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 Primary Care Improvement Plan 2018-2021

This is a : Current;#Current Policy

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

This section should be read alongside the Primary Care Improvement Plan which can be found at https://glasgowcity.hscp.scot/sites/default/files/publications/ITEM%20No%2009%20-%20Primary%20Care%20Improvement%20Plan_0.pdf Glasgow City Primary Care Improvement Plan 2018 -2021 sets out how we will further develop a range of primary care services in the communities for the next three/four years in response to the new GP contract. The new General practitioners (GPs) contract aims to guarantee a long term future for general practice and to substantially improve patient care, by maintaining and developing the role of primary care as the 'cornerstone of the National Health Services system'. It also provides a spotlight on primary care as a foundation on which to deliver more integrated care to patients throughout the city. While the new contract is intended to primarily benefit patients - by reducing and re-focussing GPs and GPs practice workload to support the development of the GPs role as an expert medical generalist and to act as senior clinical leaders within wider multi-disciplinary teams - its implications are much wider; There is an expectation that many GCHSCP services will need to be reconfigured and, crucially, there are clear expectations of gains for patients in the city, in terms of easier access to effective integrated assessment, treatment, advice and support as well as improvements in how they are directed to local support networks. A key objective is to enable patients with more complex conditions to spend more time with their GPs. The requirements set out in the related Memorandum of Understanding (MoU) to meet the commitments made to GPs as part of the first phase of the contract negotiations represent a significant programme of transformational change that will affect all practices. While this is a unique opportunity to shape primary care alongside community care services, there can be no doubt that this represents a major undertaking and it will be a challenge to deliver the agreed changes within the timelines. Glasgow City Health and Social Care Partnership (GCHSCP) welcome the new monies that the Scottish Government has allocated to support the change over the next four years. We are mindful, though, that they may not be sufficient to meet the costs of such an extensive programme of change across so many practices, especially in Glasgow where the extensive health inequalities experienced by our population place additional burdens on health care. We recognise that this will leave us with choices to make and decisions on how we spend the available funding wisely to achieve the most impact. Where we can we have identified firm actions for implementation in 2018-19 but at this stage there is much we do not know or are not yet certain of. This will require further investigatory work to be undertaken in the first year to establish assurance of a clear, confident and agreed path of action. The Memorandum of Understanding (MoU) - agreed between the Scottish Government, the British Medical Association, Integration Authorities and NHS Boards - identifies six priorities for reducing the workload of GPs as part of the broader plan for sustaining primary care services. These priorities are Vaccination services, Pharmacotherapy services, Community treatment and care services, Urgent care services Additional professional services, including acute musculoskeletal physiotherapy services, community mental health services Community link worker services. To inform the development of the PCIP over 370 people attended the series of 50 engagement sessions in 38 locations across Glasgow City consisting of Primacy Care health staffs including GPs and 3rd sector organisations (Coalition for Racial Equality and Rights (CRER) and Glasgow Equality Forum) between Feb to May 2018. There are other planned events/sessions still to report. This item is also a standing items GPs committee and GP Forum agendas, and Primary Care Implementation Group and regular up-dates for Older People services and other services. The nature and detail of the first Primary Care Improvement Plan is very much an initial plan however it is likely that any changes to Primary Care services will have both positive and negative impacts on vulnerable patient groups. With this in mind, this Equality Impact Assessment was undertaken to formally capture contextual information relating to Primary Care for different protected characteristic groups and will be used to inform final plan development and subsequent service change proposals. Future service re-design and/or changes in services will require equality impact assessments to be undertaken to ensure any service change is compliance with the GCHSCP legal duties in respect of their Equality Act 2010 and the Public Sector Equality Duties. This Equality Impact Assessment is not assessing the GP contract or the MoU but on the changes in the provision of services brought about by these two agreements in Glasgow City. This Equality Impact Assessment will be re-visited once the final plan and services changes are agreed to complete and will be used to provide a baseline for future equality impact assessments for front line services to patients/service users. This EqIA was approved by the members of the Primary Care Strategy Group.

3. Lead Reviewer

Gary Dover

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

Paul Adams (Head of Primary Care & Community Services); Margaret Black (Primary Care Development Officer); Graeme Bryson (Lead Pharmacist); Caroline Fee (Primary Care Development Officer); Harrison, Alan (Lead Pharmacist Community Care); Kelly, Lorna (Head of Primary Care Support and Development); Kathy Kenmuir (Practice Nurse Support and Development Team Manage); Marshall, Graeme (Clinical Director); Susan Middleton (Primary Care Development Officer); Janice Miller (MSK Service Manager and Professional Lead -Partner); Joan Miller (Prescribing Support Pharmacist); Ellice Morrison (Professional

