Equality Outcomes

2013–2017
Foreword

Creating a fairer society is fundamental to improving the health of the whole population and tackling inequalities in health. Healthcare Improvement Scotland is fully committed to developing a culture that supports equality and diversity in all we do to bring about this fairer society. Our equality outcomes will ensure that we deliver on this commitment in selected areas of our work that we believe will have the most impact or make the biggest difference to people’s life chances as we endeavour to meet our equality duties.

Our equality outcomes will be published on our website and we will continue to seek feedback from people to help shape and influence how we achieve them. By working together, we are confident we can deliver meaningful outcomes that will enable us to influence positive experiences for our staff and for patients who benefit from our work.

Progress in achieving our equality outcomes will be monitored and evaluated, taking account of relevant evidence and data. Where appropriate, our equality outcomes will be refreshed to ensure continuing relevance and proportionality.

As Chair and Interim Chief Executive, we are determined to provide leadership and support to achieve our outcomes by creating a working environment in which everyone feels respected and valued and through which our work to improve healthcare will make a marked contribution to the advancement of equality.

Dr Denise Coia  
Chair  
Healthcare Improvement Scotland

John Glennie  
Interim Chief Executive  
Healthcare Improvement Scotland
1 Introduction

Healthcare Improvement Scotland is a national health body. Our organisation has the key responsibility to support NHS Scotland and independent healthcare providers to deliver high quality, evidence-based, safe, effective and person-centred care, and to scrutinise services to provide public assurance about the quality and safety of that care.

The equality outcomes we have developed are underpinned by these organisational objectives and will ensure that we concentrate effort on areas that will influence our policies and activities and which will have a positive impact on people with protected characteristics.

We have considered relevant evidence of existing gaps in service provision to the people with protected characteristics of: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Healthcare Improvement Scotland has relatively limited direct interface with patients and works primarily to support NHS boards and independent healthcare providers to deliver improved healthcare services. Our equality outcomes are evidence based and are particularly relevant to age and disability, as these are the areas where we are able to make most impact.

We recognise that inequalities are rarely experienced in isolation and cannot be restricted solely to one equality group, as they are often closely linked. This being the case, we hope the implementation of our outcomes will bring positive benefits to other protected characteristic groups not specifically targeted.

2 Background

Context

Before public bodies were legally required to develop and publish equality outcomes, our equality agenda was driven by our Single Equality Scheme. In the scheme, we identified ways of ensuring equality is embedded in all our work by recognising the:

- role of senior leadership and its accountability in implementing the actions
- importance of building capacity among staff
- need to mainstream the agenda through existing organisational planning tools, and
- legal obligation in the reporting of good practice in staff issues.

Our equality outcomes supersede our former Single Equality Scheme, but the underlying principle of advancing equality for people with protected characteristics remains the same as does our approach outlined above.
Gathering of evidence

In developing our outcomes, we have consulted with relevant protected characteristics groups as a way of gathering evidence on which to base our outcomes. We have:

- used existing internal documented evidence that came from consultations and involvement we have had with various equality groups during the development of our Single Equality Scheme and the Participation Standard
- used desk top research evidence gathered from our equality impact assessment reports, annual equality monitoring report, annual exit interviews report
- involved our Disability Advisory Group (a group of disabled people we set up 2 years ago to contribute to our decision-making processes)
- attended a working group with representatives from the Scottish Delirium Association, the Clinical Lead for Dementia at the Scottish Government and Alzheimer Nurse Consultants and briefed them on expected input from them and agreed on the way forward, and
- involved staff groups and senior managers through workshops and project analysis meetings.

We have used the information gathered to influence and shape shared aims that will make policy development processes more inclusive. The evidence has also helped us to prioritise the equality outcomes that will make the biggest difference in tackling inequality in our work.

Leadership involvement

To ensure robustness of consultation and evidence gathering and a timely setting of the equality outcomes, progress updates were regularly provided to our Equality and Diversity Action Group, Partnership Forum, Scottish Health Council Committee, Staff Governance Committee and Executive Team. This has been helpful in ensuring high level ownership and awareness of the equality agenda in the organisation.

3 Our equality outcomes

Equality outcomes are results which an organisation seeks to achieve to further one or more of the needs of the general equality duty, such as eliminate discrimination, advance equality of opportunity and foster good relations to achieve specific and identifiable improvements in people’s life chances. These may include short term benefits such as changes in awareness, knowledge, skills and attitudes and longer term benefits such as changes in behaviours, decision-making, social and environmental conditions.

