NHS Greater Glasgow and Clyde
Equality Impact Assessment Tool

Equality Impact Assessment is a legal requirement as set out in the Equality Act 2010 (Specific Duties) (Scotland) regulations 2012 and may be used as evidence for cases referred for further investigation for compliance issues. Evidence returned should also align to Specific Outcomes as stated in your local Equality Outcomes Report. Please note that prior to starting an EQIA all Lead Reviewers are required to attend a Lead Reviewer training session or arrange to meet with a member of the Equality and Human Rights Team to discuss the process. Please contact Equality@ggc.scot.nhs.uk for further details or call 0141 2014560.

Name of Policy/Service Review/Service Development/Service Redesign/New Service:

MFT Clinical Vision and Roadmap

Is this a: Current Service ☐ Service Development ☐ Service Redesign ☒ New Service ☐ New Policy ☐ Policy Review ☐

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

What does the service or policy do/aim to achieve? Please give as much information as you can, remembering that this document will be published in the public domain and should promote transparency.

MFT Clinical Vision and Roadmap – Principles and Proposed Model of Care

The NHS Greater Glasgow & Clyde Moving Forward Together (MFT) Clinical Vision and Roadmap is based on the principles set out in Figure 1. This vision describes a whole system approach in which services are delivered by a network of integrated teams across primary, community, specialist, and acute care. Where possible, care is delivered in, or close to, home with provision of both local hospital care and specialist hospital care.

Figure 1. MFT Principles	Figure 2. MFT Tiered Model of Care

The MFT Clinical Vision and Roadmap proposes a tiered model of care, set out in Figure 2, which puts people at the centre, promoting self-management and empowering our population to be more involved in their own health and wellbeing, and make better informed decisions relating to their own care.

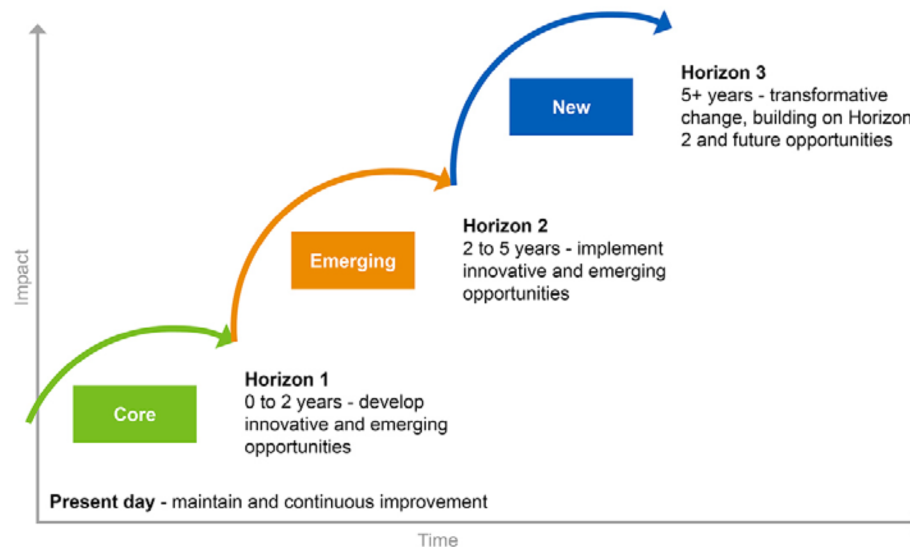
The MFT Clinical Vision and Roadmap represents a whole system transformation which aims to improve health outcomes and patient experience. The vision includes focus on supporting people to remain at home or to receive care in their local community, with a greater range of services, diagnostics and support delivered in communities, and greater use of digital interactions with patients where this is appropriate for the person and their care. We expect these initiatives will result in reduced reliance on hospital care, fewer hospital admissions and shorter stays in hospital. In the longer term, specialist hospital care may be centralised on fewer hospital sites to deliver best quality and outcomes for patients, and to modernise the buildings infrastructure.

Implementation and Timescale

Change associated with the MFT Clinical Vision and Roadmap will take place over a number of years, as illustrated in Figure

3. The Target Operating Models (TOMs) in the diagram describe how operational activity would flow to achieve transformation within each service to achieve the future ‘ideal state’. Specific changes to patient journeys through services will be described along with the actions required to support and direct patients effectively through the new models of care. The Clinical Roadmap presents each service group’s TOM, along with a discussion of why change is needed, what the ‘current state’ of the service is and the vision for change over the short, medium and longer term.

Figure 3: The Three Horizons (Adapted from McKinsey and Co)



The 2035 vision for our healthcare system is to provide person centred care, at the right time, in the right place through:

Empowerment

- Promotion of self-management and empowering people to be more involved in their own health and wellbeing, increasing awareness and knowledge of how and where to access care and advice.
- Delivering more care within our local communities with a focus on early intervention and support. We will expand our community care networks e.g. professional to professional clinical advice networks and support services, our hospital at home service and the Maximising Independence Programme. This will enable us to:

- Increase the number of patients who can be supported to remain at home and avoid unnecessary hospital admissions
- Increase the proportion of patient who access same day ambulatory urgent care who can then be discharged home same day with the right support
- Reduce patients in delay through discharging patients into a supportive community environment, freeing hospital beds and reducing the risks from protracted hospital stay.

Digital First / Digital Transformation

- Further deployment of community and primary care digital solutions including asynchronous consultation, the use of wearable devices and remote monitoring technologies to support empowerment of patients to actively participate in managing their own health and maximise their independence.
- Increase the proportion of virtual patient consultations. Utilising predictive analytics will enable us to offer personalised and targeted proactive interventions. This will not only enhance the patient experience but also optimise our resource allocation, helping to reduce health inequalities.

Early Intervention

- Implementing the 'Making Every Contact Count' (MECC) initiative to increase opportunities to tackle mental and physical well-being will be taken at the earliest stage, this will help lead to early identification of mental health issues, brief intervention or effectively signposting the patient to the most appropriate community mental health service. This will be supported by the development of Primary Care Mental Health and Wellbeing hubs to increase primary care and mental health system capacity to deliver integrated responses to promote good mental health. By improving access to the right support and treatment at the right time existing demands on the wider system will reduce.

