will carry a potentially higher risk level for dementia. However, as life expectancy is lower in more deprived communities; there may be correspondingly lower levels of dementia within these communities.</td>
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<tr>
<td></td>
<td>There was a query over whether day care services are physically located in more affluent areas of the region, making them less accessible to people on lower incomes who may not have access to a car.</td>
</tr>
<tr>
<td>Homeless people</td>
<td>There are general health issues for this group in terms of nutrition, alcohol, and accessing services; although data is missing on the whether there is a greater prevalence of dementia.</td>
</tr>
<tr>
<td>People involved in the criminal justice system</td>
<td>Nothing formal is known in relation to dementia and people from this group, although occasionally someone with dementia is convicted of a criminal offence. The main issue for the prison population relates to mental health.</td>
</tr>
<tr>
<td>People with low literacy</td>
<td>There are obvious issues of communication and access to information for this group which are similar to those noted above.</td>
</tr>
<tr>
<td>People in remote, rural and/or island locations</td>
<td>There are rurality issues in Tayside, which require risk to be managed and access to services (including transport and potential mobility of services themselves) to be considered. (The potential for unrealistic campaigns to preserve under-used services in rural settings was also acknowledged).</td>
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<tr>
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<td>The current tight budget pressures may mean that more rural services are required to be redesigned because they have lower</td>
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throughputs by their nature.

Lack of nearness to family support can also be a difficulty in rural parts of the region, although there may also be tighter-knit communities in rural areas. Rural communities often rely on the community (e.g. pastoral care) rather than family members.

### Staff

The group wished to see a strong level of ‘buy-in’ from the top of the organisation and the Scottish Government to supporting dementia services, so that all staff would also recognise the importance of this area. The goal would be to create a ‘dementia-friendly’ NHS.

Equality of respect and care for people with dementia and their carers across all services will require attitudes and beliefs to change. Potential negative impact on health if staff find it challenging and stressful to achieve this change in attitude.

### Carers

Potential positive impacts if individual case management takes carers’ needs into consideration; the policy should improve this further.

Women are more likely to be carers than men (see ‘Women, men and transgender’ section above).

Carers may often be old and frail themselves and have health problems and this could compound the pressure of caring.

Carers themselves will often have a good understanding of the person and their context, though they will have had no training in dementia care, and this is a resource which can be built upon by formal services (cf expert patient concept for the expert carer).

### All patients with dementia

Potential negative impact on patients with dementia if skills training is not provided for all staff to recognise the signs of dementia. Training should not be restricted to specialist services but should be in general hospital and community settings. (Generally, the time spent on dementia issues for most professionals in non-specialist services is tiny).

Potential negative impact on patients with dementia if skills training is not properly incorporated into graduate (clinical and non-clinical) training.

All populations will benefit from a shift in perspective to living with dementia, rather than suffering from it.

### Others

The group wished to make the point that inequalities within dementia services are dwarfed by those between dementia services and other ones.

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5. Potential Impacts on Equality and Health

The group identified the following potential impacts of the policy on equality, and on health.

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<th>Potential impacts of the policy &amp; how the impacts may arise</th>
<th>Affected populations</th>
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<td><strong>5. Potential Impacts on Equality and Health</strong></td>
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<tr>
<td>Key Areas of impact</td>
<td>Potential impacts of the policy &amp; how the impacts may arise</td>
<td>Affected populations</td>
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<tr>
<td>Equality</td>
<td>The area of post-diagnostic support was felt to be very prominent in terms of apparent inequalities in the system – for instance, people with vascular dementia get a different approach to medication and follow-up compared to people with Alzheimers (the latter are more likely to receive a diagnosis from a psychologist( Clinical and neuropsychologists tend to report their findings rather than make diagnoses), whereas people with vascular dementia are more likely to be diagnosed in hospital and then discharged without all the supports in place). The revised Dementia Plan should address this issue.</td>
<td>People with pure vascular dementia tend to be relatively uncommon ( ?3% at post mortem)</td>
</tr>
<tr>
<td>Referral criteria can exclude some people in mental health services, which are focused more on certain severe cases – whilst this is an unintended form of discrimination, it is now more likely with current finances that such services will look to more complicated and disturbed behaviour and miss those with relatively less complicated dementia issues.</td>
<td>People with certain mental health problems and dementia</td>
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<tr>
<td>Concern that the long-term vision of the national and local policies may be lost if budgetary pressures mean that a ‘lowest common denominator’ approach is adopted.</td>
<td>Whole population</td>
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<tr>
<td>The elderly abuse agenda is low down on the public and policy agendas – issues around vulnerable adults bring major potential problems in relation to harassment, abuse and fraud. The Plan should take reasonable measures to prevent and address abuse or there should be signposting to relevant policies and practice documents.</td>
<td>Vulnerable adults</td>
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<tr>
<td>Potential positive impacts in terms of better inter-generational attitudes and tackling stigma, with greater emphasis in the strategy on community engagement.</td>
<td>Whole population</td>
<td></td>
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<tr>
<td>Key Areas of impact</td>
<td>Potential impacts of the policy &amp; how the impacts may arise</td>
<td>Affected populations</td>
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<tr>
<td><strong>Potential negative impacts in shifting patients from acute hospital wards (in Ninewells) to community settings that may not be geared up to manage these patients. There was a suggestion that should this scenario arise that it might constitute a form of unequal service.</strong></td>
<td>People with dementia</td>
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<tr>
<td><strong>Lifestyle</strong></td>
<td>There should be potential positive impacts on the lifestyles of people with dementia. Dietary issues are raised in the strategy and this will relate both to obesity and diabetes in the general population and links to dementia, as well as feeding and physical activity within care settings (where malnutrition and lack of exercise can also be a problem for older people).</td>
<td>Patients with dementia</td>
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<td></td>
<td>Carers’ dietary issues are not addressed in the Plan (there is a carers’ group which can look at such matters).</td>
<td>Carers</td>
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<td></td>
<td>Care homes are regulated by the Care Commission and any issues arising will be addressed by the Care Commission.</td>
<td>People with dementia residing in care homes</td>
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<td>There are no higher rates of smoking or alcohol intake amongst dementia groups than the general population, but there is greater incidence of these for people from deprived areas in any case.</td>
<td>People with dementia living in deprived areas</td>
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<td></td>
<td>There are no major sexual health issues around dementia, although there may be ones around sexuality, as previously noted.</td>
<td>LGB People with dementia</td>
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<td></td>
<td>For education and learning, the Plan should raise awareness and enable people to be more informed. There was a feeling that there is a responsibility on some key groups to be better informed – eg staff from private care homes, which are publicly funded. There is nothing in the Care Commission to address this and the group wished to see this matter addressed more robustly.</td>
<td>Staff Education Providers</td>
</tr>
<tr>
<td>Key Areas of impact</td>
<td>Potential impacts of the policy &amp; how the impacts may arise</td>
<td>Affected populations</td>
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<tr>
<td><strong>Social Environment</strong></td>
<td>The Plan will benefit the social status of older people as it aims to change attitudes and ensure that they are more valued and not seen as a burden.</td>
<td>Older people</td>
</tr>
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<td></td>
<td>There are major disadvantages for carers in terms of employment and income, especially (if as a result of earlier diagnosis/early intervention actions) there are increased numbers of carers for people with relatively early onset dementia. The Plan's proposed support for carers should consider employability support or there should be signposting to relevant employability initiatives.</td>
<td>Carers</td>
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<tr>
<td></td>
<td>The Plan will promote support for people with dementia within the community. This will enable people with dementia to keep and enjoy their assets, rather than going into a care home.</td>
<td>People with dementia</td>
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<td></td>
<td>In respect of crime, people with dementia have similar issues to other vulnerable adults in terms of potential abuse (which can be financial, psychological or by neglect). The Plan should take reasonable measures to prevent and address abuse or links should be made to relevant policies (e.g. community safety, social services).</td>
<td>People with dementia</td>
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<tr>
<td></td>
<td>The strategy should promote the involvement of community and family networks in the care of patients with dementia. This should impact positively on dementia patients, although there are differences across both geography and between communities in terms of capacity and preparedness to help.</td>
<td>People with dementia Informal Carers Social networks: Families &amp; Friends</td>
</tr>
<tr>
<td>Key Areas of impact</td>
<td>Potential impacts of the policy &amp; how the impacts may arise</td>
<td>Affected populations</td>
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<tr>
<td>Living conditions: improvements in the built environment are needed to ensure that enough homes are adapted or that new build homes address accessibility from the start. The revised Dementia Plan should take this contextual issue into consideration and link to local housing and regeneration strategies.</td>
<td>People with dementia Informal Carers Families</td>
<td></td>
</tr>
<tr>
<td>Physical Environment</td>
<td>Working conditions: the Plan should better support people who work in care homes and other service settings.</td>
<td>People with dementia</td>
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<tr>
<td></td>
<td>Pollution – nothing much here, although more people cared for at home may have implications for energy usage/car use (and corresponding effects on household budgets, esp. in colder winters).</td>
<td>People with dementia Informal Carers Families</td>
</tr>
<tr>
<td></td>
<td>Injuries – there is a risk of falls for all elderly frail people, with an increased risk for people with dementia linked to certain psychotropic medications.</td>
<td>Older people with dementia</td>
</tr>
<tr>
<td></td>
<td>Infectious disease – uncertain impacts, although the Plan should mean that people spend less time in hospital and therefore are less exposed to hospital-acquired infections.</td>
<td>People with dementia</td>
</tr>
<tr>
<td></td>
<td>Generally speaking, if the Plan is successful, then other non-specialist services will have greater numbers of people using them, but without any additional resources, as people are able to stay at home.</td>
<td>Whole population</td>
</tr>
<tr>
<td>Services</td>
<td>There could be issues around services for rural residents and transport as services are likely to move away from smaller, more isolated communities.</td>
<td>People with dementia in rural/isolated communities</td>
</tr>
<tr>
<td></td>
<td>The above points emphasise the need to get the right planners and services together, as well as engage with the public, to think through the consequences of putting the Plan into action in the context of diminishing public sector budgets.</td>
<td>People with dementia Staff Service providers</td>
</tr>
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6. **Potential Impacts on Human Rights**