To develop our equality outcomes, we followed the process and approach outlined in *Equality outcomes and the public sector equality duty: A guide for public authorities (Scotland)* published by the Equality and Human Rights Commission Scotland. As a result, we identified four equality outcomes that will influence positive outcomes for staff and health service users.

Our equality outcomes were informed by our Strategic Plan 2011-2014 and Local Delivery Plan 2013-2014 objectives. These outcomes also reflect the 2020 Vision and the three
ambitions of safe, effective and person-centred care in the NHSScotland Healthcare Quality Strategy in addition to an outcome for our workforce issues.

Equality outcome 1: Equality in older people services

Eliminate ageist attitudes of staff that sometimes underpin the diagnosis and treatment of older people with delirium in acute care undermining their dignity, autonomy and respect.

Delirium is a mental disorder characterised by disturbance of consciousness, change in cognition and perception with reduced ability to focus or shift attention that develops over a short period of time (usually hours or days) and tends to fluctuate during the course of the day. Delirium can have serious consequences (such as increased risk of dementia and/or death) and may increase the length of stay of people already in hospital and their risk of new admission to long-term care. (NICE Guideline, 2012). Delirium is not always identified or managed appropriately and as such, has been identified as an area for improvement within the Improving Care for Older People workstream. The programme will look at services to older people specifically of age 75 and above. When developing improvement strategies for delirium, it has to be recognised that equality of care for older people lies in ensuring that respect, dignity, autonomy and fairness is maintained in the management of healthcare services provided.

In this regard, there is evidence that delirium can be at times undermined by inherent ageism in either the attitudes of care givers or often the systems through which care is given.

There is an assumption that confusion is part of ageing. This assumption can lead to mismanagement of the disorder and cause discrimination in the ways services are provided. Healthcare Improvement Scotland will work with and support hospital teams in Scotland to identify, promote and connect good practice and demonstrate improvement in the identification and management of delirium through the development and testing of delirium care bundles. We will recommend and support strategies to address any discrimination arising from age and/or disability associated with delirium and make necessary interventions at the outset to eliminate it and ensure that dignity, respect and fairness underpin the service being provided.

Equality outcome 2: Equality in mental health services programme

Minimise harm resulting from restraint of people with mental health issues in particular equality groups such as women, men, adolescents, older people and ethnic minorities.

Restraint is a restrictive intervention used to restrict the movement or behaviour of a person. This could be by physical (for example manual, handcuffs, harnesses, straps), chemical (for example sedative medication) or emotional means (for example fear of expressing views, coercion, threats). The key factor that differentiates restraint from other forms of care or medical treatment is intent. It is used when there is inability to provide appropriate mental health care. In some circumstances, restraint is used in situations of non-compliance with prescribed medication, when a patient is unwell and on treatment. In this case, the restraint is not always an emergency situation; it may be a planned intervention. Whilst incidences of restraint can be due to failings in care provision, there is
also a need to take into account demographic factors, co morbid alcohol drug use and abuse and illegal highs that contribute towards violent and aggressive incidents requiring restraint.

Although restraint is generally accepted as an appropriate management strategy by staff in emergency and violent situations, there is evidence it can contribute to negative health outcomes. There are also key equality principles that need to be considered when applying this method.

- Service users and staff should be treated with dignity and respect, their rights and responsibilities being central to promoting safety. Ultimately, strategies to eliminate restraint should be developed, implemented and evaluated with the involvement of staff, service users and carers considering service users’ views, wishes and feelings so far as they are reasonable, and following those wishes wherever practicable. In the interim, a high quality evidence-based theory of recognition and de-escalation of incidents, incident debrief framework and critically monitored use and justification for restraint should be put in place.

- Staff require specialist skills and alternative options to interact respectfully and in a dignified manner with users and carers.

Healthcare Improvement Scotland will work with and support staff to minimise harm resulting from restraint.

Equality outcome 3: Bullying, harassment and victimisation

Our workforce is treated fairly and with dignity and can work freely without fear of bullying, harassment or victimisation.

Bullying is offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient while harassment is unwanted conduct affecting the dignity of men and women in the workplace.

Bullying and harassment in a small organisation like Healthcare Improvement Scotland is characterised with under-reporting through formal Human Resources structures. The reasons for this could include fear of breach of confidentiality or victimisation. However, an anonymous 2011-2012 Staff Survey report showed:

- 13% of the respondents experienced emotional or verbal abuse (by members of the public, service users/patients and other colleagues), and
- 13% of the respondents experienced bullying or harassment (of this number over 50% reported this coming from their manager/team leader or other colleagues, and 4% reported there had been more than 10 incidents of this).

This is an area we can influence positive outcomes that will enhance dignity, respect and good relations among our staff.
Equality outcome 4: Engagement of younger people in our work

Increased engagement with young people of the age 16-30.

