



EQUALITY SCHEME

2006-2009

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CHIEF EXECUTIVE FOREWORD

NHS Greater Glasgow and Clyde is fully committed to promoting equality and diversity. Tackling inequalities is one of the key transformational themes that are central to our recent major reorganisation. We have identified this as part of our core business as an organisation that employs people, plans and delivers services, engages with local communities and works in partnership with a range of other organisations. Our rationale for this is that we need to do things differently to impact more significantly and equitably on the health of our communities. This, in turn, will be more satisfying for staff as they see their efforts turned into enhanced improvements in health outcomes.

Continuing to do things the way we did them before is not an option for us. There is therefore a focus on how we change the culture of our organisation and build our capacity to understand and address the needs of the diverse population we serve, whilst building on the good practice that currently exists. You will see from our single Equality Scheme that we have placed responsibility for taking forward this agenda at the highest possible level within our organisation and as Chief Executive it is my role to ensure we deliver on this commitment. Mainstreaming the issues of equality and diversity into all we do is at the centre of our system-wide approach and not the responsibility of a few committed individuals. We view our single Equality Scheme as a 'live' document which will adapt as we improve our planning to address the impact of health and social inequalities.

Tom Divers
Chief Executive
NHS Greater Glasgow and Clyde



PART 1: THE CONTEXT FOR THE EQUALITY SCHEME



SECTION 1 - INTRODUCTION

1.1 This is the first Equality Scheme produced by NHS Greater Glasgow and Clyde (NHS GG&C) in line with the requirements of equalities legislation for race, disability, gender and sexual orientation. It comprises three parts. Firstly it sets out the overarching goals of the organisation in realising both the spirit and the content of this legislation within the context of our understanding of inequalities and health. Secondly, it describes the nature of the Scheme and the arrangements for monitoring progress across the organisation. Lastly, it contains the Action Plan, along with a description of the processes and infrastructure devised to ensure implementation of the Equality Scheme.

1.2 The Equality Scheme represents a significant part of our organisation's commitment to address comprehensively the health needs of the entire population we serve. We plan to do this in a way that is both inclusive and responsive, and which explicitly recognises our responsibility in addressing the determinants of poor health and their consequences.

1.3 The Equality Scheme has been developed within a context of major re-organisation which has been devised not only to alter the structures of NHS GG&C, but also to transform the way we work. This includes the integration of health and social care services, breaking down barriers between primary and secondary care, delivering services across Greater Glasgow and Clyde and putting health improvement at the centre of the NHS. Addressing inequalities and health is core to the realisation of this transformation; a fact reflected in the prominence it has been given in our key organisational objectives. The Equality Scheme is an integral part of our plan to achieve the necessary change. It complements a commitment to the needs of a diverse population as enshrined in Fair for All and to reducing health inequalities.

1.4 The complexity of NHS GG&C, both in size and function, is recognised within the Scheme as a considerable challenge in creating meaningful change. The production of the Equality Scheme has therefore been informed by discussions that have taken place across the different parts of NHS GG&C to determine the most effective means of delivering on the legislation and how this would dovetail with the process of change that characterises our current stage of development. We have recognised this in the emphasis placed on ownership across the system and in the infrastructure created to realise the goal of promoting equality across all the different strands of inequality.



1.5 To strengthen our focus on the changes needed, we have drawn on the consultation and involvement processes with people experiencing the different forms of inequality, for developing the Scheme. We have additionally drawn on the experience derived from the body of work across the range of inequalities that we have undertaken in recent years, as well as existing consultation processes currently taking place across NHS GG&C.

1.6 This Equality Scheme details the nature of the task involved in mainstreaming the issues of equality across NHS Greater Glasgow and Clyde and our expectations of the progress that can be achieved within the next three years. As such, it is designed to reach a number of audiences: the staff of NHS Greater Glasgow and Clyde, the Commission on Race Equality, the Disability Rights Commission, the Equal Opportunities Commission and the wider communities we serve.

1.7 As part of our commitment to ensuring that this Equality Scheme is accessible to all, a summary of the Scheme is available. We will also produce the Equality Scheme in a range of formats, including the development of an 'easy to understand' version.



SECTION 2 – THE LEGAL CONTEXT

2.1 Background

2.1.1 Existing legislation on equalities issues has engendered change in society over the last 20-30 years. The degree of progress made, and the incremental nature of this, however, has not been proportionate to that required; a fact acknowledged in recent years by the UK Government. Consequently, there has been both a strengthening of existing legislation and the creation of new legislation to attempt to accelerate the pace of change.

2.1.2 One of the catalysts for change was the racist murder of Stephen Lawrence in 1993 and the deficiencies in the ensuing police investigation. The inquiry in 1997, led by Sir William MacPherson, into the handling of the investigation, identified institutional racism as a key factor in the failure to deliver justice. Thereafter, the Race Relations (Amendment) Act 2000 (RR(A)A) was introduced. The Race Relations (Amendment) Act heralded a sea change in the approach to tackling discrimination, which has been echoed in subsequent legislation on disability and gender inequality. It shifted the emphasis from the individual seeking redress for discrimination to one which placed the onus on organisations to demonstrate a pro-active approach to achieving race equality and eliminating discrimination and harassment.

2.1.3 Central to our understanding of our responsibilities in complying with this body of legislation, therefore, is the need to appreciate and act on the *organisational* change that is required. To do so, we need to understand the meaning of *institutional discrimination* which has been defined as:

“the collective failure of an organisation to provide an appropriate and professional service to people because of their race, gender, disability, age, sexuality, faith or other characteristic. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages minority ethnic people”¹

¹ Greater London Authority statement – adapted from the definition of institutional racism contained in the Stephen Lawrence Enquiry Report produced by Sir William MacPherson.

2.2 The legislation and its requirements

2.2.1 The key legislation with which NHS GG&C will comply, and which are covered in this Equality Scheme, are:

- **The Race Relations (Amendment) Act 2000** (RRAA) which strengthened the Race Relations Act, 1976
- **The Disability Discrimination Act 2005**, which strengthened the DDA 1995, through the inclusion of a Disability Equality Duty (DED) to be implemented in December 2006
- **The Equality Act 2006** which amended the Sex Discrimination Act 1975 through the requirement for a Gender Equality Duty (GED), to be implemented in April 2007. The Gender Duty covers men, women and transsexual people. This Act also made it unlawful to discriminate on grounds of sexual orientation or faith, in the provision of goods, facilities and services.
- **The Employment Equality (Age) Regulations 2006**

2.2.2 Given our intention to address all strands of inequality within this Scheme, the actions we are committed to undertaking will also apply to discrimination on the grounds of faith and age.

2.2.3 The body of legislation on Race, Disability and Gender has identified both *General* and *Specific Duties* with which organisations have to comply.

2.2.4 The *General Duties* for all three areas of legislation lay down that public bodies require to have '*due regard*' to the need to eliminate unlawful discrimination and harassment and to promote equality of opportunity. The RR(A)A also includes a duty to '*promote good relations between persons of different racial groups*'. In the DED this duty is to '*promote equality of opportunity between disabled people and other people*'. The DED further includes a duty to:

- *promote positive attitudes towards disabled people*
- *encourage participation by disabled people in public life*
- *take steps to meet disabled peoples' needs, even if this requires more favourable treatment.*

2.2.5 The *Specific Duties* apply to major public bodies primarily and are designed to set out the steps that should be taken in meeting the General Duty, the key requirements of which are:



- The development of a specific Equality Scheme in relation to each aspect of inequality. Whilst the RR(A)A focuses mainly on process in pursuit of its aims, the disability and gender legislation have a greater emphasis on *outcomes* and have therefore required the identification of specific goals in relation to disability and gender within their respective schemes.
- Consultation with stakeholders and employees in drawing up the equality schemes for race and gender. In relation to disability, the legislation is considerably stronger, requiring the *active involvement* of disabled people in drawing up the Equality Scheme.
- Publication of the equality schemes and associated action plans.
- Publication of how the organisation will assess the impact of its policies and practices for equality across the three areas and the outcomes of these.
- Monitoring of progress and production of annual reports.
- Review of each scheme every three years.
- Monitoring of employment procedures and practices. In relation to gender, a policy on developing equal pay arrangements between women and men must be developed and published.

The detail of the different elements of the legislation is included in Appendix 1

2.2.6 One of the provisions of the **Equality Act 2006** is the merger of the three existing commissions i.e. the Commission for Race Equality, the Disability Rights Commission and the Equal Opportunities Commission. In 2007, they will become one body – the *Commission for Equality and Human Rights* – which will have responsibility for assessing the extent to which organisations have fulfilled their legislative duties.

2.2.7 The Commissions expect us to provide evidence demonstrating how we have undertaken our responsibilities in relation to:

- Decisions made on the adoption of new programmes, services, functions and policies
- The ways in which we deliver these currently
- All aspects of employment practice

2.2.8 The assessment criteria against which our performance will be measured are²:

² Public Sector Duty – Three Commissions Joint Paper. *CRE, DRC, EOC Scotland, November 2005*



- *Proportionality and relevance*

Has greater consideration been given to equality in relation to functions or policies that have the most effect, particularly on disadvantaged people? It is important to recognise that relevance will differ depending on the nature of the function. Similarly the criterion of proportionality refers to the *weight* given to a function in terms of its relevance to promoting equality.

- *Effectiveness*

Are the mechanisms that are in place or created, effective in delivering the outcomes needed and have such actions impacted on equality?

- *Involvement*

Have the relevant people, both internal and external to the organisation, been involved in the process to ensure that the public authority's understanding and expertise is adequate for the issues that are being addressed?

- *Transparency*

Is the way in which due regard has been paid and consequent decisions taken, clearly understandable and transparent?



SECTION 3 - NHS GREATER GLASGOW AND CLYDE

3.1 Boundaries of NHS Greater Glasgow and Clyde

3.1.1 On 1st April 2006, the former NHS Argyll and Clyde was dissolved. Responsibility for its population was divided between NHS Greater Glasgow and NHS Highland. The new organisation, now called NHS Greater Glasgow and Clyde, covers almost a quarter of the entire Scottish population and encompasses the following local authority areas:

- East Dunbartonshire
- East Renfrewshire
- Glasgow City
- Inverclyde
- Renfrewshire
- West Dunbartonshire
- Part of North Lanarkshire
- Part of South Lanarkshire

3.1.2 The geographical area covered is diverse; it covers the major city of Glasgow, large and small towns, villages and some rural areas. As such it presents considerable challenges in ensuring that the health needs of the population are met.



3.1.3 Integration of the two health boards has meant that systems for aggregating data covering the new structure are still developing and are limited at this stage. The following data, however, represent what is available about the population of the new NHS Greater Glasgow and Clyde organisation.

3.2 NHS Greater Glasgow and Clyde population

3.2.1 NHS Greater Glasgow and Clyde has a total population of 1,190,939, of which 47.7 % are male (568,533) and 52.3 % female (622,406). The population for Scotland is 5,094,800³.

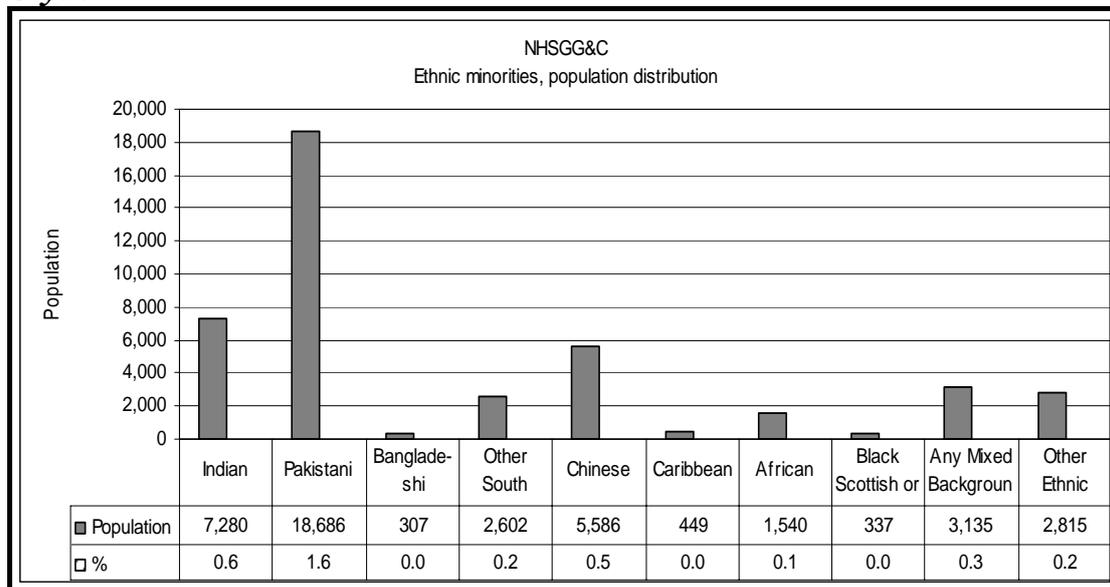
Ethnic Group:

3.2.2 The 2001 Census returns indicated below identify the estimated Black and Minority Ethnic population communities within Scotland overall and within the boundaries of NHS Greater Glasgow and Clyde. It is important to note the limitations of these data, however, since they are now 5 years old, and there has been a rapid process of change across the country, in relation to both economic migration from other EU countries, and the establishment of new asylum-seeking communities.

