

## Full equalities impact assessment

Directorate: **Provider Services** Service: **Community Nursing Service**

Piece of work being assessed: **Community Nursing Service, includes Evening & Night Nursing**

Aims of this piece of work: **To deliver holistic and pro-active quality assured nursing care within the local communities in Sheffield, 24 hours a day.**

Name of lead persons: **Janine Thornton  
Rebekah Matthews  
Sharon Fitzpatrick** Other partners/stakeholders involved: **Rebekah Matthews  
Helen Chapman  
Sharon Fitzpatrick  
Pat Whitaker  
Chris Pinder-Packard  
Paul Matthews**

Date of assessment: **17 October 2008**

Who is intended to benefit from this piece of work? **Service Users and Staff**

Single Equality Scheme strand	Baseline data and research on the population that this piece of work will affect	Is there likely to be a differential impact?
	What is available? What does it show? Are there any gaps? Use both quantitative and qualitative research and user data Include consultation with users if available	If 'yes', is that impact direct or indirect discrimination?

<p><b>Gender</b></p>	<p>Service is equally open to males and females and although gender is recorded on assessment documentation it is not collated electronically as IT systems are in place at present, it is envisaged that in the near future all community nursing teams will be using TPP, which will be able to generate reports. Gender mix of the total population of Sheffield- 51% female, 49% male. Over 75 aged group population of Sheffield- 65% female, 35% male.</p> <p>Gender of staff- 93% female and 7% male. Nationally gender mix in the caring profession is 90% female and 10% male.</p> <p>Although the gender mix of staff does not match the gender mix of patients, patients are offered choice.</p> <table border="1" data-bbox="450 683 1666 1174"> <thead> <tr> <th colspan="7">2007 Mid-Year Estimates Sheffield Council</th> </tr> <tr> <th></th> <th>Persons</th> <th>Males</th> <th>Females</th> <th></th> <th></th> <th>Persons</th> </tr> <tr> <th>All Residents</th> <th>Count</th> <th>%</th> <th>Count</th> <th>%</th> <th>All Residents</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Total Population</td> <td>530,300</td> <td>100.00%</td> <td>264,000</td> <td>100.00%</td> <td>Total Population</td> <td>530,300</td> </tr> <tr> <td>0 to 4</td> <td>29700</td> <td>5.60%</td> <td>15200</td> <td>5.80%</td> <td>0 to 4</td> <td>29700</td> </tr> <tr> <td>5 to 14</td> <td>57200</td> <td>10.80%</td> <td>29600</td> <td>11.20%</td> <td>5 to 14</td> <td>57200</td> </tr> <tr> <td>15 to 24</td> <td>91500</td> <td>17.30%</td> <td>47600</td> <td>18.10%</td> <td>15 to 24</td> <td>91500</td> </tr> <tr> <td>25 to 34</td> <td>71800</td> <td>13.50%</td> <td>37900</td> <td>14.40%</td> <td>25 to 34</td> <td>71800</td> </tr> <tr> <td>35 to 44</td> <td>76000</td> <td>14.40%</td> <td>38200</td> <td>14.50%</td> <td>35 to 44</td> <td>76000</td> </tr> <tr> <td>45 to 54</td> <td>63900</td> <td>12%</td> <td>31900</td> <td>12.10%</td> <td>45 to 54</td> <td>63900</td> </tr> <tr> <td>55 to 64</td> <td>56700</td> <td>10.60%</td> <td>28000</td> <td>10.70%</td> <td>55 to 64</td> <td>56700</td> </tr> <tr> <td>65 to 74</td> <td>42900</td> <td>8.10%</td> <td>20300</td> <td>7.70%</td> <td>65 to 74</td> <td>42900</td> </tr> <tr> <td>75 to 84</td> <td>28800</td> <td>5.40%</td> <td>12000</td> <td>4.50%</td> <td>75 to 84</td> <td>28800</td> </tr> <tr> <td>85 to 89</td> <td>7900</td> <td>1.50%</td> <td>2600</td> <td>1%</td> <td>85 to 89</td> <td>7900</td> </tr> </tbody> </table>	2007 Mid-Year Estimates Sheffield Council								Persons	Males	Females			Persons	All Residents	Count	%	Count	%	All Residents	Count	Total Population	530,300	100.00%	264,000	100.00%	Total Population	530,300	0 to 4	29700	5.60%	15200	5.80%	0 to 4	29700	5 to 14	57200	10.80%	29600	11.20%	5 to 14	57200	15 to 24	91500	17.30%	47600	18.10%	15 to 24	91500	25 to 34	71800	13.50%	37900	14.40%	25 to 34	71800	35 to 44	76000	14.40%	38200	14.50%	35 to 44	76000	45 to 54	63900	12%	31900	12.10%	45 to 54	63900	55 to 64	56700	10.60%	28000	10.70%	55 to 64	56700	65 to 74	42900	8.10%	20300	7.70%	65 to 74	42900	75 to 84	28800	5.40%	12000	4.50%	75 to 84	28800	85 to 89	7900	1.50%	2600	1%	85 to 89	7900	<p>Y - Potential indirect discrimination as gender mix of staff does not match gender mix of patients and in proportion to the population of Sheffield.</p>
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<p><b>Race</b></p>	<p>Documentation records ethnic origin. Currently this is not entered onto a database so statistics are not readily available as evidence. Patients are not excluded due to race and interpreters are arranged as required. (Need SCAIS interpreter us data here)</p> <p>Ethnic origin of staff – 96% white and 4% from BME groups. Total population of Sheffield 89% white and 11% from BME groups, based on 2001 Census information. Sheffield City Council 2005 figures suggest that the number of Pakistani Asians is 3%, Polish and Slovak 2%, whilst other ethnic categories account for less than 1% each of</p>	<p>Y-Potential, indirect, but unknown at present due to lack of data</p>																																																																																																		

	<p>the general population with the total ethnic minority population being about 14%.</p> <p>2007 Mid-Year Estimates, as rapid change in Sheffield demographics over past 5 years.</p> <p>The following demographic data is available for Sheffield:</p> <ul style="list-style-type: none"> <li>White British 86%</li> <li>White Irish 1%</li> <li>White Other (mainly Polish and Slovak) 2%</li> <li>Mixed - White/Black Caribbean 1%</li> <li>Mixed - White/Black African &lt;1%</li> <li>Mixed - White/Asian &lt;1%</li> <li>Mixed - White/Other &lt;1%</li> <li>Asian – Indian 1%</li> <li>Asian – Pakistani 3%</li> <li>Asian – Bangladeshi &lt;1%</li> <li>Asian – Other 1%</li> <li>Black – Caribbean 1%</li> <li>Black – African 1%</li> <li>Black- Other &lt;1%</li> <li>Chinese 1%</li> <li>Other 1%</li> </ul> <p>The risk linked to age for developing Type 2 Diabetes is the over 40's for the white population. However, for those from Afro-Caribbean and Asian back grounds the age risk is identified as being the over 25's</p> <p>It is well documented that the Afro-Caribbean population are 3 times more likely to develop Type 2 diabetes as their white counterparts and this risk increases to 6 times for the Asian population.</p>	
<p><b>Disability</b></p>	<p>We offer a supportive and inclusive service for people who have a disability as the service is provided in the patient's own home. Need statistical data, include all types</p>	<p>Y - as no data to assess otherwise.</p>

