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 Improvement Strategic Direction

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

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

Health improvement services and activities have traditionally been delivered on a universal basis, but a growing body of evidence has shown that health inequalities have been widening in Glasgow city over time. This evidence along with changing demography in the city, has led to significant reflection on the approaches undertaken. The Strategic Direction sets out how we intend over time to ensure that we continue to support the whole population but provide a more intensive suite of support to people with protected characteristics and those experiencing the greatest health inequalities. Our emphasis will be on creating equality of opportunity of access and equity of outcomes for those experiencing the worst in health inequalities. The strategic direction for health improvement in Glasgow city is a clear and explicit commitment to reducing health inequality over the next ten years (taking full account of the changing demographics of the city) and to maximising impact for the health improvement effort by emphasising the need to work across programmes: on co-ordinated delivery, and on measuring the collective impact of our services and activities.

Concern about the health gap is a key driver for the strategic direction.

To narrow health inequalities in Glasgow, the strategic direction commits us to a more defined set of priorities, using three levels of delivery (described fully later in this section). One level of delivery will concern neighbourhood working in a limited number of neighbourhoods in the city. In comparison with other parts of the city these are neighbourhoods where health has not improved over time. This approach has gained commitment of Community Planning partners and now forms part of the Glasgow Single Outcome Agreement (SOA) which also has a ten year duration. Partners are committed through the SOA to work in partnership with communities to seek improvements in outcomes for residents in the targeted neighbourhoods on a wide range of indicators.

The commitment to neighbourhood working is an integral part of the Strategic Direction. We recognise the need to be mindful of the health inequalities within protected characteristic groups beyond these neighbourhoods. The Policy

review “Hard to Reach, Easy to ignore” captures much of this complexity and challenges us to ensure that working in neighbourhoods – or place based working – does not result in a narrow focus on socio economic inequalities. The focus on neighbourhoods will take cognisance of the diversity within, rather than assuming that these are homogenous communities.

For these reasons, we also propose to work at two complementary levels of People and Population.

Health inequalities exist between those with protected characteristics and others, e.g. between disabled people & non-disabled people; between men and women; and between different ethnic groups. Improvements we have seen have by-passed many of our residents, with poverty an underlying contributing factor to the widening gap. To help overcome this we will shift how our resources and capacity are used towards those who most require our support. Such a shift will (over time) directly help to address the ‘inverse care law’ where those who most need medical care are least likely to receive it, whilst those with least need of health care tend to use health services more (and more effectively).

Defining more clearly the aspects of health improvement that will be delivered at people level and those which will be at population level will be part of the programme review process. Through reviewing all of our programmes of delivery, we will ascertain the appropriate targeting of effort, be it at the Place, People or Population level. Attention to the Equalities’ duties will be a key part of each programme review.

Purpose of the Strategic Direction

The strategic direction has been informed by a wealth of data on health indicators in Glasgow. (e.g. Glasgow Centre for Population Health, Community Health Profiles, SIMD Data,) Glasgow Community Health Partnership (CHP) has made a commitment to refocus its health improvement effort in the city. The fundamental purpose of this is to maximise the impact of the programmes and services delivered with an increased concentration of delivery effort in more discrete and focussed programmes of activity. A suite of papers detailing the strategic direction was approved formally at the Glasgow City Community Health Partnership (CHP) Committee in October 2012. Work streams to enact the strategic direction, committed to the Glasgow City CHP Development Plan are now underway; much of this work is expected to develop over time. Through this process we have committed to review all of our mainstream Health Improvement Programmes. This EQIA will be used as a tool to achieve this process over the coming years. The programme of review is already underway with both the Schools and the Oral Health Programme.

Changes and Outcomes

Positive change in health / quality of life can and has happened in Glasgow. For example, since 2004, 75 data zones (67,000 residents) have ‘moved out’ of deprivation. However greater change is required, as 43% of Glasgow data zones still remain in the 15% most deprived category, with approximately 42% (244,587) of Glasgow’s population living in

deprived areas.

The strategic direction commits the health improvement workforce to delivering on three themes or areas of priority.

- **Building structurally and socially resilient communities** (reducing poverty and growing aspiration)
- **Building mental well-being and resilience**
- **Creating a culture for health in the city** (alcohol, drugs, smoking, and obesity)

Building mental well-being and resilience. At an individual level, there are protective factors that mitigate against risk e.g. there is a clear gradient in the relationship between emotional adjustment in children and subsequent crime rates, misuse of drugs and alcohol, smoking and suicide rates. The health improvement specialist workforce is well placed to support programmes in communities that enhance skills, energy and personal resources. Building capacity and growing social capital supports the reduction of social isolation which itself is a contributing factor to health inequality, e.g. individuals who are socially isolated are between two and five times more likely to die prematurely than those who have strong social ties.

Building structurally and socially resilient communities (reducing poverty and growing aspiration). These are the pre-requisites identified in the Marmot Review and the Persistent Poverty analysis – including employment, income and infrastructure through which purpose and support are built and found. The heavy reliance on welfare within Glasgow means welfare reform will bring very significant change for our residents. This alongside the changing economic landscape is expected to generate further differences in health outcomes for our population. This requires a focused intervention with existing community infrastructures e.g. anchor organisations. Health improvement capacity will be realigned to work with the identified neighbourhoods to contribute to social change and seek to influence partners to work with us in this way. (Social Resilience is about communities and individuals harnessing local resources and expertise to help themselves in ways that can both compliment and challenge existing service delivery). Recognising that poverty stretches well beyond just a few key neighbourhoods in the city the strategic direction will include further Health Improvement actions to contribute to the tackling poverty requirements of the city, particularly around employability, financial inclusion, volunteering and aspiration.

