Redesign of Urgent Care

Equality Impact Assessment

Scottish Government
Riaghaltas na h-Alba
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May 2021
Equality Impact Assessment Record

Title of policy/ practice/ strategy/ legislation	Redesign of Urgent Care
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Directorate: Division: Team	Performance & Delivery; Unscheduled Care
Is this new policy or revision to an existing policy?	Revision of existing policy

National Equality Impact Assessment

Screening

Policy Vision and Aim

The Scottish Government is undertaking a system redesign of urgent care.

The aim of the Redesign of Urgent Care is to provide an accessible, efficient, effective and safe urgent care service for the public ensuring patients receive the right care, in the right place, at the right time, first time.

Objectives

1. Introduce a new clinical pathways that will see patients spending less time waiting to be seen.
2. Provide alternative, accessible and innovative solutions to A&E for urgent care needs using technology, including a Telephone and Digital First approach via NHS 24 on 111. (Access to emergency care will not change in emergency situations.)
3. Deliver a safe and robust process for scheduling attendances to our A&E and Acute Assessment Units reflecting the multiple ways that these systems can be accessed and ensuring that attendance is accessible to everyone across multiple entry points.
4. Provide equitable access by delivering effective, accessible and inclusive communication and public messaging to improve access to urgent care services with a particular focus on seldom heard groups.

Background and Context

The Scottish Government launched the Redesign of Urgent Care in December to ensure patient safety during the winter period while the NHS continued to respond to the pandemic. Further work continues to refine and enhance the new urgent care pathways to ensure equitable access and optimal patient experience.

The need for new ways of delivering services during COVID-19 has demonstrated what can be achieved to keep people safe and improve access to healthcare. The new pathway builds on the lessons learned from the COVID-19 outbreak to date. It is fundamental that, as far as we can, we deliver a service that meets the needs of everyone; particularly those most in need.

Prior to COVID-19, there was an over-reliance on Emergency and Urgent Care in Scotland, as evidenced by a rapid increase in the number of people attending A&E. This suggests more people were self-presenting at emergency departments when more appropriate care could/should have been provided by another service i.e. Pharmacy, GP, 111 etc.

Data published from Public Health Scotland shows this was underlined during the early phase of the pandemic when attendance levels dropped significantly during late March to less than 50% of normal levels[1] and the public sought alternative care through www.NHSinform.scot, as demonstrated by a sharp rise in traffic to the NHS Inform website during that period. This confirmed what we had expected for many years – that many people attending A&E could receive right care via digital channels without exposing themselves unnecessarily to a hospital setting.

The Redesign of Urgent Care (RUC) programme promotes a significant change in how we best serve the people of Scotland to provide safe and effective urgent and emergency care, on a 24/7 basis. Offering a number of significant benefits to modernising our wider unscheduled care pathways to ensure the public access the right urgent care, in the right place, at the right time, on a 24/7 basis.

Introduction

Based on the available evidence to date this document represents the first National EQIA for the Redesign of Urgent Care. It assesses some potential impacts for each of the protected characteristics, socioeconomic factors, and remote and rural settings. National and localised mitigation strategies to address any barriers to accessing the new programme are considered. This will be reviewed later this year, but several mitigating actions have already been highlighted. The EQIA has been prepared on behalf of the Scottish Government under the leadership of Helen Maitland, National Director for Unscheduled Care and Carol Goodman, Programme Director for the Redesign Urgent Care Programme.

In developing this policy the Scottish Government is mindful of the three needs of the Public Sector Equality Duty (PSED):

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between people who share a protected characteristic and those who do not;
- foster good relations between people who share a protected characteristic and those who do not.

1 COVID-19 wider impacts (shinyapps.io)

The Scottish Government recognises that while the measures may positively impact on one or more of the protected characteristics. The introduction of the measures may have a disproportionate negative impact on one or more of the protected characteristic groups.

Where any negative impacts have been identified, we have sought to mitigate/eliminate these. We are also mindful that the equality duty is not just about negating or mitigating negative impacts. We also have a positive duty to promote equality. We will seek to do this through accessible information support and guidance, inclusive communication and language. We will seek to do this through the provision of guidance and support in relation to accessible information and communications.

Who will it affect?

The Redesign of Urgent Care applies across the Scottish population and does not specifically target groups or sections of society. However, we know that particular socio-demographic groups are more likely to need urgent care and will have different needs and experiences. This assessment explores how impacts from the programme will be experienced differentially in relation to the protected social-economic characteristics.

Key changes relating to access to urgent care: instead of direct access to A&E departments for non-life threatening conditions help will be firstly available through NHS 24 (via dialling 111) who will assess and advise on next steps. NHS 24 will be available 24/7 for urgent care needs and where conditions cannot wait to be seen at the GP practice. If, following this initial assessment, the patient is deemed to require an A&E attendance they will either be directed to A&E or receive a virtual consultation with a senior clinician. This will involve technology, a telephone or video call in the first instance.

Following this consultation, if the citizen should attend A&E they may arrange for them to arrive at a certain time, to provide a safer patient experience. If the assessment shows that the citizen does not need A&E they will help them get the care they need as quickly, safely, and as close to home as possible. This could include self-care and support, and direction to a local pharmacy, who can prescribe treatments and offer advice to book an appointment with a local GP Practice.

The policy will have an impact on everyone coming into contact with urgent care services. This will include:

- people who may have one or more of the protected characteristics – everyone is a potential user of urgent care;
- the workforce, who again may have one or more of the protected characteristics – who will be expected to deliver this new model of care;
- specific groups of people, including, but not limited to, disabled people, older people etc. who are more likely to contact urgent care services. For example, previous analysis of historical data published by Public Health Scotland shows population rates of contacts with unscheduled care services on the whole are higher for those from specific age groups (aged under 5, and those aged 80 and over), females, and those from more deprived areas.

The changes aim to result in less people waiting in Emergency Departments thereby minimising the risk of infection, providing better patient outcomes and care closer to home.

What might prevent the desired outcomes being achieved?

