Equality Impact Assessment Tool: Policy, Strategy and Plans
(Please follow the EQIA guidance in completing this form)

1. Name of Strategy, Policy or Plan

Glasgow City Health and Social Care Partnership: Palliative and End of Life Plan 2018-23

This is a : Current;#Current Policy

2. Brief Description - Purpose of the policy, Changes and outcomes, services or activities affected

Glasgow City Health and Social Care Partnership Palliative and End of Life Care will be undergoing a significant transformational programme across a 5 year period. The detail of the palliative care plan will be developed to reflect the needs of the diverse populations within the city and will be delivered via the three Locality Palliative Care Implementation Groups (PCIGs) that report to the HSCP Palliative Care Steering Group (PCSG). It is important that developments in Palliative and End of Life Care (PEOLC) seek to address the needs of vulnerable groups within society. With this in mind, this Equality Impact Assessment was undertaken to formally capture contextual information relating to Palliative and End of Life care for different protected characteristic groups and will be used to inform service analysis, subsequent change proposals and the raft of service level equality impact assessments that will be undertaken at Locality to ensure any service change is compliant with the HSCP and Health Board's legal duties in respect of their Public Sector Duty. The HSCP's Palliative & End of Life Plan 2018-23 can be accessed at https://www.yoursupportglasgow.org/media/23104/glasgow-hscp-palliative-care-plan-2018-23.pdf Palliative Care is identified in the HSCP's Palliative and End of Life Plan as a function delegated by Glasgow City Council and NHS Greater Glasgow & Clyde. Effective and accessible palliative care is key to supporting people, their families and their carers. It enables people to remain safely at home, it helps to avoid hospital admissions and minimises delays in hospital. Sensitive and effective Palliative Care can be reflected in all 9 National Health & Wellbeing Outcomes as experienced by service users, carers and staff. The Scottish Government's Strategic Framework for Action adopted the World Health Organisation (WHO) definition - "Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual." Palliative care: • provides relief from pain and other distressing symptoms; • affirms life and regards dying as a normal process; • intends neither to hasten or postpone death; • integrates the psychological and spiritual aspects of patient care; • offers a support system to help patients live as actively as possible until death; • offers a support system to help the family cope during the patients illness and in their own bereavement; • uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated; • will enhance quality of life, and may also positively influence the course of illness; • is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications. Palliative Care Steering Group Locality Palliative Care Implementation Groups The above groups are part of this EqIA and the memberships comprise representation from – • Health and Social care staff (across adult and children's services), • Hospice Services • Homeless Health service • Housing • Mental Health services • Macmillan Nurse Facilitators • HSCP Planning managers • Glasgow University • Prison Health service • Acute/hospital Palliative Care • Residential Care • Public representatives and General Practice

3. Lead Reviewer

Paul Adams

4. Please list all participants in carrying out this EQIA:

Paul Adams (Head of Primary Care & Community Services)

5. Impact Assessment

A. Does the policy explicitly promote equality of opportunity and anti-discrimination and refer to legislative and policy drivers in relation to Equality

The HSCP's Palliative & End of Life Plan will align with the aims set out in the Scottish Government's Health & Social Care Delivery Plan (http://www.gov.scot/Resource/0051/00511950.pdf). In particular with the aim that by 2021; "Everyone who needs palliative care will get hospice, palliative or end of life care" and that "all who would benefit from a Key Information Summary (KIS) will receive one". The Delivery Plan also indicates that people will receive more sensitive end of life support in the setting of their choice. This may not always be possible for various reasons. The HSCP Palliative & End of Life Plan will be required to explicitly reference Human Rights Act 1998 and the Equality Act (2010) and articulate how any proposed changes in service provision will meet the requirement to eliminate unlawful discrimination, advance equality of opportunity and promote good relations. The HSCP's plan is derived from the Scottish Government

Strategic Framework for Action in Palliative & End of Life Care which was published in December 2015. https://www.gov.scot/publications/strategic-framework-action-palliative-end-life-care/#res491388 An EQIA was carried out on that strategic document and can be accessed at https://www.gov.scot/publications/equality-impact-assessment-strategic-framework-action-pallaitive-end-life-care/

B. What is known about the issues for people with protected characteristics in relation to the services or activities affected by the policy?

