Equality Impact Assessment Tool for Frontline Patient Services

Equality Impact Assessment is a legal requirement and may be used as evidence for cases referred for further investigation for legislative compliance issues. Please refer to the EQIA Guidance Document while completing this form. Please note that prior to starting an EQIA all Lead Reviewers are required to attend a Lead Reviewer training session. Please contact CITAdminTeam@ggc.scot.nhs.uk for further details or call 0141 2014560.

1. Name of Current Service/Service Development/Service Redesign:

Plastic Surgery Pre-Assessment

This is a : Current Service

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

A. What does the service do?
We are a nurse led pre operative plastic surgery clinic with 4 Nurse practitioners and 2 Health care support nurses. We cover Monday to Friday 9-5pm. Our role is to anaesthetically assess patients prior to their elective plastic surgery procedure. This could include adjusting medications, organising echos and chest x rays to optimise the patients prior to their operation. We liaise with surgeons and anaesthetists and GPs again to discuss patient health history for best management.We see roughly 200 patient a month with varying health requirements. We also assess patients coming in for dental treatment that cannot be dealt with in the community due to various health conditions. Again we work closely with the anaesthetist with this cohort of patients. Patients are asked to attend our clinic weeks before their procedure. Each individual is assessed and depending on their health we take blood, routine observations, height and weight and an ECG. The nurse practitioner will also obtain an in-depth health and socio economic history.
B. Why was this service selected for EQIA? Where does it link to Development Plan priorities? (if no link, please provide evidence of proportionality, relevance, potential legal risk etc.)
This service was selected due to the various patients we see to ensure the needs of the individuals are captured. This is an opportunity to identify, if any, areas of improvement within our service.

3. Who is the lead reviewer and when did they attend Lead reviewer Training? (Please note the lead reviewer must be someone in a position to authorise any actions identified as a result of the EQIA)

Name:	**Date of Lead Reviewer Training:**
Lorraine Carr	15/12/2017

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

Jackie Dunlop (Lead Nurse); Lynne Danskin (Nurse Practitioner)

	Lead Reviewer Questions	***Example of Evidence Required***	**Service Evidence Provided**	**Additional Requirements**
1.	**What equalities information is routinely collected from people using the service? Are there any barriers to collecting this data?**	***Age, Sex, Race, Sexual Orientation, Disability, Gender Reassignment, Faith, Socio-economic status data collected on service users to. Can be used to analyse***	During our health history we routinely obtain sex,age, gender , any disabilities (INCL bbv), pregnancy and maternity status, socio-economic, religion and belief. These details help with	We currently do not collect sexual orientation and marriage and civil partnership status as this is does not affect the patient journey and

		DNAs, access issues etc.	planning the patients admission and any special needs and requirements are highlighted to the ward staff.	is not required to assess the patients health requirements.
2.	**Can you provide evidence of how the equalities information you collect is used and give details of any changes that have taken place as a result?**	***A Smoke Free service reviewed service user data and realised that there was limited participation of men. Further engagement was undertaken and a gender-focused promotion designed.***	We pass on information eg disability to wards to make transition to inpatient care easier. Eg Hoisting requirements, the need/requirement to bring own equipment in eg zimmer frames, wheelchairs. The patients and ward then are more prepared to deal with the patients individual needs. Another example of equality information is our bariatric patients requirements. We currently are seeing an increase of bariatric patients. We communicate to the wards and Theatres details such as the requirement for bariatric beds. The wards now keep larger gowns also for patients as previously communicated from a service user that this stopped them coming into hospital due to the embarrassment.	
3.	**Have you applied any learning from research about the experience of equality groups with regard to removing potential barriers? This may be work previously carried out in the service.**	***Cancer services used information from patient experience research and a cancer literature review to improve access and remove potential barriers from the patient pathway.***	We have undertaken a lot of work around dementia care, staff have all attended study days and one NP is undertaking the Dementia Champion course to educate us in the potential of Delirium when the patient comes into hospital. We have started using a Delirium screening tool 4AMT and TIME in the pre op assessment to assess the possibility of an increased chance of this happening during their hospital stay. This is then communicated to the ward staff and used as a bench mark score.We also give advice on how to minimise delirium 'triggers'eg ensure mobility aids, glasses etc are brought to hospital and advice on hydration pre operatively.	This is currently a trial. After 3 months we will review its effectiveness.
4.	**Can you give details of how you have engaged with equality groups to get a better understanding of needs?**	***Patient satisfaction surveys with equality and diversity monitoring forms have been used to make changes to service provision.***	Not done	For service improvement a patient satisfaction survey should be undertaken.
5.	**Question 5 has been removed from the Frontline Service Form.**			
6.	**Is your service physically accessible to everyone? Are there potential barriers that need to be addressed?**	***An outpatient clinic has installed loop systems and trained staff on their use. In addition, a review of signage has been undertaken with***	Our building currently has a ramp for wheelchair access at the back. This is currently accessable however this is a steep ramp. Patients are unable to be dropped at the back door due to building	Ramp access will require a review March 2018 once building works are completed.

