

Equality Impact Assessment (Stage 1)

This is a legal document as set out in the Equality Act (2010) and the Equality Act 2010 (Specific Duties) (Scotland) regulations 2012 and may be used as evidence for cases referred for further investigation for compliance issues.

Completing this form helps you to decide whether or not to complete to a full (Stage 2) EQIA.

Consideration of the impacts using evidence and public/patient feedback is necessary.

Question 1: Title of Policy, Strategy, Redesign or Plan

Proposed Enhanced 7 day community model, Fife Specialist Palliative Care Service (FSPCS)

Question 2a: Lead Assessor’s details

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Question 2b: Is there a specific group dedicated to this work? If yes, what is the title of this group?

The Fife Specialist Palliative Care Enhanced Community model has been developed in conjunction with the Palliative Care Collaborative; a multi-agency forum for professional stakeholders in palliative care delivery across Fife.

Question 3: Detail the main aim(s) of the Policy, Strategy, Redesign or Plan. Please describe the specific objectives and desired outcomes for this work.

Aim	<p>To provide a community based 7 day model of outreach specialist palliative care for people with the most complex needs (patients and families) in all care settings, including hospice, community hospitals and the acute hospital, people’s own homes and care homes.</p> <p>To formally adopt the 7 day enhanced community service model, which has been operational since April 2020, delivered through service transformation, within existing resources which are aligned with local and national strategic aims of improving access to palliative care for all who need it.</p>
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	<p>In December 2015, the Scottish Government published the Strategic Framework for Action on Palliative and End of Life Care which set out the aim that “by 2021, everyone in Scotland who needs palliative care will have access to it”.</p> <p>The Fife Clinical Strategy 2016-2019 called for the provision of “robust 7-day specialist palliative care that is able to meet the needs of the most complex patients and their carers in all care settings (including hospice, community and acute hospital) as well as to support and lead the development, education and support of generalist palliative care across Fife”.</p> <p>AIM:</p> <ul style="list-style-type: none"> • People in Fife have an equitable access to palliative and end of life care, regardless of age, gender, ethnicity, diagnosis, socioeconomic status or location, 7 days a week. <p>OUTCOMES:</p> <ul style="list-style-type: none"> • People with advanced illness, their families and carers have equitable access to timely conversations with skilled professionals to plan their care and support towards the end of life (anticipatory care planning) • People with advanced illness, their families and carers, receive, responsive, reliable, coordinated, compassionate palliative and end of life care, equitably and in all care and residential settings, 7 days a week
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Question 4: Identifying the Impacts in brief

Consider any potential Impacts whether positive and/or negative including **social and economic impacts** and human rights. Please note, in brief, what these may be, if any. **Please do not leave any sections blank.**

Relevant Protected Characteristics	Impacts negative and positive Social / Economic Human Rights
<p>Age - <i>think: children and young people, adults, older age etc.</i></p>	<p>Adults, aged 18 and over</p> <p>The service aim to positively impact on the lives of people nearing the end of life – including the person with advanced illness, their families and other unpaid carers.</p> <p>The service offers:-</p> <ul style="list-style-type: none"> • Specialist support to make informed decisions and to be involved in the planning for palliative and end of life care in their preferred location • Care to people aged over 85 years who may be under-served, in home, care home and hospital settings, as well as

	<p>in the hospice</p> <ul style="list-style-type: none"> • Specialist Children and Families support where young people face the loss of a parent or another significant adult in their lives. Including liaison and coordination with education and social work colleagues as needed.
<p>Disability – <i>think: mental health, physical disability, learning disability, deaf, hard of hearing, sight loss etc.</i></p>	<p>Each person will receive personalised care, including tailoring of care to accommodate all disabilities.</p> <p>We will aim to manage their care in surroundings which are familiar to them, where they feel safe, and working with care teams who they may have existing relationships.</p> <p>Focus on increasing referrals for people with long-term disabilities to specialist palliative care through more joint working with their usual care and support teams (e.g Learning Disability team), improved co-ordination and reasonable adjustments for palliative care provision for people with disabilities.</p> <p>Potential negative impact of not all services and equipment being fully in place to provide end of life care according to place of choice by the patient.</p> <p>Some people with disabilities, and their families and wider carers, require significant additional support around decision making (e.g when mental capacity is impaired). Typically this involves close working with their family and other unpaid carers, but also with identified key workers (e.g Learning Disability Specialist Nurse or Dementia Nurse) who often know the individual and their family and can support person-centred decision making. Careful assessment of capacity for each person’s specific situation will be offered and tailored decision making support will be offered accordingly.</p>
<p>Race and Ethnicity – <i>Note: Race = “a category of humankind that shares certain distinctive physical traits” e.g. Black, Asian, White, Arab</i> <i>Ethnicity = “large groups of people classed according to common racial, national,</i></p>	<p>All patients referred to the specialist palliative care service are referred on the basis of clinical need regardless of their race or ethnicity.</p> <p>The service aim to negate discrimination and promote equality by identifying all palliative care patients who require their specialist input</p>