Transforming Urgent Care

- Providing immediate access to urgent advice or urgent care through a "digital front door". Emergency care will be provided in the right place at the right time, whether that is by supported self-management, primary care, community providers or in our acute hospitals. Only those who require to do so will attend our Emergency Departments, eliminating delays and optimising emergency care for our most urgent patients.

Protecting Planned (Elective) Care

- A ‘tiered model’ for acute hospital care will support the centralisation of complex specialist hospital care (supporting GGC patients and beyond), supported by both local hospital inpatient provision and elective surgical hubs. This will enable us to make full use of our state of the art facilities to maximise short stay surgery capacity support optimal use of resources and improving patient access.

Why was this service or policy selected for EQIA? Where does it link to organisational priorities? (If no link, please provide evidence of proportionality, relevance, potential legal risk etc.). Consider any locally identified Specific Outcomes noted in your Equality Outcomes Report.

The MFT Clinical Vision and Roadmap sets out the key principles and direction of travel for the whole system transformation of clinical services between now and 2035. Services specific strategies and improvement programmes and projects will be developed to deliver the clinical vision.

The MFT Clinical Vision and Roadmap requires that a high level EQIA be conducted at the outset due to its organisation wide and far-reaching scope. We expect that as the work progresses, proposals for many more specific service reconfigurations (across all services, sites, settings and specialities) will be developed for individual EQIAs. Significant benefits to citizens and patients are expected over the medium to long term, however this overarching EQIA is being performed to assess the MFT principles and high-level models of care against the NHSGGC equalities criteria and identify any areas where potential changes to existing services or their location may ‘leave some people behind’ due to protected characteristics or other factors so that appropriate further work and mitigations may be put in place.

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

Name: Claire MacArthur, Director of Planning, NHSGGC	**Date of Lead Reviewer Training:** 2018

Please list the staff involved in carrying out this EQIA

Ann Lees, Senior Planning Officer, Corporate Planning, NHSGGC

		Example	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
1.	**What equalities information is routinely collected from people currently using the service or affected by the policy? If this is a new service proposal what data do you have on proposed service user groups. Please note any barriers to collecting this data in your submitted evidence and an explanation for any protected characteristic data omitted.**	***A sexual health service collects service user data covering all 9 protected characteristics to enable them to monitor patterns of use.***	The MFT Clinical Vision and Roadmap covers all services across NHS GGC, including Community Services, Primary care, Mental Health and Inpatient services. Data are collected via Trakcare and the Emergency Medical Information System EMIS. Trakcare, the patient information management system used across NHSGGC has options to record a patients age, sex, postcode, religion and belief, ethnicity and whether the patient required interpreting support. These systems allow additional information relating to support needs to be recorded. For example we collect age, sex and social class via postcode related data. Information relating to additional needs such as hearing loss and learning disability is recorded on Trakcare. Other items relating to EQIA are not currently recorded. NHSGGC has the largest population of Scotland's Health Boards, accounting for over a fifth (21.7%) of the population.	Additional service specific data would be collected as any service specific MFT changes are identified to analyse detail relating to service users and protected characteristic groups.

			This is distributed across six Local Authorities (LAs), with wide demographic variations both between and within these areas. According to preliminary 2022 census data, the total population of NHSGGC comprised of 1,177,100 people - increasing faster than Scotland as a whole (3.6% since the previous census in 2011 compared to 2.7% for Scotland). Different patterns of change occurred across LAs. Population increases were seen in East Renfrewshire (6.9%), Renfrewshire (5.1%), Glasgow City (4.6%) and East Dunbartonshire (3.8%), whilst declines were seen in Inverclyde (3.8%) and West Dunbartonshire (2.6%). The proportion of the NHSGGC population who are in older age groups has increased over time. In 2022, 17.4% (205,100) people in NHSGGC were aged 65 years or older compared to 15.7% in 2011. Of these, 2.1% (25,100) were 85 years or older in 2022, compared to 1.9% in 2011. The proportion of the population in NHSGGC aged 65 years and older was lower than for Scotland overall (20.1%). However, there were marked differences in age structure by LA across NHSGGC, with	

			the highest proportion of the population aged 65 years or older in East Dunbartonshire (24.0%), and the lowest in Glasgow City (14.0%). Closely associated with population need, material deprivation is measured using the Scottish Index of Multiple Deprivation (SIMD) system, which allocates deprivation rankings to data zones. (A data zone is a small unit of population of approximately 1,000 people. The deprivation ranking of data zones is commonly grouped into quintiles, Quintile 1 represents the most deprived fifth of the population and Quintile 5 the least deprived fifth of the population). In 2021, more than one third (34.3%) of the total population of NHSGGC resided in the most deprived Scottish data zones (Quintile 1), compared with 19.7% across Scotland. Within NHSGGC, the proportion resident in the most deprived data zones (Quintile 1) varied from 4.0% in East Dunbartonshire to 44.9% in Glasgow City. Ethnicity is also an important indicator, as there are significant inequalities in health needs and outcomes between	

			ethnic groups in Scotland. According to the 2011 Scottish census estimates, 84.4% of the NHSGGC population identified as white Scottish (ranging from 78.6% in Glasgow City to 93% in West Dunbartonshire). The ethnic diversity of the population is likely to have increased since 2011, with international inward migration the main driver of population increase for NHSGGC and in particular for Glasgow City between 2011 and 2021. Population figures above are from the NHSGGC DPH Report January 2024 (Public Health Scotland data). Working Together To Stem The Tide.pdf (scot.nhs.uk)	
		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
3.	**Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination,**	***A physical activity programme for people with long term conditions reviewed service user data and found very low uptake by BME (Black and Minority Ethnic)***	The clinical services provided by the Health Board capture a broad range of data in line with NHS Scotland and legal guidance and specific to the type of service provided. When specific proposals for service change are brought forward, data will be analysed, public engagement undertaken and individual EQIAs developed.	Understanding Greater Glasgow and Clyde's diverse population and potential barriers experienced when accessing services will assist sensitive and inclusive planning.

