

NHS Lothian Equality and Rights Outcomes and Mainstreaming Report 2017

EQUALITY VERSUS EQUITY



In the first image, it is assumed that everyone will benefit from the same supports. They are being treated equally.



In the second image, individuals are given different supports to make it possible for them to have equal access to the game. They are being treated equitably.



In the third image, all three can see the game without any supports or accommodations because the cause of the inequity was addressed. The systemic barrier has been removed.

CECHR [City for All Women Initiative \(CAWI\), Ottawa](#)

What is this report about?

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

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

Our Staff

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

So, what's in the report?

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

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

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What has gone well

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

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

What is still challenging us

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

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

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

What we have learned

Here is what we have learned so

far: [Two good starting points](#)

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

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

Two important stages

- 1) **Awareness**; we have to understand what the world feels like from the point of view of the people we are working for. It is always important to have good conversations with each person we are working with. There are common features about what works well for groups of people too – and we need to keep our knowledge and understanding of this up to date. As staff, all of us need a basic level of knowledge about all the different groups, how to meet people's needs and ensure that their rights are respected. Some of us in particular jobs need a much deeper understanding of the particular groups we work with.
- 2) **Action**; once we understand something of what the world feels like for a person or a group of people, we should decide if we need to take particular actions in response. We use a process called Integrated Impact Assessment to help to think this through and agree actions whenever we change how we use our funding, plan a new policy or service.

How change happens

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

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

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

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

Resources

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

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

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

Other important initiatives

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

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

What are we going to do now?

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

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

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

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

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

NHS Lothian Equality and Rights Outcomes and Mainstreaming report 2017

Main Report

How this report is laid out

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

Under each outcome is a summary of where we were in 2013, what we have done, and what we have learned.

After that are links to more detail about that work. This appears at the end of this Full Reference Report. After looking at a detailed report you can navigate straight back to the list of Outcomes.

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

1.1 [All healthcare developments, policies and plans take account of the diversity of needs and characteristics of patients and the community](#)

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

1.3 [The pay gap between staff of different genders, ethnicity and for disabled staff is reduced](#)

1.4 [There is improved dignity at work for all staff and volunteers](#)

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

2.1 [Access to health services is more equitable for people with protected characteristics](#)

2.2 [NHS Lothian has minimised architectural, environmental and geographical barriers to its services](#)

2.3 [Health promotion and public health campaigns are inclusive, reach all intended audiences and address stigma in the community](#)

Outcomes relating to equitable quality of care for all patients.

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

3.2 [People in Lothian are more assured that health services will respect their dignity and identity](#)

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

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

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

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

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

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

5.2 [Individuals and communities who are vulnerable to, or victims of hate crime feel safer and more secure](#)

INTEGRATED IMPACT ASSESSMENT

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



Where were we in 2013?

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



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

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



What have we learned?

We have learned that:

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

You can read some impact assessments [here](#)

COMMUNITY HEALTH INEQUALITIES TEAM

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



Where were we in 2013?

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

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



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

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

The Wellbeing Team:

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

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

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

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

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

The Community Health Inequalities Team previously worked in our prison settings and in conjunction with Criminal Justice Social Work partners to provide

'links worker' style support to individuals with high needs. Some of this work was embedded within our prison settings.

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



What have we learned?

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

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

You can see our Equality and Diversity Monitoring Report [here](#)

TRAINING AND SUPPORTING STAFF: EQUALITY AND DIVERSITY

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



Where were we in 2013?

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



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

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

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



What have we learned?

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

IMPROVING CAREER PROGRESSION FOR BLACK AND MINORITY ETHNIC NURSES

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

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



Where were we in 2013?

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



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

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

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

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

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



What have we learned?

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

EQUAL PAY

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

EQUAL PAY STATEMENT 2017

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

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

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

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

It is good practice and reflects the values of NHS Lothian that pay is awarded fairly and equitably. NHS Lothian employs staff on national negotiated and agreed NHS contracts of employment which includes provisions on pay, pay progression and terms and conditions of employment. These include National Health Service Agenda for Change Contract and Terms and Conditions of Employment, NHS

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Consultant and General Practice and General Dental Practice contracts of employment and, for a very small cohort, Executive contracts of employment which are evaluated using national grading policies with prescribed pay.

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

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

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

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

- Eliminate unfair, unjust or unlawful practices and other discrimination that impact on pay equality;
- Promote equality of opportunity and the principles of equal pay throughout the workforce;
- Promote good relations between people sharing different protected characteristics in the implementation of equal pay.

We will:

- Review this policy, statement and action points with trade unions and professional organisations as appropriate, every 2 years and provide a formal report within 4 years;
- Inform employees as to how pay practices work and how their own pay is determined;
- Provide training and guidance for managers and for those involved in making decisions about pay and benefits and grading decisions;

- Examine our existing and future pay practices for all our employees, including part-time workers, those on fixed term contracts or contracts of unspecified duration, and those on pregnancy, maternity or other authorised leave;
- Undertake regular monitoring of the impact of our practices in line with the requirements of the Equality Act 2010;
- Consider, and where appropriate, undertake a planned programme of equal pay reviews in line with guidance to be developed in partnership with the workforce;
- Empower staff and managers to work flexibly and effectively with a focus on outcomes, supporting flexible and agile working arrangements and work-life balance;
- Continue to progress through the Carer Positive Framework to support carers in the workplace;
- Ensure that equal pay is central to our commitment to fair organisational change, and that the outcome for staff in relation to equal pay and occupational segregation are monitored;
- Continue to monitor staff development, taking action as appropriate to ensure that all staff are appropriately trained and developed.

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

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

Staff Governance Standard

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

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

- well informed;
- appropriately trained and developed;
- involved in decisions;

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

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

Analysis of Equal Pay and Occupational Segregation in NHS Lothian

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

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

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

Actions Being Taken to Address Pay Inequality and Occupational Segregation

Minimum Level of Earnings

In April 2016, there was a commitment given that all employers in NHS Scotland would pay as a minimum the Scottish Living Wage. This resulted in the bottom points of our pay scales being taken away and any staff in training posts where their earnings were less than the Scottish Living Wage had their earnings uplifted to this new rate. In addition during 2016, an opportunity was given to those staff in the lowest of our pay bands in Agenda for Change (Band 1), with the support of additional training to take on an extended role for which they would be paid at the next highest pay band, Band 2 with the

corresponding increase in earnings. The majority of the staff are within Support Services in roles such as Domestic Assistants, Catering Assistants, Laundry and Linen Assistants and Porters with a high predominance of females in these occupations. This therefore resulted in an increase in the average pay rate for females within NHS Lothian and a reduction in the gender pay gap.

Flexible Working Practices

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

Disability

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

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

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

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

- Challenge attitudes towards disability
- Increase understanding of disability

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

The core actions are grouped under two themes as follows;

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

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

Theme 2 – Core Actions: Keeping and developing your people

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

Ethnicity

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

Modern Apprenticeships

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

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

Future Actions

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

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

[You can see our equal pay statement data here](#)

STAFF POLICIES

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



Where were we in 2013?

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



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

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

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

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

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



What have we learned?

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

SCREENING & INEQUALITIES

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



Where were we in 2013?

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



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

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

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

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

social media campaign focusing more on symptoms than screening [Contribution of stage 1 breast, colorectal and lung to HEAT performance](#)].

A targeted approach is being taken to reduce the differences in cancer survival rates between the most and least affluent areas. [Targeted approach to address inequality](#)



What have we learned?

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

ADDITIONAL NEEDS & DIVERSITY INFORMATION TASK FORCE

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



Where were we in 2013?

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



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

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

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

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



What have we learned?

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

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

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

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

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



Where were we in 2013?

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

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

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

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

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



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

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

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

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

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

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



What have we learned?

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

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

Paper: <http://qir.bmj.com/content/5/1/u210506.w4243.full>

Films: <https://vimeo.com/161217337> (quality improvement)/

<https://vimeo.com/102126052> (patient and staff talking about work)

REINTRODUCING A SPERM DONOR AND DONOR INSEMINATION SERVICE IN NHS Lothian

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



Where were we in 2013?

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



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

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

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



What have we learned?

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

Rapid Impact Assessment for service (October 2013):
<http://www.nhslothian.scot.nhs.uk/YourRights/EqualityDiversity/ImpactAssessment/Rapid%20Impact%20Assessments/Donor%20Insemination%20NHSL.pdf>

Newspaper article about reintroduction (December 2013):
<http://www.edinburghnews.scotsman.com/news/health/sperm-bank-calls-for-donations-1-3219763>

TRANSGENDER SERVICES

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

Where were we in 2013?



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

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



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

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



What have we learned?

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

ESTATES

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



Where were we in 2013?

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

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

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

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

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



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

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

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

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

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

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



What have we learned?

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

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

CASE STUDY: AGEING WELL

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



Where were we in 2013?

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



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

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

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



What have we learned?

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

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

You can learn more about this work for [East Lothian](#), [Edinburgh](#), [Midlothian](#) and [West Lothian](#)

INTERPRETATION AND TRANSLATION SERVICE

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



Where were we in 2013?

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



What good work have we done

- and where are we now?

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

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

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

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

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

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



What have we learned?

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

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

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

<Z:\PublicHealth\Equalities and Human Rights\Interpretation and Translation Improvement Action Plan 2015 - 2017.pdf>

CASE STUDY: TUBERCULOSIS (TB) SERVICE

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

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

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

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



Where were we in 2013?

The collaborative BCG service in Lothian continued to work well, however the nurse responsible for the community clinics retired in 2013 and various options for delivery of BCG vaccinations were explored. The TB service could not take this on along with their existing TB related work. Working with the Health Protection Team, the newly established community vaccination team was approached to help. They obtained funds and training to deliver the community BCG service.



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

The TB nursing service continues to provide training for administering the BCG



vaccine, enabling staff to deliver a safe, effective service.. In 2014/15 the community clinics administered by the community vaccination team commenced, alongside the established clinics in West Lothian and the Royal Infirmary.

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

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

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

What have we learned?

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



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

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

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

HOUSE OF CARE

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

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

Where were we in 2013?



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

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

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



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

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



What have we learned?

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

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

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

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

LEARNING DISABILITY – BROADENING OUR APPROACH

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



Where were we in 2013?

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

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



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

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

This work includes the following

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

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

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

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

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

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

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

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



What have we learned?

We have learned that;

- 1) When we take the time to understand the additional needs of people with disabilities, we can readily address these and provide more effective healthcare
- 2) the best way to find out what matters to people is by having good conversations with them
- 3) people are realistic about the support they need
- 4) Greater understanding of the exposure to health inequalities is directly informing how our integrated services need to work e.g. informing support plans with the individual to ensure that they more directly address issues such as social isolation
- 5) We need to record both numbers and stories to understand how our whole system is working. The continued role out of the Health
- 6) Equalities Framework will allow us to do this in localities and across the Health Board in Lothian
- 7) We know that more straightforward public information that works for people with learning disability also works for large groups of the general population

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

Outcomes relating to equitable quality of care for all patients

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

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

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

Introduction

NHS Lothian Minority Ethnic Health Inclusion Service (MEHIS)

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

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



Where were we in 2013?

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

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

DESMOND is only offered to those who can speak English and do not

require language support. Both Health Boards reported a very low uptake of DESMOND from South Asians. In addition, several Diabetes Educators reported that DESMOND is fairly prescriptive and too inflexible to adapt to meet the needs of minority ethnic people whose diet, culture and lifestyles are different from the majority group.



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

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

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

The main issues we encountered were:

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



What have we learned?

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

- The factors contributing to difficulties in recruitment were due to:
- NHS systems issues
- timing of education sessions
- Indian /Pakistani community / patient perception of diabetes and diabetes education
- under diagnosis of diabetes in the Indian /Pakistani population in West Lothian
- Providing group education to a gender segregated group from one language / cultural group was advantageous.

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

Some issues addressed following the pilot:

Ethnicity and Language recording:

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

In 2017, the Diabetes Retinopathy Screening Programme in Scotland will change their system to request ethnicity information from patients with diabetes throughout Scotland.

- The SCI-Diabetes register has included a field on the patient's preferred language.

Provision of language support:

In 2017, we have planned to trial simultaneous interpretation in group settings

You can learn more about this work at:

- <http://clinmedjournals.org/International-Archives-of-Nursing-and-Health-Care.php>
- Link to PDF of MEHIS Service Leaflet

Bi-lingual Bangladeshi Support Worker

Outcomes relating to equitable quality of care for all patients

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

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

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

Introduction

NHS Lothian Minority Ethnic Health Inclusion Service (MEHIS)

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

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



Where were we in 2013?

In 2013, MEHIS had an opportunity to appoint a Bi-lingual Bangladeshi Support Worker, (Band 3). Prior to 2013, the only language specific staff were Bilingual Link workers, (Band 5.)

Link workers have a dual role in supporting both minority ethnic clients and staff involved in their care. (Please see the attachment below for more information on the Link worker role)



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

The Support worker's role was to:

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

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

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

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



What have we learned?

The Support Worker (Band 3) role freed up Link worker (Band 5) time for more complex work.

The Link worker / Support worker model allows staff to not only bridge access to services but also to provide more intensive support to enable clients to improve their life circumstances and life styles.

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

DECLARATION FESTIVAL

Outcomes relating to equitable quality of care for all patients.

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

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

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



Where were we in 2013?

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



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

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

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

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

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



What have we learned?

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

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

GAMECHANGER

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

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



Where were we in 2013?

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



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

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

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

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

'Conversations for Change'

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

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

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

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

In November 2016, GameChanger partnered with Joined up for Business to bring an "Employ with Confidence" networking event to Edinburgh. The event

was an opportunity for businesses to gain advice and information on what funding and resource support is available to them for employing a member of staff who has a disability or health issue or indeed develops a disability or health issue. Hibernian FC also officially signed up on the day as a Disability Confident Employer and keynote speeches were delivered by Edinburgh East MP Tommy Sheppard, Hibernian Chief Executive Leeann Dempster and Alistair Kerr of the Shaw Trust.

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

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

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

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

Our Learning Centre at the Hibernian Community Foundation continues to expand, with a number of courses running, including ESOL (English for Speakers of Other Languages) classes.

Our first GameChanger Christmas Lunch took place on 25th December 2016.

Ninety people joined a team of volunteers for a festive get together and lunch in a safe and positive environment, entirely for free.



What have we learned?

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

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

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

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



Where were we in 2013?

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

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



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

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

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

[Tell us 10 things](#)

The Tell Us Ten Things Survey questions are as follows

1. Do you feel that staff took account of the things that matter to you?

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

Person Centred Key Performance Indicators

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

KPI1 Consistent delivery of nursing/midwifery care against identified need

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

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

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

KPI5 Time spent by nurses and midwives with the patient

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

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

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



What have we learned?

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

We are still learning from our work on understanding and improving care experience.

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

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

CASE STUDY: LEARNING DISABILITY HEALTH EQUALITY FRAMEWORK (HEF)

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

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



Where were we in 2013?

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



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

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

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

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

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

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



What have we learned?

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

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

It does require determined leadership.

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

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

Now we have opportunities to do more.

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

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

BUILDING ON THE WORK OF FOODBANKS

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



Where were we in 2013?

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

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



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

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

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



What have we learned?

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

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

Working together has provided a better service for food bank users.

[Food poverty poster](#)

[Foodbanks Map](#)

[Quick guide to 'crisis response' resources](#)

BOARD DIVERSITY MONITORING REPORT

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

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

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

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

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

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

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



Where were we in 2013?

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



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

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

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

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

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



What have we learned?

- That we can increase staff awareness of children's rights, but there is a long way to go to ensure that we adopt a rights based approach that shapes all of our services.
- That staff engaging directly with children enables staff to understand how important this is to children and how it could be incorporated into their work – people need to see the work to understand the difference it can make.
- That some adults automatically link rights and responsibilities and that this is unhelpful to children. Rights are given to children and their rights should not be conditional.

COLLECTIVE VOICE

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



Where were we in 2013?

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



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

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

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

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

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

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

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



What have we learned?

We have learned that:

- there is an appetite and enthusiasm for bringing supported self-management into the mainstream of planning and delivery in Midlothian
- it will take time to build Collective Voice as a group
- it is crucial to have conversations with individuals and networks to build an understanding of what we are trying to do.

HARM REDUCTION HEALTH NEEDS ASSESSMENT

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

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



Where were we in 2013?

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



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

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

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

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

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

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



What have we learned?

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

FEEDBACK & COMPLAINTS

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



Where were we in 2013?

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

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



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

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

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

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

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

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



What have we learned?

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

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

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

PROCUREMENT

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



Where were we in 2013?

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



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

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

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

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

Objectives:

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



What have we learned?

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

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

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

[Equalities in Procurement Policy.pdf](#)

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



Where were we in 2013?

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



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

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



What have we learned?

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

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

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

Conclusions and next steps

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

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

What we will do next

- Firstly we will take account of any immediate comments you make about this draft report.
- then in May 2017 we will publish our Equalities Outcomes 2014- 17 final report.
- On the basis of that report, we will devise an improvement plan for 2017-18, also including responses to any specific issues raised by internal and external audit.
- Implement an action plan for delivery of British Sign Language and Assistive and Augmentative Communication in line with new Scottish legislation.
- take time to convene and develop an expert equalities and human rights network in Lothian.
- obtain resources to support improved coverage and quality of impact assessment processes and evidence the use of Integrated Impact Assessments to shape policies affecting the wider determinants of health at national and local level.
- Support delivery of a successful **1st World Congress on Migration, Ethnicity, Race and Health – Diversity and Health** in May 2018 in Edinburgh.
- Develop and publish an updated Equality and Human Rights strategy in June 2018.

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

Equality and Diversity Monitoring Report – 2016-17

Introduction

The Northgate Empower (PWA) HR system includes Electronic Staff Records (ESR) for all staff employed within NHS Lothian.

This allows for reports to be compiled on the diversity profile of the organisation's workforce by individual job family. While ethnic monitoring for all new staff recruited to the organisation is recorded, there remains a proportion of the workforce for which no record exists on account of their original start date and that they have been in post for a significant period of time.

As at March 2017, 24,495 staff are covered by the ethnic monitoring process. This report includes sections on ethnicity, disability, gender and age of the workforce and also provides a similar breakdown for new employees within the year, training intake, promotion, regradings and leavers. Staff Bank data is not included within the main part of the report but there is a separate section on Staff Bank under section 9.

Section 1: Ethnic Profile

The following table illustrates the breakdown, by job family, of those employees covered by the ethnic monitoring process to date. It shows that of those covered by the process, 65% responded - remaining the same as recorded at the same period last year.

Table 1: Responses to ethnic monitoring as at March 2017

Ethnic Origin Description	Administrative Services	Allied Health Professional	Executive	Healthcare Sciences	Medical	Medical and Dental Support	Nursing Bands 1-4	Nursing Bands 5+	Other Therapeutic	Support Services	Personal and Social Care	Grand Total
Declined	1,113	511	63	273	1,470	160	926	2,259	197	1,521	27	8,520
Declined to Comment %	31.45	24.73	52.50	32.62	52.07	39.80	30.61	28.50	24.53	52.65	41.54	34.78
Responded	2,426	1,555	57	564	1,353	242	2,099	5,667	606	1,368	38	15,975
Responded %	68.55	75.27	47.50	67.38	47.93	60.20	69.39	71.50	75.47	47.35	58.46	65.22
Grand Total	3,539	2,066	120	837	2,823	402	3,025	7,926	803	2,889	65	24,495

The above table shows headcount and excludes those staff working on the Nurse Bank and with more than one job with NHS Lothian. A total of 15,975 responses have been received to date. The following table chart details the percentage of staff within job family that responded.

Chart 1: Overall Response rate by Job Family

Breakdown of Ethnic Response by Job Family as at March 2017

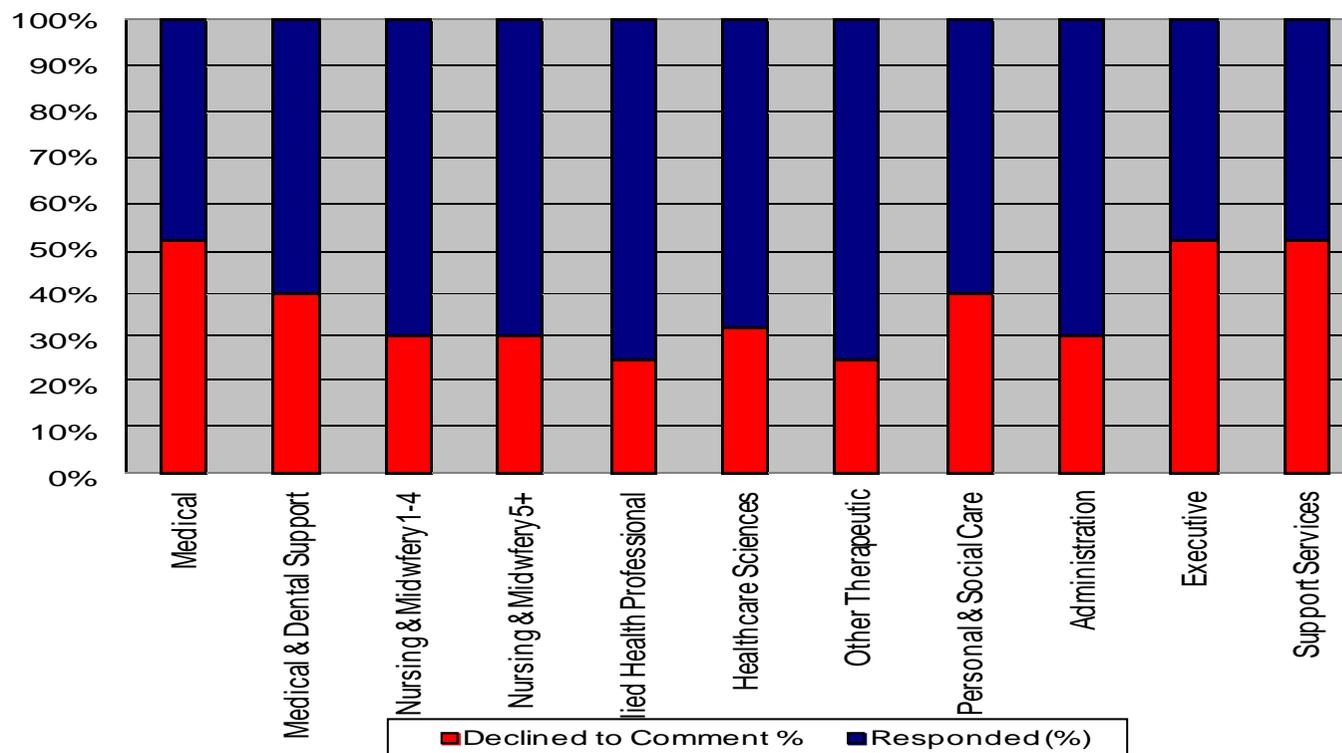


Table 2: Identifying Ethnic Backgrounds of those who responded (Heacount) – As at March 2017

The lowest response levels are in Executive, Medical and Personal & Social Care Job Family and the highest response levels are in Allied Healthcare Professionals and Other Therapeutic.

The following table maps the ethnic origin within individual job family groups. It shows that of the responses received to date, 68% are of 'White Scottish' origin.

Job Family	African	Any Mixed Background	Bangladeshi	Caribbean	Chinese	Indian	Other Asian	Other Black	Other British	Other Ethnic Background	Other White	Pakistani	White Irish	White Polish	White Scottish	Grand Total
Administrative Services	15	16		3	8	16	7	3	243	8	204	4	21	2	1,876	2,426
Healthcare Sciences	7	7			4	5	3		102	2	87	5	12		330	564
Medical and Dental Support	2			1	1	2	1	1	20		21		2	1	190	242
Other Therapeutic	4	7			3	5	2	1	105	3	64	5	29	1	377	606
Personal and Social Care									3		3	1	2		29	38
Support Services	19	9	2		17	13	14		77	6	109	3	5	1	1,093	1,368
Allied Health Professional	8	13			6	4	3		288	5	107	7	120	3	991	1,555
Nursing Bands 1-4	27	9	3		9	16	27	4	154	9	135	8	20	3	1,675	2,099
Nursing Bands 5+	75	24	2	10	33	80	47	5	734	33	642	11	144	6	3,821	5,667
Medical	9	26	2	3	27	50	23	2	429	21	221	23	58		459	1,353
Executive									12		7		3		35	57
Grand Total	166	111	9	17	108	191	127	16	2,167	87	1,600	67	416	17	10,876	15,975
Percentage of those who responded	1.04	0.69	0.06	0.11	0.68	1.20	0.79	0.10	13.56	0.54	10.02	0.42	2.60	0.11	68.08	15,975

Section 2: Gender Profile

The following table illustrates the breakdown, by gender distribution, of those employees covered by the ethnic monitoring process to date.

Table 3: Gender Distribution

Gender	Administrative Services	Healthcare Sciences	Medical and Dental Support	Other Therapeutic	Personal and Social Care	Support Services	Allied Health Professional	Nursing Bands 5+	Medical	Nursing Bands 1-4	Executive	Grand Total
Female	2,960	561	294	674	55	1,578	1,860	7,088	1,443	2,535	56	19,104
Male	576	276	108	128	10	1,307	204	838	1,309	490	63	5,309
Not Provided	3			1		4	2		71		1	81
Grand Total	3,539	837	402	803	65	2,889	2,066	7,926	2,823	3,025	120	24,495

The above table shows a predominantly female workforce of 78% compared to a male workforce of 21.6%. By far the greatest number of female are found within Nursing Bands 5+, with high numbers also in Nursing Bands 1-4 and Admin Services.

Section 3: Demographic Profile

Table 4: Age Distribution by Job Family

Job Family	Under 20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+	Grand Total
Administrative Services	14	118	235	278	283	376	534	629	613	339	79	41	3,539
Healthcare Sciences	1	33	89	106	129	97	100	111	102	57	12		837
Medical and Dental Support	1	10	44	64	35	49	59	69	51	17	2	1	402
Other Therapeutic	2	32	104	127	135	96	119	92	60	29	3	4	803
Personal and Social Care			5	6	7	7	11	7	14	7		1	65
Support Services	58	171	234	218	186	244	317	438	461	330	113	119	2,889
Allied Health Professional	1	85	279	295	339	260	252	278	190	76	9	2	2,066
Nursing Bands 5+		376	893	948	1,028	1,055	1,188	1,362	800	245	24	7	7,926
Medical		81	479	436	446	388	343	317	218	87	19	9	2,823
Nursing Bands 1-4	23	243	388	278	244	260	397	509	420	188	57	18	3,025
Executive			1	1	4	4	16	44	31	11	5	3	120
Grand Total	100	1,149	2,751	2,757	2,836	2,836	3,336	3,856	2,960	1,386	323	205	24,495

The above table demonstrates that overall 34.5% of the workforce are over the age of 50 years old. The category with the single largest number of staff age 50-54, in contrast to 10 years ago when it was 40-44.

Section 4: Disabled Profile

The table below shows those members of staff, during the recruitment process, who have declared themselves as having a disability when asked *“Do you have a physical or mental health disability that: has a substantial effect on your ability to carry out day to day activities and has lasted or is expected to last 12 months or more?”*

Table 5 shows that a total of 347 individuals declared themselves as having a disability. Of these, 79.67 (28.75%) were recorded against

administrative services and a total of 118.34 wte against all Nursing and Midwifery (41.3%).

Table 5: Employees who have declared themselves as having a disability by Job Family as at March 2017.

Job Family	Headcount	WTE
Administrative Services	102	82.32
Healthcare Sciences	12	10.8
Medical and Dental Support	7	6.41
Other Therapeutic	19	14.9
Support Services	28	18.39
Allied Health Professional	35	26.73
Nursing Bands 5+	90	83.4
Medical	8	6.47
Nursing Bands 1-4	44	34.94
Executive	2	2
Grand Total	347	286.36

Of the 24,495 staff covered by the monitoring exercise to date, the number of staff declaring themselves as having a disability amounts to just over 1% (1.1%).

Section 5: New Starts Profile

There were a total of 3,287 new starters in the year to March 2017. The following tables outline the profile of new starters by job family, age and gender.

Table 6: Age Category and Gender for New Starts from Aril 2016 – March 2017

Job Family	16 to 20	21 to 25	26 to 30	30 to 35	31 to 35	36 to 40	41 to 45	46 to 50	51 to 55	56 to 60	61 to 65	66 or older	Grand Total
Administrative Services	19	63	68	0	38	37	47	39	39	26	7	0	383
Allied Health Professionals	2	73	63	0	25	14	17	8	9	2	0	0	213
Healthcare Sciences	1	17	22	0	12	13	0	6	5	2	0	0	78
Medical	1	371	288	12	136	65	40	26	18	9	1	0	967
Medical and Dental Support	0	3	1	0	2	1	1	1	0	1	0	0	10
Nursing Band 1-4	47	160	92	0	53	37	32	38	36	17	1	1	514
Nursing Bands 5+	16	191	126	0	91	56	50	54	51	14	3	1	653
Other Therapeutic	5	28	36	0	16	13	15	10	5	3	0	0	131
Personal and Social Care	0	0	3	0	1	2	0	1	0	0	0	0	7
Support Services	55	39	39	2	29	22	24	36	45	26	8	3	328
Executive	0	0	0	0	0	1	0	1	1	0	0	0	3
Grand Total	146	945	738	14	403	261	226	220	209	100	20	5	3,287

Job Family	Female	Male	Unknown	Grand Total
Administrative Services	303	77	3	383
Allied Health Professional	189	24		213
Healthcare Sciences	54	24		78
Medical	532	389	46	967
Medical and Dental Support	5	5		10
Nursing Bands 1-4	432	82		514
Nursing Bands 5+	588	65		653
Other Therapeutic	112	18	1	131
Personal and Social Care	6	1		7
Support Services	189	139		328
Executive	2	1		3
Grand Total	2,412	825	50	3,287

The following table outlines the ethnic profile of new starters in the year to March 2017 as well as noting by job family those who declined to respond to the ethnic monitoring exercise.

Table 7: Ethnicity of New Starts by Job Family from April 2016 to March 2017

Job Family	African	Any Mixed Background	Bangladeshi	Caribbean	Chinese	Declined	Indian	Other Asian	Other Black	Other British	Other Ethnic Background	Other White	Pakistani	White Irish	White Polish	White Scottish	Grand Total
Administrative Services	6	2		1		45	5	1	1	55	3	26	1	6		231	383
Allied Health Professional		1			2	6		3		43		19	2	24	1	112	213
Healthcare Sciences	1	1			1	3		2		12		13	3	5		37	78
Medical	4	11	1		20	464	17	6	1	196	6	49	7	30		155	967
Medical and Dental Support				1	1	1						2				5	10
Nursing Bands 1-4	7	3		1	3	27	4	5		36	2	21	5	8		392	514
Nursing Bands 5+	11	7		3	6	42	4	4		88	2	44	5	31		406	653
Other Therapeutic	2	2				13	2	1		18	1	9	2	6	1	74	131
Personal and Social Care												1				6	7
Support Services	1				2	154	2	2		12		26	1			128	328
Executive						3											3
Grand Total	32	27	1	6	35	758	34	24	2	460	14	210	26	110	2	1546	3,287

Overall there were a total of 3,287 new starters in the year to March 2017, of which 77% responded to the ethnic monitoring exercise. Of those new starts who responded, 47% were 'White Scottish'. The next highest group were those under 'Other British' amounting to approximately 13.5%. The number who declined to respond was 758 (23%).

Section 6: Training and Attendance Profile

Course Bookings and Attendances

A total of 63,492 bookings for internal courses were recorded in the year to March 2017. Within the same time-line there was a total of 47,373 attendances made on training courses. The figures for 'Booked' represent those who have applied during monitoring period, in some cases the course/training instance will take place in the following monitoring period and as such will not show up as an attendee until the following period.