Creating a culture for health in the city. As a consequence of its high levels of poverty, Glasgow has a high prevalence of health issues / behaviours, i.e. alcohol use, drug use, smoking, and obesity that have led to much of its health inequalities that contributes to its 'unhealthy' culture. We know that the impact of these issues has greatest effect on our poorest, most isolated or stigmatised groups and are both a consequence of poverty & are often a direct response to the social circumstances many of our citizens experience in their daily lives. Tackling these deep seated issues goes beyond changing individual behaviours. By tackling poverty & isolation and growing community aspirations/social capital, we will work toward addressing the following key public health issues for which we have the

strongest evidence base as being contributors to the gap in life expectancy.

- **Alcohol**. The Ripple Effect research (2007) found that 99% of communities in the city reported alcohol significantly affected their community, with 95% reporting this issue as having a negative impact on where they live. Health Improvement should work to create a City less reliant and associated with drinking alcohol.
- **Drugs.** Glasgow City has more than double the rate of drug users than the next nearest local authority area in Scotland. Drugs prevention programmes are crucial in an environment of continual growth in the number of people directly and indirectly affected by drugs. The Glasgow Effect work has clearly identified drug deaths as a very significant contributor to the state of health in the city.
- **Smoking**. Tobacco remains the number one cause of preventable death and ill health in Glasgow city, again concentrated in the most deprived areas. Cessation services are well established and have been a notable success in health improvement. Targeting particular sectors of the city's population will be a key focus, for example expectant mothers and fathers, children and young people to support them to quit and to prevent addiction to tobacco.
- **Obesity**. Our population's weight is drifting upwards. Health Improvement have a role to support a culture of healthy weight, reducing the drift over time and the drift upward with age.

The three priority themes described above will be supported at three different levels of delivery. These three levels will be connected by utilising the learning and data captured from all three levels to influence mainstream service delivery.

- **Population Level**: priorities for cultural change across the city that require universal action across the population at various life stages. The priorities will be tailored across the life course with an emphasis on affecting change within families and for children and young people.
- **Place Level**: priorities that affect a selection of neighbourhoods within the city and a more select number of priority neighbourhoods for which there are so many health inequalities that we will make a longer term commitment to support these to become more empowered, involved & connected to allow for an asset based approach to be developed. Asset models accentuate positive ability, capability and capacity to identify problems and activate solutions which promote the self esteem of individuals and communities leading to less reliance on professional services. However, approaches adopted within the strategic direction recognise that in many of our communities the required 'assets' may not be readily available. In these circumstances higher levels of support will be developed to help to 'grow' these sufficiently to allow any asset based approach to take effect.
- **People Level**: working with identified groups of people who experience events/circumstances which challenge their ability to remain well e.g. those experiencing discrimination, and key groups of people who experience multiple vulnerabilities resulting in considerably lower healthy life expectancy e.g. the mean age of death for someone experiencing homelessness is 41 years for men and 37 years for women. For people experiencing extreme life events place is not the defining characteristic.

Services and Activities Affected
It is recognised that the evidence of outcome data we currently have in some programme areas is not sufficient. Our performance measures in respect of HEAT and other targets are limited and not always meaningful. Part of the work we set out to achieve will be to build the evidence base and ensure that we have robust ways of capturing the outcomes of the strategic direction. In particular in new ways of working, such as the emphasis on defined neighbourhoods. The outcomes of the strategic direction will require to be monitored over its duration. There is likely to be a level of change in all Health Improvement Services and activities over the coming years, as the strategic direction is realised. This will involve standardising the collection of disaggregated data by protected characteristics both for health improvement programmes and for any commissioned services. As noted above the EQIA process will be used as a tool to review all Health Improvement Programmes over the coming years.

The development of the implementation plan will be through an iterative process, which will inform future developments. For example, the changes in the number of programmes delivered and determining which programmes will cease to be delivered will be achieved through a continued cycle of review and re-review. Two existing Health Improvement delivery programmes, i.e. Schools & Oral Health, are already currently being reviewed. Ultimately programme reviews may affect how staff capacity is deployed, but this will vary depending on the scale of change required.

3 Lead Reviewer

Fiona Moss – Head of Health Improvement, Glasgow City Community Health Partnership

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

Nichola Brown, Health Improvement Manager; Eric Duncan, Health Improvement Senior; Nicola Fullerton, Health Improvement Lead; Julie McCarthy, Health Improvement Lead; Janet Tobin, Health Improvement Manager Support.

This document has also been informed by all Health Improvement Leads in Glasgow city and managers in the three sector teams.

