

**NHS Greater Glasgow and Clyde
Equality Impact Assessment
For Policies, Strategies and Plans**

**GUIDANCE NOTES AND
EQUALITY IMPACT ASSESSMENT TOOL**

July 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). 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 NHS GG&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.

NHS GG&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 and this is now being expanded to include policies and strategies.

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 NHSGG&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 NHSGG&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 has undertaken an exercise to pilot an EQIA tool and guidance for use with patient services, which has been evaluated and revised. 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 in Health website (www.equality.scot.nhs.uk).

A second phase will use the revised tool for frontline services until March 2009 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.

In addition a separate tool for use with policies, strategies and plans has also been developed and this document provides step by step guidance to utilising the tool. Support for its implementation will come from the Corporate Inequalities Team.

The aims of the NHSGG&C EQIA process are:

- to identify existing or planned good practice
- to identify negative impacts for the different equality categories, in existing services or as a result of planned changes

- 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 March 2009 to ascertain whether further refinements of the tools 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 POLICIES, STRATEGIES AND PLANS

Effective EQIA of policies, strategies and plans involves consideration of the aims and who will be affected. The guide is intended to be used in conjunction with NHSGGC's Policy Development Framework which sets out further general guidance on the process for developing and approving policies, strategies and plans.

STEP 1: Identify the need for EQIA

An initial assessment tool to identify whether EQIA is required for policies^{*}, is attached at Appendix 3. Priority for EQIA should be given to policies where the **primary purpose** will be a change **directly** affecting staff or patients. Priority should also be given to policies where:

- It is already known or expected that the policy or the service it relates to now, or in future, impacts differently on different groups of people. This may be based on EQIA of existing services
- The policy aims to address inequalities or specific requirements of equalities legislation.
- The policy has a major impact on the organisation in terms of scale or significance, for example is likely to be high profile in the media or politically sensitive.

Where a need for EQIA is identified, the assessment itself should take place when the policy is in draft form. This should be at a point where the policy is well enough developed that the likely impact and changes to services or functions can be identified, but where there is still time for review or change to the policy if negative impacts are identified. EQIA is not a substitute for considering equalities issues and information in planning and policy development from the very earliest stages.

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 policy 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. The lead reviewer for EQIA will normally be the overall lead manager for the policy, or an appropriately delegated individual.

STEP 3: Seek advice and support, if required.

* "policies" is used throughout this document as shorthand for "policies, strategies and plans"

Further advice and support on EQIA for policies, strategies and plans can be provided by the Corporate Inequalities Team.

STEP 4. Decide on who should be involved

Successful EQIA processes require a number of people to be involved. All policies, strategies and plans should involve appropriate engagement and consultation with key stakeholders. This will include staff directly involved in providing services or implementing the policy and those with expertise in information and planning; consideration should be given to the involvement of these stakeholders in EQIA. Patients or their representatives also bring an essential perspective on how the service is experienced, and therefore should be involved in the discussions. 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 briefed on the EQIA process. The group also need to consider relevant evidence on equalities 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 web links with further good practice information
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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 Policy, Strategy or Plan – complete the name of the policy and note whether it is a new policy or review of an existing policy.

Brief description of the above – it is essential to identify the aim and scope of the policy. Please indicate the aims of the policy and who it will affect, for example patients and carers, general public, staff.

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 Information - this section requires you to consider any information currently available on the service or function which the policy covers which identifies risks or barriers in relation to patients from the equalities categories. The following provides a set of key questions to inform the assessment.

- Do existing assessments of services or functions which will be affected by the policy provide information on the current impact on equalities groups?
- Is there any information from other similar services or wider evidence and research?

Information sources for this may include:

- Any data currently collected and disaggregated in relation to the equalities categories for the affected group of patients / staff
- Any issues with the current Physical Environment which impact on the needs of the equalities categories
- Any assessment of communication and language support needs of the people likely to be affected by the policy
- Any evidence of higher or lower uptake of services from some groups, for example the uptake of mental health services by members of BME communities
- Evidence that a particular community has a higher incidence of a disease, or complications of a disease, e.g. South Asian communities and diabetes; perinatal mortality in BME groups.

Impact assessment – negative and positive impacts

The next part of the tool requires an assessment of the likely impact of the changes which will result from the policy, strategy or plan.

Negative impact may include ways in which the changes to the service or function might lead to individuals or groups being treated 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. It should also include situations where existing inequalities are identified and not addressed by the policy.

Positive impact is where the change brought about by the policy directly or indirectly improves access, treatment, outcome or opportunity for individuals or groups where inequalities have previously been identified.

The EQIA group should consider the following:

- What are the main changes which the policy, strategy or plan will bring about?
- What impact is this likely to have on access or outcomes for particular equalities categories?
- Is this impact known or highly likely, or is it an unknown and unquantifiable risk or opportunity?

Answering these questions is difficult and will require a degree of speculation and assumption about the impact on behaviour and outcomes. It can be informed by evidence of best practice and outcomes from other services or initiatives, or previous experience. Patient, carer or staff groups may also be well placed to advise on the likely impact on particular groups or individuals of any changes. 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 requires a set of actions to be identified to address any potential negative impacts. Actions need to be allocated both a date for completion and a person responsible for taking the action forward.

Action may take the form of:

- **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.

Actions will fall into two categories:

- Those which require changes to the policy, strategy or plan before it is finalised. This is likely to be where a potential negative impact is identified and a change to the policy will avoid this, or additional action can be taken to compensate for any negative impact. These actions should be reviewed at the point where the policy is approved.
- Those which require monitoring of the policy once it has been implemented. This will include both negative and positive impacts. Arrangements for ongoing monitoring and evaluation of policies should be made clear as part of the implementation plan for the policy, and include assessment of the actual impact of the policy. This will enable negative impacts to be identified, and ensure that expected positive impact is achieved. This may be done through ongoing EQIA of the service or function which the policy affects, in line with the guidance in section 1

above. As a minimum, the impact of the policy should be considered when the policy is reviewed every 3 years.

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 the Director and lead manager for the policy, and any other senior managers who will be required to lead action.

Signing off the document - the Lead Reviewer should sign and date the document.

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 in Health website (www.equality.scot.nhs.uk) in line with legislative responsibilities.

NHS Greater Glasgow and Clyde
Equality Impact Assessment Tool For Strategy, Policy and Plans

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

Name of Strategy, Policy or Plan

Update of Glasgow Tobacco Strategy

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

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

The Glasgow Tobacco Strategy has been updated by the Glasgow Community Planning Partnership. The updated strategy details recent developments in tobacco control such as the introduction of the smoke free legislation, publication of the National Smoking Prevention Action Plan and new targets for tobacco as well as new structures that now exist within the city – the Community Health and Care Partnerships (CHCPs) and new structural arrangements within the Council. In addition this updated strategy includes an action plan for the first time – identifying action to be taken, by when and by whom. It involves actions in the areas of prevention, protection and stop smoking services.

The strategy will be overseen by the Joint Health Improvement Officers Group. This is a group which brings together staff from a range of departments across Glasgow City Council as well as bodies such as Culture and Sport Glasgow, Glasgow Community Planning Ltd and CHCPs and is chaired by the Director of Public Health.

The updated document has been developed in conjunction with key partners.

Who is the lead reviewer and where based?

Fiona Dunlop, Health Improvement Lead – Tobacco, Acute Planning and Health Improvement, Dalian House

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):

Two Health Improvement and Inequalities Managers, Three Health Improvement Leads, Three Health Improvement Specialists, Two Corporate Policy Officers (Glasgow City Council), Trading Standards Manager (Glasgow City Council) and Team Leader (Health at Work)

As the Tobacco Strategy is a document that has been produced by Glasgow Community Planning and therefore has been developed jointly by the Council and by NHS GGC it was important that both organisations were involved in the EQIA process

Impact Assessment – Equality Categories

Equality Category	Positive Impact	Negative Impact
Gender	The Strategy takes account of both male and female gender issues in relation to tobacco throughout. Strategy makes reference to male and female smoking patterns in Glasgow and to death rates	There is no known negative impact
Ethnicity	<p>The Tobacco Strategy has a section relating to minority ethnic groups and smoking</p> <p>Sourcing ethnicity evidence /data for local plans is ongoing e.g. minority ethnic groups and smoking statistics.</p>	<p>The font size on the graph relating to smoking prevalence by CHCP (Graph 2, page 13) needs to be enlarged</p> <p>The strategy has too great an emphasis on the Bangladeshi community, given that there are only low numbers of people from Bangladesh in Glasgow compared to other minority ethnic groups such as those from Pakistan.</p> <p>The strategy needs to focus on the largest minority ethnic communities and use locally</p>