	harassment and victimisation **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ☐	***people.*** ***Engagement activity found promotional material for the interventions was not representative. As a result an adapted range of materials were introduced with ongoing monitoring of uptake.*** ***(Due regard promoting equality of opportunity)***	Data will be captured to allow evaluation of new service pathways and where appropriate this will include equalities assessments. Some early data capture examples are: **Empowerment** As part of our overall approach to cardiovascular disease reduction, the roll-out of the My Diabetes My Way self-management tool has commenced and a cluster led approach is now being tested. The number of care plans issued has also more than doubled from 64 to 173 across 14 practices. **Digital First** The high discharge rate for the Flow Navigation Centre (FNC) has been maintained at an average of 44% with a trajectory of 40-45%. All referrals to the Flow Navigation Centre (FNC) are offered a Near Me consultation as default and approx. 77% of all FNC calls are currently via Near Me. 98% of patients surveyed following a 'Near Me' FNC video consultation would use service again. **Early Intervention**	

			New Call Before you Convey Pathways have been implemented for SAS, Care Homes and Falls. This has led to approx. 400 fewer presentations to emergency departments per month. Initiatives to optimise our hospital flow through further improving discharge pathways includes focus on Discharge without Delay (DwD) bundle rollout across 130 adult acute wards. Planned Date of Discharge (PDD) accuracy has also shown significant improvement against the baseline (averaging >40% against original baseline of 23%). Public engagement has taken place for the high level MFT Clinical Vision and Roadmap relating to the direction of travel. As MFT work progresses, proposed service changes which meet the criteria for EQIA and/ or Fairer Scotland assessment will be subject to these assessments for the specific proposals and their potential impact on protected groups.	
		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
4.	**Can you give details of**	***A money advice***	Engagement in 2024 has built upon	As we implement new ways

	how you have engaged with equality groups with regard to the service review or policy development? What did this engagement tell you about user experience and how was this information used? The Patient Experience and Public Involvement team (PEPI) support NHSGGC to listen and understand what matters to people and can offer support. **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of** ■	***service spoke to lone parents (predominantly women) to better understand barriers to accessing the service. Feedback included concerns about waiting times at the drop in service, made more difficult due to child care issues. As a result the service introduced a home visit and telephone service which significantly increased uptake.*** ***(Due regard to promoting equality of opportunity)*** **** The Child Poverty (Scotland) Act 2017 requires organisations to take actions to reduce poverty for children in***	previous engagement carried out over several years capturing feedback and insights from over 5,000 patients, service users and members of the public. This included work to inform several core strategies including Maternity and Neonatal, Primary Care, Mental Health and the Quality Strategy. This 2024 activity built on earlier insights and tested public understanding and perceptions of key areas including self-management, community-based approaches, use of technology and resource allocation. This was further refined to engagement testing the 2035 Healthcare Vision and the priority areas emerging through the Clinical Roadmap. Public Survey: A survey was conducted during July and August 2024 receiving 285 responses. This aimed to capture public opinion on the key principles of the 2035 Healthcare Vision and their alignment with the roadmap. Focus Group Sessions: Three targeted focus group sessions were held, with 45 participants attending these sessions. Each session was organised around a specific work stream of the MFT strategy including: Primary and	of working arising from the MFT Clinical Vision and Roadmap in both the short and longer term, meaningful and effective engagement will continue to ensure that our health and care services are fit for purpose and lead to better outcomes for people. This will include an appropriate public engagement process prior to significant decisions being made and EQIAs for specific proposals to assess their impact on protected groups.

<table>
<tr>
<td></td>
<td>opportunity

3) Foster good relations between protected characteristics ☐

4) Not applicabl ☐</td>
<td>households at risk of
low incomes.</td>
<td>Community Care, Urgent Care, and Planned Care.
Social Media: In addition to the surveys and focus groups, a social media campaign was undertaken to gather feedback from a broader audience. This helped in capturing diverse opinions and ensured wider public participation.

Feedback received through engagement
The MFT Public Engagement Report (August 2024) reports positive feedback received through engagement.

<table>
<tr><th>Priority Area</th><th>Agreement</th></tr>
<tr><td>Empowerment</td><td>73%</td></tr>
<tr><td>Digital Transformation</td><td>64%</td></tr>
<tr><td>Early Intervention</td><td>75%</td></tr>
<tr><td>Transforming Urgent Care</td><td>76%</td></tr>
<tr><td>Protecting Planned Care</td><td>78%</td></tr>
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Across all areas of healthcare (maternity, primary care, and mental health), there has been significant feedback to support work to reduce waiting times for appointments and treatment. This includes enhanced patient access and involvement in care by developing tiered models with elective hubs and using technology to minimise delays.
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			• Strong desire for increased community-based services and the integration of digital platforms to improve access to care. This includes increasing the availability of community-based services, enhancing 'telehealth' options, and ensuring digital services are accessible to all demographics, particularly those with digital literacy challenges or without easy access to technology. • Strong emphasis on the need for better integration and coordination between different healthcare services and levels of care. This includes seamless communication between primary, secondary, and community care providers, as well as between different departments within healthcare facilities. For future significant specific changes there will be further public engagement prior to significant decisions being made as well as an EQIA on the specific proposals and their impact on protected groups.	
		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**

5.	**Is your service physically accessible to everyone? If this is a policy that impacts on movement of service users through areas are there potential barriers that need to be addressed?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicab** ☐	***An access audit of an outpatient physiotherapy department found that users were required to negotiate 2 sets of heavy manual pull doors to access the service. A request was placed to have the doors retained by magnets that could deactivate in the event of a fire. (Due regard to remove discrimination, harassment and victimisation).***	Some of the service developments or new ways of working developed as part of the MFT Clinical Vision and Roadmap may be taken forward for detailed planning. Where the proposed service or policy redesign impacts on the movement of patients/service users, NHS GGC will wish to know if there are any barriers arising from the proposal that could prevent people from getting into, through and out of an area providing care. If new buildings are proposed to be developed or existing buildings require to be refurbished as part of the service/policy redesign, an appropriate consultation process will be undertaken with services users with input and support from the design team to ensure that the building not only complies with all current legislation but also works from a practical perspective for disabled people.	As detailed plans are developed for specific service transformation or change we will ensure access audits and, where appropriate, engagement with specific groups relating to physical service provision.

