NHS BORDERS

EQUALITY MAINSTREAMING REPORT

MARCH 2013

Including:

Equality Outcomes
Gender Pay Gap Information
Occupational Segregation Information
Equal Pay Statement

NHS Borders aims to ensure that all of our information is accessible.

Information can be made available in large print, Braille, on tape, easy read (with pictures), and in different languages.

If you would like this information in any of these formats please contact:

Tel: 01896 825560
Fax: 01896 823396
Email: equality@borders.scot.nhs.uk

CONTENT

INTRODUCTION

This mainstreaming report describes how NHS Borders intends to deliver its vision of itself as an organisation which values diversity and promotes equality. Not only is the report required by the Equality and Human Rights Commission (EHRC) to report progress on mainstreaming the public sector equality duty under the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012, but it is a valuable tool for the organisation to assess progress and plan further action. It includes, as appendices, our equality outcomes; our revised equal pay statement; information on occupational segregation and the gender pay gap within NHS Borders. Employee information by protected characteristic as a percentage of the workforce is also contained within these pages.

NHS Borders aims to be an organisation which values its different communities, fosters respect for diversity, challenges prejudice and discrimination and promotes equality. Mainstreaming equality is the process by which we hope to achieve this goal. Mainstreaming is the systematic integration of an equality perspective into our everyday work, involving policy makers across all departments, as well as equality specialists and external partners.

Mainstreaming is a long term strategy that aims to make sure that the decisions we make are fully sensitive to the diverse needs and experiences of patients, carers, staff and members of the wider Scottish Borders community. It will improve our decision making process through providing better evidence and information and offers greater transparency and openness.

Through mainstreaming equality NHS Borders aims to involve groups and individuals in the Scottish Borders who experience inequality and discrimination in the policy& decision making process, through effective consultation mechanisms. In turn this will help us, and our partner agencies, to tackle the under-representation of disadvantaged and excluded groups through encouraging wider participation.

By mainstreaming equality NHS Borders aims to tackle the structures, behaviours and attitudes that contribute to, or sustain, inequality and discrimination. This approach can avoid policies and programmes being adopted that continue existing inequalities or make them worse. It complements lawful positive action that is designed to address long-term historic disadvantage experienced by specific groups as a result of discriminatory practices and structures.

Mainstreaming equality aims to change organisational cultures so that an equalities perspective becomes an integral part of the decision making process. NHS Borders recognises that mainstreaming equality requires:

- Leadership commitment to the principles and processes of mainstreaming equality.
- Commitment and ownership from staff across the organisation for the principles and processes of mainstreaming.
- Work on mainstreaming equality to be integrated with departmental work plans and policy objectives.

- Guidance, advice, training and support to help staff understand the importance of equality & diversity and to help NHS Borders to develop mainstreaming.
- An appropriate and accurate evidence base to inform the decision making process.
- Policy appraisal, review and equality impact assessment with ongoing monitoring, evaluation, audit and review.
- Effective consultation and engagement methods to enable engagement with equality group within NHS Borders and within the wider community.
- Partnership working.
- An acknowledgement that mainstreaming is not a quick fix and requires time and resource.

NHS Borders Workforce Information

At the time of writing this report NHS Borders has 3210 employees. Of these, 82% are female, 18% are male. Less than 1% have stated that they are either lesbian, gay or bisexual (LGBT). Less than 1% have stated that they have a disability. Less than 4% have stated that they are from an ethnic minority. None have stated that they are transgender (T). Over 50% of NHS Borders workforce is over 45 and 3% of the workforce are over 60. This information is currently gathered on entry to NHS Borders and there are significant numbers of staff who decline to comment on the monitoring information - for example 50% declined to comment on the race question, 70% declined to comment on the religion or belief question and 70% declined to comment on the sexual orientation question. Please see *Appendix - 1 Workforce Structure by Protected Characteristic* for a more detailed breakdown.

In order to improve the information NHS Borders gathers about our staff, we have taken steps to raise awareness of the benefits of accurate monitoring and will provide clear and comprehensive information at entry to enable new starts to complete monitoring more confidently. EASE, a new HR system will soon be implemented and will provide NHS Borders with an opportunity to disseminate this information and also offers the opportunity for staff to input their own information which may help address concerns about confidentiality.

In recognition of the particular issues around stigma and discrimination that our LGBT staff face, NHS Borders has signed up to the Stonewall Good Practice Programme (along with several of our Community Planning Partners), which will support NHS Borders with mainstreaming LGBT equality and is supportive of our partnership approach to addressing LGBT Equality.

LEGISLATIVE CONTEXT

All health boards across NHS Scotland are required to comply with the three aims of the Public Sector General Duty, Equality Act (2010) and (Specific Duties) (Scotland) Regulations 2012, outlined below. The implementation of these legal duties will be monitored by the EHRC in Scotland.

The Equality Act (2010) and Public Sector General Equality Duty

The Equality Act (2010) is the law which bans unfair treatment and helps achieve equal opportunities in the workplace and in wider society. This single Act replaces previous anti-discrimination laws to make the legislation simpler, to remove inconsistencies and to provide specific protection to people who are discriminated against on the basis of a defined set of nine “protected characteristics”. The nine protected characteristics are:

1. Age
2. Disability
3. Gender reassignment
4. Marriage and civil partnership
5. Pregnancy and maternity
6. Race
7. Religion and belief
8. Sex
9. Sexual orientation

These characteristics cannot be used as a reason to treat people unfairly. Every person has one or more of the protected characteristics, so the Act protects everyone against unfair treatment.

The three aims of the Act’s Public Sector General Equality Duty are as follows:

1. Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under this Act
2. Advance equality of opportunity between persons who share a relevant characteristic and persons who do not
3. Foster good relations between people who share a protected characteristic and those who do not

The Public Sector General Equality Duty replaces the previous Race Equality Duty (2002), the Disability Equality Duty (2006) and the Gender Equality Duty (2007).

Purpose of the Public Sector General Equality Duty

The purpose of the Public Sector general Equality Duty is to ensure that all public bodies, including health boards, mainstream equality into their day to day business by proactively advancing equality, encouraging good community relations and addressing discrimination. The current duty requires equality to be considered in relation to key health board functions including the development of internal and external policies, decision making processes, procurement, workforce support, service delivery and improving outcomes for patients/service users.

Specific Duties

In Scotland, an additional set of specific duties were created by secondary legislation: the Equality Act (2010) (Specific Duties) (Scotland) Regulations 2012, which came into force in May 2012.

The specific duties listed below are intended to support public bodies, including health boards, in their delivery of the General Equality Duty:

- Report progress on mainstreaming the public sector equality duty
- Publish equality outcomes and report progress
- Assess and review policies and practices (impact assessment)
- Gather and use employee information
- Publish statements on equal pay
- Consider award criteria and conditions in relation to public procurement
- Publish in a manner that is accessible

HEALTH CONTEXT

The challenge for the NHS is to translate these legislative requirements into an approach to mainstream equality into health policy and practice, which aims in turn to tackle health inequalities and improve health outcomes.

Actions to deliver on equality and address health inequalities are intrinsically linked - health inequalities reflect the systematic differences in health associated with people's unequal positions in society. Given this, health inequalities relate to and interact with other structures of inequality, for example socio-economic; gender; ethnicity and disability.

In order to address health inequalities effectively, consideration has to be given to the associated implications for people with equality characteristics and the often complex intersections between these. NHS Borders and its Community Planning Partners have endeavoured to address health and social inequalities through a local partnership approach.

OVERARCHING POLICY CONTEXT

Scottish Government: We live longer, healthier lives and have tackled significant inequalities in Scottish society

↑

National NHS policy priorities:
Quality Strategy, Equally Well, Staff Governance Standards
CELs, Christie Report, HEAT Targets/SOAs
(equality integrated)

↑

NHS Board Corporate Strategies
(equality integrated)

It makes sense to ensure that the equality agenda is aligned explicitly with existing NHS and Scottish Government (SG) policy priorities and is integrated into internal board performance management systems where possible.

Health boards have a role to work in partnership with patients, carers, the public, and cross sector partners. Given this, ongoing engagement and collaboration is critical to the delivery of equality mainstreaming. NHS Borders is a member of the Scottish Borders Community Planning Partnership which is underpinned by equality and diversity considerations, acknowledgment of the strategic priorities and corporate objectives of partnership agencies and the comprehensive strategic integration of these within the Single Outcome Agreement.

BENEFITS OF EQUALITY MAINSTREAMING

- Equality is embedded in the systems, functions and culture of the board.
- Policy making is improved by avoiding the development of policies and programmes that inadvertently sustain or compound existing inequalities.
- Enhanced performance of core health practice and improved outcomes for patients and service users.
- Improved quality of service design and delivery i.e. equitable access and equality informed person-centred care.
- Established transparency in relation to board functions such as procurement and workforce recruitment, development and equal pay.
- Workforce is trained, supported and equipped to deliver an equality and person-centred informed health care response.
- Capacity is maximised through collaborating with partner agencies and Community Planning Partnerships (CPPs).
- Maximised participation in decision-making by local people with protected equality characteristics and those with experience of social inequalities.
- Able to demonstrate compliance with equality legislation to the EHRC.

