NHS Greater Glasgow & 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 ggc.equality.team@nhs.scot for further details or call 0141 201 4874.

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

Palliative Care and Care Around Dying Strategy 2026–2030

Please tick the relevant box:

- Current Service ☐
- Service Development ☐
- Service Redesign ☐
- New Service ☐
- New Policy ☒
- Policy Review ☐

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Description of the service & rationale for selection for EQIA. (Please state if this is part of a service-wide consideration 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.

The Palliative Care Strategy sets out how Greater Glasgow and Clyde will improve palliative care and care around dying for people of all ages, across all settings, at all times, ensuring care is based on what matters to individuals and those important to them.

The Strategy aligns with the Scottish Government's Palliative Care Matters for All (2025–2030) strategy and wider NHSGGC and Integration Joint Board priorities.

The strategy identifies five key priorities:

- Early identification and person-centred care planning
- Equitable, coordinated and responsive care
- Access to information, digital inclusion and community empowerment
- Compassionate bereavement support
- A supported, skilled and resilient workforce

The strategy aims to:

- Improve experiences and outcomes for people with life-shortening conditions
- Ensure equitable access to palliative care across NHSGGC
- Support families, carers and communities
- Improve coordination across services and settings

Expected outcomes include:

- Earlier identification of need
- Improved person-centred care planning
- Reduced inequalities in access and experience

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.

As a public sector body, we are bound by the Equality Act 2010 to have due regard to the equality considerations set out in section 149 when we are exercising our functions.

This Equality Impact Assessment will help us to consider the equality impact of this important policy in a consistent, transparent and accountable way. In doing so it will demonstrate that we have had due regard to the Public Sector Equality Duty. This Impact Assessment will continue to be updated as decisions on drafting and content for the policy are taken.

More specifically, palliative care intersects with our patients, families and carers at a point where care must be truly person-centred and inclusive of the needs of all protected characteristic groups. Omissions, oversights or failure to investigate risks of unintended consequences will leave lasting deficit for patients and their families during a critical period of care and erode trust in the services provided.

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: Gail Young (Planning Officer) / Leanne Connell (Chief Nurse Interface Division)
Date of Lead Reviewer Training: Internal training for team

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)

Staff from NHSGGC, IJBs, the third sector, and independent providers have been involved among others as part of the Design and Development Group. Key contacts including co-chairs, SLWG leads, and others are listed below. A full list of Design and Development Group members is available in Appendix 1.

- Leanne Connell, Chief Nurse Interface Division, NHSGGC **(co-chair)**
- Alexis Chappell, Chief Officer, East Renfrewshire HSCP **(co-chair)**

- Claire O'Neill, Lead Nurse, CHAS
- Kathleen Halpin, Chief Nurse, East Dunbartonshire HSCP
- Beatrix von Wissman, Consultant in Public Health, NHSGGC
- David Gray, Consultant in Palliative Medicine, NHSGGC / Renfrewshire HSCP
- Laura Kelly, Consultant in Palliative Medicine, NHSGGC / Prince and Princess of Wales Hospice
- Emma Dymond, Consultant in Palliative Medicine, NHSGGC
- Jude Marshall, Deputy Medical Director for Primary Care, NHSGGC
- Lucy Dorrian, Patient Experience Public Involvement Manager, NHSGGC
- Jonathan Downie, Consultant in Paediatric Palliative Medicine, NHSGGC
- Anne Marie Harris, Consultant in Paediatric Palliative Medicine, NHSGGC
- Karen Pirrie, Head of Planning and Improvement, NHSGGC
- Gail Young, Planning Officer, NHSGGC
- Paul Corrigan, Information Officer, NHSGGC
- Ann McLinton, Person Centred Health and Care Programme Manager, NHSGGC

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 below any barriers to collecting this data in your submitted evidence and an explanation for any protected characteristic data omitted.

Example: A sexual health service collects service user data covering all 9 protected characteristics to enable them to monitor patterns of use.