Nurse Advisor); Fiona Moss (Head of Health Improvement & Inequality); Neylon, Kerri (Clinical Director); John Nugent (Clinical Director); Kirsty Orr (Planning Manager - OOHs Review); Salmon, Eileen (Professional Nurse Advisor); Anne 11. Thomson (Lead Clinical Pharmacist); David Walker (Head of Operations (South)); Wearing, Sharon (Chief Officer Finance and Resources); Wylie, David (Podiatry Service Manager & Professional Lead); Fiona Brown (members of the Primary Care Strategy); Mike Burn (members of the Primary Care Strategy); Ronnie Burns (members of the Primary Care Strategy); Stephen Fitzpatrick (members of the Primary Care Strategy); Richard Groden (members of the Primary Care Strategy); Margaret Hogg (members of the Primary Care Strategy); Jacqueline Kerr (members of the Primary Care Strategy); Hilary McNaughtan (members of the Primary Care Strategy); Anne Mitchell (members of the Primary Care Strategy); John Montgomery (members of the Primary Care Strategy); Frank Munro (members of the Primary Care Strategy); John O'Dowd (members of the Primary Care Strategy); Alan Speirs (members of the Primary Care Strategy); Sheila Tennant (members of the Primary Care Strategy)

5. Impact Assessment

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

The Glasgow City Primary Care Improvement Plan (PCIP) will be required to explicitly reference the equality Act (2010) and articulate how any proposed changes in service provision will meet the requirement to: • Eliminating unlawful discrimination, harassment and victimisation • Advancing equality of opportunity between groups of people with different protected characteristics • Fostering good relations between these different groups

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

		Source
All	In 2007 there were 156 practices in Glasgow City but these had reduced to 146 by October 2017. The 146 practices in Glasgow represent 15% of all practices in Scotland (956) and provide care for 13% of all patients. 65 (44%) out of the 146 practices in Glasgow City are based in health centres, whilst the remaining 56% are based in their own premises. There are 23 single handed practices in Glasgow. (Source: Primary Care section of the ISD website http://www.isdscotland.org/Health-Topics/General-Practice/) The demographic profile of patients registered with GPs: Between 2007 and 2017 the registered patient population for Glasgow City increased from 661,319 to 717,255 (8.5%). This was a higher rate of increase than for Scotland, which was 5% over the same period. • The average practice size in Glasgow has approximately 1,000 fewer patients than the Scottish average (4,913 patients compared to 5,961 for Scotland). • Glasgow has the smallest and largest GP list sizes in NHSGGG&C: ranging from about 1,400 to almost 40,000 patients. • Compared to Scotland, older (65 years+) patients make up a smaller percentage of the overall patient population in Glasgow (13% compared to 18% for Scotland). • Glasgow has a much larger percentage of patients who are of working age than Scotland as a whole (the 24 to 64 year olds represent 60% of Glasgow's patients compared to 55% for Scotland). • The profiles for children and young people (0 to 24 year olds) are similar at 28% of the patient population in Glasgow and 27% for Scotland. (Source: http://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-Populations/) Glasgow City Council (2013): Briefing Paper 2011 Census - Release 2A suggested that in recent years there has been a large increase in the number of the population from ethnic minorities in both Glasgow and Scotland. The current estimates suggest that black minority ethnic (BME) population in Glasgow now represents 15.4% of the total population. Recent observation also suggests a significant increase in the number of African and Caribbean population in recent years. Glasgow is home to over 130,000 student population from 135 countries around the world. The number of international students in Glasgow has also changed the size and diversity of the ethnic minority population. Almost half of the city's full time students belong to an ethnic minority, increasing the number of people in the city born outside the UK. 2.7% of Glasgow's ethnic minority population 'do not speak English well' or at all. • The number of asylum seekers in Glasgow work out around 10% of the UK's annual total. • There is on average around 2,500 asylum seekers (people going through the asylum system) in Glasgow at any one time. • Glasgow's Roma Gypsy/Travellers population is estimated to be between 3,000-4,000; about 2,000-2,500 are Slovakian (with small numbers of Czechs) and about 1,000 are Romanian. • In 2014, 54.6% of ethnic minorities in Glasgow group employed compared to 62.8% in Scotland. • 2.1% of GCC employees are from BME groups compared to 72.5% of white employees. • Over three quarters (78.5%) of social services users in Glasgow are of White- ethnic origin compared to (4.5%) of BME. We are particularly cognisant of the considerable health inequalities experienced by many patients living in Glasgow City. In preparing our plan we have given considerable thought to how we will design our services to address both the underlying causes of inequality and how we respond to the poor health outcomes, which these inequalities both create and exacerbate. Other Equality Impact Assessments (EqIAs) must be considered in relation to this EqIA are: GCHSC Mental Health Strategy (2018): https://glasgowcity.hscp.scot/sites/default/files/publications/Glasgow%20HSCP%20transformational%20Programme%20Mental%20Health%20Services.pdf Transformational Changes Programme Children Service 2018-202 (2018) https://glasgowcity.hscp.scot/sites/default/files/publications/EQIA%20-%20Transformational%20Change%20Programme%20-%20Children%20Services%20Glasgow%20HSCP.pdf Glasgow City Health and Social Care Partnership: Older people Transformational Change Programme 2018-2 (2018): https://glasgowcity.hscp.scot/sites/default/files/publications/Glasgow%20City%20Health%20and%20Social%20care%20Partnership%20-%20Older%20Peoples%20Transformational%20Change%20Programme%202018-21.pdf Primary Care Mental Health	Sources in text

