NHS
Greater Manchester
Integrated Care

Equality Analysis Template

Step 1 Evidence | Step 2 Assess | Step 3 Strengthen | Step 4 Monitor | Step 5 Approve

Step 1 Evidence

This equality analysis is being undertaken to prevent my policy, plan or project from adversely affecting people with different protected characteristics or at known disadvantage.

I am using this template to identify potential discrimination or disadvantage, propose steps to strengthen against those and record and monitor the success of those strengthening actions.

Name of your strategy/policy/plan/project	Integrated Elective Care (IEC)		
Contact details for the person completing the assessment	Becky Leahy Rebecca.leahy@nhs.net Susan Toole Susan.toole2@mft.nhs.uk		
Design date for the strategy/policy/plan/project	September 2022		
Date your equality analysis is completed			
Does this template form part of a business case or investment proposal submission?	Yes	No	Unsure
Are you completing this as a result of organisation change?	Yes	No	Unsure
Is there another reason for you completing this template – e.g. renewal of a current service/change to current service – please specify:	To support the IEC pillar as part of the GM Elective Care Recovery and Reform Programme.		

If you are unsure about any part of this template, please read the accompanying guidance paper before you complete. ALL sections must be completed – N/A is not applicable in this template as it is used to inform legal compliance. If you need to explain your bespoke approach further, please do so in the text boxes.

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1. Initial screening assessment

What are the main aims, purpose of your policy, plan or project?

Aim and Purpose

A GM strategy has been developed to help improve the elective care recovery position over the next three years. To deliver this, the GM Elective Recovery Strategy is focused on six key programmes, of which Integrated Elective Care is one. The Integrated Elective Care Programme has been established to support the early stages of the patient pathway and contribute to the overall aim of the Elective Care Recovery and Reform Programme to reduce the flow of patients onto waiting lists.

Programme objectives:

- Development and implementation of system wide, shared principles and ways of working across primary and secondary care.
- Improve the use of referral optimisation tools and approaches for the benefit of timely patient care including:
  - Advice and Guidance
  - Referral Assessment Services
  - PIFU & Stratified Follow-Up
  - Virtual consultations
- Support the development and implementation of Care Navigation Hubs, ensuring patients are treated in the most appropriate settings
- Development of transformational approaches such as straight to discharge/ stratified follow up / or PIFU
- Application of the principles of personalised care.
- Identify and address health inequalities through the whole of the integrated care programme of work

What is your expected outcome?

- Meet national Targets / Guidance for PIFU, advice and guidance, referral assessment services and virtual consultations
- The expected impact and outcomes include:
  - Reduced waiting times (including reducing variation)
  - Improved patient experience (E.g. patient at centre of own care)
  - Improved staff experience
  - Utilisation of modern technology to support efficiency and accessibility (as a benefit from national targets)
  - Reduced waiting lists
  - Capacity freed for the most complex and clinically urgent patients
  - An increase in available capacity for patients needing specialist Elective Care in GM

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There are a number of National Targets that have been set out within the Integrated Elective Care area.

Targets:
A&G and RAS

- Diversion Rate Target– **40%** by March 2023
- Utilisation Rate Target – **16** specialist advice requests per 100 Outpatient First Attendance by March 2021

PIFU

- **5%** of appointments to be moved or discharged to a PIFU pathway by **March 2023**

VC

- **25%** of OPD appointments carried out virtually by **March 2023**

Waiting List reduction

- Waiting list reduction against 19/20 activity levels of 25% by **March 2023**

During the Greater Manchester Planning Submissions (June 2022), GM also set out their targets. It's important to note that the GM targets for 22/23 may not align with National and this has been communicated to the National NHSEI Team (this has been due to a change in target expectation).

GM Targets as per June 2022 Planning Submission:

PIFU

- **2.40%** of all outpatient attendances of which patients are moved or discharged to a PIFU pathway by **March 2023.**

Who will benefit?

