

Full equalities impact assessment

Directorate: **Provider Service** Service: **Early Discharge Team.**

Piece of work being assessed: **Early Discharge team**

Aims of this piece of work: **The Early Discharge Team provide a service to ensure a safe discharge from hospital, with the appropriate service in place to support and care for individual patients needs.**

Name of lead person: **Janet Laylor** Other partners/stakeholders involved: **EDT nurses therapy staff. Multi-disciplinary team.**

Date of assessment: **17/12/08, revised June 2009**

Who is intended to benefit from this piece of work? **EDT, Patients and service users.**

Single Equality Scheme strand	Baseline data and research on the population that this piece of work will affect 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	Is there likely to be a differential impact? Yes or no

<p>Gender</p>	<p>EDT provides a service to both male and females equally.</p> <p>Three months data September to November 2008: Service was accessed by; 488 females and 342 males.</p> <p>2001 Annual Sheffield statistical data: Female 262664. Male 250630.</p> <p>Sheffield General population split = 50% males, 50% females 55 to 89 population split = 46% males, 54% females</p> <table border="1" data-bbox="465 683 848 790"> <thead> <tr> <th></th> <th>Male</th> <th>Female</th> </tr> </thead> <tbody> <tr> <td>55 to 89</td> <td>62900</td> <td>73500</td> </tr> <tr> <td></td> <td>46%</td> <td>54%</td> </tr> </tbody> </table> <p>Workforce data, number of nurses working in EDT? Gender? 1 band 7 team leader female 5 band 6 nurses female 2 therapy staff female 1 social worker female 1 male physiotherapist on 6 month rotation.</p>		Male	Female	55 to 89	62900	73500		46%	54%	<p>Yes – Slight under representation of Male patients via early discharge team, Possible through population mix, needs investigating further.</p> <p>Yes – No evidence of Gender identity and transgender patients accessing services.</p>
	Male	Female									
55 to 89	62900	73500									
	46%	54%									
<p>Race</p>	<p>Service is available to all irrespective of all different ethnic minority communities. Although Race is not formally recorded via EDT. System one will be adapted to enable the service to capture this information.</p> <p>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 the general population with the total ethnic minority population being about 14%. Patients are not excluded due to race and interpreters are arranged as required. Statistics of interpreter use over past 12 months & languages accessed. Ethnic origin of staff is 100% White British.</p>	<p>Yes – no data. Anticipate under representation of BME patients being approached by Early discharge Team.</p>									

2007 Mid-Year Estimates, Sheffield Council data as rapid change in Sheffield demographics over past 5 years.

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%
- Black – African 1%
- Black- Other <1%
- Chinese 1%
- Other 1%

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 (National Screening Commission).

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 (World Health Organisation).

Evidence obtained from care home staff attending the Diabetes training, delivered by the POPPS team shows that the risk factors for non-white people is not well known.

Furthermore, older people from ethnic minority groups are under represented in the care home population, even in homes known to be situated in areas of the City of

	<p>Sheffield which have well established culturally diverse communities. This raises a question about what level of monitoring older people from Black and Ethnic Minority groups are receiving within the community and whether they are being actively targeted as they are clearly in the high risk group.</p> <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>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</p> <p>Workforce data, number of nurses working in EDT? Race? Data on interpreters accessed via EDT services is needed. Anecdotally, no interpreters are used.</p>	
<p>Disability</p>	<p>EDT provide a service to all patients with disabilities, but currently don't collate this information. System one will be adapted to enable EDT service to capture this information</p> <p>2001 Census indicates 21% of UK population have a 'long standing illness'</p> <p>Disability data is to be collected and sub-divided as follows: Sensory impairment Physical disabilities Mental health Learning difficulties</p> <p>Patients 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>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),</p>	<p>Yes – no data. Anticipate under representation of patients with various Disabilities and mental health needs being approached by Early discharge Team.</p>

	<p>but also cognitive problems – due to identified links with certain types of dementia e.g. Vascular Dementia. Severe disability including aphasia, dysphasia and paralysis may result due to complications of Diabetes.</p> <p>The Team is aware that 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, and this group of homes, in spite of the growth of their older residents currently fall outside the remit of this team.</p> <p>Workforce data, number of nurses working in EDT? Disabilities?</p>	
<p>Sexual orientation</p>	<p>EDT provides a service to all irrespective of sexual orientation, but currently don't collate this information. System one will be adapted to enable EDT to capture this information.</p> <p>Sheffield Census information collected in 2001. This information is not collected by the census but a figure of 5% of the population is one generally used by government. Stonewall puts this figure at 10% for Sheffield as cities historically attract more gay people and Sheffield is also seen as a gay friendly city.</p> <p>Workforce data not available. Service user data not available.</p> <p>There is literature which suggests that the homosexual older population in care homes 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). Interviews with care staff have revealed that they find sexual expression to be 'problematic' in the dementia care setting, which is often mediated by the perspectives and interests of the staff working in them Ward R <i>et al</i> 2005).</p>	<p>Yes – no data. Anticipate under representation of patients who are homosexual or bi-sexual being approached by Early discharge Team.</p>