5. Impact Assessment

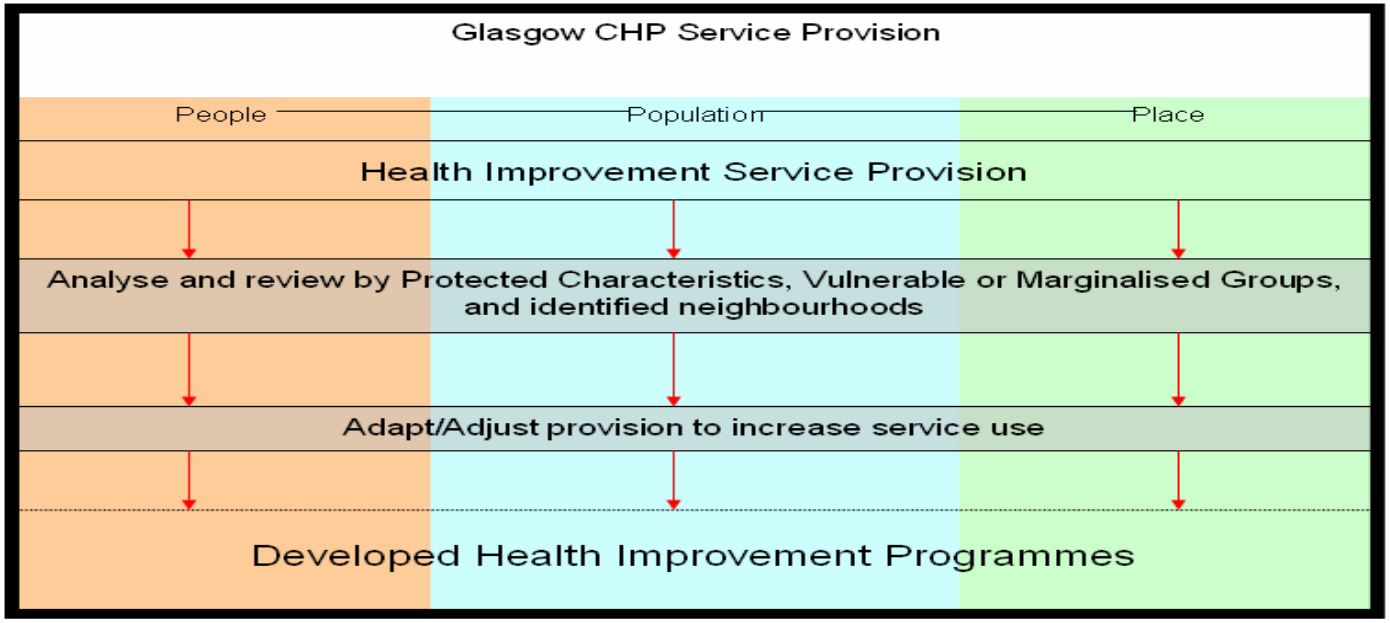
A Does the policy explicitly promote equality of opportunity and anti-discrimination and refer to legislative and policy drivers in relation to Equality

The policy allows Glasgow CHP Health Improvement Services to respond more directly to the Equality Act 2010 and to the 3 general duties:

- **To eliminate discrimination, harassment, victimisation and any other conduct prohibited under the act by**
- **Advance equality of opportunity between persons who share a characteristic and those who do not**
- **Foster good relations between people who share a protected characteristic and those who do not**

The framework diagram below shows the mainstreaming approach to delivery within the policy and illustrates the process of review, redesign and programme development that will work together to ensure the 3 General Duties are met.

Glasgow CHP Framework to Review
Health Improvement Programmes and Delivery for Strategic Direction



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	Health is not the product of a single circumstance or experience. It is shaped by socio-economic, political and societal circumstances as well as by environmental, biological and behavioural factors. If the health of the people living in Greater Glasgow & Clyde is to improve we must address all of these factors and circumstances. The inequalities in health that we experience in our population requires policies to reduce poverty and disadvantage as well as to improve delivery of services that ensure access for everyone, taking account of people's life circumstances. Nine hundred and seventy-six of Scotland's 6,505 data zones constitute the 15% most deprived. Based on the Overall SIMD Index for 2009, Glasgow City has the highest share of Scotland's 15% most deprived data zones for a local authority - three-tenths (302, 30.9%). In relative terms, Glasgow City has the largest proportion of its data zones in Scotland's 15% most deprived, over two in five (43.5%). The most recent SIMD data (December 2012) continues to highlight the poverty issues faced in the city, with 39% of residents living in the most deprived 15% SIMD data zones (233,714 people) in Scotland. 46% of Scotland's poorest 5% data zones are within Glasgow and over half of these areas have been in the bottom 5% in every index since it commenced in 2004. HI Teams have traditionally sought to overcome this issue by delivering services on a geographical basis, using poverty and deprivation indices as a means to identify geographical target areas. Whilst this 'geographic approach' has been working relatively effectively in tackling health inequalities for Poverty / Social Class it has performed less well for other protected characteristic groups. Historically people in any targeted neighbourhood were assumed to be homogenous with deprivation and social class being seen as the defining characteristic that bonds each to the other. The policy approach acknowledges that this is not so. We know that need is differential across and within each protected characteristic group. An example of a targeted health improvement	**A Call to Debate : A Call to Action A Report on the Health of the Population of NHS Greater Glasgow and Clyde 2007-2008** **Scottish Index of Multiple Deprivation Data 2004-2009** Social Work Demographic Report June 11 CHP Development Plan 2013 – 16 Keepwell Anticipatory

	approach which takes cognisance of this is the Keepwell Anticipatory Care Programme. This delivers in SIMD 1 areas across Glasgow, targeting vulnerable people and protected characteristic group within these areas.	Care Project Report
Sex	There are inequalities of life expectancy between men and women across Glasgow. Generally women live longer than men. The average life expectancy for women in Glasgow is 78 years and for men is 71.6 year. However in areas of highest deprivation life expectancy falls for both men and women. Males in the 10% most deprived areas can expect to live to 68.2 years and females in the 10% most deprived areas can expect to live to 75.7 years. The links between gender and health are becoming more widely recognised. An example of this can be illustrated by looking at mental illness. Although there do not appear to be sex differences in the overall prevalence of mental and behavioural disorders there are significant differences in the pattern and symptoms of the disorders. These differences vary across age groups. In childhood a higher prevalence of conduct disorders is noted for boys than in girls. During adolescence girls have a much higher prevalence of depression and eating disorders and engage more in suicidal thoughts and suicide attempts than boys. Boys experience more problems with anger, engage in high risk behaviours and complete suicide more frequently than girls. In adulthood the diagnosis of depression and anxiety is much higher in women, while substance use disorders and antisocial behaviours are higher in men. In the case of severe mental disorders, such as schizophrenia and bipolar disorder, men typically have an earlier onset of schizophrenia while women are more likely to exhibit serious forms of bipolar disorder. In older age groups the incidence rates for Alzheimer's disease is reported to be the same for women and men, however as women generally have a longer life expectancy there are more women than living with the condition. In the Glasgow area 82% of domestic violence incidents were committed against women. Gender based violence is recognised as a significant public health problem. Its physical and mental health consequences are profound. In addition, childhood physical, emotional and sexual abuse, domestic abuse and sexual	**Increase in Scottish Life Expectancy** 19/10/2011 **A Call to Debate : A Call to Action A Report on the Health of the Population of NHS Greater Glasgow and Clyde 2007-2008**