- **Patients & Carers** – shorter waiting times, improved patient experience and outcomes (right place right time) and accessibility to services.
- **GM system** – improved performance and partnership working (reduced backlog and waiting lists, validated demand coming into the system (right place right time), further embedding of partnership working between Primary and Secondary.

Is your project part of a wider programme or strategy (for example, the locality plan)?

This work is part of the GM Elective Care Recovery and Reform Programme (which is part of the Greater Manchester Recovery and Reform Strategy)

2. Are there any aspects/activities of the policy, plan or project that are particularly relevant to equality, socio-economic disadvantage, or human rights?

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At this stage, you do not have to list possible impacts, just identify the areas. (E.g. we are commencing a new programme of health care aimed at Caribbean men with diabetes)

As this pillar is one of a number within the overall GM Elective Care Recovery and Reform Programme, we will need to consider how the different themes interact and how we prevent widening of inequalities unintentionally and ensure that patient choice does not result in longer waiting times where barriers are not removed.

3. What existing sources of information will you use to help you identify the likely impact on different groups of people? (For example, statistics, JSNA's, stakeholder evidence, survey results, complaints analysis, consultation documents, customer feedback, existing briefings, comparative data from local or national external sources).

This EIA is based on known barriers for different people to health and care services, however we need to ensure that we continue to gather intelligence and evidence as the programme progresses. Data will be used from providers and trusts, including: • Patient and public feedback and surveys • ICS Engagement leads • Business Intelligence (BI) – GM Tableau • NHS Futures Platform (Including Health Characteristics report) • Intelligence, data and feedback will also be provided through each CRG • Patient stories • Complaints • National resources and data (JSNA's/Public Health Profiles etc) In addition to this EIA we need to review and act on EIAs or performance, quality and improvement monitoring completed by the CCGs as the lead commissioners. We have looked at existing research and reports relating to these initiatives or known barriers for certain groups. Evidence is linked in the table.

4. Evidence gaps

Are there gaps in information that make it difficult or impossible to form an opinion on how your proposals might affect different groups of people? If so, what are the gaps in the information and how and when do you plan to collect additional information? Note this information will help you to identify potential equality stakeholders and specific issues that affect them - essential information if you are planning to consult as you can raise specific issues with particular groups as part of the consultation process. EIAs often pause at this stage while additional information is obtained.

No: Please go on to question 5. (Be sure to have fully considered all communities and parts of communities – e.g. have you considered the needs of gypsies, travellers and Roma communities, other transient communities, do you need to better understand take up of your service by Muslim women or Orthodox Jewish men, for example.)

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Yes: Please explain briefly how you will fill any evidence gaps. You might want to start with contacting research or policy colleagues to see whether they can point you in the right direction. Our third sector colleagues will also be pleased to offer support and direction.

Evidence gap	How will the evidence be collated	Individual or team responsible and timeframe
There are limitations around the data we have (e.g. PIFU - would hope to have data on who and a reflection of population in each area). To enable full view of health inequalities and to check we are reaching the right communities, we are linking in with intelligence, research and reporting. We know that not all data is able to incorporate HI information. Rachel Richardson (GM Elective Care Programme Communication and Engagement Lead) is working with engagement leads at localities and trusts (seldom heard groups/underserved population - there is not a way to record this information in primary care records at the moment). There is different levels of information available.	Good data intelligence and resource to support primary care, other areas in variance. (Graham Beales, GM Head of Business Intelligence, won't have ability to produce further information). Continued engagement with comms/research/reporting is required to ensure HI principles can be applied. Access to NHS Collaborative Platform	

5. Involvement and Engagement

Note: You are required to involve and consult stakeholders during your assessment. The extent of the consultation will depend on the nature of the policy, plan or project.

(Don't forget to involve trade unions and inclusion staff groups if staff are affected and consider socio-economic impact as well as community and third sector groups for different protected characteristics. If there is potential for different impact across different neighbourhoods, consult your neighbourhood leads)

Engagement and involvement that has taken place, who with, when and how?