		Example	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
6.	**How will the service change or policy development ensure it does not discriminate in the way it communicates with service users and staff?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics** ☐	***Following a service review, an information video to explain new procedures was hosted on the organisation's YouTube site. This was accompanied by a BSL signer to explain service changes to Deaf service users.*** ***Written materials were offered in other languages and formats.*** ***(Due regard to remove discrimination, harassment and victimisation and promote equality of opportunity).***	Engagement with staff as part of development of the MFT Clinical Vision and Roadmap has been in-depth and broad in scope. Stakeholders from across the NHS including Primary Care and community services as well as Local Authority colleagues have been consulted as part of the development of the Clinical Vision and Roadmap for each HSCP. Since The MFT Clinical Vision and Roadmap work commenced in 2022, regular meetings and specific communications events include: • MFT Programme Board - Monthly • NHS GGC Website – section on MFT • Staff feedback • Core Group • Clinical Leads Group • Stakeholder Engagement Sessions • Public Survey (public & staff responses were received) • Events to discuss the future vision and develop future models of care	

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<td>4) Not applicabl☐

The British Sign Language (Scotland) Act 2017 aims to raise awareness of British Sign Language and improve access to services for those using the language. Specific attention should be paid in your evidence to show how the service review or policy has taken note of this.</td>
<td></td>
<td>Regular messaging to all staff and invitations for input/ comments has taken place throughout, following the communications plan below.
<table>
<tr><th>Tool</th><th>To provide</th></tr>
<tr><td>Core brief (issued daily)</td><td>NHSGGC wide updates on the MFT Implementation Strategy linked to key milestones such as the start of the Engagement Workshops</td></tr>
<tr><td>Informal Directors (weekly)</td><td>Important updates on progress and or decisions to be made by NHSGGC Director Group</td></tr>
<tr><td>Ad Hoc Email Cascade to specific Groups</td><td>Targeted updates and requests to specific Groups across NHSGGC and or communication of urgent or time dependent requests / updates to all GGC staff</td></tr>
<tr><td>Acute Brief / Chief Executive Brief</td><td>Acute or NHSGGC wide updates as and when appropriate</td></tr>
<tr><td>NHSGGC Standing Board Meetings</td><td>Monthly updates on progress against key milestones and general awareness.</td></tr>
<tr><td>Integrated Joint Boards / Health & Social Care Partnership Board Meetings</td><td>Monthly updates on progress against key milestones and general awareness.</td></tr>
<tr><td>Other stakeholder groups including Local Authorities, Scottish Government and NHS</td><td>Monthly updates on progress against key milestones and general awareness.</td></tr>
<tr><td>NHSGGC intranet</td><td>To provide a home for all key facts on he MFT IS, incl. FAQs, and contact us details</td></tr>
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<tr>
<td>7</td>
<td colspan="2">Protected Characteristic</td>
<td>Service Evidence Provided</td>
<td>Possible negative impact and Additional Mitigating Action Required</td>
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<tr>
<td>(a)</td>
<td colspan="2">Age

Could the service design or policy content have a disproportionate impact on people due to differences in age? (Consider any age cut-offs that exist in the service design or policy content. You will need to objectively justify in the evidence section any segregation on the grounds of age promoted by the policy or included in the service</td>
<td>Although age is not in itself a barrier to using digital, many of the factors that can make this difficult are more common for older people (familiarity, access to internet, disability) as reported in Age Concern UK's Digital Inclusion report (UK), March 2022 digital-inclusion-policy-position-march-2022.pdf (ageuk.org.uk)</td>
<td>• Individual programmes of work associated with the MFT Clinical Vision and Roadmap Strategy will be subject to equality impact assessment.
• Where disproportionate impact on the grounds of Age is identified,</td>
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	design). **If this decision is likely to impact on children and young people (below the age of 18) you will need to evidence how you have considered the General Principles of the United Nations Convention on the Rights of the Child. Please include this in Section 10 of the form.** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☒ **2) Promote equality of opportunity** ☒ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ☐	• 2.2 million (40 per cent) of people aged 75+ and 800,000 (12 per cent) of people aged 65-74 in the UK had not used the internet in the last three months. • The pandemic has not led to a greater proportion of people aged 65+ getting online than would be expected by the trend in increased use over the last decade. • Not everyone who goes online, stays online – five per cent of people aged 75+ do not use the internet but have done in the past, while some internet users only carry out limited activities online. • At the start of 2020, 53% of people aged 65 and over in GB used a smartphone. **Older People** Older people with a communication barrier e.g. hearing impairment or age-related dementia may have more difficulty using virtual consultations and digital communications through Patient Hub. Some older people may not be able to	reasonable adjustments will be put in place. • In this way NHSGGC will ensure transformation in the way we deliver care while ensuring no-one is left behind e.g. Mitigation for some older people who have difficulty with digital communications and virtual consultations will be paper letters and face to face consultations. Involving carers is also helpful where appropriate.

		use virtual appointing systems such as Patient Hub due to lack of technology or ability to use technology. The mitigation will be traditional face to face consultations and paper letter communications. These may be slower forms of communication however will ensure that people receive their health care and older people will not be left behind. The MFT vision is likely to impact positively on older patients who may have reduced mobility or are frail where travel can be difficult as there will be less need to travel and in addition infection risk will be reduced. Involvement of carers is a mitigation where appropriate for older people and this should be written in to the communication plan. **Children** We note that service changes impacting on children and young people require consideration of the Rights of the Child. This assessment will take place where it is appropriate as specific service	