- People do not know about or understand the new system. It is imperative that we ensure good and effective public communications and messaging on the new systems encompassing of all groups in a range of languages and formats i.e. Easy Read and in different languages including Braille & Moon and British Sign Language (BSL and tactile BSL). Channels for communication must be considered too, to ensure they reach as many people as possible across different communities. The framing of the message must also be adequate to ensure people are not deterred from accessing care.
- The resources and workforce are not in place to deliver the right care, in the right place, at the right time to meet everyone's needs. It will be vital that we have adequate staffing levels at each stage of the urgent care journey and staff have the correct skills, knowledge and competencies to meet people's needs. We also need a workforce that has the ability to support people with communication or language barriers.
- Digital exclusion of certain groups in the community. This is based on lack of connectivity, limited IT literacy, lack of device, income (including phone and data costs) associated with mobile data.
- Unconscious bias in dealing with citizens accessing urgent care services, leading to care needs being unrecognised and / or unfulfilled.
- Citizens or particular groups of citizens lacking confidence in their care needs being adequately identified and met through the digital or telephony first approach.

To ensure the successful delivery of the Redesign Urgent Care programme, the Scottish Government is working with citizens and key stakeholders as equal partners, to consult, engage and co-design the new urgent care service and ensure there is buy-in from the public, clinicians and other stakeholders.

Specifically, the EQIA assesses any impacts of applying a proposed new or revised policy or practice against the needs relevant to a public authority's duty to meet the public sector equality duty.

The needs are to:

- eliminate discrimination, harassment and victimisation;
- advance equality of opportunity; and
- foster good relations.

In developing this policy we are consulting with a range of external stakeholders in Scotland. However, this EQIA has also sought to use existing and emerging information and evidence and analysis, as part and parcel of the decision making process.

Engagement and evidence gathering

In developing this EQIA, a range of engagement and evidence gathering approaches have taken place to further understand the potential benefits and barriers of the new pathway. An eight-week discovery project was undertaken by the Scottish Government Digital Transformation team. Additionally a scoping exercise has been carried out to further understand existing demand on these services.

This EQIA will be revised throughout this year as we continue to engage and consult with the public and evaluate the impact of the new system on different groups, monitoring the changes as they embed. A number of data gaps have been identified through this process and work is underway with the Scottish Government, Public Health Scotland and Healthcare Improvement Scotland to allow improvement.

Stage 1: Framing

Extent/Level of EQIA required

The outbreak of COVID-19 in early March and subsequent risk of hospital-associated infection accelerated the requirement to redesign our urgent care services – work which was already in development prior to the pandemic – in time for the winter period when A&E departments are often busy and overcrowded. As work now begins to further develop and refine these pathways it was timely and essential to produce the national EQIA. Local EQIAs are already in place and we will work with Boards to ensure these are further developed and informed by the national EQIA.

Understanding the patient experience is fundamental to the redesign of urgent care. A key principle of this work is to ensure we do not further health inequalities. To support this ambition we need to we need to:

- understand the needs of all citizens and key stakeholders;
- explore the impact of the Redesign of Urgent Care on all parts of the system; and
- identify if patients are receiving right care first time.

Following the identification of the protected characteristics relevant to the policy, a broad evidence base was collated to allow the Scottish Government to properly assess the strategy's impact on each relevant characteristic. This evidence base included a number of national statistics gathered by the Scottish Government or other national bodies and various other relevant studies, reports and surveys that are referenced throughout this report.

Results of the framing exercise

An initial scoping exercise was carried out using Management Information from Public Health Scotland covering Emergency Department (ED) attendances (including specific data on self-referrals), contacts with the NHS 24 on 111 service, contacts with Primary Care Out of Hours services and Scottish Ambulance Service (SAS) attended incidents broken down by sex, age and Scottish Index of Multiple Deprivation (SIMD). Demand of these services by age and sex varies by service, while those from the most deprived SIMD areas use a higher service.

- The NHS 24 on 111 service is used more by women (57%; January to July 2020), particularly among younger working age adults (aged 15-34) where women make up over 60% of contacts and contact rates per population are also substantially higher among women for this age group.
- Women are more likely to have childcare responsibilities and be parents to children under 5, therefore are more likely to access urgent care.
- Annually over half of all contacts with NHS 24 on 111 are 15-64, and over a fifth are aged 14 and under. Over three quarters of younger age groups (5-9, 10-14) were self-referrals to emergency departments.
- Volume of demand at Emergency Departments is broadly similar among men and women (51% male; January – July 2020), though men tend to attend (and also self-present) at a slightly higher rate than women across most age groups.
- Older age groups attending Emergency Departments are also much less likely to self-present: a quarter of Emergency Department attendances aged 85+ were self-referrals. Older age groups (aged 60+) represent a larger proportion of Scottish Ambulance Service attendances compared to other services such as NHS 24 on 111.
- Urgent care services are more likely to be used by people from more deprived areas: around twice as many more (self-presenters) attending Emergency Departments and contacts with NHS 24/111 are from the 20% most deprived areas than the 20% least deprived areas.
- It was identified that there were some data gaps particularly around disability and race.

To understand the impact on users/ potential users an analysis of existing evidence was undertaken. Key issues identified suggested that any protected characteristic groups identified as being more likely to experience socio-economic deprivation will also be more likely to access urgent care services.

Groups of people noted as being more likely to experience poverty include:

- minority ethnic people (including Gypsy/Travellers, migrants, refugees and asylum seekers);
- people who are Muslim;
- a person with disabilities

- care-experienced young people;
- people experiencing homelessness; and
- people living in the most deprived areas of Scotland according to the Scottish Index of Multiple Deprivation.

The NHS National Services Scotland 'Who Attends Emergency Departments' report notes that people living in the most deprived areas accounted for twice as many attendances to emergency departments compared to those living in the least deprived areas. The was linked to a number of potential reasons, including poorer health, more complex social needs and service provision in areas experiencing higher deprivation. It was also noted that people with children under 5 and people aged over 65 were also more likely to access urgent care.

