

**NHS Greater Glasgow and Clyde
Equality Impact Assessment
For Frontline Patient Services**

**GUIDANCE NOTES AND
EQUALITY IMPACT ASSESSMENT TOOL**

January 2008

EQUALITY IMPACT ASSESSMENT

1. Introduction

The aim of this document is to provide members of NHS GG&C staff with the means to carry out Equality Impact Assessment (EQIA) of frontline patient services. In order to do this it contains:

- the reasons why EQIA is necessary
- the importance of EQIA for the health service and why NHS GG&C is committed to it
- an explanation of what EQIA sets out to achieve
- a description of the EQIA process that is being developed within NHS GG&C
- information about the implications of equality categories for health and health care
- a step-by-step guide to undertaking EQIA including the support that is available
- the EQIA tool
- additional useful information.

It is essential to read all of this document before completing the EQIA tool.

2. Why is EQIA necessary?

The existence of equality legislation is a reminder that we do not yet live in a society that protects individuals and groups from discrimination, inequality and prejudice. The distribution of opportunities for good health and quality of life differ between people of different social classes, women and men, white populations and black and ethnic minorities, non-disabled and disabled people, heterosexual and lesbians, gay, bisexual and transgender people and across the life course. Religion also plays a part in denying some people opportunities.

There is a prevailing view that a fair society is one in which everybody is treated the same regardless of circumstances. Whilst superficially attractive, such an approach can mean that many people are actually denied equal access to goods and services. It is important therefore for organisations that are responsible for the provision of services to test out whether these services are able to meet a range of needs, thereby making them

accessible and effective for all. Equality impact assessment is one means of doing this.

EQUALITY LEGISLATION aims to:

- Address unlawful discrimination
- Eliminate harassment
- Promote equality
- Ensure consultation and dialogue with a diverse community

Details about equality legislation are available in Appendix 1

3. The importance of EQIA to NHSGG&C

There is a growing body of evidence that shows the relationship between discrimination and poor health. Further there is evidence that shows that the way the health service is designed and operates means that, unintentionally, it discriminates in favour of those people who:

- have knowledge of the health care system and the confidence and assertiveness to use it;
- can communicate and be communicated with at several levels – i.e. have spoken English as the first language, who are literate and who have no sensory impairments;
- are familiar and comfortable with medical information;
- can travel easily to health care settings or for whom there are no physical barriers to getting into and journeying through our buildings;
- have health problems which fit one diagnostic category;
- have health problems, which are largely unrelated to life circumstances or discrimination as the result of personal identity.

Without a systematic assessment of the extent to which health services explicitly address these issues, there is a considerable risk that some people will not receive the kind of service they require to maximise the chance of a good health outcome. There is a further risk that this will also be unlawful.

NHSGG&C is committed to realising the aims of equality legislation as it recognises its significance in addressing health inequalities overall. In order to meet the requirements of the legislation, a unified Equality Scheme for 2006-9 has been produced (www.equality.scot.nhs.uk). This identifies the need for

effective scrutiny of policies, plans and service delivery to ensure that negative impacts on equality are identified and addressed using a formal EQIA process. It is however recognised that formal EQIA is only one part of an effective change process.

4. What does EQIA set out to achieve and what issues need to be taken into account?

EQIA sets out to assess any organisational activity – policy, plans, project, service delivery, practice - in order to identify actions that can be taken to improve the ability of the activity to address discrimination and promote equality. A successful EQIA results in change, not just the recommendations for change. In NHS GG&C, the priority focus for testing EQIA has been within frontline patient services.

EQIA requires an explicit consideration of potential negative implications of the equalities categories that relate to social identity. These relate to:

- Gender
- Ethnicity
- Disability
- Sexual orientation
- Religion and belief
- Age
- Socioeconomic status and social class

Potential additional marginalisation as the result of, homelessness, asylum seeking or refugee status, being a member of the travelling community, being in the criminal justice system or substance misuse problems.

Whilst each of these equality categories pose inherent difficulties for individuals, no-one is defined by one form of identity and individuals can often face multiple inequality and discrimination.

