Equality Impact Assessment (EQIA)

Person-Centred Design and Improvement Programme (PCDI)

December 2022

Name (policy/ procedure/ practice/ function)	Person-Centred Design and Improvement (PCDI) Programme
Directorate	Transformational Redesign Unit
Team	Person-Centred Design and Improvement (PCDI)
EQIA Lead	Charis McElhinney
Responsible Manager	Diane Graham
Date	12/12/2022

Contents

1.   Background

For all new or revised work, Healthcare Improvement Scotland has a legal requirement under the Public Sector Equality Duty to actively consider the need to:

> Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010.

> Advance equality of opportunity between people who share a protected characteristic and those who do not.

> Foster good relations between people who share a protected characteristic and those who do not.

Additionally:

> We give consideration to the principles of the Fairer Scotland Duty by aiming to reduce inequalities of outcome that are based on socio-economic disadvantage.

> If the work will have a specific impact or relevance for children up to the age of 18, its impact on children's human rights and wellbeing should be independently assessed.

> As the Children and Young People (Scotland) Act 2014 names Healthcare Improvement Scotland as a corporate parent, we must consider the needs of young people who have experienced care arrangements, and young people up to the age of 26 who are transitioning out of these arrangements.

> If the work is relevant to islands communities as well as mainland communities, any specific impacts on islands communities should be assessed.

This template is designed to guide teams through assessing the impact of their work. A team should begin this assessment as soon as they start planning a new piece of work or revising an existing piece of work. A team might use this template solely as a planning tool, or keep it as a live document to review and update as the work progresses.

2. Aim/Purpose of the Programme

The Person-centred Design and Improvement (PCDI) Programme was established in April 2020 and was underpinned by the preceding Person-centred Health and Care Programme.

The PCDI programme is delivered by a team of service design and quality improvement advisors, who specialise in taking a person-centred approach to both disciplines.

This is a core ihub programme that aims to integrate service design, person-centred and quality improvement approaches, and to ensure the involvement of people with lived and living experience in health and social care service redesign and quality improvement.

The programme's vision is '*to enable health, social care, and third sector organisations to improve their services using person-centred design and improvement expertise to meet the needs and improve outcomes for people receiving and delivering services*'.

Service change and quality improvement is common practice within health and social care services and ultimately impacts on how services are delivered, and how they are experienced by the people receiving them. How organisations approach change is therefore a key part of service delivery, and should be approached with a person-centred ethos, as is expected of any other aspect of a service.

Policy context

The duty to involve people and communities, in planning how their public services are provided, is enshrined in law in Scotland. The PCDI team's workplan and activity is therefore guided by the involvement and equality and equity principles found in national policy and guidance, such as:

The national Care Service Bill (as introduced, 2022)

- 'Opportunities are to be sought to continuously improve the services provided by the National Care Service in ways which (i) promote the dignity of the individual, and (ii) advance equality and non-discrimination' (Pg4, Part 1, Chpt 1, principle 1e)

- 'the National Care Service, and those providing services on its behalf, are to communicate with people in an inclusive way, which means ensuring that individuals who have difficulty communicating (in relation to speech, language or otherwise) can receive information and express themselves in ways that best meet their individual needs' (Pg 5, Part 1, Chpt 1, principle 1f)

Independent Review of Adult Social Care (IRASC, 2021)

- 'It is vital that we amplify the voice of lived experience at every level in our redesign. We have a duty to co-produce our new system with the people who it is designed to support, both individually and collectively.' (IRASC, pg 5)

- 'There must be a relentless focus on involving people who use services, their families and carers in developing new approaches at both a national and local level.' (IRASC, Recommendation 30, pg 69)

Care Services – planning with people guidance (2021)

- 'Effective community engagement and the active participation of people is essential to ensure that Scotland's care services are fit for purpose and lead to better outcomes for people.
- 'NHS Boards, Integration Joint Boards and Local Authorities all have a statutory responsibility to involve people in developing and delivering care services.'
- 'All relevant public bodies are expected to demonstrate how they are engaging with communities, and to evidence the impact of engagement.' (Part 1 – planning with people, pgs7&9)