	violence contribute to physical and mental ill health of children, adolescents and adults, affecting a significant proportion of the population throughout their lives. Women are likely to have higher qualifications, but lower employment rates and income than men. In April 2010 the reported difference between female and male full time hourly median earnings excluding overtime in Scotland was 7.2%. Women were found to be less likely than men to have savings and to be coping less well financially. Single working age women with dependent children are more likely to be in relative poverty than single, working age men with dependent children.	*(Scottish Governments social research, 2011, the position of Scotland's equality group's revisiting resilience in 2011).*
Gender Reassignment	There is no reliable information on the number of transgender people in Scotland. In the UK, the number of people aged over 15 presenting for treatment for gender dysphoria is thought to be 3 in 100,000 or around 150 per year. In Scotland a scoping exercise found this number to be slightly higher at approximately 200 per annum. Over a 2 year period (2010 & 2011) 591 people attended the Glasgow City Gender Reassignment Service at the Sandyford Initiative. 134 of whom were new referrals. Scotland wide survey found a 4:1 ratio of trans women to trans men. Although limited, data collected by NHS identified a number of factors that have significant effect on the health of trans people, including: • Inconsistent funding and access to gender reassignment services throughout Scotland • Lack of access to essential medical treatment for gender identity issues, i.e. electrolysis for trans women • Lack of awareness and understanding of care providers so that transgender people are inappropriately treated in single gender out-patient and in-patient services • Lack of social work service to support children, young people, adults and families with gender identity issues • Mental health problems including suicide, self harm anxiety and depression.	Gender Reassignment Services Protocol, NHS Health Scotland The Scottish Transgender Survey, & Scottish Government and the Equality and Human Rights Commission

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Experiences of social exclusion, violence and abuse and the resulting negative impact on health and well-being.

There is no definitive figure for the number of transgender people in Glasgow; however It is likely that a greater percentage of trans people will live in Glasgow, being drawn by better access to services, better trans services, greater anonymity, less stigma & discrimination etc.
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<td>Page 4 Briefing Paper: Gender Reassignment and Transgender</td>
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<tr>
<td>Race</td>
<td>
Ethnic Groups in Glasgow
<table>
<tr><td>All People</td><td>593245</td></tr>
<tr><td>White</td><td>52,4561</td></tr>
<tr><td>White Scottish</td><td>46,6241</td></tr>
<tr><td>White Other British</td><td>24,154</td></tr>
<tr><td>White Irish</td><td>1,128</td></tr>
<tr><td>White Gypsy Traveller</td><td>407</td></tr>
<tr><td>White Polish</td><td>8,406</td></tr>
<tr><td>White Other White</td><td>14,124</td></tr>
<tr><td>Mixed or Multiple Ethnic Groups</td><td>2,879</td></tr>
<tr><td>Asian, Asian Scottish or Asian British</td><td>47,758</td></tr>
<tr><td>Asian, Asian Scottish or Asian British, Pakistani, Pakistani Scottish or Pakistani British</td><td>22,405</td></tr>
</table>
In 2004 it was estimated that 5.4% of Glasgow’s population were from other ethnic groups. More recent analysis by Glasgow City Council in 2008 concluded that 11.4% of Glasgow’s population could be determined to be of Asian, Black, Mixed or other ethnic backgrounds. This work has not only highlighted that the ethnic diversity of our population has more than doubled in the last decade but also how neighbourhood composition has also changed during this time. Glasgow currently has more than 74 spoken languages with BME people more likely to require communication support to navigate into, through and out of services. Currently Health Improvement do not routinely collect data disaggregate by race but what data we have indicates a lower % uptake of health improvement activities by BME groups than would be expected. We know that impacts of racism, cultural bias,
</td>
<td>Scotland’s Census 2011 – National Records of Scotland