5. EQIA process that is being carried out in NHS GG&C

Currently there are many EQIA tools available that have been developed to help individuals undertake impact assessment. These have different strengths and weaknesses but an initial assessment within NHS GG&C has indicated that there is no one complete tool that meets all requirements due to the complexity of

the organisation. As a result, the Corporate Inequalities Team have undertaken an exercise to pilot an EQIA tool and guidance for use with patient services, which has been evaluated. The pilot was also used to test out a facilitation process using specified facilitators. The report of the evaluation of this pilot is available on the NHSGG&C Equality and Health website (www.equality.scot.nhs.uk).

As the result of the findings of the pilot, a revised version of the EQIA tool comprises part of this document. A second phase will use the revised tool until June 30th 2008 when it will be reviewed again. The Equality and Diversity Team within Organisational Development will be overseeing Phase Two in order to gather more evidence as to the effectiveness of the tool and this guidance, supporting its implementation and further development through exploring the type and level of support required to ensure a systematic approach.

The aims of the NHSGG&C EQIA process are:

- **to identify existing good practice**
- **to identify outstanding negative impacts for the different equality categories**
- **to agree an action plan for introducing further good practice to address the identified negative impacts.**

As roll out of the EQIA process takes place, a centralised system for collating the assessments and agreed actions is being put in place to monitor the application of EQIA across the system in terms of relevant process and outcomes, to monitor the distribution of EQIA within each part of NHSGG&C system and to share learning. A further review will be carried out after June 2008 to ascertain whether further refinements of the tool are required and the type and extent of ongoing support that needs to be put in place.

EQUALITIES CATEGORIES AND THEIR HEALTH AND HEALTH CARE IMPLICATIONS

Gender

Society has a set of gender expectations of women and men that differ for each sex. Currently, masculine characteristics are more highly valued than feminine characteristics and world-wide, this ascribes more power and wealth to men than to women. This in turn reinforces sets of behaviour, which have significant implications for the pathways into poor health.

Evidence shows that men are more likely to participate in risk-taking behaviour which leads to premature mortality and to commit acts of violence and abuse which affect themselves and women and children of both sexes. They are also less likely than women to participate in health improvement activity or to present to primary care in the early stages of illness. Where men have experienced abuse in childhood, this experience can manifest itself in a range of health and social problems in both childhood and adulthood but is often not identified as part of medical presentations.

Women still tend to have multiple social roles as employees, as carers and as the primary managers of domestic life. This imposes stresses that can have physical and psychological implications and practical and cultural difficulties in accessing health care. Gender-based violence is an outcome of gender inequality and has a range of potentially severe physical and psychological effects for women, which are often not identified as part of medical presentations and can also affect opportunity and confidence in accessing health care.

In addition, genetic and physiological differences between women and men mean that there are differential pre-dispositions to certain diseases which require careful consideration when planning services to make sure that the needs of one sex or the other are not ignored. Where single sex services exist they need to take account of the impact of gendered behaviours on presenting problems.

There is little understanding of deviation from the expectations of gender norms - you are either male or female and subsequently behave like a woman or a man. However, transgender people

report that their ascribed birth gender is not aligned with the sex they feel they are. Some may seek a gender change by transitioning to a sex that better fits their sense of self. Around 1 in 11,500 people are transgender and there is strong evidence they experience increased health risks and discrimination as a result of their transgender status.

Ethnicity

Recent reports and investigations highlight the persistent imbalance of power between the white population, and black and ethnic minority groups. As a result, people from black and ethnic minority groups are often exposed to harassment and discrimination that can lead to differences in opportunities, differences in access to health care, treatment and outcomes and differences in access to health information. This is often invisible to organisations because there is limited monitoring of service use by ethnic group. The experience of racism can result in physical ill health as well as mental health problems but this experience is rarely investigated when people present to health care and therefore its significance is not considered or noted.

Access to health care can be affected by the extent to which services and recipients are able to communicate with each other about what they can offer and what they need. There is also manifest distrust of what are seen as white services by the black and minority ethnic communities.

In addition, genetic and physiological differences between different ethnic groups can pre-dispose some groups and individuals to certain diseases which require careful consideration when planning services to make sure that uptake is maximised. Heart disease and diabetes are examples of this.

Disability

Disability is often also viewed negatively and disabled people as inferior. Recent findings on disability hate crime show that more than two thirds of disabled people surveyed about this experienced victimisation in the previous two years of which nearly a quarter had experienced physical assault. These experiences of inequality and discrimination have a profound affect on physical and psychological health.