Health and Social Care Standards: my support, my life (2017)

- 'These Health and Social Care Standards set out what we should expect when using health, social care or social work services in Scotland. They seek to provide better outcomes for everyone; to ensure that individuals are treated with respect and dignity, and that the basic human rights we are all entitled to are upheld.'
- 'The Standards are underpinned by five principles: dignity and respect, compassion, be included, responsive care, and support and wellbeing.' (Introduction, pg 3)

Healthcare Quality Strategy for Scotland (2010)

The Quality Strategy builds on these foundations and is about three things:

- 'It is about putting people at the heart of our NHS. It will mean that our NHS will listen to peoples' views, gather information about their perceptions and personal experience of care and use that information to further improve care.'

- 'It is about building on the values of the people working in and with NHS Scotland and their commitment to providing the best possible care and advice compassionately and reliably by making the right thing easier to do for every person, every time.'

- 'It is about making measurable improvement in the aspects of quality of care that patients, their families and carers and those providing healthcare services see as really important.' (Section 2, Executive Summary, pgs 5-6)

National Health Service Reform (Scotland) Act 2004

- It is the duty of every Body to which this section applies to take action with a view to securing, as respects health services for which it is responsible, that persons to whom those services are being or may be provided are involved in, and consulted on (a) the planning and development, and (b) decisions to be made by the body significantly affecting the operation,.' (Part 1, Section 7 - Public involvement 2B)

Outcomes

The anticipated outcomes of the PCDI programme for 2022 - 2023 are:

Short-term outcomes (what they learn and gain)

- **S1** Health and social care organisations gain knowledge and capabilities in person-centred design principles and person-led improvement approaches.
- **S2** Health and social care, independent and third sector gain increased access to information on innovative practice and implementation support tools.
- **S3** National organisations develop insights into the workforce support needs to develop person-centred practice and apply person-centred design.
- **S4** Healthcare Improvement Scotland internal teams further develop knowledge and skills relating to person-centred design approaches
- **S5** Scottish Government develop knowledge and evidence of how person-centred design approaches are being applied within health and social care systems

Medium-term outcomes (what they do differently)

- **M1** Health and social care organisations apply person-centred design principles and approaches to redesign processes and pathways of care that improve the quality of care experience and outcomes for their population.
- **M2** National organisations develop their support and resources to reflect the workforce needs in developing capabilities in person-centred design and person-led improvement.
- **M3** Healthcare Improvement Scotland teams design programmes and supports that promote person-centred design principles and person-led improvement approaches to the redesign of processes and pathways of care.
- **M4** Scottish Government apply knowledge and evidence generated to inform future policy and legislation

Long-term outcomes (what difference this makes)

- **L1** People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide (NHWO 8)
- **L2** Health and social care organisations can sustainably redesign and continuously improve services in a person-centred way.
- **L3** People who receive or access health and social care services have positive experiences of those services, and have their dignity respected (NHWO 3)
- **L4** People who use health and care services see how their involvement has impacted on the way in which health and social care services are designed.
- **L5** People who work in health, social care, independent, and 3rd sectors are able to collaboratively provide person-centred and joined up approaches and services.
- **L6** Scottish Government are more aware of the person-centred innovations being developed across Health and Social care services in Scotland.

Scope

The PCDI programme does not aim to impact one particular service or one specific stakeholder group, instead it aims to support the whole system to work in a way which puts the person at the centre from the beginning to end of service design, delivery, and improvement.

The team focus their expertise on enabling health and social care organisations to plan person centred approaches to redesigning services and quality improvement. Where possible, they support the building of workforce capabilities in service design approaches and person-centred practice.

In addition, they support capability development within the ihub's internal programme teams to advise and coach around involving people in change processes.