<p><i>tribal, religious, linguistic or cultural origin/background”</i> <i>Think: White Gypsy Travellers, Black African, Asian Pakistani, White Romanian, Black Scottish, mixed or multiple ethnic groups.</i></p>	<p>and treating them as individuals.</p> <p>Increase access to palliative and end of life care from black, Asian and minority ethnic (BAME) groups by ensuring that services understand where their needs may differ and how we can best meet these needs. The service plan to do this as part of their ongoing participation and engagement plan.</p> <p>The service aims to improve recording of ethnicity data in order to reliably understand whether access to specialist care is equitable.</p>
<p>Sex – <i>think: male and/or female, intersex, Gender-Based Violence</i></p>	<p>All patients referred to the specialist palliative care service are referred on the basis of clinical need regardless of their sex.</p>
<p>Sexual Orientation - <i>think: lesbian, gay, bisexual, pansexual, asexual, etc.</i></p>	<p>All patients referred to the specialist palliative care service are referred on the basis of clinical need regardless of their sexual orientation.</p> <p>The service plan to do this as part of their ongoing participation and engagement plan.</p> <p>All patients to be treated with dignity and respect, regardless of their sexual orientation.</p>
<p>Religion and Belief - <i>Note: Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief including a lack of belief.</i> <i>Think: Christian, Muslim, Buddhist, Atheist, etc.</i></p>	<p>All patients referred to the specialist palliative care service are referred on the basis of clinical need regardless of their religious or spiritual beliefs.</p> <p>Anticipatory Care Planning (ACP) will include, as standard, spiritual needs alongside the physical, social and psychological</p> <p>Access to spiritual care and support will be provided equitably, regardless of religion or none.</p> <p>The service work closely with the Spiritual Care Team and their own assessment is based on the holistic and spiritual needs.</p>
<p>Gender Reassignment – <i>Note: transitioning pre and post transition regardless of Gender Recognition Certificate</i></p>	<p>All patients referred to the specialist palliative care service are referred on the basis of clinical need regardless of their gender status. Sensitive consideration will be given to the use of pronouns.</p>

<p><i>Think: transgender, gender fluidity, nonbinary, agender, etc.</i></p>	<p>Sensitive consideration will be given to the placement of trans patients who require admission to hospital and/or hospice. Allocation of side-rooms will be the preferred option.</p>
<p>Pregnancy and Maternity – <i>Note: Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after birth.</i> <i>Think: workforce maternity leave, public breast feeding, etc.</i></p>	<p>Family support will be offered in instances where appropriate however there are no anticipated impacts on this group.</p>
<p>Marriage and Civil Partnership – <i>Note: Marriage is the union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as a civil partnership.</i> <i>Think: workforce, inpatients visiting rights, etc.</i></p>	<p>All patients referred to the specialist palliative care service are referred on the basis of clinical need regardless of their marital/civil partnership status.</p> <p>Specialist Children and Families support where young people face the loss of a parent or another significant adult in their lives. Including liaison and coordination with education and social work colleagues as needed.</p>

Question 6: Please include in brief any evidence or relevant information, local or national that has influenced the decisions being made. This could include demographic profiles, audits, publications, and health needs assessments.

In December 2015, the Scottish Government published the Strategic Framework for Action on Palliative and End of Life Care which set out the aim that “**by 2021, everyone in Scotland who needs palliative care will have access to it**”.

The Fife Clinical Strategy 2016-2019 called for the provision of “**robust 7-day specialist palliative care that is able to meet the needs of the most complex patients and their carers in all care settings (including hospice, community and acute hospital) as well as to support and lead the development, education and support of generalist palliative care across Fife**”.

Quality of patient care: In response to a significant and sustained reduction in demand for specialist in-patient hospice beds since April 2020 across Fife, the Fife Specialist Palliative Care Service introduced a responsive, community-based service model to address and meet the increasing need across community settings. This enhanced service model ensures that patients are cared for in their preferred setting to better meet their needs and those of their families and carers. The increased demand for community-based palliative and end of life care continues to be observed UK-wide.

Workforce: Our workforce and more widely across the FHSCP have been integral partners in the redesign, and ongoing refinements, of our service model. Overall there has been a positive impact on the FSPC workforce, through new developments and training opportunities

and more collaborative working. The optimal service model has been agreed and will be fully implemented when the model is approved.

Financial: Under the previous model 80% of the budget was allocated to specialist in-patient hospice care where 4% of the Fife population died. Typically this model was caring for a maximum of 19 in-patients at any one time. Under this new proposed model the service will hold a daily caseload for 60 patients across all care settings. The optimal service model can be delivered within existing resources.

Risk: If the decision is taken not to proceed with this clinical model, there is a risk in returning to the previous service model as the clinical service will simply not be able to support patients to die in their place of choice. Additionally this will impact adversely on many services including primary care, district nursing, out of hours, acute services, end of life care team, the ambulance service and carers. Inability to meet local and national clinical strategy.

Question 7: Have you consulted with staff, public, service users, children and young people and others to help assess for Impacts?

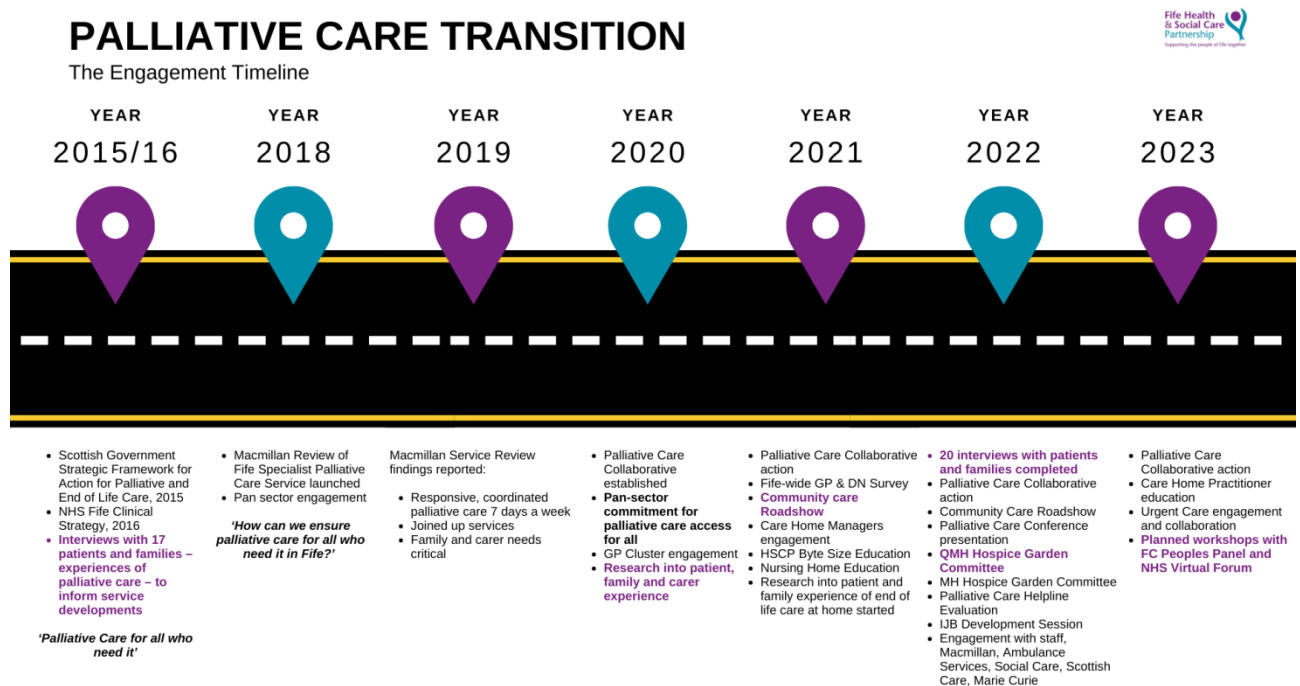
(Please tick)

Yes	X	No	
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If yes, **who** was involved and **how** were they involved?

If not, why did you not consult other staff, patients or service users? Do you have feedback, comments/complaints etc that you are using to learn from, what are these and what do they tell you?

Think: Who did you ask? When and how? Did you refer to feedback, comment or complaints etc?