HOW NHS BORDERS IS MAINSTREAMING EQUALITY

- *Adopting an incremental approach*, setting realistic, measurable goals, in recognition that equality mainstreaming is a long term process of change. This includes taking steps to ensure that staff understand why we ask for their protected characteristic information through our monitoring process and also have confidence that this information remains confidential. Monitoring of patients information is also an area we are currently seeking to improve upon. Equality & diversity training is mandatory for all staff and the Equalities Steering Group is currently looking to develop a training strategy.
- *Building on, and strengthening, the foundation of existing good practice* on equalities, established through our previously published Single Equality Scheme. This includes updating our equality impact assessment tools and providing clear guidelines for staff, effectively engaging with local equality groups including LGBT equality representatives and the local equality forum, introducing a partnership physical disability strategy and continuing to work closely with our community planning partners.
- *Demonstrating leadership* from the Board of Directors, the Chief Executive and other senior managers, providing a mandate to integrate equality into all board functions. Our Executive lead for Equality and Diversity is the NHS Borders and Scottish Borders Council Joint Director of Public Health.
- *Devising and supporting a clear equality infrastructure* to drive change within the board and evolving responsibility and accountability across the organisation in recognition that this work is not solely the remit of Equality & Diversity Leads by establishing an Equalities Steering Group. *(Appendix 2 – Equalities Steering Group, Draft Terms of Reference)*
- *Establishing an equality evidence base* drawn from the collection and analysis of routine equality data, relevant research, involvement and feedback from staff, patients, carers and local communities, including those with protected characteristics and applying this evidence to inform the development and delivery of equality outcomes for patients and staff. *(Appendix 3 - Evidence)*
- *Integrating equality into key functions* such as finance and procurement and into key health agendas such as the Person-Centred Health and Care Programme, Public Health and public policy (through Community Planning), Health Improvement, HEAT Targets and Keep Well.
- *Devising and delivering a set of equality outcomes*, in line with the specific duties, to benefit patients and staff. *(Appendix 4 – NHS Borders Equality Outcomes)*
- *Publishing employee/gender pay gap information* and providing a statement on equal pay In line with the specific duties. *(Appendix 5–Statement on Equal Pay including Occupational Segregation and Gender Pay Gap Information)*
- *Mainstreaming equality* into board policy, departmental work plans, including monitoring, impact assessment, evaluation and audit systems to measure change.
- *Providing guidance, information, advice and training to equip staff* to understand equality, human rights, health inequalities and relevance to their role through, for

example, the provision of mandatory equality and diversity training and a comprehensive intranet microsite which includes guidance on how to complete equality impact assessment, how to access interpretation and translation services and signposts to other relevant information. *(Appendix 6 – NHS Borders Equality Impact Assessment Procedure & Toolkit)*

NHS Borders will continue to work with our staff, our patients, the wider community, local and national equality organisations and our community planning partners to tackle the health and social inequalities within the Scottish Borders and within our own organisation.

Appendix 1 - Workforce Structure by Protected Characteristic

Ethnic Origin	**% of Workforce**
Declined to Comment	50%
White Scottish	37%
White British	7.1%
Other White	1.9%
Other British	1.4%
Caribbean	Less than 1%
Chinese	Less than 1%
Indian	Less than 1%
Other Asian	Less than 1%
Other Ethnic Background	Less than 1%
Bangladeshi	Less than 1%
Pakistani	Less than 1%
Any Mixed Background	Less than 1%
White Irish	Less than 1%
African	Less than 1%

Disability	**% of Workforce**
No	97.5%
Declined to comment	1.7%
Yes	Less than 1%

Transgender Y/N	**% of Workforce**
No	93.4%
No information / blank	4.7%
Declined to comment	1.8%

Marital status	**% of Workforce**
Married	43.9%
No information / blank	31%
Single	15.3%
Other	3.5%
Divorced	3.3%
Not married	1.4%
Civil Partnership	Less than 1%
Widowed	Less than 1%
Separated	Less than 1%

Age Group	**% of Workforce**
46-50	19.6%
51-55	17.8%
41-45	15.8%
36-40	11.6%
56-60	11.3%
31-35	7.9%
26-30	6.9%

20-25	4.9%
61-65	3.4%
Over 65	Less than 1%
Under 20	Less than 1%

Sexual Orientation	% of Workforce
No information / blank	51.6%
Heterosexual	34.2%
Declined to comment	13.6%
Gay	Less than 1%
Bisexual	Less than 1%
Lesbian	Less than 1%
Other	Less than 1%

Religion	% of Workforce
Declined to Comment	54.7%
Church of Scotland	14.6%
No information / blank	10.1%
No religion	8.7%
Christian - Other	4.4%
Other	4%
Roman Catholic	2.5%
Muslim	Less than 1%
Sikh	Less than 1%
Buddhist	Less than 1%
Hindu	Less than 1%

Appendix 2 - Equalities Group Draft Terms of Reference

Equalities Group

DRAFT Term of Reference

Version 3

Date: 28 Sep 2012

Author: Warwick Shaw

Owner: Eric Baijal, Joint Director of Public Health

Document Location

This document is only valid on the day it is printed.

The source of the document will be found at \\itsnasU:\Equality and Diversity\NHS Borders Equalities Group\Equalities Group ToR V3 Oct 2012.doc. All electronic documents associated with the project with the exception of emails will be found in the folder and sub-folders at \\itsnas\Nurses Home File Structure\\Delivery Support\NHS Borders Equalities Group\. Emails are stored in a sub-folder named '"E&D" in a folder named "2012" in the Author's email account Inbox. Paper copies of documentation are kept in OPAC folders in:
Office 67
NHS Borders HQ
Newstead
MELROSE
TD6 9DA

Revision History

Revision Date	Summary of Changes	Version Altered
	❑ Added membership ❑ Expand content in line with standard NHS Borders Terms of Reference ❑	1
28th Sep 12	❑ Updated Membership ❑ Added identified National Themes to Purpose	2
	❑	3

Approvals

This document requires the following approvals:

Name	Signature	Title	Date of Issue
Eric Baijal		Joint Director of Public Health	18th October 2012

Distribution

TO BE UPDATED on issue This document has been distributed to:

Title	Date of Issue	Version
Joint Director of Public Health		2
Lead for Delivery Support		2

DRAFT TERMS OF REFERENCE

Purpose
The Group has been established as a steering group accountable, via the Public Governance Committee, to the NHS Board.

Enable senior staff of NHS Borders to set and monitor the strategic direction for work to promote equality and embrace diversity within NHS Borders and within services for staff, patients and their families.

- Raise the profile of the equalities agenda across the range of corporate functions in NHS Borders highlighting existing good work and ensuring that the contribution to promoting equality and embracing diversity is corporately recognised and understood.

- Ensure a chain of accountability to deliver governance of work to promote equality and inclusion. This will include Performance Reviews and the NHS Board and is shown in the hierarchy chart at Annex A.

1.2 Membership

Representing	***Title & Name***	***Deputy***
(Chair)	Joint Director of Public Health	
Vice Chair	Chief Operating Officer	
BGH	BGH Rep	
Public Partnership	Nominee - tbc	
Learning Disabilities	Consultant Clinical Psychologist	
Training and Professional Development	Corporate Business Training Manager	
Public Health	Health Improvement Specialist	Health Improvement Practitioner
Partnership	Employee Director	
HR	HR Manager	HR Officer
Estates and Facilities	Nominee - tbc	
Clinical Governance and Quality	Head of Clinical Governance and Quality	Public Involvement Manager

Public Involvement	Public Involvement Manager	Public Involvement Officer
Occupational Health	Occupational Health Service Manager	
Mental Health	Consultant Clinical Psychologist	Clinical Psychologist
SBC Liaison	Corporate Equality & Diversity Officer	
Planning & Performance	Planning & Performance Manager	
P&CS	Assistant General Manager P&CS and Contracts Community Nurse Manager, Service Development	Professional Lead Podiatry
	Head of Delivery Support	
Finance (as required)	Directorate Accountant	

It is **essential** that in the absence of the nominated member, deputies attend the meeting. Such deputies should be empowered to act and will be responsible for the delivery of any actions agreed to be the responsibility of the named member.

The Chair has the right to vary the membership. The group should appoint at least one vice Chair.

1.3 Meetings

The Group shall meet at least bi-monthly and shall be quadrate if there are 5 members present including representatives of at least 2 Clinical Boards. Any variance to the agreed meeting schedule will be at the discretion of the chair.

1.4 Remit

The Group and its members will:

- oversee the delivery of agreed improvement action plans ensuring that all actions are embedded into operational practice;
- ensure that actions are allocated to responsible officers and that they are held accountable for their delivery;
- oversee the development of such policies and procedures that are necessary to support best practice and will ensure that they are disseminated and implemented across the organisation;
- promote effective coordination across the Clinical Boards and Support Services.
- ensure appropriate partnership working is integrated in the mainstream delivery of services to ensure effective delivery of the equality and

diversity agenda within NHS Borders and to the public and patients in the area.

- agree corporate responses to address emerging equality and diversity issues within the context of national policy and legislative duties.
- encourage individuals and groups from all sections of the organisation to engage with, contribute to and participate in the work of promoting equalities and inclusion and put in place appropriate monitoring processes to ensure that this is effective.
- identify and evaluate all significant risks relating to equalities and inclusion activity and delivery of mitigating action.
- provide recommendations to the Borders NHS Board for any allocations of funding.
- ensure NHS Borders representation at local Equalities Groups and fora including, but not only:
    1. SBC Local Housing Strategy
    2. Community Planning Partnership

- ensure NHS Borders representation at National Equalities Groups and Events including, but not only:
    1. National Equalities Leads meeting
    2. Eastern Action Learning Set
    3. Health and Homelessness Group

The Equalities Group role as corporate champion for equality and diversity is significant in reinforcing an integrated mainstream approach.

