Item No. 11

Meeting Date **Wednesday 7th February 2018**

Glasgow City
Integration Joint Board
Finance and Audit Committee

Report By:	**Stephen Fitzpatrick, Assistant Chief Officer, Older People's Services and South Sector**
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DELIVERY OF OLDER PEOPLE'S TRANSFORMATION PROGRAMME

Purpose of Report:	To outline delivery arrangements for the HSCP's Older People's Transformation Programme.

Background/Engagement:	As part of its approval of the Older People's Transformation Programme in November 2017, the IJB sought this separate report outlining delivery arrangements.

Recommendations:	The IJB Finance and Audit Committee is asked to: a) note this report.

Relevance to Integration Joint Board Strategic Plan:

The contents of this report relate to the delivery of the core elements of the Older People component of the Joint Strategic Plan.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome:	As per 8 November IJB report.

Personnel:	As above.

Carers:	As above.

Provider Organisations:	As above.

Equalities:	As above.

Financial:	As above.

Legal:	As above.

Economic Impact:	As above.

Sustainability:	As above.

Sustainable Procurement and Article 19:	As above.

Risk Implications:	As above.

Implications for Glasgow City Council:	As above.

Implications for NHS Greater Glasgow & Clyde:	As above.

1. Purpose

1.1 At its meeting of 8 November 2017 the IJB approved the Older People's Transformational Change Programme 2018-21 - (https://glasgowcity.hscp.scot/publication/item-no-7-older-peoples-transformational-change-programme-2018-21). As part of that approval the IJB requested that this further report be presented to Finance and Audit Committee outlining further details in relation to the delivery arrangements for the transformation programme, including key metrics.

1.2 The purpose of this paper is to provide the requested additional level of detail.

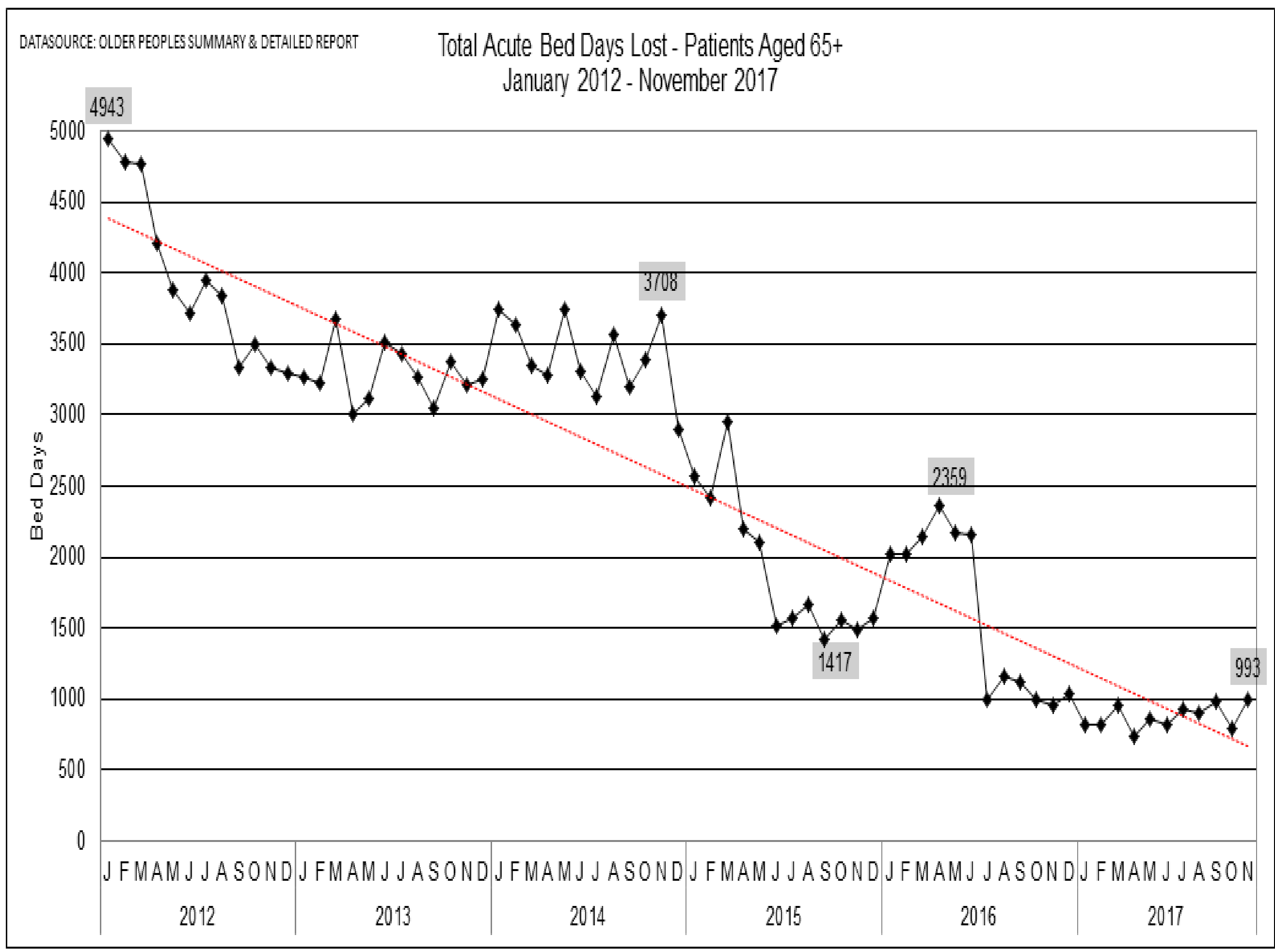
2. Strategic Context

2.1 By way of recap from the November report the IJB approved a 3 year older people's transformation strategy based upon the following 5 key priorities from the IJB strategic plan:

- Early intervention, prevention and harm reduction.
- Providing greater self-determination and choice.
- Shifting the balance of care.
- Enabling independent living for longer.
- Public protection – including keeping vulnerable people safe from harm.

2.2 Key themes in the transformation programme approved by the IJB include shifting attitudes from risk avoidance to risk enablement; an acceptance that more frail, older people with complex needs will be supported in the community in the future; there will be an ever greater emphasis on family and carer support; and, technology enabled care will be a growing feature of care and support.

2.3 IJB members sought reassurance that the savings attached to this transformation programme are achievable without generating ever greater demand on the Acute system, expressed most commonly by the level of delayed discharges. Whilst this report proceeds below to itemise how the anticipated impact of all relevant savings will be managed over the lifetime of the transformation programme, as a general reassurance it should be noted that over the past 5 years there has been a 21% reduction in care home placements (3,558 in 2012 to 2,821 in 2017) with a corresponding 80% improvement in delayed discharge performance.



2.4 Nonetheless the IJB report did acknowledge there are significant risks attached to a programme being delivered during a period of significantly growing demand for community services at a time of sharply reducing resources. Appendix 1 includes a risk register itemising anticipated risks.

3. Anticipated Impact of Savings Attached to Transformation Programme

3.1 Shifting the Balance of Care – Set Aside budget saving of £3.27M

In line with the qualifications outlined in the November IJB report, this saving assumes agreement with the Health Board and Acute Services regarding appropriate baseline benchmarks and performance improvement targets that will enable release of savings from this budget.

At the time of writing a more detailed paper outlining those baselines and performance targets is being developed in partnership by all NHSGGC HSCPs for consideration by the Ministerial Steering Group for Health and Social Care Integration at the end of January. These specific metrics can be presented to the Finance and Audit Committee at its February meeting.

However, general reassurance can be drawn at this juncture from the latest Scottish Government unscheduled care data. Published on 9 January 2018, the data indicates that the number of unscheduled hospital bed days lost in Glasgow City for Acute specialties reduced from 45,731 in January 2017 to 30,966 in October 2017 (the latest available data). That represents a significant reduction of 32.3% over a 9 month period during which unscheduled care action plans were being formulated and implemented across the health and care system. A key contribution to these overall figures came from reduced bed days lost to delayed discharges in the city. However, it should be noted there is an expectation that these figures will have increased again over the winter period in response to significantly increased demand on the health and care system. Nonetheless the underlying trend over recent years has been positive.

Cause and effect of individual service reforms and other measures are impossibly difficult to delineate given the complexity of the health and care system. It is likely that this improvement arises from the combined impact of actions taken by both the Acute system and the HSCP, separately and collectively, over that period through their respective Unscheduled Care plans (HSCP Action Plan presented as Appendix 2). However, it does demonstrate significant progress in unscheduled care activity and the November IJB report sought to establish the principle that the HSCP must share in the associated financial benefit if it is to continue to meet increasing community demand.

3.2 Shifting the Balance of Care – Care Home Placements saving of £4M

This saving continues a trend in purchased placement reduction that has been in place for a number of years. For 2018/19 this saving will result in a net reduction of 215 purchased placements. The older people's transformation plan will seek to address that reduction through a number of means, including sustaining more frail older people at home through a combination of home care, family and carer support and expanding deployment of advanced telecare. The cumulative impact of sustaining a sizeable number of frail older people at home for even a short period will help offset some of the reduced care home capacity. Our expectation is that the combined effect of advances and increased investment in each of these service areas will reduce demand for care home placements by around 80 during 2018/19.

There will be a renewed focus on the percentage of people returning home from Intermediate Care in support of this programme. Over the past year the number of people returning home from Intermediate Care has averaged 25-30%. During 2018/19 the intention is that this figure will increase to between 35-40%. The recent audit of intermediate care provides encouragement that this improvement in performance is achievable. A detailed report on this audit is also being presented to Finance and Audit Committee.

In addition, the continued expansion of supported living services for those at risk of admission to care homes will continue during 2018/19 and will be a key driver for offsetting demand for care home placements. Supported living services will be expanded during 2018/19 both on a core and cluster (third sector providers) and dispersed (Cordia) basis.

Specifically, the re-direction of the remaining former housing support will be used to complement core supported living budgets to purchase 125 additional core and cluster supported living places in local communities across the city. Detailed plans with individual third sector providers are at an advanced stage and will be agreed with local operational teams.

Cordia are re-directing £2M from mainstream home care budgets to support the expansion of its dispersed supported living service. This will deliver a further c80 such places across the city.