Further issues identified were:

- the lack of digital enablement may be a barrier for some people experiencing socio-economic disadvantage;
- a lack of access to transport, particularly in remote and rural areas, or during the out of hours period, might be an issue for people experiencing socio-economic disadvantage, if they are directed to attend a healthcare setting that is outside their local area;
- it was noted that the new model could have a positive impact in relation to travel and transport, as more people will avoid A&E attendance due to advice virtually and may be directed to care at a hospital which suits them or at a time where they can organise transport;
- minority ethnic and disabled people were identified as groups more likely to experience socio-economic disadvantage;
- those whose first language is not English may experience greater barriers with the introduction of a telephone triage system and the move to more appointments being offered using digital technology; and
- therefore communication of the changes to urgent care should be targeted at the groups identified as being more likely to experience socio-economic disadvantage.

‘Discovery Project’: user research

In developing this EQIA, an eight-week discovery project was undertaken by the Scottish Government Digital Transformation team to better understand the needs, motivations and potential issues that self-presenting citizens accessing urgent and emergency care may encounter, with a specific focus on the impact that the change in service will have on vulnerable citizens.

The project team targeted three user groups they deemed most likely to be disadvantaged by the change of service; those whose first language was not English, those experiencing homelessness, and those with anxiety and depression. The reasons for this are set out below.

As outlined above research shows urgent care services are more likely to be used by people from more deprived areas. Among homeless individuals there exists a higher level of depression and suicide than in the general population. The conditions many homeless people are exposed to can have a negative impact upon their mental health and this is a common reason for attending A&E. Previous primary research has also found that, as a result of the coronavirus pandemic, BAME individuals (a higher proportion of whom do not speak English as their first language, compared to the general population) are more likely to develop anxiety and depression as a direct result of lockdown. It has also been noted that a disproportionate number of individuals experiencing homelessness – when compared to the general population – are refugees (a demographic group that is less likely to speak English as their first language).[2][3][4]

Overall the report finds that those who encounter little or no difficulty interacting with the redesigned urgent care pathway can expect to experience many benefits from the changes including:

- avoiding the cost of transport;
- accessing medical consultation from the comfort of home;
- scheduling visits to the hospital around care responsibilities;
- access to local specific information hubs;
- avoiding or minimising the discomfort of attending A&E;
- avoiding unnecessary travel;
- source of reassurance;

2 Health and homelessness briefing http://www.healthscotland.scot/media/1251/health-and-homelessness_nov2016_english.pdf

3 Hard Edges Scotland https://lankellychase.org.uk/resources/publications/hard-edges-scotland-summary-report/

4 Hwang, S.W., 2001. Homelessness and health. Cmaj, 164(2), pp.229-233

- minimising risk of infection; and
- minimising crowding in waiting areas.

However, by improving access to urgent care for some, without providing additional measures for those who already experience barriers to technology-enabled care, we risk widening health inequalities. A number of potential mitigations were identified which focus on improving access to digital; improving telephone services for those with language barriers; ensuring call handlers have appropriate training to ensure appropriate and equitable care; targeting national messaging at disadvantaged groups; ensuring collaborative working with partner agencies.

A strong theme was concern that moving to a system where video consultation is the default would be detrimental to certain protected characteristic groups. It is therefore important to reinforce that the continued use of Face to Face appointments is important. A further mitigation of this potential inequality could be to ensure that there are options of local places outside the home where people can have access, support, and privacy to have their appointments.

Workforce

The impact of specific staff groups was considered particularly in cognisance of the increased focus on staff wellbeing in national and local policy, the very size of the workforce, and what we know about the links between staff experience and positive patient outcomes. It was recognised that there may be many potential benefits for staff including reduced crowding and attendance to A&E departments leading to improved staff experience and the opportunity to potentially work from home.

After reviewing the policy and the initial evidence gathering, no significant potential negative impacts have been identified for the workforce. This will be further explored in future consultation.

Overview high level summary analysis

Feedback from public engagement highlighted potential benefits and barriers across the characteristics. This was also the case within each protected characteristic reflecting their heterogeneity.

A strong theme was concern that moving to a system where video consultation is the default would be detrimental to certain protected characteristic groups particularly older age groups. Connected to this was a worry that for various groups, including women and the LGBT community who are in difficult domestic situations, where families may not be aware of a particular health issue they want to discuss, that it would not be appropriate to have a consultation from home. Domestic abuse is another related consideration, particularly since we know a higher proportion of women are accessing urgent care. Women or others in abusive situations may not feel/be safe to seek or receive medical advice within the home environment. The Near Me Public Engagement report[5] highlights this risk in their findings, citing that one of the main barriers identified was lack of private space for video calls.

5 Public and clinician views on video consulting: Near Me Public Engagement Report September 2020 https://tec.scot/wp-content/uploads/2020/09/Near-Me-public-engagement-Full-Report.pdf

It is important to note that for some, often those with mental health issues, it was important to see a healthcare professional face to face; it has also been established that not all people can confidently take part in a virtual consultation. Consideration needs to be made for people who are unable or prefer not to access digital technology, who lack the necessary digital skills and/or who may require support from paid/unpaid carers to take part in a virtual appointment; mechanisms need to be put in place which appropriately identify and support these individuals.

A number of barriers were linked to age, particularly linked to digital access with those in older age groups less likely to engage digitally. It is also important to consider that older age groups are more likely to attend an emergency department and are more likely to be admitted to hospital following their attendance. As such the necessary mitigations must be put in place to ensure the change of service is not detrimental to this age group.

It was noted that those with a disability are more likely to require urgent care. Pertinent to this is a concern that those experiencing a disability are more likely to be digitally excluded and as such may feel disenfranchised by the change in service. It has also been acknowledge that disabled people whose condition(s) impact their verbal communication could be deterred from accessing urgent care further to the introduction of the requirement to call NHS 24.

Sociocultural and linguistic barriers was noted also noted as a key theme. It was noted that many ethnic minorities seek medical advice within their own communities before approaching NHS services often resulting in their first experience of NHS services being in A&E. It is also important to acknowledge the lack of awareness in these communities of services such as NHS 24 and NHS Inform. An important mitigation strategy will be to ensure communication plans consider many channels for communication to ensure they reach as many people as possible across different communities. Of equal importance is ensuring appropriate measures are built into the new system to meet the needs of those for whom English is not a first language.

