Table of Evidence on Protected Characteristics and Socioeconomic Inequality

See also http://www.equalitiesinhealth.org/public_html/evidence-briefings.html

Protected Characteristic	Key Messages	Source
DISABILITY		
Learning Disability	The quality and effectiveness of health and social care given to people with learning disabilities has been shown to be deficient in a number of ways. Despite numerous previous investigations and reports, many professionals are either not aware of, or do not include in their usual practice, approaches that adapt services to meet the needs of people with learning disabilities	Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) - Final report Heslop, P. Et al. Norah Fry Research Centre. http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf
	Despite recent incentives, people with learning disability in the UK are significantly less likely to receive	Access to Cancer Screening in People with Learning Disabilities in the UK: Cohort Study in the

	screening tests for cancer that those without learning disability. Other methods for reducing inequalities in access to cancer screening should be considered	Health Improvement Network, a Primary Care Research Database David P. J. Osborn, D.P.J. et al PLOS ONE | www.plosone.org, August 2012 | Volume 7 | Issue 8 | e43841 http://discovery.ucl.ac.uk/1362909/1/1362909.pdf
	37% of deaths were avoidable compared to 11% in general population	The Confidential Inquiry into premature deaths of people with intellectual disabilities in the UK: a population-based study. Dr Pauline Heslop et al The Lancet Volume 383, No. 9920, p889–895, 8 March 2014 http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62026-7/abstract

	With increasing longevity amongst people with learning disabilities, it is not surprising that prevalence and incidence rates of cancer are growing at a significant rate. Much of the research undertaken in the area of psycho-oncology has focused on the ‘general population’, and over the last decade, there has been increasing interest in using a narrative approach to explore the lived experiences of people who have had cancer. Traditionally, research into cancer amongst people with learning disabilities has focused upon epidemiology or palliative care. However, the present article uses a narrative analysis to explore the lived and told experience of a person with a learning disability, who has been given a diagnosis of cancer. This article highlights provides justification, for more qualitative research to be undertaken in this area.	Jo's Story: the journey of one woman's experience of having cancer and a ‘learning disability’ Melissa Hannah Martean, M. H et al British Journal of Learning Disabilities Volume 42, Issue 4, pages 282–291, December 2014 http://onlinelibrary.wiley.com/doi/10.1111/bld.12072/full
British Sign Language Users	The research findings from NHS Boards elicited the following: • Sourcing of interpreters varied from one NHS	Report on NHS BSL/English interpreting provision within health settings in Scotland, British

	Board to another with no consistency • There was a similar lack of consistency in the tendering process • There was confusion on the registration process for BSL/English interpreters, with some NHS Board unclear as to the status of the interpreters they used • Not all NHS Boards required the interpreters to translate the Patient Consent forms • There were no confidentiality concerns by all the NHS Boards • 7 of the 9 NHS Boards actively consult with Deaf BSL users • 3 NHS Boards have systems to monitor quality of BSL / English interpreting provision • Suppliers are responsible for ensuring that interpreters are able to work in mental health settings • 6 NHS Boards expressed satisfaction with their experience of working with BSL/English interpreters • There was no uniform provision of interpreters for medical setting such as opticians, dentists and pharmacies • All 9 NHS Boards were willing to consider online	Deaf Association / Scottish Government October 2012 http://bda.org.uk/uploads/BDA/files/pdf/NHS%20Interpreting/NHS%20Interpreting%20(Scotland)%20-%20cover.pdf

	provision of interpreting. The evidence from Deaf people indicate that: • There was a lack of satisfaction with the management of communications within the GP surgeries, the process of booking interpreters • Rural areas were particularly affected by a shortage of a interpreting provision • Deaf people wanted to continue the NHS Board consultations • There was unanimous agreement that all interpreters should be qualified and registered • There was concern about confidentiality as the Deaf community is small and close-knit • Deaf people would like to be able to choose their own interpreter • It was felt important to have same sex interpreters for some situations • Deaf people generally want to chat with the interpreter before appointments – described as a soft and informal approach • Online interpreting is only applicable in some situations, Deaf people were clear about where it should not be used	

	A number of participants referred to how engaging in healthcare services left them feeling. Many mentioned being 'talked down to', patronised or left feeling small or treated like a child rather than an adult. Often it was felt that appointment services were very Inaccessible due to the fact that you have to 'phone this number to confirm you can attend your appointment'. There seemed to be a general lack of understanding that BSL is a Deaf person's first language and there was an expectation on Deaf people to be able to understand written notes. Also they often received letters written in a high level of English, which they struggled to understand. Many Deaf people reported feeling like 'an inconvenience' when practitioners realised that they were Deaf. Often huffing and shrugging their shoulders and making the Deaf person feel unwelcome. A common theme was the begrudging manner of Dentists when asked to remove their surgical masks in order for the Deaf person.	Healthwatch Oxfordshire, Access to Healthcare Services for Deaf People March 2014 http://signlingual.org.uk/wp-content/uploads/2014/07/Oxon-Healthwatch-Report-final-pdf.pdf