1.5 Principles of Operation

- Has clear responsibilities and accountabilities.
- Gives clear direction and leadership to those responsible for implementing actions.
- Drives the agenda forward within agreed timescales.
- Operates in an open and transparent manner.

1.6 Work Groups and Relationships

- Members will represent their clinical board / service or department, ensuring that they communicate appropriately the work of the group.
- Members will act as an Equality & Diversity resource within their own clinical board / service or department, this will include assisting with Equality Impact Assesments.

1.7 Performance Management

The group will adopt a formal approach to monitoring and reporting progress including but not limited to:

- An action tracker will be circulated after each meeting and reviewed 2 weeks before the next meeting under arrangements by the Chair.
- analysis of progress against action plans at all meetings and identification at an early stage of any variance;
- narrative reports to support such variance to the plan;
- the maintenance of a risk and issues logs at Clinical Boards that provides the detail of mitigation measures as agreed;
- regular liaison with Performance and Planning over monitoring and reporting issues.

1.8 Communication

A Communication Plan will be agreed, this will include and exploit all existing communication systems within NHS Borders to ensure better information to all ward and department staff. The Plan will embrace the need to enforce lessons learned across all elements of NHS Borders and specifically the Clinical Boards.

1.9 Authority

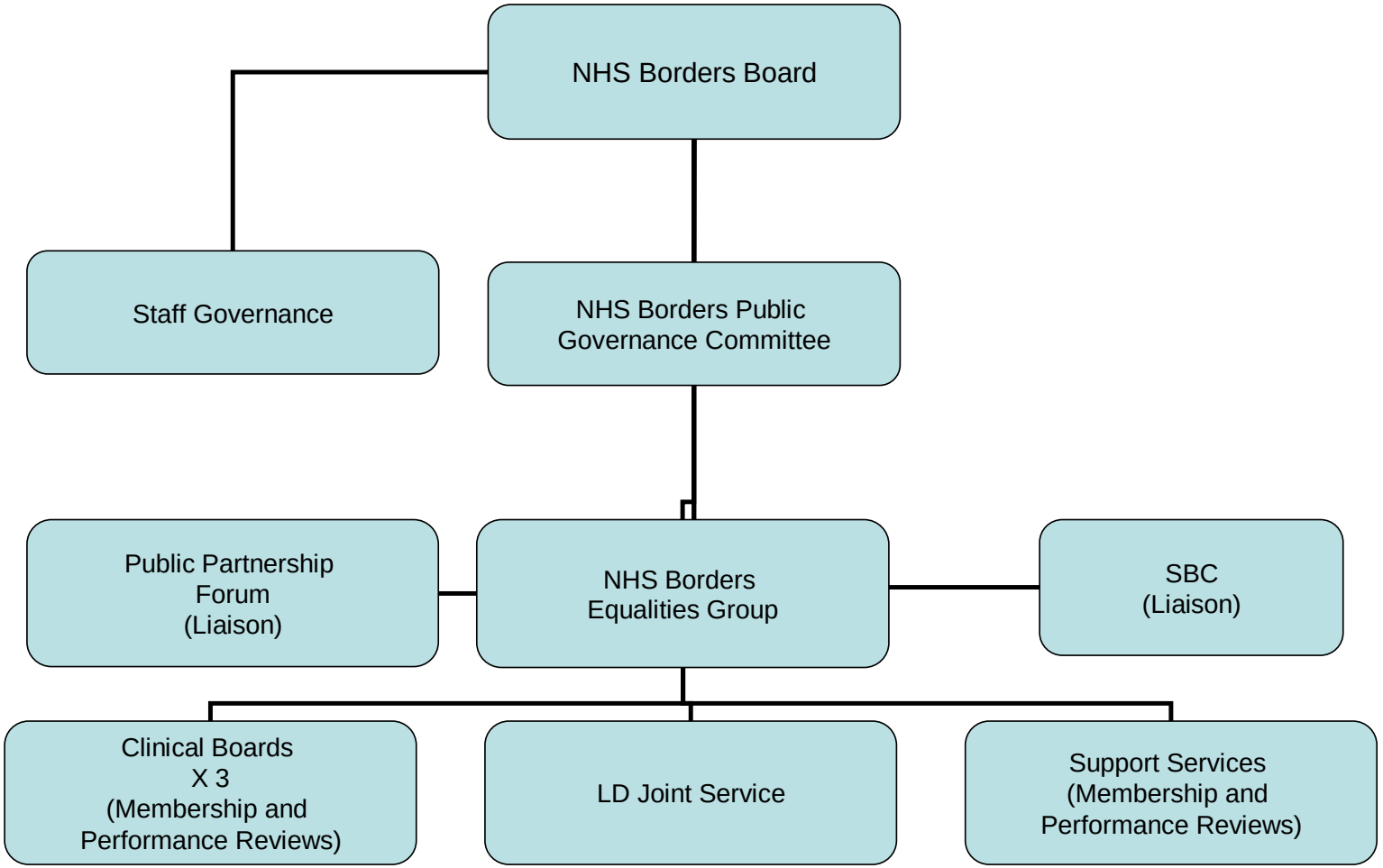
The Joint Director of Public Health is the accountable Director and will Chair the Group. The Group has the authority of the Chief Executive and Executive Team within its defined remit. It has no dedicated budget but will report issues that can only be resolved by investment.

1.10 Reporting Arrangements

A regular report will be made to the NHS Borders Board through Staff Governance and NHS Borders Public Governance Committee.

Prepared by:
W Shaw 18th October 2012
Sponsored by:
E Baijal

Equalities Group Governance Relationships



Appendix 3 - Evidence

We would like to acknowledge the contribution of our Scottish Borders Council colleagues in providing disaggregated data from the household survey and other sources which have proved invaluable in the compilation of this evidence.

NHS Borders

NHS Borders current staff monitoring data indicates that the NHS Borders workforce is not representative of the communities it serves. Less than 1% of our staff have declared a disability when 20% of the work age population within the Borders have a disability. Less than 2% of our staff have declared that they are from an ethnic minority when estimates suggest 10% of the communities we serve are ethnic minorities. Less than 1% of our staff have declared they are either Lesbian, Gay or Bisexual when it is estimated that around 10% of the population is either Lesbian, Gay, Bisexual or Transgender.

Over half of NHS Borders staff are aged over 45, with 3% of the workforce aged 60 and above. NHS Borders workforce is made up of 82% female and 18% male staff although there is an equal 50/50 split for senior managers. There are a significant number of staff declining to comment on the monitoring information – it is unclear why this is but anecdotal evidence suggests that they may be unclear or even fearful about what the information might be used for, and why it is required.
Issues with service delivery have been highlighted by all of the protected characteristic groups. National evidence suggests for example that LGBT people face barriers accessing health services.

Cohesive communities

It is very well acknowledged that people with protected equality characteristics find it harder to participate in public life and indeed it is one of the main drivers behind the Equality Act. This is evident within the Scottish Borders and is demonstrated through the results of the household survey. Younger people, women, ethnic minorities and disabled people all indicated that they were less satisfied with their opportunities and ability to participate in public life.

The same survey also indicates that ethnic minority people and people with disabilities are less likely to attend art, cultural and social events, engage in voluntary work or take part in physical activities.

Local equality groups have highlighted numerous physical and social barriers which prohibit their opportunities and ability to participate in public life. The equality groups also highlighted the impacts that this had on their lives and the community around them, with factors such as the negative effects on health and wellbeing, inability to reach their full potential and the inability to contribute within society and to the community.

Community tensions were an issue raised by all of the equality groups through the engagement work carried out by community planning partners. Issues were raised around hate crime by people from the ethnic minority community, people with learning disabilities and the LGBT community. There were also issues raised around violence against women which is of significant public health concern. These finding

are supported by local data. Lothian and Borders Police have consistently recorded hate crime to be 86% race related over a five year period within the Borders. Within the Household survey women, older people, people with disabilities and ethnic minority people all felt less safe to walk alone in their local area after dark.

Poverty

12% of the Borders population is living in financial exclusion and experiencing multiple deprivation relative to the Scottish population(SIMD). Statistical evidence of gender difference within the Borders in terms of access to income from earnings, assets, savings and benefits indicate that women's income from earnings and other sources are persistently lower than men's income, that women are more vulnerable to poverty and that specific groups of women are particularly vulnerable. In 2009 there was a 21.6% difference between men and women's weekly earnings in the Borders. This pay gap decreases for those who commute out with the area.

Significantly more women than men are claiming housing benefits, pension credits, attendance allowance and income support. In November 2011 there were 13,205 claims for health related benefits.

Nearly half of the children within the Scottish Borders live in low income households. This, coupled with the effect of the Welfare Reform Bill and the current economic climate, presents serious challenges for the Scottish Borders community as a whole. The changes which are of particular concern in terms of health impact are the proposed changes to Disability Living Allowance (DLA), Incapacity Benefit and Housing Benefits, as a result of changes in conditionality, in the mechanisms for claims and payment and in the underlying assumptions about the availability of work. There will be a significant net financial loss to individuals and to the Scottish Borders economy.

Equality Groups are the most vulnerable when it comes to the effects of these changes. The impact is expected to increase demand on all services and resources and so it is essential that work towards safeguarding these groups and reducing inequalities is mainstreamed into the working of the Community Planning Partnership.

