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 HSCP/NHS GGC - Review of West Glasgow Minor Injuries Services

This is a : New Policy

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

Minor Injuries is a service where patients are seen by highly experienced Emergency Nurse Practitioners who a can assess and treat minor injuries such as cuts, minor burns, sprains and strains, broken bones and fractures. They can also arrange for patients to be transferred elsewhere if they find a more serious problem. In Glasgow City the unit is open from 09:00-21:00, seven days a week and sees adults and children from the age of 5 and upwards. The Minor Injuries Unit at Yorkhill serving West Glasgow was closed on a temporary basis in December 2016. There is a need to consider options for the future of minor injuries services for West Glasgow, those options include reopening the service at Yorkhill; transfer services to Gartnavel; continue to provide the service at Queen Elizabeth University Hospital or transfer the service to a Health Centre in West Glasgow. Glasgow City Health and Social Care Partnership (HSCP) Integration Joint Board have strategic planning responsibility for unscheduled care including minor injury services. The NHS Board has responsibility for the delivery of acute services, and so reviews of this kind need to be considered jointly, with the final decision resting with the Integration Joint Board. A joint Review and Stakeholder Group has been established led by the Integration Joint Board. An EQIA is required as part, of the Review of Minor Injuries Services for West Glasgow to assess the potential equalities impacts, and identify possible actions to mitigate them. This EQIA will not focus on the individual options being considered as part of the review. When an agreed option is finalised an EQIA on that option is recommended as part of the planning and implementation process.

3. Lead Reviewer

Simpson, May

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

Alex MacKenzie (Chief Officer, Operations, HSCP.); Hamish Battye, (Head of Planning & Strategy (Older People & South), HSCP); Gary Campbell, (Staff Side, Acute Services.); Jacqueline Carrigan, (Head of Finance, South Sector, Acute Services.); David Dall, (Head of HR, Acute Services.); Neil Ferguson, (Head of Planning, South Sector, Acute Services.); Malcolm Gordon, (Emergency Medicine Consultant, Acute Services.); Anne Harkness, (Chief Operating Office, South Sector, Acute Services.); Jacqueline Kerr, (Head of Operations, North West Locality, HSCP.); Kerri Neylon, (Clinical Director, North West Locality, HSCP); Rachel Killick, (Public Involvement Manager, NHS Board.); Anne Marie Kennedy, (Public Partner); Gillie MacDonald, (Public Partner); John MacVicar, (Public Partner); Lilian Woolfries (Public Partner); Louise Wheeler, (Service Change Advisor, Scottish Health Council. (as an observer))

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

Scottish Government guidance states that in accordance with equalities legislation, a Board is responsible for ensuring that any potentially adverse impact of the proposed service change on different equality groups has been taken into account by undertaking an equality impact assessment. The Guidance on the Principles for Planning and Delivering Integrated Health and Social Care state that the planning and delivery principles should take account of: • the particular needs of different service-users; • the particular needs of service-users in different parts of the area in which the service is being provided; • the particular characteristics and circumstances of different service-users; and, • the dignity of service-users.

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

		Source
	Glasgow City Integration Joint Board Public Engagement Committee – West Glasgow Minor	Sources are

