NHS Greater Glasgow and Clyde
Equality Impact Assessment Tool

Equality Impact Assessment is a legal requirement 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. Evidence returned should also align to Specific Outcomes as stated in your local Equality Outcomes Report. Please note that prior to starting an EQIA all Lead Reviewers are required to attend a Lead Reviewer training session or arrange to meet with a member of the Equality and Human Rights Team to discuss the process. Please contact Equality@ggc.scot.nhs.uk for further details or call 0141 2014560.

Name of Policy/Service Review/Service Development/Service Redesign/New Service:

Revised Hospital at Home Service Model

Is this a: Current Service ☐ Service Development ☐ Service Redesign ☐ New Service ☐ New Policy ☐ Policy Review ☐

Description of the service & rationale for selection for EQIA: (Please state if this is part of a Board-wide service or is locally driven).

This EQIA aligns with the IJB Financial Allocations and Budgets 2024-25 paper, being presented to IJB members May 2024.

Published evidence notes significant risks to older people associated with (avoidable) attendance or admission to hospital. This includes deconditioning not directly associated with the presenting medical condition that triggered admission, reduced mobility, muscle wastage, higher risk of falls, confusion due to changes in environment, demotivation, increased risk of incontinence, higher risk of exposure to hospital acquired infection and an increased risk of transfer to a higher level of care placement upon discharge. Deconditioning drives increased higher levels of post-discharge care and support from social care, primary care and community services. There are broader system-wide benefits from supporting the person in their own home or care setting.

Hospital at home (H@H) is short-term, targeted service that provides a level of acute care for certain conditions in an individual's own home that is equivalent to that provided within a hospital. Hospital at home is a nurse led service that includes secondary care level specialist leadership with a designated responsible medical officer. Care is delivered by multi-disciplinary teams of healthcare practitioners within the community, complying with a combination of acute & community standards of care. It complements other community-based health and care initiatives which support patients to remain in their own homes, however it provides a different level of interventions that would normally only be provided in an acute hospital setting, such as access to intravenous anti-biotics, intravenous fluids and oxygen. In 2020 it was agreed Glasgow City HSCP would start a test of change in its South locality initially on behalf of GGC. The service commenced in January 2022 and operates over seven days, 8am – 8pm. A full evaluation of the service formed the basis of agreement of the new model of provision through the SEG/RTG and also Board Corporate Management Team during 2023. This agreement of the model moved the test of change into mainstream operational provision. This proposal includes the phased growth of the service from current South and partial North-West locality to a city-wide service. The initial proposed capacity of the H@H model is 11 virtual beds that can support up to 1,000 patients per annum.

Call Before you Convey (CBYC) involves assessment and review of clinical need with the aim of supporting the care home to prevent the admission of the resident where possible and provide interventions such as support around catheter care, prescribing (oral antibiotics, analgesia) and escalation to Hospital at Home or to an acute care

setting. There is capacity for visits to the care home to provide support and review of residents. Where demand exceeds capacity, referrals will be prioritised.
This being achieved via preventative assessment by an appropriately qualified clinician such as an Advanced Nurse Practitioner. Glasgow City's initial development of CBYC was very much an interim model/test of change, having been developed at very short notice in advance of winter 2023/24 and reliant on overtime and agency funded nurses as well as some GP sessions. Its coverage was partial, covering only a fifth of the city's care homes, all of which were in North-East Locality. The proposal is that the CBYC function is resourced from within H@H staffing. This will, over time, move the model on to a sustainable footing and enable expansion of CBYC to all 61 of the city's care homes. Based on the evaluation of the past winter's CBYC model this expansion can be expected to further reduce the number of the city's care home residents being conveyed to hospital.
Under the proposal the H@H team will provide telephone advice and reassurance as well as the opportunity to visit and review the resident, prescribe or escalate to admission to either the H@H team or into an acute setting. The residents in-scope for this service will predominantly be aged 65 or over, but under 65 presentation is also a possibility.

