Equality Impact Assessment Tool: Policy, Strategy and Plans

(Please follow the EQIA guidance in completing this form)

1. Name of Strategy, Policy or Plan

Health and Social Care Strategic Plan

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

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

East Renfrewshire's Strategic Plan for Health and Social Care leads on from the earlier Reshaping Care for Older People Joint Strategic Commissioning Plan, extending to the general population the same principles of personalisation, prevention, integration, and enablement. This is in keeping with the statutory requirement of Joint Integration Boards to develop a strategy for the integration of health and social care services.

The plan spans a period of three years, to be renewed and updated every three years. The Strategic Plan is developed in close and ongoing communication with relevant stakeholders, including staff, service providers, service users (including potential service users), carers, and the Third Sector. This reflects the principles of community engagement and empowerment which are fundamental to integration and by extension the Strategic Plan. The National Health and Wellbeing Outcomes are embedded within the plan, as follows:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected.

Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Outcome 5. Health and social care services contribute to reducing health inequalities.

Outcome 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

Outcome 7. People using health and social care services are safe from harm.

Outcome 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services.

Also embedded within the plan are the National Outcomes related to Children and Young People, and Criminal Justice:

- Our children have the best start in life.
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
- We have improved the life chances for children, young people and families at risk.
- We live our lives safe from crime, disorder and danger.

These outcomes are closely linked to East Renfrewshire's local outcomes and the personal wellbeing outcomes which are integral to the work of the Health and Social Care Partnership, such as our Talking Points for adults and older people, and the GIRFEC SHANARRI indicators for children and young people.

The process of the integration of health and social care, for which the Plan provides clear direction over the coming years, will affect all health and social care services. The Plan encompasses care provided to people of all ages in East Renfrewshire, outlining plans for a range of key care groups.

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

5. Impact Assessment

A Does the policy explicitly promote equality of opportunity and anti-discrimination and refer to legislative and policy drivers in relation to Equality
The Strategic Plan aims to improve health and wellbeing outcomes for all people in East Renfrewshire. The plan explicitly considers the demographics of East Renfrewshire's population, such as the ageing population, and the increasing numbers of people with long term conditions and disabilities. The principle of integration, at the core of the Strategic Commissioning Plan, aims to make access to services easier and improve outcomes for people who require access to both health and social care services, which may be particularly important for people with disabilities or long term conditions, many of whom are older people. Multimorbidity is also more common in more deprived areas than more affluent areas, meaning that integration is likely to be of particular benefit to those experiencing other social and economic inequalities. The plan takes a locality based approach, highlighting data, consultation findings, and targeted plans relating to four defined areas of East Renfrewshire, in which differential experiences and outcomes are evident due to a number of factors such as greater levels of deprivation in some areas than others, and larger population proportions of older people in some areas. For example, the Levern Valley locality has higher levels of deprivation and tends to have poorer health outcomes than the rest of East Renfrewshire. A key aim of the plan is to reduce health inequalities, between and within all areas of East Renfrewshire. An important focus within this will be to promote preventative and capacity building approaches. Running through the Strategic Plan will be the key themes highlighted in the Scottish Government guidance, which align with the recommendations of the Christie Commission Report. Namely: integration, prevention, workforce development, and improving performance. At the heart of each of these is the endeavour to improve outcomes, reduce inequalities, and to involve and empower local partners, communities and individuals in the process. The Strategic Plan focuses on person centred care, through self-directed support and capacity building to allow people to take a key role in shaping their own care and improving their own health. This approach is expected to reduce health inequalities. The ability of an individual to choose support and care options appropriate to their personal needs can allow a greater diversity of needs to be met, including cultural, religious and language related needs. At the same time, consideration will be taken to the potentially unequal impacts which personalisation may have on different individuals. As suggested by the Equality and Human Rights Commission, 'people who have traditionally been marginalised or discriminated against in society may face particular barriers to acting as empowered consumers' (2011).

The development of the Strategic Plan will be shaped by partnership working and on-going consultation with a range of stakeholders from across East Renfrewshire to identify local priorities.

The nine protected characteristics covered in the Equality Act (2010), as well as socio-economic status, will be taken into consideration throughout the process of developing the strategy. In the consultation stages, this will include asking specific questions around equalities, allowing any concerns or proposals for improvement to be raised. Points raised from this consultation will then inform the continuing development of the Strategic Plan.

Barriers to participation in consultation will also be considered and attempts made to allay these wherever possible. For example, different methods of consultation will be adopted to ensure a wider reach, such as using both online and face to face methods.

As explained in Section B, people who identify with particular protected characteristics are not homogenous or mutually exclusive groups, and each of these factors can interact in complex ways to impact upon individuals' experiences, in terms of their health and wellbeing needs and the barriers they may face in accessing services. A person centred, rather than service driven, approach to health and social care provision is key to improving experiences and outcomes for individuals, allowing for this myriad of needs to be taken into consideration.

We are committed to promoting understanding of Equalities issues among staff across our partnership through training opportunities, and will include this within the Strategic Plan as part of our planning for workforce development. We will work together with partners such as the Community Planning Partnership, the Third Sector, and the wider community to address, alleviate and prevent health inequalities. We will provide fully accessible and equitable services, ensuring that any disadvantage experienced is mitigated through targeted intensive support.