As outlined above research shows urgent care services are more likely to be used by people from more deprived areas. Potential mitigation strategies include ensuring that the NHS is free at point of access for all and that those who cannot afford data costs or do not have access to WIFI. It was also suggested that providing temporary accommodation facilities with training and resources would support access to NHS remote consultations, to provide targeted support to people with significant emotional and practical barriers to accessing care.

In the next section, Stage 2, the detail behind the analysis of the evidence is summarised. The supporting evidence gathered is summarised in Appendix 1.

Stage 2: Table setting out data gaps, actions taken and possible mitigation, by each characteristic

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
AGE	Urgent Care Use The NHS NSS 'Who Attends Emergency Departments' report highlights that very young (0 to 4) and older people (65+) are more likely to attend an emergency department and more likely to be admitted to hospital following their attendance. Digital Age is the leading characteristic of low digital engagement, with digital engagement decreasing as age rises. Those over 70 are particularly less likely to engage digitally. Older people are less likely to have internet access, and even if they do they are less likely to use it. Over a third (36%) of households where all adults are over 65 do not have home internet access. This rises to three fifths (60%) of households where all adults are over 80. Two-thirds (65%) of adults aged 60+ used the internet in 2018 – compared to under one-third (29%) in 2007.	NHS NSS (2015) Understanding Emergency Care in Scotland. Who Attends Emergency Departments. Lloyds Bank 2020 ONS 2019 Scottish household survey 2019: key findings - gov.scot (www.gov.scot)	Working with Public Health Scotland we will undertake a population needs assessment to further identify the needs of the population and the ongoing improvement data required for monitoring purposes. Working with third sector organisations and Healthcare Improvement Scotland (HIS) Community Engagement we will co-produce the change needed to deliver urgent care which meets the needs of the Scottish population using local HIS engagement offices within Boards to undertake gathering views exercises, HIS citizen panel and jury. Potential mitigation strategies identified include: • Improving access to basic mobile telephones with specific instructions on how to access NHS 24. • Exceptions to current visiting guidelines when appropriate.

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
	Moreover, older Asian people are significantly less likely to have used the internet than white people belonging to the same age groups, suggesting that there may be particular digital barriers to the engagement of some older minority ethnic groups. While almost all young people use the internet, there are still many who lack good digital skills or access to resources such as home computing and broadband. Evidence relating to care-experienced young people has highlighted the inequalities they can experience when accessing health services. They are also a group of people more likely to experience socio-economic disadvantage. Ensuring that efforts are made to engage with this group of people to convey information around the changes is essential.		• By partnership working with local libraries to provide private space for remote consultations, this may increase access to video enabled care for those without access to video devices. Noted that further mitigation will need agreed to ensure 24 /7 access. Further mitigation strategies will be developed after the feedbackfrom public and professional engagement has been fully explored, particularly for those digitally excluded. Monitoring Impacts Data on the age of those using urgent care (attending A&E, contacting NHS 24 and contacting out of hours) are published by Public Health Scotland. Additional data or research may be needed over time to understand impacts.

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
DISABILITY	Urgent Care Use Some people with a disability have conditions which make them more prone to needing urgent care and more likely to present to A&E. Moreover, some disabled people may be experiencing gaps in social care provision as a result of Covid-19 and responses to the pandemic (e.g. this could mean they are in less regular contact with social care staff/a PA and may be more inclined to contact emergency services. Reduced availability of some therapies and treatment may mean people feel they can cope less well with existing conditions. They may then be more likely to request emergency care. Digital Disabled people are also more likely to live with socio-economic deprivation. Disabled people are more likely to be digitally excluded. For example, in 2018, 27% of adults in Scotland with a long-term physical or mental health condition reported not using the internet, compared with 8% of adults who do not have any such condition.	Scottish Government (2019) Scottish Household Survey 2018 Poverty and Inequality Commission THE HEALTH OF DEAF PEOPLE IN THE UK .pages (bridgewater.nhs.uk)	Actions: as above Potential mitigation strategies identified include: • Providing call handlers, clinicians, and reception staff with any information related to the practical and emotional needs of the user, may reduce the user's anxiety and fatigue by repeatedly reassuring them at every step that they have been listened to and their needs are being addressed. • Improving NHS 24 automated messaging menu to meet the needs of those for whom English is not a first language, while improving awareness of these improvements among affected communities, may minimise difficulty and frustration people have when accessing interpretation support when in need of urgent care. • Improving access to basic mobile telephones with specific instructions on how to access NHS 24 for issues most commonly experienced by people who experiencing homelessness.

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
	Clear communication and access options at every stage will be important for people who rely on information in, for example, Easy Read, BSL, Braille, audio/visual formats. A range of access points for information will also be important for people who are more likely to be digitally excluded and/or without regular access to media. Separate accessible info/ communication and language barriers. Disabled people whose conditions impact their verbal communication could be deterred from accessing urgent care further to the introduction of the requirement to call NHS 24. For example, a person with a stammer may be deterred from calling because of their anxiety around having telephone conversations. When promoting changes to the urgent care model and the new NHS 24 pathway, consideration should always be given to the provision of information in accessible formats, such as Easy Read, large print, colour contrasted backgrounds or audio. The need to make information accessible to British Sign Language Users and others with language barriers should also be met.		• Exploring how NHS practitioners and third sector organisations might collaboratively provide clinical, practical and emotional support in community spaces trusted by vulnerable people, may enable greater access to preventative treatments and avoid later trips to A&E. • Providing a simple, clear, and dignified exemption process to allow supporters to attend A&E appointments similar to that for mask exemptions, may reduce user anxiety, enable better clinical outcomes, and reduce health inequalities through access. • Increasing awareness among clinicians and patients of functionality to enable multi-person conversations via Near Me, may improve access to additional emotional and practical support for those who need it most. • Introducing a feature whereby communication and language support needs are highlighted on the call handling system, so that NHS 24 staff are immediately aware of a caller's specific needs.