		<p>relevant information</p> <p>In addition there needs to be reference to other minority ethnic groupings such as asylum seekers.</p>
Disability	Issues relating to mental health are addressed in the strategy.	<p>More clarity is required in the section on smoking and mental health. The section should be expanded to include more information on smoking and mental health generally, and should address both acute and community settings.</p> <p>The strategy needs to include more information relating to smoking and disability (physical and learning) and this needs to be followed through to the action plans</p> <p>Information about the stop smoking services and tobacco publications and materials in general should be available in a range of formats and languages upon request.</p> <p>Aspects of the smoking cessation service model may need adapted to meet the specific needs of those with disability</p>
Sexual Orientation	No examples of good practice identified	Currently there is no information within the Tobacco Strategy on smoking prevalence in

		lesbian, gay, bisexual and transgender (LGBT) groups. Information on smoking and LGBT should be included within the tobacco strategy where available.
Religion and belief	No examples of good practice identified	<p>The tobacco strategy does not directly address religion and belief; however some related issues are highlighted in the section relating to smoking and minority ethnic groups.</p> <p>There are some specific cultural and religious issues in relation to tobacco that may be missed. For example,</p> <ul style="list-style-type: none"> • smoking not discussed with Muslim patients as staff may assume these patients don't smoke due to their religion • Patients may stop Nicotine Replacement Therapy and other medication for example if they feel the products are not culturally sensitive e.g. (Muslim, Jewish, Hindu or Sikh Faiths) • Medication may also be stopped during Ramadan (month of fasting for the Muslim Faith)
Age (Children/Young People/Older People)	The tobacco strategy does address the issue of smoking and children/young adults.	The strategy does not highlighted specific issue in relation to smoking and older people and information if available should be included.

		<p>Promotional materials for the stop smoking services are currently targeted at the general adult population. The elderly may need different approaches/messages in order to effectively engage these groups.</p> <p>The strategy has no reference to issue of fire safety and the elderly in the main document though does make reference to this within the action plan.</p> <p>The strategy needs to consider the issue of carers exposed to second hand smoke.</p> <p>Though emphasising the impact and prevalence of smoking within the under 16's there is no reference to smoking levels and issues in relation to "older" young people i.e. 16 – 24 year olds though this is mentioned within the action planning section of the document</p>
<p>Social Class/ Socio-Economic Status</p>	<p>Social class and deprivation issues reflected in depth throughout the strategy</p>	<p>No negative impact</p>

<ul style="list-style-type: none"> ▪ Expand the information within the section on minority ethnic groups and smoking to include relevant information on prevalence within different communities within Glasgow, where available, and include information on religious issues, ensure most emphasis is placed upon the largest of the minority ethnic communities within Glasgow i.e. Pakistani 	September 2009	FD
<ul style="list-style-type: none"> ▪ Information on tobacco must meet the needs of all marginalised groups and must be available on request in different formats e.g. easy read, Braille and different languages. This needs to be highlighted within the action plan 	As required	Organisations responsible for producing the information
<ul style="list-style-type: none"> ▪ Produce a summary of the strategy in an easy read format. 	Sept 2009	FD/JW
<ul style="list-style-type: none"> ▪ The mental health section of the strategy requires to be strengthened to include further relevant statistics and information on learning and physical disabilities and smoking 	September 2009	FD
<ul style="list-style-type: none"> ▪ As, in the development of local action plans related to the strategy, community engagement will be conducted through both Community Reference Groups and Patient and Partnership Forums, there is a need to ensure that these groups are representative of the local population and reflect all equality strands. Reference to this should be included in the strategy. 	September 2009	FD
<ul style="list-style-type: none"> ▪ Issues that are related to tobacco and lesbian gay, bisexual, and transgender groups should be included within the tobacco strategy 	September 2009	FD
<ul style="list-style-type: none"> ▪ Add information to the strategy on smoking and the older population, including reference to fire safety and the elderly. Within the action plans Pg 47 (6.1 and 6.2) add additional point in relation to fire safety. 	September 2009	FD

<ul style="list-style-type: none"> University and colleges are mentioned as a key setting within the action plan however there is no rationale for their inclusion or reference to 16 – 24 year olds and smoking within the main body of the document. This needs to be amended to provide the rationale for inclusion within the action plan. 	September 2009	FD
<ul style="list-style-type: none"> Under the section that describes the effectiveness of the stop smoking services, information should be highlighted by equality strands, if available. 	September 2009	FD
<ul style="list-style-type: none"> The final point highlighted in the Core Principles states that all smokers have the right to receive stop smoking services. Within this point there should be specific reference to equality groups to demonstrate that the intention to offer stop smoking services that can meet the needs of all equality groups, where practical. 	September 2009	FD
<ul style="list-style-type: none"> Local tobacco plans at a strategic planning area level will also need Equality Impact Assessed as will the forthcoming communications plan for tobacco 	To be negotiated with each of the CHCPs	FD

Ongoing Review. Please write the date when the policy and EQIA will be reviewed.

March 2010

Lead Reviewer:	Name:	Fiona Dunlop
Sign Off:	Job Title	Health Improvement Lead - Tobacco
	Signature	
	Date:	30 August 2009

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 211 0354) 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

- NHSGG&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 NHSGG&C and beyond.

The website has links to NHSGG&C Equality Scheme; all Equality Scheme action plans and the annual monitoring report; NHSGG&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. NHSGG&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.