Healthy and better lives for everyone

NHS Lothian Equality and Human Rights Strategy 2023-2028

Evidence paper & impact assessment results

Contents

1. Introduction

The NHS Lothian Equality and Human Rights Strategy was developed between August 2022 and January 2023 using:

- Equality and human rights evidence from existing research and the views of staff, patients, and equality organisations,
- The Scottish Government National Performance Framework and equality and human rights policies, and
- The equality and human rights legal framework to ensure the strategy follows the requirements and policy intentions of equality and human rights law.

This paper sets out the findings from a review of existing research and summarises the views of the staff, patients and equality groups who engaged with the development of the strategy. It also sets out relevant Scottish Government equality and human rights national outcomes and policies. Finally, it includes the results of the assessment of:

- the potential equality impact of the Strategy on relevant protected characteristic groups, and
- how the Strategy can help NHS Lothian meet the needs of people who are care experienced, refugees and asylum seekers and reduce the inequalities of outcome which result from socio-economic disadvantage.

2. Research evidence

2.1 Population

The most recent NHS Lothian Director of Public Health (DPH) Annual Report[1] provides a summary of the current statistical evidence about Lothian's population and health. Lothian has a total population of 916,310, representing an increase of around 17.6 per cent since mid-2001. Women make up 51.3 per cent of the Lothian population and men 48.7 per cent. This is comparable with Scotland.

Lothian has a similar proportion of under 16-year-olds as the rest of Scotland (16.6 per cent). The population aged 16-64 is slightly larger than seen in Scotland, largely due to the working-age population in and around Edinburgh. The proportion of the population over 64 years old is slightly smaller than seen nationally.

Around 11 per cent of Lothian's population (just over 100,000 people) live in areas categorised as among the 20 per cent most deprived areas in Scotland. The greatest number of these areas are located within Edinburgh (affecting approximately 62,000 individuals). Proportionately, West Lothian has the highest share of its population (14.3 per cent) living in the most deprived communities.

Scotland's population has become increasingly ethnically diverse. The 2021 Census results will provide greater clarity about the ethnicity of the Lothian population. Those

[1] NHS Lothian (2023) Director of Public Health Annual Report

describing themselves as Indian, Chinese and mixed/multiple ethnic group are more likely to live in the least deprived areas of Scotland. High proportions of those of 'other' (non-White) and 'other Asian' ethnic groups live in both the least and most deprived areas. The deprivation profile of the Pakistani group is more similar to that of the White population, but with higher numbers also living in the 'middle' areas. People describing themselves as African, Caribbean or Black are much more likely to be living in the most deprived areas.[2]

In 2017, the Scottish Health Survey estimated that 32 per cent of adults and 10 per cent of children were disabled. There is a higher prevalence of poverty, food insecurity and material deprivation among disabled adults and children.[3]

It is estimated that approximately 9 per cent of Scotland's population over the age of 65 years have a diagnosis of dementia. A smaller percentage (less than 0.2 per cent) of people under 65 are also affected. As the population ages, the number of people with dementia is steadily increasing because the risk of development increases with age.[4]

From the Scottish Government Equality Evidence Finder[5] we know:

- Between 2008 and 2017 the proportion of women who were disabled increased from 28 to 34 per cent and the proportion of men who were disabled increased from 23 to 29 per cent.
- In 2018, the largest ethnic group was White Scottish (76.7 per cent) and Black and Minority Ethnic (BME) adults represented 4.6 per cent of the population.
- In 2019, around 95 per cent of adults in Scotland identified as straight or heterosexual and around 3 per cent identified as lesbian, gay, bisexual or other.
- In 2019 there were 26,007 marriages in Scotland. This includes 912 same sex marriages involving 347 male couples and 565 female couples.
- In 2018, around half of adults belong to no religion, people of Christian faith (Church of Scotland, Roman Catholic and Other Christian) represented 46 per cent of the adult population; 1.6 per cent belong to the Muslim faith and 1.9 per cent were categorised as belonging to Other Faiths.

2.2 Health outcomes

Average life expectancy in Scotland has stalled since 2013, a phenomenon driven mostly by declining life expectancy among the most deprived communities in the country. Although life expectancy in Lothian is typically slightly above the Scottish average, aggregate figures mask wide inequalities in life expectancy, particularly for men. For instance, in the City of Edinburgh, men living in the most deprived areas live an average of 12 fewer years than those living in the least deprived areas (2016-

[2] Walsh, D., Buchanan, D., Douglas, A. *et al.* Increasingly Diverse: the Changing Ethnic Profiles of Scotland and Glasgow and the Implications for Population Health. *Appl. Spatial Analysis* 12, 983–1009 (2019)
[3] Scottish Government (2019) Scotland's Wellbeing: national outcomes for disabled people
[4] Public Health Scotland (2016) Dementia and Equality Briefing Paper
[5] Scottish Government Equality Evidence Finder

2020 averages of 71.3 vs 83.1 years respectively). It is notable that in West Lothian female life expectancy and healthy life expectancy is lower than Scotland average.[6]

Evidence in the Women's Health Plan[7] tells us an estimated 1.5 million (1 in ten) women in the UK of reproductive age are affected by endometriosis, and it takes an average of 8.5 years to diagnose. Almost 1 in 10 deaths in women in Scotland each year are caused by ischaemic heart disease. In the most affluent areas of Scotland, women experience 25.1 more years of good health compared to the most deprived areas. It is estimated there are currently 300,000 people in Scotland living with osteoporosis, a condition which is more common in women than men. Women aged under 25 are the group most at risk of being diagnosed with an STI. Death from stroke is more common for women than men. Heart disease is the leading cause of maternal death in the UK. Around 400,000 women in Scotland are of menopausal age. The average age at which a woman will reach menopause is 51. On average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population. 61 per cent of unpaid carers are women.