Table 8: Course Bookings and Attendances April 2016 to March 2017 (Episodes)- by Job Family and Age Category

Status	Job Family	16 to 20	21 to 25	26 to 30	31 to 35	36 to 40	41 to 45	46 to 50	51 to 55	56 to 60	61 to 65	66 or older	Grand Total
Attended	Administrative Services	143	372	474	308	446	533	574	585	148	50	14	3,647
	Allied Health Profession	26	554	581	450	338	445	353	192	32	6	1	2,978
	Healthcare Sciences	8	97	118	91	92	85	112	58	31	3		695
	Medical	2	660	521	349	210	196	168	78	15	7	5	2,211
	Medical and Dental Support	26	92	59	59	79	109	75	34	8	1		542
	Nursing Bands 1-4	620	1,426	995	715	743	935	940	668	160	49	9	7,260
	Nursing Bands 5+	314	4,613	3,629	3,188	3,047	3,421	2,833	1,301	334	54	24	22,758
	Other Therapeutic	9	154	204	128	137	110	84	43	9	5		883
	Personal and Social Care		9	10	10	9	17	14	20	8			97
	Support Services	609	507	515	472	521	875	986	974	547	190	62	6,258
Executive			2	1	5	19	13	3	1			44	
Attended Total		1,757	8,484	7,108	5,771	5,627	6,745	6,152	3,956	1,293	365	115	47,373
Booked	Administrative Services	20	75	111	86	116	167	158	153	42	13	3	944
	Allied Health Profession	16	117	100	91	97	108	71	39	5			644
	Healthcare Sciences	5	18	23	18	14	20	27	25	11			161
	Medical		21	23	46	25	34	24	8	1			182
	Medical and Dental Support	3	6	7	11	5	18	6	9				65
	Nursing Bands 1-4	211	476	301	256	225	338	365	231	57	17		2,477
	Nursing Bands 5+	77	1,383	1,248	1,020	1,061	1,095	978	404	105	11	6	7,388
	Other Therapeutic		14	35	18	30	26	21	5	3	1		153
	Personal and Social Care		3	5	2	2	7	3	5	7			34
	Support Services	21	14	31	18	30	32	64	55	26	8		299
Executive					3	2	4	3				12	
Grand Total		2,110	10,607	8,992	7,337	7,235	8,592	7,873	4,893	1,550	415	124	59,732

Table 9: Ethnic Breakdown for Course Bookings and Attendances for April 2016 to March 2017

Status	Post Family Description	African	Any Mixed Background	Bangladeshi	Caribbean	Chinese	Declined	Indian	Other Asian	Other Black	Other British	Other Ethnic Background	Other White	Pakistani	White Irish	White Polish	White Scottish	Grand Total	
Attended	Administrative Services	40	24		3	6	763	28	7	5	331	16	258	6	31	1	2,128	3,647	
	Allied Health Profession	11	31	1		12	628	5	5		425	5	183	12	156	4	1,495	2,978	
	Healthcare Sciences	5	8			6	186	3	3		83	1	69	7	14		310	695	
	Medical	14	25	3	3	33	995	39	27	2	436	18	124	18	55		419	2,211	
	Medical and Dental Support	9	1		3	2	187	1	4		26		33		1		1	274	542
	Nursing Bands 1-4	105	34	9		37	1,417	36	76	12	452	33	325	34	81	11	4,598	7,260	
	Nursing Bands 5+	267	86	5	21	93	5,049	230	164	24	2,414	103	1,784	48	592	12	11,866	22,758	
	Other Therapeutic	11	6			2	206	5	4			113	5	57	9	41	3	421	883
	Personal and Social Care						37					10		2	3	1		44	97
	Support Services	74	21	3			23	2,934	29	35		187	12	209	5	9	2	2,715	6,258
Executive							19				3		6				15	44	
Attended Total		536	236	21	30	214	12,426	376	325	43	4,480	193	3,050	142	982	34	24,285	47,373	
Booked	Administrative Services	7	4			2	260	6	1		58	1	51	2	11		541	944	
	Allied Health Profession		5	1		1	161	1			101		37		32	1	304	644	
	Healthcare Sciences					1	42	2			24		17		1		74	161	
	Medical		3			1	81	6			37		12	1	6		35	182	
	Medical and Dental Support						26				3		5				31	65	
	Nursing Bands 1-4	63	10	6		5	542	11	16	3	134	16	74	8	6	4	1,579	2,477	
	Nursing Bands 5+	111	27		3	25	1,821	63	41	8	736	23	519	3	219	5	3,784	7,388	
	Other Therapeutic	2	3			1	34		1		18		9	2	2		81	153	
	Personal and Social Care						11				1						22	34	
	Support Services	7					126	1			12		12	1			140	299	
Executive						4				1				2		5	12		
Booked Total		726	288	28	33	250	15,533	466	384	54	5,605	233	3,786	159	1,261	44	30,881	59,732	

Staff Participating in Training

The following table shows the breakdown by ethnic profile and by Job Family for those staff who participated in training in the year to March 2017. These figures differ from 'Booked' and 'Attended' figures due to inclusion of staff attending externally run training.

In total there were 55, 136 episodes of staff participating in training during the year to March 2017. Of those who responded to the monitoring exercise, 50.8% were accounted for by those under 'White Scottish' while all non-white episodes amounted to 10%. A total of 27% of the total number of episodes did not allow for further ethnic monitoring as these staff did not respond to the monitoring process.

Table 10: Staff Participating in Training by Ethnic Group for April 2016 to March 2017 (Episodes)

Ethnic Category	16 to 20	21 to 25	26 to 30	31 to 35	36 to 40	41 to 45	46 to 50	51 to 55	56 to 60	61 to 65	66 or older	Unknown	Grand Total
African	9	31	54	157	166	82	84	19	6				608
Any Mixed Background	16	94	55	34	10	14	15	25			2	3	268
Bangladeshi	6	3		2	1	4	7						23
Caribbean		6		3		19	2	4					34
Chinese	11	49	28	51	34	57	18	2					250
Declined	300	835	1,450	1,684	2,079	2,997	2,864	1,632	564	156	63	154	14,778
Indian	4	49	64	120	84	57	12	11	3	12			416
Other Asian	1	57	43	56	88	77	35	11				1	369
Other Black				4	7	22	5	6	5				49
Other British	107	1,131	880	751	636	651	515	361	105	14	13	2	5,166
Other Ethnic Background	10	22	18	47	44	35	17	13	1	5			212
Other White	11	201	769	557	607	527	580	240	71	12	1		3,576
Pakistani	21	59	16	17	18	12	12	3					158
White Irish	19	450	298	164	69	42	40	55	7	3			1,147
White Polish		9	5	9	4	7		2				4	40
White Scottish	1,537	6,646	4,557	2,967	2,668	3,338	3,051	2,279	733	212	51	3	28,042
Grand Total	2,052	9,642	8,237	6,623	6,515	7,941	7,257	4,663	1,495	414	130	162	55,136

Section 7: Staff Promotion/ Re-Grading

The following table identifies those staff who have been promoted or have been re-graded (incl temporary upgrades) in the year to March 2017 by ethnicity and by Job Family.

Table 11: Staff Promotion/ Re-Grading profile by ethnic category and job family – April 2016 to March 2017

Job Family	African	Any Mixed Background	Bangladeshi	Caribbean	Chinese	Declined	Indian	Other Asian	Other Black	Other British	Other Ethnic Background	Other White	Pakistani	White Irish	White Scottish	Grand Total
Administrative Services				1		26	1	1		3		7			20	59
Allied Health Professional Healthcare Science		1				9				10	1	2		8	31	62
Medical	1				1	42	5	3		3		6			11	22
Medical and Dental Support		2	1			5				27	3	7	4	6	40	145
Nursing Bands 1-4						1						1			1	3
Nursing Bands 5+						14				4		5			49	72
Other Therapeutic	4	1	1		3	42	1		1	35		12		8	167	275
Personal and Social Care					1	3				4		1	1	2	18	30
Executive						1				1					1	2
Support Services						1						1			1	3
Support Services					2	29	1	1		2		2			25	62
Grand Total	5	4	2	1	12	167	8	5	1	89	4	44	5	24	364	735

In total, 719 ethnic profiles were known and of these 49.5% were 'White Scottish'. In contrast all non-white categories amounted to 19.7% of the known ethnic returns of those who had been promoted or been re-graded in the year to March 2017, of these 44 (6.5%) were in Black and Minority Ethnic categories which is an increase from 38 (0.4%) in the year to March 2016.

Section 8: Leavers

The following table shows the leavers profile by ethnicity and by Job Family

Table 12: Leavers by Staff category and Ethnic Breakdown – April 2016 to March 2017

Job Family	African	Any Mixed Background	Bangladeshi	Caribbean	Chinese	Declined	Indian	Other Asian	Other British	Other Ethnic Background	Other White	Pakistani	White Irish	White Polish	White Scottish	Grand Total	
Administrative Services	1	2				92	2	2	24	2	13	1	6		152	297	
Allied Health Professional		2				36		1	30		12	1	18			87	187
Healthcare Sciences	1					25	1		10		1	2	6			26	72
Medical	2	5	3	1	12	239	18	7	128	9	37	6	16	1		89	573
Medical and Dental Support						10		1	2							6	19
Nursing Bands 1-4	7	1		1		66	1	2	15	1	18	1	2	1		182	298
Nursing Bands 5+	5	2			1	163	2	3	67	2	48	2	22			262	579
Other Therapeutic	1	1				22			8	1	8		6			37	84
Personal and Social Care						4			3			1				5	13
Executive						5										8	13
Support Services	4				1	113		4	7		8		1	1		91	230
Grand Total	21	13	3	2	14	775	24	20	294	15	145	14	77	3	945	2,365	

Of those leavers who responded to the monitoring exercise, 49.4% were accounted for under 'White'. In contrast all non-white leavers accounted for 5% of those who responded to the data gathering exercise.

Section 9: Ethnicity, Gender and Age Information on Bank staff

The information below includes those staff not included in the above figures and who hold a bank only contract.

Table 13: Bank Staff by Job Family and Ethnic Category

Job Family	African	Any Mixed Background	Bangladeshi	Chinese	Declined	Indian	Other Asian	Other Black	Other British	Other Ethnic Background	Other White	Pakistani	White Irish	White Polish	White Scottish	Grand Total
Admin Services					69	1			2		1		1		18	92
AHP Bands 1-4															2	2
AHP Bands 5+		1			23				6		3	1	2	1	12	49
Healthcare Sciences					3				4				1		8	16
Medical		1			59	2			19		5	1	3		26	116
Medical & Dental Support					1											1
Nursing Band 1-4	15	5		5	277	3	12	1	67	1	44	3	21	4	419	877
Nursing Band 5-7	8	1		2	226	6	4	1	44	3	26	1	12	2	249	585
Nursing Band 8+					4				1						2	7
Other Therapeutic					4				2							6
Support Services	2	1	1		77	4	1		7	1	11	1	1		80	187
Grand Total	25	9	1	7	682	16	17	2	152	5	90	7	41	7	816	1,938

Table 14: Bank Staff by Job Family and Gender

Gender	Admin Services	AHP Bands 1-4	AHP Bands 5+	Healthcare Sciences	Medical	Medical & Dental Support	Nursing Band 1-4	Nursing Band 5-7	Nursing Band 8+	Other Therapeutic	Support Services	Grand Total
Female	27	2	45	10	53		734	510	6	5	99	1,491
Male	11		4	6	63	1	141	65		1	87	379
Declined	54						2	10	1		1	68
Grand Total	92	2	49	16	116	1	877	585	7	6	187	1,938

Table 15: Bank Staff by Job Family and Age Category

Age Category	Admin Services	AHP Bands 1-4	AHP Bands 5+	Healthcare Sciences	Medical	Medical & Dental Support	Nursing Band 1-4	Nursing Band 5-7	Nursing Band 8+	Other Therapeutic	Support Services	Grand Total
Under 20							25				10	35
20-24	6		2	1			184	28			19	239
25-29	9	1	5	1	23		171	46			7	263
30-34	13		5	1	47		122	62			14	254
35-39	5		2	1	14		86	64			17	189
40-44	9		3		11		40	70		1	12	146
45-49	10		10	1	9		60	68	1		10	169
50-54	9		5	2	4		58	58		1	14	151
55-59	14		5	2	3		59	93	1	2	24	203
60-64	11	1	6	4	3		36	70	3		37	171
65-69	4		5	3	2		30	24	2	1	21	92
70+	3		1			1	6	2		1	2	16
Grand Total	92	2	49	16	116	1	877	585	7	6	187	1,938

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

Equal Pay Statement Data

Table 1 – Overall Gender Pay Gap for NHS Lothian

	Female			Male					
	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Monetary Variance Male to Female £	Gender Pay Gap	Total Count of Gender
Medical Staff	1,335	28.40	54%	1,142	33.26	46%	4.87	17%	2,477
Executive/Senior Managers	39	35.81	45%	47	38.50	55%	2.68	7%	86
Agenda for Change Staff	17,484	13.58	82%	3,953	12.76	18%	-0.81	-6%	21,437

The Equality Act 2010 specifies that public authorities must report the gender pay gap in the form of information on the percentage difference among its employees between men's average hourly rate (excluding overtime) and women's average hourly rate (excluding overtime).

Table 1 provides a summary of the hourly pay rate and the gender pay gap for each contract group. The figures reported in this table show a comparison between men's and women's average hourly pay within the specific contract group. Thus, within Agenda for Change the average hourly pay for women is £13.58 and for men is £12.76. The overall pay gap within the specific contract groups is small. **Tables 2, 3 and 4** below provide a more detailed analysis of pay within the specific contract groups and compares the average hourly rate by gender across each of the pay bands in the particular contract group to determine whether there are differences within the individual pay grades.

Gender Profile - Each of the tables 1-4 also provides an analysis across each of the contract groups and by grade of the number of men and women employed by NHS Lothian in each of these categories. The gender split is expressed as a percentage of the total workforce based on headcount.

Table 2 – Pay Deferential for Medical and Dental Staff

Row Labels	Female			Male			Monetary Variance Male to Female £	Gender Pay Gap	Total Count of Gender
	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family			
Associate Specialist	46	40.6	2%	11	39.8	0%	-0.81	-2%	57
Ast Clinical Director	N/A	N/A	N/A	2	39.6	0%	N/A	N/A	2
Clinical Director	N/A	N/A	N/A	1	42.9	0%	N/A	N/A	1
Consultant	387	43.4	16%	537	44.3	22%	0.81	2%	924
Dental Officer	32	30.1	1%	8	37.5	0%	7.48	25%	40
DENTAL PRACTICE ADVISER LHB	N/A	N/A	N/A	4	75.7	0%	N/A	N/A	4
FORENSIC M/EXAMINER SALARY RANGE	1	0.0	0%	N/A	N/A	N/A	N/A	N/A	1
FY1	94	11.3	4%	52	11.3	2%	0.00	0%	146
FY2	100	14.0	4%	62	14.0	3%	-0.07	0%	162
GEN MED PRAC PARA 94 + 107	5	26.3	0%	5	26.3	0%	0.00	0%	10
GP	46	37.7	2%	45	39.1	2%	1.38	4%	91
GP APPRAISER	25	42.2	1%	12	42.4	0%	0.13	0%	37
GPST	47	16.5	2%	13	16.1	1%	-0.38	-2%	60
Hospital Practitioner	N/A	N/A	N/A	3	34.6	0%	N/A	N/A	3
Locum Consultant	20	40.0	1%	33	45.7	1%	5.62	14%	53
LOCUM MEDICAL OFFICER SESSIONAL	1	26.3	0%	N/A	N/A	N/A	N/A	N/A	1
MEDICAL PRACTITIONER P/T COMM	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Senior Dental Officer	9	34.0	0%	N/A	N/A	N/A	N/A	N/A	9
SHO	7	17.7	0%	3	17.0	0%	-0.74	-4%	10
Speciaist Dental Officer	6	40.7	0%	4	40.7	0%	0.00	0%	10
Specialty Doctor	96	29.1	4%	59	29.3	2%	0.19	1%	155
Specialty Registrar	413	18.9	17%	288	18.9	12%	-0.01	0%	701
Total	1,335	28.4	54%	1142	33.3	46%	4.87	17%	2,477

Table 3 – Pay Deferential for Senior Managers

	Female			Male					
	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Monetary Variance Male to Female £	Gender Pay Gap	Total Count of Gender
Exec/SM - A	17	27.44	20%	19	28.51	22%	1.06	4%	36
Exec/SM - B	8	33.62	9%	5	32.60	6%	-1.02	-3%	13
Exec/SM - C	4	35.15	5%	7	39.60	8%	4.45	13%	11
Exec/SM - D	1	46.03	1%	3	41.92	3%	-4.12	-9%	4
Exec/SM - E	5	51.24	6%	9	48.55	10%	-2.70	-5%	14
Exec/SM - F	1	47.51	1%	1	50.97	1%	N/A	N/A	2
Exec/SM - G	3	56.93	3%	1	52.68	1%	-4.24	-7%	4
Exec/SM - I	N/A	N/A	N/A	2	80.55	2%	N/A	N/A	2
Total	39	35.81	45%	47	38.50	55%	2.68	7.5%	86

Table 4 - Pay Deferential for Staff on Agenda for Change Pay bands

Administrative									
Band	Female			Male			Statutory Variance Male to Female £	Gender Pay Gap	Total Count of Gender
	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Gender Count	Average of Basic Hourly Rate	Gender Count as % of JF			
1	1	8.25	0%	1	8.25	0%	0.00	0%	2
2	966	9.13	28%	146	8.93	4%	-0.20	-2%	1,112
3	597	9.93	17%	66	9.80	2%	-0.13	-1%	663
4	814	11.43	23%	84	10.98	2%	-0.45	-4%	898
5	235	13.67	7%	108	13.34	3%	-0.33	-2%	343
6	145	16.81	4%	90	16.81	3%	0.00	0%	235
7	85	19.72	2%	47	19.71	1%	-0.01	0%	132
8+	72	27.31	2%	33	27.61	1%	0.30	1%	105
Total	2,915	11.44	84%	575	13.34	16%	1.90	17%	3,490

ALLIED HEALTH PROFESSION									
Band	Female			Male			Statutory Variance Male to Female £	Gender Pay Gap	Total Count of Gender
	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family			
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	48	8.90	2%	2	9.46	0%	0.56	6%	50
3	165	9.91	8%	26	9.71	1%	-0.20	-2%	191
4	74	11.25	4%	20	11.20	1%	-0.05	0%	94
5	361	13.18	18%	56	12.51	3%	-0.67	-5%	417
6	743	17.07	37%	61	16.74	3%	-0.33	-2%	804
7	324	20.71	16%	19	19.94	1%	-0.77	-4%	343
8+	84	26.42	4%	11	28.69	1%	2.27	9%	95
Total	1,799	16.27	90%	195	14.93	10%	-1.34	-8%	1994

Dental Support									
Band	Female			Male			Statutory Variance Male to Female £	Gender Pay Gap	Total Count of Gender
	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family			
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	31	8.98	12%	1	9.46	0%	0.48	5%	32
3	7	9.60	3%	N/A	N/A	N/A	N/A	N/A	7
4	165	11.38	62%	5	11.33	2%	-0.05	0%	170
5	29	14.23	11%	3	13.82	1%	-0.41	-3%	32
6	16	16.88	6%	4	16.03	1%	-0.85	-5%	20
7	2	19.35	1%	3	19.14	1%	-0.21	-1%	5
8+	1	22.23	0%	1	24.81	0%	2.58	12%	2
Total	251	11.82	94%	17	14.94	6%	3.12	26%	268

HEALTHCARE SCIENCES									
Band	Female			Male			Statutory Variance Male to Female £	Gender Pay Gap	Total Count of Gender
	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family			
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	54	9.12	6%	8	9.25	1%	0.13	1%	62
3	65	9.87	7%	39	9.71	4%	-0.16	-2%	104
4	38	10.89	4%	25	11.07	3%	0.18	2%	63
5	68	13.07	8%	33	12.84	4%	-0.23	-2%	101
6	188	16.89	21%	86	17.18	10%	0.29	2%	274
7	125	20.42	14%	59	20.59	7%	0.17	1%	184
8+	52	27.65	6%	43	29.07	5%	1.42	5%	95
Total	590	16.28	67%	293	17.39	33%	1.11	7%	883

MEDICAL SUPPORT									
Band	Female			Male			Statutory Variance Male to Female £	Gender Pay Gap	Total Count of Gender
	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family			
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	4	8.46	3%	2	8.25	2%	-0.21	-2%	6
3	N/A	N/A	N/A	1	9.90	1%	N/A	N/A	1
4	2	10.89	2%	1	11.60	1%	0.71	7%	3
5	43	14.19	32%	44	14.33	33%	0.14	1%	87
6	7	17.19	5%	16	17.44	12%	N/A	N/A	23
7	4	19.49	3%	8	21.04	6%	1.55	8%	12
8+	N/A	N/A	N/A	1	24.81	1%	N/A	N/A	1
Total	60	14.40	45%	73	15.62	55%	1.22	8%	133

NURSING									
Band	Female			Male			Statutory Variance Male to Female £	Gender Pay Gap	Total Count of Gender
	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family			
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	2,007	9.03	18%	391	9.03	4%	-0.01	0%	2,398
3	426	10.02	4%	104	10.02	1%	0.00	0%	530
4	126	11.07	1%	13	11.15	0%	0.08	1%	139
5	4,308	13.78	39%	461	13.90	4%	0.13	1%	4,769
6	1,935	17.10	18%	237	17.07	2%	-0.03	0%	2,172
7	789	20.37	7%	115	19.98	1%	-0.39	-2%	904
8+	111	27.10	1%	29	25.71	0%	-1.39	-5%	140
Total	9,702	13.95	88%	1350	13.49	12%	-0.45	-3%	11,052

OTHER THERAPEUTIC									
Female				Male					
Band	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Statutory Variance Male to Female £	Gender Pay Gap	Total Count of Gender
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	39	8.92	5%	11	9.30	1%	0.38	4%	50
3	5	10.02	1%	3	9.64	0%	-0.38	-3%	8
4	67	10.87	9%	8	10.02	1%	-0.86	-6%	75
5	98	13.71	13%	10	13.25	1%	-0.45	-3%	108
6	81	15.33	11%	19	15.47	3%	0.13	1%	100
7	154	19.25	20%	20	18.94	3%	-0.31	-1%	174
8+	200	26.29	26%	40	26.78	5%	0.49	3%	240
Total	644	18.53	85%	111	18.81	15%	0.28	1%	755

PERSONAL AND SOCIAL CARE									
Female				Male					
Band	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Statutory Variance Male to Female £	Gender Pay Gap	Total Count of Gender
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	2	9.77	3%	N/A	N/A	N/A	N/A	N/A	2
4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5	16	13.49	20%	7	13.06	1%	-0.43	-2%	23
6	27	17.45	34%	5	18.02	1%	0.57	3%	32
7	17	20.74	22%	3	21.37	0%	0.63	2%	20
8+	2	25.17	3%	N/A	N/A	N/A	N/A	N/A	2
Total	64	17.34	81%	15	16.38	2%	-0.96	-6%	79

SUPPORT SERVICES									
Band	Female			Male			Total		
	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Gender Count	Average of Basic Hourly Rate	Gender Count as % of Job Family	Monetary Variance Male to Female £	Gender Pay Gap	Total Count of Gender
1	217	8.25	0.08	83	8.25	0.03	0.00	0.00	300
2	985	8.49	36%	825	8.78	30%	0.29	3%	1,810
3	181	10.05	7%	182	9.86	7%	-0.19	-2%	363
4	20	11.14	1%	144	10.93	5%	-0.21	-2%	164
5	8	13.38	0%	24	13.34	1%	-0.04	0%	32
6	3	16.03	0%	18	15.75	1%	-0.28	-1%	21
7	5	19.36	0%	26	19.77	1%	0.41	1%	31
8+	5	31.69	0%	12	29.24	0%	-2.45	-28%	17
Total	1,424	8.85	52%	1314	9.72	48%	0.86	10%	2,738

Occupational Segregation by Disability and by Race

Table 5 below shows the Occupational segregation by disability and also the average hourly basic pay for each of the staff groups for each of the responses. Only 1% of the NHS Lothian staff identifies as disabled; 32% identify as not disabled and 67% either declined to respond or preferred not to declare.

Table 6 below shows the Occupational segregation by race across each of the contract groups along with the average hourly basis pay for each group of staff. The race categories used are the NHS Scotland monitoring categories harmonised to the Scottish Census.

It is clear from the information in both tables below that there is wide under reporting within the organisation and this will be a focus of attention during 2017/18 to improve the disclosure rates for protected characteristics including disability and race.

Job Family	Disabled	Total Employments	Average of Basic Hourly Rate
ADMINISTRATIVE SERVICES	No	2203	11.53
	Yes	99	10.64
	Not Known	1214	12.22
	ADMINISTRATIVE SERVICES Total	3516	11.75
ALLIED HEALTH PROFESSION	No	1224	14.89
	Yes	29	13.93
	Not Known	741	18.29
	ALLIED HEALTH PROFESSION Total	1994	16.14
DENTAL SUPPORT	No	175	11.64
	Yes	5	13.75
	Not Known	88	12.68
	DENTAL SUPPORT Total	268	12.02
HEALTHCARE SCIENCES	No	420	14.84
	Yes	12	12.62
	Not Known	452	18.42
	HEALTHCARE SCIENCES Total	884	16.64
MEDICAL SUPPORT	No	35	12.59
	Not Known	98	15.96
	MEDICAL SUPPORT Total	133	15.07
NURSING/MIDWIFERY	No	2795	10.70
	Yes	76	10.87
	Not Known	8183	15.01
	NURSING/MIDWIFERY Total	11052	13.89
OTHER THERAPEUTIC	Not Known	771	18.29
OTHER THERAPEUTIC Total		771	18.29
PERSONAL AND SOCIAL CARE	Not Known	79	17.16
PERSONAL AND SOCIAL CARE Total		79	17.16
SUPPORT SERVICES	Not Known	2738	9.27
SUPPORT SERVICES Total		2738	9.27
Grand Total		21437	13.43

Table 6 - Occupational segregation by Race

Job Family	Ethnic Category	Total Employments	Average of Basic Hourly Rate
ADMINISTRATIVE SERVICES	African	14	10.96
	Any Mixed Background	16	12.49
	Caribbean	3	10.73
	Chinese	10	13.80
	Declined	1,123	12.21
	Indian	16	11.45
	Other Asian	7	11.53
	Other Black	2	9.32
	Other British	238	12.42
	Other Ethnic Background	7	11.96
	Other White	198	11.92
	Pakistani	5	11.85
	White Irish	21	11.38
	White Polish	2	8.56
	White Scottish	1,854	11.38
ADMINISTRATIVE SERVICES Total		3,516	11.75
ALLIED HEALTH PROFESSION	African	8	13.79
	Any Mixed Background	13	16.08
	Chinese	7	12.35
	Declined	497	17.99
	Indian	4	13.76
	Other Asian	1	11.09
	Other British	277	16.03
	Other Ethnic Background	4	13.52
	Other White	101	15.72
	Pakistani	6	11.67
	White Irish	117	14.22
	White Polish	2	23.55
	White Scottish	957	15.60
	ALLIED HEALTH PROFESSION Total		1,994
DENTAL SUPPORT	African	1	11.60
	Any Mixed Background	1	10.18
	Declined	96	12.52
	Other Asian	1	9.46
	Other British	9	12.35
	Other White	5	11.55
	White Irish	1	18.19
	White Polish	1	11.60
	White Scottish	153	11.67
DENTAL SUPPORT Total		268	12.02
HEALTHCARE SCIENCES	African	6	14.56
	Any Mixed Background	9	13.76
	Chinese	4	12.05
	Declined	271	18.15
	Indian	6	17.31
	Other Asian	3	15.66
	Other British	114	17.63
	Other Ethnic Background	2	15.13
	Other White	90	15.32
	Pakistani	6	12.89
	White Irish	12	16.97
	White Scottish	361	15.70
	HEALTHCARE SCIENCES Total		884
MEDICAL SUPPORT	Caribbean	1	11.36
	Declined	65	15.87
	Indian	1	8.25
	Other Black	1	8.88
	Other British	11	14.99
	Other White	13	15.65
	White Scottish	41	14.07
MEDICAL SUPPORT Total		133	15.07

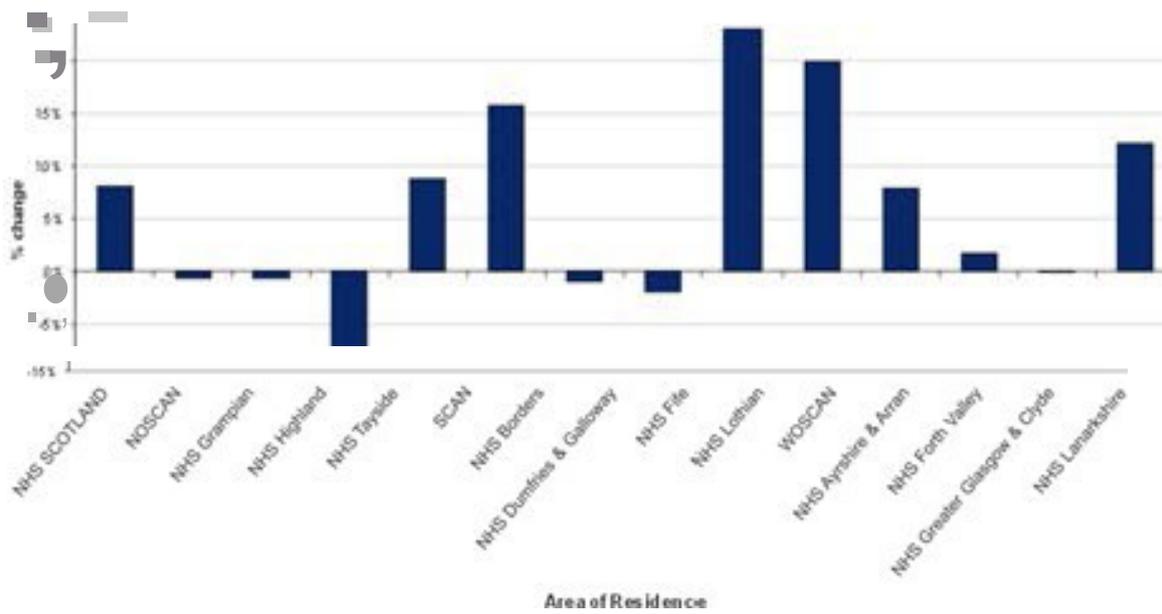
NURSING/MIDWIFERY	African	106	12.75
	Any Mixed Background	30	12.59
	Bangladeshi	4	12.08
	Caribbean	11	14.70
	Chinese	41	12.89
	Declined	3,266	14.87
	Indian	98	13.10
	Other Asian	77	11.81
	Other Black	10	12.97
	Other British	881	14.46
	Other Ethnic Background	43	13.40
	Other White	783	15.44
	Pakistani	17	11.09
	White Irish	165	13.66
	White Polish	11	11.92
	White Scottish	5,510	13.16
NURSING/MIDWIFERY Total		11,052	13.89
OTHER THERAPEUTIC	African	4	19.36
	Any Mixed Background	5	22.67
	Chinese	3	18.30
	Declined	196	19.93
	Indian	5	15.10
	Other Asian	3	11.39
	Other Black	1	18.72
	Other British	112	19.63
	Other Ethnic Background	2	19.20
	Other White	61	17.47
	Pakistani	3	24.57
	White Irish	30	17.63
	White Polish	2	13.59
	White Scottish	344	17.80
OTHER THERAPEUTIC Total		771	18.24
PERSONAL AND SOCIAL CARE	Bangladeshi	1	9.65
	Declined	29	18.89
	Other British	8	16.64
	Other White	4	16.92
	Pakistani	1	14.70
	White Irish	2	19.05
	White Scottish	34	16.00
PERSONAL AND SOCIAL CARE Total		79	17.16
SUPPORT SERVICES	African	22	8.69
	Any Mixed Background	9	8.43
	Bangladeshi	2	8.45
	Chinese	16	8.38
	Declined	1,325	9.22
	Indian	12	8.62
	Other Asian	14	8.44
	Other British	79	9.29
	Other Ethnic Background	7	8.61
	Other White	109	8.90
	Pakistani	3	8.53
	White Irish	5	8.61
	White Polish	1	8.25
	White Scottish	1,134	9.41
SUPPORT SERVICES Total		2,738	9.27
Grand Total		21,437	13.43

The differences between the basic hourly rate between ethnic categories will reflect differing numbers of staff on each band.