	Anticipate similar experiences of Patients in Hospital.																																																																																																			
Age	<p>EDT provides a service to patients over the age of 65yrs of age. Recently the service is now extended to patients over the age of 18yrs.</p> <p>Sheffield EDT statically data 2001 identify patients: 65-69 22609. 70-74 20325. 80-84 12869. 85-89 7206. 90 over 3433.</p> <p>The 2001 Census figures report Sheffield's population as 522,400 with 2,9232 in the preschool population</p> <p>The following census data is available for Sheffield:</p> <table border="1" data-bbox="450 906 1666 1398"> <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>All Residents</th> <th>Persons</th> </tr> <tr> <th></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> <p>Workforce data, number of nurses working in EDT?</p>	2007 Mid-Year Estimates Sheffield Council								Persons	Males	Females		All Residents	Persons		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>Yes – date to be amended to collect for patients over 18, not just over 65.</p>
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	Staff age range between 26yrs to 52yrs.	
Religion/belief	<p>EDT provides a service to all irrespective of different faiths and beliefs, but currently don't collate this information. System one will be adapted to enable EDT to capture this information.</p> <p>Sheffield Census information collected in 2001.</p> <ul style="list-style-type: none"> Christian 68% None 18% Not stated 8% Muslim 5% Hindu 0.3% Buddhist 0.2% Other 0.2% Jewish 0.1% Sikh 0.1% <p>Workforce data not available.....</p> <p>Service user data not available.</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>	Yes – no data. Anticipate under representation of patients who are are non Christian Faiths being approached by Early discharge Team.
Human Rights	Will this piece of work impact on anyone's human rights?	Yes, positively.

Equalities Impact Assessment Action Plan

Strand	Issue	Action required	How will you measure the impact/outcome?	Timescale	Lead
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<p>All strands</p>	<p>E&D monitoring not currently on referral form.</p> <p>Current monitoring data is very poor and need urgent attention.</p>	<p>Training & to ensure referrals are amended and staff are equipped with the skills and knowledge of data monitoring from all patients.</p> <p>Staff to actively ask for data rather than not asking.</p> <p>Seek further advice and guidance from the Equality & Diversity Lead.</p>	<p>Data to be collected for next round of EIA update and for CEHR group on a regular basis.</p>	<p>6 months December 2009</p>	<p>Janet Laylor</p>
<p>Gender</p>	<p>EDT have identified insufficient male staff on team.</p> <p>Potential indirect discrimination as gender mix of staff does not match gender mix of patients.</p> <p>Ensure staff are aware of gender and transgender issues, commission appropriate training if needed.</p>	<p>Male staff from other teams (i.e. ward male staff) to request assistance as required. Explore other measures of positive action if needed, with E&D Lead.</p>	<p>Documented evidence where service declined if no male staff available. Increase number of Male staff within ED teams.</p> <p>Raised staff awareness/ training delivered in Gender issues and parent/carer needs and sensitivity, as and where appropriate in functions of role.</p> <p>* Established requirements from appropriate</p>	<p>6 months December 2009</p>	<p>Janet Laylor</p>

			communities/patients (2-way consultation). Incorporate in new EIA as revised.		
Language	<p>Approved interpreter service. Data not currently collated by Early discharge team. But the service is widely available to all ethnic groups</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 EDT service(s).</p> <p>Data to be sourced on interpreter & languages to be sourced from SCAIS/other providers (past 12 months).</p> <p>All information booklets only produced in English</p>	<p>Utilize approved Service interpreter service as appropriate.</p> <p>Redesign EDT audit forms to include ethnicity and race.</p> <p>Staff with language skills in Life threatening emergencies only not to be used in place of professional interpreters.</p> <p>Ensure patient is fully aware of visit and purpose of visit, using telephone interpreting on initiation and interpreter is needed, at visit.</p> <p>Identify Budget for interpreters with Service Head & commissioners.</p> <ul style="list-style-type: none"> • Use Health Library resources available to source 	<p>Recognise client needs 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> <p>Information booklets produced in Different formats, visual and in different languages.</p> <p>Booklets distributed to appropriate patients/communities for full effectiveness.</p> <p>Staff training and update regarding interpreter</p>	Initially September 2009 then review January 2010.	Janet Laylor

