

Full equalities impact assessment

Directorate: **Provider Services** Service: **Lymphoedema Service**

Piece of work being assessed: **Lymphoedema Service**

Aims of this piece of work: We exist to provide quality, appropriate, patient focused evidence based lymphoedema information, education and management to all patients who have a Sheffield-based General Practitioner and who are at risk of developing or have developed lymphoedema as a result of cancer, or it's treatments. The service also addresses the needs of patients with non-cancer related lymphoedema. It will also provide the appropriate information, quality education and training to all professionals who have contact with patients who are at risk of developing or have developed lymphoedema.

Name of lead person: **Paul Matthews** Other partners/stakeholders involved: **Lymphoedema Team**

Date of assessment: **16 October 2008**

Who is intended to benefit from this piece of work? **Service Users Accessing the Lymphoedema Service**

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? If 'yes', is that impact direct or indirect discrimination?

<p>Gender</p>	<p>Service is equally open to males and females, and gender is recorded on assessment documentation. 85% of patients are female and 15% male. This variation is explained given the relationship with Lymphoedema and breast cancer in females. All 3 staff are female.</p> <table border="1" data-bbox="450 424 1666 916"> <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>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	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>Potential indirect but difficult to assess given so few staff. No male staff.</p>
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<p>Race</p>	<p>Documentation records ethnic origin. Need this data to be collated & analysed manually if not onto a computer yet. Currently this is not entered onto a database so statistics are not readily available as evidence. 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>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:</p>	<p>Potential given only 3 staff in the service (but all white.)</p>																																																																																																		

	<p>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%</p>	
<p>Disability</p>	<p>The service offers a supportive and inclusive approach for people who have a disability. The Buildings where clinics are held all have disabled access. Service users who are unable to attend the clinic are offered a home visit. 2001 Census indicates 21% of UK population have a 'long standing illness'. Statistics of staff and service users with disabilities required.</p> <p>Disability is sub-divided as follows: Sensory impairment Physical disabilities Mental health Learning difficulties</p> <p>No data at present.</p>	<p>No</p>
<p>Sexual</p>	<p>Service is available to all irrespective of sexual orientation; this is not currently formally recorded. System One will be adapted to enable the service to capture this information.</p>	<p>Potential, but unknown at</p>

orientation	No Sheffield Census information collected in 2001.	present due to lack of data																																																																																																		
Age	<p>The service is available to all residents of Sheffield aged 18 and over although the service has cared for patients younger than 18 as appropriate. Data is recorded regarding the age of patients but it is not collated Age of staff- staff in the service are aged between 40 – 50.</p> <table border="1" data-bbox="450 499 1666 991"> <thead> <tr> <th colspan="7">2007 Mid-Year Estimates Sheffield Council</th> </tr> <tr> <th></th> <th colspan="2">Persons</th> <th colspan="2"></th> <th colspan="2">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				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	Potential, but unknown at present due to lack of data
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Religion/belief	<p>The service aims to offer unbiased and culturally appropriate service and is available to all patients of Sheffield. Religion is not currently recorded on the referral documentation. But changes to the documentation will be made to capture this.. There is currently no evidence of clients refusing the service on religious grounds.</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</p>	Potential, but unknown at present due to lack of data																																																																																																		

	Service user data not available.	
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Equalities Impact Assessment Action Plan

Strand	Issue	• Action required	How will you measure the impact/outcome?	Timescale	Lead
Gender	<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>Ensure are all services are provided at accessible venues and times for parents/carers.</p> <p>^ TPP IT system needs to alert staff if a same gender nurse is required.</p>	<p>Identify if there is a need to recruit Male staff? Identify skills match and male staff to work alongside senior female staff.</p> <p>Consider to advertise service to attract more male patients/referral into service. (if necessary)</p> <p>Monitor & measure need to gender match male patients.</p> <p>^ For community nursing to be on TPP. gender to be entered onto TPP to allow collation of statistics and future reporting.</p>	<p>Annual measure of gender of staff.</p> <p>* Planned and implemented adjustments as a result of data.</p> <p>Implemented changes to attract more male patients/referral into service. (If identified as necessary).</p> <p>Raised staff awareness/ training delivered in Gender issues and parent/carer needs and sensitivity, as</p>	Annually	Paul Matthews & Janine Thornton