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At the moment, no specific engagement has taken place regarding this programme of work. The GM Elective Recovery Programme has a dedicated Communications and Engagement, & Equality, Diversity & Inclusion resource who will be developing a strategy for the programme to ensure people and communities are involved in the work.

Two key pieces of work will be happening initially:
1. Development of a lived experience panel to support the programme
2. A GM Wide piece of engagement work around the elective programme, which will include gathering insight around key initiatives such as PIFU.

Engagement around the programme will be an iterative approach to ensure that we continue to listen to patients and act on their feedback. The Communications and Engagement, & Equality, Diversity & Inclusion leads will also work to increase involvement and consultation with wider stakeholders. Plans for this are still evolving.

At the moment, information within this EIA is drawn from existing insight on these specific initiatives or known barriers and challenges for certain groups. Our engagement work will supplement this over time.

Key feedback from consultation:

We don't have any GM feedback at the moment.

We are pulling insight from existing research around patient access to services, virtual services etc where it is relevant to apply here. This will be supplemented as we undertake our engagement and gain more insight.

For significant or large strategies and programmes, please provide a link to any written record of the consultation to be published alongside this assessment here:
N/A for this element

How engagement with stakeholders will continue
Here you need to explain how you continue to engage throughout the course of the delivery to ensure the measures you take to address any disparity are working.

Involvement group	Consultation dates	Strengthening actions
• Elective Care Recovery and Reform Programme Team (ED&I lead) • Elective Care Recovery and Reform Programme Board • Integrated Elective Care Programme Group • GM Elective Care	A strategy is being developed to ensure we work with people and communities in our work. This includes the development of a Lived Experience Panel to work alongside the programme, and a GM wide piece of	Key programme forums include representation from Health Inequality leads. At the point of completing this EIA, the GM Elective Care Recovery and Reform Programme is developing a Lived Experience Panel.

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Recovery and Reform Operational group • GM Clinical Reference Groups	engagement work.	

Step 2

Assessing impact and opportunities to promote equality and human rights

6. If you have piloted a project you want to roll out, add here what you learnt about communities not taking up, accessing or having poorer outcomes from it and what you have done to address those disparities.

Gynaecology Care Navigation Hub has just begun its pilot (Sept 2022), with roll out not considered until Q4 22/23 Q1 23/24. At the point of consideration, this EIA will be reviewed and updated to include key learning and will explore the impact of this hub.

7. What barriers have you identified for the different groups listed by your proposals?

Add the impacts in the box next to the group. (e.g. we have found that working age people are not taking up our services because of our opening hour restrictions)

Complete the identified barriers for each group and identify which group you have identified You should complete each category. If you believe there is no adverse impact, you should put an explanation as to why.

Age • Young • Middle age • Older age	**PIFU** / Memory issues can be more common in older people. If a person has memory issues, they may not remember the issues to look out for or the process to follow. The assessment of suitability of whether the person should go on a PIFU pathway should take this into account. / Young people could also face poorer outcomes if there is not consideration of how PIFU works when children transition to adult services. Communication and support would be required.

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	⁄ So far, there are limited studies relating to PIFU. Nuffield Trust reviewed those available one of which suggested no differences to outcomes by age or gender. ⁄ One available study reviewed by Nuffield Trust found that older patients and those who had had the long-term condition longer declined PIFU. We need to build in a process to capture declines and work with people to address concerns and barriers. **A&G and referral assessment services** ⁄ Health services will need to think about managing people's expectations. This could be across all ages, but perhaps those who have greater experience of access health services. In terms of the way people have traditionally accessed services, where referrals are made to secondary care, we will need to support with effective communication to explain why an advice and guidance approach is being taken, and why a referral may not be made if deemed unnecessary. **Virtual consultations** ⁄ We know that some individuals (of all ages) may not have access or understanding of how to use technology. This may limit people's ability to engage in virtual consultations. Digital poverty, combined with the current cost of living crisis, may limit people's ability to access services in this way. Services should not assume all patients will be able to access virtual consultations with a process built in to ensure patients can access services in the traditional way if needed. ⁄ A potential benefit of virtual consultations is that the patient does not have to travel to clinic, this may be particularly beneficial to working age, people in education pr carers for example who are more likely to struggle to take time to attend health appointments.
Disability Types of impairment can be categorised as physical, sensory, psychosocial, and intellectual. There are several types of barriers that cause exclusion including	**PIFU** ⁄ Patients who have particularly complex health needs, who are on medications that require robust monitoring or who are unable to contact health services easily are unlikely to be good candidates for PIFU. Assessment of suitability will need to be built into the pathway and patients who aren't candidates for PIFU should receive care in a way appropriate for them.

