NHS
Greater Manchester
Integrated Care

Equality Analysis Template

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	Children & Young People Pillar		
Contact details for the person completing the assessment	Sandra Sah		
Design date for the strategy/policy/plan/project	From Aug 2022		
Date your equality analysis is completed	Current version – 27 February 2023		
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 Children & Young People 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.

1. Initial screening assessment

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

The key objectives for this programme are:

- The Development and implementation of system wide, shared principles and ways of working within clinical specialities across trusts / sectors.
- To maximise the potential capacity of each speciality within - GM sites, Neighbouring trusts, Independent Sector.
- Development of a weekly annual plan update from each specialty at each site reporting: actual completed activity against planned activity, reasons for variance, recovery plan to achieve agreed end of year forecast
- Consistent use of the HAPPs (Holistic Assessment Paediatric Patient Score) tool which includes assessment of psychological impact, organ damage / deformity, pain, and other symptoms for children across all children's surgical services.
- Develop a generic / common children's surgical pathway, which can front -end speciality pathways
- Develop speciality surgical hubs to maximise the efficient use of resources and staffing.
- Optimise day cases/ WIWO activity across all C&YP elective care.
- Development and implementation of a single referral process for C&YP elective care
- Development of C&YP diagnostic referral pathways for primary care

What is your expected outcome?

The expected impact and outcomes include:

- Benefits to patients:
    - Reduced waiting times
    - Equity of access and clinical outcomes.
    - Improved patient experience
- Benefits to GM trusts:
    - Reduced waiting lists
    - Capacity at RMCH for the most complex and clinically urgent patients
    - Improved effectiveness and efficient use of resources within specialities
    - Improved relationships, team working and clinical practice, facilitating improved staff development opportunities.
- Benefits to GM:
    - Deliver national expectations in relation to equitable access for children and young people.
    - Contribution to the reductions of 78+ and 52+ week waiters across GM
    - An increase in available capacity for children and young people needing specialist elective care across GM
    - Improved workforce retention and recruitment as a best place to work.

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?

   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 theme is only one of a number within the overall Elective Care 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 linked to poverty 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 • 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.

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.)

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
Further engagement work is needed.		

5. Involvement and consultation

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)

Consultation and involvement that has taken place, who with, when and how?
The GM Elective Recovery Programme has a dedicated Communications and Engagement, & Equality, Diversity & Inclusion resource who will be responsible for the communications across GM for the whole of the programme and supporting ED&I objectives. They will take an overview of the programme as a whole to the ICS and Trust Engagement leads who will in turn be asked to engage with their patient and public/health inequalities groups, feeding back on any gaps and need for actions. It is proposed that this 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 engagement with wider stakeholders. This will be in collaboration with the nominated pillar EIA champion.		
Key feedback from consultation: At this time, it is unknown if a consultation will be required as part of this Programme. This will be closely monitored, and consultation requirements will be followed at the point of identification. The Communications and Engagement, & Equality, Diversity & Inclusion leads will also work to increase involvement and engagement with wider stakeholders. Plans for this are still evolving		
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 Board • Children and Young Peoples' Pillar Programme Group. • GM Elective Care Recovery and Reform Operational group • GM Elective Care Recovery and Reform COO Group • GM Clinical Reference Groups	Ongoing review as progress is made and regular communication will be maintained with all key groups.	Nominated EIA Champion for the pillar and will ensure EIA is reviewed and repeated as proposals are put to board.

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.

Ongoing clinical prioritisation tool pilot with possible roll out in 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 tool.

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 aged 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	Some patients of all ages may not be able to access hospital sites due to: • Travel – carers may not own transport or limited public transport available in area they live. • Carer working and services not available at suitable times. • Limited availability of carer to take them to sites or dependent on carer • Parents/carers of multiple children may struggle with childcare arrangements when attending appointments • Potential negative impact on education due to attendance of appointments that may be further away from home. • Additional barriers for children and young people might include anxiety around attending medical appointments and the impact of Covid on the mental health of many young people, particularly for neurodiverse young people. • Children and young people will mostly be reliant on a parent or carer to take them to the appointment so this will be a barrier for those living in households with people of working age who are in low paid, insecure work and who have restrictions on when they can take a child to an appointment and stay with them, especially if this requires a longer journey.
Disability Types of impairment can be categorised as physical, sensory, psychosocial, and intellectual. There are several types of barrier that cause exclusion including • Physical • Social/attitudinal	Some known barriers may include: • Communication of information in the right format to meet the Accessible Information Standard, information in alternative formats, such as large print, braille or easy read, this will need to be provided to enable them to make an informed decision • Travel and transport • Anxiety linked to new, unfamiliar venues for neurodiverse children and young people or for those with mental health conditions and those with visual impairments, • Need for an advocate.