	Ensure staff are aware of gender and transgender issues, commission appropriate training if needed.	<p>^ Amendment to assessment and referral documentation to cover this. Ensure new monitoring tool is implemented & staff are aware</p>	<p>and where appropriate in functions of role.</p> <p>* Established requirements from appropriate communities/patients (2-way consultation). Incorporate in new EIA as revised.</p>		
Race	<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>^ 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>^ For Lymph oedema service to fully utilise TPP. Race to be entered onto TPP to allow collation of statistics and future reporting</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/translated as appropriate.</p> <p>Anticipate under representation of settled and new BME communities as service users, establish BME community consultation to make service</p>	<p>^ Data is manual collected & analysed.</p> <p>* Analyse data and address any issues raised.</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>May 2009</p> <p>To start when TPP can produce reports</p>	<p>Paul Matthews & Janine Thornton</p>

	<p>2. Data to be sourced on interpreter & languages to be sourced from SCAIS/other providers (past 12 months).</p>	<p>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 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>* Established requirements from appropriate communities/patients (2-way consultation).</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>Establish if data is collected manually or on the TPP system.</p> <p>^ Ensure data is collected & recorded of format/type of communication appropriate to patient to enable effective 2-way communication (induction</p>	<p>^ Amendment to assessment and referral documentation to cover this. Ensure new monitoring tool is implemented & staff are aware</p> <p>Ensure data is collected & recorded onto TPP.</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>May 2009 Within the next 6 months</p>	<p>Paul Matthews & Janine Thornton</p>

	<p>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 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>Are carer needs and Learning disability advocates needs identified?</p>	<p>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>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>First page of patient TPP records show language & type of format required to communicate effectively with patient (Braille, 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>		
<p>Sexual orientation</p>	<p>Not currently recorded at referral to the service. Need to collect & record data</p>	<p>^ Amendment to assessment and referral documentation to cover this.</p>	<p>^ Data collection has begun and entered onto TPP database system &</p>	<p>May 2009 Within the next 6</p>	<p>Paul Matthews & Janine</p>

	electronically.	<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 Data to be inputted in time for records Audit (May 2009)</p> <p>Analyse results and act on findings.</p>	<p>analysed for EIA purposes.</p> <p>* Analyse data and address any issues raised.</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>	months	Thornton
Age	<p>Currently this data is collected at referral and not entered electronically, therefore difficult to measure but need to measure data manually.</p> <p>Need to collect & record data electronically.</p>	<p>^ For Lymph oedema service to fully utilise TPP. Age to be entered onto TPP to allow collation of statistics and future reporting</p> <p>^ Amendment to assessment documentation to cover this. Ensure new monitoring tool is implemented & staff are aware.</p> <p>Ensure data is collected & recorded. Data needs to be collected manually if not</p>	<p>^ Data is manual collected, entered onto TPP & analysed for EIA purposes.</p> <p>* Analyse data and address any issues raised.</p> <p>* Plan adjustments as a result of results.</p> <p>* Established requirements from appropriate communities/patients (2-way consultation).</p>	<p>Within the next 6 months May 2009</p> <p>To start when TPP can produce reports</p>	Paul Matthews & Janine Thornton

		<p>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>			
Religion	<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 where necessary.</p> <p>Consult & consider if you need</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 marketed to include a higher uptake of the cross section of the population.</p> <p>Ensure new monitoring tool is implemented & staff are aware.</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> <p>Established requirements from appropriate</p>	<p>To commence immediately By May 2009.</p>	<p>Paul Matthews & Janine Thornton</p>

	<p>to provide a prayer space/reflection room for staff or patients.</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 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 necessity to book interpreters, how to work with interpreters and how interpreters can guide staff on cultural and religious norms for patients.</p>	<p>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> <p>* Established requirements from appropriate communities/patients (2-way consultation).</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.