		clearer directional information now provided.	works. We are a ground floor building with wheelchair accessible toilets. All doors have to be accessed with a swipe card therefore all patients are escorted with a nurse.	
7.	**How does the service ensure the way it communicates with service users removes any potential barriers?**	***A podiatry service has reviewed all written information and included prompts for receiving information in other languages or formats. The service has reviewed its process for booking interpreters and has briefed all staff on NHSGGC's Interpreting Protocol.***	We endeavour to meet the requirements of the NHSGGC Interpreting Services for patients. Interpreters booked regularly for the service incl. BSL for the pre op assessment and for admission.	
8.	**Equality groups may experience barriers when trying to access services. The Equality Act 2010 places a legal duty on Public bodies to evidence how these barriers are removed. What specifically has happened to ensure the needs of equality groups have been taken into consideration in relation to:**			
(a)	**Sex**	***A sexual health hub reviewed sex disaggregated data and realised very few young men were attending clinics. They have launched a local promotion targeting young men and will be analysing data to test if successful.***	Staff trained in disclosure of GBV, study days and learn pro modules are undertaken. We can at times work with survivors of FGM and patients who have been victims of physical trauma and torture. We have Clinical psychologists on site and have a good working relationship and excellent referral system. 3 NPs have complete the in house psychology course.	
(b)	**Gender Reassignment**	***An inpatient receiving ward has held briefing sessions with staff using the NHSGGC Transgender Policy. Staff are now aware of legal protection and appropriate approaches to delivering inpatient care including use of language and technical aspects of recording patient information.***	Our clinic work with gender reassignment patients. We are referred patients at various stages of reassignment. Staff are aware of the NHSGGC reassignment policy. Our patients are all treated equally and we have not experienced any challenges with this cohort of patients.	Further awareness/update to all clinic staff regarding NHSGGC reassignment policy.
(c)	**Age**	***A urology clinic analysed their sex specific data and realised that young men represented a significant number of DNAs. Text message reminders were used to prompt attendance and appointment letters highlighted potential clinical complications of non-attendance.***	We operate a service from aged 17 to no limit of age. Due to the aging population we see a high percentage of elderly. All patients despite age are treated equally and each requirement / needs are dealt with accordingly. We have many posters giving information regarding carer needs/help, usually focusing on the elderly.	Look into posters that incorporate all age groups.
(d)	**Race**	***An outpatient clinic reviewed its ethnicity data capture and***	We use the interpreting service for all patients that have difficulty with the	

		realised that it was not providing information in other languages. It provided a prompt on all information for patients to request copies in other languages. The clinic also realised that it was dependant on friends and family interpreting and reviewed use of interpreting services to ensure this was provided for all appropriate appointments.	English language. We make provisions for interpreters and at times female interpreters are requested due to their culture, also due to the sensitivity of some of the procedures we will request gender matching of interpreters with patients where appropriate. Staff are made aware again attending equality study days and learn pro modules related to race related crimes. We rarely have patients that have experienced this, or that choose to tell us these details as it may not be relevant to their impending operation.	
(e)	**Sexual Orientation**	***A community service reviewed its information forms and realised that it asked whether someone was single or 'married'. This was amended to take civil partnerships into account. Staff were briefed on appropriate language and the risk of making assumptions about sexual orientation in service provision. Training was also provided on dealing with homophobic incidents.***	We do not capture this information as part of our assessment. This information may be volunteered as part of the 'next of kin' question. Staff do not make assumptions about relationship status across all age groups. Staff use the appropriate language eg partner rather than husband/wife/boyfriend/girlfriend. Staff again treat each person as an individual irrelevant of sexual orientation.	
(f)	**Disability**	***A receptionist reported he wasn't confident when dealing with deaf people coming into the service. A review was undertaken and a loop system put in place. At the same time a review of interpreting arrangements was made using NHSGGC's Interpreting Protocol to ensure staff understood how to book BSL interpreters.***	We consider all disabling factors for patients incl. BSL provision. We generally are aware of patients requirements prior to their visit, eg interpreting. The physical environment is suitable for all wheelchair users. We also accommodate assistance dogs. All details captured at the assessment is communicated to the ward to aid the patient on admission. Loop system is available if required	No loop system in place - investigate
(g)	**Religion and Belief**	***An inpatient ward was briefed on NHSGGC's Spiritual Care Manual and was able to provide more sensitive care for patients with regard to storage of faith-based items (Qurans etc.) and provision for bathing. A quiet room was made available for prayer.***	We capture patients religion and beliefs at the assessment. We communicate eg HALAL meals required. Jehovah witness patients information regarding transfusion beliefs are particularly important while undergoing a surgical procedure. A legal document is required.	
(h)	**Pregnancy and Maternity**	***A reception area had made a room available to breast feeding***	This information is captured during the assessment. We routinely do not operate on	