	Review (2013) http://www.nhsggc.org.uk/media/220542/EQIA_Primary_Care_Mental_Health_Team_Review.pdf Mental Health Strategyhttps://beta.gov.scot/publications/equality-impact-assessment-results-mental-health-strategy/ Scottish Government Mental Health Strategy EqIA (2017): https://beta.gov.scot/publications/equality-impact-assessment-results-mental-health-strategy/ Scottish Government Carers (Scotland) Act 2016 EqIA (2018): https://beta.gov.scot/publications/carers-scotland-act-2016-equality-impact-assessment/	
Sex	Each section must be read within the context of the intersectional nature of all the protected characteristics. Lyle K. (2017) in Addressing Race Inequality in Scotland: The way forward for the Scottish Government reflected that SHELS data demonstrate that 23 years after the introduction of the UK's national breast screening programme, the uptake at first invite is substantially lower for almost every BME group in Scotland particularly for Pakistani and African women. This matters because research shows that women who attend breast screening at first invitation are more likely to attend for subsequent screens. The consequent ethnic inequity in the extent of preventable cancer mortality may be marked, especially for Pakistani and African women. Banks I. and Baker P. (2013) : Men and Primary Care: improving access and outcomes report found that Primary care services are not yet providing men with sufficiently effective prevention and screening services or diagnosing and treating potentially serious conditions soon enough. This is not just a UK problem – it affects Europe and, indeed, most of the world. In June 2013, the European Men's Health Forum (EMHF) convened a roundtable meeting in Brussels of the widest possible range of primary care professions to identify the barriers to men's effective engagement with primary care and, more importantly, how these could be overcome. In England, in 2008–9, females aged 15–80 years had significantly more consultations with GPs than males; the biggest gap was in the 20- to 44-year age group. A lower use of services by men can also be found in pharmacy and dentistry. According to the National Pharmacy Association, men visit a pharmacy on average four times a year compared to 18 times a year for women. The Adult Dental Health Survey for England, Wales and Northern Ireland 2009 found that women were more likely to have made an appointment with an NHS dentist in the past three years (62 versus 54 per cent). There is evidence suggesting that men in the UK are diagnosed at a later stage than women for malignant melanoma, lung, bladder and other urological cancers, and later in Ireland for colorectal, lung and stomach cancers as well as malignant melanoma. Men are less likely to seek help for mental health problems even when they are experiencing significant levels of psychological distress; this may well help to explain the higher suicide rate in men. Men over 50 are nearly twice as likely as women to have undiagnosed type 2 Diabetes, which could be indicative of insufficient screening in primary care. Diabetes UK has implicated poor use of health services in the increased risk of diabetes-related amputations run by white men living in poor areas. A Danish study based on almost 36 million GP contacts and 1.2 million hospitalisations in 2005 hypothesised that men's lower use of GPs resulted in later diagnosis and therefore higher use of hospital services. Greater Glasgow and Clyde NHS Board's Black and Ethnic Minorities Health and Wellbeing survey (2016) found that three in five (58%) BME women aged 20-60 years said they had been invited for cervical screening; of these, 87% had attended cervical screening. Four in five (79%) BME women aged 50-70 said they had been invited for breast screening; of these, 90% had attended breast screening. Two in three (64%) BME adults aged 50-74 said they had been invited for bowel screening; of these, 68% had completed the home test. Among the target gender/age groups, Chinese people were among the least likely to say they had been invited for cervical, breast or bowel screening. African people were the most likely to say they had been invited for these. One in eight (12%) BME adults had used the interpreting service for NHS appointments. Among those who did not speak English well, 44% had used the interpreting service.	Sources in text
Gender Reassignment	Each section must be read within the context of the intersectional nature of all the protected characteristics. In addition to gender-affirming medical care, transgender people have primary and preventive health care needs that are similar to the general population. Depending on an individual's history of gender-affirming care, primary and preventive care may require special considerations. Transgender patients often experience discrimination in the health care setting and lack of access to medical personnel who are competent in transgender medicine. This results in lack of access to preventive health services and timely treatment of routine health problems. The role of the primary care provider for transgender patients includes the tasks typical for all patients (eg, primary and secondary prevention), in addition to the specific needs of transgendered individuals. (Feldman j. and Deutch M. (2016); Primary care of transgender individuals). Williamson C. (2010) in Providing Care to Transgender Person: A clinical Approach to Primary Care, Hormones and HIV Management for Journal of the Association of Nurses in AIDs Care (Vol 21, Issue 3 pg 221-229) highlighted that transgender persons have had historically difficult interactions with health care providers, leading to limited care and risks for a broad spectrum of health problems. This is of particular concern for transgender persons with or at risk of HIV infection. Transgender people are a poorly understood, frequently invisible, and high-risk population, and many health care providers find it difficult to care for them because of a lack of formal training and few professional resources. Transgender people need routine care as well as care for concerns specific to transgender people. Additionally, some transgender persons are at risk of or have already been infected with HIV. Transgender persons are more likely to become homeless at a young age and to experience hate crimes in school (Gay, Lesbian, and Straight Education Network, 2008). Transgender young persons are particularly vulnerable and are at higher risk of attempting suicide (Garofalo, Deleon, Osmer, Doll, & Harper, 2006). Poteat T. et al (2013) in Managing uncertainty: A grounded theory of stigma in transgender health care encounters (Social Science and Medicine, Vol 84 pg 22-29) points to a growing body of literature supports stigma and discrimination as fundamental causes of health disparities. Stigma and discrimination experienced by transgender people have been associated with increased risk of depression, suicide, and HIV. Transgender stigma and discrimination experienced in health care	Sources in text