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
	Interactive voice recorded menus could be a barrier to some disabled people. People with hearing impairments may struggle to hear the options or people with cognitive impairments may find long questions, or multiple response options, difficult to remember. In 2019, NHS 24 staff undertook a number of engagement activities (Art of the Possible) with disabled people who can experience barriers to communication. This engagement highlighted a number of things for NHS 24 to consider when delivering telephone-based services. They include: • Complex language and jargon can make it difficult for people who can experience barriers to communication to interact with services. It was noted that not everyone has the confidence to ask questions when they are given information they don't understand.		Mitigation already in place includes: • The communication plan for the policy has been drafted to now ensure that public messaging is delivered in a variety of languages including BSL and Easy Read format. Monitoring Impacts There are no specific plans to routinely monitor the disability status of those using urgent care. Additional data or research may be needed over time to understand impacts.

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
	• Staff should have an awareness and understanding of communication and language differences, and how this negatively impacts the accessibility of phone-based services. For example, background noise in a contact centre environment can make it difficult for someone with a hearing loss impairment to communicate effectively, and they may need more time. It can also be a distraction for those with attention difficulties too. • There was a general lack of awareness of healthcare services and knowledge of how to access them. • Involving range of users in the development of services, and planning access and for reasonable adjustments at the start of a project. *BSL (Scotland) Act 2015: promote and support the language, culture & identity of British Sign Language users.*		

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
	Augmentative and Alternative Communication (AAC) Duty In 2016, the Scottish Parliament passed legislation which entitles people with severe communication difficulties to be provided with communication equipment and support. Referred to as Augmentative and Alternative Communication (AAC), this equipment includes communication aids and accessories, as well as other non-electronic aids such as symbol communication books. The duty to fulfil the legislation lies with NHS Boards and Integration Joint Boards throughout Scotland. People who require AAC equipment may contact healthcare services, but it is more likely that a carer, a relative or a friend will call on their behalf, which means for those without a 24-hour care presence, it can be difficult to make the call when they might need it. It could be difficult for healthcare providers to meet the needs of people who use AAC equipment. However, an approach proposed to address this is to create a national communication hub similar to the service provided by Contact-SCOTLAND-BSL.		

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
	One UK study recorded that BSL/ English interpreters were present at just 17% of GP and 7% of A&E consultations. Another study found that over three-quarters of Deaf patients had difficulty communicating with hospital staff.		
SEX	Urgent Care Use Children and parents/care-givers are noted as more frequent attenders at A&E. Around 60% of unpaid carers are women. People who provide unpaid care for someone because of a long-term physical condition, mental ill-health or disability, or problems related to old age. Women do more unpaid caring than men in most age groups. 90% of single parents are women, with 45% of single parents living in poverty. Just over half (51%) of Scotland's population are women.	Poverty and Inequality Commission Scottish Health Survey 2017 Scottish Health Survey 2018 Mid-Year Population Estimates Scotland, Mid-2019 Domestic Abuse: statistics 2018-19	Actions: as above Understanding the impact on women, particularly those who are the primary care-givers for children or who are experiencing domestic abuse. Gaps in data relate to why people access urgent care and how the genders may be disadvantaged or advantaged by the change. Potential mitigation strategies may include: • Providing access to text based communication methods for initial urgent inquiries via 111, may improve access to urgent care for people who are vulnerable to the surveillance or judgement of people they live with, improving safety and the ability to provide essential, confidential information.

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
	There are a higher ratio of women to men in older age groups, reflecting women's longer life expectancy. Therefore it is possible that women may need to access unscheduled care more frequently. Women are disproportionately more likely to experience domestic abuse. In 82% of all incidents of domestic abuse recorded by the Police in 2018-19 the victim was a woman and the accused was a man (where gender information was recorded). Digital This could make a preliminary conversation/digital engagement with services more risky if it takes place in the home. However, further research would be beneficial here. Women are more likely to be the victim of controlling behaviours/ coercive control and this could impact on their access to healthcare or access to healthcare for their families.		• By working with community based charities to provide access to space for private conversation, may reduce user anxiety, enable better clinical outcomes, and reduce health inequalities through access. Monitoring Impacts Data on the sex of those using urgent care are published by Public Health Scotland. Additional data or research may be needed over time to understand impacts.

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
PREGNANCY AND MATERNITY	Urgent Care Use Complications or health conditions associated in pregnancy may create a need for urgent care. People who are pregnant or who have recently had a baby are often offered a direct contact number for their labour unit ward so that they can speak directly to a midwife. Ensure clear messaging on the best route for urgent care is provided for people who are pregnant/recently had a baby.		Actions: as above
GENDER REASSIGNMENT	Urgent Care Use Past experience of discrimination or poor treatment can mean that LGBT people are less likely to access some key health services, like GP services and screening programmes, but are more likely to use A&E and minor injuries clinics. Digital Some trans people may experience mis-gendering over the phone depending on a number of factors. It may be that their CHI details do not recognise the gender they identify as or call handlers could mistakenly assume someone's gender based on the sound of their voice.	LGBT populations and mental health inequality – 2018 report Stonewall's LGBT in Britain Health Report - 2018	Actions: as above To understand fully what would make a new urgent care system accessible to LGBT people. Gaps in data in relation to why people access urgent care and how the gender reassignment may be disadvantaged or advantaged by the change. Monitoring Impacts There are no specific plans to routinely monitor the gender reassignment status of those using urgent care.

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
SEXUAL ORIENTATION	Urgent Care Use Past experience of discrimination or poor treatment can mean that LGBT community are less likely to access some key health services, like GP services and screening programmes, but are more likely to use A&E and minor injuries clinics. Though there is evidence to suggest that LGBT people can experience poorer health outcomes than non-LGBT people, it is unclear if the redesign of urgent care would present any new issues/barriers.	LGBT populations and mental health inequality – 2018 report Stonewall's LGBT in Britain Health Report - 2018	Actions: as above To understand fully what would make a new urgent care system accessible to LGBT community. Gaps in data relate to why people access urgent care and how people's sexual orientation may be disadvantaged or advantaged by the change. Potential mitigation strategies include: • Augmenting the national campaign with specific messaging for communities vulnerable to health inequalities with people from those communities, delivered by people trusted by the communities, may reach people who may not engage with national communication campaigns and increase the numbers of people from these communities seeking urgent care support and mitigate the spread of inaccurate information about the service. Monitoring Impacts There are no specific plans to routinely monitor the sexual orientation of those using urgent care. Data or research may be needed in future to understand impacts.