		mothers and had directed any mothers to this facility. Breast feeding is now actively promoted in the waiting area, though mothers can opt to use the separate room if preferred.	pregnant ladies unless it is a emergency. Patients that are breast feeding do require consideration due to the anaesthetic drugs therefore the anaesthetist is always included in those patients. We do not have crèche facilities, however patients that require to bring children in are welcomed.	
(i)	**Socio - Economic Status**	***A staff development day identified negative stereotyping of working class patients by some practitioners characterising them as taking up too much time. Training was organised for all staff on social class discrimination and understanding how the impact this can have on health.***	As we are a regional service we do find patient's are far travelled and can struggle with finances to fund the visit. We have a Cashiers office on site - clients advised what to bring and escort to cashiers office for reclaim. We have some flexibility in working with patients in their locality, completing a telephone assessment and asking them to get blood tests are their local GP, however this is only possible for certain patients as it is critical we see the majority of our patients at our clinic.	
(j)	**Other marginalised groups - Homelessness, prisoners and ex-offenders, ex-service personnel, people with addictions, asylum seekers & refugees, travellers**	***A health visiting service adopted a hand-held patient record for travellers to allow continuation of services across various Health Board Areas.***	We see patients from our local prison at the pre op assessment clinic. Due to poor appointment systems this was not done previously. We now have a robust system that the prisoners are not disadvantaged and can attend our clinic. We treat all patients on an individual basis and look at their needs, eg addictions - we liaise with local pharmacy regarding methadone dispensing prior to surgery.	
9.	**Has the service had to make any cost savings or are any planned? What steps have you taken to ensure this doesn't impact disproportionately on equalities groups?**	***Proposed budget savings were analysed using the Equality and Human Rights Budget Fairness Tool. The analysis was recorded and kept on file and potential risk areas raised with senior managers for action.***	no cost savings in effect.	
10.	**What investment has been made for staff to help prevent discrimination and unfair treatment?**	***A review of staff KSFs and PDPs showed a small take up of E-learning modules. Staff were given dedicated time to complete on line learning.***	All staff are given the chance to attend all relevant study days related to diversity & equality. modules are undertaken on learnpro.	

11. In addition to understanding and responding to our legal responsibilities under the Equality Act (2010), services have a duty to ensure a person's human rights are protected in all aspects of health and social care provision. This may be more obvious in some areas than others. For instance, mental health inpatient care (including dementia care) may be considered higher risk in terms of potential human rights breach due to removal of liberty, seclusion or application of restraint. However risk may also involve fundamental gaps like not providing access to communication support, not involving patients/service users in decisions relating to their care, making decisions that infringe the rights of carers to participate in society or not respecting someone's right to dignity or privacy.

Please give evidence of how you support each article, explaining relevance and any mitigating evidence if there's a perceived risk of breach. If articles are not relevant please return as not applicable and give a brief explanation why this is the case.

Right to Life

Not relevant - all information provided to allow patients to self-determine treatment options.

Everyone has the right to be free from torture, inhumane or degrading treatment or punishment

Not relevant

Prohibition of slavery and forced labour

Not relevant

Everyone has the right to liberty and security

Not relevant

Right to a fair trial

Not relevant

Right to respect for private and family life, home and correspondence

As part of our service we discuss the discharge process and work with the ward to help with adequate discharge planning. We highlight care packages that are in place, also if the patient lives alone. This impacts on our decision for overnight stay etc. The ultimate decision for discharge is with the ward, they ensure a pack in place to support return to community once the patients needs are assessed.

Right to respect for freedom of thought, conscience and religion

All religious beliefs are treated with respect and dignity and provisions are made, where appropriate for eg prayer time. We have a Chaplaincy service within the hospital that patients can use and also a chapel and a Sunday service.

Non-discrimination

All patients are treated as equal and individuals and are assessed on their individual needs and requirements.

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

We have completed a lot of work around the elderly/dementia/carers and delirium. We use a 'getting to know you' form that asks patients/carers to fill in prior to admission. This gives the ward staff a good insight into the 'person' they are treating taking into account eg favourite foods, what they prefer to be called, fears and anxieties. We highlight and ask if the patients themselves are carers and help with the use of organisations to organise respite/further care for their relative while they are in hospital and the recovery period. We now screen patients at the pre op clinic for the possibility of delirium while in hospital, highlighting at an early stage to the ward staff if their are any triggers, aiming to reduce the chance of a delirium episode.