

# Equality Mainstreaming Report

Including Equality Outcomes (2017–2021)  
and Equal Pay Statement

April 2017



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## Foreword

We are pleased to present our Equality Mainstreaming Report, which sets out how Healthcare Improvement Scotland ensures equality is embedded into our work and provides the information we are required to publish by the specific duties of the Equality Act 2010.

Healthcare Improvement Scotland is the national healthcare improvement organisation for Scotland. We drive improvements that support the highest possible quality of care for people in Scotland. We seek to improve care services by focusing on the needs and experiences of people, their families and their carers. Embracing, understanding and mainstreaming equality across our organisation is key to achieving our commitment to support the highest standards of health and social care in Scotland.

This report contains examples of how we have mainstreamed equality throughout the diverse range of our work, from involving people with lived experience of particular conditions to help inform and influence what we do, to providing NHS boards with a database which can capture equality monitoring information about their volunteers. We report on our progress in delivering the equality outcomes we set for ourselves in 2013 and set out four new equality outcomes to ensure we continue to advance equality, eliminate discrimination and foster good relations through our workforce and all that we do. Finally, we set out our policy on equal pay and report on occupational segregation and gender pay gap information.

While we have made good progress we are committed to continuous improvement to achieve equality. We will draw up an Equality Mainstreaming Action Plan based on our experience, knowledge and evidence to support our continued progression. We seek to maintain a working environment in which everyone feels included, respected and valued, and we will provide leadership, support and guidance to help ensure that equality is consistently considered by everyone across our organisation.



**Dr Dame Denise Coia**  
Chair  
Healthcare Improvement Scotland



**Robbie Pearson**  
Chief Executive  
Healthcare Improvement Scotland

# 1 Introduction

## **The specific duties in summary**

The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 (as amended) require us to:

- report on mainstreaming the equality duty
- report progress on the equality outcomes we set in 2013
- publish new equality outcomes for 2017–2021
- assess and review our policies and practices
- gather and use our employee information
- publish gender pay gap information
- publish a statement on equal pay between women and men, people who are disabled and people who are not, and people who fall into a minority racial group and people who do not
- consider award criteria and conditions in relation to public procurement
- use information on members or Board members gathered by the Scottish Ministers, and
- publish in a manner that is accessible.

Mainstreaming equality means taking steps to ensure that equality is considered within everything that we do, and by everyone who works, volunteers or collaborates with us.

This report has been produced to demonstrate how we are meeting the specific duties.

## 2 Mainstreaming equality

Healthcare Improvement Scotland seeks to mainstream equality considerations across the range of work we do. In this section of our report we provide information about the ways in which we do this.

### The Equality and Diversity Working Group

Our Equality and Diversity Working Group supports the organisation to meet its legal obligations under the Equality Act 2010. The group provides a key route to involve and consult staff on equality and diversity issues and aims to embed equality across each of our directorates. The group specifically:

- supports the development, implementation, monitoring and review of our equality outcomes and related action plans
- helps to evaluate the effectiveness of our equality outcomes and reports progress to the Board through the Scottish Health Council and Staff Governance committees
- supports the development of initiatives, including training and use of case studies, which promote an organisational culture where equality, respect and fairness are valued and discriminatory practices are not tolerated
- promotes a partnership approach with other organisations to help improve the effectiveness of equality and diversity activities
- identifies key issues and prioritises required actions in relation to equality or inequalities relevant to our work, and
- recognises and values the diverse nature of our workforce and stakeholders by promoting equality of opportunity in recruitment and engagement of both staff and volunteers.

### Equality Impact Assessments

The consideration of Equality Impact Assessments (EQIAs) is one of the main ways in which we seek to ensure equality is mainstreamed across the organisation.

EQIA training is included as part of the mandatory induction training for all new staff. An EQIA screening form and full EQIA tool, along with a guidance document, are available to support staff to assess the impact of their work against the needs of the general equality duty. Staff undertaking equality impact assessments are offered additional support, advice and guidance from our Equality and Diversity Advisor.

Our Knowledge Management Team is also available to conduct a thorough literature search to help gather relevant information and evidence. This assists with the identification of appropriate recommendations, intended to address any issues identified by the EQIA.

We maintain an EQIA database to help ensure that all EQIAs are progressed appropriately. A statement on the coversheet of every paper presented to our Board

provides information about the equality considerations, including any EQIA, relevant to the issue being discussed. Completed EQIAs are published on our website.

Our EQIA process has led to the early identification of potential inequalities when reviewing, designing and developing policies and so we have been able to put a greater emphasis on building in relevant equality considerations to all policies as they are developed and implemented.

## **Health inequalities**

As well as taking account of the impact our work will have on our ability to meet the general equality duty, our equality impact assessment process takes into consideration the potential for our policies to widen the health inequalities gap. For example, consideration is given to the impact our policies may have on people because of their socioeconomic status, their experience with the criminal justice system or homelessness.

## **Taking a human rights based approach**

A member of our staff attends Scotland's National Action Plan - Human Rights Action Group on Health and Social Care. The role of the action group is to identify opportunities for using human rights as a driver for change in health and social care.

In 2015, we began to explore the benefits of embedding human rights more explicitly in our work. We decided to focus on two existing programmes of work, as they had already identified that respecting the rights and interests of particular groups was especially important to their work. These were Our Voice and the Scottish Patient Safety Programme - Mental Health.

The Scottish Human Rights Commission (SHRC) provided us with advice and support during this process. The SHRC delivered a training session for relevant staff to help improve their understanding of human rights and how they relate to their programmes of work. The training also highlighted the use of the [PANEL](#)<sup>1</sup> principles as a way of breaking down how to incorporate the use of a human rights based approach in practice.

After the training, our programme leads assessed how they applied each of the PANEL principles in their work. This allowed them to establish where they were already incorporating the principles to good effect and to highlight any areas for improvement. The SHRC provided feedback and suggestions on these assessments, acting as a 'critical friend'. Both programmes identified additional steps they could build into their work.

Scotland's National Action Plan for Human Rights highlighted our use of the PANEL principles in their publication 'Human rights in health and social care – putting it into practice'. The link to this publication is below:

[www.scottishhumanrights.com/media/1408/shrc\\_case\\_studies\\_report.pdf](http://www.scottishhumanrights.com/media/1408/shrc_case_studies_report.pdf)

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<sup>1</sup> Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality

In 2016, the SHRC delivered a similar training session to our staff from four different programmes of work. During the coming year, we will be considering the learning from this activity and how a more explicit human rights based approach might be used across the organisation more routinely.

### **Workforce equality monitoring**

Our workforce equality monitoring data is used to measure our performance and progress towards our equality and diversity goals and has been used to inform the development of our equality outcomes for 2017–2021.

We will be taking steps to improve our equality monitoring disclosure rate and anticipate that this will be supported with the introduction of a new human resources system in 2017, intended to improve the data capture of staff details.

Our Workforce and Equalities Monitoring Reports for 2014–2015 and 2015–2016 are published on our website and can be accessed using the links below:

[www.healthcareimprovementscotland.org/previous\\_resources/policy\\_and\\_strategy/workforce\\_monitoring\\_2014-2015.aspx](http://www.healthcareimprovementscotland.org/previous_resources/policy_and_strategy/workforce_monitoring_2014-2015.aspx)

[www.healthcareimprovementscotland.org/previous\\_resources/policy\\_and\\_strategy/workforce\\_monitoring\\_2015-16.aspx](http://www.healthcareimprovementscotland.org/previous_resources/policy_and_strategy/workforce_monitoring_2015-16.aspx)

### **Public involvement equality monitoring**

Our Engaging People Strategy 2014–2020 sets out our commitment to ensure that people are engaged in everything we do. We involve patients, service users, carers, members of the public, public partners (volunteers who work with us) and third sector organisations in a range of ways and in different aspects of our work.

Equality monitoring helps us to understand if our engagement has been inclusive and helps identify if action is required to address any potential inequality. Our most recent public involvement equality monitoring data has been used to inform the development of our equality outcomes for 2017–2021.

### **Procurement**

We consider equality throughout our tender processes and comply with all legislative procurement requirements. Public sector procurement is governed by various pieces of legislation and two new pieces of legislation came into force in 2016:

- The Public Contracts (Scotland) Regulations 2015, which implement the new EU Directive on public procurement, and
- The Procurement (Scotland) Regulations 2016, which implement the Procurement Reform (Scotland) Act 2014.

These regulations support the implementation of our equality duty in different ways. The new EU Directive specifically permits social issues to be considered, so this will further support the inclusion of equality considerations in our award criteria.

The Procurement Reform Act requires public bodies to publish procurement strategies for their regulated procurements (over £50,000 for goods and services, and over £2m for works). These strategies must include a range of policy statements, including ‘treating suppliers equally and without discrimination’, and ‘consulting and engaging with those affected by its procurements’, both of which will assist us in complying with the equality duty.

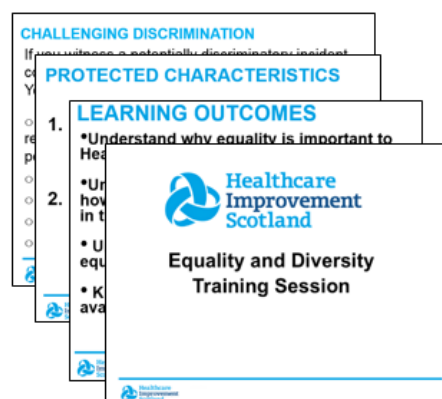
Healthcare Improvement Scotland is included as part of the Scottish Ambulance Service Shared Procurement Service draft procurement strategy for regulated procurements. This strategy supports procurement staff to work with stakeholders to implement the requirements of the Procurement Reform Act. The Shared Procurement Service carries out equality impact assessments for relevant procurements. Annual reports on procurement strategies are required to be published from 2018 onwards and so will be available for the public to access.

## Equality and diversity training

Equality and diversity training is mandatory for all our staff. The training consists of an online e-learning module and a group training session facilitated by the Equality and Diversity Advisor, or another suitably trained member of the Public Involvement Unit.

The training provides an overview of the requirements of the Equality Act and the public sector equality duties and emphasises how equality relates to staff in their role. Elements covered in the training include:

- what equality and diversity means
- the benefits of equality and diversity
- the legal requirements
- the protected characteristics
- types of discrimination
- how to challenge inequality, and
- equality impact assessments.



## Equal pay and gender occupational segregation information

As at 31 March 2016, we employed 283 (75.47%) female staff and 92 (24.53%) male staff.

Female staff are represented well at all levels of the organisation and we believe there is not a lack of opportunities for female staff to enter the workforce at any grade or to progress once they are employed.



Analysis of our pay gap and additional information relating to occupational segregation is presented in Section 6 of this report.

## Flexible working

We encourage our staff to have a healthy work-life balance and our flexible working policy is intended to support this. Flexible working hours are available to the majority of our staff. The only exception is the Death Certification Review Service Team, who are employed on agreed shift patterns due to the requirements of the service.

## Positive about disabled people symbol

We have maintained the use of the 'two ticks' positive about disabled people symbol awarded by Job Centre Plus. The 'two ticks' symbol is given to employers who have made commitments to:



- interview all disabled applicants who meet the minimum criteria for a job vacancy and to consider them on their abilities
- discuss with disabled employees, at any time but at least once a year, what you can both do to make sure they can develop and use their abilities
- make every effort when employees become disabled to make sure they stay in employment
- take action to ensure that all employees develop the appropriate level of disability awareness needed to make these commitments work, and
- review these commitments every year, assess what has been achieved, plan ways to improve on them and inform employees and Jobcentre Plus about progress and future plans.