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

		Source
All		
Sex	As of the 2013 NRS population estimates, women make up 52.4% of East Renfrewshire's population, and men make up the remaining 47.6%. The proportion of women increases with age. While the proportion of women among those aged under 16 is just 49.1%, this increases among over 60s to 56.4%, and to 61.3% among over 75s. This trend is linked to	National Records of Scotland, Mid-Year Population Estimates 2013.

	the fact that women live longer, on average, than men. Based on 2013 estimates, women have a life expectancy of 83, while men have a life expectancy of 79.7. In Scotland, women make up 65% of Social Care at home clients and 69% of long stay care home residents; in East Renfrewshire, 74% of people living in care homes are women (Care Home Census, Health and Social Care Survey 2014). Women are also more likely to be unpaid carers than men; 59.9% of carers in East Renfrewshire in the 2011 census were women. In February 2014, women in Scotland were over twice as likely as men to be receiving Carers Allowance (15 compared to 7 per 1, 000 of the population) (DWP). Caring responsibilities can be associated with health problems. Based on the 2011 census, those who provide care are more likely to rate their health as bad or very bad, and this trend becomes more pronounced with age. According to NHS Health Scotland, men consult their GP less often and are more likely to assess their health as good or very good than women, while men are more likely to attend an emergency department. Women are more likely to consult their GP about depression or anxiety, to be diagnosed with depression, or to be admitted to hospital for self-harm, while men are three times as likely as women to commit suicide. Suicide is the leading cause of death among young men in Scotland. Rates of alcohol and drug misuse are also higher among men than women; the 2012 estimate for prevalence of drug misuse in East Renfrewshire was more than twice as high for men than women (ScotPHO). The Scottish figure in 2011 for problem drinking was 13.9% among men, compared to 9.5% for women, and 26% for binge drinking among men compared to 16.7% for women (ScotPHO). Domestic abuse, which official statistics and research suggest is perpetrated at significantly higher rates by men against women than the reverse (for example, 80% of domestic abuse incidents recorded by the police in 2012-13 were perpetrated by men against women), is a cause of physical and mental health and wellbeing problems for those who experience it (Scottish Women's Aid).The Scottish Government recognises Violence Against Women as both a symptom and a cause of ongoing inequalities between men and women (Equally Safe, 2014).The Joint Strategic Commissioning Plan includes Adult Support and Protection and domestic abuse. The East Renfrewshire Domestic Abuse Project aims to 'support and empower women, children and young people who are experiencing, or have experienced domestic abuse'. The HSCP is committed to working in	Census 2011, Scottish Government, Care Home Census, Health and Social Care Survey, NHS Health Scotland, ScotPHO, national research.

	partnership towards this aim, and this will be reflected in the Strategic Plan. Other issues which are particularly pertinent to pregnant women and new mothers are considered in the Strategic Plan through its reference to the Integrated Children's Services Plan. See Pregnancy & Maternity below for more details. We understand the importance of taking into consideration differing health needs and service use related to gender in planning health and social care services. The Strategic Needs Assessment, which will inform the development of the Strategic Plan, will highlight any such significant differences between men and women in East Renfrewshire, and will both share and seek information on this when engaging with the community, service users and providers throughout the plan's development. Other equalities issues can combine with gender to pose distinct issues for health and social care services. It is important to consider the complexity of these interactions in order to develop a truly person centred approach to improving outcomes for people.	
Gender Reassignment	The Trans Mental Health Study was carried out by a partnership of organisations working with trans people and Sheffield Hallam university, with 889 trans adults in the UK. The study found that over half of participants had self-harmed at some point, and 84% had thought about ending their lives, 48% of whom had attempted suicide at some point in their lives (McNeil *et al*. 2012). 91% of respondents had made or wanted to make physical changes to their bodies, and over 4 in 5 people who had undergone either hormone treatment or any form of surgery reported that they were more satisfied with their life after the physical intervention. 75% of respondents said they had used general mental health services, 63% of whom said they experienced one or more negative interactions with these services. Of the 90% who said they had used general health services, 65% had experienced one or more negative interactions, and among the 61% who had been to a gender identity clinic, 62% said they experienced one or more negative interactions. Particularly in general health and mental health services, a significant proportion had experienced insulting language about trans people (24%, 17%), a professional refusing to discuss a trans-related health concern (29%, 13%), being told they weren't really trans (16%, 20%), being discouraged	National research, NHS Health Scotland.

from exploring gender (20%, 25%), or being told the professional didn't know enough about a particular type of trans-related care to provide it (54%, 29%), among other issues.

In accessing mental health services, a common concern among participants was that their transgender identity would be treated as a symptom or cause of their mental health issues, and that this could interfere with their access to other treatments. Overall the study indicated significant unmet needs for transgender people, and a range of experiences which are likely to act as a barrier for trans people choosing to access services and/or be open about their transgender identity in future. Only half of participants who had used mental health services said they did not have concerns about accessing these services again. Many of these findings are supported by prior research into transgender people, as evidenced in the NatCen and Equality and Human Rights Commission's Transgender Research Review (2009).

In planning for health and social care services it is important to be aware of the possibility that potential transgender service users will have such concerns, and to make people aware, as far as possible, that the service will be inclusive and understanding of transgender identities and needs. In these circumstances the assumption that a service is open to everyone is unlikely to be sufficient.

Equalities monitoring for gender reassignment and gender identity by services is also an issue which requires consideration. The Trans Mental Health Study notes that there are people who may be considered as trans who will not define in that way (for example, after transition they may choose not to identify as a trans person), and there are many trans people who are extremely private about their trans identity or history (McNeil *et al*. 2012).

NatCen research (commissioned by the EHRC) into developing a monitoring question for gender identity found that there was a need for a cognitively tested, understandable way of capturing evidence on gender reassignment (Balarajan *et al*. 2011). They found that transgender people required particular assurances about the privacy and confidentiality of data being recorded, and recommended that more than one question be asked to capture how the person's sex was described at birth, the gender with which they identify, and any transgender identity with which they identify. They found that transgender participants found existing gender reassignment monitoring questions off-putting due to a number of

