NHS Greater Glasgow and Clyde
Equality Impact Assessment Tool for Frontline Patient Services

Equality Impact Assessment is a legal requirement and may be used as evidence for cases referred for further investigation for legislative compliance issues. Please refer to the EQIA Guidance Document while completing this form. Please note that prior to starting an EQIA all Lead Reviewers are required to attend a Lead Reviewer training session. Please contact CITAdminTeam@ggc.scot.nhs.uk for further details or call 0141 2014560/4967

Name of Current Service/Service Development/Service Redesign:

Sexual Abuse/Assault Service (SAAS)

Please tick box to indicate if this is a : Current Service ■ Service Development ☐ Service Redesign ☐

Description of the service & rationale for selection for EQIA: (Please state if this is part of a Board-wide service or is locally determined).

What does the service do? The Sexual Abuse/Assault Service (SAAS) provides evidence based psychological therapies to adults aged 16-65 who present with moderate to severe mental health difficulties as a result of complex trauma (namely childhood sexual abuse and/ or sexual assault). Why was this service selected for EQIA? Where does it link to Development Plan priorities? (if no link, please provide evidence of proportionality, relevance, potential legal risk etc.) Over the past few years there have been a number of local and national priorities and initiatives which link directly to adult survivors of childhood sexual abuse. There have also been a number of staff changes recently and we felt it timely to come together as a team to reflect on ourselves as a service and how we are meeting the needs of our client group.

Who is the lead reviewer and when did they attend Lead reviewer Training? (Please note the lead reviewer must be someone in a position to authorise any actions identified as a result of the EQIA)

Name: Dr Ruth Keenan, Principal Clinical Psychologist	Date of Lead Reviewer Training: December 2012

Please list the staff involved in carrying out this EQIA
(where non-NHS staff are involved e.g. third sector reps or patients, please record their organisation or reason for inclusion):

Dr Joanna McColl, Consultant Clinical Psychologist; Dr Ruth Keenan, Principal Clinical Psychologist; Dr Emma Lidstone, Clinical Psychologist; Mrs Annemarie Coleman, Senior Counsellor; Mrs Sharon Blake, Team Secretary,

	Lead Reviewer Questions	*Example of Evidence Required*	Service Evidence Provided (please use additional sheet where required)	Additional Requirements
1.	What equalities information is routinely collected from people using the service? Are there any barriers to collecting this data?	*Age, Sex, Race, Sexual Orientation, Disability, Gender Reassignment, Faith, Socio-economic status data collected on service users to. Can be used to analyse DNAs, access issues etc.*	We routinely collect information on age and sex. Information on socio-economic status and race is recorded on the CORE protocol but is not routinely analysed. The patient Information Management System (PIMS) has the facility to record marital status, religion and occupation but if we do not specifically ask for this information it doesn't get logged. Barriers to collecting information include the fact that we do not have our own referral form on sci-gateway. A referral form would standardise the information we receive from referrers and make it possible to record and later analyse this	Develop a referral form to be added to sci-gateway. This will ensure we are routinely and consistently gathering information in relation to the protected characteristics. Once this has been done more complete equalities information can be assessed each year through the annual report. Conduct a demographic audit including information on SES and race. This information is routinely collected but has not been analysed. Create a database on which equalities

				information can be recorded. This will be progressed following recruitment of an assistant psychologist.
2.	Can you provide evidence of how the equalities information you collect is used and give details of any changes that have taken place as a result?	*A Smoke Free service reviewed service user data and realised that there was limited participation of men. Further engagement was undertaken and a gender-focused promotion designed.*	Demographic information (age and sex) are analysed annually through our annual report. We have identified recently that there has been an increase in referrals for those in the 55-64 age-bracket and have wondered whether this might be a reflection of the recent media spotlight on sexual abuse allegations. We have planned a literature review and audit to investigate this further. We have also identified that we have had a higher percentage of males referred to the service (31% compared with 20% in previous years). It would be timely to conduct a service user audit to ensure we are meeting the needs of our changing population. The majority of our referrals are for females who are also parents and have some identified difficulties with parenting. We have submitted a bid	