We have recently updated our agreement to use the new Disability Confident Scheme symbol administered by the Department for Work and Pensions, which will supersede the positive about disabled people symbol in 2017.



## NHSScotland Equality and Diversity Lead Network

We continue to be part of the NHSScotland Equality and Diversity Lead Network. This is a peer support network for equality leads from all the NHS boards in Scotland. The group shares best practice examples, discusses the current legal requirements relating to equality and horizon scans for changes or new requirements.

For example, a representative from the network is part of the Scottish National Equality Improvement Project (SNEIP). The SNEIP was set up in 2014 to help drive improved performance on the public sector equality duty and the Core Project Team consists of the Scottish Government, the Equality and Human Rights Commission (EHRC) and Close the Gap. The information and guidance obtained from the SNEIP

through the network has helped inform Healthcare Improvement Scotland's approach to reporting on our progress towards mainstreaming the equality duty.

There is also an opportunity for external speakers or guests to join the network meeting to support improvement, learning and development, for example representatives from the Scottish Government, the EHRC and the Scottish Council on Deafness have all attended meetings.

### **Special NHS board action learning set**

Throughout 2016, we attended and contributed to fortnightly meetings held between the equality leads from each of the special NHS boards. The purpose of the meetings was to share good practice and information about the work being undertaken by each of the special NHS boards to meet the reporting requirements of the specific duties. We collaborated with the other special NHS boards to engage with NHS staff, and third sector organisations that represent the interests of people with the relevant protected characteristics, to gather evidence that was used to inform our equality outcomes.

### **Board diversity**

The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 (as amended) require relevant listed authorities to use information on Board members gathered by the Scottish Ministers to help ensure that those appointed to public boards better reflect the diversity of the Scottish population.

Guidance<sup>2</sup> published by the Equality and Human Rights Commission in October 2016 sets out that relevant listed authorities must publish:

- the number of men and women who have been Board members of the authority during the period covered by the report
- how the information provided about the relevant protected characteristics of its Board members has been used so far, and
- how the authority proposes to use the information provided in the future to promote greater diversity of Board membership.

There has been a constraint on our ability to fully achieve these requirements, as the Scottish Ministers have not gathered or shared all the information we require in time for inclusion within this report.

We can report that during the period April 2015 to March 2017 we have had 16 Board members: eight were female and eight were male. We will take all reasonable steps to implement the Scottish Government's [Guidance on Succession Planning for Public Body Boards](#) once the required information is shared with us.

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<sup>2</sup> [Board diversity and the Public Sector Equality Duty: A guide for public authorities in Scotland](#)

### 3 Mainstreaming examples

The following examples illustrate how we mainstream equality in our work in practice. While this is not an exhaustive list of examples of what we do, it provides information on a range of different areas of our activity.

#### Public involvement

Through the Scottish Health Council, we promote how the NHS in Scotland is continually improving how it involves people in decisions about health services. We promote good practice, exchange ideas and develop new approaches on how to involve people in health services, which includes guidance on involving diverse groups of people.

Public involvement is also an integral part of how we work. We have a pool of 35 public partners, who are members of the public who are involved in our work as volunteers. They play a pivotal role in helping shape our own work and help to ensure it reflects the needs of the people who use health services in Scotland.



In 2017, we achieved our Investing in Volunteers (IIV) quality standard accreditation, for the third time, for the way in which we involve and support our public partners. The award demonstrates our long-standing commitment towards volunteer development within Healthcare Improvement Scotland. The standard, overseen by Volunteer Scotland, sets out the ways in which volunteers are treated in an organisation, from recruitment until they leave.

The involvement of public partners is just one way in which we involve people in our work. When developing new national guidelines, we will also seek to involve people with experience of specific health conditions or disabilities. For example, a member of the public, who was first diagnosed with glaucoma more than 20 years ago, joined our guideline development group for this condition. He used his own perspective and experience to help us develop a new national guideline for clinicians to use, to support the referral and safe discharge of people with glaucoma across Scotland. You can read more about this patient story and other stories about the difference our work has made on our website using the link below:

[www.healthcareimprovementscotland.org/casestudies2016/index.html](http://www.healthcareimprovementscotland.org/casestudies2016/index.html)

#### Volunteering

As part of the Volunteering in NHSScotland programme, the Scottish Health Council provides a Volunteering Information System (VIS) for use by NHS boards, including our own organisation. The VIS is a database that is intended to help NHS boards

manage their volunteer programmes. The VIS includes the functionality to capture equality monitoring information for volunteers. Whilst this is not a legal requirement, it is promoted as good practice and supports the attainment of the Investing in Volunteers award.

The VIS currently provides NHS boards with a breakdown of the profile of volunteer applicants. A new function will soon be added to the system, allowing NHS boards to compare the profile of their engaged volunteers with the profile of their volunteer applicants. This will help NHS boards identify whether positive action measures are required to improve the under-representation of particular protected characteristic groups.



By including the equality information fields in the VIS, we are encouraging NHS boards to mainstream the collection and analysis of equality monitoring data for volunteers as a routine element of volunteer recruitment and engagement.

### **Death certification**

We run the Death Certification Review Service (DCRS), which was set up in 2015 to provide independent checks on the quality and accuracy of a sample of Medical Certificates of Cause of Death (MCCDs). An MCCD is the form a doctor completes when someone has died.

We were aware of the potential impact the introduction of this service may have had on some religious groups and so undertook engagement with representatives from a number of different faiths from across Scotland. This engagement provided the DCRS Team with valuable insight into the different religious and cultural requirements of people living in Scotland.

The DCRS Team created a frequently asked questions section on our website, which includes information about how people can apply for advance registration where special circumstances, such as religious or cultural beliefs, require a funeral to take place within a short period of time after the death. A telephone number and email address are also available to support people who require assistance.

Since the service commenced, around ten per cent of advance registration requests have been noted as being related to religious or cultural beliefs. Feedback on how the service has handled these requests has been very positive.

### **Glasgow Centre for Inclusive Living (GCIL)**

In 2015, we worked in partnership with the Glasgow Centre for Inclusive Living (GCIL) to support their Professional Careers Programme. This programme provides disabled graduates with an opportunity to gain work experience. We were delighted to welcome a graduate to our organisation in October 2015 and they were happy to share their experience with us, as detailed below.

“Since starting with Healthcare Improvement Scotland (HIS) last October, I have learned a great deal. I have been fortunate to be part of a friendly, supportive team who are willing to be patient.

“Before starting with HIS I had limited work experience, therefore I was unaware of the support I would require to fully participate in the workplace. However, Access to Work has been extremely helpful in this sense as well as GCIL, and my manager at HIS. Access to Work had the expertise to suggest and provide software and devices to support my work process, to allow my skills to be utilised effectively. Without support from GCIL and Access to Work I would not have been aware of the technological support that was available to me at work.

“It did take some time to find my place in the team, however, I must say my manager has been extremely supportive and we have regular meetings to assess my workload. Although we have a workplan for my two years with HIS, we are able to be flexible and adjust the plan to suit the situation.

“At the end of this placement I would like to have an understanding of my capabilities within the workplace. I would also like to gain work experience within a relevant team which can then be used to start my career. I would ultimately like for this experience to help me develop my skills so that I can be successful in securing permanent employment.

Healthcare Improvement Scotland is a really great organisation to work for, and I would love to be able to continue working for HIS as a member of staff, after my two years of training is finished.”

## Person-Centred Health and Care Programme

Our Person-Centred Health and Care Programme seeks to improve the quality of healthcare services, by focusing on the needs, experiences and wishes of people, their families and carers. The programme supports people to develop the knowledge, skills and confidence they need to more effectively make informed decisions, be involved or support involvement in their own health and care. It promotes care that is personalised, co-ordinated and enabling so that people can make choices, manage their own health and live independent lives, where possible.

Embracing equality is integral to achieving person-centred care and we promote listening, enablement, dignity, compassion and respect when interacting with people to find out what matters most to them.

This programme is supported by three of our public partners, who provide a public perspective on our approach and promote the consideration of the distinct individual needs of people.





Our public partners helped to identify aspects of the programme that could limit the ability of some people to participate in the conversation that happens at the point of care, where we aim to better understand individuals' care experience in order to inform improvement opportunities. It was noted that there may be challenges for some people to participate in these conversations if they required additional communication support, for example a person with a cognitive impairment, or a learning disability, or people whose preferred language is not English.

To help promote equality and improve the opportunity for people to benefit from this programme, all organisations participating in the programme carried out local equality impact assessments of their projects and provided, where necessary, additional information and training around translation services, language line and other forms of conversation aids such as [Talking Mats](#)<sup>3</sup>, for the staff undertaking the care experience enquiry.

### **SIGN Guideline on the Assessment, Diagnosis and Interventions for Autism Spectrum Disorders**

The Scottish Intercollegiate Guidelines Network (SIGN) is part of Healthcare Improvement Scotland and produces evidence-based clinical guidelines to aid clinician and patient decision-making.

To ensure issues of importance to patients are included in the guidelines, their views are gathered through a patient-focused literature search and a survey of relevant patient organisations. In some cases, focus groups are held to gather views from specific groups. The views are discussed when agreeing the remit of the guideline and during the considered judgement process where guideline group members consider the evidence alongside benefits, harms and acceptability to patients.

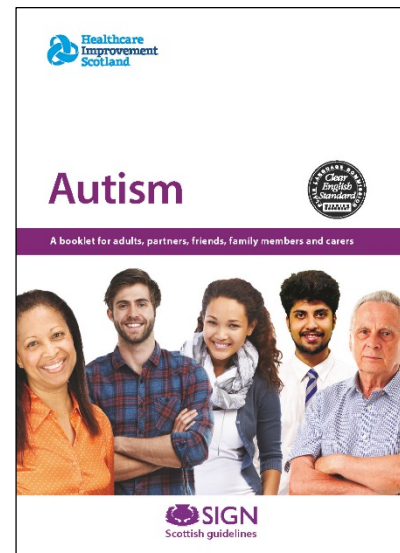
SIGN's first guideline on assessment, diagnosis and clinical interventions for children and young people with autistic spectrum disorders (ASD) was published in 2007. Two patient versions of the guideline were produced to translate the clinical language used in the guideline to more accessible formats for parents and carers, and for young people with ASD. As well as the standard booklet, the patient and carers booklet was produced in seven different languages, a British Sign Language version on DVD and an App.

Since 2007, there has been an increasing awareness that ASD is a lifelong condition and adults and older people may not be receiving the care or access to services that they need due to a lack of recognition or diagnosis of ASD. The revision of the SIGN guideline on ASD for healthcare professionals, published in 2016, therefore included adults and older people as well as children and young people.

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<sup>3</sup> Talking Mats is an interactive resource intended to help improve the lives of people with communication difficulties by increasing their capacity to communicate effectively about things that matter to them.

To help adults with ASD, or undiagnosed ASD, understand the diagnostic process and what clinical interventions are available, an additional patient version of the clinical guideline for adults was developed. Consultation on the draft patient version provided considerable feedback from potential users around the layout and language used. A focus group with adults with ASD took place to help shape the format and content of the patient version. The draft was revised in light of this feedback to improve accessibility for people with ASD. The patient version of the Assessment, Diagnosis and Interventions for Autism Spectrum Disorders Guideline was published in December 2016.



