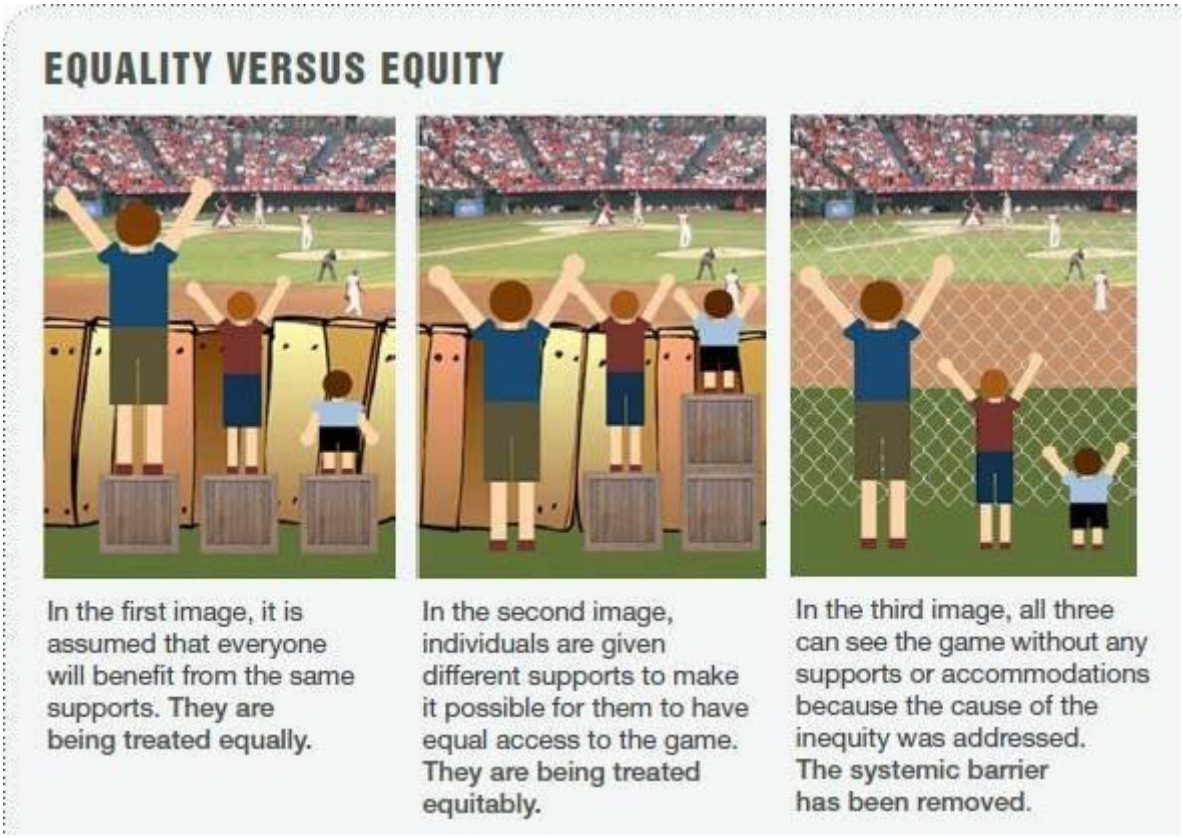
NHS Lothian Equality and Rights Outcomes and Mainstreaming Report 2017



CECHR City for All Women Initiative (CAWI), Ottawa

What is this report about?

Public authorities, including NHS Lothian, make decisions that affect the lives of people in Lothian. The Lothian NHS Board want a society that is fair and just, in which everyone can participate, flourish and benefit, where we respect and value diversity, and where we work together to build strong local communities. We know that there are stark inequalities in our society and communities in Lothian. This means we must promote equity, foster good relations, address inequalities and ensure that our policies, services and actions are not unjust or discriminatory.

This report is a summary of progress in work on NHS Lothian's Equality and Rights Outcomes Report, which was published in 2013. This report also sets out what we have learned about Mainstreaming Equalities and Human Rights – that is, what we now understand about how to make this part of how everybody works every day. The public sector equality duty sets out the minimum standard we need to reach. As part of meeting that duty we have to publish reports like these every four years. Our progress report came out in 2015.

Our Staff

NHS Lothian's Equalities and human rights duties extend to staff. This report includes information on employees, including where we stand on equal pay and on our recruitment, promotion and development of staff.

So, what's in the report?

Over the four years since 2013, we have improved how we tackle discrimination and disadvantage in Lothian. In the main report, you will find details of changes and improvements to our services, with case studies telling stories in more depth. There are also hyperlinks so you can look at the detailed evidence if you want to.

However, we also know that specific groups of people experience inequalities. While these can be long-standing and deep-rooted, they are not inevitable. They can be avoided or their impact reduced (see here for example). We are required to take actions that prevent individuals and communities experiencing the effects of inequality on health and wellbeing. We are also required to reduce the health and social consequences of inequalities. An important part of this is 'mainstreaming'. This means using all our resources and providing every service in ways that enable everyone to use them and which respect people's rights, particularly people with greater and more complex health needs,. If we recognise reducing inequalities in health outcomes as our core purpose, take a rights-based approach in our decision making and in how we design our services, we will have greater success in reducing the size of these inequalities, and the proportion of people affected by them. We will also be more likely to prevent new inequalities from arising. So we have tried to think carefully about what is most likely to work well as we try to make equality and human rights part of everyday practice.

What has gone well

We have made good progress in a lot of separate areas of work.

- There are new or better services for many groups of people with protected characteristics. There are also lots of examples where we have made the "ordinary" services better at responding appropriately to people with particular needs.
- We have some great examples of collaborations with partner organisations to do things better with and for local people.
- Perhaps most importantly, we are getting better at working with people and communities to decide together what we should do and how best to do it. There is some evidence that is becoming part of "how we do things around here".

What is still challenging us

There is always room for improvement – and that is what motivates many of our staff to do better every day in their work.

In particular, we know we need to do better in:

- hearing and responding to patient feedback and complaints,
- understanding who is working for us and who is using our services,
- designing our services with equality and human rights in mind,
- providing Interpreting and Translation Services,
- collaborating with our key partners,
- bringing together our work around a central intention to reduce inequalities by planning and using resources with that specific intent.

What we have learned

Here is what we have learned so far:

<u>Two good starting points</u>

In our work with children and young people, when we ask them what they think, they tell us that the most important thing we can do for them is to "make sure we feel like we matter". That seems a very good starting point for all of our work, be it with patients, the public, each other as staff, or with local communities.

At the same time, we have to make sure that we design our services so that those people who have traditionally been underserved, find NHS Lothian welcoming and that they are confident that we will work with them to understand what will work best for them.

Two important stages

1) **Awareness**; we have to understand what the world feels like from the point of view of the people we are working for. It is always important to have good conversations with each person we are working with. There are common features about what works well for groups of people too – and we need to keep our knowledge and understanding of this up to date. As staff, all of us need a basic level of knowledge about all the different groups, how to meet people's needs and ensure that their rights are respected. Some of us in particular jobs need a much deeper understanding of the particular groups we work with.

2) **Action**; once we understand something of what the world feels like for a person or a group of people, we should decide if we need to take particular actions in response. We use a process called Integrated Impact Assessment to help to think this through and agree actions whenever we change how we use our funding, plan a new policy or service.

How change happens

The information in the full report shows three different ways in which we have made progress with the outcomes we agreed back in 2013.

1) Planned work – we agreed the outcomes in 2013, decided what to do about them, and did it. Sometimes the actions we took have been very effective. In other cases, they have not. Where we asked people to do things that they had not developed themselves, or which they did not see as important or relevant, they have not always done them.
2) Reactive work – new information told us that there was a new need – and we decided how to respond to that.
3) Emergent work – new opportunities to work with different partners presented themselves, so we took them. Some very good work has come about in this way, which we could not have known about in 2013.

We think that we need to learn from this experience. It is not always possible to plan everything out in advance – some important changes will emerge as time goes by. We should expect this and learn from it.

Also, approaches that rely on experts to tell everyone else what to do, and how have often failed. We want to develop a new approach to our equalities and rights work that links to people's own motivations, the reasons they do the work they do.

Resources

Prioritising the use of our diminishing resources is always a challenge. We have not always made reducing inequalities and respecting people's rights our top priority.

We have not been able to keep all of the equality lead posts we used to have.

So we need to invest in and support the staff, volunteers and advocates who are already doing this work with patients, communities and staff across Lothian. We will develop a network of people across our organisation and with partners which supports "champions" and gets others to join in too, so that we get to the point where everyone is working to a new standard, and working out how we can continue to get better at this.

Other important initiatives

Our Chief Executive has started work internally to improve Staff Experience and Engagement. We will make sure that work is founded on people's rights and principles of equity.

Finally, our Quality Strategy says that our aim is to improve the health of the people of Lothian. We need to put equality and human rights at the heart of that work so that we can learn from the diverse knowledge and skills of the people who live, work and play in our area about how to improve their health and experience of heathcare.

What are we going to do now?

We are not going to rush to produce a new set of Equalities Outcomes.

We will develop an improvement plan to address the points we have learned about from this report over the next 12 months.

At the same time, we will support a network of people from across Lothian who want to work to reduce inequality, promote rights, and commit to work and learn together. .

We will support and facilitate that network to devise a new strategy, responding to all of our statutory requirements, but also choosing our own priorities for concerted action.

We will devise a new set of outcomes that the network will commit to improve from June 2018 onwards.

NHS Lothian Equality and Rights Outcomes and Mainstreaming report 2017

Main Report

How this report is laid out

This report is organised around a list of our published equality & rights outcomes 2013 - 17.

Under each outcome is a summary of

- where we were in 2013,
- what we have done, and
- what we have learned.

The report concludes with information about our next steps in improving equality and rights.

Outcomes relating to the way NHS Lothian develops its policies and strategies, and the way it employs its workforce.

1.1 All healthcare developments, policies and plans take account of the diversity of needs and characteristics of patients and the community

1.2 The NHS Lothian workforce better reflects the diversity of the population it serves, and staff with protected characteristics are represented more appropriately at all levels of the organisation

1.3 The pay gap between staff of different genders, ethnicity and for disabled staff is reduced

1.4 There is improved dignity at work for all staff and volunteers

Outcomes relating to access to NHS Lothian's healthcare services.

2.1 Access to health services is more equitable for people with protected characteristics

2.2 NHS Lothian has minimised architectural, environmental and geographical barriers to its services

2.3 Health promotion and public health campaigns are inclusive, reach all intended audiences and address stigma in the community

Outcomes relating to equitable quality of care for all patients.

3.1 Patients with a protected characteristic have a more personalised, individualised service where they are better able to exercise their independence, control and autonomy with an advocate if needed, and where their Human Rights or Children's Rights are protected

3.2 People in Lothian are more assured that health services will respect their dignity and identity

3.3 Staff are better equipped to deliver health care that takes into account patients' protected characteristics, health literacy needs and dignity

Outcomes relating to the way NHS Lothian involves and consults with people when developing services or policies.

4.1 NHS Lothian involves people in a more inclusive and equitable way, including people with all protected characteristics and from across the socio-economic spectrum

4.2 NHS Lothian ensures that any individual can provide feedback or make a complaint and this is addressed equitably and transparently

Outcomes relating to the way NHS Lothian promotes equality and diversity in its work with partners, in its contracts and in its procurement of goods and services.