Whilst there are many specialist services designed to address specific disabilities especially learning disability, access by disabled people to routine health services is often denied to them because their needs have not been taken sufficiently into account. Disabled people are often invisible to services as there is no routine monitoring of their attendance. Access can also be affected profoundly by geography, mobility and insufficient attempts to communicate with people who do not have written or spoken English or who have literacy and comprehension issues.

People with mental health problems are considered as disabled under legislation and there is currently significant additional stigma and discrimination against mental illness. This can preclude people receiving non-judgemental care when using mainstream health services.

Some forms of disability also predispose individuals to particular health problems, which need to be taken into account when planning population approaches to good health. An example of this relates to the levels of obesity experienced by some groups of people with learning disabilities.

Sexual orientation

Everyone has a sexual orientation, yet some people face discrimination because they are not heterosexual. Homophobic attitudes towards lesbians, gay men, bi-sexual people is still commonplace and like other forms of prejudice can have physical and psychological effects on individuals. This too is rarely identified in the course of presentations to health care. Research with young LGBT people in Glasgow found suicide ideation was 2-3 times higher than for heterosexual young people and the 'Live to Tell' report, 2003, found that 28% of young gay men had at some point deliberately injured themselves compared to only 2% of the general population.

People from the LGBT community often feel that they cannot disclose their sexual orientation for fear of discrimination when accessing health care. There is strong evidence to validate this fear with 40% of LGBT people who disclosed their sexual orientation to health professionals reporting negative care experiences. This can affect the options for treatment or interventions offered and can have wider implications for their care and social support. There are a number of reports of same sex-

partners not being accepted as next of kin and therefore denied information about partners who are patients. Reports also indicate gay couples are afraid to show emotional support for partners in inpatient care for fear of harassment and bullying.

Religion and belief

For some people, their religion is important to their health yet often the cultural and practical dimensions of religion are not assessed and taken account of when individuals attend for health care. This can be considered as a form of discrimination, can cause distress and as a result can have a negative impact on the effectiveness of diagnosis and treatment. In the same way that other examples of equality categories often remain invisible to health care organisations and therefore in the way that services are planned, there is lack of data on patients for whom religion is significant to their wellbeing.

In addition, strong views on any particular form of religion can lead to prejudice and discrimination against other beliefs – often referred to as sectarianism. This too can have an impact on the physical and psychological wellbeing of individuals.

Age

Ageism can be very subtle but is pervasive throughout society: it can affect wellbeing, damage confidence and create exclusion. Throughout the life course, individuals are affected by the age group that they are in. The youngest and oldest groups in society are most likely to suffer discrimination or inequality in access, attitudes or treatment. Assumptions about lifestyle, cognitive ability and effectiveness of treatment are also common. At these two ends of the life course, access to health care is often mediated through others thus potentially limiting opportunities for individuals to receive the type of health care that is important to them.

Although the age of individuals presenting to health care is collected routinely, this data is rarely disaggregated to inform local service planning and day-to-day service delivery issues. The absence of this monitoring can contribute to a lack of consideration of the implications of the needs of a specific age group especially older people.

Socioeconomic status and social class

There is a gradient of opportunity across social classes and this is reflected in the distribution of poor health. Social class as measured by wealth, income, occupation, status, power and education is central to the experience of inequality and health outcomes.

A key indicator of class inequality is poverty, which can materially and psychologically affect health. Poverty is also distributed differentially across equality categories. Women are more likely to experience poverty than men, even in areas of disadvantage. One in three children in poverty has a disabled parent and the rate of poverty for Pakistani children is 60% as compared to 25% amongst white children.

An understanding of the effects of social class on health and its relationship to other forms of inequality is important to the delivery and distribution of health care. People who experience poverty are often blamed and marginalised by society and this is often reflected in people's experience of health services. Poverty can also make accessing health care difficult if due attention is not paid to its location.

Potential additional marginalisation

Some people experience a set of social circumstances, which can add extra practical difficulties in accessing health care or maximising treatment opportunities. They may also be affected by the attitudes of staff. For people without a permanent address as the result of homelessness or being a member of a travelling community, there are the practical difficulties of communication about appointments. For asylum seekers and refugees, particular issues for services can be addressing severe isolation, health implications of persecution / torture in their own country, language barriers and poverty. For asylum seekers, homelessness may be an issue if application for permanent stay is denied. Particular issues around privacy and confidentiality are key if prisoners or people involved in criminal activity use services. In mainstream services, people with substance misuse problems may experience difficulties in having their needs met due to staff attitudes. For all these issues, services need to consider any specific actions arising from 'additional marginalisation'.