	<p>of disabilities and mental health. 2001 Census indicates 21% of UK population have a 'long standing illness'</p> <p>Disability is sub-divided as follows:  Sensory impairment  Physical disabilities  Mental health  Learning difficulties</p>																																																																																																			
<p><b>Sexual orientation</b></p>	<p>Service is available to all irrespective of sexual orientation; this is not currently formally recorded.  Sexual orientation of staff is not currently recorded.  There is no evidence of patients being refused care due to their sexual orientation.  No Sheffield Census information collected in 2001.</p>	<p>Y-Potential, but unknown at present due to lack of data</p>																																																																																																		
<p><b>Age</b></p>	<p>The service is available to all residents of Sheffield regardless of age. (all ages can access this service).  DOB of patients is recorded but there are no current statistics of age of staff as not entered onto a database for statistical purposes.</p> <table border="1" data-bbox="450 1018 1664 1505"> <thead> <tr> <th colspan="7">2007 Mid-Year Estimates Sheffield Council</th> </tr> <tr> <th></th> <th colspan="2">Persons</th> <th colspan="2">Males</th> <th colspan="2">Females</th> </tr> <tr> <th>All Residents</th> <th>Count</th> <th>%</th> <th>Count</th> <th>%</th> <th>All Residents</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Total Population</td> <td>530,300</td> <td>100.00%</td> <td>264,000</td> <td>100.00%</td> <td>Total Population</td> <td>530,300</td> </tr> <tr> <td>0 to 4</td> <td>29700</td> <td>5.60%</td> <td>15200</td> <td>5.80%</td> <td>0 to 4</td> <td>29700</td> </tr> <tr> <td>5 to 14</td> <td>57200</td> <td>10.80%</td> <td>29600</td> <td>11.20%</td> <td>5 to 14</td> <td>57200</td> </tr> <tr> <td>15 to 24</td> <td>91500</td> <td>17.30%</td> <td>47600</td> <td>18.10%</td> <td>15 to 24</td> <td>91500</td> </tr> <tr> <td>25 to 34</td> <td>71800</td> <td>13.50%</td> <td>37900</td> <td>14.40%</td> <td>25 to 34</td> <td>71800</td> </tr> <tr> <td>35 to 44</td> <td>76000</td> <td>14.40%</td> <td>38200</td> <td>14.50%</td> <td>35 to 44</td> <td>76000</td> </tr> <tr> <td>45 to 54</td> <td>63900</td> <td>12%</td> <td>31900</td> <td>12.10%</td> <td>45 to 54</td> <td>63900</td> </tr> <tr> <td>55 to 64</td> <td>56700</td> <td>10.60%</td> <td>28000</td> <td>10.70%</td> <td>55 to 64</td> <td>56700</td> </tr> <tr> <td>65 to 74</td> <td>42900</td> <td>8.10%</td> <td>20300</td> <td>7.70%</td> <td>65 to 74</td> <td>42900</td> </tr> <tr> <td>75 to 84</td> <td>28800</td> <td>5.40%</td> <td>12000</td> <td>4.50%</td> <td>75 to 84</td> <td>28800</td> </tr> <tr> <td>85 to 89</td> <td>7900</td> <td>1.50%</td> <td>2600</td> <td>1%</td> <td>85 to 89</td> <td>7900</td> </tr> </tbody> </table>	2007 Mid-Year Estimates Sheffield Council								Persons		Males		Females		All Residents	Count	%	Count	%	All Residents	Count	Total Population	530,300	100.00%	264,000	100.00%	Total Population	530,300	0 to 4	29700	5.60%	15200	5.80%	0 to 4	29700	5 to 14	57200	10.80%	29600	11.20%	5 to 14	57200	15 to 24	91500	17.30%	47600	18.10%	15 to 24	91500	25 to 34	71800	13.50%	37900	14.40%	25 to 34	71800	35 to 44	76000	14.40%	38200	14.50%	35 to 44	76000	45 to 54	63900	12%	31900	12.10%	45 to 54	63900	55 to 64	56700	10.60%	28000	10.70%	55 to 64	56700	65 to 74	42900	8.10%	20300	7.70%	65 to 74	42900	75 to 84	28800	5.40%	12000	4.50%	75 to 84	28800	85 to 89	7900	1.50%	2600	1%	85 to 89	7900	<p>Y - as no data to assess otherwise.</p>
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<p><b>Religion/belief</b></p>	<p>The service aims to offer an unbiased and religiously &amp; culturally appropriate service and is available to all patient's of Sheffield. Religion is recorded on the referral documentation, but is not statistically collated. This needs to be manually collated &amp; analysed.</p> <p>There is no evidence of patients being refused or refusing care due to religion or belief.</p> <p>Pakistani Muslims are twice as likely to develop Type 2 Diabetes than Indian Hindus. So, there is an underlying genetic tendency towards Diabetes in the Asian population. The risk seems to increase, dependant on dietary and cultural factors. Furthermore, Black and Minority Ethnic groups are suspected of being at greater risk of the development of Metabolic Syndrome, which is identified as a precursor to the development of Diabetes.</p> <p>Census data not collected. Workforce data not available Service user data not available.</p>	<p>Potential, but unknown at present due to lack of data analysis.</p>
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## Equalities Impact Assessment Action Plan