In his annual report for 2011 / 12 Dr Eric Baijal, Scottish Borders Joint Director of Public Health, notes the following:

Predicting or quantifying the health impacts (of welfare reform) is very difficult in view of the interplay of many different factors. Nevertheless, the research literature demonstrates that illnesses in adults and children that require treatment and care are likely to increase as follows:

- *poorer mental health, increased cardiovascular and respiratory illness (associated with low income, income inequalities)*

- *increases in obesity-related illnesses such as diabetes, arthritis and cancer arising from poorer nutrition (associated with low income, income inequalities)*

- *poorer mental and general wellbeing, reductions in / disruption to health care access (associated with housing difficulties / housing insecurity)*

- *potential increases in avoidable winter mortality (associated with fuel poverty)*

Low income is associated with poorer health outcomes, including poorer mental health. It is likely that the welfare benefit reforms will contribute to: increases in inadequacy of housing; reductions in dietary quality; increase in fuel poverty; possible adverse changes to health risk behaviour including smoking, alcohol and drug use; increases in stress and anxiety and suicidal behaviour.

Deprivation and poverty remain major factors when looking at health inequalities - more affluent people live longer and have better health. Age, gender and ethnicity are also significant. Poverty and low income are already significant problems within the Borders, there are substantial variations in health between different towns in the region – breastfeeding rates, hospital admissions, smoking and so on, related to deprivation and poverty. There is evidence that greater inequalities in society exercise a 'downward drag' effect on wider population outcomes including health outcomes. The general health of the population in more unequal societies is worse than in societies which are more equal *(Dr E Baijal).*

Equally Well: report of the ministerial task force on health inequalities states:
There are inequalities in the health of people in Scotland which are unfair and unjust, because they are based on social structures and factors such as how much money people have. These inequalities mean that some people are more likely to be ill or have low levels of wellbeing and to die younger than others. In Scotland in 2006, people who had a low household income, or reported finding it difficult to manage on their household income, had poorer mental wellbeing than those with a high household income or who reported finding it easy to manage on their income.

Those living in the most deprived 10% of areas of Scotland have a suicide risk double that of the Scottish average. Compared with the non-South Asian population, the incidence of heart attacks in Scottish South Asians is 45% higher in men and 80% higher in women. Lesbian/gay/bisexual and transgender people experience lower self-esteem and higher rates of mental health problems and these have an impact on health behaviours, including higher reported rates of smoking, alcohol and drug use. Just under a quarter (24%) of all individuals in households with at least one disabled adult or disabled child are living in relative low income, compared to 16% of those in households with no disabled adults or disabled children. Health outcomes and health risks may also vary according to people's age, disability, gender, race, religion or belief, sexual orientation and other individual factors

<u>Employment & economy</u>
Barriers to employment opportunities have been highlighted by all of the local equality groups. The economic downturn and the Welfare Reform Act have raised serious concern and challenges for those from the equality groups who makeup many of those furthest away from work.

In November 2011 there were 13,205 claims for health related benefits in the Scottish Borders.

Only 64% of disabled people in the Borders were in work in 2008.

In 2010 there were 4290 claims for Incapacity Benefit in the Scottish Borders. All of these claimants are required to go through a work capability assessment as part of the Welfare Reform. It is expected that 71% will be declared fit for work related activity.

In August 2012 there were 745 young people (under 25) claiming Job Seekers Allowance in the Scottish Borders which equates to 36% of all claimants *(NOMIS).*

Between 2006 and 2011 the employment rate for people aged 16-24 in the Scottish Borders dropped over 20% to 51%;more that the drop experienced for Scotland which was only 8% to55%*(APS).*

Only 10% of Care Leavers in the Borders in 2011/12 went on to further education, training or employment *(Children's Social Work Statistics 2012 Edition).*

The number of women in the Borders Claiming Jobseekers Allowance increased by 123% between 2008 and 2012. Overall claims increased by 97.7% during the same period.

Education

The Public Health agenda can now be summarised as inequalities driven by poverty and poor education*(Dr E Baijal).*It is widely acknowledged that low educational achievement at age 16 is strongly (but not universally) associated with disadvantage and also a variety of outcomes by gender and ethnic group.

Several equality groups highlighted issues around education with bullying was seen as a significant issue by all of the equality groups - it was felt that this greatly impacted on educational attainment.

Females consistently outperform males within Scottish Borders Schools with more females going on to Higher Education.

There is a significant gap in educational attainment between pupils who have an additional support need (ASN) and those who do not, with only 75.9% of ASN pupils gaining English and Maths at SCQF 3 or above in 2010/11 compared with 94% of pupils without an ASN.

Housing

Links have been drawn between poor health and poor housing since the nineteenth century with the social gradient to health remaining strong in contemporary societies, including Scotland. Housing is widely acknowledged to actively reinforce or reduce social inequality not only in health, but in other areas too, such as education and employment.

Population and household numbers are growing in the Scottish Borders with households getting smaller and older. The Borders has a greater proportion of older people than Scotland overall and neighbouring local authority areas – 30% of households will be aged over 65 years by 2033, compared to 20% in 2008.

The number of people that require support to live independently in the Scottish Borders is also increasing – particularly older people and those suffering with dementia, people with physical disabilities and learning disabilities.

Wages in the Scottish Borders are some of the lowest in Scotland (28 out of 32 local authority areas). This low wage economy has major implications on what housing 'local' households can afford with over 50% of households working locally being unable to afford housing market prices in the Borders.

The 2001 Census shows that 2,697 individuals or 2.5% of the population of the Scottish Borders is made up of individuals from minority ethnic communities. Of these, 2108 state that they are White Irish or 'Other White' including people from other European countries or other parts of the world. A very small proportion – 589 people, or 0.55%, of the Scottish Borders population includes other ethic minorities such as Indian, Pakistani, and other south Asian, Chinese, Caribbean, African or other black. The youthful age profile of a number of minority ethnic communities suggests that this population is likely to grow at a faster rate than white UK communities. We expect that the 2011 Census data when available will show a significant increase in Ethnic minorities within the Scottish Borders (in line with current local data) and the Community Planning Partnership is aware that people from these communities have very unique challenges in terms of housing.

The main increases in homelessness applications in the Scottish Borders have come from single people, and young people aged 16-17 years. The main reasons for homelessness in the Scottish Borders are where family of friends are not willing to accommodate the homeless applicants, violent and non-violent relationship breakdown, and loss of private tenancies. This is in line with trends across Scotland. *(SBC Local Housing Strategy 2011-2017).*

Appendix 4 - NHS Borders Equality Outcomes

An equality outcome is a result which NHS Borders (and its partners) aims to achieve in order to further one or more of the needs mentioned in the general equality duty: eliminate discrimination, advance equality of opportunity and foster good relations. They will focus NHS Borders equality work for the next four years and are closely linked with our corporate objectives and the strategic priorities of our partners. Visible leadership from Councillors, Board members and senior managers will be an important factor in their successful delivery.

The Equality and Human Rights Commission state:
"By focusing on outcomes rather than objectives, this specific duty aims to bring practical improvements in the life chances of those who experience discrimination and disadvantage. So in practice, you might find it helpful to think of equality outcomes as results intended to achieve specific and identifiable improvements in people's life chances."

In setting our Equality Outcomes we have considered the wider determinants of health and social inequalities including poverty, education, housing and local community. We have taken a Community Planning Partnership approach, working with Scottish Borders Council, local Police representatives, local Fire & Rescue Service representatives and Borders College. We have agreed to align our equality outcomes with the Community Planning Partnership Equality Outcomes, with our own responsibilities and actions within the outcomes to take forward.

1. We are seen as an inclusive and equal opportunities employer where all members of staff feel valued and respected and our workforce reflects our community.
2. Our services meet the needs of and are accessible to all members of our community
3. Our staff treat all service users, clients and colleagues with dignity and respect
4. We work in partnership with other agencies and stakeholders to ensure everyone has the opportunity to participate in public life and the democratic process
5. We work in partnership with other agencies and stakeholders to ensure that our communities are cohesive and there are fewer people living in poverty and the health inequality gap is reduced
6. We work in partnership with other agencies and stakeholders to ensure our citizens have the freedom to make their own choices and are able to lead independent, healthy lives as responsible citizens
7. We work in partnership with other agencies and stakeholders to ensure the difference in rates of employment between the general population and those from under represented groups is improved
8. We work in partnership with other agencies and stakeholders to ensure the difference in educational attainment between those who are from an equality group and those who are not is improved
9. We work in partnership with other agencies and stakeholders to ensure we have appropriate housing which meets the requirements of our diverse community

Situation	Activities	Equality Outcome	General Duty
The NHS Borders workforce is not representative of the communities it serves. Over half of NHS Borders staff are aged over 45, with 3% of the workforce aged 60 and above. The NHS Borders workforce is made up of 82% female and 18% male staff although there is an equal 50/50 split for senior managers. There are a significant number of staff declining to comment on the monitoring information.	Establish accurate baseline Identify and meet needs of target groups Stonewall good practice programme and other workplace initiatives Partnership community initiatives Gather and use staff information	1. We are seen as an inclusive and equal opportunities employer where all members of staff feel valued and respected and our workforce reflects our community.	Eliminate discrimination, advance equality of opportunity and foster good relations
Issues with service delivery have been highlighted by all of the protected characteristic groups.	Identify and meet needs of target groups Interpretation and translation services Appropriate signposting Partnership approach to household survey (NHS Borders questions to be included for the first	2. Our services meet the needs of and are accessible to all members of our community 3. Our staff treat all service users, clients and colleagues with dignity and respect	Eliminate discrimination, foster good relations

	time) Complaints process		
It is very widely acknowledged that people with protected equality characteristics find it harder to participate in public life. In the Scottish Borders younger people, women, ethnic minorities and disabled people all indicate that they are less satisfied with their opportunities and ability to participate. Ethnic minority people and people with disabilities are less likely to attend art, cultural and social events, engage in voluntary work or take part in physical activities. Local equality groups have highlighted numerous physical and social barriers which prohibit their opportunities and ability to participate in public life and have highlighted the impacts that this had on their lives and the community around them, with factors such as the negative effects on health and wellbeing, inability to reach their full potential and the inability to contribute within society and to the community.	Identify and meet needs of target groups Partnership community initiatives Representation on local equality groups (eg LGBT Equality, Elder Voice, Equality Forum) Public involvement processes	4. We work in partnership with other agencies and stakeholders to ensure everyone has the opportunity to participate in public life and the democratic process	Eliminate discrimination, advance equality of opportunity and foster good relations
12% of the Borders population is living in financial exclusion and experiencing multiple deprivation relative to the Scottish population (SIMD). Women's income from earnings and other sources are	Identify and meet needs of target groups Partnership initiatives	5. We work in partnership with other agencies and stakeholders to ensure that our communities are cohesive and there are fewer people living in poverty and the	Eliminate discrimination, advance equality of opportunity

persistently lower than men's income; women are more vulnerable to poverty and specific groups of women are particularly vulnerable. More women than men are claiming housing benefits, pension credits, attendance allowance and income support. Nearly 50% of children in the Scottish Borders live in low income households. The impact of the Welfare Reform Bill & the current economic climate is expected to increase demand on all services and resources. Community tensions were an issue raised by all of the equality groups with issues raised around hate crime by people from the ethnic minority community, people with learning disabilities and the LGBT community. There were also issues raised around violence against women which is of significant public health concern. Women, older people, people with disabilities and ethnic minority people all feel less safe to walk alone in their local area after dark. There are significant variations in health between different towns in Scottish Borders – breastfeeding rates, hospital admissions, smoking and so on, linked to deprivation.	Established health programmes	health inequality gap is reduced	and foster good relations
		6. We work in partnership with other agencies and stakeholders to ensure our citizens have the freedom to make their own choices and are able to lead independent, healthy lives as responsible citizens	Eliminate discrimination, advance equality of opportunity, foster good relations

Barriers to employment opportunities have been highlighted by all of the equality groups. The Economic downturn and the Welfare Reform Act have raised serious concern and challenges for those from the equality groups who makeup many of those furthest away from work. In November 2011 there were 13,205 claims for health related benefits in the Scottish Borders. Only 64% of disabled people in the Borders were in work in 2008. In 2010 there were 4290 claims for Incapacity Benefit in the Scottish Borders. All of these claimants are required to go through a work capability assessment as part of the Welfare Reform. It is expected that 71% will be declared fit for work related activity. In August 2012 there were 745 young people (under 25) claiming Job Seekers Allowance in the Scottish Borders which equates to 36% of all claimants (NOMIS). Between 2006 and 2011 the employment rate for people aged 16-24 in the Scottish Borders dropped over 20% to 51%; more that the drop experienced for Scotland which was only 8% to55%(APS). Only 10% of Care Leavers in the Borders in 2011/12 went on to further education, training or employment	Identify and meet needs of target groups Partnership initiatives	7. We work in partnership with other agencies and stakeholders to ensure the difference in rates of employment between the general population and those from under represented groups is improved	Eliminate discrimination, advance equality of opportunity

(Children's Social Work Statistics 2012 Edition). The number of women in the Borders Claiming Jobseekers Allowance increased by 123% between 2008 and 2012. Overall claims increased by 97.7% during the same period.			
The Public Health agenda can now be summarised as inequalities driven by poverty and poor education. It is widely acknowledged that low educational achievement at age 16 is strongly (but not universally) associated with disadvantage and also a variety of outcomes by gender and ethnic group.	Identify and meet needs of target groups Partnership initiatives Established health programmes	8. We work in partnership with other agencies and stakeholders to ensure the difference in educational attainment between those who are from an equality group and those who are not is improved	Eliminate discrimination, advance equality of opportunity and foster good relations
Health, housing and poverty are widely acknowledged to be strongly (although not universally) linked. The Borders has a greater proportion of older people than Scotland overall and neighbouring local authority areas – 30% of households will be aged over 65 years by 2033, compared to 20% in 2008. The number of people who require support to live independently in the Scottish Borders is increasing, this includes older people, people with dementia and people with learning disabilities. Housing inextricably links to poverty and wages in the Scottish Borders are some of the lowest in Scotland (28th lowest out of 32 local authority areas). We expect that the 2011 Census data when available will show a significant increase in ethnic minorities	Identify and meet needs of target groups Partnership initiatives	9. We work in partnership with other agencies and stakeholders to ensure we have appropriate housing which meets the requirements of our diverse community	Eliminate discrimination, advance equality of opportunity

within the Scottish Borders and we are aware that people from these communities have very unique challenges in terms of housing. The main increases in homelessness applications in the Scottish Borders have come from single people, and young people aged 16-17 years. The main reasons for homelessness in the Scottish Borders are where family of friends are no willing to accommodate the homeless applicants, violent and non-violent relationship breakdown, and loss of private tenancies. (SBC Local Housing Strategy 2011-2017).			

Appendix 5 - Equal Pay Statement including Occupational Segregation Information & Gender Pay Gap

NHS Borders Equal Pay Statement

This statement has been agreed in partnership and will be reviewed on a regular basis by the NHS Borders Staff Governance Committee.

NHS Borders is committed to the principles of equality of opportunity in employment and believes that staff should receive equal pay for the same or broadly similar work, or work rated as equivalent and for work of equal value, regardless of their age, disability, ethnicity or race, gender reassignment, marital or civil partnership status, pregnancy, political beliefs, religion or belief, sex or sexual orientation.

NHS Borders understands that the right to equal pay between women and men is a legal right under both domestic and European Law. In addition, the Equality Act 2010 (Specific Duties)(Scotland) Regulations require NHS Borders to taking the following steps:

- Publish gender pay gap information by 30 April 2013

- Publish a statement on equal pay between men and women by 30 April 2013, and to include the protected characteristics of race and disability in the second and subsequent statements from 2017 onwards.

It is good practice and reflects the values of NHS Borders that pay is awarded fairly and equitably.

NHS Borders recognises that in order to achieve equal pay for employees doing the same or broadly similar work, work rated as equivalent, or work of equal value, it should operate pay systems which are transparent, based on objective criteria and free from unlawful bias.

In line with the General Duty of the Equality Act 2010, our objectives are to:
- Eliminate unfair, unjust or unlawful practices and other discrimination that impact on pay equality

- Promote equality of opportunity and the principles of equal pay throughout the workforce.

- Promote good relations between people sharing different protected characteristics in the implementation of equal pay

We will:
- Review this policy, statement and action points with trade unions and professional organisations as appropriate, every 2 years and provide a formal report within 4 years;

- Inform employees as to how pay practices work and how their own pay is determined;

- Provide training and guidance for managers and for those involved in making decisions about pay and benefits and grading decisions;

- Examine our existing and future pay practices for all our employees, including part-time workers, those on fixed term contracts or contracts of unspecified duration, and those on pregnancy, maternity or other authorised leave;

- Undertake regular monitoring of the impact of our practices in line with the requirements of the Equality Act 2010;

- Consider, and where appropriate, undertake a planned programme of equal pay reviews in line with guidance to be developed in partnership with the workforce.

Responsibility for implementing this policy is held by the NHS Borders Chief Executive.

If a member of staff wishes to raise a concern at a formal level within NHS Borders relating to equal pay, the Grievance Procedure is available for their use.

Occupational Segregation and Gender Pay Gap

Agenda for Change (AFC) aims to address pay inequality. This information is taken from Section 30 of the Agenda for Change handbook:

30.1 All parties to this agreement commit to building a NHS workforce which is valued and whose diversity reflects the communities it serves, enabling it to deliver the best possible healthcare service to those communities. The NHS will strive to be a leader in good employment practice, able to attract and retain staff from diverse backgrounds and communities.

30.2 The parties will strive to ensure that:

- everyone working in the NHS should be able to achieve his or her full potential, in an environment characterised by dignity and mutual respect;
- the past effects of institutional discrimination are identified and remedial action taken;
- equality of opportunity is guaranteed;
- individual difference and the unique contribution that individual experience, knowledge and skills can make is viewed positively;
- job descriptions, person specifications and the terms and conditions of service fit with the needs of the service and those who work in it, regardless of age, disability, race, nationality, ethnic or national origin, gender, pregnancy or maternity, marriage or civil partnership, religion, beliefs, sexual orientation, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation or trades union membership.