The under-30s are currently an under-represented group in Healthcare Improvement Scotland’s pool of public partners. To address this, we originally explored a range of techniques to improve our recruitment to the role of public partner for people in this age group. However, the time commitment, length of service and timings, and locations and types of engagement opportunities are also perceived to be deterring younger people from being involved in our work.

Outside of the public partner role, additional types of engagement are ongoing across the organisation in terms of working with young people. We will review our recording processes for engagement activity to ensure that young people who are participating in our work are recognised as part of our wider efforts. We will explore additional ways to engage with younger people that are compatible with their competing commitments and offer alternative mechanisms to input their views, including social media, meeting outwith office hours and supporting any additional training needs.

Evidence from literature searches and digests collated on behalf of Healthcare Improvement Scotland indicate that traditional methods of engagement employed in both health and social care environments are unsuccessful in securing meaningful engagement of young people. It is suggested that organisations survey and discuss with younger people their preferred means of engagement and adapt to these. Involvement of younger people in the discussions about increasing their engagement must therefore be the first step towards improving our approach.

Limitations

Equality outcomes 3 and 4 above relate to our staff and those engaged in our work on a voluntary basis and are within our direct control. In contrast, equality outcomes 1 and 2 are not solely within our direct control and can only be achieved through working with other NHS boards. Success in delivering these equality outcomes will therefore depend on effective collaboration with these NHS boards for the benefit of people who receive relevant healthcare services.

Monitoring these outcomes will also partly depend on the commitment and support of the NHS boards and other partner bodies we will work with on these projects, making measurement of these outcomes challenging.
### Appendix 1: Action plan

**Equality outcome 1: Equality in older people services**

Eliminate ageist attitudes of staff that sometimes underpin the diagnosis and treatment of older people with delirium in acute care undermining their dignity, autonomy and respect.

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<td>There are issues with early identification of delirium and its care co-ordination and care pathway planning which can be partly because of the assumption that confusion is part of ageing, an assumption which can lead to mismanagement of the disorder. In cases, it can be mistaken for dementia which may lead to inappropriate medication prolonging hospital stay or lead to death. There is a requirement to improve service provision and management options in order to achieve best possible health outcomes for older people with delirium and those with additional needs such as physical, sensory and/or learning disabilities. NICE clinical guideline 103 – Delirium, indicates a need for culturally appropriate services implying a likelihood of differential elimination of discrimination; advancing equality of opportunities for: age, disability</td>
<td>Identify and involve a wide range of stakeholders in the development of the work programme for delirium. Identify and involve a wide range of stakeholders in the development and testing of a care bundle for the immediate management of delirium. This will support healthcare providers to understand how people from diverse backgrounds and cultures may understand and respond to a diagnosis of delirium. Ensure that information provided meets the</td>
<td>Ongoing</td>
<td>Interviews with patients, families and carers to understand their experience of delirium. Focus group with staff to understand mental health service providers’ experience of delirium, identify challenges and opportunities for improvement. Development and testing of a care bundle, as an improvement tool, to respond to the needs and situation of the older person and their</td>
<td>Michelle Miller</td>
<td>Michelle Miller</td>
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<td>service provision to people who do not read or speak English.</td>
<td>cultural and language needs of the person.</td>
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<td>family/carer. Provide equality training session on cultural diversity, dignity, respect and autonomy for focus groups and staff responsible for designing of the care bundle.</td>
<td>Jeniffer Kibagendi</td>
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### Equality outcome 2: Equality in mental health services programme

Minimise harm resulting from restraint of people with mental health issues in particular equality groups such as women, men, adolescents, older people and ethnic minorities.

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<td>Restraint as a method of restricting movement and behaviour has been associated with high levels of stress and psychological harm among users of mental health services. Evidence shows that the user’s dignity, respect and autonomy as basic human rights are not recognised when this procedure is applied. There is need for a human rights-based approach strategy to reduce harm caused to already vulnerable patients and those that witness restraint incidents. Although from England, a cross-sectional study of 1,361 service users and 1,226 staff in acute care mental health services, using the Attitudes to Containment Measures Questionnaire, found gender and age differences in how coercive measures were viewed:</td>
<td>Encourage and support an increase in consumer participation in the review of restraint practices, policies and process. Support awareness sessions for staff to increased awareness of the effects of the effects of restraint. Support provision of training to skill staff with alternative approaches to restraint and increased review of restraint.</td>
<td>End of programme 2013</td>
<td>Reduction of restraint episodes. Training of staff cultural awareness and human rights in relation to restraint. Increased level of involvement with service users and carers in producing an appropriate care plan. Provide support in understanding of change management processes to managers of mental health services.</td>
<td>Selina Stephen Jeniffer Kibagendi Selina Stephen</td>
<td>Elimination of discrimination; advancing equality of opportunities and fostering good relations regarding to: age, disability</td>
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### What the evidence tells us