## Care of Older People in Hospital Standards

During the consultation period on the Draft Care of Older People in Hospital Standards, we sought to better understand the experience of older lesbian, gay, bisexual and transgender (LGBT) people. We attended an LGBT Age meeting, to help us achieve this. LGBT Age is a project run by LGBT Health and Wellbeing for LGBT people aged 50 and over.

Two examples were given from the meeting, which were fed back to the development group and informed the wording of our final standards published in 2015:

- In the draft standards, we talked about ‘patients and/or their family’ being involved in decisions about their care. Many of the group members noted that they had severed all ties with their families, had not seen them for many years and in fact had moved to another part of the country to begin a new life and so they did not want their family to be involved in any decisions about their health. As a result, the final standards referred to ‘patients (and/or representatives)’ being involved.
- A transgender man told us that on admission to hospital he was taken to a women’s ward, as his birth certificate stated that he had been born female. He had undergone gender reassignment and had been living as a man for many years. He informed us that being placed in a female ward caused him deep embarrassment as well as making the women in the ward uncomfortable. This feedback informed the wording of Standard 2: Maintaining patient dignity and privacy, where the standard statement is: ‘Older people in hospital will be treated with dignity and privacy, particularly during communication, physical examination and activities of daily living.’

## Prevention and Management of Pressure Ulcers Standards

In 2016, we published new standards for the prevention and management of pressure ulcers. Pressure ulcers can occur in any person who has limited mobility, or who is acutely ill or malnourished. Other factors that can contribute to a person being

susceptible to developing pressure ulcers include diabetes, palliative and end of life care, incontinence and nutrition.

We held a number of focus groups and engagement exercises when developing the standards. From this engagement, we received feedback from a young woman who had experienced pressure ulcers. The young woman was a wheelchair user and had severe oedema, which is a build-up of fluid in the body which causes the affected tissue to become swollen. The issue highlighted was around access to appropriate seating, as being given a smaller wheelchair was putting more pressure on her pressure ulcers, and so made them worse. As a result of this feedback, the project group ensured that the standards specifically made reference to individuals being assessed for appropriate equipment such as mattresses, seating and environment. This feedback also resulted in the inclusion of a recommendation for regular reviews from the point of initial risk assessment, right through to care planning and treatment.

Another focus group held with a staff and parent group at a children's hospital highlighted a wide range of issues from neonatal babies to children within the education system. The feedback from this group was focused around education and training for staff who treat babies and children, and access to support and information for parents and carers. This feedback was considered and the standards include specific criteria around education and training for all staff, regardless of the age of the person they are caring for. Other criteria focus on individuals and their representatives having appropriate support and information about the risks of pressure ulcers, how to prevent them and when to report any concerns.

### **Diabetic Retinopathy Screening Standards**

Diabetic retinopathy is a common complication of diabetes which affects the eyes.

During the consultation period for the Draft Diabetic Retinopathy Screening Standards, a focus group was held with people with a learning disability from a group based in Forth Valley. The group highlighted the need to make the invitation letter for screening and the accompanying information leaflet more user friendly and accessible. The group provided guidance on what would be beneficial to them and discussed the language, images used, patient stories, how contact details are presented and the format. This information was fed back to the project group and, although this information could not have a direct impact on the standards, it was forwarded onto the diabetic retinopathy screening programme co-ordinator, so that these points could be acted upon.

### **Pregnancy and Newborn Screening Indicators**

During the consultation period for the pregnancy and newborn screening project, a number of focus groups were set up to get feedback on the indicators.

Feedback provided by a pregnant woman and new mum's group influenced the final indicators. One parent highlighted that her baby, who was born prematurely, did not receive their newborn hearing screening test until the age of 9 weeks old. This



feedback was considered by the group and covered within the indicators, where it states that babies (including those in neonatal units) have their newborn hearing screening tests completed by 4 to 5 weeks of age.

Feedback from pregnant women within Cornton Vale prison highlighted that maternity notes and information about screening tests were sometimes being lost during transition from community services to prison services. This was specifically having an impact on the timeliness of some tests, including those for Down's syndrome. The feedback was considered by the project group and influenced the final wording of Indicator 9: Screening for Down's syndrome – timeliness. This indicator measures the proportion of Down's syndrome screening tests performed during the first trimester. This applies to all care settings, including within prison services.

### **Prison Inspectorate partnership**

The responsibility for the provision of healthcare to prisoners in Scotland was transferred from the Scottish Prison Service (SPS) to the NHS in 2011.

The transfer of responsibility aimed to ensure equity in healthcare for prisoners. Working with Her Majesty's Inspectorate of Prisons for Scotland, Healthcare Improvement Scotland has a pivotal role to set and monitor standards of healthcare in prisons.

Prisoners in Scotland are predominantly from the most deprived areas of the country. Consequently, their health circumstances tend to be very poor, with alcohol and drug addiction being more prevalent, as well as there being higher numbers with long term health conditions such as asthma and epilepsy. In addition to physical health conditions, mental health problems are also significantly greater within the prisoner population than in the wider community in Scotland.

Since the transfer, we have supported the co-ordinating of the National Prisoner Healthcare Network, with the aim of developing and encouraging quality improvements specific to the needs of the prisoner population. The network has created a workplan to address and make recommendations on a range of prisoner health needs, including mental health, substance misuse, brain injury and throughcare.

The intention of the network's workplan and the various workstreams is to create increased opportunities for offenders upon their release, to help them to successfully reintegrate into the community, with a greater likelihood of reducing re-offending, and as a result, creating a safer, healthier Scotland.

## 4 Equality outcomes (2013–2017) - Final Progress Report

The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 required us to publish equality outcomes we intended to achieve over the period April 2013 to April 2017. We set the following four equality outcomes.

1. Eliminate ageist attitudes of staff that sometimes underpin the diagnosis and treatment of older people with delirium in acute care that undermine the patient's dignity, autonomy and respect.
2. Minimise harm that results from restraining people with mental health issues with particular focus on the equality characteristics of gender (women and men), age (young and older people) and race (ethnic minorities).
3. Our workforce is treated fairly and with dignity and can work freely without fear of bullying, harassment or victimisation.
4. Increased engagement with young people of the age 16–30.

This final progress report provides information on the positive actions we undertook to achieve the intended outcomes. It also identifies the challenges we encountered and the lessons we learned.

### 4.1 Equality Outcome 1: Eliminate ageist attitudes of staff that sometimes underpin the diagnosis and treatment of older people with delirium in acute care that undermine patients' dignity, autonomy and respect

#### The issue

Delirium is a state of mental confusion which can be caused by illness, surgery and medications. It is a recognised problem in older people that is frequently overlooked or misunderstood and can be very distressing to individuals, their families and carers. It is estimated to affect up to 20% of older people admitted to hospital. The aim of this outcome was to improve the quality of care of older people with delirium.

#### Our action

In collaboration with the Scottish Delirium Association, NHS Education for Scotland and colleagues across NHSScotland, we have developed a range of tools and resources to raise awareness of delirium and to support improvements in the identification and immediate management of delirium.

The delirium TIME bundle (Think/Triggers, Investigate/Intervene, Manage, Engage/Explore) guides staff to consider triggers for delirium, investigate underlying causes, implement an appropriate management plan and engage both the patient and family members.

The 4 'A's Test, or 4AT, is an assessment tool for delirium and cognitive impairment. The 4AT tool was designed to be used by any health professional at first contact with the patient, and at other times when delirium is suspected.



To help provide easy access to all of the tools and resources, we collated them into a single Delirium Toolkit. Posters and information leaflets were also created to help raise awareness, and these were distributed and displayed appropriately.

We produced a leaflet aimed at patients, relatives and carers of people with delirium, containing information about what delirium is, what it is like to have delirium, who is at risk of developing delirium and how you can help someone who has delirium.

We have also produced three short films featuring the stories of women whose mothers all experienced delirium. These videos will be used in a variety of ways to help raise awareness of delirium.

In June 2016, in collaboration with the Scottish Delirium Association, we facilitated Delirium Awareness Week, which concluded with a national learning event that was attended by over 150 people and streamed live to over 100 additional people. Throughout the day, delegates were asked to make a pledge to 'think delirium' and over 1,650 people tweeted using the hashtag #scotdel. Feedback from the event was extremely positive, with attendees reporting an increased awareness and understanding of delirium.



## Outcome

The resources we created are being used by every NHS board in Scotland and we continue to receive requests for additional copies, in particular the information leaflets and the delirium toolkit. We have also shared our resources internationally with colleagues in Europe, Norway, Australia, New Zealand, USA and China.

With improved awareness and understanding of delirium, staff are more aware of the risk of delirium occurring and understand the difference between delirium and dementia.

Our emphasis on being aware of the assumptions that can be made in relation to older people are bringing about changes in perceptions. There is now a more conscious, systematic assessment for delirium, with information and tools available to support staff, reducing the risk of potentially discriminatory tendencies. Whilst we are confident that our work has made a positive difference, collating data that measures and demonstrates progress has remained a challenge. As we identified when we set this outcome, it is not within our direct control to measure the

success of patient outcomes, as we do not deliver frontline NHS services. However, we can show increased compliance with the use of delirium assessment and improvement in associated outcomes such as a reduction in falls in some areas. We have also received positive feedback from staff and family members in relation to the resources that they have used in practice.

## **4.2 Equality Outcome 2: Minimise harm resulting from restraint of people with mental health issues in particular equality groups such as women, men, adolescents, older people and ethnic minorities**

### **The issue**

Restraint is defined as ‘the holding or blocking of movement, stopping from leaving, staff use of physical intervention on a patient, for the purposes of managing an actual or potential escalation in violent, aggressive and/or disruptive behaviour.’

This method of restraint has been associated with high levels of stress and psychological harm among users of mental health services. Studies carried out between 2003 and 2013 (Begri et al. 2013, Donovan et al 2013, and Mental Welfare Commission 2011) show that:

- males were significantly more likely to be restrained than females
- young adults were significantly more likely to be restrained than older adults
- ethnic minority patients were significantly more likely to be restrained than non-ethnic minority patients as cited in an Equality Impact Assessment from the Department of Health (2009), and
- deaf patients were more likely to be restrained than non-deaf patients (Diaz & Landsberger, 2010).

Evidence from England showed an over-representation of young men with African/Caribbean heritage in mental health inpatient units accounting for 20% of those who die in custody, despite being 3% of the population. There have been notable fatalities in this group caused by the application of restraint. Inquiries into these cases reveal a disregard of mental health service users’ dignity, respect and autonomy as basic human rights. The inquiry into the death of Rocky Bennett revealed a disproportionate use of restraint on ethnic minorities and the findings were that:

- institutional racism played a big role
- there was an over-diagnosis of severe mental illness in black people with mental health problems
- there was over-use of restraint and seclusion of black patients, and
- there was over-medication of black patients.

While there is no evidence of this unequal application of restraint in Scotland, lessons learned from England indicated that we should take proactive steps to avoid similar incidents.

## Our action

The Triangle of Care (Carers Included: A Guide to Best Practice in Mental Health Care in Scotland) has been embedded within the Scottish Patient Safety Programme - Mental Health (SPSP-MH), including the Restraint and Seclusion workstream.

