NHS Greater Glasgow and Clyde
Equality Impact Assessment Tool for Frontline Patient Services

Equality Impact Assessment is a legal requirement and may be used as evidence for referred cases regarding legislative compliance issues. Please refer to the EQIA Guidance Document while completing this form. Please note that prior to starting an EQIA all Lead Reviewers are required to attend a Lead Reviewer training session. Please contact CITAdminTeam@ggc.scot.nhs.uk for further details or call 0141 2014817.

Name of Current Service/Service Development/Service Redesign:

Greater Glasgow and Clyde Trauma Service: The Trauma and Homelessness Team, Mental Health Partnership.

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

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

What does the service do?
The Trauma and Homelessness Team is a city wide specialist trauma service for people who have a history of complex trauma and who are homeless/have a risk of homelessness. The Trauma and Homelessness Team are part of GGC Mental Health partnership and is linked to Homeless Health Services and other GGC Trauma Services. Referrals are received from statutory e.g. GPs, Primary Care and Community Mental Health Teams, homelessness services and community addiction teams, and non-statutory services e.g. voluntary sector mental health, addiction and homelessness services. The team also offers training, consultation as well as individual and group interventions. The service is being developed to link directly with Leaving Care Services and women at risk of sexual exploitation through prostitution.

Why was this service selected for EQIA? Where does it link to Development Plan priorities? (if no link, please provide evidence of proportionality, relevance, potential legal risk etc.)
This EQIA coincided with pathway re-design

Who is the lead reviewer and where are they based? (Please note the lead reviewer must be someone in a position to authorise any actions identified as a result of the EQIA)

Dr Lisa Reynolds. Consultant Clinical Psychologist / Team Lead Trauma and Homelessness Team, Carswell House.

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

Team Lead, Clinical Psychology (x2), AHP staff (x1), Mental Health Practitioner (x1) and admin staff (x1). Whole Team involvement in EQIA process and consultation

	Lead Reviewer Questions	*Example of Evidence Required*	Service Evidence Provided (please use additional sheet where required)	Additional Requirements
1.	What equalities information is routinely collected from people using the service? Are there any barriers to collecting this data?	*Age, Sex, Race, Sexual Orientation, Disability, Gender Reassignment, Faith, Socio-economic status data collected on service users to. Can be used to analyse DNAs, access issues etc.*	Age, sex, ethnic origin, country of origin, language spoken, housing status, disability including any mobility difficulties are routinely collected. Any sexual orientation, gender reassignment, relationship status (including civil partnership) and faith information are documented in case notes after assessment. This is because referrers frequently do not have this information at the point of referral. Data regularly analysed re. DNAs and engagement difficulties.	Service Reports regularly include audit of equality date to ensure needs are being met.
2.	Can you provide evidence of how the equalities information you collect is used and give details of any changes that have taken place as a result?	*A Smoke Free service reviewed service user data and realised that there was limited participation of men. Further engagement was undertaken and a gender-focused promotion designed.*	Data and outcome measures evidenced a high prevalence of re-victimisation among female clients with a history of childhood trauma. The team has developed and is delivering a group intervention aimed at increasing skills and awareness to reduce further re-victimisation.	
3.	Have you applied any learning from research about the experience of equality groups with regard to removing potential barriers? This may be work previously carried out in the service.	*Cancer services used information from patient experience research and a cancer literature review to improve access and remove potential barriers from the patient pathway.*	A systematic review was carried out with research regarding revictimisation and complex trauma. This led to the development of a group intervention aimed at reducing distress associated with complex trauma and preventing revictimisation.	
4.	Can you give details of how you have engaged with equality groups to get a better understanding of needs?	*Patient satisfaction surveys have been used to make changes to service provision.*	Outcome measures and client satisfaction surveys are routinely completed for all individual and group interventions. A key theme from	