Glasgow City Council in 2008</td>
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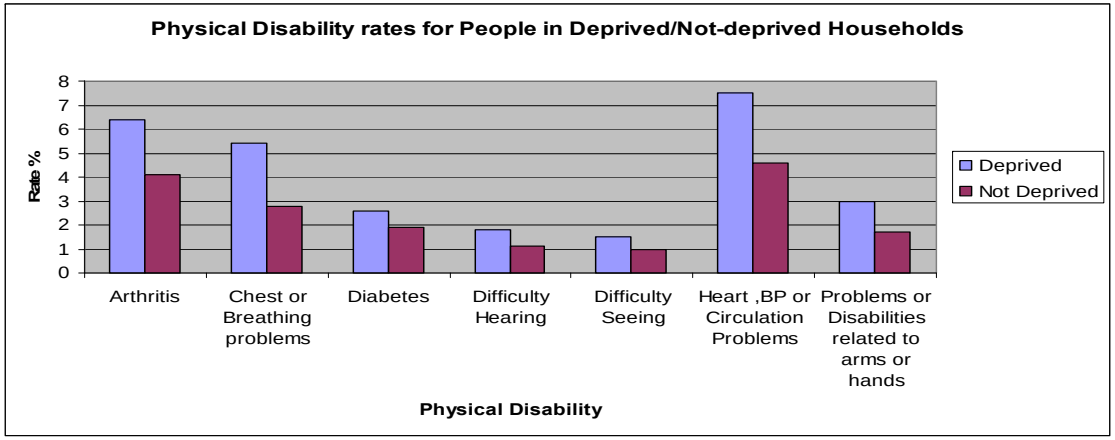
	can hinder BME uptake of services.	
Disability	Glasgow has an average rate of 17% of people who identified themselves as being disabled compared with a Scotland average rate of 14.1%. In the 2006 Scottish Index of Multiple Deprivation (SIMD) the disability rate for people living in deprived areas in Glasgow was estimated at 20.1%, compared with a Scotland average rate of 14.1%  More recent information from Scotland's Census 2011 shows that there are 75,864 people in Glasgow whose long term health problem or disability limits their day to day activities. In addition there are 58,998 whose day to day activities are limited a little. Due to a lack of disaggregated patient data identifying disabled patients, it is not possible to show how recorded disability features in current uptake of Health Improvement Services, however evidence from our patient groups suggests that disabled people have more difficulties in accessing health services than non-disabled people. The barriers that have been identified are commonly given as: • Difficulty in reading and understanding letters • Difficulty using telephones to arrange appointments • Transport difficulties including costs • Engagement in health services arising from mental health problems	(Population with a Disability in Glasgow, 2011) Scottish Household Survey 2007/2008 Scotland's Census 2011 – National Records of Scotland NHS Greater Glasgow and Clyde Communication Support and Language Strategy and Action Plan

Sexual Orientation	***Population estimates*** As the census and most large scale surveys do not include categories to describe Lesbian, Gay and Bisexual (LGB) identity there is no definitive or consistent way to measure those in the population who are LGB. In planning for introducing civil partnerships, the UK Government's best estimate based on synthesising survey data is that between 5-7% of the population identified as LGB. It is known that many LGB people tend to migrate towards cities, therefore this number will likely to be higher for the Glasgow City area with a recent study showing that Glasgow is a favourable place to migrate to for LGB people as it is easier to be LGB, has good social facilities, allows more self-confidence and self acceptance, when compared to other parts of Scotland. Using an estimate figure of 6% suggests around 17,500 men & 18,500 are or will grow up to be LGB in the Glasgow City representing more than 50% of the total estimated LGB population across the whole NHSGGC area. LGB health & well-being outcomes have been shown to be notably poorer than in the heterosexual community. A greater percentage reported higher hazardous alcohol use, smoking and poorer psychological well being with less LGB people reporting Good / Very good health. Where lesbian, gay, bisexual and transgender (LGBT) people are concerned there is an added dimension of discrimination which can make the difference between good and bad health. Problems associated with homophobia in early life such as bullying and low self-esteem can continue into adulthood and have serious long term negative effects on health. This has been evidenced in that attempted suicide rates amongst gay men are higher than in the heterosexual population and anxiety, depression, self-harm and attempted suicide have been linked with experiences of prejudice and discrimination. A needs assessment of young lesbian, gay and bisexual people in Glasgow recorded that 80% of them had experienced discrimination. Those surveyed had up to three times as many suicidal thoughts as the general population.	The Needs and Experiences of Lesbian, Gay, Bisexual and Transgender People in Glasgow (NHSGG&C, 2011 ?? The Scottish Health Survey, 2010 A Call to Debate : A Call to Action A Report on the Health of the Population of NHS Greater Glasgow and Clyde 2007-2008

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<tr>
<td>Religion and Belief</td>
<td>According to the 2011 census the largest faith groups in Glasgow are:
❖ Christian 322,954
❖ No Religion 183,835
❖ Religion not stated 42,050
❖ Muslim 32,117
❖ Hindu 4,074
❖ Buddhist 2,570
❖ Sikh 3,149
❖ Other Religions 1,599
❖ Jewish 897

There is little evidence to indicate specific faith groups fare more poorly than others in terms of access to Health Improvement services. However, some faith groups may require services that are sensitive to commitments to religious observance – for instance patients may not be able to attend hospital appointments due to religious festivals. There is some evidence that highlights that some faith groups are clustered within some of Glasgow's more disadvantages neighbourhoods which impacts on their health and wellbeing outcomes.</td>
<td>Scotland's Census 2011 – National Records of Scotland</td>
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<tr>
<td>Age</td>
<td>The CHP is responsible for services to the people of Glasgow City; a total population of 588,470 as shown in the table below.