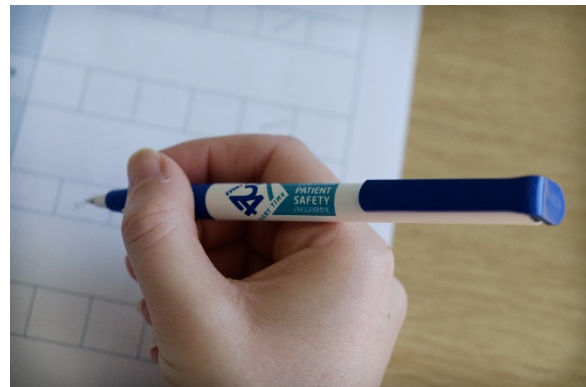
We increased the level of involvement with service users and carers from the relevant protected characteristic groups when producing appropriate care plan pathways. We also increased the service user, carer and third sector involvement with the SPSP-MH programme. Third sector organisations including the Carers Trust Scotland, Support in Mind and Bipolar Scotland were involved.

SPSP-MH leads attended training, delivered by the Scottish Human Rights Commission, that promoted taking a human rights based approach. The training also helped to raise programme leads' awareness of the inequalities that can arise from personal, cultural and structural discrimination. SPSP-MH has subsequently taken a human rights based approach to the delivery of its programme.

## Outcome

The impact of our actions has been difficult to measure because it is not within our direct control to monitor the success of patient outcomes, as we do not deliver frontline NHS services.

We have engaged with NHS boards and promoted the adoption of capturing consistent equality monitoring data. Although the equality monitoring data of people experiencing restraint is still not consistently gathered, in taking action to achieve the outcome, we have been advised that the statistics from England, which highlight inequalities, are not reflective of the position in Scotland.



Anecdotal reporting from a number of NHS boards over the last 12 months has shown that unlike England, there are no known biases regarding the restraint of any particular minority ethnic groups.

An increasing number of wards and units are showing improvements in rates of violence and restraint, seclusion and percentage of individuals self-harming. In some wards, there are examples of reductions in restraint of up to 57%, reduction in the percentage of patients who self-harm of up to 70% and reduction in the rates of violence of up to 78%.

SPSP-MH continues to promote the use of the Patient Safety Climate Tool to NHS boards, as it is a reliable measure for monitoring the success of their initiatives intended to develop or improve a culture of safety. Over 600 facilitated Patient Safety Climate Tool surveys have been completed and over 3,000 staff climate surveys have been undertaken. There are a number of references in NHS boards to suggest SPSP-MH has influenced attitude and cultural change, including the approach taken to the prescribing and administration practice of as required psychotropic medication, how restraint is viewed and how challenging behaviour is managed.



We remain committed to ensuring that improvements continue and the adoption of a human rights based approach within SPSP-MH will support the ongoing improvement of equality.

SPSP-MH has adopted this approach through using the PANEL principles (P – participation, A – accountability, N – non-discrimination and equality, E – empowerment, L – Legality) working with partners such as the Scottish Human Rights Commission and See Me to help ensure that service users' rights are being upheld. Mention is made of the positive impact of SPSP-MH in the Mental Welfare Commission report<sup>4</sup>:

'The Scottish Patient Safety Programme - Mental Health (led by HIS) aims to systematically reduce harm experienced by people receiving care from mental health services in Scotland, by supporting frontline staff to test, gather real-time data and reliably implement interventions, before implementing them across their NHS board area. Human rights are an overarching theme of the programme and the programme is actively considering ways to further embed rights-based approaches across their work.'

The work undertaken to achieve this equality outcome will continue as business as usual within SPSP-MH.

### **4.3 Equality Outcome 3: Our workforce is treated fairly and with dignity and can work freely without fear of bullying, harassment or victimisation**

#### **The issue**

In 2013, our Staff Survey results indicated that 13% of staff had experienced bullying or harassment in the workplace. We committed to reducing incidents of bullying and harassment, with an aim of eliminating them entirely through a zero tolerance policy.

<sup>4</sup>Human rights in mental health care in Scotland: A report on progress towards meeting Commitment 5 of the Mental Health Strategy for Scotland 2012-2015 (published September 2015)

## Our action

We have implemented a series of complementary approaches and interventions to target the various ways in which bullying and harassment can occur in the workplace.

We are making greater use of informal approaches to resolution, which are often more effective and allow us to reach a satisfactory outcome more quickly. We are also focusing more on organisation-wide strategies to ensure as far as possible that our policies and working practices don't tacitly make room for inappropriate behaviour. Individual cases are predominantly resolved effectively and in a timely manner.



Bullying and harassment is a main course component in both our online and facilitated equality and diversity training. One exercise in the facilitated session provides work based examples of bullying and harassment, and provides guidance to staff on how they can respond to inappropriate behaviour. Strategies of dealing with this type of behaviour are discussed and staff are signposted to sources of assistance. Both the online and facilitated equality and diversity training are mandatory for all new staff, and existing staff are also invited to attend as refresher training.

The Dignity and Respect Advisory Service was launched in 2015. Posters were displayed in all offices, and an announcement was made in the Chief Executive's email update to all staff. A publicity campaign to promote this service was also undertaken by the Communications Team. Regular all-staff emails continue to be sent to promote the service and how they can help. These messages are subsequently incorporated into the Partnership Forum updates and the intranet news pages. Training and support sessions for the Dignity and Respect Advisors are run by the Human Resources Team.

The Values and Behaviours Group was re-launched in 2016 to help reinvigorate the organisational commitment to the adoption and promotion of appropriate values and behaviours.

iMatter, a staff survey and improvement tool designed to help individuals, teams and NHS boards understand and improve staff experience, was rolled out across the organisation. Subsequently, team action plans intended to improve staff experience have been developed.

## Outcome

In 2016, we conducted an internal staff survey, some of which reflected the questions asked in the national survey of 2014–2015. Our staff survey reported that 7% of respondents indicated that they had encountered behaviours which could be



perceived as bullying or harassment from other colleagues during the 12-month period (there was a total of 313 respondents to this question).

Only 17% of those who responded to that question stated that they had reported it, and only 33% of those who did were satisfied with the response received.

In 2016, all issues raised with the Human Resources Team were resolved, that is the issue was directly addressed, or a solution was brokered. This was through a combination of facilitation, mediation, advice and guidance, or informal or formal redeployment.

By prioritising employee wellbeing and morale, we are able to seek out rapid and creative solutions rather than relying solely on grievance or disciplinary investigations. Our informal interventions appear to be working effectively as none of the informal issues were subsequently escalated to formal. Evidence from exit interviews also suggest that staff are not leaving due to unresolved bullying and harassment complaints, or the inappropriate behaviour of colleagues.

When trying to measure the effectiveness of our actions against the intended outcome, we acknowledge that the staff survey question did not ask if the bullying or harassment was related to a protected characteristic and as it was anonymous, follow-up with respondents was not possible. We recognise the challenge of defining, measuring and addressing bullying and harassment, especially in relation to gathering and analysing data that is disaggregated by protected characteristics.

In taking action to achieve the outcome, it is now clear that there are few instances of extreme bullying or harassment within the organisation and reported instances could be more accurately described as ranging from low impact one-off instances of rude or inconsiderate behaviour, through to more regular negative, undermining or disrespectful behaviour. There is no evidence to suggest that the root cause of any of the reported bullying and harassment incidents were related to a protected characteristic.

We nevertheless remain committed to improving the culture, behaviours and understanding of equality amongst our workforce and have set a new equality outcome for 2017–2021 to help achieve this. As an output of this new outcome, we will continue to monitor reported incidents of bullying and harassment to help identify if they are related to a protected characteristic. Appropriate action will be taken if any negative trends emerge. Tackling bullying and harassment across the organisation also remains part of the Staff Governance Action Plan (2016– 2018).

#### **4.4 Equality Outcome 4: Engagement of younger people in our work. Increased engagement with young people of the age 16 to 30**

##### **The issue**

In 2013, the pool of people involved in our work on a voluntary basis was within the age range of 31 to 74. This highlighted a gap of involving younger people aged 16 to



30 within our formal public partner volunteer role. Public partners are members of the public who are interested in the design, development and delivery of our work. They volunteer their time to get involved, providing a public view to key areas of our work.

We aimed to ensure that people aged between 16 to 30 years of age were consistently engaged in our work, whether as a public partner or through other mechanisms.

### **Our action**

In order to understand how to improve our approach to involving younger people, we consulted other health and social care organisations in Scotland about their volunteer recruitment practices. We found that the most successful either used partner organisations specialising in youth work to carry out their recruitment, training and support for young people, or they offered short term, strictly defined and closely supervised roles, with limited freedom to act. Given the nature of our work and limitations in resource, we were unable to adopt these models of engagement to our work.

We also researched barriers to volunteering for younger people. Key issues included competing for young people's time with paid employment, or unpaid work, which might improve their career opportunities and future employability.

We included an action related to this outcome within the Scottish Health Council's workplan, and in the Healthcare Improvement Scotland Local Delivery Plan, embedding this as part of our mainstream work. We took this approach instead of developing a separate plan solely focused on volunteering to ensure that ownership for the task of improving the way we engage with young people was a cross-organisational issue, rather than limited to one directorate or team.



As a result of mainstreaming this work, we have looked beyond our initial intended outcome of increasing the number of people aged 16 to 30 involved as public partners. We are now looking more broadly at the effective engagement of younger people in all our work, including consultations, user involvement, volunteering and work experience. This approach has also helped prepare the organisation to undertake work to meet our statutory duties as Corporate Parents.

We have worked to develop relationships with organisations that represent the interests of younger people, including but not limited to:

- The National Union of Students
- The Care Inspectorate
- Move On

- Includem
- Who Cares? Scotland
- The Centre for Excellence for Looked After Children in Scotland (CELCIS)
- Mumsnet
- Listen2Us
- The Scottish Youth Parliament

A key achievement has been the agreement of a strategic partnership with Includem, an organisation which works with young people who may be troubled or at risk. The partnership includes the establishment of a 12-month post within Healthcare Improvement Scotland that is intended to strengthen our work with children and young people during 2016–2017.

We have also:

- become a repeat host for work experience students of school age
- developed a strand of Our Voice to specifically seek and collect the views of children and young people about their awareness and experience of health and social care issues (Our Voice is a project aimed at improving public involvement in health and social care across Scotland)
- met our duty of collaboration with fellow Corporate Parents, and
- developed presentations, which we delivered to two primary school classes to help raise awareness of the organisation's work.

In order to increase our ability to engage with young people online, we significantly increased our capacity for Twitter activity. However, trends in social media usage have moved on significantly since we started this work, and while we have gained significant exposure through both individual and corporate accounts, engagement using Twitter is no longer as effective as it once was.

Our Scottish Health Council local offices have worked with individual young people and organisations that support them. They have engaged with them on a range of topics, which has helped to strengthen and build relationships and networks.

## Outcome



We have seen a year on year increase of discussions about work relating to the involvement of children and young people across the organisation, at governance, strategic and operational levels. This has resulted in the establishment of a cross-organisational working group which focuses on how we engage children and young people in our work. The group, chaired by the Director of the Scottish Health Council, has a strategic action plan, with clear deliverables set on an annual basis, and will continue to meet while we work towards meeting and exceeding the duties placed on us by the Children and Young People (Scotland) Act 2014.

Between 2013 and 2017, we successfully recruited four people under 30 to be public partners, retaining three of them for a significant period of their public partner term. We achieved this through targeted online advertising, increased engagement using social media and by distributing a clearer, more comprehensive outline of the public partner role during the recruitment process.

While we consider this equality outcome work to be concluded, we remain committed to improving our engagement with younger people and having mainstreamed our work towards this outcome, it will continue as a business as usual activity.

For example, we are currently testing models of how to engage effectively with young people, to empower them to have their voices heard and be taken seriously, and for their voices to be acted upon in the future planning and delivery of local health and social care services. We are also engaging with staff and residents at five residential children's units in Forth Valley to understand the experience of looked after young people when undergoing health assessments and we will be seeking to learn if improvements can be made.