The PCDI team predominantly works with the organisations and people who directly engage with adults, young people, and children when redesigning or improving services. Within each of these age groups is a range of people who may experience inequalities in relation to disability, gender reassignment, pregnancy and maternity, race, religion and belief, sex, sexual orientation, or marriage and civil partnership.

The health and social care workforce are in many ways representative of the Scottish population, therefore they also experience inequalities in relation to all of the above mentioned protected characteristics. The PCDI team most often work with staff in health or social services and must take account of all this in planning all activities, to be accessible for both staff and people using services.

Workstreams

The programme operates across several workstreams. The active workstreams during 2022 – 2023 are outlined in the table below.

Workstream Code	Workstream Title	Description	Outcome Key
CL1	CEIM Leaders	CEIM Leaders enables health and social care teams across Scotland, through a capability development programme, to deliver continuous improvement in the outcomes and experiences of people who use their services, through listening to feedback and making meaningful and continuous improvements. This programme supports the delivery of in-house training and coaching that enables care and support teams to embed and sustain the CEIM approach.	S1, 3 M1, 2
PN1	Person-Centred Care Network (PCCN)	A community of practice that supports health and social care staff to put people at the centre of care	S1, 2, 3, 5 M1, 2, 4

		and support and make improvements in person-centered care and practice	
DP1	Design Community of Practice (DCoP)	DCoP works with designers and people working on design projects across health, housing and social care to spread knowledge, experience and challenges, and to provide support to embed user-centred design within health and social care	S2, 3, 4, 5 M1, 2, 4

3. Assessment of impact

Barriers to involving people in the design and development of health and care services can lead to underrepresented groups experiencing poorer health outcomes because their needs, views and experiences are not considered.

The PCDI programme aims to ensure health and social care services are designed and changed with involvement and with an understanding of what matters to the people for which these services are intended to support.

The programme considers in its planning and delivery of work the impact of inequalities for anyone delivering or receiving health and social care services in Scotland. This is to ensure stakeholders supported by the programme do not perpetuate or exacerbate existing inequalities in their change projects.

Actively considering equalities in the work of this programme could improve the success and involvement of people in service design/redesign and quality improvement activities, as well as improving the services and outcomes for people who use them.

Paying particular attention to groups who have been marginalised and excluded may help tackle the inverse care law[1], whereby those with the most need for services are the least likely to receive them and least likely to feel safe to participate.

Building involvement approaches that include people who are currently not supported well by existing services, can help us design models of care that meet the needs of all their communities and address inequalities.

The following is a summary of the factors that could potential impact for people in both the programme's core stakeholder group (i.e. people who work in health, social care or 3rd sector services), and also those people with lived or living experience, supported by the health, social care or 3rd sector services that the programme team connect with.

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[1] Inverse care law: https://www.health.org.uk/publications/reports/tackling-the-inverse-care-law

Age

- We know that older people are more likely to experience sight or hearing loss as part of the ageing process. In Scotland there is around 6.6% of the population[2] experiencing hearing loss and 3.3% with significant sight loss[3] (across all age ranges). This may cause communication and involvement approaches to be more challenging for these individuals. This requires attention to adapting the programme information, communication and engagement opportunities in a range of ways that consider these challenges, for example providing documents larger text, making audio information available, using telephone meetings, or making information digital, so screen readers can be used. However it is also important to consider digital exclusion where engagement and resources are only made available online.
    - **Consideration of this impact is required for workstreams: CL1, DP1 and PN1**

- Research from the University of York has highlighted that by January 2023 over half of the households in the UK (15 million) will be in fuel poverty. This includes more than 72% of households in Scotland, and 86.4% of pensioner couples in the UK, are expected to fall into fuel poverty[4]. The impact of fuel poverty through living in a cold and damp home, is a clear contributory factor in health issues such as respiratory diseases, heart diseases, circulatory diseases, and mental health problems[5]. Discrimination can occur when assumptions are made about people experiencing poverty and their ability to participate in change and improvement activities. Poverty, and fuel poverty can significantly affect adults and young people working in the public and 3rd sectors as much as those working in other sectors or not in work. It would be important to consider how reimbursement of expenses or proactive support for potential expenses might support involvement.
    - **Consideration of this impact is required for workstreams: CL1, DP1 and PN1**

Disability

- Physical impairments and sensory loss should be considered when scoping venues for in-person workshops and events, to ensure they are fully accessible to facilitate equal participation.