SCREENING & INEQUALITIES

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

HEAT (Health, Efficiency, Access and Treatment)
Success in Lothian -20% baseline change



Source:60 luty 2016-combir M 2014/ Sdm

Contribution of stage 1 breast, colorectal and lung to HEAT performance

Percentages

	All Combined		Breast		Colorectal		Lung	
	Scotland	Lothian	Scotland	Lothian	Scotland	Lothian	Scotland	Lothian
2010/2011	23.2%	22.6%	38.2%	37.4%	17.2%	14.6%	13.1%	16.1%
2011/2012	24.0%	24.9%	39.3%	41.4%	17.9%	14.5%	14.6%	17.7%
2012/2013	24.3%	25.8%	38.8%	41.5%	17.7%	15.9%	15.8%	18.9%
2013/2014	24.7%	26.2%	40.1%	41.8%	17.0%	16.5%	16.4%	19.1%
2014/2015	25.1%	27.1%	40.5%	42.0%	15.4%	16.6%	17.9%	20.2%

Source: ISD July 2016

Targeted approach to address inequality

Cancer Stage (combined breast, colorectal and lung)	NHS Lothian SIMD Quintile				
	1 - most deprived	2	3	4	5 = least deprived
Stage 1	24%	23%	29%	29%	33%
Stage 2	27%	25%	26%	26%	29%
Stage 3	19%	20%	17%	17%	13%
Stage 4	25%	26%	23%	23%	20%
Stage Not Known	5%	5%	5%	5%	4%

Source: ISD July 2016 - combined 2014/15 data

Cancer Screening & DCE Priorities for 2017/18 – Beating Cancer in Scotland: Ambition and Action

National Plan	Programme	Priority	Funding Stream Existing programme or new monies	Comments
		<u>Board level initiatives</u> Local and national work to improve the effectiveness, quality and accountability of screening		
<input type="checkbox"/>	Bowel	Support the implementation of QFIT in line with national requirements.	Additional work but likely to be within existing envelope	NSD project plan awaited. Business case accepted by Chief Executives 2016
<input type="checkbox"/>	Bowel	Link with colonoscopy services to ensure QFIT modelling delivers necessary capacity expansion.	Additional capacity but likely to be within existing envelope	NSD project plan awaited. Business case accepted by Chief Executives 2016
<input type="checkbox"/>	Cervical	Support the implementation of the HPV primary screening business case in line with national requirements.	Likely to be within existing envelope	Ministerial decision awaited on business case
<input type="checkbox"/>	Cervical	Link with laboratory services to ensure NHS Lothian is best placed to tender for Scottish wide HPV primary screening service.	Existing	
	Cervical	Support colleagues to maintain cytology provision whilst uncertainty around HPV undermines capacity to deliver current service.	Existing	On Board risk register
<input type="checkbox"/>	Breast	Support further implementation of the SBSP IT system including quality assurance for new functionality.	Existing	NSD commissions service for Board

	Breast	Implement recommendations for NHS Lothian arising from HIS review of breast screening incidents.	Existing	
	Bowel Cervical Breast	Undertake HIS external reviews scheduled for screening programmes over the next 24 months.	Existing	HIS timetable awaited. Subject to agreement by Scottish Standing Committee
	cross cutting	Strengthen government arrangements for cancer screening at Board level.	Existing	
	cross cutting	Contribute to discussions around new commissioning models for screening programmes as part of shared services review.	Existing	
	cross cutting	Contribute to national and local discussions redefining 'informed choice' in relation to cancer screening.	Existing	
	cross cutting	Contribute to national and local discussions relating to 'Duty for Candor' and cancer screening.	Existing	
National Plan	Programme	Priority	Funding Stream	Comments
		<u>Raising awareness in target audiences</u> Local promotional work to support national cervical, breast and bowel public awareness campaigns		
<input type="checkbox"/>	Bowel Breast	Undertake a series of special events at venues targeting low uptake groups.	New (2 year funding)	
<input type="checkbox"/>	Cervical	Establish a joint forum of smear taker practitioners and women in the 25-30 year age group to tackle barriers to cervical screening and to develop practice level guidance for dissemination across Lothian.	New (1 year funding)	Consider expansion to bowel and breast programmes subject to evaluation.
<input type="checkbox"/>	cross cutting	Design and roll out an online staff training package to educate practitioners on screening principles ethics, 'informed choice' and 'Duty of Candor'	New (one off funding)	

<input type="checkbox"/>	Cervical	Develop specialist promotional resources for young women targeting lifestyle venues such as gyms, beauty salons and high street shops.	New (one off funding)	
<input type="checkbox"/>	Cervical	Support for sexual health outreach teams to extend cervical screening interventions to tanning salons, targeting women at high risk of disease.	New (1 year funding for pilot)	
<input type="checkbox"/>	Cervical	Develop a cancer screening toolkit for work place health programmes, trialled with the NHS work force. Interventions include employer mechanisms for communicating with staff, LearnPro training modules, a staff screening survey and provision of amnesty clinics.	New (2 year funding)	Consider expansion to bowel screening subject to evaluation
	Cervical	Redesign smear taker training course in conjunction with provider. Develop new LearnPro modules for updating skills in conjunction with NES.	New (one off funding)	
<input type="checkbox"/>	Breast	Implement the breast screening inequalities action plan for target groups.	Existing	Project funded from cancer plan 2016/17 £28,000
National Plan	Programme	Priority	Funding Stream	Comments
		<u>Practice level Interventions</u> Efforts to establish small change projects to address inequality and embed new ways of working		
<input type="checkbox"/>	Cervical	Develop and test a messaging alert system for GP IT systems to provide information on screening status and smear test invitation, aimed at practitioners undertaking consultation for contraceptive advice.	New (one off funding)	
<input type="checkbox"/>	Bowel	Support roll out of novel resources for 'informed choice' for hard to reach groups (developed as part of the CHIT Project)	New (recurrent funding required)	Pilot funded from diagnostic monies 2016/17

				£15,000
<input type="checkbox"/>	cross cutting	Implement and evaluate profiling (targeted at practices with lowest screening uptake) aimed at embedding sustained mechanisms to overcome screening barriers.	Existing	Project funded from cancer plan 2017/17 £30,000
<input type="checkbox"/>	Melanoma	Trial provision of referral data to practices for clinical decision making via engagement, training and feedback.	New 1 year funding for pilot	Bid submitted directly to SG DCE £15,000
<input type="checkbox"/>	Melanoma	Test feasibility of a community GP led pigmented lesion clinic serving a practice cluster.	New 2 year funding	Future funding subject to evaluation

Moving Beyond Food Poverty through Inter-agency Team Work

Tracy McGillivray, (Senior Health Promotion Specialist)
NHS Lothian Health Promotion Service

Aim

Food poverty is a growing problem within the UK; the number of food banks in Edinburgh is increasing, together with the number of people using them.

Our project focused on how NHS Lothian and The City of Edinburgh Council could better link with these new initiatives. Based on work published by the Poverty Alliance on behalf of the Scottish Government, we aimed to follow recommendations to promote the development of a Food bank Plus model, where users are offered additional services to help move them beyond their current crisis.

Methods

A scoping exercise of current food bank providers in Edinburgh was carried out by Food and Health Task Group members. This gave the group an opportunity to arrange a Food Bank Network day to look at the current service, current issues and future plans.

This day was attended by:

- Co-ordinators of food banks
- Staff involved in supporting food banks users
- Staff of support services who may refer into food banks.

The day consisted of talks by guest speakers and discussion groups facilitated by Food and Health Task Group.

Outcomes

Following the Network day, a food bank network group was established, comprising food bank co-ordinators and NHS and council staff. This helped to establish a stronger dialogue between the NHS Health Promotion Department, City of Edinburgh Council and food bank workers and supporters.

This group developed into an informal network meeting every three months to:

- Share different practice
- Discuss planning future work
- Showcase future plans
- Link with statutory services.

Benefits of this network include:

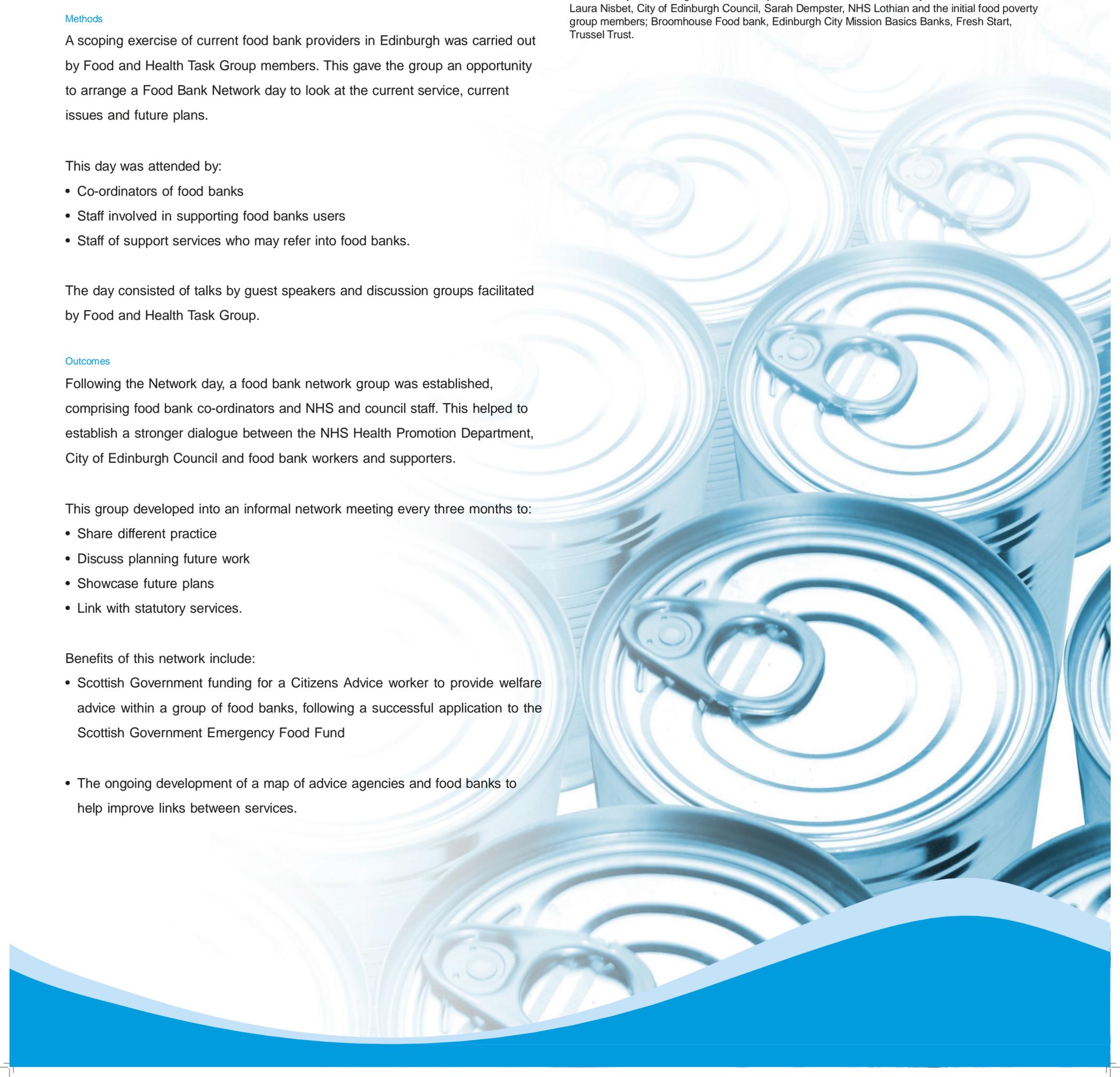
- Scottish Government funding for a Citizens Advice worker to provide welfare advice within a group of food banks, following a successful application to the Scottish Government Emergency Food Fund
- The ongoing development of a map of advice agencies and food banks to help improve links between services.

Conclusion

Creating the network has shown the benefits of NHS, council and voluntary sector collaboration to tackle an issue such as increasing food bank use. This approach provides users with an enhanced service by improving links between voluntary and statutory services. Improved dialogue between agencies allows food bank users to more easily access support services to aid their journey beyond food poverty.

Acknowledgements

Thanks to all involved in this work from The Edinburgh Food and Health Task group, Suzanne Lowden, City of Edinburgh Council, Lesley Blackmore, Lothian Community Health Initiatives Forum, Laura Nisbet, City of Edinburgh Council, Sarah Dempster, NHS Lothian and the initial food poverty group members; Broomhouse Food bank, Edinburgh City Mission Basics Banks, Fresh Start, Trussel Trust.

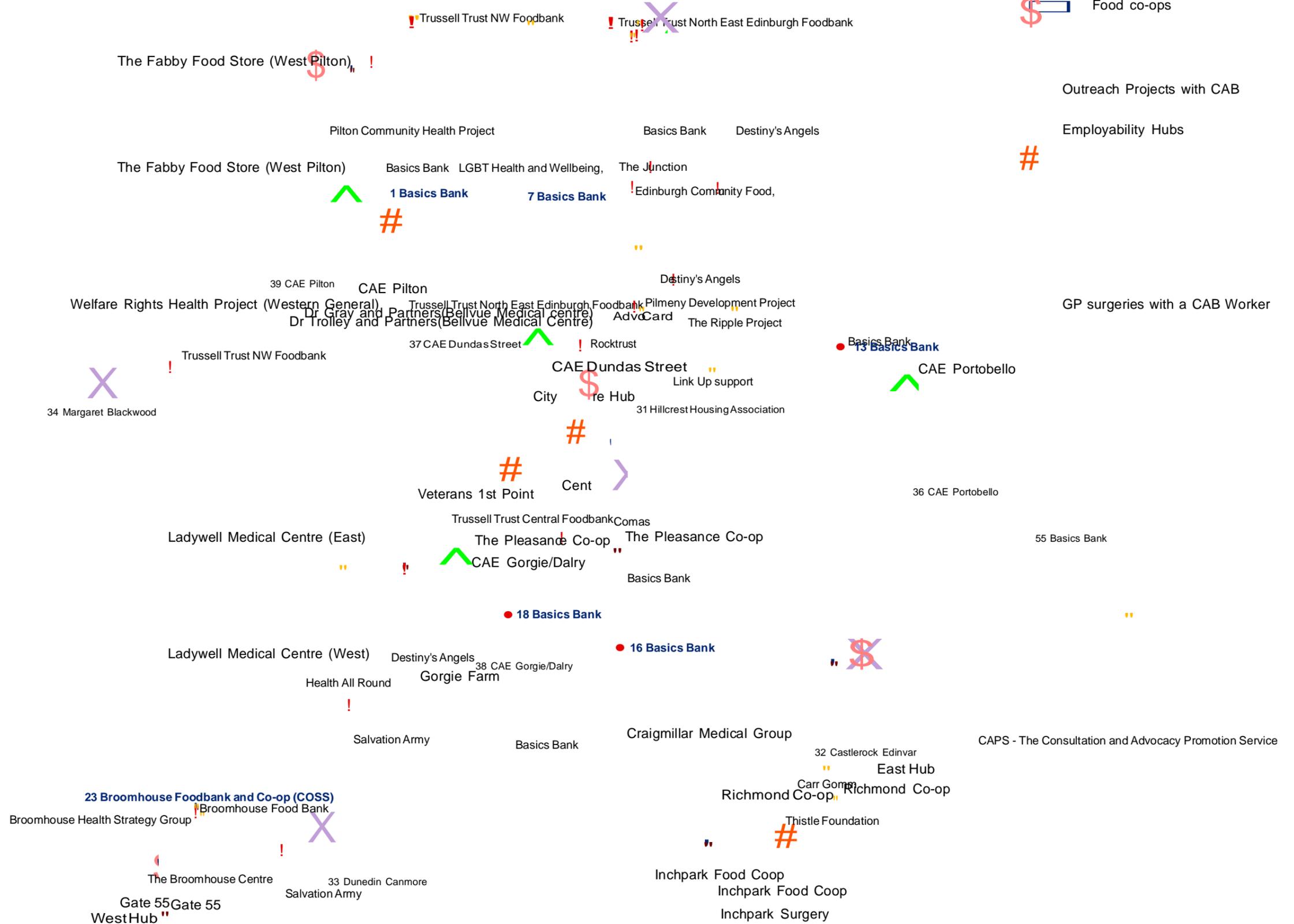


Foodbank and Citizens Advice services in Edinburgh, April 2015

Legend

-  Foodbanks
-  Citizens Advice locations
-  Housing Associations with CAB
-  Community Health Initiative
-  Foodbanks with a CAB worker
-  Food co-ops

South Queensferry Medical Practice



Outreach Projects with CAB

Employability Hubs



GP surgeries with a CAB Worker

CAPS - The Consultation and Advocacy Promotion Service

Foodbank	Referral Process	Maximum number of referrals	Sources of Funding	Volume per week	Frequency of use	No of people fed 2013/14	No of people fed 2014/2015
1 Basics Bank West Pilton	Formal Referral Process	3 month wait between referrals	Donations	17	no information provided	623	no information provided
2 Trussell Trust NW Pilton	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760
3 Trussell Trust NE N Leith	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760
4 & 5 Trussell Trust NE HQ and S Leith	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760
6 Destiny's Angels Salamander	Formal Referral Process	No limit	CEC, Donations	no information provided	no information provided	no information provided	no information provided
7 Basic Bank Leith	Formal Referral Process	3 month wait between referrals	Donations	17	no information provided	623	no information provided
8 Fareshare (Cyrenians)	Formal Referral Process	One off food parcels	CEC, NHS, Donations	no information provided	no information provided	no information provided	no information provided
9 Edinburgh Community Food	Formal Referral Process	no information provided	CEC, NHS, Donations, Big Lottery	30	no information provided	no information provided	no information provided
10 Destiny's Angels Salamander	Formal Referral Process	No limit	Donations	no information provided	no information provided	no information provided	no information provided
11 Trussell Trust NE St Andrews	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760
12 Trussell Trust NE Pilrig	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760
13 Basics Bank Portobello	Formal Referral Process	3 month wait between referrals	Donations	17	no information provided	623	no information provided
14 Rocktrust	Formal Referral Process	no information provided	CEC, Big Lottery	7	300-400 per year	no information provided	no information provided
15 Trussell Trust Central	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760

Foodbank	Referral Process	Maximum number of referrals	Sources of Funding	Volume per week	Frequency of use	No of people fed 2013/14	No of people fed 2014/2015
16 Basics Bank Newington	Formal Referral Process	3 month wait between referrals	Donations	17	no information provided	623	
17 Trussell Trust SE	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760
18 Basics Bank Bruntsfield	Formal Referral Process	3 month wait between referrals	Donations	17	no information provided	623	no information provided
19 Destiny's Angels Gorgie	Formal Referral Process	No limit	CEC Donations	no information provided	no information provided	no information provided	no information provided
20 Salvation Army Gorgie	Formal Referral Process	4 referrals per person	Donations	20	708 per year	no information provided	no information provided
21 Salvation Army Slateford	Formal Referral Process	4 referrals per person	Donations	20	708 per year	no information provided	no information provided
22 Basics Bank Wester Hailes	Formal Referral Process	3 month wait between referrals	Donations	17	no information provided	623	no information provided
23 Broomhouse Food Bank	Self referral	No limit	CEC, Big Lottery, Donations	16	no information provided	no information provided	no information provided
24 Trussell Trust NW Rannoch	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760

Name of foodbank	Address	Postcode	Day's	Telephone Number	Email	Contact Name
Granton(Basics Bank)	Granton Baptist Church, 99 Crewe Road North	EH5 2NW	Tuesday	no info available	no information available	no information available
Portobello(Basics Bank)	Wilson Memorial Church, 7 Kekewich Ave	EH7 6TZ	Tuesday	no info available	no information available	no information available
Leith(Basics Bank)	Ebenezer United Free Church, 31 Bangor Road, Leith	EH6 5IX	Wednesday	no info available	no information available	no information available
Newington (Basics Bank)	Edinburgh Community Church, 41a South Clerk Street	EH8 9NZ	Thursday	no info available	no information available	no information available
Musselburgh(Basics Bank)	Musselburgh Baptist Church, 68 New Street	EH21 6JQ	Thursday	no info available	no information available	no information available
Bruntsfield (Basics Bank)	Bruntsfield Evangelical Church, 70 Leamington Terrace	Eh10 4JU	Friday	no info available	no information available	no information available
Broomhouse Foodbank (COSS)	3 Broomhouse Market	EH11 3UU	Monday to Saturday	0131 443 6223	cossinfo@ymail.com	Carol Swan

Name of Organisation	Address	Postcode	Type of CAB Service	Telephone Number	Email	Contact Details	Opening Times
Edinburgh Sherrif Court	Office (next to Court 15) Chambers Street		In Court Advice	0131 202 5114	inca@caed.org.uk		Monday to Friday
Edinburgh Sherrif Court	Office (next to Court 15) Chambers Street		Court Mediation	0131 220 1092	court.mediation@caed.org.uk	Wilma Bailey	Tuesday to Friday
Veterans 1st Point	5th Floor Charlotte House 2 South Charlotte Street	EH2 4AW	Advice for Veterans	0131 220 9920			no info available
Welfare Rights Health Project	Royal Infirmary Hospital 51 Little France Crescent	EH16 4SA	Welfare Rights Advice	0131 536 1000			Monday and Tuesday
Welfare Rights Health Project	Western General Hospital Crewe Road South	EH4 2XU	Welfare Rights Advice	0131 537 1000			Thursday and Friday

Employability Hub	Address	Postcode	Telephone Number	Opening Days
North Hub	11 Pennywell Court	EH4 4TZ	0131 529 6161	Monday to Friday
West Hub	Gate 55, 55 Sighthill Road	EH11 4PB	0131 529 6161	Monday to Friday
East Hub	Haywired 3 Hay Avenue	EH16 4RW	0131 529 6161	Monday to Friday
City Centre Hub	St James Centre		0131 529 6161	Monday to Friday
South Hub	Gate 13, 13 Newtoft Street	EH17 8RG	0131 529 6161	Monday to Friday

Name of GP Practice	Address	Postcode	Telephone Number	Open Times for CAB Advice
Dr Trolley and Partners(Bellvue Medical Centre)	26 Huntingdon Place	EH16 4DT	0131 556 2642	No information provided
Dr Gray and Partners(Bellvue Medical centre)	26 Huntingdon Place	EH16 4DT	0131 556 8196	No information provided
Craigmillar Medical Group	106 Niddrie Mains Road	EH16 4DT	0131 536 9500	No information provided
Inchpark Surgery	10 Marmion Crescent	EH16 5QU	0131 666 2121	Monday afternoons
Ladywell Medical Centre (East)	Ladywell Road	EH12 7TB	0131 334 3602	Tuesday afternoons
Ladywell Medical Centre (West)	Ladywell Road	EH12 7TB	0131 334 3602	Tuesday afternoons
South Queensferry Medical Practice	41 The Loan	EH30 9HA	0131 331 1396	Tuesday mornings, Wednesday afternoons
Wester Hailes Medical Practice	7 Murrayburn Gate	EH14 2SS	0131 537 7300	Monday mornings Wednesday mornings

Citizens Advice Office	Address	Postcode
CAE Dundas Street	58 Dundas Street	EH3 6QZ
CAE Leith	12 Bernard Street	EH6 6PY
CAE Pilton	661 Ferry Road	EH4 2TX
CAE Portobello	8 a&b, Bath Street	EH15 1EY
CAE Gorgie/Dalry	Fountainbridge Library, 137 Dundee Street	EH11 1BG

Community Health Initiative	Address	Town/City	Postcode	X	y
AdvoCard	332 Leith Walk	Edinburgh	EH6 5BR	326635	675275
Broomhouse Health Strategy Group	1 Broomhouse Market	Edinburgh	EH11 3UU	320173	671351
The Broomhouse Centre	79-89 Broomhouse Crescent	Edinburgh	EH11 3RH	320332	671242
CAPS – The Consultation and Advocacy Promotion Service	Old Stables, Eskmills Park, Station Road	Musselburgh	EH21 7PQ	333845	672237
Carr Gomm	11 Harewood Road	Edinburgh	EH16 4NT	329411	671941
Comas	8 Jackson's Entry	Edinburgh	EH8 8PJ	326549	673720
CHAI Wester Hailes:	Wester Hailes Healthy Living Centre, 30 Harvesters Way,	Edinburgh	EH14 3JF	319775	669701
CHAI Oxfangs	8 Firrhill Neuk,	Edinburgh	EH13 9FF	323695	669378
CHAI South Edinburgh	40 Captains Road (in the CEC Office),	Edinburgh	EH17 8HR	328008	668366
Edinburgh Community Food, Edinburgh & Lothians Greenspace Trust	22 Tennant Street, Swanston Steading, 109/11 Swanston Road	Edinburgh	EH6 5ND	326605	675883
Health All Round	24 Westfield Avenue	Edinburgh	EH11 2QH	322370	672411
The Junction	82-86 Great Junction Street	Edinburgh	EH6 5LL	326837	676060
LGBT Health and Wellbeing,	9 Howe Street,	Edinburgh	EH3 6TE	325064	676060
Link Up support	Lochend House, 33 Lochend Road South	Edinburgh	EH7 6BR	327736	674314
Pilton Community Health Project	73 Boswall Pkwy,	Edinburgh	EH5 2PW	323295	676545
Pilmey Development Project	19-21 Buchanan Street	Edinburgh	EH6 8SQ	326644	675133
The Ripple Project	Restalrig Lochend Community Hub, 198 Restalrig Road South,	Edinburgh	EH7 6DZ	328063	675129
Thistle Foundation	Niddrie Mains Road	Edinburgh	EH16 4EA	329495	671421
Wester Hailes Healthy Living Centre	30 Harvesters Way	Edinburgh	EH14 3JF	319775	669700

Name of Food Co-op	Address	Postcode	Telephone	Contact Details
Broomhouse Co-op	1 Broomhouse Market, Broomhouse	EH11 3UU	0131 467 7678	Lucy Aitchison
Gate 55	Sighthill Road, Edinburgh	EH11 4PB		Denis MacKay
Gorgie Farm	51 Gorgie Rd	EH11 2LA	0131 337 4202	www.gorgiecityfarm.org.uk
Inchpark Food Coop	Inchpark Community Centre, 225 Gilmerton Road	EH16 5UF	0131 664 1520	Tom Ritchie
The Pleasance Co-op	Kirk O' Field Church, St Ninians Hall, 138-140 The Pleasance	EH8 9RR	0131 664 1520	Mary Wilson
Richmond Co-op	Richmond Craigmillar Church, 227 Niddrie Mains Road	EH16 4PA	0131 661 6561	Liz Henderson
The Fabby Food Store (West Pilton)	West Pilton Neighbourhood Centre, 19 West Pilton Grove	EH4 4BY	0131 551 3194	no info available

Name of Housing Association	Address	Contact Name	Telephone Number	Opening Times
Port of Leith Housing Association	108 Constitution Street, Edinburgh EH6 6AZ	Fiona Neilson	0131 553 8745	no info available
Margaret Blackwood	Craigievar House, 77 Craigmount Brae, Edinburgh EH12 8XF	Craig Henderson at Dunedin Canmore	0131 624 5772	no info available
Castlerock Edinvar	1 Hay Avenue, Edinburgh, Midlothian EH16 4RW	Financial Inclusion Team	0131 657 0605	no info available
Hillcrest Housing Association	Canongate, Edinburgh, Midlothian EH8 8DD	Angela Lamb at POLHA	0131 657 0684	no info available
Dunedin Canmore	8 New Mart Road, Edinburgh EH14 1RL	Craig Henderson	0131 624 5772	no info available

Staff Group / Department:

Interpretation and Translation Service (ITS)

Role & Function:

To provide a comprehensive interpretation and translation service to patients and their significant others ensuring that care and communication is equal for all.

NHS Lothian Equality and Human Rights Strategy and Outcomes Framework 2013 to 2017

NHS Lothian is committed to the principles of the Equality Act 2010 in our Public Sector Equality Duty (referred to as the General Equality Duty). Our main aims are as follows -

- **Eliminate** discrimination, harassment, victimisation or any other prohibited conduct.
- **Advance** equality of opportunity between people who share a relevant protected characteristic and those who do not
- **Foster** relations between people who share a protected characteristic and those who do not

This plan outlines the actions being taken to provide the highest quality Interpretation and Translation Service in NHS Lothian.

The **NHS Lothian Equality and Human Rights Strategy (EHRS) and Outcomes Framework 2013 to 2017** has the following 5 Equity Standards on which the Interpretation and Translation Action Plan Aims were based -

- ✓ **Standard 1:** NHS Lothian is fair and equitable in the way it develops its policies and strategies, and in the way that it employs its workforce
- ✓ **Standard 2:** Access to NHS Lothian's healthcare services is equitable
- ✓ **Standard 3:** NHS Lothian's healthcare services deliver an equitable quality of care to all patients
- ✓ **Standard 4:** NHS Lothian involves and consults with people in an inclusive and equitable way when developing services or policies
- ✓ **Standard 5:** NHS Lothian promotes equality and diversity in its work with partners, in its contracts and in its procurement of goods and services

Interpretation and Translation Priorities for 2015-2017:

1. Improve ITS systems and processes
2. Review NHS Lothian's Interpretation and Translation Policy and Procedure
3. Increase training and awareness regarding ITS
4. Ensure that the interpretation and translation methods used are effective, efficient and the most current
5. Ensure that patients interpretation and translation needs are recorded and available for relevant staff
6. Improve the suitability of the patient environment to interpretation and translation needs
7. Ensure that public information, feedback and complaints processes are accessible for people with communication, interpretation and translation needs
8. Improve NHS Lothian's governance, leadership and accountability in interpretation and translation

Interpretation and Translation Improvement Action Plan 2015 to 2017

1. IMPROVE INTERPRETATION AND TRANSLATION (ITS) SYSTEMS AND PROCESSES

Outcome measuring - To improve the systems and processes, staff and users of the service will be consulted to ensure that changes and adaptations take place in the areas of concern and that there is an improvement in their satisfaction with the service.

Item	AIM	ACTION	EHRS STANDARD	ACCOUNTABLE OFFICER	STRATEGIC LEAD	COMMENCED	NOTES	Timescale from 1 st September 2015			COMPLETE
								Short Term (Within 6 months)	Medium Term (Within 1 Year)	On-Going	
1.1	Review current written processes and providers	Review meetings – ITS Manager, Public Involvement Manager, Project Manager, CEC ITS Managers and staff	1, 2, 3, 4, 5	Lee McGuinness	Fiona Ireland	YES	NHS Lothian reviewed the current processes and providers and are working on ways to streamline the processes so the services are provided in a more timely, effective and straight-forward manner (projects include: service flowchart, booking system and single phone number). UPDATE: external providers have now been further reviewed. The agency framework was tendered by the City Council (the ITM participated as an evaluator), and new NHS Lothian in-house service to be put in place to provide ITS services to NHS Lothian areas.	✓			12/09/15
1.2	Review previous patient and user satisfaction and opinion surveys	Review previous surveys	1, 2, 3, 4, 5	Lee McGuinness	Fiona Ireland	YES	NHS Lothian reviewed the 2015 Focus group results and summary notes. It is now in the hands of Edinburgh City Council ITS to apply the recommendations accordingly. UPDATE: the recommendations will be taken into account in the new NHSL ITS service.	✓			03/11/15
1.2a	Gather previous user opinion on the service	Carry out a patient / user satisfaction and opinion survey	1, 2, 3, 4, 5	Lee McGuinness	Fiona Ireland	YES	The ITM has organised meetings with various NHS Lothian staff groups (GP practices, Health Visitors forum, link workers, management teams and Charge Nurses on hospital sites) to gather feedback on ITS and answer any questions. A staff survey is currently in circulation amongst all NHS Lothian employees. We have received 120+ responses. Patients and staff will be involved in the revision of the new Policy and Procedure document as well as interpreters. Their opinion will be solicited during the Public Involvement exercise.	✓	✓		02/05/16

Delphine Jaouën v7 06022017

Interpretation and Translation Improvement Action Plan 2015 to 2017

1.3	Review staff satisfaction and opinion	Survey Monkey	1, 2, 3, 4, 5	ITM*	Fiona Ireland	YES	The staff survey will enable the ITM to review trends and key points once significant data is gathered.	✓	✓		
1.4	Undertake a Public Opinion exercise with the updated policy and procedures to ensure that it fits requirements and that satisfaction is improved from 1.2a	Arrange date when new ITS Policy and Procedure has been written	1, 2, 3, 4, 5	ITM *	Fiona Ireland	NO	The Public Opinion exercise has been postponed as the Policy and Procedure will be finalised once the new service is in place.		✓		
1.5	Install annual reviews of the service to ensure that methods are always up to date and that user satisfaction is high	Annual survey of opinion using the same methods as described in 1.3 and 1.4	1, 2, 3, 4, 5	ITM *	Fiona Ireland	NO	An annual review will take place at the end of the financial year (16-17) based on the methods put in place this year. The service will then be reviewed annually.		✓		
1.6	Ensure that an Integrated Impact Assessment (IIA) is carried out on the new ITS Policy and Procedure	Arrange date when new ITS Policy and Procedure has been written	1, 2, 3, 4, 5	ITM *	Fiona Ireland	NO	To be carried out once Public Opinion exercise is complete.		✓		

2. REVIEW NHS Lothian's Interpretation and Translation Policy and Procedure

Outcome measuring - Review the policy and procedure and staff and user satisfaction currently, after changes and three yearly.