3.2.3 Whilst the percentage of the NHS GG&C population which are categorised as 'white Scottish' is similar to that of Scotland overall, i.e. around 88%, the former Greater Glasgow area has the largest Black and Minority Ethnic (BME) population in Scotland (4.5% or 39,318 people). 38.7% of the total Scottish BME population live in the Greater Glasgow area.

³ Source – GRO-Scotland 2005 estimates

Figure 1 : Minority Ethnic Population NHS Greater Glasgow and Clyde



Source: 2001 Census (GGC Information Services)

3.2.4 Data on asylum seekers were not captured in the 2001 census. There are approximately 5340 asylum seekers who are in receipt of support from the National Asylum Support Service who are being accommodated in Glasgow City at present. It is estimated, however, that there are a further 6500 asylum seekers approximately in the city who have been dispersed here since 2000, many of whom now have refugee status.

Disability:

3.2.5 One of the factors impeding a common understanding of inequality in terms of disability is the range of definitions that have been used to conceptualise it. Definitions used reflect either the individual (or medical) model or the social model of disability dependent on the purpose of the measurement. This leads to a lack of comparable data and it is therefore necessary to assess the information from various sources depending on the purpose.

3.2.6 A person is defined as being disabled under the DDA if s/he has a physical or mental impairment that has a substantial and long-term adverse effect on her/his ability to carry out normal day-to-day activities. The term 'disabled person' therefore covers people with a wide range of disabilities and health conditions - from a visual impairment to arthritis,

cancer, multiple sclerosis, heart disease, depression, Down's Syndrome and diabetes.

3.2.7 Again, despite the limitations of being 5 years old, the Census 2001 data are still one of the best measures available of estimating the disabled population.

3.2.8 The following table presents the number of people in NHS GG&C areas who reported having a long term limiting illness in the 2001 Census by age group and sex:

Table 1: Limiting Long-Term Illness by Sex and Age

	Total	Limiting long-term	Male limiting long-term	Female limiting long-term	% of population
All people	1,107,973	248,729	113,198	135,531	22.4
0-15	215,894	11,314	6,765	4,549	5.2
16-34	290,822	27,220	13,579	13,641	9.4
35-49	248,569	44,763	21,552	23,211	18.0
50-59	128,873	43,130	20,966	22,164	33.5
60-64	55,744	25,707	13,107	12,600	46.1
65-84	153,064	85,196	34,441	50,755	55.7
85and over	15,007	11,399	2,788	8,611	76.0

3.2.9 People receiving certain benefits are another common way of defining the disabled population in an area. The following table shows the number of adults within Greater Glasgow and Clyde, within each of



the local authorities, who are unable to work due to illness or disability, measured by those claiming Incapacity Benefit or Severe Disablement Allowance:

Table 2: Incapacity Benefit/Severe Disablement Allowance Caseload, Feb 2006

	Total Caseload	Female Caseload	Male Caseload
Local Authority	(Thousands)	(Thousands)	(Thousands)
East Dunbartonshire	4.02	1.94	2.08
East Renfrewshire	3.48	1.64	1.84
Glasgow City	59.88	24.84	35.04
Inverclyde	7	2.77	4.23
North Lanarkshire(part)	1.6	0.8	0.8
South Lanarkshire(part)	4.8	2.1	2.6
Renfrewshire	11.58	5.07	6.51
West Dunbartonshire	7.26	3.08	4.18

Source: Department of Work and Pensions 2006

3.2.10 Although the above data do not fully represent the extent of disability within the population of NHS GG&C, they do give some indication of its prevalence. Almost a quarter of our population has a long-term limiting illness, which is higher than the Scottish average. Unsurprisingly, the risk of developing such conditions increases with age. The implications of this need to be addressed given the rate at which our population is ageing and that by 2024 it is predicted the 65-85 year old population will increase by almost 15% and the over 85s will increase by 57%.

Lesbian, Gay, Bisexual and Transgender (LGBT)

3.2.11 Determining the size of our LGBT population is difficult because of the discrimination they face in Scotland, and the fear of homophobia



from being 'out'. The commonly accepted average of between 5 - 10% of any given population being lesbian or gay means that potentially there are between 59,547 – 119,094 people who are gay or lesbian within the NHS GG&C area. This figure does not take account of those who may have same sex experiences at some point in their lives and who may experience similar issues as people who identify as LGBT.

3.2.12 In relation to transgender, it is difficult to provide accurate figures. In part this is because of the wide range of definitions and identities (e.g. transsexual, biological intersex conditions, transvestism) that fall within this term. It is important to recognise, however, that transsexual and transgender issues are not issues of sexuality or sexual orientation. They relate to gender identity and as such are included within the Gender Equality Duty.

Social Deprivation:

3.2.13 There is a strong correlation between health and socio-economic status. This has to be considered in attempting to address inequality in all its dimensions. One of the ways in which this status is defined within the Health Service in Scotland is by using a measure called the '*Carstairs Deprivation Category*'. This seeks to identify the range of affluence or poverty across the population, with the highest category (or DEPCAT) being **1** and the poorest being **7**.

3.2.14 Comparative profiling of the former NHS Greater Glasgow and NHS Clyde populations, by Carstairs deprivation categories, suggests that there were more people in the intermediate socio-economic categories in the Clyde area and far fewer people in the most deprived category (DEPCAT 7) than in Greater Glasgow. The merger in April 2006 enables NHS GG&C's combined statistics at the most extreme end of the spectrum to improve considerably at the expense of an increased percentage in deprivation category 5.

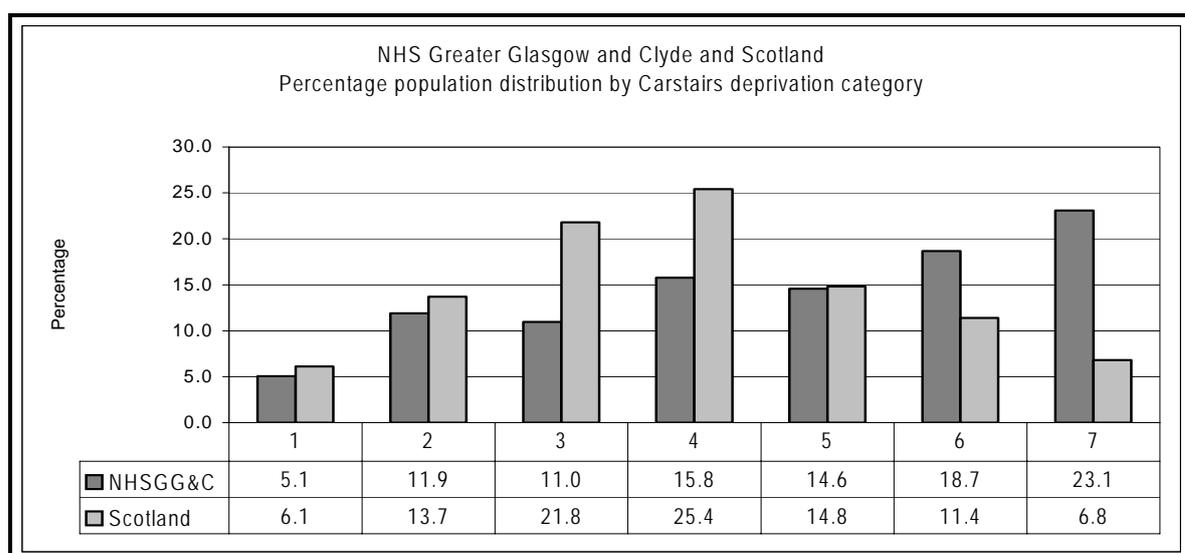


Table 3: Percentage population distribution by Carstairs Deprivation category for NHS Greater Glasgow, NHS Clyde, and NHS GG&C

Deprivation Category	Greater Glasgow	Clyde	NHS GG&C
1	5.4	4.1	5.1
2	12.2	11.1	11.9
3	9.7	14.3	11.0
4	15.5	16.6	15.8
5	9.6	27.7	14.6
6	18.2	20.0	18.7
7	29.5	6.2	23.1

3.2.15 The following table demonstrates just how much more socially deprived NHS GG&C is compared to Scotland. This remains a considerable challenge for NHS GG&C given the strong links between social deprivation and ill health.

Figure 2: Percentage population distribution by Carstairs Deprivation category for NHS GG&C and for Scotland.



Source: GGC Information Services

3.2.16 Currently, the collection and analysis of data in relation to different forms of inequality within the NHS in Scotland are insufficient. Greater Glasgow and Clyde NHS Board is committed to developing appropriate inequalities monitoring to ensure its service users are receiving a service which meets their needs. This will happen using the national standards being developed by the Equality and Diversity Information Programme, which is led by the Information and Statistics Division Scotland. We have carried out an exercise to assess what inequalities data are currently being collected and are keen to work towards monitoring of our services and using the data to ensure it meets the needs of our population. Work has also been undertaken by NHS GG&C in collaboration with the Equality and Diversity Information Programme to assess the willingness of patients to provide equality and diversity information.

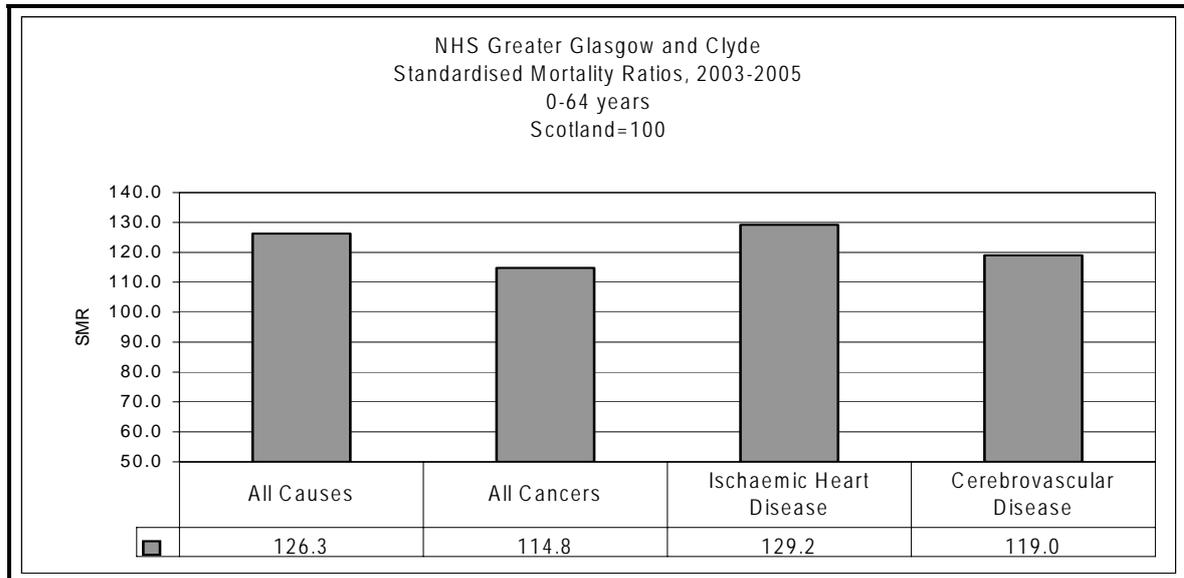
3.3 Health status of the population

3.3.3 Within Western Europe, Scotland has a relatively poor health record. The variations with the country, however, reveal that the area covered by NHS GG&C, particularly Glasgow, has significantly poorer health. The three national clinical priorities identified to improve health are: *Cancer, Coronary Heart Disease and Stroke, and Mental Health*.