- People who are neuro-divergent or have learning disabilities, dementia or anxiety disorders may be particularly affected by new and unfamiliar surroundings, especially where in-person involvement is part of design processes
There may be specific interventions that are reassuring for these groups and help facilitate

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[2] DeafScotland Census (2020) https://deafscotland.org/wp-content/uploads/2021/05/Deafness_Predicting-the-future-for-Scotland_The-Census-and-Beyond.pdf

[3] Sight Scotland Annual Report (2021) https://sightscotland.org.uk/our-impact/annual-reports

[4] Fuel Poverty Research: https://www.ageuk.org.uk/scotland/latest-news/2022/august/new-research-reveals-vast-majority-of-pensioner-couples-face-fuel-poverty/

[5] Institute of Health Equity report on Fuel Poverty in UK : https://www.instituteofhealthequity.org/resources-reports/fuel-poverty-cold-homes-and-health-inequalities-in-the-uk/read-the-report.pdf

their engagement. For example, accessible venues and information and having well displayed photographic name-badges.

- People who are immunosuppressed or who care for someone who is immunosuppressed may be unable to attend in-person engagement activities due to ongoing circulation of the covid-19 virus. It will therefore be important to offer a range of engagement options to ensure safe and equal participation.

  – **Consideration of this impact is required for workstreams: CL1 and PN1**

- For some people who are neuro-divergent or who have learning disabilities, dementia or anxiety disorders, adapting to unfamiliar circumstances, some meeting formats, involvement approaches, digital breakout rooms and so on, may prove challenging. The way information is presented and how conversations take place, will therefore have an impact on involvement. This may include providing more visual information, information in advance, or using communication aids.

  – **Consideration of this impact is required for workstreams: CL1 and PN1**

- Digital participation among disabled adults is lower than it is among the general population[6]. Some of the reasons for this can be lack of access to computers or the internet, lack of accessible technology and potentially prohibitive cost, lack of opportunity to acquire digital skills, lack of motivation to engage with technology, and lack of trust towards technology and the internet. This may limit the ways that some disabled people engage with engagement or involvement activities. To benefit from the use of digital communication tools, they may need additional support or 1:1 coaching to be considered.

  – **Consideration of this impact is required for workstreams: CL1, DP1 and PN1**

- There are specific communications considerations for people with hearing and speech differences. For example, people who are hard of hearing and rely on lip-reading will need to be able to see faces / mouths during conversations or have access to another means of communication such as writing or the Relay UK service. They may also struggle to see screens and therefore experience more difficulty using virtual forms of communication without assistive technology.

  – **Consideration of this impact is required for workstreams: CL1, DP1 and PN1**

- There are specific communications considerations for people who are Deaf and Deafblind and/or who use British Sign Language (BSL). They may need access to writing, interpreters, Language Line or the Contact Scotland service.[7]

  – **Consideration of this impact is required for workstreams: CL1, DP1 and PN1**

- Disabled people are more likely to be experiencing difficult situations which impact on their general health and wellbeing or mental health and may generate anxiety about their ability to cope and therefore they may need more support to engage,

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[6] Digital participation amongst people with disabilities: https://peopleknowhow.org/wp-content/uploads/2017/12/Digital-Participation-Amongst-people-with-Disabilities.pdf
[7] NHSScotland Interpreting, communication support and translation national policy: http://www.healthscotland.scot/media/3304/interpreting-communication-support-and-translation-national-policy.pdf

or give their views as part of improvement or redesign activities. Poor mental health can make communication more challenging and, without detection, could lead to heightened feelings of isolation.