5.1 NHS Lothian's partner organisations and suppliers operate in a way that is consistent with its approach to the promotion of equality

5.2 Individuals and communities who are vulnerable to, or victims of hate crime feel safer and more secure

INTEGRATED IMPACT ASSESSMENT

Outcome 1.1 All healthcare developments, policies and plans take account of the diversity of needs and characteristics of patients and the community: impact assessment

Where were we in 2013?

We used Rapid Impact Assessment to assess whether our plans would meet the needs of all our populations. We had been using this since 2006.

What good work have we done – and where are we now?

We have developed an approach called Integrated Impact Assessment jointly with the four Lothian councils. We have developed guidance and training on this. We are using this for new plans in NHS Lothian, the Integrated Joint Boards and some council plans.

What have we learned?

We have learned that:

1. The impact assessments are a good way to find out if our plans are likely to miss some people's needs.
2. We need more people in NHS Lothian who can do impact assessments.
3. We need to follow them up to make sure that actions have been taken after the assessments are done.
4. We want more people to do impact assessments. We need to work out what would help that to happen.

COMMUNITY HEALTH INEQUALITIES TEAM

Outcome 1.1 All healthcare developments, policies and plans take account of the diversity of needs and characteristics of patients and the community

Where were we in 2013?

Keep Well was a Scottish Government led initiative launched in 2006/7. It was introduced with the aim of reducing cardiovascular disease and associated risk factors among those living in areas affected by socio-economic deprivation. Up until 2014, the programme was constrained by nationally generated minimum data sets with a largely biomedical focus. Recognising that 50% of those experiencing deprivation do not live in our most deprived data-zones, in Lothian we expanded the Keep Well work beyond geographically defined areas of deprivation to offer support to other vulnerable groups. These included: those who had committed an offence, those with chronic and enduring mental health problems, people affected by substance misuse and the gypsy/travelling community (irrespective of their postcode of residence).

The Government's phased withdrawal of all funding for this programme meant our activity had to diminish significantly. However, reduced funding was accompanied by a removal of the constraints of the above reporting arrangements. This allowed us to use the remaining tapering funding to develop the programme into a more person-centred and inequalities-focussed offer which recognised the wider elements of health and wellbeing (beyond the purely biomedical). See below for how the work developed.

What good work have we done - and where are we now?

The Community Health Inequalities Team – an evolution of the Keep Well Programme – developed a number of streams of work which sought to support those with higher needs:

The Wellbeing Team:
Thistle Foundation and NHS Lothian co-lead the Lothian House of Care Collaboration, which exists to help people experience person-centred care and support. The Collaboration supports 11 early adopter partners. These are primary care practices that use the house of care approach. The Wellbeing Team offers person centred support for people with, or at higher risk of, long term conditions who are 18 years and over. Wellbeing Practitioners take referrals from GPs and other health professionals based in the practice.

The Wellbeing practitioner arranges a one-to-one appointment with each person either in or outside the practice, depending on the needs of the person. This provides time for the person to explore their health needs and the underlying issues that are having an impact on their health. These might include low income, insecure work, caring responsibilities, loneliness, experiencing discrimination – or any other factors that affect daily living. There is no prescribed time limit around working with a person. Once they have been referred by the primary care team, people can refer themselves directly to the service should they need any support in the future.

In Midlothian, the Health and Social Care Partnership have continued this work in partnership with Thistle Foundation. The Wellbeing work is integrated as part of the Midlothian Health and Wellbeing strategic plan linking with projects such as the Permanence and Care Team, Transforming Care after Treatment (cancer) and Occupational Therapy Living Well service to support individuals to self manage and access appropriate services.

In Edinburgh, NHS involvement with the work ceased as Scottish Government funding for Keep Well stopped and the Edinburgh Health & Social Care Partnership did not continue this model.

Community Health Inequalities Team work with other vulnerable groups: The work below recently stopped following the withdrawal of Scottish Government funding and in the absence of any local investment.

The Community Health Inequalities Team previously worked in our prison settings and in conjunction with Criminal Justice Social Work partners to provide 'links worker' style support to individuals with high needs. Some of this work was embedded within our prison settings.

- The Community Health Inequalities Team was one of NHS Lothian's few points of contact with our Gypsy/Traveller communities both on authorised and unauthorised sites. The team had good links with Police Scotland and Council staff and provided helpful links with these underserved populations.
- The team supported people living in temporary accommodation or who were homeless in Midlothian, again working with council homeless teams
- In Edinburgh, delivery of support to those with chronic and enduring mental health issues through mental health services (both NHS and non-statutory)
- Support for carers, individuals in contact with social workers, women attending criminal justice programmes in East and Midlothian and many other in contact with literacy education veteran services across Midlothian.

What have we learned?

A need for Health and Social Care Partnerships and NHS Lothian to be better joined up in their approaches to developing and delivering inequalities interventions. We need less short-term funded, project- based work and more evidence-based/well-evaluated and then integrated services and interventions (like the Wellbeing service in Midlothian).

EQUALITY AND DIVERSITY MONITORING REPORT

Outcome 1.2 NHS Lothian's workforce better reflects the diversity of the population it serves, and staff with protected characteristics are represented appropriately at all levels of the organisation

You can see our Equality and Diversity Monitoring Report (15 pages) in the Equalities & Rights Outcomes and Mainstreaming Full Reference Report.

TRAINING AND SUPPORTING STAFF: EQUALITY AND DIVERSITY

Outcome 1.2 NHS Lothian's workforce better reflects the diversity of the population it serves, and staff with protected characteristics are represented appropriately at all levels of the organisation

Where were we in 2013?

There was a reasonable understanding by managers and staff of equality and diversity issues but recognition that this could be improved in order to reach the goal of having staff with protected characteristics represented appropriately at all levels of the organisation.

What good work have we done – and where has it got us to now?

Management in Practice Module 4 (Equality and Diversity) is targeted at senior staff and managers and is an essential requirement for staff chairing recruitment and selection panels.

All staff are required to complete the mandatory Equality and Diversity training module every 2 years. Recognising that there are always staff on leave from the service, our current compliance rate is 87.2%. We are currently updating the module to make sure it is right up to date.

What have we learned?

We have learned that we can only truly monitor this outcome when we have robust workforce data and staff feeling supported to provide relevant data on any protected characteristics. We have learnt that this can be improved in the organisation and therefore during 2017/18 we will be undertaking a staff awareness campaign to improve the percentage of people disclosing protected characteristics. This will provide us with more meaningful information about our workforce and enable us to have more meaningful conversations with staff about any barriers that they face to achieving their potential.

IMPROVING CAREER PROGRESSION FOR BLACK AND MINORITY ETHNIC NURSES

Outcome 1.2

Big Lottery funding was used to fund a project to improve career progression for black and minority ethnic nurses.

Where were we in 2013?

Workforce data has consistently shown for a number of years that NHS Lothian's registered nursing workforce is among one of the most ethnically diverse of all the job families in the organisation. However there is a continued shortfall in nurses from black and minority ethnic backgrounds attaining roles in the nursing hierarchy at band 6 and above. Research has shown the importance of ensuring a proportionate distribution of black and minority ethnic nurses to help improve team working and thus increase patient satisfaction.

What good work have we done – and where has it got us to now?

Funding was provided by the Big Lottery (£571,288) over a five year period to develop and run a leadership programme for 250 black and minority ethnic nurses and training for 84 mentors and coaches to support these nurses. In addition to provide management training for 120 managers of black and minority ethnic nurses. The project projected that this would lead to 25 nurses attaining promotion into nursing management pay bands.

Funding commenced in July 2014, with the appointment of two facilitators to develop and deliver the leadership programme for black

and minority ethnic nurses. The first leadership course commenced in January 2015.

Since commencement of the programme in January 2015, there have been 65 black and minority ethnic nurses who have undertaken the leadership training, 51 individuals have undertaken the mentorship/ coach training and 113 managers and others have undertaken the training to support the black and minority ethnic nurses. To date four nurses have obtained promotions. In addition, 3 have also moved jobs within NHS Lothian after 10 years.

What have we learned?

It has been found via the project that many of the black and minority ethnic nurses remain in the same post for many years. This means they don't develop the relevant experience required for promotion. The project appears to be encouraging movement in this staff group. This is a good start.

EQUAL PAY

Outcome 1.3 The pay gap between staff of different genders, ethnicity and for disabled staff is reduced

EQUAL PAY STATEMENT 2017

This statement has been agreed in partnership and will be reviewed on a regular basis by the NHS Lothian Partnership Forum and the Staff Governance Committee.

NHS Lothian is committed to the principles of equality of opportunity in employment and believes that staff should receive equal pay for the same or broadly similar work, or work rated as equivalent and for work of equal value, regardless of their age, disability, ethnicity or race, gender reassignment, marital or civil partnership status, pregnancy, political beliefs, religion or belief, sex or sexual orientation.

NHS Lothian understands that the right to equal pay between women and men is a legal right under both domestic and European Law. In addition, the Equality Act 2010 (Specific Duties)(Scotland) Regulations require NHS Lothian to taking the following steps:

- Publish gender pay gap information by 30 April 2017 and every two years thereafter, suing the specific calculation set out in the Regulations;
- Publish a statement on equal pay between men and women, persons who are disabled and persons who are not and persons who fall into a minority racial group and persons who do not, to be updated every four years;
- Publish information on occupational segregation among its employees, being the concentration of men and women, person who are disabled and persons who are not; and persons who fall into a minority racial group and person who do not, to be updated every four years.

It is good practice and reflects the values of NHS Lothian that pay is awarded fairly and equitably. NHS Lothian employs staff on national negotiated and agreed NHS contracts of employment which includes provisions on pay, pay progression and terms and conditions of employment.

These include National Health Service Agenda for Change Contract and Terms and Conditions of Employment, NHS Consultant and General Practice and General Dental Practice contracts of employment and, for a very small cohort, Executive contracts of employment which are evaluated using national grading policies with prescribed pay.

NHS Lothian recognises that in order to achieve equal pay for employees doing the same or broadly similar work, work rated as equivalent, or work of equal value, it should operate pay systems which are transparent, based on objective criteria and free from unlawful bias.

NHS Lothian also recognises underlying drivers of pay inequality, including occupational segregation, inequality of unpaid care between men and women, lack of flexible working opportunities, and traditional social attitudes, and will take steps within its remit to address these factors in ways that achieve the aims of the NHS Scotland Staff Governance Standard and the Equality Duty.

It is good practice and reflects the values of NHS Lothian that pay is awarded fairly and equitably.

In line with the General Duty of the Equality Act 2010, our objectives are to:

- Eliminate unfair, unjust or unlawful practices and other discrimination that impact on pay equality;
- Promote equality of opportunity and the principles of equal pay throughout the workforce;

- Promote good relations between people sharing different protected characteristics in the implementation of equal pay.