			for funding to conduct research into the specific needs of this group with the aim of developing a specialised parenting group intervention. This bid has been approved.	
3.	Have you applied any learning from research about the experience of equality groups with regard to removing potential barriers? This may be work previously carried out in the service.	*Cancer services used information from patient experience research and a cancer literature review to improve access and remove potential barriers from the patient pathway.*	A recent audit was carried out with the aim of gathering service user feedback about the name of the service. We see a very vulnerable and marginalised population (adult survivors of childhood sexual abuse who are experiencing moderate to severe mental health difficulties) and informal feedback from service users and staff had suggested that the name of the service might be off-putting for some. The feedback suggested that service users appreciate the fact that the name of the service reflects what we do and the consensus was to keep the current name. The results have been accepted for publication in a peer reviewed journal. Research has indicated that people with PTSD and depression can experience cognitive (including memory) difficulties. Similarly many of our clients have experienced	Audit impact of text messaging service after 6 months to one year.

			repeated loss of consciousness through violence or substance use which again may be linked to cognitive difficulties. We have recently implemented a text messaging service to remind patients of upcoming appointments. This increases the range of ways we have contact with service users . The impact of this on our DNA rate will be audited in the future. Research on adapting CBT for deaf individuals has been used to inform therapy with one individual service user. Knowledge of the extent of Gender Based Violence has helped inform the way the service has been set up. For example all staff routinely enquire about ongoing physical, sexual or emotional abuse. We are very mindful of client confidentiality and ensure clients know that they will not be distinguished from other clients in the waiting room (i.e. other people will not know why they are here). We implement a “red dot” system whereby a client’s file is	

			clearly marked should they wish correspondence from the service to be anonymised.	
4.	Can you give details of how you have engaged with equality groups to get a better understanding of needs?	*Patient satisfaction surveys with equality and diversity monitoring forms have been used to make changes to service provision.*	The name audit above was designed to seek the views of service users and empower them by having a say into what the service should be called. Feedback on access to the service was sought from a deaf client.	Patient satisfaction surveys have been carried out on the service in the past but not for a number of years. We are currently in the early stages of preparing an audit to capture the views of service users. Once an assistant psychologist has been recruited, this can be progressed. We are considering creating a webpage on the NHSGG&C website so that service users can feel more engaged with the service.
5.	Is your service physically accessible to everyone? Are there potential barriers that need to be addressed?	*An outpatient clinic has installed loop systems and trained staff on their use. In addition, a review of signage has been undertaken with clearer directional information now provided.*	We see clients in a building on one level with disabled access. There are a range of seats available in the waiting area including low seats and seats with arms/no arms. To access the building a client needs to press a buzzer and await	

			an answer. If a client has specific access requirements (such as sensory impairment) reception staff are made aware of this beforehand. This has worked well with a recent service user who is deaf. The security entry buzzer is not accessible from a wheelchair. We have added a line onto our initial appointment letter encouraging service users to contact us if they have any specific access requirements. There is no loop system although this is available in the main hospital. There is little background noise in the building as most interactions occur 1:1. There is a disabled parking pace immediately adjacent to the building. Parking at the hospital is limited and service users have commented that they have found it difficult to get parked at certain times of day (i.e. during hospital visiting hours). Where possible we can be flexible	

			with appointment times to enhance accessibility to the service (for example to fit in with bus times).	
6.	How does the service ensure the way it communicates with service users removes any potential barriers?	*A podiatry service has reviewed all written information and included prompts for receiving information in other languages or formats. The service has reviewed its process for booking interpreters and has briefed all staff on NHSGGC's Interpreting Protocol.*	We have reviewed signage within the building as we noticed that the name of our service is not present until after access to the building. We have started enclosing inserts with first correspondence from the service detailing how to access the written information in alternative languages (including British Sign Language) and in large print. We have introduced a text messaging service to remind clients of upcoming appointments, with their consent. Many of our clients have difficulties with addictions and/or are involved with multiple services. This will hopefully enhance attendance rates. We are also aware that many of our clients might still be within abusive and controlling relationships. Text messaging a private number might be a safer and more discreet way of communicating appointment times	We are in the process of reviewing our service information leaflets with the aim of improving readability. This will include reducing the reading age and using larger print. Audit impact of text messaging service.