3.3.4 Standardised Mortality Ratios (SMRs) provide an indication of the commonest causes of death in a population and how the rates compare to the Scottish average. These indicate that residents of NHS GG&C aged 0-64 years have 26% higher premature death rates from all causes, and higher death rates from common causes of death such as cancer, ischaemic heart disease and cerebrovascular disease. Qualitatively, this profile reflects typical western disease profiles due to dietary and other lifestyle factors including smoking, excessive alcohol consumption, lack of exercise, etc. The high SMRs for NHS GG&C suggest that several risk factors are working synergistically to bring about early deaths (e.g. a combination of poor diet with smoking and excess alcohol intake).



Figure 3 : Standardised mortality ratios for various causes of premature death for residents of NHS GG&C aged 0-64, during 2003-5. Scotland = 100.



Source: GGC Information Services

3.3.5 The prevalence of mental health problems in Scotland is of major concern. It is estimated that one in four people will develop a mental health problem over the course their lives. Approximately 25%-30% of all GP consultations are in relation to depression, stress and anxiety.

3.3.6 What the national data do not reflect adequately is the distribution of these and other health problems across the population, nor the differential risk factors that may apply to different groups. They do not factor in the adverse health impact of inaccessible services e.g. in relation to disability, ethnicity or gender, which may deny individuals the opportunity to utilise preventive measures or services, or exacerbate their condition because of a delay in diagnosis and treatment.

3.3.7 To address appropriately the health concerns identified above, we need to take more cognisance of such differences and their impacts. For example, in relation to heart disease, we have to address the higher rates of this amongst some black and minority ethnic groups, particularly south asian communities, compared to the white population. Similarly we have to consider the significance of the fact that people within south asian communities are six times more likely to have Type 2 Diabetes, and that they have a higher risk of developing renal and cardiac complications because of poorer levels of knowledge about appropriate management of blood glucose levels, as well as the fact that access to mainstream services is often limited by cultural and language barriers.

3.3.8 Similarly in relation to the development of cancer, we need to consider who is most at risk and why. Data for the ten year period 1993-2003 demonstrate a reduction in the incidence of lung cancer across Scotland, for example, which is a welcome development. On inspection, however, they show that this falling rate applies to men (who have previously had, and continue to have, higher rates of this cancer than women). Should this trend continue there is a possibility that women will develop similar rates to men. Any measures to counteract this will have to address the gender dimension

3.3.9 The relationship between physical and mental health is often neglected leading to poorer levels of service and treatment. People experiencing severe mental health problems, for example, are likely to die ten years earlier than their counterparts who do not have such problems. Higher risk and rates of heart disease, diabetes, respiratory disorders and infections, as well as higher levels of smoking, alcohol and drug consumption contribute to the significantly poorer quality of life within this population group.

3.3.10 The costs of depression and anxiety, both in terms of financial resources and human suffering, are immense. The World Health Organisation estimates that by 2020 it will be the primary cause of disability worldwide. Yet this burden is not shared evenly across the population. Both at a global and a local level there is disparity between the sexes. In Scotland, and in NHS GG&C, women are between two and two and a half times more likely to experience depression and anxiety than men; an excess attributed to a combination of social, economic, biological, and emotional factors.

3.3.11 The prevalence of gender-based violence⁴ has been identified as one of the leading causes of mental distress in women. For example, it is estimated that between one in three and one in five women will experience abuse from a partner or ex-partner. This, and other forms of abuse, stem from, and are sustained by, gender inequality.

3.3.12 The impact of gender on mental health is also apparent in suicide rates which are almost three times higher in men than in women. Attempted suicide rates amongst gay men are also higher than in the heterosexual population

⁴ Gender-based violence comprises a range of abuse that is predominantly aimed at women and children including domestic abuse, rape and sexual assault, child sexual abuse, prostitution, female genital mutilation, forced marriage, honour killings.



3.3.13 The relative invisibility of LGBT communities in monitoring data similarly conceals the health and healthcare needs of this population. Anxiety, depression, self-harm and attempted suicide have been linked with the combined effects of the experience of prejudice and discrimination. A study carried out by MIND identified higher levels of psychological distress amongst LGB people. In a Needs Assessment of young LGB people in Glasgow, 80% had experienced discrimination and suicidal ideation was up to two to three times higher among respondents.

3.3.14 The experience of discrimination within society has clear implications for health and well-being which the NHS has to understand more fully if it is to respond appropriately. Whilst the NHS cannot eradicate discrimination and inequality it can ensure that it provides accessible and relevant services to all its population. For example, in one national survey of deaf and hard hearing people, 24% said they had missed an appointment because of poor communication - such as not being able to hear staff calling out their name. Some 19% have missed more than five appointments⁵. This is avoidable. Another piece of research revealed that nearly half of deafblind people sampled had undergone procedures (operations, injections, drips) that had not been explained⁶. This, too, is avoidable. We have a duty to ensure that we understand the impact of inequality on health, and to try to mitigate such effects by providing responsive, inclusive services.

3.4 NHS Greater Glasgow and Clyde staff:

3.4.1 NHS Greater Glasgow and Clyde employs nearly 44,000 staff. Workforce information is now captured through the Scottish Workforce Information Statistics (SWISS) – Workforce Information Repository. SWISS is the data collection and analysis system now being used by the whole of NHS Scotland for local, regional and national reporting.

3.4.2 Monitoring of inequalities in relation to staff has been hampered by the poor response rate of the SWISS project. Greater Glasgow and Clyde is working with the Scottish Executive Workforce Team and staff to improve this response rate. It is hoped in future years, good quality staff

⁵ Royal National Institute for the Deaf (2004), A simple cure. London: RNID.

⁶ Sense UK and Deafblind UK (2001), Who Cares? Access to healthcare for deafblind people. London: Sense UK and Deafblind UK.

data will be available to enable the Board to use this to identify and address inequalities in this area.

3.5 Reforming the NHS in Greater Glasgow and Clyde

3.5.1 The last eighteen months have witnessed huge changes within the structures of the former NHSGG which has now migrated to the newly constituted NHS GG&C. The context and nature of these changes have major significance for addressing the institutional change required by the equalities legislation.

3.5.2 Some of the re-organisation has been in response to national directives from the Scottish Executive Health Department, particularly the creation of Community Health Partnerships. Similarly, the integration of Clyde was the result of the decision taken nationally to dissolve NHS Argyll and Clyde. Other developments have been driven locally to maximise existing resources and provide a coherent structure within which to meet more effectively the health needs of our population.

3.5.3 Until April 2006, NHS Greater Glasgow had four Divisions - North, South, Yorkhill and Primary Care - each of which had responsibility for providing health care within their areas. The Health Board had responsibility for commissioning these services. Within the new structure, however, these divisions have been dismantled and there is no longer a '*commissioning / provision*' split. NHS GG&C has moved to single system working and is now a unified structure. An outline of the structure of the organisation is contained in appendix 2.

3.5.4 In terms of organisation, this has created a clearer, more defined set of corporate responsibilities performed by Headquarters, and a considerable devolution of responsibility accorded the constituent parts of the organisation which now comprise:

- ***Community Health Partnerships (CHPs)***

3.5.5 These are new partnerships, created largely within local authority boundaries, which are designed to develop more locally sensitive provision of health care. These include health visiting, district nursing, speech and language therapy, physiotherapy, podiatry, mental health, addiction and learning disability services. Staff delivering these services will work closely with other local health professionals, including GPs, dentists, pharmacists and opticians to plan and develop services across the CHP area.



3.5.6 In Glasgow City and East Renfrewshire, the partnerships have integrated Social Care services to form Community Health and Care Partnerships (CH(C)Ps). Given the size of the area covered by Glasgow City Council, there are 5 CH(C)Ps within its boundary. In total therefore, there will be eleven CH(C) Ps in the catchment area of NHS Greater Glasgow and Clyde, including two that cover areas previously managed by two different NHS Boards. All Partnerships have responsibility for consulting actively with local populations to ensure services reflect local needs, and demonstrate a more consistent and co-ordinated approach to planning of services.

- ***Acute Operating Division***

3.5.7 The reorganisation of NHSGG brought together the previous acute divisions to provide structural coherence to facilitate the design and implementation of the Acute Services Strategy. Within this division there are eight directorates covering Emergency Care and Medical Services, Surgery and Anaesthetics, Oral Health, Women and Children's Services, Regional Services, Rehabilitation and Assessment, Diagnostics and Facilities. A further directorate managing the Acute services within the Clyde area has been established.

3.5.8 NHS Greater Glasgow and Clyde is implementing a far-reaching programme of hospital modernisation, comprising an investment of £750m, which means radical changes to healthcare. The new West of Scotland Cancer Centre at the Gartnavel site is nearing completion and will open in early 2007, whilst construction has just begun on two new Ambulatory Care hospitals at Stobhill and the Victoria Infirmary. There will also be considerable investment at the Southern General and Royal Infirmary sites which will create centres of excellence for surgical, medical and emergency care supported by significant investment at Gartnavel General. A further £100m is to be invested to create a new children's hospital co-located with adult and maternity services on the Southern General site. Mental health services are also undergoing transformation – more than £100m are being used to create new purpose built facilities at three locations.

- ***Mental Health Partnership***

3.5.9 The Partnership is responsible for overseeing all adult mental health services. Its remit is :



- a) To manage Greater Glasgow wide services in partnership with Community Health Partnerships;
- b) To ensure a whole system approach to the planning and delivery of mental health services;
- c) To ensure clear and consistent implementation of performance management arrangements, reflecting all aspects of health and Local Authority governance requirements;
- d) To provide effective managerial and professional leadership at all levels of the Partnership;
- e) To provide robust and safe arrangements for the management of mental health services with particular focus on balancing the risk to individuals to that of the community;
- f) To lead the development of health improvement and prevention strategies for mental health and wellbeing in partnership with Community Health Partnerships

3.5.10 The *Addictions Partnership* and *Learning Disability Partnership* are part of the overarching Mental Health Partnership but have been designed to provide specific leadership on these two areas.

3.5.11 Whole system arrangements in other areas, such as Clinical Governance, Health Information and Technology have also been established to provide a pan-Greater Glasgow & Clyde approach. A series of Planning Groups and Managed Clinical Networks also focus on ensuring that key clinical priorities are planned, managed and co-ordinated across the spectrum of prevention, diagnosis, treatment and care.

Infrastructure for engaging with communities

3.5.12 Community engagement is an integral feature of the work across all the component parts of the organisation. It is undertaken through our Patient Focus and Public Involvement structures. Within the Acute Division, CH(C)Ps, and the Mental Health Partnership there are specific arrangements in place to ensure involvement of, and consultation with, our communities.

3.5.13 Across NHS GG&C there is a well-developed infrastructure for involving people at many levels to fulfil the expectations of this Scheme, and to locate meaningful involvement and consultation within our key functions. These comprise:



- *Community Engagement Team – Acute Division*

3.5.14 Following consultation on the Acute Services Review for the former NHSGG, the Health Minister indicated that a specific team would be established to inform and involve patients and the public in the design and implementation of the hospital modernisation programme. The Team was appointed by the spring of 2004. The role of the team is threefold:

- to inform members of the public and key stakeholder groups of the plans to modernise Glasgow's Hospitals and acute services,
- to involve members of the public and stakeholders groups (patients, special interest groups – disabled people, faith community members, neighbours) in the design of the new hospitals and their services
- to listen to these groups to ensure that their views, concerns and aspirations inform all aspects of the Boards work in relation to the hospital modernisation programme.

3.5.15 This approach harmonises with the Scottish Executive Health Department requirement for NHS boards to involve patients and the public in major service changes and redesign, as well as ensuring that services and processes are fully compliant with discrimination legislation.

3.5.16 NHS GG&C has a history of community engagement in respect to improving access to community premises, existing hospital accommodation, and in respect to Glasgow's ongoing programme to rebuild and modernise its acute hospitals.

- *CH(C)Ps – Public Participation Fora (PPF)*

3.5.17 It is the responsibility of each CH(C)P to build community involvement into all of its work. Locally, a Public Partnership Forum (PPF) will be a key mechanism to achieve this, by undertaking the following:

- Mapping the different ways that it will establish for people to be involved in its work in processes, services and planning.
- Making involvement easier for people and indicating what people can expect from all staff within the CH(C)P including senior managers.
- Identifying the resources it will make available, financial or in kind, to support the work of the PPF and wider community involvement.