	influence transgender people's health care access and utilization. Thus, understanding how stigma and discrimination manifest and function in health care encounters is critical to addressing health disparities for transgender people.	
Race	Each section must be read within the context of the intersectional nature of all the protected characteristics. NSS Information and Intelligence NHS Scotland reported in Measuring use of Health Services by Equality Group (2017) that the largest minority ethnic group in Scotland was "Asian", (141,000; 3% of the population) and around a third of whom were "Pakistani". In the Scottish Census, recording for minority ethnic groups includes Scottish and British, for example: "Pakistani" includes "Pakistani/Pakistani Scottish/Pakistani British". "African", "Caribbean" or "Black" groups made up 1% of the population of Scotland in 2011; mixed or multiple ethnic groups represented 0.4% (20,000) and other ethnic groups and 0.3% (14,000) of the total population. Glasgow City Council Area had the highest proportion of minority ethnic groups (12% of the population). The Greater Glasgow and Clyde NHS Board's Black and Ethnic Minorities Health and Wellbeing survey (2016) found that more than nine in ten (92%) BME adults overall had a positive perception of their quality of life, which was higher than Glasgow City. The Pakistani groups were less likely than other ethnic groups to have a positive perception of their quality of life. Fifteen percent of BME adults had an illness or condition that limited what they could do, and one in four (26%) were receiving treatment for at least one illness or condition. Overall, BME groups were less likely than those in Glasgow City to have a limiting condition or to be receiving treatment for any illness/condition. However, the Pakistani group was much more likely than other BME adults to have a limiting condition or illness or to be receiving treatment for a condition/illness. Those who did not speak English well and those who had lived in the UK for 10 years or more were more likely than others to have a limiting long-term condition or illness.	Sources in text
Disability	Each section must be read within the context of the intersectional nature of all the protected characteristics. Psarros A. (2014) in the Women's voices on health addressing barriers to accessing primary care found that women with learning disabilities reported that cervical screening is a potential neglected area of health for this group. Many of the women found the issue of sexual and reproductive health difficult and embarrassing to talk about. The women spoke of the 'postcode lottery' of mental health services, and the fact that their low-level disability meant they may not qualify for social worker support. Many disabled women only have access to mainstream services, which may be poorly equipped to support them. World Health Organization (2018) in Disability and Health suggested that disability is extremely diverse. While some health conditions associated with disability result in poor health and extensive health care needs, others do not. However all people with disabilities have the same general health care needs as everyone else, and therefore need access to mainstream health care services. People with disabilities report seeking more health care than people without disabilities and have greater unmet needs. For example, a recent survey of people with serious mental disorders, showed that between 35% and 50% of people in developed countries, and between 76% and 85% in developing countries, received no treatment in the year prior to the study. Health promotion and prevention activities seldom target people with disabilities. For example women with disabilities receive less screening for breast and cervical cancer than women without disabilities. People with intellectual impairments and diabetes are less likely to have their weight checked. Adolescents and adults with disabilities are more likely to be excluded from sexual health education programmers.	Sources in text
Sexual Orientation	Each section must be read within the context of the intersectional nature of all the protected characteristics. In the LGBT Youth survey of 2017 for Life in Scotland for LGBT young people found 84% of LGBT young people and 96% of transgender young people indicated that they had experienced mental health problems and associated behaviours. 73% of LGBT young people and 83% of transgender young people who had experienced mental health problems had been bullied at School. Half (50%) of LGBT young people and 63% of transgender young people experienced suicidal thoughts or behaviors. Many young people commented on the lack of local services and long waiting times for appointments (especially for Gender Identity Clinics and mental health services). When asked LGBT young people what would make (or does make) them feel safe and supported by health services common comments included a desire for health professionals to be sensitive to their needs and to treat them with respect. Davy Z. and Sieiwardona A.N. (2012) wrote in the British Journal of General Practices (To be or not to be LGBT in Primary Care: Health Care for Lesbian, Gay, Bisexual and transgender people) pointed that teaching has tended to position heterosexuality and gender normative people as conforming to social standards of what is 'appropriate' feminine and masculine behaviour as the primary context in which health and illness is viewed. Models of health care that promote these views of sexuality and gender identity over others can create an environment in which gender stereotypes and "heteronormativity" - the cultural bias in favors of opposite-sex over same-sex sexual relationships - result in LGBT people becoming 'add ins', if and when they are considered at all. Even the term LGBT assumes that transgender patients have similar health care issues with those who are lesbian, gay, or bisexual, and can be taught together as an extension of the same theme. While sometimes there will be transgender people who identify with a lesbian, gay, or bisexual sexuality there is no intrinsic connection. It is important to respond to the requirements of lesbian, gay, bisexual, and transgender populations accessing primary care with different models.	Sources in text
	Each section must be read within the context of the intersectional nature of all the protected characteristics. Rumun A. (2014) in Influence of Religious Beliefs on Health Care Practices for the International Journal of Education and Research advised that the perceived role of 'God' in illness and recovery is a primary influence upon the health care beliefs and behaviors of people. The religious beliefs of the people result in many health care beliefs and practices which are	Sources in text