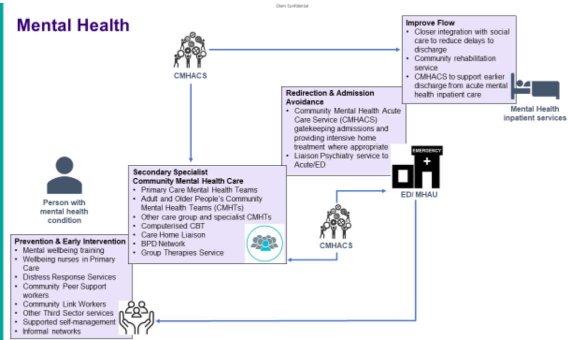
		changes are identified. MFT Clinical Vision and Roadmap changes involving babies and children are all associated with the Scottish ‘Best Start’ programme for Maternity and Neonatal Care and as such they have been subject to consultation and engagement. The Best Start programme commenced in 2017 and outlines a vision for future planning, design and safe delivery of maternity and neonatal services in Scotland. It puts family at the centre of decisions, while promoting person centred care. Best Start early adopter sites in the Clyde area implemented several Best Start recommendations. Engagement work included: • Midwifery teams across Clyde tested new ‘continuity of carer’ models to promote patients seeing the same staff throughout their maternity journey to analyse the new model of care from a patient perspective. • Care Opinion was implemented in Clyde to capture patients’ experiences of continuity of carer models in Clyde. • The Maternity Services Liaison	

		Committee explored new approaches to engaging with patients to shape maternity services. Results included making greater use of social media to engage effectively. • Engagement with women and partners around maternity visiting informed the revision of the Board's maternity visiting policy and accommodation provision for partners. **Flow Navigation Centre – EQIA for Integration of Paediatrics** An indication of how the MFT Clinical Vision and Roadmap might apply to children can be seen in the Flow Navigation Centre EQIA which was published for the adult service in December 2020. From 1st June 2021 paediatric services across NHSGGC integrated with the adult service model. This means if a child aged five or older requires urgent medical attention in a non-life threatening capacity they have the option to be referred through the NHSGGC Flow Navigation Centre. Staff at the centre then provide triage and clinical assessment virtually, over the phone, or if required, provide them with a time slot to attend one of our	

		emergency departments or minor injuries units. The original adult EQIA was reviewed to ensure relevance to children and it was agreed for the addition of paediatrics. Mitigating actions are in place for the EQIA including face to face attendance where required.	
(b)	**Disability** **Could the service design or policy content have a disproportionate impact on people due to the protected characteristic of disability?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ☐	We expect there will be positive impacts resulting from service changes brought forward from the MFT Clinical Vision & Roadmap. For example, service change may positively impact on some disabled patients who may have reduced mobility where travel can be difficult as there will not be a need to travel and the infection risk will be reduced. However, it will be crucial to ensure that appropriate and timely engagement and EQIAs are undertaken on any proposed service changes which may impact on people with disability. Initial access by telephone and video appointments could be more difficult to access for some disabled people. Telephone is a particular issue for people with a hearing loss or other communication issues, Access by telephone and video appointments may	• Individual programmes of work associated with the MFT Vision & Roadmap will be subject to equality impact assessment and where disproportionate impact on the grounds of disability is identified, proportionate adjustments will be put in place. In this way NHSGGC will ensure transformation in the way we deliver care while ensuring no-one is left behind. • A mitigation for virtual service delivery if unsuitable is to attend the service in person. This will remain an option where appropriate for individuals.

		also be more difficult for people with learning disabilities and visual impaired people. Disabled people experience high levels of digital exclusion. Disabled people are more likely to experience poverty as a consequence of their disability and may not have access to internet or devices. Deaf / BSL users can access the telephone service through contact Scotland. Some older BSL users however may not have access to the technology needed to use Patient Hub or video appointments. **Example - Flow Navigation Centre** The 'Flow Navigation Centre' (FNC) operates as a Virtual Accident and Emergency Department for non life-threatening illnesses. The FNC operates seven days a week and covers the whole of the NHSGGC. Patients access the service by calling 111. They will receive a video call back. If this is not possible the consultation can occur by phone. The patient is then triaged and directed to; self-care and safety netting, or given a scheduled arrival time at minor injury unit or ED, or finally referred	

		on to specialised care. Equity of access to this model of care has been considered, including with a focus on disability i.e. a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on ability to do normal daily activities. Sensory impairments. For service users who are deaf/with a hearing impairment, calling 111 and undertaking a video call requires appropriate adjustments. Specifically, for service users who communicate via BSL, technology utilised within the FNC could integrate with existing services such as SignVideo or Contact Scotland BSL. For individuals who are blind/ those with a visual impairment the technology should be accessible for users. If video calling is not possible, phone calls could be made instead. Associated web pages, apps and documents could be available in alternative/accessible formats i.e. large font, audio or braille as appropriate. If communication between clinician and patient through the FNC virtually is not possible despite adjustments, it can remain clear that the patient can still access ED in person.	

<table>
<tr><td></td><td></td><td>For patients with conditions that impact mobility, the virtual nature of the FNC may be favourable. Effective triaging may result in reduced waiting times in the hospital, and the ability to organise transport in advance, or may prevent unnecessary visits altogether.</td><td></td></tr>
<tr><td></td><td></td><td>Mental Health
The TOM for mental health includes prevention and early intervention, specialist community mental health care, redirection and admission avoidance, and improving flow, as below.


This future model aims to deliver earlier and improved mental health care for all. It is not anticipated that protected groups will be disadvantaged.</td><td></td></tr>
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		EQIA of Mental Health Assessment Units is summarised below Protected Characteristic: **Assessment** Age: It is not anticipated there will be a negative impact on service users with this protected characteristic. For individuals below eighteen, this service has expanded to include the nursing staff from the Specialist Children's Service. There is no upper age limit for this service Older patients have specific psychiatric care needs due to comorbidities, and variations in presentation and treatment. Integration with the Old Age Psychiatry Team could be considered within the service model.	

EQIA of Mental Health Assessment Units is summarised below

Protected Characteristic	**Assessment**
Age	It is not anticipated there will be a negative impact on service users with this protected characteristic. For individuals below eighteen, this service has expanded to include the nursing staff from the Specialist Children's Service. There is no upper age limit for this service Older patients have specific psychiatric care needs due to comorbidities, and variations in presentation and treatment. Integration with the Old Age Psychiatry Team could be considered within the service model.