	issues with the question wording, including listing transgender as a separate gender. With this in mind, any monitoring around gender reassignment should look to questions which have been tested with transgender people to ensure not only accurate data capture, but that service users are not potentially alienated by the questions themselves. There is also evidence that trans women can face difficulties accessing domestic abuse services which are often specific to women, due to a lack of understanding or acceptance of their gender identity. Concerns over experiencing discrimination, the fear of being 'outed', and greater isolation from family and friends as a result of transphobia can pose barriers to trans women accessing these services. Each of these issues can similarly be experienced by trans men, in addition to limited available services which provide support around domestic abuse to men. For those who do not identify with a specific gender, there may be concerns over whether this will be accepted or understood, and difficulties in accessing or knowing how to access services which are often gender specific. Research such as the examples cited here should be used alongside good practice resources, including the NHS Greater Glasgow & Clyde Transgender Policy, when developing the Joint Strategic Commissioning Plan. The NHS GG&C offer guidance on health needs of transgender people and how to address discrimination against trans people in their Briefing Paper on Gender Reassignment and Transgender people, as well as offering training for NHS staff on the subject of transgender people. An integrated approach to care, embedded in the Plan, is likely to be beneficial for transgender people who, as indicated above, may be likely to require support for more than one health or social care issue. The strong partnership working, inclusive of the Third Sector, which is promoted by the Plan should also impact positively upon transgender people as major research and policy direction around trans people are as yet largely shaped by the Third Sector organisations who work closely with this group.	
Race	East Renfrewshire is the fifth most diverse local authority in Scotland, based on the proportion of people in the 2011 census who recorded their ethnicity as being in any category not among the 'white' categories. Our ethnic minority population grew from 3.8% in 2001 to 6% in 2011, suggesting our area is becoming more diverse. In 2011, 92.6% of	Census 2011, NHS Health Scotland, National

	the population were White Scottish, British or Irish, 1.4% were White Polish or Other White, 4.6% were Indian, Pakistani or Other Asian, 0.5% were Chinese, and 0.4% were Mixed. We also have growing African (0.1%) and Arab (0.1%) populations, some identified as 'Other' (0.1%), and small numbers of Bangladeshi, Caribbean, Other Black, and White Gypsy/Traveller people. This varies between different areas of the local authority; the areas with the proportionally highest populations of ethnic minority people were Giffnock and Thornliebank, and Newton Mearns. 4.8% of the population were born outside of the UK (0.4% in Republic of Ireland, 0.9% in other EU countries, and 3.5% outside of the EU), and of those born outside the UK, 69.3% had been resident in the UK for ten years or more. 96.5% of those aged 16 or over in East Renfrewshire have good English reading, writing, listening and speaking skills. According to NHS Health Scotland, people from minority ethnic groups generally have lower mortality than the general population in Scotland. Scotland has internationally high rates of cardiovascular disease (ASH Scotland, 2014), and BME people in Scotland, particularly South Asian people, are at an even higher risk of cardiovascular disease. Diabetes has been found to be significantly more common among all BME groups, with the incidence of Type 2 diabetes being 6 times higher in the South Asian population than in the White population (MECOPP, Briefing Sheet on Health of Scotland's BME communities). African and Caribbean people experience high rates of hypertension and strokes. Research has suggested that an important factor in health inequalities experienced by BME is socio-economic status (ASH Scotland, 2014). Research by the Disability Rights Commission (2006) notes that BME people experience mental health issues at higher rates. There are high rates of suicide among women in the UK who were born in South Asia (Nazroo, 2014). NHS Health Scotland research (2008) found that BME people may experience barriers to accessing support for mental health. They found that specific experiences among people who have immigrated to the UK may make them vulnerable and have an impact on mental health, including discrimination, isolation, and language barriers. A common theme among participants was stigma faced in their own communities, which they felt was based on cultural attitudes and a lack of open discussion around mental health within their community.	Research.

	BME women can also have distinct experiences in relation to domestic abuse, influenced by culture and tradition: for example, honour based violence or forced marriage (Hemat Gryffe Women's Aid). The comparative lack of knowledge and resources available specific to these experiences, as well as a more limited understanding of minority cultures and religious beliefs in general, can compound the issues generally faced by women experiencing domestic abuse. This may make access to appropriate support and services more difficult, or result in lower confidence in accessing these services among women from minority cultural or religious communities. Isolation, which is common among women experiencing domestic abuse, may be intensified for women who face language barriers or who do not have access to friends or family to confide in (Shakti Women's Aid). Depending on a person's immigration status, they may also experience additional difficulties in gaining financial independence due to a lack of access to public funds. A Disability Rights Commission (2006) study into BME people with disabilities, which involved 8 focus groups, found that participants in all groups identified the experience of stigma around disability and learning disability in their communities. Some noted that disabilities were attributed to wrongful behaviour in a person's previous life, or in their present life if the disability was acquired. This could impact on rates of accessing services and support, as participants frequently suggested reluctance to identify with the label 'disabled', partly due to this stigma. Older BME people in particular may face barriers to accessing information due to language and the places in which the information is disseminated. The Disability Rights Commission found that a number of participants felt that having family members as paid carers could be beneficial for BME people who may otherwise be supported by someone who does not speak their language or understand their culture; these issues resulted in concerns over using residential care, as well as concerns about experiencing racism. A MECOPP Briefing Sheet on SDS highlights some concerns around BME people accessing Self Directed Support. They suggest that more clarity is needed on the 'relatives rule' whereby local authorities can now allow family to be employed as carers in	