– Consideration of this impact is required for workstreams: CL1, DP1 and PN1

- Living with disability increases the risk of experiencing fuel poverty. We know that 27 per cent of households that include someone who is disabled are on a low income and their cost of living is higher. Disabled people also face higher energy bills due to having additional needs (such as medical equipment that requires a power source) and spending longer periods at home.[5] These financial pressures can have a significant effect on the ability of people to get involved in service change and improvement activities and it would be important to consider how the programme can support those on a low income with disabilities to participate as much as possible.

– Consideration of this impact is required for workstreams: CL1, DP1 and PN1

Gender reassignment

- Trans people experience disproportionately poor mental health and are more likely to experience suicidal ideation.[8] This could make communications more challenging and, if undetected, could lead to a worsening sense of isolation and poor mental health. Also, many Trans people find being misgendered with the wrong pronouns in conversation or in written communication, upsetting and hurtful. We must ensure we check people's preferred pronouns and not make assumptions.

– Consideration of this impact is required for workstreams: CL1, DP1 and PN1

- A person's Trans status is protected by the Gender Recognition Act 2004 and should not be officially gathered, and any informal disclosure should be treated with the same high level of confidentiality as sensitive personal medical information. Revealing someone is Trans ('outing' them) can place them at risk of hate crime and discrimination. Even if a Trans person appears open about their Trans status, we must never assume you can tell others.

– Consideration of this impact is required for workstreams: CL1, DP1 and PN1

Pregnancy and maternity

- *Currently the programme doesn't work with pregnancy and maternity services.*

- Living in fuel poverty may not only impact the mental health of children – a longitudinal study in Ireland found that mothers of young children may be up to 64 per cent more likely to experience maternal depression if living in fuel-poor households, even after taking account of income, education and employment.[4] Where any programme workstream finds

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[8] LGBTI Populations and Mental Health Inequality: https://www.lgbthealth.org.uk/wp-content/uploads/2018/08/LGBTI-Populations-and-Mental-Health-Inequality-May-2018.pdf

pregnant women and young mothers are part of the improvement work, reducing financial burdens of participation must be considered.

Race

- The lack of diversity in the health and social services workforce will result in lower cultural awareness when planning engagement activities. For example, only 6% of the NHS workforce in Scotland comes from a minority ethnic background[9].

    – **Consideration of this impact is required for workstreams: CL1, DP1 and PN1**

- People from minority ethnic backgrounds often have poorer access to healthcare services as well as poorer experiences of care and treatment. They are less likely to raise concerns or make complaints about the standards of their care or support[10]. This could make clear and compassionate communications all the more important.

    – **Consideration of this impact is required for workstreams: CL1, DP1 and PN1**

- Hard Edges 2019 report[11] states that 2% of cases of adults experiencing severe and multiple disadvantages (homelessness, substance abuse and offending) have a minority ethnic background. Including people at the intersection of these experiences requires a range of different approaches.

    – **Consideration of this impact is required for workstreams: CL1, DP1 and PN1**

- Some people from minority ethnic backgrounds, including refugees, may not speak English or have English as a first language. This can increase feelings of isolation and require communications in a person's preferred language.

    – **Consideration of this impact is required for workstreams: CL1, DP1 and PN1**

- Asylum seekers and refugees face unique and complex challenges related to their mental health. Research suggests that asylum seekers are five times more likely to have mental health needs than the general population, and more than 61% will experience serious mental distress, however they are less likely to receive support than the general population.[12]

- Refugees and those without immigration status may be experiencing economic deprivation or destitution and/or lack access to support. In addition, refugees may have family members in other countries, potentially living in unsafe situations and therefore experience feelings of isolation and poor mental wellbeing. These factors could affect their will and ability to communicate, or get involved around improving services that could support them.