			than having multiple letters/appointment slips arriving at the home. This service will be audited within the next year. We implement a “red dot” system whereby a client’s file is clearly marked should they wish correspondence from the service to be anonymised. In these cases, information relating to the name of the specialist service is removed and the letterhead will read Psychology instead. We are aware that some of our clients live in households where other members may not know about contact with our service and we respect their confidentiality. Similarly if we make telephone contact with a client we will not identify ourselves as specifically being from the SAA service when leaving a message. Posters providing details of alternative languages/interpreting services are visible in the waiting area.	

7.	Equality groups may experience barriers when trying to access services. The Equality Act 2010 places a legal duty on Public bodies to evidence how these barriers are removed. What specifically has happened to ensure the needs of equality groups have been taken into consideration in relation to:			
(a)	Sex	*A sexual health hub reviewed sex disaggregated data and realised very few young men were attending clinics. They have launched a local promotion targeting young men and will be analysing data to test if successful.*	Our service is equally available to men and women. There has been an increase over the past year of men being referred into the service. We see this as a positive step forward both in the wider recognition by society that men can be victims of abuse as well as women and in the confidence that survivors have of being heard when they disclose. This may in part be due to the implementation of routine enquiry and the widespread discussions of abuse in the media. All of our workers are female so there is no choice of gender of worker. Many clients who have been sexually abused state that they feel	

			more comfortable with a female worker but there may be those who would prefer to work with a male. At present we have no formal way of assessing this but informal feedback from service users does not suggest that this is a difficulty. If a client felt strongly that they would prefer to be seen by a male we are able to liaise with our colleagues in clinical psychology and/or addictions as appropriate. We have an equal opportunities policy for recruiting new staff. Staff have had training in Gender Based Violence and enquire routinely about childhood sexual abuse and domestic violence. We are aware that this may be ongoing for some of our clients and work sensitively with this information. Although service users may bring a partner/family member or friend along for support, we encourage them to have individual clinical time to be able to disclose/discuss this as appropriate.	

			Clients are offered a choice of gender of interpreter.	
(b)	Gender Reassignment	*An inpatient receiving ward held sessions with staff using the NHSGGC Transgender Policy. Staff are now aware of legal protection and appropriate ways to delivering inpatient care including use of language and technical aspects of recording patient information.*	We do not routinely collect information regarding this so it is difficult to make any conclusions about how we are meeting the needs of this population. However, during the EQIA process, staff have become aware of the existence of the NHSGG&C transgender policy. We are aware of the existence of a specialist service at The Sandyford for individuals affected by Gender Dysphoria. Information on this has been distributed to all team members and an information leaflet has been saved on the shared drive. We follow the NHSGG&C equal opportunities policy when recruiting new staff.	Raise awareness of the GGHB transgender policy by distributing it to all team members and saving a copy onto the service shared drive.
(c)	Age	*A urology clinic analysed their sex specific data and realised that young men represented a significant number of DNAs. Text message reminders were used to*	The lower age limit of our service is 16. This is lower than most adult mental health services who have an entry of 18. This was to tie in with young people's services so that	Contact with CAMHS Services to ensure they are aware of our referral criteria.

		prompt attendance and appointment letters highlighted potential clinical complications of non-attendance.	there could potentially be a smoother transition between child and adult specialist services in this very vulnerable population. However, we are unsure whether CAMHS services are aware that they can refer to us. It would be timely to make contact with Child services and raise awareness of our referral criteria. Historically we have had an upper age limit of 65, with older adults mental health services picking up referrals for individuals older than this. This does not fit in with recent legislation which prevents discrimination by denial of services to individuals on the basis of age. Similarly it is discordant with our sister trauma teams within NHSGG&C. There is no evidence that the treatment of complex trauma in individuals older than 65 should be different to those under 65 unless it is complicated by age related organic issues such as dementia. We have reviewed our referrals over the past year and	We don't have strong links into services which cater for children leaving care or other vulnerable groups. However, we are aware that our sister team - the Trauma and Homelessness team have done some specific work with this population. It would be timely to talk to them and familiarise ourselves with the work they are doing in this area. Amend referral criteria to include adults over the age of 65. Look at implications of this for our service and older adults services. Communicate this change to referrers.