STEP BY STEP GUIDE TO SUCCESSFUL EQIA OF PATIENT SERVICES

Effective EQIA of patient services involves consideration of the patient journey in relation to getting in, getting through and getting out of the service. Ideally, all three stages should be considered but it is possible to carry out an EQIA on individual component parts of the journey.

STEP 1: Identify the service for EQIA

The following are viewed as good practice in identifying priorities for EQIA:

- If a particular service is being redesigned or developed, then it is good practice to start scheduling in a process of EQIA.
- If there is a higher/lower uptake of patients from some groups using the service, it may then be possible to investigate the reasons behind this, for example, the uptake of mental health services by members of BME communities. Statistics show that the uptake is low within this group.
- Evidence that a particular community has a higher incidence of a disease e.g. South Asian communities and diabetes.

High incidence of complaints associated with a particular group.
Evidence of perceived discrimination by the service.

Care should be taken to ensure that the choice of services for EQIA relates to priorities for action in the local Action Plan for the Equality Scheme.

STEP 2: Identify the Lead Reviewer

In order to undertake an EQIA it is essential to have a Lead Reviewer. This person will be the key contact point for the EQIA and be involved in setting up the necessary infrastructure to support the EQIA process. The Lead Reviewer needs to have overall responsibility for ensuring the service being assessed meets its legislative requirements in terms of equality, and will be in a position to ensure that the actions agreed are sanctioned by the organisation and followed through on. They will also lead on the 6 monthly reviews to identify progress against agreed actions.

STEP 3: Seek advice and support, if required.

For an organisation of the size of NHS GG&C, it is difficult to determine the most appropriate type and intensity of support required for an ongoing programme of EQIA. For Phase 2, the Equality and Diversity Team (E&D), based within the Organisational Development function will be coordinating support and advice around the EQIA process in relation to equality and diversity issues, how to use the guidance and complete the form. They will take the lead role in gathering and analysing the learning from the EQIA process in relation to the types of support required, the utility of the tool, and any future training requirements to aid EQIA. The Equality and Diversity Team can be contacted on 0141 201 4977. Where there are pre-existing facilitators who have experience of EQIA and are available to support settings in the EQIA process it is advisable to draw on their expertise.

STEP 4. Decide on who should be involved

Successful EQIA processes require a number of people to be involved. For a typical NHS service there are several key practitioners involved in the patient journey. For example this could include receptionist, clerical officer, medical records staff, allied health professionals, consultants, practice nurses, service manager etc. For every service, this will be different. All of these staff will have different experiences of patients and thus ideas on how barriers can be removed and equality promoted. Patients or their representatives also bring an essential perspective on how the service is experienced, and therefore should be involved in the discussions if possible. The Lead Reviewer should consult various members of staff about who is appropriate to be involved.

STEP 5. Establish the EQIA group and consider what evidence is available.

At the first meeting, participants need to be briefed on the EQIA process. The group also need to consider relevant evidence on equality categories in relation to their service. This should include consideration of local and national information on differential uptakes, morbidity and mortality, and satisfaction rates.

See Appendix 2 for weblinks with further good practice information

STEP 6: Complete the tool in draft form

The EQIA group needs to meet further for at least 2 hours, in order that actions are based on consideration of evidence, current good practice and existing negative impact.

In completing the EQIA tool, please follow the instructions given below:

Name of Current Service/Service Development/Service Redesign – complete the name of the service and tick the appropriate box to indicate if this is a current service, service development or service redesign.

Brief description of the above – it is essential before completing the rest of the EQIA tool to identify what aspect of the service is being assessed e.g. Radiotherapy Services in the Beatson Oncology Unit. Please indicate the objectives of the service and indicate whether the service is regional or local.

Who is the lead reviewer and where based? – it is crucial to identify the lead person for the EQIA process as a contact point for any questions around the impact assessment.

List those involved in carrying out the EQIA – for staff, record their staff grouping and for others record whether they are patients, carers or the organisation they represent. Do not record individual's names. A file note of the names and contact addresses of all those involved in the EQIA process should be kept for future involvement in the review processes.