	'appropriate circumstances', which it is felt would be a popular option among BME communities. This is because, even with SDS, there may be limited options in practice for access to paid carers who can speak the appropriate language or have knowledge of the person's culture. Additionally, barriers may be posed by the language and venues in which information on SDS is distributed, and the concept of independent living which SDS supports may not be understood in the same way by people whose cultures are typically based on closer family interdependency. ASH Scotland (2014) cites examples from England where smoking cessation projects increased uptake of the service for BME people by actively engaging with the local community, including specific cultural and religious groups, to target relevant venues and produce materials with culturally relevant values and images. This suggests that working in partnership and taking a planned, targeted approach to ensuring the inclusion of BME people in health and social care services could be an important factor in improving health outcomes for these groups. As indicated here there are a whole range of factors to take into consideration in developing the Strategic Plan and the services included within it. These differences in health and social care needs and access to services will be taken into consideration in the consultation process. The Strategic Plan promotes a person-centred approach to health and social care, which aims to allow for the needs of all service users to be met, including cultural and religious needs. It will be important to recognise any concerns around this to ensure that this can work well in practice for all communities. Partnership working and community capacity building are key aspects of integration, both of which should play a positive role in reducing some of the inequalities referred to here.	
Disability	Based on the 2011 census, 27.3% of people in East Renfrewshire have one or more long term conditions, including physical disability (5.4%), learning disability (0.5%), learning difficulty (1.8%), developmental disorder (0.6%), blindness or partial sight loss (2%), deafness or partial hearing loss (6.2%), mental health condition (3.5%), or an 'other condition' (17.1%). In May 2013, 4, 310 people in East Renfrewshire claimed Disability Living Allowance. Between 2000 and 2011, the number of children with disabilities known to social work steadily increased from 130 to 279. Increasing life expectancy has also	Census (2011), CHCP service data, NOMIS, NHS Health Scotland, national research.

been linked to increasing numbers of people with disabilities and long term conditions, because such conditions are more common among older people.

NHS Health Scotland research (2010) notes that people with disabilities have poorer health on average. In the 2011 census, 54.4% of all those in East Renfrewshire with one or more long term health conditions rated their health as very good (19.2%) or good (35.2%). 20.2% of people in East Renfrewshire with physical disabilities rated their health as very good (4%) or good (16.2%), and 55.2% of those with learning disabilities rated their health as very good (22.2%) or good (33%). This compared to 97.2% (73.6%, 23.6%) of people with no long term health conditions or disabilities. Gordon *et al.* explain that there may be an assumption that health issues are symptoms of the person's disability or long-term condition, when there may be separate health issues which could be treated (2010).

Disabled people are more likely to live in deprived areas: Almost one in three (31%) adults living in the most deprived SIMD quintile reported a limiting long-standing illness, disability or infirmity, compared to 16% in the least deprived SIMD quintile (Scottish Health Survey, 2009). Rates of employment among disabled people are lower, income on average is lower, and people with disabilities were twice as likely to be living in poverty as people without disabilities in 2005/6 (Gordon *et al.*, 2010). Gordon *et al.* suggest that these figures would likely have worsened in light of the economic recession. Capacity building work, addressed in the Strategic Plan, could be a vital aspect of supporting people with disabilities to improve their health and wellbeing outcomes, from example through support to enter the labour market.

NHS Greater Glasgow & Clyde explain in their Briefing Paper on Learning Disability that people with learning disabilities die younger than the general population, are more likely to have physical or mental health problems, and on average have 5 co-morbidities (more than one health problem at once) compared to one or two in the general population (NHS GG&C, 2013), are less likely to eat healthily or exercise as they may not have the knowledge or understanding to make healthy choices. People with learning disabilities are also more likely to experience poverty, unemployment, and poor housing, regardless of whether the level of deprivation of the area in which they live (NHS GG&C).

	People with learning disabilities have been found to have untreated medical conditions that would normally have been identified and resolved for other members of the community, these can be minor conditions but also include serious concerns such as breast lumps or diabetes (Gordon *et al.*, 2010). Research in England has found that eligible people with learning disabilities had substantially lower rates of reported cancer screening than for the total population (Glover *et al.*, 2014). This may be an indication of barriers in accessing information about health and social care. Such barriers can be experienced by others with disabilities and long-term conditions, for example, RNIB found that only 10.8% of 217 blind and partially sighted people surveyed said that they received health information in their preferred format. Accessibility issues in terms of such information could act as a barrier to accessing services. NHS Greater Glasgow & Clyde's Briefing Paper on Sensory Impairment notes that 35% of Deaf and hard of hearing people had experienced difficulty communicating with their GP, and 15% avoided going to their GP because of this. Among BSL users, 30% avoided going to their GP for this reason. 45% of Deaf people are likely to experience mental ill health compared to 25% of the general population (NHS GG&C, 2013). NHS GG&C has a range of policies and procedures which aim to address accessibility issues and barriers to services, and offer training to NHS staff on sensory impairment. The Strategic Plan will put forward plans for health and social care services which directly aim to improve the health and wellbeing of people with disabilities and long-term conditions. The Plan also holds improving the lives of people with learning disabilities as one of its key strategic priorities. The principle of integration itself is expected to be of benefit to people with disabilities and long-term conditions, who are particularly likely to require access to more than one health or social care service (Scottish Government, 2014).	
Sexual Orientation	Research by LGBT Youth Scotland with 350 LGBT people aged 13-25 (27 of whom reported that they identify as transgender) found that 38.4% of LGBT respondents were out to their doctor, and 56% would be comfortable discussing sexual health issues with their doctor (Logan & Lough Dennell, 2012). Just 56.5% agreed that they felt 'safe and	National research, NHS Scotland.

	supported' by the NHS in relation to their sexual orientation or gender identity. The proportions of gay/lesbian women (16.2%), bisexual women (17.9%) and bisexual men (18.8%) who said they would not feel comfortable coming out to their doctor were at least twice as large as the figure for gay men (8.1%). 43.1% of all LGBT women felt safe and supported by the NHS compared to 67.7% of men, gay men were also more likely to feel comfortable discussing sexual health issues with their doctor (64.1%) than bisexual men (56.3%), bisexual women (52.6%) or gay/lesbian women (43.2%). Anecdotal responses revealed a number of negative experiences with health professionals, particularly among women, such as being refused access to a smear test, being repeatedly told to take the contraceptive pill, and being asked by a GP whether lesbians could get STIs (these were 'thematic' examples which appeared in the comments of a number of different respondents). Participants indicated positive experiences with sexual health clinics, as compared to GPs. Stonewall UK previously found in a study of 6178 LGB women that 1 in 5 lesbian/gay and bisexual women who had never had a cervical screening had been told by a health worker that they were not at risk, and 1 in 50 were refused a test (Hunt & Fish, 2008). NHS Scotland's information for lesbian and bisexual women on cervical screening explains that it is a 'myth' that LGB women cannot get cervical cancer. Stonewall UK found evidence of a higher rate of 'risk taking behaviours' among LGB women than in women overall: 40% drank 3 times a week compared to 25% of women overall, they were 5 times as likely to have taken drugs, and 10% had taken cocaine compared to 3% of all women (Hunt & Fish, 2008). They found that one in five LGB women had self harmed in the last year, and 5% had attempted to take their life in the last year. The LGBT Youth Scotland study (2012) supported previous findings that LGBT people may be at greater risk of mental health problems, as did the Gay and Bisexual Men's Health Survey Scotland (2011). NHS GG&C's briefing report on Sexual Orientation cites the Bisexuality Report (2012) as finding that bisexual people can be more likely to have mental health issues than either the heterosexual or gay/bisexual population. There is evidence that people in same-sex relationships experience domestic abuse at the same rates as those in heterosexual relationships (Hunt & Fish, 2008). There is evidence that lesbian, gay or bisexual women can face barriers to accessing support for domestic	