The group identified the following potential Human Rights impacts.

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<tr>
<th>Article</th>
<th>Potential Relevance</th>
<th>Affected populations</th>
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<tbody>
<tr>
<td>Life (Article 2, ECHR)</td>
<td>Potential positive impacts if end of life care becomes part of advanced care planning - which will therefore benefit from earlier diagnosis. There will be different needs potentially for different groups (eg BME communities). Potential positive impacts if earlier diagnosis could address issues such as proxy appointment or legal issues at an early stage, thereby avoiding issues of who takes decisions (usually an NHS professional or the family). The Plan should potentially lower the risks of abuse. Through this programme more palliative care will be provided at home and more people enabled to die at home and be able to make end of life decisions.</td>
<td>People with Dementia BME People with different religions Vulnerable people Carers/advocates Families</td>
</tr>
<tr>
<td>Freedom from ill-treatment (Article 3, ECHR)</td>
<td>The Plan should support greater dignity and care for people with dementia, particularly with its focus on care within the home (this is an aim also recognised in the national Plan). If fewer people are in residential care as a result of the Plan, there is potentially a greater risk of harm (eg in relation to feeding) if resources are not maintained. See ‘Equality’ and ‘Social Environment’ and ‘Life’ Sections above on issues of abuse and neglect.</td>
<td>People with Dementia</td>
</tr>
<tr>
<td>Liberty (Article 3, ECHR)</td>
<td>Potential negative impacts on people who are in locked care homes and who may not have been out of the building for a long while. There remain difficult issues to distinguish between restriction and deprivation of liberty for vulnerable people. Greater awareness of human rights and vulnerable adults issues for staff is needed.</td>
<td>People with Dementia Staff Staff Employers</td>
</tr>
<tr>
<td>Topic</td>
<td>Description</td>
<td>Impacted Parties</td>
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<td>How people can appeal a decision on welfare guardianship was also a concern.</td>
<td>There are likely to be relatively small numbers of people with dementia who can remain in employment and they will be covered by existing employment law.</td>
<td>People with Dementia, Employers</td>
</tr>
<tr>
<td>Fair hearing (Article 6, ECHR)</td>
<td>Positive impacts on promoting the right to family life - Care for people will take place more within specific settings (mainly the home), rather than being automatically being transferred to general settings like a hospital. Conversely, there may be a potential negative impact on a carer’s right to a family life, if caring responsibilities (within the home) increase. People with learning disabilities are most likely to have these rights disrupted or infringed, respite care can bring these issues to the fore for people with dementia as well as carers. There is a general problem of ageism within society and a misperception that all older people end up in care homes (an image of people always having something done to them, rather than being active in society). The actions within the Dementia Plan should help to mitigate against this. Different professionals will take different stances on what constitutes informed consent, whether it can be given, and what differences there are between opt-in and opt-out approaches.</td>
<td>People with dementia, Informal carers, Families, People with learning disabilities and dementia, Carers, Older people with dementia, People with dementia, Staff</td>
</tr>
<tr>
<td>Private &amp; family life (Article 8, ECHR)</td>
<td>Access to appropriate information and to speech &amp; language therapy and interpreters is important (and it was observed that many people with dementia and English as a second language will revert to their first language).</td>
<td>People with dementia and communication difficulties, People with dementia and English as a second language</td>
</tr>
<tr>
<td>Freedom of expression (Article 10, ECHR)</td>
<td>The right to socialise may be compromised especially for those in residential care along with the right to forms of representation. The Plan should take reasonable measures to promote this right.</td>
<td>People with dementia</td>
</tr>
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</table>
1. Improve the Organisation and Quality of Care to Older People in Acute Settings with a Particular Focus on People with Dementia

Acute Care Collaborative

NHS Tayside continues to make progress in improving the care and experience of older people, however in response to growing interest from the hospital community in better understanding and improving the experience of patients and their families, NHS Tayside are leading on the development of an 18 month collaborative to provide a structure for learning and action that will engage staff in making real, system-level changes that will lead to dramatic improvements in care. The aim of the collaborative is to improve the experience of older people (in particular those with cognitive impairment) and their carers during their journey through Acute Care by November 2013.