All	Injuries Services Review – Public Engagement https://glasgowcity.hscp.scot/meeting/27-september-2017 A Review and Stakeholder Group (R&SG) was established with members from the HSCP, NHS Board, acute services, staff and four patient representatives. The R&SG guided the review process, undertook an option appraisal exercise and developed an engagement plan which ran from early July 2017 until 29 September 2017 and consisted of: • Presentation and discussion at three North West Locality Engagement Forum meetings, • Four public meetings held in Maryhill on 6/9/17, Drumchapel on 12/9/17, in Partick on 14/9/17 and in Clydebank on 26/9/17. • Meeting with General Practitioners (NW Glasgow, invitation to East Dunbartonshire and West Dunbartonshire GPs) • A poster campaign with 'reminder' notifications to GP surgeries, Dental, Practices, Opticians, Housing Associations, Health and Social Care unit and offices, Hospitals, Community Councils, North West Voluntary Sector Network, Libraries, community Halls, local community networks and groups. • Social media utilised and HSCP web site page set up to provide information on the Review, engagement opportunities and details on how to make a direct comment on the Review. • Information was directed to specific groups who are known to use the Minor Injuries Service - University and College Student bodies, equality and Integration Networks (posters translated into the six community languages), North West Youth Network and families were targeted via the Voluntary Sector Network. There were main themes to emerge from the engagement process which could impact on people with protected characteristics were that. • Gartnavel was a better location for serving the West Glasgow area, and was the preferred option for many people; • a perception that the service at Yorkhill was not well used because there was a low level of awareness about its existence; • a concern that Yorkhill was not a good location for such a service because of problems with access for patients travelling by public transport or car; • there was a lack of awareness and understanding among the general population about what services should be to accessed for certain conditions / issues, and what different services did e.g. the community pharmacy minor aliments service, minor injuries services and A&E; • public transport links to the Queen Elizabeth University Hospital from West Glasgow needed improved if the status quo option was to be approved. The cost and frequency of public transport can be a barrier to accessing services - 'It can take 1 ½ hours to get to QEUH with 2 changes of buses, the cost, frequency of buses and distance to walk from bus stop were all points noted' • Accessibility - it was highlighted West Minor Injury Unit provides a service to communities in North West Glasgow including 'Drumchapel which one of the poorest communities in Glasgow with the greatest need for health services'. It was noted that 'many residents in Drumchapel are limited both physically and financially' and the feedback was 'health services and support are being moved out the area'. Gulliford M et al (2002): What does 'access to health care' mean? Journal of Health Services Research & Policy2002 Jul;7 (3):186-8. Facilitating access is concerned with helping people to command appropriate health care resources in order to preserve or improve their health. Access is a complex concept and at least four aspects require evaluation. If services are available and there is an adequate supply of services, then the opportunity to obtain health care exists, and a population may 'have access' to services. The extent to which a population 'gains access' also depends on financial, organisational and social or cultural barriers that limit the utilisation of services. Thus access measured in terms of utilisation is dependent on the affordability, physical accessibility and acceptability of services and not merely adequacy of supply. Services available must be relevant and effective if the population is to 'gain access to satisfactory health outcomes'. The availability of services, and barriers to access, have to be considered in the context of the differing perspectives, health needs and material and cultural settings of diverse groups in society. Equity of access may be measured in terms of the availability, utilisation or outcomes of services. Both horizontal and vertical dimensions of equity require consideration.	quoted within this section
Sex	Each section must be read within the context of the intersectionally of all the protected characteristic Information Services Division (ISD) Scotland https://www.isdscotland.org/Health-Topics/Equality-and-Diversity/Publications/2017-06-27/2017-06-27-Measuring-Use-of-Health-Services-by-Equality-Group-Report.pdf This report focuses on the following equality groups: age; disability; ethnicity/race; gender/ sex; religion and belief; sexual orientation; and gender identity. It is primarily concerned with measuring use of health services at Scotland level using routine administrative health datasets held by Information Services Division.	Sources are quoted within this section
Gender Reassignment	Each section must be read within the context of the intersectionally of all the protected characteristic The most significant healthcare need for trans people is treatment for gender reassignment. However, like other groups, trans people have wider health care needs, although there is considerably less research in this field compared to research on access to treatment for gender reassignment. The briefing highlights a range of evidence sources about trans health inequalities http://www.healthscotland.com/documents/20525.aspx Qualitative research highlights barriers experienced by trans people when accessing health services. For example: • Research by Engender in 2010 found that trans people reported experiences of General Practitioners having little or no knowledge of gender reassignment. • A survey of 71 trans people http://www.scottishtrans.org/wp-content/uploads/2013/03/staexperiencessummary03082.pdf by the Scottish Transgender Alliance https://www.scottishtrans.org/ reported that trans people are less likely to seek out-of-hours medical care because of uncertainty of how NHS professionals may react to their transgender background or identity. • A survey of 873 trans people by Press for Change	Sources are quoted within this section