	abuse, such as the fear of experiencing discrimination or a lack of understanding, the fear of being 'outed', and greater isolation from family and friends as a result of homophobia. Each of these issues can similarly be experienced by gay or bisexual men, in addition to limited available services which will provide support around domestic abuse to men. Negative experiences and exposure to negative societal attitudes towards LGB people in earlier life, when rights for LGB people were far more limited, can pose a barrier to LGB older people accessing services and being open about their family circumstances (Ward et al, 2010). Older LGB people are likely to fear negative treatment as a result of their sexual orientation (Hunt & Dick, 2008), for example, only 49% of LGB people aged 60+ reported that they could be open about their sexual orientation without fear of prejudice in their local health practice or hospital (Ellison and Gunstone, 2009). Research and good practice recommendations suggest that using language which does not presume someone's sexual orientation can make it easier for LGB people to be comfortable to discuss issues relating to their sexual orientation (Stonewall, LGBT Youth Scotland, Ward et al.). As with transgender populations, is difficult to estimate populations for sexual orientation as the information is not recorded in the census or in other major datasets in the same was as some other characteristics. An EHRC study into LGB population estimates concluded that there were at present no reliable estimates, and existing estimates range from 2-10% of the UK population (Aspinall, 2009). Collecting such information at a local level can be a useful way of identifying needs and outcomes across protected characteristics, providing evidence of and continued direction for work to meet equality duties specified in the Equality Act 2010. A 2009 study found that 75% of 1, 759 heterosexual respondents felt that it was acceptable to record information on sexual orientation in national surveys, 81% of 1, 148 bisexual respondents felt this, and 90% of 1, 707 gay and lesbian respondents agreed (Ellison and Gunstone, 2009). An EHRC study into personalisation (2011) found that LGBT participants raised the issue of the lack of monitoring of sexual orientation or gender identity by health and social care services and felt that this would limit service providers' understanding and reduce LGBT service users' confidence that their needs would be met.	

	It will be important in developing the Strategic Plan to be aware of differing needs of LGB people and potential barriers to accessing services or being open about sexual orientation and relationships when doing so. Consultation opportunities should aim to offer unthreatening and private ways in which LGB people can share their views, lest the same barriers to service use emerge as barriers to involvement in consultations. NHS Greater Glasgow & Clyde offer resources on addressing discrimination based on sexual orientation, and training to NHS staff. The ethos of partnership working entrenched within the Strategic Plan should have a positive impact in addressing some of the issues referred to here, through effective signposting and linking in with Third Sector organisations with relevant expertise, and working together to ensure positive outcomes.	
Religion and Belief	Just over one in four people (26.5%) in East Renfrewshire did not have a religion in the 2011 census, compared to over a third (36.7%) in Scotland, making East Renfrewshire the local authority with the fourth highest religious population in Scotland. As with Scotland as a whole, the largest religious group was 'Church of Scotland', with 33.4%. East Renfrewshire also has a significant Catholic population, with 22.2% identifying in this way, compared to 15.9% in Scotland as a whole. East Renfrewshire has a greater Muslim population proportionally than Scotland on average, with 3.3% compared to the Scottish total of 1.4%. 2.6% of the East Renfrewshire population is Jewish, compared with 0.1% in Scotland; 40.8% of the Jewish population in Scotland lives in East Renfrewshire. The religious makeup of different areas of the local authority is different. Barrhead has the highest proportion of Roman Catholic people in their population at 30%, while Giffnock and Thornliebank has the highest Muslim population, and Newton Mearns and Giffnock and Thornliebank have the highest Jewish population. Since the 2001 census, the Muslim population has risen by 1, 084 people, while the Jewish population has reduced by 729 people. This can be linked to the ageing population of Jewish people, as only 30% of Jewish people in East Renfrewshire are aged 0-44, whereas 38% are aged 65 or over. This age distribution is commonly an indication of a declining population group (ERC Single Outcome Agreement). This is in contrast with the Muslim and Roman Catholic populations, of whom 77% and 58% respectively are aged 0-	Census 2011, NHS Health Scotland, National Research.