Item	AIM	ACTION	EHRS STANDARD	ACCOUNTABLE OFFICER	STRATEGIC LEAD	COMMENCED	NOTES	Timescale from 1 st September 2015			COMPLETE
								Short Term (Within 6 months)	Medium Term (Within 1 Year)	On-Going	
2.1	Policy and Procedure are up to date, using current methods and fit for purpose	Review the current policy and procedure	1, 2, 3, 4, 5	Lee McGuinness	Fiona Ireland	YES	We are working on the final draft of the revised Policy & Procedure document (to be updated with latest changes emerging from the set up of the new service), which will then go through the Integrated Impact Assessment and Public Involvement exercise, revision, and approval process by the relevant committee.		✓		12/09/15
2.2	Review provision of three way telephones in acute and primary clinical areas for telephone interpreting	Emergency areas have these systems but need a third unit	1, 2, 3, 4, 5	Dermot Gorman	Fiona Ireland	YES	RIE A&E already has this in place (cordless phones). Next step: identify how many third units are needed and provide them in identified places. Telecomms are not able to provide an exhaustive log of all three way telephones in Lothian however Chris Aitken (Telecomms Project Officer) will provide a list of sites which	✓			12/09/15

Delphine Jaouën v7 06022017

Interpretation and Translation Improvement Action Plan 2015 to 2017

							were provided with three way telephones as part of the new telephone interpreting contract in 2011.				
2.2a	Ensure that all emergency areas have an immediate method of communicating with patients who do not speak English	Provide three way telephones for use in all emergency areas. Other ideas include a multilingual phrasebook (British Red Cross), and video interpreting for Sign Language Interpreters.	1, 2, 3, 4, 5	ITM*	Fiona Ireland	NO	The ITM visited RIE A&E: 3-way telephones and multilingual phrasebook are already in place. Further telephone interpreting training material provided to reception area. The team are interested in contactScotland now that WiFi has been installed however the remit of contactScotland must be clearer (to find out if emergency situations are acceptable or only phone conversations). Visits to other Emergency Units being organised (WGH, SJH). NHS 24 – 111 services have a telephone interpreting contract in place. This service is being promoted.		✓		
2.3	To have mobile phones in clinical areas to text deaf patients	This is not acceptable within NHS Lothian Data protection policy	1, 2, 3, 4, 5	Dermot Gorman	Fiona Ireland	YES	No action can be taken as NHS Lothian security policies would not allow sensitive information to be texted to patients. The risk of breaching data protection is too high. UPDATE: an exception was made at REH for a particularly acute case. ITM to meet with Deaf Action on 07/02/17 to discuss further as they supported the Deaf patient throughout care.	✓			3/11/15
	To have a means of 2 way communication with deaf patients	Seek expert advice and liaison between itm and NHS Lothian eHealth to find an acceptable method	1, 2, 3, 4, 5	ITM*	Fiona Ireland	NO	Information in written form is not acceptable to all Deaf patients as English is often used as a second language and proficiency levels may vary. The ITM has met with a Senior Videoconferencing Analyst to discuss existing video conference systems within NHS Lothian and assess suitability for BSL interpreting. This is possible, however self-employed BSL interpreters sourcing is to be explored (currently all requests are sent to agencies). Sign Language Interactions provide video interpreting service and have forwarded a price list. This is being pilot in Greater Glasgow and Clyde on acute sites. UPDATE: The agency framework for BSL was nullified and interim contracts will be put in place until action plans around BSL Scotland Act are published. NHS Lothian should now be	✓	✓		

Interpretation and Translation Improvement Action Plan 2015 to 2017

							able to start a video interpreting pilot with Sign Language Interaction (currently piloted within NHS Greater Glasgow and Clyde).				
2.4	To have a Standard Operating Procedure so that staff can use up to date methods of interpretation and translation and know how to access these	Write a Standard Operating Procedure and user flowchart	1, 2, 3, 4, 5	Lee McGuinness	Fiona Ireland	YES	A user flowchart was designed. Once the single phone number is put in place with the new service, the flowchart will be adjusted for consistency (this is currently being explored with the Telecomms team).		✓		
2.5	Ensure that interpretation and translation support is available at all times	Develop a procedure for when an interpreter is not available	1, 2, 3, 4, 5	ITM *	Fiona Ireland	YES	Emergency services in place for interpretation and included in user flowchart. CEC ITS use agencies when an interpreter is not available, and thebigword is a 24/7 service which staff can revert to at any point. As for BSL interpreters, DeafAction have an emergency service, and video interpreting is being explored for those times when an interpreter cannot make it to the appointment location. NHS 24 – 111 services have a phone interpreting contract in place. UPDATE: emergency out of hour cover will be provided as part of the new in-house service. Processes are being explored.		✓		21/4/16
2.6	Ensure that user opinion is known and there is a method of gauging views to new methods regularly	Establish an Interpretation and Translation Users Group	1, 2, 3, 4, 5	ITM *	Fiona Ireland	YES	The staff survey is circulating. The questions were designed in a way that the same survey can be used as a benchmark for next year. User /reference group to be explored.		✓		

3. ENSURE THAT STAFF HAVE THE KNOWLEDGE TO SUPPORT PEOPLE WITH COMMUNICATION DIFFICULTIES

Outcome measuring - NHS Lothian did not have an Interpretation and Translation Learnpro module but Equality and Diversity has been mandatory on Learnpro since 2010.

Item	AIM	ACTION	EHRS STANDARD	ACCOUNTABLE OFFICER	STRATEGIC LEAD	COMMENCED	NOTES	Timescale from 1 st September 2015			COMPLETE
								Short Term (Within 6 months)	Medium Term (Within 1 Year)	On-Going	
3.1	Establish current staff training	Review current training available for staff	1, 2, 3, 4	Lee McGuinness	Fiona Ireland	YES	The Tayside learnpro module is on the development website (UPDATE 03/2015: it is now being "lothianised" by learnpro developer Dawn Currell in collaboration with the ITM). No evidence	✓			21/04 /16

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							of other training to do with ITS. Through the survey and visits to team meetings, it was clear that some staff members are more aware of how to work with interpreters through interest, personal experience, discussions with ITS or if the site frequently receives interpreters.				
3.2	Gauge staff knowledge gaps	Review current staff knowledge of Interpretation and Translation – legal position and current Policy and Procedure	1, 2, 3, 4	Dermot Gorman	Fiona Ireland	YES	The staff survey includes questions designed to identify knowledge gaps. A few gaps were also identified via forwarded feedback: raised by staff/patients/interpreters to emphasise the lack of awareness of ITS services/the need of interpreters/the use of friends or relatives to interpret.	✓			21/04 /16
3.3	Provide specific training	Develop a Learnpro module for staff as a mandatory requirement	2, 4	Lee McGuinness	Fiona Ireland	YES	The Tayside learnpro module has been approved by the EGB board and is now being “lothianised” by learnpro developer Dawn Currell in collaboration with the ITM. The “lothianised” version will be evaluated with the team and the module will hopefully launch alongside the new service so new procedures can be advertised in one large training exercise.		✓		
		Learnpro module available for staff use	2, 4	ITM *	Fiona Ireland	NO	The module should be made available to staff by the summer of 2017.		✓		
		Equality and Diversity Learnpro module continues to be mandatory	1, 2, 3, 4	Lee McGuinness	Fiona Ireland	YES	UPDATE: The module is currently being reviewed by Sheila Wilson and Dawn Currell.	✓			✓ date tbc
		Provide sensory awareness training for all staff as mandatory Learnpro	1, 2, 3, 4	ITM *	Fiona Ireland	YES	Sensory impairment training was provided to some specific NHS Lothian staff groups via different initiatives. Learnpro modules are being developed by NES and NHS Highland. NHS Lothian will be invited to download these modules shortly once they are ready. Various agencies provide sensory awareness training. Next step: find out if there are internal trainers within NHS Lothian (asked Amanda Langsley from the Education department), and if not, look at contract framework and the possibility of doing it online via training videos for staff who cannot attend. Each department can then identify a BSL “champion” as the go-to person for advice.		✓		

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		Training module to be developed on the new policy and procedure	1, 2, 3, 4	ITM *	Fiona Ireland	YES	Looking into face-to-face training for targeted staff groups on top of the learnpro module. The staff survey includes a question about appropriateness of training format so the sessions will be designed accordingly. The possibility of doing it online via training videos for staff who cannot attend is being explored.		✓		
		Interpreting training for bilingual staff	1, 2, 3, 5	ITM*	Fiona Ireland	YES	Identified resources to provide this training in-house as an introduction to interpreting to ensure staff are more comfortable and understand the roles and ethics of interpreting. Next step: identify members of staff who would like to participate. RIE have started drawing up a list of bilingual staff.		✓		
3.4	Raise staff awareness of the importance of good communication	Communication to be part of safety briefs	1, 2, 3	Lee McGuinness	Fiona Ireland	YES	To be done via Nurse Directors meetings.	✓	✓		
		Implementation plan to be formulated and enacted to ensure that the new Policy and Procedure is utilised. Communication Team to be involved	1, 2, 3, 4	ITM *	Fiona Ireland	YES	The new policy writing guidelines were followed when revising the Policy and Procedure. The document will be circulated via site managers, and an announcement will be placed in the NHS Lothian newsletter.		✓		
		Ensure that guidance is circulated to staff regarding written information readability	1, 2, 3, 4	ITM *	Fiona Ireland	YES	There is an easy-read project in Lothian currently (symbol-based documentation in plain English). More guidance on plain English is now part of the new NHS Lothian Policy on writing Procedure and Health Literacy is a high-profile topic currently. The CPDIG group will also be using easy-read principles when reviewing new or updated documentation and Patient Information Leaflets. Work is also being undertaken to improve health lieteracy in Lothian as part of the quality directorate.		✓		

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4. ENSURE THAT THE INTERPRETATION AND TRANSLATION METHODS USED ARE EFFECTIVE, EFFICIENT AND THE MOST CURRENT

Outcome measuring – Establish baseline numbers of people with communication difficulties in Lothian and review each year to see trend. Review against numbers of patients seen in NHS in Lothian, what methods of communication support they utilised, how much this cost and how satisfied they were with the service they received.

Item	AIM	ACTION	EHRS STANDARD	ACCOUNTABLE OFFICER	STRATEGIC LEAD	COMMENCED	NOTES	Timescale from 1 st September 2015			COMPLETE
								Short Term (Within 6 months)	Medium Term (Within 1 year)	Ongoing	
4.1	Ensure that service is effective	Review outcome of Action 1.5 annually and identify appropriate actions	1, 2, 3, 4, 5	ITM *	Fiona Ireland	NO	First annual review will be at the end of the 16-17 financial year.			✓	
4.2	Ensure service is efficient	Renew contract with City of Edinburgh Council with renegotiated rates – per minute rather than quarter hour	1, 2, 3, 4	Lee McGuinness	Fiona Ireland	YES	UPDATE: NHS Lothian and the City Council have met monthly between August-December to discuss the future of ITS. Due to various factors, a change in management was proposed. Negotiations and talks have resulted in a joint decision that setting up an NHS Lothian in-house service would be in everybody's best interest.	✓	✓		08/12 /16
		Review baseline numbers of deaf, blind, deafblind, alternative language speakers in Lothian annually	1, 2, 3, 4	ITM*	Fiona Ireland	YES	National statistics are available for Deaf people (see BSL Act full report), Blind and Deafblind people. Alternative language speakers are difficult to quantify, since the 2011 census does not provide an accurate picture. Asked CEC ITS to extract a report with numbers of patients so we could use this as a basis. Followed up with new ITS Manager in December 2016.	✓	✓		
		Review numbers of patients requiring communication support in Lothian annually – via CEC ITS	1, 2, 3, 4	Fiona Ireland	Fiona Ireland	YES	As above – asked CEC ITS to extract a report with numbers of patients.	✓	✓		
		Ensure that TRAK is fitted with a functionality to give numbers of patients with these difficulties	1, 2, 3, 4	Fiona Ireland	Fiona Ireland	YES	This is being looked into as part of a national project coordinated by Emma Davidson entitled "Access Support Needs project" (ASN), as a result of the Additional Needs and Diversity Information Task Force (ANDI TF). The ANDI TF project found that this information was being recorded but that more consistency and compatibility was needed between sites and electronic systems to ensure appropriate arrangements were made for the patients' care. The ASN Short Life Working Group (1 year project) aims to facilitate national coordination of the development of e-Health capacity to record patients' ASN information and		✓		✓

Interpretation and Translation Improvement Action Plan 2015 to 2017

							transmit this information between Primary and Secondary healthcare services.				
		Ensure that staff are encouraged to enter this information to each patients record on TRAK		Fiona Ireland	Fiona Ireland		As above. There is now a note on the intranet, and in best practice in draft P&P doc to remind staff to record this as best as possible. The functionality should perhaps be made mandatory to ensure it is used.		✓		
4.3	Ensure that service is using up to date methods	Attend launch of 'Happy To Translate' – Scottish Government – 13 th November 2015	1, 2, 3, 4, 5	Lee McGuinness	Fiona Ireland	YES	The benefits of "Happy to translate" were reviewed and deemed achievable by NHS Lothian without opting for membership. NHS Lothian will design their own signage and training. Health Scotland provided accessibility symbols which NHS boards are able to re-use. Looking into including this in the template for Patient Information Leaflets and as signage at reception areas so patients could point to a symbol to indicate they need communication support.		✓		13/05 /2015
		Meet with TranslateMe – 24 th November 2015	1, 2, 3, 4, 5	Lee McGuinness	Fiona Ireland	YES	The software was installed on the first participants' computer on 28/4 and on the ITM's computer. Other potential participants have been contacted. Pilot delayed until TranslateMe have human translators in place to ensure accuracy, and languages that match NHS Lothian's needs. Testing of translation quality was carried out in October 2016. The quality did not meet NHS Lothian's standards.		✓		28/04 /16
		ITM to advise and instigate new methods / projects	1, 2, 3, 4, 5	Lee McGuinness	Fiona Ireland	YES	<p>Pharmacy project ongoing in NHS Grampian to provide bilingual prescription forms (TransMED project). Maureen Reid investigating the costs incurred by a re-branding exercise (from Grampian to Lothian).</p> <p>NHS24 initiative to educate the population on how to use the health services in Scotland (i.e. when to call NHS24, when to use NHS inform, when to go to the pharmacy etc.) via the Health in my language project.</p> <p>Muirhouse Practice have developed signposting material in other languages to explain how to make the best use of health services.</p> <p>NHS GGC have translated appointments letters and missed appointment letters into several languages (to fill in with date / time / name / tel). Asked whether other boards could use these.</p>			✓	
		Develop an action plan to implement the 'See Hear' Strategy. National target of March 2016.	1, 2, 3, 4, 5	ITM *	Fiona Ireland	NO	<i>Standard 1: There is a detailed description of how best to communicate with individuals. This will be met thanks to the service flowchart.</i>		✓		

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							<p><i>Standard 2: Services demonstrate how they support individuals with communication needs to be involved with decisions about their care and their services. Interpretation and translation services available free of charge to the patient. Staff aware of their responsibilities thanks to the new policy and posters / reminders / training on learnPro and on Deaf awareness.</i></p> <p><i>Standard 3: Staff value and use competently the best approaches to communication with each individual they support. Staff awareness training underway.</i></p> <p><i>Standard 4: Services create opportunities, relationships and environments that make individuals want to communicate. Staff awareness training, updated policy, improvement of feedback processes and environment suitability as well as ITS user group should enable NHS Lothian to meet this standard.</i></p> <p><i>Standard 5: Individuals are supported to understand and express their needs in relation to their health and wellbeing. As above.</i></p> <p>Action Plan to be discussed with E&D Lead as a BSL Action Plan ("authorit plan") must also be put in place. Draft due by March 2017.</p>				
		Promote 'bigword' use	1, 2, 3, 5	ITM *	Fiona Ireland	YES	<p>Emphasised in P&P, intranet and staff meetings. Ongoing promotion will take place as and when meetings take place, and during training sessions. Single phoneline should redirect to thebigword for most cases, unless inappropriate. UPDATE: new targets as per the recovery plan (50% in Primary care and 10% in hospitals). Looking into having a reason code on the Allocate system to justify face-to-face use.</p>	✓			✓

5. ENSURE THAT PATIENTS INTERPRETATION AND TRANSLATION NEEDS ARE RECORDED AND AVAILABLE FOR RELEVANT STAFF

Item	AIM	ACTION	EHRS STANDARD	D	e	p	n	e	J	Timescale from 1 st September 2015		Com
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Interpretation and Translation Improvement Action Plan 2015 to 2017

								months)	(Within 1 Year)		
5.1	TRAK has patient communication needs in each patient record which can be accessed as a report	TRAK to have the local reporting functionality - needs to be done Nationally	1, 2, 3, 4, 5			YES	The functionality can be added to TRAK. See 4 th item in point 4.2 issue will be discussed. Representatives from electronic systems are part of the Short life Working Group to facilitate coding of needs and implementation on system.		✓		
5.2	Full ITS user data available	Negotiate with CEC to release full patient data monthly and when required	1, 2, 3, 4, 5			YES	NHS Lothian will have full access to ITS use once the Bank Staff system is being used, with CHI numbers (not patient names as not allowed to be inputted on the system).		✓		✓

6. IMPROVE THE SUITABILITY OF THE PATIENT ENVIRONMENT TO INTERPRETATION AND TRANSLATION NEEDS - compliance with the environmental aspects of the Equality Act 2010

Outcome measuring - To review and update NHS Lothian's environmental suitability for patients and visitors with additional communication needs and ensure that staff consider these aspects when new signage and departments are being commissioned

Item	ACTION	EHR STANDARD	ACCOUNTABLE OFFICER	STRATEGIC LEAD	COMMENCED	NOTES	Timescale from 1 st September 2015			COMPLETE	
							Short Term (Within 6 months)	Medium Term (Within 1 Year)	On-Going		
6.1	Enable two way communication with deaf patients – see Item 2.3	1, 2, 3, 4	Lee McGuinness	Fiona Ireland	YES	See 2.3, part 2.	✓	✓			
	Scope and improve access to loop systems across NHS LOTHIAN	1, 2, 3, 4, 5	ITM *	Fiona Ireland	NO	The existing provision needs to be reviewed and scope/costs must be estimated. Loop systems will be installed in the new Royal Hospital for Sick Children.		✓			
6.2	All patients can find their way around NHS Lothian buildings	All NHS LOTHIAN signage is reviewed for suitability for those with communication support	1, 2, 3, 4	ITM *	Fiona Ireland	YES	Signage will be reviewed during site visits. The ITM also met with Eileen Duncan who developed symbol-based documents for people with Learning Disabilities. Using symbols / colour codes in NHS		✓		

Interpretation and Translation Improvement Action Plan 2015 to 2017

		needs					<p>buildings is being explored. NHS Tayside have developed accessible signage for their acute sites. The ITM met with Tayside's ITM who advised this was managed by the E&D team rather than the ITS team. Santosh Chima (Diversity and inclusion Manager) to be contacted.</p> <p>Colours and artwork will be used in the new Royal Hospital for Sick Children to increase accessibility.</p> <p>Meeting to be arranged between the ITM and Neil Joshi from RIE Records team to review RIE signage and ITS posters.</p>				
6.3	All patients can communicate with reception areas	All NHS LOTHIAN reception areas to be reviewed for suitability for those with communication support needs	1, 2, 3, 4	ITM *	Fiona Ireland	YES	<p>Telephone interpreting available in reception areas 24/7/365 so long as a telephone is available. Language cards and language identification posters distributed. Distribution and awareness raising is ongoing.</p>		✓		✓

7. ENSURE THAT PUBLIC INFORMATION, FEEDBACK AND COMPLAINTS PROCESSES ARE ACCESSIBLE FOR PEOPLE WITH INTERPRETATION AND TRANSLATION NEEDS

Item	AIM	ACTION	EHRS STANDARD	ACCOUNTABLE OFFICER	STRATEGIC LEAD	COMMENCED	NOTES	Timescale from 1 st September 2015			COMPLETE
								Short Term (Within 6 months)	Medium Term (Within 1 Year)	On-Going	
7.1	Ensure accessibility for the deaf	Review patient documentation via the Clinical Policy, Documentation and Information Group (CPDIG).	1, 2, 3, 4, 5	Jeannette Morrison	Fiona Ireland	YES	<p>The ITM met with CPDIG. Standard information about ITS is now added to new and updated documentation / Patient Information Leaflets template in order for all documents to have this as mandatory information.</p> <p>Investigating the possibility to include symbols instead, and a link to an NHS Lothian accessibility page with information in alternative formats about available support.</p> <p>Delphine Jaouën v7 06022017</p>			✓	

Investigating the production of material in
BSL.

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7.2	Ensure accessibility for the Blind and the Deafblind	Investigate	1, 2, 3, 4, 5	Jeannette Morrison	Fiona Ireland	YES	<p>Discussed with the NHS Lothian Web team who advised that the web is so ubiquitous nowadays there is much less need to "help users know what to do", as if using the web is something new. PC users will more than likely already have their machines set up the way they like it, with CSS being ignored or re-interpreted as they see fit. They will also more than likely already be using any talking plugins if they choose or be using in-built features of the Operating Systems like Narrator on Windows or VoiceOver on Mac. The EHRC website promotes using the web browser to adapt settings. NHS Lothian accessibility page redirects users to the BBC accessibility guidelines.</p> <p>Other methods to be investigated for the Deafblind.</p>			✓	
7.3	Ensure accessibility for patients whose first language is not English	Investigate	1, 2, 3, 4, 5	Jeannette Morrison	Fiona Ireland	YES	<p>The brochure on how to feed back to NHS Lothian is available in other languages. The new PET Policy may be available in other languages as part of a Quality Improvement project.</p> <p>Also exploring the creation of a database with all translated documents for quick access from NHS Lothian sites.</p> <p>There is ongoing work on the use of RefHelp as a repository for all NHS Lothian documentation. Translated versions could integrate in this system.</p> <p>The NHS 24 brochure on how to call 111 via an interpreter has been translated into several languages upon our request by the NHS24 translation partner.</p>			✓	
7.4	Ensure that the NHS LOTHIAN Intranet information is current and compliant with EU Directive Action 64		1, 2, 3, 4, 5	ITM *	Fiona Ireland	YES	See point 7.2. The emphasis is now on web users to set up their browsers to make the web accessible.		✓		✓
	Regularly review NHS LOTHIAN Intranet information to ensure that information is current		1, 2, 3, 4, 5	ITM *	Fiona Ireland	YES	The page has been updated with latest information. The ITM will keep updating the intranet page with any new processes or information.			✓	✓
	Promote the National communication service based in West Lothian for Mental Health and Learning Disability patients and users – include in training under Item 3		1, 2, 3, 4, 5	Lee McGuinness	Fiona Ireland	YES	To be investigated.			✓	

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	Comply with the Accessible Information Standard	From 31st July 2016, all NHS and adult social care organisations are required by law to follow a new set of rules called the Accessible Information Standard.	1, 2, 3, 4, 5	itm*	Fiona Ireland	YES	The Standard seems to be for NHS England only.		✓		✓
7.5	Ensure that the complaints and feedback service works for patients with communication support needs	Ensure that each DATIX complaint is populated with information regarding patients communication difficulty	1, 2, 3, 4, 5	Jeannette Morrison	Fiona Ireland	YES	Awaiting to meet with Head of Patient Experience. The ITM asked the PET Team Lead to receive notification of any feedback / complaint to do with ITS. Being investigated.		✓		
		Monitor annually	1, 2, 3, 4, 5	Jeannette Morrison	Fiona Ireland	YES	Report extracted in February 2017 and cases flagged up by Deaf Action (which are not currently on DATIX as no formal complaint has been received) have been followed up. Awaiting to meet with Head of Patient Experience.			✓	

* - Interpretation and Translation Manager
Jeannette Morrison – Head of Patient Experience

Interpretation and Translation Improvement Action Plan 2015 to 2017

IMPROVE NHS Lothian's GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY IN INTERPRETATION AND TRANSLATION

Outcome measuring – Annual review as part of the Equality and Diversity Strategy

Item	AIM	ACTION	EHRS STANDARD	ACCOUNTABLE OFFICER	STRATEGIC LEAD	COMMENCED	NOTES	Timescale from 1 st September 2015			COMPLETE
								Short Term (Within 6 months)	Medium Term (Within 1 Year)	On - Going	
8.1	Leadership for the ITS service from NHS Lothian	Identify a Project Manager for the Interpretation and Translation Service	1, 2, 3, 4, 5	Lee McGuinness	Fiona Ireland	YES		✓			01/08 /15
8.2	Skilled and knowledgeable permanent manager for the NHS Lothian ITS	Review the Job Description, hours and seniority of the current operational manager of the Interpretation and Translation Service	1, 2, 3, 4, 5	Lee McGuinness	Fiona Ireland	YES		✓			01/09 /15
		Employ Interpretation and Translation Manager (ITM)	1, 2, 3, 4, 5	Lee McGuinness	Fiona Ireland	YES		✓			14/04 /16
8.3	Ensure that ITS attends the overarching steering group which manages and monitors NHS Lothian's Equality Outcome Framework	Appoint Chair of NHS Lothian Corporate Equality and Diversity Committee	1, 2, 3, 4, 5	Lee McGuinness	Ruth Kelly	NO	An E&D Lead has now been identified.		✓		November 2016
		Ensure complaints team (Patient Experience Team – PET) involvement in the Interpretation and Translation Users Group to ensure that patients and users of NHS Lothian can feed back their concerns	1, 2, 3, 4, 5	Jeannette Morrison	Fiona Ireland	YES	<p>Currently, patients can feed back to CEC ITS by post/email, via staff, independent interpreter or social workers. Answer phone idea was the preferred method as per the 2015 focus group.</p> <p>If complaints are received by the PET in another language, translation can be provided by CEC ITS. If communication is made verbally (i.e. a patient has a meeting face-to-face with PET or wants someone to phone them), telephone interpreting and face-to-face interpreting are available.</p> <p>The ITM liaised with the PET Manager and clarified. How to encourage patients to feed back in</p>	✓	✓		

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							<p>their preferred language is being investigated (e.g. add an interpreter from thebigword to the call was investigated however this is not possible with normal desk phones – conference facilities would be needed). There is currently a Polish speaking member of staff in the PET team.</p> <p>Going forward with the new service, complaints/feedback could all go via the PET team.</p>				
8.4	Ensure that all NHS Lothian staff are focussed on this issue	Each member of staff to have ITS included in their PDP KSF	1, 2, 3, 4, 5	Lee McGuinness	Ruth Kelly	YES		✓			✓
		Ensure that all staff continue to have a mandatory competence via KSF regarding Equality and Diversity. Ensure all senior staff have Equality and Diversity in their objectives	1, 2, 3, 4, 5	ITM *	Ruth Kelly	YES		✓			✓
8.5	Monitor and address any incidents or complaints regarding this issue	DATIX incidents and complaints involving communication issues are fed back monthly and addressed via the Interpretation and Translation Users Group	1, 2, 3, 4, 5	Jeannette Morrison / ITM*	Fiona Ireland	YES	DATIX has been set up so if there are any complaints that are to do with Language or Communication, they will be accessible by the ITM. Investigating with PET team lead if a notification could be sent.		✓		✓
8.6	Set up a nation-wide committee to discuss ITS with other NHS boards	Establish links with other NHS boards to and identify who is responsible for ITS across Scotland. Set up a committee and regular meetings to discuss ITS provision, share resources and work on service improvement collaboratively.	1, 2, 3, 4, 5, 8	itm *	Fiona Ireland	YES	The ITM and Lee McGuinness visited NHS GGC ITS on 25/8/16 and attended a national discussion group on ITS on 10/01/2016. Key contacts from most health boards are now known and in touch with the ITM.		✓		10.01 .16
8.7	Participate in research around ITS to enable the improvement of ITS training and practice across the region	Be involved in research projects as professional	1, 2, 3, 4, 5, 8	itm *	Fiona Ireland	YES	Meetings were organised with Heriot-Watt University researchers. The ITM participated in the Critical Link 8 conference where academics, researchers, service users, interpreters gather to discuss issues revolving around ITS. A researcher contacted the ITM to involve interpreters in a piece of research on telephone interpreting quality.		✓		

Interpretation and Translation Improvement Action Plan 2015 to 2017

8. 8	Taking over the interpreting and translation services from City of Edinburgh Council to NHS Lothian.	Service transfer to take place on 1 st January 2017.	1, 2, 3, 4, 5, 8	itm *	Fiona Ireland	YES	A separate Action Plan has been drawn up specifically for the new service (separate document).	✓			
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Foodbank	Referral process	Maximum number of referrals	Sources of Funding	Volume per week	Frequency of use	No of people fed 2013/14	No of people fed 2014/2015
1 Basics Bank West Pilton	Formal Referral Process	3 month wait between referrals	Donations	17	no information provided	623	no information provided
2 Trussell Pilton	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760
3 Trussell Trust NE N Leith	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760
4 & 5 Trussell Trust NE HQ and S Leith	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760
6 Destiny's Angels Salamander	Formal Referral Process	No limit	CEC, Donations	no information provided	no information provided	no information provided	no information provided
7 Basic Leith	Formal Referral Process	3 month wait between referrals	Donations	17	no information provided	623	no information provided
8 Fareshare (Cyrenians)	Formal Referral Process	One off food parcels	CEC, NHS, Donations	no information provided	no information provided	no information provided	no information provided
9 Edinburgh Community Food	Formal Referral Process	no information provided	CEC, NHS, Donations, Big Lottery	30	no information provided	no information provided	no information provided
10 Destiny's Angels Salamander	Formal Referral Process	No limit	Donations	no information provided	no information provided	no information provided	no information provided
11 Trussell Trust NE St Andrews	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760
12 Trussell Trust NE Pilrig	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760
13 Basics Bank Portobello	Formal Referral Process	3 month wait between referrals	Donations	17	no information provided	623	no information provided
14 Rocktrust	Formal Referral Process	no information provided	CEC, Big Lottery	7	300-400 per year	no information provided	no information provided
15 Trussell Trust Central	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760

Foodbank	Referral process	Maximum number of referrals	Sources of Funding	Volume per week	Frequency of use	No of people fed 2013/14	No of people fed 2014/2015
16 Basics Bank Newington	Formal Referral Process	3 month wait between referrals	Donations	17	no information provided	623	
17 Trussell Trust SE	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760
18 Basics Bank Bruntfield	Formal Referral Process	3 month wait between referrals	Donations	17	no information provided	623	no information provided
19 Destiny's Angels Gorgie	Formal Referral Process	No limit	CEC		no information provided	no information provided	no information provided
20 Salvation Army Gorgie	Formal Referral Process	4 referrals per person	Donations	20	708 per year	no information provided	no information provided
21 Salvation Army Slateford	Formal Referral Process	4 referrals per person	Donations	20	708 per year	no information provided	no information provided
22 Basics Bank Wester Hailes	Formal Referral Process	3 month wait between referrals	Donations	17	no information provided	623	no information provided
23 Broomhouse Food Bank	Self referral	No limit	CEC, Big Lottery, Donations	16	no information provided	no information provided	no information provided
24 Trussell Trust NW Rannoch	Formal Referral Process	3 referrals per year	CEC, Donations	75	32500 meals per year	3608	2760

Name of	Address	Postcode	Day's	Telephone	Email	Contact Name
Granton(Basics Bank)	Granton Baptist Church, 99 Crewe Road North	EH5 2NW	Tuesday	no info available	no information available	no information available
	Wilson Memorial Church, 7 Kekewich Ave	EH7 6TZ	Tuesday	no info available	no information available	no information available
Leith(Basics Bank)	Ebenezer United Free Church, 31 Bangor Road, Leith	EH6 5IX	Wednesday	no info available	no information available	no information available
	Edinburgh Community Church, 41a South Clerk Street	EH8 9NZ	Thursday	no info available	no information available	no information available
Musselburgh(Basics Bank)	Musselburgh Baptist Church, 68 New Street	EH21	Thursday	no info available	no information available	no information available
Bruntsfield (Basics Bank)	Bruntsfield Evangelical Church, 70 Leamington Terrace	Eh10 4JU	Friday to Monday	no info available	no information available	no information available
Broomhouse Foodbank	3 Broomhouse Market	EH11 3UU	Saturday	0131 443 6223	cossinfo@ymail.com	Carol Swan

Name of Organisation	Address	Postcode	Type of CAB Service	Telephone Number	Email	Contact Details	Opening Times
Edinburgh Sherrif Court	Office (next to Court 15) Chambers Street		In Court Advice	0131 202 5114	inca@caed.org.uk		Monday to Friday
Edinburgh Sherrif Court	Office (next to Court 15) Chamber Street		Court Mediation	0131 220 1092	court.mediation@caed.org.uk	Wilma Bailey	Tuesday Friday
	5th Floor Charlotte House 2						
Veterans 1st Point	Charlotte Street	EH2 4AW	Advice for Veterans	0131 220 9920			no info available
Welfare Rights Health Project	Royal Infirmary Hospital 51 Little France Crescent	EH16 4SA	Welfare Rights Advice	0131 536 1000			Monday and Tuesday
	Western General Hospital						
Welfare Rights Health Project	Crewe Road South	EH4 2XU	Welfare Rights Advice	0131 537 1000			Thursday and

Employability Hub	Address	Postcode	Telephone Number	Opening Days
North Hub	11 Pennywell Court	EH4 4TZ	0131 529 6161	Monday to Friday
West Hub	Gate 55, 55 Sighthill Road	EH1 4PB	0131 529 6161	Monday to Friday
East Hub	Haywired 3 Hay Avenue	EH1 4R	0131 529 6161	Monday to Friday
City Centre Hub	St James Centre		0131 529 6161	Monday to Friday
	Gate 13, 13			
South Hub	Newtoft Street	EH1 8RG	0131 529 6161	Monday to Friday

CAB Name of GP Practice	Address	Telephone Postcode	Open Times for Number
Dr Trolley and Partners(Bellvue Medical information Centre)	26 Huntingdon Place	EH16 4DT	0131 556 2642 No provided
Dr Gray and Partners(Bellvue Medical centre)	26 Huntingdon Place	EH16 4DT	0131 556 8196 No information provided
Craigmillar Medical Group	106 Niddrie Mains Road	EH16 4DT	0131 536 9500 No information provided
Inchpark Surgery	10 Marmion Crescent	EH16 5QU	0131 666 2121 Monday afternoons
Ladywell Medical Centre (East)	Ladywell Road	EH12 7TB	0131 334 3602 Tuesday afternoons
Ladywell Medical Centre (West)	Ladywell Road	EH12 7TB	0131 334 3602 Tuesday afternoons
South Queensferry Medical Practice	41 The Loan	EH30 9HA	0131 331 1396 Tuesday mornings, Wednesday afternoons
Wester Hailes Medical Practice	7 Murrayburn Gate	EH14 2SS	0131 537 7300 Monday mornings Wednesday

Citizens Advice	Address	Postcod
CAE Dundas Street	58 Dundas Street	EH3 6QZ
CAE Leith	12 Bernard Street	EH6 6PY
CAE Pilton	661 Ferry Road	EH4 2TX
CAE Portobello	8 a&b, Bath Street	EH15 1EY
CAE Gorgie/Dalry	Fountainbridge Library, 137 Dundee Street	EH11 1BG

Community Health Initiative	Address	Town/City	Postcode	X	Y
AdvoCard	332 Leith Walk	Edinburgh	EH6 5BR	326635	675275
Broomhouse Health Strategy Group	1 Broomhouse Market 79-89 Broomhouse	Edinburgh	EH11 3UU	320173	671351
The Broomhouse Centre	Crescent	Edinburgh	EH11 3RH	320332	671242
CAPS – The Consultation and Advocacy Promotion Service	Old Stables, Eskmills Park, Station Road	Musselburgh	EH21 7PQ	333845	672237
Carr Gomm	11 Harewood Road	Edinburgh	EH16 4NT	329411	67194
Comas	8 Jackson's Entry	Edinburgh	EH8 8PJ	326549	67372
CHAI Wester Hailes:	Wester Hailes Healthy Living Centre, 30 Harvesters	Edinburgh	EH14 3JF	319775	66970
CHAI Oxgangs	8 Firrhill Neuk, 40 Captains Road (in the CEC Office),	Edinburgh	EH13 9FF	323695	66937
CHAI South Edinburgh	Edinburgh	Edinburgh	EH17 8HR	328008	66836
Edinburgh Community Food, Edinburgh & Lothians	22 Tennant Street, Swanston Steading, 109/11	Edinburgh	EH6 5ND	326605	67588
Greenspace Trust	Swanston Road	Edinburgh	EH10 7DS	323935	66751
Health All Round	24 Westfield Avenue	Edinburgh	EH11 2QH	322370	67241
The Junction	82-86 Great Junction	Edinburgh	EH6 5LL	326837	67606
LGBT Health and Wellbeing,	9 Howe Street, Lochend House, 33	Edinburgh	EH3 6TE	325064	67606
Link Up support	Lochend	Edinburgh	EH7 6BR	327736	67431
Pilton Community Health Project	73 Boswall Pkwy,	Edinburgh	EH5 2PW	323295	67654
Pilmey Development	19-21 Buchanan Street	Edinburgh	EH6 8SQ	326644	67513
The Ripple Project	Restalrig Lochend Community Hub, 198 Restalrig Road South,	Edinburgh	EH7 6DZ	328063	67512
Thistle Foundation	Niddrie Mains Road	Edinburgh	EH16 4EA	329495	67142
Wester Hailes Healthy Living Centre	30 Harvesters Way	Edinburgh	EH14 3JF	319775	66970

Name of Food Co-op	Address	Postcode	Telephone	Contact Details
Broomhouse Co-op	1 Broomhouse Market, Broomhouse	EH11 3UU	0131 467 7678	Lucy Aitchison
Gate 55	Sighthill Road, Edinburgh	EH11 4PB		Denis MacKay
Gorgie Farm	51 Gorgie Rd	EH11 2LA	0131 337 4202	www.gorgiecityfarm.org.uk
Inchpark Food Coop	Inchpark Community Centre, 225	EH16 5UF	0131 664 1520	Tom Ritchie
The Pleasance Co-op	Kirk O' Field Church, St Ninians Hall, 138-140 The	EH8 9RR	0131 664 1520	Mary Wilson
Richmond Co-op	Richmond Craigmillar Church, 227 Niddrie Mains	EH16 4PA	0131 661 6561	Liz Henderson
The Fabby Food Store (West Pilton)	West Pilton Neighbourhood Centre, 19	EH4 4BY	0131 551 3194	no info available

Name of Housing	Address	Contact Name	Telephone Number	Opening Times
Port of Leith Housing Association	108 Constitution Street, Edinburgh EH6 6AZ	Fiona Neilson	0131 553 8745	no info available
Margaret Blackwood	Craigievar House, 77 Craigmount Brae, Edinburgh EH12 8XF	Craig Henderson at Dunedin Canmore	0131 624 5772	no info available
Castlerock Edinvar	1 Hay Avenue, Edinburgh, Midlothian EH16 4RW	Financial Inclusion Team	0131 657 0605	no info available
Hillcrest Housing	Canongate, Edinburgh, Midlothian EH8 8DD	Angela Lamb at POLHA	0131 657 0684	no info available
Dunedin Canmore	8 New Mart Road, Edinburgh EH14 1RL	Craig Henderson	0131 624 5772	no info available

A quick guide to “crisis response” resources to help individuals with immediate essential living costs

Getting advice:

Citizen Advice Edinburgh (CAE)

For money (debt, benefits, tax) **Family** (relationships, health, housing, education) **Daily life** (employment, consumers affairs, communication, travel) **Your rights** (civil rights, immigration, legal rights and responsibilities)

CAE Dundas Street, 58 Dundas Street, EH3 6QZ

Appointments only, unless otherwise noted

Appointments only: **0131 558 3681**

Monday: 9.10am - 4pm

Tuesday: 9.10am - 4pm

Employment Clinic: **0131 603 7714**

Wednesday: 9.10am - 1pm | 1.30pm - 4pm (Drop-in) | 6pm - 8pm

Thursday: 9.10am - 4pm | 6pm - 8pm (Employment Clinic, Fuel Bills Clinic)

Friday: 9.10am - 1pm (Drop-in) 1pm - 4pm (appointment only)

CAE Leith, 23 Dalmeny Street, EH6 8PG

Telephone: **0131 554 8144**

Monday to Friday: 9.30am - 12.30pm (Drop-in) | 12.30pm - 4.30pm (appointment only)

Tuesday: 5.00pm - 8pm (Legal/Employment/Money Clinics, appointment only)

CAE Pilton 661 Ferry Road, EH4 2TX

Telephone: **0131 202 1153**

Monday to Friday: 9.30am - 12.30pm (Drop-in) | 12.30pm - 4.30pm (appointment only)

CAE Portobello 8a-8b Bath Street, EH15 1EY

Appointments only unless otherwise stated

Appointments only: **0131 669 9503**

Monday: 9.30am - 4.30pm

Tuesday: 9.30am - 12.30pm (Drop-in) | 12.30pm - 4.30pm (appointment only)

Wednesday: 9.30am - 4.30pm | Evening clinic 6.30pm - 7.30pm fortnightly

Thursday: 9.30am - 12.30pm (Drop-in) | 12.30pm - 4.30pm (appointment only)

Friday: 9.30am - 4.30pm

CAE Gorgie/Dalry Fountainbridge Library Building (2nd Floor) 137 Dundee Street, EH11 1BG

Appointments only

Monday to Friday: 10.15am - 4.30pm

Appointments only: **0131 474 8081**

Monday: 5.30pm - 7pm

Citizens Advice Edinburgh also runs services in 30 outreach locations

Details: www.citizensadviceedinburgh.org.uk

Citizens Advice Direct

A national service for help and assistance Telephone: **0808 800 9060**. Calls from all UK landlines are free. Mobiles may vary. Open Monday to Friday: 9am - 8pm and Saturday: 10am - 2pm.

The Advice Shop Edinburgh City Council

249 High St, Edinburgh, Midlothian EH1 1YJ. Telephone: **0131 200 2360**

Opening hours for enquiries: Monday, Wednesday, Thursday: 8.30am - 4.30pm; Tuesday 10am - 4.30pm; Friday 8.30am - 3.40pm. Information, advice and representation to access welfare

benefits and deal with debt. This is a free, impartial and confidential service. Drop-in service

available for more in-depth enquiries Monday, Thursday and Friday 9am. Tuesday 1pm. This is on a first come first served basis.

Granton Information Centre

Granton Information Centre (GIC) provides free, impartial and confidential expert advice, information and representation to the residents of North Edinburgh on a range of issues: welfare benefits, housing advice and debt/money advice.

134-138 West Granton Road, Edinburgh EH5 1PE. Telephone: **0131 5512459 / 0131 552 0458**

Email: enquiries@gic.org.uk

Monday to Thursday: 9.30am - 12.30pm and 1.30pm - 4pm

Friday: 9.30am - 12.30pm

To make an appointment contact GIC.

CHAI – Community Help and Advice Initiative

For advice on housing, welfare benefits, debt/money, employability. They offer appointments and operate a drop-in service on Wednesday morning (from 9.30am). Please call for information or an appointment. CHAI Head Office, ELS House, 555 Gorgie Road, Edinburgh EH11 3LE

Telephone: **0131 442 2100** Email: chai@chaiedinburgh.org.uk

CHAI Advice Service: **0131 442 1009**

Income Advice Team, Edinburgh City Council

For advice about applying for housing benefit and council tax reduction or other benefits, including tax and pension credits. They also let you know about other ways you might be able to get financial help. For City of Edinburgh Council Tenants only. Telephone: **0131 529 7463**.

Scotland's Financial Health Service

www.scotlandfinancialhealthservice.gov.uk/ Talk to Scotland's Financial Health Service advisers directly by calling **0800 707 6696**.

Getting money:

Scottish Welfare Fund (SWF):

Crisis Grants for people on income-related benefits who, due to an emergency or disaster, have no money to pay for immediate essential living costs, or **Community Care Grants** to pay for essential items to help a vulnerable person to leave care or supported accommodation, or remain in their own home.

Contact: SWF is administered by Edinburgh City Council; telephone: **0131 529 5299**

Department of Work & Pensions (DWP):

Short Term Benefit Advances: may be available if someone has applied for benefits or has had a recent change to their benefit entitlement but hasn't had their first payment yet.

Hardship Payments: may be available to people claiming Job Seekers Allowance / Employment Support Allowance whose benefit has been suspended or "**sanctioned**." To receive a hardship payment, you must prove that without it you are in danger of going without essentials, like food or heat.

Severe Hardship Payments: may be available to 16-17 year-olds living away from their family home.

To find out more or apply, contact the local job centre: Telephone: **0345 608 8545**

Social Fund:

Budgeting loans (minimum £100 - maximum £1,500) for people who have been claiming income-related benefits for at least 26 weeks to help pay for larger items or can cover certain debts, like utility bills or rent arrears. Budgeting loans are interest-free but need to be repaid.

Funeral payments: if you get certain benefits and are responsible for arranging a family funeral (maximum £700).

Sure Start Maternity Grants: For new mothers on income-related benefits (up to £500)

Contact the Social Fund; telephone: **0843 515 8360** (or application forms from Job Centre).

Discretionary Housing Payments (DHP):

DHPs may be available to people receiving Housing benefit who are having trouble paying their rent, for example due to the “bedroom tax” or other shortfalls between their rent and housing benefit payments.

For further details or to apply online, visit the City of Edinburgh Council’s website at:

www.edinburgh.gov.uk

Social Work Payments:

Edinburgh City Council has a statutory duty to support vulnerable adults or children in need if there is an emergency. To ask about Section 12, 22 or 27 social work payments, contact Social Care Direct; telephone **0131 200 2324** or, if homeless, The Access Point; telephone **0131 529 7438**. Out of office hours, call the Out of Hours Social Work service (**emergencies only**) on **0800 731 6969**.

Employability: Get On

Support for getting into work or training. Telephone: **0131 529 6161** or email:

geton@edinburgh.gov.uk

Getting Free/Cheap Food:

Foodbanks: Free food

Referral to basic food banks: E: referrals@ecm.org.uk or Edinburgh City Mission: telephone **0131 225 9445**. Service-user must present with a completed referral form. Please phone or email for a form which must be signed by a third party. Emergency food packs and long term provision (initially a maximum of six weeks). Financial and welfare advice from Citizen Advice Edinburgh available at all basic banks

- **Granton (Basic Bank)** Granton Baptist Church, 99 Crewe Road North EH5 2NW .
Tuesday 10am - 1.30pm, For referral details, see above
- **Newington (Basic Bank)** Edinburgh Community Church, Kings Hall, 41a South Clerk Street, EH8 9NZ Thursday 10:30am - 1.30pm. For referral details, see above.
- **Leith (Basic Bank)** Ebenezer United Free Church of Scotland, 31 Bangor Road EH6 5JX
Wednesday: 11.30am - 2pm. Referral details, as above.
- **Bruntsfield (Basics Bank)** Bruntsfield Evangelical Church, 70 Leamington Terrace EH10 4JU Friday: 10am - 2pm. Referral details, as above.
- **Portobello (Basics Bank)** Wilson Memorial Church, 7 Kekewich Avenue (corner of Moira Terrace), Portobello EH7 6TZ: Tuesday 10am - 1pm. Referral details as above
- **Corstorphine (Basic Banks)** Corstorphine United Free Church, 7 Glebe Terrace EH12 7SQ.
Thursday 10.30am-12.30pm Referral details as above.

Edinburgh Central Mosque Food Banks, 50 Potterow, EH8 9BT. Tel 0131 667 1777. Friday 9.30am – 12noon. Referral needed. Muslims from whole of Edinburgh welcome. Non Muslims from South east Edinburgh only.

Wester Hailes Holy Trinity Church, Hailesland Place, Wester Hailes EH14 2SL.

Telephone **0131 442 3304**. Tuesday: 2pm - 3pm. No referral needed, not specifically for Wester Hailes. Fortnightly packages up to 10 times.

NW Foodbank (Trussell Trust) For postcodes EH 1-5, 9, 10, 12, 28-30. Referrals only.
Telephone **0131 444 0030**.

- **Rannoch Community Centre**, Rannoch Terrace, EH4 7ER.
Tuesday and Thursday: 1pm - 3pm, referrals only. Tel: 07794849945
- **The Priory Church**, Hopetoun Road, South Queensferry, EH30 9RA
Thursday: 11am - 1pm, referrals only. T: 07837532169
- **Pilton**, 34A Muirhouse Crescent (next to Muirhouse Social Work Centre)
EH4 4QL Monday: 1pm - 3pm and Friday: 10am -1pm, referrals only. T: 07794850009
- **Kirkliston**, Kirkliston Parish Centre, The Square, Kirkliston EH29 9AS.
Tuesday: 2.30pm - 4pm. Referrals only
- **Oxgangs**, All Nations Christian Fellowship, 1c Oxgangs Avenue EH13 9JA.
Tel: 07904538996, Wednesday: 10am – 2pm. Referrals only.
- **Craigmillar, Bristo Church**, 196 Peffermill Road EH4 3DJ. Tuesday and Thursday 12pm
– 3pm and Saturday 11am – 2pm. Opening 7th November 2016

SW Foodbank (Trussell Trust) 431 Gorgie Road, EH11 2RB. Telephone **0131 346 2875**.
Open Monday: 2pm - 4pm, Wednesday 11am - 1pm and Friday 10am - 12 noon.

SE Foodbank (Trussell Trust) Blytheswood Care, 47 Southhouse Broadway, EH17 8AS.
Monday, Tuesday, Thursday: 11am - 2.30pm Telephone: **0131 664 9353** or **07521 097 670**

Central Foodbanks (Trussell Trust) Telephone: **0131 440 0030**.

- **Grassmarket Community Project**, 86 Candlemaker Row, EH1 2QA,
Tuesday and Friday: 2pm - 4pm. Referrals only. T: 07805203852
- **Tollcross Distribution Centre**, 2 West Tollcross (entrance via corner shop under Central Hall) EH3 9BP, Monday: 2pm - 4pm, Thursday: 10am -12 noon. Referrals only.
T:07805203744
- **Broughton St Mary's Parish Church**, 12 Bellevue Crescent, EH3 6NE
Wednesday: 10am -1pm and Thursday: 1pm - 4pm. T:07805204009

Salvation Army (Trussell Trust) Slateford Longstone Church, 52 Kingsknowe Road North,
EH14 2DF, Telephone: **07752 314 497**. Referrals only
Monday: 10am -12pm.

NE Foodbank (Trussell Trust) Main contact 6 Henderson Street, Leith EH6 6BS
Telephone: **0131 554 2578**. Referrals only.

Monday:	1pm - 2.30pm	South Leith Parish Church , 6 Henderson Street.
Tuesday:	10am - 12 noon	North Leith Parish Church , 1a Madeira Place.
Tuesday:	1pm - 2.30pm	Leith St. Andrews Parish Church , 410-412 Easter Road.
Wednesday:	4.30pm - 6pm	Pilrig St. Pauls Church , 1b Pilrig Street.
Wednesday:	11am - 12.30pm	St.Marys Parish Church , McLaren Halls, 48 Restlrig Road South
Thursday:	1pm - 2.30pm	Leith St. Andrews Parish Church , 410-412 Easter Road.
Friday:	10am - 12 noon	North Leith Parish Church , 1a Madeira Place.
Friday:	3pm - 5pm	South Leith Parish Church , 6 Henderson Street.

Broomhouse Community One Stop Shop (COSS) 3 Broomhouse Market EH11 3UU.
Monday to Thursday: 9am - 5pm,

Friday: 9am - 12pm.

Self-referral. Telephone: **0131 443 6223**. E-mail: **cossinfo@ymail.com**

There is also a CAB adviser and employability worker present for support and help.

Westerhailes Healthy Living Centre 30 Harvesters Way, EH14 3JF Telephone: **0131 453 9400**. Referral only; must be living in Wester Hailes area. Monday to Thursday: 10am - 5pm, Friday: 10am - 12.30pm.

Free food

St Catharine's Convent: 4 Lauriston Gardens. Monday - Friday: 9am -11.30am and 5.30pm - 6.30pm (closed July and August). Hot meal (showers available) Telephone: **0131 229 2659**.

Destiny Angels: 106 Salamander Street, Leith. Telephone: **0131 454 2001**
Ladies Coffee Stop - referral needed.

Missionaries of Charity: 18 Hopetoun Crescent. Telephone: **0131 556 5444**
Every day at 4pm, except Wednesdays and Thursdays. No referral needed.

Bethany Care Van

Lunchtime: Monday, Wednesday, Thursday and Saturday: 12.40pm from Waverley Bridge, then George Street, Lothian Road, King's Stable's Road, George IV Bridge, Chamber Street, North Bridge / Royal Mile Junction; reaching Leith Walk (just North of McDonald Road) at 2pm. Evening follows same route as lunchtime, minus Leith Walk and George Street. Starts at 9pm on Lothian Road.

Jericho House, 53 Lothian Street, entrance on Bristo Place. Telephone: **0131 225 8230**
Sunday: 10am - 2pm – coffee/lunch.

Carrubbers Christian Centre: 65 High Street, Royal Mile, EH1 1SR. Telephone: **0131 556 2626**.
Free breakfast every Sunday: 8am - 9.30am (men's clothes and blankets provided at breakfast).
Free lunch Tuesdays from 12pm - 1pm (not July/August - runs roughly with school term time).

South Leith Parish Church, 6 Henderson Street. Telephone: **0131 554 2578**
Sunday: 9.30am - 10am, Takeaway breakfast.

Grassmarket Centre, 86 Candlemaker Row, Monday: 4pm - 5.30pm, (closes for the festival), soup, sandwiches, biscuits and cake. Telephone: **0131 225 3626**.

Social Bite, offers free coffee and food, but not always guaranteed.
131 Rose Street, Edinburgh, EH2 4JN, 89 Shandwick Place, Edinburgh EH2 3DT. Telephone: **0131 220 8206**. Monday - Friday: 7am - 11am and 3pm - 5pm

Cheap food

Salvation Army, 25 Niddrie Street: Monday - Friday, 9am - 10am, breakfast £1.25, 12 noon - 1pm, lunch £1 (vouchers available). Telephone: **0131 523 1060**. Provides clothing, a shower and advice also.

Vouchers

With **Healthy Start**, you get free vouchers every week to spend on milk, plain fresh and frozen fruit and vegetables, and infant formula milk. You can also get free vitamins.

Pregnant or have children under the age of four? You could qualify if you're on benefits, or if you're pregnant and under 18. Speak to your midwife or health visitor for an application form or visit <http://www.healthystart.nhs.uk/> Telephone: **0345 607 6823**

Fuel poverty and keeping warm:

Changeworks Affordable Warmth Service:

provides specialist advice and practical support to help people stay affordably warm in their homes. They can help people to manage fuel debt and avoid disconnection and to access winter fuel and cold weather payments, discounts and grants. To make a referral, contact Jane Adams Telephone: **0131 555 4010** or email warmth@changeworks.org.uk

Additional emergency credit for pre-payment meters

In an emergency, if a vulnerable person or family has no money for a pre-payment gas or electric meter, it may be possible to negotiate a small amount of extra emergency credit by contacting their energy supplier (although this needs to be repaid).

Freephone contact numbers for the main domestic fuel suppliers, for help with paying for gas/electric

British/Scottish Gas: telephone **0800 107 3391**; EDF Energy: telephone **0800 269 450**;

EON: telephone **0800 051 1480**; Npower: telephone **0800 073 3000**;

Scottish Power: telephone **0800 027 0139** or Scottish Hydro Electric: telephone **0800 622 838**

Energy matters - the fuel bills advice service

A Citizens Advice Edinburgh project providing free, specialist support about how to reduce household fuel costs. Negotiating with energy suppliers, avoiding disconnection, switching tariffs, managing arrears and billing issues, accessing grants and increasing household income.

Service is available via Thursday evening advice clinics at CAE Dundas Street and via Edinburgh-wide home visits by arrangement. To make an appointment, email: iain.waugh@caed.org.uk or telephone **07825 519 081**.

Home Energy Scotland

Home Energy Scotland from the Scottish Government is a free, impartial energy advice service to help people save money and stay warm in their homes. Home Energy Scotland offers a wide range of support and advice, for example, it provides energy saving tips and advice, carries out home energy checks to identify energy efficiency measures and improvements, provides guidance on what funding and support is available and makes referrals to the relevant funding streams.

Free phone Home Energy Scotland on **0808 808 2282** or visit www.homeenergyscotland.org

Homelessness and at risk of losing your home:**Edinburgh Housing Advice Partnership**

If someone is at risk of losing their home because their landlord or mortgage company is taking legal action to evict them, they should immediately contact Edinburgh Housing Advice Partnership, telephone **0131 442 1009** or **0845 302 4607**, who can provide advice and arrange for someone at risk of losing their home to be represented at court hearings. Advice also provided on a wide range of housing issues - phone for an appointment with an Adviser at venues across the City. www.ehap.org.uk

The Access Point (TAP)

Anyone 18+ without children and homeless in Edinburgh can register here. Advice about entitlements, eligibility for temporary accommodation and benefits. 17 and 23 Leith Street. Telephone **0131 5297438**. They also offer medical and social work support. Out of hours, call the City of Edinburgh Council's out of hours service on **0800 032 5968**.

Housing Options Team

For under 18s or those with children. Advice about entitlements, eligibility for temporary accommodation and benefits. 1a Parliament Square. Telephone: **0131 529 7368**.

Out of hours, call the City of Edinburgh Council's out of hours service on **0800 032 5968**.

Streetwork Crisis Service

24 hour provision of advice and support. Food, laundry, showers and lockers available for those accessing support. 22 Holyrood Road. Telephone: **0131 557 6055**.
Crisis line 24/7: telephone **0808 178 2323**.

The Rock Trust

The Rock Trust works with young people (16- 25) who are homeless or at risk of becoming homeless. They provide advice, educate and support for young people. 55 Albany Street. Telephone **0131 557 4059**.

Council Housing Officer

Your local neighbourhood council Housing Officer can help with housing needs.
West: telephone **0131 529 7440**, East: telephone **0131 529 3111**
South: telephone: **0131 529 5151**, South West: telephone **0131 527 3800**
Leith: telephone **0131 529 6170**, North: telephone **0131 529 5050**.

Cyrenians Homeless Prevention Service

For Edinburgh East and South residents who are at risk of losing their home.
Telephone: **0131 475 2556** Email: hps@cyrenians.org.uk

Gateway Visiting Support

For Edinburgh City and North residents who are at risk of losing their home.
Telephone: **0131 561 8910** Email: gvs@bethanychristiantrust.com

Shelter's Free Housing Advice Line

Provides free and confidential advice on housing problems and rights. Telephone: **0808 800 4444**
Monday to Friday: 9am - 4pm

Health and Wellbeing:

Health Concerns:

If financial difficulties are affecting someone's health they should speak to their GP (many advisors are based in GP Practices) or other health practitioner (e.g. Health Visitor or Community Psychiatric Nurse) or contact the NHS inform helpline for advice on **0800 22 44 88**. 8am - 10pm 7 days a week. For urgent medical advice out of hours, phone NHS 24 on **111** (free).

The Access Practice

If you are homeless and need a GP or medical attention, contact The Cowgate, 20 Cowgate, Edinburgh or The Access Point, 23 Leith Street, Edinburgh. Telephone: **0131 240 2810**

Mental Health

24/7 from the Edinburgh Crisis Centre, Freephone helpline: telephone **0808 801 0414**,
Text 0797 442 9075, email crisis@edinburghcrisiscentre.org.uk

As well as phone support, face-to-face support is available in the centre and people can stay at the centre for up to a week, whilst in crisis.

Mental Health

If you require an emergency mental health assessment, your GP can refer you to the Mental Health Assessment Service based at the Royal Edinburgh Hospital. Self referrals may also be made by telephoning **0131 537 6000**. This may result in you being offered an appointment for an assessment or you may be signposted to other more appropriate services.

Breathing Space

is a phone-line for people feeling anxious or depressed. Telephone **0800 83 85 87**
Monday to Friday: 6pm - 2am: Weekends Friday 6pm - Monday 6am (24 hours).

The Samaritans

If someone is feeling depressed or suicidal, the Samaritans provide a confidential listening service at any time (24/7). Telephone Free: 116 123.

Grapevine Disability Information Service

Providing up-to-date, reliable and accessible information to disabled people and their supporters in Edinburgh, East Lothian and Midlothian.

Telephone: 0131 475 2370 (Monday to Thursday: 10am - 4pm)

E: grapevine@lothiancil.org.uk

Women's Services:

Domestic Abuse:

If a woman and/or her children are experiencing or at risk due to domestic abuse, they can phone Edinburgh Women's Aid. Telephone **0131 315 8110**;

email: info@edinwomensaid.co.uk. **In an emergency** phone The Police on **999**. Other contacts are the National Domestic Abuse Helpline: telephone **0800 027 1234** (24 hours) or for all black / minority ethnic women, Shakti Women's Aid: telephone **0131 475 2399**.

Streetwork Women's Project

Advice, support to women in a crisis situation: risk of violence and physical/mental health issues, addictions, housing, benefits, sex work. Telephone **0131 3440825**. email: mail@streetwork.org.uk
18 South Bridge, EH1 1LL

The Access Practice Women's Clinic

17 Leith Street, Edinburgh. Telephone **0131 240 2810** Thursday: 1.45pm - 4pm.

For homeless women and pregnant women only.

Women's Clinic Spittal Street

Specifically for women who are affected by substance use (alcohol and drugs) or/and are involved in sex work. A holistic service with mental health, sexual health, women's health, social support, including welfare advice and employability issues and 1:1 support.

Thursday: 2pm - 7.30pm. Drop-in (no appointment needed) 22-24 Spittal Street, Edinburgh EH3 9DU. Telephone: **0131 537 8300**.

Rape Crisis Scotland National Helpline

Phone free any day between 6pm and midnight on **08088 01 03 02**

Local Office helpline **0131 556 9437**.

Email: support@ercc.scot

For more information contact

Sylvia.Baikie@nhslothian.scot.nhs.uk

Telephone: **0131 537 9326**

Sabina.McDonald@nhslothian.scot.nhs.uk

Telephone: **0131 537 9403**

Correct at time of print: December 2016 (updated version 4)

Procurement
Equalities in Procurement Policy

Policy Manager Andy Hay	Policy Group Procurement
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Policy Established	Policy Review Period/Expiry	Last Updated
November 2013	29.01.2018	29.01.2016

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Aims & Objectives

The purpose of these guidelines is to ensure that any supplier of goods or services chosen to supply NHS Lothian meet the same values of Equality and Diversity (E&D) held by NHS Lothian.

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

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

Objectives:

- All of our suppliers are actively following E&D Guidelines
- Our Suppliers and NHS Lothian are E&D Compliant.

Introduction

This guide gives advice on how to meet the public sector equality duty. It will help NHS Lothian to comply with their legal duties under:

- Section 149 of the Equality Act 2010 (the public sector equality duty), and
- The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012.

The public sector equality duty is set out in sections 149–157 and schedules 18 and 19 of the Equality Act. It replaces the previous public sector equality duties, the Race Equality Duty, introduced in 2002, the Disability Equality Duty (2006) and the Gender Equality Duty (2007).

The public sector equality duty covers the following protected characteristics:

- Age
- Disability
- Gender
- gender reassignment
- pregnancy and maternity
- race
- religion or belief
- Sexual orientation.

The public sector equality duty also covers marriage and civil partnerships, with regard to eliminating unlawful discrimination in employment

NHS Lothian is committed to ensuring that all E&D legislation and Duties are met and within NHS Lothian. The Procurement Department has the responsibility for ensuring that all procurement meets the requirements of the E&D legislation. This includes the delivery of national contracts. NHS Lothian Procurement also has the responsibility for ensuring that existing and new suppliers of goods and services are aware of the requirements of Equality Act 2010 with regard to the duties on public authorities, and the need to observe conditions of contract which safeguard against discrimination. This is notwithstanding the existing regulations and obligations for procurement.

Legal and Policy Framework

To comply with the duties under the E&D legislation, all public authorities in Scotland must take E&D into account when procuring goods, works, or services from external providers. Compliance with this duty is compatible with the obligations under; EC rules, best value, value for money, and with other national policies and strategies. The key principles that apply throughout any procurement linked to E&D are:

- o Relevance
- o Proportionality
- o Accountability
- o Transparency
- o Mainstreaming
- o Appropriateness
- o Complying with the law
- o Risk Assessment

NHS Lothian Procurement has produced legally agreed terms and conditions for all contracts let by NHS Lothian. These terms and conditions include detailed legal clauses to ensure compliance with all relevant legislation regarding Procurement and the Duty to Promote E&D across the 9 Strands.

Procurement is one of the functions relevant to all E&D Duties. To ensure compliance, an E&D Impact Assessment (EDIA) is required for all procurement strategies, policies and practice in relation to the promotion of equal and fair treatment. This will include an assessment of all objectives, general procedures, and the outcomes in terms of involvement of, and impact on, service users, suppliers, and employees from different racial groups.

Planning Procurement Projects – E&D as a Core Requirement

E&D is a core requirement as part of the contract process. For example, if the purpose of the contract is to provide services directly to the public, a supplier must be able to provide a service that meets the needs of everyone affected by the E&D legislation. As a core requirement, it must be reflected in the specification and conditions of the contract. It must be considered at each stage of the procurement process, and in the arrangements for monitoring and managing the contract.

For each contract, or group of similar contracts, the relevance of the contract to the duty to promote E&D, needs to be assessed. As a core requirement of any contract, this factor needs to be taken into account at each stage in the procurement process, and in the subsequent monitoring arrangements.

Certain types of contracts for services, involving direct contact with members of the public, are likely to be highly relevant to the E&D duties, as are requirements in relation to a contractor's workforce, especially when the contract involves services that are highly relevant to the duties specified in the legislation duties.

At Annex A, are 5 key questions, which should form part of any pre-contractual work. The answers will enable procurement staff to assess whether E&D is a core requirement, and whether specifications should be included in the contract to comply with the E&D duties. In addition, two 'tests' can be applied. The first is to decide whether application of the E&D legislation is 'necessary' and the second if it is 'appropriate'. By applying these tests, it should be possible to define the core requirements that reflect the contract's relevance to promoting E&D – in proportion to other essential elements of the contract. Whilst E&D is more likely to be relevant to contracts for services, it cannot be assumed that there will not be relevance to contracts for goods or works. It is important not to overlook the less obvious E&D implications.

Contracts for Services

Under the E&D duties, all reasonable steps are expected to make sure that an external provider of any service assessed as being relevant to the E&D duties, meets the same E&D standards as those services provided internally. An example of such services is at Annex B.

Planning Procurement – A Step by Step Approach

Initial Actions. To achieve best value and meet the E&D duties, the following initial actions should be taken:

- Clarify how best E&D objectives can be met to define what is to be contracted.
- Consistent with best value, review all existing arrangements for providing the goods, works, or services and define whether they are successful or not in promoting E&D. This should involve challenging current provision and considering alternative arrangements, and consulting externally and internally.
- Ensure that all relevant information is to hand, including the background and characteristics of the potential service users.
- Use the experience and knowledge available within the organisation, as well as different local communities, external suppliers, and trades unions.

Contract Specifications. The following should be considered when drawing up contract specifications:

- Define the E&D requirements clearly and objectively.
- Wherever possible frame the specification as measurable outcomes, allowing the contractor to develop methods for achieving these.
- Where appropriate, specify 'outputs', such as consultation or training, consistent with arrangements in the organisation's E&D Scheme, to ensure the contractor achieves the desired outcomes.
- In contracts that will last a number of years, the contractor may be required to achieve year-on-year improvements in E&D performance.
- In relation to certain services, it may be appropriate to include positive action measures to meet special needs of particular groups.

- Specifications may include requirements to ensure the contractor's workforce is able to carry out the specified E&D service requirements.

Contract Conditions. Standard clauses for all contracts should require the contractor:

- Not to discriminate unlawfully.
- To co-operate with any investigation or proceedings concerning alleged contravention of legislation, arising out of the contractor's acts or omissions; and
- To indemnify the organisation in the case of any finding under the legislation arising out of the contractor's acts or omissions; and
- To impose the same obligations on any sub-contractor.
- To comply with the employment, and E&D policies of the organisation where the contractor's staff are working.
- To adhere to any other contract clauses or workforce measures that are relevant to the E&D duties.
- Acknowledge enforcement measures for failure to meet E&D requirements.

Contract Terms and Conditions

The Guidance provides details on two aspects of Terms and Conditions to be applied to all contracts in NHS Lothian. The first is the definitive Terms and Conditions for every contract in NHS Lothian. These will be integral to all contracts and are shown at **Annex C**. The second is an additional aspect, which would only apply where it has been assessed that the subject matter of the contract is highly relevant to NHS Lothian's Procurement's compliance with its duty under the legislation. In this case, where the contract documents are issued with a Tender, the Conditions of Contract are issued together with a "Supplementary Conditions of Contract". The Supplementary Conditions contain the particular matters relating to that contract and are prepared individually for each contract. An example of Supplementary Conditions of Contract is shown at **Annex D**.

Selecting Tenderers. When E&D is relevant to any contract and to the selection of suitable tenderers, this should be made clear in the OJEU notice and all other advertisements. The pre-qualification questionnaire (PQQ) can ask about E&D workforce matters, with scope for wider enquiries where the subject of the contract is highly relevant to the E&D duties. If E&D is a core requirement, the questionnaire can ask providers about their track record in service provision. Suppliers should only be disqualified where a finding of unlawful discrimination against them has been recorded or if they are unable to offer good evidence of measures taken to avoid future discrimination.

If the contract in question is highly relevant to the E&D duties, higher E&D standards may have to be set. However, in selecting suitable suppliers, more formal policies and procedures may be required from larger firms with greater resources. If possible, procurement officers, who have the appropriate training/experience in E&D matters, should carry out the evaluation of replies to E&D questions.

Appropriate Questions. Care should be taken to ensure that all providers understand the importance of answering all questions in full. Better co-operation is likely if a clear explanation is provided as to the background to the question and an indication given of the kind of evidence expected. Some model pre-qualification questions are provided at **Annex E**.

Invitation to Tender

The Invitation to Tender (ITT) and the contract documentation should provide tenderers with all the information considered relevant to the E&D requirements of the contract. In particular, it must be stated clearly what criteria will be used to evaluate tenders, and the evidence that tenderers are expected to submit to demonstrate how they will perform the E&D elements of the contract. Also, tenderers will be expected to confirm that, if successful, they will comply with the E&D contract conditions.

The procedures outlined in this guide are based, generally, on the two-stage restricted procedure, as defined in the EC directives. Some contracts will be more suited to either the open or negotiated procedure, and it should be reasonably easy to adapt the guidance if other formal procedures are used. This includes where the contract is outside the EC directives. Guidance as to what information should be included in the invitation to tender is at **Annex F**. One example of how criteria for an ITT might be drafted is at **Appendix 1 to Annex F**.

Evidence of the Tenderer's ability to meet E&D Requirements

If the contract specification includes promoting E&D to certain standards, it must be made clear in the ITT what information tenderers are expected to supply in evidence of their ability to meet those standards, as well as the criteria used to evaluate the tender. If necessary, separate tender documents could be included to describe in more detail the information on E&D required. A standard format is available from NHS Lothian procurement.

Where appropriate, tenderers could be asked to submit a structured, timetabled "method statement", which would allow scope for each tenderer to develop their own preferred methods of achieving the E&D outcomes in the specification. In cases where the services to be provided could have a significant effect on particular racial groups, tenderers could be asked to include an EQIA (Equality Impact Assessment) of their proposals. The ITT should also make clear what information tenderers are expected to provide about the staff performing the contract. This could include information about the qualifications, levels at which they will be employed, the training given (including E&D training), and the arrangements tenderers intend to make for supervising delivery of the contract.

Evaluating Tenders

In advance of any tender, the evaluation process should be clarified to ensure that officers involved in evaluating E&D aspects of tender submissions, have appropriate training. The task is to evaluate tenderers' ability to meet the E&D requirements of the contract, applying the basic criterion of "best overall whole-life value for money", and the specific criteria stated in the invitation to tender

Emphasis given to E&D criteria in evaluating tenders must be proportionate to the significance of E&D requirements in the contract as a whole. The tenderers' acceptance of E&D contract conditions also needs to be checked.

Monitoring, Managing and Enforcing Contracts

If E&D contract requirements are to be followed, there must be effective procedures in place for monitoring and managing the contract. Officers with responsibility for monitoring and managing the contract will need briefing and training on the E&D requirements. Objectives are best achieved if organisations can establish and maintain a positive partnership with the contractor. The contractor must be made to understand, from the outset, their responsibilities for E&D performance, including monitoring and reporting. Prompt and effective action should be taken whenever monitoring indicates inadequate performance of E&D obligations.

After award, it is important for contractors to maintain positive action, and promotion of sub-contracting opportunities for small firms and ethnic minority businesses. A 'best value review' of the success, or failure of the contract in meeting E&D objectives, will offer lessons for future contracts.

Checklist for Contracting Organisations

A useful Checklist to assist contracting organisations is shown at **Annex G**.

ANNEX A

Planning Procurement Projects – E&D as a Core Requirement Suggested Pre-contractual Questions

It is suggest that the following five questions assist in determining whether E&D is a core requirement in any contract for goods, works, or services.

- What is to be provided under the contract?
- Is the provision of the goods, works, or services in question one of the functions or policies already assessed as being relevant to meeting the duty to promote E&D?
- Is the provision of the goods, works, or services in question likely to affect, directly or indirectly, the ability to meet the duty to promote E&D?
- If the answer to either 2 or 3 is yes,
- Is it necessary to include requirements for promoting E&D in the contract, to make sure the duty is met?
- If the answer to 4 is yes,
- What E&D requirements are appropriate for the contract in question?

ANNEX B

Examples of Contracts for Services

- A contract to supply vehicles, drivers, and provide transport to day centres for elderly and disabled people from different ethnic groups requires the contractor to provide suitable training to all staff who will have contact with their passengers, and to take other reasonable measures to ensure that any sensitivities of people from different groups (the elderly, disabled people, LGBT people, ethnic communities etc) are respected.
- A catering contract where the requirement to provide multi-faith menu options needs to be understood and sensitively delivered.
- Home delivery services where delivery or installed equipment requires staff to be in patients homes

This list is not intended to be either prescriptive or exhaustive. Annex A should be used to assess the likely E&D impact of any contract.

ANNEX C

Equality & Diversity – Terms and Conditions

The following Terms & Conditions are integral to all NHS Scotland contracts:

1. The contractor shall not:
 - Discriminate directly, or indirectly or by way of victimisation or harassment against any person on any grounds which contravene any of the following acts:
 - The Human Rights Act 1998
 - Employment Equality (Sexual Orientation) Regulations 2003
 - Employment Equality (Religion or Belief) Regulations 2003
 - Gender Recognition Act 2004
 - Equalities Act 2010: Specific Duties
2. The Contractor shall notify the Authority immediately of any investigation of or proceedings against the Contractor under the legislation, outlined at sub-paragraphs 1.1.1 to 1.1.9, above and shall co-operate fully and promptly with any requests of the person or body conducting such investigation or proceedings, including allowing access to any documents or data required, attending any meetings and providing any information requested.
3. The Contractor shall indemnify the Authority against all costs, claims, charges, demands, liabilities, damages, losses and expenses incurred or suffered by the Authority arising out of or in connection with any investigation conducted or any proceedings brought under the legislation, outlined at sub-paragraphs 1.1.1 to 1.1.9 above, due directly or indirectly to any act or omission by the Contractor, it's against, employees or sub- contractors.
4. The Contractor shall impose on any sub-contractor obligations substantially similar to those imposed on the Contractor by this Clause.

ANNEX D

The Contractor shall, for purposes of ensuring compliance with Clause 36.1 of the NHS Lothian Conditions of Contract in relation to all persons employed by the Contractor to perform the Contract (“the Contractor’s Staff”) observe as far as possible the provisions of the Code of Practice in Employment as approved by the UK Parliament in 1983 including, but not limited to, those provisions recommending the adoption, implementation and monitoring of an equal opportunities policy.

Duty to consider award criteria and conditions in relation to public procurement

- Where a listed authority is a contracting authority and proposes to enter into a relevant agreement on the basis of an offer which is the most economically advantageous, it must have due regard to whether the award criteria should include considerations to enable it to better perform the equality duty.
- Where a listed authority is a contracting authority and proposes to stipulate conditions relating to the performance of a relevant agreement, it must have due regard to whether the conditions should include considerations to enable it to better perform the equality duty.
- Nothing in this regulation imposes any requirement on a listed authority where in all the circumstances such a requirement would not be related to and proportionate to the subject matter of the proposed agreement.

In this regulation—

- “contracting authority”, “framework agreement” and “public contract” have the same meaning as in the Public Contracts (Scotland) Regulations 2012⁽¹⁾; and
- “Relevant agreement” means a public contract or a framework agreement that is regulated by the Public Contracts (Scotland) Regulations 2012
- The Contractor shall [•] months from the Commencement Date of the Contract and [annually] thereafter submit a report statement to NHS Lothian demonstrating its compliance with Clauses [1.1 and 1.2] and such additional information as NHS Lothian may reasonably require for the purpose of assessing the Contractor’s compliance with such clauses.

[NOTE: It is anticipated that this Clause will be relevant in an agreement for the provision of services that comprise a function of NHS Lothian which NHS Lothian has assessed as highly relevant to its compliance with the provisions of the Equality Duty 2010 (i.e. as per General Duty to Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under this Act)

- Advance equality of opportunity between persons who share a relevant characteristic and persons who do not,
- Foster good relations between people who share a protected characteristic and those who do not

Where in connection with this Contract:

- The Contractor, its agents or sub-contractors or the persons employed by the Contractor to perform the Contract (“the Contractor’s Staff”) are required to carry out work on any premises and land occupied by NHS Lothian for the purposes of carrying out its functions or alongside NHS Lothian’s employees on any other premises, the Contractor shall comply with NHS Lothian’s own employment policy and codes of practice relating to racial discrimination and equal opportunities, copies of which are annexed at Schedule [•].

[NOTE: This Clause, which would not normally be suitable in contracts for goods, could be met by the Contractor demonstrating that its employment policy and codes of practice provide E& D protection equivalent to or greater than do those of NHS Lothian. In such circumstances the Contractor’s policies and codes of practice could be annexed to the Contract in place of NHS Lothian’s]

- The Contractor shall [•] months from the Commencement Date of the Contract and [annually] thereafter submit a report statement to NHS Lothian demonstrating its compliance with Clause [2.1] and such additional information as NHS Lothian may reasonably require for the purpose of assessing the Contractor’s compliance with such clause.
- The Contractor shall Monitor the representation among all persons employed by the Contractor to perform the Agreement (“the Contractor Staff”) of persons of different racial groups (which shall mean groups of persons classified as “ethnic groups” in the most recent official census by the Office of National Statistics or successor body), having regard to NHS Lothian’s procedures for monitoring representation among its own employees.

Where it appears to the Contractor in relation to particular work of the Contractor Staff, either that the Contractor Staff includes no members of a particular racial group doing that work or that members of that racial group are under-represented among Contractor Staff doing that work compared to their representation in the Contractor Staff as a whole or in the population from which Contractor Staff are normally recruited, undertake the following actions as may be appropriate and reasonably practicable:

- The placing and use of job advertisements to reach members of such racial groups and to encourage their application;
- The use of employment agencies and careers offices in areas where members of such racial groups live and work;
- The promotion of recruitment and training schemes for school leavers and /or unemployed persons intended to reach members of such racial groups; and
- The provision of appropriate training and the encouragement of members of Contractor Staff from such racial groups to apply for promotion or transfer to do work in which such racial groups are under-represented.

The Contractor shall [•] months from the Commencement Date of the Contract and [annually] thereafter submit a report statement to NHS Lothian demonstrating its compliance with Clauses [3.1 and 3.2] and such additional information as NHS Lothian may reasonably require for the purpose of assessing the Contractor's compliance with such clauses.

ANNEX E

Model pre-qualification questions relating to Equality in the Workplace

Note: Questions 1, 2 and 3 are designed to obtain necessary background information.

- What is the size of the firm?
- Please state total number of:
 - o Partners; and
 - o Employees; (including all full-time and part-time employees).
- Of the total number of employees above, how many are managers?
- Is the firm part of a commercial group or a consortium? If it is, which of the employment policies are determined by the organisation, and which ones apply to all firms within the group or consortium?
- Is it the policy as an employer to comply with the statutory obligations? Under all the Equality which applies in Great Britain, or equivalent legislation that applies in the countries in which the firm employs staff? Accordingly, is it the practice not to discriminate directly or indirectly on grounds of colour, race, nationality, or ethnic or national origins in relation to decisions to recruit, select, remunerate, train, transfer, and promote employees?
- In the last 3 years, has any finding of unlawful racial discrimination in the employment field been made against the organisation by an Employment Tribunal, an Employment Appeal Tribunal, or any court, or in comparable proceedings in any other jurisdiction?
- In the last 3 years, has the organisation been the subject of formal investigation by the Commission for Equality and Human Rights (CEHR), or a comparable body, on the grounds of alleged unlawful discrimination in the employment field?
- If the answer to question 5 is yes or, in relation to question 6, the CRE or comparable body made a finding adverse to the organisation, what steps have you taken as a result of that finding?
- Is the policy on race relations set out?
- In instructions to those concerned with recruitment, selection, remuneration, training, and promotion;
- In documents available to employees, recognised trade unions, or other representative groups of employees; and
- In recruitment advertisements or other literature?

- If the answer to a, b, or c is 'No', can you provide other evidence to show how you promote E&D in employment?
- Are staff who have managerial responsibilities required to receive training on equal opportunities?
- Do you observe, as far as possible, all Regulatory Bodies' Codes of Practice for employment, as approved by parliament, or a comparable statutory code? Or guidance issued under equivalent legislation in another member state, which gives practical guidance to employers and others on the elimination of racial discrimination and the promotion of equality of opportunity in employment, including monitoring of workforce matters and steps that can be taken to encourage people from ethnic minorities to apply for jobs or take up training opportunities?
- Is it policy as an employer to comply with the statutory obligations or equivalent legislation in the countries in which you employ staff? Under the Sex Discrimination Act 1975, as amended, the Equal Pay Act 1970, and the Disability Discrimination Act 1995 – all of which apply in Great Britain.
- In the last 3 years, has any finding of unlawful sex or disability discrimination in the employment field been made against the organisation by an Employment Tribunal, an Employment Appeal Tribunal, or any court, or in comparable proceedings in any other jurisdiction?
- If the answer to question 12 is yes, what steps have you taken as a result of that finding?
- If you are not currently subject to UK legislation, please supply details of the experience in complying with equivalent legislation that is designed to eliminate discrimination (especially racial discrimination) and to promote equality of opportunity.

ANNEX F

What information should be Included about the Duty to promote E&D in the Invitation to Tender?

The invitation to tender should include the information listed below, so that tenderers can submit a tender that encompasses the E&D elements of the specification. Where possible, you should enclose copies of relevant documents, or indicate where they can be seen.

- Relevant policies, including E&D scheme, and other equal opportunities policies
- Facts that are relevant to the contract. These might include population data, broken down by ethnic group and any cross-referred to relevant factors such as languages, and religion.
- Details of the current provision of the service in question, including any information from monitoring, consultation, or other assessment relating to its impact on the promotion of E&D.
- Based on the review of current provision what the contractor sees as the key challenges to improve E&D performance under the proposed contract.
- Where TUPE is invoked their terms and conditions, including those that guarantee protection against discrimination and provide for equality of opportunity.

Appendix 1 to Annex F

Example of Criteria to be used in ITT

A police force had been given new targets for the recruitment of ethnic minority police constables. The policy authority has awarded a contract for recruitment services. The following criteria were stated in the invitation to tender.

- Ability to meet all the requirements of the contract
- Price of the contract
- Quality of the service
- Ability to put into practice proposals for increasing job applications from under- represented ethnic minority groups
- Ability to recruit, train, and supervise staff to meet the requirements of the contract
- Ability to develop new measures that will encourage applications from suitable ethnic minority candidates

ANNEX G

USEFUL CHECKLIST FOR CONTRACTING ORGANISATIONS

Steps to Take in All Contracts

- Determine who will be responsible for evaluating E&D elements at each stage.
- Provide necessary training on E&D for all relevant

staff. Planning

- Determine whether E&D is a core requirement of the proposed contract
- Ensure staff responsible for drawing up specifications and contract conditions understand the requirements of E&D

Drafting Contract Conditions

- Include non-discrimination contract

clauses Selecting Tenderers

- Ask about findings of discrimination in employment and any action taken as a result in the pre-qualification questionnaire.

Evaluating Tenders

- Check tenderers' acceptance of E&D contract

conditions ADDITIONAL STEPS TO TAKE WHEN E&D IS A

CORE REQUIREMENT

Planning

- Review the E&D impact of the current arrangements.
- Consult internally and externally on how better to meet the duty to promote

E&D. Drafting Specification

- Include the E&D requirements in the

specification. Drafting Contract Conditions

- Where relevant, include additional contract clauses on E&D in

employment. Selecting Tenderers

- State the E&D requirements in OJEU and any other notice
- Where relevant, ask questions about E&D policy, training, and compliance with the CRE code of practice in employment, or equivalent, in the questionnaire

- Where relevant, ask questions about E&D in service

delivery Invitation to Tender

- Refer to the E&D duty, and state E&D evaluation criteria in the invitation to

tender Evaluating Tenders

- Evaluate tenderers' proposals for meeting E&D requirements in the specification

MANAGING AND MONITORING THE CONTRACT

Steps to take in All Contracts

- Meet the successful contractor to ensure full understanding of non-discrimination contract conditions, and agree reporting arrangements
- Consider a voluntary agreement with the contractor for additional E&D measures.
- Monitor the contractor's performance of E&D contract conditions
- Where E&D performance is inadequate, invoke default provisions or warn the contractor that they may not be considered for future contracts

Additional steps to take when E&D is a Core Requirement

- Meet the successful contractor to ensure full understanding of the E&D duty and E&D requirements in contract specification, and to agree contract management and monitoring
- Monitor the contractor's performance of E&D requirements in the specification.



Creating “A sense of belonging 2”

A joint strategy for improving the mental health and wellbeing of Lothian’s population

“the big dialogue”

Date: Wednesday 5 October 2016
Time: 9.30 am for Registration with event start at 10.00 am to 4.30 pm
Place: Conference Hall, Morton Park Conference Centre, 57 Albion Road
Edinburgh EH7 5QY

We would like to invite you to attend the *Big Dialogue* event to discuss the content and priorities of “A ‘Sense of Belonging 2””. This will be a ten year strategy building on what we have achieved to date, taking due account of the national policy context and changing health and social care, housing and welfare landscape.

The programme is informed by some clear emerging priority areas which emerged over the life course of the current strategy and themes and topics which stakeholders have raised with us.

The event is free but limited to 100 people. Light lunch and refreshments will be available. If you want to attend please:

Email: mentalhealth.admin@nhslothian.scot.nhs.uk

By post: Prappy Campbell, HS Lothian, Waverley Gate2-4, Waterloo Place, EH1 3EG

Please book your place **by 15 September 2016**. All places will be confirmed no later than 20 September.

If you book a place but are unable to attend, please let us know so someone else can have your place. Thank you.



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“One of the important things is to be treated on an equal basis. We are individuals. It is so important to be treated like a human being.”

“What I was wanting was not to be treated differently because of a mental health diagnosis, but to be treated accordingly for a mental health diagnosis.”

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Foreword – Why Peer Research?

Becky Leach, Community Collective Advocacy, AdvoCard

People with lived experience of mental health issues bring with them a huge amount of value, precisely because of their experience. They are experts in what their needs are and how they can best be met.

A&E | All & Equal was led and delivered by a team of peer researchers, all of whom have lived experience.

Because of their own lived experience, the peer researchers were easily able to put themselves in the shoes of the people who they would be interviewing, bringing an insight that the project would not otherwise have had. This enabled us to: establish a more equal relationship with the interviewees based on trust and respect; make sure that the interviewees understood the purpose of the research and what we would do with their contributions, and so could give full and informed consent to participating; make the interviews more accessible; and ensure that we created a welcoming, safe and informal atmosphere in the interviews where the interviewees felt that they could speak freely and not be judged.

We had feedback from some of the interviewees afterwards that they felt safe and heard in the interviews, and this is testament to the skills and understanding of the peer researchers and the care they put in to their work. .

We would argue though that not only should people with lived experience be involved in carrying out research regarding issues that affect their lives because of the value they bring to it, but also because they have a right to be involved.

The Mental Health (Care and Treatment) (Scotland) Act 2003¹ gives anyone who has a mental health issue the right to access independent advocacy to make sure that their voices are heard and they are fully involved in the decisions that affect them.

The decisions which affect people's lives are not just decisions regarding their individual treatment or support but also wider decisions which are made, for instance regarding service provision or policy.

Further to this, the Scottish Human Rights Commission champions the PANEL Human Rights Approach in the planning and delivery of health and social care services, whereby they are planned and delivered in a way that is Participative, Accountable, Non-discriminatory and equal, Empowering and Legal².

Our experience at AdvoCard Community Collective Advocacy is that research is often referred to and drawn upon in decision making processes. If people with lived experience are not involved in delivering research, then their participation in decision making in Scotland is limited. The generation of knowledge and understanding regarding mental health and wellbeing, services and policy affects their lives, so it is essential that they have the opportunity to play a part in this generation, where they play a key role in deciding how research is carried out and identifying the issues to be researched. It is vital that peer research in Scotland is properly supported and funded and seen as both valid and valuable.

Introduction

A&E | All & Equal is a peer research project from Edinburgh Community Voices which has been looking into the experiences in Accident and Emergency (A&E) of people with lived experience of mental health issues.

We started to develop the project in early 2015 after hearing from many different people about their experiences in A&E. We decided to record some of these experiences and do something about the issues that were coming up.

Luckily, at this time, funding became available from the See Me Community Innovation Fund, which funds projects that develop or deliver innovative ideas for tackling the stigma and discrimination faced by people with lived experience.

We applied for and secured a Local Grant of £4,000 for a six month project.

The project ran from September 2015 to February 2016.

The See Me Community Innovation Fund fit well with our ideals as it specifies that work should be led by people with lived experience of mental health issues, with them not just being consulted but playing an active role in decision making and delivery, on at least an equal basis with organisations and service providers.

We had a fantastic team of eleven peer researcher volunteers, all of whom have lived experience, who played a lead role in planning and delivering the project:

- Taking the lead in planning, preparing and designing: how we carried out the interviews; the ethics assessment; the information given to interviewees ahead of the interviews; the consent form; and the interview questions. AdvoCard supported this process, but the key decisions were made by the volunteers.
- Carrying out the interviews.
- Helping facilitate and taking notes at the focus group.
- Summarising the interview transcripts, for use when analysing.

- Analysing the interview results, highlighting the issues and themes that arose.
-
- Planning the group workshops.
 - Helping facilitate at the group workshops.
 - Planning, helping to write and reviewing this report.

Timeline

September and October – Peer Researcher Training and Planning

November and December – Interviews and Focus Group

January and February – Workshops

Edinburgh Community Voices is a collective advocacy group for people in the community in Edinburgh who have lived experience of mental health issues.

Edinburgh Community Voices is facilitated and supported by AdvoCard Community Collective Advocacy.

Methodology

This project was first and foremost about hearing about people's experiences as they themselves interpret and feel about them.

Although we hoped to find out more about the stigma and discrimination that people experience, we did not specify that the experiences people told us about should be ones of stigma or discrimination. This was because people don't always use words like that to define their experiences, because they may not know for certain if their treatment was affected by their diagnosis and because indirect discrimination is not always obvious.

We therefore did not mention stigma or discrimination in the advert for interviewees, instead saying that we were keen to hear about any and all experiences, 'good', 'bad' or 'mixed', and regarding physical health issues, mental health issues or a combination of the two. The only specifications we gave in the advert for the interviews was that we wanted to hear from people with lived experience of mental health issues about their experiences at the Emergency Department at the Edinburgh Royal Infirmary or St John's Hospital Livingston from 2011 – 2015.

We also decided to leave the main interview questions as open as possible, not using the words 'stigma' or 'discrimination' at any point, but including a question that would help us capture whether a case could be considered as such.

We had five main interview questions which we asked.

1. Why did you go to the Emergency Department?
2. What was your experience?
3. Do you feel your treatment was affected by your mental health diagnosis?
4. Were there any consequences for you of what happened, or did it have any kind of impact on you and your life? This can be positive as well as negative.
5. What could be learned from this? / What would have made the experience better?

After making contact with potential interviewees for the first time, we gave them detailed information about what was involved so that they could make an informed decision about whether or not to take part.

In order to reach as many people as possible, we went out to three other organisations, two in Edinburgh and one in West Lothian, to hold interviews, as well holding interviews at AdvoCard on Leith Walk. This meant that we could engage with people where they felt comfortable, safe and supported, in one instance where they had access to childcare, and in two instances where the duration and/or cost of travel would have been a barrier.

We also held a focus group at one of the organisations, using the interview questions. This was facilitated by Patricia Rodger from AdvoCard Community Collective Advocacy, together with one of the Peer Researchers.

Our Findings

We carried out thirteen interviews, twelve with people with lived experience and one with a carer.

Ten of the interviewees discussed one or more experiences which took place at the Emergency Department at the Edinburgh Royal Infirmary and two discussed experiences which took place at the Emergency Department at St John's Hospital.

One of the interviews concerned an experience at the Pregnancy Support Unit at the Royal Infirmary. We included this because it was an emergency admission and because the person really wanted to tell us about it.

The interview with the carer came about by chance. They found out about the project when we were at one of the organisations and they asked if they could do an interview. The peer researchers decided to include it as an extra perspective.

There were six participants in the Focus Group, which was held in Edinburgh. Four of the participants had experiences which they talked about, while the other two joined in the discussion about the issues raised.

This is what we heard.

(All names have been changed.)

Diagnostic Overshadowing

Diagnostic overshadowing is what happens when a physical health problem isn't treated properly because the symptoms are attributed to the person's mental health diagnosis.

Two clear examples of diagnostic overshadowing came out in the interviews.

Ben

Ben had recently had an operation to remove haemorrhoids. He had a great deal of blood loss following this, and physical exertion, even trying to walk to the GP surgery, left him faint and unable to stand.

When he was in the ambulance, the paramedics asked him about any medication that he was taking. As soon as he mentioned his mental health medication, the paramedics' attitude changed. They told Ben that he was having a panic attack and didn't need to go to the Emergency Department, even though Ben had explained the situation in full. Ben had to argue and absolutely insist that he was physically ill before the paramedics would take him to the Emergency Department at the Edinburgh Royal Infirmary.

There the condition was correctly diagnosed - he had a dangerously low haemoglobin count and needed five days of hospital treatment. If he hadn't been as confident in speaking up and arguing his case, the paramedics would have taken him home and the delay in treatment, or lack of treatment altogether, could have been life threatening.

Ben made a complaint to the ambulance service, the department who had initially carried out the operation and his GP. Ben feels that all three complaints were treated with contempt.

Ben's mental health deteriorated as a result of both the experience itself and the way in which his complaints were treated.

"You can imagine what it feels like when you're physically ill, and not only are you physically ill but you're actually unable to do something as simple as standing up, and people just keep insisting that you're effectively faking it because you're mentally ill."

"They're not looking at people, they're either looking at mental health or they're looking at physical, they're not looking at both. And if you have a mental health issue, what you say about your physical health is not being believed."

Rebecca

Rebecca had a serious injury to the nerves in her shoulders (neuropraxia of the brachial plexii). This affected the movement and feeling in her arms, with limited movement and feeling in her right arm and none in her left.

Rebecca had fallen in her bathroom where she most likely sustained the injury, but had no memory of what happened before the fall. She was taken by ambulance to the Emergency Department at the Edinburgh Royal Infirmary.

After an X-ray did not show the cause of the problem, and her medical notes showed that she was 'known to psychiatric services' (as Rebecca heard one doctor say to another), it was assumed that the problem was psychological.

After this point, no further physical tests were carried out at the Emergency Department and Rebecca was only seen by psychiatrists.

When she was in the Emergency Department, she was given a sandwich. She asked for help to eat it, but was given none. With a great deal of difficulty, by putting her head down to the hospital tray, she managed to eat a small bit of the sandwich.

"I didn't know at this point that this would count profoundly against me. Nobody had been there at that point to see how I had eaten it. And this all seemed to add to the theory ... that this was some sort of strange psychosomatic episode and that as soon as their backs were turned I would be moving my arms and waving and, you know, gobbling sandwiches."

Rebecca was moved to the general ward. She was there for nearly a week. The nursing staff there were actively hostile and treated her as if she was malingering and 'faking it'. She asked for help to eat and shower but was given none because it said in the notes from the Emergency Department that she didn't need any. She continued to insist that this was a physical problem, but was still only seen by psychiatrists.

Things only progressed when Rebecca was able to persuade a junior psychiatrist ~~that further physical tests were required. She was referred to Neurology at the~~ Western General Hospital, where the correct diagnosis was very quickly made.

The arm most affected, the left arm, had been put in a sling when Rebecca was initially picked up by the ambulance. But when the X-ray at the Emergency Department did not show the physical cause of the problem, the sling was taken off and Rebecca was left without a sling for about a week, until the correct diagnosis was made.

The delay in treatment and this inappropriate treatment (the sling being removed) made the injury much worse. Rebecca was in hospital for a further five weeks and needed physiotherapy three times a week for over a year. The injury happened four years ago, but Rebecca's left arm has still not fully recovered.

As well as the physical effects, Rebecca's mental health suffered greatly as a result of the distress she experienced, not being believed and the dehumanising way in which she was treated.

"There was a toxic loop going on ... with my mental health, getting more and more distressed, despairing of all of it, because I couldn't do anything. So it had an incredibly detrimental effect on my mental health, which was in a very poor state before all of this started and was sure as hell in a worse state after."

"The senior staff, the doctors, the consultants, disbelieved me as soon as they saw a psychiatric record. They didn't accept the reality of what was happening to me, or the fear and distress it was causing me."

‘Attention Seeking’ Stigma

In the two cases of diagnostic overshadowing, Ben and Rebecca both talked about professionals making the assumption that because someone has a mental health issue, they must be ‘faking it’ if they present with a physical health problem. This ties into the wider stigma around people with lived experience of mental health issues which considers them to be ‘attention seeking’.

Lucy’s experience provides a very clear example of this stigma and how it can particularly affect people who self harm when they present at A&E.

Lucy

Lucy had self harmed by burning. She tried to take care of the wound, by herself and with the help of her local practice nurse, but the wound became infected. Lucy rang NHS 24 and was advised to go to the Emergency Department at St John’s Hospital, Livingston.

Lucy was seen mainly by psychiatrists and burns doctors. She felt that she was talked down to, ignored and dismissed by the psychiatrists, that they tried to make the experience as unpleasant as possible and that they asked the same questions again and again as if they wanted to catch her out:

“They were very, very clear just what they think, you know – ‘wasting time’, ‘attention seeking’. They don’t hide it. ... It’s almost like, ‘don’t give her any attention, she’ll get bored. Ignore her and she’ll get bored’.”

Lucy feels that there is a basic misunderstanding around self harm and why she herself self harms:

“I’m not saying that there aren’t some people that are seeking attention, but they put everybody in that box. And it wasn’t for me. Self harm is for anxiety

- if I sit with anxiety and I can't cope with it. I haven't meant to do that much

*damage, so if it's ended up that way, I think they've thought... They just
assume that you've done it, run to them for help, and it's like.. I was
embarrassed having to ask them for help. I think they just didn't understand."*

On this occasion, Lucy had actually delayed going to the Emergency Department in the first place, because she had had a similar experience the last time she was there. Because of this delay, the wound was in a worse state and she needed more treatment in the Burns Unit than if she had gone there when she first needed help.

We heard about a very different experience from one of the Focus Group participants. This person had had an accident at work and scalded their hand and wrist. They received treatment from a nurse practitioner who was very practical, until she saw the scars from self harm on the person's arms, at which point her attitude changed. She seemed genuinely sympathetic, more than she had been before rather than less, indicating that the attitude that people who self harm are 'attention seeking' is not held by all staff.

Staff Understanding and Awareness

"There's a lot of training needed because they don't actually understand it, because mental health is a hidden illness. It's not like if you broke your leg, that you can actually see."

Six people stated that staff do not have enough awareness and understanding of mental health issues. This was not just about staff not understanding a person's diagnosis, but also about not understanding and giving due consideration to the particularly heightened or acute anxiety and distress that people who have mental health issues can feel.

One person felt that representations of mental health in the media, stigma and lack of training contribute to lack of understanding of mental health issues.