Strand	Issue	Action required	How will you measure the impact/outcome?	Timescale	Lead
<p><b>Gender</b></p>	<p>Currently this data is collected at referral and not entered electronically, therefore difficult but need to measure data manually. (Planned records audit in May 2009)</p> <p>Ensure are all services are provided at accessible venues</p>	<p>^ For community nursing to be on TPP. gender to be entered onto TPP to allow collation of statistics and future reporting. Data needs to be analysed manually if not available on TPP</p> <p>^ Amendment to assessment and referral documentation to</p>	<p>^ Data is manual collected, entered onto TPP &amp; analysed for EIA purposes.</p> <p>* Analyse data and address any issues raised.</p> <p>* Identified need to recruit more Male staff (if found to</p>	<p>May 2009 For 3 months</p>	<p>Janine Thornton &amp; Rebekah Matthews &amp; Sharon Fitzpatrick</p>

	<p>and times for parents/carers.</p> <p>^ TPP IT system needs to alert staff if a same gender nurse is required.</p> <p>Ensure staff are aware of gender and transgender issues, commission appropriate training if needed.</p>	<p>cover this.</p> <p>Ensure new monitoring tool is implemented &amp; staff are aware</p> <p>Ensure data is collected &amp; recorded onto TPP. Data needs to be collected manually if not available on TPP</p> <p>^ Data to be inputted in time for records Audit (May 2009)</p> <p>Data needs to be collected manually if not available on TPP Data to be inputted in time for records Audit (May 2009)</p> <p>Analyse results.</p> <p>Consider advertising service to more potential male patients/referral services to identify access to service needs.</p>	<p>be required).</p> <p>* Monitored&amp; measured need to gender match male patients.</p> <p>* Considered advertisement of service to attract more male patients/referral into service. (if necessary)</p> <p>* Planned adjustments made as a result of data.</p> <p>Staff training identified with Training department in Gender issues and parent/carer needs and sensitivity, as and where appropriate in role.</p> <p>* Established requirements from appropriate communities/patients (2-way consultation).</p>		
<b>Race</b>	<p>Currently this data is collected at referral and not entered electronically, therefore difficult but need to measure data manually. (Planned records audit in May 2009)</p>	<p>^ For community nursing to be on TPP. Race to be entered onto TPP to allow collation of statistics and future reporting.</p> <p>Data needs to be collected</p>	<p>^ Data is manual collected, entered onto TPP &amp; analysed for EIA purposes.</p> <p>* Analyse data and address any issues raised.</p>	<p>May 2009</p> <p>To commence when TPP can</p>	<p>Janine Thornton &amp; Rebekah Matthews &amp;</p>

	<p>^ TPP IT system needs to alert staff as to if an interpreter needs to be booked, and of language, dialect and gender required.</p> <p>Data to be sourced on interpreter &amp; languages to be sourced from SCAIS/other providers (past 12 months).</p>	<p>manually if not available on TPP Data to be inputted in time for records Audit (May 2009)</p> <p>^ Ensure data is collected &amp; recorded of patients first language &amp; dialect (if not English) to enable two way communication to be interpreted/translated as necessary.</p> <p>Data on interpreter &amp; languages to be sourced from SCAIS/other providers (past 12 months). TPP</p> <p>Anticipate data findings to demonstrate and under representation of service uptake by BME patients.</p>	<p>Anticipated under representation of settled and new BME communities as service users, establish BME community consultation to make service more culturally and religiously sensitive.</p> <p>Appropriate publicly is designed, translated and interpreted (where appropriate) and distributed to BME communities citywide using a community development model of approach.</p> <p>Staff training identified with Training department cultural and religious sensitivity, as and where appropriate in role.</p> <p>Anticipated recruitment of BME staff, with appropriate skills and cultural &amp; religious intelligence, if under represented.</p> <p>First page of patient records show language &amp;</p>	<p>produce reports</p>	<p>Sharon Fitzpatrick</p>
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			<p>dialect of patient is interpreter/translation required.</p> <p>* Established requirements from appropriate communities/patients (2-way consultation).</p>		
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<p><b>Disability</b></p>	<p>Not currently recorded at referral to the service. Need to collect &amp; record data electronically.</p> <p>Establish if data is collected manually or on the TPP system.</p> <p>^ Ensure data is collected &amp; recorded of format/type of communication appropriate to patient to enable effective 2-way communication (induction loop, braille, audio tape/cd/dvd or large print, font, makaton/rebus).</p> <p>Ensure all services are provided in physically accessible venues (for staff and patients) wheelchair users, use of crutches, etc.</p> <p>Consider all disabilities and mental health in access needs external and internal building requirements. The community nursing service only delivers care into peoples own home, so access is not an issue for patients.</p>	<p>^ Amendment to assessment and referral documentation to cover this.</p> <p>Ensure new monitoring tool is implemented &amp; staff are aware</p> <p>Ensure data is collected &amp; recorded onto TPP. Data needs to be collected manually if not available on TPP</p> <p>^ Data to be inputted in time for records Audit (May 2009)</p> <p>Analyse results.</p> <p>Consult and source advice from Estates Service and E&amp;D lead as to ensure accessibility of each service building (to staff and patients).</p>	<p>^ Data is manual collected, entered onto TPP &amp; analysed for EIA purposes.</p> <p>* Analyse data and address any issues raised.</p> <p>* Plan adjustments as a result of data.</p> <p>Anticipated an under representation of Patients who have a Learning Disability, mental health needs or other needs.</p> <p>Appropriate publicly is designed, translated and interpreted (where appropriate) and distributed to appropriate communities citywide using a community development model of approach.</p> <p>First page of patient TPP records show language &amp; type of format required to communicate effectively with patient (Braille, Signer, Makaton, rebus, advocate etc) and if interpreter/translation</p>	<p>Within the next 6 months May 2009</p>	<p>Janine Thornton &amp; Rebekah Matthews &amp; Sharon Fitzpatrick</p>
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	<p>Are carers young carers needs and Learning disability advocates needs identified?</p>		<p>required.</p> <p>Staff training identified with Training department in disability &amp; mental health sensitivity and awareness, as and where appropriate in role.</p> <p>* Building access needs are identified and actioned where immediate need is required and identified in the next EIA update.</p> <p>* Established requirements from appropriate communities/patients ( 2-way consultation).</p>		
<p><b>Sexual orientation</b></p>	<p>Not currently recorded at referral to the service. Need to collect &amp; record data electronically.</p>	<p>^ Amendment to assessment and referral documentation to cover this. Ensure new monitoring tool is implemented &amp; staff are aware</p> <p>^ Ensure data is collected &amp;</p>	<p>^ Data collection has begun and entered onto TPP database system &amp; analysed for EIA purposes.</p> <p>* Analyse data and address any issues raised.</p>	<p>Within the next 6 months May 2009</p>	<p>Janine Thornton &amp; Rebekah Matthews &amp; Sharon</p>

		<p>recorded onto TPP.</p> <p>Data needs to be collected manually if not available on TPP Data to be inputted in time for records Audit (May 2009)</p> <p>Analyse results.</p>	<p>* Plan adjustments as a result of data.</p> <p>Staff training identified with Training department in sensitivity to different sexualities, as and where appropriate in role.</p> <p>* Established requirements from appropriate communities/patients ( 2-way consultation).</p>		Fitzpatrick
<b>Age</b>	<p>Not currently recorded at referral to the service, although DOB is collected and therefore difficult to collect manually but needed to measure data.</p> <p>Need to collect &amp; record data electronically.</p> <p>Ensure staff ages are recorded and analysed and representation is reflective of patients.</p>	<p>^ Amendment to assessment documentation to cover this. Ensure new monitoring tool is implemented &amp; staff are aware.</p> <p>Ensure data is collected &amp; recorded. Data needs to be collected manually if not available on TPP</p> <p>^Data to be inputted in time for records Audit (May 2009)</p> <p>^ Amendment to referral documentation to cover this/TPP.</p>	<p>^ Data is manual collected, entered onto TPP &amp; analysed for EIA purposes.</p> <p>* Analyse data and address any issues raised.</p> <p>*Planned adjustments as a result of findings.</p> <p>* Established requirements from appropriate communities/patients (2-way consultation).</p>	<p>Within the next 6 months May 2009</p>	<p>Janine Thornton &amp; Rebekah Matthews &amp; Sharon Fitzpatrick</p>

<p><b>Religion</b></p>	<p>Currently this data is collected at referral and not entered electronically, therefore difficult to collect manually but needed to measure data.</p> <p>Need to collect &amp; record data electronically.</p> <p>Ensure data is collected &amp; recorded of religion/belief and if practising of patient to enable the service to be religiously sensitive, (if appropriate) dietary requirements to be catered for, dignity and respect is shown to patients, appointment times do not interfere with religious obligations (days &amp; times).</p> <p>Ensure staff are aware of religious festivals (link on intranet) and obligations', training is provided where necessary.</p> <p>Consult &amp; consider if you need to provide a prayer space/reflection room for staff or patients.</p>	<p>^ For community nursing to be on TPP religion to be entered onto TPP to allow collation of statistics and future reporting.</p> <p>Information to be sought from PALS &amp; Complaints teams where service has been refused due to religious insensitivity.</p> <p>Ensure new monitoring tool is implemented &amp; staff are aware. Further work is undertaken to establish need within Different faiths and how this affects staff and the service to enable us to be more responsive and match need.</p> <p>Further work is undertaken to establish need within Different faiths and how this affects staff and the service to enable us to be more responsive and match need.</p> <p>Services are not "western style" /Eurocentric and adapt to the needs and requirements of the patient.</p> <p>Nursing staff are trained to be more aware of different faiths</p>	<p>^ Data is manual collected, entered onto TPP &amp; analysed for EIA purposes.</p> <p>* Analyse data and address any issues raised.</p> <p>*Address according to findings to ensure service respects religious requirements.</p> <p>Staff training identified with Training department in cultural and religious sensitivity, as and where appropriate in role.</p> <p>* Sought E&amp;D advice on different faiths from Diversity lead and other sources.</p> <p>Action plan to ensure service and staff are not operating on a holistic non-western style service.</p> <p>* Established requirements from appropriate communities/patients (2-way consultation).</p>	<p>To commence when community nursing on TPP Within the next 6 months May 2009</p>	<p>Janine Thornton &amp; Rebekah Matthews &amp; Sharon Fitzpatrick</p>
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		<p>and beliefs and how to treat patients in their own home or advice on palliative care and or ensure palliative care is able to meet the needs of diverse patients.</p> <p>Establish if service publicity needs to be marketed to include a higher uptake of the cross section of the population.</p> <p>Staff are aware of the necessity to book interpreters, how to work with interpreters and how interpreters can guide staff on cultural and religious norms for patient/family.</p>			
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ALSO: Ensure all staff appraisals are measured against KSF Equality and Diversity. Ensure KSF level to be increased, if level is basic.

Are services meeting the needs of people in deprived areas of Sheffield, is public transport/affordable access an issue?

BME – Black and Minority Ethnic.

TPP-The Phyniox Project (computer system).

\* Planned follow up EIA in 12-18 months from publishing, to update with data needs.

^ Anticipate new Monitoring tool to be launched to staff and patients, (by commissioning servicers) with staff training and an IT system that compliments the new data entry and supports the analysis of data.

Completed feb 09