	44. This will likely have implications for the health needs of these populations, for example as there may be a large proportion of Jewish people who require access to both health and social care, due to the age demographics of this group. Evidence has been found that discrimination based on religion may be a contributing factor in ill health among Catholic people in the West of Scotland, as increased stress levels, limited employment opportunities and early exit from the labour market have been identified among this group (Gordon *et al*., 2010). Based on the 2001 census, it was found that people who identified as Roman Catholic or Muslim were more likely than others to live in the two more deprived quintiles of Scotland (55%, 47%). It was also found that health inequalities were evident in later working life, as people who identified as Roman Catholic, Muslim or Sikh reported poorer health than the Scottish average, and Roman Catholic and Sikh people were more likely to report having a long term condition than the Scottish average (Gordon *et al*., 2010). Conversely, there is evidence that religion or spirituality have a positive impact on health and wellbeing, and can improve quality of life for older people at the end of life (Gordon *et al,* 2010; Holloway et al., 2011). A number of the issues addressed above in relation to 'race' also touch upon religion, due to the overlap between these characteristics. For example, concerns around access to carers, residential care homes and support services in general which have a clear understanding of an individual's religious beliefs and requirements. The positive potential of self-directed support to allow for appropriate, person-centred care, as outlined above, should have a positive impact in relation to religion or belief, while the same considerations for ensuring that this approach does not pose its own barriers also apply here. The Strategic Plan will be guided by an ongoing commitment to partnership working, including Third Sector and faith groups. This approach will be taken in consulting with communities, in the community capacity building work which is embedded within the Plan, and in developing models of care. The impact of the Plan is, for these reasons, expected to be positive.	
Age	As of the 2013 mid-year estimates, 19.7% of the population in East Renfrewshire are	National Records

	children (under 16), compared to 17.1% in Scotland; 61.4% are adults (aged 16-64), compared to 65.1% in Scotland; and 18.9% are aged 65+, compared to 17.8% in Scotland. While the child population has increased slightly both in absolute number and as a proportion of the total since 2011 (from 19.6%), and the older population has increased more significantly (from 18%), the adult population has reduced in number and proportion (from 62.3%). This, and the projected continuation of this trend, has implications for future demands on health and social care services. Disabilities and long term-health conditions are more common among older people: based on the 2011 census, 46.6% of those aged 65 and over had their day-to-day activities limited a little or a lot by a disability or long-term condition. This compares to 4.3% those aged 0-15, and 12.1% of those aged 16-64. In 2013, there were 1, 637 people with dementia in East Renfrewshire, and just 3.2% of these were under 65 (Alzheimer Scotland, 2013). Older people frequently experience more than one condition for which they require support from health or social care services (Scottish Government, 2014). The integration of health and social care should actively reduce health inequalities related to age, through make access to health and social services easier, more connected and more person-centred for the older people using them. There is evidence that older people experience discrimination in health and social care, for example through being less involved in decision making, excluded from conversations about their care, and having assumptions made about them based on their age (Clark, 2009). Older people are an important focus of the Strategic Plan, building on our work on Reshaping Care for Older People. The plan also provides for the needs of unpaid carers, many of whom are older people themselves. Based on the 2011 census, those who provide care are more likely to rate their health as bad or very bad, and this trend becomes more pronounced with age: 15.2% of those aged 65+ providing 35 or more hours of unpaid care rated their health as bad or very bad, compared to 5.6% providing up to 34 hours of unpaid care. It is expected that the Strategic Plan's aims of maximising independent living and its focus on re-ablement and rehabilitation will have a positive	of Scotland, Mid-Year Population Estimates 2013, Census 2011, Scottish Government.

	impact on older people and their carers. It was found in a study into one local authority in England that older people in particular faced difficulties with personal budgets and felt the system was complex, preferring not to assume full control for their budget (Norrie *et al*., 2014). The Social Care (Self-directed Support) (Scotland) Act 2013 is integral to the services provided by the CHCP which the Strategic Plan encompasses. The four options provided by this Act should allow for care to be personalised in such a way that greater support can be provided where this is the appropriate and preferred model of care for the individual in question. This means that greater opportunity for independence among older people can be promoted, while also ensuring that the required level of support remains accessible. Children and Families are also integrated and included within the Strategic Plan. The three national outcomes relating to children and young people are embedded within our plan, which state that 'our children have the best start in life', 'our young people are successful learners, confident individuals, effective contributors and responsible citizens', and 'We have improved the life chances for children, young people and families at risk'. The Integrated Children's Services Plan measures progress against each of these outcomes, specifically in relation to each of the Getting it Right for Every Child SHANARRI (Safe, Happy, Active, Nurtured, Active, Respected, Responsible, Included) indicators. We recognise the importance of promoting equality in health and wellbeing from the earliest stages of life. This is a central aim of the Early Years Collaborative, which is included within the Strategic Plan. The Strategic Plan presents evidence on health experiences and outcomes in different areas of East Renfrewshire. There is evidence that better outcomes at the earliest stages of life are closely linked to future outcomes for an individual. We know that experiences and outcomes for children and young people in relation to health and across other aspects of life such as education are linked to the level of deprivation or affluence experienced by their family. This is also discussed below in relation to 'pregnancy and maternity'.	
Pregnancy and Maternity	According to NHS Health Scotland, 'estimates suggest that up to 1 in 7 mothers will experience a mental health problem in the antenatal or postnatal period', and women with mental health issues are less likely to access antenatal services and other sources of	NHS Health Scotland, Growing Up in

	support. This in turn can put such women at a higher risk for maternal and infant mortality. Based on Growing Up in Scotland research, women from vulnerable or disadvantaged groups, such as those with lower educational attainment, household incomes, and socioeconomic classification are less likely to access early years services and other sources of support (Mabelis and Marryat, 2011). In order to address health inequalities for a child throughout life, it is important to address inequalities in pregnancy (NHS Health Scotland). Teenage pregnancy is more common in less affluent areas; for example, 17.5% of first births between 2009-11 in Barrhead and 12.7% in Neilston (both in Levern Valley) were to mothers under 20, compared with 4.3% in Giffnock and 3.8% in Newton Mearns. In turn, younger mothers are more likely to be unemployed or in low income than older mothers (Bradshaw *et al*, 2014). Growing up in Scotland research found that mothers aged 24 and under rated themselves more poorly than mothers aged 25+ on all general health and mental wellbeing outcomes and were less likely to attend antenatal groups, and mothers aged under 20 tended to report poorer health behaviours during their pregnancy (Bradshaw *et al*, 2014). A Growing Up in Scotland report on infant feeding notes that breastfeeding outcomes- beginning breastfeeding and continue to six weeks- are much more likely to be achieved for women in less deprived areas and families where either parent has a degree (Warner, 2013). In 2012/13, 27.3% of babies were being breastfed at the first antenatal visit and 18.6% were being breastfed at the six-eight week antenatal visit, compared to Giffnock where 52.7% were being breastfed at the first visit and 42% at the six-eight week visit. The Strategic Plan references the Early Years Strategy, and Integrated Children's Services Plan, and incorporates planning for Children and Families Services. The Integrated Children's Services Plan details a range of measures which are monitored by Children & Families, including reducing low birth weight, increasing breastfeeding rates and positive evaluations of the Triple P parenting programme. The locality approach taken in the Strategic Plan allows for recognition of the existing differences between areas of East Renfrewshire based on relative deprivation. The implications of the plan should therefore be positive for equality around pregnancy and maternity, directly aiming to	Scotland, East Renfrewshire Council S.O.A (ISD data), Integrated Children's Services Plan.