One in three people in Scotland experience mental health problems, and more than half of those face stigma and discrimination.[8] Inequality related to disability, age, sex, gender, sexual orientation, ethnicity and background can all affect mental wellbeing and incidence of mental illness. Some groups are more likely than others in our society to experience mental ill health and poorer mental wellbeing.[9]

The deep-rooted health and socio-economic inequalities faced by BME communities have been repeatedly raised by a range of organisations and researchers as priority areas for action.[10] In addition to the important role played by living conditions, the impact of racism as well as ethnicity needs to be considered as an additional cause of stress and disadvantage only experienced by people who are racialised. Racism is a stressor in its own right, because of persistent, unavoidable disempowerment. Childhood exposure to racism (like other Adverse Childhood Experiences ACE's) has lifelong effects. Expanded ACEs include experience of racial discrimination and are associated with poor outcomes in adulthood.[11]

The most recent Saving Lives, Improving Mothers' Care Core Report[12] found that Black women were 3.7 times, and Asian women were 1.8 times more likely to die

[6] NHS Lothian (2023) Director of Public Health Annual Report
[7] Scottish Government (2021) Women's Health Plan
[8] SeeMeScotland Understanding Mental Health Stigma and Discrimination
[9] Scottish Government (2017) Mental Health Strategy 2017 to 2027
[10] Walsh, D., Buchanan, D., Douglas, A. et al. Increasingly Diverse: the Changing Ethnic Profiles of Scotland and Glasgow and the Implications for Population Health. Appl. Spatial Analysis 12, 983–1009 (2019).
[11] Qureshi, K., Meer, N. and Hill, H. (2020) 'Different but Similar? BAME Groups and the Impacts of Covid-19 in Scotland', in: Meer, N., Akhtar, S. and Davidson, N. (2020) Taking Stock: Race Equality in Scotland. London: Runnymede.
[12] Knight M, Bunch K, Patel R, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2022 https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_MAIN_Report_2022_v10.pdf

than White women. More women from deprived areas are dying and this continues to increase. 1 in 9 women who died had severe and multiple disadvantage.

An Inquiry by the Scottish Parliament Health and Sport Committee[13] found that disabled people were a key group affected by health inequalities. They experience health inequalities in two ways, by living in poverty and through discrimination that exists in access to health services.

Many refugees and asylum seekers arrive in Scotland with physical and mental health problems associated with the reason they have had to seek asylum. This includes gender-based violence, sexual violence, torture, experience of war and other degrading treatment. The experience of seeking asylum, incidents of racism or prejudice and the challenge of understanding and exercising rights can exacerbate existing health problems or create new ones.[14]

The NHS Greater Glasgow & Clyde and NHS Lothian LGBT Health Needs Assessment found that non-binary and trans people have very poor health and wellbeing indicators (for example - social health, physical health, mental health). For general mental health, depression and anxiety, LGBT people are at a much higher risk of mental health problems than heterosexual/ cisgender people. This was highest for trans-masculine (75 per cent) and non-binary people (72 per cent). Only 9 per cent of non-binary and 12 per cent of trans masculine people rated their general mental and emotional wellbeing positively. Self-harm and eating disorders were most prevalent among trans masculine and non-binary people. Trans and non-binary people were particularly likely to speak about suicidal thoughts, although these tended to subside after transition. LGBT asylum seekers were most likely to have attempted suicide.[15]

2.3 Access to health services

Many disabled people find it difficult to access mainstream transport so often need to rely on more expensive transport, such as taxis, making it difficult and / or more expensive to get to healthcare appointments. Flexible systems such as phone or online appointments are often not available to disabled people either because they are not accessible options for them, or hospitals and surgeries don't use them.[16]

Older and disabled people, and those living in a deprived area or living in social housing were at risk of exclusion from access to digital services.[17]

The UN Committee for the Rights of Persons with Disabilities[18] raised concerns about the UK's legal standards to make the physical environment, housing,

[13] Scottish Parliament (2015) Health and Sport Committee Report on health inequalities
[14] Scottish Government (2018) New Scots: refugee integration strategy 2018 to 2022
[15] Leven T (2022) Health needs assessment of lesbian, gay, bisexual, transgender and non-binary people: Full research findings report prepared for NHS Greater Glasgow & Clyde, NHS Lothian and Public Health Scotland
[16] Scottish Parliament (2015) Health and Sport Committee Report on health inequalities
[17] EHRC (2018) Is Scotland Fairer?
[18] EHRC (2018) How well is the UK performing on disability rights?

transport, information and other services accessible to disabled people, and that austerity measures obstruct improvements in accessibility for disabled people.

An EHRC analysis[19] of the Scottish Inpatient Survey data in 2010 shows that patients with deafness or a severe hearing impairment were less likely to report a positive experience of their time in accident and emergency, being told what was happening in a way they could understand. Visually impaired and blind patients had similar experiences to non-disabled people but they were less likely to know how and when to take their medicines, and were less confident of being able to look after themselves once they got home.

In 2014, the EHRC supported a profoundly deaf patient to raise a claim of discrimination under the Equality Act 2010 against NHS Tayside after she spent seven days in hospital without any British Sign Language (BSL) interpretation services made available to her. This greatly limited her ability to understand what treatment she was receiving, to participate in her care or to ask questions. This case resulted in a formal agreement between the EHRC and NHS Tayside and had a knock-on positive impact on improving the provision of BSL interpreters across NHS Scotland.

People with learning disabilities face barriers accessing health services, compounded by communication difficulties and a lack of support provided by organisations and wider society. Research by the Scottish Learning Disabilities Observatory (SLDO) found that adults with intellectual disabilities receive poorer health care, despite health care needs being more prevalent.[20] Another piece of SLDO research[21] indicates that adults with learning disabilities are admitted to hospital for preventable conditions more often than the general population and that they often have a longer length of stay than other people.

Mental health care and treatment engages a range of human rights including the right to life, liberty, freedom from inhuman and degrading treatment and respect for private and family life. People with mental ill health are also often disadvantaged in accessing other rights like the right to an adequate standard of living, to participate in communities and to employment and work opportunities.

The Scottish Mental Health Review[22] published its final report in September 2022. The Scottish Human Rights Commission (SHRC)[23] has commended the report and proposals and said that if implemented would move Scotland much closer to complying with international human rights standards and have the potential to deliver a much improved experience for people experiencing mental ill health. The report

[19] EHRC (2014) Being Disabled in Britain, A journey less equal
[20] Cooper S, Hughes-McCormack L, Greenlaw N et al (2017) Management and prevalence of long-term conditions in primary health care for adults with intellectual disabilities compared with the general population: A population-based cohort study
[21] Dunn K, Hughes-McCormack L and Cooper, S (2017) Hospital admissions for physical health conditions for people with intellectual disabilities: Systematic review
[22] SMHLR (2022) Final report
[23] SHRC (2022) Human Rights and the Mental Health Law Review

recommends people should be supported to exercise their capacity, even in situations of crisis, by reframing the law and the support provided so that interventions in someone's life are based on understanding and focusing on someone's own wishes. The report also recommends wider programmes of action, such as initiatives to reduce the use of coercion and improve the experiences of the people who are subject to it, and to develop a comprehensive system of supported decision-making.

Following inspection visits, the Mental Welfare Commission[24] has made recommendations to NHS Lothian to deliver rights-based care to young people who are detained under mental health legislation, including meaningful participation in care and activity planning.