Religion and Belief	significantly different based on the persons religion. Only by understanding the religious beliefs of individuals can medical practitioners effectively meet the health care needs of patients of diverse religious beliefs. Hordorn J. (2016), in a Science Direct article on Religion and Culture suggested that religion, belief and culture should be recognized as potential sources of moral purpose and personal strength in health care, enhancing the welfare of both clinicians and patients amidst the experience of ill-health, healing, suffering and dying. Communication between doctors and patients and between health care staff should attend sensitively to the welfare benefits of religion, belief and culture.Doctors should respect personal religious and cultural commitments, taking account of their significance for treatment and care preferences.	
Age	Each section must be read within the context of the intersectional nature of all the protected characteristics. World Health Organisation (2017) in their report on integrated care for older people found that as a consequence of more people living longer there will be larger numbers of people experiencing a decline in physical and mental capacity who may also need care for day-to-day activities. These needs are not well met within existing models of health care. There is a pressing need to develop comprehensive community-based approaches to prevent declines in capacity and to provide support to family caregivers. Sherlaw-Johnson (2018) completed an evaluation for Nuffield Trust in outer East London which reported that patient-centred care for older people with complex need suggested that primary care hubs - that are dedicated to the care of older people with complex health needs - can have a positive impact on quality of care, and on the experiences of both patients and staff. NSS Information and Intelligence NHS Scotland reported in Measuring use of Health Services by Equality Group (2017) that the number of people aged over 40 years has increased year on year for the past twenty years whilst the number of people aged under 40 years has fallen and then plateaued. There have been consistently higher numbers of elderly women than men aged 70+ years, but the number of men in these age groups is increasing more steeply over time than it is for women of the same age. According to Information Services Division (ISD) statistics on GP consultations, a higher rate and number of females visit their GP practice, except in the very youngest and oldest age groups where the rate for males is slightly higher. This seems to have been a consistent pattern over time.	Sources in text
Pregnancy and Maternity	Each section must be read within the context of the intersectional nature of all the protected characteristics. NSS Information and Intelligence NHS Scotland suggested in Measuring use of Health Services by Equality Group (2017) ISD maternity statistics show that the average age of women giving birth is increasing: the number of babies born to women aged over 35 years has increased threefold over the past forty years. Meanwhile, teenage pregnancies are decreasing over time. Smith et al (2010); "The roles of GPs in maternity care- what does the future hold?" for the King's Fund - suggested that early antenatal care is an area in which GPs could play an important role. The management of miscarriage and hyperemesis gravidarum are other areas where GPs take the lead role. They can also refer women for either midwife-led or consultant-led care, and can encourage lifestyle modifications. GPs can also play an important role in antenatal care especially in the management of any on-going medical conditions.	Sources in text
Marriage and Civil Partnership	Each section must be read within the context of the intersectional nature of all the protected characteristics. King M. and Bartlett A. (2006) write in "What same sex civil partnerships may mean for health?" that the attempts of western governments and the World Health Organisation to address the social determinants of health, in particular the effects of social exclusion, has relevance here. Firstly, domestic violence has serious health and social consequences. It occurs in some same sex partnerships, just as it does in some heterosexual marriages. Legislation for civil partnerships may entitle same sex couples to the same protection against domestic violence as married heterosexual couples. 51% in the UK are married and living with their spouses and although many studies have not clearly distinguished between marriage and cohabitation, married people seem to have better physical and psychological health than single people. Unmarried people have increased rates of all-cause mortality compared with married people.	King M. and Bartlett A. (2006) ;Journal of Epidemiology and Community Health
Social and Economic Status	Each section must be read within the context of the intersectional nature of all the protected characteristics. Professor Watt G. (2011) : GPs at the Deep End report describes many health conditions that are more prevalent (typically more than twofold) in deprived compared with affluent populations, especially mental health problems. For example, comparing typical deprived and least deprived general practices, more than three times as many antidepressants and bronchodilators were dispensed per 1000 patients living in deprived areas	Sources in text
	Each section must be read within the context of the intersectional nature of all the protected characteristics. Eavis C. (2017): The barriers to healthcare encountered by single homeless people, in Primary Health Care indicated that when individuals are homeless, their health and well-being are at risk; this risk increases the longer they are homeless (Public Health England (PHE) 2016). Homeless people often have tri-morbidity: mental ill health, physical ill health and may have drug or alcohol misuse (Medcalf and Russell 2014). They are more likely to lead unhealthy lifestyles, which can cause long-term illness or exacerbate existing illnesses (Homeless Link 2014). A homeless person is more likely to present with a disease rather than attend for screening, or at the prevention stage of a disease (Power et al 1999). Consequently, homeless people have higher premature death rates: on average, a homeless man lives to 47 years, a homeless woman to 43, compared with 77 years for the general population (Thomas 2011). Homeless people are still dying of treatable medical conditions (Medcalf and Russell 2014). In Primary care service framework: Gypsy & Traveller Communities (2009) - noted that not all Gypsies and Travellers live a nomadic life; many are settled although they may choose to travel for part of the year. Although there are differences of opinion, some experts say there are seven groups of Gypsies & Travellers living in the UK. The aspects of Gypsy Traveller health	Sources in text

Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	that show the most marked inequality are self-reported anxiety, respiratory problems including asthma and bronchitis, and chest pain. The excess prevalence of miscarriages, stillbirths, neonatal deaths and premature death of older offspring were also conspicuous. There was less inequality observed in diabetes, stroke and cancer. Travellers' health beliefs and attitudes to health services demonstrate a cultural pride in self-reliance. There is stoicism and tolerance of chronic ill health, with a deep-rooted fear of cancer or other diagnoses perceived as terminal and hence avoidance of screening. Some fatalistic and nihilistic attitudes to illness were expressed; that is, illness was often seen as inevitable and medical treatment seen as unlikely to make a difference. There is more trust in family carers rather than in professional care. In relation to Gypsy Travellers' experiences in accessing health care and the cultural appropriateness of services provided, we found widespread communication difficulties between health workers and Gypsies and Travellers, with defensive expectation of racism and prejudice. Barriers to health care access were experienced, with several contributory causes, including reluctance of GPs to register Travellers or visit sites, practical problems of access whilst travelling, mismatch of expectations between Travellers and health staff, and attitudinal barriers. However, there were also positive experiences of those GPs and health visitors who were perceived to be culturally well-informed and sympathetic, and such professionals were highly valued. Roma Health Report Health status of the Roma population Data collection in the Member States of the European Union(2014), European Union: There is consistent evidence demonstrating the Roma population has a considerably shorter life expectancy compared to the non-Roma population. Indeed for many years, published information has persistently shown the Roma population has a markedly lower life expectancy than the general population. The gap in longevity may be a decade or more. Data is less able to explain the cause(s) of the difference between Roma and non-Roma health and to sufficiently explore issues around the impact of specific social determinants on particular health outcomes. Smoking prevalence levels are consistently higher in Roma than non-Roma communities. Mixed findings indicate significantly lower illicit drug use amongst Roma communities, although overall there appear to be a number of cultural factors which have a negative impact on the lifestyles of Roma. Roma tend to have illnesses associated with poor diet, and stress. Depression and psychosomatic complaints are common and there is a high frequency of eye and dental problems, which can be attributed to poor diet and malnutrition. Poor health and an unhealthy lifestyle are significant problems associated with low income. The London-based Roma Support Group's evaluation of its three year Mental Health Advocacy Project (2012) found recurring themes of barriers to mental health services including a lack of knowledge of the existence of mental health services, communication, language and literacy barriers and the stigma of mental health issues. In the UK issues such as a lack of a postal address, having to travel long distances to visit their GP and evictions due to a lack of authorised sites are all relevant. Slovak Roma in the UK have been found to have high rates of type two diabetes mellitus, cardiovascular disease, premature myocardial infarction, obesity and asthma, and it is common for Roma to have undiagnosed health conditions. Williamson M. in his presentation title: Improving the health and social outcomes of people recently released from prisons in the UK – A perspective from primary care. In its key findings: Imprisonment can be good for physical health and improving health intervention opportunities but is usually not good for mental health. The post release period is extremely dangerous in physical and mental health terms and for recidivism. Prisons can be seen as another, 'community based health care station'. Imprisonment rates are increasing especially amongst women and the elderly and alternatives, whenever possible, should be used to avoid the deleterious health effects of incarceration. Health and social care services need to be designed to be acceptable to and accepting of young people. Women and young prisoners have special needs. Other sections of the population, e.g. older men, should be considered and their special needs identified. Glasgow City Council (Social Work Services) report that Glasgow hosts one of the largest asylum and refugee populations outside of London. Glasgow is currently the number one dispersal area in the UK in terms of numbers. There are currently 3,589 asylum seekers in Glasgow which work out around 10% of the UK's annual total. On average there are around 2,500 asylum seeking people going through the asylum system in Glasgow at any one time with people coming from about 68 countries. In 2015, about 3,105 asylum seekers received accommodation and financial support in Glasgow. Psarros A. (2014) in the Women's voices on health addressing barriers to accessing primary care reported that women who are asylum seekers or refused asylum felt that they received mixed messages in relation to what healthcare they were entitled to. They put this down to health professionals' lack of knowledge, but also prejudice and discrimination. Many felt that they were treated differently from non-migrants. Health-related costs are a big barrier to the women, most of whom are destitute and mental health problems were associated with a lot of stigma in this group. Psarros also suggested that documentation requirements are a barrier to registration when passport, photo ID or utility bills are not obtainable. Insisting on these documents restricts access to healthcare for groups like asylum seekers, homeless women and members of the Traveller community.	