		FEMALE			MALE						
Post Family Description	**Band**	**Count of Gender**	**Av basic Hourly Rate**	**Gender Count as %age of JF**	**Count of Gender**	**Av basic Hourly Rate**	**Gender Count as %age of JF**	**Monetary Variance Male to Female**	**Monetary Variance Male to Female %**	**Gender Grand Total**	**Total Av of Basic Hourly Rate**
ADMINISTRATIVE SERVICES	1	1	*	0.2			0.0	-7.60	-100.00	1	7.60
	2	96	8.32	17.7	6	8.17	1.1	-0.15	-1.77	102	8.31
	3	133	9.32	24.5	2	8.24	0.4	-1.08	-11.63	135	9.30
	4	154	10.85	28.4	6	10.44	1.1	-0.40	-3.73	160	10.83
	5	50	13.05	9.2	10	13.44	1.8	0.39	2.9	60	13.12
	6	25	15.90	4.6	10	15.79	1.8	-0.11	-0.71	35	15.87
	7	29	19.24	5.4	6	20.09	1.1	0.85	4.38	35	19.39
	8A	5	*	0.9	4	*	0.7	*	*	9	*
	8B	3	*	0.6	1	*	0.2	*	*	4	*
	8C	2	*	0.4			0.0	*	*	2	*
ADMINISTRATIVE SERVICES Total		498	11.22	91.7	45	14.78	8.3	3.55	30.87	543	11.52
ALLIED HEALTH PROFESSION	2	1	*	0.4			0.0	*	*	1	*
	3	23	9.46	9.1	2	*	0.8	*	*	25	*
	4	10	10.91	4.0	1	*	0.4	*	*	11	*
	5	33	12.03	13.1	4	*	1.6	*	*	37	*
	6	104	16.60	41.3	6	15.60	2.4	-1.01	-6.09	110	16.55
	7	51	19.89	20.2	2	*	0.8	*	*	53	*
	8A	4	*	1.6			0.0			4	*
	8B	4	*	1.6	4	*	1.6	1.83	6.69	8	27.32
	8C	3	*	1.2			0.0	*	*	3	*
ALLIED HEALTH PROFESSION Total		233	16.19	92.5	19	17.01	7.5	0.83	5.08	252	16.25
HEALTHCARE SCIENCES	2	5	*	6.1	2	*	2.4	*	*	7	*
	3	15	9.28	18.3	3	*	3.7	*	*	18	*
	4	1	*	1.2	1	*	1.2	*	*	2	*

	5	2	*	2.4	5	*	6.1	*	*	7	*
	6	26	15.84	31.7	3	*	3.7	*	*	29	*
	7	5	*	6.1	9	19.66	11.0	*	*	14	*
	8A	2	*	2.4	3	*	3.7	*	*	5	*
HEALTHCARE SCIENCES Total		56	13.83	68.3	26	15.88	31.7	2.05	14.15	82	14.48
		FEMALE			**MALE**						
Post Family Description	**Band**	**Count of Gender**	**Av basic Hourly Rate**	**Gender Count as %age of JF**	**Count of Gender**	**Av basic Hourly Rate**	**Gender Count as %age of JF**	**Monetary Variance Male to Female**	**Monetary Variance Male to Female %**	**Gender Grand Total**	**Total Av of Basic Hourly Rate**
MEDICAL AND DENTAL	Associate Specialist	10	37.03	4.0	3	34.98	1.2	-2.05	-5.62	13	36.56
	Clinical Assistant			0.0	2	*	0.8	*	*	2	*
	Clinical Director			0.0	1	*	0.4	*	*	1	*
	Consultant	31	41.80	12.5	61	43.52	24.6	1.72	4.01	92	42.94
	Dental Practitioner	14	25.88	5.6	5	*	2.0	*	*	19	26.31
	Foundation Year 1	11	11.03	4.4	6	10.80	2.4	-0.24	-2.15	17	10.95
	Foundation Year 2	5	*	2.0	2	*	0.8	*	*	7	*
	Hospital Practitioner	1	*	0.4			0.0	*	*	1	*
	Medical Director	1	*	0.4	1	*	0.4	*	*	2	*
	Salaried GP	18	38.98	7.3	7	41.57	2.8	2.60	6.54	25	39.70
	Senior Dental Offr	3	*	1.2	3	*	1.2	*	*	6	*
	Specialty Doctor	10	28.71	4.0	5	*	2.0	*	*	15	*
	Specialty Registrar	29	17.02	11.7	17	17.25	6.9	0.23	1.35	46	17.10

	Staff Grade	2	*	0.8			0.0	*	*	2	*
MEDICAL AND DENTAL Total		135	28.91	54.4	113	34.46	45.6	5.55	17.65	248	31.44
MEDICAL AND DENTAL SUPPORT	2	2	*	2.8	6	7.95	8.5	*	*	8	*
	3	9	8.55	12.7	1	*	1.4	*	*	10	*
	4	35	10.59	49.3			0.0	-10.59	-100.00	35	10.59
	5	13	13.07	18.3			0.0	-13.07	-100.00	13	13.07
	6	2	*	2.8	2	*	2.8	*	*	4	*
	7	1	*	1.4			0.0	*	*	1	*
MEDICAL AND DENTAL SUPPORT Total		62	11.08	87.3	9	9.98	12.7	-1.10	-10.01	71	10.94
		FEMALE			**MALE**						
Post Family Description	**Band**	**Count of Gender**	**Av basic Hourly Rate**	**Gender Count as %age of JF**	**Count of Gender**	**Av basic Hourly Rate**	**Gender Count as %age of JF**	**Monetary Variance Male to Female**	**Monetary Variance Male to Female %**	**Gender Grand Total**	**Total Av of Basic Hourly Rate**
NURSING/MIDWIFERY	2	129	8.39	9.2	11	8.33	0.8	-0.06	-0.72	140	8.39
	3	192	9.66	13.7	18	9.64	1.3	-0.02	-0.16	210	9.66
	4	10	10.59	0.7			0.0	-10.59	-100.00	10	10.59
	5	536	13.69	38.3	55	13.54	3.9	-0.14	-1.05	591	13.67
	6	283	16.82	20.2	22	16.90	1.6	0.08	0.47	305	16.83
	7	93	19.41	6.6	20	19.86	1.4	0.45	2.30	113	19.49
	8A	16	23.01	1.1	1	*	0.1	*	*	17	*
	8B	4	*	0.3	4	*	0.3	*	*	8	*
	8C	6	32.57	0.4			0.0	-32.57	-100.00	6	32.57
NURSING/MIDWIFERY Total		1269	13.88	90.6	131	14.51	9.4	0.62	4.45	1400	13.94
OTHER THERAPEUTIC	2	11	8.45	10.5	1	*	1.0	*	*	12	*
	3	1	*	100.0			0.0	*	*	1	*

	4	12	10.31	100.0			0.0	-10.31	-100.00	12	10.31
	5	18	13.28	100.0			0.0	-13.28	-100.00	18	13.28
	6	11	14.21	78.6	3	*	2.9	*	*	14	*
	7	9	17.25	81.8	2	*	1.9	*	*	11	*
	8A	18	22.86	81.8	4	*	3.8	*	*	22	*
	8B	5	*	100.0			0.0	*	*	5	*
	8C	2	*	40.0	3	*	2.9	*	*	5	*
	8D	1	*	20.0	4	*	3.8	*	*	5	*
OTHER THERAPEUTIC Total		88	16.30	83.8	17	24.56	16.2	8.25	46.79	105	17.64
PERSONAL AND SOCIAL CARE	4	1	*	2.9			0.0	*	*	1	*
	5	14	13.33	40.0			0.0	-13.33	-100.00	14	13.33
	6	12	16.22	34.3	3	*	8.6	*	*	15	*
	7	1	*	2.9	2	*	5.7	*	*	3	*
	8A	1	*	2.9			0.0	*	*	1	*
	8B	1	*	2.9			0.0	*	*	1	*
PERSONAL AND SOCIAL CARE Total		30	15.13	85.7	5	18.71	14.3	3.57	22.84	35	15.64

		FEMALE			MALE						
Post Family Description	**Band**	**Count of Gender**	**Av basic Hourly Rate**	**Gender Count as %age of JF**	**Count of Gender**	**Av basic Hourly Rate**	**Gender Count as %age of JF**	**Monetary Variance Male to Female**	**Monetary Variance Male to Female %**	**Gender Grand Total**	**Total Av of Basic Hourly Rate**
SENIOR MANAGERS	Health Board Member	4	*	17.4	3	*	13.0	*	*	7	*
	Other			0.0	1	*	4.3	*	*	1	*
	Grade A			0.0	1	*	4.3	*	*	1	*
	Grade B	3	*	13.0	5	*	21.7	*	*	8	*

	Grade C	1	*	4.3			0.0	*	*	1	*
	Grade D	4	*	17.4			0.0	*	*	4	*
	Grade F			0.0	1	*	4.3	*	*	1	*
SENIOR MANAGERS Total		12	22.66	52.2	11	25.11	47.8	2.45	10.29	23	23.83
SUPPORT SERVICES	1	189	7.59	40.6	82	7.58	17.6	-0.02	-0.22	271	7.59
	2	49	8.40	10.5	52	8.39	11.2	-0.01	-0.07	101	8.39
	3	22	9.58	4.7	23	9.54	4.9	-0.03	-0.36	45	9.56
	4	3	*	0.6	23	11.35	4.9	*	*	26	*
	5	1	*	0.2	7	13.59	1.5	*	*	8	*
	6			0.0	7	16.13	1.5	16.13	100.00	7	16.13
	7	2	*	0.4	3	*	0.6	*	*	5	*
	8B			0.0	1	*	0.2	*	*	1	*
	8C			0.0	1	*	0.2	*	*	1	*
SUPPORT SERVICES Total		266	8.06	57.2	199	9.40	42.8	1.34	15.58	465	8.63
Grand Total		2649	13.83	82.2	575	17.29	17.8	3.46	23.92	3224	14.45

NHS Borders Pay Gap		
Female Average	**Male Average**	**pay gap = 100 - ((Femaleave / Maleave)*100)**
£13.83	**£17.29**	**20.01%**