The high level aims of the collaborative are as follows:

- 85% of patient satisfaction scores are > 8
- Reduction in complaints (days between formal complaints and or % reduction)
- 95% of appropriate patients receive a standardised comprehensive assessment

This will be achieved by the following:

- Reliable and appropriate person centred assessment and planning of care by the multidisciplinary team.
- Delivery of patient and family centred care
- Collaborative multidisciplinary team and person centred culture
- Leadership framework to support a culture of quality and improvement.

NHS Grampian will work in partnership with NHS Tayside; collectively to develop and implement this collaborative, starting with 7 pilot teams in the first phase using the ‘Breakthrough’ series model.

The collaborative will identify the improvements that are required by the multidisciplinary team to provide exceptional patient and carer inpatient hospital experience (defined as care that is patient centred, safe, effective, timely, efficient, and equitable). These changes will form the vision for ideal care for older people in acute care, that when applied locally within a ward will improve significantly the experience of patient and carers.

A suite of core measures have been developed to support teams to track their progress in the acute care for older people. These measures will help teams to understand their local systems and the steps required to improve processes, experience, efficiency, effectiveness and outcomes of care.
2. Improvement Plan for the Mental Welfare Commission Report – Dementia Care

- **Education and Training**
  - A Knowledge & Skills Training Plan to provide Holistic Care in Mental Health (including physical health) and Learning Disability is being implemented. The implementation plan is being driven locally by the operational and clinical nurse team managers.
  - Following the Dementia Champions training, action learning sets are being run for staff. This work is being led by the Nurse Consultant for Dementia and the Associate AHP Director.
  - A local training programme for Angus nursing staff have been delivered and there are now 11 dementia champions, 9 of whom working within in-patients units in Angus. Each general ward within Angus now has at least one dementia champion. Meetings held with SCN of all areas, Dementia Champions and Dementia Liaison Team have agreed how this role will contribute to the improved care of those with dementia. These individuals have also been a key resource in relation to the implementation of the Butterfly Scheme.
  - Butterfly Scheme - The Butterfly Scheme is accompanied by educational sessions focussing on communication and understanding of people with Dementia. The scheme was tested in PRI with very good results, and is now being rolled out pan Tayside with key leads identified in each area.

- **Liaison service has been enhanced on a temporary basis through the Change Fund in all 3 areas of Tayside:**
  - **Angus CHP:** The Angus Dementia Liaison Team has worked with care homes and individual residents/patients and their formal/informal carers. They offer specific assessments and therapeutic treatment options to help people remain in their placement, reduce anti-psychotic prescribing, and provide advice on environmental issues. The team also provides training and advice to both local authority and private care homes to support them in providing care for people with dementia experiencing behaviourual and psychological symptoms. Training focused on understanding dementia, communication, person centred care and managing behaviour that challenges, as well as the environment and meaningful activity. Care homes understand the importance of ensuring residents get adequate nutrition and fluid and are actively trying to improve this care. To assist with this, the Angus Dementia Liaison Team worked with NHS Tayside Nutritional Standards Leader to deliver study days on nutrition and the mealtime experience.
  - **Dundee CHP:** Dundee CHP have recently recruited nursing staff to enhance the Old Age Psychiatric and Care Home liaison service. Even now the Topas activity is showing an upward trend.
  - **Perth CHP:** The PRI Liaison Service have been very instrumental in undertaking Dementia Care Mapping of the acute wards to identify training needs of staff. They are currently implementing this training and education programme in Wd3 and Wd6 initially. Perth have also developed a referrers leaflet PRI, POA Liaison and have operational policy and key performance indicators for Perth POA Liaison Team. The activity data shows an upward trend.
• Environmental
  ○ A programme of work to develop a prototype ward that meets the needs of people with Dementia has now commenced with phased completion between September and December 2012. The prototype ward will incorporate colours, signage and fabrics which will assist Dementia patients, which in turn will improve standards for all older people.

• Professionalism
  ○ A programme of presentation / discussion about professionalism and accountability is in situ, these sessions continue to be delivered. During January 2012 – March 2012, staff who attended these sessions included those from Perth & Kinross CHP, Acute and Mental Health Services Angus CHP. Planned sessions for June 2012: Community Hospitals in Perth & Kinross CHP and Paediatric services.
  ○ Board Nurse Director has held a series of sessions with nurses across NHS Tayside
  ○ Board’s Chief Executive, Nurse Director, Medical Director and Chief Operating Officer and have had sessions with staff at Older People Summits
  ○ Board’s Chief Executive, Nurse Director, Medical Director and Chief Operating Officer are leading a series of sessions “Right for Older People, Right for Everyone” to prepare ALL staff members for the Older People’s Inspections which have been introduced by the Scottish Government

5. Volunteering

V Enable

The V Enable project is a partnership between NHS Tayside and Volunteer Development Scotland (VDS) and is working with patients and carers, volunteers, local authorities, health services and voluntary organisations, to explore the scale and scope of volunteers’ contribution to the wellbeing of older people in Tayside. The project has allowed ideas to be shared, identified potential gaps that may need to be filled, and started exploring the potential for further development of volunteering for the benefit of the growing number of older people living in Tayside’s communities.

Information has been gathered by reviewing current information available on voluntary services provided in Tayside and conducting a series of interactive drop in events throughout Tayside for volunteers, staff and people with an interest in Older People’s Care. By listening to staff and volunteers who support Older people on a regular basis the V Enable project have gathered views and ideas based on experience which will inform the baseline of information that will be produced as part of the V Enable project. An important aspect of the V Enable project is sharing learning and transferring knowledge including the process undertaken to deliver the project which will be shared with other health boards across Scotland to inform practice.

The information available on the support volunteers can be fragmented across Health and Social Care including how people can be signposted and referred to various support services and opportunities. This is being explored as part of the V Enable project particularly where potentially services and support could be more joined up and better sharing of resources and information could reduce potential for
duplication. There are some excellent examples of good practice already in Tayside where volunteers are supporting older people in their communities and hospitals which will be shared across Tayside and wider through the V Enable project.

Looking to the future, we know that Scotland’s health and social care systems face severe challenges, especially in regard to sustaining high-quality services for a growing number of older people. We believe that the careful integration and continued development of volunteering may help us to achieve our aims, and the V Enable project is an important part of the information-gathering process.

**Angus Volunteer Centre**

The Older People team also continue to work with Angus Volunteer Centre helping older people to remain in the community, for example Volunteer led response team providing assistance and delivering essential supplies to vulnerable and/or isolated people who have been discharged home from hospital.
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</table>
1 INTRODUCTION

This policy sets out the operational processes for the appropriate provision of Spiritual Care in NHS Tayside and compliments NHS Tayside Spiritual Care Strategic Framework which contains the vision of the department to work as part of the multi-professional healthcare team in NHS Tayside to provide good experiences for people, patients, families and friends while in the care of NHS Tayside, in hospital and the community. As staff are the greatest resource NHS Tayside has, this vision includes having well supported staff who recognise their own skills in spiritual care in the support of those they care for and are themselves supported in the environment they work in.