Limited co-ordination of antenatal and postnatal appointments and a lack of flexibility to schedule appointments to fit around work commitments, childcare patterns or travel restrictions place additional financial pressure on low-income families and can push women into having to prioritise the appointments they felt were more important.[25]

An Inquiry[26] by the UK All-Party Parliamentary Group on Muslim Women and the Muslim Women's Network investigating the maternity experiences of Muslim women in England, particularly from Black, Asian and other minority ethnic backgrounds, found:

- Black women were more likely to receive poorer standards of care followed by South Asian women.
- Muslim women were denied choice when accessing services and interventions and had to unnecessarily suffer because they were denied pain relief despite repeated requests.
- There were reports of health professionals in antenatal care dismissing concerns (including pain), not offering treatment to relieve symptoms, inconsistency in the way foetal growth was being measured and vital signs being missed.
- The biggest criticism of maternity care was healthcare professionals not listening to Muslim women and having their concerns dismissed by midwives and doctors. They were described as rude, blunt, patronising, abrupt, dismissive, having negative body language, lacking experience and 'gaslighting'.
- More than half of the Muslim women participating in the inquiry felt they were not treated with respect and dignity in the way they were spoken to or through other acts of care giving. During health conversations women encountered phrases that made them feel uncared for, disrespected, dismissed, not believed, judged and unwelcome.
- A clear cultural competence gap across maternity services.

[24] MWC (2021 & 2022) Report on an announced visit to The Melville Young People's Mental Health Unit April 2021 and Report on announced visits to The Melville Young People's Mental Health Unit August 2022
[25] Suphi M, Bishop R and Miller A (2000) Exploring the Cost of the Pregnancy Pathway, NHS Greater Glasgow & Clyde and NHS Ayrshire & Arran.
[26] MWNUK (July 2022) Invisible Maternity Experiences of Muslim Women from Racialised Minority Communities

- Despite the likelihood of certain ethnic groups having particular health issues, additional screening is not being offered and their care not always managed according to their risk. About 1 in 4 women were also not sufficiently screened for domestic abuse.
- Muslim women were more likely to have had an emergency caesarean (21 per cent) compared to the national average 16 per cent. This means they were at increased risk of adverse outcomes associated with this procedure.
- 18 per cent of survey participants had postpartum haemorrhage, which is very high compared to the national average of 7 per cent, indicating they are 2.4 times more likely to experience excessive blood loss. This is one of the leading causes of maternal death in the UK.
- 7 per cent said they were diagnosed with an infection or sepsis within the first few days or weeks of giving birth. Women recounted not being believed by midwives and sent home then having to return to the hospital. Missing signs of sepsis is a concern because it is among one of the leading causes of maternal mortality.
- 55 per cent said they were concerned about their healthcare during the recovery period and 44 per cent said they were not satisfied with the care provided to their babies.

The Birthrights Inquiry[27] found that maternity services often lacked respect for cultural needs around Halal food and drinks, including milk for babies, and wanting to follow traditional post-partum customs. There were also reports of requests for no male staff and to have female interpreters being denied, and failures to provide interpreters or adequate translation services having an impact on women's ability to provide informed consent.

A majority of responses to the written call for evidence described a lack of basic dignity, respect and rudeness. One midwife commented on how there can be an entrenched view of Black and Brown bodies being deemed as 'other' which often leads to people being dehumanised and pathologized.

A Mental Welfare Commission review[28] examining racial inequality across mental health services in Scotland report found differences in the way the Mental Health Act is applied when BME people are detained for mental health care and treatment compared to white Scottish people, particularly between Black women and White Scottish women.

A study in England, which is the largest published qualitative study exploring the experiences and preferences for communication about sexual orientation, gender identity and gender history in healthcare, found that poor communication and assumptions made by clinicians about patients' gender and sexual orientation undermines clinical relationships, leading to disengagement and loss of trust. Some routinely used terminology and practices can feel excluding to LGBT people and

[27] Birthrights (2022) Systemic Racism, not Broken Bodies: Inquiry into racial injustice in maternity care
[28] MWC (2021) Racial Inequality and mental health services in Scotland: A call for action

negative experiences can be linked to incorrect assumptions about partners and gender identities, use of incorrect pronouns. This can cause unnecessary anxiety and distress.[29]

The NHS Greater Glasgow & Clyde and NHS Lothian LGBT health needs assessment[30] found there were issues about GPs misdiagnosing people through assumptions about their sexuality or gender identity, inadequate knowledge about some identities and some concerns around confidentiality. Qualitative research in 2019 highlighted huge frustration and dissatisfaction with the waiting times for the Gender Identity Clinics (GIC) in both Glasgow and Edinburgh. By the time of the 2021 survey, waiting times had increased to approximately three years, and trans and non-binary people were frustrated with the lack of communication. People described the impact on them as including anxiety, depression and anguish caused by the prolonged wait and continued dysphoria. Some mentioned suicidal thoughts and self-harm.

2.4 Employment

The EHRC Is Scotland Fairer?[31] report tells us:

- Disabled people are less likely to be in employment and more likely to be unemployed.
- Women are less likely than men to be in employment and more likely to be in part-time work.
- Young people are most likely to be unemployed and many are in insecure jobs.
- Women continue to experience sexual harassment and discrimination related to pregnancy and maternity in the workplace.
- Women continue to earn less than men on average, and the gender pay gap has changed very little in recent years.
- Disabled people continue to earn less than non-disabled people, and the disability pay gap is wider.
- Women, young people aged 18–24, disabled people, Black people and those in the Other White ethnic group are more likely to be in low-paid work.
- Women continue to be under-represented in senior positions, even where women account for the majority of the workforce, such as in education and health.
- Women, people from BME groups and disabled people remain under represented in Modern Apprenticeships. Reflecting the labour market, Modern Apprenticeships continue to show strong gender segregation within sectors.

The NHS Lothian 2021-22 Workforce Equality Report[32] tells us:

- Over three quarters of NHS Lothian staff are female (78 per cent) and around one quarter are male (22 per cent).