We will:

- Review this policy, statement and action points with trade unions and professional organisations as appropriate, every 2 years and provide a formal report within 4 years;

- Inform employees as to how pay practices work and how their own pay is determined;

- Provide training and guidance for managers and for those involved in making decisions about pay and benefits and grading decisions;

- Examine our existing and future pay practices for all our employees, including part-time workers, those on fixed term contracts or contracts of unspecified duration, and those on pregnancy, maternity or other authorised leave;

- Undertake regular monitoring of the impact of our practices in line with the requirements of the Equality Act 2010;

- Consider, and where appropriate, undertake a planned programme of equal pay reviews in line with guidance to be developed in partnership with the workforce;

- Empower staff and managers to work flexibly and effectively with a focus on outcomes, supporting flexible and agile working arrangements and work-life balance;

- Continue to progress through the Carer Positive Framework to support carers in the workplace;

- Ensure that equal pay is central to our commitment to fair organisational change, and that the outcome for staff in relation to equal pay and occupational segregation are monitored;

- Continue to monitor staff development, taking action as appropriate to ensure that all staff are appropriately trained and developed.

Responsibility for implementing this policy is held by the NHS Lothian Chief Executive.

Any member of staff who wishes to raise a concern should in the first instance do this informally with their Line Manager. Should the issue remain unresolved staff can use the NHS Lothian Grievance Procedure to formally raise their concerns.

Staff Governance Standard

NHS Boards work within a Staff Governance Standard which is underpinned by statute. The Staff Governance Standard sets out what each NHSS employer must achieve in order to continuously improve in relation to the fair and effective management of staff.

The Standard requires all NHS Boards to demonstrate that staff are:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently, with dignity and respect, in an environment where
- diversity is valued; and
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

Delivering equal pay is integrally linked to the aims of the Staff Governance Standard.

Analysis of Equal Pay and Occupational Segregation in NHS Lothian

The attached tables at Appendix 1 provide a summary of NHS Lothian's analysis of occupational segregation within the organisation by gender, race and disability. Occupational segregation refers to the distribution of people defined by specific characteristics for example gender, race or disability, into different types of work. Occupational segregation occurs both between and within economic sectors and is typically described in two ways:

- Horizontal segregation refers to the clustering of people, e.g. men and women, into different types of work. For example in the NHS the majority of nurses are women, while me are more likely to work in the Facilities and Maintenance roles.
- Vertical segregation refers to the clustering of people e.g. men and women, into different levels of work for example at different pay bands.

The tables also provide information on NHS Lothian's gender pay gap, as set out in the Equality Act 2010 (Specific Duties) (Scotland) Regulations.

Actions Being Taken to Address Pay Inequality and Occupational Segregation

<u>Minimum Level of Earnings</u>

In April 2016, there was a commitment given that all employers in NHS Scotland would pay as a minimum the Scottish Living Wage. This resulted in the bottom points of our pay scales being taken away and any staff in training posts where their earnings were less than the Scottish Living Wage had their earnings uplifted to this new rate. In addition during 2016, an opportunity was given to those staff in the lowest of our pay bands in Agenda

for Change (Band 1), with the support of additional training to take on an extended role for which they would be paid at the next highest pay band, Band 2 with the corresponding increase in earnings. The majority of the staff are within Support Services in roles such as Domestic Assistants, Catering Assistants, Laundry and Linen Assistants and Porters with a high predominance of females in these occupations. This therefore resulted in an increase in the average pay rate for females within NHS Lothian and a reduction in the gender pay gap.

Flexible Working Practices

Within NHS Lothian we have a range of flexible working options from Term Time Working, Annualised Hours, Job Share, Compressed Working Week and also Home Working. We also have a range of opportunities for part time working across all levels in the organisation, all of which are a contributing factor to our gender occupational segregation.

Disability

NHS Lothian also supports Project Search and the Glasgow Centre for Inclusive Living Disabled Graduate Employment Scheme. Project Search is a partnership between NHS Lothian as the employer, an educational provider and also a supported employment specialist, working with and assisting young people in the age bracket of 16-24 years with a disability to secure and retain full time paid employment. The model blends work based education and practical work experience to deliver a unique preparation and induction to employment. Two programmes have run at the Western General Hospital with 10 individuals on each programme and out of the first cohort the majority of the individuals moved into full time employment with NHS Lothian.

The aim of the Glasgow Centre for Inclusive Living Disabled Graduate Employment Scheme is to provide a 2 years employment opportunity for disabled graduates by providing them with a challenging and reqarding experience of employment and to help set them up for a long-term sustainable career.

Both of these schemes are assisting in reducing the occupational segregation for disabled people.

In recognition of our commitment to equality and diversity, NHS Lothian has agreed to take action to meet the aims of the new ‘Disability Confident Scheme’ which comes into effect from 1 July 2017, which are to:

- Challenge attitudes towards disability

- Increase understanding of disability
- Remove barriers to disabled people, and those with long term health conditions in employment
- Ensure that disabled people have the opportunities to fulfill their potential and realise their aspirations

The core actions are grouped under two themes as follows;

Theme 1 – Core Actions: Getting the right people for your business

1. Actively looking to attract and recruit disabled people
2. Provide a fully inclusive and accessible recruitment process
3. Offering an interview to disabled people who meet the minimum criteria for the job
4. Flexible when assessing people so disabled job applicants have the best opportunity to demonstrate they can do the job
5. Making reasonable adjustments as required
6. Encouraging suppliers and partner firms to be Disability Confident
7. Ensuring employees have sufficient disability equality awareness

Theme 2 – Core Actions: Keeping and developing your people

1. Promote a culture of being Disability Confident
2. Support employees to manage their disabilities or health conditions
3. Ensure there are no barriers to the development and progression of disabled staff
4. Ensure managers are aware of how they can support staff who are sick or absent from work
5. Value and listen to feedback from disabled staff
6. Review the self-assessment paperwork to continually improve

Ethnicity

Workforce data has consistently shown for a number of years that NHS Lothian's registered nursing workforce is among one of the most ethnically diverse of all of our job families. However, it was recognised that there was a continued shortfall in nurses from BME backgrounds attaining roles in the nursing hierarchy at Band 6 and above. Funding was obtained over a 5 year period to develop and run a leadership programme for 250 BME nurses and training for 84 mentors and coaches to support these nurses. The first training commenced in January 2015 and since the commencement of the project 65 BME nurses have undertaken the leadership training, 51 individuals have undertaken the mentorship/coach training and 113 managers have undertaken the training to support the BME nurses. To date 4 nurses have obtained promotions. This project is again encouraging the movement of BME nurses through the pay grades.

Modern Apprenticeships

NHS Lothian is also committed to the Modern Apprenticeship Scheme. Modern apprenticeships are nationally recognised, accredited programmes of learning delivering the skills and knowledge needed to set an individual on a pathway of development and future career opportunities and are an important part of staff recruitment and development. Modern apprenticeships help employers to develop their workforce by training new staff and developing new skills in their existing employees. It can be a great starting point for a career in healthcare or an opportunity to support a change in career for an existing member of staff.

With more than 37,000 young people working, learning and earning as Modern Apprentices in Scotland, NHS Lothian is creating new opportunities for both non clinical and clinical service areas in modern apprenticeships for the future. Modern apprenticeships are expanding job and career opportunities for young people and in also assisting in tackling occupational segregation.

Future Actions

One of the key actions that will be addressed in the coming year is to improve disclosure rates amongst staff within NHS Lothian. Learning from work carried out in other organisations, we will commence a staff awareness campaign about the reasons and rationale for trying to improve disclosure rates so that we can ensure that staff from every diverse group are equally represented in the organisation.

STAFF POLICIES

Outcome 1.4 There is improved dignity at work for all staff and volunteers

Where were we in 2013?

We had policies and procedures in place to support this aim but these required to be reviewed.

What good work have we done – and where has it got us to now?

The Preventing and Dealing with Bullying and Harassment policy replaced the Dignity at Work policy. This is based on the national Partnership Information Network Guideline and contains the best practice in this area. With the development of HR Online and HR Enquiries, information is readily available to managers and staff to deal with such issues.

A Gender Based Violence Policy was developed and implemented and recently reviewed to ensure it remains fit for purpose.

A Transgender Workplace Support Guide has also been developed and is available to support managers and staff.

The revised Organisational Values – Values into Action were adopted in 2013 and have been woven into the day to day work of NHS Lothian.

What have we learned?

We have learned that there is more that we can be doing in this area particularly around staff networks for those staff with protected characteristics. This will be a focus for our attention in the coming year. We are keen to work with organisations such as Stonewall who have been asked by Scottish Government to help Health Boards.

SCREENING & INEQUALITIES

Outcome 2.1 Access to health services is more equitable for people with protected characteristics

Where were we in 2013?

The Detect Cancer Early Programme was launched in February 2012. It involves a whole systems approach to improving outcomes through diagnosis and treatment of cancer at the earliest stages. The HEAT (Health, Efficiency, Access and Treatment) target is to increase the proportion of people diagnosed with stage 1 bowel, breast and lung cancers by 25% by the end of 2015. The aim is to reduce differences in cancer survival rates between most and least affluent areas.

What good work have we done – and where has it got us to now?

Lothian achieved a 20% baseline change towards meeting the HEAT target in 2014/5.. Work in Lothian to encourage GP practices to look at ways of increasing participation in the bowel screening programme in their patient population has contributed towards the improvement in detection of colorectal cancer in Lothian from 14.6% in 2010/2011 to 16.6% in 2014/2015.

Improvement in detection of lung cancer from 16.1% in 2010/2011 to 20.2% in 2014/2015 may relate to pathway work in Lothian focusing on faster referral of those with chest x-rays suspicious of lung cancer, along with a social media campaign and the new cancer referral guidelines.

Detection of stage 1 breast cancer improved despite difficult circumstances (negative publicity regarding breast screening and a

social media campaign focusing more on symptoms than screening).

A targeted approach is being taken to reduce the differences in cancer survival rates between the most and least affluent areas.

What have we learned?

Analyses indicate our success in meeting the Detect Cancer Early national target and subsequent investigation of variation by deprivation has led to a renewed focus on trying to address the inequalities gap in detection of cancer, and an action plan (with 25 projects).

ADDITIONAL NEEDS & DIVERSITY INFORMATION TASK FORCE

Outcome 2.1: Access to health services is more equitable for people with protected characteristics

Where were we in 2013?

In 2013 the Additional Needs & Diversity Information Task Force was established to develop a way in which patients' additional needs are recorded and acted upon with NHS Lothian services. It was informed by the earlier work of the NHS Lothian Ethnicity Coding Task Force which focused on improving recording of information on patients' ethnic group.

What good work have we done – and where has it got us to now?

A sub-group of the Additional Needs & Diversity Information Task Force continued the work of the NHS Lothian Ethnicity Coding Task Force to analyse and promote the use of ethnicity data within NHS Lothian. The first analyses of NHS Lothian service usage by ethnic group for In-patient, Out-patient and Accident and Emergency services demonstrate variation in service use according to ethnic group. These data require further interpretation and analysis but will ultimately enable services to

- monitor equity of access and
- improve service provision and
- provide guidance on analysis and utilisation of other additional needs and diversity data in the future.

An additional patient needs management system pilot run in an outpatient department at the Royal Infirmary of Edinburgh showed that patients with additional needs (interpreter required; hearing needs; visual needs; learning disabilities) were being identified. If implemented across outpatient clinics this system has the potential to improve our ability to meet the needs of approximately 2030 patients per year.

What have we learned?

The development and implementation of the pilot additional patient needs management system has provided lots of information on how to progress to a fully functional additional needs system and has highlighted the need for continuing national collaboration and coordination.