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• Physical • Social/attitudinal • Institutional • Communication Complete which *barriers* you will need to consider in your programme.	⁄ The roll of our PIFU will need to consider different conditions. A patient-initiated pathway for a patient with a long-term, chronic symptomatic condition might have very different requirements and considerations than one for a short term or temporary condition, like surgery or injury. ⁄ For patients with a learning disability, there is a risk that they might not be considered for PIFU unless it is adapted to work for them with information and support available in easy read for example. ⁄ For patients with a mental health condition, there is a risk that they might not be considered for PIFU unless it is adapted to work for them. Some of these patients may also struggle to initiate an appointment during a mental health episode (e.g. depression). ⁄ Patients who are profoundly deaf or hard of hearing may be unable to proactively contact the hospital via telephone. The process needs to include an understanding of the patients' communication needs and alternative methods of contact being in place that support successful PIFU. ⁄ Patients with a disability such as a visual impairment may be adversely impacted without information resources that meets their needs, e.g. information in braille or audio. **Advice & Guidance and Referral Assessment Services** ⁄ People with disabilities or co-morbidities are more likely to be in contact with healthcare services. We will need to support through effective communication if the pathway doesn't follow the expected course, e.g. being managed in primary care or community rather than referral to secondary care. **Virtual Consultations** ⁄ People with autism and/or learning disabilities may struggle with virtual consultations, as they may rely on body language queues. Patient preference and communication needs should be taken into when assessing suitability for PIFU. ⁄ If someone has a physical disability which means travelling to hospital/clinic is difficult, virtual consultations may benefit them if they are able to access. ⁄ Deaf community unlikely to be able to use virtual consultations, needing BSL interpretation in person.

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Sex Identify any potential adverse impact to men or women.	**PIFU** / So far, there are limited studies relating to PIFU. Nuffield Trust reviewed those available and one study identified no clinical differences by age of gender. / In another study reviewed by the Nuffield Trust it was found that there are some potential differences in service use; men reduced their overall number of clinic visits and phone contacts by a larger degree than women. It will be important to build demographic monitoring into processes. / Men may be less likely to initiate a follow-up appointment when required so could be adversely impacted. **Advice & Guidance and referral management** / Gynaecology is one of the specialties in Greater Manchester with the greatest waiting lists. Waiting lists for gynaecology have been disproportionately affected and women have been disproportionately affected. We have two care navigation pilots taking place in this specialty to support women to get access to care quicker and in the most appropriate place. **Virtual Consultations** / Women are more likely to be carers so may not be able to travel further/have the same flexibility of availability. Virtual consultations may be beneficial. / There is a potential that the choice of the gender of the healthcare practitioner/consultant etc cannot be communicated in advance of Virtual Consultations.
Race Identify any adverse potential impact on different ethnic groups and identify which ethnic groups you may need to specifically consider.	**PIFU** / Some people may require a chaperone for ethnic, religious or cultural reasons. There is a potential that individuals who require a chaperone may not be able to do so when attending a virtual consultation. There needs to be a process of identifying the need for chaperones. / If English is not the first language, Information and advice about PIFU will need to be available in the appropriate language and format. This includes for the discussion when assessing suitability of PIFU and any written advice or communications thereafter.

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	Advice & Guidance and Referral Assessment Services / Refugees and asylum seekers are less likely to understand the NHS healthcare system with expectations that the hospital is where you get healthcare. Effective communication will need to be provided if the patient is to be managed away from hospital. **Virtual Consultations** / There is a potential that some individuals may encounter communication barriers when accessing virtual consultations (e.g. individuals requiring translator support/ accessing online information in accessible language) and accessing PIFU pathway (ability to get in touch with the Provider to arrange an appointment). / People who don't speak or write English as their first language, may struggle to navigate IT to enable them to take part in virtual consultations. Support and guidance in alternative languages will be needed. / Asylum seekers likely to have devices that can access the internet but unlikely to have access to the internet. / Virtual consultations add another layer of complexity to communication which may affect people who require translation services.
Religion/ belief Identify any adverse potential impact on different religious groups and identify which you may need to specifically consider.	**PIFU** / Some people may require a chaperone for ethnic, religious or cultural reasons. There is a potential that individuals who require a chaperone may not be able to do so when attending a virtual consultation. There needs to be a process of identifying the need for chaperones. **Advice & Guidance and Referral Management Services** No known barriers at this time. **Virtual Consultations** / Some patients may require their healthcare professional to be a particular gender. There is a potential that the choice of the gender of the healthcare practitioner/consultant etc cannot be communicated in advance of VC/PIFU. / There is a potential that individuals who require a chaperone may not be able to do so when attending a virtual consultation.

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Sexual Orientation Identify any adverse potential impact on different sexual orientations and identify which sexual orientations you may need to specifically consider.	**PIFU** / We know that LGBTQI+ people are more likely to have negative experiences of health services. They are less likely to access healthcare when needed. As PIFU relies on people being confident to come forward for care, this may have an impact. More work needed with LGBTQI+ community. / A Pride Practice type model for secondary care should be followed to ensure that patients feel welcome and safe. **Advice & Guidance and Referral Management Services** / LGBTQI+ people are more likely to have negative experiences accessing healthcare. We will need to support patients through effective communication to understand if their pathway doesn't follow the course expected, i.e. not being referred to hospital but managed in a different way. / The LGBT Foundation is working with GP practices to roll out the Pride in Practice to improve care for the LGBTQI+ and improve Trust between health professionals and patients. If patients have a strong relationship with their GP / primary care clinicians being cared for by them, rather than being referred to hospital, may be beneficial. **Virtual consultations** / Some LGBTQI+ people have had negative experiences of health services and may be reluctant to access care in a different way. A Pride Practice type model should be followed to ensure that patients feel welcome and safe.
Transgender Identify any adverse potential impact on transgender or non-binary people.	Gender services are not included in our GM Elective Care Recovery and Reform Programme **PIFU** / We know that LGBTQI+ people are more likely to have negative experiences of health services. This can prevent people from coming forward to access care. As PIFU relies on people being confident to come forward for care, this may have an impact. More work needed with LGBTQI+ community. **Advice & Guidance and Referral Management Services** / LGBTQI+ people are more likely to have negative experiences accessing healthcare. We will need to support patients through effective communication to understand if their pathway doesn't follow the course expected, i.e. not being referred to hospital but managed in a different way. / The LGBT Foundation is working with GP practices to roll out the Pride in Practice to improve care for the LGBTQI+ and improve Trust between health professionals and patients.