			feedback is that commonality of difficulties relating to complex trauma reduces feelings of stigma.	
5.	If your service has a specific Health Improvement role, how have you made changes to ensure services take account of experience of inequality?	*A service for teenage mothers includes referral options to smoking cessation clinics. The clinics are able to provide crèche facilities and advice on employability or income maximisation.*	Health improvement goals are identified as part of treatment and clients are signposted or referred onto other services when appropriate.	
6.	Is your service physically accessible to everyone? Are there potential barriers that need to be addressed?	*An outpatient clinic has installed loop systems and trained staff on their use. In addition, a review of signage has been undertaken with clearer directional information now provided.*	As an active outreach service we meet with clients in a location that is both geographically and physically appropriate to their needs. However, this also means that the team are dependent on the quality of the different NHS and non-statutory sector service resources available for them to utilise. The team selects venues based on availability, geographical proximity to the client, safety for client and staff and confidentiality.	
7.	How does the service ensure the way it communicates with service users removes any potential barriers?	*A podiatry service has reviewed all written information and included prompts for receiving information in other languages or formats. The service has reviewed its process for booking interpreters and has briefed all staff on NHSGGC's Interpreting Protocol.*	Resources have been developed specifically for clients but are as yet only in written form. Appointment letters and leaflets are available in other languages. The team have recently developed a website so that service users and services can access information and resources in their own time. The team currently communicates with clients by phone or letter in addition to	The team aims to develop their 'Understanding Complex Trauma' information brochure into audio format. All staff to increase awareness of NHSGG&C's Accessible Information Policy.

			liaising with Care Managers and other community supports to remind clients of their appointments. As a team we are exploring the option of utilising text messaging. An interpreter is always provided when appropriate. Client preferences regarding gender of interpreter are respected.	
8.	Equality groups may experience barriers when trying to access services. The Equality Act 2010 places a legal duty on Public bodies to evidence how these barriers are removed. What specifically has happened to ensure the needs of equality groups have been taken into consideration in relation to:			
(a)	Sex	*A sexual health hub reviewed sex disaggregated data and realised that very few young men were attending clinics. They have launched a local promotion targeting young men and will be testing sex-specific sessions.*	• Awareness of impact of gender on psychological difficulties associated with trauma. • Team Lead Dr Lisa Reynolds, Consultant Clinical Psychologist, developed and delivered GBV Sensitive Routine Enquiry Training to mental health staff teams. All the team attended training and practice Routine Enquiry of GBV, documenting this electronically and in case notes. • All the team are involved in evaluating and championing the	No choice of male worker within the team. If a male worker was requested one would be sourced from mainstream psychology services, who was trained and experienced in working with complex trauma.

			GBV Action Plan. • Team audits gender and gender based violence. • Accessible service to meet the child care needs of service user including the timing of appointments and the availability of crèches. • Option of gender of interpreter given to client. • Within trauma service users have only ever requested specifically a female worker and therefore the gender configurement of the team has been carefully considered and informed by research. • Issues relating to gender have been integrated into team training materials and website	
(b)	Gender Reassignment	*An inpatient receiving ward has held briefing sessions with staff using the NHSGGC Transgender Policy. Staff are now aware of legal protection and appropriate approaches to delivering inpatient care including use of language and technical aspects of recording patient information.*	• Team adopt an anti-discriminatory approach to transgender issues.	Staff briefing to take place in January 2013 to ensure all staff are aware of NHS GG and C's Transgender Policy. This will include use of language and technical aspects of recording client information.
(c)	Age	*A urology clinic analysed their sex specific data and realised that young men represented a significant number of DNAs. Text message reminders were used to prompt attendance and*	• Team reduced lower referral age to 16 years to ensure young people who require service can have access. • No upper age limit for referrals • Age routinely assessed, recorded	

		appointment letters highlighted potential clinical complications of non-attendance.	and utilised in service reports / audits and informs service changes e.g. Referral numbers from April 2011 to March 2012: Ages 16-18 - 21 referrals 19-24 - 49 25-34 - 59 35-44 - 70 45- 54 - 24 This data shows that. the pattern over the last few years is that both males and females are being referred to the team at a younger age. • Whether clients have young dependents is assessed and considered throughout client journey • Appointments are arranged across the city at a time to meet with childcare requirements or with physical environmental needs e.g. if client has to bring child then a child friendly area available • Venue for appointments matched to physical/ mobility needs of client • Liaison with children and older people services • Awareness of impact of trauma at different ages and this age – awareness is communicated through our training e.g. variety of ages used in clinical case examples; age appropriate language used; family and systemic approaches are utilised when appropriate; thoughtful engagement	