[29] Braybrook D, Bristowe K, Timmins L et al GMJ (2023) Communication about sexual orientation and gender between clinicians, LGBT+ people facing serious illness and their significant others: a qualitative interview study of experiences, preferences and recommendations Qual Saf 2023; 32:109-120
[30] Leven T (2022) Health needs assessment of lesbian, gay, bisexual, transgender and non-binary people: Full research findings report prepared for NHS Greater Glasgow & Clyde, NHS Lothian and Public Health Scotland
[31] EHRC (2018) Is Scotland Fairer?
[32] NHS Lothian (2022) Equality and Diversity Monitoring Report

- Senior Management is the only job family that has more men than women. Support Services has an almost 50/50 split.
- Only 1.9 per cent of NHS Lothian workforce declared themselves as disabled.
- 5.2 per cent of staff are from BME groups.
- The highest percentage of BME staff are in Medical and Dental at 11 per cent. The majority are Asian, specifically Chinese (15.4 per cent), Indian (28.8 per cent), Pakistani (10.8 per cent) and Other Asian (11.1 per cent) or Mixed Ethnicity (15.0 per cent) and 8.8 per cent are Black British/African/Caribbean.
- A large number of BME staff are in Nursing/Midwifery Band 5+, concentrated at Band 5, with 1 at Band 8A and none above that.
- Black and Caribbean staff make up less than 0.11 per cent of staff while being 0.16 per cent of the population of Lothian in 2011.
- 0.2 per cent of staff are Polish while the Lothian Polish population was almost 2.1 per cent in 2011.
- 3.3 per cent of promotions were obtained by BME staff compared to 81.2 per cent White and 15.5 per cent whose data was incomplete.
- The area with the highest percentage of BME applicants was in Medical and Dental. This is also the only area where BME applicants outnumbered White and 'Incomplete' applicants. This gap closes in shortlisting and is almost fully reversed in hiring. 21.3 per cent of BME applicants were shortlisted and 11.1 per cent of those were successful, making a 2.4 per cent success rate for BME applicants. This is compared to 62.6 per cent of White applicants shortlisted, 19.3 per cent of which were successful, making a 12.1 per cent success rate for White applicants.
- There are no BME senior managers. There are 41 White senior managers and 21 senior managers with 'Incomplete' data.
- 4.8 per cent of leavers were BME staff and 63 per cent were White.
- 3.2 per cent of staff identified as Lesbian, Gay or Bi-sexual. There are no data on trans and non-binary staff.
- 0.7 per cent of staff identify as Lesbian/ gay women, 1.2 per cent identify as gay men, 1.1 per cent identify as bisexual/other women and 0.2 per cent identify as bisexual/other men. In a female dominated staff group, the number of lesbians/gay women appears to be disproportionately low, and the total percentage of bi/other people is lower than would be expected. However, a significant number of staff have not provided information about sexual orientation – 34 per cent.
- 1.5 per cent of leavers identified as Bisexual/other, which is disproportionately high, and a larger number than people who identify with other LGB groups.

2.5 Discrimination and harassment

2.5.1 Workers' experiences of discriminatory treatment

An EHRC Inquiry[33] into racial inequality in health and social care gathered substantial evidence of poor treatment of BME workers in Britain. Many ethnic

[33] EHRC (2022) Experiences from health and social care: the treatment of lower-paid ethnic minority workers

minority workers felt that others were treating them in a negative or unfavourable way because of their race or nationality. Examples included being treated with contempt, being belittled by managers and colleagues and having concerns unreasonably dismissed. Migrant workers often felt they were belittled for not understanding certain cultural references, words or phrases. Such treatment ranged from subtle behaviours, often experienced on a daily basis, to more open expressions of prejudice.

The Inquiry heard reports that colleagues and employers in both sectors are sometimes reluctant to tackle racist abuse from patients or service users. This was also highlighted in the Inquiry's review of existing research which identified that obvious or direct racism towards ethnic minority workers from service users was often not taken seriously by managers and supervisors.

A 2019 UNISON and Nursing Times survey of NHS line managers[34] (of all ethnicities) in the UK found that 52 per cent of line manager respondents did not feel they had received 'adequate training to deal with issues of racism against staff in the workplace.' The biggest barriers were a lack of support from senior managers, difficulty knowing how to challenge poor behaviour from patients and a fear of getting it wrong. The EHRC Inquiry's literature review[35] also identified unsupportive line managers of lower paid ethnic minority workers in health and social care as one of the reasons for fewer positive social networks in the workplace.

The Inquiry also found that ethnic minority workers are less likely to raise concerns, which worsens their mental health. Reports were made to the Inquiry of ethnic minority staff facing excessive criticism and reproach for mistakes, which they felt was unfair. Some felt that White staff were treated more favourably. Some ethnic minority respondents to the Inquiry also said they had not been allowed annual leave or time off for religious holidays, unlike White colleagues, or had struggled to find someone to cover their shift. Some staff felt that their employers lacked a sense of fairness, understanding and even-handedness when handling such requests.

The Inquiry's research with NHS workers in Scotland suggested the existence of a two-tier workforce, in which outsourced staff struggled to gain new qualifications and progress in their careers. While this can affect staff from all backgrounds, those from ethnic minorities are over-represented in outsourced roles. The evidence collected in the Inquiry suggests that ethnic minority staff often felt they had little support for career progression from management. They felt that managers had occasionally blocked their development deliberately. This had led to over-qualified ethnic minority staff getting stuck in junior positions for long periods. This is particularly true for migrant workers because overseas qualifications are not always recognised.

[34] Nursing Times (2019) Exclusive: High level of racial discrimination face by nurses revealed
[35] EHRC (2022) Experiences from health and social care: the treatment of lower-paid ethnic minority workers

2.5.2 Patient experiences of discriminatory treatment

The Inquiry by Birthrights[36], reviewing in-depth testimony from over 300 people, found that racism is at the root of many inequities in maternity outcomes and experiences and that this is an urgent equality and human rights issue in the UK. 31 per cent of Black, Asian and Mixed Ethnicity respondents said that they were treated poorly by their midwife or doctor and felt this was because of their race or ethnicity. Reports included: A White health visitor and hospital doctor not recognising jaundice in a Black baby and only did blood tests to give 'mum some reassurance.' Midwifery staff repeatedly minimising Black and Brown women's concerns and not taking them seriously, being ignored and disbelieving the pain they were experiencing. Asian women being referred to as 'princesses' or 'precious' and Black women as 'angry' or 'aggressive.'

Racist attitudes and behaviours by caregivers manifesting as stereotypes, 'microagressions' and assumptions about risk based on race are having a serious detrimental impact on people's maternity experiences. Healthcare professionals described their colleagues saying that Black women and babies have 'thick, tough skin' and that a ward 'smells of curry' when South Asian families were being cared for, and that Chinese people are 'dirty'. They also observed Black and Brown women and birthing people experiencing differential treatment compared to their White counterparts – such as White women being allowed visitors out of hours, receiving more responsive care, being granted time for multiple questions and given more patience listening to concerns.