			found that we have only turned down one referral on the basis of age. We have contacted our colleagues within older adults services to begin a conversation about the implications of us opening up our referrals to adults of any age. We are sensitive to the effects of childhood sexual abuse at different developmental stages and maintain a developmental perspective within our clinical formulations. A recent audit revealed that there has been an increase in people referred to our service in the 55-64 age-bracket. We are interested in finding out why this might be and whether the recent media discussions of CSA has affected this. We are currently discussing ways of exploring this in more detail. Similarly, we are interested in why we do not receive more enquiries into services available for survivors over 65. This is potentially an area with a huge unmet need. We bear in mind the specific needs	

			of young people. If it is a first referral into mental health services we will consider referring on to voluntary agencies to avoid the possible pathologising of symptoms and stigma of being involved in mental health services at such a young age. However, we also have a list of "see soon" criteria and if it is a first disclosure or if the young person's school/college work is being affected we will see them as a priority. We do not have the resources to provide a crèche for service users who are parents but where possible we consider childcare arrangements when offering appointments. A recent audit has identified the majority of our clients are parents with specific parenting needs. We have recently been granted funding to research their specific needs in more detail with the aim of developing a tailored intervention.	
(d)	Race	*An outpatient clinic reviewed its ethnicity data capture and realised*	Information on race should be routinely gathered via the CORE	Complete demographic audit (as detailed above)

		that it was not providing information in other languages. It provided a prompt on all information for patients to request copies in other languages. The clinic also realised that it was dependant on friends and family interpreting and reviewed use of interpreting services to ensure this was provided for all appropriate appointments.	protocol at first contact with service users. However, some team members do not fill out this aspect of the CORE as knowledge of specific codes is required. Staff have been reminded of the importance of this and the codes have been distributed to all staff. Data on race has not been reviewed or audited. There is a general perception that we do not see many clients form ethnic minorities. When we do, we have access to interpreting services if required. We have strong links with our colleagues in COMPASS which is a specialist service for asylum seekers and refugees who have experienced complex trauma. An insert will be sent out with all first correspondence from the service, informing service users how to access information in alternative languages. Information on interpreting services is displayed in the waiting area. However, on review this was not	

			clearly visible and we have moved it to a more prominent position. We have a resource file accessible to all staff with information on different countries so that we can research human rights, cultural and religious information relevant to a client's case if required. Staff can add to this at any time should they come across information that the feel might be useful.	
(e)	Sexual Orientation	*A community service reviewed its information forms and realised that it asked whether someone was single or 'married'. This was amended to take civil partnerships into account. Staff were briefed on appropriate language and the risk of making assumptions about sexual orientation in service provision. Training was also provided on dealing with homophobic incidents.*	This information is not formally collated within the service although there is a perception that we see a relatively high proportion of clients from the LGB population. Issues of sexuality regularly come up during therapy with clients and this is dealt with sensitively and professionally by therapists. We do not make assumptions about a person's sexuality but always enquire sensitively about significant relationships.	Begin to record this information. This can be done when the new referral form (see above) is implemented.
(f)	Disability	*A receptionist reported he wasn't confident when dealing with deaf people coming into the service. A review was undertaken and a loop*	Recent work with a deaf service user has lead to team members becoming better informed about the issues affecting the deaf community.	We do not formally record disability within our demographic data. However, this information

		system put in place. At the same time a review of interpreting arrangements was made using NHSGGC's Interpreting Protocol to ensure staff understood how to book BSL interpreters.	Information and recommendations from the NHSGG&C best practice guidelines for sensory impairment have been distributed to all team members. Rape crisis offer a minicom service for deaf service users. We have added this information onto the useful contact numbers sheet that we routinely give out to all service users. We see service users who present with mild learning disability. However, for those with impairments which would impede too much with therapeutic engagement, we link in with local learning disability services. We are in the process of reviewing the readability of correspondence that we send out to clients. We will ensure that it is printed in 12 point minimum with a 14 point line at the bottom, informing service users of how to access information in large print or Braille.	will be collated once our new referral form has been implemented. We are going to investigate the possibility of getting a team mobile phone so that clients have an alternative method of contacting the service. Following referral to our service, clients are asked to opt-in for an assessment. We need to review this form to ensure its readability.