Staff – key clinical partners and the Palliative Care Collaborative

Staff engagement sessions within Fife Specialist Palliative Care Service, attended by HR and Staff-Side

Feedback from patients and carers via compliments, letters, e-mail and Care Opinion

Organisations – Ambulance Service, Marie Curie, Fife Carers, Queen Margaret Hospice Garden Charity, Scottish Care

Effective communication and public engagement will be central to the support of this service change and this is incorporated within the Communication and Engagement Plan which have been developed.

Three public engagement events will be held on-line with the NHS Fife Virtual Group, Fife Council's Peoples Panel in April 2023. Engagement will also take place during April with The Fife Carers Centre, Independent Private Sector, 3rd Sector via Fife Voluntary Action, Fife Equalities Forum, Fife Centre for Equalities, ESOL Group and (People First) People with Learning Disabilities. Engagement will also be co-ordinated with appropriate community groups representing LGBT and BAME interests.

Involving key stakeholders will help to:-

- Build public understanding of why this change has occurred and how care can be delivered differently
- Demonstrate and reassure that the service redesign has improved the clinical model and will continue to make a positive difference to patients, their families and carers when they require to access palliative and end of life care.

Question 10: Which of the following 'Conclusion Options' applies to the results of this Stage 1 EQIA and why? Please detail how and in what way each of the following options applies to your Plan, Strategy, Project, Redesign etc.

Note: This question informs your decision whether a Stage 2 EQIA is necessary or not.

Conclusion Option 1: No further action required

Where no negative impacts or potential for improvement is identified, no further action is required.

No stage 2 EQIA required.

N/A

Conclusion Option 2: Adjustments Made

Potential or actual negative impacts and/or potential for a more positive impact has been identified, therefore appropriate adjustments have been made to mitigate risks and/or make further improvements.

No Stage 2 EQIA required

N/A

Conclusion Option 3: Requires Further Adjustments

Potential or actual negative impacts and/or potential for a more positive impact has been identified, but were not successfully made during the Stage 1 EQIA, therefore further adjustments must be made to mitigate risks and/or make further improvements.

Stage 2 EQIA is required to ensure further adjustments are made and appropriate workforce/public/stakeholder engagement has been undertaken.

Impacts have been identified, and mitigations have been made however further work regarding public engagement is due to take place if this proposed model is approved for permanent change. Evidence collated through further engagement work and review of the overall projects history will be used to shape a Stage 2 EQIA in due course.

Conclusion Option 4: Continue Without Adjustments

Continue with Plan, Project, Strategy, Redesign etc despite a potential or actual negative impact or potential for a more positive impact being identified, but the decision to not make adjustments can be objectively justified.

Stage 2 EQIA is required to fully explore the potential to make adjustments by appropriate workforce/public/stakeholder engagement, or to develop evidence for continuing with the plan without making said adjustments.

N/A

Conclusion Option 5: Stop

Stop the Plan, Project, Strategy, Redesign etc due to a serious risk of negative impact being identified.

Stage 2 EQIA required to fully explore the serious negative impact and engage appropriately with workforce/public/stakeholders to source solutions to mitigate the serious impact, and where no mitigations found, stop the Plan, Project, Strategy, Redesign etc.

N/A

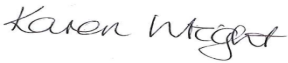
PLEASE NOTE: ALL LARGE SCALE DEVELOPMENTS, CHANGES, PLANS, POLICIES, BUILDINGS ETC MUST HAVE A STAGE 2 EQIA.


If you have identified that a full EQIA is required then you will need to ensure that you have in place, a working group/ steering group/ oversight group and a means to reasonably address the results of the Stage 1 EQIA and any potential adverse outcomes at your meetings.

For example you can conduct stage 2 and then embed actions into task logs, action plans of sub-groups and identify lead people to take these as actions.

It is a requirement for Stage 2 EQIA's to involve public engagement and participation.

You should make contact with the Participation and Engagement team at fife.participationandengagements@nhs.scot to request community and public representation, and then contact Health Improvement Scotland to discuss further support for participation and engagement.

To be completed by Lead Assessor	
Name	Karen Wright
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Signature	
Date	20/03/2023

To be completed by Equality and Human Rights Lead officer – for quality control purposes	
Name	Isla Bumba
Email	Isla.bumba@nhs.scot
Telephone (ext)	29557
Signature	
Date	20/03/23

**Return to Equality and Human Rights Team at
Fife.EqualityandHumanRights@nhs.scot**