The Inquiry by the Muslim Women's Network UK[37] found evidence of discrimination which involved women being blamed, humiliated and insulted as well as being coerced and bullied into decisions. Many women said they felt this was because they were a woman of colour, sometimes the prejudice was overt, sometimes it was put down to their 'Muslim appearance'. The Somali women in the focus group provided the most unfavourable assessments of healthcare professions and felt certain they had been subjected to racist attitudes.

[36] Birthrights (2022) Systemic Racism, not Broken Bodies: Inquiry into racial injustice in maternity care
[37] MWNUK (July 2022) Invisible Maternity Experiences of Muslim Women from Racialised Minority Communities

Table 5 - Comments from interviews

"I felt my labour was deliberately speeded up at every step (breaking my waters, giving me an episiotomy) rather than letting it take its natural course."	"The way she spoke to me was nothing less than bullying, she was very condescending, belittling, and she said 'I see five of you lot per day."	"Maternity nurse did not help me to put my legs on the bed I was very sore. She left me with my underwear down and blood covered sanitary towel."
"We felt invisible."	"She was so awful and rude."	"I felt unheard, and unseen."
"I asked to stop the examination because of pain and was ignored and told to 'man up'."	"I remember making 'dua' (prayers) and saying to my husband, they are going to kill me."	"A humiliating experience - standards have dropped so low they do not care for the mum."
"I took my headscarf off and I made sure that I was more vocal - it was a very conscious shift."	"I do remember them continuing to say 'we know best', which made me feel like a child."	" I do feel they deliberately threw the milk away so they could formula feed."
"They made mistakes but kept blaming me, implying I was the one doing something wrong."	"Consultant did not listen and / or brushed it off, gaslighting all the way."	"Women from 'your communities' should know how to (breast feed)."
"I was also in a lot of pain, they were always late with painkillers."	"I was shell shocked, discharged myself from hospital after 24hours."	"I was in excruciating pain yet a nurse berated me for asking for help."
"I was crying and begging for a long time."	"I was treated like a nuisance and had to beg for help."	"I was getting scoffed at mocked and ignored."
"I was ignored and shouted at by the staff."	"The midwife kept shouting at me whilst I was in active labour."	"I remember being spoken to like I was stupid."
"I found the sonographer blunt, rude and miserable."	"I sat there holding back tears already feeling like I had failed."	"I was told I was fibbing when I said breastfeeding hurt."
"The midwife kept rolling her eyes."	"I felt 'pressured' and 'bullied' to have a caesarean."	"Friends kept telling me 'they'll mash you up'."
"Shouting and blaming for not pushing baby out instead of being encouraging and motivating."	"I had a door shut on my face and spoken to in a harsh tone – was apologised to eventually."	"I was made to feel like I was being demanding and unreasonable. I remember feeling like they resented me even being there."

Some LGBT people experience homophobic, biphobic and transphobic language and behaviour in health and social care settings. When seriously ill LGBT people can feel unable to share important aspects of their identity and the impact can be devastating.[38] Research from Stonewall Scotland[39] found that 24 per cent of LGBT

[38] Braybrook D, Bristowe K, Timmins L et al GMJ (2023) Communication about sexual orientation and gender between clinicians, LGBT+ people facing serious illness and their significant others: a qualitative interview study of experiences, preferences and recommendations Qual Saf 2023; 32:109-120

[39] Stonewall Scotland (2019) LGBT Health Report

people have witnessed discrimination or negative remarks against LGBT people by healthcare staff and 37 per cent of trans people avoid seeking healthcare for fear of discrimination from staff. Of the LGBT people who had sought support for their health needs, 13 per cent said they had experienced some form of unequal treatment from healthcare staff because of their sexual orientation or gender identity. 12 per cent said they had avoided treatment for fear of discrimination.

3. Engagement evidence

Between August 2022 and January 2023, groups of staff, patients and equality organisations were approached and asked about their experiences of how NHS Lothian delivers on equality and human rights. The questions focused on what people thought the current equality and human rights challenges or issues are for the organisation and what they thought NHS Lothian was doing or had done well. The information below reflects the views of the people who participated in the engagement process. A list of the groups who participated in the engagement is included as an appendix.

3.1 Challenges

3.1.2 Meeting people's needs, removing disadvantage and increasing understanding

- The older population is growing and likely to have more health needs that we need to respond to.
- We have an aging workforce, we need to be flexible and keep people in work.
- Supporting dementia patients, knowing and acting on their wishes to provide person-centred care and treatment.
- People who don't speak English as their first language can find it difficult to access an interpreter and get support to access health services in the same way as others.
- Not enough patient information is produced in Easy Read, Large Print, BSL or plain English.
- We don't always know in advance what patients' additional needs are, we don't always record them and have that information available to clinical and booking staff so they can plan to make sure people's needs are met in advance or send information out in the right language or accessible format.
- In letters to patients, we always put at the end - 'if English isn't your first language or you need this letter in a different format, you can get alternative formats and versions in a different language.' This should be at the start of the letter, otherwise there's a risk that people won't look to the end, won't be able to understand the correspondence and will disregard it. Why don't we put this at the front / start of all correspondence?
- We should proactively encourage disabled people and older people and carers to visit health care settings or offices to orientate themselves, before their appointment / meeting.

- Making reasonable adjustments for disabled staff. When reasonable adjustments are made for disabled staff, sometimes they are told the agreed reasonable adjustments can't transfer with them to new roles.
- Staff are not identifying themselves as disabled, there may be a lack of confidence to identify this, but we don't know who is disabled and what reasonable adjustments we need to make.
- Low awareness of neurodiversity and how to support staff and patients who are neurodivergent.
- Engagement between the Gender Identity Clinic (GIC) and LGBT young people has reduced and there is a need to get back to the standard it was pre-covid. LGBT young people are frustrated and feel cut off. They don't know where to find the right information, it isn't easy to find or make sense of and the resources that are available aren't up to date.
- Extensive waiting times for trans and non-binary young people to access the GIC. Counselling service for trans people is over-subscribed and has waiting lists.
- We should recruit more trans people.
- Unnecessary categorising of binary genders and use of titles in correspondence. These are exclusionary practices and risk misgendering people.
- Making sure the non-NHS providers of gender reassignment treatment services, such as electrolysis, are safe spaces for trans and non-binary people.
- Families with trans parents exist, it's incumbent on the NHS to do its best to understand, include and meet their needs.
- Patients in mental health settings don't always know what they should expect and what should happen. There is a need for human rights education for patients and staff in mental health settings. More action and investment in supported decision-making and participation in care and discharge planning. People must be encouraged to voice their opinions and not be judged, and we must understand and overcome the barriers to patient involvement and getting patient's views.
- Psychological safety of patients and work to remove fear of physical restraint, coercion and seclusion.
- There are so many things wrong with the environment in mental health settings and so much we could improve to make it a better place for people with mental ill health.
- Implementation of the relevant recommendations from the COVID-19 and ethnicity: expert reference group to focus on tackling racialised health inequalities.
- Race equality organisations are looking for reassurance that public bodies recognise that racism exists and will take action to end it. Leaders and senior managers can learn more effectively by meeting with people from their diverse communities, rather than doing equality and diversity modules. Visit community places where people meet and discuss with the community what their experiences and needs are. Talk around a specific issue or proposal. Going to meet people in their spaces will build trust and greater understanding on both sides.
- There needs to be more diversity at senior levels, particularly BME and disabled people.