OVERALL ORGANISATION COMPARISON – Med/Dent – Senior Managers – AFC Bands

	FEMALE			MALE						
	Count of Gender	Av basic Hourly Rate	Gender Count as %age of JF	Count of Gender	Av basic Hourly Rate	Gender Count as %age of JF	Monetary Variance Male to Female	Monetary Variance Male to Female %	Gender Grand Total	Total Av of Basic Hourly Rate
Medical And Dental	135	28.91	54.4	113	34.46	45.6	5.55	17.65	248	31.44
Senior Managers	12	22.66	52.2	11	25.11	47.8	2.45	10.29	23	23.83
Agenda for Change	2502	12.98	84.73	451	12.80	15.27	-0.18	-1.38	2953	12.95
Org total	2649	13.83	82.17	575	17.29	17.83	3.46	23.92	3224	14.45

EQUALITY
IMPACT ASSESSMENT
(EIA)
Procedure and Toolkit
Version 2

You can get this document on tape, in large print, on disc and in various other formats. We can also provide information on language translations and extra copies. To arrange for an someone to meet with you to explain any parts of this document that may be unclear contact:

Equality and Diversity
Directorate of Public Health
NHS Borders
Newstead
MELROSE
TD6 9DB
Tel: 01896 826000

Foreword

Everyone wants to live in a community where they can participate fully and feel equally valued. We want to know that we will receive equal treatment when we visit public places and access public services and we want these services to be delivered in a way in which we feel included within society.

We know that for many disadvantaged groups this has not yet happened, and there remains considerable work to be done across public services before all people are treated equally.

Ending discrimination is not just about making buildings accessible by putting in ramps or producing documents in alternative formats. It is about systematically identifying barriers and reducing inequalities.

NHS Borders is committed to delivering the very highest standards of access and care for all community members and service users regardless of, age, disability, race, religion or belief, sexual orientation and /or gender, as well as enabling every member of staff within the organisation to contribute and maximise their potential.

NHS Borders endeavours to design, implement and deliver services, policies and functions that are fit for purpose and meet the requirements of the local population and workforce, ensuring that none are disadvantaged over the other.

NHS Borders' Single Equality Scheme and action plan set out how we aim to deliver equitable services, policies and functions that comply with all legal requirements. This Equality Impact Assessment (EIA) Process aims to support the commitments set out in the scheme. The guidance aims to do this by ensuring that EIAs are carried out on all new and revised strategies, policies, services and functions, ensuring that NHS Borders does not discriminate and wherever possible (e.g. :tests of reasonableness of adaptation and possible constraints of other legislation [e.g. Health and Safety]) promotes equality and fosters good relations.

-

Content

Introduction

We should Equality Impact Assess all of our policies in order to:

- Promote social inclusion
- Encourage meaningful engagements with diverse groups and strengthen understanding and sensitivity
- Enable effective targeting of services and resources, linked to needs
- To strengthen decision making and inform future business plans
- Increase confidence in NHS Borders and minimise the risk of legal action

The Equality Act 2010 states that all public bodies have a legal responsibility to assess and consult on how their policies, functions and services impact upon people from the different equality groups, and requires them to take account of the findings of their impact assessment within it's decision making process.

To take account of these duties, NHS Borders has developed an updated and generic Equality Impact Assessment (EIA) procedure. The procedure aims to ensure that by focussing on all equality groups we can deliver services, polices and functions that meet the legal requirements by not discriminating, promoting equal opportunities and fostering good relations.

Scope

This procedure applies to all areas of NHS Borders work. This procedure sets out the means by which the EIA process will be carried out across the organisation. Overall responsibility for the implementation within NHS Borders lies with the Board, Chief Executive and Directors. EIA's should be incorporated into and conducted within current departmental budgets.

Working arrangements include advice and support from the NHS Borders Equality Group members to staff implementing this procedure. All lead officers, managers and commissioners will be responsible for conducting EIAs on all new and revised/redesigned, services, policies, projects, strategies, committee reports and functions, this includes efficiency and financial decisions.

EIA outcomes should be agreed by the policy/service /function/strategies key stakeholders and a copy of the EIA and any supporting documents should be forwarded to the Equality and Diversity generic email account (equality@borders.scot.nhs.uk) or Public Health for publishing, monitoring and review purposes.

NHS Borders Equality Group along with the Corporate Quarterly Review process will monitor and review the EIA process and will report any findings and amendments to the Board.

What is Equality Impact Assessment (EIA) and why do we need to do them?

An Equality Impact Assessment (EIA) is a tool to help the NHS Board make sure its policies, services and functions are fit for purpose by meeting the needs of its community, service users and staff. An EIA also helps the Board ensure it doesn't discriminate and where possible promotes equality and inclusion.

Carrying out an EIA involves systematically assessing the likely (or actual) effects of policies on people in respect of what are known in the Equality Act 2010 as protected characteristics. These are:

- age,
- disability
- gender
- race,
- religion or belief,
- sexual orientation,
- marriage and civil partnership, and
- gender reassignment.

In addition we also take into account themes of rurality and deprivation in our assessment.

Under the Equality Act 2010 the NHS Board, as a public body, is required to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a characteristic and those who do not; and
- Foster good relations between people who share a characteristic and those who do not.

Having "due regard" means giving appropriate weight to equality in proportion to how relevant it is to a particular policy. An EIA provides the necessary evidence that the NHS Board has given due regard to equality issues before taking a decision.

For the purposes of the Act a "policy" is understood to be a broad term covering the full range of functions, activities (including service delivery) and decisions (including financial decisions) of the Board: **potentially anything NHS Borders does or Commissions.**

How is an EIA carried out?

Before carrying out an EIA it is first necessary to assess the relevance of the policy to equality and determine whether the policy has the potential to discriminate against any particular group in the community or employees. This should be done by completing an Equality Scoping Template (similar to the previously used Rapid Impact Assessment) which is attached at Annex A. Essentially this scoping exercise is a quick way (less than 20-25 minutes) of determining whether a full impact assessment is going to be necessary. This small step will provide a means of demonstrating that the equality implications have been considered and where no EIA is conducted providing evidence for that decision. A copy of the completed Equality Scoping Template should be forwarded to equality@borders.scot.nhs.uk and it will be published on the Equality and Diversity section of the Board's web site.

If, however, the conclusion of the equality scoping exercise is that an EIA is necessary this should then be carried out using the template in Annex B.

Who should carry out Equality Assessments?

The Director/General Manager/Head of Service responsible for the policy, project or service under consideration is the person responsible for ensuring that an EIA is carried out. However, all employees, including independent contractors, directors, managers and clinicians, have some degree of responsibility for ensuring that EIAs are conducted.

The NHS Board and the Chief Executive are ultimately accountable for ensuring that Equality Impact Assessments are completed and published. When policy or service proposals are submitted for consideration, the Chief Executive and Board members will now be expecting to see the results of an EIA within these reports.

The role of the Equality Group is to support staff to carry out the legal obligation to undertake the EIA process.

As a minimum an EIA should be prepared by the lead person responsible for developing or reviewing the policy, together with a critical "friend" (often a member of the Board Equality Group) who is familiar with the EIA procedure but not necessarily the policy being assessed. Involving a critical friend is important to help ensure the EIA procedure is carried out systematically and robustly. It may be that involving a small number of key stakeholders might also be advisable but guidance and advice is available at any stage from the Boards Equality Group membership.

When should an EIA be undertaken?

For Board Members to meet their responsibility to give due regard to equality and diversity within the decision making process, equality impact assessments must not be retrospectively completed. All policies should be impact assessed as part of the development and planning stage, and thereafter as part of the review process. It is important to note that the impact and relevance of a policy does not just depend on the number of those people and groups who are affected, but also by the significance of the effect on them.

An impact assessment should be carried out when:

Developing a new policy, strategy, project, service or function
Reviewing existing policies, strategies, services or functions

Reporting and Accountability

Where an EIA is completed, the summary sheet should be attached as an Annex to the Clinical Board or NHS Borders Board report. However, for significant policies, consideration should be given to including the full EIA as an Annex to the report. A copy of the full EIA should be forwarded to equality@borders.scot.nhs.uk and it will be published on the Equality and Diversity section of the Board's website.

Annex A

NHS Borders
Equality and Diversity Impact Assessment Guidance

How to Complete the Equalities Scoping Template

Title:	*Insert the name of the policy, service, function etc. that is being considered. From here onwards in the documentation this will be referred to as the policy.*

Which communities, groups of people, employees or thematic groups do you think will be, or potentially could be, impacted upon by the implementation of this policy? Please indicate whether these would be positive or negative impacts

The purpose of this section is to highlight what communities or groups you are likely to need to take into consideration within the equality impact process. Since most of the Board's services are people centred and have a direct impact on people at some time it is likely that most policies will impact on all or at least some.

There is no need to discuss at this stage how or when the needs of specific groups will be met. Instead, it is sufficient to indicate whether there are likely to be positive or negative impacts on these communities or groups if the policy is implemented.

1. **Who does the proposed piece of work/policy/proposal affect?**

Staff	Patients/Service Users/Carers	Communities/Voluntary Groups	Public
☐	☐	☐	☐

Tick all that apply. Note that a policy might be aimed at one particular group but still affect others

2. **What are the aims and objectives of the work/policy/proposal being assessed?**

Give a brief summary of the aims of the policy i.e. its purpose. This should include reference to other relevant documents such as the Delivery Plan and/or Directorate Plans.