The pilot system cannot be scaled up for full implementation without further development of national e-Health systems which requires national coordination, collaboration and funding.

We helped organise the first meeting of the national group and will be involved in taking this work forward.

LOW INCOME PREGNANT WOMEN IN LEITH ARE SUPPORTED TO APPLY FOR BENEFITS, UNCLAIMED ENTITLEMENTS, AND OTHER FORMS OF SUPPORT

Outcome 2.1 Access to health services is more equitable for people with protected characteristics

Where were we in 2013?

The Equality Act (2010) introduced the term “protected characteristics”. It says that people cannot be discriminated against because of their age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity.

The Healthy Start scheme for low income pregnant women and children addresses several of these characteristics directly – that is, age, sex, pregnancy and maternity. We also know that poverty and ill health are closely linked, and this scheme tries to tackle poverty too. So it is a good example of work we have done under this Outcome.

The benefits system in the UK is difficult to navigate, but voluntary sector and local authority teams can provide support to families in making applications. The number of pregnant women referred for welfare rights advice in Lothian was very small in 2013, and this was the case for the Leith community midwife team as well.

The Healthy Start food and vitamins voucher scheme for low income pregnant women and children was available across the UK, but in Scotland around 25% eligible women and children were missing out on vouchers.

The Early Years Collaborative was launched in January 2013, introducing women and children’s services across the statutory and voluntary sectors to quality improvement methodology. This provided a potential approach to improve processes and outcomes around welfare rights.

What good work have we done – and where has it got us to now?

The Leith community midwife team started to look at the application process for Healthy Start during 2014, boosting the number of applications.

As a consequence of this process improvement, the percentage of eligible women and children in receipt of Healthy Start vouchers increased (up from 73% January 2014 to 79% November 2015). So more women were receiving vouchers they were entitled to, and using those vouchers to get healthy, nutritious food for themselves and their children. Eating this food and the associated improvements in health are outcomes of the improved process that the team had worked on.

Voucher receipt in Leith continues at around the 79% level, at a time when figures for the rest of Lothian and the rest of Scotland are declining.

In February 2015, following a successful grant application to Scottish Legal Aid Board, we started working closely with Granton Information Centre (GIC). Two welfare rights advisers provided support to pregnant women and families, with additional support available for Polish speaking families. Working closely with the community midwife team, the local nursery and early years centre, and other voluntary organisations, GIC has secured over £2m unclaimed benefits and other entitlements in Leith (an average of £4,000 per referral, to April 2017). Again this is an improved process, with an outcome of alleviating poverty by making sure that less well-off families have more income.

In November 2016 the work won Top Team award at the first national Children and Young People Improvement Collaborative Awards.

What have we learned?

We tried to boost voucher receipt and arrange welfare rights advice using traditional methods (newsletter, cascade email, team meetings), but this did not achieve the desired outcomes.

Quality improvement approaches, starting at a small level (one woman, one midwife), sharing data at team and small area level, and taking practical steps to break down barriers between organisations (e.g. by arranging shared working space, honorary contracts, secure email addresses) were required to achieve initial gains.

REINTRODUCING A SPERM DONOR AND DONOR INSEMINATION SERVICE IN NHS LOTHIAN

Outcome 2.1 Access to health services is more equitable for people with protected characteristics

Where were we in 2013?

NHS Lothian did not have a sperm donor or donor insemination service in 2013. This service had ceased following changes to donor anonymity in 2005. We learnt that fertility centres in other areas had successfully reintroduced a service. Rather than purchasing sperm from other areas, at considerable expense, we opted to recruit sperm donors locally. This would allow us to treat more couples, including LGBT couples, and provide a sustainable service.

What good work have we done – and where has it got us to now?

The NHS Lothian fertility service has supported LGBT couples to conceive over the past 25 years. The loss of a viable donor insemination service impacted couples regardless of sexuality. We worked with LGBT groups (LGBT Health and Stonewall) to ensure that we were meeting the needs of all couples in the reintroduction of the donor insemination service (rapid impact assessment carried out October 2013).

The Edinburgh Fertility and Reproductive Endocrine Centre at Royal Infirmary Edinburgh started to recruit sperm donors in December 2013. After screening donors and sperm, a process that requires a 6 month quarantine period, the donor insemination service was reintroduced in October 2014. . So far 30 donors have been recruited (22 cleared for use after screening and quarantine; limit of 10 families per donor). There have been 62 couples treated, with 36 pregnancies in total, 12 ongoing pregnancies and 15 live births..Of the 62 couples treated 41 were LGBT couples (66% of the total).

What have we learned?

We have learnt that major change (e.g. loss of anonymity of donors in 2005) does not present an insurmountable problem. Discussion with LGBT groups ensured that concerns were met and helped break down any perceived barriers.

TRANSGENDER SERVICES

2.1 Access to health services is more equitable for people with protected characteristics

Where were we in 2013?

Transgender services were provided on an ad hoc basis based on relationships and personal commitment, rather than established systems.

What good work have we done – and where has it got us to now?

Guidance for employers working with transgender staff has been produced. We are developing training for employers and staff to improve understanding of transgender issues and how to deliver services appropriately. All doctors who want to teach students or doctors in training have to be trained in equality and diversity. The Transgender Stakeholder Group inputs into training, guidance and service development. This work will be done together with the City of Edinburgh Council as a need for transgender training in the area of alcohol and drugs has been identified there.

The Gender Identity Clinic has taken on additional nursing staff and this has reduced waiting from 178 months to 3 months in the last year or so. Access to specific treatments such as gender reassignment surgery, female to male breast surgery and hair removal is producing good equity of access. However there are still issues with access to male to female breast surgery, facial feminisation and wigs. We are working on that. Transgender Services for young people are provided through Glasgow but the Lothian clinic is assisting by taking patients as soon as they are 16 years, and we are planning to develop a young persons' service in Lothian.

What have we learned?

It is important to work closely with NHS and Local Authority and 3rd sector partners as well as patients so that needs can be accurately identified and appropriate steps taken to meet them**.**

ESTATES

Outcome 2.2 NHS Lothian has minimised architectural, environmental and geographical barriers to its services

Where were we in 2013?

The items identified in the Disability Discrimination Act audits in 2005, and the annual surveys of the estate undertaken on behalf of the Board, had been costed and the ability to carry out works assessed, prioritised and where possible undertaken. This included providing appropriate signage, ramps, hearing loops, chair lifts and accessible toilets and showers.

It was acknowledged that a number of the Board's properties could not be upgraded to meet the needs of service users. This was because the space was not suitable or the cost of upgrade would have reduced the funding available for other aspects of care. Planned business cases or reprovision projects were intended to address some of these problems. Examples of proposed new buildings include the Royal Hospital for Sick Children and Phase 1 of the new Royal Edinburgh Hospital.

The Royal Victoria, Rosslynlee and Loanhead Hospitals, had been replaced by the Midlothian Community Hospital (in 2011) and Royal Victoria Building (2013/14). These were designed to comply with access requirements and to meet the needs of the specific patient groups i.e, appropriate floor coverings, lighting, signage and space.

Wester Hailes Partnership Centre opened in August 2013, providing accessible primary care and including social care services. The Centre also accommodates the Health Agency. This provides services that help improve people's health and wellbeing, such as counselling, massage and relaxation as well as activities including walking groups, exercise classes and volunteering opportunities.

The former Gullane General Practice clinic was replaced by a new, local Medical and Day Centre. The West End Medical Practice which had been located in a converted house, was moved to a specially designed, single storey building.

What good work have we done – and where has it got us to now?

Business cases have been developed and approved for the East Lothian Community Hospital and further redevelopment of the Royal Edinburgh Hospital site. The new East Lothian Community Hospital will provide an increased range of local services in a purpose built facility.

Phase 1 of the Royal Edinburgh Hospital Campus is now complete and provides single en-suite accommodation for patients in an environment which has been designed to meet the needs of the various patient groups. The campus has also been designed to encourage the use of indoor and outdoor spaces and will provide opportunities for the patients to interact with the local community.

A new purpose-built GP practice is being provided in Ratho to replace the current surgery which is located in a converted ground floor flat with restricted space. This will provide opportunities to improve the range of services that local people require on the one site. The new building will have consulting and treatment rooms on ground floor level and be fitted out to allow access and use for all.

The new Royal Hospital for Sick Children and the Department of Neurosciences are due to open in 2018. More than half of the beds are single, en-suite bedrooms. Children and adults suffering from physical and mental health problems will benefit from the availability of both services on one site, at Little France. Signage has been designed for ease of use by everyone with a different theme and colour scheme for each floor.

Various projects are underway to upgrade existing buildings across Lothian to further improve access, signposting, toilet and bathing facilities, bed spacing, soundproofing and, where appropriate to provide dementia friendly environments.

What have we learned?

Surveys, audits, feedback from patients and a good knowledge of the Board's estate have given a good understanding of what work requires to be done.

Restricted resources mean that work needs to be prioritised and risks assessed. We also need to find creative solutions to some issues so that they do not require additional funding.

CASE STUDY: AGEING WELL

Outcome 2.3 Health promotion and public health campaigns are inclusive, reach all intended audiences and address stigma in the community

Where were we in 2013?

- NHS Lothian Health Promotion Service funds four Ageing Well programmes across Lothian, in partnership with East Lothian Leisure, Edinburgh Leisure, Midlothian Leisure, and West Lothian Leisure. Projects aim to promote health and wellbeing in over 50's through increased physical activity and reduced social isolation. There is a strong focus on volunteer involvement.
- Projects are well attended. There was an observation that mainly the 'worried well' and people who are already well-resourced and who engage with services and their local community attend. Since 2010 Health Promotion had been working with the projects to focus efforts on reducing health inequalities. This was done via a conference in 2010, the introduction of a new Service Level Agreement, including the requirement for completion of an approved action plan which would outline work to tackle inequalities.
- By 2013 this work was well underway. Since 2013, further input to the projects was provided to increase the focus of activity on inequalities, as outlined below.

What good work have we done – and where has it got us to now?

- Introduced requirements for an impact assessment to be conducted and an action plan detailing activity to focus on inequalities groups.
- Workshops were held with Ageing Well coordinators covering health inequalities, outcomes and indicators, monitoring tools for mental health and wellbeing.

- Developed monitoring and evaluation tools e.g. an Inequalities monitoring form, guidance for demonstrating progress towards short-term outcomes of Service Level Agreement, tools for measuring confidence, knowledge and skills in target populations.
- Increased focus on engaging with older people more vulnerable to health inequalities – from areas of deprivation, rural areas, frail elderly, people with mental health difficulties, physical impairments/ health conditions e.g cancer, stroke, COPD, dementia, learning disabilities, men.
- Activities are now being designed and jointly led by participants so that they meet access requirements for people with a range of different abilities in a wide range of venues.

What have we learned?