Whilst with the Call before You Convey service the resident will remain under the responsibility of their registered GP and any interventions, prescribing or record of care will be shared with the care home, the GP and any Care Home Liaison staff or ANPs linked to the care home. Resident profiles may include those at risk of deterioration of a known condition where a short term input may be required to stabilise them, where they have developed an infection that may be helped by an early prescribing input, or where the resident has a condition or circumstance where the care home does not have the knowledge or skills to manage a device that is causing immediate distress to a resident – such as a catheter or stoma. An essential component of this process is the feedback to the care home clinical lead/ ANP and GP to identify opportunities for learning, training and avoiding similar issues in future.

The service will be available weekends and public holidays from 8am to 6pm and will involve a proactive element at the end of the week to identify potential issues that can be dealt with before the weekend. This proposal includes the phased implementation providing support over time to all 61 Glasgow City Care Homes. The proposed capacity of the CBYC model is c2,600 care home residents per annum.

The current service has the option to contact the Department of Medicine for the Elderly (DME) on-call consultant up to 8pm. With the new service there would be a requirement to renegotiate the relationship with the DME on a city-wide basis. From 8pm to 8am there is an agreed process of escalation with the GP Out of Hours Service. Evidence over two years of the existing H@H service indicates very little escalation during the out of hours period. Attendance at hospital can be arranged immediately where the patient deteriorates beyond the limits of the service.

This proposal includes a reduction of 8.17 FTE. However some posts are time limited and will not be replaced – eg trainee posts and some of the reduction is due to a reallocation and/or apportioning of costs to areas to reflect shared responsibility/role. Potential equality impacts would relate to the workforce profile. Glasgow City HSCP NHS staff are predominantly; Female (84%), 51% are aged 30 – 49 years and 33% and are aged 50 – 64 years.

It is anticipated that the reduction will aim to be achieved through natural attrition or redeployment. An impact assessment is required to further consider what impacts there would be on staff, if any, and mitigate where possible. An assessment will be undertaken when plans for implementation are more fully developed. If this proposal is approved, there will be normal continued consultation with Unions as proposals are developed and implemented. Any appropriate workplace supports for any changes in roles or responsibilities will be identified and given further consideration where required.

Given the stage of this programme of work, this EQIA can only provide a general overview. Where specific proposals emerge from the programme, a more tailored EQIA will be produced.

Who is the lead reviewer and when did they attend Lead reviewer Training? (Please note the lead reviewer must be someone in a position to authorise any actions identified as a result of the EQIA)

Name:	**Date of Lead Reviewer Training:**
Anne Mitchell, Head of Older People and Primary Care	

Please list the staff involved in carrying out this EQIA
(Where non-NHS staff are involved e.g. third sector reps or patients, please record their organisation or reason for inclusion):

Chris Rowley, Service Manager
Alan Gilmour, Planning Manager
Glenda Cook, Planning Manager
Lynn Haughey, Interim Service Manager
Suzanne Adams, Lead Nurse, Hospital at Home

		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
1.	**What equalities information is routinely collected from people currently using the service or affected by the policy? If this is a new service proposal what data do you have on proposed service user groups. Please note any barriers to collecting this data in your submitted evidence and an**	***A sexual health service collects service user data covering all 9 protected characteristics to enable them to monitor patterns of use.***	The data captured will be limited to those fields available via Trackcare patient information management system. -There are: -Name -Address -Religion -Ethnicity -Interpreter required -Communication format -Gender -Age -Marital status	Trackcare doesn't routinely capture all protected characteristics.

	explanation for any protected characteristic data omitted.			
		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
2.	**Please provide details of how data captured has been/will be used to inform policy content or service design.** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ■	***A physical activity programme for people with long term conditions reviewed service user data and found very low uptake by BME (Black and Minority Ethnic) people. Engagement activity found promotional material for the interventions was not representative. As a result an adapted range of materials were introduced with ongoing monitoring of uptake. (Due regard promoting equality of opportunity)***	The programme uses data to identify whether access to the services is equal in terms of any protected characteristics and to use protected characteristic data analysis to check for patterning of alignment to service.	