- Describing how it plans to keep people up-to-date on what it is doing.

3.5.18 Guidance produced for CH(C)Ps asks PPFs to pay particular attention to *'those who are more socially excluded and facing discrimination when accessing services.'* In some parts of the city there are groups and individuals able to represent communities of interest/identity and PPFs will be expected to make links with these and support their involvement from the start. Each CH(C)P needs to have a Co-ordinating or Executive Group to progress the day-to-day work.

- *Acute – Patient Access Panels*

3.5.19 Many NHS GG&C acute sites have engaged on access issues by establishing hospital access panels usually consisting of disabled people, members of the public with an access interest, current or ex-patients or carers, members of clinical staff and NHS estates. These panels require to be reviewed in the light of the new organisational arrangements.

Infrastructure for engaging with Staff

Ensuring that staff are involved in the changes within NHS GG&C is crucial in achieving the outcomes we wish in terms of organisational transformation. The key mechanisms by which their views are solicited and represented are:

- *Staff survey*

3.5.20 The Staff Survey is a tool used to understand staff needs and satisfaction with the NHS as an employer. The survey has been useful in identifying where people feel they are treated with dignity and respect and where harassment and bullying exists across the system. The data are not, however, aggregated by gender, ethnicity or disability. This will be the focus of a future piece of work to ensure the information can be fully utilised.

- *Greater Glasgow and Clyde NHS Board Area Partnership Forum*

3.5.21 The Local Partnership Forum has representatives of both employees and management working together in formulating and implementing employment policies and practices, and ensuring that Greater Glasgow and Clyde NHS Board meets its objectives. The Partnership entails a commitment to involve staff at the earliest stage



when making decisions, particularly when considering changes which will affect the way people work or are managed.

3.5.22 Staff Governance arrangements place a responsibility on the relevant partnership fora to monitor and report on achievements and progress in meeting specific criteria in relation to the way NHS Greater Glasgow manages its staff. This forum will be utilised to ensure that diversity and equality issues relating to staff are managed appropriately in and line with the legislation.

Conclusion

3.5.23 As the above makes clear, NHS GG&C is an organisation of considerable size and complexity. The creation of wholly new structures has necessitated a huge process of reorganisation and staff dislocation. Our priority in the first instance is therefore to establish a robust process and structure to support the work designed to implement the legislation around inequality. The measures we have devised to do so are included in the next section and in the detail of the Equality Scheme and Action Plan in parts 2 and 3 of this document.



SECTION 4 - ADDRESSING INEQUALITIES AND HEALTH

This section outlines the commitment and resources devoted to mainstreaming equality throughout NHS Greater Glasgow and Clyde and the means by which this is being integrated into the new organisational structures. It is presented against the backdrop of existing work on inequality within NHS GG&C upon which we will build to deliver the objectives of the Equality Scheme. It is crucial, however, in assessing the approach of NHS GG&C to locate this within an understanding of the nature of the challenge faced by the NHS in tackling inequalities and health.

4.1 The relationship between inequalities and health

“Biological and biomedical models do not explain adequately why population distributions of disease generally follow the contours of power, with the overall patterning closely associated with a society’s economic and social structure, standard of living and degree of social inequalities”

4.1.1 Inequality is bad for your health. Its importance as a determinant of health has been recognised in health policy in recent years. As a result there is now a more prominent focus on the reduction of inequalities as a means of improving health. Understanding the power differentials referred to in the above quote, however, is crucial to deliver such improvements.



Inequality and Diversity

Although they are sometimes used interchangeably, there is a distinction between inequality and diversity which is important to remember to avoid blunting the meanings of both.

***Inequality** refers to the experience of discrimination and oppression. It is concerned with differentials in terms of allocation of power, wealth, status, access to resources, and equality of opportunity.*

***Diversity** refers to differences within groups or populations; it is not synonymous with unfairness or discrimination.*

To illustrate the difference, consider the example of culturally sensitive services. In delivering the latter for minority ethnic groups within the population, these might comprise the provision of certain foods or facilities which cater for their distinct needs. This would be addressing **diversity**. In dealing with racial **inequality**, however, we would need to consider how our practices contributed to discrimination or disadvantage e.g. if we recruited only people from the dominant ethnic group.

4.1.2 Health is not the product of a single circumstance or experience. It is shaped by prevailing socio-economic, political and societal circumstances as well as by environmental, biological and behavioural factors. The relationship between health and inequalities is therefore a complex one.

4.1.3 The experience of inequality can be both a pathway to poor health, and a consequence of poor health. Gender, race/ethnicity, disability, sexual orientation and social class are all contributory factors to health. The methods of interaction between and amongst them, however, are also powerful determinants of health.

4.1.4 Socio-economic status is central to the experience of inequality. According to one commentator "*Scientists have known for decades that poverty translates into higher rates of illness and mortality. But an explosion of research is demonstrating that social class - as measured not just by income but also by education and other markers of relative status - is one of the most powerful predictors of health, more powerful than genetics or exposure to carcinogens, even smoking.*" (Goode)

4.1.5 All forms of inequality are mediated by social class and status. For example, the experience of racial inequality and discrimination adversely affects opportunities for educational and material advancement. The

poorer socio-economic status of black and minority ethnic populations compounds their experience of disadvantage.

4.1.6 Disabled people are less likely to be employed than those who do not have a disability thereby increasing the likelihood of dependency upon welfare benefits. According to national statistics, 68% of disabled people have an annual income of less than £10,000.

4.1.7 Poverty is gendered. Women are more likely to be poor because they tend to have lower paid jobs, and are more likely to work part-time. They are also more likely to be lone parents (90% of lone parent families are headed by women). Despite progress in recent decades differential access to power and resources continues to keep women in a subordinate and disadvantaged position. The unequal division of domestic labour, family responsibilities and the disproportionate numbers of women living in poverty are evidence of such divergence of opportunity

4.1.8 The experience of inequality has a number of impacts on health – some of which are tangible and demonstrable, and others which are more difficult to measure. We know, for example, about barriers to services in relation to language or physical access. What is less identifiable is the impact on the individual or groups of the experience of inequality. For example, a Glasgow city council survey on sectarianism carried out in January 2003 amongst 1000 representative respondents found surprisingly low evidence of sectarian prejudice, but revealed significant undercurrents of homophobia and racism. The number of people who would be ‘very concerned’ if someone who was lesbian or gay moved in next door was amongst the highest expressed and was similar to those who would feel the same if people with a criminal record became their neighbours⁷.

4.1.9 To appreciate the consequences of inequality we need to think about the meaning of discrimination for individuals and groups, and how this may affect health and well-being. So we need to consider what it means to be disabled in a culture that values ‘ability’, what it means to be female in a culture which places more value on the male, what it means to be black in a predominantly white society and what it means to be lesbian or gay in a culture where heterosexuality is the ‘norm’.

⁷ NFO Social research (2003) *Sectarianism in Glasgow Glasgow City Council* (unpublished) quoted in *Towards a Healthier LGBT Scotland*, Inclusion Project, NHS Scotland October 2003

4.1.10 These issues are important if we are to understand that the social impact of inequality can be an internalisation of oppression i.e. a feeling of inferiority, of failure and lack of power. The sense of control over one's life, of being valued and respected is essential for health; the absence of such factors can thus negatively affect both physical and mental well-being.

“Evaluating these differences means more than simply adding one dimensional terms like race/ethnicity or social class to a long list of other variables..... it instead requires asking questions about deprivation, privilege, discrimination, and aspirations, to permit characterising people more fully, and as more than the sum or product of their parts”⁸

4.2 Tackling inequalities and health – the challenge for the NHS

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”⁹

4.2.1 The underlying ethos and principles of the NHS were enshrined in the 1946 NHS Act which led to the establishment of the NHS in 1948. The vision at that time of a Health Service that was universal and free at the point of need has endured. But this essentially was a benevolent and paternalistic vision, which envisaged a largely passive role for the patient. In seeking to treat everyone equally, it overlooked some of the key factors which determine poor health and which prevent equal access to services.

4.2.2 The challenge for the NHS in identifying and responding to the different forms of inequality and discrimination lies not only in the size and diversity of its functions, but in its perception of its purpose and role. From inception, its design was the embodiment of a welfarist, egalitarian vision which firmly located health within a bio-medical model. Improvements in health were seen to flow from the provision of free, accessible healthcare services, which would incorporate technological advances.

4.2.3 In part, this limited view of the role of the NHS was a product of the understanding of the nature of health itself. Although the World Health Organisation defined health as *“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”*, the

⁸ Krieger, N., and Zierler, P.H., (1995) Accounting for the health of women *Current Issues in Public Health* 1:251-6 Quoted in Payne Sarah, *The Health of Men & Women*, Polity press (2006) p186

⁹ Constitution of World Health Organisation

NHS has been charged primarily with responding to ill health, not in promoting good health across society. One of the results of this has been the dominance of what is referred to as the '*medical model*' of health.

What are the medical and social models of health?

4.2.4 The *medical model* of health focuses predominantly on symptom identification and management; it is concerned with the diagnosis of pathology and with the treatment regime required to eradicate disease or dysfunction. At the heart of this model is the clinician, who is considered the 'expert' in this area and in whom considerable authority is vested. Although the provision of skilled and technically competent health care is a fundamental tenet of the NHS, the narrowness of the medical model means that it neglects the wider factors that influence health and illness. In this way, it fails to address the context within which health is shaped.

4.2.5 In contrast, the *social model* of health recognises that the wider social and economic environments are crucial in addressing health and healthcare. Within this concept, there is recognition that experiences of discrimination and disadvantage both create pathways to poor health and are also consequences of poor health.

4.2.6 The paradox for the health service therefore is that we are now tasked with redressing the balance and expected to tackle inequalities and health, yet have been established in a framework which makes this problematic. Making the *institutional* changes envisioned in the equalities legislation is consequently a sizeable undertaking but is indivisible from the challenge of meeting health and health care needs in the 21st Century.

4.3 National developments in NHS Scotland

4.3.1 Recognition of the pivotal role of inequality as both a cause and consequence of poor health is increasing within the health service. At a national level, in 2001 the Scottish Executive published *Fair for All*¹⁰ to address problems of access to, and use of, NHSScotland services for people from Black and Minority Ethnic communities. Subsequently, in *Partnership for Care*¹¹, it further committed the NHS in Scotland to extending the principles set out in Fair for All to ensure that '*our health services recognise and respond sensitively to the individual needs,*

¹⁰ Fair For All ***

¹¹ Partnership for Care (2003) Scottish Health Department

background and circumstances of people's lives'. The **National Health Service Reform (Scotland) Act 2004** turned this into specific duties to involve the public and encourage equal opportunities.

4.4 NHS Greater Glasgow and Clyde commitment to addressing inequalities and health

4.4.1 There are many examples of good practice in addressing inequalities and health at a local level in NHS GG&C. Some of this has been evidenced in the progress made around implementation of Race Equality Schemes in compliance with earlier legislation and in our approach to Fair for All. The creation of the Multi-Cultural Health Team and the extensive interpretation services, for example, have made significant improvements in the drive to developing culturally sensitive and competent health care.

4.4.2 Similarly, in the former NHSGG the establishment of a Women's Health Team and a Men's Health Team highlighted the impact of gender inequality and provided exemplars for designing gender sensitive services. There has additionally been locally based programmes that have targeted resources at disadvantaged groups with good effect. Key issues, such as gender-based violence, have also been a focus for much of this work.

4.4.3 Despite the progress made by this plethora of initiatives, their impact on mainstream planning and service delivery has been limited. This is attributable in part to the difficulties in translating learning across such diverse and complex systems. In the main, however, the absence of a systemic approach has entrenched the difficulties of the medical model in being fully able to respond to the differing needs of the population.

4.4.4 As part of the process of re-designing the NHS in Greater Glasgow, a review was undertaken in 2004 by a short-life working group to assess the extent to which health inequalities were being addressed. In particular, the review considered the role of senior management in providing leadership and guidance on this issue. The findings revealed a lack of understanding of the significance of the range of inequalities for health and healthcare. Their lack of clarity on the role of the NHS in this regard was mirrored in the lack of priority accorded this issue. This process informed some of the thinking around the explicit inclusion of inequalities in the restructuring of the organisation.