		<p>information in other languages</p> <ul style="list-style-type: none"> • Use of computer Tools to produce diagrammatic information • Seek guidance of Diversity Lead for further guidance. <p>Anticipate the need for staff training in cultural religious needs. Staff education and training regarding interpreter services.</p> <p>Availability of multi faith calendar and staff and education.</p> <p>Anticipate recruitment of black and ethnic minority staff to the team where under presentation exists.</p>	services.		
Race	Currently this data is not always available at referral stage and not entered electronically, therefore difficult but need to measure data manually.	^ For the EDT service to fully utilise TPP. Race to be entered onto TPP /or other system to allow collation of statistics and future reporting.	^ Data is manual collected & analysed. * Analyse data and address any issues raised.	Initially October 2009 then review January 2010.	Janet Laylor.

	<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 needs to be collected manually if not available on TPP Data to be inputted in time for records Audit (May 2009)</p> <p>^ Ensure data is collected & recorded of language & dialect of patient to enable communication to be interpreted (Verbal) or translated (written) as appropriate.</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>Identify staff training as in cultural and religious sensitivity, as and where appropriate in role.</p> <p>Identify recruitment of BME staff, with</p>	<p>^ First page of patient TPP records show language & dialect of patient is known and if interpreter/translation required.</p> <p>Action plan and implementation identified with diversity lead and work to be feedback to CEHR group regularly.</p> <p>* Established requirements from appropriate communities/patients (2-way consultation).</p>		
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	<p>2. Data to be sourced on interpreter & languages to be sourced from SCAIS/other providers (past 12 months).</p>	<p>appropriate skills and cultural & religious intelligence, if under represented.</p> <p>2. 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>2. Appropriate publicly is designed, translated and interpreted (where appropriate) and distributed to BME communities citywide using a community development model of approach.</p>		
Disability	<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 are all services are provided in physically accessible venues (for staff and patients) wheelchair users, use of</p>	<p>^ Amendment to assessment and referral documentation to cover this.</p> <p>Ensure new monitoring tool is implemented & staff are aware</p> <p>Ensure data is collected & recorded onto TPP.</p> <p>Data needs to be collected manually if not available on TPP</p> <p>^ Data to be inputted in time for records Audit</p>	<p>^ Data is manual collected, entered onto TPP & analysed for EIA purposes.</p> <p>* Analyse data and address any issues raised.</p> <p>*Planned adjustments as a result of data.</p> <p>First page of patient TPP records show language & type of format required to communicate effectively with patient (Braille,</p>	Initially October 2009 then review January 2010.	Janet Laylor.

	<p>crutches, etc.</p> <p>Consider all disabilities and mental health in access needs external and internal building requirements. Some service access is via home visits.</p> <p>Needs of Adults with Learning Disabilities are historically under represented in most sectors of Health services, Address the needs of people with Learning disabilities, through themselves, their carers and their advocates.</p> <p>As well as Disabilities, identify ill Mental health needs from patients and staff who this may affect.</p>	<p>(May 2009)</p> <p>Analyse results.</p> <p>Anticipate and under representation of Patients who have a Learning Disability, mental health needs or other needs.</p> <p>Ensure appropriate publicly is designed, translated and interpreted (where appropriate) and distributed to appropriate communities citywide using a community development model of approach.</p> <p>Consult and source advice from Estates Service and E&D lead as to ensure accessibility of each service building (to staff and patients).</p>	<p>Signer, Makaton, rebus, advocate etc) and if interpreter/translation required.</p> <p>Staff training needs identified in disability & mental Health sensitivity, as and where appropriate in role.</p> <p>* Building access needs are identified and implemented where immediate need is required and identified in the next EIA update.</p> <p>* Established requirements from appropriate communities/patients (2-way consultation).</p>		
Sexual orientation.	No current monitoring of the sexual orientation of the predominantly elderly EDT patients	^ Amended assessment and referral documentation to cover this.	Monitoring process acceptable to patient group in place	Initially October 2009 then review January 2010.	Janet Laylor.