			BSL interpreters are available and recent contact with a deaf client has ensured that admin staff are aware of the correct booking procedure. We can offer appointments outwith the service base if required but availability of this is limited due to resources. Staff are aware of how to access the NCT001 form which would entitle eligible service users to free bus travel. Disabled parking spaces are available adjacent to the building. The building is all on one level with disabled access and a disabled toilet. There are two heavy fire doors which may impede access to some but staff can help clients who have access requirements with these. Regular house meetings are held between all users of the building. Any issues affecting access to the building are discussed here.	

			We have recently started implementing a text messaging service.	
(g)	Religion and Belief	*An inpatient ward was briefed on NHSGGC's Spiritual Care Manual and was able to provide more sensitive care for patients with regard to storage of faith-based items (Qurans etc.) and provision for bathing. A quiet room was made available for prayer.*	This information is not collated routinely. Staff should be sensitive to religious festivals when planning appointments. We are an equal opportunities employer.	This information should be routinely collated at assessment. Once an assistant psychologist has been recruited and a database set up then this information can be recorded.
(h)	Pregnancy and Maternity	*A reception area had made a room available to breast feeding mothers and had directed any mothers to this facility. Breast feeding is now actively promoted in the waiting area, though mothers can opt to use the separate room if preferred.*	Many of our clients are parents and we have recently been awarded funding to consider how best to meet their needs. We recognise that pregnancy and becoming a parent are often times when our clients disclose sexual abuse for the first time. We are also aware of the multiple risk factors around for this vulnerable population, particularly in terms of early bonding and attachment to their child and the risks posed by worsening mental health difficulties including self harm and substance	

			misuse. Pregnancy and maternity are part of our "see soon" criteria and we prioritise such referrals. We have received referrals from obstetrics and gynaecology and from the perinatal mental health service. The waiting area has an array of childrens toys for those service users who bring their children to appointments. We can offer an empty clinical room for breastfeeding mothers	
(i)	Socio – Economic Status	*A staff development day identified negative stereotyping of working class patients by some practitioners characterising them as taking up too much time. Training was organised for all staff on social class discrimination and understanding how the impact this can have on health.*	We see clients from a geographical area where a disproportionately high amount of residents are on benefits. We are aware of the impact of poverty and deprivation on our clients and incorporate this within formulations. We are aware of the power imbalance between client and therapist and are respectful of this within therapy. Staff regularly write letters of	We have a folder of community resources available to staff for information and advice on how to foster links between our clients into their local communities. This will be updated once an assistant psychologist has been recruited. In the past, clients on benefits have been entitled to have their

			support for clients to help with their benefits and housing applications. We are aware that there have been recent changes to the benefits system and that this has been causing anxiety to many of our service users. Staff are aware to direct clients to their local Citizens Advice Bureau for further information. Staff are aware of the free bus pass that is available to certain service users.	travelling costs reimbursed. However, in practice the majority of our clients don't do this and we need to review the policies and procedures surrounding this.
(j)	Other marginalised groups – Homelessness, prisoners and ex-offenders, ex-service personnel, people with addictions, asylum seekers & refugees, travellers	*A health visiting service adopted a hand-held patient record for travellers to allow continuation of services across various Health Board Areas.*	By definition we see a marginalised and vulnerable population - people experiencing moderate to severe mental health difficulties as a result of complex trauma (childhood sexual abuse). Many of our service users have a history of homelessness, substance misuse, prostitution and severe mental health difficulties. However, we do not keep a record of these marginalised groups. We have close links to our sister teams within trauma (Trauma and	Conduct a detailed demographic audit which will give us a more detailed profile of who uses our service and which will identify what information we need to focus on collecting. This will in turn inform future service developments. Ensure we fill out the assessment clinic front sheet, detailing which clients have addictions.

			homelessness and COMPASS) which provide services to asylum seekers and refugees and the homeless population. These include joint teaching and training and CPD where knowledge and clinical expertise is shared. Many of our clients have a forensic history but we do not audit or monitor how many. We are not set up to deal with clients who may pose a risk or threat of violence to staff. We are an all female service and all clinical staff work part time and so there is often noone else around. This is an area that we regularly discuss as a team and we have had specialist training by our colleagues who work in forensic settings. We liaise regularly with the family protection unit within the police to monitor and report areas of risk. We have recently started auditing this within the department. We aim to set up regular meetings with the FPU.	