## 5 Equality outcomes (2017–2021)

The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 (as amended) requires Healthcare Improvement Scotland to publish equality outcomes. Our equality outcomes specify a result that we aim to achieve in order to further one or more of the needs of the general equality duty, which are to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it, and
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

To help inform our equality outcomes, Healthcare Improvement Scotland gathered and considered relevant evidence. Evidence was obtained through:

- engagement with third sector organisations that represent the interests of people with the relevant protected characteristics
- an analysis of reports published by the Scottish Government, third sector organisations that represent the interests of people with the relevant protected characteristics, public bodies and other organisations
- an analysis of our workforce data
- an analysis of our public involvement data
- public engagement
- staff engagement, and
- public partner engagement.

In order to maximise our evidence base and to help reduce the burden on third sector organisations, we worked in partnership with the seven other special NHS boards to collate relevant evidence.

Analysis of the evidence identified many different issues. As Healthcare Improvement Scotland does not provide services directly to patients, we had to carefully consider what we could realistically achieve through the delivery of our own functions.

Three of our outcomes relate to one of each of the following protected characteristics:

- Disability
- Gender Reassignment and Sexual Orientation, and
- Race.

We chose these protected characteristics ahead of others because, having considered the evidence, we identified three issues that affect a significant amount of people and we believe there is potential for our actions to make an improvement. Our fourth outcome relates to all protected characteristics.

## 5.1 Equality Outcome 1 – Disability

**Aim** – Attract and retain a more diverse workforce to help:

- create a workforce that better reflects the diverse population of Scotland
- increase the number of high quality applicants available
- demonstrate our commitment to treat all people fairly, and
- maintain a skilled and knowledgeable staff cohort.

### The General Equality Duty

The general duty need that this outcome is intended to support is:

- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

### Situation/Evidence

An analysis of our workforce data shows:

- 2.7% of staff identified as having a disability in 2015–2016, which is a 1.4% increase from 2013–2014
- 6.7% of staff declined to disclose whether they had a disability or not during 2015–2016, in comparison to 18.8% during 2013–2014
- 90.7% of staff stated that they did not have a disability in 2015–2016, in comparison to 79.9% in 2013/14
- 4.8% of job applicants identified as having a disability in 2015–2016
- 3.7% of people who were offered a job in 2015–2016 identified as having a disability, and
- no staff applying for internal promotions identified as having a disability in 2015–2016.

According to the 2011 Census, the proportion of people in Scotland with a long-term activity-limiting health problem or disability was 20%, which is the same as reported in the 2001 Census.

The Scottish Survey Core Questions 2014 reported that 23% of adults living in Scotland have a long-term limiting health condition or disability, covered under the Equality Act 2010.

The Scottish Government's Equality Evidence Finder reports that in 2015:

- the employment rate for disabled people was 42.0% compared to 80.3% for those who do not identify as disabled, and 73.1% for the total population aged 16–64, and
- 51.5% of disabled people were economically inactive.

Overall, disabled people have much lower employment rates and are more likely to be economically inactive than non-disabled people.

The Department for Work and Pensions Access to Work Statistics for 2014–2015 report that only just over 2% of working age disabled people in Scotland get support from Access to Work, which is proportionately less than for the rest of the UK. Access to Work can provide a grant to pay for practical support for an employee that has a disability, health or mental health condition to help them start working or stay in work.

Anecdotal evidence received from Healthcare Improvement Scotland's Partnership Forum suggests that the number of staff seeking support from them for stress and anxiety has recently increased, although this has not translated into an increased number of requests for support from the Human Resources Team.

In a recent publication<sup>5</sup>, the Mental Health Foundation reported that around a third of all people with a mental health problem have sought no professional help. The same report advises that on average around 1 in 6 people have experienced mental health problems.

Mental health conditions are often regarded to be a hidden disability. The UK Government reports<sup>6</sup> that hidden impairments/disabilities are thought to affect 10– 15% of the UK population. Hidden impairments/disabilities are conditions that are not apparent to others and, as well as mental health conditions, can also include:

- autism spectrum disorders
- dementia
- dyslexia, dyspraxia, attention deficit hyperactivity disorder, dyscalculia, and
- learning disabilities.

Evidence shows that many disabled people experience barriers in entering and succeeding in employment. Healthcare Improvement Scotland is committed to promoting wellbeing at work and supporting all staff. Disabled staff and job applicants should feel confident about disclosing their disability and be aware that they will be fully supported by the organisation throughout their employment.

Whilst the number of disabled staff we employ has risen by 1.4% since 2013–2014, the overall percentage of staff who disclosed having a disability is significantly lower than the reported national percentage.

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<sup>5</sup> Fundamental Facts about Mental Health 2016

<sup>6</sup> Information from the Department for Work and Pensions website on [www.gov.uk](http://www.gov.uk)

**Note:** The Equality Act says that a person has a disability if they have a physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities. Physical or mental impairment includes sensory impairments such as those affecting sight or hearing.

Healthcare Improvement Scotland has considered the evidence available and set the following outcome to help improve equality for disabled people.

### **Equality Outcome 1 – Disability**

Disabled staff and job applicants experience improved support and career opportunities within Healthcare Improvement Scotland.

**Activity 1: Ensure that all staff develop an appropriate level of disability awareness.**

**Output** – Provide staff access to information about disability.

**Output** – Continue to provide mandatory equality and diversity training to all new staff and offer more opportunities for existing staff to attend refresher training.

**Output** – Invite the Business Disability Forum to provide disability awareness training to Human Resources staff and staff with line management responsibility.

**Measure** – Qualitative data gathering and analysis to establish baseline information and evidence improvement.

**Measure** – Annual analysis of workforce data evidences an improved disclosure rate.

**Activity 2: Raise staff awareness of people with hidden disabilities and their experience within the workplace.**

**Output** – Engage with third sector organisations that represent the interests of people within hidden disabilities to gain a better understanding of them and share information with staff.

**Output** – Refresh and promote the Mental Health - Manager's Frequently Asked Questions document.

**Output** – Refresh and promote Healthcare Improvement Scotland's Mental Wellbeing Framework document.

**Activity 3: Promote Healthcare Improvement Scotland as an inclusive employer that actively supports disabled staff.**

**Output** – Sign up to and promote the new Disability Confident scheme.

**Output** – Take positive action to encourage job applications from disabled people by:

- advertising job vacancies in publications and websites commonly used by disabled people
- including a message in job adverts stating that Healthcare Improvement Scotland particularly welcomes interest and applications from disabled people, and
- engaging with third sector organisations that represent the interests of disabled people to promote the role of Healthcare Improvement Scotland and to raise awareness of career opportunities.

**Output** – Raise awareness amongst staff of the availability of Access to Work grants.

**Measure** – Monitor the number of disabled people who apply for roles and are subsequently shortlisted or appointed through an analysis of equality monitoring data.

**Activity 4: Take steps to ensure career pathways are free from potential barriers.**

**Output** – Establish monitoring to check if there is a relative shortlisting or appointment deficit in comparison to people who do not identify as disabled.

**Output** – If a shortlisting or appointment shortfall of disabled applicants is identified, carry out work to better understand the potential reasons for the deficit.

**Output** – Review competency pass rates of disabled applicants and compare these with candidates who do not identify as disabled.

**Output** – If a shortfall exists, take positive action to help improve the competency pass rates of disabled applicants. Work with disability-led third sector organisations to engage with disabled people to help them better understand the recruitment process, including providing opportunities to improve their ability to undertake competency-based interviews.

**Measure** – Annual analysis of the equality monitoring data shows improved competency pass rates for disabled applicants.

**Measure** – Qualitative and quantitative data comparison between those who identify as disabled and those who do not.



## 5.2 Equality Outcome 2 – Gender Reassignment and Sexual Orientation

**Aim** – Identify and promote practice that works to reduce inequalities, discrimination and barriers for lesbian, gay, bisexual and transgender (LGBT) people, in relation to recruitment, career progression and employment retention.

**Aim** – Improve the experience of LGBT people accessing health and social care services by tackling prejudice and promoting understanding.

### The General Equality Duty

The general duty needs that this outcome is intended to support are:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it, and
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

### Situation/Evidence

To help improve LGBT inclusion in NHSScotland, the Scottish Government has agreed a partnership between NHSScotland and Stonewall Scotland. This agreement includes the review of NHSScotland's Partnership Information Network (PIN) policies by Stonewall Scotland to ensure LGBT considerations are included.

An analysis of our workforce data shows:

- 3.1% of job applicants identified as LGBT at recruitment during 2015–2016
- 0.9% of job applicants appointed identified as LGBT during 2015–2016
- 0.3% of staff identified as bisexual during 2015–2016, in comparison to 0.6% during 2013–2014
- 1.9% of staff identified as gay during 2015–2016, in comparison to 2.8% during 2013–2014, and
- 0.3% of staff identified as lesbian during 2015–2016, which is consistent with 2013–2014 data
- 57.6% of staff identified as heterosexual during 2015–2016, in comparison to 73.9% during 2013–2014
- 40% of staff declined to disclose their sexual orientation during 2015–2016, in comparison to 22% during 2013–2014
- No staff identified as transgender during 2015–2016, which is consistent with 2013–2014 data.

Overall, 2.5% of Healthcare Improvement Scotland's staff identified as lesbian, gay, bisexual or transgender during 2015–2016.

Training in relation to LGBT equality is currently undertaken by all staff as part of wider equality training during their induction.

Research<sup>7</sup> from Stonewall, shows that a quarter of lesbian, gay and bisexual health and social care staff in Scotland have experienced bullying or poor treatment from colleagues in the last 5 years as a result of their sexual orientation. The same research shows that 9% of health and social care staff are aware of colleagues experiencing discrimination or poor treatment because they are transgender.

Another report<sup>8</sup> by Stonewall highlights that public involvement of LGBT people during the design and development of services is low, with eight out of 10 LGBT people reporting that they have never been asked for their views by local service providers.

A report<sup>9</sup> by the Equality Network on LGBT people's experiences of inequality in Scotland highlights concerns about disadvantages faced by LGBT people in Scotland when accessing healthcare. The report states that many respondents said that more needed to be done to effectively tackle health inequalities and specific health issues facing LGBT people, such as a higher prevalence of mental health problems, specific sexual and reproductive health needs, and a higher rate of smoking, alcohol and substance abuse. Concern about health professionals not being adequately trained to understand the issues affecting LGBT people was also raised in the report. The report makes a number of recommendations to help address the main issues raised. One of the recommendations relates to training staff on the needs and health concerns of LGBT people.

Healthcare Improvement Scotland has considered the evidence available and set the following outcome to help improve equality for LGBT people.

### **Equality Outcome 2 – Gender Reassignment and Sexual Orientation**

Lesbian, gay, bisexual and transgender (LGBT) people who currently work with Healthcare Improvement Scotland, who wish to work with us or who wish to volunteer with us, experience improved opportunities.

### **Activity 1: Take action to help ensure that we promote an inclusive culture and environment for LGBT staff in the workplace.**

**Output** – Update all staff policies to include any changes or recommendations arising from Stonewall Scotland's review of PIN policies.

**Output** – Communicate to staff annually how to report incidents of bullying and harassment and specifically highlight a zero-tolerance approach to bullying and harassment on the grounds of sexual orientation and gender identity.