4.4.5 The magnitude of the restructuring in NHSGG required a process that incorporated cultural change, not just re-configuration of existing resources. To realise the vision of single system working there had to be a concomitant acceptance of the need to work differently. The nature of this cultural change has been articulated in the following 9 *transformational themes* that have been developed to alter radically the way in which NHS GG&C functions as an organisation:

- Achieving an organisation in which the component parts work together to shared aspirations and objectives, not competing ones, and managers and clinical leaders work in teams with shared values and priorities
- The whole senior team and organisation contributing to leadership on health improvement and tackling inequalities
- Focusing on service improvement and equipping and supporting frontline staff and first line managers to help us deliver it
- Moving away from functional systems of management to general management with managers at all levels responsible for the quality of service delivered to patients and professional staff developed into management and leadership roles
- An organisation where people take responsibility for their area of work and for the wider performance of the organization
- An organisation focused on learning and development, as individuals and collectively, to improve our performance
- A culture of clear objectives, accountability and performance management at all levels
- Driving integration of acute and community and health and social care services to improve the experience of patients
- Leaders and managers who have a value base of public services, acting in the interests of patients and the communities we service, behave in a collaborative not competitive way but constructively challenge each other

4.4.6 To clarify the responsibilities of senior management in relation to inequalities, a number of seminars were delivered in 2006. It is expected that as progress against each of these transformational themes is being monitored and reviewed, we will be able to measure the extent to which tackling inequalities has been taken on board across the organisation. We will also be able to identify where there is need for more support and guidance in this respect.

4.6 Mainstreaming equality in NHS Greater Glasgow and Clyde



4.6.1 Essentially the Equality Scheme is part of the ongoing process of transformation of the NHS in Greater Glasgow and Clyde. It articulates the means by which we intend to ensure the mainstreaming of equality throughout our organisation.

What do we mean by mainstreaming equality?

4.5.2 Mainstreaming equality means that we will integrate equality concerns into all our functions, including policy, planning, service delivery and financial plans. Fundamentally, it requires us to identify and address inequalities within these spheres, and to do so at the *outset* of processes, not as a ‘bolt on’ afterthought when key decisions have already been taken.

4.5.3 The need to address inequalities has been included in the Planning and Priorities Guidance issued to senior management to establish the framework within which the whole of NHS GG&C will operate to deliver our corporate responsibilities. This in turn drives the personal objectives of senior management.

4.5.4 We have a Corporate Plan which reflects the planning priorities for NHS GG&C. Within this plan there will be an explicit identification of how equality will be integrated in relation to the overarching set of corporate themes which aim to:

- a) **Improve Resource Utilisation:** making better use of our financial, staff and other resources.
- b) **Shift the Balance of Care:** delivering more care in and close to people’s homes
- c) **Focus Resources on Greatest Need:** ensure that the more vulnerable sectors of our population have the greatest access to services and resources that meet their needs
- d) **Improve Access:** ensure service organisation, delivery and location enable easy access
- e) **Modernise Services:** provide our services in ways and in facilities which are as up to date as possible
- f) **Improve Individual Health Status:** change key factors and behaviours which impact on health
- g) **Create an Effective Organisation:** be credible, well led and organised and meet our statutory duties

4.5.5 Given the size of NHS GG&C there are many structures designed to ensure we discharge our responsibilities appropriately. In seeking to



mainstream equality, we need to ensure that our key structures will support this drive and present a coherent, co-ordinated approach. Specifically, these include *Clinical Governance, Performance Management, Organisational Development, Education and Learning and Communications*.

4.5.6 The latter two functions will be pivotal in assisting the transformation of the organisation, in equipping staff with the knowledge and skills to undertake the work required and in identifying processes that support this process.

4.5.7 In relation to Performance Management, we need to find a means of exploring the performance targets set to ensure that they are sensitive to the dimensions of inequality, and give us more useful data against which we can measure our progress and determine our priorities.

4.5.8 Clinical Governance refers to the corporate accountability of an NHS board for clinical quality and performance. Its work is reviewed and assessed against national standards by NHS Quality Improvement Scotland (NHS QIS) that has responsibility for improving the quality of healthcare in Scotland.

4.5.9 The focus of Clinical Governance is on improving quality of care, patient safety, clinical effectiveness, identifying the training and professional development needs of clinical staff and assisting the development of an environment that supports staff to deliver high quality care. As such, it is integral to any attempt to mainstream equality. Across NHS GG&C local Clinical Governance committees carry out these functions, and are overseen by the Clinical Governance Committee to the Board. The issue of inequality has already been identified within these groups, and we will need to ensure that their work is undertaken in harmony with the implementation of the Equality Scheme and its Action Plan.

Supporting the development of a mainstreaming approach

4.5.10 Commitment to, and ownership of, the drive to tackle inequalities is the cornerstone of our approach. This commitment is reflected in the allocation of resources to support the organisation in its endeavour. These include:

- *The Corporate Inequalities Team*



4.5.11 The Corporate Inequalities Team, managed by the Head of Inequalities and Health Improvement, has been established to work alongside the Directors of Corporate Planning and Policy, Public Health, and Finance to ensure that the reformed NHS GG&C maximises its potential in addressing the causes and health consequences of the different forms of inequality and discrimination. (See Appendix 3 for an outline of its location within the new structure).

4.5.12 The team's primary role is to facilitate and support the development of an inequalities sensitive approach within the key functions of the organisation. The work of the Corporate Inequalities Team includes the development of policy, managing the legal requirements of public sector duties, developing a monitoring and performance framework and supporting the development of new, effective methodologies for changing practice. It has been constructed to maximise leadership and expertise for different aspects of inequality – disability, race and faith, gender and sexual orientation, socio-economic status. There are also lead managers for Information, Gender-Based Violence and Homelessness.

- *Management Responsibility Across the System*

4.5.13 Within CH(C)Ps, Heads of Planning and Health Improvement have responsibility to ensure that an understanding of health improvement and health inequalities informs the decision-making and resource allocation within their respective partnerships. To this end, they are supported by Health Improvement and Inequalities Managers who manage teams of health improvement and community development staff and oversee key developments such as community health projects, healthy living centres and healthy eating initiatives.

4.5.14 Health Improvement and Inequalities Managers have also been established within the Acute Planning Directorate and the Mental Health Partnership to build capacity of frontline services to support health improvement activities with patients and to address issues of inequality.

- *Public Health Resource Unit (PHRU)*

4.5.15 A Public Health Programme Manager and a Public Health Resource Unit (PHRU) has been created under the leadership the Director of Public Health. The aim of the PHRU is to strengthen the corporate functions of the Board to improve health and address inequalities and provide support and resources to the public health workforce across NHS



GG&C. A key component will be the establishment and development of Public Health Networks based on the needs of the public health workforce in NHS GG&C.

- *Equality and Diversity Team*

4.5.16 The Equality and Diversity Team has been newly created and sits with the Organisational Development function of NHS GG&C. This team, alongside the wider team of OD specialists, will support the organisation in developing approaches to mainstreaming equality and diversity into the planning and delivery of services. They will advise and support the development of links into diverse communities from various parts of NHS GG&C. In addition, they will assist in the development of inequalities sensitive practice and in sharing this across our organisation.

- *Inequalities Sensitive Practice Initiative (ISPI)*

4.5.17 The Inequalities Sensitive Practice Initiative, managed within the Corporate Inequalities Team, has been funded for two years by the Scottish Executive Social Inclusion and Voluntary Issues Division. Its aim is to support a sustainable shift in practice in four settings – maternity, integrated children’s services, addictions and primary care mental health – to reflect a social model of health and then mainstream this approach.



PART 2: THE EQUALITY SCHEME

SECTION 5 – STRUCTURE AND PURPOSE OF THE EQUALITY SCHEME

5.1 Our vision

5.1.1 Our vision is to embed throughout the entire NHS GG&C an understanding of, and capacity to respond appropriately to, the different forms of inequality.

5.2 We believe that the highest health status of our population can only be achieved through the integration of inequality concerns into the analyses, formulation and monitoring of policy, planning and delivery. The benefits derived from such an approach are visible from a range of perspectives – from an equity perspective, a human rights perspective, a health outcome perspective and from an efficiency perspective. Achieving this would mean not only doing the *right* thing, but also getting our most basic purpose *right*.

5.2 Why we have chosen to develop a combined Equality Scheme

5.2.1 As noted earlier, each of the three key pieces of legislation require the development of an Equality Scheme and associated Action Plan. NHS GG&C has decided to harmonise the production of these schemes and develop a single Equality Scheme, the timing of which will coincide with the requirement of the Disability Equality Duty i.e. by 4th December 2006. This decision has been taken for the following reasons:

- The intersection of different forms of inequality mean that the complexities of these have to be addressed if we are to realise the aims of a social model of health care i.e. one which addresses the social context of people's lives. Although particular experiences of inequality e.g. in relation to disability or ethnicity may dominate a person's experiences, these will also be mediated by gender, age, sexual orientation and socio-economic status. It is therefore potentially problematic to *define* someone solely by their relationship to a given circumstance or characteristic whilst disregarding other significant factors. For example, the numbers of registered blind and sight impaired people increases significantly over the age of 65 with an almost 2:1 ratio of female to male. In seeking to meet the needs of this group in relation to *disability*, it will also be imperative that the *gender* and *age* concerns are addressed.



- Good health policy and planning are derived from a robust and thorough understanding of the needs of the population. This should be informed by a process that takes cognisance of the impact of the experience of multiple forms of discrimination, and the differential importance of these depending on the circumstances of the individual or group.
- The development of a single scheme is pragmatic, in that it will be more manageable for an organisation of the size and diversity of NHS GG&C. The key challenge of the legislation is to *mainstream* our day-to-day work in such a way that these issues are addressed from the outset and provide an important *starting point* for the development of policy, strategy and service provision. Combining the duties will provide a coherent and clear framework within which the differing needs of the population can be considered, and encourage the development of a co-ordinated and effective approach across the duties.

5.2.2 Although this is an integrated Equality Scheme, it recognises some of the differences within the three areas of legislation. For the avoidance of doubt, the legislative basis is identified within our action plan. Given our commitment to best practice it is our intention that the more stringent duties detailed in the DED will provide the benchmark for this work, and that the unified approach will benefit from a ‘levelling up’ across the other duties.

5.3 Involving people in the development of the Equality Scheme

5.3.1 NHS GG&C has a history of consulting with different population groups in redesigning services to become more sensitive and accessible. Evidence from this work have utilised to build up our scheme and this has been supported further with consultation on a draft Scheme. It is recognised however that this is just a starting point and that key component of the development of the Scheme will be the establishment of further dialogue with different groups.

Strategic consultation

5.3.2 The former NHSGG adopted a Women’s Health Policy in 1996. It evolved from consultation with women across the city to identify their priorities in relation to health. It was pivotal in identifying the lack of gender sensitive approaches in health provision and local unmet need. From this development, a programme of work at both strategic and



operational levels was undertaken, which was informed by ongoing consultation with women and with women's organisations.

5.3.3 The Men's Health programme was developed in consultation with men. It helped shape the delivery framework for Glasgow's Well Man pilot programme and continues to involve local men through delivery planning and review.

5.3.4 As part of the process of developing the detailed action plans to accompany the Race Equality Scheme (2002 – 2005) a series of 'open space' events were undertaken with four identified BME communities – south Asian, Chinese, African / Caribbean, and Asylum Seekers and Refugees. The purpose of these events was to identify the health related issues within the individual communities and to understand how they wished to engage with NHSGG. Following these events a consensus conference was held to identify common themes for action.

Consultation on the Equality Scheme

5.3.5 A series of involvement activities took place in November 2006 as the first stage in the development of the planned dialogue on the Equality Scheme with different population groups. In relation to gender specific work the approach was two fold. Firstly, there was an email based consultation with voluntary organisation with specific interests in women's and men's health. Secondly, clients who have used services with a specific focus on men or women's health were also contacted.

5.3.6 In terms of disabled people, a consultant was brought in to seek the involvement of disabled people in the development of the strategic Action Plan, the Scheme itself and the visibility of the disabled aspect of the Scheme. Gender sensitivity and issues around sexuality, ethnicity and age were built into this involvement strategy to accommodate the other strands of the equalities agenda. The findings from these involvement processes have been incorporated into this Strategy and associated Action Plan.

5.3.7 Given the wide range of age, gender, ethnicity, socio-demographic characteristics and types of disability that were included in the interviews and discussion groups, a broad range of improvements were identified. These are as follows:

- Physical access into and within buildings where healthcare services are provided.