    – **Consideration of this impact is required for workstreams: CL1, DP1 and PN1**

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[9]Racial Inequalities in Scotland Report 2021: https://www.mwcscot.org.uk/sites/default/files/2021-09/Racial-Inequality-Scotland_Report_Sep2021.pdf

[10] Care Quality Commission Research: https://www.cqc.org.uk/news/releases/new-research-care-quality-commission-shows-racial-disparity-people-raising-concerns

[11] Hard edges report: https://www.therobertsontrust.org.uk/publications/hard-edges-scotland/

[12] Eaton, V., Ward, C., Womack, J., & Taylor, A. (2011). Mental Health and Wellbeing in Leeds: An Assessment of Need in the Adult Population. NHS Leeds.

Religion and belief

As Scotland is a religiously and culturally diverse country, our programmes of work will see us engaging and collaborating with individuals of different religions and beliefs and we should be culturally sensitive and respectful.

- Cultural and religious festivals should be acknowledged and recognised, so that staff who may wish to celebrate them are able to. There is a risk that religious events, such as Ramadan, may reduce involvement/participation and this should be taken into account when planning meetings and events.

- Many religions have strict rules about diet such as halal (Islam), and kosher (Jewish), and vegetarian and vegan (Buddhist, for example). Use of pork products (gelatine) and other animal derivatives in non-food items may be forbidden.
  This should be taken into account when planning catering for any in-person events. Show respect and consideration when people are fasting for religious reasons by being sensitive to the requirements and implications of fasting.

  – **Consideration of this impact is required for workstreams: CL1, DP1 and PN1**

Sex

- Women account for the majority of the health[13] and social care[14] workforce and therefore the programme needs to carefully plan representative involvement of both men and women in engagement activities and communication.

  – **Consideration of this impact is required for workstreams: CL1, DP1 and PN1**

- Women are more likely to be the primary unpaid care-giver for both children and adults[15]. Women are also more likely to be the care-givers for people with mental health illnesses[16]. With women over-represented in the health and social care workforce, this could present both caring and childcare challenges, and increased stress in this particular group. Considering how the programme can support people with caring responsibilities to enable participation, both male and female, would ensure a significant perspective and voice in any improvement or change activity.

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[13] NHSScotland Workforce Report 2022: https://turasdata.nes.nhs.scot/media/j0vdmiul/workforce-report-june-2022-formatted.pdf
[14] National Care Service - adult social care workforce: evidence: https://www.gov.scot/publications/national-care-service-adult-social-care-workforce-scotland/
[15] National Care Service – people who access adult social care and unpaid carers: evidence: https://www.gov.scot/publications/national-care-service-people-access-adult-social-care-unpaid-carers-scotland/pages/4/
[16] Gender differences in caregiving among family - caregivers of people with mental illnesses (World J Psychiatry, 2016): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4804270/

It is also important to note that some discrimination can be associated with being labelled as a 'carer'.

- Consideration of this impact is required for workstreams: CL1, DP1 and PN1

- Women are more likely to experience domestic violence. This could make communicating with family difficult, particularly if a desire to communicate with an abusive partner is assumed. There may be issues around disclosure and concerns about keeping safe after treatment.

  Domestic violence also impacts the workforce and trauma informed approaches could be important if discussing keeping women safe within health settings and also when engaging victim-survivors. When working with anyone we have concerns for, we should refer to our Gender Based Violence policy.

  - Consideration of this impact is required for workstreams: CL1

Sexual orientation

- LGBT people may be at increased risk of homelessness and domestic abuse[17]. They may be more isolated or have concerns about how their involvement may be perceived or impact on their situation. They may find it challenging to participate in traditional approaches to involving people.
  - Consideration of this impact is required for workstreams: CL1, DP1 and PN1

- LGBT people are more likely to be estranged from their families and to experience social isolation and so it is helpful if assumptions are not made as to who a person may want us to be in contact with.
  - Consideration of this impact is required for workstreams: CL1

- LGBT people can find that their identities and/or relationships are sometimes assumed or overlooked, contributing to a poorer sense of wellbeing and to conversations that feel more difficult or risky if they have to 'come out'.
  Again, it is helpful to avoid assumptions and give people opportunities to communicate the information they want about themselves.
  - Consideration of this impact is required for workstreams: CL1, DP1 and PN1