- Projects need initial support to overcome barriers to tackling health inequalities, but are often able to find innovative ways to progress.
- Projects benefit from having a named link officer to advise and monitor re health inequalities, particularly in the initial stages of re-focusing.
- Once a period of initial more intensive support has been provided, to orientate projects to an equalities focus, projects are able to integrate this to become a core principle to their their work. In line with governance arrangements, reporting takes place.
- Barriers: Transport can be a barrier but this is taken into account by working in partnership to utilise venues that are easier for people to access.
- Barriers: Enabling people to move from attending to participating in groups run by local people themselves can be a challenge as participants benefit so much from the activities. Projects encourage groups to become self-sustaining so that workers are able to engage new people.
- Barriers: Staff changes can also be a barrier to integrating the approach. This is exacerbated by short term-funding. The two areas which have been most successful in implementing reporting on Equality and Diversity have had the same Coordinator for several years.
- Learning: Try to secure funding periods for at least 3 years.

- Learning: Recruit people who already understand and have experience of working to tackle inequalities and of working to improve outcomes.
- Work is continuing to achieve consistency of Equality & Diversity monitoring across all 4 projects.

INTERPRETATION AND TRANSLATION SERVICE

Outcome 3.1 Patients with a protected characteristic have a more personalised, individualised service where they are better able to exercise their independence, control and autonomy with an advocate if needed, and where their Human Rights or Children's Rights are protected

Where were we in 2013?

In 2013 interpretation and translation services were provided to NHS Lothian areas via a partnership agreement with the City of Edinburgh Council Service. NHS staff awareness and training was limited to those areas and services where there were well-established populations with specific needs.

What good work have we done - and where are we now?

Interpretation and translation services including BSL-English interpretation and alternative formats are funded by a central budget. - The service is currently organised by the City of Edinburgh Council on behalf of NHS Lothian.

Telephone interpreting services are available as required for staff 24/7/365 with an average response rate of under 40 seconds and in a wide variety of languages (via a contract with a telephone interpreting provider called thebigword).

Language identifying charts are available in some areas and can be downloaded from the intranet, Hearing loop systems are equipped in some areas.

A focus group was organised in collaboration with the City of Edinburgh Council Interpretation and Translation Service to gather feedback from patients.

An Interpretation and Translation Manager was employed in 2016 to provide organisation wide expertise and advice, develop training and the service itself.

A decision was recently made to develop an NHS Lothian in-house interpretation and translation service. This will enable us to work more closely with interpreters and translators, address our patients' needs directly and efficiently, and raise awareness among our staff about their responsibility to arrange interpretation and translation services to enable patients and staff to work together to ensure that care is safe and effective.

What have we learned?

We have learned that our current interpreting and translation offer is inconsistent. Not all staff are aware of the services at their disposal, or how to work with interpreters. This means that not all staff ensure that professional interpreting support is available to them and their patients. Some areas are high users of face-to-face interpretation services but do not use telephone interpreting, and vice-versa. The clinical and patient reasons for this variation are not yet clear.

We intend to take direct control over the distribution of appointments and the budget by bringing the new service in-house.

Sharing resources, good practice and innovative practice around Interpretation and Translation Services with other health boards and other public organisations has been very beneficial. Barriers that we met on the way include quality limitations of new technologies, ways to process patient data on IT systems, and budget constraints.

CASE STUDY: TUBERCULOSIS (TB) SERVICE

OUTCOME 3.1 Patients with a protected characteristic have a more personalised, individualised service where they are better able to exercise their independence, control and autonomy with an advocate if needed, and where their Human Rights or Children's Rights are protected

BCG vaccination: a shift from a hospital only based service to delivering multi-site vaccination clinics through collaborative working.

Background: BCG vaccination, to protect against tuberculosis, has been in use in the UK since the early 1950's and was universally delivered to school-aged children aged 14 years. This was the model of delivery until 2005, when a review of BCG vaccination was undertaken after a sustained period of declining TB rates in the UK population; the result of this was that the schools programme was stopped. Since then, BCG vaccination delivery has been via a targeted programme where neonates and young children at greatest risk of TB exposure are identified and subsequently vaccinated.

In NHS Lothian, the BCG vaccination programme was delivered by the TB nursing service based at the Edinburgh Royal Infirmary. With increasing numbers of TB cases and birth rates, delivery of BCG vaccination was reviewed in 2009/10. A nurse was employed part time to set up community based clinics across Edinburgh. This was very successful and a further clinic in West Lothian was also set up.

Where were we in 2013?

The collaborative BCG service in Lothian continued to work well, however the nurse responsible for the community clinics retired in 2013 and various options for delivery of BCG vaccinations were explored. The TB service could not take this on along with their

existing TB related work. Working with the Health Protection Team, the newly established community vaccination team was approachedto help. They obtained funds and training to deliver the community BCG service.

What good work have we done – and where has it got us to now?

The TB nursing service continues to provide training for administering the BCG vaccine, enabling staff to deliver a safe, effective service.. In 2014/15 the community clinics administered by the community vaccination team commenced, alongside the established clinics in West Lothian and the Royal Infirmary.

The teams are now working well together and communication has improved significantly. The community vaccination team identified specific hubs in which to base their clinics and developed their own appointment system.

The community based BCG service in Edinburgh has developed into a more person centred programme with the hub clinics based close to home for the babies at risk. This makes it easier for families to attend and to ensure that their children are protected against avoidable illness. It is also now very easy to access advice from the expert TB nursing service.

BCG vaccination rates are still below the recommended rates but there has been a year on year improvement in uptake. All of the teams involved are looking constantly at what strategies may further improve clinic attendance and vaccination rates.

What have we learned?

All teams involved in the delivery of BCG vaccine, have learned how to work with each other to improve the service for people at risk in Lothian across the board. This was challenging at first because

each group had slightly different priorities, based on the needs of the people who were using their existing service and their experience of how best to address unmet need. The current working relationships, however, demonstrate a shared commitment to responsive and collaborative joint working.

This has been particularly evidenced recently where BCG vaccine supply was severely restricted. All of the teams came together to formulate a plan to maintain the programme in Lothian. Clinics had to be concentrated on one site to maximise vaccine availability and staff from the community vaccination team placed to provide these clinics and extra administrative support supplied.

The service runs three clinics per week, staffed jointly by the community vaccination and TB nursing teams. There is now no waiting list for these clinics., Although this has meant potentially greater travel time to the hospital we are able to provide some flexibility in appointment times.

HOUSE OF CARE

Outcome 3.1 Patients with a protected characteristic have a more personalised, individualised service where they are better able to exercise their independence, control and autonomy with an advocate if needed, and where their Human Rights or Children's Rights are protected

Outcome 3.3 Staff are better equipped to deliver health care that takes into account patients' protected characteristics, health literacy needs and dignity

Where were we in 2013?

In 2013, we were starting to explore the patient pathway work for

NHS

Lothian's Strategy for 2014-24 (Our Health, Our Care, Our Future). Our focus was on Hannah, a fictional middle-aged person living with several long term conditions, a low-paid job and various caring responsibilites. Although fictional, her story reflected the lives of many people living in Lothian –people recognised her, her family circumstances and central role in keeping the extended family's health and wellbeing on track. We consulted with many stakeholders, professionals and people with lived experience, and decided that the house of care was a powerful evidence based framework to help us make things better for people like Hannah. We realised that

- Hannah needed more support to manage her life and conditions herself
- Health and care workforce needed support to enable professionals to have "good conversations" with Hannah (including helping her identify her personal outcomes), and
- We needed to think about how to make the best use of community based support and care from voluntary and volunteer –led organisations as well as informal support.

What good work have we done – and where has it got us to now?

We formed the Lothian House of Care Collaboration, co-led by the NHS and the Thistle Foundation. We identified a range of stakeholders across health, social care and third sector. With funding support from the Scottish Government, British Heart Foundation, Integrated Care Fund and Primary Care Modernisation Fund, we have supported over 20 GP practices to develop “good conversations”, either between primary care staff and people, or between Wellbeing practitioners embedded in practices and people. We are supporting other early adopters of the house of care approach in cardiac rehabilitation, diabetes out-patients, and primary care pharmacy. Support is offered through facilitated learning cycles, measurement and evaluation, training for staff (Care and Support Planning, “good conversation” and health literacy) and IT support.

What have we learned?

Much of the work in primary care is focused on areas of relative deprivation, and initial monitoring shows that people from areas of socio-economic deprivation are more likely to be using the Wellbeing service.

Patient reported outcome data shows that the service is associated with improved mental wellbeing. Qualitative evidence also shows that these people are experiencing increased confidence and coping, are identifying personal outcomes and receiving support to link in with a range of community based sources of support where appropriate.

We have also learned that there is not a widely shared understanding of the concept of person-centredness. We need to support people to understand that the concept includes enablement as a key principle.

Enablement is linked strongly to the activities of supported self-management and shared decision making. There is a strong focus on shared decision making as a result of Realistic Medicine. However, there is a risk that health inequalities will increase if people with reduced capacity to self-manage are not well-enough supported .

LEARNING DISABILITY – BROADENING OUR APPROACH

Outcome 3.1 Patients with a protected characteristic have a more personalised, individualised service where they are better able to exercise their independence, control and autonomy with an advocate if needed, and where their Human Rights or Children's Rights are protected

Where were we in 2013?

In 2013 we had an established group which held the overview of work across the system to identify and improve heath equality for people with learning disability. There was an ongoing range of initiatives in partnership with our local authority partners and colleagues in both acute and primary care services. Whilst we had engagement with some people who use services and carers, this was not as systematic as we wanted it to be, and the work tended to focus on initiatives that were learning disability specific rather than identifying mainstream issues and changing custom and practice across and beyond the NHS.

We did not have such established processes for people with physical disability or long term conditions and wanted to address the balance.

What good work have we done – and where has it got us to now?

There has been a significant range of work undertaken with the ambition of changing our approaches in healthcare and mainstream practice in partnership with patients and carers that will identify inequalities and reduce exposure to them.

This work includes the following

1. Placing a local area co-ordinator with a Primary Care practice to support and enable social prescribing as an option for GPs / adults with learning disability. This means that doctors and other staff can confidently broaden the range of suggestions and recommendations that they offer patients beyond medication or

treatment to include activities or connections with local people and groups, for example.

2. Supporting the development of patient stories to inform emerging plans for enabling people with profound and multiple disability to live in more homely settings and help us modernise our services for this group of people. We worked with Artlink, a third sector organisation that uses art to support people to engage and communicate with each other.
3. Investing in additional independent advocacy for people with learning disabilities in hospital, to facilitate their engagement in modernisation plans for specialist Learning Disability services and to help their voice to be heard.
4. In partnership with parents and specialist learning disability acute liaison nurses, developing “My Important Heath Information”, a version of a healthcare passport that provides key information about how the person with learning disabilities needs to be supported whilst in hospital.
5. Use of a communication system called Talking Mats to support patient involvement in their day to day use of services, and in planning forums that are informing the development of new services.
6. Implementation of the Health Equalities Framework as a tool to identify the range of health inequalities people with learning disability are exposed to, and, in partnership with them, identify priority areas, interventions and support plans which reduce their exposure to these. (See separate Case Study)
7. Continued use of the local enhanced services programme with Primary Care across Lothian has enabled us to understand the most frequent health complaints that people with learning disabilities see their GP practice about.
8. Implementation of the Ekis (electronic key information summary) which identifies, amongst other things, the presence of sensory impairments and mobility needs and the need for reasonable adjustments including the need for the individual to be escorted to healthcare appointments.
9. We piloted the use of accessible information across all radiology patients and sought feedback on the appropriateness of this, and what people liked/ didn’t like. Over 70% of all patients told us they preferred the accessible version compared to the usual appointment information. This has informed a more general approach to improving health information. Through our Accessible

Information Project, we have people with disability directing the content of our health information to the public.

