NHS Greater Glasgow and Clyde
Equality Impact Assessment Tool

Equality Impact Assessment is a legal requirement as set out in the Equality Act (2010) and 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:

Primary Care Mental Health Team Review

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.

Primary Care Mental Health teams provide a high volume therapy service to patients with significant mental illness and/or mental health problems. They are a psychological intervention service but not a sole psychology service. The service offers patients good outcomes and it does so effectively and efficiently at a relatively low cost. They are highly valued by patients and stakeholders – particularly GPs. Patients with common and debilitating levels of illness are consistently able to be assessed quickly and offered a suitable therapy within nationally set timescales. Across GG&C, the service deals with over 20,000 referrals each year.

Throughout 2024, a comprehensive internal review of the service was conducted across NHS GG&C

The review aimed to;

- Undertake a scoping exercise to map existing models, range of services delivered, identify potential gaps in provision and overlap with other services.
- Refine patient pathways into and through the PCMHT services, ensuring a person centred approach.
- Ensure coherence of service models across the board area
- Ensure individuals needs are matched to the most appropriate set of interventions delivered by the right staff and at the right tier of the service
- Review staffing profiles and skill mix within existing services and ensure this matches future models and need.
- Ensure an equalities based approach and actively address inequalities in access and outcomes. Ensure the services are sensitive to needs of BAME population within its catchment area and considering tests of change in coproduction and delivery of new services

- Map interfaces with existing commissioned and secondary care MH services to identify gaps and overlaps. Recommended connections/ collaborations across services and external partners
- Review existing MH service structures and pathways to ensure alignment with proposed models.
- Ensure linkage and interdependencies with existing work-streams including the Effective and efficient community services work-streams.
- Share learning from models in other areas and ensure an evidence based approach to the process

The review identified that although challenging to quantify, the service is very likely to avoid progressing to more intensive and expensive mental health services and it was recommended that GG&C's investment in PCMHTs is maintained. The review also identified opportunities to further improve the services – to ensure more equitable provision of therapies across all areas, increased standards in relation to governance and associated improvements in outcomes.

Review Conclusions

Primary Care Mental Health Teams operate significant different models across each HSCP. There is a lack of consistency in referral, screening processes, and treatments available or offered. Team composition differs from Nurse/AHP lead to Psychology led.
PCMHTs are a psychological intervention services and do not necessarily have to be a psychology led service, although Psychology should provide overall governance in line with the Scottish Government's Psychological Therapies Specification. PCMHTs should have a wide enough 'bandwidth' of tiers and clinical expertise to offer, in line with a matched-stepped care model, treatment that meets the needs of a significant proportion of the presenting population. Their offer should include both low intensity psychological interventions and high intensity psychological therapies where appropriate. It would benefit the service as a whole if PCMHTs across the areas could develop joint working and resource sharing to ensure equitable access to the wide range of therapies. This would allow individuals with needs which match to a LI or HI psychological intervention to have their needs met in PCMHTs, and benefit from the ease of access and shorter wait times of this tier of service.

Recommendations

1. There is a need for the PCMHT Operational Policy to be updated and a Standard Operating Procedure to be developed across services. This should detail standardised referral, screening, assessment and allocation processes both to PCMHTs and onward pathways to third sector service provision. This should take into account relevant policy documents and guidance, including the Scottish Government's Psychological Therapies Specification, the updated NES Matrix, NES's trauma training framework, professional Codes of Conduct, and other relevant professional guidelines. It should further include guidance on standard assessment tools and the use of CRAFT risk screening and assessment tool.