In addition, the transfer of continuing care resources to the HSCP has provided access to a number of additional care home beds within the city. Typically there are bed vacancies of around 20-30 at any given time, which provides further reserve capacity to maintain the system in balance. This is exactly how these beds have been used to manage increased pressures over the winter period.

Through a combination of the above measures, the HSCP anticipates it will be able to deliver the reduction in purchased care home placements and the associated £4M saving during 2018/19.

3.3 Other savings of £2.7M

The other elements of savings plan approved by the IJB are not expected to risk displacing demand onto other parts of the health and care system and are therefore not presented in the same detail as the shifting the balance of care savings above that represent the critical mass of older people's savings for 2018/19.

In summary:

Personalisation savings – will be delivered through reviews of individual service user support plans.

Evolving Partnership with Housing – will release housing support savings associated with individuals that do not meet the eligibility criteria for social work support.

Palliative and End of Life Care – will be released via a programme of internal efficiencies by the hospice providers without impacting their service capacity.

Low Risk, Ad Hoc provision – will be realised through a range of relatively low level funding reductions to former Integrated Care Fund provision.

Clinical Redesign – will be delivered from a combination of vacant posts and recurring underspends in clinical budgets.

3.4 Equality Impact

The EQIA attached to this programme is presented as Appendix 3.

4. Recommendation

4.1 The IJB Finance and Audit Committee is asked to:

a) note this report.

Appendix 1

					Initial Risk Level					Current Risk Level								
Referenc	Status	Description of Risk	Risk Owner	Risk Manager(s)	Likelihood	Consequences	Risk Ranking	Risk Level	Control Actions	Likelihood	Consequences	Risk Ranking	Risk Level	Date Last Checked	Next update due	Most recent update	Risk Chronology	Future Issues
1		**There is a failure of community services to provide the necessary level of support to an increased population of frail older people living in the community, leading to poor or unsafe outcomes for service users and patients.**	Asst Chief Officer, Older People	Heads of Service	3 - Possible	4 - Major	12	High	HSCP investment in alternative provision via re-direction. Including carer support, supported living, telecare, aids and equipment. Partnership working with housing, voluntary sector and across HSCP services. Continuous performance review and audit activity to monitor impact.			0	Low					
2		**A significant number of family/ carers experience difficulty sustaining their caring role for longer as the older person they care for becomes frailer over time.**	Asst Chief Officer, Older People	Heads of Service	3 - Possible	3 - Moderate	9	Medium	Investment in carer support. Implementation of Carers Strategy. Partnership working with carers. Monitor general wellbeing of carers, including through continued close joint working with carers centres across the city and through caseholding HSCP staff.			0	Low					
3		**Some care home providers experience a reduction in HSCP funded placements placing into question the commercial viability of some homes.**	Asst Chief Officer, Older People	Service Manager Commissioning	4 - Likely	2 - Minor	8	Medium	Monitor through contract management relationship with individual care homes and care home providers. Financial monitoring. Managed closures if necessary, drawing upon experience of previous closures, with resident wellbeing the utmost priority.			0	Low					
4		**Failure of the HSCP to maintain and/ or improve performance in relation to delayed discharges and unscheduled care leads to pressure on the Acute system and reduced performance in relation to A&E and other key Acute performance measures.**	Asst Chief Officer, Older People	Heads of Service	3 - Possible	4 - Major	12	High	Implementation of HSCP and NHSGGC Unscheduled Care Action Plans. Implementation of Winter Plans. Ad hoc service responses to demand surges.			0	Low					
5		**HSCP staff and GPs experience difficulty in adjusting to changing population need in the community in addition to other pressures, including revised roles and responsibilities arising from the new GP contract.**	Asst Chief Officer, Older People	Heads of Service	3 - Possible	3 - Moderate	9	Medium	Continuous programme of communication and engagement with key stakeholder groups, including via GP Committees, trade unions and professional leads. OD programmes for relevant staff groups. Professional and clinical issues managed via HSCP governance processes.			0	Low					
6		**There is the potential for challenge to/ criticism of the HSCP/ GCC/ NHSGGC arising from public concerns about individual elements/ overall transformation programme.**	Asst Chief Officer, Older People	Asst Chief Officer, Older People	4 - Likely	2 - Minor	8	Medium	Proactive management of expectations via IJB and HSCP public facing communications. Consistent messaging via engagement forums, including Public Engagement Committee. Consistent messaging in response to any formal or information challenges, including via the media.			0	Low					
7		**Savings associated with the transformation programme are not delivered, resulting in an IJB overspend against its budget.**	Asst Chief Officer, Older People	Heads of Service	2 - Unlikely	4 - Major	8	Medium	Routine progress monitoring through Older People Management structures and HSCP Integration Transformation Board. Urgent remedial measures to be undertaken in the event of any slippage.			0	Low					

Likelihood Scores:

5	**Almost Certain** to occur	(>80% certainty)
4	**Likely** to occur	(51% - 80% certainty)
3	**Possible** that it may occur	(26% - 50% certainty)
2	**Unlikely** to occur	(10% - 25% certainty)
1	**Rare/Extremely Unlikely** that it may occur	(<10% certainty)

Consequences/Impact Scores

5	Incidence would be **fundamental/catastrophic** to the ability to delivery the defined objectives of the project
4	Incidence would be **major** to the ability to delivery the defined objectives of the project
3	Incidence would be **moderate** to the ability to delivery the defined objectives of the project
2	Incidence would be **minor** to the ability to delivery the defined objectives of the project
1	Incidence would be **insignificant** to the ability to delivery the defined objectives of the project

Examples of different categories of consequences are provided in the table below:

Example category	**1** (Insignificant)	**2** (Minor)	**3** (Moderate)	**4** (Major)	**5** (Fundamental)
Financial	<1% of budget	1%-2.5% of budget	2.5%-10% of budget	10%-25% of budget	>25% of budget
Schedule	<10% overrun	10%-15% overrun	15%-25% overrun	25%-50% overrun	>50% overrun
Regulatory	Minor internal breach	Major internal breach	Minor external breach	Major external breach	Stops work
Health & Safety	Trivial injury(ies)	Minor injury(ies)	Major injury	Major injuries	Death(s)
Reputation	Complaints	Local media	Regional media	National media	International media

GLASGOW CITY HEALTH & SOCIAL CARE PARTNERSHIP

UNSCHEDULED CARE ACTION PLAN/WINTER PLAN REPORTING TEMPLATE

This template was originally developed to enable monitoring of the HSCP's action plan which was developed to take forward the specific actions identified in the HSCP's draft Unscheduled Care Strategic Commissioning Plan, as approved by the Integration Joint Board on 15 March 2017. It will be used to report upon progress to the HSCP's unscheduled care planning group; HSCP SMT; Integration Joint Board; North and South Sector Delivery Groups; and the GG&C Unscheduled Care Steering Group. It has since been added to with the incorporation of the actions contained within the HSCP Winter Plan.

Each action has been classified against the Themes of Change outlined within the boardwide Unscheduled Care Programme plan; as well as the local priorities identified within the HSCP's Unscheduled Care Strategic Commissioning Plan. Against each of the actions, leads are required to complete the following information on a monthly basis.

- Any revisions to start/end dates or to the actions themselves
- An overall summary of progress to date
- Any specific deliverables achieved in the last month
- Any specific deliverables which it is anticipated will be achieved in the next month
- Any positive outcomes or causes of concern which it is felt should be highlighted
- RAG status using the following classification

Legend

RAG	Description
Red	*Major issues which require decisions/replanning by the HSCP Unscheduled Care Planning Group*
Amber	*Proceeding to plan, with any significant issues being addressed and/or risks monitored*
Green	*Proceeding to plan within stated tolerances*

Action	Lead	Start Date	End Date	Summary of Progress to Date.	Project/service deliverables achieved (December)	Project/service deliverables anticipated (January)	Positive outcomes/ causes for concern	RAG Status
Alternatives to admission								
HSCP led programme to reduce avoidable admissions/Community based alternatives to admission								
Review data on potentially avoidable admissions by GP practice and share with GP Clusters	Alan Gilmour	Nov 2017	March 2018	LIST team have agreed to analyse data and make available to clusters for review. Focus is on all unplanned attendance at A&E / AAU and admissions	Additional LIST resource identified to progress this task.	Phase 1 – release of data at practice level and establishing framework for sharing information.	First release of practice level data on potentially avoidable admissions. Phase 2 - Looking at Lothian model using SPC approach as a useful visual means of communicating information to practices – likely to be March 2018 for first stage of this development	A
Ongoing development and review of the city wide COPD/respiratory service.	Paul Adams	Apr 2017	Mar 2020	Service ongoing citywide. Work undertaken on referral criteria and systems and funding bid prepared via the COPD Collaborative.	Referral criteria for city wide service have been refined and disseminated on Staff net. Electronic referrals systems developed to improve the efficiency of administration. NHSGGC COPD Collaborative Bid for £250k funding secured	Begin the use of electronic referral across the city. Work within structure of successful bid: COPD care bundles, track care alerts, sharing of information between primary and secondary care. Explore EMIS use/ IT access for team to improve efficiency and quality of patient care.	Data from 2016 to 2017 demonstrate a 29% increase in self referrals for acutely unwell patients, who otherwise would present to A&E or their GP, potentially avoiding admissions. Temporary increases in routine waiting times. Staffing gaps plus	G

Action	Lead	Start Date	End Date	Summary of Progress to Date.	Project/service deliverables achieved (December)	Project/service deliverables anticipated (January)	Positive outcomes/ causes for concern	RAG Status
					looking at Emergency Care Enhanced Pathways 'from patient self-care to hospital specialist care'. Glasgow's share £50k.	Produce costing/pilot proposal for 7 day service.	short staffing over Summer. Existing staff working overtime and will continue over the winter.	
Introduce revised model of assessment at home by the Scottish Ambulance Service, with the intention that any non-injured fallers who do not need to be conveyed to hospital and who can be safely left at home are referred to rehabilitation services.	Anne Mitchel / SAS with support from Acute	Apr 2017	Nov 2017	Taken forward as part of the implementation of the falls strategy. Pathway introduced 1st November. Slow uptake by SAS	Ongoing	GGC wide awareness sessions to be arranged by SAS. Date tbc. Intention is to increase the awareness and confidence of the crews to refer to community rehab as an alternative to conveyance.	Slow uptake of new pathway from SAS with small number of referrals so far.	A
Frailty review								
Develop test of change to pilot integrated care between GPs and consultant geriatricians including OPMH to manage more patients in the community and reduce acute admissions	Paul Knight / Hamish Battye	Oct 2017	March 2018	Proposal considered at HSCP UC planning group, and agreed to focus work on practices supporting a care home in the North East.	Proposal discussed at HSCP UC Planning Group in November and refined following discussion with GPs, geriatricians, acute and HSCP managers with a view to establishing pilot in the North.	Meeting arranged for 18/12/17. Agreed to pilot based on a care home in the North East. Pilot to be overseen by group tasked with reducing acute admissions from care homes.	None at this stage	A
Adult mental health unscheduled care review								