People from every belief and faith community or life stance need support systems, especially in times of crisis. They face ultimate questions about life and death. They search for meaning in the experience of illness. They look for help to cope with their illness and with suffering, loss, loneliness, anxiety, uncertainty, impairment, despair, anger and guilt. They consider ethical dilemmas which advancing technology and heightened expectations generate at the beginning and end of life. They address in depth, perhaps for the first time, the meaning of life.

By listening to an often silent cry for help, those providing spiritual care for patients, carers and staff allow people to explore their innermost feelings and ask the most difficult questions about suffering, illness and death. By listening to their doubts, anxieties and fears those in need may be helped to find peace of mind.

In NHS Tayside we seek to meet the spiritual care needs of patients, carers and staff from remote rural areas, county towns and a large city. We recognise the varying needs of those of different beliefs and faiths and of those who would not wish to be associated with any particular group but also ask many questions about the meaning of life.

For those who express their spirituality through a religious framework processes are in place to have their religious needs met through the provision of appropriate people and facilities for their support while in NHS Tayside hospitals.

It should be recognised that all staff have an important role to play in this area because of the relationships they have or build with patients and families. This provides effective holistic care. There are many levels of spiritual care from an acknowledgement that someone matters because they have been spoken to with dignity and respect, by professionals who have been trained in specific areas such as bereavement, to the specialist spiritual care and advice provided by the members of the Department of Spiritual Care who have the necessary knowledge, skills and experience in this field of spiritual care to help people explore the deepest meaning of life. It is important that the most appropriate person provides spiritual support in each situation.

Recognising the gifts of volunteers in befriending, listening and supporting those in need they can complement health staff working in hospitals and the community when supported by effective training, deployment and support.
2 STANDARDS

i. Scottish Government Health Department Guidance

The Scottish Government Health Department document *Spiritual Care and Chaplaincy* contains the Chief Executive’s Letter (2008) 49 SPIRITUAL CARE and Revised Guidance published by the Scottish Government Health Department. These set out the processes which should be followed for the delivery of an effective and efficient Spiritual Care Service.

- All NHS Tayside spiritual care services will be delivered in accordance with this document.

ii. Standards for NHS Scotland Chaplaincy Services 2007

This document sets out the standards required for an efficient and effective spiritual care service. It has been developed and supported by the professional chaplaincy bodies, the Association of Hospice & Palliative Care Chaplains, the College of Health Care Chaplains and the Scottish Association of Chaplains in Healthcare, and NHS Education for Scotland.

- NHS Tayside spiritual care services will be audited every two years by peer review in accordance with these standards

iii. Spiritual and Religious Care Capabilities and Competences For Healthcare Chaplains

This NHS Education for Scotland document describes the experience, knowledge and skills required of all employed healthcare chaplains/spiritual care providers to deliver an efficient and effective spiritual care service.

- All employed NHS Tayside chaplains/spiritual care advisors will be appointed and trained according to the standards set out in these capabilities and competences.

iv. Registration with UK BHC (United Kingdom Board of Healthcare Chaplains)

The UK BHC works on behalf of and derives its authority from the professional associations of chaplaincy to whom it is accountable. The UK BHC has a voluntary register at present while working towards formal registration with the Health Professionals Council, to

- demonstrate the accountability of healthcare chaplains
- promote high standards of practice and behaviour
- support professional regulation

- All employed NHS Tayside chaplains/spiritual care advisors will be registered with UK BHC

v. Code of Conduct for Healthcare Chaplains

The *Code of Conduct* sets out the professional standards of conduct expected of healthcare chaplains/spiritual care advisors towards those in their care. It applies to all healthcare chaplains/spiritual care advisors who are registered with the UK Board of Healthcare Chaplaincy or who are members of one of the professional associations of healthcare chaplaincy. (UKBHC Code of Conduct for Healthcare Chaplains)

- All employed NHS Tayside chaplains/spiritual care advisors will adhere to this professional code.
3 RESEARCH AND EVIDENCE BASE

In the Scottish Government Heath Department document Spiritual Care and Chaplaincy in NHS Scotland 2008: Revised Guidance: Report and Recommendations: 1.5 Research and Evidence Base, all NHS Health Board spiritual care services are advised to develop research to inform their practice and to ensure that all practice is delivered in accordance with present research findings. Education and practice are most effective when it informed by research into practice.

- In NHS Tayside Department of Spiritual Care, all spiritual care should be informed by research to ensure evidence based practice therefore all chaplains will be expected to be knowledgeable about research into spiritual care and translate this into practice.
  - All employed NHS Tayside chaplains/spiritual care advisors will be able to demonstrate that their practice is informed by research
  - All research carried out by NHS Tayside chaplains/spiritual care advisors will follow the department protocol on research

4 DATA PROTECTION AND PATIENT CONFIDENTIALITY

In the Scottish Government Heath Department document Spiritual Care and Chaplaincy in NHS Scotland 2008: Revised Guidance: Report and Recommendations: Recommendation 20, all NHS Health Board spiritual care services are required to ensure that all practice is carried out in accordance with present legislation.

- In NHS Tayside the following will be required:
  - All records will be kept according to the Department of Spiritual Care Records Management Protocol
  - A Protocol for Belief and Faith Community Visitors will be implemented and reviewed regularly

5 GOVERNANCE ARRANGEMENTS

Detailed below are the most significant roles and responsibilities for the efficient and effective delivery of spiritual care in NHS Tayside

i. NHS Tayside Board

NHS Tayside Board will:

- ensure a personal and corporate commitment to the Spiritual Care Policy and Spiritual Care Strategic Framework
- appoint a Designated Senior Manager with responsibility to ensure that spiritual care is provided to patients, carers and staff in ways that are responsive to their needs and ensure appropriate arrangements are in place to monitor and review the spiritual care service.

ii. NHS Tayside Improvement and Quality Committee

NHS Tayside Improvement and Quality Committee will:

- assure that the NHS Tayside spiritual care provision is satisfactory and in accordance with the Scottish Government Health Department Guidance
• approve an annual work plan for NHS Tayside Spiritual Healthcare Committee
• approve an annual report for NHS Tayside Spiritual Healthcare Committee

6 NHS TAYSIDE SPIRITUAL HEALTHCARE COMMITTEE

The role of NHS Tayside Spiritual Healthcare Committee.

Function

The role of members is

• to provide an advisory function on all aspects of healthcare in relation to spiritual care for the Department of Spiritual Care. See appendix 1.
• to monitor and review the Spiritual Care Policy
• to agree, monitor and review an annual work plan for NHS Tayside Spiritual Healthcare Committee for submission to Tayside Improvement and Quality Committee.
• to agree an annual report for NHS Tayside Spiritual Healthcare Committee for submission to Tayside Improvement and Quality Committee

Membership

• Members will be nominated from professions involved in the delivery of healthcare and in the education of healthcare employees, representatives of local belief and faith communities and Patient Public Groups. See appendix 2.
• Members representing professions will fulfil the competences required for their role. See appendix 3.
• Members will have a nominated deputy who will attend in their absence.