	Yes	No

3.	**Will the proposal have any impact on equality of opportunity, discrimination between groups or relations between groups?** *Could this policy reduce or help make progress towards reducing discrimination and harassment for particular communities or groups, including employees? Could the implementation of this policy improve or reduce access to the service provided for any groups?*		
4.	**Is the proposal controversial in any way in terms of equality and diversity (including media, academic, voluntary or sector specific interest)?** *Could the implications of the policy be seen as controversial in anyway e.g. a decision to remove funding, cut or change a service.*		
5.	**Will the workforce or users of the service be disadvantaged as a result of the proposed work?** *Could this policy possibly have a negative impact on any of our workforce or patients/service users*		
6.	**Is there doubt about answers to any of the above questions (e.g. there is not enough information to draw a conclusion)?** *If you are unsure of any of the answers tick yes and do a full impact assessment.*		

If the answer to any of the above questions is yes or you are unsure of your answers to any of the above a full impact assessment is recommended.

7.	**Given the above statement, do you recommend a full impact assessment is completed?** *Simply indicate by selecting 'yes' or 'no' whether your assessment above indicates a need to conduct an equality impact assessment.*		
8.	**If a full impact assessment is not required briefly explain why and provide evidence for the decision.** *Where a decision has been taken not to progress with an EIA it is important to record this, and provide an explanation of how you made your decision.* *Generally, this will only require a brief explanation, however you must ensure that you provide sufficient information to demonstrate that your decision was reached objectively* *Not only will this help you to refer back to why certain decisions were taken in the future, you will also be able to provide the necessary evidence in order to defend your decisions should the need arise.*		

Completed By

Name		Dept.	
Post		Date	

For your records, keep one copy of this Equality Scoping Assessment form and send an electronic copy plus any supporting documentation to evidence your decision to equality@borders.scot.nhs.uk

NHS Borders

Annex B

Record of Equality Impact Assessment (EIA)

Section One:

Details of Service	
1.1	**Name and brief description of the service, policy or function:** *Insert the name and a short description of the policy, strategy, project, funding application, initiative or financial decision*
1.2	**What are the aims and purpose of the service, policy or function? (*consider explicit and implicit aims and outcomes)*** *Give a brief summary of the aims of the policy i.e. its purpose. This should include reference to other relevant documents such as the Delivery Plan and/or Directorate Plans. Give a brief summary of the expected outcomes of the policy i.e. what you hope to achieve.*
1.3	**Which groups or individuals have you involved or consulted with about your service, policy or function? *(see guidance: Issues you will need to consider when undertaking an Equality Impact Assessment.)*** *Both the relevant equalities legislation and the duty to achieve best value demand effective consultation and engagement. This question allows the policy maker to describe how this was achieved. Setting out the details can also help to identify those groups that may have been unintentionally missed out* *Auditors will expect to see evidence of engagement with relevant groups where policies are targeted those groups. For example if a policy has been developed for a group of people with a particular disability, have people from that group been involved in its development?*

Section Two:

In this section the assessment should be used to identify the main impacts that the policy could have on different groups or themes particularly relevant to the Scottish Borders.

The groups listed relate to the new statutory requirements of the legislation i.e. the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex and sexual orientation, together with equality and diversity themes particularly relevant to The Scottish Borders – health, human rights, rurality and deprivation.

For each group you should identify any particular impact or issues that the policy may have for the group. Impacts could be positive or negative and both should be described. A new policy may set out to improve service provision for a particular group, but it might also have unintended consequences for other groups or it might present particular challenges in relation to a group.

Impact assessment is not a precise science and it will not be possible to identify all the possible consequences of a policy. For service related policies where you are unsure of the likely impacts on a particular protected characteristic it may be helpful to contact a member of the Equality and Diversity Forum or circulate the draft to stakeholders - both partners and community groups, who can help to identify unforeseen impacts.

Please ensure that if there are no impacts on a particular protected characteristic or theme that you state the reasons for this within the response box. This indicates that you have considered the impact on each characteristic.

It is also important to consider people with multiple protected characteristics as they can potentially face greater incidences of discrimination and consideration than those only falling into a single category or a few categories.

For example a Muslim female who has a physical disability and requires access to the NHS to maintain her health has the potential to have a very different experience from a male with a physical disability who is an atheist.

Please use the table below to assess the impact of the service, policy or function on different equality groups. Please mark negative or positive impacts for each equality group.

Equality Groups	Nature of Impact					Please set out details of negative and positive impacts
	Negative			Positive	No Impact	
Age: Effects on children, young people and older people	low	med	high			*Although, there is a higher than average number of older people in the Scottish Borders, you should consider the impacts on all age ranges including children and young people. Both the Older and Younger age groups within the population are predicted to grow in the coming years.*
Disability e.g. Effects on people with mental, physical, sensory impairment, learning disability, visible/invisible, progressive or recurring	low	med	high			*A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.* *Consider if what is being proposed causes or removes any barriers for disabled people to access or participate.*
Gender: Effects on Male, Female, Transgender and Transsexual people	low	med	high			*Consider if there are impacts that relate to women or men. For example, there are a larger proportion of women who work part-time than men and women tend to have more caring responsibilities. So to ensure inclusivity of access to your service, you may like to consider alternative opening hours, evening consultation and publicity events.*

Equality Groups	Nature of Impact					Please set out details of positive and negative impacts
	Negative			Positive	No impact	
Effects on Race Groups: including colour, nationality, ethnic origins, including minorities (e.g. gypsy travellers, refugees, migrants and asylum seekers)	low	med	high			*The Scottish Borders has an ethnic minority population of about 1%, which is made up of a large number of different ethnicities with 42 different languages being spoken. We have a significant migrant community from Eastern Europe and Portugal who may have specific requirements which you must consider. Consideration should be given to language* *Insert the impact/issues for both ethnic minority communities and the settled community – this is an important consideration for fostering good relations.*
Effects on people with Religious or other Beliefs: different beliefs, customs (including atheists and those with no aligned belief)	low	med	high			*Religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.Consider whether there are any adjustments needed to ensure all religions and beliefs are included in what is being proposed e.g. timing of events/services to allow for religious observance.*
Effects on Sexual Orientation, e.g. Lesbian, Gay, Bisexual, Heterosexual	low	med	high			*Over half LGB people conceal their sexual orientation when using a public service, for fear of discrimination. Does your policy impact on LGB people, and if so does the policy tackle discrimination or are there opportunities to positively profile LGB people?* *Does the policy treat people transitioning their sex with equal dignity and respect?*

Equality Groups	Nature of Impact					Please set out details of positive and negative impacts
	Negative			Positive	No Impact	
Effects on Poverty Groups: (including impacts on communities in rural areas, people on low wages, who have literacy and other difficulties etc.)	low	med	high			*Does the policy improve people's life circumstances e.g. improve access and health for those on low incomes or in unemployment?* *Does it take account of the limitations people in poverty may face such as access to services, transport and education?*
Effects on people with health problems/issues or needs (including those with recognised medical and mental health conditions). The effects on public health and the general health of the population caused by the service change should also be assessed here.	low	med	high			*Detail how the policy improves or negatively affects people's health and well-being*?

Effects on staff including full time, part time, permanent temporary, job share etc.	low	med	high			*How will the policy impact upon staff? Eg will additional duties need to be undertaken, will additional hours be required, will there be capacity issues; will these be positive or negative impacts?*

Section 3: Summary Findings of Equality Impact Assessment

3.1	**Please summarise the general impact of the service, policy or function and its impact on the equality groups:** *Summarise your findings from the above assessment. Include a general assessment and conclusion and also note any findings or areas which need further investigation/work.* *We are required to take into account the findings of our impact assessments within the decision making process. Therefore you must ensure that everybody involved in the process including elected members are given this information.*
3.2	**Please summarise mitigation actions to deal with negative impacts of the service, policy or function:** *If any negative impacts have been found include the steps you are going to take to eradicate them or where this is not possible what you will do to minimise the impact.* • *Please note that if this assessment shows that one group is going to be discriminated against the proposal must not go ahead until the discrimination is eradicated.*

Section 4: Signing off your Equality Impact Assessment

I confirm that this report is an accurate and correct account of the EIA findings for this service change and I am satisfied with the conclusion and outcome of the impact assessment: ☐	
Agreed by Manager or Head of Service	*The Director, General Manager or Head of Service Responsible for the policy must be satisfied with the findings and sign off the EIA.*

Equality Impact Assessment (EIA)
SUMMARY (Publishing Form)

Title of Policy/Function/Service:		
Directorate/Department: **Head of Service:**		
Telephone No: **Email Address:**		
Names/ Job titles of Assessors		
Summary of Policy / Service /Function aims:		
Strands Impacted: **Please note:** If you leave any box blank in this section you will have decided that your proposed service or function has no impact on that particular strand.	Age ☐ Disability ☐ Gender ☐ Race ☐ Religion or Belief ☐ Sexual Orientation ☐ Poverty/Social Exclusion ☐ Health ☐	
Summary of key issues arising and decisions made	**We are required by law to publish our EIA findings:** **Fill out this section and forward it to equality@borders.scot.nhs.uk so that it can be published on the website.**	
Summary of key recommendations		
Agreed by *(insert appointment)*	Name:	Date:

For further information, a copy of the full assessment or if you require this information in an alternative format or language please contact:

Equality and Diversity, Directorate of Public Health, NHS Borders,
Newstead, MELROSE, TD6 9DB
Tel: 01896 826000