Impact Assessment – Existing Good Practice - this section requires you to consider any practice undertaken throughout the patient journey, which has tackled barriers in relation to patients from the equalities categories. This includes accessing the service, or gaps in the way the service responds to their needs. The following provides a set of key questions to inform the assessment of good practice.

Is Patient Data currently collected and disaggregated in relation to the equalities categories?

Is there currently any Patient Information which reflects the needs of the equalities categories?

Have any modifications to the Physical Environment been made which takes the needs of the equalities categories into account?

Do assessments of the Communication and Language Support needs of patients take place routinely?

Are the health implications of the experience of inequality, discrimination or marginalisation taken into account at different points in the patient's journey?

Are there arrangements in place to address the practical difficulties of inequality or marginalisation?

Is the experience of inequality, discrimination or marginalisation recorded in the patients notes?

Are referrals made systematically to appropriate agencies to provide support in relation to inequality, discrimination or marginalisation?

Is there a programme of learning and education for staff to improve knowledge and practice in relation to inequalities categories?

It is intended that examples illustrating good practice will be utilised on the NHS GG&C's equality in health website (www.equality.scot.nhs.uk).

Impact assessment – negative impacts

The next part of the tool requires an assessment of negative impact. This relates firstly, to gaps in good practice and secondly, to remaining 'negative impacts'. Assessment of 'negative impact' is not straightforward and requires consideration of the overall ways in which the service might be treating individuals or groups less favourably than others. This includes where there is a likelihood that some individuals or groups are being potentially denied a service because their needs are not made explicit or where the actions of the service reinforce inequality, discrimination or marginalisation.

One example of negative impact would be when epidemiological evidence shows that a specific group or community carries the burden of a specific health problem yet they are under-represented in the uptake of appropriate services. Another example would be when patients raise issues of discrimination such as racism as being important for their health and this is ignored by staff. The information on 'Equalities Categories' (Pages 5-8) provides further examples. Appendix 2 provides key web links for those wishing to explore further examples.

Impact assessment – Actions

This section of the EQIA tool is based on the mismatch between good practice and negative impact and requires a set of actions to be identified in the previous section on impact assessment. Actions need to be allocated both a date for completion and a person responsible for taking the action forward.

This section is split into two separate parts:

Cross cutting actions: actions which address identified barriers for all or most equality categories / additional marginalisation.

Specific actions: actions, which are specific to particular equality categories or additional marginalisation.

These actions will then form the focus of ongoing 6 monthly review processes. It is important to note that change will be incremental over time and that not everything should be attempted within the first year.

STEP 7 Complete the final version of the tool and secure agreement for actions

This step allows for review and reflection on the tool by the EQIA Group and others if necessary. The Lead Reviewer should request feedback and finalise the tool on the basis of the comments before re-circulating.

The Lead Reviewer is required to secure agreement for a programme of implementation of recommended actions from senior management.

Signing off the document - the Lead Reviewer should sign and date the document and write down the date of the 6 month review date.

The completed tool should then be submitted to Irene Mackenzie from the Corporate Inequalities Team who is compiling a database of completed Equality Impact Assessments. (irene.mackenzie@ggc.scot.nhs.uk) All completed tools will also be published on the NHS GG&C Equality and Health website (www.equality.scot.nhs.uk) in line with legislative responsibilities.

STEP 8 – Implementation of recommended actions and review after six months

A six month review is crucial to assess the extent to which the implementation plan is on track and to do this the EQIA Group should be reconvened, progress considered and noted on the six month review form.

The specific tool for 6 monthly reviews will be posted on NHS GG&C Equality & Diversity website (www.equality.scot.nhs.uk) in early 2008.

The CIT will send a reminder to the Lead Reviewer about the need for this step and the review form should be returned to the CIT as part of the audit process.

This documentation has been produced as the result of the work of EQIA Review Group, comprising representatives of the Corporate Inequalities Team, Equality and Diversity Team, Learning and Education and Acute Services

NHS Greater Glasgow and Clyde

Equality Impact Assessment Tool For Frontline Patient Services

It is essential to follow the EQIA Guidance in completing this form

Name of Current Service/Service Development/Service Redesign:

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

Brief description of the above: (Please include if this is part of a Board-wide service or is locally determined).