			We rarely see clients from within the travelling community. When we do, therapy can be planned around times when they are likely to be in one place (for example many people travel over the summer months but settle for the winter). Many of our clients are being seen of have been seen in the past by the community addictions team. We attempt to keep a record of this by filling out a sheet during assessment clinics. However, we need to check that this is routinely being done.	
9.	Has the service had to make any cost savings or are any planned? What steps have you taken to ensure this doesn't impact disproportionately on equalities groups?	*Proposed budget savings were analysed using the Equality and Human Rights Budget Fairness Tool. The analysis was recorded and kept on file and potential risk areas raised with senior managers for action.*	N/A	
10.	What investment has been made for staff to help prevent discrimination and unfair treatment?	*A review of staff KSFs and PDPs showed a small take up of E-learning modules. Staff were given dedicated time to complete on line learning.*	All staff involved in recruitment have attended selection awareness training. All staff have yearly appraisals	Arrange GBV training for newly recruited members of staff

			where gaps in their experience and training can be identified. Most staff have attended Gender Based Violence Training	

If you believe your service is doing something that 'stands out' as an example of good practice – for instance you are routinely collecting patient data on sexual orientation, faith etc. - please use the box below to describe the activity and the benefits this has brought to the service. This information will help others consider opportunities for developments in their own services.

Demographic data is analysed on an annual basis as part of the annual report. This is used to inform service development priorities for the next year. The most recent report identified some changes in the profile of clients we see. For example in the past year, 31% of referrals have been for men whereas in the past this has always been around 20%. Similarly there appears to have been an increase in referrals for clients in the 55-64 year age bracket. We have met as a team to discuss why we are seeing these changes and wondered whether the recent proliferation of media reports could have had an impact. We have conducted a literature search on this area and plan to carry out a service user audit to ensure we are meeting the needs of our client group.

As part of a recent audit, it was identified that the majority of our clients are parents and that their specific needs had not been looked at in any detail. A detailed proposal for funding to develop a research study was recently submitted to the NHSGG&C Research Partnership. This was successful and we are in the process of recruiting a research assistant to take this piece of work forward.

We recognise that we see a marginalised and vulnerable population who can find it difficult to access mental health services. We recognise the importance of people being referred into the most appropriate service at an early stage in their treatment pathway to ensure that they have the most positive experience that they can and to maximise their chance of recovery. We therefore spend a lot of time liaising with referrers during the early stages prior to assessment to discuss suitability for our service. We hold a weekly allocations meeting during which we have detailed discussion regarding a clients specific needs and suitability for the service. Any potential barriers to accessing the service are identified here and followed up with the referrer. Similarly, if a client fails to opt-in to our service, we spend time as a team looking through their case file and identifying any vulnerability (for example child protection) which should be highlighted to the referrer before discharge.

Literacy barriers are highlighted as early on as possible, usually during the allocations stage. These clients do not get given the routine CORE Questionnaire to fill out in the waiting room at assessment clinic. Instead they will be given the opportunity to go through this with a member of staff.

We run a weekly assessment clinic which all clinical staff contribute to and during which the needs of new clients are discussed in detail, culminating in a joint formulation of their difficulties which informs the decision about future treatment. In this way any specific vulnerabilities or potential barriers to accessing the service are identified early on and can be discussed with the client. We feel that this provides a rich and meaningful assessment of a clients needs and enhances engagement with the service.