7 WORKING IN PARTNERSHIP WITH LOCAL BELIEF AND FAITH COMMUNITIES

An important part of the work of the Department of Spiritual Care is maintaining effective links with local belief and faith communities to inform the delivery of healthcare and ensure appropriate care of members of their communities.

i. Working in Partnership Advisory Forum

• A forum will be held twice a year for local belief and faith communities to discuss issues relating to healthcare and their communities and advise NHS Tayside on the appropriate delivery of care in relation to belief and faith.

• All local belief and faith community representatives interested in healthcare will be invited to attend this forum within the capacity of the venue.

ii. Working in Partnership with Belief and Faith Communities: Standard Operational Procedures

The purpose of this document is to set out the roles and responsibilities of NHS Tayside Department of Spiritual Care working in partnership with local belief and faith communities to provide spiritual care for people of all faith and life stances.

Six strands

In developing a service which gives equity of care to all patients, carers and staff of all belief and faith communities and those of no particular community NHS Tayside Department of Spiritual Care will work with other healthcare professionals and volunteers and in partnership
with colleagues in the community to provide best practice in spiritual care in accordance with guidance from the Scottish Government as set out in CEL (2008) 49. This fits with the NHS model of a hierarchy of care.

A register will be kept of these representatives of local belief and faith communities who may be called upon when a request is received for a visit from someone of their community, other than a specific belief or faith community leader known to the patient or their family.

ii. Referral to local belief and faith communities

- NHS Tayside staff will ask patients if they wish their own belief or faith community leader to be notified and refer this to the Department of Spiritual care.
- The Department of Spiritual Care will maintain up-to-date records of the leaders of local belief and faith communities.
- The Department of Spiritual Care will maintain a Belief and Faith Communities Visitors Protocol to ensure all staff are aware of the importance of such visits.

8 SPIRITUAL CARE ADVISORY GROUPS

To ensure the efficient and effective working of NHS Tayside spiritual care services it is important that members of the Department of Spiritual Care work in partnership with other professions involved in healthcare and with local belief and faith communities to ensure the appropriate provision of spiritual and religious care for members of these communities. See appendix 4.

Local

Department

Leads will be appointed from the department to call topic based work groups as required, e.g. Acute, Bereavement Group, Community, Staff support, Education Group

NHS Tayside

- NHS Tayside Improvement and Quality Committee
- NHS Tayside Board

Belief and faith communities

- A forum will be held twice a year for local belief and faith communities to discuss issues relating to healthcare and their communities and advise NHS Tayside on the appropriate delivery of care in relation to belief and faith.

National

- Advisory Group
- Audit Group
- Co-ordinating Chaplains Group
- Education Group
- Research Group

9 EQUALITY AND DIVERSITY

This policy has been assessed in accordance with the Equality and Diversity Assessment Toolkit.
The lead officer for Equality and Diversity will

- review and update the Equality and Diversity Policy Checklist at every policy review date.
10 NOTE OF NATIONAL PUBLICATIONS

All NHS Tayside staff should be aware of the following documents which give them information and advice on delivering healthcare in a way which reflects holistic care.

Standards for NHSScotland Chaplaincy Services 2007 (pdf)

Spiritual and Religious Care Capabilities and Competences for Healthcare Chaplains (pdf)

Spiritual Care Matters - An Introductory Resource for All NHS Scotland Staff

A Multi-Faith Resource for Healthcare Staff (pdf)

Religion and Belief Matter - An Information Resource for Healthcare Staff (pdf)

Arrangements will be made to provide a copy of this policy in Urdu, Punjabi, Hindi, Bengali, Arabic or Chinese if requested. This can be obtained by contacting, Mrs Lynne Downie, Department of Spiritual Care, Trust Offices, Royal Dundee Liff Hospital, Dundee. Tel: 01382 423110, email – lynne.downie@nhs.net
APPENDIX 1

NHS TAYSIDE SPIRITUAL HEALTHCARE COMMITTEE

MEMBERS ROLES:

1. Act as a prime source / link for uni-professional advice to Tayside NHS Board, either directly or through the designated senior manager.

2. Develop and utilise comprehensive communication networks and processes within the represented professions across NHS Tayside.

3. Use own judgement as to when to consult and collate collective responses and when to act autonomously on behalf of the represented professions.

4. Contribute to the formulation, communication and evaluation of national and local policy, strategy and implementation.

5. Appraise, interpret and communicate to Tayside NHS Board, the impact of national or professional directives, policy changes or recommendations about the professions or service delivery.
APPENDIX 2

NHS TAYSIDE SPIRITUAL HEALTHCARE COMMITTEE

MEMBERSHIP

1 Member from

- Designated senior manager - chair
- AHP directorate
- Doctor from GP Practice
- Head of department
- Nursing director
- Senior chaplains
- Staff side
- University
- Volunteer
- Belief and faith representative from Interfaith Association

2 members from PPG
APPENDIX 3

NHS TAYSIDE SPIRITUAL HEALTHCARE COMMITTEE

COMPETENCIES FOR PROFESSIONAL MEMBERS

Competence is a characteristic of a person, which is linked to an effective performance or to a superior performance.

Competencies required include:

1. Knowledge of and understanding of the spiritual care issues at Scottish and UK national, and local level, as well as multiprofessional issues and perspectives.

2. Ability to establish and maintain communication with various individuals and groups on complex and potentially stressful topics in a range of situations in relation to spiritual care.

3. Ability to develop oneself and contribute to the development of others in relation to spiritual care.

4. Ability to work in partnership with others to develop, take forward and evaluate direction, policies and strategies in relation to spiritual care.

5. Skills in appraisal, evaluation and communication on the impact of legislation, policies and procedures in relation to spiritual care and be able to formulate and present both uniprofessional and multi-professional responses.

6. Skills in contributing to developing, testing and reviewing new concepts, models, practices and innovations in relation to spiritual care to determine the impact on profession and service areas.
Appendix 4: Spiritual Care Advisory Groups

NHS Tayside Department of Spiritual Care – called by leads as appropriate

NHS Tayside Board

NHS Tayside Improvement and Quality Committee

NHS Tayside Spiritual Healthcare Committee

NHS Tayside Working in Partnership Advisory Forum

National

Advisory Group

Audit Group

Coordinating Chaplains Group

Education Group

Research Group

Acute Group

Bereavement Group

Community Group

Education Group

Staff support Group

13th February 2012
SPIRITUAL CARE STRATEGIC FRAMEWORK

A document to outline the strategic direction of Spiritual care for Patients, carers and staff in NHS Tayside

Author Gillian Munro
Head of Spiritual Care
Forward

NHS Tayside has seen significant changes in recent years in the development of a Spiritual Care Department and we have grown greatly in our understanding of spiritual care within the Health Service.

