Single Equality Scheme (SES) 2011-2014

For:	Ratification by Trust Board
Summary:	The Single Equality Scheme (SES) replaces the existing equality schemes for Race, Gender and Disability and is extended to cover Religion & Belief, Sexual Orientation and Age. This new scheme and action plan will be used to deliver the Trusts obligations to the Equality Act 2010 and the new Equality General and Specific Duties for public bodies. The SES will be reviewed at least annually and the action plan updated to reflect the needs of the organisation, the community it serves and future changes in equality legislation.
Action:	The Board is asked to: Ratify the Scheme
Presented by:	Yvonne Parker, Director of HR
Author:	Sally Knight, Head of Equality & Diversity
Notes:	

Trust objective:	Please list number and statement this paper relates to.
	Engaging with our community (Patient survey, Communication and PPI strategies) and an effective organisation (develop a motivated, trained & developed workforce)
Legal:	What are the legal considerations and implications linked to this item? Please name relevant act
	Equality Act 2010. Single Equality Scheme replaces the individual equality schemes for Race, Gender and Disability and is extended to cover Religion & Belief, Sexual Orientation and Age
Regulation:	What aspect of regulation applies and what are the outcome implications? This applies to <u>any</u> regulatory body – key regulators include: Care Quality Commission, MHRA, NPSA & Audit Commission
	Equality & Human Rights Commission, Care Quality Commission

Date	24th March 2011
Author	**Sally Knight, Head of Equality & Diversity**
Department	**HR**
Audience	Trust Board Members

Single Equality Scheme

2011 - 2014

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Acknowledgement

This Scheme has been developed in partnership with NHS Surrey and NHS West Sussex and we acknowledge their help and assistance in providing community and population data used in this document.

If you would like this Scheme in another format that would better suit your needs, or in another language, then please contact:

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Foreword

Surrey and Sussex Healthcare NHS Trust (the Trust) is committed to eliminating discrimination, promoting equality and diversity and protecting human rights (ED&HR). These principles are at the heart of the NHS, they underpin the NHS Constitution and all employees have a role to play in achieving them.

The Single Equality Scheme (SES) is the most recent document outlining our commitment to create more accessible services, policies and measures that meet the diverse needs of our population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the equality legislation and promotes equal opportunities for all.

The Scheme includes an Action Plan which sets out how we will move forward to achieve this, how we intend to meet our duties to promote equality and eliminate discrimination relating to the protected characteristics of age, disability including carers, gender, gender identity, marriage and civil partnership, pregnancy or maternity, race, religion or belief or sexual orientation. We want all of our policies and practices to be as inclusive as possible.

Liberating the NHS is a government White Paper published on 12 July 2010, which sets out the government's vision for the NHS to reconfigure to achieve increasing quality of services at a time when we are required to deliver on quality, performance and efficiency savings. Although this presents us with a significant challenge, we are committed to delivering our ED&HR objectives whilst the new system is being implemented. This is therefore designed to be a living document which will be regularly reviewed and updated.

Alan McCarthy   Michael Wilson
Chairman, Trust Board   Chief Executive

1. Introduction

The Trust has a legal responsibility to ensure action on race, disability and gender equality in policy-making and in the delivery of services and employment. The three separate public sector equality duties were similar in spirit and intention. We have a duty to take action to deliver better patient choice, experience and outcomes for people. Our duty is not just to eliminate unlawful discrimination and harassment, but also to actively advance equality, as well as foster good relations between people from different communities. We have published Equality Schemes for race, disability and gender, setting out how we intend to fulfil the three existing duties and providing objectives in our Action Plans. These Action Plans contain priorities for each of the areas which have been captured within the SES Action Plan to ensure that they are retained.

The Equality Act 2010 introduces a single public sector equality duty which requires public authorities to promote equality and eliminate discrimination over a wider range of protected characteristics including age, religion and belief, sexual orientation, gender reassignment, pregnancy and maternity as well as race, sex and disability. This Scheme also sets out the arrangements planned for meeting this wider duty and is a public statement of our commitment to carrying out our work in a way that promotes equality.

The SES was produced following consultation with internal and external partners and stakeholders and outlines our arrangements for:

- identifying which of our policies and services are relevant to our equality commitments
- assessing and consulting on the impact of our policies
- monitoring equality and publishing the results of Equality Impact Assessments
- providing information to staff and the public, and
- training and developing our staff's competencies to deliver on our equality commitments.

The SES will be reviewed and updated regularly by the ED&HR Steering Group.

2. Strategic Aims and Objectives of the Scheme

As a Trust we recognise our legal responsibilities in relation to equality to:

- men and women, including transgender men and women
- disabled people, including people with a learning disability, mental health conditions, sensory or physical impairments
- people in all ethnic groups
- lesbians, gay men, bisexual and heterosexual people
- people of any faith or belief or none
- people of all ages

- the protected characteristics of marriage and civil partnerships, and
- pregnancy and maternity.

We also recognise our responsibilities to reduce health inequalities and to improve the health of the population that we serve.

This Scheme brings together our existing work in relation to race, disability and gender and extends it to include age, sexual orientation, religion and belief. It replaces our Race, Disability and Gender Equality Schemes and provides a single response to our obligations under the new equality duties. We also include the new protected characteristics of gender reassignment, marriage and civil partnership and pregnancy or maternity. However, we recognise the importance of maintaining our commitment to the race, disability and gender equality duties. We have recently reviewed and updated these three schemes and the priorities identified as part of that consultation and review will be incorporated into the SES.

The objectives of the SES are to:

- focus on eliminating discrimination, harassment and victimisation for our staff, patients and other users of hospital services
- advance equality of opportunity for our employees and equality of patient outcomes in service delivery
- foster good relations between people of different groups
- ensure communities, patient and staff and groups are engaged and consulted with in a meaningful way
- improve our data collection and monitoring systems for both service users and staff
- integrate Equality Impact Assessment into all areas of work
- ensure promotion of equality is integrated into service decisions and arrangements including access and communication
- train and develop our staff in ways that will facilitate the achievement of the SES objectives, and
- publish all information in a way which is easy to access and meets the needs of the equality general and specific duties.

3. Duties and Responsibilities

The Trust is committed to fulfil its statutory duties in all of its work. Statutory responsibility for the SES rests with the Chief Executive and the Trust Board. The organisation has given a strong commitment to promoting equality by appointing executive and non-executive director leads for this area of work. The executive lead (Director of Human Resources) provides internal leadership and drive in collaboration with the ED&HR Steering Group members. Each group member acts as an ED&HR champion within their role and challenges and encourages others to support the equality agenda within the functions and directorates of the organisation. The Steering Group meets bi-monthly and specialist advice, support and guidance in implementing the SES is provided by the Equality and Diversity Lead.

4. The Role of Surrey and Sussex Healthcare NHS Trust

Surrey and Sussex Healthcare NHS Trust is a major local employer with a workforce of approximately 3,100, and provides acute and non-acute services to a resident population of 353,000 and thousands more patients from the catchment area.

We provide a comprehensive range of emergency and non-emergency services to the residents of East Surrey, north-east West Sussex, and south Croydon, including the major towns of Crawley, Horsham, Reigate and Redhill. Our proximity to the M25 and M23 motorways and Gatwick Airport means that we also treat many patients from outside the area and from overseas.

We are responsible for East Surrey Hospital in Redhill, where we provide the more acute and complex services. In addition, we reach out into the community to provide a range of outpatient, diagnostic and less complex planned services closer to home. We provide services at Dorking and Caterham Dene Hospitals and Oxted Health Centre in Surrey, and at Crawley, Horsham and Queen Victoria Hospitals in West Sussex, working in partnership with NHS Surrey and NHS West Sussex.

We provide services across the Surrey and West Sussex County Council areas and we work with the district, borough and town councils of Reigate and Banstead, Mole Valley, Tandridge, Crawley, Horsham and East Grinstead. Our services are commissioned mainly by Surrey, West Sussex and Croydon Primary Care Trusts (PCTs).

Services Currently Provided by the Trust:

- **Surgery** - General Surgery and Urology, with Trauma and Orthopaedics, Gynaecology, ENT and Ophthalmology provided principally at East Surrey Hospital.

- **Specialist Maternity Services** and services for children including those for newborn babies with a 20 cot neo-natal unit with capacity for 4 intensive care cots based at East Surrey Hospital. There is a paediatric walk-in centre at Crawley Hospital.

- **General Medicine** - including Care of the Elderly, Cardiology, Diabetes, Gastroenterology, Rheumatology, Dermatology, Genito-Urinary Medicine, Respiratory Medicine, Neurology, Clinical Oncology and Haematology services. Stroke services are at Crawley together with medical rehabilitation.

- The major Accident and Emergency and Trauma Centre is based at East Surrey Hospital, which is supported by an established Acute Assessment Unit. Crawley Hospital provides a 24 hour Walk-In Centre and there is a weekday 9 – 5 Minor Injuries Unit at

Horsham Hospital. The Accident and Emergency Department is a receiving centre in the event of a major incident at Gatwick Airport.

- 10 Intensive Care beds and 6 high dependency beds, operating theatres and dedicated Day Case facilities.

- A range of Diagnostic (X-Ray and Pathology including 24 hour CT scanning), Therapy and clinical and non-clinical support services.

- A full range of community services, community hospitals and clinics are provided jointly with the PCTs.

- Mental health services - there are well established links with the Mental Health Trusts.

The Trust is linked with St George's Hospital and medical schools at St George's, Imperial College and Brighton University.

Consultants have activities at both East Surrey and Crawley Hospitals as well as in the community hospitals.

All junior doctors are based at East Surrey Hospital and some travel to Crawley Hospital for outpatients, theatres and specialist services.

The Vision of Surrey & Sussex Healthcare NHS Trust

The Trust will provide 'Safe, High Quality Healthcare which puts our community first'.

Corporate Trust Strategy

To provide: Safe, High Quality Healthcare which puts our Community First		
Safe, High Quality, Coordinated care	**Engaging with our Community**	**An Effective Organisation**
Safety & Quality	Better Information	Control on Costs with productivity improvements
Engaged Teams	Putting People First	Revitalising our Environment
Patient Experience & Empowerment	Engaging Stakeholders	High Performing
Clinical & Strategic Partnerships	Care closer to home	Accountable
Service Developments: Clinical Strategy, Non-Clinical Services		
TRANSFORMATION PROGRAMME Workforce / Estates / IT / Finance / OD - FT Development		

There are 3 components to our strategy:

1. District General Hospital providing acute and emergency care to our local population

2. To work in an integrated way with our partners and GP consortia

3. To develop a strategic partnership with a larger organisation with an academic and tertiary base.

The Trust will continue to provide a range of emergency and acute services based at the East Surrey Hospital site, as well as at a range of outreach community locations. This includes maternity and neo-natal services.

Services will increasingly be delivered in community settings for both emergency and elective care, in particular emergency assessment units and out-patient services. These services will be reviewed and developed with commissioners to meet the needs of the local population. Where changes are led by the Trust we will ensure appropriate engagement with our staff and patients. Where service development/change is led by commissioners or other providers we will ensure we are appropriately represented in order to contribute to the wider engagement process.

Services will be developed to ensure equitable access to all services delivered by SASH

5. The Population served by the Trust

The population served by the Trust spans the borders of both Surrey and West Sussex. For this reason, general population and community data has been sought from the PCTs in both counties. Where possible, we have included data specific to our given catchment areas.

Health Inequalities in Surrey (extracts from *Surrey Joint Strategic Needs Assessment (JSNA)2009/2010*)

Surrey is the most urbanised shire in England with an estimated population of 1,098,300 in mid 2007 and has a range of health and social care needs.

Surrey is the third least deprived local authority area in England and Wales (IMD 2007). People tend to live healthier lifestyles and live longer than average across the county. Although the population is generally affluent, there are significant inequalities in health and inequality in access to health and illness services. The populations with greatest need are in relatively small pockets across the county, often close to populations of significant wealth which further emphasises the inequalities gap.

The respective population estimates for districts in Surrey served by the Trust are:

District	Population estimate – mid year 2009

Mole Valley	83,800
Reigate and Banstead	136,100
Tandridge	82,200

(Source: Population Estimates Unit, ONS)

Within the population served by the Trust, one area where people experience poorer health outcomes is in Merstham in Reigate. For example:

- Older people who live or are born to parents in Merstham ward have significantly lower life expectancy than other people nationally and locally within Reigate and Banstead Borough.

- 46% more people from Merstham's ward die earlier than would be expected given the age and gender profile of this population.

- Clinical activity data suggests that the main health conditions of concern for the people in Merstham are cancer, coronary heart disease, stroke and ischemic attacks, diabetes, asthma and mental ill health. These conditions are significantly influenced by lifestyle choices detrimental to health, such as smoking, obesity and high intake of alcohol.

Health Inequalities in West Sussex (*extracts from West Sussex Joint Strategic Needs Assessment (JSNA)*).

Overall, people in West Sussex have a long life expectancy and enjoy good health, but this masks the considerable differences within the county. Differences in life expectancy are higher in West Sussex than in other parts of the South East Coast Strategic Health Authority (SHA) region.

The respective population estimates for Crawley and Horsham are:

District	Population estimate – mid year 2011
Crawley	102,700
Horsham	131,700

Source: West Sussex County Council

Local Neighbourhood Improvement Areas (LNIAs) are determined by ranking areas of the country according to their relative order of deprivation. Within the Trust's catchment area of West Sussex, the Crawley wards of Bewbush, Broadfield North and South and Langley Green have been identified as LNIAs.

Age in Surrey

In Surrey, 43% of the adult population (16+) is aged over 50 and this group represents over a third of the total population of the county. It includes people with very different needs and aspirations, including people who are working, those approaching or in retirement, people who take an active part in their communities, as well as vulnerable people who may need support. Surrey's population is projected to rise steadily over the next 25 years. In line with national trends, the county's older population will increase much more rapidly. The number of over 85s is projected to increase by 92% by 2030, (from 28,500 in 2009 to 54,900 in 2030) with a 67% increase in the 80 - 84 age group (27,800 to 46,500).

An ageing population has implications for service provision in Surrey, particularly on healthcare services for older people. Average life expectancy at birth in Surrey is 79.8 years for men and 83.3 years for women. There is a gap of more than 10 years between the wards with the highest and lowest life expectancy. Surrey has a comparable number of pensioners living alone (14%) to the South East and to England. However, there are single pensioner households in Surrey with no access to central heating.

Age in West Sussex (for a more detailed report -
http://www.westsussex.nhs.uk/domains/westsussex.nhs.uk/local/media/publications/about_us/Publications/NHSWS_DPH_report_0910.pdf

The county of West Sussex has an older population than the national average and the population is not evenly distributed across age bands, with more people aged 60 - 64 and aged 40 - 44 years and a notably lower proportion of 20 - 39 year olds. This means that if those people remain in West Sussex as they get older, a significant number of people will be entering the older age group of 65 years and over during the next 20 years. After age 64, the number of people in each age band gradually decreases, although still remains higher than the average for England. Eleven per cent of the population in West Sussex is aged 75 years or over – this compares to 8% in England overall.

The chart below shows the projected change in age groups in West Sussex, between 2011 and 2026.

Projected Population (All Persons) 2011 to 2026
(Source: West Sussex County Council)
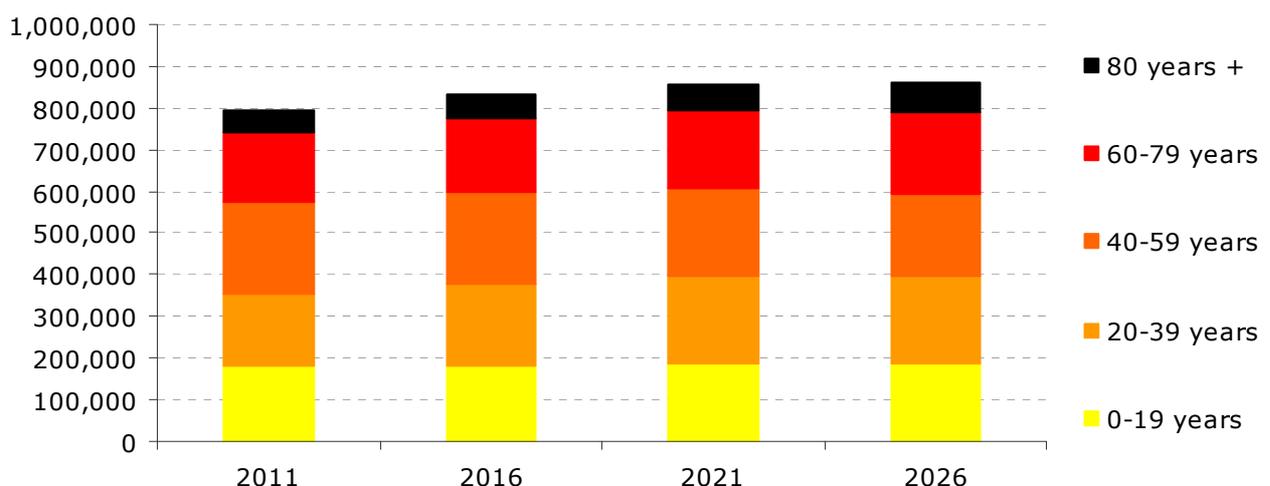
All areas of West Sussex are projected to have increasing numbers of older people. The table below details the projected change in older age groups for the district council areas of Crawley and Horsham between 2011 and 2026. Both areas are within the catchment population served by our Trust and show considerable projected increasing numbers of older people in the population.

Projected Population Change (Older Age Groups)
(Source: West Sussex County Council)

	Age Group	2011	2026	% increase
Crawley	65+	14,600	21,500	47.3%
	85+	2,400	3,200	33.3%
Horsham	65+	24,800	35,600	43.5%
	85+	3,600	5,800	61.1%

An ageing population means that age dependency ratios are increasing and there will be fewer people of working age. A healthy workforce with reduced rates of sickness absence is, and will become, increasingly important.