10. We undertook focus groups with people with progressive neurological conditions to design a website which guided the public to our services. The website, whilst still in development, provides the information that the focus groups told us was important to them in a manner that allows people to plan their consultations and consider how they wish to be supported.

The work above has supported us to work more effectively in partnership with people with disabilities, either individually or in groups. We have identified that a are key priority for people is that we take a more collaborative effort to addressing the social determinants of health, e.g. engagement through being better informed, isolation, poverty, lack of employment and disengagement from local communities.

We are working to ensure the system supports the identification of additional needs and ensuring that reasonable adjustments are addressed. We are clear from patient stories and experiences that when we do this, it provides people with disabilities with a more effective healthcare experience, is better use of the clinicians' time, and should deliver improved health outcomes for the individual person.

The Health Equalities Framework (H.E.F.) in particular will enable us to measure the impact at individual level as well as the improvement in the population of people with learning disability. In time this should provide the evidence to improve local and Health Board policy and service provision.

What have we learned?

We have learned that;

1) When we take the time to understand the additional needs of people with disabilities, we can readily address these and provide more effective healthcare
2) the best way to find out what matters to people is by having good conversations with them
3) people are realistic about the support they need

4) greater understanding of the exposure to health inequalities is directly informing how our integrated services need to work e.g. informing support plans with the individual to ensure that they more directly address issues such as social isolation
5) we need to record both numbers and stories to understand how our whole system is working. The continued role out of the Health Equalities Framework will allow us to do this in localities and across the Health Board in Lothian
6) We know that more straightforward public information that works for people with learning disability also works for large groups of the general population

CONVERSATION MAPS: Improving support around Diabetes in people of South Asian origin

Outcomes relating to equitable quality of care for all patients

3.1 Patients with a protected characteristic have a more personalised, individualised service where they are better able to exercise their independence, control and autonomy with an advocate if needed, and where their Human Rights or Children's Rights are protected

3.2 People in Lothian are more assured that health services will respect their dignity and identity

3.3 Staff are better equipped to deliver health care that takes into account patients' protected characteristics, health literacy needs and dignity

Introduction

NHS Lothian Minority Ethnic Health Inclusion Service (MEHIS)

MEHIS aims to work with black, minority ethnic and refugee communities Lothian-wide and it aims to:

- Link minority ethnic and refugee individuals and communities with primary care and other services to improve the accessibility and appropriateness of services across Lothian.
- Work collaboratively with minority ethnic and refugee communities, health and other professionals to address health inequalities.
- Encourage best practice and race equality in health service planning and provision.

Where were we in 2013?

People of South Asian origin are at a greater risk of developing type 2 diabetes compared with the majority white European population, as well as being at increased risk for a number of macro vascular and micro vascular complications of diabetes.

Structured patient education is one aspect of supporting self management for people with diabetes. NHSGG&C and NHS Lothian, the two Scottish Health Boards with the largest population of South Asians in Scotland, offer diabetes education and self management for ongoing and newly diagnosed (DESMOND) programme to people with newly diagnosed Type 2 Diabetes.

DESMOND is only offered to those who can speak English and do not require language support. Both Health Boards reported a very low uptake of DESMOND from South Asians. In addition, several Diabetes Educators reported that DESMOND is fairly prescriptive and too inflexible to adapt to meet the needs of minority ethnic people whose diet, culture and lifestyles are different from the majority group.

What good work have we done – and where has it got us to now?

Funding was acquired from the Scottish Diabetes Group to pilot an orally based diabetes education model, Conversation Maps™ in NHSGG&C and NHS Lothian, and compare the use of Interpreters with Link workers in Diabetes group education.

Conversation Maps™ were delivered without modifications except for the use of interpreters or Link workers. The rationale for this was that a mainstream approach for culturally specific delivery would facilitate integration and ensure long term sustainability. By using normal methods, any adaptations or adjustments would be identified and recommendations for modifications could then be justified.

The main issues we encountered were:

- challenges in recruitment from primary care
- Language support, though essential, impacted on the group process.
- Low health literacy of the people attending the education

What have we learned?

This pilot resulted in a lot of learning around using routine educational tools in a normal manner with a view to sustainability of practice.

- The factors contributing to difficulties in recruitment were due to:
  - NHS systems issues
  - timing of education sessions
  - Indian /Pakistani community / patient perception of diabetes and diabetes education
  - under diagnosis of diabetes in the Indian /Pakistani population in West Lothian

- Providing group education to a gender segregated group from one language / cultural group was advantageous.
- There were aspects of Link worker support which were beneficial in the delivery of group education
- Conversation Maps™ were well received, assisted engagement and the group process. Supplementary resources and modifications are required to support health literacy and make Conversation Maps™ more effective.
- Training needs were identified for Interpreters, Link workers and Educators

Some issues addressed following the pilot:
Ethnicity and Language recording:

- Ethnicity recording was promoted via the Diabetes Retinopathy Screening Programme in Scotland. This improved ethnicity recording rates for people with diabetes in many Scottish Health Boards.

  In 2017, the Diabetes Retinopathy Screening Programme in Scotland will change their system to request ethnicity information from patients with diabetes throughout Scotland.
- The SCI-Diabetes register has included a field on the patient's preferred language.

Provision of language support:
In 2017, we have planned to trial simultaneous interpretation in group settings

Bi-lingual Bangladeshi Support Worker

Outcomes relating to equitable quality of care for all patients
3.1 Patients with a protected characteristic have a more personalised, individualised service where they are better able to exercise their independence, control and autonomy with an advocate if needed, and where their Human Rights or Children's Rights are protected
3.2 People in Lothian are more assured that health services will respect their dignity and identity
3.3 Staff are better equipped to deliver health care that takes into account patients' protected characteristics, health literacy needs and dignity

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MEHIS aims to work with black, minority ethnic and refugee communities Lothian-wide and it aims to:

- Link minority ethnic and refugee individuals and communities with primary care and other services to improve the accessibility and appropriateness of services across Lothian.
- Work collaboratively with minority ethnic and refugee communities, health and other professionals to address health inequalities.
- Encourage best practice and race equality in health service planning and provision.

Where were we in 2013?

In 2013, MEHIS had an opportunity to appoint a Bi-lingual Bangladeshi Support Worker, (Band 3). Prior to 2013, the only language specific staff were Bilingual Link workers, (Band 5.)
Link workers have a dual role in supporting both minority ethnic clients and staff involved in their care. (Please see the attachment below for more information on the Link worker role)

What good work have we done – and where has it got us to now?

The Support worker's role was to:

- Work collaboratively with Link workers and other staff to provide intensive 1:1 support for clients.
- Support clients to engage with health and other services in order to improve their lifestyle and life circumstances. This includes inter-agency

working, escort and ‘buddy’ support to appointments with various service providers, community leisure and support services.

- Assist the MEHIS team with health promotion and screening events in community and faith venues.
- Assist the MEHIS team in the development and quality assurance of culturally sensitive, outreach and health information resources in various languages / formats.

In addition to more intensive support in one to one work we have recently been able to provide group support. In partnership with a minority ethnic agency, we arranged specifically tailored group support for Bangladeshi women with similar needs who were not accessing any local services. Several women took up volunteering opportunities and all requested further training to improve their literacy and future employment prospects.

What have we learned?

The Support Worker (Band 3) role freed up Link worker (Band 5) time for more complex work.
The Link worker / Support worker model allows staff to not only bridge access to services but also to provide more intensive support to enable clients to improve their life circumstances and life styles.

To achieve equal outcomes for more marginalised minority ethnic people, bilingual staff are more cost effective as they reduce the need to utilise interpreting services. In addition, clients benefit from support which is sensitive to their religious and cultural beliefs. Client satisfaction can also be increased as continuity of worker is ensured.

DECLARATION FESTIVAL

Outcomes relating to equitable quality of care for all patients.

3.1 **with a protected characteristic have a more personalised, individualised service where they are better able to exercise their independence, control and autonomy with an advocate if needed, and where their Human Rights or Children's Rights are protected**

3.2 **People in Lothian are more assured that health services will respect their dignity and identity**

3.3 **Staff are better equipped to deliver health care that takes into account patients' protected characteristics, health literacy needs and dignity**

Where were we in 2013?

Working hard to promote the right to independent collective advocacy as part of the requirements of the Mental Health Care and Treatment Act (2003) – expanding independent advocacy to those in prison, those who have experienced a stroke and those who were subject to the reality of welfare reform.

What good work have we done – and where has it got us to now?

NHS Lothian became a partner in **Declaration,** a groundbreaking festival of ideas which took place at Summerhall in Edinburgh on Thursday 2 and Friday 3 March. This was programmed in partnership with the ALLIANCE, NHS Health Scotland and the University of Strathclyde.

The festival sought to highlight part of Scotland's National Action Plan on Human Rights. This year's festival explored how we ensure that the 'right to health' is protected for everybody in society, and how far that

right extends. Declaration 2017 launched on Thursday 2 March with an evening reception and discussion event, examining the role of the welfare state in protecting our right to health, based around a screening of Ken Loach's Palme d'Or winning film I, Daniel Blake.

Further highlights included a discussion with artist Emma Jayne Park about how being diagnosed with cancer two years ago has shaped her thinking about the right to health and her future artistic work, as well as events led by the People's Health Movement, Nourish, Scottish Recovery Network and Scottish Care. Glasgow-based women's collective TYCI took over on the Friday night with a unique event featuring spoken word, animation, music and performance, culminating in an epic DJ closing party.

What have we learned?

The importance of discussing human rights in the context of healthcare with people who are marginalised.

Recognising and naming the impact of poverty on the right to health.

GAMECHANGER

Outcomes relating to access to NHS Lothian's healthcare services.

- **3.1 Access to health services is more equitable for people with protected characteristics**
- **2.2 NHS Lothian has minimised architectural, environmental and geographical barriers to its services**
- **2.3 Health promotion and public health campaigns are inclusive, reach all intended audiences and address stigma in the community**

Where were we in 2013?

In October 2014 a seed of an idea was planted between Hibs and NHS Lothian about football and health and using the assets of Hibernian FC and Community Foundation to improve the lives and life chances of Lothian's citizens. The idea of using a *Public Social Partnership* (PSP) model was agreed. The first Stakeholder Gathering was held at Easter Road in December 2014 with more than 90 people in attendance. A comprehensive report was produced from this event and a second Gathering was held at Easter Road and Ormiston in February 2015 with over 70 people attending. The PSP Management Group agreed to meet fortnightly to ensure momentum was maintained. GameChanger was agreed as our name and the Management Group agreed shared values and priorities which were consolidated by agreeing a high level Memorandum of Understanding.

What good work have we done – and where has it got us to now?

GameChanger is led by NHS Lothian, Hibernian Football Club and the Hibernian Community Foundation. The aim is to unlock the power and passion associated with football and to make greater use of all.

Hibernian's physical, cultural and professional assets, to deliver a better, healthier future for the most vulnerable, disenfranchised or disadvantaged people in our communities.

300 ideas have been generated by over 300 stakeholders into developments and set out under the five strategic objectives of the Scottish Government: Wealthier and Fairer; Smarter; Healthier; Safer and Stronger; and Greener. Working groups have been set up to take these forward and a project manager has been appointed.