- Availability and awareness of suitable specialist equipment for both healthcare providers and service users.
- More in-depth and empathetic understanding of the issues faced by patients with a disability.
- Communication

5.3.8 It was recognised that the Equality Scheme would effectively enable service users to contribute to the way in which decisions are made by NHS GG&C, help to change the attitudes of healthcare staff towards patients with a disability and build upon the progress that has been made since the inception of the Disability Discrimination Act 2005. Further it was felt that the Equality Scheme pulled the key points of the three acts together very well and were very supportive of this element of the draft Scheme.

Staff involvement

5.3.9 The Equality Scheme was sent out in the staff Core Brief to inform and involve staff in the process of developing the Scheme and Action Plans. Staff were asked to indicate if they were interested in becoming involved in a wider process to contribute to the development of the locally driven Action Plans. Staff from black and minority ethnic and LGBT groups, disabled staff and staff with a particular interest in gender were specifically encouraged to participate in the future development of the Equality Scheme Action Plans.

5.3.10 A series of events have been put in place to energise the NHS around the Scheme. These include inputs to protected learning for CH(C)Ps, training for Acute staff on the disability legislation and a Senior Managers Event to increase awareness of the forthcoming legislation within the wider context of addressing inequalities in health.

5.4 Transforming our organisation – strategic aims and initial priorities

5.4.1 Mainstreaming equality into our core functions – as employer, planner, service provider, procurer, partner and engager with communities – is a key aim of NHS GG&C. To begin the process of realising our vision of embedding equality into all these functions, we have developed a number of strategic aims which we expect to progress within the next three years.



5.4.2 The process of transforming NHS GG&C to an organisation which can effectively integrate an understanding of, and response to, all aspects of inequality within and across its functions is a major undertaking. As part of the process of achieving such change, we have prioritised the role of leadership and the creation of robust structures in all parts of the system to ensure demonstrable ownership, commitment and accountability. These are our key building blocks for change. Since this is the first Equality Scheme covering all strands of inequality, we have also identified initial priorities which we consider to be the foundation for future progress.

5.4.3 Strategic Aims

- a) To ensure demonstrable leadership and governance across the corporate functions of Planning & Policy, Finance, Human Resources, and Public Health in relation to addressing inequalities and health, challenging discrimination, and prioritising and monitoring cultural change within and across functions.*
- b) To manifest ownership of, and responsibility for, implementation of the Equality Scheme across the constituent parts of the organisation in line with Planning Guidance.*
- c) To ensure that all planning and service delivery processes are scrutinised for their implications in relation to inequalities.*
- d) To deliver on a set of initial priorities identified for the whole system to mainstream action in tackling inequalities.*
- e) To make consultation with patients and communities integral to all our functions, and ensure that information accrued informs the development of corporate and local priorities.*

5.4.4 Initial Priorities

5.4.5 The range of priorities referred to in *Strategic Aim d* is detailed below.

5.4.6 It is anticipated that across the system, there will be the identification of local priorities which local communities have been involved in determining. There are some fundamental changes required in NHS GG&C without which it will be impossible to make a real difference to the communities we serve. A priority for us therefore is to ensure accessibility to all our services, both in relation to physical access as well as in relation to language and communication. Similarly, we need to address urgently the inadequacy of our current data collection and



analysis systems that preclude the development of robust planning across the different strands of inequality. To do so requires a greater understanding among staff about the importance of this, as well as an understanding of the impact of inequality in relation to health.

5.4.7 The inclusion of Cancer, CHD and Mental Health reflect the biggest areas of clinical priority across Scotland and as such, are key to the process of tackling inequalities and health. Implementation of the national Sexual Health Strategy is similarly prioritised.

5.4.8 Gender-Based Violence is perhaps the most sensitive indicator of gender inequality. It has major implications for both health and healthcare. We cannot make serious inroads in the development of a gender sensitive NHS if we fail to address this issue.

5.4.9 Underpinning all of this change is the need to ensure that staff and service users are treated with respect and are not discriminated against on the basis of gender, race, disability or sexual orientation. We need therefore to concentrate our efforts on promoting such a culture within NHS GG&C.

5.4.10 To address the above issues, we have identified the following as crucial first steps in realising the aims of the equalities legislation:

- a) To build capacity across the organisation in terms of training and learning to develop an appropriate skills and knowledge base within all staff groups to understand and address discrimination and harassment across all strands of inequality.*
 - b) To improve the collection and analysis of data in relation to ethnicity, disability, gender and sexual orientation to provide a sound basis for planning and service delivery across the population.*
 - c) To deliver tangible improvements in the provision of accessible information and communication services to people with sensory impairments or who do not have English as a first language.*
 - d) To deliver improvements to ensure that NHS GG&C services are physically accessible to all in line with Disability Discrimination Act requirements.*
- 

- e) *To ensure the needs of all survivors of gender-based violence are identified and addressed across the system.*
- f) *To maximise equality of opportunity, and systems for addressing harassment and discrimination of staff.*
- g) *To ensure that users of NHS GG&C services are treated with dignity and respect in an environment that is free from discrimination.*
- h) *To develop a mechanism for ensuring that the 3 national clinical priorities i.e. Cancer, Coronary Heart Disease and Mental Health, and the National Sexual Health strategy are prioritised for action across the continuum of care in relation to addressing gender, disability, ethnicity and sexual orientation inequality.*
- i) *To ensure that all purchased and contracted services comply with the requirements of equality legislation*

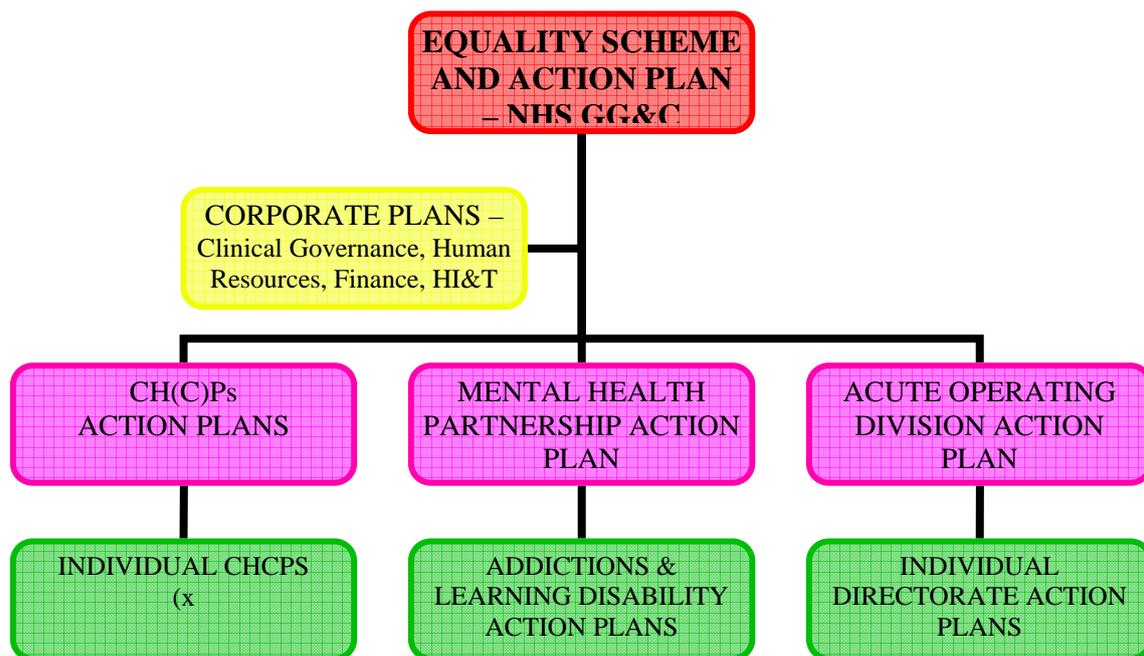
5.5 Implementation of the Equality Scheme in NHS Greater Glasgow and Clyde

5.5.1 The Action Plan below identifies the key areas across the system to progress these priorities. Serving a population of over 1million people, with a staff complement of 44,000, NHS GG&C is a very large organisation. To realise the aims of the legislation, and those of the organisation in relation to addressing inequalities, it is essential that ownership of this issue is established across the system in both vertical and horizontal structures, as reflected in our strategic aims. To deliver this we propose:

- *To establish corporate mechanisms for ensuring that sensitivity around inequalities is built into overseeing all functions of the organisation.*
- *To establish an infrastructure for ensuring that each part of the organisation – i.e. CH(C)Ps, Acute Operating Division, Mental Health Partnership, Human Resources etc, - incorporates inequalities into its local plan.*

5.5.2 Fundamental to this process is the requirement for each constituent part of the organisation to establish internal structures for developing a **local Action Plan** detailing how they will implement the Equality

Scheme. A clear line of accountability is required to facilitate monitoring of the Action Plan and to review when required. This should not only assist in the creation of locally relevant planning, but also ensure transparency in the diverse range of settings in NHS GG&C, and allow for more accurate monitoring of progress. For integrated CH(C)Ps, it will be essential that planning for inequalities is harmonised with Local Authority requirements and that Local Action Plans cover both health and social services.



5.5.3 To ensure compliance with the legislation, these Action Plans must include an assessment and review of all the functions of NHS GG&C i.e. in relation to employment, service planning and delivery, procurement, community engagement and its role as a partner agency.

5.5.4 Given the range of partnerships with which we are engaged, and the local autonomy exercised by Community Health (Care) Partnerships, we need to have clear and productive working relationships with Local Authorities. The development of local Action Plans will therefore be progressed within this context.

5.6 Equality Impact Assessment (EQIA)

5.6.1 Equality Impact Assessments (EQIA) will have to be undertaken in relation to key functions and decisions to demonstrate that due regard has been given to the areas of inequality identified above.



5.6.2 NHS GG&C considers Equality Impact Assessments as a means of mainstreaming the equality agenda. We have identified an appropriate EQIA tool that has utility across the whole system. This has been modified to allow rapid impact assessments to be carried out initially and this has been tailored to suit the situation in which it will be used – examining policy, delivering service, or considering clinical guidelines. This tool will be used in line with the details outlined in the Action Plan.

5.6.3 The results of EQIAs will be published on the Boards website - www.nhsggc.org.uk/publications/strategies. Publishing also means directly feeding back to people and/or groups involved from the EQIA process to inform them of changes made as a result of the assessment.

5.7 Monitoring and review

5.7.1 Implementation of the Equality Scheme and associated action plans will be subject to both internal and external monitoring.

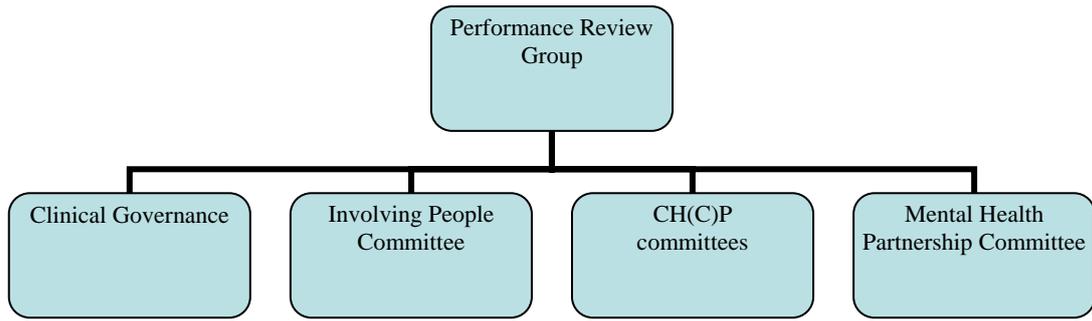
5.7.2 Externally, NHS GG&C is accountable to the Commission for Racial Equality, Disability Rights Commission and the Equal Opportunities Commission until 2007 when these three bodies will merge to become a unified Commission for Equality and Human Rights. In line with legislative requirements, we will review our Single Equality Scheme on a three yearly basis. In addition, we undertake to produce an annual review of progress against action plans for our Board that will be made available to the Commission.

5.7.3 Whilst the Equality Commissions will monitor and assess our scheme, we will also be subject to scrutiny from the Scottish Health Council which has been delegated responsibility on behalf of the Scottish Executive Health Department to appraise Equality Schemes developed by Scottish Health Boards.

5.7.4 Further monitoring of our progress in relation to integrating appropriate responses to tackling inequality is undertaken by the QIS process – external clinical governance.

5.7.5 Internally, there are a number of structures through which governance of our functions is managed, as outlined in the chart below. Reports on progress within NHS GG&C will be presented to the Performance Review Group which currently has overarching responsibility for ensuring the implementation of organisational priorities.