	<p>Not currently recorded for patients at referral to the service.</p> <p>. Need to collect & record data electronically.</p> <p>Staff Orientation needs to be recorded.</p>	<p>Ensure new monitoring tool is implemented & staff are aware</p> <p>^ Ensure data is collected & recorded onto TPP.</p> <p>Data needs to be collected manually if not available on TPP</p> <p>Analyse results and act on findings.</p> <p>Address staff training needs to understand issues.</p>	<p>^ Data collection has begun and entered onto TPP database system & analysed for EIA purposes.</p> <p>* Analyse data and address any issues raised.</p> <p>* Plan adjustments as a result of data.</p> <p>Anticipate 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>		
Religion and belief.	<p>Staff awareness raising on different Cultural festivals, food, culture, norms and celebrations etc, and how this affects the patients they work with and will be planning services for.</p>	<p>Identify different cultural festivals and celebrations.</p> <p>Staff training to be planned with E&D Lead.</p> <p>Re design EDT audit forms to ensure individual recording of religion and belief.</p>	<p>Staff are able to begin to apply cultural and religious norms of different patients to the planning of services and delivery of service for all patients.</p> <p>Staff training is delivered.</p>	Initially October 2009 then review January 2010.	Janet Laylor.

		<p>Collate the required information from STH nurse admission documentation.</p> <p>Multi faith calendar to be accessed and used more regularly.</p>	<p>Availability of multi faith calendar.</p> <p>Address and improve access and awareness to different ethnic minority services available.</p>		
Religion data	<p>Currently no patient information is collected relating to religion.</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</p>	<p>Religion needs to be included in referral documentation/TPP. and new monitoring tool.</p> <p>Data to be inputted in time for records Audit (May 2009)</p> <p>Establish formal and informal complaints from patients refusing service due to lack of cultural and religious sensitivity.</p> <p>Information to be sought from PALS & Complaints teams where service has been refused due to religious insensitivity.</p> <p>Establish if service publicity needs to be</p>	<p>Address according to findings to ensure service is appropriate for different cultures and religions and accessible and taken up by a cross section of the population.</p> <p>* Analyse data and address any issues raised.</p> <p>*Plan adjustments as a result of 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>	Initially October 2009 then review January 2010.	Janet Laylor

	<p>where necessary.</p> <p>Consult & consider if you need to provide a prayer space/reflection room for staff or patients.</p>	<p>marketed to include a higher uptake of the cross section of the population.</p> <p>Ensure new monitoring tool is 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>Services are not “western style”/eurocentric and adapt to the needs and requirements of the patient.</p> <p>Clinical staff are trained to be more aware of different faiths 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>Staff are aware of the</p>	<p>Established requirements from appropriate communities/patients (2-way consultation)</p> <p>* E&D advice sought from diversity lead and other sources on different faiths.</p> <p>Established action plan to ensure service and staff are not operating on a holistic non-western style service.</p>		
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		necessity to book interpreters, how to work with interpreters and how interpreters can guide staff on cultural and religious norms for patients.			
ALL	Identify Training needs for staff to understand complex diversity needs more easily.	Language issues, working with interpreters, Race and cultural sensitivity, sexuality issues, Ensure staff are aware of religious festivals (link on intranet) and obligations', training is provided where necessary.	Training identified and developed with Education & training teams. Training delivered to all staff in team.	March 2010	Janet Laylor Alison Hales Sajida Bashir Chris Stocks
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	Janet Laylor Alison Hales Sajida Bashir Chris Stocks
Other Vulnerable Groups	Ensure service does not exclude the Homeless population, Traveller Communities and Asylum seeker/refugees	Provide an EDT service to all sections of the population. Work with E&D Lead to	Activity data from outreach clinics. Needs addressed, as and where required. Service	Initially December 2009 then review every 6 months.	Janet Laylor

	<p>for an out of Hospital discharge services.</p> <p>Ensure multi agency discharge arrangements have considered such needs.</p> <p>Access the Homeless population, Traveller Communities and Asylum seeker/refugees communities in Sheffield, directly or via advocate organisations to provide service for different community needs in and around of Sheffield.</p>	<p>find solutions.</p> <p>Seek information and guidance from Homeless organisations and other organisations in the City to establish needs within the SPCT.</p> <p>Seek other National good practice of working to support the Homeless population, Traveller Communities and Asylum seeker/refugees community for specific needs to be met through the EDT Service.</p> <p>Seek further advice and guidance from the Equality & Diversity Lead.</p>	<p>amendments set up as appropriate.</p> <p>E&D Lead is updated with progress and is satisfied the service accesses a range of needs in the communities mentioned.</p>		
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BME - Black and Minority Ethnic.

E&D - Equality & Diversity.

EDT – Early Discharge Team.

EIA - EQUALITY Impact Assessment.

SCAIS – Internal interpreting service.

TPP – The Phyniox Project (computer system)

The Phyniox Project (computer system)

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?

* 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.

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