			of young people leaving care. • Service has specifically targeted young people who are at risk of trauma and homelessness, and related services, through the Leaving Care Development. Service has an early intervention	
(d)	Ethnicity	*An outpatient clinic reviewed its ethnicity data capture and realised that it was not providing information in other languages. It provided a prompt on all information for patients to request copies in other languages. The clinic also realised that it was dependant on friends and family interpreting and reviewed use of interpreting services to ensure this was provided for all appropriate appointments.*	• Assessment of language, communication and support needs completed with client. • Ethnicity information requested on referral forms. • Ethnicity information recorded routinely on PIMS (Patient Information Management System) and CORE (Clinical Outcomes Routine Evaluation). If not documented on Referral Form, staff including admin. will request information: 100% compliance. • Information of political, social and economic situation of clients' homeland gathered before first appointment to raise awareness. • For advice, resources and information regarding ethnicity the team has strong links with the COMPASS Team (a mental health team for asylum seekers and refugees who have experienced complex trauma). • Leaflets/ Letters (appointment) and information sent to clients in their own language routinely e.g. Farsi, French, Kurdish Sorani. • Maps/ journey plans are routinely	

			sent to clients who may not have knowledge of the area • Staff will book interpreters if required. This is also recorded in case notes for future reference. • Team Referral Form has been amended to capture information regarding ethnicity. • The team's Mental Health Practitioner has co-facilitated a group for refugees with the Compass Team. • Issues relating to ethnicity have been integrated into both team training materials. • Team Lead completed an Audit of equality training uptake for staff group. • Racist incidents are dealt with as per NHS GG and C's policies and procedures and recorded on DATIX if appropriate.	
(e)	Sexual Orientation	*A community service reviewed its information forms and realised that it asked whether someone was single or 'married'. This was amended to take civil partnerships into account. Staff were briefed on appropriate language and the risk of making assumptions about sexual orientation in service provision. Training was also provided on dealing with homophobic incidents.*	• Team are aware of sensitivities around sexual preferences in relation to complex trauma • Equalities awareness training available to staff • Client's relationship status routinely asked and documented • Staff are aware of the importance of using appropriate terminology e.g. partner rather than husband/wife. • Any homophobic incidents will be dealt with via the Homophobic Guidelines.	

(f)	Disability	*A receptionist reported he wasn't confident when dealing with deaf people coming into the service. A review was undertaken and a loop system put in place. At the same time a review of interpreting arrangements was made using NHSGGC's Interpreting Protocol to ensure staff understood how to book BSL interpreters.*	• Assessment of physical, learning, language and communication needs completed at assessment and further action taken as required e.g. arranging for a British Sign Language Interpreter or accessing a venue where a loop system is available for clients who are hard of hearing or deaf. • Learning / communication difficulties routinely recorded on the Glasgow Risk Assessment • Will phone client and referrer to advise of appointment if there are literacy difficulties. • Disability needs including communication and literacy needs considered at every point in clients' journey and treatment / assessment adapted in line with needs. • Awareness of literacy needs of population when preparing materials • Accessible / outreach service where clients are seen for appointments at safe locations which meets their needs including disability provision • Consideration of Disability needs prior to arranging appointment including environmental needs as well as whether someone requires to be accompanied • Referral Form amended to enquire routinely about physical disability • As an active outreach service we	Ensure any physical disabilities are recorded in the case notes as well as the referral form.

			meet with clients in a location that is both geographically and physically appropriate to their needs. However, this also means that the team are dependent on the quality of the different NHS and non-statutory sector service resources available for them to utilise. • The team are working towards the minimum requirements for accessible information as stated in the Accessible Information Policy.	
(g)	Faith	*An inpatient ward was briefed on NHSGGC's Spiritual Care Manual and was able to provide more sensitive care for patients with regard to storage of faith-based items (Qurans etc.) and provision for bathing. A quiet room was made available for prayer.*	• Awareness of the importance of faith at each stage of client's journey. • Sensitive enquiry regarding client's faith / beliefs at assessment when appropriate. This is documented in the case notes. • Routine assessment of faith • Links with COMPASS Team for resources.	
(h)	Socio – Economic Status	*A staff development day identified negative stereotyping of working class patients by some practitioners characterising them as taking up too much time. Training was organised for all staff on social class discrimination and understanding how the impact this can have on health.*	• Awareness of impact of social class / social economic class on presenting difficulties. • Accessible service to minimise expense of travelling to maximise treatment opportunities for all e.g. select venues close to clients location as possible. • Consideration of social class and social economic class throughout treatment journey. • Staff can refer clients to Social	