<sup>7</sup> Stonewall's "Unhealthy Attitudes Scotland Report"

<sup>8</sup> Stonewall's "Your Services, Your Say, 2014"

<sup>9</sup> The Equality Network's "The Scottish LGBT Equality Report"

**Measure** – Monitor the number of reported incidents of LGBT related bullying and harassment.

**Measure** – Monitor issues raised during exit interviews to identify trends relating to sexual orientation or gender identity.

**Measure** – Monitor the number of disciplinary cases relating to incidents of LGBT-related bullying, harassment or discrimination.

**Activity 2: Raise staff awareness of the distinct issues LGBT people may encounter when accessing health services or seeking employment.**

**Activity 3: Improve staff confidence to disclose equality monitoring information in relation to their sexual orientation and gender identity.**

**Output** – Display LGBT promotional material in offices.

**Output** – Analyse the need for specific LGBT training/e-learning and introduce it on the basis of need.

**Output** – Work with third sector organisations to provide information on the intranet about the health concerns of LGBT people.

**Output** – Invite a third sector organisation that represents the interests of LGBT people to engage with our staff.

**Measure** – Qualitative data gathering and analysis.

**Measure** – Annual analysis of workforce data shows an increased disclosure rate.

Activities 2 and 3 share the same outputs and measures.

**Activity 4: Advance equality, tackle prejudice, and improve visual leadership and support for LGBT staff.**

**Output** – Ensure staff applying for roles with recruitment and line management responsibilities have undertaken equalities training.

**Measure** – Statistics relating to the completion of equality training.

**Measure** – Equality competencies tested during interviews for roles with recruitment and line management responsibilities.

**Output** – Formalise an agreement with an external LGBT staff network and promote this internally to all staff.

**Output** – Allow staff the opportunity to attend Stonewall's Allies and Role Models training programmes, or similar initiative.

### **Activity 5: Attract more LGBT job applicants.**

**Output** – Take positive action to encourage job applications from LGBT people by:

- advertising job vacancies in publications and websites commonly used by LGBT people
- offering a single point of contact during the recruitment process to people who identify as transgender, and
- providing clearly presented information in relation to when someone will be asked for details relating to their gender during the recruitment process.

**Measure** – Monitor the overall number of job applicants who identify as LGBT and the number subsequently shortlisted or appointed through an annual analysis of workforce data.

### **Activity 6: Attract more LGBT public partner applicants.**

**Output** – Take positive action to encourage public partner applications from LGBT people by:

- advertising volunteering opportunities in locations commonly used by LGBT people
- engaging with the LGBT community directly and third sector organisations that represent their interests
- offering a single point of contact during the recruitment process to people who identify as transgender, and
- providing clearly presented information in relation to when someone will be asked for information relating to their gender during the recruitment process

**Measure** – Monitor the number of LGBT people who apply for voluntary roles and the number subsequently shortlisted or appointed through an analysis of equality monitoring data.

### **Activity 7: Participate in Stonewall’s Workplace Equality Index<sup>10</sup> or similar initiative annually as an additional measure of the overall progress made towards achieving the outcome.**

**Output** – Complete Stonewall’s Workplace Equality Index.

**Measure** – Placing within the index reflects a year on year improvement.

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<sup>10</sup> The Workplace Equality Index is a benchmarking tool used by employers to help ensure all lesbian, gay, bisexual and trans employees can be themselves in the workplace.

### 5.3 Equality Outcome 3 – Race

**Aim** – Identify and promote practice that works to help tackle health inequalities experienced by minority ethnic people because of discrimination, barriers to access and a lack of public involvement.

#### The General Equality Duty

The general duty need that this outcome is intended to support is:

- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

#### Situation/Evidence

The Scottish Health Council, a directorate of Healthcare Improvement Scotland, promotes and supports Patient Focus and Public Involvement in our own work and across the NHS in Scotland. By ensuring that NHS boards listen and take account of people's views, we aim to achieve a 'mutual NHS', where the NHS works in partnership with patients, carers and the public. We believe that participation will be more meaningful, representative and effective, if we involve a diverse range of people from across the country.

The Scottish Government's Race Equality Framework for Scotland 2016–2030 sets out the following visions.

- 'Minority ethnic participation and representation is valued, effective, fair and proportionate at all levels of political, community and public life.'
- 'Minority ethnic communities in Scotland have equality in physical and mental health as far as is achievable, have effective healthcare appropriate to their needs and experience fewer inequalities in housing and home life.'

One of the goals outlined in the Scottish Government's Race Equality Framework states: 'We will ensure effective engagement with minority ethnic communities in the developing Our Voice framework, so that minority ethnic voices are heard and meaningfully involved in improving health and social care services.' The implementation of the Our Voice framework is being overseen by a Programme Board based within the Scottish Health Council.

An analysis of Healthcare Improvement Scotland's public involvement data for 2015–2016 shows that of the 632 people who provided their details at public involvement events:

- 559 identified as either White Scottish or White British
- 16 people identified as Asian Scottish or Asian British
- 1 person identified as being from a mixed or multiple ethnic group
- 2 people identified as African, Caribbean or Black
- 44 people selected other as their ethnic group, and

- 17 people preferred not to answer.

We involve around 35 public partners and recruit new members annually, depending on the organisational need for additional public involvement. Public partners are members of the public who are interested in the design, development and delivery of our work, and volunteer their time to get involved, providing a public view to key areas of our work.

Forty-two people applied for a public partner role in 2016, with 40 providing equality monitoring data: 38 applicants identified as either White Scottish or White British, with 1 applicant identifying as White Irish and 1 applicant identifying as Asian Pakistani.

Twenty-four people were subsequently invited to take part in an interview process and 14 were then offered a role as a public partner, with 11 remaining in post after a 6-month period. All the people offered a role as a public partner identified as either White Scottish or White British.

Healthcare Improvement Scotland has considered the evidence available and set the following outcome to help improve equality for minority ethnic people.

### **Equality Outcome 3 – Race**

Minority ethnic people's views and experiences are better represented in the design, development and delivery of Healthcare Improvement Scotland's work.

**Activity 1: Understand and take action to remove any barriers that might prevent minority ethnic people from volunteering with Healthcare Improvement Scotland.**

**Output** – Engage with minority ethnic communities to gain an understanding of whether specific barriers exist in relation to public involvement.

**Measure** – Qualitative data gathering and analysis from this engagement.

**Activity 2: Take positive action to increase the number of public partner applications Healthcare Improvement Scotland receive from minority ethnic people.**

**Output** – Engage with minority ethnic communities to inform them of the opportunities available to get involved with their local health and social care services.

**Output** – Include a message in volunteer adverts stating that Healthcare Improvement Scotland particularly welcomes interest and applications from minority ethnic people.

**Output** – Encourage applications from minority ethnic people by advertising public partner vacancies in locations commonly used by minority ethnic communities.

**Measure** – Annual analysis of the public partner monitoring data shows an increased number of applications from minority ethnic people.

**Measure** – Annual analysis of equality monitoring data collected for service users at public involvement events shows we have engaged with an increased number of minority ethnic people.

**Activity 3: Establish monitoring to check if there is a relative shortlisting or appointment deficit in comparison to people who do not identify as minority ethnic.**

**Output** – If a shortfall is identified, carry out work to better understand the potential reasons for the shortlisting or appointment deficit of minority ethnic applicants.

**Output** – Review competency pass rates of minority ethnic applicants and compare with those of candidates who do not identify as minority ethnic.

**Measure** – Qualitative and quantitative data comparison between those who identify as minority ethnic and people who do not.

**Output** – Work with minority ethnic communities to help them better understand the public partner recruitment process, including providing opportunities to improve their ability to undertake competency based interviews.

**Measure** – Annual analysis of the public partner monitoring data shows improved competency pass rates for minority ethnic applicants.

**Activity 4: Our Voice is committed to ensuring equality and diversity is identified as a key ambition of the programme.**

As Our Voice evolves, additional specific outcomes and measurement indicators will be identified to demonstrate progress on the diversity of Our Voice and all its component activities, for example membership of the Citizens Panel, participation in Voices training, and capacity building.

## 5.4 Equality Outcome 4 – All Protected Characteristics

**Aim** – To positively change the attitudes, behaviours and culture of staff. To empower staff to feel confident about being themselves at work and to promote a greater understanding of equality and diversity across Healthcare Improvement Scotland.

### The General Equality Duty

The general duty need that this outcome is intended to support is:

- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

### Situation/Evidence

We are pleased with the progress we have made to mainstream equality, and good practice examples of how this has been achieved are contained within our Mainstreaming Equality Report 2017. However, we recognise that there is more that we can do and we believe that an equality outcome in relation to fostering good relations for all protected characteristics will help to drive further improvements.

We recognise the difficulties associated with setting outcomes that intend to improve equality for all protected characteristics. Such outcomes can often fail to address the distinct needs of each protected characteristic group and be problematic to measure.

However, we will use the workforce data equality monitoring disclosure rate as a baseline measure of our staff's understanding of the importance of equality and diversity. This will also provide an indication of how confident and supported staff feel in relation to disclosing their protected characteristics.

An analysis of our workforce data shows:

- 38.1% of staff declined to disclose their religion or belief during 2015–2016, in comparison to 23.6% during 2013–2014
- 40% of staff declined to disclose their sexual orientation during 2015–2016, in comparison to 22% during 2013–2014
- 6.7% of staff declined to disclose whether they had a disability or not during 2015–2016, in comparison to 18.8% during 2013–2014
- 32% of staff declined to disclose whether they had undergone or proposed to undergo gender reassignment during 2015–2016, in comparison to 17.9% during 2013–2014, and
- 3.5% of staff declined to disclose their race during 2015–2016, in comparison to 17% during 2013–2014.

The staff disclosure rate of both disability and race has seen significant improvement since 2013–2014, conversely the disclosure rate of other protected characteristics has decreased.



In 2013, we set the following equality outcome: Our workforce is treated fairly and with dignity and can work freely without fear of bullying, harassment or victimisation.

Our progress made towards this outcome is contained within this report. Whilst there was not any evidence to suggest that bullying harassment or victimisation took place in relation to a protected characteristic, we will continue to monitor this and use it as a measure to ensure that an inclusive culture and environment is maintained.

All new staff are required to undertake equality and diversity training through both an e-learning module and a classroom-based training session. Existing staff are also regularly invited to attend equality and diversity training sessions to refresh their knowledge.

We believe that regular, targeted, equality-focused awareness raising activity across the organisation will help to consolidate the training activities and improve our staff members understanding of each of the protected characteristic groups. Whilst we acknowledge that some of these actions could be considered as mainstreaming activities, as previously stated, this outcome is intended to provide an additional focus to promoting understanding and tackling prejudice between persons who share a relevant protected characteristic and persons who do not share it.

Everyone performs better when they can be themselves and as an organisation, we promote values and behaviours that are intended to create a culture that supports inclusion, equality, and diversity.

This type of working environment will help to embed equality considerations.

Healthcare Improvement Scotland has considered the evidence available and set the following outcome to help improve equality for all protected characteristic groups.

#### **Equality Outcome 4 – All Protected Characteristics**

Healthcare improvement Scotland will maintain an inclusive culture and environment, where staff understand the importance of equality and diversity in their work and interactions with others, and feel valued, respected and supported.

#### **Activity 1: Improve visual leadership and support for equality.**

**Output** – Provide regular equality and diversity awareness raising updates to the senior management team.

**Output** – Provide regular equality and diversity awareness-raising updates to Board members.

**Output** – Seek to appoint equality and diversity champions at a senior level.

**Measure** – Monitor the number of sessions and participants, and gather qualitative data to evidence improved awareness.