		Disability	The built environment should be accessible and comply with relevant building regulations. Documents provided should be available in alternative/accessible formats (i.e. large font/audio/braille). BSL translation to be readily available (in person or via means such as Contact Scotland BSL). There are no exclusion criteria and therefore people with Learning Disabilities who are experiencing mental health crisis can access the MHAU.		
		Gender Reassignment	It is not anticipated that there will be a negative impact on service users or employees with this protected characteristic. However, for optimised care, integration with Gender Identity services throughout NHS GGC could be considered.		

	Protected Characteristic	Service Evidence Provided		Possible negative impact
		Marriage and Civil Partnership	It is not anticipated that there will be a negative impact on service users or employees with this protected characteristic.	
		Pregnancy and Maternity	Pathways are available with specialist Perinatal services and Inpatient Mother and Baby unit to ensure optimised care for patient.	
		Race	Ensure to provide translators when required, utilising services such as language line or face to face translator service.	
		Religion and Belief	If safe/plausible provide space for access to prayer/chaplaincy support.	
		Sex	It is not anticipated that there will be a negative impact on service users or employees with this protected characteristic	
		Sexual Orientation	It is not anticipated that there will be a negative impact on service users or employees with this protected characteristic.	

			and Additional Mitigating Action Required
(c)	**Gender Reassignment** **Could the service change or policy have a disproportionate impact on people with the protected characteristic of Gender Reassignment?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ☐	It is not anticipated that there will be a negative impact on employees or service users with the protected characteristic of gender reassignment. However, any potential negative impact will be identified as part of the engagement and EQIA process as described in the right hand column.	• Individual programmes of work associated with the MFT Clinical Vision and Roadmap will be subject to equality impact assessment and where disproportionate impact on the grounds of gender reassignment is identified, proportionate adjustments will be put in place.
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(d	**Marriage and Civil Partnership**	No anticipated impact on the grounds of	• Individual programmes of

)	**Could the service change or policy have a disproportionate impact on the people with the protected characteristics of Marriage and Civil Partnership?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportuni y** ☐ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ■	marriage and civil partnership	work associated with the MFT Clinical Vision and Roadmap will be subject to equality impact assessment and where disproportionate impact on the grounds of Marriage or Civil Partnerships is identified, proportionate adjustments will be put in place.
(e)	**Pregnancy and Maternity** **Could the service change or policy have a disproportionate impact on the people with the protected characteristics of Pregnancy and Maternity?**	We expect there will be positive impacts resulting from service changes brought forward from the MFT Clinical Vision and Roadmap. These include the benefits of the Best Start Maternity and Neonatal Review, as outlined in the section above relating to children.	• Individual programmes of work associated with the MFT Clinical Vision and Roadmap will be subject to equality impact assessment and where disproportionate impact

	Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ☐	However, it will be crucial to ensure that appropriate and timely engagement and EQIAs are undertaken on and proposed service changes.	on the grounds of Pregnancy and Maternity is identified, reasonable adjustments will be put in place.
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(f)	**Race** **Could the service change or policy have a disproportionate impact on people with the protected characteristics of Race?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■	Service change associated with the MFT Clinical Vision and Roadmap may have a disproportionate impact on people with the protected characteristics of race particularly for those whose first language is not English. People who do not speak English as a first language are likely to have difficulty with receiving accurate information about how to access new services and with their initial contact with the service if this is via telephone triage or video assessment. NHSGGC has more than 80 spoken	• NHSGGC is committed to ensuring that inclusion through interpreting provision and translated resources remains an essential mainstream support available to all. • Individual programmes of work associated with the MFT Clinical Vision and Roadmap will be subject to equality impact assessment and where disproportionate impact

	3) Foster good relations between protected characteristics ☐ **4) Not applicable** ☐	languages in our patient population. Access to interpreting and translated information is necessary to ensure equitable access to all services. Staff can access an interpreter for people requiring communication support through the GGC interpreting Service and our telephone interpreting provider. Planned rather than unplanned appointments would mean that the patient is expected and an interpreter could be arranged. This is possible for telephone and video appointments as for face to face. Information at both national and local level will need to be provided in all languages needed by our patients about this service change to ensure equitable access for all. BME people who cannot access the service by telephone are likely to go to their nearest GP practice or emergency department to access the service they need. This access would be a mitigation as required, as people will not be turned away if they present at a health care setting in need of urgent health care.	on the grounds of Race is identified, reasonable adjustments will be put in place. In this way NHSGGC will ensure transformation in the way we deliver care while ensuring no-one is left behind.
(g	**Religion and Belief**	No anticipated impact on the grounds of	• Individual programmes of

)	Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Religion and Belief? Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☐ 2) Promote equality of opportuni y ☐ 3) Foster good relations between protected characteristics. ☐ 4) Not applicable ■	Religion and Belief. We expect there will be positive impacts resulting from service changes brought forward from the MFT Clinical Vision and Roadmap. However, it will be crucial to ensure that appropriate and timely engagement and EQIAs are undertaken on and proposed service changes.	work associated with the MFT Clinical Vision and Roadmap will be subject to equality impact assessment and where disproportionate impact on the grounds of Religion and Belief is identified, reasonable adjustments will be put in place.
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(h)	**Sex** **Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sex?** **Your evidence should show which of the 3 parts of the General Duty have been**	No anticipated impact on the grounds of sex. We expect there will be positive impacts resulting from service changes brought forward from the MFT Clinical Vision and Roadmap. However, it will be crucial to ensure that appropriate and	Individual programmes of work associated with the MFT Clinical Vision and Roadmap will be subject to equality impact assessment and where disproportionate impact on the grounds of Sex is identified, reasonable

	considered (tick relevant boxes). **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ☐	timely engagement and EQIAs are undertaken on and proposed service changes. Community-based services could be more accessible in terms of costs for women who will disproportionately bear the burden of poverty. Providing a balance of digital first in respect of providing protected space for people who experience GBV will be important – for example community library access to internet and the development of community library hubs which provide a dedicated safe space for near me video consultations is likely to develop in NHSGGC.	adjustments will be put in place.
(i)	**Sexual Orientation** **Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sexual Orientation?** **Your evidence should show which of the 3**	No anticipated impact on the grounds of sexual orientation. We expect there will be positive impacts resulting from service changes brought forward from the MFT Clinical Vision and Roadmap. However, it will be crucial to ensure that appropriate and	Individual programmes of work associated with the MFT Clinical Vision and Roadmap will be subject to equality impact assessment and where disproportionate impact on the grounds of Sexual Orientation is

	parts of the General Duty have been considered (tick relevant boxes). **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportuni y** ☐ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ■	timely engagement and EQIAs are undertaken on and proposed service changes.	identified, reasonable adjustments will be put in place.
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**

(j)	**Socio – Economic Status & Social Class** **Could the proposed service change or policy have a disproportionate impact on people because of their social class or experience of poverty and what mitigating action have you taken/planned?** **In addition to the above, if this constitutes a 'strategic decision' you should evidence due regard to meeting the requirements of the Fairer Scotland Duty (2018). Public bodies in Scotland must actively consider how they can reduce inequalities of outcome caused by socioeconomic disadvantage when making strategic decisions and complete a separate assessment. Additional information available here:** [Fairer Scotland Duty: guidance for public bodies - gov.scot (www.gov.scot)]	Poverty is often cited as the single biggest determinant of digital exclusion, compounding barriers for other protected characteristic groups. The Carnegie Trust (2016) found a strong relationship between SIMD and internet uptake with uptake amongst the 10% most deprived areas in Scotland at 53% compared to 81% for the 10% least deprived areas. The Digital Poverty Alliance state that 53% of people who are offline can't afford to pay an average monthly broadband bill. Work has been undertaken to identify areas of deprivation as part of the demographic analysis of the hole of NHS GGC's geographical area and this will be used as part of the ongoing MFT Clinical Vision and Roadmap planning process. NHSGGC is committed to reducing the burden of poverty and the barriers to equity of access poverty can create. To comply with this commitment, and proposals for service redesign coming forward from the MFT Clinical Vision and Roadmap will clearly articulate how they have factored in experience of	• Individual programmes of work associated with the MFT Clinical Vision and Roadmap will be subject to equality impact assessment and where disproportionate impact on the grounds of Socio Economic Status & Social Class is identified, reasonable adjustments will be put in place. In this way NHSGGC will ensure transformation in the way we deliver care while ensuring no-one is left behind - A key mitigation for people living in deprivation will be to continue to offer person centred face to face care in a health care setting and to provide paper letters - We will work with Local Authority and third sector partners to determine how means of accessing digital services can be enhanced and improved for people

		poverty as a barrier to achieve equality and what mitigating factors have been considered. There will be significant benefits for people living in areas of deprivation in terms of person centred care delivered closer to home. However two aspects will require particular consideration: • Potential digital exclusion • Suitability for care at home Where difficulties with accessing care are identified, the key mitigation will be to direct individuals to face to face care which may be in a health care setting. **Care at Home** For home-based care such as Hospital at Home there may be financial implications e.g. electricity or considerations to do with suitability of the home environment for this type of care such as a quiet space for home hospital. Similarly for video appointments there may be issues to do with privacy, or availability of internet in the home. **Digital Exclusion** There could be more difficulties in engaging with newer service models	affected by poverty and/or digital exclusion.

		such as virtual consultations, asynchronous appointments and patient initiated contacts with services for some people because of the social class or experience of poverty. Some digital developments will support improved access for those requiring more telephone or face to face access – e.g. GP asynchronous consulting will free up capacity within GP practices to both answer telephone calls promptly and provide access to appointments as non-urgent queries are dealt with using a new asynchronous consult process. Lower rates of health literacy, higher rates of health inequalities and co morbidity makes navigating the health service more complex. Lack of power or perceived lack of power in making decisions about health and health care could impact negatively for these groups too. Similarly, the complex reasons that mean DNAs are higher in SIMD 1 may impact on the ability to request a patient initiated review. The need to attend appointments would be tailored to individual needs and would reduce the need for travel and attendance at a hospital site.	

		Patients who may have less ability to be away from work may find it an advantage to have remote appointment, reducing travel time and possibly lost earnings. Digital exclusion may impact negatively on this patient group's ability to access remote appointments. One positive example is the NHSGGC experience with a digital platform for COPD, where there has been high uptake in patients from SIMD1 residencies inputting their COPD data and messaging their clinician online, and the digital platform user demographic mirrors that of the COPD population. **Example – North East Hub** In hosting a range of co-located health and social care services, with improved access for service users, the hub will facilitate the delivery of person-centred, effective, high quality care to improve health and wellbeing and may help to address health inequalities.	

		Across all services, the Hub will allow for better integrated services as a result of co-location, and will make it easier for families who attend multiple services, potentially saving time and money, compared to the current arrangements. There will be reduced reliance on traditional signposting 'methods and more proactive matching of families' needs with appropriate sources of support, including community resources, library groups or support from other local residents through community café initiatives. An overall assessment is underway to document the high level plans in relation to the Fairer Scotland Duty (2018).	
(k)	**Other marginalised groups** **How have you considered the specific impact on other groups including homeless people, prisoners and ex-offenders, ex-service personnel, people with addictions, people involved in prostitution, asylum seekers & refugees and travellers?**	There could be more difficulties in engaging with newer models of care for people experiencing homelessness who may not have money for a phone, electricity for charging or a suitable place or technology to use for virtual consultations. Asylum Seekers with no recourse to public money may not be able to access support for a phone, electricity for	- Individual programmes of work associated with the MFT Clinical Vision and Roadmap will be subject to equality impact assessment and where disproportionate impact for other marginalised groups is found, proportionate adjustments will be put in place. In this

		charging or a suitable place or technology to use for virtual consultations. Gypsy Travellers may not have money for a phone, electricity for charging or a suitable place or technology to use for virtual consultations. Examples of how we will mitigate this include: It would be possible to provide telephone and video in hostels and local centres for people and police would also offer use of a phone in an urgent situation. Another example is provision of community library access to internet and the development of community library hubs which provide a dedicated safe space for near me video consultations. Work to develop the Collective Force for Health and Wellbeing has started in NHSSGGC with Johnstone library part of the national pilot and Port Glasgow library developing health related support including a Macmillan Hub. For people in marginalised groups, alternative or adapted models of care	way NHSGGC will ensure transformation in the way we deliver care while ensuring no-one is left behind.