<table>
<tr><th colspan="5">Table 2 – Glasgow City CHP population by sector</th></tr>
<tr><th></th><th>North East</th><th>North West</th><th>South</th><th>Glasgow City CHP</th></tr>
<tr><td>Total Population</td><td>177,649</td><td>190,332</td><td>220,489</td><td>588,470</td></tr>
<tr><td>Age 0 - 15</td><td>29,538</td><td>28,402</td><td>38,743</td><td>96,683</td></tr>
<tr><td>Age 16 - 64</td><td>122,092</td><td>136,549</td><td>151,602</td><td>410,243</td></tr>
<tr><td>Age 65 - 74</td><td>13,810</td><td>12,911</td><td>15,622</td><td>42,343</td></tr>
<tr><td>Age 75+</td><td>12,209</td><td>12,470</td><td>14,522</td><td>39,201</td></tr>
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<td>Glasgow City CHP Development Plan 20 March 12</td>
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	The Equality Act 2010 introduced a ban on age discrimination within public services. The ban which became effective in October applies to people aged 18 years and over. Within health policy & services the term 'older population' refers to people aged 65. The 2011 Census reported 890,300 people in Scotland aged 65 and over, representing 16.8% of the total population. Between the 2001 and 2011 census Scotland wide showed 10.6 % rise in over 65s; however in the NHSGGC a lower rise of 7.6% was reported. Despite the overall predicted rise in the 'ageing population' over the next 20 years it appears that in the GCC area this rise will not be to the same extent. Generally people die younger in more disadvantaged areas with data showing that older populations tend to be more concentrated in local authority areas of greater wealth and less so in those most deprived. For example in Glasgow City Council area the older population lowered by 9.2% while in East Dunbartonshire Council area it rose by 21.8%. People who live in disadvantages area tend to prematurely age and suffer from long term limiting illnesses in these communities. The overall trend for premature deaths is one of steady improvement; however premature death remains much more common in the more deprived areas. Over the last decade the rate of deaths among those aged 55 – 64 years in Scotland has been at least a quarter higher than in England and Wales for both men and women which show that the high Scottish rate is not just due to high rate in a few local authority areas. Life expectancy at birth is also less in Scotland than in any EU country apart from Portugal. The standardised mortality rate for stomach cancer, lung cancer and heart disease in Glasgow is almost twice as high as that in the best areas. Total deaths of those aged under 65 years show a similar geographic pattern with the rates in the worst local authority (Glasgow City) twice as high as those in the best (East Dunbarton).	1998 data from *Chasing the Scottish effect: why Scotland needs a step-change in health if it is to catch up with the rest of Europe*, Hanlon P. et al, Public Health Institute of Scotland, 2001. Excludes the accession countries. Macintyre, S., *Socio-economic inequalities in health in Scotland*, Social Justice Annual Report 2001, Scottish Government, 2001, page 116.

Pregnancy and Maternity	It is known that there were 7,631 births in the Glasgow city area during 2011 (51% female and 49% male). There is no disaggregated data available to determine how pregnancy or maternity impacts on attendance at Health Improvement activity.	National Records of Scotland, Glasgow City council Area Demographic Factsheet
Marriage and Civil Partnership	In 2011 there were 2846 marriages in Glasgow City and 41 male and 55 female Civil Partnerships. Currently we do not routinely collect data by marital status /civil partnerships therefore we have no evidence of any relationship between marriage and civil partnership and non-attendance at Health Improvement services.	(2011: The Registrar General's Annual Review of Demographic Trends)
Social and Economic Status **Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders**	The latest SIMD figures (SIMD 2009) estimate that over 190,000 Glaswegians, a third of the city's population, reside in the 10% of most deprived areas in Scotland. The population of NHS GG&C faces significant and challenging health problems. It has shorter life expectancy than the rest of Scotland, and is marked by higher levels of deprivation. The standardised mortality rate in the 10% most deprived neighborhoods is a third higher than in the most prosperous 50%. The difference in male life expectancy between the most and least socio-economically disadvantaged local government districts in Scotland was 7.6 years in 2001 (Glasgow City had a life expectancy of 68.7 years, whereas East Renfrewshire was 76.3 years). Research has suggested that the serious economic decline experienced by areas such as Glasgow and Inverclyde might have "impacted on population health status over and above the aggregate health status of poor individuals living within that area".	NHSGG&C's Acute Services Plan 2010 – 2013 Glasgow City Community Health Partnership Development Plan 2011/12 Paterson, I., *Geographic and social inequalities in*

	Differences in health behavior account for some of the health outcome inequalities between social classes. 49% of men in the most deprived areas smoke regularly compared to 26% of men in the least deprived areas. The divide is similar for women: 43% smoke in the most deprived areas, compared to 24% in the least deprived. We are aware that poverty and deprivation affects the likelihood of attendance for hospital appointments and this is confirmed by our SIMD patient data. Some patients may not be able to afford to attend their hospital appointments due to its geographical location if appointment is offered outwith their local catchment area. E.g. Travelling expenses are usually claimed on the day, however, some may not be able to wait for reimbursement and therefore they may not be able to access public transport. **Marginalised groups:** Asylum Seekers, Refugees, and Prisoners **Prisoners: prison population** In 2008-09, the average daily prison population was 7,835, the highest annual level ever recorded. Of these 1,678 (21%) were on remand. 95% were men and (5%) were women (Statistics Scotland 2008/09). Most prisoners (95%) are male, young (49% were aged < 30 years) and white (96%) Over the nine year period, 1999/00–2008/09, the average daily prison population increased by 31%, with the female prison population having increased over three times (97%) that of the male population (29%) There is a linear relationship between social class and imprisonment with those from the most deprived areas most likely to experience imprisonment. Based on data from 2003, it was estimated that each year about 1 in 9 men aged 22-24 from the most deprived 27 wards in Scotland (2.2% of all wards) will spend some time in prison (Ref: Houchin R, 2005). 50% return to custody within 2 years, with half of these returning within six months	*health: the Scottish picture*, in Blamey, A., Hanlon, P., Judge, K., and Muirie, J., (eds.), Health Inequalities in the New Scotland, Health Promotion Policy Unit and Public Health Institute of Scotland, 2002. Prison Statistics Scotland 2008/09 Bain, M., *Patterns and trends in health inequalities* in Blamey, A., Hanlon, P., Judge, K., and Muirie, J., (eds.), Health Inequalities in the New Scotland', Health Promotion