**Activity 2: Engage with organisations that represent the interests of people with the relevant protected characteristics to help raise awareness of each protected characteristic group.**

**Output** – Consider signing up to low cost, high impact equality awareness-raising initiatives that are currently available. For example:

- See Me's See Me in Work Programme
- Stonewall Scotland's NoBystanders campaign
- the Equality and Human Rights Commission's Working Forward initiative
- the Jobcentre Plus Disability Confident symbol, and
- the Carer Positive Employer Accreditation.

**Output** – Invite organisations that represent the interests of people with the relevant protected characteristics to engage with staff.

**Measure** – Monitor the number of engagement sessions and staff participants, and gather qualitative feedback to evidence improvement in staff awareness.

**Activity 3: Promote the cultural awareness of staff through the acknowledgement of key calendar dates and events.**

**Output** – Publish an equality calendar on the Intranet with information about significant equality-related dates and events due to take place.

**Output** – Publicise upcoming equality-focused events and promote opportunities for staff to get involved or attend.

**Output** – Regularly display equality promotional material throughout offices.

**Measure** – Monitor the number of awareness-raising communications and events, and gather qualitative feedback to evidence improvement in staff awareness.

**Activity 4: Ensure that all staff develop an appropriate level of equality awareness.**

**Output** – Continue to provide mandatory equality and diversity training to all new staff and offer more opportunities for existing staff to attend refresher training.

**Measure** – The overall success of this outcome will be measured through the workforce equality monitoring disclosure rate.

**Measure** – Monitor the number of staff discrimination issues reported to the Human Resources Team.

**Measure** – Annual analysis of qualitative data gathering through staff engagement.

## 6 Equal pay statement

This statement has been agreed in partnership and will be reviewed by Healthcare Improvement Scotland's Area Partnership Forum and Staff Governance Committee by April 2019.

Healthcare Improvement Scotland 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, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation or political beliefs.

Healthcare Improvement Scotland employs staff on nationally negotiated and agreed NHS contracts of employment which include provisions on pay, pay progression and terms and conditions of employment. These include National Health Service Agenda for Change (A4C) Contracts and Terms & Conditions of employment. Some staff are employed on NHSScotland Executive contracts of employment (Executive Cohort) or Medical contracts, which are evaluated using national grading policies with prescribed pay ranges and terms and conditions of employment.

NHS boards work within a Staff Governance Standard, which is underpinned by statute. The Staff Governance Standard sets out what each NHSScotland employer must achieve in order to continuously improve in relation to the fair and effective management of staff.

The Standard requires all NHS boards to demonstrate that staff are:

- well informed
- appropriately trained and developed
- involved in decisions
- treated fairly and consistently, with dignity and respect, in an environment where diversity is valued, and
- provided with a continuously improving and safe working environment, that promotes the health and wellbeing of staff, patients and the wider community.

Delivering equal pay is integrally linked to the aims of the Staff Governance Standard. Healthcare Improvement Scotland understands that the right to equal pay between women and men is a legal right under law. Healthcare Improvement Scotland is committed to ensuring that pay is awarded fairly and equitably to everyone, and will particularly ensure that there is no difference in treatment between people who are disabled and people who are not, and people who fall into a minority ethnic group and people who do not.

Healthcare Improvement Scotland 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. We recognise the impact the lack of access to flexible working can have on achieving equal pay and we have a flexible working policy that encourages staff at all levels to have a healthy work-life balance.

Occupational segregation is a factor that can contribute to pay inequality and we are committed to ensuring that opportunities exist for people to work and progress from any role, at any grade, regardless of their protected characteristics. If a member of staff wishes to raise a concern at a formal level relating to equal pay, the grievance procedure is available for their use.

In line with the General Duty of the Equality Act 2010, our objectives are to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it, and
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

**We will continue to ensure that we:**

- review this policy, statement and action points with trade unions as appropriate, every 2 years and provide a formal report within 4 years
- inform employees about how pay practices work and how their own pay is determined
- provide advice 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, and
- undertake an equal pay review by April 2020.

Responsibility for implementing this policy is held by Healthcare Improvement Scotland's Chief Executive, who will be supported by the Director of Finance and Corporate Services.

## **6.1 Occupational segregation data**

Occupational segregation is the concentration of staff based upon their protected characteristics:

- in different job roles (horizontal segregation), or
- at different pay bands (vertical segregation).

This data reflects the position of the organisation as at 31 March 2016. At this time we employed 375 members of staff.

Where staff numbers are below 10 and where it may make someone identifiable, we have used <10 in the tables to indicate this. Where it is possible to work out this missing data from the other information we have published, we have replaced the number with an asterisk.

Percentages have been rounded up to the nearest 2 decimal places.

## Disability

**Table 1**

Job Family	Band	Disabled Employments	Non-Disabled Employments	Unknown/Declined to disclose	Total Employments
<b>Administrative Services</b>	3	0	4	4	8
	4	<10	59	5	*
	5	0	71	0	71
	6	0	57	0	57
	7	<10	67	8	*
	8A	<10	36	2	*
	8B	0	13	0	13
	8C	0	3	1	4
	8D	0	7	0	7
<b>Medical and Dental</b>	Clinical	0	11	2	13
<b>Other Therapeutic</b>	8A	0	4	1	5
	8B	0	2	0	2
	8C	0	2	2	4
	8D	0	1	0	1
<b>Senior Managers</b>	Executive	0	3	0	3
<b>Total</b>		<b>10</b>	<b>340</b>	<b>25</b>	<b>375</b>

Of our total workforce, 2.67% identified as having a disability and 340 members of staff disclosed that they did not have a disability. It is unknown whether 25 employees have a disability or not, as they either chose not to disclose or the data is not held.

The number of disabled staff we employ is relatively low in comparison to census<sup>11</sup> data and we have set an equality outcome to help improve opportunities for disabled staff who work with us or who wish to work with us.

<sup>11</sup> 20% of people identified as having a long-term activity-limiting health problem or disability in Scotland's Census 2011.

## Race

**Table 2**

Job Family	Band	Asian - Bangladeshi	Asian - British	Asian - Chinese	Asian - Indian	Black - African	Declined/ Unknown	Mixed or Multiple Ethnic Group	White - Irish	White - Other	White - Other British	White - Polish	White - Scottish
Administrative Services	3	0	0	0	0	0	0	0	0	<10	0	0	<10
	4	0	<10	0	0	0	1	0	0	<10	<10	<10	55
	5	0	0	<10	<10	0	1	<10	<10	<10	12	<10	52
	6	<10	0	0	0	<10	0	0	<10	<10	11	0	38
	7	0	0	0	0	<10	5	<10	<10	<10	13	0	50
	8A	0	0	0	0	0	1	0	<10	<10	10	0	24
	8B	0	0	0	0	0	0	0	0	0	<10	0	10
	8C	0	0	0	0	0	1	0	0	0	0	0	<10
	8D	0	0	0	0	0	0	0	0	0	<10	0	<10
Medical and Dental	Clinical	0	0	0	0	0	0	0	0	<10	<10	0	<10
Other Therapeutic	8A	0	0	0	0	0	1	0	0	<10	<10	0	<10
	8B	0	0	0	0	0	0	0	0	0	0	0	<10
	8C	0	0	0	0	0	2	0	0	0	<10	0	<10
	8D	0	0	0	0	0	1	0	0	0	0	0	
Senior Managers	Executive	0	0	0	0	0	0	0	0	0	<10	0	<10
Total		*	*	*	*	*	13	*	*	20	67	*	255

The ethnic origin of 3.47% of staff is unknown, as they either chose not to disclose their details or their data is not held. We have set an equality outcome to help improve the overall disclosure rate of our staff member's equality monitoring information across all protected characteristic groups.

No staff identifying as minority ethnic are employed at band 8B or above.

The number of staff we employ who identify as minority ethnic is relatively low<sup>12</sup>. We will look at whether there are reasons behind this and consider appropriate solutions, which may include the use of the positive action provisions contained within the Equality Act 2010.

<sup>12</sup> As per Scotland's Census 2011, 4% of people in Scotland were from minority ethnic groups.

## Sex

As at 31 March 2016, we employed 283 (75.47%) female staff and 92 (24.53%) male staff.

Table 3 shows the number of female staff and male staff employed at each pay band.

**Table 3**

Job Family	Pay Band	Female Employments	Male Employments	Total Employments
<b>Administrative Services</b>	3	<10	<10	*
	4	65	<10	69
	5	60	16	76
	6	42	15	57
	7	56	21	77
	8A	24	16	40
	8B	<10	<10	13
	8C	<10	<10	*
	8D	<10	<10	*
<b>Medical and Dental</b>	Clinical	<10	<10	13
<b>Other Therapeutic</b>	8A	<10	0	*
	8B	<10	0	*
	8C	<10	0	*
	8D	<10	0	*
<b>Senior Managers</b>	Executive	<10	<10	*
<b>Total</b>		<b>283</b>	<b>92</b>	<b>375</b>

The number of female staff employed at every pay band is greater than the number of male staff, with the exception of the Clinical and Executive pay bands. There are very low numbers of staff working within these two pay bands.

Table 4 shows the average hourly pay and the percentage difference in pay between female staff and male staff at each pay band. Positive percentages show a difference in favour of male staff and negative percentages show a difference in favour of female staff.

**Table 4**

Job Family	Pay Band	Female average hourly pay	Male average hourly pay	Gender Pay Gap Male to Female %
<b>Administrative Services</b>	3	£9.87	£10.20	3.24%
	4	£10.96	£10.24	-7.03%
	5	£13.39	£13.72	2.41%
	6	£16.29	£16.16	-0.80%
	7	£19.31	£19.19	-0.63%
	8A	£23.17	£23.18	0.04%
	8B	£28.50	£27.89	-2.19%
	8C	£35.09	£32.27	-8.74%
	8D	£39.91	£40.66	1.84%
<b>Medical and Dental</b>	Clinical	£48.42	£50.19	3.53%
<b>Other Therapeutic</b>	8A	£24.25	N/A	N/A
	8B	£26.69	N/A	N/A
	8C	£34.63	N/A	N/A
	8D	£42.63	N/A	N/A
<b>Senior Managers</b>	Executive	£66.10	£42.07	-57.12%

The differences in the average hourly pay between female staff and male staff across each pay band is predominantly due to length of service and the incremental salary point each member of staff has reached. Table 4 shows that women on average earn more than men at the majority of pay bands, including at the most senior level.

Table 5 shows the gender split by percentage at each pay band.

**Table 5**

Job Family	Pay Band	Percentage of Female Employments	Percentage of Male Employments
<b>Administrative Services</b>	3	75%	25%
	4	94.2%	5.8%
	5	78.95%	21.05%
	6	73.68%	26.32%
	7	72.73%	27.27%
	8A	60%	40%
	8B to 8D	66.67%	33.33%
<b>Medical and Dental</b>	Clinical	30.77%	69.23%
<b>Other Therapeutic</b>	8A	100%	0%
	8B	100%	0%
	8C	100%	0%
	8D	100%	0%
<b>Senior Managers</b>	Executive	33.33%	66.67%

The gender split at pay band 4, the Clinical pay band, and the Executive pay band are three of the main factors that contribute to our gender pay gap.



Table 6 shows the distribution of the total number of female staff and male staff across each pay band by percentage.