The Scottish Government Health Department continues to emphasise in policy documents that spiritual care is integral to healthcare. Following their guidance in 2002 we created a very effective Spiritual Care Department which at the time was part of the Operations Directorate. Seven years on it has found its natural home in the Directorate of Allied Health Professions. The service has strong leadership from the Head of Department and experienced senior chaplains, who lead a valuable team with a mix of skills which are appropriate for good support of patients, carers and staff. The NHS Tayside Board, senior management, staff and Spiritual Care Forum are very supportive of the work of the department. Working in partnership with belief and faith communities, a Spiritual Care Policy was produced and a five year plan to deliver and further develop spiritual care within NHS Tayside was implemented. This new Spiritual Care Strategic Framework sets out our direction of travel and future focus on spirituality, caring differently and relates to the Health Quality Strategy. There can be no doubt that NHS Tayside is at the forefront of Spiritual Care in NHS Scotland.

Spiritual care offers and provides a myriad of services such as confidential patient encounters, bereavement services, patient advocacy, ongoing support for long term patients, families and carer support. We also provide support to staff, facilitate faith and belief group involvement and offer spiritual care in all our hospitals and within the community. Our service is welcomed and widely used by those of all faiths and personal beliefs. In everything we do we are about people coming alongside people in situations when it is common to feel stressed or vulnerable, afraid or uncertain – when a skilled, sensitive and supportive encounter can calm, reassure and offer understanding for this part of the journey.

We are ambitious in NHS Tayside, not only to improve the health of the communities we serve, but also to improve the wellbeing of all.

Elizabeth Forsyth
Non Executive Board Member
Chairman of the Spiritual Care Forum

“Patients and physicians have begun to realise the value of elements such as faith, hope and compassion in the healing process……a more holistic view of health that includes a non-material dimension, emphasising the seamless connections between mind and body.”
(World Health Organisation (WHO), 1998)
Why spiritual care?

The strength of our model is that it begins to put a gap between a medical model and a solution focussed approach based upon self. Many of the other approaches used do this but do not come from a place of hope. This brings an approach and attitude, which I believe, makes the interaction fundamentally different and transcends religious belief systems. It is so important for people who find themselves low on confidence and self-worth. The fact that the patients with no religious tendencies got as much out of chaplaincy as those with, is a testament to a philosophy of hope."

Dr Andrew Russell, NHS Tayside Medical Director
Contents

1. The Challenge of Change

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6. Developing best practice: education, research and training

7. Working in Partnership with local communities

8. Quality and wellbeing
1. The Challenge of Change

Change is never easy. It can be viewed as an imposition on what is working well. Or it can be seen as a challenge to review what there is, identify what is good and make it even better, find gaps and design spiritual care services to improve patient care, and support staff to develop their own skills and confidence in dealing with questions and situations which they face day to day as people struggle with what is happening to them in a healthcare setting.

The Scottish Government Health Department Chief Executive’s Letter (2008) 49, Spiritual Care, is written with a view to encouraging development in Spiritual Care by recognising the major changes taking place in Scottish society; describing the essence and practice of spiritual care in ways which take account of such changes among people with and without any faith commitment; and signals a significant movement in the understanding and practice of spiritual care and chaplaincy in the NHS in Scotland.

A number of documents have been produced by National Education Scotland in response to the Chief Executive’s Letter to support development and education in spiritual care and these may be accessed by going to NHS Tayside Staffnet Spiritual Care site on ………………………..

The important role of all staff in the proper provision of spiritual care to support the wellbeing of people, patients, carers and colleagues, is explored in Spiritual Care Matters – An Introductory Resource for All NHS Scotland Staff.

While all staff have this important role to play there are situations where a higher level of knowledge, skill and experience is required to provide support so clear guidelines have been set down by the UK BHC – United Kingdom Board of Healthcare Chaplains. All NHS Tayside chaplains will be required to be registered with this Board to maintain appropriate standards of service while the whole service will be audited regularly against the Standards for NHSScotland Chaplaincy Services 2007.
2. What is Spiritual Care?

Spiritual wellbeing is recognised as being necessary to the overall healing process as it is an important aspect of all human experience.

Every day of life brings questions of health and illness to many people either personally or through friends and colleagues raising questions about the meaning of life or challenging coping mechanisms.

When their health is challenged patients face many questions beyond those relating to their physical care. Why is there suffering, how may this affect their lifestyle, what will be the long-term outcome of what is happening and why is this happening to them.

Watching and waiting with people who are an important part of your life may be very challenging as parents watch over the struggles of a new born baby who is not responding to treatment, an elderly husband wonders how he will cope at home with his disabled wife or a young wife is anxious for her whole family as decisions are made about treatment for her husband’s chronic illness.

By listening to and supporting patients, carers and staff as they explore the questions raised and challenges faced, the chaplains in NHS Tayside place Spiritual Care as a focus for health care and healing for all.

How can Spiritual Care help you?

**Patient** – *Having someone to speak to, to talk about things with, made ‘you’ feel better.*

**Carer** – *It’s difficult always putting on a brave face when you are worrying about the future – it’s good to have someone to share your worries with.*

**Member of staff** – *When you see your own family in the young folk you’re caring for then it’s difficult to keep that balance – you need someone to talk through the questions you hope you’ll never have to ask for your own daughter or son.*

“A focus on spirituality forces us to ask different questions and in answering these questions we begin to care differently.”

Professor John Swinton, Centre for Spirituality, Health and Disability
3. Our Vision for NHS Tayside Department of Spiritual Care

In the first five years of the department the vision was focused on consolidating the well established good practice of chaplains working in hospitals throughout NHS Tayside and beginning to introduce new practice
- developing education for staff
- raising awareness of the service provided by the department
- introducing volunteer visitors as an important part of the team working in the acute setting.

As the second five years of the department approached discussions took place with a wide range of stakeholders to discuss how development of the service might bring added value and support good quality of care for patients and carers and encourage staff in the valuable work they do. From this a Five Year Vision document was written and a Stakeholders’ Event, Caring in Partnership, held to consult on the ideas put forward. In bringing all of these ideas together we now have a clear vision for NHS Tayside Department of Spiritual Care.

Our **VISION** is to work as part of the multi-professional healthcare team in NHS Tayside to provide good experiences for people, patients, families and friends, while in the care of NHS Tayside, in hospital and the community. As staff are the greatest resource for NHS Tayside our vision includes having a well supported staff who recognise their own skills in spiritual care in the support of those they care for.

Our **AIM** to fulfil this vision is to
To develop efficient, effective, safe, sustainable and high quality spiritual care services equitably throughout NHS Tayside for patients, carers and staff.

And you’ll know if we are getting there because
- We will have chaplains working across NHS Tayside providing good practice in Spiritual Care
- We will have an education programme to support all healthcare staff in facilitating spiritual care as part of holistic care and wellbeing
- We will have a research programme to inform our work to develop best practice
- We will be working in partnership with local belief and faith communities, voluntary organisations and local authority colleagues
4. Our Values and Promises

The particular skills the members of the Department of Spiritual Care bring are from their required education and experience which enable them to help people consider the 'big' questions about life, death, suffering, the origin of the universe, life after death, etc. which so many face when given diagnosis of ill health, bad news, or they wish to celebrate hope of recovery.