		Source
All	We are cognisant of the considerable health inequalities experienced by many people living in Glasgow City. In preparing the Palliative and End of Life Plan, considerable thought has been given to how services need to be designed to address both the underlying causes of inequality and how we respond to the poor health outcomes, which these inequalities both create and exacerbate. Other Equality Impact Assessments (EQIAs) must be considered in relation to this EQIA are: Equity in the Provision of Palliative Care in the UK: Review of Evidence (April 2015) https://www.mariecurie.org.uk/globalassets/media/documents/policy/campaigns/equity-palliative-care-uk-report-full-lse.pdf/ Scottish Government EQIA on the Strategic Framework for Action In Palliative Care https://www.gov.scot/publications/equality-impact-assessment-strategic-framework-action-pallaitive-end-life-care/ GCHSC Mental Health Strategy (2018): https://glasgowcity.hscp.scot/sites/default/files/publications/Glasgow%20HSCP%20transformational%20Programme%20Mental%20Health%20Services.pdf Transformational Changes Programme Children Service 2018-202 (2018) https://glasgowcity.hscp.scot/sites/default/files/publications/EQIA%20-%20Transformational%20Change%20Programme%20-%20Children%20Services%20Glasgow%20HSCP.pdf Glasgow City Health and Social Care Partnership: Older people Transformational Change Programme 2018-2 (2018): https://glasgowcity.hscp.scot/sites/default/files/publications/Glasgow%20City%20Health%20and%20Social%20care%20Partnership%20-%20Older%20Peoples%20Transformational%20Change%20Programme%202018-21.pdf Primary Care Mental Health Review (2013) http://www.nhsggc.org.uk/media/220542/EQIA_Primary_Care_Mental_Health_Team_Review.pdf Mental Health Strategyhttps://beta.gov.scot/publications/equality-impact-assessment-results-mental-health-strategy/ Scottish Government Mental Health Strategy EQIA (2017): https://beta.gov.scot/publications/equality-impact-assessment-results-mental-health-strategy/ Scottish Government Carers (Scotland) Act 2016 EQIA (2018): https://beta.gov.scot/publications/carers-scotland-act-2016-equality-impact-assessment/	Sources in text
Sex	Each section must be read within the context of the intersectional nature of all the protected characteristics There is evidence suggesting that men in the UK are diagnosed at a later stage than women for malignant melanoma, lung, bladder and other urological cancers, and later in Ireland for colorectal, lung and stomach cancers as well as malignant melanoma. Saeed F. et al (2018) in Preference for Palliative Care in Cancer Patients: Are Men and Women Alike? (Journal of Pain and Symptom Management) found significant gender differences in patient preference for palliative care could partially account for gender disparities in end-of-life care. Interventions to promote palliative care among men could reduce these disparities. Lopez-Acevedo M. (2013) et al; Palliative and hospice care in gynaecologic cancer: A review (in Gynaecologic Oncology Volume 131, Issue 1, October 2013, Pages 215-221) found that despite the increasing availability of palliative care, oncology providers often misunderstand and underutilize these resources. The goals of palliative care are relief of suffering and provision of the best possible quality of life for both the female patient and her family, regardless of where she is in the natural history of her disease. Lack of understanding and awareness of the services provided by palliative care physicians underlie barriers to referral. Terzioglu F. and Sahan F. (2016) in Palliative Care in Gynaecologic Cancers (in Journal of Palliative Care & Medicine) found for women palliative care has been shown to improve quality of life, mood, symptom control, satisfaction, survival duration, and caregiver satisfaction, depression, and stress burden. Palliative care improves healthcare utilization outcomes such as decreased hospital costs	Sources in text
Gender Reassignment	Each section must be read within the context of the intersectional nature of all the protected characteristics Transgender people often experience discrimination in the health care setting and lack of access to medical personnel who are competent in transgender medicine. This results in lack of access to preventive health services and timely treatment of routine health problems. Williamson C. (2010) in Providing Care to Transgender Person: A clinical Approach to Primary Care, Hormones and HIV Management for Journal of the Association of Nurses in AIDs Care (Vol 21, Issue 3 pg 221-229) highlighted that transgender persons have had historically difficult interactions with health care providers, leading to limited care and risks for a broad spectrum of health problems. This is of particular concern for transgender persons with or at risk of HIV infection. Transgender people are a poorly understood, frequently invisible, and high-risk population, and many health care providers find it difficult to care for them because of a lack of formal training and few professional resources. Transgender people need routine care as well as care for concerns specific to transgender people. Additionally, some transgender persons are at risk of or have already been infected with HIV Transgender stigma and discrimination experienced in health care influence transgender people's health care access and utilization. Thus, understanding how stigma and discrimination manifest and function in health care encounters is critical to addressing health disparities for transgender people. These finding above can be challenging or barriers for transgender people to access palliative and or end of life care.	Sources in text
	Each section must be read within the context of the intersectional nature of all the protected characteristics Glasgow City Council (2013): Briefing Paper 2011 Census - Release 2A	

Race	suggested that in recent years there has been a large increase in the number of the population from ethnic minorities in both Glasgow and Scotland. The current estimates suggest that black minority ethnic (BME) population in Glasgow now represents 15.4% of the total population. Recent observation also suggests a significant increase in the number of African and Caribbean population in recent years. Glasgow is home to over 130,000 student population from 135 countries around the world. 2.7% of Glasgow's ethnic minority population 'do not speak English well' or at all. Glasgow's Roma population is estimated to be between 3,000-4,000; about 2,000-2,500 are Slovakian (with small numbers of Czechs) and about 1,000 are Romanian. Over three quarters (78.5%) of social services users in Glasgow are of White- ethnic origin compared to (4.5%) of BME. NSS Information and Intelligence NHS Scotland reported in Measuring use of Health Services by Equality Group (2017) that the largest minority ethnic group in Scotland was “Asian”, (141,000; 3% of the population) and around a third of whom were “Pakistani”. Glasgow City Council Area had the highest proportion of minority ethnic groups (12% of the population). Macmillan Cancer support in their “The rich picture on people with cancer from BME groups” found 13% of people living in the UK describe themselves as belonging to a BME group. People from Asian and Mixed communities are 20%-60% less likely to get cancer than the White population. In Black men the risk of getting cancer is comparable to White men. Uptake of cancer screening invitations is generally lower in people from BME groups than people from the White population. There is no single definition of ethnicity and no single approach to capture it. Many definitions highlight its multifaceted and changing nature, and a sense of belonging to a group. Ethnicity can be described as “the social group a person belongs to as a result of a mix of cultural and other factors including language, diet, religion, ancestry and physical features”. There is a great need for more robust cancer data on ethnicity as the quality of ethnicity recording in routinely collected health data remains poor. This raises concerns around completeness and accuracy of analysis when using existing data, with the main area of concern being primary care. It is important to be mindful that not everyone with a diagnosis of cancer will require palliative and or end of life care. Worth A. et al (2009) in the BMJ pointed out that despite a robust Scottish diversity policy, services for South Asian Sikh and Muslim patients with life limiting illness were wanting in many key areas. Active case management of the most vulnerable patients and carers, and “real time” support, from where professionals can obtain advice specific to an individual patient and family, are the approaches most likely to instigate noticeable improvements in access to high quality end of life care. Improving access to palliative care for all, particularly those with non-malignant illnesses, as well as focusing on the specific needs of ethnic minority groups, is required. Grant, L et al, (2009) in Developing services to meet the end-of-life care needs of South Asian Sikh and Muslim patients and their families in Scotland (in Edinburgh Ethnicity and Health Research Group) found although the experiences of South Asian Sikh and Muslim patients and their families were in many respects similar to those identified in other end-of-life studies in the general population, terminal illness and death brings about different tangents in cultural and religious dynamics that need to be better incorporated into service provision. The Greater Glasgow and Clyde NHS Board’s Black and Ethnic Minorities Health and