'Conversations for Change'
GameChanger supported the public mental health art project 'Conversations for Change'.

In partnership with Living it Up, GameChanger challenged fans to walk 500 miles in competition against players and staff at Hibernian FC. The step challenge proved so popular, that fans asked for it to be re-instated after the first challenge was completed. Pedometers were given out to fans on match days when they signed up for the community challenge on the Living it Up website.

Easter Road played host to the Gypsy Traveller Family Event at the end of 2015.

In April 2016 we organised and hosted a successful Community Awareness Event at Easter Road, which brought together 44 local agencies to showcase their work and services to each other and to the public. The event was arranged after overwhelming feedback from our partners indicated that the public did not know what great services were out there to benefit them, and neither did many of the organisations and other specialists. The response to the event was extremely positive and all attendees asked if the event could be repeated, which GameChanger is delighted to do and will work on making it even

more successful next time.

In November 2016, GameChanger partnered with Joined up for Business to bring an “Employ with Confidence” networking event to Edinburgh. The event was an opportunity for businesses to gain advice and information on what funding and resource support is available to them for employing a member of staff who has a disability or health issue or indeed develops a disability or health issue. Hibernian FC also officially signed up on the day as a Disability Confident Employer and keynote speeches were delivered by Edinburgh East MP Tommy Sheppard, Hibernian Chief Executive Leeann Dempster and Alistair Kerr of the Shaw Trust.

The stadium at Easter Road supported the delivery of Stress Control and Anxiety and Depression Groups for the local NHS mental health team. It also supported focus group work with Hibernian FC fans and Scottish Association for Mental Health.

In May 2016, Easter Road hosted a pilot project to look at using the stadium and its assets and ‘experience’ to assist the community mental health team in providing health checks for some of their clients. The event was a great success and further evidenced the power that football has in tackling inequalities and improving health and life chances in partnership with others.

In 2015 and again in 2016, GameChanger partnered with Choose Life and hosted their football tournament as part of Suicide Prevention Week at Hibernian’s Training Centre in Ormiston. The event raises some important awareness around an extremely important subject and ex Hibernian players also kindly supported the event and presented the prizes.

GameChanger is proudly leading on the government led ‘Good to Go’ initiative encouraging the public to take home any uneaten food after a meal out if they wish to do so. Hospitality and event guests at Easter Road are now able to take home any of their unfinished food after their meal in a dedicated and environmentally friendly carton.

Our Learning Centre at the Hibernian Community Foundation

continues to expand, with a number of courses running, including ESOL (English for Speakers of Other Languages) classes.

Our first GameChanger Christmas Lunch took place on 25th December 2016. Ninety people joined a team of volunteers for a festive get together and lunch in a safe and positive environment, entirely for free.

What have we learned?

- **Relationships**: key role of GameChanger Public Social Partnership in the delivery of strategic priorities.
- **Contribution**: to assist with delivering on a number of strategic objectives, with a particular focus on connecting communities and individuals who experience significant health inequalities.
- **Transforming**: relationships and helping us to reach the people we need to reach in their environment and on their terms.
- **Ambition** : Important to build and maintain momentum and think the impossible.

Outcome 3.2 People in Lothian are more assured that health services will respect their dignity and identity

Since 2013 we have carried out work in two main areas that impact on this outcome. These are

- improvements to the physical estate, and
- our person centred health & care work.

Where were we in 2013?

We had more hospitals that were built a long time ago and did not offer dignified accommodation for patients

We were part way through a nationally co-ordinated programme called the Person Centred Health and Care Collaborative.

What good work have we done – and where has it got us to now?

We have opened several new buildings – hospitals and primary care centres – which are great improvements on the old facilities. We have made sure that people know about this work and this should assure them that we will be better able to respect their dignity and identity if they need to use our services. There is more detail about this under Outcome 2.2.

The National Person Centred Health and Care Collaborative came to an end in 2015. That meant that we had to consider how to keep the work going, without any external funding. We decided to focus on local priorities called Tell us 10 things and the Care Assurance Standards.

Tell us 10 things

The Tell Us Ten Things Survey questions are as follows
1. Do you feel that staff took account of the things that matter to you?

2. If you started any new medicines or tablets on this ward, were you given enough explanation about what these were for?
3. How much information about your care or treatment was given to you?
4. Were you involved, as much as you wanted to be, in decisions about your care and treatment?
5. Were you treated with kindness and compassion by the staff looking after you?
6. In your opinion, how clean was the hospital room or ward you were in?
7. I was bothered by noise at night from hospital staff?
8. Do you think the staff did everything they could to help control your pain?
9. I was happy with the food/meals I received.
10. Overall: I had a very poor/good experience?

Person Centred Key Performance Indicators

To complement the Care Assurance Standards, NHS Lothian is adopting a complementary set of 8 Person-centred Key Performance Indicators:

KPI1 Consistent delivery of nursing/midwifery care against identified need

KPI2 Patient's confidence in the knowledge and skills of the nurse/midwife

KPI3 Patient's sense of safety whilst under the care of the nurse/midwife

KPI4 Patient involvement in decisions made about their nursing/midwifery care

KPI5 Time spent by nurses and midwives with the patient

KPI6 Respect from the nurse/midwife for patient's preference and choice

KPI7 Nurse/midwife's support for patients to care for themselves, where appropriate

KPI8 Nurse/midwife's understanding of what is important to the patient

What have we learned?

In relation to our buildings, we know that people appreciate modern, appropriate settings when they use NHS care. We are continuing to bring all of our buildings up to the best standards we can.

We are still learning from our work on understanding and improving care experience. This involves a shift in thinking away from simply measurement in terms of numbers to a range of methods of data collection including patient survey, observation of nurse-patient interactions, patient stories to understand care experience and reviewing the patient record in conjunction with staff interviews.

We have learned that telling stories alongside hard numbers can give us a better insight into how well we are doing in improving outcomes for people.

CASE STUDY: LEARNING DISABILITY HEALTH EQUALITY FRAMEWORK (HEF)

3.3 Staff are better equipped to deliver health care that takes into account patients' protected characteristics, health literacy needs and dignity

The Health Equality Framework (Atkinson, Boulter, Hebron & Moulster 2013) is an electronic tool based on the determinants of health inequalities. It is designed to help people with learning disabilities, their **families** and the professionals supporting them to look at outcomes and to understand the impact of services provided. https://www.ndti.org.uk/resources/useful-tools/the-health-equality-framework-and-commissioning-guide1.

Where were we in 2013?

Learning Disability Nursing services in Lothian did not have an outcome measurement tool in place.

What good work have we done – and where has it got us to now?

The Health Equality Framework was developed in 2013 for learning disability practitioners.

The Learning Disability Managed Care Network appointed a Project Manager for the Health Equality Framework (HEF) in December 2014 to work regionally across NHS Borders, NHS Fife, NHS Forth Valley and NHS Lothian.

The HEF has been widely accepted in the learning disability nursing workforce in the four health boards.

Analysis of evaluation indicates that the project has been effective to date, and there is some evidence that health of people with learning disabilities has improved.

Learning Disability nurses are now using an outcome measurement tool to evidence their practice and impact on patient care.

What have we learned?

HEF is evidence based, and it produces evidence about the work of Learning Disability nurses, and their impact on people's lives.

All managers and nurses could see the value of the approach, but change in practice takes time and continues to be hard work.

It does require determined leadership.

Despite an unprecedented amount of organisational change over the past three years, external to the project, impacting on the tolerance and ability of nurses (and other) to cope with and implement any changes in practice, this project has still delivered. That is partly due to having someone to lead the work.

We will only get more data if the nurses get feedback, see their contribution matters and why, and feel confident they can shape service improvement as well as evidence their practice.

Now we have opportunities to do more.

We need to consider how we involve other learning disability health and social care practitioners to become involved, taking a whole team approach to use of the HEF.

HEF data can information on patients with learning disabilities to improve service planning and design, and quality of clinical practice. It also provides information about how the wider determinants of health impact on people with learning disability and provides information to assist learning and quality improvement for health and social care practitioners.

BUILDING ON THE WORK OF FOODBANKS

Outcome 3.3 Staff are better equipped to deliver health care that takes into account patients' protected characteristics, health literacy needs, and dignity

Where were we in 2013?

In 2013, a number of food banks were operating in Edinburgh, some well established, a lot were new. These are all funded in different ways - mostly self funded via church groups. There was growing concern about the number in the city and the support being provided to users. Were we perpetuating the need for ongoing emergency support by only handing out food? There was also a level of unease between foodbanks as they were unsure of what each other did.

We brought together a food bank working group, which was facilitated by NHS and council and had all of the major food bank providers in the city at it. They shared best practice and started a dialogue around each others' strengths and areas to work on.

What good work have we done – and where has it got us to now?

There has been a network day with support services attending to begin to develop partnership working. There was an information session for council members and the food bank group has been overseen by the Communities and Neighbourhood Committee. There is a basic map of food banks and income maximisation services. There is now a referral system for the food banks. There is a crisis guide with lists of support services for food banks to refer onto. There is improved engagement

with income maximisation services and all food bank users are encouraged to engage with a support service to reduce the likelihood of continued crisis. People have said they would like help to stop smoking as another way to help maximise their income so the smoking cessation services is being linked in more systematically.

What have we learned?

Users of food banks are generally from a part of the local population who we usually find hard to reach. Trying to make every contact count has resulted in the coming together of many services to meet with people when in a crisis, to alleviate immediate needs **and** hopefully reduce the risk of the cycle of crises continuing.

It has been difficult to link with so many agencies who have competing agendas. In terms of funding, everyone is equal as none of the services were funded by NHS or council – so people attended or not due to choice. Over time relationships have been built and this has helped to result in more agreement and action.

Working together has provided a better service for people who use food banks.

BOARD DIVERSITY MONITORING REPORT

Outcome 4.1 NHS Lothian involves people in a more inclusive and equitable way, including people with all protected characteristics and from across the socio-economic spectrum

NHS Lothian continues to work on embedding equalities into practice across the protected characteristics, the socioeconomic duty and beyond through visible leadership, organisational commitment, training staff and students and working with patients and the wider public. Mainstreaming the Equality Duty is an organisational responsibility to which NHS Lothian's Board is fully committed. Its significance, as part of our core business, is demonstrated by regular progress reports to the Board against the Equality Outcomes Framework. Detailed scrutiny is delegated to the Staff Governance Committee.

The gender balance of the Board membership was 14 males (54%) and 12 females (46%) on 31 March 2017. Whilst the Board can influence the appointment of the majority of Board members, 8 of the members are Non Executive Stakeholder Members. These members are elected representatives by virtue of being local councillors or having been elected by members of specific stakeholder groups.

When undertaking the recruitment process for Board members, the Board works with the Scottish Government Public Appointments Team. The advert makes it clear that we are committed to diversity and equality. The associated paperwork includes a section on valuing diversity. As a Board, we value diverse views and experience. We hope to receive applications from talented people from all faith and belief groups, genders and gender identities, ages, disabilities, sexual orientations, ethnicities, political beliefs, relationship statuses or caring responsibilities. Accessibility is a fundamental requirement of public appointments. The recruitment process attempts to promote, demonstrate and uphold equality of opportunity for all applicants. Reasonable adjustments will be made to enable applicants to participate fully in the selection process. All applicants are encouraged to complete their equality monitoring form to help us ensure that the appointments process is accessible and that we are reaching all sections of the population.