	http://www.pfc.org.uk/pdf/EngenderedPenalties.pdf reported that 21 per cent of respondents' GPs did not want to help with providing gender reassignment treatment. • The research also found that 29 per cent of respondents felt that their trans identity affected their experiences of healthcare in other areas beyond gender reassignment services. It was also reported that some healthcare professionals see trans people as transsexual first, regardless of the non-trans healthcare needs that they may present with.	
Race	Each section must be read within the context of the intersectionally of all the protected characteristic Population in Glasgow City 2012: http://worldpopulationreview.com/world-cities/glasgow-population/ Glasgow has an estimated population of 596,000, which is little changed from 595,000 in 2012 and 593,000 in 2011. Glasgow has a population density of 3,400 people per square kilometre, which makes it the most densely populated city in Scotland. The larger Greater Glasgow area has an estimated population of 1.2 million, while the region surrounding the conurbation has about 2.8 million residents. This represents about 42% of the population of Scotland. Glasgow has a much higher percentage of ethnic minorities than Scotland as a whole. At the 2011 United Kingdom census, the population of Glasgow was: •White: 88.3% (Scotland: 96% •Asian: 8.1% (Scotland: 2.7%) •Black: 2.4% (Scotland: 0.8%) -Christian: 54.5% (Scotland: 54.0%) •Muslim: 5.4% (Scotland: 1.4%) More than 15% of the population belongs to an ethnic minority group. Glasgow has the lowest life expectancy of any UK city at 73 years NHS Scotland: Health issues and access to services web link: http://www.healthscotland.com/equalities/race/acessingservices.aspx Ethnic minorities can face greater difficulties when trying to access services, for example due to a lack of knowledge about existing services and differences in language and cultural expectations. Scottish Government Race Equality framework for Scotland 2016-2030 In order to achieve the previous goal, workers in the health and social care sector need to have the right interpersonal approaches and knowledge to enable them to identify and meet needs. Health and social care workers understand the importance of a flexible, person-centred approach; no two people are exactly the same, and service provision must reflect this. Where service users have additional requirements linked to language, culture or understanding of services, these need to be met effectively. Additional learning and development may be required for workers to be able to confidently carry out this approach. A good understanding of issues around racial inequality and racism is also necessary to deal with any incidents which may occur in a health and social care environment. Both service users and staff from minority ethnic backgrounds are at risk of facing both direct and subtle forms of racism; public service organisations need to be able to take appropriate action where this occurs. Glasgow City Integration Joint Board Strategic Plan 2016 - 2019 https://glasgowcity.hscp.scot/sites/default/files/publications/IJB_21_03_2016_ItemNo_5_-_Strategic_Plan.pdf In North West Locality the minority ethnic population, including black or minority ethnic (BME 11.9%) and other white non UK/non Irish (4.9%) is higher than the overall Glasgow level (BME 11.6% and other white non UK/non Irish 3.9%). The percentage of the minority ethnic population varies significantly across the North West locality from 8% in Drumchapel/Anniesland to 32% in Anderston/City.	Sources are quoted within this section
Disability	Each section must be read within the context of the intersectionally of all the protected characteristic The links between poverty and ill-health are well established and people living with long term ill-health or disability are more likely to be living in poverty, a key factor in poorer health outcomes that have far-reaching effects on individuals and their families. (Dobbie L. and Gillespie M. (2010) :The Health Benefits of Financial Inclusion: A Literature, Review Report for NHS Greater Glasgow and Clyde: Scottish Poverty Information Unit) Published in the British Medical Journal in Health services research 'Access to healthcare for men and women with disabilities in the UK: secondary analysis of cross-sectional data' http://bmjopen.bmj.com/content/7/8/e016614 This research found that after adjusting for age, sex and other factors, people with a severe disability had higher odds of facing unmet needs. The largest gap was in 'unmet need for mental healthcare due to cost', where people with a severe disability were 4.5 times (CI 95% 2.2 to 9.2) more likely to face a problem, as well as in 'unmet need due to cost of prescribed medicine', where people with a mild disability had 3.6 (CI 95% 2.2 to 5.9) higher odds of facing a difficulty. Women with a disability were 7.2 times (CI 95% 2.7 to 19.4) more likely to have unmet needs due to cost of care or medication, compared with men with no disability. The research concluded that 'people with disabilities reported worse access to healthcare, with transportation, cost and long waiting lists being the main barriers. These findings are worrying as they illustrate that a section of the population, who may have higher healthcare needs, faces increased barriers in accessing services'.	Sources are quoted within this section
Sexual Orientation	Each section must be read within the context of the intersectionally of all the protected characteristic EHRC (2016) Is Scotland Fairer? The state of equality and human rights 2015, section 6: Access to healthcare; EHRC Evidence suggests that some groups such as Gypsy/Travellers, transgender people and people who need palliative care can experience problems accessing healthcare services. Lesbian, gay, bisexual, transgender people: LGBT people are less likely to access some key health services such as GP surgeries, and are more likely to use accident and emergency services and minor injury clinics. LGBT people who have been to their GP in the last year were more likely to rate their experience as poor or extremely poor than the general population (9% compared with 2%) (Stonewall Scotland, 2014b). Specific evidence on the health of transgender people is limited. However, at UK level there is research which indicates that transgender people can experience problems	Sources are quoted within this section