Service Evidence Provided:

- HSCP District Nursing services undertake holistic assessments for all patients with palliative care needs admitted to their caseload.
    - Data includes gender, date of birth, ethnicity, religion, preferred language and interpreting requirements, postcode, frailty score, and number of long-term conditions
    - The service also captures key metrics around future care planning conversations, preferred place of death and if preferred place of death was achieved. These key metrics are reported at Board level and monitored locally by operational leads to enable themes and opportunities for improvement.

- Acute HPCTs collect referral information about patients receiving specialist palliative care in hospital
    - Holistic assessment of patients referred to (hospital) palliative care takes place when practical to gather any specific needs that may be relevant to treatment, eg. religion. This will be added to the patients notes. Age and postcode are collected for all referred to hospital palliative care teams.
    - Discharge letter - specific needs of patient may be included when a discharge letter is sent, again religion or other cultural considerations.
- Information is collected differently by independent providers, e.g. care homes and hospices. Aggregated data can be made available to the health board however equalities data is not collected in the same way from one to the next

Possible negative impact and additional mitigating action required:

Consideration needs to be given to how we collect other equalities data from patients and service users. The lack of comprehensive data on protected characteristics such as race/ ethnicity, sexual orientation, and others will need to be a key focus of any engagement work associated with service change or improvement programmes that stem from this strategy.

2. 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. Please tick the relevant box:

1) Remove discrimination, harassment and victimisation ☐

2) Promote equality of opportunity ☐

3) Foster good relations between protected characteristics. ☐

4) Not applicable ☐

Example

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) 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)

Service Evidence Provided:

Data around most protected characteristics are not routinely collected by palliative care services. Age and sex of patients and service users are collected, as well as postcodes which give an indication of socio-economic status through SIMD quintiles.

Engagement surveys performed to support and inform this strategy collected standard equalities monitoring information. This information was collected on a voluntary basis and separate from survey responses to allow anonymity for respondents. A rough breakdown is provided in section 4.

Possible negative impact and additional mitigating action required:

The draft strategy emphasises equity of access for all. While research has been done into the intersection of various protected characteristics with the provision of and attitudes to palliative care, specific mitigating actions will be considered when planning any implementation or improvement programmes relating to the strategy.

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. Please tick the relevant box:-

1) Remove discrimination, harassment and victimisation ☐

2) Promote equality of opportunity ☐

3) Foster good relations between protected characteristics ☐

4) Not applicable ☐

Example

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).

Service Evidence Provided:

Evidence used to inform the development of the Palliative Care Strategy includes:

- Scottish Government Palliative Care Matters for All (2025–2030) (Link: Palliative Care Matters for All: palliative care strategy 2025 to 2030 - gov.scot)
- Engagement with over 200 people with lived experience

- Accelerated Design Event (2025) involving stakeholders and communities
- Marie Curie Evidence on health inequalities and end-of-life poverty (Link: dying-in-poverty-briefing-2025.pdf)
- Engagement Survey responses – please see Section 4 for breakdown.

Possible negative impact and additional mitigating action required:

Nil

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 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. Please tick the relevant box:-

1) Remove discrimination, harassment and victimisation ☐

2) Promote equality of opportunity ☐

3) Foster good relations between protected characteristics ☐

4) Not applicable ☐

Example

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 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.

Service Evidence Provided:

As part of our lived experience, patient, carer and public engagement we collected equalities data using the standard equalities capture questions established with EHRT.

Our engagement approach was shared among our own network via the Involving People Network and via our partner organisations that were part of the Design and Development Group and included 3rd sector organisations and charities.
Key themes were gathered throughout the first two phases of engagement via surveys and community events, targeted in locations with low responses to the survey. We shared the engagement routes with carer groups and with local engagement networks. The survey gathered EQIA data as a standard approach to any engagement. Our responses to our EQIA data are voluntary but indicated further work with BME communities, young people under 25 and 3rd sector groups such as Glasgow Disability Alliance would be beneficial for further phases.

While not relating to the draft strategy itself, a programme is underway to design and build a purpose-built paediatric palliative care suite at the RHC site, aligning with the principles of the draft strategy. Engagement work took place with children and families around this through CHAS and the appointed architectural firm, which informed much of the design of the space.

Possible negative impact and Additional Mitigating Action Required:
Further work will be required in identifying and engaging with groups with seldom-heard voices and wider representation across the NHSGGC area population when moving into an implementation phase and proposing any potential improvement programmes.

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. Please tick the relevant box:-

1) Remove discrimination, harassment and victimisation ☐

2) Promote equality of opportunity ☒

3) Foster good relations between protected characteristics ☐

4) Not applicable ☐

Example

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).

Service Evidence Provided:

No specific plans have been made so far for changes to physical access to care. If new buildings are proposed to be developed or existing buildings require to be refurbished as part of specific service change relating to this strategy, we will ensure that access audits are undertaken and, where appropriate, engagement with specific groups relating to physical service provision.

Developing digital access to care as part of the strategy will increase options for people living with physical disabilities to connect with health and other professionals from their own homes, reducing the need to travel to places of care where appropriate.

Possible negative impact and additional mitigating action required:

No negative impacts identified at this stage. Many conditions or diagnoses which result in a requirement for palliative care can lead to disabilities, and as such ensuring access for all regardless of ability will a key component in any improvement programmes resulting from this draft strategy.

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. Please tick the relevant box:-

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 review or policy has taken note of this.

Example

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).

Service Evidence Provided:

- NHSGGC Clear to All Information Policy (Link: Clear to All - NHSGGC)
- NHSGGC Interpreting Service (Link: Interpreting Services - NHSGGC)

All information leaflets and content for web pages including videos will comply with Clear to All requirements and content will be checked by seeking feedback from people with lived experience. Within palliative care services, interpreters will continue to be sought if required, including for people who require BSL support.

The strategy sets out a person focused approach which will allow people to access services in the ways that are most suitable for them, including their preferences around communication options.

Possible negative impact and additional mitigating action required :
No significant impact anticipated. Any impact on the accessibility of palliative care services is anticipated to be positive, particularly under the key priority of clear information and support for patients and service users.

7. Protected Characteristic

(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).

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. Please tick the relevant box:-

1) Remove discrimination, harassment and victimisation ☐

2) Promote equality of opportunity ☐

3) Foster good relations between protected characteristics. ☐

4) Not applicable ☐

Service Evidence Provided:

Acute adult HPCT referrals by age band (2024/25):

- Total referrals – **5,348**
- 65+ – 4,077 **(76.2%)**
- 51-64 – 996 **(18.6%)**
- 41-50 – 172 **(3.2%)**
- 25-40 – 88 **(1.6%)**
- 16-24 – 15 **(0.3%)**

Acute paediatric PSPCT accepted referrals by age band (2024/25)

- Total referrals – **72**
- 13+ – 13 **(18.1%)**
- 8-12 – 6 **(8.3%)**
- 3-7 – 9 **(12.5%)**
- 1-2 – 10 **(13.9%)**
- Under 1 – 34 **(47.2%)**

Older people
The numbers above show 65% of adult palliative care referrals accepted are for people aged 65 and over and NRS statistics report 80% of adult deaths in Scotland in 2024 were in ages 65 and over.

The strategy notes that there will be increasing numbers of people living into older years with increasing frailty who will require palliative care for longer periods and the challenge will be to ensure that palliative care continues to be offered to all who would benefit, regardless of age.

Children and young people
Palliative care referrals accepted for children and young people are greatest for babies under one year of age (47%), as in the numbers above. This corresponds to the epidemiology of child deaths in Scotland (2014) report which reported 60% of child deaths being in those under one year, with most of these occurring within the first four weeks of life, with services are already in place.

The strategy also highlights the increasing young adult population requiring palliative care, with 18% of palliative care referrals accepted being for young people aged 13 and over, and plans will be needed for these young people transitioning into adult services.

Possible negative impact and additional mitigating action required:

Possible negative effect of assumptions around age mitigated as noted above.

(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. Please tick the relevant box:-

1) Remove discrimination, harassment and victimisation ☐

2) Promote equality of opportunity ☐

3) Foster good relations between protected characteristics. ☐

4) Not applicable ☐

Service Evidence Provided:

A person-centred approach is proposed which allows service providers to support people to engage with services, including support with how to access information and support digitally where this is helpful and may reduce the need for people to travel to places of health care.

Where people who are already living with physically limiting disabilities, disabilities that require adjustments for communication support or learning disabilities also require palliative care, their holistic assessment will consider adjustments required to deliver the full package of palliative care according to their current needs.

Possible negative impact and additional mitigating action required:

The holistic palliative care approach will aim to mitigate any risks of palliative care needs being missed due to pre-existing disabilities. Many conditions or diagnoses which result in a requirement for palliative care can lead to disabilities, and as such ensuring access for all regardless of ability will a key component in any improvement programmes resulting from this draft strategy.

(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. Please tick the relevant box:-

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:

No significant impact anticipated. Any impact on people under the protected characteristic of gender reassignment is anticipated to be positive, through the provision of coordinated and respectful palliative care.

The impact of the Supreme Court ruling on biological sex and access to single sex spaces and subsequent EHRC guidance will be adhered to in line with any relevant NHSGGC policies when considering any service change or improvement programmes as a result of this draft strategy.

(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. Please tick the relevant box:-

1) Remove discrimination, harassment and victimisation ☐

2) Promote equality of opportunity ☐

3) Foster good relations between protected characteristics ☐

4) Not applicable ☐

Service Evidence Provided:

Limited relevance – no impact anticipated

Possible negative impact and additional mitigating action required:

Nil

(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. Please tick the relevant box:-

1) Remove discrimination, harassment and victimisation ☐

2) Promote equality of opportunity ☐

3) Foster good relations between protected characteristics ☐

4) Not applicable ☐

Service Evidence Provided:

Limited relevance – no impact anticipated

Possible negative impact and additional mitigating action required:

Nil

(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. Please tick the relevant box:-

1) Remove discrimination, harassment and victimisation ☐

2) Promote equality of opportunity ☐

3) Foster good relations between protected characteristics ☐

4) Not applicable ☐

Service Evidence Provided:

- Ethnicity and Palliative Care: we need better data (Link: Ethnicity and palliative care: we need better data – five key considerations | BMJ Supportive & Palliative Care)
- NHS Greater Glasgow and Clyde Anti-Racism Plan (Link: NHSGGC Anti-Racism Plan April2025 - NHSGGC)

Black and Minority Ethnic people in the UK report consistently experiencing lower access to and poorer experiences of palliative and end-of-life care. Data to support this within the NHSGGC area are largely unavailable as race and ethnicity information are not routinely collected from patients or service users.

The priorities within the draft strategy, particularly around clear communication and person-centred care, align with those set out in the NHSGGC Anti-Racism Plan. Any impact on people under the protected characteristic of race is anticipated to be positive, through the provision of coordinated and respectful palliative care.

Possible negative impact and additional mitigating action required:

Nil

(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?

Your evidence should show which of the 3 parts of the General Duty have been considered. Please tick the relevant box:-

1) Remove discrimination, harassment and victimisation ☐

2) Promote equality of opportunity ☒

3) Foster good relations between protected characteristics. ☐

4) Not applicable ☐

Service Evidence Provided:

- NHSGGC Spiritual Care Service (Link: The Spiritual Care Service - NHSGGC)

Palliative care as holistic care centred on the person helps people manage a range of issues including their spiritual wellbeing during this time. Care around dying aims to provide holistic care in the last hours, days or few weeks of life, focusing on comfort and supports those close to the person into bereavement. This will include facilitating access to a person's own faith and belief support network or to the NHS GGC Spiritual Care Team if desired.

Possible negative impact and additional mitigating action required:

No negative impact anticipated. Ensuring compassionate, person-centred care to people of all faith groups is a key component of the draft strategy. Engagement with various groups will need to be a key consideration if proposing any service change or improvement programmes aligned with or as a result of this draft strategy.

(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. Please tick the relevant box:-

1) Remove discrimination, harassment and victimisation ☐

2) Promote equality of opportunity ☐

3) Foster good relations between protected characteristics ☐

4) Not applicable ☐

Service Evidence Provided:

- Experiences of palliative care (Link: Preference for Palliative Care in Cancer Patients: Are Men and Women Alike? - PMC)
    - Study found that men's attitudes to and experiences of palliative care are less favourable than women

Acute adult HPCT referrals by sex (2025):

- Male – **49.2%**
- Female – **50.8%**

Acute paediatric PSPCT accepted referrals by age band (2024/25)

- Total referrals – **72**
- Male – 29 **(40.3%)**
- Female – 38 **(52.8%)**
- Indeterminate – **5 (6.9%)**

Possible negative impact and additional mitigating action required:

The draft strategy applies to all, regardless of gender. Priorities relating to equity and person-centred care aim to ensure no group is marginalised as a result of their care.

(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. Please tick the relevant box:-

1) Remove discrimination, harassment and victimisation ☐

2) Promote equality of opportunity ☐

3) Foster good relations between protected characteristics. ☐

4) Not applicable ☐

Service Evidence Provided:

- Marie Curie Palliative and end of life care for LGBTQ+ people (Link: Palliative and end of life care for LGBTQ+ people | Marie Curie)
- Health needs assessment of lesbian, gay, bisexual, transgender and nonbinary people (Link: Health_needs_assessment_of_LGBT_.pdf)

Possible negative impact and additional mitigating action required:

No significant impact anticipated. Any impact on people under the protected characteristic of sexual orientation is anticipated to be positive, through the provision of coordinated and respectful palliative care.

(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 below 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 from the Fairer Scotland Duty: guidance for public bodies - gov.scot

Service Evidence Provided:

- Marie Curie Dying in Poverty 2025 Report (Link: dying-in-poverty-report-2025.pdf)
    - Over 100,000 people die in poverty every year in the UK, particularly fuel poverty – approximately 1 in 6
- Macmillan Improving the Cancer Journey (Link: Improving the Cancer Journey Summary)

While palliative and end of life care are free at the point of delivery in Scotland there is suggestion of indirect costs to people receiving palliative care and their families. The strategy states that poverty impacts people in their last year of life, and that in 2024/25 20% of people who died at pension age and 22% to 34% of people who died at working age would have experienced end of life poverty. Scottish Government statistics report 18% of working age adults and 13% at pension age are in relative poverty. This issue may be greater for families with children receiving palliative care, as almost 50% of children in Scotland with a life shortening illness live in the two most deprived SIMD postcode areas, while the Scottish Government poverty statistics March 2026 reported that 21% of children in Scotland are in relative poverty.

Digital health care has mixed impacts on people living in poverty, with cost savings if communications can take place from home however there may be lower levels of access to the technology and skills required. The holistic approach offered by palliative care services could help to ensure that people have the digital infrastructure and skills required to establish helpful digital communications.

In highlighting these issues, the strategy will focus attention, and it may be helpful to gather information on the support that is available to people and families living in poverty including this in communications at the start of the palliative care journey.

Possible negative impact and additional mitigating action required:

A key focus of the draft strategy is shifting the balance of care to the community. With adequate resources in place, people at end of life should feel empowered to stay at home or in the community without incurring significant costs, particularly when it comes to fuel and bills.

MacMillan Improving the Cancer Journey offers support in some HSCPs for accessing additional benefits and financial help for anyone with a cancer diagnosis.

Increasing cost of living will need to be a key consideration if proposing any service change or improvement programmes aligned with or as a result of this draft strategy.

(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?

Service Evidence Provided:

Prison Population
The palliative care strategy applies to prison populations through its commitment to equitable, person-centred care across all settings, requiring targeted actions to address structural barriers in custody and disproportionate health need. The most significant equalities risk is loss of continuity at liberation, which must be mitigated

through structured pre-release planning, coordinated referrals, and sustained engagement with community and specialist palliative care services.

- Outcomes for homeless populations (Link: Holistic health and social care outreach for people experiencing homelessness with recent non-fatal overdose in Glasgow, Scotland: the Pharmacist and third sector Homeless charity worker Outreach Engagement Non-medical Independent prescriber Rx (PHOENIx) pilot randomised controlled trial – NHS Scotland)
- Cancer rates among homeless population in Glasgow (Link: jepicomh00180-0058.pdf)

Homeless Population

Homeless populations frequently experience poorer health outcomes than housed people. Glasgow has a relatively high homeless population compared to other cities in the UK, with many unhoused people experiencing multiple complications such as substance use, mental health issues, and complex trauma. This often leads to a reluctance to seek healthcare, or an inability to do so. Palliative and end of life care outcomes are impacted by this.

Cancer rates are often higher than average in homeless populations, particularly those of the oral cavity, lungs, and other respiratory tissues. This population is particularly marginalised within healthcare as a whole, and not just palliative care.

Gypsy/Travelling Community

There remain significant barriers to accessing health and social care among gypsy/traveller communities in Scotland and across the UK. National programmes are underway to address this, including Community Health Worker and Carer Support Services through the Minority Ethnic Carers of People Project (MECOPP). These have fostered greater trust in health and social care services, and monitoring shows greater health outcomes for communities served.

- MECOPP services (Link: Our Services — MECOPP)
- Scottish Government Health and Social Care for Gypsy/Traveller Communities (Link:L Health and social care - Gypsy/Travellers - gov.scot)

Possible negative impact and additional mitigating action required:

- Structured pre-release planning for patients in prison with palliative care needs must be prioritised in any implementation plans of this draft strategy
- The implementation of the strategy must align with broader NHSGGC and IJB plans and strategies around health and social care for homeless populations to improve outcomes for these individuals
- Any implementation or improvement programmes aligned to or as a result of this draft strategy should look at gaps in engagement, particularly in those groups listed 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. Please tick the relevant box:-

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 below recorded completion rates of statutory and mandatory learning programmes (or local equivalent) covering equality, diversity and human rights.

Service Evidence Provided:

The national Palliative Care Education Framework 2025 published by Public Services Delivery Scotland outlines the need for equality, diversity, and inclusion in palliative care training.

Overall GGC compliance for completion of equalities & human rights module was 88% at end of July 2026.

Possible negative impact and additional mitigating action required:

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 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.

Any specific service change as a result of or aligned with this draft strategy will require an EQIA of its own. The draft strategy is high-level and does not propose specific changes or improvement initiatives and as such does not pose any risks as described.

Please explain 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* (see below).

Engagement took place in three phases

Phase 1 was the discovery phase and gathered lived experience to inform the Accelerated Design Event and the priorities for the draft strategy.

Phase 2 included the Accelerated Design Event itself and the coproduction of the strategy itself alongside lived experience volunteers input.

Phase 3 tested the priorities with the public and refined the definition and what mattered to the public for success measures.

*FAIR is an acronym for the following -

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

11. 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. Go to the full list of articles to be considered for further 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.

We coproduced engagement with families who are and have been users of palliative care services both at RHC and at CHAS through different stages in our engagement.

This feedback was core to developing the 5 priorities and also when we cross checked the priorities with our stakeholders.

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.

The five priorities in the draft strategy cover palliative care for adults, children, and young people. Paediatric palliative care services have been key partners in the co-design and development of the strategy, ensuring that the best interests of children and young people are built into the strategy throughout.

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 significant impact anticipated. This will need to be considered when proposing any improvement programmes or service change aligned to this draft strategy.

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.

Paediatric engagement focussed on engagement with bereaved families on a 1-to-1 basis. This highlighted the importance of continuity of care and considerations of the UNCRC.

Having completed the EQIA template, please tick the relevant box that you, the 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) X ☒

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) ☐

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 space 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 sections completed above, please summarise the actions this service will be taking forward or tick the box next to 'No Actions Identified'

Further work will be required in identifying and engaging with groups with seldom-heard voices and wider representation across the NHSGGC area population when moving into an implementation phase and proposing any potential improvement programmes.
Lead: PEPI Team Due 1/4/27

Assess impact of strategy move towards community based care on costs of living for individuals
Lead: Gail Young to take to Implementation group 1/4/27

No actions identified ☐

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

Lead Reviewer:
Name Claire O'Neill
Job Title Lead Nurse – Palliative Care
Signature Claire O'Neill
Date 24/8/26

Quality Assurance Sign off:
Name Dr Noreen Shields
Job Title Planning Manager
Signature Noreen Shields
Date 3/9/26

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 & 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

Action:

Status:

Completed
Date
Initials

Action:

Status:

Completed
Date
Initials

Action:

Status:

Completed
Date
Initials

Action:

Status:

Completed
Date
Initials

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

Action:

Reason:

To be completed by
Date
Initials

Action:

Reason:

To be completed by
Date
Initials

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

Action:

Reason:

To be completed by
Date
Initials

Action:

Reason:

To be completed by
Date
Initials

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@nhs.scot

Appendix 1: Membership of Design and Development Group

Name	Job Title	Representing
Aimie Holland	Lead Clinical Improvement Co-ordinator	NHSGGC Person Centred Care
Alastair Low	Manager, Equality & Human Rights Team	EHRT
Allan Drummond	Consultant in Acute Medicine	Acute Medicine
Charlene McLaughlin	Change and Development Manager	E-Health
Claire Ireland	Professional Nurse Lead-Older Peoples Services	Glasgow City HSCP
Dawn Allan	Spiritual Care Team Lead	Spiritual Care Service
Elayne Harris	Macmillan Lead Pharmacist Palliative Care	Palliative Care Pharmacist
Fiona Somerville	Interim Professional Nurse Lead	Prison Health care – Primary care/ Police custody
Ioana Stanciu	Service Improvement Officer	Planning & Strategy
Jude Marshall	Deputy Medical Director NHSGGC (Primary Care)	Primary Care / Realistic Medicine
Neil Ritchie		
Pauline McIntyre	Director of Patient and Family Services	Ardgowan Hospice
Scott MacKinnon	Clinical Effectiveness Lead	SAS
Stephanie Pollard	Nurse Team Lead	PEOLC Strategic lead West Dunbartonshire HSCP
Susan Fitzpatrick	Senior Graphic Designer - Communications	
Laura Moore	Chief Nurse - Inverclyde HSCP	PEOLC Strategic lead Inverclyde HSCP
Graham Gardiner	Chief Executive Officer	Ardgowan Hospice
Alexis Chappell	Chief Officer	Co-Chair / East Renfrewshire HSCP
Ann McLinton	PCHC Programme Manager	NHSGGC Person Centred Care
Anne Marie Harris	Consultant	Paediatric Supportive and Palliative Care Team
Barbara Simpson	Lead Nurse Palliative Care	Co-chair Palliative Care acute group
Beatrix Von Wissmann	Consultant - Public Health	Public health
Bridget Johnston	Clinical Professor of Nursing and Palliative Care	Board Bereavement Lead / University representative Palliative Care
Chris Kidson	Consultant Paediatric Intensive Care Medicine	PELiCaN The Paediatric End of Life Care Network
Claire ONeill	Lead Nurse Palliative Care	NHSGGC Palliative Care / Chief Nurse Acute Services
Claire O'Neill	Chief Nurse	CHAS
David Gray	Consultant - Palliative Medicine	Palliative Care Clinical Lead Acute Clyde
Elaine Hamilton	Lead Nurse Care Home Collaborative	Care Home Collaborative

Elizabeth Ferguson		
Elizabeth Lochrie	Interim Head of Service (North West Locality)	PEOLC Strategic lead Glasgow HSCP
Emma Dymond	Consultant - Palliative Medicine	Palliative Care Clinical Lead Acute North
Fiona Ralph	Interim Chief Nurse	Chief Nurse (HSCP)
Gail Young	Planning Officer	Planning Representative
Gillian Green	Chief Executive	St. Vincent's Hospice
Graham Whyte		
Gail Winters	Patient representative (GAIL WINTERS)	Public partners Adult and paediatric Palliative Care
Heather Tonner	MacMillan Advanced Nurse Specialist in Palliative Care	Care Home Collaborative
Helen Cadden	Patient representative (HELEN CADDEN)	Public partners Paediatric Palliative Care
Holly McGuigan	Consultant in Palliative Medicine	Ardgowan Hospice
Isabelle Cullen	Clinical Director for East Dunbartonshire HSCP	Clinical Director (OOH)
Jacki Smart	Chief Executive	Accord Hospice
Jane Edgecombe	Consultant - Palliative Medicine	Co-chair Palliative Care acute group
Jennifer Rodgers	Director of Nursing and Family Support	CHAS
John Brown	Director of Finance & Corporate Services	St. Margaret of Scotland Hospice
Jonathan Downie	Consultant in Paediatric Palliative Medicine	Paediatric Supportive and Palliative Care Team
Julie Tomlinson	Chief Nurse East Renfrewshire	PEOLC Strategic lead East Renfrewshire HSCP
Karen Pirrie	Head of Planning and Improvement	Planning Representative
Kathleen Halpin	Chief Nurse	East Dunbartonshire HSCP
Linda Moir	Patient representative (LINDA MOIR)	Public partners Paediatric Palliative Care
Laura Kelly	Consultant - Palliative Medicine	Palliative Care Clinical Lead Acute South
Leanne Connell	Chief Nurse Interface Division	Co-Chair / Interface Division
Liam Herbert	Head of Planning & Strategy	Planning & Strategy
Libby Milton	Associate Director and strategic lead for Marie Curie in Scotland	Marie Curie Hospice Glasgow
Lucy Dorrian	Patient Experience Public Involvement Manager	Patient Experience Public Involvement
Lynsey O'Dwyer	Clinical Team Lead, Community Nursing	PEOLC Strategic lead East Renfrewshire HSCP
Mairi-Clare McGowan	Consultant in Palliative Medicine	St. Vincent's Hospice
Mandy Meechan	Chief Nurse	Paediatric

Marie Gilchrist	PDN	Chief Nurse adult mental health services
Morag Lynagh	Senior Nurse Manager	West Dunbartonshire HSCP
Neil Mcseveny	Deputy Director of Communications	GGC Communications Team
Nicola Dooley		Staff Partnership/APF
Noreen Shields	Planning & Development Manager - Equality and Human Rights Team	EHRT
Paul Corrigan	Information Officer	NHSGGC Palliative Care
Pauline Robbie	Interim Head of Heath and Community Care	PEOLC Strategic lead Renfrewshire HSCP
Phillip Davies	CD for Paediatric sub specialities	Paediatric CD
Rhona Baillie	Chief Executive	The Prince & Princess of Wales Hospice
Sheonad Laidlaw	Transitions Lead	Transitions
Shona Ballentyne	Care Group Lead/Occupational Therapist for Rehab	Occupational Therapy
Susan Watt	Director of Care & Quality	St. Vincent's Hospice
Teresa Merino	Medical Director	St. Margaret of Scotland Hospice
Cathy Miller (Replaced)	Unison	Staff Partnership/APF