When particular traditions, sacraments or celebrations are requested to help people on their healthcare journey the members of the department have knowledge of the local belief and faith communities to make the necessary connections and have the skills to provide or facilitate what is required in the holistic care of the people in their care.

The chaplains also share their knowledge through training and workshops with colleagues so that all staff may be encouraged to facilitate spiritual care of patients, carers and colleagues at whatever level they feel competent to do so.

The skills of the members of department are also essential in providing support to staff who deal with stress through illness, trauma, work and personal issues perhaps on a daily basis. These skills are available to all and may be the means of supporting a workforce which is not only skilled in their own particular field of care but feels rewarded in the work they do through the care they give day by day.

All members of the department are committed

- in recognising the essential place of spiritual care in promoting the wellbeing of all people to value and respect the dignity of each person with their individual physical, psychological, emotional and spiritual needs

- in recognising the importance of the search for meaning in life and the need to express their thoughts and feelings throughout their journey of care to provide support for patients and carers by listening to their life story, their concerns and their hopes and responding appropriately.

- in recognising the varied spiritual and religious needs of the human spirit when faced with trauma, ill health or sadness to provide a service which is professional, informed, skilled and equipped to respond

- in recognising that experiences of illness, loss and work stress impact on the personal and professional lives of staff to provide support for staff by helping them to reflect on their experience and manage the impact on their lives

- in recognising the importance of all staff in their role in assessing spiritual need and providing and facilitating spiritual care to patients, carers and colleagues to provide appropriate training and awareness-raising in spiritual care, where and when required.
5.1 The Five Strands of Spiritual Care and Support: Acute

Last year, chaplains across Scotland participated in a “Snapshot” of our work. For one week, we each kept a record of the spiritual encounters we had with people – staff, patients, visitors, etc. Reassuringly, this snapshot showed that we were engaged in a wide variety of situations, supporting people within the hospitals, often at times of great distress. These ranged from supporting patients, carers and staff by listening to their concerns and helping them explore coping strategies to supporting parents coping with the loss of an infant by conducting a naming ritual. By taking part in multidisciplinary team meetings, leading training sessions for staff in different parts of Tayside, developing the volunteer programme and contributing to the development of policies and protocols, in addition to our pastoral work, the chaplains are contributing significantly to improving quality and inclusion within our organisation.

Over the last couple of years we have worked with nursing colleagues in developing a patient needs assessment tool. Spiritual care has been included in this but, in the wake of it being rolled out, we have real work to do in providing training for ward staff, enabling them to feel more comfortable exploring spiritual need with patients. If we can help ward staff think more broadly about spiritual care and the broad-based, person-centred service we offer, we could, as an organisation, provide a more equitable service for people who have real spiritual need but who do not necessarily belong to a faith community. Similarly, although we have good relationships with the different belief communities and a wide membership of the Spiritual Care Forum, we could work towards strengthening our day to day working relationship with the different communities. Recently, for example, we have been developing a spiritual care leaflet in conjunction with the Muslim community in different languages and for members of that community who are admitted to hospital. It would be good to see more of this kind of working in partnership at a practical level.

David Gordon
Senior Chaplain for Acute Services
5.2 The Five Strands of Care and Support: Bereavement

Bereavement is a spiritual experience.

Most, if not all religions have something to say about the experience of death and what follows. But whether a person is “religious” or not the loss of someone close has an effect on our sense of who we are and what we think and believe.

From early years we develop a sense of security in which we believe we can depend on the relationships we have with those close to us. These people, our relationships with them and the sense of security that gives us, are among the assumptions on which we build our lives.

When such a relationship is irreparably broken, as happens when a person dies, these assumptions are challenged and our understanding of who and what we are is thrown into confusion.

What now can we depend on – if anything?

The ensuing feeling of “lostness”, the emotional loneliness, the inability to make sense of what is happening, constitutes a spiritual dis-ease. The journey of recovery from that is often rough and painful, but the majority of people will come through with the support of their family and friends.

The basis of bereavement care is to help people rebuild that sense of self, and to construct a new normality, in which security can once again be established underpinned by new attachments and by a new understanding of the continuing bond to the person who has died.

John Birrell
Bereavement Coordinator
5.3 The Five Strands of Care and Support: Community

Holistic care in primary care involves an understanding of how physical health exists in continuity with emotional and spiritual wellbeing, each influencing and impacting the others. Existing primary care services seek to provide appropriate, safe and effective care and as such are an environment where the offer of spiritual support can play an important role in provision of person centred care of the whole person.

Current models of General Practice service provision are largely driven by funding incentives which focus on the biomedical model of care, with much clinical activity driven by achievement of biometric targets. By working beside existing services, spiritual care can broaden the scope of care offered by helping people to explore issues raised by illness such as finding hope, meaning and purpose, and establishing contact with healthy community and supportive relationship with other people. Specialist knowledge of faith related issues can ensure that patients’ belief and religious needs are acknowledged and addressed as part of the journey of care. Chaplains and other providers of spiritual care are ideally placed to help patients handle the impact of illness in such areas as long term conditions, palliative care and terminal illness, bereavement and acute crisis, adjustment reaction and substance and alcohol addictions, all of which constitute a substantial portion of the workload of primary care. Strengths which existing primary care can offer to providers of spiritual care include community based equitable accessibility, local to the patient, long term relationship with patients, comprehensive record keeping and multidisciplinary thinking and care.

Current pilots exist to assess in practice populations the benefit of listening services, currently offered by trained chaplains. Dependent on evaluation of these pilots, there may be opportunity to offer training to a volunteer workforce, trained in listening skills, working in practices.

As primary care works in the context of the patient’s own community, spiritual care should seek to act as a bridge to the supportive pastoral networks of family, friendships, faith communities, voluntary agencies and statutory social support. A working knowledge of locally based networks would aid the integration of patients into normal, healthy community contributing to their holistic wellbeing.

Dr Katherine Emslie-Smith
GP, Erskine Practice and Honorary Chaplain

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**Emma's Story**

This was different from psychology. I knew I didn’t need a psychologist, and spiritual care was a different way of tackling what’s wrong. So I went for spiritual rather than psychological help.

Spiritual support helped me go through processes of thought and come out the other side.

You are respected as an individual not as a category of illness. It was tailored to suit the person and you felt free to express yourself, your individuality. You weren’t stereotyped.

What was most helpful was being understood, accepted for myself, recognising it was alright to be down and believing it could be fixed.

Finding a coping mechanism, setting a bigger target and small focuses to help you get there like just preparing a meal for the kids, taking some exercise – and not beating yourself up if you didn’t manage it today.
5.4 The Five Strands of Care and Support: Staff Support: the benefits

Private and public organisations are increasingly investing in their employees through staff supportive initiatives. Healthy Working Lives and “Investors In People” continue to promote, encourage and support these schemes.

Principally staff support enhances employees’ sense of feeling valued by their employer and organisation.

Feeling valued (and even cared for) raises morale in the workforce, and there are significant beneficial consequences that ensue for patient care. Raising morale also develops a sense of wellbeing at work, resulting in:

- Increased attendance at work leading to more continuity in patient care and, of course, reduced additional demand on colleagues.
- “Win/win” consequences, as staff feel healthier and happier at their work and tend to have less time off, therefore sickness absence is reduced.
- Raised morale optimises service-delivery, as employees who are happier at their work perform better and produce enhanced outcomes in patient care. Additionally there are likely to be a reduction in complaints.
- Retention: employees, who are content at their work, are less likely to look for other work and move on, with its concomitant costs to the organisation.
- Recruitment: the organisation enhances its reputation as valuing and caring for its employees and this encourages people to want to work in NHS Tayside.
- Improved relationships: staff who are happier at work, tend to get on better with their colleagues and managers, creating a more efficient working environment with less time spent on grievances, conflict and issue resolution.

Many of the above factors enhance the productivity and efficacy of the organisation.

Nick Bernam
Staff Support

A pilot project

The Department of Spiritual Care is piloting the provision of an informal, confidential and responsive listening service to staff, through skilled, trained volunteers.

This will complement other initiatives within the Department of Spiritual Care, such as developing Values in Healthcare, strengthening links with HR, and the existing Hospital-based support that chaplains provide as a matter of course in supporting staff. Chaplains are also involved in providing training to wards and departments on a variety of topics related to spiritual care.

Facilitating staff support and encouraging the participation of employees will reduce managers’ workload. It is therefore essential that clear direction, encouragement and support is provided by senior officers to enable employees and the organisation to benefit from these initiatives.
5.5 The Five Strands of Care and Support: Volunteering

Spiritual care is a vital part of the healing process but increasingly nurses have less time to spend on a one to one relationship with their patients. As it is important to all faiths and beliefs this requires more people to be involved, particularly in a large hospital. This is where the Volunteer system is an invaluable resource. Particularly so as they give their time freely and thus have a high level of commitment.

It is of course important that there is sufficient and proper training; not only to ensure that the Volunteers are suited to the job but so they may decide if they themselves feel suited. The training, as it is run by people who are in a professional and experienced capacity ensures that at the end the Volunteers know in depth what is involved. Volunteering has to be properly managed so as to give an efficient and effective service. The Chaplaincy with all its experience in the matters of spiritual care is most valuable here.

We now have a plural society consisting of many faiths and a significant number with none. This does not mean however that the latter do not have a spiritual side or, more importantly, do not need spiritual support. Spiritual thus has become to mean more than just comfort from a religious point of view but also comfort from simply having peace of mind. Whichever path is taken the result is the same.

So, the listening skills, empathy and the fact that Volunteers have no agenda and are non-judgemental means that they can give spiritual comfort to most people whatever their beliefs or faith. In a large hospital it is very easy for a patient to become institutionalised and start to forget they have a life outside; a family, home, hobbies etc. A visit from a volunteer who, importantly, is neither a relative nor medical person, gives them the opportunity to talk about these things to someone who does not know them but shows an interest in them. Also they may want to talk about their worries or fears rather than upset a relative. This helps give them a sense that they are someone worthwhile; a person not just a patient. It improves their spirit.

Sandy Edwards
Volunteer in Acute Service
6. Developing best practice: education, research and training

Training
All staff are involved in providing spiritual care and will be encouraged to develop their skills in this aspect of care through a local programme of training provided by the Department of Spiritual Care and in partnership with Further Education Institutes.

Links will also be further developed with local Further Education Institutes to provide training for undergraduate and post graduate students.

Members of the Department of Spiritual Care provide spiritual care at a higher level of competency with the specialist knowledge and skills they are required to have. This enables them to support staff in providing spiritual care through training, providing information and advice, and working with individual patients, carers and staff to provide support.

Education
To ensure educational governance and in developing best practice in spiritual care those involved in the service must be able to demonstrate that they have the knowledge and skills necessary to function at the highest level of provision of spiritual care. To this end all members of NHS Tayside department of Spiritual care will work towards a post-graduate Certificate in Spiritual Care.

Research
Education is most effective when it is informed by research into practice.

All spiritual care should be informed by research to ensure evidence based practice therefore all chaplains will be expected to be knowledgeable about research into spiritual care and translate this into practice.
7. Working in Partnership with local communities

_Shifting the Balance of Care_ is a Scottish Government initiative to support the NHS in delivering care where and when it is most efficient, effective and safe. Spiritual wellbeing is fundamental to this as we consider whether people would rather receive care in their own home, if healing is more effective surrounded by family and friends and the importance of partnership of patient and healthcare professional in decisions made in relation to care.

Wellbeing of individuals has been shown to be supported by developing viable communities which may be geographical or a community on shared interest.

In NHS Tayside we are fortunate in having good relations with local faith and belief communities which care well for their own members and those who request to be put in touch with them and these are being developed in a number of ways.

- membership of the Spiritual Care Forum to advise on particular issues of belief and faith
- belief and faith community visitors, appointed by their community and NHS Tayside, and trained by the Department of Spiritual Care in health care matters, to visit members of their own belief and faith communities
- referral protocols for belief and faith communities
- research projects involving NHS staff, local belief and faith communities and action researchers to develop good practice in spiritual care and support in the community
- workshops on aspects of health care pastoral support

The department is also committed to involvement in developing work with joint local authority and NHS initiatives to develop viable communities. This may link with developing the service in the community through GP practices and in taking listening services out into the community linking with belief and faith communities where appropriate.
8. Quality and wellbeing

The Healthcare Quality Strategy for NHSScotland was launched in May 2010 by the Scottish Government. This sets out the six strands which should be the measure of high quality care which every person has the right to expect.

The value of spiritual care in supporting the Healthcare Quality Strategy for NHSScotland to ensure both quality and wellbeing for all is:

- **caring and compassion**: these are the focus of care and support in spiritual care
- **collaborating**: all members of staff are involved in spiritual care and chaplains work as part of the multi-professional team
- **confidence**: caring for people in a holistic manner encourages patients to have confidence in care received
- **clean and safe**: in supporting staff both in the care they give and as individuals they are encouraged to value themselves and the work they do resulting in better environments
- **continuity**: spiritual care encourages recognition of the whole person and therefore the importance of considering their whole journey of care from diagnosis to end of care.
- **clinical excellence**: research has shown that where the place of wellbeing is recognised in holistic care through spiritual care then patients may respond better to treatment and the overall patient experience is improved.

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**Healthcare Quality Strategy for NHSScotland**

**AIM**

The ultimate aim of our Quality Strategy is to deliver the highest quality healthcare services to people in Scotland and through this to ensure that NHSScotland is recognised by the people of Scotland as amongst the best in the world.

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**Healthcare Quality Strategy for NHSScotland**

**What people have said.....**

A unique and important opportunity for all of us to work together to make our NHS even better, for everyone.

We all need to understand what our respective expectations, roles and responsibilities are, and make a shared commitment to take the action required of each of us to make the changes needed to ensure that our NHS delivers the very best quality healthcare for us all, now and into the future.