	(Ref: Ash R & Bigger H, 2003). The most common causes of imprisonment are non-sexual crimes of violence (37%). Serious assault and attempted murder is the main crime for 17% of sentenced prisoners, homicide for 14% and drug-related crimes for a further 14% (Ref: Prison Statistics Scotland 2008/09). Scotland has one of the highest imprisonment rates in Western Europe (150 per 100,000 populations) (Ref: Prison Statistics Scotland 2008/09). Offenders from Glasgow City represent a disproportionately large group in the prison population: while Glasgow has 11% of the total 16+ Scottish population, 21 per cent of prisoners are from Glasgow This is reflected in the imprisonment rate per 100,000 population, which is highest for Glasgow at 337, followed closely by Dundee at 328. West Dunbartonshire, Inverclyde, North Ayrshire and Renfrewshire also have relatively high imprisonment rates (Chart 8). Orkney has the lowest rate (30), followed by Aberdeenshire (53), Eilean Siar (69), East Lothian and East Dunbartonshire (70 for both) (Ref: Statistical Bulletin: Crime and Justice Series: Prison Statistics Scotland: 2008-09) **Asylum seekers** As of January 2008, the number of asylum seekers supported in Glasgow was 4,887, broken down into these categories: • Section 95 (accommodation and support) 3,913 individuals/1,546 households • Section 4 (failed applicants receiving support) 606 individuals/446 households • Subs only: 55 indivuduals/26 households Glasgow is the only Scottish City that has agreement with the National Asylum Support Services to provide accommodation to asylum seekers. This means that	Policy Unit and Public Health Institute of Scotland, 2002, Box 4, page 22. **http://www.equalitiesinhealth.org/asylumseekers.html** **http://www.ica**

	the majority of asylum seekers in Scotland live in Glasgow.	**r.org.uk/?lid=9982**
	Refugees While it is relatively easy to account for the number of people seeking asylum who live in Glasgow, it is more challenging to establish the number of refugees. There are no reliable figures available on the number of refugees in the UK, Scotland or Glasgow. However recent research estimates that approximately 300 people seeking asylum receive a positive outcome each year. There is no way of knowing how many remain in Glasgow.	
	Addictions In 2012-13, Glasgow CATs received 15,477. The vast majority of these referrals were for people who reside in the most deprived areas of the city. 14% of all people in prison are there for drug related crimes.	**Glasgow City Addiction Services**
	Gypsy/Travellers Latest figures for Scotland in the census states approx 4,200, however this number may be low due to low rate of self-identification as a Gypsy Traveller due to stigma, literacy levels, etc.	**Census 2011**
	Homelessness The Scottish Government have published the homelessness statistics covering April to September 2010. The figures show that the number of homelessness applications in Glasgow increased by 1.2% compared with the same period on 2009 – a total of 5,442 households. At 31st December 2010 there were 2,212 households in temporary accommodation in Glasgow, 850 of which contained dependent children or pregnant women. The total number of children in temporary accommodation at this point was 1,542.	Scottish Government
	Research by Glasgow Homeless Network found homeless people are 5 times more likely to use A&E than the general population. Homeless Link's Health Audit found that 42% clients had used A&E at least once in the past 6 months. Glasgow Homeless Network has reported that staff attitudes are the single largest deterrent to homeless people taking up services, with 54% quoting this as the reason they did not go to a GP or hospital.	Glasgow Homeless Network

C Do you expect the policy to have any positive impact on people with protected characteristics?			
	Highly Likely	**Probable**	**Possible**
General	The three levels of delivery and the three main themes within the strategic direction will benefit the people of Glasgow in a range of ways, including • The gathering of data disaggregated by protected characteristics will allow us to assess the use, and therefore the accessibility, of HI delivered, supported or commissioned services in a range of local & city wide settings • Supporting a process toward the refocusing & re allocation of HI & partners resources more appropriately taking into account the needs of the city's Protected Characteristic groups and other communities • Its focused and targeted approach will help tackle Glasgow's most deep rooted health inequalities and so will improve the	• It will impact on delivery mode of NHS, and other stakeholders to improve care pathway for people with protected characteristics and to those without. • It will support wider engagement of Glasgow's communities in a range of local delivery settings, reducing social isolation, building social capital and to enable learning to be shared and adopted by NHS and Stakeholder organisation and groups alike • Health improvement commissioned service design will take account of the need to provide equitable services for those with and without protected characteristics, thereby improving outcomes and accessibility	• Approaches will increase democratisation of Glasgow by engaging communities in local decision making processes and in planning and delivery of local asset based programmes

	health & well-being of the people of Glasgow including those with protected or marginalised status		
Sex	• Monitoring data will allow assessment of current use of HI programmes and will allow the people, place and population approach to address inequalities in service access and outcomes between / within the sexes. • Targeting Glasgow's most deprived communities may help to overcome the inequality of service use and inequity in outcomes for marginalised men and women. This will enhance the efforts of key city partners to increase well-being and will produce a synergy between statutory delivered and commissioned services.	Health inequalities in and between women and men may be reduced through specific targeted interventions, e.g. tackling stigma and misconception around GBV interventions, through delivery of perinatal mental health improvement programmes. There will be greater uptake of services such as; Keep Well and Bowel Screening programmes by men in our most deprived areas and by other marginalised or protected groups.	
Gender Reassignment	See general above		Currently Health Improvement does not collect data disaggregated by gender reassignment, doing so may provide NHS and partners an opportunity to understand and address the needs of trans people.
Race	See general above	Specific programmes,	