As the population ages, there will be increasing numbers of people with long-term conditions and disabilities, including dementia, physical, mobility and sensory impairments and general problems with carrying out daily activities. Increasing numbers of older people recognise their role as unpaid carers.

Mental and emotional health and well-being in older age is a priority. The South East Health Strategy (2008) highlighted that the South East has the second highest hospital admission rate for depression among women aged 65 and over in the country and that nationally depression amongst older people is under–diagnosed.

Carers

"Carers look after family; partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid."

This includes adults looking after other adults, parent carers looking after disabled children and young carers under 18 years of age who care for a family member.

Carers in Surrey

In Surrey there are about 100,000 carers; 21,538 carers were identified in the 2001 Census as providing over 20 hours care a week. Of these, 14,119 were

providing 50 hours a week or more. There were 56,211 carers who reported having to juggle work and caring responsibilities, 56.7% of the total number of carers.

Carers in Surrey save the nation an estimated £1.17 billion a year (University of Leeds, 2007). At present over 5,500 carers get some form of break. Five percent of these carers are from a Black or Minority Ethnic (BME) background.

Carers in West Sussex

The 2001 Census collected, for the first time, information relating to the provision of unpaid care. The table below shows the results for West Sussex and comparisons with the South East and England. Approximately 10% of the population stated that they were carers, which was in line with national findings. The specific data for Crawley and Horsham is highlighted.

Area	All People Providing Unpaid Care	% of People Providing Unpaid Care	Hours per week (as % of all people)		
			1–19	20-49	50+
Adur	6,169	10.3	7.4	1.0	2.0
Arun	14,787	10.5	7.4	0.9	2.2
Chichester	10,728	10.1	7.6	0.8	1.6
Crawley	8,846	8.9	6.3	0.9	1.7
Horsham	11,641	9.5	7.5	0.7	1.3
Mid Sussex	12,116	9.5	7.6	0.7	1.3
Worthing	9,524	9.8	7.0	0.9	1.9
West Sussex	**73,811**	**9.8**	**7.3**	**0.8**	**1.7**
South East	737,751	9.2	6.8	0.8	1.6
England	4,877,060	9.9	6.8	1.1	2.0

(Source: 2001 Census)

When asking people to define their own health, people providing care (notably those providing 20 or more hours a week of unpaid care), report poorer health. West Sussex has over 8,500 carers based in areas classified as "villages and isolated dwellings".

Young Carers

In relation to young carers, using a prevalence assumption of 2% of 5 – 17 year olds, it is estimated that there approximately 2,400 young carers in West Sussex.

From 1 October 2010, the Equality Act will prohibit discrimination against carers. Work has been undertaken with carers' organisations to consider how best to include carers in the SES.

Disability

There is no single data source which describes or quantifies the number of people who are considered (or who describe themselves) as 'disabled'. Measuring disability within a population is difficult because:

- perception, including self-perception, varies. Two people may have identical conditions, with one considering themselves to be disabled, the other not
- conditions and illnesses themselves can fluctuate, so "disability status" over time is not necessarily set, and
- surveying for estimates itself is problematic. Surveying methods have varying levels of accessibility so can underestimate some disabilities.

Disability in Surrey

The Disability Rights Commission estimates that 17% of the population have a disability; equating to 182,835 people in Surrey, based on the total population figures from the 2001 Census. It is often the case that people will have more than one disability: 14% of people registered with Surrey Adult Link Disability Registers (SALDR) have more than one disability.

There are an estimated 222,000 people with common mental health problems in Surrey (based on national prevalence from Office of Population, censuses and surveys applied to NHS Surrey registered population). Mental ill health accounts for over a third of all illness in Britain and 40% of all disability. Up to one in four consultations with a GP concerns mental health problems. It is estimated that 4.5% of the national population are blind or partially sighted, but this rises to 20% of the population aged 75 plus (based on Visual Impairment and Disability in Great Britain 1996/7 survey of disability). There are approximately 6,000 people with visual impairment on Surrey Association for Visual Impairment's database, approximately 4,500 of whom are registered as:

- severely sight impaired
- blind and sight impaired
- partially sighted.

The majority of the users of this service are over 65 years.

It is estimated that nearly one in five adults in Surrey is obese and is therefore significantly more likely to experience chronic illness early in life and be unable to contribute towards the economy. Obesity reduces life expectancy by as much as nine years.

Learning Disabilities

We do not know exactly how many people with learning disabilities are living in England and Wales. Recent estimates (2008) suggest that 985,000 people in England have a learning disability (2% of the general population) including 828,000 people aged 18 or over.

Nationally, the number of people with a learning disability is growing due in part to greater life expectancy. Emerson & Hatton, C; have estimated that there will be a growth in the number of people with a learning disability within the general population of 5-6% in the next decade (Estimating Future Need / Demand for Supports for Adults with Learning Disabilities in England, Lancaster University, 2004).

Within Surrey, the catchment areas around Redhill and Reigate have the highest percentage of people with learning disabilities in Europe and are therefore a high priority user group for the Trust. Historically there were a number of mental health institutions within the area which have evolved into the current community care settings. The Trust has employed a specialist nurse for Learning Disability and we use people with learning disabilities in the training of managers and provide work experience placement for young adults with a learning disability.

Disability in West Sussex

There are increasing numbers of people in West Sussex living longer with disabilities, learning difficulties and limiting long-term illness. According to the 2001 Census, 15.8% of the population of West Sussex had a limiting long-term illness, which is lower in all age groups than either the regional or the national figures.

Given the nature of the question, it is not surprising that the percentage of people with a limiting long-term illness increases with age, so that in the 0 - 4 years age group, 2.6% had a limiting long-term illness, compared with over 70% in the 90+ years age group. Therefore, as the population ages, there will be increasing numbers of people with long-term conditions and disabilities, including dementia, physical, mobility and sensory impairments and general problems with carrying out daily activities

Mental and emotional health and well-being in older age is a priority. The South East Health Strategy (2008) highlighted that the South East has the second highest hospital admission rate for depression among women aged 65 and over in the country and that nationally depression amongst older people is under–diagnosed.

Learning Disabilities

From both national models (Institute of Public Care, 2004) and a local mapping exercise, the number of adults in West Sussex with a *moderate* to *severe* learning disability is estimated to be 2,925 with 420 of these aged 65 and over. This is broadly in line with the national model.

Gender and Life Expectancy in Surrey

In 2007, the mid-year population estimates showed that Surrey has a male population of 535,700 and a female population of 562,500. Life expectancy at birth is 79.8 years for men and 83.3 years for women compared to that for England, which is 77.6 and 81.8 respectively. Circulatory disease and

cancers are the main causes of death, in line with national trends. The most common causes of death by cancers in males in Surrey are lung cancer, prostrate cancer and colorectal cancer. The most common cancers in females in Surrey are breast cancer, lung cancer and colorectal cancer.

The Standard Mortality Rate (SMR) of bronchitis and emphysema in men at all ages is 50. However, in the under 75 year age group the SMR is 54 which highlights the importance of stop smoking services for younger men.

The number of domestic abuse incidents reported to Surrey Police between April 2008 and March 2009 was 10,779. Thirty one percent of these were noted repeat victims. The majority of domestic abuse victims are female (90% in 2008/2009). East Surrey had a higher rate of male contacts (11.3%) compared with the rest of the providers.

Gender and Life Expectancy in West Sussex

In 2008, the population of West Sussex was estimated to be 781,500, comprising 377,400 males and 404,100 female (Office of National Statistics (ONS) mid-year 2008 population estimates).
There were an estimated 182,200 0 - 19 year olds (of which 43,500 were 0 - 4 years old) and 159,300 people were estimated to be aged 65 or over (with 8,500 of these being aged 85 years or over). Given the long life expectancy for females, there are many more older (65+) women than men, with 91,400 older women compared to 68,000 men.

Although overall mortality statistics show the main causes of all deaths, a clearer understanding or premature mortality (using Years of Potential Life Lost (YPLL) as a measure) shows that:

For women, breast cancer is the biggest cause of premature mortality in West Sussex, as it is nationally, although there are considerable differences between West Sussex and England in the other main causes of premature mortality, with accidents, suicides and colorectal cancer accounting for more premature deaths in women in West Sussex compared to national figures.

For men, Coronary Heart Disease (CHD) is the biggest cause of premature mortality in West Sussex (as it is nationally), and the main causes of premature death broadly reflect the national picture, although accidents, undetermined injury and suicide again have a greater impact on premature deaths in West Sussex compared with England as a whole.

Ethnicity in Surrey

Although Surrey has low levels of ethnic minorities overall, this varies between local authorities. Some local authorities show similar or higher levels of ethnic groups than England. This provides a challenge to ensure that the health needs of these small communities and individuals are appropriately met. It is essential to work across partner organisations to ensure a good understanding of the varying needs that this diversity brings.

- White British make up the largest percentage of the resident population in Surrey (84.4%). Elmbridge has the lowest percentage (78.6%) and Waverley the highest (88.9%).

- The proportion of all Surrey residents who described themselves as White was 92.1% in 2006, 93% in 2004, 95% in 2001 and 97% in 1991. This proportion is slightly lower compared with the South East, but greater than for England as a whole where 88.2% described themselves as White.

- Mole Valley and Waverley each had just over 94% of their population who considered themselves White (94.1% and 94.2%).

- Other White is the second largest ethnic group in Surrey (White British is the largest). The largest ethnic minority group in Surrey is Indian at 1.5% of the population. The overall estimate of the BME population in Surrey is in the region of 15.6% according to the experimental statistics taken (Mid 2007 UK National statistics website).

Ethnicity in West Sussex

http://www.westsussex.nhs.uk/domains/westsussex.nhs.uk/local/media/publications/about_us/Publications/NHSWS_DPH_report_0910.pdf

In 2007 the ONS estimated that over 94% of the West Sussex population aged over 60 years were classified as White British. White Irish and White Other were the next two largest groups. Of the non-White ethnic groups living in West Sussex, almost 40% live in Crawley, which has the smallest proportion of older people in the county.

According to the 2001 Census, Crawley had the highest percentage of people of BME origin in West Sussex (15.5%). Since 2001 the percentage of people of BME origin is estimated to have increased and the ethnic mix in that area is changing, as it is across the county. The ONS has produced (2007) experimental estimates of ethnic group populations. For West Sussex, estimates of the proportion of population born outside the UK show an increase from 7% in 2004 to 10% in 2007. The estimates show an increase of 4.5% in the BME population of Crawley. However, the estimated BME population for Horsham of 9.6% is below the average for both the South East and England as a whole.

Estimated Percentage BME Population in West Sussex
(Source: ONS 2007 estimates)

	All Groups	% White British	% BME
Adur	60,600	91.6	8.4
Arun	146,400	92.8	7.2
Chichester	109,400	92.4	7.6
Crawley	100,100	81.0	19.0

Horsham	129,900	90.4	9.6
Mid Sussex	130,300	89.4	10.6
Worthing	99,600	90.5	9.5
West Sussex	776,300	89.9	10.1
SOUTH EAST	8,308,700	87.2	12.8
ENGLAND	51,092,000	83.6	16.4

Gypsies and Travellers

Research has shown that Gypsies and Travellers have possibly the worst health outcomes of any ethnic group in the UK. They have significantly lower life expectancy than the general population and higher rates of miscarriage, stillbirth and infant deaths. Gypsy and Traveller women are twenty times more likely than the rest of the population to have experienced the death of a child.

The largest study of Gypsy and Traveller health in England found that the most marked inequalities, compared with the general population and with other ethnic minorities, were for respiratory problems including asthma and bronchitis, chest pain and anxiety. Gypsies and Travellers are more likely to have a long-term condition, health problem or disability than the general population.

Gypsies and Travellers in Surrey

Surrey has the fourth largest Gypsy and Traveller population in England based on the Office of the Deputy Prime Minister's caravan count statistics. Anecdotal evidence suggests that Travellers are Surrey's largest ethnic minority group and described by the Joint Parliamentary Human Rights Committee as the hardest to reach. A study was undertaken in 2005, *Surrey Change Up Additional Support Programme – Gypsy and Travellers Research*[1]*by Jake Bowers,* which attempted to estimate the numbers of Travellers in Surrey. The estimate quoted suggests at least 10,000 live in Surrey either in caravans or housed. The research found that they are the most socially excluded group in the UK. They experience prejudice and discrimination from local people and occasionally from providers of local services. Many places of residence for Travellers (sites) are built in very unhealthy environments such as next to motorways and busy roads, on former refuse sites or areas that flood, which have an impact on health.

Gypsies and Travellers in West Sussex

http://www.westsussex.nhs.uk/domains/westsussex.nhs.uk/local/media/publications/Health-professionals/Gypsies___Travellers_Exec_Summary_Final_Oct10.pdf

There are, as a broad estimate, between 3,000 and 3,500 Gypsies and Travellers living in West Sussex in 2010. The figure includes people living on authorised local authority and private sites, on unauthorised sites and developments and in settled/bricks and mortar housing. This represents about 0.4% of the West Sussex population and compares with estimates of around 2,300 people of Bangladeshi origin and 3,500 people of Chinese origin in West Sussex. It also compares with latest government estimates of around 368,000 Gypsies and Travellers across the UK.

Gypsies and Travellers live right across West Sussex at 11 well-established local authority-run sites, at 82 pitches, at private authorised sites concentrated in Chichester, Horsham and Mid Sussex and on unauthorised sites and developments concentrated in Horsham, Arun, Chichester and Mid Sussex.

A high proportion of Gypsies and Travellers have very poor levels of literacy, and Gypsy and Traveller children have been found to have the lowest educational attainment of any minority ethnic group in England.

Religion and Belief in Surrey

The following statistics on religion and belief in Surrey are based on the 2001 Census:

- 74.6% of Surrey's population, around 789,609, said that their religion was Christianity

- the proportion of people in Surrey who said they had no religion was 15.2%

- the religion question on the census form was not compulsory and 7.1% of the population did not answer

- the above numbers are similar to the South East and England as a whole

- the greatest number of people belonging to another religion in Surrey was Islam, 14,190 (1% of the population). Woking has the greatest number of Muslims in Surrey (4,550 = 5% of the Woking population)

- the highest number of people (936) of the Jewish faith in Surrey live in Elmbridge

- Epsom and Ewell has 1,236 Hindu residents out of a total of 7,458 across Surrey, which also has 3,362 Buddhists that reside across the county

- the 2010 British Social Attitudes national survey shows about 50% Christian, 43% having no religion and 3% Muslim (1% in 1983).

Religion and Belief in West Sussex

Religion

There is little robust or consistent data collected outside of the census and the question relating to religion in the 2001 Census was a voluntary question. In West Sussex, 561,100 people stated their religion as Christian, 117,600 said they had no religion and 55,400 did not state a religion. Of the remainder, the data is shown below.

(Source: 2001 Census)
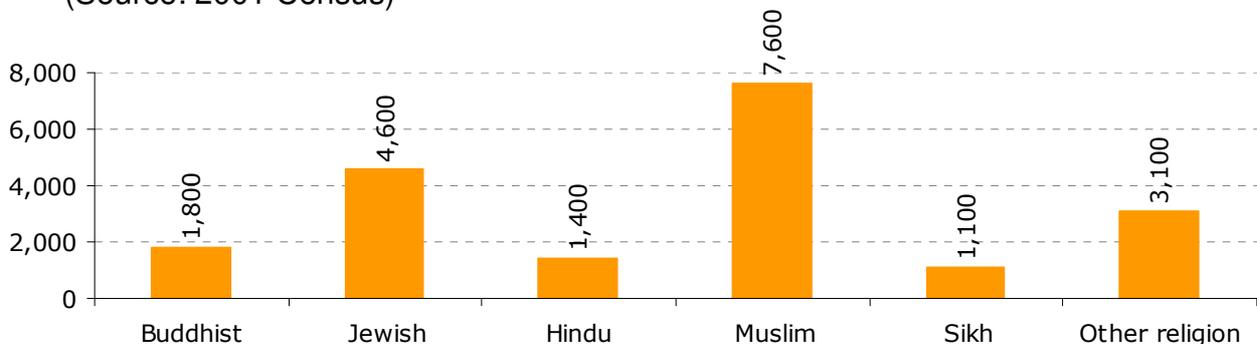
Lesbian, Gay and Bisexual People

Whilst there are many community groups and organisations that work with the Lesbian, Gay and Bisexual (LGB) population in Surrey, key information on the number of people identifying as lesbian, gay or bisexual, is not available. The National Census did not ask any questions regarding sexual orientation in 2001, and the government has confirmed that it will not be asking any questions in the 2011 Census. This presents a clear challenge when attempting to determine the size of the LGB community in Surrey. For the purposes of this Scheme, the following methodology has been applied.

There has been a long-held assumption that one in 10 people are LGB, whilst the Department for Trade and Industry recently announced the culmination of a 15 year programme of research that gave the figure as being one in 16. To establish a 'best guess' at a baseline figure, a figure of 1 in 12 will be used to take into account variances in self-identification of those who are LGB. It is expected that this will be at best a slight overestimation or at worst an underestimation as to the true number. The estimated LGB population in Surrey is approximately:

Area   **Population (2001)**   **LGB Population (est)***

Surrey	1,059,015	88,251
Elmbridge	121,936	10,161
Epsom and Ewell	67,059	5,588
Guildford	129,701	10,808
Mole Valley	80,287	6,690
Reigate and Banstead	126,523	10,543
Runnymede	78,033	6,502
Spelthorne	90,390	7,532
Surrey Heath	80,314	6,692
Tandridge	79,267	6,605
Waverley	115,665	9,638
Woking	89,840	7,486

Surrey Research conducted by the University of Southampton (Count Me In: Findings from the lesbian, gay, bisexual and transgender community needs assessment 2000) showed that among LGB youth under the age of 24:

• 53% had thought seriously about suicide, and

• 19% had been prescribed medication for depression in the preceding 12 months.