	4) Not applicable ☐			
		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
3.	**How have you applied learning from research evidence about the experience of equality groups to the service or Policy?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ☐	***Looked after and accommodated care services reviewed a range of research evidence to help promote a more inclusive care environment. Research suggested that young LGBT+ people had a disproportionately difficult time through exposure to bullying and harassment. As a result staff were trained in LGBT+ issues and were more confident in asking related questions to young people.*** ***(Due regard to removing discrimination, harassment and victimisation and fostering good relations).***	The Hospital at Home service has been fully evaluated through both a qualitative and quantitative review process. In the previous year the service has supported 506 patients and provided care at least to the equivalent of 2316 bed days that would otherwise have occurred within the acute setting. Patient and referrer satisfaction is at a very high level and the service also has evidenced wider benefits to the system by managing people at home such as reduced risk of delayed discharges, reduced transport requirements and early intervention opportunities. The test of change, Call Before you Convey, was evaluated with both Care Homes and staff. Qualitative feedback questionnaires from Care Homes indicated that staff found the pathway positive and beneficial. The strongest benefit derived from the tested pathway for care home staff, was communication, assurance, and oversight from the senior decision makers. By timeously identifying deteriorating residents with confidence, resulted in improved collaborative relationships and increased trust between HSCPs and care home staff. Effective identification and concern escalation supported outcomes for the residents with timely and proportionate treatment plans being put in place. The pathway increased 69% TOC care home staff confidence to contact for HSCP senior decision makers prior to calling 111. Emerging evidence of the experience and benefits of Hospital at Home in Scotland, UK and internationally has been published via Rapid Response: Admission avoidance hospital at home for older people with frailty (Healthcare Improvement Scotland 2022). This evidence suggests that Hospital at Home can be a cost-effective option with patients generally expressing a higher	

			level of satisfaction compared with inpatient care. This evidence also suggests that Hospital at Home can be delivered safely without increased rates of death or re-admission to acute care and reduced likelihood of patients living in residential care after the acute episode. The evidence base for hospital at home is growing and the UK Hospital at Home Society provides access to a comprehensive range of peer-reviewed journals that report on the development and testing of hospital at home services. This programme was a test of change but was progressed into operational provision through RTG/SEG and CMT approval in 2023.	
		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
4.	**Can you give details of how you have engaged with equality groups with regard to the service review or policy development? What did this engagement tell you about user experience and how was this information used? The Patient Experience and Public Involvement team (PEPI) support NHSGGC to listen and understand what matters to people and can offer support.** **Your evidence should show which of the 3 parts of the**	***A money advice service spoke to lone parents (predominantly women) to better understand barriers to accessing the service. Feedback included concerns about waiting times at the drop in service, made more difficult due to child care issues. As a result the service introduced a home visit and telephone service which significantly increased uptake.*** ***(Due regard to promoting***	The Hospital at Home service has been fully evaluated through both a qualitative and quantitative review process. In the previous year the service has supported 506 patients and provided care at least to the equivalent of 2316 bed days that would otherwise have occurred within the acute setting. Patient and referrer satisfaction is at a very high level and the service also has evidenced wider benefits to the system by managing people at home such as reduced risk of delayed discharges, reduced transport requirements and early intervention opportunities. There has been engagement with staff and trade unions since the initial savings were proposed. This will continue and If the plan is approved will continue to enable the shaping and delivery of the new model The test of change, Call Before you Convey, was evaluated with both Care Homes and staff. A questionnaire was sent out to all Glasgow care homes that participated in the CBYC TOC to	A comprehensive communications and information plan will be developed to maximise activity and use of available capacity and to ensure that staff are aware of these services.