			Work and other support agencies if required. • Clients are able to reclaim travel expenses if required.	
(i)	Other marginalised groups – Homelessness, prisoners and ex-offenders, ex-service personnel, people with addictions, asylum seekers & refugees, travellers	*A health visiting service adopted a hand-held patient record for travellers to allow continuation of services across various Health Board Areas.*	• Homelessness dedicated service due to awareness of relationship between trauma and homelessness • Training remit of team to increase capacity to maximise treatment / support opportunities for homeless patients • Links through training programme with substance misuse services to ensure consistency and continuity of care • Assertive Outreach service with proactive response to non-attendance • Awareness of engagement / treatment / support needs of homeless / addiction / mental health clients • Appointments often arranged within Community Mental Health Teams (CMHT) / Mental Health services which improves communication between services • Clients are able to reclaim travel expenses if in financial need • Team is aware of the high-incidence of literacy difficulties within this client group and present information in as accessible a way as possible. • The team had recently launched a	

			website that enables information and resources to be accessed in electronic form as per the Accessible Information Policy • The team are working towards the minimum requirements for accessible information as stated in the Accessible Information Policy.	
9.	Has the service had to make any cost savings or are any planned? What steps have you taken to ensure this does not impact disproportionately on equalities groups?	*Proposed budget savings were analysed using the Equality and Human Rights Budget Fairness Tool. The analysis was recorded and kept on file and potential risk areas raised with senior managers for action.*	N/A	
10.	What does your workforce look like in terms of representation from equality groups e.g. do you have a workforce that reflects the characteristics of those who will use your service?	*Analysis of recruitment shows a drop off between shortlisting, interview and recruitment for equality groups. Training was provided for managers in the service on equality and diversity in recruitment.*	The team consists of a variety of ages and backgrounds.	
11.	What investment has been made for staff to help prevent discrimination and unfair treatment?	*A review of staff KSFs and PDPs showed a small take up of E-learning modules. Staff were given dedicated time to complete on line learning.*	All staff including trainees have completed Equality and Diversity training on-line. All staff have KSF's and PDP's. The Principal Psychologist has completed equality and diversity in recruitment training.	

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

The Trauma and Homelessness Team routinely asks about Gender Based Violence and documents this in casenotes.

Actions – from the additional requirements boxes completed above, please summarise the actions this service will be taking forward.	Date for completion	Who is responsible? (initials)
<u>Cross Cutting Actions</u>		
Equalities information will be regularly audited to ensure we are meeting needs appropriately	June 2013	LR
All staff to be aware of Accessible Information Policy and their role in meeting these requirements	March 2013	LR
Further progress to be made on the minimum requirements for accessible information as per Accessible Information Policy	June 2013	All staff
<u>Specific Actions</u>		
Physical disability will be recorded in case notes as well as Referral Form	Ongoing	All staff
Staff briefing session on the Transgender Policy	Jan 2013	All staff
Ensure there is a protocol in place for clients who request a male member of staff.	June 2013	LR

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

June 2013

Lead Reviewer: Name Dr Lisa Reynolds
EQIA Sign Off: Job Title Consultant Clinical Psychologist / Team Lead
Signature

Date

Quality Assurance Sign Off: Name
Job Title
Signature
Date

Please email a copy of the completed EQIA form to EQIA@ggc.scot.nhs.uk, Corporate Inequalities Team, NHS Greater Glasgow and Clyde, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, G12 0XH. Tel: 0141-201-4560. The completed EQIA will be subject to a Quality Assurance process and the results returned to the Lead Reviewer within 3 weeks of receipt.