Action	Lead	Start Date	End Date	Summary of Progress to Date.	Project/service deliverables achieved (December)	Project/service deliverables anticipated (January)	Positive outcomes/ causes for concern	RAG Status
Develop an overarching service model for a 24 hour unscheduled care service which incorporates inpatient beds (crisis admissions) and crisis services over 7 days, and interface with community services and other specialist MH Services.	Katrina Phillips	April 2017	March 2018	Sub group established and work progressing to develop model. Final model to be agreed by February 2018 for approval by 5 year MH Strategy programme Board with implementation plan developed by March 2018.	GGC wide frontline staff event took place on 4th December	Further work to be taken forward to review output of event prior to confirming final model	None at this stage	A
Older people system of care – home is best team								
Introduce home is best team as part of wider older people system of care and implementation of integrated neighbourhood teams.	Stephen Fitzpatrick	Sept 2017	Dec 2017	Implementation underway.	Team manager appointed	Team leader appointments	None at this stage	A
Review of Out of Hours Service								
Develop a more streamlined, integrated and efficient provision of HSCP OOHs services in line with national review	Kirsty Orr	Apr 2017	Project report in 2019	Project Manager in post. Steering Group established along with work streams across health and social care to support the programme. Developing and ensuring links with other relevant programmes of work. Mapping of services underway. Exploring models of OOHs health & social care provision	Overarching Project plan agreed by Steering Group Members. Key Stakeholder event for GP OOHs Workstream held on the 7 Dec. Some guiding planning principles proposed to support the development of a	Process maps and data measurement framework developed to ensure baseline understanding of pathways, activity and outcomes of services in scope. Work plan to be updated and progressed through January 2018. Benchmarking of OOHs provision across Scotland will be nearing completion.	None at this stage	G

Action	Lead	Start Date	End Date	Summary of Progress to Date.	Project/service deliverables achieved (December)	Project/service deliverables anticipated (January)	Positive outcomes/ causes for concern	RAG Status
				across Scotland/UK	sustainable service.	Communication and Engagement Strategy and workstream being developed to support the review. First draft planned for end Jan 2018.		
Emergency Department Processes								
Adult mental health unscheduled care review								
Develop service model for liaison/out of hours services which will interface with Emergency Departments, NHS 24, GP Out of Hours and the third sector. These will enable support out of regular working hours to facilitate more appropriate care and admission avoidance. **(NB Unscheduled Care & Winter Plan action).**	Katrina Phillips	April 2017	March 2018	Test of change commenced – CPN based in QEUH and GRI and control test at RAH with dedicated response time of 1 hour from referral. Focus is on those patients who have been reviewed in terms of physical presentation and require further specialist mental health assessment to determine any ongoing care or discharge. These will run for 8 week period.	Test of change commenced - CPN based in QEUH and GRI for entire OOH shift – 8pm – 8am four days one week and three days the following week to capture activity and data discharge	Continue test of change	None at this stage	A
Alternatives to referral to GP Assessment Unit/ A&E/ Redirection from A&E								
Establish system for planned and emergency access to consultant specialist advice for GPs as an alternative to A&E.	Joint Acute/ HSCP/ clinical leads	Sept 2017	TBC	This is being considered as part of the work on frailty above and the development of enhanced care pathways.	See progress updates provided on enhanced care pathways in the Board wide unscheduled care reports.		None at this stage	A

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Create capacity and process for same day or next day emergency out-patient slots for assessment as alternative to A&E examination.	Joint Acute/ HSCP/ clinical leads	Sept 2017	TBC	Included in GG&C unscheduled care programme. Action to be scoped as part of enhanced care pathways for top 12 conditions	See progress updates provided on enhanced care pathways in the Board wide unscheduled care reports.		None at this stage	A
Establish system of GP access to urgent diagnostic tests (e.g. bloods) as an alternative to A&E referral for the same purpose.	Joint Acute/ HSCP clinical leads	Sept 2017	TBC	Included in GG&C unscheduled care programme. Action to be scoped as part of enhanced care pathways for top 12 conditions	See progress updates provided on enhanced care pathways in the Board wide unscheduled care reports.		None at this stage	A
Scope proposal for small test of change to pilot re-direction of non-urgent cases from A&E that could appropriately and safely be seen in primary care.	Alan Gilmour	Oct 2017	TBC	Initial proposals considered at HSCP UC Planning Group in November 2017.	Revised proposal discussed at North Delivery Group in December.	Discussion to take place at South Delivery groups in January. Outcome of discussions to be reviewed at HSCP UC Planning Group.	None at this stage	A
HSCP led programme to reduce avoidable admissions								
GP rapid access to community supports as alternative to Acute Assessment Unit referrals and/ or pending planned outpatient appointments (see also alternatives to referral)	Stephen Fitzpatrick	April 2017	Teams starting late 2017.	New neighbourhood teams will bring together a range of community supports to better support GPs.	Appointments to service managers completed	Teams operational	None at this stage	A
Management of Current Inpatient Capacity								
Improving discharge process/delayed discharges/reduction in bed days								

Action	Lead	Start Date	End Date	Summary of Progress to Date.	Project/service deliverables achieved (December)	Project/service deliverables anticipated (January)	Positive outcomes/ causes for concern	RAG Status
Review and audit process for acute referrals to Cordia to support discharge.	Acute / Frances McMeeking	Oct 2017	TBC	Report analysing trends has been produced and is informing next steps. This showed postponed and cancelled averaging 25% a period.	Meeting taken place between HSCP and Acute to discuss report and agree next steps. Agreed to ensure staff identified by the NHS working at the front door would get access to the Cordia Home Care IT system (Caretracker).	Session will be organised to map the discharge process from hospital for ordering home care, with a focus on transport.	None at this stage	A
Augment the frailty hub pathways at QEUH and GRI by providing additional AHP, Social Work and Homecare support staff to work with the established teams and improve the effectiveness and quality of discharge planning, avoiding unnecessary admissions and shortening length of stay. **(NB Winter Plan Action)**	Fiona Brown/ Anne Mitchell	Dec 2017	TBC	Work underway at GRI and QEUH.	**GRI Up-date:** ***HIS Frailty Tool*** Meeting took place with acute leads to review test of change and discuss application of HIS Frailty Tool or other models for identifying patients who may be medically fit to target community involvement. ***Homecare***: Enhanced input agreed including access to home care by relevant Frailty Team Staff (up to 10pm for new HC) and IT solution to view home	At GRI additional AHP resource test of change element ceased at week 4 due to- • lack of evidence of benefit and improved outcomes or impact on discharge for patients; • role confusion /duplication with Acute AHP staff and ECAN staff; • lack of meaningful evidence led to a lack of Rehab Team volunteers to continue	At GRI 3 patients discharged following direct involvement from rehab over the 4 week test of change period, however it was considered that discharges would have progressed in any case as patients were medically fit.	G

Action	Lead	Start Date	End Date	Summary of Progress to Date.	Project/service deliverables achieved (December)	Project/service deliverables anticipated (January)	Positive outcomes/ causes for concern	RAG Status
					care service agreement in place. ***Webcare tracker*** has access re: live Homecare plan details and it has been provided to all named acute leads as agreed ***Community Rehab:*** Community Rehab Service AHP in place 12- 7pm, 7 days. Role- currently involves desktop screening all admissions to wards 2 50/51/53 and following up on assessment where patient medically fit. However very low incidence of patients who are medically fit and therefore very low incidence of early discharge (3 to date). Rehab team recording in medical records relevant information regarding community knowledge of patient to support discharge planning when patient	test of change During test of change Rehab staff screened all patients admitted to wards 50/51 and 53 and shared information regarding previous involvement in medical records and where patient was determined medically fit arrange follow up full rehab assessment- however incidence of patients who were medically fit was negligible. Going forward proposal from rehab that pre-admission test of change in partnership with GP/Rehab may prevent admission for some patients rather than current test of change. View is that the process leading up to admission, including travel can exacerbate fitness of patients.		

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					medically fit. ***Social Work:*** Social Work continues to be available to attend the Front door and provide response to early referral. **QEUH Up-date:** -There was planned additional resource into the QEUH in the form of agency physio who had agreed to start on 4/12/17 but failed to turn up. We have been unable to get any additional AHP resource via ETCH, overtime, bank or agency routes however South Rehab Service have been in regular and continuing dialogue with the staff at QEUH regarding supporting the frailty work and will continue to provide daily A&E rapid response and support to frailty huddle to maximise	Rehab teams will continue to support the GRI Front door huddle to identify patients who can be discharged early and share relevant information. Rehab will continue to support A&E 7 days where referrals are identified by acute. Access to EMIS for relevant acute staff is being progressed which would support sharing of information regarding pre-admission community input health and functional status At QEUH rehab continue to attend the daily frailty huddle, and direct access to enhanced homecare in place. Discussions continue on appropriate further HSCP input to respond to demand. Paper to be presented to		

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					community capacity whilst continuing to attempt to source additional AHP staff.	UC Steering Group 9/1/18.		
Develop District and Community Nursing teams alongside social care teams (e.g. homecare, telecare and telehealth) to provide a service 24 hours, 365 days per year inclusive of bank public holidays. These will work alongside acute and out of hours to support safe and effective discharges during weekends and over the festive period **(NB Winter Plan Action)**	Paul Adams/ Anne Mitchell/ Fiona Brown	Dec 2017	TBC	Community nursing out of hours hosted by Glasgow.	Service in place	Monitoring and review of activity	None at this stage	A
HSCP hospital discharge staff will identify residents on admission to hospital and proactively plan for their discharge (including prior to and over festive holiday periods), in order to facilitate 7 day discharge, improving patient flow and reducing length of stay, particularly at weekends. **(NB Winter Plan Action)**	Paul Adams/ Anne Mitchell/ Fiona Brown Home is Best Service Manager	Dec 2017	TBC	Process in place with acute for early referral to social work to begin discharge planning process	Service in place	Monitoring and review of activity	None at this stage	A

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HSCPs have worked with local external providers of social care, with potential to spot purchase additional intermediate care placements to increase capacity and relieve any surge in appropriate referrals from the acute system. **(NB Winter Plan Action)**	Stephen Fitzpatrick	Dec 2017	TBC	GCHSCP has a mechanism in place to increase capacity of places and demand is monitored on a weekly basis. Funding remains a challenge but there is regular dialogue to explore the feasibility of additional capacity	Arrangements in place for spot purchasing as required	Arrangements to be activated as appropriate	None at this stage	A
Transport								
Increase the capacity of the existing Red Cross Transport model and investigate the potential for widening the scope of the service' **(NB Unscheduled Care & Winter Plan action).**	Alan Gilmour / Anne Mitchell	Sep 2017	Mar 2018	Proposal discussed at November HSCP UC Planning Group	Increased capacity of existing service during December – 16 hours (Monday and Friday)	Increased capacity of existing service to be confirmed for January – requested additional vehicle and crew for Monday to Friday. Fall back is additional hours by rota.	Potential for wider scope of service beyond core service to be discussed at Board / Partnership Steering Group	A
Engage with Scottish Ambulance Service to ensure their staff have access to the information eKIS provides. **(NB Winter Plan Action)**	Anne Mitchell	Dec 2017	Dec 2017	On road crews have very basic access to the system, if authorised by the patient, however SAS Clinical advisors within Ambulance control have full access	Ongoing implementation.	Monitoring and review of activity	None at this stage	A
Reduction in Demand								
Anticipatory Care								

Action	Lead	Start Date	End Date	Summary of Progress to Date.	Project/service deliverables achieved (December)	Project/service deliverables anticipated (January)	Positive outcomes/ causes for concern	RAG Status
Roll Out Anticipatory care Planning. As part of this, will target individuals diagnosed with progressive or unstable conditions as part of work on palliative care. **(NB Unscheduled Care & Winter Plan action).**	Paul Adams	Apr 2017	March 2018	ACPs completed through primary care, intermediate care and flagged to acute as part of any referral process where these are available. On course to deliver target of 720 for 2017/18. The new National ACP is much more detailed and is unlikely to be "completed" but rather it will be an ongoing plan held by the person. Our target in 18/19 needs to change to reflect this and show "the number of plans facilitated by HSCP staff/teams"	Testing national document in residential units and with carer groups where information would previously been captured in the "carers plan"	Ongoing rollout and agreement on measureable targets for 2018/19 (during Feb/March)	Uncertainty about long-term funding of the printed National ACP & suite of materials but an online "toolkit" is available with all relevant material plus a link to the App where people want to capture their plan on their smartphone /PC http://ihub.scot/anticipatory-care-planning-toolkit/	A
Reduce admissions from care homes and directly provided residential homes								
Review data on admissions from care homes to assess what support / interventions might reduce current rate, and evaluate	Alan Gilmour / Kerri Neylon	Oct 2017	Jan 2018	Group set up, data analysed and meetings taking place with care homes where referrals are high to discuss potential actions.	Survey and focus groups underway along with targeted activity to areas where highest level of unscheduled care activity exists	Report to main group chaired by Dr Kerri Neylon. Development of implementation plan based on evidence of review Agreed metrics to measure progress.	None at this stage	G
Review data on admissions from directly provided residential homes to assess	Alan Gilmour / Clare	Oct 2017	Jan 2018	Meeting with Service Managers completed. Plan for online survey and	Survey and focus groups underway along with targeted activity	Report to main group chaired by Dr Kerri Neylon.	None at this stage	G

Action	Lead	Start Date	End Date	Summary of Progress to Date.	Project/service deliverables achieved (December)	Project/service deliverables anticipated (January)	Positive outcomes/ causes for concern	RAG Status
what support / interventions might reduce current rate, and evaluate.	Hughes			focus groups to take place by end of December. Focus Groups will take place across all 5 hubs and involve day and night shift staff. Riverside Care Home is test site and work is ongoing around review of recent hospital presentations.	to areas where highest level of unscheduled care activity exists Focus on Riverside to identify opportunities for specific actions around HSCP residential population	Development of implementation plan based on evidence of review Agreed metrics to measure progress.		
Unscheduled care pathway								
Mapping current unscheduled care pathway with supporting data to establish 'as is' position with HIS / ISD	Hamish Battye / Alan Gilmour	April 2017	Nov 2017	Map completed by HIS, and currently being populated with data from acute/HSCP/NHS24/SAS.	Completed map presented to HSCP UC planning group	Data to be populated	None at this stage	A
Map new unscheduled care pathway(s) and activity projections with HIS / ISD to inform future planning	Hamish Battye / Alan Gilmour	April 2017	Dec 2017	Under discussion and will be progressed with HIS	To be progressed as part of Board wide work on enhanced care pathways	Meeting with HIS on 8/1/18 to progress further.	None at this stage	A
Palliative care								
Develop care pathways for conditions where patient is stable and does not require admission	Paul Adams	Apr 2017	Update in Dec 2017	Draft palliative care strategy agreed at Sep IJB. Work on pathways to be progressed	Draft plan launched and out for consultation including Stakeholder events with LEF and with key delivery partners across HSCP.	Analysis of consultation comments and revised plan to go to IJB scrutiny group	Positive response to 3 year plan and constructive comments received	G
More effective use of palliative care pathway and resources (including managed	Paul Adams	Apr 2017	Update Dec 2017	Draft palliative care strategy agreed at September IJB. Work on	Meeting with Marie Curie regarding current Managed Care	Contract review meeting with Marie Curie and HSCP Commissioning /NHS	Discussion indicates potential for development of Fast	G

Action	Lead	Start Date	End Date	Summary of Progress to Date.	Project/service deliverables achieved (December)	Project/service deliverables anticipated (January)	Positive outcomes/ causes for concern	RAG Status
care and fast track services) to minimise hospital admission, accelerate discharge and provide effective community support				pathways to be progressed	and Fast Track service contracts which expire at end of March 2018	Procurement to agree terms of future provision.	Track and agreement from others that Glasgow continues to host Managed Care.	
Escalation								
Early Alert System								
District Nursing will support the Early Alert System which enables practices to highlight unexpected increases in demand. **(NB Winter Plan Action)**	Paul Adams/ Anne Mitchell/ Fiona Brown	Dec 2017	TBC	Single Point of Access in place and aims to facilitate co-ordinated activity, including early response. It frees up district nursing time to attend practice meetings and pick up on early alerts from GPs.	Service in place	Monitoring and review of activity	None at this stage	A
Business Continuity								
HSCP Business continuity plans are in place and tested with NHS Acute and other partners. **(NB Winter Plan Action)**	Janet Hayes	Dec 2017	Jan 2018	GCHSCP linked closely to Board and partner BCP process	BCPs currently being updated	HSCP BCP updated	None at this stage	A
Updated Pandemic Flu Plan in place in conjunction with NHSGGC system as a whole and other partners. **(NB Winter Plan Action)**	Alan Gilmour	Dec 2017	Jan 2018	GCHSCP linked closely to Board and partner BCP process	HSCP flu plan being updated	HSCP flu plan updated	None at this stage	A
Governance								

Action	Lead	Start Date	End Date	Summary of Progress to Date.	Project/service deliverables achieved (December)	Project/service deliverables anticipated (January)	Positive outcomes/ causes for concern	RAG Status
Performance management								
Establish key performance indicators for unscheduled care as part of HSCP performance regime, and report on activity / trends as appropriate	Hamish Battye / Duncan Goldie	April 2017	From Q2	HSCP performance framework already in place. Board wide draft set of metrics being circulated for discussion by HSCPs and acute (see below).	See below	Finalised Board wide metrics will be reviewed and inform any updates to the HSCP Performance framework.	None at this stage	A
Agree with acute and other HSCPs system wide unscheduled care metrics to routinely monitor and report on performance at hospital, HSCP and GG&C levels. As part of this, agree GG&C wide target for reduction in bed days due to overall impact of actions in the UC programme to 2020.	Hamish Battye / Duncan Goldie	April 2017	Nov 2017	Draft metrics under discussion. Needs to be linked to discussions on set aside.	Draft metrics with 2016/17 data circulated	Glasgow City specific information to be available in January 2018	None at this stage	A
Primary / Secondary care clinical interface								
Establish clinical interfaces at the QEUH and GRI between primary and secondary care	Richard Groden / Kerri Neylon / Graeme Marshall	April 2017	Nov 2017	Under discussion at North and South Delivery Groups as part of new governance arrangements.	Discussions on-going	Discussions on-going	None at this stage	A
Evaluation framework								
Develop evaluation framework for overall unscheduled care programme and small tests of change	Hamish Battye/ Katie Levin	Sept 2017	Dec 2017	Evaluation framework under discussion.	Approach discussed and proposals being developed	Proposals to be presented to HSCP UC Planning Group in January 2018.	None at this stage	A

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 - Older Peoples Transformational Change Programme 2018-21

Please tick box to indicate if this is: Current Policy, Strategy or Plan ☐ New Policy, Strategy or Plan ☒

2. Brief Description – Purpose of the policy; Changes and outcomes; services or activities affected

Glasgow City HSCP Older People services will be undergoing a significant transformational programme across a 3 year period. The detail of the implementation programme has yet to be confirmed, however, associated changes to older people services may present risk of detrimental impact to individuals with protected characteristics. With this in mind, this Equality Impact Assessment was undertaken to formally capture contextual information relevant to different groups or individuals with protected characteristics and will be used to inform subsequent service proposals and implementation programme. Specific service proposals equality impact assessments will be undertaken to ensure any service change is compliant with the IJBs legal duties in respect of their Public Sector Duty.

Older People's Transformational Change Programme – Report to IJB from 08/11/17

In line with the guiding vision for older people set out in the IJB strategic plan and as a consequence of the programme of work described below, it is envisaged that by 2021 the HSCP's older people's service provision will be characterised by the following:

- A continuing focus on delivering the best possible outcomes and quality of life to all older people in the city that require support from the HSCP.
- A profound shift will have been achieved in whole system culture, with a clearly understood and enacted emphasis on supporting more and frailer older people to remain living in the community for as long as possible.

- By extension, the profile of older people living in the community will have markedly changed. They will be older, frailer and with higher levels of support needs than at present and certainly the recent past.
- Related to this, significantly more efficient use will be being made of the Acute system. Only those older people with genuinely acute medical needs will be occupying hospital beds. Where no such needs are present, older people will either be diverted from admission at the front door or discharged speedily when their acute medical needs have been attended to. Ideally the HSCP's anticipatory care activity will preclude the need for attendance at hospital in the first place.
- Where older people are being supported in the community they will experience a more joined up and co-ordinated input from HSCP staff, irrespective of their particular professional role, exemplified by the work being undertaken for the occupational therapy review outlined below.
- Implementation of integrated operational older people teams across 10 local neighbourhoods in the city.
- Significant change for the HSCP's own staff group, as integration begins to take full effect.
- More effective co-ordination between HSCP and Acute staff and systems in three years. Focus on the front door of hospitals and the joint activity in relation to unscheduled care that is likely to bring significant changes in pathways, processes, staff and clinical roles and responsibilities and how resources are deployed across the whole system.
- Ensuring that older people either present to the correct part of the health and care system or are directed there as efficiently as possible. Aim to have significantly fewer older people with non-medical needs such as loneliness presenting to GPs, due to more connection into community supports.
- Making the best possible use of GP time and resource as clinical activity is shifted from the Acute system.
- Greater emphasis on family and carer support than at present, building on the significant progress and the new Carers Act requirements, supporting families to maintain their caring role in the community for as long as possible, alleviating demand for paid support provided by the HSCP and wider health and social care system.

- Greater and more effective application of technology to help sustain that carer role and community living in general. This will combine the use of technology enabled care for people with higher level care needs that require support from the HSCP, with generally available technology that individuals and their families may choose to purchase from the open market to provide reassurance and peace of mind at the early stages of frailty.

- Closer and more effective partnership working with the housing sector in the city to help maintain their tenants in their homes for longer. This will build upon the work undertaken to date in the Accommodation Based Strategy and link into related activity around technology, aids and adaptations, community connectors etc. As increasing numbers of owner occupiers reach old age it is recognised that this activity must be effective across all housing tenures.

- Likelihood of fewer care homes, with a frailer population.

- Closer and improved partnership working with the third sector.

The Scottish Government's draft budget announcement of December 2017 will have implications for the transformation programme's financial framework, previously considered by the IJB.

The programme is within the context of an aging and fluid population and at this point there is no prediction of the uptake of services.

3 Lead Reviewer

Stephen Fitzpatrick
Head of Strategy & Operations (Older People)

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

Hamish Battye; Glenda Cook; Amanda Ferguson; Joanna Payne; Fiona Brown, Clare Hughes…..

Circulated via IJB Finance and Audit Committee, Core Leadership Team and Older Peoples Strategic Planning Group.

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? Please provide excerpts from the document to evidence.

The Glasgow City Health and Social Care Partnership Strategic Plan outlines 5 key priorities that apply to all HSCP services, including those that support older people:

- Early intervention, prevention and harm reduction.
- Providing greater self-determination and choice.
- Shifting the balance of care.
- Enabling independent living for longer.
- Public protection – including keeping vulnerable people safe from harm.

Vision 2018-21

- A profound shift will have been achieved in whole system culture, with a clearly understood and enacted emphasis on supporting more and frailer older people to remain living in the community for as long as possible.

(*Older People's Transformational Change Programme 2018-21 Report to IJB 08/11/17)*

Throughout implementation of this programme reference will be made to the general duties (Equality Act (2010)) and will articulate how any proposed changes in service provision will meet the requirement

- to eliminate unlawful discrimination
- advance equality of opportunity
- and promote good relations

B What is known about the issues for people with protected characteristics in relation to the services or activities affected by the policy? For instance, a new flexible working policy might reflect on the additional burden experienced by carers or parents.		
		Source
All	Cross referral to sex, age, gender reassignment, race, disability, sexual orientation, marriage and civil partnership, social and economic status. Changes in older people services provision must ensure that this group of service users does not receive a lesser service due to their protected characteristics.	Sources in text
Sex	**Gendered caregiving:** Although caregiving is still predominantly a female occupation, there is growing evidence of a greater role played by men in caregiving. But, despite increasing care provision by sons and husbands, daughters and wives continue to provide more care. Likewise, grandfathers are increasingly involved in childcare provision but not to the same extent as grandmothers. (**Government Office for Science, Current and future challenges of family care in the UK, 2015)** "…analysis shows that hours spent doing unpaid care tends to balance out between genders as men and women retire."…"older males are more likely to be carers than older women, but due to population sizes there are more women than men providing care aged over 65" **Growing Older in Scotland: health, housing and care, EHRC, 2015**	Web Links to sources in text: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454514/gs-15-18-future-ageing-family-care-er09.pdf https://www.equalityhumanrights.com/en/our-work-scotland/our-work-scotland/research-scotland

	Hochlaf, Dean and Franklin, Ben, 2017, When I'm 64: the ILC-UK fact pack on retirement transitions, Page 26 provides facts and figures on the experiences of those making the transition to retirement. Reports that life expectancy is growing among older people, but so too is poor health and inequalities. Finds that inequalities in life expectancy for older people by local authority have been rising, particularly for women, and notes that these inequalities are strongly related to local differences in health **(relates to England & Wales) – cross references to age** Alzheimer Scotland estimates 2,502 males and 5,615 females in Glasgow have dementia in 2017. The majority of dementia sufferers are aged 65 or over. Scotland wide rates of dementia increase with age from 1.8% of males and 1.4% at age 65-69 rising to 32.4% of males and 48.8% of males in the 95-99 and 100+ age ranges – cross references to disability	http://ow.ly/NQTc30gN7va https://www.alzscot.org/assets/0002/5517/2017_Webpage_-_Update_Headline.pdf
Gender Reassignment	Cross referral to sex, age, disability, sexual orientation, marriage and civil partnership There are older people who had successfully transitioned and are living part time or permanently in their preferred gender role. There can be advantages as well as risks in taking this step. Many people who underwent treatment in the 1960s and 1970s are now facing all the ordinary issues that come with ageing, as well as some that are unique to middle and older trans-people. There has been no significant research into the care of older trans-people in sheltered or residential accommodation. (**Age UK factsheets 16 (2015))** The National LGB&T Partnership's roundtable has discussed the fact that LGBT older people are rarely acknowledged by service providers and commissioners. It was hinted that services for trans-people who are likely to be invisible and the attitude is often 'we don't have lesbian and gay people	Web Links to sources in text http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/FS16_Transgender_issues_and_later_life_fcs.pdf http://www.nationalcareforum.org.uk/spp-resources.asp

	in our care home' or you'll hear 'our manager's a gay man so we're probably ok [on equality]'. (**The national LGB&T Partnership (2014); The dementia challenge for LGBT Communities: a paper based on a round table discussion**) It was suggested that some of the biggest challenges are, prejudice/ stigma in current or historic services. It was also argued that these remain powerful influences on how someone perceives experiences. While some lose their inhibitions due to dementia, others who have previously come out feel unable to be open about their sexuality or transgender status. Dementia causes anguish and confusion; this experience could be exacerbated as older people with the condition struggle to deal with negative perceptions of their sexuality or gender in residential care. Kelly alluded that LGBT older people with dementia are been "forced back into the closet". **(Kelly D. (2015)** Sage implied that due to higher levels of financial insecurity at present and a general lack of affordable housing, many LGBT middle and older people find that they cannot afford homes in the communities they may have lived in for years. Others may face harassment and intimidation in their homes and in long-term care settings from aging professionals, other residents, and even their own family members. **(Sage (2015); Expanding Housing and Services for LGBT Older People).** The report: **Improving the lives of transgender older adults (2012)** from SAGE and NCTE suggested that older transgender adults face profound challenges and experiences in accessing heath, social and housing services. Many Trans adults may have more incidents of mental health's issues that will remain a feature in older lives. Many transgendered people believe that there is a lack of culturally sensitive services to meet their	The Guardian web link:https://www.theguardian.com/social-care-network/2015/mar/10/lgbt-older-people-dementia-social-care)

	needs today. In 2007 it was suggested that there were 885 Trans people in Scotland.	
Race	Ethnicity, Identity, Language and Religion in Scotland from the **2011 Census** web Of the 7% (369,000) of people in Scotland on census day in 2011 who were not born in the UK, 89% had arrived in the UK aged under 35; this pattern was generally reflected across all ethnic groups. 55,000 people were born in Poland (accounting for 15% of all those born outside the UK) making this the third most common country of birth after Scotland and England and ahead of Northern Ireland, the Republic of Ireland and Wales. This is an increase of 14 percentage points compared with 2001, when the number of people born outside the UK who reported their country of birth as Poland was 1% (2,500). The next most common country of birth outside the UK was India with 23,000 (6% of all those born outside the UK). Other countries outside the UK which were widely reported in 2011 were Germany, Pakistan, USA, China, South Africa, Nigeria, Canada and Australia. The proportion of the population aged 3 and over reported as not being able to speak English well or at all was 1.4% overall, and 11% for those born outside the UK. This proportion generally increased with age of arrival into the UK: for those who arrived aged under 16 it was 5% while for those who arrived aged 65 and over it was 31%. The highest proportions of people using languages other than English, Scots and Gaelic at home were found in councils with the larger cities:	Web Links to sources in text http://www.scotlandscensus.gov.uk/ethnicity-identity-language-and-religion **Scottish Government: Ethnic Group Demographics web link** http://www.gov.scot/Topics/People/Equality/Equalities/DataGrid/Ethnicity/EthPopMig

	Aberdeen City, City of Edinburgh and Glasgow City (each with just over 12%). ***(Butt J. and O'Neil A (2004); Black and minority ethnic older people's views on research findings, JRF)*** Older people…wanted action that would bring about change and to be involved in decisions that affected their own lives - locally and nationally. • Black and minority ethnic older people are more likely to face a greater level of poverty, live in poorer quality housing, and have poorer access to benefits and pensions than 'white' older people. • Myths about minority ethnic communities need challenging: there is not necessarily an extended family which "looks after its own". • Older people from different communities may share experiences of ageism and racism, but the circumstances of Chinese, Afro-Caribbean or Asian older people may require different approaches and solutions.	https://www.jrf.org.uk/report/black-and-minority-ethnic-older-peoples-views-research-findings
	Ethnic minority caregiving: There are about 130,000 family carers from ethnic minority backgrounds providing care for a minimum of 20 hours per week in England and Wales. Whereas intergenerational care is predominantly delivered by women, men are mainly involved in spousal care. Family carers from ethnic minorities are less likely to access health care or social services, which is a result of lack of awareness in combination with perceived 5 personal/family responsibility, experiences of stigmatisation and past negative experiences with health and social care services, particularly in the case of dementia. Another community, where there is a lack of data is the Gypsy and Travellers according to **Age UK (Working with Older Gypsies and Travellers)** believed that this community have significantly poorer health	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454514/gs-15-18-future-ageing-family-care-er09.pdf

	outcomes, in general, could experience even worse health than the general population of older adults. Their experiences of stigma, poverty and illiteracy have placed them in a disadvantaged position in seeking for support from services. They also felt that services, as a whole, are not sensitive to their culture. People over 65 from the Black and Asian communities are disproportionately affected by poor health quality health and higher rates of limiting long term illness.	
Disability	Chappell N. L. and Cooke H.A. (2010) Age Related Disabilities - Aging and Quality of Life; International Encyclopedia of rehabilitation suggested that with increasing age comes increased likelihood of disability. This is because as people live longer and do not encounter fatal diseases, their illnesses are chronic instead. The association between increasing age and increasing disability has led to a negative image of aging. Physical health does decline with age; this does not necessarily mean that older adults are incapacitated, or, in the language of some, handicapped. Disability is usually defined in terms of restrictions in the ability to perform activities of daily living (ADL), or, the inability to function independently in terms of basic ADL or instrumental ADL (World Health Organization [WHO], 2003). The relationship between disability and poverty cannot be over-emphasized. Poverty can lead to malnutrition, poor health services and sanitation, unsafe living and working conditions etc. that are associated with disability; disability can also trap people in a life of poverty (Mont 2007). The number of people who are ageing with a disability is also increasing at	Sources in text

	different rates amongst men and women, and amongst different ethnic groups. Although the prevalence of some physical impairment is higher amongst males, many of the largest sub-groups of older disabled people contain more women than men. Many older people feel that their needs – and even their existence – have been overlooked. Many are anxious about the future and feel that their independence is being threatened by the lack of appropriate and acceptable supportive resources. There are many obstacles to older disabled people being able to articulate their needs and – most important of all – have their voices heard. These problems are often particularly acute for older women, and older black and ethnic minority disabled people – many of whom live in extreme isolation. Mental health was also an issue, in particular dementia and depression. Isolation sometimes led to high levels of depression and the need for more befriending services. While some participants said that depression and mental health could be a taboo subject in their communities. **(Zarb G. and Oliver M. (1993); *Ageing with a disability. What do they expect after all these years?* University of Greenwich).**	http://disability-studies.leeds.ac.uk/files/library/Oliver-ageing-with-disability.pdf
	Worldwide more than 46 per cent of older persons – those aged 60 years and over—have disabilities and more than 250 million older people experience moderate to severe disability. Looking ahead, the global trends in ageing populations and the higher risk of disability in older people are likely to lead to further increases in the population affected by disability. The number of older persons has increased substantially in recent years in most countries and regions. Between 2015 and 2030, the number of people in the world aged 60 years or over is projected to grow by 56 per cent, from 901 million to 1.4 billion, and by 2050, the global population of older persons is projected to reach nearly 2.1 billion. The accumulation of health risks across a lifespan of disease, injury, and chronic illness contribute to the higher disability rates among older people. Urges countries to review and further explore the complementarities between the discourses on ageing and on	https://www.un.org/development/desa/disabilities/disability-and-ageing.html

	disability. **Ageing & Disability – UN Division for Social Policy and Development: Disability** Older people born with disabilities: **(Ward C. (2012); Older people with a learning disability; British Institute of Learning Disabilities).** The life expectancy of people with learning disabilities has increased over the course of the last 70 years. Older people with learning disabilities are not exempt from experiencing age discrimination. There is substantial evidence that they experience a „double jeopardy" as they age. People with learning disabilities face many disadvantages in relation to health **(Emerson and Baines 2010, Department of Health 2001).** The profile of older people with learning disabilities in the future will be even more diverse than it is today. This is because the population profile of people with learning disabilities is changing. Not only are there more people with learning disabilities from black and minority ethnic communities, but many more people with complex health needs are living longer and will present a different set of challenges for services as they age. Cross reference with Age -Alzheimer Scotland Statistics **LGBTQI+ disabled people and self-directed social care support** NIHR School for Social Care Research (SSCR), London School of Economics and Political Science, Houghton Street, London, WC2A 2AE (Report available on the internet at: http://ow.ly/xC4t30gkJdS) 2017 Pages: 6	 https://www.alzscot.org/assets/0002/5517/2017_Webpage_-_Update_Headline.pdf

	Reviews the provision for LGBTQI+ disabled people who use self-directed social care support in England. Uses qualitative interviews with 20 LGBTQI+ Disabled People, a focus group of PAs and a survey of 56 LGBTQI+ Disabled adults who use self-directed social care. Finds that LGBTQI+ Disabled People who use self-directed support reported many positives from having more choice, control and power. Finds that concerns raised included: coming out to social care staff jeopardising support; difficulties in recruiting and retaining good PAs; difficulties in securing support for `social hours' leading to social isolation; and reactions of other people. Suggests assessments should emphasise the whole person, not ignore sexual orientation or gender identity and staff should draw on their professional training, ethical practice and legal obligations to raise equalities issues confidently and sensitively. Argues there is a need for more targeted support and information for LGBTQI+ Disabled People as well as more information for their Pas. **Cross reference with <u>Sexual Orientation</u>**	
Sexual Orientation	Unlike heterosexual older people, older LGB people are more likely to age as single people. Further, they are less likely to have children or to be out of touch with their children (particularly gay men) if they do have them, compared to heterosexual people. Notions of 'family' among LGB people are broad and go beyond the traditional 'biological families' that are familiar to most heterosexual people. Musingarimi P. (2008) Social Care Issues Affecting Older Gay, Lesbian and Bisexual People in the UK, ILCUK Musingarimi P. (2008) Health Issues Affecting Older Gay, Lesbian and Bisexual People in the UK, ILC-UK, suggested that very little is known about the health outcomes and health care needs of older LGB people in the UK and how they compare to those of heterosexual individuals. Because gay men and lesbians have historically been socially defined within medical terms as being mentally ill, the healthcare system has been a primary arena through which control over their lives has been exerted. Among older LGB	Sources in text

	people, the current cohort in particular, may resist accessing healthcare services as these are the very establishments which tried to 'cure' them of their sexual orientation. The major health concern for gay men is still HIV/AIDS. According to the Terence Higgins Trust, gay men are still the group at greatest risk of acquiring HIV in the UK. New HIV diagnoses amongst gay men are the highest ever and are continuing to rise, albeit slowly. There is very little that is known about the health outcomes and health care needs of older LGB people in the UK and how they differ from those of their heterosexual peers or younger LGB people. Most of the research that is done on health issues and LGB people does not distinguish between young and old. Stigma and discrimination that is experienced across the life course is likely to have a detrimental effect on health in later life, but there is no research evidence documenting this. According to Stonewall 'YouGov' survey 2010, (Lesbian, Gay & Bisexual people in later life), the older population of LGBT people are more likely to be socially isolated and with a history of mental health issues than the heterosexual population. With the possibility of reduced support/ families network, the need to access formal support services become more pivotal against a background of low confident in the services to meet their needs.	
Religion and Belief	**Kaplan D.B. et al (2016) Religion and Spirituality in Older People)** Summarises research findings regarding spirituality and religious belief and activity among "older people" in the US. States that the level of religious participation is greater among older people than among any other age group. Finds that generally, people who are "religious" have better physical and mental health, but it is not clear exactly why this is. Conversely, people	Web Links to sources in text http://www.msdmanuals.com/home/older-people's-health-issues/social-issues-affecting-older-people/religion-and-

	who adhere to very strict religious rituals and practices may be disadvantaged in terms of medical treatment and mental wellbeing. Lists psychoses, OCD behaviours, inflexibility, excessive guilt and anxiety as potential harmful effects. Other harmful effects may be replacing what are generally seen to be lifesaving medical treatments such as insulin injection and blood transfusions with prayer and chanting. Provides an explanation of the difference between "spirituality" and "religion". Lists the benefits to healthcare providers and caregivers of exploring a service user religion or spirituality. 'You do not have to alter your values and beliefs in order to receive a service. The principle of valuing diversity means that you are accepted and valued for who you are. The legislation which outlaws discrimination has influenced care standards, and the standards in this section make it clear that you can continue to live your life in keeping with your own social, cultural or religious beliefs or faith when you are in the care home.' **(Care Inspectorate, The National Care Standards 2007: Standard 12)** **2011 Census data** Males were more likely to state they had 'No religion' (39%) than females (34%). 32% of people identified with the Church of Scotland, which had fallen from 42% in 2001. 37% of people said they had no religion which had increased from 28% in 2001. 1.4% of people (77,000 people) reported that they were Muslim, an increase of 0.6 percentage points since 2001. The numbers of Buddhists, Hindus and Sikhs accounted for 0.7 % of the population, and all had increased between 2001 and 2011. The number of Jewish people has declined slightly to just under 6,000.	spirituality-in-older-people

	In 2011 over half (54%) of the population of Scotland stated their religion as Christian - a decrease of 11 percentage points since 2001, whilst 37 per cent of people stated that they had no religion - an increase of nine percentage points. After Christianity, Islam was the most common faith with 77 thousand people in Scotland describing their religion as Muslim. This is followed by Hindus (16,000), people from Other religions (15,000), Buddhists (13,000), Sikhs (9,000) and Jews (6,000). Even with these groups added together they still accounted for less than 3% of the overall population. Scotland Census shows specific proportions of people's religion by local authority are as stated in the 2011 census. "When thinking about activities and encouraging meaningful engagement, a person's religion, nationality or culture are likely to have a major influence on their preferred music, food, clothes and every day routines…. The danger of any label is that we then make assumptions…Stereotypes do exist for particular cultures and religions, however it is important to find out what a person's actual likes and dislikes are, rather than being led by our assumptions." ***Religion and old age*, Davie, G and Vincent, J, in Ageing and Society Vol .18 1998 pp 101-110** "Older people, it appears, have always been more religious than the young. Whether elderly people have regarded God as judgmental (the source of all their troubles) or as a father figure (a rock in the storm of life), they have always taken him more seriously than their sons and daughters. This kind of	http://www.gov.scot/Topics/People/Equality/Equalities/DataGrid/Religion/RelPopMig http://www.scotlandscensus.gov.uk/ods-visualiser/#view=religionChart&selectedWafers=0 https://www.scie.org.uk/dementia/living-with-dementia/keeping-active/culture-religion.asp

	generational difference has been reflected in church membership studies for some time, and is, increasingly, supported by studies of religious belief. A Mori poll (Jacobs and Worcester 1990) illustrates this point clearly, revealing that 67% of those aged between 15 and 34 years believe in God as against 87% of those aged over 55 years. Similarly only 55% of the younger age group believe in heaven as opposed to 65% of the older. It seems that belief in God, and specifically belief in a personal God, declines with every step down the age scale, as indeed do practice, prayer and moral conservatism. In short, in Britain as in most of Western Europe, a religiously and morally conservative majority among the retired becomes a religiously conservative minority in the 18–24 age-groups. These findings are supported strongly in the two European Values Studies carried out in 1981 and 1990. In both surveys age, together with gender, is a strong and straightforward indicator of both religious practice and religious belief (cf Moberg 1990 for the USA)… Religion appears to be disproportionately attractive to elderly women in Britain…a section of the population that is growing rapidly.”	
Age	**National Care Forum (NCF) (2017) Dementia, Equity and rights** Explores key issues for people with dementia from groups that have higher prevalence rates and may experience greater disparities in the care they receive. Considers the issues for carers in these groups with regard to the support that is provided. Specifically outlines equalities issues for protected characteristics. **Growing older in Scotland: health, housing and care (2011 census data analysis: research briefing)** Outlines demographic information relative to marital status and ethnic minority populations in Scotland before examining how older people spend their time, especially around employment; how they provide unpaid care, broken down by age and gender; what housing older people live in, including information about communal living, extra rooms and overcrowding;	http://ow.ly/ubnN3095XHN http://ow.ly.HXmc309I7RC **cross referral to marriage & civil partnership, sex, race, social & economic status**

	and long term and general health data. Notes that, although the older population is predominantly white, the ethnic minority population of Scotland aged over 65 has nearly doubled since 2001; there are increasing numbers of single people and people living alone in the older population; around 11% of people over 65 undertake unpaid care with those with the poorest health more likely to provide care for over 50 hours a week; there has been a rise in single people entering communal establishments, with women over 75 being much more likely than men to do so; and that health inequalities are becoming larger for older people living in Scotland with those in social rented accommodation reporting more health problems than home-owners over 65. – "Around 10% of people over 65 undertake unpaid care with around half of them contributing over 50 hours per week. This rate is double that of the 50-64 age group and only a quarter of those carers provide the most hours." "For Scotland, there has been no indication that the amount of unpaid care has decreased with the provision of free personal and nursing care." p32 **Future of ageing: attitudes to ageing: The barriers to and enablers of positive attitudes to ageing and older people, at the societal and individual level; Government Office for Science (January 2015)** Reviews 25 years of research, some of it international, on ageism. Looks at: definitions of and perspectives on ageism; the prevalence of ageism in the workplace and health services; anti-age discrimination legislation; individual-level factors that influence attitudes towards age, including age itself, gender, education, ethnic background, employment status, residential location, subjective poverty, intergenerational contact; and macro-social factors that influence attitudes towards age, including national wealth, economic inequality, state pension age, unemployment, population age ration, urbanisation and cultural values. Discusses areas likely to be of concern for research, policy and practice. Available on the web.	https://www.gov.uk/government/publications/future-of-ageing-attitudes-to-ageing

	"Ageism is the most prevalent form of discrimination in the UK (Abrams et al., 2011a), estimated to cost the economy £31 billion per year (Citizens Advice, 2007). It restricts employment opportunities, and reduces workplace productivity and innovation (Swift et al., 2013). Ageism also results in inequality and social exclusion, reducing social cohesion and well-being (Abrams and Swift, 2012; Stuckelberger et al., 2012; Swift et al., 2012). Not only is ageism a barrier to the inclusion and full participation of older people in society, but it also affects everyone by obscuring our understanding of the ageing process. Moreover, by reinforcing negative stereotypes, ageism can even shape patterns of behaviour that are potentially detrimental to people's self-interest (Lamont et al., 2015)". "in the ESS and other national surveys, people on average tend to state that they feel more positive towards those aged 70 and over, than towards younger people in their 20s (Abrams et al., 2011a). This could lead to the erroneous conclusion that there is little age prejudice against older people. However, this positivity is entirely consistent with benevolent prejudice towards older people characterised by feelings of pity and sympathy rather than admiration and esteem. Such views can result in a common tendency to 'over-help' (Hagestad and Uhlenberg, 2005), but also ignore and exclude older adults from activities that are considered beyond their competencies (Cuddy et al., 2005). The beneficiaries of such efforts may easily feel disrespected, helpless and patronised (Avorn and Langer, 1982). This makes ageism a subtle form of prejudice that requires multiple modes of detection, and which may be more readily sensed by the target than the source of the prejudice…. Although both older men and women are viewed as less competent compared to younger people, older males are generally attributed with more competence than older women." p15 "Bringing younger and older individuals together reduces explicit and implicit negative attitudes to age and age-based stereotypes (Knox et al., 1986; Harris and Fielder, 1988; Schwartz and Simmonds, 2001; Tam et al., 2006). It also has potential to increase the well-being of older adults and decrease	https://www.gov.uk/government/publications/future-of-ageing-family-care-in-the-uk

anxiety related to own ageing for younger adults (Wu and Rudkin, 2000; Allan and Johnson, 2009). Additionally, intergenerational contact can protect older adults against negative performance outcomes induced by age-based stereotypes (Abrams et al., 2006, 2008).”p 22

Future of ageing: family care in the UK: Current and future challenges of family care in the UK; Government Office for Science (March 2015)
(Relates to England & Wales only)
Examines the ways in which the UK’s changing demographic structure will pose challenges to the future care of elderly people within their own families. Considers the demographic trends causing the need for long-term care, as well as those reducing the availability of family carers. Focuses on changing family values and their implications for family formation and intergenerational family relations. Covers issues including; population ageing; the fastest growing age group; drivers of demographic change, including longevity,, fertility and immigration; increasing female employment; plural family forms; childlessness; changing intergenerational family relations; intergenerational family care; spousal care and grandparental childcare; gendered caregiving; carer health; ethnic minority caregiving; regional variations in caregiving; working carers; and dementia care. *(Butt J. and O’Neil A (2004); Black and minority ethnic older people’s views on research findings, Joseph Rowntree Foundation*

Research from 2004 found that groups of older people from black and minority ethnic communities felt they had been "researched to death". The study also drew on a literature review.
The literature review shows that:

- The numbers (and proportions) of older people from black and minority ethnic communities rose rapidly, from 60,000 in 1981 to over 350,000 in 2001. Although the numbers have grown from being quite small, this is not a new area of research.

	• The impact of ageing (in terms of health and support needs) happens at a comparatively younger age among many minority communities. • Black and minority ethnic older people are more likely to face a greater level of poverty, live in poorer quality housing, and have poorer access to benefits and pensions than 'white' older people. • Myths about minority ethnic communities need challenging: there is not necessarily an extended family which "looks after its own". • Older people from different communities may share experiences of ageism and racism, but the circumstances of Chinese, Afro-Caribbean or Asian older people may require different approaches and solutions. As well as endorsing many of these findings, the consultation groups raised the following issues: • Access to majority services for black and minority ethnic older people remains problematic. Barriers include language issues, knowledge of what is available, and the attitudes and practices of service providers. • Older people felt that community-based voluntary organisations were more likely to reflect their needs; such organisations are, however, the least financially secure. • Older people said that they had been over-researched, with researchers often asking the same questions (or producing the same findings) as had been evident 15 years ago. They did not want yet more research for its own sake. They wanted action that would bring about change and to be involved in decisions that affected their own lives - locally and nationally. **Life Fitness: Moving more, ageing well; UKActive, 2017, Page 31** Looks at opportunities to encourage more active lifestyles among older people in different environments - the home, the community and residential care - and in the broader health and social care system. Aims to identify where existing opportunities can be used more effectively to promote	

	physical activity, promising programmes, and the additional infrastructure that would be required to deliver such a system. Discusses inactivity among people aged over 65, fitness problems associated with sedentary lifestyles and the health and social benefits of maintaining an active lifestyle. Looks at activities available in the community and the role of community-based organisations (physical activity facility operators, charities) in providing appropriate opportunities for older people. Discusses the benefits of social prescription, including physical activity behaviour intervention programmes. Includes case studies such as: Edinburgh Leisure - Steady Steps Programme, an exercise programme designed to support those who have had, or are at risk of having a fall; Let's Get Moving, an evidence-based intervention and behavioural change model; Oomph!, a social enterprise dedicated to transforming the mental, physical and emotional wellbeing of older adults; and Richmond Villages and Audley retirement living (onsite gyms). Recommends: embedding physical activity into all care pathways; creating a national centralised database of physical activity and exercise referral opportunities; and producing a national Physical Activity Strategy for older people living in care. Cross reference with disability: Chappell N. L. and Cooke H.A. (2010) Age Related Disabilities (cross reference with disability) Zarb G. and Oliver M. (1993); Ageing with a disability According to the Scottish Government around 90,000 older people receive some kind of care, whether in their own home, a care home or long-term hospital care in Scotland. If we continue delivering care the way we do right now, an extra 23,000 people will need care by 2016. The Reshaping Care	http://disability-studies.leeds.ac.uk/files/library/Oliver-ageing-with-disability.pdf

	for Older People: A Programme for Change 2011-2021 sets out the government's vision – that 'Older people are valued as an asset, their voices are heard and they are supported to enjoy full and positive lives in their own home or in a homely setting'. The 2015 population for Glasgow City is 606,340; an increase of 1.1 per cent from 599,640 in 2014. The population of Glasgow City accounts for 11.3 per cent of the total population of Scotland. The make-up of older persons aged 60 and over is 18.5 per cent of Glasgow City. Retirement is one of many events in a person's life which can bring a change of routine, including routines and practices around alcohol. Processes and circumstances associated with ageing and retiring can present sudden broken routines that can be problematic in terms of periods of increased risk of social isolation and/or increased alcohol consumption, particularly for previous heavy drinkers. (F Edgar et al, 2016: 'Alcohol use across retirement: a qualitative study of drinking in later life'; Glasgow Centre for population health) Between 2004 and 2015, pensioner employment rose by 94%, whilst the employment rate increased from 5.2% to 8.2% over the same period. This rise in pensioner employment has highlighted a need to explore the social and economic risks and benefits of working beyond state pension age and to understand the reasons why more people are choosing to work into retirement. One of the main reasons for this is likely to be the introduction of the Employment Equality (Repeal of Retirement Age Provisions) Regulations 2011 that abolished the default retirement age in April 2011. This prevents employers from compulsorily retiring workers once they reach the age of 65. **(Scottish Government, 2016: An Investigation of Pensioner Employment)**	