PART 3: THE STRATEGIC ACTION PLAN

NHS Greater Glasgow and Clyde Equality Scheme
STRATEGIC ACTION PLAN

Strategic Aim 1: To ensure demonstrable leadership and governance across the headquarters functions of Planning & Policy, Finance, Human Resources, and Public Health in relation to addressing inequalities and health, challenging discrimination, and prioritising and monitoring cultural change within and across functions.								
Objectives	Action	Lead Accountability	Support	Timescale	Legislative Applicability			
					D E D	R E D	G E D	S O
1.1 To maximize responsibility for Corporate Directors in relation to equalities legislation	1.1.1 Personal objectives to include accountability for equalities legislation	Chief Executive		2007-8 and ongoing	✓	✓	✓	✓
1.2 To ensure corporate frameworks for policy, planning and performance integrate the need for implementation of the equalities legislation	1.2.1 NHSGG and Clyde annual and 3 year Planning Guidance and financial planning to encompass requirements of equalities legislation	Director of Planning and Policy	Director of Finance	2007-10	✓	✓	✓	✓
	1.2.2 Corporate policy development to be taken forward within the context of addressing inequalities		Head of Policy	2007-10				
	1.2.2 Equality proofing of existing performance indicators to be undertaken		Head of Performance and Corporate Reporting/	2007-8				
	1.2.3 Development of performance indicators which reflect meaningful measures for the implementation of the single equality scheme		Head of Inequalities and Health Improvement	2008-9				

Strategic Aim 1: To ensure demonstrable leadership and governance across the headquarters functions of Planning & Policy, Finance, Human Resources, and Public Health in relation to addressing inequalities and health, challenging discrimination, and prioritising and monitoring cultural change within and across functions.....cont.

Objectives	Action	Lead Accountability	Support	Timescale	Legislative Applicability			
					D E D	R E D	G E D	S O
1.3 To establish corporate mechanisms for ensuring that sensitivity around inequalities is built into overseeing all functions	1.3.1 Annual reporting mechanism to GG and C NHS Board to be established	Director of CPP	Head of I and HI	2007	✓	✓	✓	✓
	1.3.2 Bi-annual progress reporting to Performance Review Group	Director of HR	Head of P & CR	2007-10				
	1.3.3 Strategic planning process to be established within HR strategic group to cover all HR policies, workforce planning, workforce information, recruitment and retention, care careers, medical staffing, OD, learning and education, partnerships, acute and staff governance			2007				
	1.3.4 Progress reporting mechanism to be instituted as part of OD Steering Group	Director of CPP/Director HR	Head of Corporate OD	2007				
	1.3.5 Clinical Governance Committee to establish monitoring arrangements for equalities legislation in relation to QIS standards	Medical Director	Head of Clinical Governance	2007				

Strategic Aim 1: To ensure demonstrable leadership and governance across the headquarters functions of Planning & Policy, Finance, Human Resources, and Public Health in relation to addressing inequalities and health, challenging discrimination, and prioritising and monitoring cultural change within and across functions

Objectives	Action	Lead Accountability	Support	Timescale	Legislative Applicability			
					D E D	R E D	G E D	S O
1.4 To ensure that the establishment of transparent corporate support mechanisms for the implementation of the single equality scheme across the NHS GG and Clyde organisation	1.4.1 Delivery of Corporate Inequalities Operational Plan	Director of CPP	Head I and HI	Annually	✓	✓	✓	✓
	1.4.2 Delivery of Equality and Diversity OD Team Operational Plan	Director of HR	Head of Corporate OD	Annually				
1.5 To ensure a process of continuous improvement in relation to the equality scheme	1.5.1 Mechanism for reporting of progress against action plan to be devised and annual progress report produced	Director of Planning and Policy	Head of Inequalities and HI	2007	✓	✓	✓	✓
	1.5.2 Production of Annual Report aggregating progress across the system			2008-10				

Strategic Aim 2: To manifest ownership of, and responsibility for, implementation of the Equality Scheme across the constituent parts of the organisation in line with Planning Guidance

Objectives	Action	Lead Accountability	Support	Timescale	Legislative Applicability			
					D E D	R E D	G E D	S O
2.1 To maximize responsibility for Directors of CH(C)Ps, Acute Operating Division and Mental Health Partnership in relation to equalities legislation	2.1.1 Personal objectives to include accountability for equalities legislation	Chief Executive		2007-8 and ongoing	✓	✓	✓	✓
2.2 To ensure an effective process for planning within each part of the organization and function to address equalities legislation	2.2.1 Lead officer identified to ensure co-ordination of planning and implementation of action in relation to equalities scheme	CH(C)P Directors, Director Mental Health Partnership, Chief Operating Officer, Acute		2007	✓	✓	✓	✓
	2.2.2 Established infrastructure for ensuring inequalities incorporated into local plan which includes the operational component of HR			2007				
	2.2.3 Production of local Action Plans derived from Local Delivery Plans and aligned to Equality scheme		Heads of Planning	April 2007				
	2.2.4 Annual reporting on progress against action plan and development of indicators		Head of I and HI	2008-10				

Strategic Aim 3: To ensure that all planning and service delivery processes are scrutinised for their implications in relation to inequalities.

Objectives	Action	Lead Accountability	Support	Timescale	Legislative Applicability			
					D E D	R E D	G E D	S O
3.1 To develop a comprehensive process for implementation of Equality Impact Assessments (EQIA)	3.1.1 To finalise appropriate EQIA tools for both Rapid and Full assessments, and accompanying guidance on utilization for staff.	Director of CPP	Head of I and HI	April 2007	✓	✓	✓	✓
	3.1.2 To develop a corporate implementation plan for Equality Impact Assessing all policies and functions, identifying clear criteria for prioritisation.		Head of Policy	2007-8				
	3.1.3 To ensure that all Board papers and Committee papers are equality proofed as standard practice.	All Directors	Director of CPP	2008				
	3.1.4 To develop an implementation plan within each part of the organisation for Equality Impact Assessing all policies and functions, identifying: <ul style="list-style-type: none"> • Criteria for assessing priority and relevance in relation to New and Reviewed policies and services. • System for auditing consistency of application • Leadership of the process, and key staff to be involved in undertaking EQIAs 	All Directors	Heads of Planning	2007-10				

Strategic Aim 3: To ensure that all planning and service delivery processes are scrutinised for their implications in relation to inequalities

Objectives	Action	Lead Accountability	Support	Timescale	Legislative Applicability			
					D E D	R E D	G E D	S O
3.1 To develop a comprehensive process for implementation of Equality Impact Assessments (EQIA) ..cont	3.1.5 To build capacity across the system for undertaking EQIAs and ensure relevant staff are trained to provide guidance on, or undertake EQIAs.	Director of HR	Head of OD/Head of Learning and Education,/ Head of I and HI	Dec 2006	✓	✓	✓	✓
3.2 To develop a transparent system for reporting on, and reviewing, the process and outcomes of EQIAs across NHS GG&C	3.2.1 To devise a centralized system for collating Impact Assessments	Director of CPP	Head of I and HI	Dec 2007	✓	✓	✓	✓
	3.2.2. To monitor the application of EQIAs in terms of relevant process and outcomes across the NHS GG&C system	All Directors		2007-10				
	3.2.3. To monitor application of EQIAs within each part of the organization							
	3.2.4. To make results of EQIAs available to the public	Director of CC		2007-10				

Strategic Aim 4: To deliver on a set of initial priorities identified for the whole system to mainstream action in tackling inequalities.

Objectives	Action	Lead Accountability	Support	Timescale	Legislative Applicability			
					D E D	R E D	G E D	S O
4.1 To build capacity across the organization in terms of induction, training and learning to develop an appropriate skills and knowledge base within all staff groups to facilitate understanding, and address discrimination and harassment across all strands of inequality.	4.1.1 To inform all new staff of the organisations commitment to addressing discrimination and harassment	Director of HR	Heads of HR	April 2007	✓	✓	✓	✓
	4.1.2 To produce an implementation plan that identifies an appropriate training and development framework for all staff i.e. clinicians, practitioners, managers, administration, ancillary and estates staff.	Director of HR	Head of Learning and Education	Sept 2007				
	4.1.3 To undertake a prioritisation process that reflects areas of clinical and organizational priorities within the scheme.	Directors CPP/HR	Head of I and HI	Dec 2007				
	4.1.4 To ensure information on the Equality Scheme is communicated effectively to staff.	Director of HR	Director of Corporate Communications	2007-10				
	4.1.5 To disseminate guidelines on tackling inequalities across the organisation	Director of HR	Director of Corporate Communications Head of I and HI					

Strategic Aim 4: To deliver on a set of initial priorities identified for the whole system to mainstream action in tackling inequalities

Objectives	Action	Lead Accountability	Support	Timescale	Legislative Applicability			
					D E D	R E D	G E D	S O
4.2 To improve the collection and analysis of data in relation to ethnicity, disability, gender and sexual orientation in order to provide a sound basis for planning and service delivery, within the context of national developments.	4.2.1 To review current arrangements for collection of inequalities related data and bring forward a plan to address shortfall	Director of Health Information and Technology	Head of Information	Dec 2007	✓	✓	✓	✓
	4.2.2 To establish routine collection and utilisation of sex, race, disability and sexual orientation disaggregated data in relation to clinical and organizational priorities within the Equality Scheme.	All Directors	Heads of Planning	2007-10				
	4.2.3 To ensure existing guidance is disseminated to enable staff to understand the need to collect these data and how to do so appropriately and sensitively.	Director of HI and T						
	4.2.4 To implement a delivery plan for the collection of routine data	All Directors						

Strategic Aim 4: To deliver on a set of initial priorities identified for the whole system to mainstream action in tackling inequalities.

Objectives	Action	Lead Accountability	Support	Timescale	Legislative Applicability			
					D E D	R E D	G E D	S O
4.3 To deliver tangible improvements in the provision of accessible information and communication services to people with sensory impairments, people who require communications support or who do not have English as a first language	4.3.1 To develop a co-ordinated and comprehensive language plan to ensure accessibility of information and services based on: <ul style="list-style-type: none"> • A system of audits to identify need, existing capacity and gaps in provision. • Guidance on the development of new materials and information 	Director of Corporate Communications	Head of PHRU	2008	✓	✓	✓	✓
4.4 To deliver improvements to ensure that NHS GG&C services are physically accessible to all in line with Disability Discrimination Act requirements.	4.4.1 To develop a phased approach over three years, with clearly defined priorities and costings, for implementing changes to existing facilities in compliance with DDA requirements. 4.4.2 To ensure that developments of all new builds, and adaptations to existing facilities, are fully compliant with the requirements of the DDA.	COO Acute CHCP Directors, Directors MHP	Head of Capital Planning and Estates	2007 – 10	✓			

Strategic Aim 4: To deliver on a set of initial priorities identified for the whole system to mainstream action in tackling inequalities

Objectives	Action	Lead Accountability	Support	Timescale	Legislative Applicability			
					D E D	R E D	G E D	S O
4.5 To ensure that the needs of all survivors of gender-based violence are identified and addressed across the system.	4.5.1 To ensure development of a Gender-Based Violence Action Plan that prioritises Mental Health, Primary Care, Maternity, Children’s Services, Addictions and A&E.	Director of CPP	Head of I and HI	Sept 2007	✓	✓	✓	✓
	4.5.2 To ensure that the GBV Plan explicitly addresses the needs of black and minority ethnic women, disabled women and lesbian women.			Sept 2007				
	4.5.3 To deliver on the priorities identified within the GBV Action Plan	All Directors	Heads of Planning	2008-10				

Strategic Aim 4: To deliver on a set of initial priorities identified for the whole system to mainstream action in tackling inequalities

Objectives	Action	Lead Accountability	Support	Timescale	Legislative Applicability			
					D E D	R E D	G E D	S O
4.6 To ensure that the attraction, recruitment, support and retention of staff maximizes equality of opportunity	4.6.1 To review existing policies to ensure recruitment practices are equitable, free from discrimination., and accessible to all.	Director of HR			✓	✓	✓	✓
	4.6.2 To review the implementation of existing policies on discrimination and harassment of staff to ensure they effectively address these issues.							
	4.6.3 To ensure implementation of revised policies	All Directors						
	4.6.4 To undertake an Equal Pay Review	Director of HR						
	4.6.5 To monitor application and outcomes of complaints of harassment and discrimination in line with national directives							
	4.6.4 To implement the SWISS project to ensure accurate data on staff are available in relation to different strands of inequality.							