Rebecca felt that a lack of understanding was a contributing factor in the diagnostic overshadowing which happened when she went to the Emergency Department following her injury³.

Two people weren't given their mental health medication when they needed it, and both think this was because of a lack of understanding of mental health issues and the attitude that mental health issues are not as real or as serious as physical health issues.

The first went to the Emergency Department at St John's because of chest pains. They said that the nurses were nice, and were brilliant at dealing with the physical health issues, but didn't understand mental health issues. The person wasn't given their mental health medication and attributes this to the lack of understanding.

The second person was Sophie.

Sophie

Sophie had a miscarriage and was admitted to the Pregnancy Support Unit at the Edinburgh Royal Infirmary.

At the time, she was taking anti-depressant medication every morning at exactly the same time.

When she was told that she would have to stay in the Pregnancy Support Unit overnight, she told the nurses that it was really important that they gave her her medication in the morning. The nurses said yes, she would get her medication. She asked several times because she was worried about the impact of missing a dose on her mental health, potentially experiencing suicidal thoughts, especially after such a traumatic event. Each time, the nurses said 'yes, you'll get your medication'. But the next morning, at the time when she needed to take her medication, she was told that the pharmacy was closed and she couldn't have it.

Sophie ended up leaving the hospital to go home to take her medication, in a state of distress and experiencing suicidal thoughts. She said that the only thing that stopped her from taking her own life was the thought of what it would do her mum.

Sophie believes that the reason that the nurses did not ensure that she received her medication is because it's a tablet for her mind and not her body, and they couldn't see the importance of it and the impact of not taking it. One of the nurses told her that she couldn't understand why she needed the medication, that her sister-in-law would be able to understand this better because she is a mental health nurse.

“She was doing her best to be kind, she just did not have the knowledge, to have a clue what I was talking about when I said I needed my mental health medicine.”

Sophie feels that she wasn't believed when she said how much distress she was in.

“If your leg's really painful, do you need to know how much pain someone's in when their leg's sore? Why do you need to understand the mental pain? Why can't you just believe them?”

She also feels that she would have been able to keep more dignity if she had not had to deal with the anxiety about missing her medication.

“I went from quiet and holding it together, though utterly devastated to a crying, blubbing mess, walking out the hospital on my own, my stuff in a bag. ... If they'd given me my medicine, I could have kept it together. And I could have gone home and fallen apart, but I fell apart in public instead, and I didn't want to.”

Sophie told us:

“What I was wanting was not to be treated differently because of a mental

health diagnosis, but to be treated accordingly for a mental health diagnosis.”

Communication and Language

One thing that became clear as we carried out the interviews was the importance and significance of communication and language. When many of the interviewees described their experiences, the conversations they had with staff and what was said to them were very much at the fore. What doctors, nurses and other staff say appears to really stick in people's heads and shape their experience, both at the time and when they look back later.

This isn't just about what is said, but how it is said. For instance, one person told us that a doctor talked very loudly and slowly to them, as if they were an idiot.

Another person made the point that a doctor or nurse can say something and mean it one way, but the patient can hear it in another way and it can have an impact that wasn't intended.

Four people felt that they weren't listened to. For the participants in the focus group, communication was a key issue, and if workers showed kindness, compassion and understanding, that could change the entire experience.

One of the interviewees made the point that it can be difficult to communicate when you're unwell, tired, in pain or distressed, and you can find yourself tripping up on your words, even if you don't have a mental health condition. This can lead to misunderstandings.

There are sometimes other factors that can complicate somebody's ability to communicate and understand, as can be seen in Andrea's case.

Andrea

We interviewed a carer, Mary, whose adult daughter, Andrea, had been taken by ambulance to the Emergency Department at the Edinburgh Royal Infirmary after falling in the street. Mary wasn't with Andrea at the time, and wasn't notified about what happened until several hours after Andrea arrived at the Emergency Department. Andrea has a learning disability as well as a mental health condition.

The learning disability affects her ability to communicate and understand what is going on or what is being said:

“She could say something and [the staff] would take that as a given. But it involves a bit of delving to actually really understand what she means. Or she might answer something incorrectly, because she doesn’t really understand what they’re saying.”

For Andrea, if she becomes stressed, it can trigger her mental health condition and she can start to hear voices and get agitated, so good communication is particularly important. Mary does not think that there was good communication with Andrea, and feels that the whole experience would have been better if there was somebody in the Emergency Department who is experienced at working with people who have learning disabilities and who could have supported Andrea and helped her communicate.

When people had good experiences, good communication played a big part, as can be seen in the case of Peter and Freya:

Peter

Peter was taken to the Emergency Department at the Royal Infirmary by ambulance after falling while running for a bus and hitting his head, while under the influence of alcohol.

He worried that he would be judged because of his alcohol problem, but that didn’t happen. The doctor and nurse who attended to him asked him questions, rather than making assumptions, were attentive and really listened:

"I couldnae have asked for much better to be honest, because not only did they listen but they listened, if you know what I mean. It wasn't a case of, 'well, we'll sit and talk to you because that's our job, this is it'. They did reassure me. They did say, 'what happened to you could have happened to anybody'."

Peter was kept in overnight. The next day, before he was discharged, a member of staff spent time talking with him, asking him about what support he had in place for his alcohol problem.

This experience had a positive impact for him, as it helped him realise that alcohol was not the answer:

"If someone helps me, I do remember it. And I did say to them, hopefully it will be a long time before you ever hear about me, let alone see me again, because I'll make sure that my alcohol is cut totally off the record now."

The experience was markedly different from another experience Peter had, where he felt confused about what was happening and felt that he was not taken seriously. That experience has put him off going back to the Emergency Department if he ever needed to.

Freya

Freya had cellulitis. She asked the GP to come for a home visit but the GP refused. The cellulitis got worse and she had to convince her husband to drive her to the Emergency Department at the Edinburgh Royal Infirmary, as she had other extensive mobility issues.

Her husband left her in the car park, but a porter came out and helped her into the Emergency Department. There was a long wait, but she was kept updated about what was happening, everyone was kind and she was well looked after. The X-rays which were taken were fully discussed with her and she felt involved in her treatment. (It should be noted that she has medical training and already knew some of the staff.)

The doctor advised that she stay in overnight. But she was very keen to keep a commitment she'd made to a community council meeting and was worried about her cat, the reaction of a volatile husband and missing her psychiatric medication. The doctor listened to her when she explained this, understood and respected it and agreed to discharge her, on the grounds that she would take the medication they had prescribed.

A taxi was arranged to take her home and it was paid for on her behalf. This meant that she didn't have to ask her husband for the money, to which he would have most likely reacted badly.

Freya feels that she was given special attention because of her mental health condition. Staff were aware that she could become worried and treated her with respect and care.

There were two really positive impacts of what happened. The first was that staff at the Emergency Department told her GP practice that they had to help her with the dressings, and that improved her relationship with the practice. The second impact was even bigger. At the time of the experience, she was starting to build her confidence. It meant a huge amount to her that she was able to keep her community council commitment, as she was starting to feel of value in the community after years of feeling valueless. This increase in confidence eventually led to her leaving her husband, who was volatile and controlling.

“If we all knew we wouldn't be stigmatised, it would be so much better. That's one of the things I learned there. It's the reassurance you will not be judged, that you will not be misrepresented, it will not be assumed this, that and the next thing and the fact – yes, because you are an equal you know what you're talking about. But if you need explanation, they will explain.”

“One of the important things is to be treated on an equal basis. We are individuals. It is so important to be treated like a human being. And that happened to me, I was treated as a human being, and what a difference that made.”

Environment

Three of the interviewees told us about the environment in A&E, about the effect this had on them and how stressful they found it. This was also discussed in the focus group.

The following issues were raised:

- The surroundings feeling cold and clinical.
- Feeling exposed or not having enough privacy.
- Feeling unsafe or vulnerable.
- There being a lot of drunk people around, coming into your personal space.

“If you're out in the street... if a drunk person was coming towards you, you'd do your darndest to avoid them. But being in a hospital and having to sit there, you can't really do that.”

One person, who went to the Emergency Department at the Royal Infirmary because they had been experiencing chest pains, described sitting on a hard chair in a cubicle with nothing else in it and the curtains open for two hours, feeling exposed.

Another person, who was also there because of chest pains, felt exposed while waiting in a trolley in a corridor.

For these people, the stress created by environmental issues like these was exacerbated by waiting for a long time and not knowing what was happening.

Some of the interviewees told us that they don't mind the waiting itself, they understand why it can take a while to be seen. What's stressful is not knowing what's happening or feeling like you've been forgotten.

One of the Focus Group participants wanted the curtains in their cubicle to be left open rather than closed, as they could easily feel paranoid and wanted to be able to see that the doctors and nurses were not talking about them behind their back.

When they asked the staff to leave the curtains open, the staff were happy to do so.

So while having the curtains in the cubicle open might create or increase anxiety for some people, for others it can be helpful. Flexibility seems to be key.

Ailsa

Ailsa was seven months pregnant. She had problems with depression and anxiety and had recently experienced suicidal thoughts due to changes in her medication. One day, her neighbour tried to attack her and threatened to kill her and her baby. She couldn't sleep that night, and a combination of the lack of sleep and the severe anxiety she was experiencing caused her to collapse the next day.

Her mum went with her in the ambulance to the Emergency Department at the Edinburgh Royal Infirmary. When they arrived, her mum was told that she would have to go in by a different entrance. Ailsa was wheeled into a cubicle, on her own with the curtains left open. She was distressed and anxious and started to have a panic attack.

"I don't know whether they leave curtains open on purpose or whatever but the whole experience felt unsafe, there wasn't a sense of safety about it. ... Not only when you have mental health problems, but when you're pregnant on top of that, you feel especially vulnerable."

A drunk man then came into her cubicle and started talking to her. A man in a uniform came in and made the drunk man leave but then told Ailsa to stop crying. A nurse also told her to stop crying and quieten down.

"I think I felt like a nuisance. Like I was a bit hysterical and I just needed to quieten down about the whole thing."

Ailsa asked the nurse to get her mum, and the nurse said yes but then forgot to do so and it took a long time for her mum to be brought through.

The baby was checked, and then Ailsa was sent home while still in tears.

Ailsa doesn't think that the staff knew about her mental health issues, as they didn't ask her or her mum anything about her medical history or any medications she was taking.

She described the whole experience as cold, distressing and frightening. She would have liked to have felt more safe and secure, to have received more care and compassion and to have been listened to and not dismissed. She feels that her mum should have been allowed to stay with her for the whole time, and that staff should maybe ask about mental health issues so they can provide more support.

Police Involvement

Four people told us about very different experiences where there was police involvement.

One person was taken to the Emergency Department at the Edinburgh Royal Infirmary after they had a 'meltdown' in the street while under the influence of alcohol. The police looked after them for the whole time while they were waiting to be seen, even though there was a change of shift, and took them home once they had been seen by a psychiatrist and discharged. The person described the police as 'brilliant' and felt that they received better treatment at the Emergency Department because they were accompanied by the police.

Another person went to the Emergency Department at the Royal Infirmary after developing a bad migraine, including sickness and confusion, following an operation. It was presumed that they were drunk and that the sickness was self-inflicted. The staff called the police and the police took them away without their coat and cigarettes.

One of the focus group participants told us about a time when they sat on the wall of a bridge with the intention to kill themselves. They were talked down by the police and

taken to the Emergency Department at the Royal Infirmary by paramedics, before being taken into custody for 48 hours and charged with Breach of the Peace. They did not receive their mental health medication in this time and nobody referred them for further psychiatric care.

Michael

Michael had become mentally unwell when he was at home. He was 'on a high' and hearing voices. His support worker called the police and the police took him to the Emergency Department at St John's Hospital, Livingston.

He expected to be admitted to the psychiatric ward from the Emergency Department, but that didn't happen. He was seen by the duty consultant who told him that they couldn't assess him because he was high. The duty consultant then told the police to bring him back in the morning.

Michael was taken to St Leonard's Police Station in Edinburgh and kept in the cells overnight. When he was taken back to the Emergency Department in the morning, he was referred to the Acute Care and Support Team.

He told us that it would have been better if he had been admitted when he was first taken to the Emergency Department because the nursing staff know him, and could have talked to him or 'talked him down'.

He was charged with Breach of the Peace and given a fixed penalty, and feels that if he had been looked after in the Emergency Department or in the psychiatric ward when he arrived, and not taken to the cells, this would not have happened.

He also feels that being kept in the cells overnight had a negative impact on his mental health.

He said that it would be better if there was a place of safety that the police could take you to in these kind of circumstances, so that they didn't have to take you to the cells.

After Discharge

People's experiences in A&E don't always finish at the point when they are discharged.

Eilidh

Eilidh was taken by ambulance to the Emergency Department at the Edinburgh Royal Infirmary, after falling from a ladder and injuring her leg. In the ambulance, the paramedics assured her that somebody would make sure she made it home okay, as this was something she was worried about.

She was generally happy with the medical treatment that she received. But after being discharged, she was given no help to get home, even though it was one o'clock in the morning, she was on crutches and barely able to walk, did not have enough money for a taxi and did not have a friend or family member who could pick her up. This was so stressful that she says it's put her off going back to the Emergency Department if she ever needed to, because she would be so worried about how she would get home again.

"Because of the mental health, I haven't got as many friends as I used to have, and the ones I know, they don't have transport, they just don't. There's too much of this attitude that everybody's got somebody to phone and they can just ask them to do this and ask them to do that, and I just don't have that."

Complaints and Feedback

Two of the interviewees made a complaint about their treatment, and neither was happy with the response. One felt that the department tried to brush the issue under the carpet. The other felt that their complaint had been treated with contempt, and also found the NHS complaints system difficult to negotiate.

One person really wanted to complain, but by the time they had recovered enough, both physically and mentally, too much time had passed and it was outwith the window of time in which they could have made a complaint to NHS Lothian.

“When you get out you're just so bloody relieved to be out, you kind of don't want to go there again, you don't want to revisit it. I was in a kind of extended shock, I was battling with daily living. I didn't have the energy or the wherewithal to make the complaints that I wanted to make.”

Another person's family encouraged them to make a complaint, but they also didn't feel able to complain because of the state of their mental health.

Two people told us that they would not have known how to go about making a complaint.

There generally seemed to be a reluctance to complain, either because the idea of it is too stressful or because you don't want to be seen as 'one of those people'.

When we were discussing this issue in the first of our group workshops, which was just for people with lived experience⁴, it was suggested that perhaps the word 'feedback' should be used instead of complaints, because a 'complaint' feels like a big thing and people don't always want to criticise. It was also said that people are put off sending a complaint or feedback because complaints procedures can come across as very bureaucratic.

We had an example of how things can be done differently. One of the interviewees compared her experience in A&E with her experience when she was giving birth a couple of months later. It had been a difficult birth, but she had had the opportunity to go back for a debrief to discuss what had happened and speak to the staff involved. This enabled her to give feedback directly and also process the event mentally and emotionally, something she found incredibly helpful.

Impact – Mental Health

A strong theme that came up in the interviews was the impact on mental health, with people's mental health being made worse as a result of what happened in the Emergency Department.

We were given the following reasons for this:

- The experience was distressing or stressful.
- The way they were treated made people feel bad about themselves.
- For one person, the complaint they made afterwards was treated with contempt and they felt ignored.

Impact – Returning to A&E or Hospital

Eight of the interviewees and one of the focus group participants told us that their experience has made them reluctant or scared to go back, to A&E, and in some cases, to hospital altogether.

For one person, it was the stress caused by the environment in the Emergency Department that made them reluctant to go back.

Another person is reluctant to go back because they felt judged:

“There's no way that I'd go back to A&E. Just to be sitting there, and feeling as though I've got to explain myself, instead of explaining what's wrong.”

Another person said that they cut themselves off from the NHS completely after their experience, as they had lost confidence in it.

Three people had had good experiences in A&E on other occasions, but one bad experience was enough to put them off going back.

There is potentially a big problem here, if people who have mental health issues are delaying treatment or not getting treatment as a result of the experiences they've had. This could have a major impact, not just for them and their health but potentially also for the NHS if more complicated or expensive treatment is required as a result of the delay.

The reluctance to go back to A&E or to hospital can extend beyond going back for treatment themselves. The person whose experience was at the Pregnancy Support Unit told us that they didn't visit their father in hospital when he was ill, even though they badly wanted to, because the idea of going anywhere near the Royal Infirmary filled them with dread.

What Could be Learned? / What Would Make Things Better?

We asked everyone the question, 'What could be learned?' or 'What would have made the experience better?' This is what they told us.

Staff should:

- See people as individuals and as human beings.
- Not make assumptions.
- Listen to people and believe them.
- Treat the physical symptoms, even if they don't know the cause.
- Stop the approach of ignoring people so that they get bored and stop self harming, it doesn't work.
- Show more care, compassion and kindness.
- Make sure people get home okay.
- Help people access the resources that are there for them.

Other things that would help:

- Better communication between staff when shifts change.
- More understanding and awareness of mental health.
- Follow through of care after treatment.
- A place of safety that's not a police cell.
- More privacy so that patients can speak to staff confidentially and not be bothered by disruptive patients.
- If you have brought someone with you for support, that person should be able to stay with you the whole time.
- Someone in the Emergency Department, like a buddy or befriender who could support people with mental health issues if they don't have support with them. This person could also help them communicate what they need and what their wishes are.
- Complaints should be taken seriously and lessons learned from them.

Stigma and Discrimination

There were three very clear examples of stigma and discrimination which came through in the interviews. In the two cases of diagnostic overshadowing⁵, assumptions were made by medical staff because they knew that Ben and Rebecca both had a mental health diagnosis.

Rebecca:

“They were making assumptions based on no knowledge. I have no history of presenting with psychosomatic disorders like that, that's not what my psychiatric history shows.”

The assumptions made led directly to appropriate treatment for Ben and Rebecca's physical health conditions being delayed which in turn had a significant impact on their physical recovery. The way in which they were treated by staff, because of assumptions made, also had a significant impact on their mental health.

Assumptions made in the Emergency Department about the cause of Rebecca's condition were re-iterated in the notes that were sent to the General Ward. Rebecca was treated in a horrific way when she was in the General Ward as a result of these assumptions and the belief which the nursing staff on the ward appeared to hold that people who have mental health issues are 'attention seeking' and that they will fake physical symptoms in order to manipulate and get attention.

This 'attention seeking' stigma can also be seen in Lucy's case⁶, previous experiences of which led to her actively delaying attending at the Emergency Department because she expected to be treated badly. This delay meant that there was a longer recovery time and Lucy needed much more intensive treatment.

These are the only clear and explicit examples of stigma and direct discrimination that we were told about. Showing the prevalence of stigma and direct discrimination

is difficult as people with lived experience don't always know if their mental health diagnosis is known when they attend at the Emergency Department.

Indirect discrimination can perhaps be seen to a much greater extent in our findings.

Indirect discrimination is where a group of people are not treated in a different way from other people but are put at a disadvantage because how things are or the way in which things are done does not meet their specific needs or impacts on them negatively.

The environment in the Emergency Department and the lack of help for getting home can be stressful for anyone who attends, not just people who have mental health issues. However, for many people with mental health issues, the stress and anxiety experienced as a result of these things can be heightened by a considerable degree. At the time, as well as being horrible in itself, this stress and anxiety can affect people's ability to communicate effectively and understand what they are being told and questions they are being asked, which can in itself lead to poorer health outcomes if the communication difficulties lead to misunderstandings which affect the treatment they receive.

In Eilidh's case an assumption had been made that she would have someone who could support her and help her get home, but as a result of her mental health issues, that was not the case. Assumptions like these can disproportionately affect people who have mental health issues, who often do not have the support networks that other people have, sometimes because of wider stigma towards people have mental health issues.⁷

As referred to earlier, eight of the interviewees and one of the focus group respondents told us that the experiences they had made them reluctant to go back to the Emergency Department or hospital, or to access other NHS services, if they ever needed to. Where there is direct or indirect discrimination, the impact of the discrimination could extend beyond the incident itself if, on later occasions, the people affected delay going for help when they need it, or don't go at all, and the

delay in or lack of treatment affects their recovery or health or leads to them losing their life.

The impact of direct or indirect discrimination could also extend beyond the incident itself when a person's mental health has been affected. There is a question that should be asked here of the extent to which consequences for mental health are taken as seriously as consequences for physical health.

Sophie's case⁸ is a clear example of mental health not being taken as seriously as physical health. The emphasis of the Scottish Mental Health Partnership, in February 2016, on promoting 'parity of esteem between mental and physical health provision'⁹ indicates that Sophie's case is reflective of a wider inequality in Scotland between how mental health and physical health are considered and resourced.

The Change We Want to See

We held two workshops in January and February 2016, the first just for people with lived experience and the second for people lived experience, professionals and other stakeholders. Based on the interview findings and the discussions at the workshops, this is the change we want to see.

Mental health and physical health would be seen and treated as **equally important**.

People with lived experience of mental health issues would **not receive poorer treatment for physical health issues**.

The **stigma that people who have mental health issues are 'attention seeking' would no longer be prevalent** and would not affect how people with lived experience of mental health issues are seen and treated.

People with lived experience would be seen by all as individuals and treated with **care, kindness, compassion, empathy and understanding**. They would be listened to, taken seriously, believed and not judged.

Staff would have a **greater awareness and understanding** of mental health. They would **not make assumptions**. They would treat the symptoms presented, even if they didn't know the cause. They would **take people's mental health into account in order to support them**.

People with lived experience would be **involved in the decisions** about their treatment. They would be kept informed of what treatment they were getting and why they were getting it. They would be spoken to in a way that they understand, without being treated like an idiot.

People with lived experience would **feel safe** in the Emergency Department.

Personal space and privacy would be protected.

There would be **follow through of care** after

treatment.

Services would be **accountable**. Complaints would be taken seriously and lessons learned from them.

Staff would be supported for their own wellbeing.

How can we bring about this change?

It is essential that human rights are at the centre of any work that is done to bring about change. It is also important that we recognise and build upon good practice.

Here are some specific ideas for bringing about change that we explored during the workshops:

Redesign Complaints and Feedback

The complaints system is clearly not fit for purpose. There is space for innovation in this area, we could have a totally new way of doing things which could make a big change by identifying where there are problems and responding to them and acting upon them on both an individual basis and a department or organisation wide basis. The system could also enable people with lived experience, or any patients, to give positive feedback and show appreciation when they have been treated well. Good practice could be highlighted and learned from.

An open and non-adversarial culture would be essential. Patients would be encouraged to come forward. Procedures would be easy to navigate rather than bureaucratic. The NHS would respond quickly, address any issues, admit any mistakes and be willing to learn from them.

Pro-active individual, person to person, debriefs are already being used elsewhere. These show promise and could be developed for use in A&E.

Training led by people with lived experience

People with lived experience should be involved and play a lead role in delivering staff training. Training should focus on human rights, equalities and using a less judgemental approach, as well as specifically tackling stigmatising attitudes.

Support Communication

Self harm report cards are already available from the National Self Harm Network¹⁰. These can help somebody who has self harmed or taken an overdose, but is too distressed, anxious, disassociated, or otherwise unable to effectively communicate verbally what has happened. These should be made more readily available, for instance at services and GP and A&E reception desks. If they were more readily available, it could reduce the stigma around using them by normalising them.

There could also be a more general simple form that could be used by anyone who would struggle to communicate verbally, whatever their reason for attending. This could include not just what had happened, but also any preferences for treatment, anything that makes them feel anxious or anything that helps.

Explore role of volunteers

The role of volunteers could be explored. Some people might find it helpful if there were volunteers who could sit with them and chat when they are feeling anxious and don't have anyone with them for support. These volunteers could also help them communicate their needs and wishes. A volunteer transport service might also help, so that there is someone who can drive people home if they are unable to use public transport and have no other way of safely getting home.

Open up and build spaces for human contact

One to one human contact can be incredibly powerful. Spaces could be opened up and developed where NHS staff and people with lived experience can have an informal chat to build awareness and understanding that people with lived experience are people too, as are doctors, nurses and other staff. This could potentially break down barriers and stereotypes and build empathy.

A Human Rights Perspective

Cathy Asante, Scottish Human Rights Commission

The interview findings raise a number of issues when looked at through a human rights lens. Of course, people with mental health issues have the same human rights as all members of society. This includes the right to life, the right to freedom from inhuman and degrading treatment, and the right to private and family life, all of which can be engaged when a person is denied health care or is provided with inadequate health care. The right to private and family life also includes the right to privacy and to make decisions regarding one's own health care, with the support to do so, if required. These rights are protected by the European Convention on Human Rights and the Human Rights Act 1998.

The state and its public authorities, such as the NHS, also have a duty to take active steps towards achieving the right to the highest attainable standard of physical and mental health for its citizens, under a United Nations treaty which the UK has signed, the International Covenant on Economic, Social and Cultural Rights. This does not mean a right to be healthy but an obligation to provide services which are:

- **Available** in sufficient quantity.
- **Accessible** to everyone without discrimination, especially the most vulnerable or marginalised people. This includes being physically accessible and affordable and includes the accessibility of health information;
- **Acceptable**, respecting issues of confidentiality and being sensitive to cultures, communities and gender;
- Scientifically and medically **appropriate and of good quality**.

All of these rights must be provided to everyone on an equal basis, without discrimination on the basis of a person's particular characteristics, such as whether they have a mental health diagnosis or not. These rights are further protected by another important United Nations treaty – the Convention on the Rights of People with Disabilities. This treaty recognises and protects the rights that disabled people, including those with mental health issues, have on an equal basis with others. It also

sets out obligations to remove the barriers that disabled people face in achieving those rights. The rights mentioned above appear in this context, breaking down in more detail what it means to realise those rights for disabled people. For example, the right to health specifies that people with disabilities must be provided with the same range, quality and standard of health care as other people, as well as those health services that they require specifically because of their disabilities.

These rights all come into focus when considering the interview findings. The right to health should be considered if a person with mental health issues is not receiving adequate treatment for their physical health issues due to assumptions about 'attention seeking'. In those circumstances, are people with mental health issues receiving a quality standard of health care without discrimination? In individual cases, failing to provide health care could lead to serious distress or life-threatening consequences which might engage the right to life or the freedom from inhuman and degrading treatment. Are systems set up in a way which ensures they provide those aspects of health care required specifically because of a person's disability? This might be essential medication for management of their mental health issues, tackling risks of self harm, or providing communication support to a person with a learning disability.

As the interviews show, many of these experiences have an emotional and psychological toll leading, in some cases, to a fear of approaching services. This may, in turn, contribute to deepening health inequalities between people with mental health issues and the rest of the population, if people feel discouraged from seeking treatment for health issues that need to be addressed. In human rights terms, active steps must be taken to remove those barriers so that health services are indeed equally accessible to all.

A&E | All & Equal - Conclusion

We heard about a number of issues in our research. While it is not possible to gauge how widespread the issues are, it is unlikely that these are isolated incidents. Even if the issues only affect a small number of people, for those people who are affected, the distress or avoidable harm experienced, the impact on their lives and the infringement of their human rights is significant enough in itself to justify action.

We believe that the change we have outlined is realistic and achievable. Through our discussions, we identified a number of ideas for making change happen, improving people's experiences and tackling discrimination. We are keen to develop these further and potentially put some of these into action, as well as identifying and developing other ideas, possibilities or opportunities.

It is important that any work that happens has human rights at its centre. It should involve everyone who has a stake, with people with lived experience playing a leading role, and requires commitment and investment from staff, providers and policy makers.

We would like to invite anyone who is interested in developing the ideas identified, developing new ideas or otherwise taking action, to get in touch

You can contact us by email, phone or post: collectiveadvocacy@advocard.org.uk, 0131 554 5307, AdvoCard, 332 Leith Walk, Edinburgh, EH3 5AY.

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Lothian Voices

The People's Conference 2016:

Dear Doctor...



Stop



Amber



Go!

What people in Lothian with experience of mental health issues think about;

“How can your GP practice improve the way it works with you as someone who has experience of mental health issues?”

CAPS Independent Advocacy is a Scottish Charitable Incorporated Organisation (SCIO) Scottish Charity No SC021772

CAPS
independent
advocacy



What is CAPS?

CAPS is an independent advocacy organisation for people who use or have used mental health services.

CAPS works with people who use or have used mental health services as individuals or as members of a group to set their own agenda, to find a stronger voice, to get their point across, and influence decisions which affect their lives.

CAPS provides individual and collective advocacy in Midlothian and East Lothian. CAPS also has several Lothian-wide experience-led projects.

Individual Advocacy is about working alongside a person to help them express their views and have more influence over decisions being made about their lives.

Collective Advocacy is about groups of individuals with a common cause who come together to raise awareness, campaign and influence service planning and provision.

CAPS is an Independent Advocacy organisation.

This means that it:

- Puts the people who use advocacy first
- Is accountable
- Is as free as it can be from conflicts of interest
- Is accessible

CAPS is funded by East Lothian & Midlothian Councils and
NHS Lothian

CAPS is a Scottish Charitable Incorporated Organisation Scottish
Charity Number SC021772

Who are Lothian Voices?

Lothian Voices are a collective advocacy group of people who gather together to give their views on NHS Lothian's Mental Health and Wellbeing Strategy. Lothian Voices is supported by CAPS. Every year they organise the People's Conference.

What is the People's Conference?

The People's Conference is a one-day inclusive event for people with lived experience of mental health issues in Lothian. It is a space where people feel safe, able and welcome to be honest about their lives.

Every year there is a stakeholder event about the NHS Lothian Mental Health and Wellbeing strategy. This event is called 'Taking Stock' and is organised by NHS Lothian. Anyone who has an interest in mental health services in Lothian can go to Taking Stock. The aim of Taking Stock is to look at what work has been done over the year and what still needs to be done.

CAPS organised The People's Conference because people who have lived experience of mental health issues told us that they would like more opportunities to give their views on NHS Lothian's Mental Health and Wellbeing Strategy.

Last year, the topic was "Working With All of Me" which involved looking at how services work with us holistically, with everything that is going on in our lives. Lothian Voices members decided the 2016 conference should look at people's experiences of using primary care services.

This year's topic:

How can your GP practice improve the way it works with you as someone who has experience of mental health issues?

Planning the People's Conference

The People's Conference steering group was open to anyone who identified as having their own experiences of mental health issues. The group had five members. Two staff members from CAPS were involved to help facilitate the meetings and actions coming out from the meetings.

The group decided that they wanted to focus on people's experiences of using primary care services.

We also talked about how we wanted people to feel at, and after, the conference, and what we wanted people to get out of it. The words that the steering group came up with in this conversation were:



Venue

A Sense of Someplace at the Walpole Hall was chosen as the venue again for the conference as people had largely welcomed this as a venue for the 2015 People's Conference.

The Conference

On the day, staff from CAPS Independent Advocacy facilitated the activities, with steering group members taking on the role of welcoming people to the event.

At the entryway of Walpole Hall, we asked people to write down their experiences of making appointments, dealing with receptionists and the waiting area.

During the morning, before coffee break, we worked in small groups with one facilitator at each table discussing;



What is good about your GP surgery?

Following the break in the same groups we continued discussions focusing on;

What could be better about your GP surgery?

After lunch people had the opportunity to develop Prescriptions for Change. We gave people the opportunity to use several methods of exploring these themes, from artistic methods to group discussion, to working alone.

We asked people to think about the morning's discussions and to identify what changes people thought would improve their experience with GPs.



What people said

When we looked at the responses from all the activities throughout the day we found that most of them could be gathered into five themes. The following pages give a summary of each category and what people told us would be their prescriptions for change:

Access

To improve access, people think the following changes would make a big difference:

- Make it easier to book appointments by offering a choice - online, on the phone or in person. Remember that not everyone has a computer
- Offer more flexibility around making urgent appointments.
- Give us a choice about how much we have to tell receptionists when trying to make appointments, especially urgent appointments and double appointments.
- Make it easier to book double appointments. We find that appointments sometimes aren't long enough but asking for double appointments can be difficult. Some of us feel we don't deserve them or we worry that we will be thought of as time-wasting.
- Improve privacy in reception areas and provide breakout space. They can be too small, not private and too busy.
- We would like to know which GPs in the practice have a particular interest in mental health, it could be on the website and in practice leaflets.
- Some of us like getting text reminders about our prescriptions.
- We appreciate having different ways of getting information, for example, in accessible formats.
- Make it easier to register at a new practice; some practices have closed their lists and others only allow you to register at a set time and day of the week
- Give us easier access to our information, for example, share what is entered on the screen while we are in the appointment.

Attitudes and Communication

The attitudes of GPs and how they communicate with us have a big impact on us.

- Listen.
- Take our physical health seriously and don't assume everything is because of our mental health problems. Diagnostic overshadowing is a problem for most of us.

"It is helpful] when the GP considers other things about your life too - person centred approach."

- Welcome advocates accompanying us to appointments.
- Allow us to communicate in ways which are easier for us e.g. listen to my advocate or read my list.
- Learn about us and our mental health problems over time because continuity of care is particularly important for us. We find having to tell our story over and over again difficult.