	accessing health services. A Trans Mental Health and Emotional Wellbeing Study in the UK and Ireland in 2012 (with part-funding from the Scottish Government) found that 6 out of 10 respondents had experienced negative questions, attitudes or services in relation to gender identity clinics (62%), mental health services (63%) and general health services (65%) (McNeil et al., 2012).	
Religion and Belief	Each section must be read within the context of the intersectionally of all the protected characteristic In the British Medical Journal http://bmjopen.bmj.com/content/5/11/e008687 Barriers and enablers to healthcare access and use among Arabic-speaking and Caucasian English-speaking patients with type 2 diabetes mellitus: a qualitative comparative study (H Alzubaidi; K Mc Namara; Colette Browning and J Marriott, 2015) Research by Centre for Health and Social Care Research, Faculty of Health, Birmingham City University - Understanding mental health and experience of accessing services among African and African Caribbean Service users and carers in Birmingham.(Fatemeh Rabiee, BSc MScPh PhD CertHEd, Centre for Health and Social Care Research, Faculty of Health, Birmingham City University and Paula Smith, BSc MSc, Health Promotion Specialist and Part-Time Lecturer, De Montfort University, Leicester, UK) ttps://www.bcu.ac.uk/Download/Asset/a739b884-a165-e411-b649-0026558290c8	Sources are quoted within this section
Age	Each section must be read within the context of the intersectionally of all the protected characteristic Glasgow City Integration Joint Board Strategic Plan 2016 - 2019 https://glasgowcity.hscp.scot/sites/default/files/publications/IJB_21_03_2016_ItemNo_5_-_Strategic_Plan.pdf In North West Locality there is a large proportion of people of working age, due partly to the very high numbers of young people aged 16- 24 years (with students representing 13.5% of the total population in North West). Glasgow City Integration Joint Board Public Engagement Committee – West Glasgow Minor Injuries Services Review – Public Engagement https://glasgowcity.hscp.scot/meeting/27-september-2017 During the public engagement process concerns about how difficult it was for older people to attend the Minor Injury Unit at the Queen Elizabeth University Hospital were expressed Review of West Minor Injuries Services Presentation - https://glasgowcity.hscp.scot/publication/minor-injuries-services-west-glasgow-presentation 'the attendance at the West Glasgow MIU in 2016 were 16% aged 5-15 years, 20% of attendees were aged 56-105 years with the largest population around 58% aged 16-55 years' National Records of Scotland 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. In Glasgow City, 23.9 per cent of the population are aged 16 to 29 years. This is larger than Scotland where 18.2 per cent are aged 16 to 29 years. Persons aged 60 and over make up 18.5 per cent of Glasgow City. This is smaller than Scotland where 24.2 per cent are aged 60 and over. Since 1989, Glasgow City's total population has fallen overall. Scotland's population has risen over this period. • Between 2013 and 2014 Glasgow City experienced a 2.9 per cent increase in the number of births, rising from 7,254 in 2013, to 7,465 in 2014. The number of births in Scotland rose by 1.3 per cent. • Fertility in Glasgow City increased from 51.6 births per 1,000 women aged 15 to 44 in 2013, to 53.2 in 2014. For Scotland as a whole, the general fertility rate increased from 53.7 births per 1,000 women aged 15 to 44 in 2013, to 54.7 in 2014. • Female life expectancy at birth (78.7 years) is greater than male life expectancy (73.4 years), but both were lower than the Scottish average. Male life expectancy at birth in Glasgow City is improving more rapidly than female life expectancy. In Glasgow City female life expectancy at age 65 (18.1 years) is greater than male life expectancy at age 65 (15.2 years). • There were 2,584 marriages in Glasgow City in 2014; no change from 2013. Scottish Government research on migration (2009) identified that GP registration among economic migrants in Scotland was low and their use of services limited, with some reporting a suggested preference to return to their home country for treatments. The report suggested that migrants made few demands on health services because they were, on average, younger, in employment and without children. It also suggested that migrants needs for health services will change as they decide to settle and to raise children in Scotland. Older people: key points ◦Scotland's population, like that of the UK, is ageing. ◦Life expectancy and healthy life expectancy are increasing for both men and women, but so is the length of time spent in ill-health. ◦Increasing life expectancy and years spent in ill-health mean that the proportion of the population dependent on carers is increasing. ◦The prevalence and incidence of most health conditions rises with increasing age (e.g. cancer, coronary heart disease and type 2 diabetes). ◦Causes of death change with increasing age. Cancer, cardiovascular disease and respiratory disease cause a higher proportion of mortality in older people than in younger people. ◦Pensioner poverty, a key determinant of ill-health and life expectancy, has decreased overall in the last two decades but has changed little in the last 5 years. ◦Healthcare associated infections are a particular health risk for older people since they have higher hospital admission rates ◦Dementia is more common in older people and, with an aging population; we are likely to see an upward trend in the number of people with dementia.	Sources are quoted within this section
	Each section must be read within the context of the intersectionally of all the protected characteristic One Parent Families Scotland http://www.opfs.org.uk/speaking-out/the-facts While families in Britain come in many shapes and sizes, the proportion of families headed by a lone parent appears to have stabilised over the past ten years, refuting suggestions that tax and benefit policies in recent years have favoured or created more lone parent families. What hasn't changed for lone parents is that they remain the poorest family type.	Sources are quoted within this section