	General Duty have been considered (tick relevant boxes). **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ☐	***equality of opportunity)*** **** The Child Poverty (Scotland) Act 2017 requires organisations to take actions to reduce poverty for children in households at risk of low incomes.***	gather qualitative feedback on the first 3 months of this model. 34 homes responded to the questionnaire (40% response rate) and 41% of those homes used the pathway in the past 2 quarters. 92% of homes that responded said they found the pathway beneficial. The main benefit of the pathway for care home staff was the communication and oversight from CHLN to identify residents deteriorating. The pathway has increased staff confidence to contact for assistance prior to calling 911 for 69% of staff. The most common reasons for homes not using the pathway are staff having limited knowledge of the pathway or no clinical need for the pathway during the past 2 quarters. A questionnaire was also sent out to HSCP staff to gather qualitative feedback from the staff who have been delivering this service over the 3-month period. 14 staff members responded to the questionnaire (36% Inverclyde, 21% East and West Dunbartonshire, 14% Glasgow City, 7% Renfrewshire). 79% of staff members found the pathway beneficial. 76% of staff rated the pathway good or excellent and 77% rated the outcomes of the patients good or excellent. Staff were asked if there were any improvements that could be made to the service. It was fed back that providing the service over longer hours, expanding the service to include more conditions, and including residents who are unwell would all help improve the service. Some staff also advised that the service should be advertised further to all care homes as some care home staff are unaware and not utilising the pathway. There was no permanent staff base for CBYC as it was staffed by overtime and bank/agency.	
		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
5.	**Is your service physically accessible to everyone? If**	***An access audit of an outpatient physiotherapy***	The service will continue to be delivered in an individual's own home (Hospital at Home) or Care Home (Call before you convey	

	this is a policy that impacts on movement of service users through areas are there potential barriers that need to be addressed? **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ■	***department found that users were required to negotiate 2 sets of heavy manual pull doors to access the service. A request was placed to have the doors retained by magnets that could deactivate in the event of a fire.*** ***(Due regard to remove discrimination, harassment and victimisation).***	and Hospital at Home). In line with the existing model this service will exclude any patients who present with an urgent condition that would be expected to be managed in an acute hospital setting. For example stroke or MI/Heart attack	
		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
6.	**How will the service change or policy development ensure it does not discriminate in the way it communicates with service users and staff?** **Your evidence should show**	***Following a service review, an information video to explain new procedures was hosted on the organisation's YouTube site. This was accompanied by a BSL signer to explain service***	No anticipated change for existing service users. Future referrals for Hospital at Home from GPs, Scottish Ambulance Service (SAS) and Acute (Emergency Department (ED), Acute Assessment Units (AAU) and wards). Communications will be subject to the Clear to All Policy.	A comprehensive communications and information plan will be developed to maximise activity and use of available capacity and to ensure that staff are aware of these services.

	which of the 3 parts of the General Duty have been considered (tick relevant boxes). **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ☐ **The British Sign Language (Scotland) Act 2017 aims to raise awareness of British Sign Language and improve access to services for those using the language. Specific attention should be paid in your evidence to show how the service review or policy has taken note of this.**	***changes to Deaf service users.*** ***Written materials were offered in other languages and formats.*** ***(Due regard to remove discrimination, harassment and victimisation and promote equality of opportunity).***		
7	**Protected Characteristic**		**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(a)	**Age** **Could the service design or policy content have a**		As a component of Older people provision, the service is targeted to those over 65 years. (Average age 84.2 years with a range of 65-102 years). The service supports those who are	In line with the existing model this service will exclude any patients who present with an urgent condition that