- Fewer BME staff are promoted than White staff, some people are not given feedback or support. Some BME staff are not integrated into teams, induction processes can be poorly run, and can be made to feel unwelcome and different. Some BME staff said they have been treated unfavourably compared to their White colleagues.
- Differential attainment rates for BME doctors in training, cultural issues, different treatment in terms of feedback and support and International Medical Graduate (IMG) doctors don't want to stick out any more than they already do.
- Some members of staff have unacceptable behaviours, attitude, and culture towards race and that affects outcomes for staff and patients.

3.1.2 Dealing with discrimination and harassment

- People don't know what happens with information about complaints of discrimination and harassment, and whether the organisation monitors and acts on this information. Some staff don't have trust or confidence in the informal and formal reporting systems to stop and resolve discrimination and harassment.
- Leaders and managers should take a zero-tolerance approach to racism from patients to staff.
- Some managers don't know how to handle discriminatory behaviours that exist in their teams. How do we challenge passive discriminatory behaviours by patients and staff? We need to take action to stop the less obvious forms of racism and discrimination. We need to know how to call it out respectfully and effectively. We need to give people confidence to react in the moment, 'I know this is a problem, I can do something, I am going to act' and make sure they have a range of options available to them to help them act appropriately.
- Some staff are worried about doing the wrong thing and offending people.
- Staff involved in education and training of others in medical and administrative roles are looking for ideas about how to provide education and training in the most inclusive way, recognising that we are predominately white, middle class, middle-aged people. Ideas about how to promote inclusion more and how to make sure we are actively being anti-racist.
- There is a place for email add-ons that promote inclusion and respect. Everyone should include some information about how to pronounce their name and what their pronouns are. These small things can help break down barriers.

3.1.3 Getting the process right

- We need to take a wide range of people's different lived experience into account when we make decisions.
- We need to embed processes that ensure we support equality in our day-to-day activities.
- We have pockets of good / excellent practice and how do we make this system wide to achieve system wide change.
- We should improve our understanding of when and how to meet the Fairer Scotland Duty.

- Building respectful relationships with people with lived experience of discrimination and disadvantage and the organisations that represent them. Don't keep coming back and asking for the same information, and not making any changes or progress on these issues. Make sure engagement and participation in service design is meaningful and if people are unemployed and contributing, make sure they get some financial payment.
- We should treat care experience as if it is a protected characteristic and include it in our impact assessments and equality monitoring information.
- Some patient and equality groups are starting to distrust the system, caused by excess consultation, and not seeing any positive change as a result.
- We don't collect robust equality data about people working, using, and complaining about our services. For example, we have made ethnicity a mandatory field on Trak Care, but this hasn't achieved robust completion rates.
- Impact assessments have become a tick box exercise, a burden and chore. They often don't include views of people with lived experience or include relevant equality groups. The results are often not asked for or considered as part of decision making.
- Senior managers don't always have equality and human rights information available at the right time to properly consider unintended consequences or opportunities.
- How we communicate with patients and staff in an accessible way. We need to always remember the average reading age in Scotland is 9 years old. All communication should be accessible and inclusive – how do we do we make sure we all do this?
- We have under-resourced equality and human rights education and awareness raising. On its own, mandatory online training doesn't work to change behaviour.

3.2 What NHS Lothian is doing well

- In response to challenges facing staff during the Covid-19 pandemic, we have successfully established and supported staff networks to be independent groups of peers who support each other and help the organisation advance equality.
- The development and delivery of the annual Advancing Equalities Action Plan.
- Staff and the public have commended us for starting the process of acknowledging the Royal Infirmary of Edinburgh's historical links with Atlantic slavery and trying to learn from this to become an anti-racist organisation.
- Coffee roulette with senior managers and BME staff.
- Participating and supporting work to understand cultural differences between medical graduates. Improving IMG induction and support.
- Building on the success of the Leading Better Care Leading Across Differences Positive Action Programme that sought to address the gap in leadership within Nurses and Midwives from BME communities.
- The Access to Work pilot in West Lothian.
- Staff support services.
- Speak Up Ambassadors.

- Committing to being an Anchor's Institution. Living Wage Accreditation. Using public procurement to help advance equality.
- The Healthy Respect team are a 'shining light' – in particular, the Wellbeing Hub Young People and Top Tips for Supporting Transgender Patients.
- The GIC work to secure additional staff resources and try new ways of working. Both these things are starting to bring down waiting times.
- Cervical screening letters and leaflets are examples of good gender inclusive practice.
- Building equality into screening programmes to understand who is not accessing screening, why and changing the way we do things to increase uptake.
- Building equality and human rights into the winter vaccination programme and making changes to help increase the confidence and uptake in particular groups (disabled people and BME groups).
- Public Health Intelligence Team analysing population data including equality data, where available, and supporting services to use this in planning and delivery.
- East Lothian Primary Care Improvement Plan was developed using data from the Public Health Team to understand the health inequalities facing particular groups, allowing us to focus resources in certain areas. Some challenges in working through this approach but we can see health outcomes improving after 2-3 years.
- Starting to look at and use data to understand why patients don't attend appointments, who they are and why they don't attend.
- Royal Hospital for Children and Young People working on achieving the LGBT Youth Charter.
- Tonic Arts participatory programmes for patients and staff.
- Developing a Staying Well Plan for Community Mental Health.

4. National Outcomes

The National Performance Framework[40] gives Scotland's public services, including NHS Lothian, a common set of outcomes to work towards. It provides a breakdown of equality data and shows where people with protected characteristics are progressing and how they compare to other groups of people. The data aims to help design policies and services that meet the needs of everyone in Scotland. The national outcomes that are relevant to the NHS Lothian equality and human rights strategy (this Strategy) are:

Health – we are healthy and active. We regard the health of all of our people as being of upmost importance. Consequently, we live long, healthy and active lives regardless of where we come from. We use evidence intelligently to continuously improve and challenge existing healthcare models. Our approach is integrated, preventative and person-centred. We are focused on resolving needs in order to achieve positive health, care and wellbeing outcomes.