Pregnancy and Maternity	Half of children growing up in a one parent family are poor – even though nearly sixty per cent of lone parents are now in work. Information Services Division (ISD) Scotland http://www.isdscotland.org/Health-Topics/Maternity-and-Births/ The health of a woman is an important factor in pregnancy, as we know from evidence that in general, healthy women have healthy babies. There are many lifestyle factors relating to the physical and emotional well-being of a woman during pregnancy. For example, maintaining a healthy diet and taking regular exercise are known to be beneficial to the health of the woman and the baby. Medical care is also important during pregnancy and through regular antenatal care and screening, the health of the woman and the baby can be monitored. There are also factors associated with risk to the health of the mother and baby e.g. smoking, alcohol, drug abuse, age and deprivation. Maternal smoking can influence the health of a woman and can influence the risk of having a low birth weight baby. Another important factor is the rising proportion of births to older women. Older maternal age may be associated with pre-existing ill health, low fertility, complications of pregnancy and an increased risk of adverse outcomes, including stillbirths and congenital anomalies. Statistics on both maternal smoking and age can be found here on our Births in Scottish Hospitals' web pages. Alcohol and drug misuse are also known risk behaviours and can impact on the health during pregnancy	
Marriage and Civil Partnership	Each section must be read within the context of the intersectionally of all the protected characteristic Calderwood E. (2015): The lived experience of women accessing local health services, when accommodated in a woman's refuge.: University of the West of Scotland found that the it is estimated that 1 in 4 women will experience domestic abuse over their lifetime resulting in a significant impact to their physical and mental wellbeing, as well as their social and financial standing. The impact on women's health can be acute, including injuries sustained from physical assault or chronic, leading to depression, self-harming, chronic pain and loss of hearing or vision. Health services have a pivotal role to play in identifying abuse and promoting health through provision of support services for women and their children. This is an ethos supported by the Scottish Government. Women may experience very high levels of abuse and control from their partner resulting in them moving to a Woman's Aid refuge which provides a safe place to live away from the perpetrator. This often places them out with their current health service area, causing them to seek a new General Practitioner (GP) and other primary care services. The researcher previously worked as a liaison health visitor in a woman's refuge. At this time it was observed that access to services was uncoordinated and disorganised. There is very limited evidence published to indicate if this has changed therefore justifying the need for this research. This study will interview eight women living in local refuges to ascertain their experience of accessing health services and aims to capture their personal thoughts, feelings and actions. The interviews will be conducted in the local Woman's aid office and will last no longer than one hour. The study will inform future service planning and delivery, to ensure women and children living in refuge are offered appropriate health services to address the health issues previously mentioned and to improve quality of care.	Sources are quoted within this section
Social and Economic Status	Each section must be read within the context of the intersectionally of all the protected characteristic Glasgow Centre for Population Health – Glasgow: health in a changing city http://www.gcph.co.uk/publications/621_glasgow_health_in_a_changing_city This report is primarily concerned with describing life expectancy trends since the early 1990s in Glasgow and examining these in terms of changes in neighbourhood-, deprivation- and gender-related inequalities. In order to reflect the broader context for these health trends, a description is given of changes in population, housing, environmental and socioeconomic circumstances at a city and neighbourhood level. The study reaffirms known health challenges and identifies new concerns: • despite improvements in life expectancy for men and women in the last fifteen years, life expectancy in Glasgow remains significantly lower than in Scotland and there has been no appreciable narrowing of the gap relative to Scotland • the health gap between our most deprived and affluent communities persists • a widening in the gap in female life expectancy between our most and least deprived areas • a relatively poor trajectory for female life expectancy compared to males over recent years, particularly in the most deprived half of Glasgow. In the Child Poverty Action Group Scotland Report http://www.cpag.org.uk/content/hard-choices-reducing-need-food-banks-scotland highlighted transport and the cost of transport as a barrier to accessing health services for families on low or fixed incomes In the Joseph Rowntree Foundation report: Monitoring Poverty and Social Exclusion in Scotland 2013 www.jrf.org.uk/report/monitoring-poverty-and-social-exclusion-scotland-2013 one of the key finding was 'health inequalities in Scotland were not only stark but growing. A boy born in the poorest tenth of areas can expect to live 14 year less than one born in the least deprived tenth. For girls the difference is 8 years' Glasgow City Integration Joint Board Strategic Plan 2016 - 2019 https://glasgowcity.hscp.scot/sites/default/files/publications/IJB_21_03_2016_ItemNo_5_-_Strategic_Plan.pdf A significant feature of North West locality is the very marked difference in the social and economic circumstances of people living in different areas in the locality, ranging from some of the most affluent areas in Scotland to some of the most deprived. Therefore an overview of statistics relating to the entire North West can mask stark inequalities within the locality. For example, male and female life expectancy is 71 and 77.2 years in North West (compared to a Scottish average of 74.5 and 79.5 years). However there is a gap of 16 years between average male life expectancy in Possilpark compared with Kelvinside, and 12.3 years gap in female life expectancy between Drumry East and	Sources are quoted within this section