Who is the lead reviewer and where based?

Please list the staff groupings of all those involved in carrying out this EQIA
 (when non-NHS staff are involved please record their organisation or reason for inclusion):

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Impact Assessment – Equality Categories

Equality Category	Existing Good Practice	Remaining Negative Impact
Gender		
Ethnicity		
Disability		
Sexual Orientation		
Religion and belief		
Age (Children/Young People/Older People)		

Social Class/ Socio-Economic Status		
Additional marginalisation		

Actions	Date for completion	Who is responsible?(initials)
Cross Cutting Actions		
Specific Actions		

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

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

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

Irene Mackenzie, Corporate Information and Development Manager, Corporate Inequalities Team, NHS Greater Glasgow and Clyde, Dalian House, 350 St Vincent Street, Glasgow, G3 8YZ. Tel: 0141-201-4970.

Appendix 1: Requirements from equality legislation

The body of legislation on Race (Race Equality Duty), Disability (Disability Equality Duty) and Gender (Gender Equality Duty) has identified both General and Specific Duties with which public organisations have to comply.

The General Duties for all three areas of legislation lay down that public bodies require to have 'due regard' to the need to eliminate unlawful discrimination and harassment and to promote equality of opportunity. The RR(A) also includes a duty to 'promote good relations between persons of different racial groups'. In the Disability Equality Duty (DED) this duty is to 'promote equality of opportunity between disabled people and other people'. The DED further includes a duty to:

- promote positive attitudes towards disabled people;
- encourage participation by disabled people in public life;
- take steps to meet disabled peoples' needs, even if this requires more favourable treatment.

The Specific Duties apply to major public bodies primarily and are designed to set out the steps that should be taken in meeting the General Duty, the key requirements of which are:

- The development of a specific Equality Scheme in relation to each aspect of inequality.
- Consultation with stakeholders and employees in drawing up the equality schemes for race and gender. In relation to disability, the legislation is considerably stronger, requiring the active involvement of disabled people in drawing up the Equality Scheme.
- Publication of the equality schemes and associated action plans.
- Publication of how the organisation will assess the impact of its policies and practices for equality across the three areas and the outcomes of these.
- Monitoring of progress and production of annual reports.
- Review of each scheme every three years.
- Monitoring of employment procedures and practices. In relation to gender, a policy on developing equal pay arrangements between women and men must be developed and published.

One of the provisions of the Equality Act 2006 is the merger of the three existing commissions i.e. the Commission for Race Equality, the Disability Rights Commission and the Equal Opportunities Commission. In 2007, they became one body – the Equality and Human Rights Commission – which has responsibility for assessing the extent to which organisations have fulfilled their legislative duties.

There is also new legislation on sexual orientation. The Equality Act (Sexual Orientation) Regulations 2007 protects individuals from direct or indirect discrimination on grounds of sexual orientation, in provision of goods, facilities, services, education, disposal and management of premises and exercise of public functions. There is also European legislation on age and religion and belief discrimination in employment.

Appendix 2: Good practice websites

The following websites are very good for key information around good practice around equalities issues. The Equality and Diversity Team in Organisational Development (Tel: 0141 201 4977) have a wider list of good practice websites available if you require this.

- The 'Fair For All' website (www.fairforall.org.uk) is NHS Scotland website on equality and diversity.
- It is very good for examples of good practice and national guidance documents on gender, disability, ethnicity, sexual orientation, age, religion and belief
- NHS GG&C Equality and Health website (www.equality.scot.nhs.uk) will provide key information on each of the different equality categories, the key health issues related to equality categories and good practice examples from NHS GG&C and beyond.
- The website has links to NHS GG&C Equality Scheme; all Equality Scheme action plans and the annual monitoring report; NHS GG&C Equality Impact Assessment Guidance, Tools and Evaluation report.
- The Equality and Human Rights Commission (www.equalityhumanrights.com) is the governing body for

equalities legislation implementation. NHS GG&C has to provide annual reports to the Commission on its implementation of its Equality Scheme.

- The website includes legislative and good practice information on the rights of workers and service users and responsibilities of public sector employers.
- The Scottish Government Equality Unit website (www.scotland.gov.uk/mainstreamingequality) provides information on the national context for action on equalities issues and provides many national statistics about equality strands in relation to government activities.