Actions – from the additional requirements boxes completed above, please summarise the actions this service will be taking forward.	Date for completion	Who is responsible?(initials)
Referral form to be added to sci-gateway. This will ensure we are routinely and consistently gathering information in relation to the protected characteristics. Once this has been done more complete equalities information can be assessed each year through the annual report.	Nov 2014	JM
Conduct a demographic audit . This will give us a more detailed profile of who uses our service and can help inform future service development.	March 2014	Assistant Psychologist
Create a database on which equalities information can be recorded. This will be progressed following recruitment of an assistant psychologist.	June 2014	Assistant Psychologist
Review our service information leaflets and correspondence to clients with the aim of improving readability. This will include reducing the reading age and using larger print.	December 2013	RK
Audit text messaging service.	March 2014	Asst. Psychologist/EL
Conduct a patient satisfaction survey.	Dec 2014	RK/Asst./Trainee
Look into creating a page on the NHSGG&C website.	June 2014	JM
Arrange GBV training for newly recruited members of staff	Ongoing	RK
Ensure we fill out the assessment clinic front sheet, detailing which clients have addictions. Update this front sheet once we have identified what information we want to collect for our database.	Review June 2014	Assistant Psychologist
Review the policies and procedures surrounding reimbursement of travel expenses.	March 2014	AMC
Update folder of community resources.	March 2014	Assistant/EL

Investigate the possibility of getting a team mobile phone so that clients have an alternative method of contacting the service. Make contact with CAMHS Services to ensure they are aware of our referral criteria. Amend referral criteria to include adults over the age of 65. Look at implications of this for our service and older adults services. Communicate this change to referrers. Find out more about services available to other marginalised groups such as children leaving care and the travelling population and consider how we can link in with them if required.	December 2013 JM December 2013 JM March 2014 ALL March 2014 RK

Ongoing 6 Monthly Review please write your 6 monthly EQIA review date:

April 2014

Lead Reviewer: Name: Dr Ruth Keenan
EQIA Sign Off: Job Title: Principal Clinical Psychologist
Signature

Date

Quality Assurance Sign Off: Name
Job Title
Signature
Date

Please email a copy of the completed EQIA form to eqia1@ggc.scot.nhs.uk, or send a copy to Corporate Inequalities Team, NHS Greater Glasgow and Clyde, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, G12 0XH. Tel: 0141-201-4560/4967. The completed EQIA will be subject to a Quality Assurance process and the results returned to the Lead Reviewer within 3 weeks of receipt.
PLEASE NOTE – YOUR EQIA WILL BE RETURNED TO YOU IN 6 MONTHS TO COMPLETE THE ATTACHED REVIEW SHEET (BELOW). IF YOUR ACTIONS CAN BE COMPLETED BEFORE THIS DATE, PLEASE COMPLETE THE ATTACHED SHEET AND RETURN AT YOUR EARLIEST CONVENIENCE TO: eqia1@ggc.scot.nhs.uk

NHS GREATER GLASGOW AND CLYDE EQUALITY IMPACT ASSESSMENT TOOL
MEETING THE NEEDS OF DIVERSE COMMUNITIES
6 MONTHLY REVIEW SHEET

Name of Policy/Current Service/Service Development/Service Redesign:

Please detail activity undertaken with regard to actions highlighted in the original EQIA for this Service/Policy

		Completed	
		Date	Initials
Action:			
Status:			
Action:			
Status:			
Action:			
Status:			
Action:			
Status:			

Please detail any outstanding activity with regard to required actions highlighted in the original EQIA process for this Service/Policy and reason for non-completion

		To be Completed by	
		Date	Initials
Action:			
Reason:			
Action:			
Reason:			

Please detail any new actions required since completing the original EQIA and reasons:

		To be completed by	
		Date	Initials
Action:			
Reason:			
Action:			
Reason:			

Please detail any discontinued actions that were originally planned and reasons:

Action:	
Reason:	
Action:	
Reason:	

Please write your next 6-month review date

Name of completing officer:

Date submitted:

Please email a copy of this EQIA review sheet to eqia1@ggc.scot.nhs.uk or send to Corporate Inequalities Team, NHS Greater Glasgow and Clyde, JB Russell House, Gartnavel Royal Hospitals Site, 1055 Great Western Road, G12 0XH. Tel: 0141-201-4560/4967.