We will continue to work with the Public Appointments Team to improve

the recruitment process for Board members. Our aim is to ensure that Board members have the necessary skills, experience, knowledge and other attributes to enable the Board to perform effectively. This includes taking steps to ensure the appointment of a Board whose diversity reflects the local population.

CHILDREN'S RIGHTS AND CHILDREN'S VOICES IN PLANNING SERVICES

Outcome 4.1 NHS Lothian involves people in a more inclusive and equitable way, including people with all protected characteristics and from across the socio-economic spectrum

Where were we in 2013?

We had started work on a strategy for children and young people for NHS Lothian. We wanted to make sure that children's and young people's voices and experiences contributed to the strategy.

What good work have we done – and where has it got us to now?

We worked with the Children's Parliament to create a model workshop for engaging children and then trained a group of staff from public and third sector to hold workshops with children and young people. The views of 351 children and young people were used to shape the strategy.

More recently we invited the Children's Parliament to lead a discussion at the Children's Service's Children & Young People (Scotland) Act Implementation Group to discuss what a rights based approach means for public services. In addition, work is underway with the Edinburgh Children's Partnership to test out ways of including children and young people in planning children's services. This work is part of a pilot funded by Scottish Government to support learning for community planning partnerships.

In January 2017, the Royal Hospital for Sick Children (RHSC) Clinical Management Team received a report on the Duties of Public Authorities in Relation to the United Nations Convention on the Rights of the Child (UNCRC) and tasked a group to evidence the steps they have taken to secure better or further effect of the requirements of the UNCRC. This is currently work in progress with update reports on Children's Rights requested by the Clinical Management Team.

Much of our training for new staff working in Children's Services references Children's Rights and the UNCRC, with reinforcement in on-line (LearnPro) and face-to-face delivered training on areas including Getting IT Right for Every Child (GIRFEC) and Child Protection.

What have we learned?

- That we can increase staff awareness of children's rights, but there is a long way to go to ensure that we adopt a rights based approach that shapes all of our services.

- That staff engaging directly with children enables staff to understand how important this is to children and how it could be incorporated into their work – people need to see the work to understand the difference it can make.

- That some adults automatically link rights and responsibilities and that this is unhelpful to children. Rights are given to children and their rights should not be conditional.

COLLECTIVE VOICE

Outcome 4.1 NHS Lothian involves people in a more inclusive and equitable way, including people with all protected characteristics and from across the socio-economic spectrum

Where were we in 2013?

We involved people with lived experience in the development of the Hannah patient pathway.

What good work have we done – and where has it got us to now?

Under the umbrella of the House of Care Collaboration, co-led by NHS Lothian and the Thistle Foundation, we have begun to develop Collective Voice in Midlothian. Collective Voice is a group which aims to:

- make sure people with long term conditions have a voice and
- make sure that voice influences and shapes the support we provide to others.

During the summer of 2016 we had conversations with individuals and networks from across Midlothian who were already familiar with the self-management approach and have their own experience of using it within their own lives. We then held 6 training / development sessions run by The Thistle Foundation and Chest Heart and Stroke Scotland. The sessions ran once a week during the autumn. The sessions looked at different aspects of self-management and health and social care, and worked with the group to develop their ideas and suggestions about how best to influence and improve support.

We now have a core group of 4 people who are keen to:

- recruit more people into the group and be part of the design and delivery of a new set of sessions.

- to promote supported self-management strategically and operationally, including looking at how best to support individuals to prepare to have 'good conversations' with the people that support them.

What have we learned?

We have learned that:

- there is an appetite and enthusiasm for bringing supported self-management into the mainstream of planning and delivery in Midlothian

- it will take time to build Collective Voice as a group

- it is crucial to have conversations with individuals and networks to build an understanding of what we are trying to do.

HARM REDUCTION HEALTH NEEDS ASSESSMENT

Outcome 4.1 NHS Lothian involves people in a more inclusive and equitable way, including people with all protected characteristics and from across the socio-economic spectrum

In 2016/17, NHS Lothian in partnership with the Edinburgh Alcohol and Drugs Partnership (EADP) undertook a health needs assessment of harm reduction services for drug users in Lothian.

Where were we in 2013?

In 2013 there was more funding for harm reduction services (the Edinburgh Alcohol and Drugs Partnership is currently facing cuts to those services). This population has high levels of chronic illness and is also vulnerable to outbreaks of infectious diseases if living conditions worsen or injecting increases. One example of this was the outbreak of soft tissue and skin infections related to use of novel psychoactive substances in Lothian.

What good work have we done – and where has it got us to now?

The Harm Reduction Health Needs Assessment has consulted with current drug injectors through one to one interviews and focus groups (one focus group consulted with ex-addicts). These interviews have elaborated on the current patient and user experience in services and how we can adapt services to the needs of those accessing harm reduction services.

We looked at routine data sources and identified where there were gaps in the collection of essential data. We also identified several vulnerable

groups of drug users. We need to understand more about their needs and undertake further work with groups including those who are homeless (one third of current drug users), young people and those who use image and performance enhancing drugs.

We outlined the numbers of people lost to follow up along the pathway of Hepatitis C Virus testing and treatment and are now looking at measures to improve uptake of services. We also found that pharmacies were a location that most drug users were accessing and have recently piloted enhanced services in pharmacies.

Finally, we have looked at those in the criminal justice system and its relation to drug related deaths. We have identified those in prison and police custody as being a group at high risk of complications who require greater attention. We need to look at how to redesign services to meet their needs more effectively.

What have we learned?

- There are important gaps in our information about drug users and we have identified target groups of drug users who may be at particular risk of complications and where we need to put more resource so that we can intervene more effectively
- We have compiled a list of interventions required and made recommendations about how to tackle the most pressing of the issues we have identified. Now we are consulting with stakeholders about these.

FEEDBACK & COMPLAINTS

Outcome 4.2 NHS Lothian ensures that any individual can provide feedback or make a complaint and this is addressed equitably and transparently

Where were we in 2013?

We had a team in place to support patients and members of the public service to make a complaint or provide feedback to us. The team also supported staff across the organisation to investigate and respond to feedback and complaints. Information on the complaints and feedback process was available to patients on our internet site and in clinical areas. To support people to give us feedback or make a complaint we sign posted them to the Patient Advice and Support Services, which is an independent service that supports patients and their families about NHS Healthcare.

We had a local in-patient survey (Tell us Ten Things) in place in one hospital and patients were given the opportunity to give us feedback on the things that they felt were important

What good work have we done – and where has it got us to now?

In 2015 we improved out internal IT systems to make sure that all information about complaints was quickly available to the relevant service manager.

There are several ways for speakers of other languages to feed back to NHS Lothian Patient Experience Team (PET). If communicating in writing, messages can be translated. If communicating over the phone, an interpreter can be connected to the line. If communicating in person, a face-to-face interpreter can be booked, or a telephone interpreter can be used (on demand 24/7/365).

The categories of complaint that we currently use don't include protected characteristics, which means that we cannot ensure we are delivering an equitable service. We did some additional work on complaints from people who were deaf or hearing impaired and those who required BSL because there was no routine data on them.

We have developed a local dashboard for all staff to review and celebrate their Tell us Ten Things results with their teams and in the ward, allowing patients to see this feedback which is generally positive. During this time, patients have also had the opportunity to give us feedback via national surveys that have taken place –including General Practice, Maternity and In-patient services.

We are looking at various ways as how we hear the patient voice and this includes Patient Opinion. We are also working to implement the Care Assurance Standards which includes giving patients the opportunity through surveys and stories to give us their feedback.

What have we learned?

We need to do some more detailed analysis to ensure that we are capturing complaints and feedback from all equalities groups.

We have reviewed our systems for dealing with complaints and undertaken a service redesign. As of 1 April 2017, we have a new model complaints handling procedure which we are in the process of implementing. This forms a large improvement programme. Learning from complaints is a key sub-group as we recognise that this is a challenge for us.

The City of Edinburgh Council Interpretation and Translation Service organised a focus group with patients and found that the preferred option to provide feedback to public services was to leave a voicemail in the preferred language.

PROCUREMENT

5.1 NHS Lothian's partner organisations and suppliers operate in a way that is consistent with its approach to the promotion of equality

Where were we in 2013?

The Procurement Team were fully aware of the hot spot areas where Equality and Diversity would have to be considered in contracts and used appropriate contract terms and conditions to comply with the law and best practice.

What good work have we done – and where has it got us to now?

Procurement now have a specific Equality & Diversity Procurement policy for procurement officers to refer to when letting contracts. The purpose of this policy is to ensure that any supplier of goods or services chosen to supply NHS Lothian meet the same values of Equality and Diversity held by NHS Lothian.

As per our legislative requirements: Where a listed authority is carrying out a public procurement exercise, it must have due regard to whether its award criteria should include equality considerations which will help it to better perform the equality duty.

Where it proposes to stipulate performance conditions in its procurement agreement, it must have due regard to whether the conditions should include equality considerations which will help it to better perform the equality duty.

Objectives:
· All of our suppliers are actively following Equality and Diversity Guidelines
· Our Suppliers and NHS Lothian are Equality and Diversity Compliant

What have we learned?

We have learned that consideration of Equality and Diversity is another “business as usual” check alongside Sustainable Procurement and other considerations.

Our team have their policy to act as a framework and prompt when letting contracts, and know where to seek further advice from if required.

We are confident that our rigorous approach and contractual powers are enabling us to comply with our Equality and Diversity responsibilities in procuring goods and services.

5.2 Individuals and communities who are vulnerable to, or victims of hate crime feel safer and more secure

Where were we in 2013?

The Equality and Diversity Team suspected that people who were victims of, or vulnerable to hate crime would form an identifiable sub-population of our service users.

What good work have we done – and where has it got us to now?

We have analysed our data about people using services in an emergency and we did not find any evidence of people identifying themselves as victims of hate crime.

What have we learned?

We have learned that whilst hate crime is an important issue, it is not identified by people when they use our emergency services.

We decided that it would not be appropriate for us to focus on hate crime if people themselves do not raise it as an issue when they use our services.

Instead, we will continue to work with our partner agencies and communities to find out what if anything NHS Lothian can do to reduce hate crime.

Conclusions and next steps

We have looked through all of the learning from the range of work we have described in this report.

There are a lot of important clues about what has worked well, and what has not worked so well, in improving the outcomes we set out in 2013.

What we will do next

- On the basis of this report, we will devise an improvement plan for 2017-18, also including responses to any specific issues raised by internal and external audit.
- Implement an action plan for delivery of British Sign Language and Assistive and Augmentative Communication in line with new Scottish legislation.
- take time to convene and develop an expert equalities and human rights network in Lothian.
- obtain resources to support improved coverage and quality of impact assessment processes and evidence the use of Integrated Impact Assessments to shape policies affecting the wider determinants of health at national and local level.
- Support delivery of a successful **1st World Congress on Migration, Ethnicity, Race and Health – Diversity and Health** in May 2018 in Edinburgh.
- Develop and publish an updated Equality and Human Rights strategy in June 2018.