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| • male service users' approval ratings were higher than females, and  
  • male staff approval ratings were higher compared to female.  
  There was a correlation between age and manual restraint with older service users expressing greater approval for these methods.  
  Younger service users were more likely than older service users to have been subjected to physical restraint.  
  *(Approval ratings of inpatient coercive interventions in a National Sample of Mental health Service Users and Staff in England. Whittington et al. 2009)* | | | | |
Equality outcome 3: Bullying, harassment and victimisation

Our workforce is treated fairly and with dignity and that it work freely without fear of bullying, harassment or victimisation.

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<td>Bullying and harassment is a reality in our workplace, although it is not captured through the existing HR structures. This is an issue that may stem in discriminatory attitudes and undermines dignity and respect of staff and can impact negatively on performance. The fact that this comes out through the Staff Survey report indicates a need to investigate the reasons for staff’s election to withhold the information from HR and reveal it through an anonymous mechanism. Considering the size of our workforce, 13% bullying and harassment is high and this is an area we can work on to reduce incidents of bullying and harassment, with an aim of eliminating them entirely through our zero tolerance policy.</td>
<td>Through regular equality and diversity training, ensure all staff are aware of organisational policy and culture around bullying and harassment, and the reporting procedure. Explain the need for full compliance with Equality Act 2010. Raise awareness of workplace equality policies, such as Dignity at Work and Equal Opportunities Policies and ensure that these are followed consistently. Any issues or concerns raised are handled in full accordance with established policies and procedures, with full consideration of the establishment of dedicated</td>
<td>Ongoing</td>
<td>100% attendance at equality and diversity training for all new employees. Evaluation of training impact with a focused question on bullying and harassment. Attendance at awareness raising sessions. Evaluation of sessions, specifically around increased confidence in our reporting and escalation processes. Establishment, use and evaluation of contact persons’ process. Establishment, use and review of confidential log process.</td>
<td>Jeniffer Kibagendi, Anthony McGowan</td>
<td>Elimination of discrimination and advancement of equal opportunities and fostering good relations</td>
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<td>contact persons, and a single confidential log to record staff concerns and seek staff feedback on alternative approaches. Identify, monitor and address any trends relating to the established protected characteristics.</td>
<td>August / September 2013</td>
<td>Analysis of potential trends and live issues from qualitative and quantitative data, including external data and staff-reported data. Two-yearly staff survey, Communications survey, the temperature check and the exit interview feedback are all examples of where further staff feedback will be gained and measures of success identified, including the percentage of staff reporting incidences of bullying and harassment.</td>
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### Equality outcome 4: Engagement of younger people in our work

Increased engagement with young people of the age 16-30.

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<td>The pool of people we involve in our work on a voluntary basis is currently populated from the age range 30-74. There is a gap in involvement of young people below 30 years of age within the formal public partner role. The organisation must demonstrate that robust mechanisms are in place to ensure that people from the 16-30 age group are engaged in its work. We can address this issue as we seek to involve more people in our work.</td>
<td>Review and report on the existing evidence base for supporting public engagement with under 30s, supplementing this report with the organisation’s own experiences and learning. Develop an action plan for the organisation based on findings from the above. Strengthen our relationships with young persons’ organisations. Increase our capacity to reach young people online. Ensure that new engagement methodology being introduced by the organisation is accessible to over-16s and monitor the population groups</td>
<td>May to September 2013</td>
<td>Produce a summary report of findings. Publish an action plan. Hold a minimum of two meetings or small events in 2013-2014. Develop and test procedures for engaging with people online by end March 2014. Increase staff confidence in using these methods 2014-2015.</td>
<td>Rosemary Hampson</td>
<td>Elimination of discrimination and advancement of equal opportunities and fostering good relations and addressing age differential in engagement: <strong>age</strong></td>
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<td>There is published research that will help us improve engagement in our work, using existing mechanisms and suggested new ways of working. This will inform our approach to extending our engagement with the under-30s.</td>
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1 Volunteers Equality Monitoring Report, 2012

2 Involving Young People Literature Search and Digest, 2013
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<td>using it.</td>
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<td>Analyse the protected characteristics of people involved in public engagement methods to assess whether this approach increases our overall levels of engagement with younger people (review annually, 2014-2017).</td>
<td>Rosemary Hampson</td>
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