Across all age groups:

• 41% had had thoughts of suicide

• 18% had attempted suicide

• 18% had had thoughts of self-harm, and

• 10% had self-harmed.

In 2008, Gay Surrey published its findings from a year-long Lifestyle Survey hosted on its website. Of specific interest to LGB Youth and Mental Health are the following statistics:

• To the question 'Have you ever self-harmed?' 22% of respondents said yes

• To the question 'Have you ever attempted suicide?' 23% said yes

• To the question 'Has any member(s) of your family disowned you due to your sexuality?' 12% said yes.

Sexual Orientation data for West Sussex has not been published by the PCT

Transgender People

Gender-variant people are present in healthcare services, both as employees and as service users.

Gender experiences and expressions vary widely and only a small number of these individuals make permanent changes to their gender status. Those who have significant discomfort with their gender role and perhaps also with their bodies, are said to experience gender dysphoria. In its extreme form, where this leads to a permanent change in gender status (gender reassignment), this is called transsexualism and those experiencing it may be called transsexual people. Some prefer the broader umbrella terms, transgender or trans.

The number of people approaching medical services for assistance in dealing with their gender discomfort is doubling every five years. However, in relation to other minority groups, numbers are still small. An overall prevalence of 20 per 100,000 has been estimated from government sources. The number is prone to regional variation. It is estimated that for every trans person who has sought medical care, another 50 are either completely 'closeted' or are expressing their gender variance partially, intermittently or not at all. A small number of these individuals will ultimately transition their gender role. The tendency to live in stealth, sometimes for many years, has kept the average age of transition at around 40. The ratio of trans women to trans men - historically 4:1 in the UK - is narrowing and Gender Identity Clinics are reporting that the two groups are close to parity.

On average, each GP consortium can expect 50 trans service users, and an annual rate of 8 new patients.

Trans people frequently suffer transphobia, that is, prejudice and misunderstanding, which leads to difficulties in the workplace as well as problems in accessing treatment. Most trans adults report that, as young people and through their adult lives, they experienced significant levels of bullying, harassment and discrimination, even from their teachers. The great majority of transphobic crimes are not reported to the police.

Organisations providing public services are bound, under the Equality Act 2010, to have due regard to the needs of those who have the 'protected characteristic' of 'gender reassignment'. This protection dates from the moment that trans people tell someone else that they 'propose to undergo' reassignment. Regardless of the law, organisations should take pre-emptive steps to embed good practice in relation to trans employees and service users.
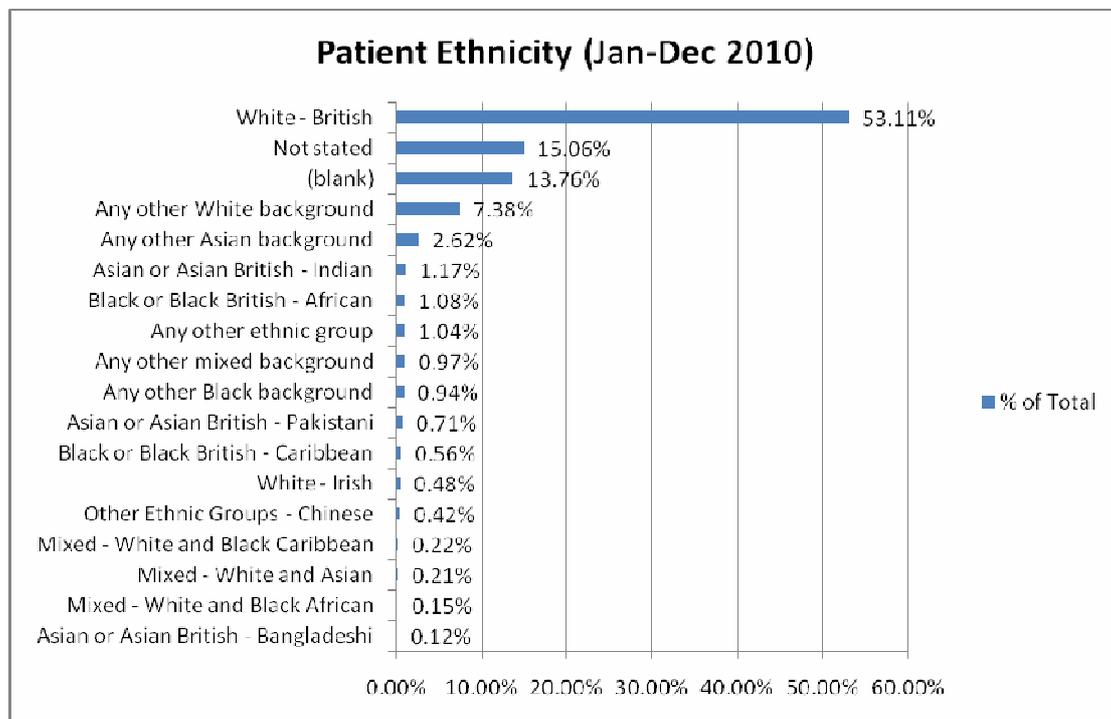
6.   The People who use our Services

Patient data is collected every time a patient has contact with the Trust including: Inpatient, Outpatient, Emergency and other services. The data is analysed for ethnicity, gender and age. Patients are asked for their personal

data however some will decline to provide the information and this will be entered as "not stated" or "blank".
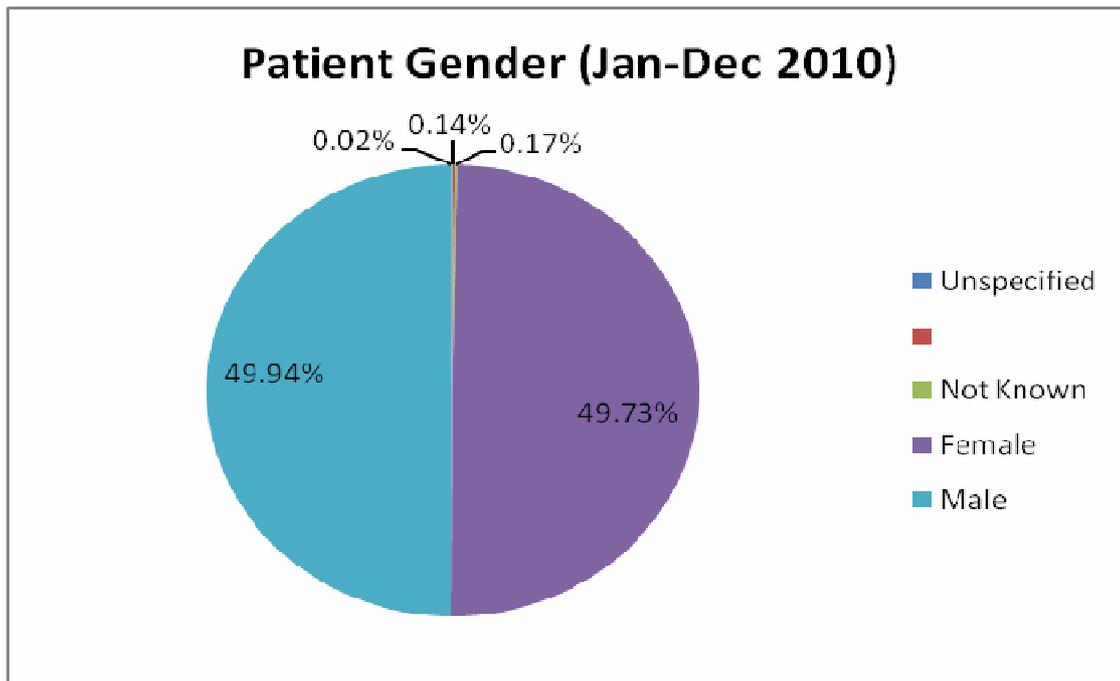
Patient Ethnicity

An analysis of trust data for the ethnicity of patients during the period 1 January – 31 December 2010 indicated that White- British patients at 53.11% were the largest sub-group of patients. This is under representative of the White British population of Surrey and West Sussex. However if the data is combined with the "not stated" or "blank" then a figure of approximately 82% is obtained. The combine figure for the remaining categories is approximately 18% and inline with the published population data for Surrey and West Sussex.

It is important that the Trust reduces the percentage of patients in the "not stated" or "blank" categories to allow more accurate indications of who is and who isn't accessing our services.

Patient Ethnicity (Jan-Dec 2010)

Ethnicity	% of Total
White - British	53.11%
Not stated	15.06%
(blank)	13.76%
Any other White background	7.38%
Any other Asian background	2.62%
Asian or Asian British - Indian	1.17%
Black or Black British - African	1.08%
Any other ethnic group	1.04%
Any other mixed background	0.97%
Any other Black background	0.94%
Asian or Asian British - Pakistani	0.71%
Black or Black British - Caribbean	0.56%
White - Irish	0.48%
Other Ethnic Groups - Chinese	0.42%
Mixed - White and Black Caribbean	0.22%
Mixed - White and Asian	0.21%
Mixed - White and Black African	0.15%
Asian or Asian British - Bangladeshi	0.12%

Patient Gender
The patient population served by the Trust was almost evenly divided between female and male patients at 49.94% and 49.7% respectively. The slight female bias may be due to the number of mothers using our maternity services. However this bias is also seen in the general population of Surrey (females = 51.2%) and West Sussex (females =51.7%) and also reflects the increased life expectancy of females over men.
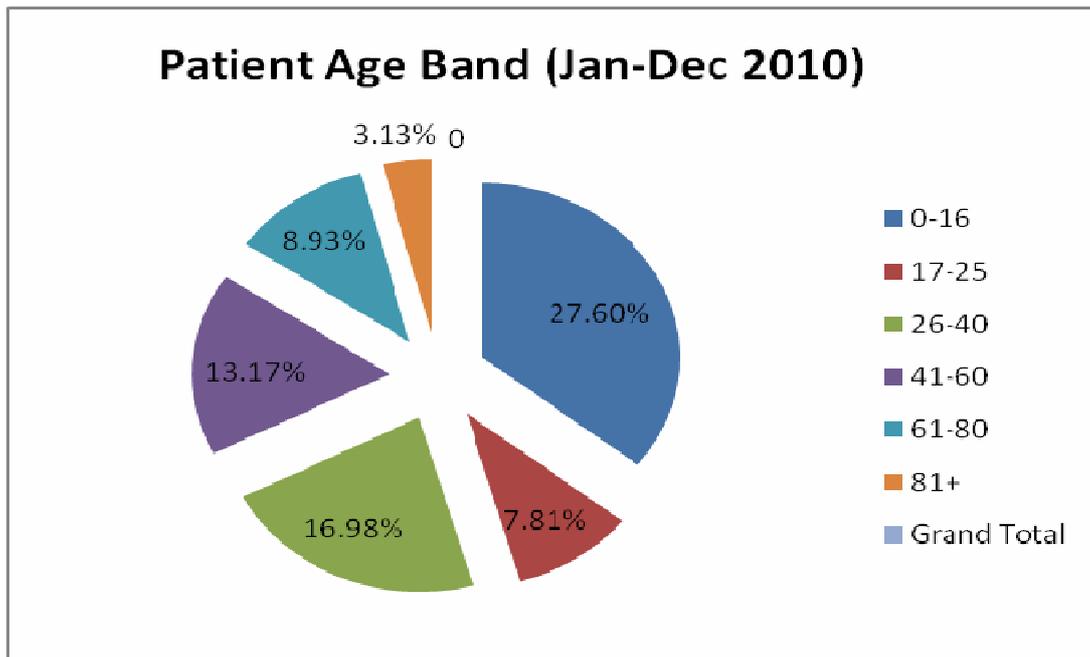
Patient Gender (Jan-Dec 2010)

0.02% 0.14% 0.17%

49.94%   49.73%

Legend:
- Unspecified
-
- Not Known
- Female
- Male

Patient Age

The highest level of patient contacts with the Trust in 2010 belonged to the 0 -16 years age group at 27.6% (this is probably due to the number of babies born in the Trust and may not indicate a disproportionate use of the services by this age group).

On average about 25.2% of patients were aged over 41, which was under representative to the large population of adults over 41 years in the Trust's catchment area. (Surrey :43% of population is over 50)

For the older age groups there were approximately 12% of 61 years and above using our services which is also under representative of the population data (West Sussex: 20% of population is over 61)

Direct comparison of the Trust data with population data for Surrey and West Sussex shows inconsistencies and more analysis on consistant and robut data is required. This will help with service planning for example, for care of the elderly and end of life care.

Patient Age Band (Jan-Dec 2010)

Pie chart showing Patient Age Band percentages:
- 0-16: 27.60%
- 17-25: 7.81%
- 26-40: 16.98%
- 41-60: 13.17%
- 61-80: 8.93%
- 81+: 3.13%

Reliable data on religion, disability and sexual orientation is not currently available as patients are reluctant to provide such information.

7.   Workforce

To deliver effective services to our community we need to have a workforce that reflects the community population and can respond effectively to its diverse needs. Our current staff profile (December 2010) is:

Gender:

- 78.7% women compared to 21.3 % men.

Age:

- 9.2 % aged under 25

- 22.5 % aged 26 - 35

- 27.5 % aged 36 - 45

- 25.5 % aged 46 - 55

- 14.9 % aged 56 - 65 and

- 0.4 % aged over 65.

Ethnicity:

- 62.2% are White British

- 3.1% are White Irish

- 9.0% are White Other

- 24.6 % are from minority ethnic backgrounds and

- 1.1 % are Not Stated.

We collect, analyse and report our workforce data by ethnicity, gender and age. Extending this to include more robust data on disability, sexual orientation or religion or belief is to be implemented as part of the SES Action Plan. This data will be reported annually in the Equality, Diversity and Human Rights Annual Report.

Across the Trust, very high numbers of women are employed. This is due partly to the traditional aspects of women's employment in health and social services and partly to the opportunities for flexible and part-time working that women continue to access at higher levels than men.

Additionally we have a relatively high level of BME representation in relation to the local community, although we are aware that these patterns are typical in health service organisations across the country.

The majority of the workforce are aged between 26 – 65 with the largest percentage population 27.5 % aged 36-45; The age bands with the lowest numbers of staff are the under 20s and the over 65s.

Staff Networks

The Black and Minority Ethnic (BME) Staff Network was launched in September 2008. It is open to all BME staff (and any other staff who wish to support it in driving forward race equality).

The Trust is committed to making sure that the network is effective and this includes strong support from the Chief Executive. Managers are encouraged to facilitate and enable BME colleagues to attend meetings. They are also expected to be aware of and understand the network's activities, use the network as a reference group to learn more about diverse cultures, race equality, promote culturally-sensitive practices at local level and to assess the impact of policies and strategies with regard to ED&HR.

The development of a Trust Lesbian, Gay, Bisexual and Trans (LGBT) group is part of the SES Action Plan. We will also investigate if there is a need for a disability support group.

Staff are also supported by a network of Listening Ears, a Trust mediation service and a free Employee Assistance programme from Counselling in Companies (CIC). All support is confidential and open to all staff.

8. Meeting the Duty

The Trust has a number of legal duties in relation to equality which are summarised in Appendix A. These place a duty on public sector organisations to promote equality of opportunity and eliminate discrimination for service users and staff which aim to ensure that equality is integrated and diversity is seen as a benefit to everyone.

The first public sector duty relating to race equality was introduced in the Race Relations (Amendment) Act in 2000 which came into force in May 2002. This was followed by the Disability Equality Duty in December 2006 and the Gender Equality Duty in April 2007. The Human Rights Act has been in place since 1998.

The Equality Act 2010 extends the existing legislation and strengthens the equality law by placing a new equality duty on public bodies to promote equality of opportunity and eliminate discrimination relating to the new protected characteristics mentioned previously. The Act will be implemented in stages over a period of time and therefore this section will be updated in line with the publication of the specific codes of practice and guidance. The Act signifies a shift in thinking regarding equality and diversity legislation as it had previously been based on preventing discrimination and although this is still key, the Act highlights the move towards positive duties. It reinforces the duty on public bodies to promote good community relations, engagement and transparency of decision-making.

The new general duty has three aims; it requires public bodies to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people from different groups, and
- foster good relations between people from different groups.

Having *due regard* means consciously thinking about the three aims of the general duty as part of the process of decision-making. This means that consideration of equality issues must influence the decisions reached by public bodies – in how they act as employers, how they develop, evaluate and review policy, how they design, deliver and evaluate services and how they commission and procure from others.

Having *due regard* to the need to advance equality of opportunity involves considering the need to:

- remove or minimise disadvantages suffered by people due to their protected characteristics
- meet the needs of people with protected characteristics, and
- encourage people with protected characteristics to participate in public life or in other activities where their participation is low.

Fostering good relations involves tackling prejudice and promoting understanding between people from different groups.

Complying with the general duty may involve treating some people better than others, as far as this is allowed by discrimination law. For example, it may involve making use of an exception or the positive action provisions in order to provide a service in a way which is appropriate for a particular group.

The general duty also explicitly recognises that disabled people's needs are different from those of non-disabled people. In considering meeting the needs of disabled people, public bodies should therefore take account of their disabilities. This might mean making reasonable adjustments for them or treating them better than other people.

The general duty is underpinned by a number of specific duties which provide a framework to help public bodies meet the general duty. Most public bodies subject to the general duty are also subject to the specific duties. The specific duties require public bodies to set specific, measurable equality objectives and to publish information about their performance on equality, so that the public can hold them to account. All information must be published in a way which makes it easy for people to access it.