	Victoria Park. Glasgow: health in a changing city (March 2016)	
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	Each section must be read within the context of the intersectionally of all the protected characteristic Equality and Human Rights Commission (2016) Is Scotland Fairer? The state of equality and human rights 2015, section 6: Access to healthcare; EHRC Evidence suggests that some groups such as Gypsy/Travellers, transgender people and people who need palliative care can experience problems accessing healthcare services. In how fair is Britain? (EHRC, 2010b), it was noted that the physical and mental health of Gypsy/Travellers was poorer than the rest of the population, and this group experienced poorer access to GPs and other primary care services. The Scottish Parliament (2012) noted that some GP practices would not register Gypsy/ Travellers on the grounds that they had no fixed address or photographic ID, or could not guarantee that they would stay in the area for at least three months. In evidence to the Scottish Parliament's 2012 Equal Opportunities Committee on Gypsy/Travellers improve services for Gypsy/Travellers were highlighted, including outreach initiatives, health visits to sites, and linking patients directly to GP practices and dentists (Scottish Parliament, 2012). Practice guidance has been produced for GPs on Gypsy/Traveller patients (NHS Health Scotland, 2015) and a revised GP registration form includes explicit guidance that the 'regulations relating to GP registration apply equally to members of the travelling or settled populations' and 'there are no inherent obstructions which relate solely to the Gypsy/Traveller community' (Scottish Government, 2013d). Refugees and asylum seekers: A study based on data from 2010/11 found that few refugees or asylum seekers had experienced any problems in accessing healthcare in Scotland (Scottish Refugee Council, 2011). Most of those who did were refused asylum seekers; reasons for non-registration included being asked for a letter from the Home Office, being new to the area, not knowing where to register or not having any health problems. More recently, a study (Da Lomba and Murray 2014) of refused asylum seekers' access to and experiences of maternity care in Glasgow found that, although women who had received a negative decision on their asylum claim experienced difficulties relating to language and information, they nonetheless received access to free NHS primary and secondary care. NHS Scotland: Health issues and access to services web link: http://www.healthscotland.com/equalities/race/acessingservices.aspx Asylum Seekers Research with asylum seekers and refugees representing 26 different nationalities in Glasgow by NHS Greater Glasgow and Clyde in 2005 revealed these groups experience a multitude of problems which prevent them from promoting their physical and mental health and wellbeing. The complexity of seeking asylum, poor living conditions, lack of money, language barriers, racism and lack of control over their future appear to manifest themselves in mental health problems. These problems also make asylum seekers and refugees vulnerable to developing other health related problems e.g. drug and alcohol misuse. The research recommended that it is important that service providers address practical problems facing asylum seekers and refugees through providing a much more holistic and needs led approach. Gypsies/Travellers have some of the poorest health outcomes in Scotland. The Health Protection Agency in England has conducted a mapping exercise of Primary Care Trusts to explore what is known about local Gypsy Traveller populations, estimate immunizations rates and describe current services to increase immunization as well as to address wider health issues. It was found that there is an ongoing need to improve knowledge of population numbers and the provision of and access to services that are culturally sensitive and responsive to the needs of Gypsy Traveller communities. Immunization services are only one component of a wider strategy for improving the health of Gypsy Travellers through effective health and social care interventions.	Sources are quoted within this section