[40] Scottish Government National Performance Framework How it Works

Human rights – we respect, protect and fulfil human rights and live free from discrimination. We recognise the fundamental equality of all humans and strive to reflect this in our day-to-day functioning. We demonstrate our commitment to these principles through the way we behave with and treat each other. We provide care for people with love, understanding and dignity.

Poverty – we tackle poverty by sharing opportunities, wealth and power more equally. We are addressing the links between poverty and income, housing, ethnicity, gender, health, disability and age. Our achievements, potential and life choices are not decided at birth or by class or background.

5. National Health and Wellbeing Outcomes

There are nine national health and wellbeing outcomes[41] which apply to Health Boards, Local Authorities, and Integration Authorities. This Strategy should contribute to achieving these outcomes.

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including disabled people or people with long term conditions or are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
7. People who use health and social care services are safe from harm.
8. 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.
9. Resources are used effectively and efficiently in the provision of health and social care services.

6. National policies

The **2022-23 Programme for Government**[42] explains that the Scottish Government will continue to take action to mainstream equality and human rights and take forward specific action to address discrimination, including racism, to tackle violence against women and girls and end conversion practices.

The national equality and human rights policies that are relevant to this Strategy are:

Care experience – The Promise Plan 2021-24 includes a commitment that every child that is 'in care' in Scotland will have access to intensive support that ensures

[41] Scottish Government (2015) National health and wellbeing outcomes framework
[42] Scottish Government (2022) A stronger and more resilient Scotland: the Programme for Government 2022 to 2023

their educational and health needs are fully met. Organisations that have responsibilities towards care experienced children will be able to demonstrate that their rights under UNCRC are being consistently upheld and they are embedding destigmatising language and practices across the way they work.[43]

Children's rights– the Scottish Government is implementing the UNCRC and incorporating it into Scots law to make it unlawful for public bodies to act incompatibly with UNCRC requirements.[44]

Disabled people – the Scottish Government's ambition to at least halve the disability employment gap in Scotland and to have greater and more meaningful involvement by disabled people in designing policies and services.[45]

Gender equality – the Women's Health Plan actions aim to improve women's health inequalities by raising awareness around women's health, improving access to health care and reducing inequalities in health outcomes for girls and women, both for sex specific conditions and in women's general health.[46]

Gypsy/ Travellers – Improving the lives of Gypsy / Travellers through improved access to public services.[47]

LGBTI – centrally funding Gender Identity Service improvements until late 2024 and a programme of work to improve the rights and wellbeing of non-binary people, informed by the Non-Binary Working Group.[48]

Poverty – Through Fairer Scotland, working with communities and learning from those with real experience of inequalities and poverty to shape our policies and actively considering how to reduce inequalities of outcome caused by socio-economic disadvantage when making strategic decisions.[49]

Race equality – the Scottish Government aims to design new, multi-year anti-racist work that will start in 2023. As part of this it is delivering an Immediate Priorities Plan to deliver the recommendations of the Expert Reference Group on COVID-19 and Ethnicity and has established an Ethnicity and Anti-Racism Interim Governance Group to develop National Anti-Racist Infrastructure. [50]

Refugees and asylum seekers – the New Scots Strategy aims to ensure refugees and asylum seekers are supported and integrated from day one. [51]

Violence against women and girls (VAWG)[52] – the Equally Safe Strategy aims to prevent and eradicate violence against women and girls. This includes how public bodies respond to the initial disclosure of rape or sexual assault.

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[43] Scottish Government (2021) The Promise Scotland Plan 2021-24
[44] Scottish Government Children's rights
[45] Scottish Government (2016) Fairer Scotland for disabled people: delivery plan
[46] Scottish Government (2021) Women's Health Plan
[47] Scottish Government (2019) Improving the lives of Gypsy / Travellers: 2019-21
[48] Scottish Government LGBTI and gender recognition
[49] Scottish Government Poverty and Social Justice
[50] Scottish Government (2022) Terms of Reference for the Anti-Racism Interim Governance Group to Develop National Anti-Racist Infrastructure
[51] Scottish Government (2018) New Scots refugee integration strategy 2018-22
[52] Scottish Government (2018) Equally Safe: Scotland's Strategy to eradicate violence against women

7. Assessment of impact

7.1 Aim

The aim of this Strategy is to put equality and human rights at the centre of everything NHS Lothian does, so that everyone who works for NHS Lothian is contributing to the vision set out in the Lothian Strategic Development Framework (LSDF).[53] The vision is for a health and care system where:

- Everyone in Lothian lives longer, healthier lives, with better outcomes from the care and treatment NHS Lothian provides.
- Health and social care services are connected seamlessly, wrapping around every person in their home.
- Performance across our system is improved, with better experiences for everyone who lives in Lothian and everyone who work for and with us.

7.2 Alignment with National Outcomes

This Strategy contributes to achieving the National Outcomes:

- We are healthy and active,
- We respect, protect, and fulfil human rights and live free from discrimination,
- We tackle poverty by sharing opportunities, wealth, and power more equally, and
- We grow up loved, safe and respected so that we realise our full potential.

7.3 Relevant protected characteristic groups

Protected characteristic is a term used in the Equality Act 2010 to describe the characteristics that people have, and people are protected from unlawful discrimination on grounds of any of these characteristics. Under the Act there are nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The protected characteristics that are relevant to this strategy are:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

We have also considered the potential impact of the strategy on the needs of:

- Care experienced people
- Refugees
- Asylum seekers

[53] NHS Lothian (2022) Lothian Strategic Development Framework 2022-27

7.4 Potential equality impact

The Scotland Public Sector Equality Duty (PSED) specific duty on public bodies to assess the equality impact of proposed new or revised policies or practices requires an assessment of how this Strategy, and how the priorities, will help to eliminate discrimination, advance equality of opportunity and foster good relations for each relevant protected group.

The priorities are:

1. Equality and human rights are a central part of our planning, decision-making, delivery, and reporting processes.
2. We are an anti-racist organisation, and our work helps to eliminate racism, remove racialised inequalities and reduce prejudice.
3. We anticipate and meet the needs of disabled people who use our services and work for us so they can access services, employment opportunities and have better outcomes.
4. We are gender inclusive, we do not discriminate on grounds of sex or gender identity and our work helps to tackle persistent gender inequalities.
5. We support people with dementia and people who use our mental health services to know about and claim their rights, and to make decisions about their care and treatment.
6. We reap the benefits of equality and human rights education and training.