Information showing that they have complied with the general duty

Public bodies covered by the specific duties must publish sufficient information to show that they have considered the three aims of the general duty across their functions. Public bodies other than schools must publish this information by 31 July 2011. Subsequent information must be published at least annually. The information published must include information on the effect that the public body's policies and practices have on equality for service users, and (for those with 150 or more staff) on equality for their employees. Public bodies with 150 or more staff will be expected to publish information on significant and long-standing inequalities such as the gender pay gap and the proportion and distribution of disabled employees and staff from ethnic minority communities.

Evidence of equality analysis undertaken

To comply with the general duty, public bodies need to understand how their policies and practices will affect equality for different groups and do this early enough to influence how things are done. Under the specific duties, they must publish evidence of equality analysis they have undertaken to establish whether their policies and practices would further, or have furthered, the three aims of the general duty. They must also publish details of the information they considered in conducting that analysis. Public bodies other than schools must publish this evidence and information by 31 July 2011. Subsequent information must be published at least annually.

Equality objectives

Public bodies covered by the specific duties must publish equality objectives that will help them to further the aims of the general duty. These must be based on published equality evidence and analysis and they must be specific and measurable. Public bodies must also publish how they will measure progress towards their equality objectives. Public bodies must publish their equality objectives and how they will measure progress by 6 April 2012. Subsequent objectives and accompanying information must be prepared and published at least every four years.

Details of engagement undertaken

Public bodies covered by the specific duties must publish information about engagement they have undertaken with people who have an interest in furthering the three aims of the general duty. They must also publish details of the engagement they undertook in developing their equality objectives. Public bodies must publish details of their general engagement activity by 31 July 2011 and then at least annually. Details of engagement undertaken in developing equality objectives must be published at the same time as the objectives.

We have already published Race, Disability and Gender Equality Schemes, which outline our duties under the legislation and contain Action Plans detailing how the duties will be met. This SES has been developed to enable us to extend our duties to the other protected characteristics.

Human Rights

"A human rights-based approach is about applying internationally agreed standards across the whole of healthcare. It's a way of thinking and seeing that should underpin everything that we do."
Department of Health (2008) Human Rights in Healthcare: a short introduction

The Trust is committed to a human rights-based approach. We recognise that much of our work has the potential to promote key human rights, such as the right to life and the right to education. This SES and the actions it sets out are therefore a key part of our human rights-based approach. The Scheme details how we will promote, protect and monitor the right of everyone who works for or comes into contact with the Trust not to be discriminated against.

9.   Equality Impact Assessments (EIAs)

Note: the General Equality Duty comes into force on 6 April 2011 and includes the duty to carry out Analysis of the Effects on Equality. The change in terminology is intended to focus more attention on the quality of the analysis and how it is used in decision-making, and less on the production of a document. Where organisations have an established method for reviewing policies to assess their impact on the aims of the previous duties, they may be able to continue to use this tool, although the Equality and Human Rights Commission has advised all public bodies to review their current tools to ensure that they work under the new equality duty.

Like current EIAs, Analysis of the Effects on Equality is a way of considering the effect on different groups protected from discrimination by the Equality Act 2010. There are two reasons for this. First, to consider if there are any unintended consequences for some groups, and second, to consider if the policy will be fully effective for all target groups. It involves using equality information and the results of engagement with protected groups and others,

to understand the actual effect or the potential effect of your functions, policies or decisions.

The Trust will incorporate Analysis of the Effects on Equality in its decision-making processes when this element of the Equality Act 2010 takes effect. This reflects the live nature of this Scheme.

What is an Equality Impact Assessment?

An EIA is a legal requirement. The primary function of an EIA is to determine the extent of differential impact (can be negative, neutral or positive) upon individuals or groups included in the protected characteristics of ED&HR. If a negative impact (or potential for negative impact) is identified, the policy document or service function will need to be further assessed to eliminate, reduce or justify the impact. An EIA should assess for possible disadvantage to any of the protected characteristics.

Why do we need them?

They help to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people from different groups, and
- foster good relations between people from different groups

in policy documents and service functions. The process helps to highlight areas where remedial action may need to be taken.

Who is responsible?

Policy writers, managers, service leads and ultimately the Board.

The EIA Process

EIAs are carried out in two stages:

1. screening for relevance to the protected characteristics, relevance to the general equality duties and prioritising for a full EIA (carried out by the policy author / manager/ service lead)

2. full EIA carried out by a panel of representatives which may include the author / manager or service lead following consultation with the equality groups affected or potentially affected.

An EIA has four possible outcomes and more than one may apply to a single policy:

> **Outcome 1**:
> No major change: the EIA demonstrates the policy is robust and there is no potential for discrimination or adverse impact. All opportunities to promote equality have been taken.

> **Outcome 2**:
> Adjust the policy: the EIA identifies potential problems or missed opportunities. Adjust the policy to remove barriers or better promote equality.

> **Outcome 3**:
> Continue with the policy: the EIA identifies the potential for adverse impact or missed opportunities to promote equality. It clearly set out the justifications for continuing with it. The justification should be included in the EIA and must be in line with the duty to have due regard. For the most important relevant policies, compelling reasons will be needed.

> **Outcome 4**:
> Stop and remove the policy: the policy shows actual or potential unlawful discrimination. It must be stopped and removed or changed (the codes of practice and guidance on each of the public sector duties on the Equality and Human Rights Commission's website provide information about what constitutes unlawful discrimination).

10.   Consultation

During the process to review and update our existing Equality Schemes, we undertook consultation with service users and staff. We then built on that consultation to ensure that we engaged as widely as possible with religious and faith groups, transgender people, carers and older people. We thank everyone who contributed to our consultation and helped us to develop our key priorities and actions. Appendix C includes details of the questions we asked, who contributed to the process and their responses.

The key issues raised by people as part of the consultation can be summarised under the following themes:

- access to information
- communication support and good practice
- staff awareness and training
- Equality Impact Assessment
- delivery of services, and
- data collection.

These themes have been highlighted in Appendix B of the Action Plan. The feedback from the consultation shows that although we have made progress, there remains more work to do on the above areas.

11. Communication

We will ensure that the contents of our SES are made available to the widest possible audience. The Scheme will be communicated to the following groups:

EXTERNAL
- The Care Quality Commission (CQC)
- NHS Litigation Authority
- The Equality and Human Rights Commission
- South East Coast SHA.

INTERNAL
- Trust Board
- Management Board for Quality and Risk
- ED&HR Steering Group
- BME Staff Network
- Trade Unions Stewards' Committee (TUSC)
- Staff.

12. Monitoring and Review

Care Quality Commission Requirements

The CQC is the independent regulator of health and adult social care services in England and their core function is to drive improvement across health and adult social care by:

- putting people first and championing their rights

- acting swiftly to remedy bad practice, and

- gathering and using knowledge and expertise and working with others.

All healthcare organisations are required to comply with the regulatory framework outlined by the CQC.

From 1 April 2010 the CQC introduced a new registration and regulatory framework with specific areas of priority in relation to:

- involvement and information for service users

- personalised care and treatment and support

- issues of safety and safeguarding

- suitability of staffing

- quality of management, and

- suitability of management.

It should be noted that the standard of performance in relation to ED&HR is more firmly embedded in each of the core standards of performance rather than as a stand-alone standard. This will require organisations to embed effective ED&HR management into their core business processes to successfully achieve compliance against this new regulatory framework.

The Action Plan and progress made will be reported on annually in the Equality, Diversity and Human Rights Annual Report.

13. The SES Key Objectives and Action Plan

The following key objectives are addressed in the SES Action Plan (see Appendix B for detail):

a.   Leadership and corporate commitment, accountability and responsibility
b.   Commissioning and procurement
c.   Patient data, monitoring, reporting and publishing
d.   Equality Impact Assessments
e.   Partnership working, consultation, involvement and engagement
f.   Accessibility and communications
g.   Workforce, equal opportunities, monitoring and training
h.   Equality objectives.

14. Progress to Date with the Race, Disability, Gender and Single Equality Schemes

With the implementation of the Equality Schemes relating to race, disability and gender, we have already made considerable progress in addressing those issues most important to our staff and service users. Following the consultation that has been undertaken as part of the development of this SES we are concentrating on the issues raised as well as the key public sector duties within the Equality Act and have developed key quality objectives in the Action Plan at Appendix B.

The key issues raised by people as part of the SES consultation can be summarised into the following themes:

- Access to information
- Communication support and good practice
- Staff awareness and training
- Equality impact assessment
- Delivery of services, and
- Data collection.

All of the themes are addressed in the SES action plan Appendix B in addition full detail of the consultation carried out is found in appendix C

Leadership and Commitment

The Equality Schemes are ratified by the Trust Board and published on the Trust's website and intranet sites. They are available to staff, patients and the public and in different formats upon request.

The Board is updated by regular reports from the Director of Human Resources. An Equality, Diversity and Human Rights Annual Report is published on the Trust's website.

Equality Impacts Assessments (EIA) (see Appendix D for EIA Toolkit)

EIAs aim to improve the quality of local health services by ensuring that individuals and teams think carefully about the effect of their work on staff and service users. We have recognised that all of our policies and the functions they relate to are relative to the duty and they have been prioritised for assessment. An updated list of the policies which have been screened is published on the ED&HR page of the Trust's website.

Human Resources and clinical policies were originally identified as having the greatest potential impact on staff and service users and were prioritised for assessment. All other policies will be EIA'd as part of their review at least every three years.

A process is in place to screen and assess policies as part of their development and to make recommendations to the author on any changes needed or full EIA if needed. Following appropriate consultation with staff networks and by staff representatives a full EIA is completed by a panel of staff and patient representatives.

Our approach has been to identify issues as part of the development of a policy and to make recommendations at that stage. Policies and practices that seem neutral can have a different effect on both staff and service users, contributing to inequality and poor policy outcomes. The need to recognise possible discrimination due to part-time working or caring responsibilities is part of the EIA process. Where there is a concern that the proposed policy may result in a possible adverse affect on any of the protected characteristics, the author is advised to revisit the policy and to make the changes needed which would lead to greater equality.

The results full EIAs are published on the ED&HR pages of the Trust's website. These include the outcomes of the consultations undertaken and a plan identifying the actions, monitoring, timescales and accountability. The EIA guidance and tool for completing a full EIA is also published on the ED&HR pages of the Trust's website. The tool incorporates guidance for staff on its application, methods for consulting with stakeholders, the screening process, sources of evidence monitoring and reviewing arrangements and publication of results and enables action planning to address any evidence of adverse impacts. The Action Plan is linked to timescales and has a named person for responsibility to implement and review dates.

The EIA screening and initial assessment guidance and tool is part of the Policy for the Development of Policies and Procedural Documents.

The discussion and decisions taken as part of the EIA process help to move the culture of the organisation to a more inclusive, respectful and proactive position driven by raised awareness and understanding of ED&HR. All policies are reviewed at least every three years and the EIA is carried out again as part of the review process.

Evidence from sources such as workforce data, local population data and the staff survey are considered as part of the EIA review process. Monitoring the effective working of a policy will assist the Trust in meeting the aims of the general duty. It will help us to keep track of how a policy is working and whether it is having an adverse impact.

We also provide regular training on the EIA process for service leads and senior managers to enable us to extend this work into services, strategies and other organisational decisions.
We have recently reviewed and updated our EIA screening and full assessment training as well as the guidance and tools to ensure that we are meeting our legal duties under the Equality Act 2010. The EIA toolkit will undergo further development and revision as required by the new Public duties.

Communications and Consultation

The Trust has produced a Public and Patient Involvement (PPI) strategy and a Communications strategy with action plans. These can be found on the Trust's website. The Action Plans reflect the work we will do to improve communication and access to information for our patients.

Consultation should be appropriate for the group being consulted and the issue under consultation. It is often targeted at specific groups where a health need or great impact has been identified. Consultation is an important aspect in considering if the organisation is meeting the duty and is undertaken in a number of ways, both formal and informal. It is a key part of the EIA process. Consultation methods include: focus groups, attending local meetings, telephone interviews, one-to-one interviews, feedback from Patient Advice and Liaison Service (PALS) cases and complaints, surveys and questionnaires.

Monitoring of Services and Employment

Since 2008 we have used the Electronic Staff Record (ESR) together with the NHS Jobs website to collect and monitor workforce data relating to ethnicity. From 2010 we also included gender, age and disability data and we will be looking to extend this data collection and analysis to include the other protected characteristics as part of our Action Plan. Currently analysis is done on the following areas:

- Staff in post by pay band

- Staff who receive promotion (recorded as band changes)
- Staff who are offered training
- Performance appraisal (when these result in benefits and sanctions)
- Dismissals and other reasons for leaving
- Applicants for jobs – including internal applications
- Shortlisting for posts
- Appointed - including internal appointments
- Grievances
- Disciplinary action
- Bullying and harassment
- Capability
- Employment tribunal cases.

Data are regularly reported to and monitored by the ED&HR Steering Group. The data are provided along with narrative and actions already taken and those planned. Information from the annual staff survey is also shared with staff and senior managers, monitored and analysed for trends and issues and an action plan produced. An Equality, Diversity and Human Rights Annual Report with workforce data is produced.

We have identified where there are gaps in our data collection and monitoring processes and have included actions to take this forward in the Action Plan (Appendix B). We will also be working towards collection and analysis of staff and patient data linked to the protected characteristics and as required under the Equality Act 2010.

Patient data is collected from our electronic patient data system, Cerner and covers inpatient, outpatient and emergency departments and a summary has been presented earlier in this document. Ensuring that services are accessible and delivering quality care is a priority and the Trust ensures that the results of any satisfaction survey from regular patient/carer consultations are used in service developments and reviews.

The feedback from service users, complaints and PALS will be used to support the EIA process on the commissioning, monitoring and reviewing of services.

Publishing and Accessing the Information

The SES will join the existing Equality Schemes along with the ED&HR Strategy and will be published on the Trust's website as well as on internal sites. Information on EIAs, consultations, outcomes and action plans for EIAs, the Equality, Diversity and Human Rights Annual Report and workforce data are also published on the ED&HR pages of the Trust's website. Documents will be updated to reflect monitoring.

Training

We have reviewed our ED&HR training to ensure that staff are aware of and trained to meet the duties within the Equality Act 2010 and what this means for all of the protected characteristic groups. The importance of having a workforce trained to deliver the ED&HR agenda and with the knowledge and skills to meet the needs of all patients has been raised throughout the consultation process. We will continue to assess the staff' training needs and training will be reviewed and updated further to ensure we are meeting those needs and we will continue to work with local organisations such as the Surrey Coalition for Disabled People, Surrey Visual Impaired (SAVI) and Gender Identity Research and Education Society (GIRES) on developing training for frontline staff.

ED&HR training has been mainstreamed into the mandatory training programme for all staff. It is included in new staff induction programmes. Updates are also delivered at team training days or meetings. We are reviewing the training needs of the staff responsible for managing and delivering the Equality Schemes such as the members of the ED&HR Steering Group and senior management teams, recognising that it is important to build on the skills and understanding of key staff. Training is regularly updated in line with legislation changes and guidance and includes briefing for the Trust Board.

We have reviewed the ED&HR guidance included in our Managers Development Programme to ensure that mangers are aware of their duties as outlined in the Act to promote equal opportunities, eliminate discrimination in areas such as recruitment and selection, managing sickness, managing leave, dealing with disciplinaries, grievances and capability.

We request equal opportunities data on the training and development application forms to assist us in the monitoring and analysis of applications for training by staff.

Staff attending statutory and mandatory training programmes organised and run by the Education, Training and Development Department are required to complete an Equal Opportunities Monitoring Form.

The Trust has supported and hosted master classes for BME staff from bands 5 – 7 upwards, which have been organised by the SHA. In addition, BME at band 7 and above staff have had the opportunity to attend the Breaking Through programme.

Gender Reassignment Policy

The Trust has produced a Gender Reassignment Policy for Staff which is published on the Trust intranet.

15. Feedback and Comments on the Scheme

We welcome any feedback and comments on this Scheme. Please contact the Head of Equality and Diversity sally.knight@sash.nhs.uk or call 01737 768511. Please let us know if you require this document in any other format or language.

Appendix A   Equality and Diversity Legislation

Asylum and Immigration Act 1996
The Act makes it a criminal offence for an employer to employ an individual who does not have permission to live or work in the UK. This applies only in relation to employees who started work for the employer on or after 27 January 1997.

Civil Partnership Act 2004
The Act makes it illegal to treat someone less favourably because they are in a civil partnership. A civil partnership is a relationship between people of the same sex, which has obtained legal recognition. Civil partners now have similar rights and responsibilities to married couples on issues such as tax, pensions, employment and equality rights. It is unlawful sexual orientation discrimination to treat a civil partner less favourably than a married person in similar circumstances.

Employment Equality (Age) Regulations 2006
The Regulations make it illegal to discriminate against a person on grounds of his or her actual or perceived age, unless it can be justified as a proportionate means of achieving a legitimate aim. Protection against discrimination applies not only to older people but to people of all ages.

Employment Equality (Religion or Belief) Regulation 2003
The Regulations protect against discrimination on the grounds of religion and belief in employment, vocational training, promotion and working conditions.

Employment Equality (Sex Discrimination) Regulations 2005
The Regulations introduce new definitions of indirect discrimination and harassment, explicitly prohibit discrimination on the grounds of pregnancy or maternity leave and set out the extent to which it is discriminatory to pay a woman less than she would otherwise have been paid due to pregnancy or maternity issues.

Employment Equality (Sexual Orientation) Regulation 2003
The Regulations protect against discrimination on the grounds of sexual orientation in employment, vocational training, promotion and working conditions.