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
RACE	Urgent Care Use 35% of Minority Ethnic people are in poverty compared to 18% of White British people. A significant number of people speak English as a second language and this is more common among minority ethnic communities. Access issues such as the availability of interpreters, literacy issues and perception around short appointment times can impact early engagement with health services. For Gypsy Traveller communities, issues to consider include difficulties with GP registration, anticipated discrimination or poor treatment, digital exclusion, lower levels of literacy and the need for a tailored approach to communicating within communities, who may not be engaged with mainstream messaging or who may have concerns about a digital first approach. It is known that Gypsy travellers have poorer health than the general population.	Poverty and Inequality Commission Population level data See Scottish surveys Core Questions for detailed results by ethnicity for a number of questions: "White: Other British", "White: Other" and "All other ethnic groups" reported higher good/ very good general health than the "White: Scottish" reference group. Since 2012, levels of good/ very good general health have increased by 3.0 percentage points for the "White: Other British" group. The Scottish Government (2015) 'Which ethnic groups have the poorest health?' report, based on analysis of 2011 Census data. Key findings:	Actions: as above To understand fully what would make a new urgent care system accessible to people who are black, Asian or from a minority ethnic community. Gaps in data relate to why people access urgent care and how race may be disadvantaged or advantaged by the change. Potential mitigation strategies may include: • Improving NHS 24 automated messaging menu to meet the needs of those for whom English is not a first language, while improving awareness of these improvements among affected communities may minimise difficulty and frustration people have when accessing interpretation support when in need of urgent care. • Providing call handlers, clinicians, and reception staff with any information related to the practical and emotional needs of the user, may reduce the user's anxiety and fatigue by repeatedly reassuring them at every step that they have been listened to and their needs are being addressed.

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
	In 2017, it was reported by NHS Health Scotland that Gypsy/ Travellers had low rates of outpatient appointments, hospital admissions, A&E attendances, cancer registrations and maternity hospital admissions. It was suggested that this may be due to the under-recording of Gypsy/Travellers compared with the proportions reported in the census, and issues with accessing services. Engagement with Gypsy/Travellers, undertaken in 2015 and 2016 by NHS 24, highlighted that Gypsy/Travellers can often use urgent care services as their primary healthcare access point due to barriers relating to registering with GP services. The EHRC's 'Is Scotland Fairer? 2018' report noted migrants were generally found to be low-level users of health services, possibly due to a lack of knowledge around how the healthcare system works in Scotland. Changes to the urgent care model may increase confusion for this group of people who are already reported to have a lack of understanding of the Scottish health system.	• 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';	• Augmenting the national campaign with specific messaging for communities vulnerable to health inequalities with people from those communities, delivered by people trusted by the communities, may reach people who may not engage with national communication campaigns and increase the numbers of people from these communities seeking urgent care support and mitigate the spread of inaccurate information about the service. Mitigation strategies already in place include: • The communication plan for the policy has been drafted to now ensure that public messaging is delivered in different languages, Easy Read and BSL language format. Messages will be delivered in a range of mediums including radio, film and written and will include delivering messages in ways which meet key characteristic group's needs, for example by word of mouth to the Gypsy Traveller Community.

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
	Minority ethnic people whose first language is not English, may be unable to understand information about the changes to the urgent care model unless this information is communicated in their preferred languages. In 2018, NHS 24 undertook engagement with minority ethnic people and organisations that represent their interests to help understand what could be done to improve NHS 24 services for minority ethnic communities, refugees and asylum seekers. Findings from this engagement were as follows. • Many people identified that they would seek medical help and advice from trusted sources within their communities e.g. local networks, instead of seeking help from a health professional.	• "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. Is Scotland Fairer 2018 report'	• Providing call handlers, clinicians, and reception staff with any information related to the practical and emotional needs of the user, may reduce the user's anxiety and fatigue by repeatedly reassuring them at every step that they have been listened to and their needs are being addressed. Mitigation strategies will be developed after the feedbackfrom public and professional engagement has been fully explored Monitoring Impacts There are no specific plans to routinely monitor race of using urgent care. However, work is underway across health and social care to improve ethnicity data in health care and administrative records and Health Boards have been asked to address this as a priority. Covid has highlighted gaps in Scottish data on ethnicity. Additional data or research may be needed over time to understand impacts. Different BME groups are not evenly distributed across Scotland, so ensuring equality of treatment, and good quality monitoring will vary across boards.

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
	• More needs to be done to raise awareness of healthcare service amongst minority ethnic communities, refugees and asylum seekers. It was fed back that there is disparity between particular communities, in regards to the amount of knowledge and awareness they have of available health services. • Many will not seek help at all, until an emergency arises. This results in their first experience of using a health service being at A&E. • There was a reported lack of awareness of Language Line and it was noted that there were difficulties in understanding and using Language Line when it was accessed. • Language Line interpreters should be provided to suit the caller, for example if a woman states that she would prefer to have a woman interpret the conversation then this should be provided. • Staff should be aware of the cultural sensitivities related to sharing some health issues, for example, mental health issues or sexual health issues.		

Characteristic	Evidence Gathered and Strength/ Quality of Evidence	Source	Actions Taken / Mitigation
RELIGION OR BELIEF	We are not aware of any relevant existing evidence currently on religion or belief in relation to the Redesign of Urgent Care Programme.		
MARRIAGE AND CIVIL PARTNERSHIP	Scottish Government does not require assessment against this protected characteristic unless the policy or practice relates to work, for example, HR policies and practices. Refer to Definitions of Protected Characteristics document for details		

Stage 3: Assessing the impacts and identifying opportunities to promote equality

Having considered the data and evidence gathered Stage 3 considers the potential impacts – benefits and barriers – implementing the policy might have on each of the protected characteristics. It is important to remember the duty is also a positive one – that we are required to explore whether the policy offers the opportunity to promote equality and/or foster good relations.

