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	Elective Recovery Programme – Risk Stratification Tool		
Contact details for the person completing the assessment	Holly Crabtree, Project Manager holly.crabtree@nhs.net		
Design date for the strategy/policy/plan/project	March 2023		
Date your equality analysis is completed	Current draft – 20 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:	• This EIA will ensure that we consider the impact of introducing a risk stratification tool on health inequalities and how having a tool to support clinical prioritisation and reprioritisation can positively impact protected groups.		

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

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

The aim of this project is to pilot a GM built risk stratification tool in one specialty to understand its effectiveness in:

- Supporting Clinicians with waiting list validation
- Prioritising patients based on clinical need across various metrics
- Supporting better patient outcomes
- Reducing health inequalities

The outcome of the pilot will determine what impact the tool has on patients and if the tool is suitable to be rolled out across all specialties and Trusts.

What is your expected outcome?

- Patients will be seen on the basis of clinical priority and risk whilst taking into account other determinants of health, which will reduce the impact of other factors such as socio-economic status or ethnicity. This will help to reduce inequities in access to care and ensure that patients who need treatment the most receive it first. The tool will also help to reduce waiting times for patients by prioritising those who require urgent treatment. This can help to reduce the risk of patients experiencing deterioration in their condition while waiting for a procedure and reduce health inequalities.

Who will benefit?

- Patients – improved patient outcomes
- Clinicians – support with waiting list validation process

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

- GM Elective Recovery Programme and GM Recovery 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)

- Specific locations of GM and their patient population need to be considered. Mortality rates/access to services differ – postcode lottery factor, known inequalities for people living in more deprived areas and challenges of poor transport connectivity between some different localities

  ⁄ Risk stratification element must consider different health needs of various groups across GM

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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 project 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) Risk stratification data
- Health inequalities data – including Tableau, – Public Health England 'Beyond the Data' published in 2020, Chairs and Chief Executives Ethnic Minority Network report 24 March 2021, Greater Manchester Independent Inequalities Commission - The Next Level: Good Lives for All , Baroness Doreen Lawrence review – An Avoidable Crisis , The NHS National LGBT Action Plan 2017, Better for Women and Girls strategy 2019 , Taking place-based action to reduce health inequalities and build back better and fairer 2021, NHS Accessible information standards and the National LeDeR programme refresh, Home page - NHS - Race and Health ObservatoryNHS – Race and Health Observatory (nhsrho.org)

The risk stratification tool includes the following data sets:

- UEC interaction not leading to admission
- Emergency admission
- GP activity
- Community prescribing for pain, depression or anxiety
- Mental health care status
- Adult social care status

- In addition to this EIA we need to review and act on EIAs for performance, quality and improvement monitoring completed by the former 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

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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

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 tool has been presented and discussed at COOs, EMDs, GM operational group, Waiting List Pillar and ECRR Board. The tool has also been presented to four CRGs (Gynae, Orthopaedics, General Surgery and Ophthalmology) and two demo sessions have been run for over 40 attendees across specialties (T&O, Ophthalmology, Urology, Oral Surgery, Maxillofacial, Haematology, Vascular, Cancer).

Key feedback from consultation:
• Feedback has been mostly positive, with the only negative feedback coming from ophthalmology colleagues who didn't believe the tool would be useful within their specialty. The main feedback for the tool has been suggestions for further developments which are outlined below:
  ○ Inclusion of GP activity, observations and long-term conditions registers
  ○ Highlight patient's adult social care packages of care and reviews

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○ Inclusion of cancer pathway flag ○ Add comparisons with general population for context ○ Bring through detail of patient activity, e.g. reason for attendance at A&E, medications prescribed ○ Consultant cohort identification and re-identification of patients ○ Inclusion of observed level of risk score to support quicker identification of patients at risk ○ Predictive risk scores to understand likely deterioration of patients at risk ○ Identify the availability of 'quality of life' patient scores, e.g. PROMs ○ Investigate potential for tailoring views, e.g. one specialty's view may look different to another •
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:
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 • GM Elective Care Recovery and Reform Operational group • GM Clinical Reference Groups • GM Executive Medical Directors • Waiting List Pillar Programme Team • Chief Operating Officers • Chief Data Officers	• The tool and progress will continue to be regularly communicated with all key groups	• Key programme forums include representation from Health Inequality leads.

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.

N/A – this EIA is for the first pilot.