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[17] Stonewall, LGBT in Britain, Trans report: https://www.stonewall.org.uk/system/files/lgbt_in_britain_-_trans_report_final.pdf

Socio-economic disadvantage (cross-cutting)

- Poverty affects some protected groups disproportionately. For example, people from non-white minority ethnic groups. The poverty rate is 41% for the 'Asian or Asian British' ethnic groups, and 43% for 'Mixed, Black or Black British and Other' ethnic groups.[18]

- 38% of single women with children are living in poverty.

- Almost one in four children in Scotland live in relative poverty (statistic prior to covid-19).[19] The experience of poverty could impact how a child communicates and who they want to communicate with.

- Research tells us that those on low incomes are disproportionately likely to suffer from poor mental health. Those living in areas of socio-economic deprivation are also more likely to have lung disease, asthma and diabetes – all of which could impact treatment and outcomes.[20]

- Poverty and fuel poverty can significantly disadvantage a range of people, including those with disabilities, carers and people from minority ethnic groups.
  Any of these people could be working in the public sector and could be affected as much as those working in other sectors or not in work. It would be important to consider how reimbursement of expenses or proactive support for potential expenses might support involvement.

- People on low incomes are less likely to have a car and may have concerns about going about their daily business, safely and in a way that supports their recovery,
  or allows them to stay healthy enough to work and care for their families. These practical considerations could weigh heavily and cause poor mental wellbeing,
  or dominate a person's conversation or thinking.

  – **Consideration of this impact is required for workstreams: CL1, DP1 and PN1**

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[18] Poverty and Inequality Commission: https://povertyinequality.scot/poverty-scotland/
[19] HIS Children's Rights Report Apr 2020:
http://www.healthcareimprovementscotland.org/previous_resources/policy_and_strategy/childrens_rights_2017-2020.aspx
[20] Scottish Government Improvement Service: Poverty, Inequality and COVID-19

4.   Recommendations for change

The following actions are recommended:

Team recommendation suggestions based on the previous assessment:
(Please add all your recommendations below)

1. Establish a robust user research process to standardise practice and make work inclusive that incorporates routine assessment and completion of user research risk assessment, engagement planning, stakeholder mapping/recording and equalities recording at the start of new work.

2. Ensure the programme team adhere to an approach that maintains the confidentiality of personal data and information of people it engages with (e.g. completion of DPIA, formal consent processes and robust project information sheets).

3. Develop and establish an approach to accessible events and equalities assessment for all involvement work (in-person and virtual events, interviews, focus groups and workshops). We will apply an accessibility checklist, to ensure both venues and virtual events are fully accessible, to facilitate equal participation. We will also, where possible, provide reasonable expenses to help people participate through the routes available to HIS.

4. Source recognised language guides for ethical communication, to ensure we are communicating respectfully and also considering health literacy guidance (https://www.healthliteracyplace.org.uk/)

5. Establish team guidance/checklists to support ethical engagement with people who are: (a) vulnerable (b) in socio-economic deprivation

6. Develop an approach to assurance, involving public voice in all our programmes of work (e.g. public partner independent review of programme).

5. Monitor and review

Regular reviews ensure that policy, procedure and practice is kept up to date, and meets the requirements of current equality legislation. Where a negative impact has been identified and remedial actions are being implemented, the person leading the work should define a timescale for review.

We have agreed to review this EQIA quarterly.

Review date	Identified issue	Person responsible
12/04/2023		Charis McElhinney/PCDI team

6. EQIA sign off

Please return this completed EQIA to:

his.contactpublicinvolvement@nhs.scot

If you need any advice on completing this form, or any aspect of the Equality Impact Assessment process, please contact: rosie.tyler-greig@nhs.scot

Project Lead	Diane Graham
Sign-Off Date	12/12/2022