	reduce related health inequalities.	
Marriage and Civil Partnership	Age UK, commissioned by the EHRC, found a positive link between marriage and mental and physical health, including life expectancy (Lee, 2009). Divorce has been found to have a negative impact on male life expectancy, and women who are divorced are more likely to experience poverty in later life (Glaser et. al., 2009). However, men and women who marry early are more likely to be in poor health in older age, and women who marry early are at a higher risk of poverty in old age (Bryan, 2009; Glaser et. al., 2009). This is likely due to the employment patterns of women who marry at a young age, and the association between marrying early and other factors linked to poorer health outcomes, such as lower educational attainment. The aim of increasing independence and enabling people to live in their own homes for longer is expected to have a positive impact in terms of marriage and civil partnership, as is the support for unpaid carers encompassed within the Strategic Plan. Self Directed Support should allow for more flexibility in the model of care, which could have a positive effect on the maintenance of relationships. Additionally, combined with other equalities issues such as sexual orientation, it is expected that this flexibility will reduce barriers to accessing services, as those in civil partnerships, now same-sex married couples, or other same-sex partnerships, may have concerns over being out about their relationship, and could benefit from the option to access explicitly “LGBT friendly” services. Partnership working with the Third Sector is also expected to have a positive impact in this regard.	National research.
Social and Economic Status	East Renfrewshire is relatively affluent on average as a local authority. Of the 121 Datazones (small geographies) in East Renfrewshire, 59.5% of these are ranked in the fifth (least deprived) quintile in Scotland, and a further 15.7% are ranked in the fourth quintile. 9.1% of Datazones are ranked in the third quintile, 8.2% in the second, and just 7.4% in the first (most deprived). However, the zones with the greatest deprivation tend to be concentrated in the same areas: all of the 9 Datazones in the fifth quintile, and 8 of the 10 Datazones in the fourth quintile, are located in Levern Valley. There is evidence that Levern Valley tends to have poorer outcomes than other areas of East Renfrewshire in relation to health and other aspects of life such as employment and income.	SIMD 2012, ScotPHO 2006-10, Audit Scotland, JIT, national research.

	Audit Scotland's report on Health Inequalities in Scotland (2012), explains that deprivation is a major factor in health inequalities. Men from the least deprived areas of Scotland have a life expectancy over 10 years greater than those from the most deprived, while for women the life expectancy is over 7 years higher in the least deprived areas. The average healthy life expectancy is around 18 years lower in the most deprived areas of Scotland compared to the least deprived areas. People in more deprived areas also have higher rates of coronary heart disease, mental health problems, obesity, alcohol and drug misuse problems, diabetes and some types of cancer. There were over 7 times as many alcohol related hospital admissions in the most deprived areas than in the least deprived areas. Children in deprived areas have significantly worse health than those in more affluent areas. A JIT advice note on multimorbidity, in the context of integration, explains that multimorbidity occurs 10-15 years earlier in deprived areas compared to affluent areas. The advice note states that "A greater mix of mental and physical health problems is seen as deprivation increases, which increases clinical complexity and the need for holistic person centred care. A combination of physical and mental health conditions has a strong association with health inequalities and negative outcomes for individuals and families." The Scottish Health Survey 2013 found that the presence of multiple health risks increased with higher levels of multiple deprivation (Bromley *et al.*, 2013). ScotPHO findings from 2009-13 indicate that people from the most deprived 10% of areas in Scotland are more than three times as likely to commit suicide than those from the least deprived 10% of areas. In this context, it is vital to take an integrated approach to healthcare, support and housing. As the Strategic Plan has a clear focus on this integrated approach, the implications of the plan for health inequalities associated with social and economic status should be positive. It is necessary in planning, resource allocation and targeting of services to be aware of the varying experiences and needs in different areas of East Renfrewshire. The Strategic Plan will take a locality based approach to its strategic needs assessment, consultations, and planning, in order to ensure that needs are met, and that these inequalities can be reduced.	

Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	As noted in the NHS Greater Glasgow and Clyde Briefing Paper on Asylum Seekers and Refugees, asylum seekers or refugees may have increased health needs following arrival in the UK. Some of these may overlap with health needs experienced based on race, religion or language, and experiences which may be shared with other migrants such as a lack of awareness of entitlement, difficulties in registering, or language barriers (NHS GG&C, 2013). Other needs specific to their experience as asylum seekers or refugees may emerge, for example relating to their experiences in their former country which may have had a physical or psychological impact on their health, and they may have come from locations where health provision is poor (NHS GG&C, 2013). Evidence indicates barriers to accessing services, particularly for women; asylum seeking pregnant women are seven times as likely to experience complications during child birth than the general population. NHS Greater Glasgow and Clyde have a number of resources on working with asylum seekers and refugees on their Equalities in Health Pages.	

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

	Highly Likely	Probable	Possible
General		Probable. Several comments from the consultation process indicated that the priorities would be likely to have a positive impact in relation to the equalities characteristics. One person noted ‘For example, they mention reducing inequalities, supporting young people and enabling older people to remain	

		at home longer.' Another said 'the equalities characteristics have been looked at in a fair and unbiased manner'.	
Sex			Broadly one of the strategic priorities in the Plan is around reducing health inequalities, which relates to all protected characteristics. A more integrated way of working should be beneficial to this process through linking with wider partners including the Third Sector. The focus on a personalised, person centred approach should also be beneficial to reducing inequalities.
Gender Reassignment			Broadly one of the strategic priorities in the Plan is around reducing health inequalities, which relates to all protected characteristics. A more integrated way of working should be beneficial to this process through linking with wider partners including the Third Sector. The focus on a personalised, person centred approach should also be beneficial to reducing inequalities.
Race			Broadly one of the strategic priorities in the Plan is around reducing health inequalities, which relates to all protected characteristics. A more integrated way of working should be beneficial to this process through linking with wider partners including the Third Sector. The focus on a personalised, person centred approach should also be beneficial to

			reducing inequalities.
Disability	Highly likely. The Strategic Plan directly relates to the integration of health and social care services which is of particular benefit to people with disabilities and long term conditions who may need to access more than one service.		
Sexual Orientation			Broadly one of the strategic priorities in the Plan is around reducing health inequalities, which relates to all protected characteristics. A more integrated way of working should be beneficial to this process through linking with wider partners including the Third Sector. The focus on a personalised, person centred approach should also be beneficial to reducing inequalities.
Religion and Belief			Broadly one of the strategic priorities in the Plan is around reducing health inequalities, which relates to all protected characteristics. A more integrated way of working should be beneficial to this process through linking with wider partners including the Third Sector. The focus on a personalised, person centred approach should also be beneficial to reducing inequalities.
Age	Highly likely. The Strategic Plan directly relates to the integration of health and social care services which is of particular benefit to the		

	oldest population who often require to access more than one health or social care service. Strategic priorities include supporting people to stay at home and ensuring that people have dignity at the end of life. Improving wellbeing of children and young people is also a strategic priority within the plan, with a focus on the Early Years Strategy.		
Marriage and Civil Partnership			Broadly one of the strategic priorities in the Plan is around reducing health inequalities, which relates to all protected characteristics. A more integrated way of working should be beneficial to this process through linking with wider partners including the Third Sector. The focus on a personalised, person centred approach should also be beneficial to reducing inequalities.
Pregnancy and Maternity	Highly likely. Improving wellbeing of children and young people is a strategic priority within the plan, with a focus on the Early Years Strategy, which aims to engage with individuals, families and communities pre-birth and during the early years of a child's life to build on their strengths.		
Social and Economic		Probable. The Strategic Plan uses different localities of East	

Status		Renfrewshire in order to reflect different needs in different areas, some of which are impacted on by socio-economic inequalities with certain areas experiencing higher concentrations of deprivation. The Strategic Plan takes this into account and locality planning will aim to reduce associated health inequalities.	
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	Highly likely. A strategic priority within the Plan is to improve quality of life, including for people with mental health issues and alcohol or drug problems, with mental health services and addictions services included in the Plan. Comments from the consultation process suggest that the inclusion of sensory impairment within the plan is also positive.		

D Do you expect the policy to have any negative impact on people with protected characteristics?			
	Highly Likely	**Probable**	**Possible**
General			7 out of 22 people said ‘yes’ to the consultation question ‘Are the priorities set out in this Strategic Plan likely to have a negative impact in relation to any

			equalities characteristics? This would include socio-economic class and the 9 characteristics covered by the Equality Act 2010: Age, Gender reassignment (transgender people), Disability, Ethnicity, Marriage and Civil Partnership, Pregnancy and Maternity, Religion and Belief, Sex and Sexual Orientation.' The issues raised are highlighted under the relevant headings below.
Sex			
Gender Reassignment			
Race			
Disability			Some concerns were raised over the impact of self-directed support and the closure of day centres on adults with learning disabilities and their carers, with the potential for this to contribute to social isolation and socio-economic difficulties.
Sexual Orientation			
Religion and Belief			
Age			A couple of respondents in the consultation expressed the view that

			there the focus was primarily on older people and young children rather than on people in between.
Marriage and Civil Partnership			
Pregnancy and Maternity			
Social and Economic Status			The point was raised in consultation that deprivation and socio-economic inequality exists within each of the localities in the Strategic Plan. There was some concern that these issues within areas such as Thornliebank, Busby or Newton Mearns could be overlooked in looking at overall figures for the four localities. It was also suggested that greater reference to welfare rights and community education is needed in order to address socio-economic inequalities and improve outcomes.
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-			It was highlighted in the consultation that further information on dementia and work being done around this was needed within the Plan, and that generally more signposting to support for mental health

offenders			was needed.

E Actions to be taken		
		Responsibility and Timescale
E1 Changes to policy	Dementia and mental health- Within the updated version of the Strategic Plan and corporate version of the Strategic Plan, information will be included on dementia and work around this. Within the Joint Strategic Needs Assessment, there will be data included on mental health across localities of East Renfrewshire to support planning. Socio-economic status- For locality planning purposes, where relevant smaller areas within localities will also be looked at with the understanding that deprivation can be concentrated in small areas within larger localities, and it will be recognised that measures such as the Scottish Index of Multiple deprivation only highlight concentrations of deprivation and not all individuals experiencing socio-economic inequalities and associated health inequalities. This will be recognised within the updated version of the Strategic Plan and corporate version of the Strategic Plan. It will be ensured that all people have access to the services and supports which they require, and that any disadvantage will be mitigated.	
E2 action to compensate for identified negative impact	Learning disability- The HSCP's learning disability service has recently been consulting with people with learning disabilities and their families through engagement events and online consultation to inform the HSCP's new joint strategy for people with a learning disability in a way which will best improve and enhance the lives of people with a learning disability. The learning disability strategy will address these issues in more detail.	
E3 Further monitoring – potential positive or negative impact		
E4 Further information require		

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

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

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

Or send hard copy to:

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

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