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	⁄ If patients have a strong relationship with their GP / primary care clinicians being cared for by them, rather than being referred to hospital, may be beneficial. **Virtual Consultations** ⁄ Some LGBTQI+ people have had negative experiences of health services and may be reluctant to access care in a different way. A Pride Practice type model should be followed to ensure that patients feel welcome and safe.
Carer status	**PIFU** ⁄ Carers may be the main support for a patient going on to a PIFU pathway, they therefore would need to be involved in the discussions and also given the support to help the patient manage this. ⁄ Avoiding unnecessary trips to outpatient appointments may be beneficial to carers, both if the appointment is for the person cared for or for themselves. We know that time is a barrier for carers. **Advice & Guidance and Referral Management Services** ⁄ We will need to support the patient and carer through effective communication if the pathway doesn't follow the expected course, e.g. being managed in primary care or community rather than referral to secondary care. **Virtual Consultations** ⁄ There is a potential that carers may not be able to attend virtual appointment due to their caring responsibilities, and whether they are able to bring the person they are caring for with them to the appointment. ⁄ Virtual consultations may be beneficial to carers as they potentially reduce the difficulty from having to travel to clinic.
Socio-economic status Identify any adverse potential impact because of deprived communities and identify which communities you may need to specifically consider.	**PIFU** ⁄ We know that some individuals in more deprived areas may not have access or understanding of how to use technology. This may limit people's ability to engage in virtual consultations. Digital poverty, combined with the current cost of living crisis, may limit people's ability to access services in this way. Services should not assume all patients will be able to access virtual consultations with a process built in to ensure patients can access services in the traditional way if needed. ⁄ Health literacy tends to be lower in more deprived areas. PIFU relies on the patient having an understanding of their condition and how to look out for signs that suggest they may need a follow up. This will need to be carefully managed and patients supported with information and advice they need.

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	⁄ People in more deprived areas are more likely to experience barriers to contacting the hospital, so this will need to be carefully considered in terms of a patient's suitability to be on PIFU. ⁄ Reducing unnecessary hospital trips may be beneficial for someone on a lower income or in employment where it is more difficult to take time out to attend appointments. **Advice & Guidance and Referral Management Services** ⁄ People from more deprived areas struggle to access services. If the GP practice is closer to home, the patient may benefit from being managed in primary care with advice and guidance, rather than being referred to secondary care. **Virtual Consultations** ⁄ Some patients may be unable to travel to the sites as they may be further away from their locality and therefore more expensive to travel to, which will mean patients remaining at the trusts. ⁄ Impact on poverty on digital communications/ability to make a call where they may have no credit or data and therefore potential for higher DNAs and delay. ⁄ Impact on poverty on digital communications as potential for individuals to not have access to computers/smart devices to access PIFU and VC.
Pregnancy or maternity Identify any adverse potential impact because of pregnancy or maternity.	**PIFU** ⁄ Travel to a site might be difficult for some pregnant people. Person who has a baby may not have other childcare options, so avoiding any unnecessary referrals may be beneficial. **Advice & Guidance and Referral Management Services** ⁄ Maternity not part of A&G/RAS **Virtual Consultations** ⁄ Travel to a site might be difficult for some pregnant people. Person who has a baby may not have other childcare options, so virtual consultations may be beneficial. ⁄ The implementation of Virtual consultation may improve a pregnant patient experience with not being required to travel to a site.
Marriage /civil partnership This category is only required for employment discrimination matters.	**PIFU** ⁄ Health services play a role in identifying potential victims of domestic abuse. Potentially having less contact with health services whilst on a PIFU pathway may be a risk. ⁄ People in abusive relationships may experience their partners limiting their access to health care. Safeguarding measures needs to be considered in the implementation of PIFU. More info.

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	Advice & Guidance and Referral Management Services ／ No known barriers at this time. **Virtual Consultations** ／ Health services come into contact with victims of domestic abuse and can spot signs. By the nature of virtual consultations, staff may not spot signs of abuse as they may have done in person. Also, the patient if experiencing domestic abuse where the partner is in the same place, may not be able to speak freely on the virtual consultation – this may hinder care. Safeguarding needs to be carefully considered. More info.
Other Are there other discriminations or disadvantages that you think you need to address?	

8. Can the adverse impacts you identified be justified and the original proposals implemented without making any adjustments to them? If so, please set out the basis on which you justify implementing the proposals without adjustments.

The impacts identified above are potential impacts individuals within protected characteristics face as a result of the programme. Where possible, adjustments to the initiatives will be made line with identifying and addressing potential Health Inequalities. Where the potential as an adjustment is not possible, advice and guidance will be south from Health Inequality leads on we best support and mitigate impact.

9. Having analysed the initial and additional sources of information including feedback from consultation, is there any evidence that the proposed changes will have a *positive* impact on any of these different groups of people and/or promote equality of opportunity? Please provide details of who will benefit from the positive impacts and the evidence and analysis used to identify them.

Integrated elective care aims to have positive impacts on the population, by enabling patients to be treated quicker, and supported to lead healthier lives. However, the impact will be monitored and any barriers to access of care and inequalities noted in this assessment will be continuously reviewed.

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- Virtual consultations will negate the need for patients to travel
- A&G/RAS will support patients being seen at the right place and time, decreasing the potential of patients making unnecessary travel and attendances.
- PIFU will empower patients to have a choice in their follow up care approach, and for it to fit around their needs.
- New technology will improve accessibility for patients to view/manage appointments and care records.
- Patients with long term conditions who are put on a PIFU pathway will also benefit as PIFU will allow them to make an appointment when they are having a flare up or experiencing a change in symptoms.
- Many patients with long term conditions spend a significant amount of time visiting hospitals for routine appointments, PIFU means that they will no longer have to travel to hospital unless clinically necessary. For most patients, this will reduce time taken out of their lives to attend appointments, reducing their anxiety and the associated costs for travel and/or car parking, and therefore help reduce the inequalities that these groups face.
- PIFU and wider Patient Engagement Platform use will enable individuals to have more choice in appointment booking and will be able to avoid Religious/Holy days.

10. Is there any evidence that the proposed changes have *no* equality impacts? Please provide details of the evidence and analysis used to reach the conclusion that the proposed changes have no impact on any of these different groups of people.

No

11. Please provide details of how you will consult and involve communities on the proposed changes. If you do not plan to consult and involve, please provide the rationale behind that decision.

A strategy for involving people and communities in the GM Elective Care Recovery and Reform Programme is being developed. We will be undertaking engagement around some of the initiatives within this EIA.

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Step 3 – Strengthening your policy plan or project

Please use the table below to document your strengthening actions.

12. What changes are you planning to make to your original proposals to minimise or eliminate the adverse equality impacts you have found?

Please provide details of the proposed actions, timetable for making the changes and the person(s) responsible for making the changes.

Adverse impact	Proposed action	Person responsible
Advice and guidance Referral Assessment Services Care Navigation Hub PIFU & 'straight to discharge' Virtual Consultations Pathway redesign	⁄ Ensure diverse patient representation is included in key programme forums. ⁄ Continue to link in with Health Inequality leads to review progress and impact of project. ⁄ A&G/RAS (Specialist Advice)- GP to be thinking about needs of patients. Communication to GP and Secondary Care Clinicians for inclusion to prevent patients being referred when this is unnecessary.	Elective Care Programme Director (Vicky Sharrock) Integrated Elective Care Programme Manager (Becky Leahy) Engagement and Communications Manager (Rachel Richardson)

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	⁄ Communications should be clear around considering wider factors in patients' life, and the principles of personalised care and patient choice should be embedded in the practice. ⁄ CNH - Report will be reviewed in December '22, and final recommendations will be included and build into the project plan. ⁄ PIFU – It is important to ensure PIFU is available to people, and that it isn't avoided due to barriers. We will link into NHSEI Evaluation Pathway ⁄ Virtual Consultations – Workshops and focus sessions will include discussions around health inequalities. Learning will be shared from Personalised Care. (How to bring people into focus groups)	

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	⁄ Systems to ensure accessible information standards are met through all these services, need to be considered in the design and implementation. ⁄ PIFU and Virtual consultation implementation needs to take into account wider determinants of health, e.g., communication needs when assessing a patient's suitability. ⁄ Consider safeguarding for vulnerable groups when PIFU and VC is being rolled out.	

13. Describe here how you could further promote equality of opportunity. What action/s do you recommend and when?

This is where you are taking the opportunity to advance addressing inequalities beyond the mitigations you are putting in place, for example, your mitigations when moving a service to digital provision will be to ensure alternatives are available for those who cannot access digital services. Your opportunity to *further promote* equality with a new digital service would be to extend a service to people from their own home where they had previously experienced physical barriers to reaching your surgery.

⁄ Further promotion of equality and communication accessibility of initiatives and technology. ⁄ Increase use of diverse patient representation and personalised care representation to review and monitor project progress and identify potential impact/mitigations required. ⁄ Ensure EIA is updated/completed for specific programmes/pilots to identify any impact.

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14. Describe how you could further promote human rights principles. What action/s do you recommend and when? Please provide details.

For example, if you are putting in place improved access to interpreter provision that may enhance the human rights of those that need it to access public services.

⁄ Equality of access to health and care (ensure implementation/alignment to) as outlined in the form above. ⁄ Treating people with dignity and respect ⁄ Best interest decisions (ensure implementation/alignment)

15. Describe how you could further reduce socio-economic disadvantage. What action/s do you recommend and when?

For example, if you are undertaking a focused anti-smoking campaign in areas of high deprivation, you can expect to reduce socio-economic disadvantage.

To review options where additional support could be provided to patients. • Cost of living crises • Poverty proofing across the programme where possible

16. Describe here how you could further promote social value. What action/s do you recommend and when?

For example, you might be able to offer new jobs or apprenticeships to people struggling to get employment or offer contracts to community led social enterprises to deliver your services.

This will depend on what has been built into the contracts by the CCGs. Some require all providers to describe their approach to and delivery of social value. Where this is not a contractual requirement, ISPs will be asked to promote social value where possible on the basis that this support improved delivery of services to our communities. Any potential connections into the system through focus groups/volunteers will be explored as part of programme scoping and delivery.

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Step 4 – Monitoring and review

17. You are legally required to monitor and review the proposed changes after implementation of your strategy or programme to check they work as planned and to screen for unexpected equality impacts. Please provide details of how you will monitor, evaluate or review your proposals and when the review will take place.

What	When	How
Review of EIA in light of any new proposals/pilots/projects. At the moment the programme has a constant stream of pipeline opportunities which will need EIA consideration, as well as learning from completed initiatives.	Monthly (Monthly for the first 12 months, then move to quarterly)	EIA review by Programme Team with support from ED&I Lead. Any changes to be presented to GM HI Group
Review of EIA in light of Care Navigation Hub Pilot learning	January 2023	EIA review by Programme Team and Care Navigation Hub Lead with support from ED&I Lead. Any changes to be presented to GM HI Group

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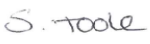
Step 5 – Sign off

Strategy, policy, plan, project or service owner or Work Programme Lead*	
Name: Rebecca Leahy Signature: 	Date: 12.01.2023
EIA Lead (the person completing this form) This equality analysis has been quality-checked and will be passed to the senior responsible officer for final sign off.	
Name: Susan Toole Signature: 	Date: 13.01.2023
Director or Senior Responsible Owner * This equality impact assessment has been completed in a rigorous and robust manner and I agree with the actions identified. It will now be progressed and published where required.	
Name: Signature: 	Date: 12.01.2023

*By signing off your EIA you are confirming that you are satisfied that the policy/strategy/project/activity/service has been designed with the needs of different equality groups and communities in mind, and that the groups it is intended to serve will be able to access the service and experience similar outcomes from it.

For records, this EIA will also need to be copied to elaine.mills7@nhs.net to ensure we can evidence our legal duties to undertake equality analysis. However, the original version must be kept with the project documents and pro-actively used to inform the progress of the work, alongside budget, risk and health and safety monitoring.

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