"My GP actually reads my notes so I don't have to retell my story which can be re-traumatising"

- Make us feel welcome, for example, come to reception to invite us to the consultation room, make eye contact and use our name.
- Consider other aspects of our lives such as our family circumstances, work, benefits situation etc.
- Offer alternatives to medication, such as talking therapies, community based support, exercise on prescription, etc.
- Ask us appropriate questions and consider whether they may be too intrusive or unnecessary.

"My doctor focuses on my mental health when I enter the room — [physical health] comes secondary to mental health. Feel I have had to really state my case about physical and mental health over and over and it's all through these 'bipolar tinted' glasses"

Knowledge and Training

We think GPs need more knowledge and training about mental health problems:

“GP has learned over the course of working with me about mental health and has definitely improved.”

- Get more training delivered by people with lived experience.
- Learn more about what is available both within the NHS and in the community, in particular social prescribing, advocacy and welfare rights.
- Be aware of how trauma may have affected us.
- Be aware of how our mental health may fluctuate.
- Respect our understanding of our mental health issues even when it is different to yours.
- Provide lots of information on display in the waiting area.

“I know my Doctor communicates with my CPN/psychiatrist [which] is really helpful, means I don't need to keep repeating myself”

Signposting

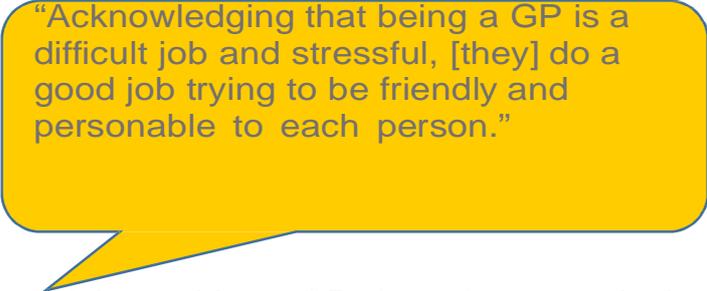
GPs are gatekeepers to other parts of the NHS and to other services. Increased knowledge and training means GPs will be able to signpost people more effectively

- Tell us about services such as counselling, drop-ins, welfare rights, and advocacy.
- Offer us more support to help us while we are on long waiting lists for secondary services.
- Refer us to specialist help more quickly and appropriately e.g. trauma services, physical health services.
- Write informative letters for the DWP.



"GP very helpful with letter for ESA"

Resources



"Acknowledging that being a GP is a difficult job and stressful, [they] do a good job trying to be friendly and personable to each person."

We are very aware of the problems GPs face, for example there are too few of them and many are part-time so there are too many locums. We know they are busy and work long days, that they are stressed and that they have too much pressure on them to meet targets and to prescribe cheaper medication.

This affects us in many ways - in particular, it is hard for many of us to see the same GP when we need to so this means there isn't the continuity of care that we value.

Employ more GPs, practice nurses and support staff in GP practices.

- Base peer support workers and information workers in GP practices.
- Provide more preventative services.

Conclusion

People with lived experience of mental health issues value good, ongoing and respectful relationships with GPs.

They are the first point of contact with the NHS and gatekeeper to secondary services. We appreciate that it is a difficult job and that primary care is under stress.

However, the suggestions we have made would improve services and the experiences of both GPs and patients

Feedback from the event



Our original word cloud described the words that we would like people to describe as their experience of the day.

People told us that they valued the opportunity to come together in a welcoming space. That they felt Listened to and that the opportunities for networking in a safe environment were valued.....but that the acoustics and heating were still an issue!

Next Steps At Steps



At the end of the People's Conference, all attendees were invited to join the steering group to take the work of the conference on. Since the conference, the steering group has been ensuring that the language in the priorities was as simple as possible, and removing any repeated points.

The experiences collected in this report were presented by people from the steering group at the People's Conference at Taking Stock in May 2016.

We then produced a briefing in response to the demand for the findings. This report is based on the briefing.

We are already looking ahead to organizing a People's Conference 2017. Please get in contact with jane@capsadvocacy.org or on 0131 273 5116 if you are interested in keeping up to date with news of the steering group.

Getting involved will be flexible around you, but could be with all stages of the process, for example, deciding what we do, organizing events or activities, writing up reports, giving presentations about the events, doing illustrations, or simply giving your opinions.

steering group
Since the
been making
and solutions
removing any

It was
group for the
in May 2016.
Based on the

Organizing a
in contact
0131 273 5116 if
you are interested in
keeping up to date
with news of the
steering group

Deciding what suits
the process, for
organizing events,
reports,
doing
illustrations.





Acknowledgements

CAPS would like to thank everyone who was involved in the planning, collaboration and organisation of the steering group.

For all those who attended and participated in this year's People's Conference, CAPS would like to thank you for your enthusiasm and involvement. It was great to see so many people attending and we look forward to seeing everybody in the future!

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CAPS

Scottish Charitable Incorporated

Organisation SCIO Number SC021772

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GAMECHANGER

Working in partnerships to harness the power of football to help tackle inequalities and to promote social justice

PHASE 3 REPORT

This report summarises our journey so far, and progress to date, as well as setting out our medium and longer term priorities for GameChanger.

The activities of GameChanger to date have been formulated by our Management Team.

We would like to take this opportunity to thank all of our partners for their work and enthusiasm to date and look forward to working even more extensively with everyone in the future as we build on our initial foundations to make a long and lasting impression by using the power of football to tackle inequalities and promote social justice.

Linda Irvine
NHS Lothian

Leeann Dempster
Hibernian FC

Laura Montgomery
GameChanger

Charlie Bennett
Hibernian Community
Foundation

On behalf of GameChanger Public Social Partnership Management Group

The idea behind the Public Social Partnership that was to become GameChanger was born in the Autumn of 2014, following a meeting between Leeann Dempster of Hibernian FC and Linda Irvine of NHS Lothian to see how football might work to improve health outcomes for the Club's supporters and the wider community, using the Club's physical and emotional assets – in other words harnessing the power of football.

Others were invited to share ideas, and several hundred individuals and organisations who attended a number of "gatherings" fed in 350 different ideas covering health, social inclusion, social justice and education. A PSP management group (see appendix one) was established to assess, filter, and prioritise the enormous input gathered and to then create a way ahead. The group represents Hibernian FC, Hibernian Community Foundation, NHS Lothian and Ready for Business, the latter representing the Scottish Government's strategy for the third sector to encourage the adoption of social value in public procurement and to increase the share of these services that the third sector delivers. The core partners have signed up to shared values and priorities (see appendix two). Using the Scottish Government's five strategic objectives – Wealthier and Fairer; Smarter; Healthier; Safer and Stronger; and Greener – the management group identified a flagship project under each heading along with roadmap projects (see appendix three). The group also decided on GameChanger as the name for the partnership, and in November 2015 Laura Montgomery was recruited as Project Manager.

These identified projects are all designed to work with our interested partners to produce positive social outcomes for Leith, Edinburgh, the Lothians and South East Scotland. Their breadth and scale clearly demonstrates the potential of GameChanger and the significant contribution it can make to delivering for Scotland. Great enthusiasm has been expressed for the approach being taken by GameChanger from within Scottish Government and the Scottish Parliament.

GameChanger Health Village / Wellbeing Hub

Due to the size and scale of our flagship projects, the GameChanger management team are focusing on one major flagship project at a time.

Our initial focus is on the Health and Wellbeing Village at the stadium and plans are well underway in conjunction with NHS Lothian to create this inspiring and unique environment right in the heart of our Easter Road stadium.

Communication and Engagement

'Conversations for Change'

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

500 mile Step Challenge

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

Press Engagement

In addition to the excellent press activity we received in the national press of our 500 mile step challenge, GameChanger has actively targeted specific stakeholders to increase awareness of the PSP. This includes publication in Holyrood magazine aimed at MSPs, Councillors and Civil Servants as well as general engagement with the national and local press. Presentations to highlight the work and intentions of GameChanger have also been delivered to the administration of the Scottish Professional Football League and the Scottish Football Association as well as engagement with other sporting bodies such as the Scottish Rugby Union and Scottish Clubs Supporters.

Parliamentary Launch

GameChanger held a Parliamentary Reception to officially launch the PSP on 16 March 2016. The reception was hosted by MSP Kezia Dugdale who is an interested partner in GameChanger. Ms Dugdale, Linda Irvine, Leeann Dempster, Stewart Regan, Chief Executive of the Scottish FA, and local GP Dr Richard Williams all spoke at the event, which was attended by over 150 people.

Conferences and Speaking Events

Our Project Manager, Laura Montgomery has been invited to speak at a number of events. These have included a conference at the Homeless World Cup and also most recently the Holyrood Conference: "Sport in the Community – delivering wider social benefits" as well as at the Hampden Park Conference: "Sport, Mental Health and Dementia."

Building Community Capacity

Gypsy Traveller Family Event

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

A Saturday in May

In partnership with Media Education, GameChanger worked with a group of children and young adults to allow them to experience working with camera equipment and interviewing people for the very first time. The group went out on to the streets of Leith a week after Hibernian's historic cup triumph and interviewed the community about the Cup win and the impact they felt it had on them. The making of the video was an incredibly positive experience for all involved and the group also enjoyed a special tour of Hibernian FC as well as a private viewing of the Scottish Cup.

Community Awareness Day

In April 2016 we organised and hosted a successful Community Awareness Event at Easter Road, which brought together 44 local agencies to showcase their work and services to each other and to the public. The event was arranged after overwhelming feedback from our partners indicated that not only did the public not know what great services were out there to benefit them, but organisations and other specialists themselves sometimes didn't know and could not adequately signpost the public either. The response from the event was extremely positive and all attendees asked if the event could be repeated, which GameChanger is delighted to do and will work on making it even more successful next time.

Disability Confident

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

Healthier

Supporting Children with Type One Diabetes

Using a Hibernian first team footballer who suffers from Type I diabetes, GameChanger hosted an event at the stadium which focused on the management of diabetes for children and young people. The event attracted families from the locality with children who are managing the condition and once again, we were overwhelmed by the response and impact the event had on all concerned.

Match Day Health Checks

In partnership with Living it Up, GameChanger hosted Health Checks at all first team home matches for the second half of the 2015/2016 football season. The Living it Up team moved around different stands each game, offering blood pressure and BMI checks to fans as well as giving general well-being and health advice. The checks identified individuals with health concerns of which they were unaware, and these individuals have now sought the appropriate medical advice. The general feedback amongst the fans attending was that while they rarely visit their GP they were more than happy to have their health checked at the environment they are most comfortable in, the ground of their home team. An end of season fans survey also indicated that 96% of Hibernian supporters think matches are a great place for health checks and advice.

Mental Health Group Programme

The stadium at Easter Road supported the delivery of Stress Control and Anxiety and Depression Groups for the local NHS mental health team.

It also supported focus group work with Hibernian FC fans and SAMH.

Mental Health Clinic

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

Defibrillator for Leith

GameChanger partnered with local Leith councillor Lewis Ritchie in his bid to run the Loch Ness Marathon to raise funds to purchase a defibrillator for Leith. Lewis ran the marathon in a Hibs shirt, with Defibrillator 4 Leith printed on the back and raised enough money to purchase the defibrillator, which will be placed on Leith Walk.

Safer and Stronger

Suicide Prevention Week

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

Greener

Good to Go

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

Smarter

Edinburgh College

Our Learning Centre at the Hibernian Community Foundation continues to expand, with a number of courses running, including ESOL (English for Speakers of Other Languages) classes.

Communication and Engagement

Website

We are looking to revamp and relaunch the GameChanger website and work is currently underway on this.

Working with Communities

Strange Town

GameChanger are working with this local theatre company on a very special production for the summer of 2017.

A Wonderful GameChanger Christmas

We are currently planning the delivery of a GameChanger Christmas Lunch on the 25th December, which will allow us to invite up to 250 vulnerable people to the stadium to enjoy a festive get together and lunch in a safe and positive environment, entirely for free.

Healthier

GameChanger Fit for Life

In early 2017, we plan to launch our first GameChanger lifestyle programme called Fit for Life. This will be a weekly fitness and well-being class pitch side at the stadium, entirely free of charge and open for all via self-referral.

As well as encouraging fitness improvements, Fit for Life will also include an indoors element after the fitness workout where participants will get the chance to make friends and find out more about what is going on in their community, along with a range of tailored advice on health and wellbeing.

Absent Friends

Talking about death, dying and bereavement is often difficult but also helpful for people to express their grief. GameChanger worked with NHS Palliative Care to bring together Absent Friends, which ran at the stadium over the course of 3 matches in November 2016.

GameChanger Absent Friends Walls were created around all of the concourses and fans were encouraged to write their memories and messages and put up pictures of those no longer with us. The Hibernian supporters engaged massively with this very emotive subject and we were overwhelmed with the response with all walls full at the end of the project.

A commemorative book is now being organised to store all of the incredible messages and memories and this will be held at the stadium.

Mental Health First Aid

In partnership with Network Rail, GameChanger plans to deliver Mental Health First Aid to local Quality Mark football clubs. This course is vital in giving as many people as possible the tools to identify mental ill health as well as knowing where to signpost vulnerable individuals so they can get the important help they need as early as possible.

Quality Mark accredited football clubs are Scottish FA approved clubs who are well organised and operate teams at all ages for boys and girls, men and women. In reaching out to these organisations we can train a volunteer in Mental Health First Aid and they will then be able to support the entire football club, which can often be hundreds of members.

GameChanger Tackles Diabetes

From the second week in January, GameChanger will launch, a GP referral diabetes type 2 prevention programme. Operating from the stadium, the programme will be delivered by NHS professionals and Hibernian Community Foundation staff and is targeted at individuals identified by their GP as pre-diabetic.

Match Fit Match Day Health Checks

In partnership with Living it Up, GameChanger continues to host health checks at all first team home matches talking all round healthy living but with a focus in particular on diabetes awareness and risk assessment. Diabetes Scotland joined forces with Match Fit on November 19th 2016 and will come back in again as the season progresses.

Young Persons Digital Challenge

GameChanger is part of an exciting project which will launch in January 2016. The project will be based around a competition for all Scottish 14 – 18 year olds to take part in to try and come up with a digital solution which will help tackle childhood challenges around lifestyle and nutrition. A famous Scottish sportsperson is behind the competition and all will be revealed in January!

Organ Donation

Hibernian Football Club and GameChanger are working closely with the Scottish Executive to promote their Organ Donation campaign. High profile players have signed up as donors, and national mainstream and digital media coverage was gained.

Safer and Stronger

Youth Offending

An ambitious programme to provide tailored support to young people who have multiple and complex needs and are considered to be vulnerable is currently being formulated with youth justice health and 3rd sector partners.

Supporting Older People in the North East

Loneliness and isolation have been recognised as a major public health issue. (Age UK, 2015). GameChanger will be linking with the recently funded “Golden Years” programme provided by the Cyrenians which has, following its successes in working with older people in West Lothian, now extended into Edinburgh. This partnership will use the stadium as a destination point for older people encouraging connections and relationships through weekly lunches and activities.

Connecting with the Polish Community

The Polish community is the largest immigrant community in Leith and we feel it is vital that we make everyone feel welcome and at home in our neighbourhood. Building on a GameChanger partnership with the Polish Family Centre in Leith, 120 members of the Polish Community were our recent special hospitality guests for the Hibernian v Queen of the South game in November. The game not only introduced many guests to a game for the first time, but it also very importantly allowed support information to be passed on.

Health and Safety at Work

In partnership with Scottish Hazards, GameChanger hosted a free workplace health and safety advice evening at the stadium. Presentations and advice were given to members of the public who had workplace concerns by worker health and safety charity, Scottish Hazards along with Thompsons Solicitors and Support Work.

Wealthier and Fairer

Community Café

GameChanger is currently working with other PSPs to support the delivery of a Community Café which hopes to be up and running next year.

GameChanger Giving Back

GameChanger is providing free Hibernian FC home match tickets to a number of PSP partners throughout the season to allow them to fundraise and/or invite service users along to a game.

Home Energy Scotland

Positive meetings have taken place with Home Energy Scotland and they will be joining us in the concourses at some points throughout the season to offer advice on saving energy and saving money. This is a key service which offers benefit to all demographics, but most importantly can be of vital importance to low income families who may not be getting all the support they are entitled to, or who could save significant sums with some energy use alterations, and in tackling fuel poverty.

Smarter

Edinburgh University

Work continues with Edinburgh University for joint working on their MOOC (Massive Open Online Course) and accredited course Football: More than a Game. This course would be delivered at the stadium and targeted at individuals furthest removed from University education.

PTS Learning for Veterans

Planning is in place with PSP partner Network Rail to deliver Personal Track Safety (PTS) training opportunities for veterans. GameChanger will work with the eight Veterans First Point (V1P) Centres across Scotland to promote this opportunity.

Work Experience

GameChanger continues to work the Leith Department of Work and Pensions Employment and Partnership team to try and facilitate work experience opportunities for individuals identified as in need of support to enter the work place.

Children's University

GameChanger is currently in discussions with Queen Margaret University regarding joining the highly exciting Children's University programme.

Name	Position	Organisation
Leeann Dempster	Chief Executive	Hibernian Football Club
Linda Irvine	Strategic Programme Manager and NHS Lothian Lead	NHS Lothian
Charlie Bennett	Chief Exec of the Foundation	Hibernian Community Foundation
David Forsyth	Director	Hibernian Community Foundation
Pauline Graham	CEO, Social Firms Scotland & PSP lead for Ready for Business	Ready for Business
David Fogg	Manager, KPMG & PSP lead for Ready for Business	Ready for Business
Laura Montgomery	Project Manager	GameChanger PSP

Our Shared Values

Equality

- Mutual respect and trust
- Open and transparent communications
- Co-operation and consultation
- A commitment to being positive and constructive
- A willingness to work with and learn from others

Our Shared Priorities

Promote health improvement and health promotion messages – maximising national awareness initiatives and campaigns.

Promote and provide opportunities for vulnerable groups and communities to be engaged with sport and exercise activities.

Provide opportunities for green space initiatives which focus on diet, exercise and eco diversity
Promote and support participatory activities which harness the power of sport and the arts to build community cohesion and capital.

Create further educational and employment opportunities including the development of social firms and enterprises.

Wealthier and Fairer	Smarter	Healthier	Safer and Stronger	Greener
FLAGSHIP				
<p>Entrepreneurial Start Up Zone at Easter Road Stadium (creative/social enterprises). High quality office accommodation.</p>	<p>State of Art Learning Centre. High quality, flexible learning environment at Easter Road, inspirational, accessible.</p>	<p>Health Village / Wellbeing Hub, working with NHS Lothian, Universities, and other interested partners. Based at Easter Road.</p>	<p>Family Centre at Hibernian Training Centre, Ormiston. Working with NHS Lothian, East Lothian Council and others. Aimed to help families at risk and in crisis.</p>	<p>Green Healthy Growing Zone, based mainly at Ormiston, working with NHS, Local Authorities, Universities and others to promote healthy eating and physical participation.</p>
ROADMAP				
<p>Hospitality training area, Community cafe, Meals for Elderly, Hibernian Apprenticeships.</p>	<p>Language and cultural classes and cafe, Multi-cultural familybase, Literacy / numeracy groups, Conversation cafes.</p>	<p>Healthy Happy Street, Well Boxes, Dementia Project, Screening Clinics, Community Treatment Centres, Outdoor Gym, Healthy Hibs Messages, Social Prescribing, Participatory Arts.</p>	<p>Mentoring for Children, Diversionary projects, Intergenerational work, Community Payback Orders, Cultural activities.</p>	<p>Outdoor Gym, Forest School, Memory Garden, Bee-Keeping, Men in Sheds, Wildlife / Woodland Activity and play, Sculpture Pathway, Walking / Cycling.</p>

A

Action Group
 Action on Depression
 Addressing the Balance
 Advocard
 Aid & Abet
 Athlete Training Systems
 Artlink

C

CAPS Advocacy
 Care for Carers
 Carr Gomm
 Circle
 The Citadel
 City of Edinburgh Council
 Department of Health and Social Care; Criminal
 Justice Services: Children and Families
 CHANGES, East Lothian
 Community Pharmacy Scotland
 Cre8te Opportunities Limited

D

Department of Work & Pensions

E

East Lothian Council
 Sport, Leisure and Countryside: Lothian Villa and
 Children and Families
 East Lothian Social Enterprise Network
 Edinburgh and Lothian's Health Foundation
 Edinburgh Access Practice
 Edinburgh Chamber of Commerce
 Edinburgh College
 Edinburgh College of Art
 Edinburgh Cyrenians
 Edinburgh Health Forum
 Edinburgh Napier University
 Edinburgh Social Enterprise Network
 EVOC
 University of Edinburgh

F

Forth Sector
 Freedom Unlimited
 Fresh Start

G

Greenspace Artspace Public Social Partnership

The Links

Restalrig
 Brunton Place
 St Tridunas'
 Baronscourt
 Leithmount

H

Healthy Active Minds, Edinburgh Leisure
 Health in Mind
 Home Energy Scotland
 Home Start

I

Individuals
 Malcolm Chisholm MSP
 Bob Donaldson
 Ben MacPherson MSP
 Kezia Dugdale MSP
 Alex Galloway
 Iain Gray MSP
 Eileen Hay
 Bill Irvine
 Kenny McAskill MSP
 Thomas Ryan
 Rhona Wilder
 Impact Arts
 Councillor Lewis Ritchie

L

Leith Festival Association
 Leith Neighbourhood Partnership
 Let's talk about Mouth Cancer
 Life Church
 Link Group

M

MECOPP
 Midlothian Council
 Midlothian and East Lothian Drugs and Alcohol
 Partnership
 Morrison Construction

N

New Caledonian Woodlands
 NHS Lothian
 Strategic Planning: *Child and Adolescent Mental
 Health Services :The Works : Occupational Ther-
 apy, East Lothian: Healthcare Innovation: Head-*

*room, Edinburgh Community Health Partnership:
East Lothian Community Hospital Project: Mental
Health Services, North East Edinburgh: Healthy
Respect: Adult Mental Health Applied Psychology:
MCN Coordinator: Women and Children's Services:
Long Term Condition: Health Promotion : The
Orchard Clinic: Acute Services ; Living It Up*

O
Orchard Centre
Ormiston Grows

P
Patients Council, Royal Edinburgh Hospital
Plusone Mentoring
Police Scotland
Polish Family Centre
Prince's Trust

Q
Queen Margret University

R
Recruit with Conviction
Ripple Project

S
SAMHS
Sacro
Scottish Hazards
The State (Leith) CIC
Spartans Football Academy
Street Heat
Street Soccer
Strive
The Stafford Centre
Social Firms Scotland
Spartans
Support in Mind
Storm Health
Strange Town Theatre Company

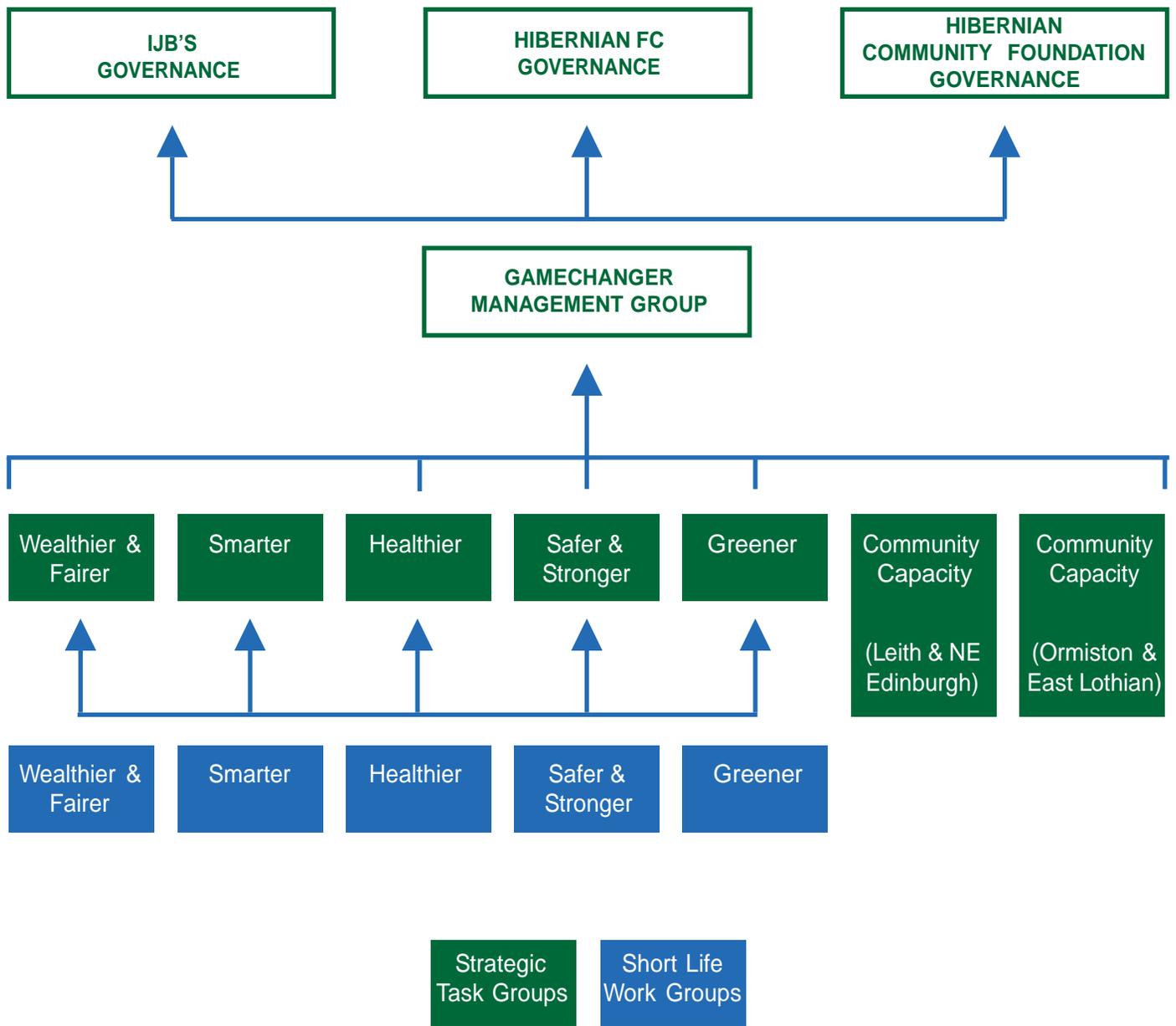
T
Transformation Station, Queen Margaret University
and NHS Lothian
Turning Point

U
Upward Mobility Project

V
V1P Scotland
Viewpoint Housing

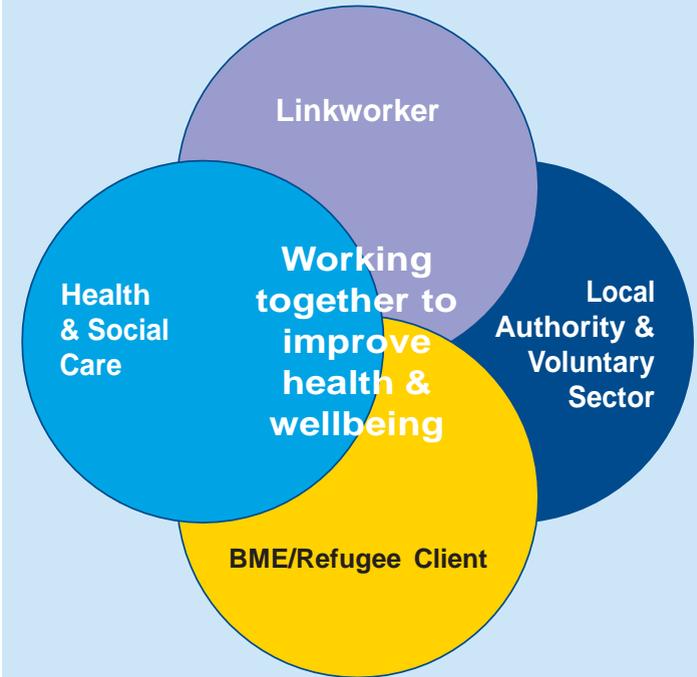
W
Willow
WorkingRite
Working On Wheels

Y
Your Gym



MEHIS

MINORITY ETHNIC
HEALTH INCLUSION SERVICE



MEHIS aims to improve the health and wellbeing of BME and refugee communities across Lothian

August 2014

Minority Ethnic Health Inclusion Service

Craigmillar Health Centre

106 Niddrie Mains Road
Edinburgh EH16 4DT
General Office Telephone Number
0131 536 9544
MEHIS@nhslothian.scot.nhs.uk

Service Manager

0131 536 9581

Bangladeshi Linkworker

0131 536 9543
07771 504 802

Chinese Linkworker

0131 536 9547
07771 504 668

Pakistani/Indian Linkworker

0131 536 9542
07825 681 884

Other Linkworkers

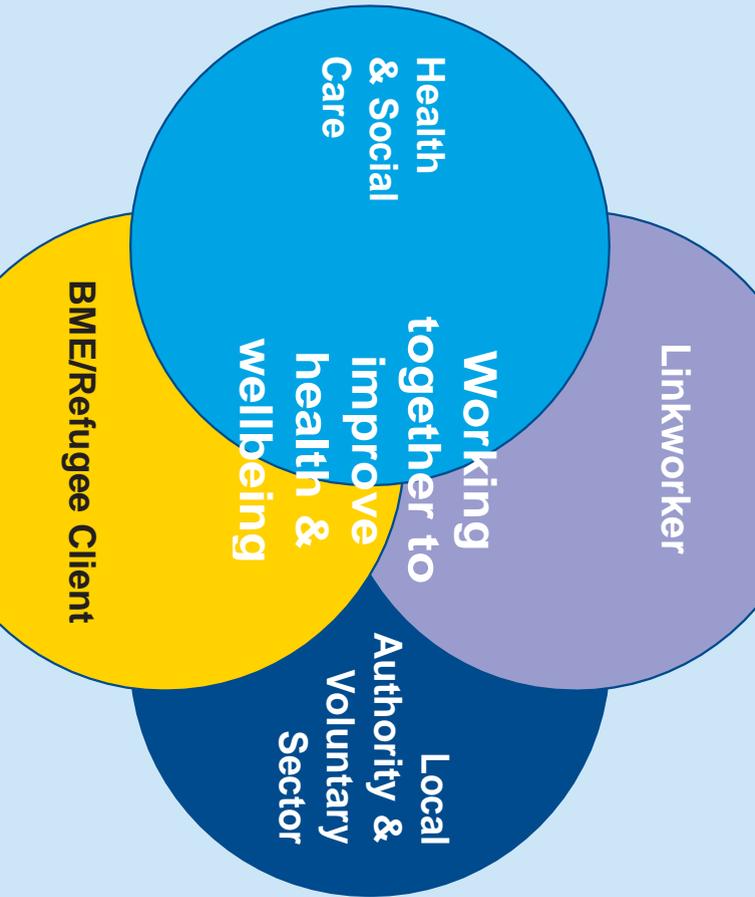
0131 536 9548
07824 606 520

Support Worker

0131 536 9546
07825 273 967



Freepost plus RTJX-CLCZ-JSXH
MEHIS
Craigmillar Health Centre
106 Niddrie Mains Road
Edinburgh
EH16 4DT



BME/Refugee Client

Health & Social Care

Working together to improve health & wellbeing

Linkworker

Local Authority & Voluntary Sector

What can MEHIS do for me?

Advice and Information

MEHIS can

- Provide information and advice on health and other services
- Search out information resources in your own language or assist you to understand information from English language resources

Multi-lingual Linkworker/ Advocacy service

MEHIS can

- Help you to access health and other services including those you can self refer to
- Explain NHS services and link you with appropriate agencies
- Enable you to talk to health professionals or speak on your behalf
- Ensure your cultural and personal concerns are taken into account
- Ensure that you have the information you require to enable you to make informed decisions about your healthcare
- Put you in touch with other support services in your local area or ethnic or faith community

MEHIS services are free and confidential

- MEHIS works with all minority ethnic communities across Lothian
- Have minority ethnic staff who can speak various languages

- Support you to access services to improve your lifestyle and life circumstances
- Support you if you have any concerns or complaints about NHS services.

How will MEHIS do this?

MEHIS Linkworkers will:

- Meet with you to discuss your concerns
- If necessary, accompany you to your health or other appointments
- Link you with the interpretation service, if you require only language support (MEHIS is not an interpretation service)

How can I contact MEHIS?

You, a family member or friend can contact MEHIS on any of the numbers listed at the back of this leaflet.

What can MEHIS do for Community Groups?

The NHS is committed to improving the health of communities. MEHIS will work in partnership with health and other professionals, faith and community groups to:

- Ensure that minority ethnic groups are able to voice their views regarding NHS services
- Enable equality of access to primary care services, which take account of their cultural and faith needs
- Plan and support the delivery of health promotion programmes to minority ethnic groups
- Facilitate Health Screening

Suggestions

We continually try to improve our service and welcome your views. Please complete this form and post it to MEHIS or speak to the MEHIS manager on 0131 536 9581.

How would you rate MEHIS services?

- Excellent 😊 😊
- Good 😊
- Satisfactory 😐
- Poor ☹️

What was good?

What was not good?

How would you like to see MEHIS's service improve?

Thank you

Once completed, please tear off the form, moisten the gummed edges, fold to seal, and post to the FREEPOST address of the reverse side.