Mental Health	The impact of serious mental illness on life expectancy is marked and generally higher than similarly calculated impacts of well-recognised adverse exposures such as smoking, diabetes and obesity. Strategies to identify and prevent causes of premature death are urgently required.	Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Care Case Register in London. Chang, C-K et al http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0019590
Mental Health and Addictions	Addiction in conjunction with mental illness is regarded within the high risk suicide category. Addiction service users can often have a history of suicide and self harm. Suicide prevention and intervention strategies should be developed as a core part of service delivery.	Final Report Mental health, substance misuse and suicide prevention research NHS Greater Glasgow & Clyde and Renfrewshire Alcohol and Drug Partnership September 2011
Hearing Loss	A lack of wider support for those with hearing loss identified. • There is an apparent lack of knowledge and support across society as a whole about hearing loss.	Commission on Hearing Loss: Final Report July 2014 http://www.ilcuk.org.uk/images/uploads/pu

	• This lack of knowledge pervades through many aspects of our daily lives including institutional settings such as GP surgeries, hospitals and care homes as well as other areas • such as the entertainment sector and transport. • There is also a lack of knowledge and support from employers which, research shows is likely to be at the heart of lower employment rates amongst those with hearing loss. • The Government's Access to Work scheme is very important in this regard because it provides financial support to deliver suitable adjustments such as communication support • and/or equipment to help those with disabilities in the workplace, but it is being weakened. • In all of these settings there is often little consideration taken for ensuring that the needs of those with hearing loss is fully supported – though there are important exceptions.	blication-pdfs/Hearing_loss_Commission_final_report_-website.pdf
Visual Impairment	Loneliness and social isolation are not inevitable consequences of sight loss; there is a range of factors that affect people's experiences. Understanding what protects people against loneliness may help in developing a better understanding.	Loneliness, social isolation and sight loss- Research Findings 44 Thomas Pocklington Trust October 2014

	• Loneliness and social isolation occur as part of a complex interactive process involving other factors, especially difficulties with everyday functional activities. • Loneliness is linked more strongly to how people experience their visual impairment rather than the clinical assessment of their vision; this highlights the importance of understanding people's personal experience of sight loss. • Relationships and social support help to prevent loneliness in people with sight loss. • People's expectations, and the way they feel about their relationships and the social support they receive, are more important than the amount of support they receive. • Difficulties with communication and social interaction can contribute to people with sight loss feeling socially isolated. • Factors that play a part in whether and how people with sight loss experience loneliness include: gender, socio-economic status and individual psychological factors. • Children with a visual impairment may be at greater risk of social isolation in school than their sighted peers.	http://www.pocklington-trust.org.uk/Resources/Thomas%20Pocklington/Documents/PDF/Research%20Publications/Research%20Findings/rf-44-social-isolation-3.pdf

Physical Disability	Adults in England with physical disability experience worse physical access into primary care buildings than those without. Physical disability is also associated with increased unmet healthcare need due to difficulty getting to GP premises, compared with the experience of adults without physical disability. Increasing age further exacerbates these problems. Access to primary care in England for patients with physical disability needs improving.	How do adults with physical disability experience primary care? A nationwide cross-sectional survey of access among patients in England. Popplewell, N.T. et al BMJ Open. 2014 Aug 8;4(8):e004714. doi: 10.1136/bmjopen-2013-004714. http://www.ncbi.nlm.nih.gov/pubmed/25107434
	AGE	
Older people	This factsheet, which is updated on a monthly basis, is the most up-to-date source of publicly available, general information on people in later life in the UK. Wherever possible, figures for the whole UK are quoted. For ease of reading and unless otherwise stated, the term "older" is used here for people aged 65 and over.	Later Life in the United Kingdom , Age UK *August 2015* http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true

	The briefing highlights difficulty with travel to hospital for older people due to mobility issues.	
Older people	This briefing note is based on a review of the research literature and a series of meetings with key stakeholders in older people's health and social care provision. While there are many examples of excellent care for older people in the UK, the review has revealed evidence of unfair age discrimination in health and social care. A wide range of services are implicated. There is clear evidence that some services have operated explicit age restrictions which have little justifiable clinical basis. Age discrimination is more often covert and subtle and is implicit in a general lack of priority for older people's services. Discrimination is sometimes difficult to separate from other issues around, gender, poverty, ethnicity and the way in which people with disabilities and long term illness are treated.	Age discrimination in health and social care Kings Fund Briefing http://www.equalitiesinhealth.org/public_html/documents/ageDiscrimination.pdf
Young people	The review spoke to 180 young people, or parents	From the pond into the sea

transitioning to adult services	of young people, between the ages of 14 and 25 with complex health needs. It found that the transition process is variable and that previous good practice guidance had not always been implemented. Young people and families are often confused and at times distressed by the lack of information, support, and services available to meet their complex health needs. They were often caught up in arguments between children's and adult health services as to where care.	Children's transition to adult health services June 2014 Care Quality Commission https://www.cqc.org.uk/sites/default/files/CQC_Transition%20Report.pdf
Dementia	In Scotland, it is estimated that approximately 9% of the population over the age of 65 years have a diagnosis of dementia. A small percentage (<0.2%) of people under 65 years are also affected. This review found a lack of evidence of effective interventions that raised awareness of dementia in different population groups with protected characteristics as defined by the Equality Act 2010. An individualised care approach that recognises all aspects of people's identity, such as race, religion and sexual identity is essential to encourage early help-seeking among different population groups.	Dementia and Equality, Health Scotland Evidence for Action http://www.healthscotland.com/uploads/documents/25417-EFA%20Dementia%20and%20equality%20briefing.pdf