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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	• Older age groups may experience more significant deterioration if waiting times are excessive • Child waiting may impact their developmental milestones • Working age people may have insecure work/zero hour contracts and excessive wait times may cause them to lose their job
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 • Institutional • Communication Complete which *barriers* you will need to consider in your programme.	• Some may experience issues with regards to keeping track of where they are on the wait list / understanding prioritisation. • Social factors may cause some patients to appear more clinically prioritised – medical assessment would be necessary, i.e. communication of symptoms taken into account • LD adaptations necessary i.e. the presence of anxiety disorders and having to travel to unfamiliar places, may be more likely to decline offers.
Sex Identify any potential adverse impact to men or women.	• Potential that the choice of the gender of the healthcare practitioner/consultant can't be guaranteed - patient may therefore decide to wait • Potential that the choice of the gender of the healthcare practitioner/consultant can't be communicated in advance of appointment • Evidence to suggest women wait longer for appointments (RC Obstetricians & Gynae)
Race Identify any adverse potential impact on different ethnic groups and identify which ethnic	• Difference in health education across various ethnic groups (migrants, refugees, asylum seekers) across GM – how to engage • Language barriers to communicating

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groups you may need to specifically consider.	• Certain groups have poorer access to primary care, for example black men presenting later for prostate cancer; south Asian women with regards to cardiovascular issues. Identify various engagement methods
Religion/ belief Identify any adverse potential impact on different religious groups and identify which you may need to specifically consider.	• Potential that the choice of the gender of the healthcare practitioner/consultant can't be communicated in advance of appointment • Potential that the choice of the gender of the healthcare practitioner/consultant can't be guaranteed - patient may therefore decide to wait • Potential of being unable to access appointments at certain times or days due to religious practice
Sexual Orientation Identify any adverse potential impact on different sexual orientations and identify which sexual orientations you may need to specifically consider.	• LGBTQI+ community is nationally disadvantaged when it comes to access and utilisation of healthcare i.e. may present later to hospital, or be reluctant to go to a new provider – Needs to be an education programme to healthcare staff of how to interact with patients from this community
Transgender Identify any adverse potential impact on transgender or non-binary people.	• LGBTQI+ community is nationally disadvantaged when it comes to access and utilisation of healthcare i.e. may present later to hospital, or be reluctant to go to a new provider, attending a follow-up appointment – Identifying within referral preferred name etc.
Carer status	• Added complication for carers if appointments are outside normal Locality – increased stress and more administration/calendar management involved
Socio-economic status Identify any adverse potential impact because of deprived communities and identify which communities you may need to specifically consider.	• People in poorer socio-economic areas may not be able to change appointments / treatment dates due to insecure work or unable to make the journey if they have to rely on someone else • May have lower health education, therefore, may not understand methodology/justification for wait times of their care.
Pregnancy or maternity Identify any adverse potential impact because of pregnancy or maternity.	• Lack of continuity of healthcare can increase risk during this time; understanding of person's specific needs important good comms and support continuity of all relevant info
Marriage /civil partnership This category is only required for employment discrimination matters.	N/A

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Other Are there other discriminations or disadvantages that you think you need to address?	• Impact of more than one protected characteristic • There are potential gaps in the recording of some of the informa which would support prioritisation as we are relying on protected characteristics and wider determinants of health being recorded consistently across GM

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, however mitigating actions will be built into the programme.

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 risk stratification tool has been designed to reach disadvantaged groups on our waiting lists, and to allow for a fairer distribution of waiting times across the population.
It is expected that those at greatest risk of deterioration will be seen quicker, which is likely to have a bigger impact on those who are most disadvantaged.

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, the risk stratification tool is designed to help those most in need to access care.

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.

As this is an initial pilot to test the usability and effectiveness of the tool there will be no engagement and involvement of communities at this point, but this will be reviewed if the tool is approved for roll out across GM.

Step 3 – Strengthening your policy plan or project

Please use the table below to document your strengthening actions.

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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
Some low-risk patients may end up waiting longer for treatment as other patients are re-prioritised above them	Offers of support whilst patients are waiting, such as while you wait website, community support	Clinician
Patients who are re-prioritised may be unable to make sooner appointments / treatment dates due to work / caring responsibilities / inability to travel	Clinician to contact patient to discuss options before making any changes and offer patient choice and transport if required.	Clinician
Some high-risk patients may not flag up if they have not been in contact with other services, and may wait longer as other high-risk patients are re-prioritised	Tool to incorporate as many data sources as possible to flag high-risk patients, with new iterations of the tool developed as feedback and data is received	BI Team

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.

If the tool is approved for full roll out following the pilot, the specialties the tool is rolled out to first would focus on those specialties most in need.

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

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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.

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.

Through use of the CORE20PLUS5 filter built into the tool, which allows clinicians to focus solely on this population

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.

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
Pilot evaluation	Post pilot	There will be a set of key measures that are monitored against throughout the pilot to evidence better patient outcomes, reduced waiting times, reduction in health inequalities
Clinician feedback	Throughout the pilot and post pilot	Qualitative data collection on effectiveness of tool in supporting decision making

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Step 5 – Sign off

Strategy, policy, plan, project or service owner or Work Programme Lead*	
Name Laura Janda	Date 22/02/2023
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 Holly Crabtree	Date 22/02/2023
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 Sharon White	Date 22/02/2023

*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.

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