Strategic Aim 4: To deliver on a set of initial priorities identified for the whole system to mainstream action in tackling inequalities.

Objectives	Action	Lead Accountability	Support	Timescale	Legislative Applicability			
					D E D	R E D	G E D	S O
4.7 To ensure that users of NHS GG&C services are treated with dignity and respect in an environment that is free from discrimination.	4.7.1 To review existing policies on racism, homophobia, sexism and discrimination against disabled people to ensure that they provide a clear statement of the NHS GG&C position on this.	Director of CPP	Head of Policy	Oct 2007	✓	✓	✓	✓
	4.7.2 To ensure effective communication to all staff of the above policies and provide guidance on how to address and challenge discrimination.	Director of HR	Director of Corporate Communications	2008-10				
	4.7.3 To develop a Transgender Policy to ensure that transsexual and transgender people are afforded access to services and are protected from harassment and discrimination.	Director of CPP	Head of I and HI	Oct 2007				
	4.7.4 To develop a system for analyzing complaints to identify issues emerging for specific populations	Director of HR	Head of Board Administration	Oct 2007				

Strategic Aim 4: To deliver on a set of initial priorities identified for the whole system to mainstream action in tackling inequalities

Objectives	Action	Lead Accountability	Support	Timescale	Legislative Applicability			
					D E D	R E D	G E D	S O
4.8 To develop a mechanism for ensuring that the 3 national clinical priorities i.e. Cancer, Coronary Heart Disease and Mental Health, and the National Sexual Health strategy are prioritised for action across the continuum of care in relation to addressing gender, disability, ethnicity and sexual orientation inequality.	4.8.1 To develop a systematic and detailed programme of activity for Cancer and CHD planning, Mental Health and Sexual Health planning that brings together all the above component parts for effective compliance with equalities legislation. 4.8.2 To deliver the above plan across all identified priorities.	Chief Operating Officer, Acute Division CHCP Directors Director MH Partnership Director CPP	Director of Public Health	Dec 2007 2007-10	✓	✓	✓	✓
4.9 To ensure that all purchased and contracted services comply with the requirements of equality legislation.	4.9.1 To ensure that contractors understand the equality requirements of the contract. 4.9.2 To include performance conditions, where relevant, to ensure compliance with legislation.	Chief Operating Officer, Acute Division	Director of Facilities / Head of Procurement	2007 - ongoing	✓	✓	✓	✓

Strategic Aim 5: To make consultation with patients and communities integral to all our functions, and ensure that information accrued informs the development of corporate and local priorities.

Objectives	Action	Lead Accountability	Support	Timescale	Legislative Applicability			
					D E D	R E D	G E D	S O
5.1 Establish meaningful involvement with communities through the nexus of community engagement structures across the organization to inform the Equality Scheme Action plan and on-going service planning and delivery	5.1.1 Establish baseline of equality population group for each part of the organisation.	All Directors		Oct 2007	✓	✓	✓	✓
	5.1.2 Develop Action Plans to ensure involvement of equalities population groups within each part of the organization utilizing PFPI structures.	All Directors		2007				
	5.1.3 Utilize information from involvement processes to inform and write Action Plans and on-going service planning and delivery	All Directors		2007				
	5.1.4 Develop a process to review the extent to which the service user involvement process has been inclusive of equalities population groups as part of the Annual Review of the Equality Scheme's Action Plan	Director of HR	Director of Corporate Communications	2007				
	5.1.5 Develop a process to capture the learning across all parts of the organization on good models of involving people and disseminate widely.	All Directors	Director of Corporate Communications	2007-10				

Strategic Aim 5: *To make consultation with patients and communities integral to all our functions, and ensure that information accrued informs the development of corporate and local priorities*

Objectives	Action	Lead Accountability	Support	Timescale	Legislative Applicability			
					D E D	R E D	G E D	S O
5.2 Ensure accountability for involving people across NHS GG&C through the Involving People Governance structure	5.2.1 Produce Annual Report of progress on involving people from equalities groups for the Involving People Governance structure	All Directors	Involving People Committee	2007-10	✓	✓	✓	✓

Structure
General Duties

GED	DED	RED
<p>Due regard to:</p> <ul style="list-style-type: none"> Eliminate unlawful discrimination and harassment Promote equality of opportunity between men & women 	<p>Due regard to:</p> <ul style="list-style-type: none"> Eliminate unlawful discrimination (DDA 1995) Promote equality of opportunity between disabled people and non-disabled people Eliminate disability related harassment Take account of disabled people's impairments even where that involves treating disabled people more favourable than non-disabled people Promote positive attitudes towards disabled people Encourage participation by disabled people in public life 	<p>Due regard to the need to:</p> <ul style="list-style-type: none"> Eliminate unlawful racial discrimination Promote equality of opportunity Promote good relations between persons of different racial groups

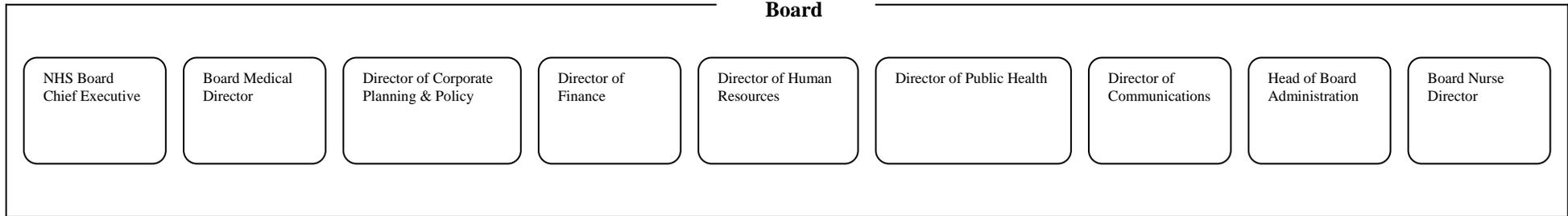
Specific Duties

GED (not confirmed)	DED	RED
<p>Publish a Gender Equality Scheme which contains:</p> <ul style="list-style-type: none"> Details for conducting impact assessments on new policies and services to understand their impact on men & women and mitigate any negative effects Specific gender equality goals and details on how they will be implemented An equal pay policy statement <p>Report on scheme Revise scheme</p>	<p>Publish a Disability Equality Scheme which:</p> <ul style="list-style-type: none"> Sets out the methodology you will use to assess the impact of existing and proposed activities on disabled people Sets out a plan for the actions you will take over the next three years to fulfil the general duty Demonstrates that disabled people have been involved in producing the scheme and developing the action plan <p>Report on Scheme Demonstrate actions taken to implement scheme Revise Scheme every three years</p> <p>Duty on Scottish Ministers to report on progress every 3 years</p>	<p>Publish a Race Equality Scheme setting out:</p> <ul style="list-style-type: none"> Functions and policies that are relevant to the general duty on race Arrangements for assessing and consulting on the likely impact of proposed policies Arrangements for monitoring policies for any adverse impact Arrangements for publishing the results of assessments Arrangements to ensure public have access to information and services provided Arrangements for training staff on the Race Equality Duty <p>Required to monitor employment procedures and practices Schools have a race equality policy</p>

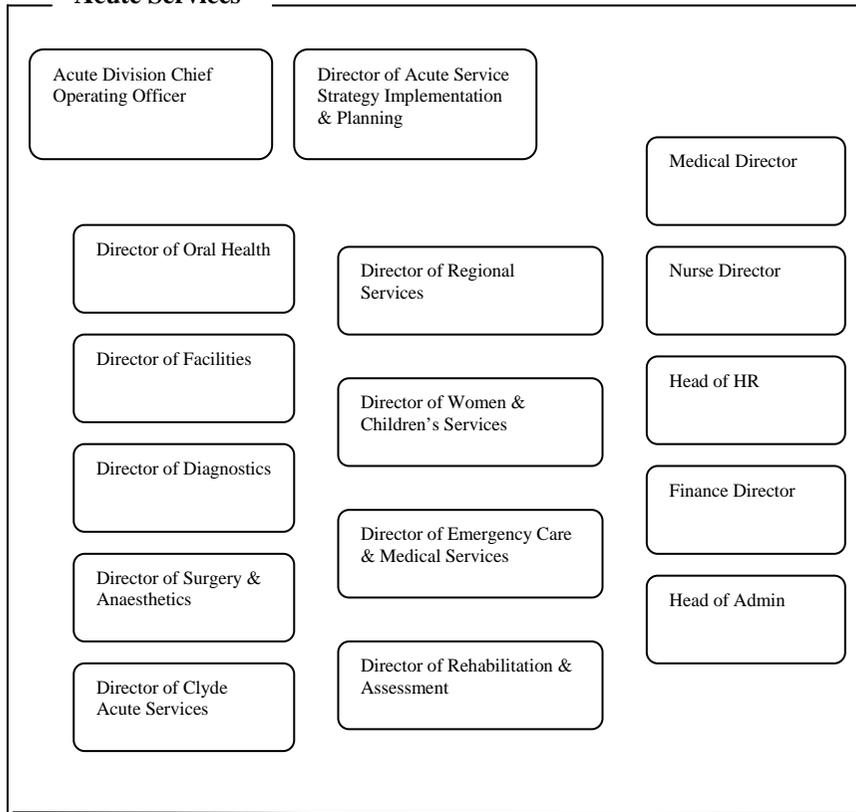
These show that there are clear differences between the duties. Any work done in a "generic" fashion must therefore clearly demonstrate how all the elements of all the duties have been fulfilled.

Appendix 2 – Structure of NHS Greater Glasgow and Clyde

Board



Acute Services

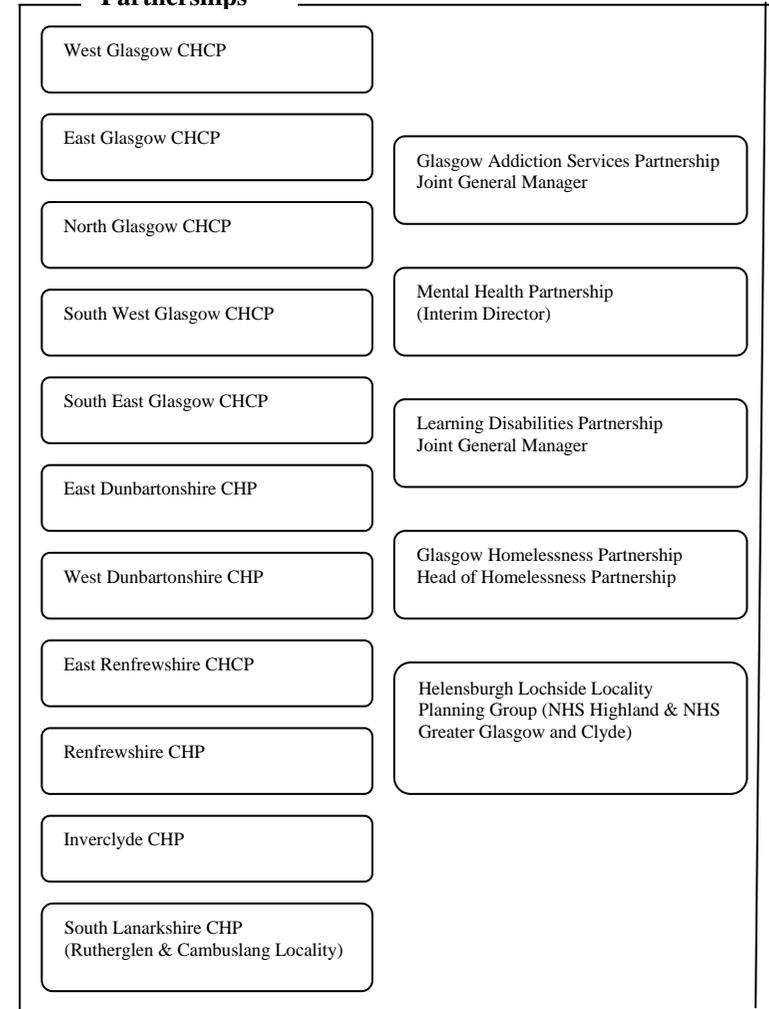


Director of Health Information and Technology

Head of Prescribing & Pharmacy Policy

Head of Clinical Governance

Partnerships



**HEAD OF
INEQUALITIES & HEALTH IMPROVEMENT
(Sue Laughlin)**