	disproportionate impact on people due to differences in age? (Consider any age cut-offs that exist in the service design or policy content. You will need to objectively justify in the evidence section any segregation on the grounds of age promoted by the policy or included in the service design). **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ☐	most complex and frail and based on the Rockwood score, the average patient score is 6.5 which is between moderately and severely frail. It is anticipated that this will have a positive impact for those accessing the service. For elderly and frail patients the benefits of remaining in their own home rather than admission to hospital are significant. An inpatient stay for these patients is more likely to result in deconditioning, delirium and compromise recovery. Based on the evaluation of the past winter's CBYC model this expansion can be expected to further reduce the number of the city's care home residents being conveyed to hospital. Under the proposal the H@H team will provide telephone advice and reassurance as well as the opportunity to visit and review the resident, prescribe or escalate to admission to either the H@H team or into an acute setting. The residents in-scope for this service will predominantly be aged 65 or over, but under 65 presentation is also a possibility.	would be expected to be managed in an acute setting. For example stroke or MI/heart attack Frailty is likely to be a component of assessment of each patient and as such there are agreed referral processes for patients identified as frail. Implementation of the integrated model will be monitored in line with governance arrangements. **Hospital at Home -** The multi-disciplinary team with a GP with Special Interest (GPwSI) and lead ANP acting as senior clinical decision makers across the Monday to Friday period. A multi-disciplinary meeting is held on weekdays to review patients and support the plan of care (including any diagnostic requirements, prescribing or discharge planning). Advanced Nurse Practitioners and Advanced Practitioners deliver higher level interventions using agreed Standard Operating Procedures that meet policy and governance standards for NHSGG&C. Case reviews, reviews of incidents and clinical reviews will be lead through the service management team with input from the GPwSI and lead ANP. **Call Before You Convey -** Nurses will deliver the agreed level of

			interventions using approved Standard Operating Procedures and interventions within their scope of practice such as prescribing or clinical interventions. The service will be managed by the service management team with clinical supervision provided through the ANP/ AP structure. There will be opportunity to review cases through the wider MDT. There will be a focus on learning and improvement to identify opportunities where the need for input could have been prevented, where intervention could have occurred at an earlier stage and any learning opportunities to feed back to the clinical lead for the care home and the ANP/ CHLN or GP associated with the care home.
(b)	**Disability** **Could the service design or policy content have a disproportionate impact on people due to the protected characteristic of disability?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ■	The service supports those who are most complex and frail and based on the Rockwood score, the average patient score is 6.5 which is between moderately and severely frail. It is anticipated that this will have a positive impact for those accessing the service. For elderly and frail patients the benefits of remaining in their own home rather than admission to hospital are significant. An inpatient stay for these patients is more likely to result in deconditioning and compromise recovery. Based on the evaluation of the past winter's CBYC model this expansion can be expected to further reduce the number of the city's care home residents being conveyed to hospital. Under the proposal the H@H team will provide telephone advice	In line with the existing model this service will exclude any patients who present with an urgent condition that would be expected to be managed in an acute setting. Frailty is likely to be a component of assessment of each patient and as such there are agreed referral processes for patients identified as frail. Implementation of the integrated model will be monitored in line with

	3) Foster good relations between protected characteristics. ☐ **4) Not applicable** ☐	and reassurance as well as the opportunity to visit and review the resident, prescribe or escalate to admission to either the H@H team or into an acute setting.	governance arrangements. **Hospital at Home -** The multi-disciplinary team with a GP with Special Interest (GPwSI) and lead ANP acting as senior clinical decision makers across the Monday to Friday period. A multi-disciplinary meeting is held on weekdays to review patients and support the plan of care (including any diagnostic requirements, prescribing or discharge planning). Advanced Nurse Practitioners and Advanced Practitioners deliver higher level interventions using agreed Standard Operating Procedures that meet policy and governance standards for NHSGG&C. Case reviews, reviews of incidents and clinical reviews will be lead through the service management team with input from the GPwSI and lead ANP. **Call Before You Convey -** Nurses will deliver the agreed level of interventions using approved Standard Operating Procedures and interventions within their scope of practice such as prescribing or clinical interventions. The service will be managed by the service management team with clinical supervision provided through the ANP/ AP structure. There will be opportunity to review cases through the wider MDT. There will be a focus on learning and

			improvement to identify opportunities where the need for input could have been prevented, where intervention could have occurred at an earlier stage and any learning opportunities to feed back to the clinical lead for the care home and the ANP/ CHLN or GP associated with the care home.
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(c)	**Gender Reassignment** **Could the service change or policy have a disproportionate impact on people with the protected characteristic of Gender Reassignment?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ■	No specific impact identified.	
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**

(d)	**Marriage and Civil Partnership** **Could the service change or policy have a disproportionate impact on the people with the protected characteristics of Marriage and Civil Partnership?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ■	No specific impact identified.	
(e)	**Pregnancy and Maternity** **Could the service change or policy have a disproportionate impact on the people with the protected characteristics of Pregnancy and Maternity?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐	No specific impact identified.	