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

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

Sex	None	individuals.	opportunities to review an equality impact on local service provision to improve the service delivery to men, women and non-binary individuals.
Gender Reassignment	None	Opportunity to promote and improve accessibility to services for Tran-men and Tran–women and their communities.	Any changes can provide opportunities to review an equality impact on local service provision to improve the service delivery to Tran-men and Tran–women and their communities.
Race	None	Opportunity to promote and improve accessibility to services for black and ethnic minorities' community.	Any changes can 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.	Any changes can 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.	Any changes can 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 and their communities.	Any changes can provide opportunities to review an equality impact on local service provision to improve the service delivery to individuals with 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.	Any changes can 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.	Any changes can 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.	Any changes can 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.	Any changes can 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/refugees, travellers, ex-offenders	None	Opportunity to promote and improve accessibility to services for individuals and communities from marginalised groups.	Any changes can provide opportunities to review an equality impact on local service provision to improve the service delivery to individuals and communities from marginalised groups.

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

	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 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 men, women and non-binary individuals.	None
Gender Reassignment	In Tran-men and Tran-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 Tran-men and Tran–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 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 with disabilities and their communities.	None
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 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	Failure to examine and reflect on local service delivery can lead to negative impacts on individuals of all age groups and their communities.	None
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 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 who are pregnant and maternity leave.	None
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