C. Do you expect the policy to have any positive impact on people with protected characteristics?

	Highly Likely	Probable	Possible
General		The new contract and additional funding through the PCIP are intended to benefit patients by reducing and re-focussing GPs and GPs practice workload to support the development of the GPs role as an expert medical generalist and to act as senior clinical leaders within wider multi-disciplinary teams. This should benefit patients who have more complex conditions. Additional posts with specialist skills, such as pharmacists, should facilitate	

		improved interventions and advice for patients especially those with complex health conditions.	
Sex		The new contract and additional funding through the PCIP are intended to benefit patients by reducing and re-focussing GPs and GPs practice workload to support the development of the GPs role as an expert medical generalist and to act as senior clinical leaders within wider multi-disciplinary teams. This should benefit patients who have more complex conditions.	
Gender Reassignment		The new contract and additional funding through the PCIP are intended to benefit patients by reducing and re-focussing GPs and GPs practice workload to support the development of the GPs role as an expert medical generalist and to act as senior clinical leaders within wider multi-disciplinary teams. This should benefit patients who have more complex conditions.	
Race		The new contract and additional funding through the PCIP are intended to benefit patients by reducing and re-focussing GPs and GPs practice workload to support the development of the GPs role as an expert medical generalist and to act as senior clinical leaders within wider multi-disciplinary teams. This should benefit patients who have more complex conditions.	
Disability		The new contract and additional funding through the PCIP are intended to benefit patients by reducing and re-focussing GPs and GPs practice workload to support the development of the GPs role as an expert medical generalist and to act as senior clinical leaders within wider multi-disciplinary teams. This should benefit patients who have more complex conditions. Additional support from mental health workers and Community Links Workers.	
Sexual Orientation		The new contract and additional funding through the PCIP are intended to benefit patients by reducing and re-focussing GPs and GPs practice workload to support the development of the GPs role as an expert medical generalist and to act as senior clinical leaders within wider multi-disciplinary teams. This should benefit patients who have more complex conditions.	
Religion and Belief		The new contract and additional funding through the PCIP are intended to benefit patients by reducing and re-focussing GPs and GPs practice workload to support the development of the GPs role as an expert medical generalist and to act as senior clinical leaders within wider multi-disciplinary teams. This should benefit patients who have more complex conditions.	
Age		The new contract and additional funding through the PCIP are intended to benefit patients by reducing and re-focussing GPs and GPs practice workload to support the development of the GPs role as an expert medical generalist and to act as senior clinical leaders within wider multi-disciplinary teams. This should benefit patients who have more complex conditions.	
Marriage and Civil Partnership		The new contract and additional funding through the PCIP are intended to benefit patients by reducing and re-focussing GPs and GPs practice workload to support the development of the GPs role as an expert medical generalist and to act as senior clinical leaders within wider multi-disciplinary teams. This should benefit patients who have more complex conditions.	