		may be required. In particular, a face to face model which may be in a health care setting could be more appropriate according to individual circumstances.	
8.	**Does the service change or policy development include an element of cost savings? How have you managed this in a way that will not disproportionately impact on protected characteristic groups?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ☐	Individual projects and programmes may deliver cost savings, for example through rationalisation of premises or improvements in utilisation or throughput. However, iti is not anticipated that any of these would disproportionately impact on protected characteristic groups. All major programmes will follow a business case approach, and this will include an EQIA to determine any disproportionate impact on people with protected characteristics.	
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
9.	**What investment in learning has been made**	All GGC staff are required to complete	

	to prevent discrimination, promote equality of opportunity and foster good relations between protected characteristic groups? As a minimum include recorded completion rates of statutory and mandatory learning programmes (or local equivalent) covering equality, diversity and human rights.	learning programmes covering equality, diversity and human rights.	

10. In addition to understanding and responding to legal responsibilities set out in Equality Act (2010), services must pay due regard to ensure a person's human rights are protected in all aspects of health and social care provision. This may be more obvious in some areas than others. For instance, mental health inpatient care or older people's residential care may be considered higher risk in terms of potential human rights breach due to potential removal of liberty, seclusion or application of restraint. However risk may also involve fundamental gaps like not providing access to communication support, not involving patients/service users in decisions relating to their care, making decisions that infringe the rights of carers to participate in society or not respecting someone's right to dignity or privacy.

The Human Rights Act sets out rights in a series of articles – right to Life, right to freedom from torture and inhumane and degrading treatment, freedom from slavery and forced labour, right to liberty and security, right to a fair trial, no punishment without law, right to respect for private and family life, right to freedom of thought, belief and religion, right to freedom of expression, right to freedom of assembly and association, right to marry, right to protection from discrimination.

Please explain in the field below if any risks in relation to the service design or policy were identified which could impact on the human rights of patients, service users or staff.

No specific risks have been identified in this high level EQIA.

Please explain in the field below any human rights based approaches undertaken to better understand rights and responsibilities resulting from the service or policy development and what measures have been taken as a result e.g. applying the PANEL Principles to maximise Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality or FAIR* .

No human rights issues have been identified in this high level EQIA.

- **F**acts: What is the experience of the individuals involved and what are the important facts to understand?
- **A**nalyse rights: Develop an analysis of the human rights at stake
- **I**dentify responsibilities: Identify what needs to be done and who is responsible for doing it
- **R**eview actions: Make recommendations for action and later recall and evaluate what has happened as a result.

United Nations Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024 came into force on the 16th July 2024. All public bodies may choose to evidence consideration of the possible impact of decisions on the rights of children (up to the age of 18). Evidence should be included below in relation to the General Principles of the Act. The full list of articles to be considered is available here for information.

No Discrimination: Where the decision may have an impact, explain how the EQIA has considered discrimination on the grounds of protected characteristics for children. You may have considered children in each of the EQIA sections and returned relevant evidence.

No discrimination issues concerning Rights of the Child have been identified in this EQIA.

Best Interests of the child: Where the decision may have an impact, explain how the EQIA has evaluated possible negative, positive or neutral impacts on children. You may find that options considered need to be reframed against the best possible outcome for children.

Life, survival and development: Where the decision may have an impact, explain how the EQIA has considered a child's right to health and more holistic development opportunities.

No impact on children's life, survival and development has been identified through this EQIA.

Respect of children's views: Where the decision may have an impact, explain how the views of children have been sought and responded to. You need to consider what steps were taken in Q4 in relation to this.

As specific service transformation or changes are identified we will engage directly with children and young people in respect of proposed service changes that will impact on them.

Having completed the EQIA template, please tick which option you (Lead Reviewer) perceive best reflects the findings of the assessment. This can be cross-checked via the Quality Assurance process:

- [x] Option 1: No major change (where no impact or potential for improvement is found, no action is required)
- [ ] Option 2: Adjust (where a potential or actual negative impact or potential for a more positive impact is found, make changes to mitigate risks or make improvements)
- [ ] Option 3: Continue (where a potential or actual negative impact or potential for a more positive impact is found but a decision not to make a change can be objectively justified, continue without making changes)
- [ ] Option 4: Full mitigation of identified risk not made, decision to continue without objective justification (Lead Reviewer to provide explanatory note here):
- [ ] Option 5: Stop and remove (where a serious risk of negative impact is found, the plans, policies etc. being assessed should be halted until these issues can be addressed)

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

Actions – from the additional mitigating action requirements boxes completed above, please summarise the actions this service will be taking forward.	Date for completion	Who is responsible?(initials)
No actions identified		

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

February 2025

Lead Reviewer:	**Name**	**Claire MacArthur**
EQIA Sign Off:	**Job Title**	**Director of Planning, NHSGGC**
	Signature	
	Date	**26/08/2024**
Quality Assurance Sign Off:	**Name**	**Alastair Low**
(NHSGGC Assessments)	**Job Title**	**Equalities and Human Rights Manager, NHSGGC**
	Signature	
	Date	**24/08/24**

Where unmitigated risk has been identified in this assessment, responsibility for appropriate follow-up actions sits with the Lead Reviewer and the associated delivery partner.

NHS
Greater Glasgow and Clyde

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

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

MFT Clinical Vision and Roadmap

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

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

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

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

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

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

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

Action:	
Reason:	
Action:	
Reason:	

Please write your next 6-month review date

February 2025

Name of completing officer: Ann Lees, Senior Planning Officer, Corporate Planning, NHSGGC

Date submitted:

If you would like to have your 6 month report reviewed by a Quality Assuror please e-mail to:
alastair.low@ggc.scot.nhs.uk