	Garstka T. et al (2004), *Psychology and Aging: How Young and Older Adults Differ in Their Responses to Perceived Age Discrimination* found older adults, however, must find ways to successfully counteract the negative consequences resulting from their permanent group membership. Age group identification appears to be a successful strategy that older adults can use to preserve well-being in the face of age discrimination. Older adults' experiences of age discrimination have been documented in a variety of everyday settings and situations, such as health care (Butler, 1975; Greene, Adelman, Charon, & Hoffman, 1986; Hillerbrand & Shaw, 1990) and the work environment. For older adults, perceived discrimination should have effects similar to those found in other low status groups whose group membership is permanent and for whom discrimination is difficult to avoid (e.g., African Americans, women), as outlined in the rejection–identification model. That is, perceptions of age discrimination should be harmful for older adults and be associated with greater identification with their age group. The Public Bodies (Joint Working) (Scotland) Act 2014 received Royal Assent, completing the process of legislation through Parliament, on 1 April 2014. The Act aims to support improvement in the quality and consistency of services through the integration of health and social care. Glasgow City Council and NHS Greater Glasgow and Clyde have integrated planning and delivery of all community health and social care services, including services for children, adults, older people, along with homelessness and criminal justice services. This work is directed by the Glasgow City Integration Joint Board, with the Council and Health Board delivering services under the banner of the 'Glasgow City Health and Social Care Partnership'. As part of this transformation process, services are been	

	review to ensure that resources are effectively and efficiency allotted. Additional Info: **Glasgow City Partnership Consultation Outcomes (2013): Report on the outcome of the consultation on the draft Joint Strategic Commissioning Plan 2013-16**	
Pregnancy and Maternity	There is no research specific to Pregnancy and Maternity which would relate to any potential equality impacts of this policy.	
Marriage and Civil Partnership	The 'oldest old' are predominantly cared for by their children, whereas married older people predominantly receive spousal care…Spouses are the most important support source for married older people in need of care. Spouses are the fastest growing group of informal care providers. Despite growing numbers of older men providing spousal care it is still predominantly provided by women. In future, spousal care is likely to become more important than it is at present. **(Hoff, A; *Current and Future Challenges of Family Care in the* UK, Government Office for Science, 2015)**	https://www.gov.uk/government/publications/future-of-ageing-family-care-in-the-uk
Social and Economic Status	In the context of homelessness older people are those over the age of fifty, some of whom continue to sleep rough others suffering from being trapped in poor, insecure and inappropriate accommodation. People also become homeless for the first time in later life often as a result of a combination of factors; such as bereavement, ill health, poverty, debt and substance	

Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	misuse. Older people over 50 are the most adversely affected by homelessness in relation to both physical and mental health, yet paradoxically they often face the greatest difficulties in gaining access to vital services. The needs of older people are often ignored because their experience of homelessness is less visible than other groups and they lack the voice and representation required to highlight their specific interests and issues. Older refugees and asylum seekers may not have the same needs, requirements or aspirations as younger refugees and asylum seekers who have grown older in this country. They may have hidden traumas, fears and mental health issues which can cause distress but have become more pronounced in older people. There may be challenges like languages and culturally sensitive services.	

C Do you expect the policy to have any positive impact on people with protected characteristics? Where you expect no impact please note None in all boxes.

	Highly Likely	Probable	Possible
General	None	Opportunity to promote and improve accessibility to services for individuals and communities	Changes provide opportunities to review an equality impact on local service provision to improve the service delivery to individual and communities
Sex	None	Opportunity to promote and improve accessibility to services for men, women and	Changes provide opportunities to review an equality impact on local service provision to improve the

		non-binary individuals.	service delivery to men, women and non-binary individuals.
Gender Reassignment	None	Opportunity to promote and improve accessibility to services for Trans-men and Trans–women and their communities.	Changes provide opportunities to review an equality impact on local service provision to improve the service delivery to Trans- men and Trans–women and their communities.
Race	None	Opportunity to promote and improve accessibility to services for black and ethnic minorities' community.	Changes provide opportunities to review an equality impact on local service provision to improve the service delivery to black and ethnic minorities' community.
Disability	None	Opportunity to promote and improve accessibility to services for individuals with disabilities and their communities.	Changes provide opportunities to review an equality impact on local service provision to improve the service delivery to individuals with disabilities and their communities.
Sexual Orientation	None	Opportunity to promote and improve accessibility to services for LGB individuals and their communities.	Changes provide opportunities to review an equality impact on local service provision to improve the service delivery to LGB individuals and their communities.
Religion and Belief	None	Opportunity to promote and improve accessibility to services for individuals with religious, beliefs and no belief	Changes provide opportunities to review an equality impact on local service provision to improve the service delivery to individuals with

		and their communities.	religious, beliefs and no belief and their communities.
Age	None	Opportunity to promote and improve accessibility to services for individuals of all age groups and their communities.	Changes provide opportunities to review an equality impact on local service provision to improve the service delivery to individuals of all age groups and their communities.
Marriage and Civil Partnership	None	Opportunity to promote and improve accessibility to services for individuals in marriage and civil partnership and their communities.	Changes provide opportunities to review an equality impact on local service provision to improve the service delivery to individuals in marriage and civil partnership and their communities.
Pregnancy and Maternity	None	Opportunity to promote and improve accessibility to services for individuals who are pregnant and maternity leave.	Changes provide opportunities to review an equality impact on local service provision to improve the service delivery to individuals who are pregnant and maternity leave.
Social and Economic Status	None	Opportunity to promote and improve accessibility to services for individuals in social and economic status and their communities.	Changes provide opportunities to review an equality impact on local service provision to improve the service delivery to individuals with regard to their social and economic status and their communities.
Other marginalised groups (homeless, addictions, asylum seekers/refug	None	Opportunity to promote and improve accessibility to services for individuals and communities from marginalised groups.	Changes provide opportunities to review an equality impact on local service provision to improve the service delivery to individuals and communities from marginalised groups.

ees, travellers, ex-offenders			

D Do you expect the policy to have any negative impact on people with protected characteristics? Where you expect no impact please note None in all boxes.

	Highly Likely	Probable	Possible
General	In general people with protected characteristics can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible.	Failure to examine and reflect on local service delivery can lead to negative impacts on individuals and communities.	None
Sex	In general men, women and non-binary persons can be negatively impacted due to changes in services. It is important that any discrimination is identified in early	Failure to examine and reflect on local service delivery can lead to negative impacts on men, women and non-binary individuals.	None

	stages and actions taken to mitigate the worst of its impact as soon as possible		
Gender Reassignment	In Trans-men and Trans-women can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	Failure to examine and reflect on local service delivery can lead to negative impacts on Trans-men and Trans–women and their communities.	None
Race	In general black and ethnic minorities' community can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	Failure to examine and reflect on local service delivery can lead to negative impacts on black and ethnic minorities' community.	None
Disability	In general people with disabilities can be negatively impacted due to changes in	Failure to examine and reflect on local service delivery can lead to negative impacts on individuals with disabilities and their	None

	services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	communities.	
Sexual Orientation	In general LGB people can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	Failure to examine and reflect on local service delivery can lead to negative impacts on LGB individuals and their communities.	None
Religion and Belief	In general people with religious, belief and no belief can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	Failure to examine and reflect on local service delivery can lead to negative impacts individuals with religious, beliefs and no belief and their communities.	None
Age	In general people of all	Failure to examine and reflect on	None

	ages can be negatively impact due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	local service delivery can lead to negative impacts on individuals of all age groups and their communities.	
Marriage and Civil Partnership	In general people in marriage and civil partnership can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	Failure to examine and reflect on local service delivery can lead to negative impacts on individuals in marriage and civil partnership and their communities	None
Pregnancy and Maternity	In general people who are pregnant and on maternity leave can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions	Failure to examine and reflect on local service delivery can lead to negative impacts on individuals who are pregnant and maternity leave.	None

	taken to mitigate the worst of its impact as soon as possible		
Social and Economic Status	In general people from lower social and economic status groups can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	Failure to examine and reflect on local service delivery can lead to negative impacts on individuals when considering their social and economic status and their communities.	None
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	In general people in marginalised groups can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible	Failure to examine and reflect on local service delivery can lead to disempowerment of individuals and communities from marginalised groups.	None

E Actions to be taken – please list amendments to the policy following assessment.		
		Responsibility and Timescale
1 Changes to policy	No changes at this stage.	
2 Action to compensate for identified negative impact	Consider options at point of service implementation to mitigate identified negative impact as appropriate.	
3 Further monitoring – potential positive or negative impact	Specific EQIAs will be completed for each component of the change programme. This impact assessment will be used to ensure the final implementation of the programme is cognisant of equality legislation and the need to explicitly state how we will eliminate unlawful discrimination, advance equality of opportunity and promote good relations. This document will be used as a guide to ensure the implementation of the programme is robust and transparent.	
4 Further information required	Consider further any changes to the implementation of the transformation programme and financial framework once finalised to ensure any negative impacts are mitigated.	

Lead Reviewer: **Name:**
Sign Off **Job Title**
Signature
Date:

Please email copy of the completed EQIA form to alastair.low@ggc.scot.nhs.uk

Or send hard copy to:

Corporate Inequalities Team, NHS Greater Glasgow and Clyde, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH