Equality Impact Assessment including Fairer Scotland Duty and Children's Rights and Wellbeing Impact Assessment

Discrimination is usually unintended, for example, in the design of a new policy a one size fits all approach may be applied with the intention to be fair to everyone but what this actually does in practice is apply differential impacts on different groups of people.

The **Equality Impact Assessment (EQIA)** process is an evidence based approach designed to help organisations ensure that policies, practices, procedures, service change or redesign and decision-making processes are fair, equitable and that they don't present barriers to participation or disadvantage to any protected groups. The equality impact assessment is used to identify any disadvantage and take appropriate steps to mitigate, or at least minimise, this. You should start the EQIA process at the outset and continue throughout the process; don't wait until the end when a decision has been made. Below are steps to consider to support filling in your EQIA.

Step 1 - Identify what is being assessed. You need to be clear what is being assessed and consider what impact this will have and on which groups.

Step 2 - Give details about the policy. You need to be clear of the purpose at this stage, what are the benefits and who are the stakeholders.

Step 3 - Gather and analyse data and information and engagement. You will need to gather evidence to inform your Equality Impact Assessment. This may come from your stakeholder group(s).

Step 4 – Assess Impact. You need to think about what impact it will have on different groups in our community/workforce. Continue to work with your stakeholders to gain 'lived experience' impacts.

Step 5 – Have you identified any adverse impacts. You need to think about what can be done to mitigate or minimise the adverse impacts.

Step 6 – Send EQIA to Equality and Diversity Adviser for publication. NHS Ayrshire & Arran has an obligation to publish the results of all our equality impact assessments.

In 2018, the **Fairer Scotland Duty** became law and this looks at the impact of socio-economic disadvantage. NHS Ayrshire & Arran have incorporated this into our equality impact assessment process. It should be borne in mind that some minority groups, such as disabled people, ethnic minority people, women, are at a higher risk of facing socio-economic disadvantage and this should be considered when completing the equality impact assessment. This should be considered under each of the area in section 2 with a specific section at 2.16.

In March 2021, the Scottish Parliament unanimously passed the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Bill. This incorporates children's rights into law and places a duty on us as a public authority to ensure children's rights are protected and promoted in all areas of their life. NHS Ayrshire & Arran are building the **Children's Rights and Wellbeing Impact Assessment** into our existing EQIA process. This is woven through the document with a specific section at 2.17.

EQUALITY IMPACT ASSESSMENT

This is a legal document stating you have fully considered the impact on the protected characteristics and is open to scrutiny by service users/external partners/Equality and Human Rights Commission

If you require advice on the completion of this EQIA, contact elaine.savory@aapct.scot.nhs.uk

'Policy' is used as a generic term covering policies, strategies, functions, service changes, guidance documents, other

Name of Policy	Vitamin D supplement – universal distribution model for midwifery, health visiting and Family Nurse Partnership		
Names and role of Review Team:	Dr Ruth Campbell, Consultant Dietitian in Public Health Nutrition Dr Kerry Ellis, Clinical Service Manager, South Ayrshire HSCP Donna Hillis, Clinical Service Manager, East Ayrshire HSCP Joanne Inglis, Senior Manager, North Ayrshire HSCP	**Date(s) of assessment:**	22nd June 2026

SECTION ONE AIMS OF THE POLICY

1.1. Is this a new or existing Policy : Existing

Please state which: **Policy** ☐ **Strategy** ☐ **Function** ☐ **Service Change** ☐ **Guidance** ☒ **Other** ☐

1.2 What is the scope of this EQIA?

NHS A&A wide ☐ **Service specific** ☐ **Discipline specific** ☒ **Other (please detail)**

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1.3a. What is the aim? Due to the reduction in funding for the provision of vitamin D supplements, eligibility for free supplements will be revised from children under 3 years of age to children under 2 years of age. This change aims to focus available resources on the age groups at highest risk of vitamin D deficiency while maintaining support for pregnant women, breastfeeding women, babies and younger children who

are most likely to benefit. Children aged 2 to 3 years will still be recommended to take vitamin D supplements in line with national guidance, but these will no longer be provided free of charge by the Health Board.

1.3b. What are the objectives?

- To clearly articulate the rationale for how vitamins are distributed at different stages of the antenatal and postnatal period
- To reflect recent changes in funding which has necessitated changes to the delivery model

1.3c. What are the intended outcomes?

The intended outcome of this proposal is to achieve a reduction in programme expenditure while maintaining access to free vitamin D supplements for the largest number of eligible babies, infants, pregnant women and breastfeeding mums. This will be done by removing the distribution at 27-30 months thus lowering the upper eligible age limit for free vitamins to 13-15 months.

1.4. Who are the stakeholders?

- Pregnant women
- Breastfeeding mums
- Babies and young infants
- Health visitors
- Family Nurses
- Midwifery

1.5. How have the stakeholders been involved in the development of this policy (this should include children and young people where appropriate)?

Health Visiting staff have been involved in scoping the options for a revised distribution model as a result of reduced funding, as well as identifying mitigating actions to minimise risk to affected families. The change that has been put in place is the most pragmatic approach to minimise the administrative burden on clinical staff, while at the same time maintaining provision to the largest number of children.

1.6 Examination of Available Data and Consultation - Data could include: consultations, surveys, databases, focus groups, in-depth interviews, pilot projects, reviews of complaints made, user feedback, academic or professional publications, reports etc)

Data on the number of vitamins issued to locality bases from Pharmacy at UHC is provided quarterly. Data on vitamins ordered, held, and distributed to Health Visitors is provided quarterly. Data is recorded on Care Partner on whether children's vitamins were issued and whether parents report they have been giving their child the vitamins provided by Health Visitors at universal contacts. Focus groups were held with

Midwives, Health Visitors and Family Nurses to gain their experience of the distribution model and questions on Care Partner. An online survey to gain mothers views and experience of locally distributed vitamins has been undertaken. Monthly financial data is available on expenditure.

Name any experts or relevant groups / bodies you should approach (or have approached) to explore their views on the issues.

We have engaged with the Maternal & Infant Wellbeing Policy Team at Scottish Government as well as Maternal & Infant Nutrition leads from other Boards to understand changes made to their local distribution model.

What do we know from existing in-house quantitative and qualitative data, research, consultations, focus groups and analysis?

Uptake of children's vitamins is high across Ayrshire with some slight variation by local authority, deprivation and age of child. A small proportion of families choose not to give their child the vitamins provided and opt to buy an alternative preparation. Reasons cited include wanting to give their child a multi-vitamin and their child not liking the taste of the preparation provided. Based on feedback from staff, families value the vitamins provided however awareness of the SOP was low.

What do we know from existing external quantitative and qualitative data, research, consultations, focus groups and analysis?

A high number of mothers who were breastfeeding reported that they did not receive vitamins for themself or their child on discharge from AMU. Based on discussions with other Boards, uptake of children's vitamins in NHS A&A is high, due to our distribution model via HV/FN staff.

1.7. What resource implications are linked to this policy?

The Scottish Government has announced that funding for the vitamin model is to stay the same as 2025/26. This creates a shortfall from a budgetary position. Last year, Public Health identified funding to cover the shortfall; however, this is not an option for 2026/27, therefore the model requires to be reviewed.

SECTION TWO	IMPACT ASSESSMENT

Complete the following table, giving reasons or comments where:

The Programme could have a positive impact by contributing to the general duty by –

- **Eliminating unlawful discrimination**
- **Promoting equal opportunities**
- **Promoting relations within the equality group**

The Programme could have an adverse impact by disadvantaging any of the equality groups. Particular attention should be given to unlawful direct and indirect discrimination.

If any potential impact on any of these groups has been identified, please give details - including if impact is anticipated to be positive or negative.

If negative impacts are identified, the action plan template in Appendix C must be completed.

Equality Target Groups – please note, this could also refer to staff

	Positive impact	Adverse impact	Neutral impact	Reason or comment for impact rating
2.1. Age • **Infants, children and young people (IC&YP)** Any impact on IC&YP requires additional completion of section 2.17 below.		x		Due to the reduced funding settlement, the current model cannot be delivered; therefore any changes will require some groups of babies and young infants, or whole age groups, to have access to the Vitamin D supplementation removed. Children from disadvantaged households may be disproportionately affected, widening health inequalities as the parents/ carers may not be able to afford to purchase the supplements.
• Adults			x	Only pregnant women and breastfeeding mums are included within the current model with no plans for this to change.

• Older People (also consider impact on IC&YP such as kinship care)			x	Older adults are not impacted by this model.
2.2. Disability (incl. physical/ sensory problems, learning difficulties, communication needs; cognitive impairment, mental health)		x		Children with disabilities, long-term health conditions or feeding difficulties may face increased risks as a result of the age range change. Households where there is a disability are also more likely to experience poverty, therefore families may be unable to afford to buy vitamins.
2.3. Gender Reassignment			x	It is not expected that the service distribution model will have an impact on this group. However, we are aware that someone assigned female at birth and who transitions to male may still become pregnant. Where this is the case those individuals will be included within the current model with no plans for this to change.
2.4 Marriage and Civil partnership			x	There would be no differential impact based on marital status.
2.5 Pregnancy and Maternity			x	Whilst the model includes pregnant women, no changes to their distribution are proposed.
2.6 Race/Ethnicity		X		Women and children with darker skin tones, including many African, Caribbean, Middle Eastern and South Asian communities, are recognised as being at higher risk of vitamin D deficiency because they produce less vitamin D from sunlight. There is a potential adverse impact on children of this race if access is reduced.
2.7 Religion/Faith			X	There would be no differential impact based on religion or belief.

2.8 Sex (male/female)			x	The proposed change to the provision of free vitamin D supplements should not have any differential impact on sex. All children, regardless of biological sex, between the age of 2 to 3 will no longer receive the supplements.
2.9 Sexual Orientation • Lesbians • Gay men • Bisexuals			x	There would be no differential impact based on sexual orientation.
2.10 Carers including young carers			x	There would be no differential impact based on caring status.
2.11 Homeless			x	There would be no differential impact based on homeless status.
2.12 Involved in criminal justice system including youth justice			X	There would be no differential impact based on involvement with the criminal justice service.
2.13 Literacy			x	No impact identified based on literacy.
2.14 Rural Areas			x	No impact identified as changes will be universally applied to all households.
2.15 Staff • Working conditions • Knowledge, skills and learning required • Location • Any other relevant factors			x	Whilst health visiting staff will need to be informed about changes to the distribution model which will require them to change their current process; by removing a whole stage of distribution, it may make it easier for staff to administer therefore a neutral impact has been considered.

2.16. What is the socio-economic impact of this policy / service change? (The Fairer Scotland Duty places responsibility on Health Boards to actively consider how they can reduce inequalities of outcomes caused by socio-economic disadvantage when making strategic decisions)				
	Positive	**Adverse**	**Neutral**	**Rationale/Evidence**
Low income / poverty		x		The reduction in funding for vitamin D supplements has the potential to result in adverse impacts on babies and young children, particularly those from lower-income households and ethnic minority communities who are at increased risk of vitamin D deficiency. By stopping vitamin distribution for babies at 27-30-months, this contradicts guidance which advocates vitamin D supplementation for all, particularly between the months of October and March. Parents/ carers will be required to purchase vitamins for their children in order to meet the population-level guidance and for low income families/ those experiencing poverty, this will have a negative impact. There is a risk that health inequalities could widen as some families may continue to purchase supplements on their own, while lower-income families may not be able to do so. As the change will be universally applied, there will be no additional impact on rural or island communities for example.
Living in deprived areas		x		
Living in deprived communities of interest			x	
Employment (paid or unpaid)		x		There is a risk that those in lower paid jobs may not be able to purchase the vitamin D supplements for their children.

2.17. What is the impact of this policy / service change on infants, children and young people (IC&YP)? (The United Nations Convention on the Rights of the Child (UNCRC) places a compatibility duty on public authorities to ensure the rights of children are protected and promoted in all areas of their life). Kathleen Winter can be contacted for further support.				
	Yes	**No**	**Not applicable**	**Rationale/Evidence**

Will this policy impact on the best interests of IC&YP?	x			The change in model will mean that infants aged 27-30-months will no longer be issued with funded vitamin D supplements. However, with the reduction in funding, the proposed change aims to deliver a model that still meets the best interests of as many children as possible.
Will this policy impact on the developmental needs of the IC&YP?	x			Vitamin D is important for healthy development and is acquired through exposure to sunlight and diet. In Scotland, Vitamin D levels are low and supplementation is recommended, particularly between October and March. By not providing vitamins to children aged 2, there will be a reduction in the numbers of children receiving appropriate supplementation and therefore a potential impact on health and wellbeing. The reduced funding may lead to lower uptake among families unable to purchase supplements, increasing the risk of deficiency, impaired bone development and other health consequences
Will this policy impact on IC&YP being able to express their views in relation to the service and have that view taken into account?		x		IC&YP will not have any say in this proposed change. However, the intended outcome of this proposal aims to focus available resources on the age groups at highest risk of vitamin D deficiency while maintaining support for pregnant women, breastfeeding women, babies and younger children who are most likely to benefit.
Will the policy have any direct or indirect impacts on IC&YP?	x			Children aged 27-30 months will no longer be issued with funded Vitamin D supplements.

Have you considered the impact of the policy across the wide range of IC&YP, e.g. preschool children; children in hospital; children with additional support needs; care experienced children; children living in poverty?	x			The changes to the policy will be implemented universally; however it is recognised that the greatest impact will likely be to low income families/ households experiencing poverty.

SECTION THREE	**CROSSCUTTING ISSUES**			
What impact will the proposal have on lifestyles? For example, will the changes affect:				
	Positive impact	**Adverse impact**	**No impact**	**Reason or comment for impact rating**
3.1 Diet and nutrition?		x		Due to the importance of Vitamin D supplementation, the reduced funding from the SG has forced a change in the distribution model meaning that a lower number of children will benefit from funded Vitamin D supplementation.
3.2 Exercise and physical activity?			x	No association with this factor.
3.3 Substance use: tobacco, alcohol or drugs?			x	Not associated with this age group of children
3.4 Risk taking behaviour?			x	Not associated with this age group of children

SECTION FOUR CROSSCUTTING ISSUES				
Will the proposal have an impact on the physical environment? For example, will there be impacts on:				
	Positive impact	**Adverse impact**	**No impact**	**Reason or comment for impact rating**
4.1 Living conditions?			X	The proposed change will have no impact on living conditions.
4.2 Working conditions?			x	The proposed change will have no impact on working conditions.
4.3 Pollution or climate change?			x	The proposed change will have no impact on pollution or climate change.
Will the proposal affect access to and experience of services? For example:				
	Positive impact	**Adverse impact**	**No impact**	**Reason or comment for impact rating**
Health care		x		There is the potential for families who benefited from the original model of distribution to be unhappy that there is no longer provision at the 27-30 month point. There is also a risk that health inequalities could widen as some families may continue to purchase supplements on their own, while lower-income families may not be able to do so.
Social Services			x	No involvement from social services in this aspect of service delivery
Education			x	No involvement from education in this aspect of service delivery
Transport			x	No involvement from trasnport in this aspect of service delivery

Housing			x	No involvement from housing in this aspect of service delivery

SECTION FIVE	**MONITORING**
How will the outcomes be monitored? Quarterly uptake returns will be submitted to the Consultant Dietitian in Public Health Nutrition. Feedback from staff will also be sought	
What monitoring arrangements are in place? Quarterly uptake returns are collated by community services/ locality co-ordinators and returned to the Consultant Dietitian in Public Health Nutrition.	
Who will monitor? Consultant Dietitian in Public Health Nutrition supported by senior staff within the three HSCPs (specifically, Health Visiting services)	
What criteria will you use to measure progress towards the outcomes? Questions on when vitamins are issued to parents and whether parents report giving these to their child will continue to be included as part of universal timeline contacts. Costs associated with the distribution will be reviewed regularly, with decisions about any future changes to the distribution model based on the financial position.	
PUBLICATION	
Public bodies covered by equalities legislation must be able to show that they have paid due regard to meeting the Public Sector Equality Duty (PSED). This should be set out clearly and accessibly, and signed off by an appropriate member of the organisation. Once completed, send this completed EQIA to the **Equality and Inclusion Manager**	

Authorised by		**Title**	

Signature		Date	

Identified Negative Impact Assessment Action Plan

Name of EQIA:

Date	Issue	Action Required	Lead (Name, title, and contact details)	Timescale	Resource Implications	Comments
22/06/2026	SG have reduced funding for the Vitamin D distribution model. There remains an ask that breastfeeding mums are prioritised which means that changes to the model are required for the baby distribution. Any changes will negatively impact on a cohort of babies and infants and on lower income families.	Exploration of all alternative distribution models	Dr Ruth Campbell, Consultant Dietitian in Public Health Nutrition Joanne Inglis, Senior Manager – Children and Families Health Team	July 2026		Every alternative distribution model will impact on a group of children (either by age and/ or deprivation status). Therefore, the most viable option which allows the model to be delivered in budget and within workforce capacity, will be to remove distribution at the 27-30 month assessment point.

Further Notes: Given the budget reduction has come from the Scottish Government, a copy of their ECRIA has been requested.

Signed: Date: