

Full equalities impact assessment

Directorate: PROVIDER Service: DOMICILIARY PHYSIOTHERAPY

Piece of work being assessed: Service and function

Aims of this piece of work: Promote health and wellbeing of adults in Sheffield by 1) Providing Physiotherapy Assessment and Intervention for people who are unable to access treatment outside of their home environment and 2) Providing Rehabilitation Group exercise programmes, in partnership with Public Health, for Chronic Disease and other Key Groups based on NICE/ NSF evidence e.g. Pulmonary Rehabilitation.

Name of lead person: Mandy Higginbottom Other partners/stakeholders involved: Provider Community Services for Older People
Public Health Nurses
Activity Sheffield West PCT Secondary Care
Neighbourhoods and Community Care
Primary Care
Healthy Living Centres
Sheffield International Venues

Date of assessment: 7th January 2009

Who is intended to benefit from this piece of work? The people of Sheffield and patients in the service

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	If 'yes', is that impact direct

¹ Patel J.V.,Lim H.S.,Gunarathne A.,Tracey I.,Durrington P.N.,Hughes E.A.,Lip G.Y.H. (Mar 2008) **Ethnic differences in myocardial infarction in patients with hypertension: Effects of diabetes mellitus** QJM, vol./is. 101/3(231-236), 1460-2725;1460-2393

	Include consultation with users if available	or indirect discrimination?
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Gender	<p>The Domiciliary Service in the period 1/10/08 – 31/12/08 was referred 363 patients 121 of these were Male and 242 Female.</p> <p>The Cardiac Rehabilitation Service had 142 male and 38 female referrals. The main patient group referred to Cardiac Rehabilitation is those who have had a Heart Attack. In this group the prevalence is at least 3 x greater in men than women.</p> <p>The Pulmonary Rehabilitation Service had 45 male and 69 female referrals. The medical prevalence would not account for more female attendees as a greater proportion of males are diagnosed with COPD. The greater proportion of female to males in the population of Sheffield may account for more female referrals.</p> <p>The service does receive requests infrequently from patients to gender match their physiotherapist due to cultural reasons. We try to respond to these requests if at all possible with staffing levels and treatment interventions required. We do not routinely ask patients if they would wish a gender matched physiotherapist.</p> <p>There is currently no data on the Transgender of patients.</p> <p>Demographical data.</p>	<p>Yes, indirect as patients generally referred are older people see Age section and there is a higher proportion of Females to Males in older age groups in population.</p>																																										
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="7" style="text-align: left; padding: 2px;">2007 Mid-Year Estimates</th> </tr> <tr> <th colspan="7" style="text-align: left; padding: 2px;">Sheffield Council</th> </tr> <tr> <th style="width: 15%;"></th> <th style="width: 15%;">Persons</th> <th style="width: 15%;">Males</th> <th style="width: 15%;">Females</th> <th style="width: 15%;"></th> <th style="width: 15%;"></th> <th style="width: 15%;">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 style="text-align: center;">530,300</td> <td style="text-align: center;">100.00%</td> <td style="text-align: center;">264,000</td> <td style="text-align: center;">100.00%</td> <td>Total Population</td> <td style="text-align: center;">530,300</td> </tr> <tr> <td>0 to 4</td> <td style="text-align: center;">29700</td> <td style="text-align: center;">5.60%</td> <td style="text-align: center;">15200</td> <td style="text-align: center;">5.80%</td> <td>0 to 4</td> <td style="text-align: center;">29700</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
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	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										
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	55 to 89 population split = 46% males, 54% females																
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	Sheffield Population 55 to 89																
	The Domiciliary Service has 28.39 WTE staff of which 5.44 WTE (20%) are Male staff. The percentage of male staff in the service is the same as the number of males registered with the Health Professions Council as a percentage of the total Physiotherapists registered.																
Race	The Domiciliary service does not currently collect data on race of patients referred.																
	The Cardiac Rehabilitation Service does collect and for the period stated had: 174 White British 5 Pakistani 1 White Asian 2 White any other background 1 Asian any other background							Yes, indirect as low uptake of offer of Cardiac rehabilitation from these racial groups following Heart Attack.									

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	<p>Indian, Bangladeshi, and Pakistani people born on the Indian subcontinent (henceforth called South Asian) but living in England and Wales have a 40-50% higher mortality from coronary heart disease than the population average¹</p> <p>The Pulmonary Rehabilitation Service collects data on race: 33 White British 5 British declared (no other sub category) 1 Pakistani 75 not declared</p> <p>Demographical data. 2007 Mid-Year Estimates, Sheffield Council data as rapid change in Sheffield demographics over past 5 years.</p> <p>The following demographic data is available for Sheffield: White British 86% White Irish 1% White Other (mainly Polish and Slovak) 2% Mixed - White/Black Caribbean 1% Mixed - White/Black African <1% Mixed - White/Asian <1% Mixed - White/Other <1% Asian – Indian 1% Asian – Pakistani 3% Asian – Bangladeshi <1% Asian – Other 1% Black – Caribbean 1%</p>	
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	<p>Black – African 1% Black- Other <1% Chinese 1% Other 1%</p> <p>The Domiciliary Staff racial background is 32 people White British, 1 Pakistani and 1 Mixed White and Black Caribbean.</p>	
<p>Disability</p>	<p>All adults accessing the service will have a physical condition but we do not currently define patients under the sub divisions of Disability. Many patients have co-morbidities coping with long-term conditions as well as physical, mental and sensory impairments</p> <p>2001 Census indicates 21% of UK population have a ‘long standing illness’</p> <p>Need 2007 Mid-Year Estimates, Sheffield Council data as rapid change in Sheffield demographics over past 5 years.</p> <p>The Service does not currently record this data from patients at present, but will address to define; Disability is sub-divided as follows: Sensory impairment Physical disabilities Mental health Learning difficulties</p> <p>Those who have developed disabilities as a result of the complications of Cardio-Vascular Diseases, are known to be in the high risk group for developing Diabetes – this being a risk factor and a complication.</p>	<p>YES – as disability and mental health is undefined, cannot establish if any prevalence is missing and to target better uptake.</p>

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	<p>Additionally, those who have developed disabilities as a result of the long term complications of their Diabetes, may suffer from not only physical (including sensory), but also cognitive problems – due to identified links with certain types of dementia e.g. Vascular Dementia.</p> <p>Severe disability including aphasia, dysphasia and paralysis may result due to complications of Diabetes.</p> <p>There is an increasingly aging population residing in Learning Disability environments. This group of people often have complex medical health problems which are not always adequately met.</p> <p>No Staff have declared any form of disability or Mental Health..</p>	
<p>Sexual orientation</p>	<p>Patients using the service may be heterosexual, lesbian, gay and bisexual. The service strives to treat all patients with dignity and respect.</p> <p>There is literature which suggests that the homosexual older population is ‘invisible’, and that there is little consultation on a general level, with residents regarding sexuality. (Ward R, <i>et al</i> 2005, Knocker S, 2006, Sale, Anabel, Unity 2002).</p> <p>Only 2 members of staff have detailed their sexual orientation as Heterosexual all others undefined. Staff data (sexuality) is not currently collected systematically.</p>	<p>Yes – sexuality of patients unknown.</p>
<p>Age</p>	<p>During the period 1/10/08 and 31/12/08 363 people were referred to the Domiciliary Service. Of these 6% were less than 55 years old, 28% between 56-75 years old and 66% over 76. The largest number (44%) were between 76-85 years.</p> <p>The Cardiac Rehabilitation Service referrals were 26% less than 55 years old, 55%</p>	<p>No.</p>

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between 56-75 years and 29% over 76 years. The largest group was 66-75 years (31%).

The Pulmonary Rehabilitation Service referrals were 4% less than 55 years old, 66% between 56-75 years and 30% over 76 years with the largest group 66-75 years (34%).

All services are available to all adults from age 16 with no older age limit.

The 2001 Census figures report Sheffield's population as 522,400 with 2,9232 in the preschool population

The following census data is available for Sheffield:

2007 Mid-Year Estimates Sheffield Council						
	Persons	Males	Females		Persons	
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	<p>people (age groups?) are known to present predominantly with Type 2 Diabetes and are in the high risk group for developing the disease.</p> <p>Staff age range as detailed</p> <table style="margin-left: 20px;"> <tr><td><35</td><td>5</td></tr> <tr><td>36-45</td><td>18</td></tr> <tr><td>46-55</td><td>8</td></tr> <tr><td>56-65</td><td>3</td></tr> <tr><td>>65</td><td>0</td></tr> </table>	<35	5	36-45	18	46-55	8	56-65	3	>65	0	
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Religion/belief	<p>No recording of this data in any service area. Only 1 staff member out of 28.39 WTE has declared a religion – Christianity.</p>	<p>Yes – data not collected, and as low uptake of BME patients, highly likely to be a low uptake of different faiths/beliefs also.</p>										

Equalities Impact Assessment Action Plan

Strand	Issue	Action required	How will you measure the impact/outcome?	Timescale	Lead
Gender	<p>Ensure staff are aware of gender and transgender issues, commission appropriate training if needed.</p> <p>Service needs to identify gender matching needs due</p>	<p>Ensure new monitoring tool is implemented & staff are aware.</p> <p>Identify training needs of staff and work with Training team & diversity lead to design specific training.</p>	<p>Monitor & measure need to gender match male patients.</p> <p>* Plan adjustments as a result of data, with advice and guidance of diversity lead.</p>	<p>April 2010</p> <p>14 months</p>	<p>Mandy Higginbottom</p>

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	to various reasons, including religious reasons, cultural or personal choice. Staff gender information required.	^ set up TPP IT system needs to alert staff if a same gender nurse is required.	Anticipate staff awareness raising or training in Gender issues and parent/carer needs and sensitivity, as and where appropriate in role. * Establish requirements from appropriate communities/patients (2-way consultation).		
Race	The Service should address the higher prevalence of CHD in Asian population Work more closely with BME CHD public Health facilitator.	<ul style="list-style-type: none"> • Complete telephone audit of reasons for none attendance (possible interpreter needed) • Work with referrers in hospital on information given to people from different racial backgrounds • Productively engage with BME communities 	Monitor uptake from people from South Asian populations to the Cardiac Rehabilitation service and map against population data Ensure service changes are in place and implemented to requirements of different Nationalities. * Analyse data and	April 2010 14 months	JR/AMc Helen Scurrrell HB SB

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	<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 & languages to be sourced from SCAIS/other providers (past 12 months).</p>	<p>to determine ways to improve access.</p> <ul style="list-style-type: none"> • Seek guidance from Diversity lead to ensure service is accessible and culturally appropriate. <p>^ Ensure data is collected & recorded of patients first language & dialect (if not English) to enable two way communication to be interpreted/translated as necessary.</p> <p>Data on interpreter & languages to be sourced from SCAIS/LL (past 12 months). TPP</p> <p>Anticipate data findings to demonstrate and under representation of service uptake by BME patients.</p> <p>Anticipate a need for staff training in cultural and religious</p>	<p>address any issues raised.</p> <p>Anticipate 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>Ensure appropriate publicly is designed, translated and interpreted (where appropriate) and distributed to BME communities citywide using a community development model of approach.</p> <p>First page of patient records show language & dialect of patient is interpreter/translation required.</p> <p>* Establish requirements</p>		
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		<p>training in cultural and religious sensitivity, as and where appropriate in role.</p> <p>Anticipate recruitment of BME staff, with appropriate skills and cultural & religious intelligence, if under represented.</p>	<p>from appropriate communities/patients (2-way consultation).</p>		
<p>Race & Disability (LANGUAGE)</p>	<p>All information booklets only produced in English</p> <p>Patients may not be able to speak or read or fully understand English and language barriers can prevent their full participation and access to service(s).</p>	<ul style="list-style-type: none"> • Use Health Library resources available to source information in other languages • Use of Physio Tools to produce diagrammatic information • Seek guidance of Diversity Lead for further guidance. • Ensure patient is fully aware of visit and purpose of visit, using telephone interpreting on initiation and <u>interpreter is needed at</u> 	<p>Information booklets produced in Different formats, visual and in different languages. Guidance from Equality & Diversity Lead to make use of information from other sources, to be translated.</p> <p>Booklets distributed to appropriate patients/communities for full effectiveness.</p> <p>Recognise client needs</p>	<p>April 2010</p> <p>14 months</p>	<p>MH</p>

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	Data to be sourced on interpreter & languages to be sourced from SCAIS/other providers (past 12 months).	<p>interpreter is needed, at visit.</p> <ul style="list-style-type: none"> Identify Budget for interpreters with Service Head & commissioners. 	<p>and implement.</p> <p>Monitor use of interpreters.</p> <p>Ensure language and dialect is recorded on Referral form and computer systems.</p> <p>Identify further needs, if arise.</p>		
Disability	<p>Identify different disabilities and mental health needs of patients.</p> <p>^ Ensure data is collected & 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</p>	<p>Ensure new data monitoring tool is implemented & staff are aware</p> <p>Ensure data is collected & recorded onto TPP. Data needs to be collected manually if not available on TPP</p> <p>Analyse results. Ensure communication methods are implemented, with guidance form the Diversity Lead.</p> <p>Consult and source advice from Estates Service and Diversity Lead as to ensure</p>	<p>* Analyse data and address any issues raised.</p> <p>* Plan adjustments as a result of data.</p> <p>Anticipate and under representation of Patients who have a Learning Disability, mental health needs or other needs who may need assistance to gain better access to referral of service.</p> <p>Ensure appropriate publicly is designed,</p>	April 2010 14 months	MH

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	users, use of crutches, etc. Ensure staff understand need to declare disabilities and sensitivity of data confidentiality.	accessibility of each service building (to staff and patients).	translated and interpreted (where appropriate) and distributed to appropriate communities citywide using a community development model of approach.		
Sexual Orientation	Reluctance of staff to record this information.	<ul style="list-style-type: none"> • Report back to Education and training department @ PCT • To seek support/ training for staff to feel confident in requesting the info • PCT to produce data collection form to be used by staff 	<p>Provision of Induction /staff training within the PCT to include being mindful of lesbian, gay, heterosexual and bisexual staff and users.</p> <p>Staff training in sensitivity to different sexualities, as and where appropriate in role.</p> <p>* Establish requirements from appropriate communities/patients (2-way consultation).</p>		MH HB SB
Religion/ Belief	Raising staff awareness of cultural norms and impact on services provided	Staff training to include personal and religious beliefs and preferences in relation to	<ul style="list-style-type: none"> • Seek support from PCT Training Department/ 	May 2010	AH SB MH

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	<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 & record data electronically.</p> <p>Ensure data is collected & 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 & times).</p> <p>Ensure staff are aware of religious festivals (link on intranet) and obligations', training is provided where necessary.</p>	<p>choice of appointments times, taking into consideration cultural calendars, choice of practitioner, use of interpreters from within same communities, expected behavioural norms while in peoples homes.</p> <ul style="list-style-type: none"> • Staff to ensure they request info on a person's religion or belief • Each work base to have access to Directory produced by PCT <p>^ For Dom. Physio. to be on TPP and religion to be entered onto TPP to allow collation of statistics and future reporting.</p> <p>Information to be sought from PALS & Complaints teams where service has been refused due to religious insensitivity.</p> <p>Ensure new monitoring tool is</p>	<p>Diversity Manager</p> <ul style="list-style-type: none"> • Audit of information recorded by staff on the computer data base <p>^ Data is manual collected, entered onto TPP & 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>To register as Audit topic with PCT 09/10</p>	<p>MH</p> <p>SB HB</p>
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	<p>Consult & consider if you need to provide a prayer space/reflection room or a prayer pack for staff at work or for patients attending groups sessions..</p>	<p>implemented & 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>Dom.Physio staff are trained to be more aware of different faiths and beliefs and how to treat patients in their own service? needs and or ensure service is able to meet the needs of diverse patients.</p>	<p>Identify staff training in cultural and religious sensitivity, as and where appropriate in role.</p> <p>Seek E&D advice on different faiths from Diversity Led and other sources.</p> <p>Work to ensure service and staff are operating on a holistic non-western style service.</p> <p>* Establish requirements from appropriate communities/patients (2-way consultation).</p>		
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ALL	<ul style="list-style-type: none"> • Referral forms are not fully completed resulting in lack of information for Physiotherapist to ensure discrimination does not occur. • New monitoring data collection tool is used. • Service not on TPP • Ensure all staff are aware of importance of data collection. • Identify staff training needs in this issue. 	<ul style="list-style-type: none"> • Process required for return of referral forms if not completed • New data monitoring tool is used and implemented. • Service to move onto TPP • Staff are informed and if appropriate trained on use of data collection as part of service delivery. 	<p>Feedback from staff group/team of full compliance on data collection.</p> <p>New data monitoring tool in full operational use.</p> <p>TPP System now addresses all areas of data collection.</p> <p>Staff training identified, designed and delivered.</p>	April 2010 14 months	DK/MH
ALL	The service needs to be responsive to the diversity of the population of Sheffield. Data systems not currently recording all 6 domains.	<ul style="list-style-type: none"> • New database with fields for collection of information • PCT to produce data collection form to be used by staff 	<ul style="list-style-type: none"> • Monitoring of referrals viewed with census population/ local information/ community profiles • Map research findings to local need and uptake of 	April 2010	MH/DK SB

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			the service		
ALL	Access to group rehabilitation dependant on ability to pay for transport or have own transport	<ul style="list-style-type: none"> • PCT strategy for transport to community services • Business case presented to a provider (ME). • Review of Community Venues against criteria for access 	Access issues to be fully identified and work with Diversity Lead to source 100% attendance.	April 2010 14 months	Jeremy Wright Liz Reid Permjeet Dhoot GA SB MH/JR/AMc
ALL	All staff appraisals are measured against KSF Equality and Diversity. To ensure full awareness and implementation of Equality and Diversity in role and service is fully addressed.	Ensure all staff appraisals are measured against KSF Equality and Diversity. Ensure KSF level to be increased, if level is basic. (Seek guidance from Training lead, Human Resources Lead and Diversity Lead).	All staff E&D KSF's are reviewed and revised accordingly.	March 2010	MH AH SB CS

HB Commissioning Diversity Lead
 SB Sajida Bashir Provider Services Diversity Lead
 MH Mandy Higginbottom Clinical Manager Physiotherapy Services
 AH Alison Hayles Head of Education and Training
 JR Julie Rees Physiotherapy Team Leader
 GA Gill Agar Clinical Specialist Physiotherapist
 AMc Angela McKinnon Public Health Lead Nurse Rehabilitation Programmes

¹ Patel J.V.,Lim H.S.,Gunarathne A.,Tracey I.,Durrington P.N.,Hughes E.A.,Lip G.Y.H. (Mar 2008) **Ethnic differences in myocardial infarction in patients with hypertension: Effects of diabetes mellitus** QJM, vol./is. 101/3(231-236), 1460-2725;1460-2393

DK Denise Kehoe Business Support Administrator Physiotherapy Services

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.

¹ Patel J.V.,Lim H.S.,Gunarathne A.,Tracey I.,Durrington P.N.,Hughes E.A.,Lip G.Y.H. (Mar 2008) **Ethnic differences in myocardial infarction in patients with hypertension: Effects of diabetes mellitus** QJM, vol./is. 101/3(231-236), 1460-2725;1460-2393