**Table 6**

Job Family	Pay Band	Percentage of 283 Female Employments	Percentage of 92 Male Employments
<b>Administrative Services</b>	3	1.06%	1.09%
	4	22.97%	4.35%
	5	21.2%	17.39%
	6	14.84%	16.3%
	7	19.79%	22.83%
	8A	8.48%	17.39%
	8B to 8D	5.65%	8.7%
<b>Medical and Dental</b>	Clinical	1.41%	9.78%
<b>Other Therapeutic</b>	8A	1.77%	0%
	8B	0.71%	0%
	8C	1.41%	0%
	8D	0.35%	0%
<b>Senior Managers</b>	Executive	0.35%	2.17%

While 24 female staff are employed at Administrative Services pay band 8A in comparison to only 16 male staff, Table 6 shows that male staff are over-represented, proportionate to their overall number within the workforce: 17.39% of our male staff are employed at Administrative Services pay band 8A in comparison to 8.48% of our female staff. This is a factor that contributes to our gender pay gap.

Table 7 shows the number of part-time female and male staff we employ at each pay band.

**Table 7**

Job Family	Pay Band	Part-time Female Employments	Part-time Male Employments
<b>Administrative Services</b>	3	<10	0
	4	17	<10
	5	16	<10
	6	10	0
	7	15	0
	8A	<10	<10
	8B	<10	0
	8C	<10	0
	8D	0	<10
<b>Medical and Dental</b>	Clinical	<10	<10
<b>Other Therapeutic</b>	8A	0	0
	8B	0	0
	8C	0	0
	8D	0	0
<b>Senior Managers</b>	Executive	0	0
<b>Total</b>		<b>74</b>	<b>11</b>

Table 7 shows that staff are supported to work part-time at the majority of pay bands. The number of part-time workers at pay bands 8A and above is low, however this is reflective of the overall number of staff employed at these pay bands.

## Data analysis

With the exception of pay bands 3, 5, 8A, 8D and Clinical level, female staff members' average hourly pay is higher than male staff. In pay band 8A, the percentage difference in favour of male staff is only 0.04%. At the other levels, the percentage pay difference in favour of male staff is 3.53% or less.

The largest percentage pay difference in favour of men is at Clinical level, where it is 3.53%. The largest percentage pay difference in favour of female staff is at Senior Manager, Executive level, where it is 57.12%. There are also significant pay differences in favour of female staff at bands 4 and 8C, where the percentage differences are 7.03% and 8.74% respectively.

There is a significantly higher concentration of female staff (22.97%) in pay band 4 in comparison to male staff (4.35%), which in terms of actual headcount equates to 65 female staff and less than 5 male staff. The gender split at pay band 4 is 94.2% female staff and 5.8% male staff.

At pay band 8A, the percentage of male staff (17.39%) employed is just over double the percentage of female staff employed (8.48%), however in terms of actual headcount this equates to 24 female staff and 16 male staff. The gender split at pay band 8A is 60% female staff and 40% male staff.

The percentage of male staff (9.78%) employed within the Clinical pay band is significantly higher than the percentage of female staff (1.41%), however in terms of actual headcount, this equates to 9 male staff and less than 5 female staff. The gender split at the Clinical pay band is 30.77% female staff and 69.23% male staff.

## 6.2 The gender pay gap

There are two measures of the gender pay gap: the mean and the median. The mean average is calculated by adding all individual employees' hourly rates of pay and dividing by the total number of employees. The median average is calculated by listing all employees' hourly rates of pay and then finding the midpoint.

To calculate both our mean and median gender pay gap, we have followed the best practice guidance published by Close the Gap<sup>13</sup> in 2016. As this is the first time that we have followed this guidance, our equal pay data published in previous years is not directly comparable.

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<sup>13</sup> Close the Gap - Public sector equality duty: Guidance for reporting on gender and employment, equal pay, and occupational segregation.

## The mean pay gap

To calculate the mean pay gap, we first determined the basic hourly rate of pay for each employee. We then used the following formula to calculate the percentage difference.

$$\frac{A-B}{A} \times 100$$

A = mean hourly rate of pay of male employees (£22.58)

B = mean hourly rate of pay of female employees (£17.72)

This provides a mean pay gap of 21.52%.

## The median pay gap

To calculate the median pay gap, we determined the midpoint of the salary scale for both female and male staff and used the following formula.

$$\frac{C-D}{C} \times 100$$

C = median hourly rate of pay of male employees (£19.81)

D = median hourly rate of pay of female employees (£15.02)

This provides a median pay gap of 24.18%.

## Pay gap analysis

The three main factors identified by Close the Gap<sup>14</sup> as potential causes for an organisation's gender pay gap are inflexible working practices, pay discrimination and occupational segregation. We believe that our flexible working practices and our pay practices are not significant factors that contribute to our pay gap. On the basis of our analysis, we believe the cause of our pay gap is the proportion of female to male staff employed at the lower pay bands within the organisation, compared with the proportion of female to male staff employed at the higher pay bands, taking account also of the distribution of staff by gender across the different pay bands. This is known as 'occupational segregation' and is explained further below.

## Flexible working

Flexible working hours are available to all our staff, with the exception of a small number of staff who provide administrative support during death certification reviews. The following flexible working practices are available to staff:

- flexi-time
- compressed hours

<sup>14</sup> Close the Gap - Public sector equality duty: Guidance for reporting on gender and employment, equal pay, and occupational segregation.

- part-time
- job share
- home working, and
- phased retirement.

Managers are encouraged to promote working flexibly and set a good example for employees, ensuring that they do not:

- regularly work long hours
- allow meetings to overrun
- regularly take work home
- send emails late at night, or
- regularly be contactable on days off.

Flexible working hours allow our staff to begin work between 7.30am and 10am, and to leave between 4pm and 6.30pm.

### **Pay practices**

Healthcare Improvement Scotland is committed to ensuring that pay is awarded fairly and equitably. We employ staff on nationally negotiated and agreed NHS contracts of employment which include provisions on pay, pay progression and terms and conditions of employment. These include National Health Service Agenda for Change (A4C) Contracts and Terms and Conditions of employment.

### **Occupational segregation**

While the overall number of women employed at the majority of the pay bands, including the higher pay bands, is greater than the number of men, men are under-represented, relative to their overall number within the organisation, at the lower pay bands and over-represented at the higher pay bands. This disproportionate distribution of staff based on their gender is the main factor that contributes to our gender pay gap and is known as occupational segregation.

Of our female staff, 22.97% are employed within Administrative Services pay band 4 in comparison to 4.35% of our male staff. In terms of actual headcount, this equates to 65 female staff in comparison to less than 5 male staff. The under-representation of male staff, coupled with the high concentration of female staff at this pay band, has a significant influence on our pay gap.

Of our female staff, 8.48% are employed within Administrative Services pay band 8A in comparison to 17.39% of our male staff. In terms of actual headcount, this equates to 24 female staff in comparison to 16 male staff. While women are more likely to apply and be appointed to jobs at this pay band, male staff are over-represented relative to their overall number within the organisation. This has a significant influence on our pay gap.

Of our female staff, 1.41% are employed at the Clinical pay band in comparison to 9.78% of our male staff. Staff numbers within this pay band are very low, however

the over-representation of male staff has a significant influence on our pay gap. If we calculate the mean pay gap minus the Clinical pay band, the gap reduces to 11.75%. The median pay gap minus the Clinical pay band equals 16.74%. This demonstrates the impact the gender split at this pay band has on our pay gap.

The number of staff employed at the Executive pay band is very low. Female staff at this pay band on average earn 57.12% more than male staff. The gender split at this pay band is 33.33% female staff and 66.67% male staff. Despite the low numbers employed, and the fact that female staff earn significantly more than male staff, the gender split at this pay band is a factor that contributes to our gender pay gap.

While the pay gap figures are significant, it is important to note that:

- more than three quarters of our staff are female, which is generally consistent with the gender split across NHSScotland.
- female staff are well represented, in terms of actual headcount, at all levels of the organisation. We employ significantly more female staff than male staff in every job family, with the only exceptions being Senior Management and Medical and Dental. In both these job families, staff numbers are very low, with the actual headcount difference between male and female staff being 5 or less.
- we believe that the overall number of female staff employed across the organisation at all levels, suggests that there is not a lack of opportunities for women to enter and progress at any pay grade.
- Table 4 shows that on average, female staff earn more than male staff at the majority of pay grades, including at the Senior Management, Executive level.

We are aware that external factors within the labour market have an influence on the occupational segregation within our workforce that contributes to our pay gap. It is commonly accepted that women are more likely to apply for and occupy jobs within administrative roles, public sector bodies and the NHS.

Our workforce data shows that during 2015–2016:

- 66.4% of the total job applications we received were from female applicants
- 70.9% of all applicants shortlisted for interview were female
- 76.9% of people offered jobs were female
- 78.9% of internal applications for promotion were from female staff members
- 81.8% of the internal applicants shortlisted for interview were female, and
- 83.3% of the internal applicants offered promotion were female.

Our workforce data evidences that women are more likely to apply for jobs with us and then subsequently be shortlisted and appointed. However, the data in tables 5 and 6 show the disproportionate distribution of male staff at particular pay bands contributes to our pay gap.

As an employer, we believe that we offer attractive working benefits at all pay bands and these benefits can be of particular appeal to women, as our inclusive policies are designed to accommodate staff to have a good work-life balance. While we do not

currently formally collect data in relation to pregnancy and maternity, it is believed that the majority of female staff who take maternity leave return to work within the same role and are supported to achieve a good work-life balance.

Our staff are empowered, with the support of their line manager, to establish the working patterns that best suit them. We regularly offer staff development opportunities and during 2015–2016, 80.9% of staff who undertook training were female. All job vacancies are promoted internally and staff are offered the prospect to gain experience from internal secondment opportunities.

The Chair of our Board is female and our Board, as at 1 February 2017, consisted of six women and seven men. We have positive female role models working at all levels within the organisation and, until November 2016, our Chief Executive was female. We do not believe that gender is a barrier to career progression within our organisation and we do not award pay based on any gender bias.

We are committed to equal pay for all and we believe we have robust measures in place, as already detailed, to allow people, irrespective of gender or any other protected characteristic, to enter the organisation at any level and progress without barriers. We engaged with Close the Gap to discuss best practice in relation to achieving equal pay and what makes an exemplary employer. These discussions informed our data analysis and the actions we propose to take in relation to our gender pay gap.

## **Actions**

In addition to our commitments detailed on page 44, we will:

- Take steps to advance equality of opportunity for disabled people through the following equality outcome: Disabled staff and job applicants experience improved support and career opportunities within Healthcare Improvement Scotland.
- Establish whether there are reasons for the relatively low number of minority ethnic staff we employ and consider appropriate solutions, which may include the use of the positive action provisions contained within the Equality Act 2010.
- Engage with staff to better understand the career pathways they believe are currently available to them and explore how they can be improved.
- Seek to collate additional information about the career progression of staff at each pay band to help identify if barriers exist.
- Seek to collate information about the uptake of training by staff at each pay band to help identify if barriers exist.
- Collate information and report on the number of female staff that take maternity leave, the grade at which they return and whether they return to the role at full time or part time in order to identify and understand any barriers women face when returning to work following pregnancy.

- Take positive action to encourage women to apply for Medical and Dental roles when they become available.
- Take positive action to encourage men to apply for Administrative Services pay band 4 roles when they become available.
- Where appropriate, highlight in job adverts vacancies that would be considered suitable for job sharing.
- Continue to engage with Close the Gap and other organisations that promote equal pay to support our improvement activity.

## 7 Contact information

If you have any comments or questions about this report, or if you would like us to consider producing this report in an alternative format, please contact our Equality and Diversity Advisor:

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