ETHNICITY		
Ethnicity	Patient-centeredness has been advocated to reduce racial/ethnic disparities in health care quality, but no empirical data support such a connection. The authors' purpose was to determine whether students with patient-centred attitudes have better performance and are less likely to demonstrate disparities with African American compared with white standardized patients. Patient-centred attitudes may be more important in improving physician behaviours with African American patients than with white patients and may, therefore, play a role in reducing health inequality.	Can patient-centered attitudes reduce racial and ethnic disparities in care? Beach, M.C. et al 2011 Jul 15. Acad Med. 2007 Feb; 82(2): 193–198. doi: 10.1097/ACM.0b013e31802d94b2
	This report examines differences in the health of ethnic groups in Scotland and uses census health data to identify variations between groups. The analysis employs age-standardised rates to compare people of similar age, which avoids the often misleading direct comparisons between	Which ethnic groups have the poorest health? An analysis of health inequality and ethnicity in Scotland Scottish Govt

	populations with very different age structures. The analysis revealed the following key findings: Most ethnic groups in Scotland reported better health than the 'White: Scottish' ethnic group; Across most ethnic groups, older men reported better health than older women. Older Indian, Pakistani and Bangladeshi women reported poor health, and considerably worse health than older men in these ethnic groups; Gypsy/Travellers in Scotland had by far the worst health, reporting twice the 'White: Scottish' rate of 'health problem or disability' and over three and a half times the 'White: Scottish' rate of 'poor general health' ; 'White: Polish' people aged under 65 reported relatively good health, whereas those aged 65 or over reported relatively poor health; The age-standardised rates of 'health problem or disability' by ethnic group in Scotland followed a similar pattern to the results for England and Wales; Older Bangladeshi men in Scotland were relatively	http://www.gov.scot/Resource/0048/00484303.pdf

	healthier than older Bangladeshi men in England and Wales.	
	In racial disparities research, perceived discrimination is a proposed risk factor for unfavourable health outcomes. In a proposed “threshold-constraint” theory, discrimination intensity may exceed a threshold and require coping strategies, but social constraint limits coping options for African Americans, who may react to perceived racial discrimination with disengagement, because active strategies are not viable under this social constraint. Results suggest that perceived discrimination affects quality of life for African Americans with cancer because their coping options to counter mistreatment, which is racially based, are limited. This process may also affect treatment, recovery, and survivorship.	Perceived Discrimination, Coping, and Quality of Life for African-American and Caucasian Persons With Cancer Merluzzi, T. V. Et al, 2014 http://www.ncbi.nlm.nih.gov/pubmed/25090144
Ethnicity and Addiction	‘My Story with Addictions’ 2010 research carried out by South CAT and Coalition for Racial Equality and Rights (CRER), reports that barriers to accessing addiction services remain, highlighting	My Story with Addictions Coalition for Racial Equality and Rights 2010

	issues such as stigma, shame, lack of awareness of service provision and a lack of cultural competency amongst mainstream addiction services. The report also highlighted that where addiction is indicated, BME populations prefer to use generic or mainstream services, community resources or family supports rather than addiction specific services.	
Refugees and asylum seekers/ gender/ mental health.	Knowledge of the healthcare system in Scotland is a prerequisite to being able to use that system. The main gap in terms of knowledge concerned out of hours GP services and the subsequent use of accident and emergency when GP surgeries are closed. Continuity of care, particularly GPs, was prized by respondents The corollary to this was the psychological difficulty experienced when not being able to keep the same GP. Mental health is a significant issue for asylum seekers and refugees, but particularly for asylum seekers, while there is also a strong gender	In Search of Normality Scottish Refugee Council Mulvey, G. January 2013 http://www.scottishrefugeecouncil.org.uk/assets/0000/5498/4093_SRC_Refugee_Integration_Doc_V4.pdf

	dimension to mental health. There are also particular issues around many refused asylum seekers who receive no support and are destitute. In some cases destitute asylum seekers were unable to answer questions about their health due to not having seen a medical professional for some years.	
	Refugees surveyed by the Scottish Refugee Council felt they had a good understanding of the range of health services available to them, but some also demonstrated misunderstandings about appropriate use of services (using Accident and Emergency rather than contacting an out-of-hours GP service for example). Registration with GPs was high amongst refugees and asylum seekers in the study and experiences of accessing health services were good. Health is impacted by experiences in people's country of origin, and also by what happens to them once they arrive in Scotland. Research by London School of Hygiene and	New Scots: Integrating Refugees in Scotland's communities, Scottish Government 2014-17 http://www.gov.scot/Resource/0043/00439604.pdf