<table>
<tr><td>

- Institutional
- Communication

Complete which *barriers* you will need to consider in your programme.</td><td>

- Access to parking, particularly disabled spaces is important and can be a barrier for some people to access care
- Access to wheelchair taxis is very limited and needs to be considered further.</td></tr>
<tr><td>Sex
Identify any potential adverse impact to men or women.</td><td>

- Flexibility is needed around choice of gender of clinician especially in some specialities linked to sex e.g. gynaecology for girls/children and young people assigned female at birth</td></tr>
<tr><td>Race
Identify any adverse potential impact on different ethnic groups and identify which ethnic groups you may need to specifically consider.</td><td>

- Need for choice of gender of clinician and/or chaperone.
- Information in the right language and access to an interpreter for not only the appointment but any booking queries.
- Known barriers experienced by refugees, asylum seekers, Roma, travellers, and migrant health communities who may not be familiar with the NHS, Greater Manchester and therefore might need more support to find sites and with transport information.
- GM Elective inequality dashboard also highlights that further barriers need to be addressed due to people from Black or Black British and Asian or Asian British are waiting longer than average for treatment.
- A lack of cultural inclusivity is known to be a barrier for some people (and low trust based on historic mistrust of public services and systemic racism). People need information that is easily accessible and culturally appropriate. If someone needs information in alternative languages, this will need to be provided. This also goes for any follow up information that is needed to support them.</td></tr>
<tr><td>Religion/ belief
Identify any adverse potential impact on different religious groups and identify which you may need to specifically consider.</td><td>Religion and spirituality can impact a person's decision on how they access health care

- Patients from some faiths would only be able to see a clinician of the same gender, may be restricted by availability of a chaperone to attend with them, may need choice of day to avoid holy days.
- Some religions have prayer times that may interfere with medical treatment. Reasonable adjustments will need to be considered.</td></tr>
<tr><td>Sexual Orientation
Identify any adverse potential impact on different sexual orientations and identify which sexual orientations you may need to specifically consider.</td><td>

- There is a need to ensure that LGBQ CYP and parents/carers who have known poorer access to, experience of and outcomes from health services don't experience discrimination when attending a different site – they may have had a bad experience with one provider and therefore low trust so need choice wherever possible.</td></tr>
</table>

Transgender Identify any adverse potential impact on transgender or non-binary people.	• Further consideration is needed regarding the impact and complexities around gender reassignment.
Carer status	• Carers may be required to work during the day which may prevent access to services during daytime for children and young people. • Some children and young people are carers for adults or siblings so need cover to be able to attend appointments
Socio-economic status Identify any adverse potential impact because of deprived communities and identify which communities you may need to specifically consider.	• We know from the GM elective inequality dashboard that people form more deprived areas are waiting longer for treatment. Parents/carers who rely on public transport can find the unreliability of transport a barrier due to the cost of transport as well as the frequency of services. • Children and young people need to rely on their parents/carers to take them for treatment and may have to wait longer for treatment due to parent/carer availability from work (which they may not always have due to the type of role/shifts and may be in insecure roles) • Impact of 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.
Pregnancy or maternity Identify any adverse potential impact because of pregnancy or maternity.	N/A
Marriage /civil partnership This category is only required for employment discrimination matters.	N/A
Other Are there other discriminations or disadvantages that you think you need to address?	N/A

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.

No, as there are several factors that need to be considered to help parents/carers of CYP attend appointments.

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.

The Children's & Young People Pillar aims to have positive impacts on the population, by enabling children and young people to be treated quicker and supported to lead healthier lives. However, impact will be monitored and any barriers to access of care and inequalities noted in this assessment will be continuously reviewed.

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, it does have impact on equality.

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.

At this time, it is unknown if a consultation will be required as part of this Programme.

This will be closely monitored, and consultation requirements will be followed at the point of identification

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
Children and young people need to rely on their parents/carers to take them for treatment and may have to wait longer for treatment due to parent/carer availability	CYP Services will need to be flexible and consider individual needs to support people to access care by incorporating use of the GM	GM Trusts

from work (which they may not always have due to the type of role/shifts and may be in insecure roles). Parents/Carers may be required to work during the day which may prevent access to services during daytime for children and young people.	Access Policy to ensure clear standardised referrals.	
If people are being asked to travel further and they don't have access to transport, this could be a barrier. Some of these people will also not be eligible for patient transport services which has quite strict eligibility criteria.	Requires further discussion across GM Trusts as to approach to be taken.	GM Trusts
Digital Communication – not all patients may have access to smart phones or to the internet	Alternative communication arrangements need to be arranged. This includes: Provide messages via letters or phone calls.	GM, Trust, and Contract leads (Depending on arrangement agreed)
Some patients may want to be seen by same sex clinician. e.g., female patients by female clinician	Patient choice needs to be considered depending on various needs & clinical priority.	GM Trusts

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.

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.

Ensuring that we regularly review the delivery of the different elements of the programme from an inequalities perspective to ensure that the design and resourcing of the programme does not create any further inequity. Each provider of healthcare services is required to ensure that patients and service users have access to translation / advocacy services. Alternative methods of communications should also be provided at trust level, e.g., alternative language leaflet, large print for visually impaired, opportunity of access to hearing loops provision within healthcare settings.

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 to encourage access to services. e.g. • Cost of living crises • Explore free transport offers • 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. Some require all providers to describe their approach to and delivery of social value. Where this is not a contractual requirement, CYP services will be asked to promote social value where possible on the basis that this support improved delivery of services to our communities. Any initiatives that propose a significant change to access or delivery will require further EIA and QIA assessments which should include workforce consideration. If changes to service delivery is proposed, where possible, we need to consider opportunities for services to offer good employment to local people to contribute to their wider health and wellbeing. Ways in which employment opportunities can be targeted at people who might benefit from this the most will need to be considered.

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.	Monthly (Monthly for the first 12 months, then move to quarterly)	EIA review by Pillar group & Programme Team with support from EIA champion. Further support can be requested from the ED&I programme lead.

Step 5 – Sign off

Strategy, policy, plan, project or service owner or Work Programme Lead*	
Name: Sandra Sah	Date: 31.01.2023
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: Jennifer Kamau	Date: 31.01.2023
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: Rachel Barber	Date: 27/02/2023

*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.