Disability Discrimination Act 1995 (DDA)
The Act makes it illegal to discriminate against a disabled person because of or for a reason related to his or her disability. It also imposes a duty on employers to make reasonable adjustments to alleviate substantial disadvantage suffered by a disabled person. The DDA introduces the public sector disability equality duty, which requires public authorities to have due regard in carrying out their functions to promote equality of opportunity for disabled people and to eliminate discrimination. Public authorities must also encourage participation of disabled people in public life, promote positive attitudes towards disabled people and take account of disabled people's disabilities even where that involves treating disabled people more favourably.

Based on the definition provided by the Disability Rights Commission in 2006, a "disabled person" is someone who has a physical or mental impairment, which has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. The 1995 Act extended the definition of disability to cover a wide range of physical, sensory and mental disabilities, including diabetes and those with long-term conditions, mental health problems, learning difficulties, HIV, cancer, multiple sclerosis and mental health service users. The Act promotes the 'social' model of disability, i.e. it is the barriers (both physical and attitudinal) which society puts in the path of disabled people which prevent them from living fuller lives, rather than their actual impairment.

Equality Act 2006
The Act established a single Commission for Equality and Human Rights by 2007 which replaced the Equal Opportunities Commission, Commission for Racial Equality and Disability Rights Commission. The Equality Act 2006 amends the Sex Discrimination Act 1975 and places statutory duties on all public bodies from 6 April 2006. The duty applies to men, women and transgender people. Transgender people are protected from discrimination and harassment on the grounds of gender reassignment, vocational training and services (from December 2007) under the Sex Discrimination Act. This includes those intending to undergo gender reassignment. Gender equality means being treated the same as others in society regardless of gender and having the same opportunities.

Equal Pay Act 1970
The Act gives an individual the right to the same contractual pay and benefits as a person of the opposite sex in the same employment, where the man and woman are doing:

- like work or
- work related as equivalent under a job evaluation study, or
- work that is proved to be of equal value.

Gender Recognition Act 2004
The Act enables transsexual (trans) people to apply for legal recognition of their acquired gender. If a person is treated less favourably on the grounds of their acquired gender this will be sex discrimination.

Race Relations (Amendment) Act 2000
The Act places a statutory duty on all public bodies to promote equal opportunity, eliminate racial discrimination and promote good relations between different racial groups. The Race Relations Act 1976 as amended by the Race Relations (Amendment) Act 2000 makes it unlawful to discriminate against anyone on the grounds of their race, nationality, ethnic origin or culture, either directly, indirectly or by victimisation, in carrying out any public function that meets the general and specific duties in the Act.

Sex Discrimination Act 1975
The Act makes it unlawful to discriminate on the grounds of sex. Sex discrimination is unlawful in employment, education, advertising or when providing, housing, goods, services or facilities. It is unlawful to discriminate because someone is married, in employment or advertisements for jobs.

Equality Act 2010
The Equality Act became law in April 2010 and will be implemented in stages over the next two to three years. The Act provides for the strengthening our equality law by putting a new Equality Duty on public bodies to promote equality of opportunity and eliminate discrimination relating to the protected characteristics of race, disability, gender, gender reassignment, religion or belief, sexual orientation and pregnancy and maternity. Other aspects of the duty include:

- giving the government power to require public authorities using public procurement to improve equality
- banning age discrimination outside the workplace
- introducing mandatory gender pay and equality reports for employers
- extending the scope to use positive action in employment and service provision
- strengthening the powers of employment tribunals

- protecting carers and others who may suffer discrimination because of their association with a person who has a protected characteristic
- protecting breastfeeding mothers
- banning discrimination in private members' clubs, and
- strengthening protection from discrimination for disabled people.

Appendix B   SES Action Plan

1. Leadership and corporate commitment, accountability and responsibility					
Action(s)	**Benefits/rationale**	**Trust Lead**	**Timescale**	**Outcomes**	**Protected characteristic(s)**
Ensure the SES is adopted at Board level and then via senior managers and champions to all staff and volunteers	Leadership and commitment from the Trust Board is essential in establishing the SES principles and Action Plan (AP) in all areas of the Trust	Executive Board lead and Non-Executive Lead	March 2011	The SES is ratified and supported by the Trust Board ensuring commitment to its Trustwide implementation	All
ED&HR Steering Group monitors progress against the SES action plan, reports on activity, progress made and identifies future priorities via regular reports from ED&HR Lead and staff networks	SES AP is progressed and updated as required	ED&HR Lead	6 monthly	Live, regularly updated document meeting needs of staff and patients	All
Regular updates provided to senior management teams	Senior management are aware of progress to ensure leadership	ED&HR Lead	6 monthly	Senior management demonstrate commitment and leadership to equality agenda	All

ED&HR Annual Report, including workforce data, is presented to the Board and published on Trust website	To meet equality legislation and equality specific duty

To maintain leadership and focus on equality agenda | ED&HR Lead | By 31 July 2011 and annually thereafter | To meet equality legislation and equality specific duty

To maintain leadership and focus on equality agenda | All |
| The Trust Board receives awareness and training on their duties under the Equality Act 2010 | For the Trust Board to understand its responsibilities | ED&HR Lead | Annually or in line with changes in legislation | Senior management demonstrate commitment and leadership to equality agenda. Board decisions are informed by equality criteria | All |

2. Commissioning and procurement

Action(s)	Benefits/rationale	Trust Lead	Timescale	Outcomes	Protected characteristic(s)
To identify a lead from Finance Directorate for equality aspects of commissioning and procurement	Embedding equality considerations into Trust's relationships with suppliers through specifications and contract management	Director of Finance	By end of March 2011	Trust complies with legislation in commissioning and procurement processes	All
For the lead to assess current levels of compliance with equality legislation in the contracting processes	Lead identifies any gaps in current commissioning and procurement	Finance Lead (TBC)	During 2011	Trust complies with legislation and addresses any gaps in current commissioning and procurement	All
For the lead to identify specific areas of activity that will help to meet the requirements of equality legislation as it relates to commissioning and procurement	Lead identifies any gaps in commissioning and procurement	Finance Lead (TBC)	During 2011	Trust complies with legislation and addresses any gaps in current commissioning and procurement	All

3. Patient data, monitoring, reporting and publishing

Action(s)	Benefits/rationale	Trust Lead	Timescale	Outcomes	Protected characteristic(s)
Review organisational protocols and systems for monitoring of patient data	To ensure that protocols and systems provide Board with necessary data and information	TBC		Board has necessary information to fulfil duties under public sector Equality Duty	All
Audit and improve patient data collection and monitoring	Staff are aware of any needs patients may have and these are addressed for patients	Information Manager		Higher rate of completed ethnic coding, religion & belief translation and interpretation and special requirements recorded and acted upon	All
Develop laminated cards to help clerical and clinical staff collect this information	Staff and patients are comfortable about being asked for the personal information	TBC		Higher rate of completed ethnic coding, religion & belief, translation and interpretation and special requirements recorded and acted upon	All
Ensure consistency of reporting	All staff dealing with same patient are able to act on same	TBC		Patients' needs are met	All

	information				
Increase reporting on under-represented groups, e.g. young men, physical and learning disabled, when profiled against local population	To identify any groups not using the Trust's services	Information Manager and Service Leads		Services understand any differences between the population spread and groups accessing services e.g. clinical, barriers to entry, etc	All
Identify relevant system fields to enable reporting of other population groups	Sufficient data is collected to ensure patients' needs are met	Information Manager		Patients' needs are met	All
Develop reporting on access to service by people with physical or learning disabilities	Reporting will allow identification of trends to enable Trust to make any necessary adjustments	Information Manager		Needs of people with physical or learning disabilities will be met	Disability
Publish patient data at least annually	Meet legislative requirements, help provide patient focused care	ED&HR Lead		Meet legislative requirements, help provide patient focused care	All
Data informs service changes, e.g. menus offer choice for all requirements/ on request	Individual dietary requirements are met	Service Leads		Patients receive choice of menu and food that meets their needs	All

4. Equality Impact Assessments

Action(s)	Benefits/rationale	Trust Lead	Timescale	Outcomes	Protected characteristic(s)
Ensure all EIA tools are robust and legally compliant, updated in line with new Equality general and Specific duties	Review and update EIA tools. Publish on website Requirement for EIA to be documented in Policy on Policies and published on website Equality and Human Rights statements are included in Policy and all relevant documents	ED&HR Lead		Trust complies with legal requirements to carry out EIAs	All
Review EIA processes and refocus on effect or outcome rather than impact	To assess whether additional training or guidance is required to advise staff of the changes in the Act	ED&HR Lead		Trust complies with legal requirements and ensures that staff are aware of changes in the Act	
EIA training for staff	Training included in learning guide for service leads and managers. Corporate staff to	ED&HR Lead		Trust ensures that all service leads and managers attend EIA training,	All

	raise awareness and provide knowledge and support on undertaking EIAs on services One-to-one guidance, team sessions provided Additional panels to be set up			supported by corporate staff ED&HR Lead provides one-to-one guidance as required Additional panels to be set up	
Identify and prioritise functions, policies and proposed policies to be EIA'd	Functions and policies are identified and prioritised according to their relevance to the equality general duty	ED&HR Lead and service leads	Ongoing	Equality general duty is delivered on, functions and policies are prioritised for EIA process	All
Conduct EIAs on high priority (people-focussed) policies/functions including existing policies/functions and publish results on website	All HR policies must be reviewed by the Trust Consultative Committee before approval All service reviews have a completed EIA before they are approved	Policy Authors and Service Leads ED&HR Lead	Completed and ongoing	Potential negative impacts are removed, reduced or justified	All
Conduct EIA of low priority policies/ functions	New policies to be EIA'd as part of development process. To be	Policy Authors and Service Leads		Trust complies with legal requirements to carry out EIAs	All

	extended to all policies and documents/functions				
Increase capacity amongst representatives from equality groups to support EIA of services and ensure communities are empowered and able to engage	Trust ensures that groups and communities are involved in its decision-making processes and panels includes representative from patient groups/ communities, including disability groups	ED&HR Lead		EIA panels are representative of the local population and staff groups	All
Ensure consultation and engagement is meaningful and contributes to EIA process	Full EIA tool contains guidance on identifying external and internal stakeholders relevant to policies and services to be consulted on and engaged with as part of EIA process	Policy Authors and Service Leads, Director of Communications		Communities, groups and staff representatives are included in the Trust's decision-making processes	All
Publish the results of such assessments, consultation and monitoring	List of all policies prioritised as high, medium or low impact in relation to EIA to be published and updated quarterly on website with EIA dates and	ED&HR Lead		Trust complies with legal requirements to publish results of EIAs internally and externally	All

				Trust undertakes reviews of EIAs	
	review dates Progress on EIAs is reported to ED&HR Steering Group at quarterly meetings and to Board in Equality, Diversity and Human Rights Annual Report			Trust undertakes reviews of EIAs	

5. Partnership working, consultation, involvement and engagement

Action(s)	Benefits/rationale	Trust Lead	Timescale	Outcomes	Protected characteristic(s)
Equality Act 2010 implemented following consultation and involvement	Single Equality Scheme produced in line with Equality Act 2010	ED&HR Lead	Ongoing	Trust complies with its legal duties	All
	Original schemes incorporated into new Scheme which covers all protected characteristics, approved by Board and published on website	ED&HR Lead	End March 2011	Trust ensures that SES is robust by incorporating actions from previous schemes	All
Consult with stakeholders on changes to services	Stakeholders play a key role in service development	Service Leads/ PPI Lead	31 July 2011 and ongoing	Patient and public involvement is robust and equitable	All
Identify and consult with local and national organisations, groups and bodies that might be used as part of consultation process, including	Stakeholders are involved in Trust's communication processes	Director of Communications / PPI Lead	31 July 2011 ongoing	Patient and public involvement is robust and equitable	All

hard-to-reach groups or seldom heard groups such as Travellers					
Ensure all services are carrying out regular patient/carer consultations and satisfaction survey results are used in service developments	Patients' views are considered when making service developments	Service Leads		Patient satisfaction information is recorded and acted on	All
Attendance at community and voluntary sector organisations and resident associations events	Trust engages widely in the community	Director of Communications / PALS / ED&HR Lead	Ongoing	Patient and public involvement is robust and equitable	All
Publication of multifaith calendar and events and cultural week celebrating diversity of staff	Staff are aware other groups' faith-based and cultural events	ED&HR Lead		Staff respect and celebrate other groups' events	Religion and belief/ race & ethnicity

6. Accessibility and communications

Action(s)	Benefits/rationale	Trust Lead	Timescale	Outcomes	Protected characteristic(s)
Ensure all new buildings and modifications to current buildings comply with DDA for access and facilities	Building and facilities are fit for purpose and comply with legislation	Head of Estates	Ongoing	All buildings are compliant with DDA for access and facilities	Disability
Hearing loop systems to be regularly checked and developed where necessary	Patients are able to access communication systems appropriate to their needs	Head of Estates	Ongoing	Patients with hearing impairment are able to access to services more easily	Disability
Act on the consultation data collected regarding the service needs of people with disabilities and barriers to accessing services	Disability consultation data is fed through to service changes and improvements and into service plans.	ED&HR Lead / Director of Communications	Ongoing	Consultation data informs service change and improvements for the benefit of disabled people	Disability
Implement Communications Strategy including accessible communication channels	ED&HR is reflected in all communications with staff and patients and communities/	Director of Communications	31 July 2011	Communications reach as many staff and patients as possible and information is accessible	All

	groups are targeted in appropriate ways				
Plan how communications team will inform staff about the SES	Strategy is adopted to ensure effective communication	ED&HR Lead / Director of Communications		Staff are aware of their responsibilities and those of Trust	All
Review and update corporate literature and website	To ensure that they reflect both the new protected characteristics and additional duties under public sector Equality Duty	Director of Communications		Trust literature embeds commitment to ED&HR	All
Staff to be trained and guided on their responsibility to 'check with patients' what their communication needs are	Patients are able to access the most appropriate communication systems for their needs	ED&HR Lead and Patient Experience Lead	Ongoing	Staff are able to help patients access different communications as necessary	All
Improve communications for people with a visual or hearing impairment	Patients are able to access communication systems appropriate to their needs	ED&HR Lead	Ongoing	Patients with visual or hearing impairment are able to access to services more easily	Disability
Implement Sign Translate	Patients using BSL are able to communicate in clinical settings	ED&HR Lead and IT		BSL users have equality of opportunity and service outcomes	Disability

Other options for communication to be explored such as SMS messaging, booking appointments online	Patients are able to access communication systems	Head of Service, Ambulatory Care	Ongoing	Patients are able to access to services more easily	All
Develop a sustainable IT solution to record and identify individual needs on the patient record system	Staff are able to identify patients' individual needs as soon as possible eg translation or communication preferences, access requirements.	Director of Business Intelligence and Estates and Environment		Patients' individual needs are identified and met as soon as possible	All
Ensure information for patients meets their needs, include in survey and user satisfaction measures	Patient information is accessible	Patient Information Group / PALS		Information provided to patients is produced in an accessible format	All
Ensure patient leaflets are EIA'd	There is no negative impact on any of the protected characteristics	Patient Information Group		Patient information is provided in accessible formats	All
Use of Easy Read documents and communications to be promoted, supported by the	Patients are able to access Easy Read documents if necessary	Patient Experience Lead		Staff are aware of the availability of Easy Read documents and how to create them	Disability / race & ethnicity / age

				if necessary	
Easy Read website with guidance for staff on how to create Easy Read materials and communications					
Guidance on how to access interpreting and translation services including: Language Line, BSL, Braille, etc promoted to staff	Staff are able to communicate with patients with assistance from interpreting and translation services	PALS / ED&HR Lead		Staff are aware of services available and are able to access them on behalf of patients/carers	All
Monitor use of interpreting and translations services and where referrals come from	Trust is aware of needs of different groups	Central Booking Office		Trust is able to plan which services will be used in future	Disability / race
SES and related consultation will be published on the Trust internet and website and be available in alternative formats if required	To allow access to the Scheme and permit consultation from both the staff and external communities including the harder-to-reach groups	ED&HR Lead / Director of Communications / PALS	By end March 2011	Scheme and consultation documents fully accessible and available for further consultation	All
Disabled people	Disabled users are	ED&HR Lead		Disabled users are	Disabled

are actively involved in the implementation of the SES and the AP. Consultation always involves disabled people or groups	involved in the Trust's actions and decision-making processes			involved in ensuring that services are accessible	

7. Workforce, equal opportunities monitoring and training

Action(s)	Benefits/rationale	Trust Lead	Timescale	Outcomes	Protected characteristic(s)
HR Policy and Practice					
Ensure equality in the promotion and management of flexible working, part- time working, leave, etc	Identify any under-representation in protected characteristic groups	HR Policies Lead/ Workforce Information Manager	April 2011 onwards	Under representation or inequality identified and addressed	All
Review and update all associated HR policies (e.g. managing absence, flexible working, harassment and bullying)	Policies must reflect the new protected characteristics in the Equality Act	HR Policy Authors with ED&HR Lead	From October 2010 onwards	Policies are based on current legislation	All
Undertake a Full EIA on the Recruitment Policy, processes and materials	There is no negative impact on any of the protected characteristics	HR Policy Authors with ED&HR Lead	April 2011 ongoing	Recruitment Policy and processes contribute to fair selection of staff	All
Revise pre-employment checking procedures in line with advise issued by NHS Employers including health	Trust ensures that it complies guidance	Recruitment Manager	October 2010 ongoing	Trust carries out checking procedures as advised by NHS Employers	All

checks, disability and guaranteed interview scheme					
Review annual staff survey to check for equality issues raised by staff	Identify any equality issues raised by staff and prioritise for directorate action plans	ED&HR Lead / HR Business Partners	March 2011 ongoing	Results from the staff survey are monitored against equality groups and action plans agreed to address issues	All
Be aware of legislation requiring the Trust to carry out an Equal Pay audit in line with Equality Act 2010	Awareness of the potential for gender stereotyping in pay scales	Director HR / Workforce Information Manager	April 2011 ongoing	There should be equality in pay between sexes	Gender
Investigate any inequalities found through data analysis against protected characteristics, prioritise and feed into equality objectives	Identify any under-representation in protected characteristic groups	HR Business Partners / Workforce Information Manager / ED&HR Lead	April 2011 ongoing, equality objectives to be published by April 2012	To address any areas which are under-represented, equality objectives are informed by data and specific measures applied	All
Publish annual workforce report and provide to Staff Networks, ED&HR Steering Group and management board and Trust Board	Workforce data trends are identified and analysed	ED&HR Lead	July 2011 and then at least annually	Staff Networks, ED&HR Steering Group and Executive teams are aware of any issues to be addressed	All