	3) Foster good relations between protected characteristics. ☐ **4) Not applicable** ■		
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(f)	**Race** **Could the service change or policy have a disproportionate impact on people with the protected characteristics of Race?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ■	Care in one's own home is often more culturally acceptable, particularly regarding aspects such as language, food and support to family as the main carers We will provide interpreters and translated information for anyone who doesn't have English as their first language.	
(g)	**Religion and Belief** **Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Religion and Belief?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant**	No specific impact identified. In line with current process, We have put measures in place to ensure there are no disproportional impacts due to individual's religion and beliefs. In the communication process we will be targeting religious groups and sending out materials to these groups. Furthermore in someone's care plan they will be able to make any asks to ensure their religious beliefs are respected for	

	boxes). **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ■	example: if they wish for female only staff we will include this and accommodate this where we can and capacity allows. We have the appropriate systems in place should someone's belief shape the level of care they receive during the process of during the palliative care process. There is chaplaincy support available through the service.	
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(h)	**Sex** **Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sex?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ■	This proposal includes a reduction of 8.17 FTE. Potential equality impacts would relate to the workforce profile. Glasgow City HSCP NHS staff are predominantly Female (84%). It is anticipated that the reduction will aim to be achieved through natural attrition or redeployment. An impact assessment is required to further consider what impacts there would be on staff, if any, and mitigate where possible. An assessment will be undertaken when plans for implementation are more fully developed. If this proposal is approved, there will be normal continued consultation with Unions as proposals are developed and implemented. Any appropriate workplace supports for any changes in roles or responsibilities will be identified and given further consideration where required. There will be no disproportionate implications for individuals accessing the hospital at home service based on their sex. Where individuals or family may desire specialists based on their sex e.g. male or female only then this is something we can look to accommodate on based on capacity and resource. Individual's sex will not inhibit their access to a service. The	

		need for this will be carefully assessed and this should be included by the patient/family or carers at the point of referral and assessment. Should there be a necessary requirement for a professional with a specific sex, and there is no capacity, we can refer the individual through the rehabilitation service.	
(i)	**Sexual Orientation** **Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sexual Orientation?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ■	No specific impact identified.	
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(j)	**Socio – Economic Status & Social Class** **Could the proposed service change or policy have a disproportionate impact on people because of their social class or experience of poverty and what mitigating action have you taken/planned?** **The Fairer Scotland Duty (2018) places a duty on public**	The H@H service will expand its geographical coverage from South Locality and part of North-West to take referrals from all of North-West Locality and from all of North-East Locality for the first time. This is intended to increase the occupancy levels of the service that until now have oscillated between 50 to 70 per cent. H@H staffing resources will also be deployed over time to deliver the CBYC model to all 61 care homes in the city. This	

	bodies in Scotland to actively consider how they can reduce inequalities of outcome caused by socioeconomic disadvantage when making <u>strategic</u> decisions. If relevant, you should evidence here what steps have been taken to assess and mitigate risk of exacerbating inequality on the ground of socio-economic status. Additional information available here: Fairer Scotland Duty: guidance for public bodies - gov.scot (www.gov.scot) Seven useful questions to consider when seeking to demonstrate 'due regard' in relation to the Duty: 1. What evidence has been considered in preparing for the decision, and are there any gaps in the evidence? 2. What are the voices of people and communities telling us, and how has this been determined (particularly those with lived experience of socio-economic disadvantage)? 3. What does the evidence suggest about the actual or likely impacts of different options or measures on inequalities of outcome that are associated with socio-economic disadvantage? 4. Are some communities of interest or communities of place more affected by disadvantage in this case than others? 5. What does our Duty assessment tell us about socio-economic disadvantage experienced disproportionately according to sex, race, disability and other protected characteristics that we may need to factor into our decisions? 6. How has the evidence been weighed up in reaching our final decision? 7. What plans are in place to monitor or evaluate the impact of the proposals on inequalities of outcome	represents an increase in coverage from the 20% of Glasgow homes that were supported by the service during winter 2023/24. This expansion across the city will include the service being available in areas of high deprivation.	

	that are associated with socio-economic disadvantage? 'Making Fair Financial Decisions' (EHRC, 2019)21 provides useful information about the 'Brown Principles' which can be used to determine whether due regard has been given. When engaging with communities the National Standards for Community Engagement22 should be followed. Those engaged with should also be advised subsequently on how their contributions were factored into the final decision.		
(k)	**Other marginalised groups** **How have you considered the specific impact on other groups including homeless people, prisoners and ex-offenders, ex-service personnel, people with addictions, people involved in prostitution, asylum seekers & refugees and travellers?**	No specific impact identified.	
8.	**Does the service change or policy development include an element of cost savings? How have you managed this in a way that will not disproportionately impact on protected characteristic groups?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ☐	This EQIA aligns with the IJB Financial Allocations and Budgets 2024-25 paper, being presented to IJB members in May 2024. The model has the potential to deliver material economic savings, with defined benefits to GPs, care homes, broader community health services, Scottish Ambulance Service and Acute Services. Successful delivery of the revised H@H model would bring significant benefits to all stakeholders, especially patients and their families. In its budget report of 20th March 2024 Glasgow City HSCP identified current H@H expenditure of £1.78M per annum as a saving. This paper proposes a recurring reinvestment of £1.072M to fund the revised H@H and CBYC combined service. Recurring funding of £0.764M has been identified from the Glasgow City HSCP District Nursing (DN) budget. This reflects	

		an underspend resulting from vacancies and will support delivery of the H@H model described in this paper. Work is being progressed to plan for the impact on reduced DN funding and to identify options for the DN workforce to effectively utilise the skills and training that they have undergone. This work will involve a review of the specification of the service, caseloads and skill mix. Work will be progressed to support staff who have undertaken or are progressing formal training to support them to enable theory to be put into practice, establish competence and build confidence. A further £0.257M will come from Glasgow City's NRAC (National Resource Allocation Formula) share of the Care Home Collaborative (CHC) funding from the Health Board to support delivery of CBYC. This funding has not yet been confirmed as recurring although the Scottish Government has given some indication the CHC funding will continue from 2025/26. A distinct piece of work will be progressed to maximise the synergy between the two elements of service provision and to implement at pace. Therefore, there is some financial risk attached to this element of the financial framework. In addition, the HSCP was recently awarded £0.164M for 2024/25 by Health Improvement Scotland (HIS) on a non-recurring basis to support development of the new approach. The total recurring H@H budget will be £1.021M with an additional non-recurring £0.164M in the current financial year.	
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
9.	**What investment in learning has been made to prevent discrimination, promote equality of opportunity and foster good relations between protected characteristic groups? As a minimum include recorded completion rates of statutory and mandatory learning programmes (or local equivalent) covering equality, diversity and**	All staff are encouraged to complete equality and human rights training, available on Learnpro and TURAS.	

	human rights.		

10. In addition to understanding and responding to legal responsibilities set out in Equality Act (2010), services must pay due regard to ensure a person's human rights are protected in all aspects of health and social care provision. This may be more obvious in some areas than others. For instance, mental health inpatient care or older people's residential care may be considered higher risk in terms of potential human rights breach due to potential removal of liberty, seclusion or application of restraint. However risk may also involve fundamental gaps like not providing access to communication support, not involving patients/service users in decisions relating to their care, making decisions that infringe the rights of carers to participate in society or not respecting someone's right to dignity or privacy.