	Tropical Medicine and the Scottish Refugee Council has shown a very high prevalence of gender based violence among asylum seeking women in Scotland, linked to complex health and support needs. Mental health is a relevant factor in terms of health outcomes. Traumatic events associated with a refugee's flight and social isolation reported by many individuals in Glasgow lead to a higher risk of mental health problems. In turn, poor mental health can lead to poor physical health such as diabetes and cardiovascular problems. Evidence in the research suggests that the asylum process itself has a significant impact on mental health and wellbeing. There is also a gender issue around wellbeing with women in general, and women asylum seekers in particular, indicating considerably lower self-reported health and wellbeing outcomes than almost any other part of the Scottish population.	
EU Migrants	Understanding users' perceptions and expectations of health care provision is key to informing practice,	'I think that Polish doctors are better': Newly arrived migrant children and their

	policy and health-related measures. This paper presents findings from a qualitative study conducted with recently migrated Eastern European children and their parents, reporting on their experiences of accessing health services post-migration. Unlike the case of adults, the experiences of newly migrated children have rarely been explored in relation to health services. We pay particular attention to three key areas: (1) migrant families′ views of health service provision; (2) barriers to health service use; and (3) transnational use of health services. By using a social capital approach, we show how concerns about the Scottish health care practices enacted by migrant parents are adopted by children and are likely to impact on families′ health beliefs and behaviours. The study highlights the important role of migrants′ active participation as users of health services. We conclude that appropriate health services need to consider more carefully migrants′ expectations and complex health care activities, in order to be fully inclusive and patient-centred.	parents′ experiences and views of health services in Scotland Sime, D. Health & Place, Volume 30, November 2014, Pages 86–93 http://www.sciencedirect.com/science/article/pii/S1353829214001233

Gypsy Travellers	Recommends that the ethnic groups Travellers and Gypsies become part of the “data dictionary” and that statistics are regularly gathered about their accessing health services and health outcomes in Ireland and the UK jurisdictions. The seeming inequality of access to, and patchy provision of, health services is unacceptable. More needs to be done to increase understanding of services, particularly among Roma, to offer translation services where necessary, and for greater trust to be built between healthcare professionals and Travellers, Gypsies and Roma.	British-Irish Parliamentary Assembly Report from Committee on Travellers, Gypsies and Roma: access to public services and community relations October 2014 http://www.britishirish.org/assets/CommitteeDRomaTravellerReport.pdf
SEX		
Gender Based Violence	Intimate partner violence and abuse can have a significant effect on women’s physical, psychological, sexual and reproductive health. Globally, 38% of murders of women are committed by their intimate partners, compared to 6% of male murders.	A brief guide to intimate partner violence and abuse NHS Health Scotland July 2015

	In Scotland, over the past 10 years 52% of women murdered were killed by their partner or ex-partner compared to 7% of male murders. 42% of women who have been physically and/or sexually abused by their partners have experienced injuries as a result of that violence. There is an association with: HIV infection; sexually transmitted infections; induced abortion; low birth weight; premature birth; intrauterine growth restriction/babies that are small for gestational age; alcohol use; depression and suicide; injuries; and death from homicide. Other health outcomes believed to be associated with intimate partner violence and abuse include: adolescent pregnancy; unintended pregnancies; miscarriage and stillbirth; intrauterine haemorrhage; nutritional deficiency; abdominal pain/GI problems; neurological disorders; chronic pain; disability; anxiety and PTSD; as well as non-communicable diseases including hypertension, cancer and cardiovascular disease.	PDF 25774-Intimate partner violence and

	Pathways between intimate partner violence and abuse and poor health outcomes may be direct, for example, between physical assault and injury or indirect by increasing exposure to risk i.e. unprotected sex. Intimate partner violence and abuse is linked to adverse health and development outcomes for children.	
	Gender-based violence is a major public health issue which causes immense pain, injury and suffering, particularly to women and children. Health staff have a unique and crucial role in identifying and supporting all those affected by it. The Scottish Government Health Directorate has issued guidance to health boards on identifying and responding to gender-based violence as part of its commitment to improving the health and healthcare of those who have experience of such abuse.	NHS Scotland What health workers need to know about Gender based violence: an overview Scottish Government 2009
	This paper describes programming to prevent violence against women and girls, and emphasises	Prevention of violence against women and girls: lessons from practice.

	the importance of systematic, sustained programming across the social ecology (ie, the delicate equilibrium of interacting social, institutional, cultural, and political contexts of people's lives) to transform gender-power inequalities. Effective prevention policy and programming is founded on five core principles: first, analysis and actions to prevent violence across the social ecology (individual, interpersonal, community, and societal); second, intervention designs based on an intersectional gender-power analysis; third, theory-informed models developed on the basis of evidence; fourth, sustained investment in multisector interventions; and finally, aspirational programming that promotes personal and collective thought, and enables activism on women's and girls' rights to violence-free lives. Prevention programming of the future will depend on all of us having a vision of, and a commitment to, gender equality to make violence-free lives for women and girls a reality.	Michau, L. et al. Lancet. 2014 Nov 21. http://www.sciencedirect.com/science/article/pii/S0140673614617979
GBV and learning	The women interviewed reported that the domestic violence they experienced was often severe	Domestic violence and women with learning disabilities

disability	(including the use of weapons, and violence during pregnancy), frequent and over long periods of time. All forms of domestic violence were reported – physical, sexual, emotional, psychological, financial, coercive control- and typically women would experience multiple forms at the same time. Unsurprisingly, the psychological impact on the women was considerable. All reported low self esteem and self-worth and many reported developing mental health problems (most commonly anxiety and depression). Some began to self-harm and a minority had had suicidal thoughts and/or had attempted suicide. The husbands or boyfriends of the women in the study did not usually have learning disabilities themselves, but did tend to have other problems such as mental health difficulties, drug and alcohol problems, unemployment.	NIHR School for Social Care Research 2014
Women and Addictions	Women make up over half the adult population. One of the consequences of having more male	National Treatment Agency Women in drug treatment: what the latest figures

	addicts in the system is that there is legitimate concern it is not suitable for women. Women are more likely than men to enter earlier into treatment and more likely to be retained. There presentation can be more complex due to care responsibilities including childcare and maternity issues, physical and sexual abuse, prostitution, sexual and mental health, and a strong risk of stigmatisation. Most women in treatment have children (60%). Services need to take into account the complexity for women and the stigma that is often associated. Women specific services and interventions should be further developed at a community level. CATs are very male service user dominant. We need to consider female clinics, choice or worker (male/female) and group work programmes that address gender identity parenting initiatives not just (pre 5), welfare rights, employability etc.	reveal, 2010
	The female prison population in Scotland has doubled in the past 10 years. Many women in the criminal justice system are frequent re-offenders with complex needs that relate to their social circumstances, previous histories of abuse and mental health and addiction problems. A set of	Commission on Women Offenders, 2012 http://www.gov.scot/Resource/0039/00391828.pdf

	recommendations is outlined which includes CJ services, community services and leadership roles.	
Female Genital Mutilation	The most valid and statistically significant associations for the physical health sequelae of FGM/C were seen on urinary tract infections, bacterial vaginosis, dyspareunia, prolonged labour, caesarean section, and difficult delivery. While the precise estimation of the frequency and risk of immediate, gynecological, sexual and obstetric complications is not possible, the results weigh against the continuation of FGM/C and support the diagnosis and management of girls and women suffering the physical risks of FGM/C.	Effects of female genital cutting on physical health outcomes: a systematic review and meta-analysis Berg, R.C. et al. BMJ 2014;4:e006316 http://bmjopen.bmj.com/cgi/content/short/4/11/e006316?g=w_open_current_tab
	Cultural competency is essential to the management of obstetric care as it increases the scope for early identification of FGM and promotes a patient centered approach to defibulation, pain management and intervention during childbirth. The eventual and absolute abolition of FGM is the preferred scenario. However, in the shorter term we must seek to improve the childbearing outcomes and experiences for women in UK.	Female Genital Mutilation and Cultural Competency: Moving towards improved management of obstetric care Moore, K. 2015

Human Trafficking	The report focused on the need for an independent system for victim identification, and deciding on their trafficking status and appropriate victim support. The recommendations are designed to help make Scotland a more hostile environment for traffickers, as well as helping to identify victims and support their recovery.	Human trafficking: is the system responding? Bennett, C. October 2012 http://www.journalonline.co.uk/Magazine/57-10/1011761.aspx
FAITH		
Muslims	The attitudes of the general British population towards Muslims changed post 2001, and this change led to a significant increase in Anti-Muslim discrimination. The study suggest that discrimination worsens blood pressure, cholesterol, BMI and self-assessed general health. Thus, discrimination is a potentially important determinant of the large racial and ethnic health gaps observed in many countries. Discrimination also has a negative effect on employment, perceived social support, and health-	Discrimination makes me sick! An examination of the discrimination–health relationship. Johnston, D. W. Centre for Health Economics, Monash University, Australia, Department of Social Policy, London School of Economics, United Kingdom

	producing behaviours. Crucially, our results hold for different control groups and model specifications	1-s2.0-S0167629611001688-main.pdf
Ethnicity and faith	An exploration of the particular impact of religion as a focus for experiences of victimization may be particularly pertinent given the increasingly negative treatment of Muslim people since the riots in Britain of 2001, the terrorist incidents of 2001, 2004 and 2005 and the political and military responses to them. Cross-sectional analyses of data collected in 2000 and 2008/2009 explore whether there is evidence that the ethnic/religious patterning of reports of different forms of victimization have varied over time, after adjusting for the impact of age, gender, migration and socioeconomic differences between the groups. In 2000 Muslim people with different ethnic backgrounds were less likely, but by 2008/2009 were more likely, to report experiences of victimization than Caribbean Christians.	Ethnic and religious variations in the reporting of racist victimization in Britain: 2000 and 2008/2009 Karlsen, S. & Nazroo, J. Aug 2014.

	However, the ethnic/religious patterning of perceptions of Britain as a 'racist society' were more consistent over time. This may suggest that, despite their increased exposure to victimization over the period, Muslim people in the United Kingdom have yet to experience the racialization characteristic of the treatment of Caribbean Christians, which requires a more prolonged exposure to racist negative attitudes. But this may be only a matter of time. The persistent expectation of poor treatment described by Caribbean Christians is testament to the difficulties of addressing these negative perceptions once racialized identities are embedded. Immediate action must be taken to prevent this occurring among other ethnic/religious minorities.	
Faith based hate crime	Police Scotland confirmed a significant spike in hate crime since last Friday's terrorist attacks in Paris, as Muslim community leaders warn of a "fierce backlash". Iain Livingstone, deputy chief constable, said there	http://www.theguardian.com/world/2015/nov/20/police-scotland-hate-crime-paris-attacks-muslim-community

	had been 64 reports of racially or religiously motivated crimes across Scotland, including online and offline abuse. There were 71 charges relating to Islamophobic hate crime in 2014-15, out of a total of 569 incidents of religiously aggravated offending in Scotland.	
	Existing literature supports this finding, that Muslims experience feelings of 'otherness' and difference resulting in part from incidents of religious and racial discrimination. The report found that a body of current literature has centred on examining the relationship between Muslim and non-Muslim communities; and in particular, whether arguments that Muslims choose to segregate from the rest of society are well founded. Typically it has been suggested that such arguments are often justified through reference to cultural explanations; placing responsibility with the Muslim communities themselves.	Experience of Muslims Living in Scotland Scottish Government Social Research 2011 http://www.gov.scot/resource/doc/344206/0114485.pdf

	Rather, a key finding of the literature is that Muslims face restricted choices and that it is necessary to understand the socio-economic circumstances of Muslim communities. Many of the research participants acknowledged that the friends they spend most time with or were closest to were people like themselves in ethnic and religious background. A picture emerged from the literature that Muslim communities, both within Scotland and across Britain, report experiencing incidences of religious discrimination and racial discrimination, supporting arguments of a 'double burden'. Findings from the focus groups highlighted that there is a perception that the prevalence of such discrimination has increased in response to global events. Awareness of the stereotyping of Muslims sometimes seemed to create a sense of the lurking possibility of racism.	
SEXUAL ORIENTATION		
Sexual orientation	Sexual minorities were two to three times more likely to report having a longstanding psychological or emotional problem than heterosexual	Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey

	counterparts. Sexual minorities were also more likely to report fair/poor health. Adjusted for socio demographic characteristics and health status, sexual minorities were about one and one-half times more likely than heterosexual people to report unfavorable experiences with each of four aspects of primary care. Little of the overall disparity reflected concentration of sexual minorities in low-performing practices. Sexual minorities suffer both poorer health and worse healthcare experiences. Efforts should be made to recognize the needs and improve the experiences of sexual minorities. Examining patient experience disparities by sexual orientation.	Elliott, M. N. Et al Journal of General Internal Medicine 2014 http://rd.springer.com/article/10.1007/s11606-014-2905-y/fulltext.html
	The report highlights NHS staff views on- • Bullying and discrimination In health and social care • Failure to support LGBT patients • Staff afraid to speak up • Unequipped to challenge prejudice • Support for LGBT equality	Unhealthy Attitudes: The treatment of LGBT people within health and social care services. Stonewall 2015

		Unhealthy Attitudes.pdf
Black and Minority Ethnic gay people	Key messages were- • Remember people belong to more than one identity • Improve staff training • Get your monitoring right • Don't let sexual orientation dominate the discussion • Signal that people can be open about their sexual orientation • Talk to black and minority ethnic lesbian gay and bisexual people • Provide practical support • Make openly gay black and minority ethnic people visible	Stonewall and Runnymede report explores Black gay people's experiences 13 August 2012 http://www.runnymedetrust.org/news/427/272/Stonewall-and-Runnymede-report-explores-Black-gay-people-s-experiences.html
Gay and Bi-sexual Men's Health	With 6,861 respondents from across Britain, this is the largest survey ever conducted of gay and bisexual men's health needs in the world. This report presents the Scottish findings which demonstrate that many people's needs are not being met and that there are areas of significant	Gay and Bisexual Men's Health Survey Scotland Stonewall, 2013, www.stonewall.org.uk/sites/default/files/Gay_and_Bisexual_Men_s_Health_Survey__2013_.pdf

	concern – most particularly in mental health and drug use - that have been overlooked by health services which too often focus solely on gay men's sexual health. More than a third (35 per cent) of gay and bisexual men drink alcohol on three or more days a week, similar to 36 per cent of men in general. More than two in five (44 per cent) gay and bisexual men have taken drugs in the last year compared to just 11 per cent of men in general.	
Lesbian's health	Nine in ten lesbian and bisexual women drink and 40 per cent drink three times a week compared to a quarter of women in general. Lesbian and bisexual women are five times more likely to have taken drugs. Over one in ten have taken cocaine, compared to three per cent of women in general.	Prescription for Change: Lesbian & Bisexual women's health check. Stonewall 2008. www.stonewall.org.uk/sites/default/files/Prescription_for_Change__2008_.pdf

GENDER REASSIGNMENT		
Transgender	Equality refers to ensuring that trans people are fully included and considered in general, with specific policies and health services being in place where their needs are different to others. This could include, for example, sending out a generic leaflet for all people who may be engaging in a fertility service (providing it does not make any assumptions about the gender identity or sexual orientation of those involved), with an additional leaflet about methods of preserving fertility for trans people prior to hormonal therapy, or information about preserving eggs/sperm on commencement of treatment.	Scottish Trans Health Conference – Report 2012 Scottish-Trans-Health-Conference-Report **See Appendix 1 for current NHSGGC Guidance on Recording the Transgender Status of Patients.**
Transgender and mental health	70% of the participants were more satisfied with their lives since transitioning and only 2% were less satisfied. Those that were less satisfied after transitioning cited poor surgical outcome, loss of family, friends and employment, everyday	Trans Mental Health Study 2012 transgender mental health study.pdf

	experiences of transphobia and non-trans-related reasons. For nearly 30% of respondents, a healthcare professional had refused to discuss a trans-related health concern. Within mental health services, 29% of the respondents felt that their gender identity was not validated as genuine, instead being perceived as a symptom of mental ill-health, within the inpatient unit due to being trans or having a trans history, including harassment, misgendering and uncertainty about placement within single sex facilities. 81% of the participants avoided certain situations due to fear. Of these, over 50% avoided public toilets and gyms, and 25% avoided clothing shops, other leisure facilities, clubs or social groups. 51% of the participants worried that they would have to avoid social situations or places in the future due to fear of being harassed, read as trans, or being outed.	

	Over 90% had been told that trans people were not normal, over 80% had experienced silent harassment. 50% had been sexually objectified or fetishised for being trans, 38% had experienced sexual harassment, 13% had been sexually assaulted and 6% had been raped for being trans. In terms of social changes that they had made in relation to being trans, only 53% had no regrets, 34% had minimal regrets, and 9% had significant regrets. In contrast, when discussing the physical changes which they had undergone in relation to being trans, 86% had no regrets, 10% had minor regrets and 2% had major regrets. The most common regrets – in terms of social, medical and in general - were: not having the body that they wanted from birth, not transitioning sooner/earlier, surgery complications (especially loss of sensitivity), choice of surgeon (if surgery resulted in complications or required revisions and repairs), and losing friends and family.	

SOCIO-ECONOMIC		
Welfare reform and low pay	Scottish government themed analysis of the impact of welfare including sanctions, gender impact and impact on disability. Although Scotland has protected some people from benefit cuts there is a high impact on lone parents, disabled people and young people from welfare reform. NHSGGC has raised over £20 million for patients through financial inclusion activity through projects such as Healthier Wealthier Children. Low pay also affecting many families living in poverty combined with rising food costs.	http://www.gov.scot/Topics/People/welfarereform/analysis. http://www.gcph.co.uk/work_themes/theme_3_poverty_disadvantage_and_the_economy/early_years/lone_parents http://www.gcph.co.uk/work_themes/theme_3_poverty_disadvantage_and_the_economy/healthier_wealthier_children http://www.gcph.co.uk/latest/blogs/458_the_rising_cost_of_food_not_just_money_but_mental_health_too The nature and extent of food poverty/insecurity in Scotland, Health Scotland http://www.healthscotland.com/documents/25717.aspx

Welfare reform and disability	Of the 190,000 existing DLA claimants in Scotland who will be reassessed for PIP, it is expected that around 105,000 working-age disabled people will lose some or all their disability benefits by 2018, with a loss of at least £1,120 per year. Greater risk of rent arrears for people with learning disabilities due to payment of the housing element of Universal Credit direct to tenants. Withdrawal of the support for disabled people who work at least 16 hours a week under Universal Credit that previously came from the 'disabled worker' element of Working Tax Credit. It may be more difficult for a disabled person to avoid the bedroom tax as they may need extra space to store equipment or to have a carer stay the night, or suitably adapted property may not be available.	Financial Impacts Of Welfare Reform On Disabled People In Scotland Scottish Government August 2014. http://www.gov.scot/Resource/0045/00457564.pdf
Tackling poverty	In general, prevention 'upstream', addressing the economic, social and environmental causes of health inequalities, is cost-effective. It is more likely	Best preventative investments for Scotland – what the evidence and experts say.

	to reduce health inequalities than either treatment of illness or 'downstream' measures to change behaviours delivered to individuals. Looking across the sources identified in this paper, we suggest the following priorities: 1. programmes that ensure adequate incomes and reduce income inequalities 2. programmes that reduce unemployment in vulnerable groups or areas 3. programmes that improve physical environments, such as traffic calming schemes 4. programmes that target vulnerable groups by investing in more intensive services and other forms of support for such groups, in the context of universal provision 5. early years programmes 6. policies that use regulation and price (for example, minimum unit price or taxes) to reduce risky behaviours.	Neil Craig, NHS Health Scotland December 2014 http://www.healthscotland.com/uploads/documents/24575Best%20Preventative%20Investments%20For%20Scotland%20%20What%20The%20Evidence%20And%20Experts%20Say%20Dec%202014.pdf
Women, poverty and mental health	A major survey of more than 20,000 people in the UK has found that women living in poor areas are almost twice as likely to develop clinical anxiety as	The anxiety puzzle: why are women in deprived areas more likely to suffer? Sept 2015

	women in richer areas. However living in poorer or richer areas made no difference to the levels of generalised anxiety disorder experienced by men. Generalised anxiety disorder (GAD) is one of the most common mental health conditions in modern society. It is debilitating, and associated with a high use of health services. If untreated, it can lead to the development of major depression and substance abuse.	Olivia Remes http://theconversation.com/the-anxiety-puzzle-why-are-women-in-deprived-areas-more-likely-to-suffer-46966
Child poverty	Cost of the school day recommended minimising costs and reducing pressure on family budgets • Providing financial support like free meals, clothing grants and Education Maintenance Allowances.[2] Children say that schools should make sure that everybody entitled is getting this support • Ensuring that anything with a cost is as affordable as possible (e.g. uniform, trips) and supporting children and parents to afford it (e.g. flexible instalments for trips, signposting to	Cost of the School Day Child Poverty Action Group in Scotland Sara Spencer 2015 www.cpag.org.uk/costoftheschoolday http://www.cpag.org.uk/sites/default/files/CPAG-Scot-Cost-Of-School-Day-Summary%28Oct15%29_1.pdf

	cheapest uniform supplier) • Covering costs, subsidising and providing sibling discounts where possible • Fundraising which doesn't always ask families to contribute (e.g. supermarket bag-packing) and not asking children for money • Letting parents know what help is available and what support there is to access it • Looking at the school year with affordability in mind – spacing events and activities out so that lots of costs don't come all at once. • Ensuring equal access to opportunities, regardless of income • Understanding the resources pupils have at home, modifying expectations and tasks and providing support to access resources, especially ICT • Ensuring consistency of rules, expectations and practice around resources between staff • Lending resources like stationery, uniform and equipment for clubs without comment or trouble and having them there for everyone so that nobody stands out • Providing opportunities (e.g. clubs, supported	

	study) at different times of the day to ensure that more people can take part and that transport isn't an issue • Reducing and challenging stigma • Putting systems in place to ensure that children and young people don't have to feel embarrassed asking for help or subsidies • Making sure that reward and merit systems are not affected by issues which could be related to finances at home • Having clear anti bullying policies and practices which are alert to income based bullying and stigma. • Children and young people also recommend that they be taught more about poverty to remove stigma and shame. They think that staff should understand poverty and know that they can't be sure about everybody's situation; staff should listen, not shout in public and ensure that there are confidential ways to disclose financial problems.	

Appendix 1. NHSGGC Guidance on Recording the Transgender Status of Patients

Introduction

NHSGGC is committed to ensuring Transgender people are not discriminated against in or services and receive appropriate treatment. NHSGGC has one of the most comprehensive transitioning services in Scotland. However, Transgender people use many NHS services where they should be treated according to their stated gender identity e.g. male or female. This briefing outlines the law in relation to recording transgender identity in patient records, confidential monitoring and research.

Why shouldn't I record Transgender status on electronic patient records?

The challenge of capturing transgender service user data is complex and brings into play the legal protection afforded to transgender people through the Equality Act 2010, the Gender Recognition Act 2004 and the Human Rights Act 1998. Identifying transgender patients by means of labelling patient records could lead to the disclosure of their birth gender to third parties without the express permission of the patient and places NHSGGC at risk of breach of one or all of the aforementioned legislation. Disclosure can lead to criminal prosecution. In addition to this, it is questionable what additional value there would be in identifying transgender patients in relation to improving their care with the risk this may lead to assumptions and pre-engagement stereotyping. NHSGGC sought guidance from the Scottish Transgender Alliance in reaching this position.

Why should I include Transgender status in anonymous equalities monitoring and research?

NHSGGC follows national NHS guidance on equalities monitoring (Happy to Ask Happy to Tell). This includes use of a standard equalities monitoring form (see here), which includes Transgender status. This equalities form is used anonymously and thus offers the protections required, as described above in relation to Transgender status. It is good practice to use the equalities monitoring form in:

- Audits to assess who is not accessing your service and contracted services
- Public engagement events
- Research

This information can then be used to improve the experience of Transgender people in our services.