Workforce Information					
Initiate data validation exercise on workforce data including new protected characteristics to improve self-reporting especially in relation to disability and sexuality. Input to ESR	To ensure that data is as accurate and complete as it can be	Workforce Information Manager	April 2011 ongoing	Accurate reporting of workforce data	All
Using Electronic Staff Records, workforce data is collected, reviewed and monitored on • Applicants for jobs, short listing and appointments (via NHS Jobs) • Staff in post • Staff who receive promotion • Staff who are offered training • Staff appraisals and PDRs • Grievances • Disciplinary	Ensure no employee is treated less favourably than others	Workforce Information Manager / HR Business Partners	April – June 2011 and ongoing	Trust monitors data to ensure equal access to opportunities	All

action • Performance dismissals and other reasons for leaving for all equality areas Exit interviews to be monitored for ED&HR issues					
Ensure all managers report appraisal and PDP information	To enable improved data recording, collection and analysis on appraisals and PDPs	ETD / HR Business Partners	Ongoing	Any equality issues and training requests are identified	All
Report regularly on workforce data to ED&HR Steering Group. Publish at least annually	Steering Group is kept updated on workforce and recruitment data	Workforce Information Manager / Recruitment Manager/ ED&HR Lead	Published by July 2011 and then at least annually	Steering Group refers any serious issues to management board	All
Recruitment and Selection					
Workforce data is compared with local population data. Positive action to be considered when under-representation is established	To ensure that the workforce is representative of the community it serves	Workforce Information Manager / Recruitment Manager/	July 2011 and at least annually	Community, minority groups and those with protected characteristics are represented in the workforce	All

Monitor recruitment and selection data against protected characteristics	Identify any under-represented groups	Recruitment Manager	July 2011 and at least annually	To address any areas which may be under-represented	All
Consider using positive action when Board vacancy arises	Board is more representative of local population	HR Director	Ongoing	Increased diversity of Board members	All
Set specific outcome targets relating to recruitment to BME staff in under-represented pay bands	Identify any BME under-representation in bands	HR Business Partners / Workforce Information Manager	March 2011 ongoing	Progress against these targets to be reported annually by the BME Staff Network and ED&HR Steering Group	Race and ethnicity
Staff Support					
Develop a culture of zero tolerance to bullying, harassment and discrimination. Via communication, e-bulletin, team briefing, training, support for ban bullying at work day, etc	Reduce bullying, harassment and discrimination between staff members and support staff with harassment from third parties	HR / Managers / ED&HR Lead	Ongoing	Trust works towards meeting its legislative duties to eliminate discrimination, harassment and victimisation	All
Provide additional support and guidance to	Managers are able to support their staff appropriately	ED&HR Lead / Occupational Health / HR	April 2011 ongoing	Disabled staff have access to necessary	Disability

managers on making reasonable adjustments and access to work		Business Partners		equipment to ensure access to work	
Ensure specialist assessments are carried out for disabled staff as required and necessary equipment provided to support them	Disabled staff are assessed and supported by appropriate reasonable adjustments	Occupational Health	Ongoing	Disabled staff have access to necessary equipment to ensure access to work	Disability
Establishment of Disability Staff Network or disability champions to be explored	Provide support for disabled staff and address any specific needs Reasonable adjustments are considered	ED&HR Lead	April 2011 ongoing	Disabled staff report feel more supported as a result Increase in the number of reasonable adjustments made More staff disclose they consider themselves to have a disability (ESR) records	Disability
Support establishment of LGBT staff network for staff	Provide support for GLBT staff and help develop an inclusive culture in the Trust	LGBT Lead / ED&HR Lead	March 2011 ongoing	LGBT staff feel more supported, able to speak out and have equality of opportunity	Sexual Orientation

Support and develop BME and other networks to achieve a positive outcome for staff	Provide support for staff	ED&HR Lead / network Leads	April 2011 ongoing	Staff feel more supported	All
Work with leads of all staff networks to ensure staff have the opportunities and support to attend meetings and events	Increased participation in attendance at staff newtwork meetings and events	Network Leads / HR Business Partners / HR Director	Ongoing	Increased participation in attendance at network meetings and events	All
Training and Development					
Ensure collection and analysis of workforce data by ethnicity on applications for training and applications relating to promotion. Extend to other protected characteristics when data available, e.g. disability and sexual orientation	Identify any under-representation in staff groups applying for training or promotion	ETD / Workforce Information Manager	July 2011 and at least annually	All staff have equality of opportunity for applying for training and promotion	All
Ensure analysis of data with regard to ethnicity for staff who receive training	Identify any under-representation in staff groups in those who receive training	ETD / Workforce Information Manager	July 11 and at least annually	Staff with protected characteristics are supported	All

and career development opportunities. Extend to other protected characteristics when data available e.g. disability and sexual orientation	or promotion			and developed in their career development	
Trust actively supports learning and development opportunities for minority staff including: Breaking Through Programmes Master Classes NVQ programmes, LGBT and Disability leadership opportunities	Minority groups staff are offered opportunities for progression and promotion	ETD Lead / ED&HR Lead	Ongoing	Minority staff (race, sexual orientation / disability) embrace progression and promotion opportunities	All
Review induction and training materials to ensure that they reflect all of the protected characteristics	Training materials are comprehensive	ED&HR Lead/ ETD Lead	Ongoing	Staff are aware of all protected characteristics	All
All new staff must attend statutory and mandatory training which includes	All staff are made aware of their responsibilities in relation to ED&HR	ETD Lead/ ED&HR Lead	Ongoing	Staff are trained in ED&HR awareness including current	All

specific session on ED&HR				legislation	
Staff are advised of learning and development opportunities through: • Staff Networks • E-bulletin • SASH Window • Intranet and Trust website	Staff are offered opportunities for progression and promotion	ETD Lead	Ongoing	Staff embrace progression and promotion opportunities	All
Regular updates/ training sessions included in senior management team meetings	Senior management demonstrate commitment to engagement on the equality agenda	ED&HR Lead	Ongoing	Senior staff responsible for overseeing the organisational compliance with the equality duties are trained and updated	All
Bespoke training sessions and updates on ED&HR are arranged in response to requests from line managers	All staff are made aware of their responsibilities in relation to ED&HR	ED&HR Lead	Ongoing	Staff are trained in ED&HR awareness including current legislation	All
Train managers in ED&HR as part of specific management	Managers understand their specific responsibilities to	ED&HR Lead / ETD	Ongoing	Reduction in complaints and reported incidents of bullying and	All

development programme	their staff and patients, e.g. bullying and harassment			harassment	
Cultural awareness sessions included in training programme	Staff need to understand diverse range of needs	ED&HR Lead and BME Network Lead	To be developed	Staff are better able to respond to individual needs	All
Disability awareness training is offered to all staff	Disabled staff and patients are treated appropriately, reasonable adjustments are made and equality of outcomes achieved	ED&HR Lead / Disability Lead	Ongoing	Improved access and reasonable adjustments ensure that disabled people are not discriminated upon in the workforce or services	Disability
E-learning packages are available on Disability Awareness and Respect for People	Staff understand specific needs of groups/communities	ETD Lead	March 2011 onwards	Staff are able to respond to specific needs of groups/ communities	Disability / All
Analyse training attendance data	Identification of those staff who have not attend ED&HR training

Training Department to arrange additional sessions | ETD / ED&HR Lead | April 2011 ongoing | All staff are trained in ED&HR awareness including current legislation | All |

8. Equality objectives

Action(s)	Benefits/rationale	Trust Lead	Timescale	Outcomes	Protected characteristic(s)
Develop and publish new equality objectives in line with the Equality General and specific duties by April 2012. Objectives to be specific & measurable and identify progress	Publishing equality objectives will help the Trust further the aims of the public duty. They will be based on published equality evidence (Data monitoring , EIAs, consultations, surveys etc)	ED& HR Lead	By April 2012	The equality objectives are driven by evidence of need and progress made. Will be focused on achieving better outcomes for staff and service users	All

Appendix C   Consultation Feedback Summary
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Single Equality Scheme Consultation Summary
Surrey and Sussex Healthcare NHS Trust (SASH) and NHS Surrey
June – September 2010

The key issues raised by people as part of the consultation can be summarised into the following themes:

* Access to information
* Communication support and good practice
* Staff awareness and training
* Equality impact assessment
* Delivery of services, and
* Data collection.

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Meeting with Lilian Bold, West Sussex Carers
Thursday 24th June 2010

It was suggested that the Disability Action Group should consider as part of its agenda how to raise awareness of the following issues with staff:

* Carers are allowed to have a free "health check", a carer's assessment to assess their own needs when caring for another, useful for considering respite care. This would be useful information to tell carers when the patient is discharged home.
* There are two support agencies in our patch - Surrey and West Sussex and the PCTs could be approached for their Carers Strategy. This would provide useful insight for the EIA process in SASH.
* There should be a Stroke Care Association carer link in the Stroke Unit at SASH.
* Admiral Nurses work with dementia patients.
* Would the hospital support a carers group (patients and staff)?
* Some carers have an Emergency Alert card so that if they are taken to A&E, staff will be aware that they have caring responsibilities (are our staff aware of this?).
* Can "Carer" status be added to patients' notes, for example, an additional box on the Cerner system, to ensure staff record this information.

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Meeting with Gender Identity Research and Education Society (GIRES)
Monday 13th September 2010

Issues / Points Made

- By 2007 10,000 people seeking gender reassignment had presented for treatment = 20 per 100,000.
- Prevalence rates are estimated to be 50 per new GP consortium with 8 new cases per annum.
- It is estimated that numbers will continue to increase with between 300,000 - 500,000 people expressing some degree of gender difference.
- 50 - 90 people are likely to present for treatment each year.
- Whatever the population numbers involved, it is essential that all policies and services must be trans friendly and meet the needs of trans people.
- Due to low numbers of people seeking gender reassignment, staff often do not have the skills and knowledge needed to treat trans people effectively
- Staff awareness and training is a key issue.
- It is important to keep transgender staff in post while they are going through transgender process and afterwards. Staff need to feel welcome and valued in their new gender.
- It is important for employers to recognise the pressure that staff are under at this time and that it might take some time for staff to feel comfortable and to function well in their new gender.
- Guidance is available and it would be helpful to ensure that employers and staff are aware of it.
- Concerns that the RIO (patient data) system is not trans friendly in its data collection.
- Single sex accommodation is still an issue (preferred option is single rooms as single sex bays still present problems with other patients.
- End of life care (see Stephen Whittle Bereavement guide).
- There has been much improvement in pathways, accessing treatment and support for trans people and their families.
- Sensitivity needs to be shown when collecting data from patients. It is very difficult to ask questions without causing offence. Take care regarding data collection – very difficult to ask the question without causing offence, why are you asking? Why do you need to know? How will it be used?
- Issues of concern for prisoners on continuation of treatment such as hormones and placement of transgender prisoners.

Additional comments from a transgender person from contact via NHS Surrey website

Question 1: When accessing or using NHS services what really helps you?

Response:
A flexible, sensitive and inclusive attitude from staff
Access to the correct and appropriate treatment
Reassurance that privacy will be protected
Usage of correct name and pronouns (and making sure that all relevant documents are changed promptly)
Not assuming that all health issues are related to being transgender.

Question 2: What makes the most difference to you?

Response:
All the issues above are important. However, I would say the attitude of staff is probably key – when you have a supportive doctor, the other issues tend to follow as well.

Question 3: What should we focus on in order to promote equal opportunities and improve services?

Response:
I think primarily on staff awareness. It often seems that while doctors and nurses are supportive, sometimes receptionists are less so.

Documentation is also a key issue.

Question 4: Is there more we can do?

Response:
At the moment, it is virtually impossible to get safer sex information for trans people, particularly trans men (this isn't NHS Surrey alone – in fact, there only appears to be one safer sex booklet in the world for trans men, published in Canada) and the safer sex materials some trans men need simply do not exist.

Unfortunately, a minority of doctors are still reluctant to treat trans people and rather more do not understand the processes for referral, etc. Some local psychiatrists still attempt to treat trans people within community mental health teams, rather than making tertiary referrals to the gender identity clinic.

The waiting list at the gender identity clinics are shockingly bad (Charing Cross GIC's waiting list fluctuates, but is currently around seven - eight months – last year it was twelve months). It is not appropriate for trans people to have to wait twelve months to see a specialist, particularly when they are in distress. There

are also unclear referral routes where a patient has already had an element of private care (usually due to being unable to wait twelve months for NHS treatment), and frequently diagnosis has to be repeated. NHS Surrey should do what it can to support calls for shorter waiting lists and clearer routes of treatment. In some cases, it may be appropriate for NHS Surrey to see whether other providers, elsewhere in the country or privately, offer better value for money.

There are some excellent Department of Health publications on transgender issues, including a guide for GPs and other medical professionals. Unfortunately these have not been widely promoted and the Department of Health now will not print more due to funding issues (though they are still available as PDFs).

The Department of Health guidance recognises that not all trans-related healthcare has to go through a Gender Identity Clinic. For example, there is no reason why a GP should not refer trans people who have already been diagnosed in the past directly to an endocrinologist for minor hormone issues, or to a gynaecologist when a hysterectomy is indicated, rather than wait twelve months for a GIC appointment so that they can then write to the GP to ask him/her to refer the patient to an endocrinologist or gynaecologist. The current situation, where care is very centralised, and the GIC tries to take control of every aspect of care, is one of the causes of the long waiting lists, and does not help patients, the GIC or PCT budgets! I would hope that with the new GP consortia, there is a move towards patient-centred care on trans health issues.

It is essential that medical care for trans people is not 'squeezed out' with changes in the NHS and budget cuts. It is internationally recognised that transsexuals do need to be treated by transitioning to live as the other gender. Preventing treatment or placing insurmountable hurdles not only causes severe distress, it is in the end likely to be counter-productive, as it will raise the risk of self-harm, violence from others, unlicensed medical treatment, etc.

Not all healthcare providers for trans people are alike. For example, some surgeons carrying out mastectomy and chest reconstruction for trans men do the peri-areolar method, which is most suitable for smaller sizes. Others do the double incision method, which is more appropriate for large sizes. Trans people should have the same rights as others to choice in their healthcare, and not just be told that the PCT funds one surgeon.

There is inconsistent policy across the NHS (I don't know about NHS Surrey specifically) on smear testing for trans men. Trans men who have not had a hysterectomy are at risk of cervical cancer, and should have smear tests. They should also have their medical records in the male gender. If NHS computer systems cannot cope with men having smear tests, the computer systems need to be altered or worked round (book tests off the system and phone through the results if necessary). It is not appropriate to put patient records in the wrong

gender or to deny someone a smear test because the computer can't process it. The computer is there to serve the patient, not the other way round.

The information sent out regarding the standard patient record across the NHS was not particularly clear in explaining its implications for trans people. It stated that all previous names would be automatically listed on the more available part of the record. Obviously that makes perfect sense in most situations where someone may have a health record in a former name. However, for trans people it immediately reveals their status – there are some situations in which health providers should know my trans status, there are others where it is irrelevant (for example, if I've gone into hospital because I've broken my leg, there is no reason why the staff treating me need to know my trans status). All issues around this should be listed in the locked or sealed part of the record, including former names.

Question 5: What do you think should be our top priorities?

Response:
Staff awareness
Maintaining health care services for trans people.
Improving processes for dealing with documentation and records for trans people.
Where possible, improving access to specialist health service for trans people.
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Surrey Community Action Workshop (BME)
Thursday 16th September 2010

- Contact person needed within services with the ability to speak the appropriate language (or access appropriate/same gender translators outside potential service users' communities) to give guidance and support regarding services available and access to them.
- Information available in relevant languages or via audio.
- Identified a fear of disclosure of personal information (date of birth, surnames, marital status) for a variety of reasons including distrust of "the Authorities", legal status, etc. Utilisation of existing community groups or other community sources, that are not identified as "Authority" figures, to disseminate clear information on mental health services and allay fears around disclosure of personal information.
- Text reminders, using mobile phones to ensure that appointments are kept.
- Development of culture / language specific support groups for people to talk about their issues and access support, with resources and a clear infrastructure enabling influence and change within service delivery.
- Further exploration of the prevalence of self-harm among young Asian women.

- Follow up on the identified links between domestic abuse and mental health issues.
- Set up a befriending service for individuals in BME communities.

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"Losing Patients" Campaign (for Visually Impaired VI people)
Bourne Hall, Ewell
Friday 17th September 2010

Issues / Points Made

- VI people cannot access health information unless it is in a format that is accessible for them, e.g. large print, electronic, Braille.
- VI people are not asked about their communication needs.
- Information on medication is frequently unreadable by VI people. This can be dangerous if prescription / dosage not followed.
- Boots are trialling "talking labels" for VI.
- VI people do not want their personal health communication to be read to them, as this leads to a loss of confidentiality and independence.
- Mid Yorkshire NHS Trust has developed a system to flag disability, VI etc which is cost free.
- People who DNA (did not attend) appointments may not have been able to read their appointment letters.
- Equality Act says alternative formats should be available.
- For some VI people it is helpful to write appointment dates / times in thick black marker pen on cards.
- Patient leaflets - try to get in minimum of point 14
- We need a system of producing information in a range of formats - RNIB, SAVI – develop a contract with these groups.
- Do not use light blue print on white paper as very hard to read.
- Develop VI awareness training for staff.
- 6,000 people registered as VI live in Surrey.