Wellbeing survey (2016) found that more than nine in ten (92%) BME adults overall had a positive perception of their quality of life, which was higher than Glasgow City. The Pakistani groups were less likely than other ethnic groups to have a positive perception of their quality of life. Fifteen percent of BME adults had an illness or condition that limited what they could do, and one in four (26%) were receiving treatment for at least one illness or condition. The Pakistani group were also much more likely than other BME adults to have a limiting condition or illness or to be receiving treatment for a condition/illness. Those who did not speak English well and those who had lived in the UK for 10 years or more were more likely than others to have a limiting long-term condition or illness.	Sources in text
Disability	Each section must be read within the context of the intersectional nature of all the protected characteristics The World Health Organization (2018) in Disability and Health suggested that disability is extremely diverse. While some health conditions associated with disability result in poor health and extensive health care needs, others do not. However all people with disabilities have the same general health care needs as everyone else, and therefore need access to mainstream health care services. People with disabilities report seeking more health care than people without disabilities and have greater unmet needs. For example, a recent survey of people with serious mental disorders, showed that between 35% and 50% of people in developed countries, and between 76% and 85% in developing countries, received no treatment in the year prior to the study https://www.who.int/news-room/fact-sheets/detail/disability-and-health In the National LD Strategy (2013), “The Keys to Life”. https://keystolife.info/ It is recognised that people with learning disabilities experience higher rates of dementia than the general population. Figures suggest that prevalence rates are 4 times higher regardless of the cause of learning disability and that onset of the condition is about 10 years earlier than in the general population. By contrast, people with Down’s syndrome experience significantly higher prevalence rates and earlier onset of the condition is also reported at between 30-40 years younger than the general population. It is also estimated that prognosis rates are poorer with an average of five years between diagnosis and death. Pain recognition and pain management is often over looked amongst people with learning disabilities and many with dementia will experience similar levels of pain as those with cancer. Life limiting illness is more prevalent in the learning disability population with an estimated 61% of people with learning disabilities living with a specific long term illness or additional disability. People with learning disabilities are less likely to access specialist palliative care than the rest of the population. In addition, people with learning disabilities are less likely to be informed of a diagnosis of a life limiting or threatening illness or condition or given indications of prognosis, compared to the general population, and they are rarely encouraged to explore sensitive issues such as loss, death and dying Furthermore, evidence suggests that many people with learning disabilities will not have their pain recognised or sufficiently managed as a consequence of the same factors that affect equity in accessing healthcare. Many now experience periods of increasing frailty, organ failure, cancer and dementia as well as other life-limiting conditions. It has been reported that people with learning disabilities encounter all of the major life- threatening diseases at least 5-10 years	Sources in text

	earlier than the rest of the population and that the time frame for survival is poorer Consideration also needs to be given to the increasing numbers of infants surviving the neonatal period due to advances in medical care. Many are surviving not just infancy but into childhood and adulthood with multiple disabilities and complex health needs requiring palliative care. With increasing numbers of people with learning disabilities requiring continuing care and support it is vital that we recognise that the skills and knowledge of health and social care staff will influence the overall experience of the individual, carers and family. It is therefore becoming increasingly important to grasp the significance of palliative care across the age range of people with learning disabilities who have life-limiting or life- threatening illness or conditions. It is only through inclusion, education, by making reasonable adjustments and developing robust partnerships that lead to collaborative working that people with learning disabilities will experience equity in accessing palliative care services. In order to move forward improvements in care for people with learning disabilities who have palliative care needs it is crucial that there is a commitment to partnership working between Palliative Care and Learning Disability services. The array of unmet learning needs experienced by both specialist services can be addressed through joint working and learning. The Scottish Government Dementia Strategy specifically highlights the increasing need of people who have learning disabilities and dementia and highlights that dementia care is a national priority for the government.	
Sexual Orientation	Each section must be read within the context of the intersectional nature of all the protected characteristics Davy Z. and Sieiwardona A.N. (2012) wrote in the British Journal of General Practices (To be or not to be LGBT in Primary Care: Health Care for Lesbian, Gay, Bisexual and transgender people) pointed that teaching has tended to position heterosexuality and gender normative people as conforming to social standards of what is ‘appropriate’ feminine and masculine behaviour as the primary context in which health and illness is viewed. Models of health care that promote these views of sexuality and gender identity over others can create an environment in which gender stereotypes and “heteronormativity” - cultural bias favours opposite-sex over same-sex sexual relationships - results in LGBT people becoming ‘add ins’, if and when they are considered at all. Even the term LGBT assumes that transgender patients have similar health care issues with those who are lesbian, gay, or bisexual, and can be taught together as an extension of the same theme. While sometimes there will be transgender people who identify with a lesbian, gay, or bisexual sexuality there is no intrinsic connection. It is important to respond to the requirements of lesbian, gay, bisexual, and transgender populations accessing primary care with different models. Almack K. (2010); Exploring the Impact of Sexual Orientation on Experiences and Concerns about End of Life Care and on Bereavement for Lesbian, Gay and Bisexual Older People pointed to the focus on end of life care and bereavement sheds light on a series of relatively neglected issues associated with lesbian, gay and bisexual (LGB) ageing and, more broadly, the topics of care and support within ‘non-traditional’ intimate relationships and personal networks.	Sources in text
Religion and Belief	Each section must be read within the context of the intersectional nature of all the protected characteristics Rumun A. (2014) in Influence of Religious Beliefs on Health Care Practices for the International Journal of Education and Research advised that the perceived role of ‘God’ in illness and recovery is a primary influence upon the health care beliefs and behaviors of people. The religious beliefs of the people result in many health care beliefs and practices which are significantly different based on the persons religion. Only by understanding the religious beliefs of individuals can medical practitioners effectively meet the health care needs of patients of diverse religious beliefs. Hordorn J. (2016), in a Science Direct article on Religion and Culture suggested that religion, belief and culture should be recognized as potential sources of moral purpose and personal strength in health care, enhancing the welfare of both clinicians and patients amidst the experience of ill-health, healing, suffering and dying. Communication between doctors and patients and between health care staff should attend sensitively to the welfare benefits of religion, belief and culture. Doctors should respect personal religious and cultural commitments, taking account of their significance for treatment and care preferences. Daaleman T. P. (2000); Placing Religion and Spirituality in End-of-Life Care suggested that the goal of a quality comfortable death is achieved by meeting a patient's physical needs and by attending to the social, psychological, and the now recognized spiritual and religious dimensions of care. This perspective is highlighted in a recent consensus statement that includes the assessment and support of spiritual and religious well-being and management of spiritual and religious problems as core principles of professional practice and care at the end of life.	Sources in text
Age	Each section must be read within the context of the intersectional nature of all the protected characteristics World Health Organisation (2017) in their report on integrated care for older people found that as a consequence of more people living longer there will be larger numbers of people experiencing a decline in physical and mental capacity who may also need care for day-to-day activities. These needs are not well met within existing models of health care. There is a pressing need to develop comprehensive community-based approaches to prevent declines in capacity and to provide support to family caregivers. Sherlaw-Johnson (2018) completed an evaluation for Nuffield Trust in outer East London which reported that patient-centred care for older people with complex need suggested that primary care hubs - that are dedicated to the care of older people with complex health needs - can have a positive impact on quality of care, and on the experiences of both patients and staff. NSS Information and Intelligence NHS Scotland reported in Measuring use of Health Services by Equality Group (2017) that the number of people aged over 40 years has increased year on year for the past twenty years whilst the number of people aged under 40 years has fallen and then plateaued. There have been consistently higher numbers of elderly women than men aged 70+ years, but the number of men in these age groups is increasing more steeply over time than it is for women of the same age. According to Information Services Division (ISD) statistics on GP consultations, a higher rate and number of females visit their GP practice, except in the very youngest and oldest age groups where the rate for males is slightly higher. This seems to have been a consistent pattern over	Sources in text

	time.	
Pregnancy and Maternity	Each section must be read within the context of the intersectional nature of all the protected characteristics The Scottish Government EQIA on the Strategic framework for Action in Palliative Care identified that "For women in pregnancy and maternity there are specialist services to care for their unborn and new born babies with palliative care needs but limited UK research on the needs of the very few mothers who have life limiting diseases in pregnancy and maternity".	Sources in text
Marriage and Civil Partnership	Each section must be read within the context of the intersectional nature of all the protected characteristics King M. and Bartlett A. (2006) write in "What same sex civil partnerships may mean for health?" that the attempts of western governments and the World Health Organisation to address the social determinants of health, in particular the effects of social exclusion, has relevance here. 51% in the UK are married and living with their spouses and although many studies have not clearly distinguished between marriage and cohabitation, married people seem to have better physical and psychological health than single people. Unmarried people have increased rates of all-cause mortality compared with married people.	Sources in text
Social and Economic Status	Each section must be read within the context of the intersectional nature of all the protected characteristics Professor Watt G. (2011): GPs at the Deep End report describes many health conditions that are more prevalent (typically more than twofold) in deprived compared with affluent populations. Koffman J et al, (2007); Demographic factors and awareness of palliative care and related services in SAGE Journals found that a total of 252 (94%) eligible clinic patients were interviewed. Only 47 (18.7%) patients recognised the term 'palliative care', but 135 (67.8%) understood the role of the hospice, and 164 (66.7%) understood the role of Macmillan nurses. Age-adjusted multiple logistic regression showed that recognizing the term 'palliative care' was more likely among the most socially and materially affluent patients than those who were the poorest. Awareness of palliative care and related services was low among black and minority ethnic groups, and the least affluent.	Sources in text
	Each section must be read within the context of the intersectional nature of all the protected characteristics Eavis C. (2017): The barriers to healthcare encountered by single homeless people, in Primary Health Care indicated that when individuals are homeless, their health and well-being are at risk; this risk increases the longer they are homeless (Public Health England (PHE) 2016). Homeless people often have tri-morbidity: mental ill health, physical ill health and may have drug or alcohol misuse (Medcalf and Russell 2014). They are more likely to lead unhealthy lifestyles, which can cause long-term illness or exacerbate existing illnesses (Homeless Link 2014). A homeless person is more likely to present with a disease rather than attend for screening, or at the prevention stage of a disease (Power et al 1999). Consequently, homeless people have higher premature death rates: on average, a homeless man lives to 47 years, a homeless woman to 43, compared with 77 years for the general population (Thomas 2011). Homeless people are still dying of treatable medical conditions (Medcalf and Russell 2014). In Primary care service framework: Gypsy & Traveller Communities (2009) - noted that not all Gypsies and Travellers live a nomadic life; many are settled although they may choose to travel for part of the year. Although there are differences of opinion, some experts say there are seven groups of Gypsies & Travellers living in the UK. The aspects of Gypsy Traveller health that show the most marked inequality are self-reported anxiety, respiratory problems including asthma and bronchitis, and chest pain. The excess prevalence of miscarriages, stillbirths, neonatal deaths and premature death of older offspring were also conspicuous. There was less inequality observed in diabetes, stroke and cancer. Travellers' health beliefs and attitudes to health services demonstrate a cultural pride in self-reliance. There is stoicism and tolerance of chronic ill health, with a deep-rooted fear of cancer or other diagnoses perceived as terminal and hence avoidance of screening. Some fatalistic and nihilistic attitudes to illness were expressed; that is, illness was often seen as inevitable and medical treatment seen as unlikely to make a difference. There is more trust in family carers rather than in professional care. In relation to Gypsy Travellers' experiences in accessing health care and the cultural appropriateness of services provided, we found widespread communication difficulties between health workers and Gypsies and Travellers, with defensive expectation of racism and prejudice. Barriers to health care access were experienced, with several contributory causes, including reluctance of GPs to register Travellers or visit sites, practical problems of access whilst travelling, mismatch of expectations between Travellers and health staff, and attitudinal barriers. However, there were also positive experiences of those GPs and health visitors who were perceived to be culturally well-informed and sympathetic, and such professionals were highly valued. Roma Health Report Health status of the Roma population Data collection in the Member States of the European Union (2014), European Union: There is consistent evidence demonstrating the Roma population has a considerably shorter life expectancy compared to the non-Roma population. Indeed for many years, published information has persistently shown the Roma population has a markedly lower life expectancy than the general population. The gap in longevity may be a decade or more. Data is less able to explain the cause(s) of the difference between Roma and non-Roma health and to sufficiently explore issues around the impact of specific social determinants on particular health outcomes. Smoking prevalence levels are consistently higher in Roma than non-Roma communities. Mixed findings indicate significantly lower illicit drug use amongst Roma communities, although overall there appear to be a number of cultural factors which have a negative impact on the lifestyles of Roma. Roma tend to have illnesses associated with poor diet, and stress. Depression and psychosomatic complaints are common and there is a high frequency of eye and dental problems, which can be attributed to poor diet and malnutrition. Poor health and an unhealthy lifestyle are significant problems associated with low income. The London-based Roma Support Group's evaluation of its three year Mental Health Advocacy	Sources in text

Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	Project (2012) found recurring themes of barriers to mental health services including a lack of knowledge of the existence of mental health services, communication, language and literacy barriers and the stigma of mental health issues. In the UK issues such as a lack of a postal address, having to travel long distances to visit their GP and evictions due to a lack of authorised sites are all relevant. Slovak Roma in the UK have been found to have high rates of type two diabetes mellitus, cardiovascular disease, premature myocardial infarction, obesity and asthma, and it is common for Roma to have undiagnosed health conditions. Glasgow City Council (Social Work Services) report that Glasgow hosts one of the largest asylum and refugee populations outside of London. Glasgow is currently the number one dispersal area in the UK in terms of numbers. There are currently 3,589 asylum seekers in Glasgow which work out around 10% of the UK's annual total. On average there are around 2,500 asylum seeking people going through the asylum system in Glasgow at any one time with people coming from about 68 countries. In 2015, about 3,105 asylum seekers received accommodation and financial support in Glasgow. Psarros A. (2014) in the Women's voices on health addressing barriers to accessing primary care reported that women who are asylum seekers or refused asylum felt that they received mixed messages in relation to what healthcare they were entitled to. They put this down to health professionals' lack of knowledge, but also prejudice and discrimination. Many felt that they were treated differently from non-migrants. Health-related costs are a big barrier to the women, most of whom are destitute and mental health problems were associated with a lot of stigma in this group. Psarros also suggested that documentation requirements are a barrier to registration when passport, photo ID or utility bills are not obtainable. Insisting on these documents restricts access to healthcare for groups like asylum seekers, homeless women and members of the Traveller community. Prison Reform Trust, 2015),The number of older prisoners has rapidly increased in recent years and the need for palliative and end-of-life care has grown correspondingly. the rise in the numbers of older prisoners; explores the particular needs of this growing population; and discusses some of the practical and emotional challenges for prison officers, health care staff, and fellow prisoners who are involved in caring for dying prisoners in a custodial environment Williamson M. in his presentation title: Improving the health and social outcomes of people recently released from prisons in the UK – A perspective from primary care. In its key findings: • Imprisonment can be good for physical health and improving health intervention opportunities but is usually not good for mental health. • The post release period is extremely dangerous in physical and mental health terms and for recidivism. • Prisons can be seen as another, 'community based health care station'. • Imprisonment rates are increasing especially amongst women and the elderly and alternatives, whenever possible, should be used to avoid the deleterious health effects of incarceration. • Health and social care services need to be designed to be acceptable to and accepting of young people. • Women and young prisoners have special needs. Other sections of the population, e.g. older men, should be considered and their special needs identified. The following extract from Equity in the Provision of Palliative Care in the UK: Review of Evidence (April 2015) https://www.mariecurie.org.uk/globalassets/media/documents/policy/campaigns/equity-palliative-care-uk-report-full-lse.pdf/. Care home residents often have complex needs, yet may not receive sufficient external palliative care or otherspecialist healthcare support, with evidence of poor coordination and confusion about the respective roles of care home staff and external providers. There is also wide variation between care homes in the proportion of residents who die in hospital, reflecting variation in care home policies and capacity to care for people at end of life. Importantly, people with non-cancer diagnoses not only receive less specialist care, they also receive less generalist care than people with cancer (although they receive more social care). Based on data for 21,522 people who died between April 2006 and September 2011 in three London primary care trust areas, cancer patients had an average of 11.4 GP visits in their last three months of life compared 3.9 visits for people with other diagnoses, as well as, based on data from nearly 11,000 patients in a single London borough, 452 minutes contact time with a district nurse compared to 191 minutes for people with other diagnoses. There are numerous potential barriers to accessing palliative care services for people from Black, Asian or minority ethnic (BAME) backgrounds identified in the literature. These include lack of cultural and religious sensitivity in how services are delivered, discrimination (and/or fear of it), absence of translation resources, different cultural views regarding the acceptability of openly discussing death, shortages of female doctors for Muslim women and assumptions that family members from BAME backgrounds will be able and willing to care for relatives at home. However, much of this research is from the US or is based on small selective samples, often in what Evans et al. (2012) refer to as 'ethnically marked places and ethnic communities'. Proposals for addressing these barriers are also not always evidence-based.		
C. Do you expect the policy to have any positive impact on people with protected characteristics?			
	Highly Likely	**Probable**	**Possible**
General	The plan is based on a national strategic framework and within the 28 action points. Within those action points, specific reference is made to people with protected characteristics. Services will be required to consider how palliative and end of life care is accessed by all those that need it.		
Sex			Improved awareness about services might