The Human Rights Act sets out rights in a series of articles – right to Life, right to freedom from torture and inhumane and degrading treatment, freedom from slavery and forced labour, right to liberty and security, right to a fair trial, no punishment without law, right to respect for private and family life, right to freedom of thought, belief and religion, right to freedom of expression, right to freedom of assembly and association, right to marry, right to protection from discrimination.

Please explain in the field below if any risks in relation to the service design or policy were identified which could impact on the human rights of patients, service users or staff.

Please explain in the field below any human rights based approaches undertaken to better understand rights and responsibilities resulting from the service or policy development and what measures have been taken as a result e.g. applying the PANEL Principles to maximise Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality or FAIR* .

*

- **F**acts: What is the experience of the individuals involved and what are the important facts to understand?
- **A**nalyse rights: Develop an analysis of the human rights at stake
- **I**dentify responsibilities: Identify what needs to be done and who is responsible for doing it
- **R**eview actions: Make recommendations for action and later recall and evaluate what has happened as a result.

Having completed the EQIA template, please tick which option you (Lead Reviewer) perceive best reflects the findings of the assessment. This can be cross-checked via the Quality Assurance process:

- [x] Option 1: No major change (where no impact or potential for improvement is found, no action is required)
- [ ] Option 2: Adjust (where a potential or actual negative impact or potential for a more positive impact is found, make changes to mitigate risks or make improvements)
- [ ] Option 3: Continue (where a potential or actual negative impact or potential for a more positive impact is found but a decision not to make a change can be objectively justified, continue without making changes)
- [ ] Option 4: Stop and remove (where a serious risk of negative impact is found, the plans, policies etc. being assessed should be halted until these issues can be addressed)

11. If you believe your service is doing something that 'stands out' as an example of good practice - for instance you are routinely collecting patient data on sexual orientation, faith etc. - please use the box below to describe the activity and the benefits this has brought to the service. This information will help others consider opportunities for developments in their own services.

Actions – from the additional mitigating action requirements boxes completed above, please summarise the actions this service will be taking forward.	**Date for completion**	**Who is responsible?(initials)**
A comprehensive communications and information plan will be developed to maximise activity and use of available capacity and to ensure that staff are aware of these services.	May 2025	CR

Ongoing 6 Monthly Review please write your 6 monthly EQIA review date:

Lead Reviewer:	**Name**	**Stephen Fitzpatrick**
EQIA Sign Off:	**Job Title**	**Assistant Chief Officer Older People Services**
	Signature	
	Date	**20th August 2024**
Quality Assurance Sign Off:	**Name**	**Alastair Low**
(NHSGGC Assessments)	**Job Title**	**Planning Manager**
	Signature	***Alastair Low***
	Date	**20/08/2025**

NHS GREATER GLASGOW AND CLYDE EQUALITY IMPACT ASSESSMENT TOOL
MEETING THE NEEDS OF DIVERSE COMMUNITIES
6 MONTHLY REVIEW SHEET

Name of Policy/Current Service/Service Development/Service Redesign:

Please detail activity undertaken with regard to actions highlighted in the original EQIA for this Service/Policy

		Completed	
		Date	Initials
Action:			
Status:			
Action:			
Status:			
Action:			
Status:			
Action:			
Status:			

Please detail any outstanding activity with regard to required actions highlighted in the original EQIA process for this Service/Policy and reason for non-completion

		To be Completed by	
		Date	Initials
Action:			
Reason:			
Action:			
Reason:			

Please detail any new actions required since completing the original EQIA and reasons:

		To be completed by	
		Date	Initials
Action:			
Reason:			
Action:			
Reason:			

Please detail any discontinued actions that were originally planned and reasons:

Action:	
Reason:	
Action:	
Reason:	

Please write your next 6-month review date

Name of completing officer:

Date submitted:

If you would like to have your 6 month report reviewed by a Quality Assuror please e-mail to: alastair.low@ggc.scot.nhs.uk