Stage 3 Table assessing the impacts and identifying opportunities to promote equality, by characteristic.

Age	Benefit	Barrier	Neutral	Reasons for our decision
Eliminating unlawful discrimination, harassment and victimisation	X	X		The new Urgent Care pathway will see people of different ages to access urgent care services in a different way from the past, using remote technology which they could create barriers or challenges for older age groups who use technology less than younger age groups. It may also have a positive impact for some age groups as they prefer to access services remotely.
Advancing equality of opportunity	X	X		The new Urgent Care pathway provides opportunities to identify people who need access to other service provision and helps to ensure that people receive the care that is best for them which should take account of their age. This should help reduce health inequalities and may advance equality of opportunity by improve health provision to key groups of the Scottish population, for example, frequent users of Emergency Departments. Older people are however more likely to experience issues with sight and hearing loss, as well as confidence in using digital tools, which may make digitally based consultations less accessible, and could reduce care choice for them.
Promoting good relations among and between different age groups	X	X		Some of the new ways of working may allow the promotion of good relations amongst different age groups. The policy is being co-produced with people from every protected characteristic and this helps build good relationships with key groups.

Disability	Benefits	Barriers	Neutral	Reasons for our decision

Eliminating unlawful discrimination, harassment and victimisation	X	X		The new Urgent Care pathway will require everyone to access services in a different way from the past, using remote technology. This could be less accessible to some people with disabilities. However, for some people with disabilities there is a potential benefit in avoiding an unnecessary trip to A&E and increased risk of infection and being signposted to the correct service.
Advancing equality of opportunity	X	X		The new ways of working may lead to an advancement of equality for disabled people making it easier for them to access the care they need first time. The new system will reduce travel time, avoid unnecessary exposure to hospital setting and has the potential to reduce distress. However, we need to ensure the necessary mitigations are built in to ensure equitable access and address support needs.
Promoting good relations among and between disabled and non-disabled people	X	X		The policy is being co-produced with people with one or more of the protected characteristics. This presents an opportunity to build good relationships through the engagement process. However, clear and accessible route to care will need to be available if benefits are to be realised in the longer term.

Sex	Benefits	Barriers	Neutral	Reasons for our decision
Eliminating unlawful discrimination	X	X		Women are more likely to be caring for children and to be lone parents (and therefore also in a SIMD group more likely to access A&E). A new system would need to ensure clear access routes to care and support. However, for both men or women there is a potential benefit in avoiding an unnecessary trip to A&E and increased risk of infection and being signposted to the correct service.
Advancing equality of opportunity	X	X		The new system allows for scheduling of urgent care appointments which will be helpful for women and men with child caring responsibilities to allow them to schedule to a time which fits.
Promoting good relations between men and women	X	X		The policy is being co-produced with people across the range of protected characteristics and this helps build good relationships with key groups. However, clear and safe access routes to care will be essential if equality of opportunity is to be realised by the new system.

Pregnancy and Maternity	Benefits	Barriers	Neutral	Reasons for our decision
Eliminating unlawful discrimination	X	X		Potential benefit in pregnant women avoiding an unnecessary trip to A&E which can be a stressful environment and poses a risk of infection.
Advancing equality of opportunity	X			Some of the new ways of working should have a positive impact on pregnancy/maternity and advance equality for this group of the population by offering choice.
Promoting good relations	X			The policy is being co-produced with people from every key characteristic and this helps build good relationships with key groups.

Gender Reassignment	Benefits	Barriers	Neutral	Reasons for our decision
Eliminating unlawful discrimination			X	Further evidence is required to assess the impact on those people who have undergone gender reassignment.
Advancing equality of opportunity			X	Further evidence is required to assess the impact on those people who have undergone gender reassignment.
Promoting good relations	X			The policy is being co-produced with people from a range of protected characteristics. Engagement with stakeholders representing transgender will be part of our strategy to building good relationships with trans people.

Sexual Orientation	Benefits	Barriers	Neutral	Reasons for our decision
Eliminating unlawful discrimination	X		X	Further evidence is required to assess the impact of the programme due to a person's sexual orientation.
Advancing equality of opportunity			X	Further evidence is required to assess the impact of the programme due to a person's sexual orientation.
Promoting good relations	X			The policy is being co-produced with people from a range of protected characteristics and this helps build good relationships with key groups.

Race	Benefits	Barriers	Neutral	Reasons for our decision
Eliminating unlawful discrimination	X	X		Further evidence is required to assess the impact of the programme due to a person's race.
Advancing equality of opportunity			X	Further work is required to assess digital exclusion within the minority ethnic population.
Promoting good race relations	X			The policy is being co-produced with people from a range of protected characteristic and this helps build good relationships with key groups.

Religion or Belief	Benefits	Barriers	Neutral	Reasons for our decision
Eliminating unlawful discrimination			X	Further evidence is required to assess the impact of the programme due to a person's religion or belief.
Advancing equality of opportunity			X	The new way of working may advance equality of opportunity for people because of their religion or belief by ensuring their needs are better met compared to the current way of working.
Promoting good relations	X			The policy is being co-produced with people from a range of protected characteristic and this helps build good relationships with key groups.

Marriage and Civil Partnership	Benefits	Barriers	Neutral	Reasons for our decision
Eliminating unlawful discrimination			X	This policy does not impact on marriage or civil partnerships.

Stage 4: Decision making and monitoring

Identifying and establishing any required mitigating action

Have positive or negative impacts been identified for any of the equality groups?	Emphasis on remote and digital creates choice for some may remove choice for others, two sides to the same coin: being better able to focus urgent care on those who really do need to see someone should be a pro, but if people feel they have no choice, this may put them off seeking care at the right time.
Is the policy directly or indirectly discriminatory under the Equality Act 2010?	There is no evidence, so far within this EQIA that the policy is directly or indirectly discriminatory under the Equality Act 2010.
If the policy is indirectly discriminatory, how is it justified under the relevant legislation?	Not applicable
If not justified, what mitigating action will be undertaken?	Not applicable

Ongoing Engagement and evidence gathering

In order to tackle the health inequalities that exist, we must ensure that our delivery of the new urgent care model meets the needs of everyone living in Scotland.