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Management Development Programme 2009/2010

When accessing or using NHS services what really helps you?	What makes the most difference to you?	What should we focus on in order to promote equal opportunities and improve services?	Is there more we can do?	What do you think should be our top priorities?
Ease of contact, clear explanations, flexibility	Being treated as an individual	Remembering what might seem obvious as a healthcare employee may not for an NHS user	Not make assumptions and listen/act on feedback	
Being treated as a person ,given plenty of information in an accessible way	Being given time at consultation	More flexibility with times of duty, aid and or location when they are held so that for e.g. Crawley patients can be seen at ESH/Dorking to suit the patient		
Flexible times Privacy	Quick and prompt service, communication	Varying choices	Respect opinions and values	Equal care and opportunity for all
Straightforward telephone access and helpful people at the other end (i.e. not a huge pre-recorded message telling you to 'press one for…etc - so annoying	Good communications	Good command of spoken English as standard. Equality should not be allowed to overshadow poor standards in some staff members who do not like being told of their shortcomings and who will	Probably by offering training in pronunciation	Ensuring a high level of communication to avoid inconsistency and misunderstanding

		say they are being bullied		
		We should also make sure that special provisions made for some members do not allow them more benefits than others		
When people greet me with a smile and introduce themselves to me	When I am treated as a person. Explained what is to happen to me, not avoid me as a nurse, but treat me like any other patient when I am a patient	Patient-centred care. Treat each patient as an individual	Ensure as a nurse you get enough information about your patient first, i.e. reading files to enable you to ensure quality care holistically	Patient care
Communication-clear reminders left for appointments Flexible hours/appointments to fit in with working life	Friendly, approachable staff Clean/well-equipped hospital, clinical areas to ensure I get the treatment I need without fear of infection	Ensure you know enough about patients, staff, etc to allow equal opportunities for all. To ensure all tools, e.g. patients passport are filled out and acted upon, e.g. an airbed	Clean hospital Better written information for patients Enough staff to provide care	Everything I have just said

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SAVI Members
Horley Methodist Church, Horley
Thursday 14th October 2010

Issue/Points Made

- Prescriptions - not everyone reads Braille yet and no-one reads it when you have stuck a label over it.
- Prescription review dates - if you cannot read your repeat prescription you don't know when this is.
- Rude notes are not appreciated even if the Pharmacy reads them to you.
- It helps to have all your drugs on the same ordering date.
- Staff on Limpsfield Eye Clinic are very good.
- Toilet doors need tactile marking so you can find them.
- Patients should not have to pay home helps to read private health letters and fill in forms for them.
- Staff need to understand disabled people may not have/want/need a carer to fill the gap to independence.
- Staff should speak to the person and not their carer.
- You should not assume you do not know about bits of non-verbal communication because you can't see them or that you have not learned any long words.
- Staff's bad day/lack of resources/poor relationship with colleagues are not my problem and I do not want to hear about them or see sexism/racism/rudeness between colleagues especially when I have been kept waiting for 2 - 3 hours.
- The law says most aids should be free - and they should.
- If you can not note sight issues on front page of notes or patient record then put a box for 'Help needed', e.g. needs to be fetched from waiting room, needs chaperoning with male staff.
- Eye clinic patient should always book in on the same side as cannot see labels.
- Stop moving the chairs in clinics.
- Is it possible to install a raised sensory stripe from the bus stop to the eye clinic.
- Volunteers to act as guide to eye clinic.
- Audio/Braille letters from the eye clinic about appointments and copy letters to GPs about results.
- Data protection is not an excuse for not sending information electronically.
- Policing of Blue Badge spaces - mostly cars/vans not displaying badges.
- Please can the car park attendant put a sign that a space is currently being used by acute patients who need to be close to services and do not have a blue badge.
- Is it possible to install a talking bus stop so passengers know that the bus is approaching?

- Recognition that blindness hurts - light sensitive.
- Big locks on toilet doors, coloured toilet seats, big signs, etc.
- Bruises from falls/collisions/headaches often as a result of sight impairment.
- Explanation of tests before they happen. Do not just stick a temperature probe in ear with out asking as a blind person does not know what is going on.
- Patient alerts - can these not be utilized for special needs?
- Staff should not get between you and the door and should never lock doors without asking first.
- Staff should recognize that your white stick is your independence and not mess with it.
- Staff should not say things like 'look over there'/or 'its over there'. You can get clues from the direction of their voice, but this is not certainty.
- Staff should understand that you feel anxious and lost and usually tired (because you have to concentrate all the time to get about in a strange place blind).

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Questions for NHS from SAVI Members Consultation
Horley Methodist Church, Horley
Thursday 14th October 2010

- Please can you consider setting up a disability action group to meet the principles of the Equality and diversity regulations (Jane).
- I have asked for help in the past from PALS at East Surrey and they have not responded. Please would you ensure that they respond by telephone to visually impaired people (Jane).
- Loads of information received about diabetic retinopathy in small print. Large print needed. Lack of communication and information (Val).
- At the eye clinic you do not get any feedback. They leave you in the air (Margaret).
- Beryl - waiting for 3/4hour for appointment.
- Tom - waiting two weeks for hearing aid to be sent to him.
- Tony – why can't they flag up that the person is visually impaired when you go to a hospital appointment.
- Need to read the forms out loud. Not helped to sign the form in the correct place when you are partially sighted (Val).
- Leaving tablets on table and not telling you where they are (Val).
- Too much reliance on computers - a lot of people do not own one. The software is expensive for visually impaired and blind.
- Doctors surgeries and reception areas on their computers just flag up the person needs extra help.

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Carers (taken from discussion with carers groups/empowerment board feedback)

Key messages from the responses are:

- better and timely access to information – on the illness or condition of the person they are caring for, on appropriate caring, on accessing benefits and other support and on financial and employment issues
- carers can often feel excluded by clinicians – both health and social care professionals should respect, inform and involve carers more as expert partners in care
- carers often feel forced to give up work to care
- carers often neglect their own health and need advice to maintain their wellbeing
- carers need breaks from caring good respite care is essential.

1. When accessing or using NHS services what really helps you?

Staff who speak good English and talk slowly and clearly. Having information about my disabilities known or shared with whoever I am seeing.
.
2. What makes the most difference to you?

Patience and good record keeping so there are fewer questions to ask.

3. What should we focus on in order to promote equal opportunities and improve services?

Improved communication between GPs and doctors and all other medical staff so that my medical history is known in advance. Also priority should be given to BEDS being available and NOT trolleys at hospital A&Es/MAU/SAU to ensure comfort for disabled people..

4. Is there more we can do?

Again better communication. More availability of transport to day centres/ rehab centres, especially White Lodge at Chertsey.

5. What do you think should be out top priorities?

Making sure each and every person is treated with dignity and given whatever extra resources are necessary to ensure good treatment on every occasion.

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Empowerment Board Meetings Summary
October to December (5 localities)

- Information in accessible formats.
- Large print.
- Flags on patients' records so all professionals know.
- Appointment letters/results, etc in accessible formats.
- Out-of-hours not helpful for disabled people - difficult to use phone system and to get through.
- Out-of-hours doctors do not know the patient or understand the needs of disabled patients.
- Automated phone systems whether at GP or hospital are difficult for anyone even slightly hearing impaired.
- There should always be a person on the end of the phone.
- Being able to make appointments in different ways such as text, online.
- Being able to communicate with staff, having a meet and greet system at hospital help with directions and finding way around.
- Increase use of talking boards.
- Staff to be trained by disabled people.
- Better information.
- Better transport – understanding the criteria for using hospital transport.
- Patients need to be treated as a person in their own right- i.e. not pigeon-holed, so that there are no pre-conceptions or judgements made by staff.
- Patients should be treated with respect and listened to - and be shown that they have been listened to.
- Understand the differences and do not make assumptions.

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East Surrey Empowerment Board
Monday 15 November 2010

When accessing or using NHS services what really helps you?	What makes the most difference to you?	What should we focus on in order to promote equal opportunities and improve services?	Is there more we can do?	What do you think should be our top priorities?
Accessibility – appointments in accessible formats	Personal contact, deals with you as an individual, do not get passed about, one point of contact	Automatic doors to GPs surgeries	Staff training, signage, accessible format	Hospital passports - Surrey independent living
Signage – maps easily understood, large print, tactile print, buttons to push (St Peter's at Chertsey)	24 hour helplines- please can these be tested Audio and visual 'call' for appointments	Help from place to place, e.g. by car to appointment Advise in advance that help is needed	A data base that flags up disabilities,needs etc	PALS -brilliant
Swale House - Epsom (Action for Blind) Height of signage/payment machines				GPs at Woking - brilliant
Telephone – clear reply. Bypassing the GP and going direct via ESH to Haywards Heath				

Gay and Lesbian Comments on Summary Questions

When accessing or using NHS services what really helps you?

To know that a service is fully open to me, for example visibility of the protected characteristics in a vision type statement.

What makes the most difference to you?

To know that I will not be judged because of my lifestyle and that lifestyle is respected.

What should we focus on in order to promote equal opportunities and improve services?

Staff training to emphasise LGBT lifestyles and that they are of no less value than a heterosexual lifestyle.

Is there more we can do?

Positive imagery at public access points to service providers, so if there are images in the service that they reflect all people and relationships.

What do you think should be our top priorities?

Staff training and vision statements that make it clear LGBT people are welcome and will be treated with respect.

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Maybury Centre, Woking
Tuesday 23 November 2010

1.   When accessing or using NHS services what really helps you?

- A quick service.
- Greater availability of appointments.
- My GP service and acute hospital services are very good. NHS internet is very helpful. I have always had a good experience with my English GP (young person's comments).
- Being able to understand and communicate with doctors (young person's comments).
- Acute hospitals are providing a good treatment service for diseases. There are good doctors/specialists at the hospital.
- GP service is fine, but when you go to hospital most of our people have a language barrier so if we have someone there for support it will help.
- Easy access to the relevant and accurate information.

- That the health visitors and all other people involved come to my house to help my son (carer).

2. What makes the most difference to you?

- Getting an appointment when required.
- Fundamental basic client care and fuller explanations that lay people can understand.
- Friendly staff and environment, accurate and precise information, good communication (young patient).
- I receive treatment in a place that feels welcoming and comfortable (young person).
- We need GP appointments at the right time not in a week. Diabetic management needs to be improved.
- Prescribing charges for young people (students) are too high and most of them cannot afford it.
- Friendly and understanding attitude of the service providers.
- All the professionals involved are friendly and very helpful (carer).

3. What should we focus on in order to promote equal opportunities and improve services?

- Getting more people who can speak other languages such as Urdu, Polish, etc.
- Ensure at the time the appointment is made that the client is asked about any language barriers so they can be accommodated with interpreters.
- For the older Asian generation you need to provide good communication and staff need to understand diverse needs of the community. There needs to be equal job opportunities for Asian ethnic backgrounds (young patient).
- Overcoming language barriers (young person).
- Equal opportunities for all people from any race, faith, gender or disability.
- Ensure there are equal NHS job opportunities for BME people.
- Improving quality of GP services.
- To improve the service - the waiting time for a child to get seen should be reduced (carer).

4. Is there more we can do?

- At the moment it is increasingly difficult to get an appointment within 2 days, which seems very poor so an appointment on the day would be nice.
- Specific training targeted to help doctors and nurses to deal with special clients with language or cultural barriers.
- More GPs, both male and female, need to be provided for patients in the Woking area. There seem to be more patients at one particular surgery and

not enough doctors. Also single sex accommodation in hospitals (young patient).
- Provide language support for those who need it (young person).
- Need to offer more support for patients with a long-term health condition, especially from BME background as they need additional support to access the service.
- Yes, you can provide language support for all services and more car parking space should be available.
- Yes, raise awareness of the availability of the not so commonly used health services, especially amongst those with English language difficulties.
- Have more visits to the child's home (carer).

5. What do you think should be our top priorities?

- Access to the service when required not two days later and not having to wait for 2 hours on the day to see a doctor.
- Ensuring that when seeing the GP that the patient feels that their reason for visiting in the first place has actually been addressed (especially females).
- GP services need to be improved in Maybury and Sheerwater wards for South Asian patients. The appointment system needs to be improved.
- Good GP service with proper treatment and referral system, good communication. Telephone consultation is not helpful - appointment needed with the GP.
- Hospital service needs to be improved.
- Improving GP surgery services.
- Reducing waiting time for specialist/consultant/hospital services.
- Improving healthcare and monitoring services in schools.
- Primary care GP services need to be improved.
- Reduce waiting lists such as portage (carer).

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Consultation with people with a learning disability
Bentley Day Centre
Thursday 25th November 2010

What is good?

- Staff who are kind, gentle and who talk to me.
- When I feel looked after and they make me feel better
- When my carer can come with me.
- Nice looking doctors and nurses.

What is not so good, what I don't like is

- Doctors who are not nice and who hurt me.
- When I feel nervous.
- The smell.
- I wanted to come home, but could not.
- The doctor talks to the carer not me.
- Doctor assumes I cannot understand, so does not try to talk to me.
- Doctor does not take time to listen to me I need a bit more time.

What do you want to happen?

- A friendly smiley doctor, who is laughing and joking and who knows my name.
- To know my doctor's name.
- For doctors and nurses to be able to sign a little when they are explaining what they are going to do such as giving an injection, taking blood pressure, offering to help me.
- Using pictures, books, easy read, charades to explain things to me and to show what the equipment is for.

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Staff Wellbeing Day
East Surrey Hospital
Friday 26th November 2010

When accessing or using NHS services what really helps you?	What makes the most difference to you?	What should we focus on in order to promote equal opportunities and improve services?	Is there more we can do?	What do you think should be our top priorities?
Extended appointment times at GP would be good	Helpful advice from First Care (absence reporting system used by SASH)	I have not experienced any problems with equal opportunities	Don't know	Don't know

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West Sussex Humanists
Friday 10th December 2010

In relation to Religion and Belief: When accessing or using NHS services what really helps you?

Staff and policies that do not discriminate on the basis of religion or belief

What makes the most difference to you?

No assumption that I am religious. Privacy of my belief. No approach from a religious chaplain. No offer of religious support. No declaration of religion from staff.

What should we focus on in order to promote equal opportunities and improve services?

Obtain impartial information from a random sample of patients. Visit the British Humanist Association website (www.humanism.org) and read their advice to the NHS.

Is there more we can do?

Make the Chaplaincy Service voluntary and include non-religious "chaplains" in proportion to the population (43% are non-religious)
or
Employ non-religious "chaplains" in proportion to the population (43% are non-religious) on an equal basis

What do you think should be our top priorities?

Finding out what the public want their taxes spent on, e.g. more nurses versus chaplains, occupational therapy versus "spirituality strategy".

Appendix D   Equality Impact Assessment Toolkit

What is an Equality Impact Assessment (EIA)?

The primary function of an EIA is to determine the extent of differential impact (can be negative, neutral or positive) upon individuals or groups with protected characteristics * and the relevance to the Equality General Duty[**] which may be low, medium or high. If a negative impact (or potential for negative impact) is identified with relevance to the Equality General Duty, the policy document or service function will need to be further assessed to eliminate, reduce or justify the impact.

* The protected characteristics that we assess against are:

- Age
- Disability
- Gender reassignment
- Race/ethnic communities/groups
- Religion or belief
- Sex (male/female)
- Sexual Orientation (bisexual, gay, heterosexual, lesbian)
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Human Rights

Why do we need them?

They help to meet the Equality General Duty to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations between people of different groups by assessing in policy documents and service functions. The process helps to highlight areas where remedial action may need to be taken.

Who is responsible?

Policy writers, managers, service leads and ultimately the Trust Board.

How are they carried out?

The EIAs are carried out in two stages:

[**] Equality General Duty relates to: eliminating discrimination, harassment and victimisation, advancing equality of opportunity and fostering good relations between people of different groups.

1   **Screening** for relevance to the protected characteristics and the Equality General Duty and prioritising for a full EIA if required (carried out by the policy author / manager/ service lead)

2   **Full EIA** carried out by a panel of representatives including the author/ manager or service lead (following consultation with the equality groups affected (or potentially affected).

An EIA has four possible outcomes.

More than one may apply to a single policy:

Outcome 1: **No major change**: the EIA demonstrates the policy is robust and there is no potential for discrimination or adverse impact. All opportunities to promote equality have been taken.

Outcome 2: **Adjust the policy**: the EIA identifies potential problems or missed opportunities. The policy is adjusted to remove barriers or better promote equality.

Outcome 3: **Continue with the policy**: the EIA identifies the potential for adverse impact or missed opportunities to promote equality. Clearly set out the justifications for continuing with it. The justification should be included in the EIA and must be in line with the duty to have due regard (see below). For the most important relevant policies, compelling reasons will be needed.

Outcome 4: **Stop and remove the policy**: the policy shows actual or potential unlawful discrimination. It must be stopped and removed or changed (the codes of practice and guidance on each of the public sector duties on the Equality and Human Rights Commission's website provide information abut what constitutes unlawful discrimination).

Due regard and proportionality

EIAs are one of the key ways in which public authorities meet their general duties on equality. These require that due regard is given to achieving the goals set out in the general duties, all with the aim of achieving greater equality for the affected groups.

Due regard comprises two linked elements: proportionality and relevance. The weight that public authorities give to equality should therefore be proportionate to its relevance to a particular function.