2. Inconsistencies in job roles and bandings across services should be resolved. Clear guidance should be developed on which presentations may be appropriately seen by each staff group within PCMHTs, in line with their core qualifications and within the limits of their competence. Job descriptions for all roles should be agreed and may include those job descriptions developed by the Psychology

Recruitment and Retention group however should also consider core professions job descriptions who are able to deliver psychological interventions as part of core training or additional post registration training. Where suitable job descriptions do not exist, they should be agreed in partnership with other relevant professional groups as appropriate, or similar mechanisms for other job families, and submitted for evaluation through the New and Changed Jobs process

3. Core service criteria should take account the skills and training of staff within PCMHTs and the evidence base for brief psychological therapies. This service criteria should detail the range of therapies to be offered but in some areas and for smaller teams it may involve different pathways for service delivery

4. A core set of interventions should be offered across PCMHTs. This may be directly provided; third sector provided, or have a clear pathway to access appropriate treatment while services are being developed.
   - Computerised CBT
   - Behavioural Activation
   - Guided self-help based on CBT or behavioural principles
   - Cognitive Behavioural Therapy
   - Group CBT
   - Person Centred Counselling
   - EMDR
   - Interpersonal Therapy
   - Person Centred Counselling (as recommended in NICE guidelines for depression, and with effectiveness in equivalent populations evidenced via studies of IAPT services)
   - Mindfulness based approaches
   - Formulation based, theoretically integrated interventions drawing upon multiple models for clients with more complex presentations who may nonetheless benefit from brief therapy

   Some teams may not be able to offer all of these interventions initially and this should be considered during the development of individual HSCP implementation plans.

5. Training opportunities should be developed and made available to existing staff to enable and support them to upskill in these interventions.

6. The Operational Policy should detail arrangements for joint working across teams to increase efficiency, e.g. joint delivery of groups and the potential for staff to help with other teams' waiting lists. This would also benefit teams where some therapies are provided in one team but not in others. This would require consideration of some joint financial framework if taken forward.

7. It may be helpful to develop guidance for interface with other teams, learning from good practice in teams where this works well. A current challenge is that PCMHTs catchments relate to GP practices while CMHT catchments relate to postcodes, which can make interface particularly difficult where catchments do not align due to the lack of established inter-team relationships.

8. Operating Hours: Most services operate during standard business hours, with some offering additional evenings appointments for groups or as a waiting list initiative. Other services are available to clients who cannot attend during working hours (such as Silvercloud, NHS24 Living Life Telephone CBT, and voluntary sector counselling services). Therefore, maintaining a consistent service model across all GGC which operates within standard business hours could be challenging and fail to meet the overall needs of the current population. Consideration should be given as to how opening hours could be extended to meet those patients who would normally be working during standard opening hours.

9. An action plan is developed alongside operational policy to address issues raised within Equality Impact Assessment.

10. Implementation plans are developed for each HSCP to be reported through Mental Health Strategy Board to ensure consistency of application.

Due to the significant differences in current service delivery, each individual HSCP will require to develop an implementation plan that enables them to meet the standards and recommendations within this review either through direct provision with PCMHTs, Partnership working with Third Sector Providers or develop appropriate joint working within their service areas between primary and secondary care services. Eqia's will be undertaken on each of the HSCP's Implementation Plan, informed by this eqia. There has been ongoing consultation with partnership trade union organisations during the review process in order to minimise any impact to current staff. Individual HSCP implementation plans will require to ensure ongoing partnership representation.

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: PCMHT EQIA Katrina Phillips	**Date of Lead Reviewer Training:** 2006/7

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

Katrina Phillips Afton Hill Tracy Buchanan

Katy Smith Charlene Nicolay-Smith Susan Lindsay Yvonne Du Pon Lorraine Currie Josie Stewart

		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.**		During the assessment phase patient's information on protected characteristics is routinely shared with clinical staff. This will be detailed in the person's clinical record with the appropriate level of confidentiality, as per clinical governance. Some services collate patient experience data which includes demographic equalities, although it does not collect the information separately or to specifically analyse data. • Age • Employment status • Unable to attend in person/digital poverty • Ethnicity • Disability – physical health and mental disorder • Maternity • Gender • Carer information • Parental responsibility for children under the age of 16. • Gender based violence	Collating data that not being analysed to inform service improvement or that the data collated highlights gaps in service provision out with service control to address, raises ethical issues. This would need further consideration to mitigate/agree reporting structures. However, without the information being collected we run an increased risk of not becoming aware of a barrier to access for those with protected characteristics, nor have the appropriate number of resources available. It was recognised that gender based violence data is not routinely collected across all areas and will be implemented as an action going forward. Work will be undertaken to increase capture of veteran status in line with EMIS guidance.