Having due regard to the need to eliminate unlawful discrimination, harassment, victimisation, and other prohibited conduct means examining the Strategy to ensure it is not discriminatory or otherwise unlawful under the Act.[54]

Having due regard to advancing equality of opportunity is also part of the PSED and is the second equality 'need.' We must have due regard to the need to advance equality of opportunity. This means we must have due regard to the need to:

- Remove or minimise disadvantages suffered by people who share a relevant protected characteristic
- Take steps to meet the needs of different people who share a relevant protected characteristic
- Encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation is disproportionately low.

Fostering good relations is the third equality 'need' in the PSED and means both:

- Encouraging the development or growth of ideas and attitudes which result in good or improved relations between people who share a protected characteristic and those who don't, and
- Encouraging the maintenance or improvement of already good relations between people in different protected characteristic groups.

[54] EHRC (2016) | Updated May 2021 Equality Act 2010 Technical Guidance on the Public Sector Equality Duty: Scotland

A summary of the results of the equality impact assessment is presented in the table below.

	Eliminate unlawful discrimination	**Advance equality of opportunity**	**Foster good relations**
Age	No identified discrimination on grounds of age.	Identified as having a positive impact because of work to deliver priorities 1, 5 (for older people with dementia) and 6.	Identified as having a positive impact because of work to deliver priorities 1 and 6.
Disability	No identified discrimination on grounds of disability.	Positive because of work to deliver priorities 1, 3, 5 and 6.	Positive because of work to deliver priorities 1 and 6.
Gender reassignment	No identified discrimination on grounds of gender reassignment.	Positive because of work to deliver priorities 1, 4 and 6.	Positive because of work to deliver priorities 1, 4 and 6.
Pregnancy and maternity	No identified discrimination on grounds of pregnancy and maternity.	Positive because of work to deliver priorities 1, 4 and 6.	Positive because of work to deliver priorities 1 and 6.
Race	No identified discrimination on grounds of race.	Positive because of work to deliver priorities 1, 2 and 6.	Positive because of work to deliver priorities 1, 2 and 6.
Religion or belief	In the development of priority 4 consideration was given to ensuring we don't unlawfully discriminate against people who hold the philosophical belief that sex is immutable and not to be conflated with gender identity. This belief is protected under the Equality Act 2010.[55] Priority 4 seeks to balance potentially competing rights, eliminate discrimination	Positive because of work to deliver priorities 1 and 6. Priority 2 will have a positive impact on some religious groups, for example BME people who are Muslim.	Positive because of work to deliver priorities 1, 2 and 6.

[55] Maya Forstater v CGD Europe and Others UKEAT/0105/20/JOJ

	and tackle the persistent inequalities faced by women, trans and non-binary people in a proportionate way. No identified discrimination on grounds of religion or belief.		
Sex	No identified discrimination on grounds of sex.	Positive because of work to deliver priorities 1, 4 and 6.	Positive because of work to deliver priorities 1 and 6.
Sexual orientation	No identified discrimination on grounds of sexual orientation.	Positive because of work to deliver priorities 1 and 6.	Positive because of work to deliver priorities 1 and 6.

This Strategy has been identified as having a potentially positive impact on meeting the needs of care experienced people, refugees and asylum seekers in the following ways. We have not identified any negative impact.

Priority 1 includes a commitment to collect and use evidence about people who are care experienced, refugees and asylum seekers when we plan, make decisions about, deliver and monitor our work. We will ensure there is alignment between this strategy and our corporate parenting plan.

Priority 4 will have a positive impact on meeting the needs of refugees and asylum seekers who may experience racism and racialised health inequalities. Priority 6 will include education and training about the needs and experiences of people who are care experienced, refugees and asylum seekers.

7.5 Reducing socio-economic inequalities

We know discrimination, poverty and access to health services impact on people's health outcomes. We have collected and used a wide range of evidence to develop this Strategy and assess how it can help to reduce inequalities of outcome which result from socio-economic disadvantage.

This Strategy prioritises work to tackle the persistent inequalities and poorer outcomes faced by people who share relevant protected characteristics. This includes outcomes that involve lower healthy life expectancy and poorer health, being in lower paid work and not in work, having less chance of being treated with dignity and respect and being more likely to experience discrimination.

Delivery of actions to achieve Priority 1 will have a positive impact on NHS Lothian's work to embed the Fairer Scotland Duty into its day-to-day work.

We know from the evidence in this paper that people describing themselves as Black, African or Caribbean are much more likely to live in the most deprived areas and there is a higher prevalence of poverty, food insecurity and material deprivation among disabled adults and children. Priorities 2 and 3 will have a positive impact on improving health and employment outcomes for these groups.

Priority 4 ensures that NHS Lothian implements the relevant actions in the Women's Health Plan, which includes reducing and removing the health inequalities facing women living in the most deprived areas.

7.6 Monitoring actual impact

We will report annually on the progress we are making against identified success measures. The success measures will require us to collect new and additional evidence to understand the actual impact of the Strategy, and to make sure our delivery is having the desired effect, and if not, how to change it and try something else. We will do this by involving staff, patient, and equality groups.

Appendix

Groups of staff, patients and equality organisations who engaged with the development of the strategy are set out in the table below. A wide range of equality organisations were asked to participate but either declined to do so because of pressure of work or did not respond.

NHS Lothian	**Patient and equality organisations**
Human Resources & Organisational Development	About Dementia (Age and Disability)
Staff Equality Networks	Deaf Action (Disability)
Public Health and Health Policy	Edinburgh and Lothian Race Equality Council (Race and Religion & Belief)
Public Health Intelligence	LGBT Health and Wellbeing (LGBT)
Trade unions	Lothian Maternity Voices Partnership (Women)
Medical and Clinical Directors	Poverty Alliance (socio-economic inequalities)
Nursing Directors	Royal Edinburgh and Associated Services (REAS) Patients' Council (Disability)
Acute Services Directors	Scottish Trans Alliance (Gender Reassignment)
Communications	Who Cares Scotland (Care experience, Age)
Public Involvement and Engagement	
Mental Health Services	
Volunteering	
Patient Experience Team	

Strategic Planning and Performance	
Business Managers Forum	
Speak Up	
Interpreting Services	
Lothian Analytical Services	
EHealth	
Medical Education	
Estates and Facilities	
Midlothian HSCP	
East Lothian HSCP	