			encourage greater access at an earlier stage.
Gender Reassignment			Opportunity for improved access and engagement of transgender people if education programmes are successful in creating greater awareness of discrimination and more skilled conversations.
Race	Work specifically targeted at ethnic minorities in South Glasgow will share learning with other localities in the city		
Disability		Collaborative work between Learning Disability and Palliative Care services should realise better access and better outcomes.	
Sexual Orientation			Similar to transgender, there is an opportunity for improved access and engagement of LGBT people if education programmes are successful in creating greater awareness of discrimination and a more skilled approach to conversation.
Religion and Belief			Collaboration between palliative care providers and chaplaincy/multi-faith leads to emphasise the impact of religion, belief and culture
Age	Work to improve identification of change in people with palliative care needs residing in care homes should result in greater awareness, more collaboration with families and carers, more ACPs and less crisis admissions to hospital.		
Marriage and Civil Partnership			Better awareness among staff regarding the difference in health between married and unmarried people.
			Continue to scan for additional

Pregnancy and Maternity			evidence to the limited research currently available regarding the small number of mothers who have life-limiting diseases in pregnancy and maternity
Social and Economic Status		The delivery model for Older People that divides the 3 Localities of Glasgow further into Neighbourhoods (total 10 Neighbourhoods) has the potential to build more effective relationships and services within the most deprived communities	
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	Palliative Care in Prisons is the subject of early collaboration between prison health service and Marie Curie and should provide a measure of the inequity and a plan to address the gaps that are identified.		Further work is needed to address the risk to those that are homeless and not registered with a GP
D. Do you expect the policy to have any negative impact on people with protected characteristics?			
	Highly Likely	**Probable**	**Possible**
General		As tests of change are implemented in different parts of the city, there is a probability that some people will experience a different service because of where they live or who they are. This should be transient until there is sufficient evidence of benefit to merit wide roll out. This applies to all of the protected characteristics.	
Sex			Men will continue to present later due to the speed at which educational programmes and awareness can be delivered.
Gender Reassignment		As tests of change are implemented in different parts of the city, there is a probability that some people will experience a different service because of where they live or who they are	
Race		As tests of change are implemented in different parts of the city, there is a probability that some people will experience a different service because of where they live or who they are	
Disability		As tests of change are implemented in different parts of the city, there is a probability that some people will experience a different service because of where they live or who they are	
Sexual Orientation		As tests of change are implemented in different parts of the city, there is a probability that some people will experience a different service because of where they live or who they are	
Religion and Belief		As tests of change are implemented in different parts of the city, there is a probability that some people will experience a different service because of where they live or who they are.	
		As tests of change are implemented in different parts of the city, there is a probability that some people will	Services for children and

Age		experience a different service because of where they live or who they are	young people could be different to the Adult population due to the needs analysis starting later.
Marriage and Civil Partnership		As tests of change are implemented in different parts of the city, there is a probability that some people will experience a different service because of where they live or who they are	
Pregnancy and Maternity		Further work needed to better understand the gaps in provision for mothers with life-limiting disease in pregnancy	
Social and Economic Status		As tests of change are implemented in different parts of the city, there is a probability that some people will experience a different service because of where they live or who they are	
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders		As tests of change are implemented in different parts of the city, there is a probability that some people will experience a different service because of where they live or who they are	