<table>
<tr><td></td><td></td><td></td><td>Interventions with patients is brief and high volume, information collected, is directly applied to service delivery, therefor it may vary and is proportionate to interventions required.

In East Dumbarton, there has been a move to gather more information as part of referral, either self-referral or by GP, including clinical information, in order support screening process.</td><td></td></tr>
<tr><td colspan="2"></td><td>Example</td><td>Service Evidence Provided</td><td>Possible negative impact and Additional Mitigating Action Required</td></tr>
<tr><td>2.</td><td>Please provide details of how data captured has been/will be used to inform policy content or service design.

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 ☐</td><td></td><td>Referral patterns are regularly reviewed to identify factors/protected characteristics which may need to be accommodated in terms of service design. Examples include;

<table><tr><th>Charateristic</th><th>Service Design</th></tr><tr><td>Age</td><td>Adapt groups to age range?</td></tr><tr><td>Employment status</td><td>Extend operational times of to enable those working atte evening/weekend service/ax</td></tr><tr><td>Unable to attend in person/digital poverty</td><td>Offer adequate remote servi</td></tr><tr><td>Ethnicity</td><td>Cultural competence and ad interpreter access</td></tr><tr><td>Disability</td><td>BSL/ Braille Health literacy. to building</td></tr><tr><td>Maternity</td><td>Urgent priority criteria</td></tr><tr><td>Gender</td><td>Access to building facilities</td></tr></table></td><td></td></tr>
<tr><td colspan="2"></td><td>Example</td><td>Service Evidence Provided</td><td>Possible negative impact and Additional Mitigating Action Required</td></tr>
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3.	**How have you applied learning from research evidence about the experience of equality groups to the service or Policy?** **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** ☐	***Looked after and accommodated care services reviewed a range of research evidence to help promote a more inclusive care environment. Research suggested that young LGBT+ people had a disproportionately difficult time through exposure to bullying and harassment. As a result staff were trained in LGBT+ issues and were more confident in asking related questions to young people.*** ***(Due regard to removing discrimination, harassment and victimisation and fostering good relations).***	The review group formed two main sub groups: • Data Analysis • Service Mapping	The PCMHT Operational Policy will take into account relevant policy documents and guidance, including the Scottish Government's Psychological Therapies Specification, the updated NES Matrix, NES's trauma training framework, professional Codes of Conduct, and other relevant professional guidelines.
		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
4.	**Can you give details of 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**	***A money advice 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***	The review brought together a range of clinical professions across NHS GGC with representation from every HSCP and Primary Care The review group formed two main sub groups: • Data Analysis • Service Mapping There was a third group planned for implementation of any recommendations as a	Area of improvement identified to increase consistency of requesting feedback and reporting on the feedback into team discussions to take forward into action planning. Action identified to identify key trigger points to request feedback and ensure consistency

	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 opportunity** ☐ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ☐	***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 households at risk of low incomes.***	result of the review, however given the significant differences across GGC in their PCMHTs Implementation plans will require to be developed individually by HSCP. In addition there was engagement with Primary Care Clinical Directors; Service User Feedback and information from Third Sector Provision The review group met every 4-6 weeks to review the information gathered and had 2 wider engagement sessions to discuss and review the emerging data and themes on the wide range of therapy provision currently provided. Ongoing feedback is available. Complaints process is in place. Service user feedback has been undertaken. A questionnaire is in place on webropol and utilised by Team Leads. Some areas share webropol link as part of discharge process and includes people who may drop out of the service. This includes people who have been referred but not engaged in the service. Suggestion box postcards are available at locations. Engagement is undertaken as part of business as usual with GP practices, to be able to have an open conversation and feedback loop from patients eg, being able to discuss any wait times, or any feedback from patients on preferred methods of appointment etc.	Action to identify agreed template for feedback form. Including option for open comment box to suggest areas for improvement and ensuring that equality data is captured and analysed as part of this. Improve feedback to HSCP's on feedback from service users. Area of improvement identified to capture views of secondary care, in particular for longer term of more complex interventions. This would help to support consistency in access to supports across wider NHSGGC. Consideration of consistency of feedback loops for third sector stakeholders. Local Service user engagement may be required as part of developing the implementation plans. There has been ongoing consultation with partnership trade union organisations during the review process in order to minimise any impact to current staff. Individual HSCP implementation plans will require to ensure ongoing partnership representation.

			GP's have also been involved in the review groups to make sure that this key stakeholder feedback is captured.	
		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 applicable** ☐	***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).***	The majority of locations are physically accessible. Alternative options are also available, including community venues; Attend anywhere service can be utilised. Telephone appointments are available. Appointments can also be supported in GP practices. Blue badge parking/Ramp/Lift access, fire evacuation process in place – risk assessment in place Health and Safety quarterly checklist also has this as a question Consideration would be given on a case by case basis, a home visit may be available, based on acute physical need. Acute psychological need would be escalated to secondary care.	
		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** ☐ **4) Not applicable** ☐ **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**	***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).***	Interpreters and Translations will be made available in line with the NHSGGC Clear for All Policy, both spoken language and BSL. However it is recognised that this can be challenging due to the wide range of languages, pressures on appointment times, interpreters not being available. Processes are in place to support accessing Interpreters for patients who need them. Interpreters are available for patients. Further consideration is needed on how promote/access same interpreter for continuity and block book through staff bank. Written information can be available in different languages and formats. NE have translated key resources into the top 10 languages. Patients are able to self-refer for appointments and initial assessments. Explore options for digital solutions for self-referrals. This would decrease response time and increase patient choice in appointment times and days etc. Other options of booking will continue to be available including GP referral, drop in to locations and telephone referrals.	May be delay/gap in access right translation for example GGC have difficulty accessing interpreters in some languages and this may impact waiting times. Action – Develop process to have Core 10, outcome ensure available on corenet in a variety of languages. Action – NE to share process and supports for access to key resources to share learning across all areas.

	review or policy has taken note of this.		
7	**Protected Characteristic**	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(a)	**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 design).** **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** ☐	Service is available for adults age 18+. Under 18s would be supported through alternative children and young people services. Through the review it was noted that Older People tended to be under represented in referrals.	Implementation plans will be developed for each of the HSCP's with an aim of progressing the review recommendation, including; • The PCMHT Operational Policy will be updated and a Standard Operating Procedure to be developed across services. This will detail standardised referral, screening, assessment and allocation processes both to PCMHTs and onward pathways to third sector service provision. • Support consistency in job roles and bandings across services • Core service criteria should take account the skills and training of staff within PCMHTs and the evidence base for brief psychological therapies. This service criteria should detail the range of therapies to be offered but in some areas and for smaller teams it may involve different pathways for service delivery. • A core set of interventions will be offered across PCMHTs. This may be directly provided; third sector provided, or have a clear pathway to access appropriate treatment while services are being developed. Some teams may not be able to offer all of these interventions initially and this should be considered during the development of individual HSCP implementation plans. Training opportunities should be developed and made available to existing staff to enable and support them to upskill in these interventions. • The Operational Policy will include arrangements for joint working across teams to increase efficiency, e.g. joint delivery of groups

			and the potential for staff to help with other teams' waiting lists. This would also benefit teams where some therapies are provided in one team but not in others. • Operating Hours: Most services operate during standard business hours, with some offering additional evenings appointments for groups or as a waiting list initiative. Other services are available to clients who cannot attend during working hours (such as Silvercloud, NHS24 Living Life Telephone CBT, and voluntary sector counselling services). Therefore, maintaining a consistent service model across all GGC which operates within standard business hours could be challenging and fail to meet the overall needs of the current population. Consideration should be given as to how opening hours could be extended to meet those patients who would normally be working during standard opening hours. A range of supports and treatments will be available to all patients through a number of locations including; community venues, attend anywhere, telephone appointments and in GP practices. Consideration would be given on a case by case basis, a home visit may be available, based on acute physical need. Service is targeted at short term interventions, some individuals may require longer term treatment. For individuals who require longer term care then discussions will be undertaken with onward referral to support intervention. Agreed with professionals The available and appropriate interventions would be discussed with the patient to create a care plan that meets their needs. Some therapies will be on an

			individual basis or on a group basis, identified on suitability and needs of patient. Where digital interventions are identified then alternatives are available. Treatment plan will be developed in discussion with the patient. If PCMHT's are not the best service to provide intervention for an individual's needs then there will be a discussion for onward referral. Actions will be taken forward through the local HSCP implementation plans. Follow up action identified for outreach campaigns in communities to raise awareness with underrepresented groups.
(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** ☐	Sensory impairments- access to timely (and confidential) interpreter services for BSL and Braille. If people have a cognitive impairment due to an illness they may not able to access the services. Patients would be referred onto alternative care including secondary care. An alternative pathway would be identified. Flexibility on appointment duration and number of appointments who may need additional support, for example autism. Interpreters and Translations will be made available in line with the NHSGGC Clear for All Policy, both spoken language and BSL. The supported offer from the Digital Therapy Team (DTT) involves asynchronous contact, via the Silvercloud platform, with a member of DTT	As above Neurodiversity- consider adaption of material/groups Increase in patients with ASD (traits) access MH services, little knowledge how to respond and adapt interventions for optimal effectiveness. Action – Staff learning required to support adaptation of materials and or groups. Access to SALT to support improvement/health literacy issues A range of supports and treatments will be available to all patients through a number of locations including; community venues, attend anywhere, telephone appointments and in GP practices. Consideration would be given on a case by case basis, a home visit may be available, based on acute physical need.

		staff on a total of three occasions during the course of the individual's engagement with the Silvercloud programme.	It is recognised that digital exclusion may be a barrier to accessing digital offer There will be a small number of service users, potentially those who are digitally excluded or those with a strong preference for an in-person guided self-help offer, for whom the DTT's offer is unsuitable. In some areas there is a third sector solution for this section of the population or roles for specific Guided Self Help Workers or equivalent outwith PCMHTs and in others this guided self-help is provided within PCMHTs as one tier of their more comprehensive offer.
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact 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** ☐	There are currently no barriers to referral for those who fall under the Gender Reassignment Group. Groups do not tend to be sex specific, however this will be considered further following the updated EHRC Code of Practice coming into statute.	As above

	Protected Characteristic	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
(d)	**Marriage and Civil Partnership** **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 opportunity** ☐ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ■	No identified barriers to this group.	As above
(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?** **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** ☐	No identified barriers to this group.	As above

	2) Promote equality of opportunity ☐ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ☐		
	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** ☐ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ☐	No identified barriers to this group of patients- see above re difficulties access interpreter services. Interpreters and Translations will be made available in line with the NHSGGC Clear for All Policy, both spoken language and BSL. It is recognised that CBT might not be suitable for all cultures and beliefs, the available and appropriate interventions would be discussed with the patient to create a care plan that meets their needs.	As above The review aims included 'Ensure the services are sensitive to needs of BAME population within its catchment area and considering tests of change in coproduction and delivery of new services.' This will be taken forward through local implementation plans.
(g)	**Religion and Belief** **Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Religion and Belief?**	There are no identified barriers to this group of patients. It is recognised that CBT might not be suitable for all cultures and beliefs, the available and appropriate interventions would be discussed with the patient to create a care plan that meets their needs.	As above

	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** ☐		
	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 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** ☐	Through the review, it was identified that Gender based violence data is not routinely collected across all areas, this will be considered as part of the local HSCP implementation plans. Groups do not tend to be sex specific, however this will be considered further following the updated EHRC Code of Practice coming into statute.	As above Gender based violence data is not routinely collected across all areas, this will be considered as part of the local HSCP implementation plans.

(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 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** ☐	There are no identified barriers to access based on sexual orientation	As above
	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?** **The Fairer Scotland Duty (2018) places a duty on public bodies in Scotland to actively consider how they can reduce inequalities of outcome caused by socioeconomic disadvantage when making <u>strategic</u> decisions. If relevant, you should evidence here what steps have been taken to assess and mitigate risk of exacerbating inequality on the ground of socio-economic status. Additional information available**	Correlation between deprivation and MH illness. Poverty is the highest social determinant that causes poor MH and wellbeing, and worsens health outcomes as well as widening the inequality gap. Any centralising of services would impact those lower economic income in terms of access to transport/digital poverty. A range of supports and treatments will be available to all patients through a number of locations including; community venues, attend anywhere, telephone appointments and in GP practices.	As above

	here: Fairer Scotland Duty: guidance for public bodies - gov.scot (www.gov.scot) Seven useful questions to consider when seeking to demonstrate 'due regard' in relation to the Duty: 1. What evidence has been considered in preparing for the decision, and are there any gaps in the evidence? 2. What are the voices of people and communities telling us, and how has this been determined (particularly those with lived experience of socio-economic disadvantage)? 3. What does the evidence suggest about the actual or likely impacts of different options or measures on inequalities of outcome that are associated with socio-economic disadvantage? 4. Are some communities of interest or communities of place more affected by disadvantage in this case than others? 5. What does our Duty assessment tell us about socio-economic disadvantage experienced disproportionately according to sex, race, disability and other protected characteristics that we may need to factor into our decisions? 6. How has the evidence been weighed up in reaching our final decision? 7. What plans are in place to monitor or evaluate the impact of the proposals on inequalities of outcome that are associated with socio-economic disadvantage? 'Making Fair Financial Decisions' (EHRC, 2019)21 provides useful information about the 'Brown Principles' which can be used to determine whether due regard has been given. When engaging with communities the National Standards for Community Engagement22 should be followed. Those engaged with should also be advised	It is recognised that digital exclusion may be a barrier to some groups and would need to be considered as part of this	

	subsequently on how their contributions were factored into the final decision.		
(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?**	Asylum seekers- health is known to deteriorate after settlement that this could be a result due to barriers to services, including language and lack of understanding of health and care system as well as cultural barriers. Temporary housing/homelessness- service doesn't accept people in period of transition. People with addictions- don't accept referrals/offer if people are actively using substances. If people have a cognitive impairment due to an illness or routine and frequent substance misuse would not be able to access the services. Patients would be referred onto alternative care including secondary care or ADRS. An alternative pathway would be identified.	As above
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).**	No savings were attached to this review, however savings may be attached to individual HSCP plans and will require exploration in associated eqia's.	

	1) Remove discrimination, harassment and victimisation ☐ **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ☐		
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
9.	**What investment in learning has been made 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.**	Equality and diversity training and resources available. Consider identifying Equality, diversity and inclusion rep within team ,	Gap in cultural competence training. Gap access other expertise to support health literacy and NDD issues/adaptions. Identify list of training that it would be expected that all staff complete. Undertake a Training Needs Analysis to be able to identify priority job related training requirements regardless of specialism or role profile. Eg suicide prevention training, gender based violence. Identify core list of training for all staff with agreed regular refresh timescales. This could then be available on sharepoint.

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.

The department do not breach any of the above articles within the Human Rights Act

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* .

All staff undertake mandatory modules in relation to this All registered under appropriate professional bodies which has a code of conduct and CPD recommendations

*

- **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.

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:

☐ 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: 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.

NE PCMHT have a patient experience survey, based on trauma informed principles and include equality demographics data. It is acknowledge that this only captures those that have accessed the service, doesn't full represent the local population. However, the data is the fed into local clinical governance meeting for analysing and action.

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)**
Identify protected groups to engage to ascertain their experience of PCMHT.	Katrina Philips	
Develop process for collating, analysing and reporting on protected characteristic data for purpose of service improvement/redesign.	Katrina Philips	
Update Standard Operating Procedure	Katrina Philips	
Identify list of training that it would be expected that all staff complete.	Katrina Philips	
Undertake eqia of detailed local implementation plans	Katrina Philips	

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

30/4/2026

Lead Reviewer:
EQIA Sign Off:

Name **Katrina Phillips**
Job Title **Head of Mental Health**
Signature *K Phillips*
Date **29/10/2025**

Quality Assurance Sign Off:

Name Dr Noreen Shields
Job Title Planning and Development Manager
Signature 
Date 30/10/25

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

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

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

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

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

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

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

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

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

Action:	
Reason:	
Action:	
Reason:	

Please write your next 6-month review date

Name of completing officer:

Date submitted:

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