Pregnancy and Maternity		The new contract and additional funding through the PCIP are intended to benefit patients by reducing and re-focussing GPs and GPs practice workload to support the development of the GPs role as an expert medical generalist and to act as senior clinical leaders within wider multi-disciplinary teams. This should benefit patients who have more complex conditions.	
Social and Economic Status		The new contract and additional funding through the PCIP are intended to benefit patients by reducing and re-focussing GPs and GPs practice workload to support the development of the GPs role as an expert medical generalist and to act as senior clinical leaders within wider multi-disciplinary teams. This should benefit patients who have more complex conditions. Additional help provided by Community Links Workers who will be based in GPs located in the most deprived areas.	
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders		The new contract and additional funding through the PCIP are intended to benefit patients by reducing and re-focussing GPs and GPs practice workload to support the development of the GPs role as an expert medical generalist and to act as senior clinical leaders within wider multi-disciplinary teams. This should benefit patients who have more complex conditions.	

D. Do you expect the policy to have any negative impact on people with protected characteristics?

	Highly Likely	Probable	Possible
General			It will be important that patients understand the new ways of working and that they may not always see a GP but another practitioner. This will be especially important for people who find it difficult to navigate the health and care system, for example, people with low levels of literacy or people who do not speak English.
Sex			It will be important that patients understand the new ways of working and that they may not always see a GP but another practitioner. This will be especially important for people who find it difficult

			to navigate the health and care system, for example, people with low levels of literacy or people who do not speak English..
Gender Reassignment			It will be important that patients understand the new ways of working and that they may not always see a GP but another practitioner. This will be especially important for people who find it difficult to navigate the health and care system, for example, people with low levels of literacy or people who do not speak English.
Race			It will be important that patients understand the new ways of working and that they may not always see a GP but another practitioner. This will be especially important for people who find it difficult to navigate the health and care system, for example, people with low levels of literacy or people who do not speak English.
			It will be important that patients understand the new ways of working and that they may not always see a GP but another practitioner. This will be especially important for

Disability			people who find it difficult to navigate the health and care system, for example, people with low levels of literacy or people who do not speak English. Ensuring accessibility of Community Treatment Rooms, if they are moved out of GP practices to other locations.
Sexual Orientation			It will be important that patients understand the new ways of working and that they may not always see a GP but another practitioner. This will be especially important for people who find it difficult to navigate the health and care system, for example, people with low levels of literacy or people who do not speak English.
Religion and Belief			It will be important that patients understand the new ways of working and that they may not always see a GP but another practitioner. This will be especially important for people who find it difficult to navigate the health and care system, for example, people with low levels of literacy or people who do not speak English.
			It will be important that

Age			patients understand the new ways of working and that they may not always see a GP but another practitioner. This will be especially important for people who find it difficult to navigate the health and care system, for example, people with low levels of literacy or people who do not speak English.
Marriage and Civil Partnership			It will be important that patients understand the new ways of working and that they may not always see a GP but another practitioner. This will be especially important for people who find it difficult to navigate the health and care system, for example, people with low levels of literacy or people who do not speak English.
Pregnancy and Maternity			It will be important that patients understand the new ways of working and that they may not always see a GP but another practitioner. This will be especially important for people who find it difficult to navigate the health and care system, for example, people with low levels of literacy or people who do not speak English. It will be important

			that patients understand the new ways of working and that they may not always see a GP but another practitioner. This will be especially important for people who find it difficult to navigate the health and care system, for example, people with low levels of literacy or people who do not speak English.
Social and Economic Status			It will be important that patients understand the new ways of working and that they may not always see a GP but another practitioner. This will be especially important for people who find it difficult to navigate the health and care system, for example, people with low levels of literacy or people who do not speak English. Ensuring patients do not have to pay additional costs of travelling to alternative locations for a services (e.g. if Community Treatment and Care Services are moved to alternative locations).
			It will be important that patients understand the new ways of working and that they may not always see a GP but another practitioner. This will be

Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders			especially important for people who find it difficult to navigate the health and care system, for example, people with low levels of literacy or people who do not speak English. GPs have expressed some concern that the transfer of the vaccination transformation programme away from GPs may mean that the opportunities to understand and respond to the wider needs of vulnerable people and families who attend the immunisation clinics may be missed. This will require joint working and good information sharing between those who are undertaking the vaccinations and GP practices.