In order to meet the general equality duty, and comply with the obligations of the Human Rights Act, and taking into consideration the need to tackle health inequalities, the following points should be considered.

1. Evidence suggests that people experiencing socio-economic disadvantage are more likely to access urgent care than those people who are not. Groups of people noted as being more likely to experience poverty include:
    - minority ethnic people (including Gypsy/Travellers, migrants, refugees and asylum seekers);
    - people who are Muslim;
    - disabled people;
    - care-experienced young people;
    - people experiencing homelessness;
    - people living in the most deprived areas of Scotland according to the Scottish Index of Multiple Deprivation; and

- older adults.

As the redesign of urgent care evolves, we should seek to ensure that these groups of people, and organisations that represent their interests, are engaged with to better understand the impact of the changes.

2. Recommendations from the Discovery Project

The project was undertaken using a small number of participants and it is important that wider engagement is undertaken. To take this forward the unscheduled care team are working with colleagues from Healthcare Improvement Scotland (HIS) to develop a robust public engagement process. This will include two initial exercises.

Gathering Views

- HIS – Community Engagement's network of engagement offices are able to collate comments and experiences from across Scotland to give local, regional and national perspectives using focus groups, interviews, questionnaires and events. Additionally this approach works with local third sector organisations and community groups to reach people, especially those who are often excluded from consultations.
- The focus for Gathering Views is to run early 2021 to address equalities-related engagement gaps in the discovery phase work with particular regard to the protected characteristics and most marginalised communities. This work will also be informed by experience gained during the NHS A&A pathfinder exercise, with findings to be published on the HIS website and publicised through their social media platforms.[6]
- The timeframe for Gathering Views is to run and report during spring 2021.

Citizens' Panel

- HIS will run a Panel in in 2021 which will comprise a series of questions relating to the Redesign of Urgent Care and in particular the service configuration, barriers to access considerations, and ways to improve. This will be directly informed by the engagement activities undertaken from October 2020 with the discovery phase, through the practical experience of operating the new delivery model over the winter period, and the learning gained from the Gathering Views work.
- The timeframe for the Citizens' Panel will be agreed following the Gathering Views exercise.

We are also working with *Care Opinion* to determine how we can assess and shape the service model. This may lead to HIS developing an evaluation framework which can be used by NHS Boards and, potentially at national level, to determine the impact of this new model of care.

6 NHS Ayrshire and Arran - redesign of urgent care - pathway finder programme: rapid external review - gov.scot (www.gov.scot)

3. Communications, Language and Engagement

Scottish Government marketing team is currently working with the following organisations to identify specific challenges in effectively reaching seldom-heard or vulnerable groups with the Redesign of Urgent Care messaging; NHS and PHS colleagues, BEMIS (umbrella organisation for Ethnic Minority Voluntary Sector), CEMVO (national intermediary partner and strategic partner of the Scottish Government Equality Unit) , MEHIS (Minority Ethnic Health Inclusion Service) MECOPP (Minority Ethnic Carers of People Project) and the Scottish Public Health Network (Gypsy/Traveller Community). Insights gathered from these conversations will help shape marketing materials, and collaborations will help to ensure messaging reaches communities via trusted voices, such as community leaders.

4. Remote and Rural

Due regard for the need to engage with those who live in remote and rural areas (including islands) should also be considered. It should be noted that the Scottish Government are considering the development of a national islands assessment. The Scottish Government continues to work with Health Boards to consider how this model can be adapted to meet the needs of local communities.

5. LGBT

We should also consider the potential impact of the proposed changes on these LGBT communities as it is not clear from the evidence available. Any engagement undertaken with these groups should seek to improve understanding of any potential impact.

6. Removing Barriers

We should seek to ensure that the introduction of the option to contact NHS 24 prior to people being able to access urgent care is not an unintended barrier for any groups of people. Particular regard should be given to the groups of people identified within this impact assessment. For example:

- How to overcome common barriers to access for disabled people should always be considered. The evidence in this report relating to disabled people, highlights some of the barriers that should be considered.
- Lack of awareness of health services within minority ethnic communities and the barriers to access they can experience when seeking to access health services should be addressed. The provision of services and information about these services in other languages should always be available. In order to reduce the health inequalities gap that exists, we must provide appropriate access and service provision for minority ethnic communities living in Scotland. The evidence in this report under Race highlights some of the barriers we should address in relation minority ethnic people.

- In order to meet the needs of disabled people who may experience barriers to effective telephone communication, consideration should be given to creating a national communication hub similar to the service provided by Contact-SCOTLAND-BSL.

Data Improvement

7. There is a lack of equality monitoring data for some characteristics in relation to who uses and who does not use NHS Scotland services/Urgent Care services. Consideration as to how we can monitor be proportionately, lawfully and purposefully which groups of people commonly access services will help establish which groups do not. This data will help NHS Scotland to understand where future engagement and promotion of services should be targeted.

It is not believed the changes recommended in this section will create any new, adverse, impacts in relation to a person's relevant protected characteristics.

Stage 5: Authorisation of EQIA

Please confirm that:

- This Equality Impact Assessment has informed the development of this policy:

  Yes ☑ No ☐

- Opportunities to promote equality in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation have been considered, i.e.:
  - eliminating unlawful discrimination, harassment, victimisation;
  - removing or minimising any barriers and/or disadvantages;
  - taking steps which assist with promoting equality and meeting people's different needs;
  - encouraging participation (e.g. in public life);
  - fostering good relations, tackling prejudice and promoting understanding.

  Yes ☑ No ☐

- If the Marriage and Civil Partnership protected characteristic applies to this policy, the Equality Impact Assessment has also assessed against the duty to eliminate unlawful discrimination, harassment and victimisation in respect of this protected characteristic:

  Yes ☐ No ☐ Not applicable ☑

Declaration

I am satisfied with the equality impact assessment that has been undertaken for Redesign Urgent Care and give my authorisation for the results of this assessment to be published on the Scottish Government's website.

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