The greater the relevance of a function to equality, the greater regard should be paid.

EIAs are crucial to enabling due regard. They can assist public authorities in fully understanding the relevance and effect of policies and they can help in identifying the most proportionate and effective responses.

NB   Most policies are likely to have some relevance to the protected characteristics, but not all policies will need to have a full EIA.

Stage 1: Screening and Prioritising

This process is to help prioritise the policy document based on the relevance to the Equality General Duty and the proportionate risk of negative impact. For example, Human Resources policies have potential for impact on ALL staff and the result of the impact is likely to be severe. Therefore the policy document would need to be prioritised over another document, for example, a Waste Management Policy, which will only affect a few staff and is unlikely to affect have any equality impact would be a low priority.

The following questions are used at the screening stage:

1.   What are the main aims, objectives of the policy?

2.   Who is the policy aimed at?

3.   Consider what information you have regarding the use of the policy or effect on diverse groups (see examples below).

4.   Is the policy/service function relevant to any of the protected characteristics?

5.   What is the nature of the impact or potential impact? What is its priority (low, medium or high)?

Low
•   The policy **may not be relevant** to the Equality General Duty as stated by law

•   Little or no evidence is available that different groups may be affected differently

•   Little or no concern raised by the communities or the public about the policy, etc, when they are consulted – recorded opinions, lack of interest.

Medium
- The policy **may be relevant** to parts of the Equality General Duty in the policy, etc regarding differential impact

- There may be some evidence suggesting different groups are affected differently

- There may be some concern by communities and the public about the policy.

High
- There **will be relevance** to all or a major part of the Equality General Duty in the policy regarding differential impact

- There will be substantial evidence, data and information that there will be a significant impact on different groups

- There will be significant concern by the communities and relevant partners on the potential impact on implementation of the policy.

6. What minor changes can be made for areas where LOW impact is identified?

7. Should the policy document be recommended for a Full EIA?

Stage 2: Full Equality Impact Assessments

Full Assessment involves:

1. further, more detailed consideration of relevant data and research

2. formal consultation with relevant stakeholders on the actual impact

3. consideration of alternative proposals, and

4. monitoring of adverse impact in the future and publishing the results of such monitoring.

Policies should, for example, reflect the diversity of the population served, make sure there is equal access for all and take into account unequal caring responsibilities, while recognising that providing the same service in the same way to everyone can sometimes create a disadvantage.

Examples of information / data sources for consideration:

*   Demographic data and other statistics, including census findings
*   Available research findings
*   Comparisons between similar policies internally and/or from other Trusts
*   Survey data, staff and patient
*   Equality monitoring data
*   Complaints, Serious Untoward incidents (SUIs), Patient Advice and Liaison Services (PALS) reports
*   Anecdotal evidence
*   Equality Schemes and annual reports.

When do they need to be carried out?

When a policy (or service change) is in its draft stage, it needs to be screened for relevance and priority. Consultation with relevant groups should have already been carried out to inform its development and this is central to the process. If there has been no consultation then the EIA screening cannot be done. Any policy or service function assessed to be of medium or high relevance will need to progress to a Full EIA.

Policies will not be ratified without evidence of a completed EIA screening or Full EIA.

What happens next?

When agreed, a completed EIA screening or Full EIA document must be attached to the policy as the final appendix and the policy can proceed to ratification.

If it is decided that the policy has an adverse impact, the Trust should consider modifying the policy or putting in place measures to mitigate the adverse impact.

If an adverse effect on any group can be identified, policy makers will need to assess whether the policy is unlawfully discriminatory, taking into account that some policies are intended to increase equality of opportunity by requiring or permitting positive action, or action to redress disadvantages.

The Trust must publish the results of EIAs on its website.

The policy/service function should be monitored and reviewed to ensure that the outcomes help to eliminate discrimination, promote equality and good community relations.

- **The information and insights that can be gained from involvement and consultation are essential and should also usually be carried out as part of the main policy development process**
- EIAs should always include an action plan
- EIAs must always inform the final decision on a policy
- Unless your policy is already perfect for equality (which is highly unlikely), an EIA should lead to policy change.

Equality Impact Assessment
Stage One: Screening for Relevance to Protected Characteristics and the Equality General Duty and Prioritising

Names of assessors carrying out the screening procedure (minimum of 3 - author / manager and staff member / patient representative)	Name of lead author/manager and contact number
1 Name of the strategy / policy / proposal / service function	Date last reviewed/created and version number
2 Who is the strategy / policy / proposal / service function aimed at?	
3 What are the main aims and objectives?	
4 Consider and list what data / information you have regarding the use of the strategy / policy / proposal / service function by diverse groups?	

5. Is the strategy / policy / proposal / service function relevant to any of the protected characteristics, Equality General Duty or human rights below?
If **YES**, please indicate if the relevance is **LOW, MEDIUM or HIGH**
Low
- The policy **may not be relevant** to the Equality General Duty* as stated by law
- Little or no evidence is available that different groups may be affected differently
- Little or no concern raised by the communities or the public about the policy, etc when they are consulted – (recorded opinions, lack of interest).

Medium

- The policy **may be relevant** to parts of the Equality General Duty in the policy, etc regarding differential impact
- There may be some evidence suggesting different groups are affected differently
- There may be some concern by communities and the public about the policy.

High

- There **will be relevance** to all or a major part of the Equality General Duty in the policy regarding differential impact
- There will be substantial evidence, data and information that there will be a significant impact on different groups

	Protected Characteristics	Patient / their carer / family	Staff
•	**Age**		
•	**Disability**		
a	Physical		
b	Learning disability		
c	Sensory impairment: hearing / sight		
d	Speech or communication difficulty		
e	Mental ill health		
f	People with HIV / AIDS		
g	Head injury, cognitive loss		
h	Other		
•	**Gender Reassignment**		
•	**Race/ ethnic communities / groups**		
•	**Religion or belief**		
•	**Sex** (male/female)		
•	**Sexual Orientation** (bisexual /gay/ heterosexual/ lesbian)		
•	**Marriage and Civil Partnership**		
•	**Pregnancy and Maternity**		
•	**Human Rights**		
1	the right to life		
2	the right not to be tortured or treated in an inhuman or degrading way		
3	the right to be free from slavery or forced labour		
4	the right to liberty		
5	the right to a fair trial		
6	the right to no punishment without law		
7	the right to respect for private and family life home and correspondence		
8	the right to freedom of thought, conscience and religion		
9	the right to freedom of expression		
10	the right to freedom of assembly and association		
11	the right to marry and found a family		
12	the right not to be discriminated against		
13	the right to peaceful enjoyment of possessions		

• There will be significant concern by the communities and relevant partners on the potential impact on implementation of the policy, etc.

14	the right to an education		
15	the right to free elections		

6 What aspects of the strategy / policy / proposal / service function are of particular relevance to the protected characteristics?

7 Does the strategy / policy / proposal / service function relate to an area where there are known inequalities? If so, which and how?

8 Please identify what evidence you have used / referred to in carrying out this assessment.

9 If you identify **LOW** relevance **only** can you introduce any minor changes to the strategy / policy / proposal / service function which will reduce potential adverse impacts at this stage? If so, please identify here.

10 Please indicate if a Full EIA is recommended. (Required for **all** where there is **MEDIUM** or **HIGH** relevance)	**YES / NO**

11 If you are **not** recommending a Full EIA, please explain why.

12 Signature of author / manager	Date of completion and submission	

Please send completed form to sally.knight@sash.nhs.uk
* Equality General Duty relates to: eliminating discrimination, harassment and victimisation, advancing equality of opportunity and fostering good relations between people of different groups.

Equality Impact Assessment
Stage Two: Full Equality Impact Assessment

<u>At this point you should have the completed Stage One screening document</u>

This assessment **must** be completed for all strategies / policies / proposals / service functions which have **MEDIUM or HIGH** relevance to any of the protected characteristics and Equality General Duty.

Assessment may be considered if there is LOW relevance which requires further data to be examined.

Strategy/Policy/Proposal/Service Function

Title	....
Lead Manager	....
Contact Details	....
Division/Directorate	....

Names of members carrying out the Full Equality Impact Assessment (minimum of 3 - author / manager and staff member / patient representative)

Name …………………………………….	Role ……………………………………………
Name …………………………………….	Role ……………………………………………
Name …………………………………….	Role ……………………………………………
Name …………………………………….	Role ……………………………………………

Part 1: Assessment of the Strategy/Policy/Proposal/Service Function

1   What is the rationale or evidence base for the remit/development of this document or service function?

2   What are the main aims intended outcomes?

3   Which protected characteristic/group(s) appears to be affected by this document or service function?

Characteristic/ group(s)	Patients/ carers	Positive/negative/ neutral impact/ discrimination/harassment/ victimization - explain	Staff	Positive/negative/ neutral impact/ discrimination/harassment/ victimization – explain

4.   Does the document or service function advance equality of opportunity and foster good community relations?

YES	Explain how
NO	Can it be modified to achieve this?

5   What evidence is in existence that you can base your assessment on?

6   Are there barriers which could inhibit access to the benefits of the strategy/ policy/proposal/service function? e.g. communication/information/ physical access/location/sensitivity, etc.

Part 2: Consultation/Involvement/Identification of Key Groups

1   If consultation has already taken place what evidence has already been identified?

2   Who was included in the consultation from the community or staff groups?

3.   Does this assessment require further consultation? **YES or NO**

4   If **YES, w**ho are you going to consult with and involve from the communities or staff groups?

5   Which key staff can support the internal part of this process?

6   Which key community partners can support the external part of the process?

7   What methods of consultation/involvement are you going to use?

Part 3: Key findings from consultation/involvement with community or staff groups (attach link for full report(s)

1   Key findings/evidence used in assessment.

2   As a result of carrying out the assessment please select one of the following four options:

Option 1	No major change: the EIA demonstrates the policy is robust and there is no potential for discrimination or adverse impact. All opportunities to promote equality have been taken.	
	Please set out your reasons for this decision in full.	
Option 2	Adjust the policy: the EIA identifies potential problems or missed opportunities. Adjust the policy to remove barriers or better promote equality.	
	Please describe the modifications to be made in full.	
Option 3	Continue with the policy: the EIA identifies the potential for adverse impact or missed opportunities to promote equality. Clearly set out the justifications for continuing with it. The justifications should be included in the EIA and must be in line with the duty to have due regard. For the most important relevant policies, compelling reasons will be needed.	
	Please set out your reasons for this decision in full.	
Option 4	Stop and remove the policy: the policy shows actual or potential unlawful discrimination. It must be stopped and removed or changed (the codes of practice and guidance on each of the public sector duties on the Commission's website provide information about what constitutes unlawful discrimination).	

3.   Identify what risks to the Trust remain: calculate by likelihood and impact (see risk assessment framework). Does it need to be placed on the Trust risk register?

Part 4: Actions, Outcomes, Monitoring Arrangements and Responsibilities

1   Objectives (eliminating discrimination, harassment and victimization, advancing equality of opportunity and fostering good relations between people of different groups).

2   What are the key actions and intended outcomes?

3   What are the timescales?

4   What monitoring/review arrangements will be put into place?

5   Who will be responsible for the actions?

6   What are the target dates?

7   Who will take responsibility for ensuring the results of the Full EIA are published and available to the public?

8   Specify date by when this will happen.

Full EIA: Signatures of all individuals who took part in the assessment

Signature	…………………………………………..
Print	…………………………………………..
Role	…………………………………………..
Date	…………………………………………..
Signature	…………………………………………..
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Date	……………………………………………..

Equality Impact Assessment: Action Plan Template

Strategy/Policy/Proposal/Service Function Title ……………………………………………………………………

Lead Manager …………………………………… Division/Directorate ………………………………… Contact Details ………………………...

Characteristic/ group(s) affected	Objectives: to eliminate discrimination, harassment and victimization, advance equality of opportunity and foster good relations	Actions and intended outcomes	Timescales for development or implementation	Monitoring and review	Director or Manager Responsible	Dates required for reporting and sign off

APPENDIX E

Equality Impact Assessment
Stage One: Screening for Relevance to Protected Characteristics and
the Equality General Duty and Prioritising

Names of assessors carrying out the screening procedure (minimum of 3 - author / manager and staff member / patient representative) • **Sally Knight** • **Derek Cooper (Patients Council)** • **Sue Clarke (Redwood)**	Name of lead author/manager and contact number **Sally Knight x 2801**
1 Name of the strategy / policy / proposal / service function **Single Equality Scheme 2011-2014**	Date last reviewed/created and version number **New**

2 Who is the strategy / policy / proposal / service function aimed at?
All staff, patients, visitors, carers, contractors and the population served by the Trust

3   What are the main aims and objectives?

- **focus on eliminating discrimination, harassment and victimisation for our staff, patients and other users of hospital services**
- **advance equality of opportunity for our employees and equality of patient outcomes in service delivery**
- **foster good relations between people of different groups**
- **ensure communities, patient and staff and groups are engaged and consulted with in a meaningful way**
- **improve our data collection and monitoring systems for both service users and staff**
- **integrate Equality Impact Assessment into all areas of work**
- **ensure promotion of equality is integrated into service decisions and arrangements including access and communication**
- **train and develop our staff in ways that will facilitate the achievement of the SES objectives, and**
- **publish all information in a way which is easy to access and meets the needs of the equality general and specific duties.**
- **To ensure all staff recognise and respect the needs of the disabled.**

4 Consider and list what data / information you have regarding the use of the strategy / policy / proposal / service function by diverse groups?

Trust equality Schemes for Race, Disability and Gender
South East Coast BME race reviews 2008/2009
Consultation data (Appendix C)
Population data (from NHS Surrey and West Sussex)
Trust patient data and workforce data

5. Is the strategy / policy / proposal / service function relevant to any of the protected characteristics, Equality General Duty or human rights below?

If **YES**, please indicate if the relevance is **LOW, MEDIUM or HIGH**

<u>**Low**</u>

- The policy **may not be relevant** to the Equality General Duty* as stated by law
- Little or no evidence is available that different groups may be affected differently
- Little or no concern raised by the communities or the public about the policy, etc when they are consulted – (recorded opinions, lack of interest).

<u>**Medium**</u>

- The policy **may be relevant** to parts of the Equality General Duty in the policy, etc regarding differential impact
- There may be some evidence suggesting different groups are affected differently
- There may be some concern by communities and the public about the policy.

<u>**High**</u>

- There **will be relevance** to all or a major part of the Equality General Duty in the policy regarding differential impact
- There will be substantial evidence, data and information that there will be a significant impact on different groups
- There will be significant concern by the communities and relevant partners on the potential impact on implementation of the policy, etc.

	Protected Characteristics	**Patient / their carer / family**	**Staff**
•	**Age**	Yes, Positive impact	Yes, Positive impact
•	**Disability**	Yes, Positive impact	Yes, Positive impact
•	**Gender Reassignment**	Yes, Positive impact	Yes, Positive impact
•	**Race/ ethnic communities / groups**	Yes, Positive impact	Yes, Positive impact
•	**Religion or belief**	Yes, Positive impact	Yes, Positive impact
•	**Sex** (male/female)	Yes, Positive impact	Yes, Positive impact
•	**Sexual Orientation** (bisexual /gay/ heterosexual/ lesbian)	Yes, Positive impact	Yes, Positive impact
•	**Marriage and Civil Partnership**	Yes, Positive impact	Yes, Positive impact
•	**Pregnancy and Maternity**	Yes, Positive impact	Yes, Positive impact
•	**Human Rights**	Yes, Positive impact	Yes, Positive impact
1	the right to life	Yes, Positive impact	No
2	the right not to be tortured or treated in an inhuman or degrading way	Yes, Positive impact	Yes, Positive impact
3	the right to be free from slavery or forced labour	No	Yes, Positive impact
4	the right to liberty	Yes, Positive impact	Yes, Positive impact
5	the right to a fair trial	Yes, Positive impact	Yes, Positive impact
6	the right to no punishment without law	No	Yes, Positive impact
7	the right to respect for private and family life home and correspondence	Yes, Positive impact	Yes, Positive impact
8	the right to freedom of thought, conscience and religion	Yes, Positive impact	Yes, Positive impact
9	the right to freedom of expression	Yes, Positive impact	Yes, Positive impact
10	the right to freedom of assembly and	No	Yes, Positive impact

	association		
11	the right to marry and found a family	No	Yes, Positive impact
12	the right not to be discriminated against	Yes, Positive impact	Yes, Positive impact
13	the right to peaceful enjoyment of possessions	No	No
14	the right to an education	No	Yes, Positive impact
15	the right to free elections	No	No

6   What aspects of the strategy / policy / proposal / service function are of particular relevance to the protected characteristics? **All**
7 Does the strategy / policy / proposal / service function relate to an area where there are known inequalities? If so, which and how? **All protected characteristics**
8 Please identify what evidence you have used / referred to in carrying out this assessment. **See q4**
9 If you identify **LOW** relevance **only** can you introduce any minor changes to the strategy / policy / proposal / service function which will reduce potential adverse impacts at this stage? If so, please identify here. **The scheme will have a positive impact on all protected characteristics and will support the new Equality General Duty.**

10 Please indicate if a Full EIA is recommended. (Required for **all** where there is **MEDIUM** or **HIGH** relevance)	**NO**

11   If you are **not** recommending a Full EIA, please explain why. **The scheme will have a positive impact on all protected characteristics and will support the new Equality General Duty. Consultation with staff and community groups has been carried out as part of the development of the scheme. On-going comment and feedback is invited**

12 Signature of author / manager Sally Knight	Date of completion and submission	7th March 2011

Please send completed form to sally.knight@sash.nhs.uk
* Equality General Duty relates to: eliminating discrimination, harassment and victimisation, advancing equality of opportunity and fostering good relations between people of different groups.