	Monitoring use of Health Improvement services will enable the identification of inequality of access to / use of these, and will be used to support any necessary service adaptations. People, Place and Population approaches, and the outcome of our HI review programme will facilitate the mainstreaming of BME groups into HI delivery.	including community capacity building activity, will be developed looking at how we can improve how BME get into and through NHS and partner services and projects. Health Improvement outcomes for existing BME groups and new migrant communities will be better developed	
Disability	See general above Will support better monitoring of service use and therefore enable engagement with wider range of disabled people.	Policy will enable HI Teams in Glasgow CHP to play a greater role in influencing the design and delivery of partner services thereby increasing accessibility and suitability of same for disabled people. Programmes to tackle stigma and discrimination will improve mental health and well being of disabled people	
Sexual Orientation	The experience of stigma and discrimination of people who are lesbian, gay or bisexual can have an adverse and negative affect on their mental health. It is expected that focussing and targeted work with this		

	protected characteristic group will have better impact and a more positive effect. Improved data collection could evidence this.		
Religion and Belief	See general above		Currently we do not collect this disaggregated data but doing so may throw up inequality of use by certain groups, e.g. non use of addiction services by Muslim men, low uptake of programmes during religious prayer time or observances.
Age	See general above People, Population and Place approach will more clearly define health improvement and partners role and so will improve service across age range groups.	Keepwell Programme will be supported to continue to deliver to those aged 40-74, with particular focus on those who do not traditionally use Primary Care Service. Early Years and Children and Families Programmes will ensure best start to the lives of our young people, thereby improving health outcomes in later life.	Monitoring of data will allow our commissioned services to design intervention suited to both men/boys and women/girls with and without protected characteristics or marginalised status
Marriage and Civil Partnership	We currently do not routinely collect data for this characteristic. However better monitoring may ensure service delivery impact of policy is at worst neutral.		
Pregnancy	We currently do not routinely	Better link with children and	

and Maternity	collect data for this characteristic. However better monitoring may ensure service delivery impact of policy is at worst neutral	families teams and delivery of perinatal mental health programme will support better health and wellbeing of women during and after pregnancy.	
Social and Economic Status	The Strategic Direction clearly recognised the connection between poor health and social and economic status. Its key aim is to address these inequalities in society through its People, Place and Population delivery approaches. Please see general above and earlier in this EQIA.		
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	The Strategic Direction clearly recognised the connection between poor health, stigma and social and economic status. Its key aim is to address these inequalities in society through its Population, People and Place approaches. Allow us greater focus on areas where marginalised groups are, and to foster better relations between and with the general population.	Take the learning from targeted Health Improvement initiatives to mainstream services for all other marginalised groups.	

D Do you expect the policy to have any negative impact on people with protected characteristics?			
	Highly Likely	**Probable**	**Possible**
General			In June 2011 the Commission on the Future Delivery of Public Services published their report which recognised the tendency for acute levels of deprivation to be 'highly localised' and recommended the use of a place-based approach to socio-economic inequality. However, it has been recognised that place-based policies may have only impact on some outcomes, for example • satisfaction with neighbourhood, • neighbourhood sustainability and • confidence and feelings of efficacy. Other issues associated with a stand alone place based approach is that many equalities strands are over-represented in terms of living in poverty, but do not necessarily live within the most deprived neighbourhoods. So, whilst some protected characteristics groups

			appear over-represented in the some of the most deprived neighbourhoods – e.g. disabled people, LGB people, & Muslims, many other groups are under-represented, with most being resident in the non lowest 15% The Strategic Direction for Health Improvement, with its combined, Population, People and Place based approaches is designed to overcome any inequity of service uptake and to provide equality of opportunity and access to all groups, thereby strengthening the mainstream approach to Health Improvement delivery. The GCHP Health Programme Framework to Review Health Improvement Programme and Delivery for Strategic Direction in Section 5 above, shows that at its highest universal level Health Improvement delivery is the responsibility of all Glasgow CHP staff not simply that of HI Teams. The People, Place and Population approaches will work jointly to remove or overcome issues of stigmatisation, problematising, 'separating out' or marginalisation of PC groups of equalities from that of the GCHP mainstream delivery model.
Sex			

Gender Reassignment			
Race			
Disability			
Sexual Orientation			
Religion and Belief			
Age			
Marriage and Civil Partnership			
Pregnancy and			

Maternity			
Social and Economic Status			
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders			

E Actions to be taken		
		Responsibility and Timescale
E1 Changes to policy	The policy will be subject to annual review in line with EQIA good practice.	
E2 action to compensate for identified negative impact	We will mitigate against any possible risks of negative impact as identified in place based work by utilising the learning across the place, people and population approaches and ensuring interconnectedness. We will do this by continuous monitoring and evaluation. This will include: • Testing of specific approaches relating to one or more equality groups to complement our mainstreaming policy, some of which will take place in the most deprived neighbourhoods as appropriate.	
E3 Further monitoring – potential positive or negative impact	• Improving data on equalities groups in all settings through standardising the collection of disaggregated data by protected characteristics both for health improvement programmes and for any commissioned services.	
E4 Further information required	A standardised database will be created to gather information for health improvement programmes, training delivered, taster sessions, health events, etc. When the data is analysed, Health Improvement can ensure mainstream delivery is tailored and influenced to improve and	

	develop programmes that are suitable for all and more accessible for people with protected characteristics.	

Review: Review date for policy / strategy / plan and any planned EQIA of services

Date to be added – Review in one year

Lead Reviewer: **Name:** **Fiona Moss**
Sign Off: **Job Title** **Health of Health Improvement, Glasgow City**
Signature

Date: **27 May 2014**

Please email copy of the completed EQIA form to EQIA1@ggc.scot.nhs.uk

Or send hard copy to:

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