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	Programme 2: Productivity & Efficiencies		
Contact details for the person completing the assessment	Waleed.abdi1@nhs.net		
Design date for the strategy/policy/plan/project	FYE: 22/23		
Date your equality analysis is completed	September 2022		
Does this template form part of a business case or investment proposal submission?	Yes	No (circled)	Unsure
Are you completing this as a result of organisation change?	Yes	No (circled)	Unsure
Is there another reason for you completing this template – e.g. renewal of a current service/change to current service – please specify:	The re-launch and re-design of the Elective Recovery Governance and programmes of work		

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?

Overarching Aim:
We will ensure that all parts of the system operate as efficiently as possible to reduce waiting times and improve overall patient experience

Programme 2 Objectives:
We will deliver improved productivity and delivery through a robust GM productivity & Efficiency programme

We will use the opportunities described in The Model Health System, incorporating GIRFT principles and Right Care intelligence, to set standards for improved clinical outcomes for patients and improved productivity by minimising unwarranted variation across the system. This includes engagement of wider stakeholder partners that influence patient flow including primary care, social care and community services.

What is your expected outcome?
Outcomes being considered are:

- Improved Theatre Touch-Time Utilisation
- Optimisation and achievement of BADS Day Surgery rates
- Implementation of HVLC lists and achievement of national GIRFT metrics
- Improving Outpatient Productivity:
  - Utilisation – reduction in DNAs / Use of Virtual appointments
  - Increase capacity - Implementation of PIFU/Straight to Discharge pathways
  - Increase productivity – increase in first appointments and outpatient procedures
  - Demand Management – A&G

- People/workforce: Utilisation of potential new staffing models and reduction in Staff absences
- Activity:
  - Supporting delivery on RTT milestone target / trajectory
  - Improving patient experience via reduced wait times for longest waiters
- Capacity:
  - An increase in available capacity for patients needing specialist Elective Care in GM
  - Capacity freed for the most complex and clinically urgent patients
- Resources:
  - Effective use of resources (including staff and estates) demonstrating achievement of productivity and efficiency gains with stretch aim for GM to be in top decile performance for Day Surgery & Theatre touch-time utilisation
  - Contribute to financial benefits for Trusts in terms of ERF funding or reduced running costs

Who will benefit?

Improved productivity and efficiencies will enable Trusts to optimise utilisation of current resources releasing capacity and enabling a reduction in waiting times for surgical procedures.

- Benefits to patients:
  - Reduced waiting times
  - Improved patient experience
  - Improved standard pathways at the centre of their own care

- Benefits to GM trusts:
  - Reduced waiting lists

- Effective use of resources which may realise financial benefits in terms of ERF funding or reduced running costs
- Capacity freed for the most complex and clinically urgent patients

➢ Benefits to GM:
- An increase in available capacity for patients needing specialist Elective Care in GM
- Contribution to the reduction of 78+ and 52+ week waiters across GM
- Meet national Targets and achieve dop decile outcome measures

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

Yes – this forms part of the GM Elective Recovery Programme 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)

It is not anticipated that this programme will impact adversely on any protected characteristics or specific patient groups. It should be noted that any initiatives being considered for implementation which will improve productivity and efficiency should ensure that the EIA process is repeated, and mitigations considered for all protected characteristics: Addressing inequalities by removing barriers to access will underpin this part of the programme. Equally important will be the need to ensure that any recommendations made within the programme e.g. demand management and increased capacity, do not unintentionally create further inequalities.

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).

The Elective recovery and reform governance structure will review waiting list types split by Age, Ethnicity, Sex and Deprivation. Should any initiatives be introduced as part of the improvement within Productivity and Efficiency across GM a separate EIA assessment will be required (E.G. Implementation of Hubs, 7 day working etc) and mitigations considered as detailed in section 2 above. We will continue to address new national and local research, evidence and intelligence about the impact of waiting times on people with different protected characteristics when reviewing the design of the programme as a whole e.g. We need to focus on inequalities to address NHS waiting list | Healthwatch and Gynaecology waits soar by 60% during pandemic - BBC News

In addition to the assessment as a GM initiative Trusts/providers are required to also ensure the required EIA and Quality Impact assessment are performed to enable an assessment at local level of any changes they wish to implement at Trust level. Trusts will be required to provide assurance to the Elective Recovery Board.

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
We need to do further work to understand the links between the different parts of the programme and how they can support improved access for people who are currently waiting longer than average e.g. a decision to focus more resources within the PIFU part of the programme may appear to be more cost effective than other options but may have a detrimental impact on people living in poverty who may be less	This needs to be collated at programme level as we start to compare the impact of the different parts of the programme.	Pillar team, Elective programme lead and, the health inequalities lead.

able to self manage than others.		

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 resource who will be responsible for the communications across GM for the whole of the programme. Within the Health Inequalities in Elective Recovery forum and Clinical Reference Groups there is a review of the waiting list by protected characteristics to understand whether any particular groups are adversely affected by longer waits. Increasing productivity is an opportunity to enable more patients to be seen more quickly and will be utilised in conjunction with a proposed risk stratification approach which will identify those that have the greatest need. **An initial overview of the whole programme has been shared with GMIC Engagement Leads at the end of June 22 who have agreed to support engagement on future phases of the programme. This will support the development of an engagement plan across all stakeholders i.e. GMIC, Trusts, ISPs, patients, public, VCSE organisations.**
Key feedback from consultation: TBC. There is no coordinated mechanism in place yet to gather and act upon feedback from localities.

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**
The Elective recovery and reform programme will direct and manage the programmes of work required to address improvements to productivity and efficiencies. Should a proposal impact on the delivery of services engagement with key stakeholders will be considered and the EIA revisited.	On-going for example covered via Deputy Place Leads meeting	The EIA will be repeated as proposals are approved via the 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.

Productivity improvement largely relates to improving the processes that enable more efficient delivery of the clinical pathway. We will ensure that any current delivery models and changes brought in do not create inequity e.g. reduction in waiting times only for those who are able to use digital services or who can travel independently to a site further away where people living in poverty do not have the same options The intention is for the changes to offer an improved experience for protected groups in being able to be seen more quickly and in a streamlined way e.g. through one stop clinics.

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	• Ensure services are accessible to an ageing population, i.e. consider patient transport options and accessibility via public transport (times, distance and ease of journey), as well as adequate car parking. • Consider how younger people can access and benefit from services and pathways. Operating hours need to ensure accessibility for young people in education as well as older people who may be reliant on working family members or carers for transport to healthcare services. • Consider how to minimise the cost of travel to sites for people with less disposable income, including young and older people. • Consider the barriers for people of working age in terms of when services are offered and their ability to take time off work
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.	• Access to appropriate transport for disabled people needs to be considered. Physical access to facilities for disabled people must be addressed. • Literature relating to service changes, including appointment letters, will have to be provided in accessible formats. • Locations and signage will need to be accessible for visually impaired patients, taking into account access routes from public transport stops • People with hearing loss may need adjustments relating to booking services (e.g. written communication as opposed to phone calls) and clinical appointments (e.g. sign language interpreters). • People with a learning disability are more likely than the rest of the population to have an impairment to communication. Therefore adjustments would be required throughout the patient journey including: Easy Read, communication of appointments, access to locations, facilities available within sites (e.g. signage, Changing Places, waiting areas), extended appointment

	times, interpreting services and support for carers, advocate services. • There needs to be appropriate training for staff to address attitudinal issues and barriers for disabled people. • Support for people who are Neurodiverse or anxious and unfamiliar with the environment and staff.
Sex Identify any potential adverse impact to men or women.	• Services need to be designed in such a way that meet the needs of both men and women. • Outreach and engagement for both men and women (condition specific) will need to be considered given varying recognition of actual risk levels pertaining to certain conditions. • Opening hours that are convenient for those with caring responsibilities will have to be considered • Need to address disproportionately longer waiting times for women
Race Identify any adverse potential impact on different ethnic groups and identify which ethnic groups you may need to specifically consider.	• The services offered and the way in which we engage people with services need to contribute to a reduction in health inequalities, and not inadvertently exacerbate them. In determining the service offer and prioritising pathway redesign work, we will have to consider those areas in which inequalities exist – there are known disparities in access, experience and outcomes for people from ethnic minority communities.. • When contemplating change we will need to ensure that staff are culturally competent so that everyone can feel confident and comfortable accessing services. Ongoing engagement to build trust with communities who experience poorer outcomes and may not currently fully access services will need to be considered. • For those for whom English is not their first language, communication regarding change in services will need to b an accessible format with access to translation services. Advocate and navigator services could also be considered Particular attention should be paid to the views of commu particularly affected by certain conditions in the developme of new related pathways • Need to ensure that information is clear and in plain English/with images and symbols for refugees, asylum seekers and migrants who are not familiar with the NHS a may not know that they do not need ID, that services are f of charge etc. They will also often need clear information c transport options as they may be less familiar with the loca of services.

Religion/ belief Identify any adverse potential impact on different religious groups and identify which you may need to specifically consider.	• The services offered and the way in which we engage people will need to consider religion and beliefs for both patients and staff. This includes consideration of appointment being offered on holy days, during fasting times etc. Need to offer chaperones for women and the ability to choose the gender of the clinician in certain situations.
Sexual Orientation Identify any adverse potential impact on different sexual orientations and identify which sexual orientations you may need to specifically consider.	• Individuals who are concerned about experiencing stigma based on their sexual orientation may be less likely to take up an offer of an appointment with a new provider but equally might prefer to choose a different provider based on previous experience of another provider.
Transgender Identify any adverse potential impact on transgender or non-binary people.	• As part of wider action, staff will need to have a good understanding of issues that trans and non-binary people have in accessing services and their rights under various legislation. • Particular attention will need to be paid to communication, including use of pronouns and proper reference to people's gender as opposed to their sex at birth when communicating with patients. However, sex at birth will be an important factor to determine what services should be made available to people who have transitioned. • Where single sex areas are required for services such as endoscopy, we will need to ensure that trans and non-binary people can be cared for in the appropriate areas and in way that provides respect and dignity • As with sexual orientation, some people may have had a poor experience with a provider which could influence their decision when offered an appointment.
Carer status	• Carers are likely to be restricted in terms of when they can attend appointments/how far they can travel and whether they can get alternative care in place both for a procedure and where they will need recovery time.
Socio-economic status Identify any adverse potential impact because of deprived communities and identify which communities you may need to specifically consider.	• It is clear that people living in the areas of highest deprivation are waiting longer for elective care. This is likely to be due to a range of issues, including digital exclusion e.g. no data, credit, smartphone; 'poor' employment where someone might not be able to know when they will have to work; cost of fuel, no car and cost of public transport. • Consideration needs to be given to groups of individuals living in poverty and how they can access services in terms of digital, location, transport obligations

Pregnancy or maternity Identify any adverse potential impact because of pregnancy or maternity.	• Where there are aims which impact on Maternity services or services for Pregnant women we should consider this impact. This might include having appropriate estate furniture, availability to parking facilities, barrier free public transport routes etc. However this should also apply to pregnant women and women with babies who need to access other services.
Marriage /civil partnership This category is only required for employment discrimination matters.	• None identified (this is from before same sex marriage and civil partnerships for heterosexual couples so the impact was on partners not being recognised as next of kin)
Other Are there other discriminations or disadvantages that you think you need to address?	• None identified

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.

This EIA is based on an overarching programme of work. Where changes to service delivery or access is proposed then a further EIA will be required to assess the impact on the characteristics and communities detailed in this assessment – adjustments can then be considered against the specific change being proposed.

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.

All protected groups are likely to benefit from the proposed improvement in productivity as the changes will enable patients to be seen quickly and in a streamlined way, particularly when implemented in conjunction with the risk stratification approach that will proactively identify those with greatest need. However this does rely on mitigating actions from individual workstreams being delivered and regular review of data to ensure that changes do not lead to

unintended inequalities. We will use national and local evidence and intelligence to ensure tha
anticipate this and design our programme to actively reduce existing inequalities.

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.

None identified.

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.

We will consult on improving productivity and efficiency as an overarching theme within the overall programme consultation. Initial the programme intends to improve service delivery within the current service delivery models in-situ.

Where it is identified that to improve productivity and efficiency it involves a change in the service delivery model significantly (e.g access to hubs, 7-day working 3 session theatres) a stakeholder analysis will be performed to identify the groups to consult and how this will be performed and it is recommended that the EIA is reviewed and consideration given to the groups identified in section 2 with mitigations considered against the specific proposal e.g hubs etc..

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

Access to services impacted in one of more of the groups detailed in this document	EIA repeated to ensure mitigations are considered and implemented if appropriate	Elective recovery Leads
Potential for changes to efficiency e.g. increased focus on PIFU to widen inequalities	EIAs for the different parts of the programme to be reviewed as a whole	Elective Care Director

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.

There could be risks within the following themes;

Digital
There is a risk that improvements to productivity and efficiencies may move to digital solutions to improve processes and access which will improve patients experience and access e.g. virtual appointments rather than Face to Face. However, there is a risk that not all patients will have this digital technology available, and it should not be assumed that all patients/service users have this knowledge. Therefore, services and access to services should continue to ensure that all patients/service user groups are considered and a non-digital appointment/services are available for those who choose not to communicate via the digital offer. This should never result in a patient having to wait longer for care.

Location
There is a risk that improvements to productivity and efficiencies may move to co-locate services or implement hub and spoke service delivery to improve processes and access which is aimed to reduce the risk of cancellation due to emergency work impact and ring fence elective activity – however there is a risk that the location of these hubs may be further for some patients than their local hospital / healthcare provider. Therefore, movement of services should assess the impact on all groups identified and put mitigations in place e.g Transport provision should be considered for both patients and their family members if overnight stays are required.

Timeliness of offer
There is a risk that improvements to productivity and efficiencies may involve utilising resources to the fullest, meaning that cancelled appointments or admissions may be offered

with short notices to all patients leading to an inequality of access to those patients who have a medical condition which prohibits them from accepting a short notice admission (e.g. patients on warfarin) or patients/service users whose work/home circumstances cannot be re-organised at short notice (e.g. Patients from lone parent families who cannot rely on support from family members). Therefore, the declining of short notice appointments should not adversely impact the waiting times or RTT status for these patients (e.g. patients should not be removed from the waiting list if a short notice appointment was given – access policies should ensure that reasonable notice for admissions and appointments is fair and equitable e.g. 3 weeks)

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.

By mapping out patient transport services across trusts and ISPs and comparing eligibility criteria, we can support a dialogue with the provider collaborative/federation regarding equity of access longer term as part of the GMIC model.

NHS
Greater Manchester
Integrated Care

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.

The productivity and efficiency programme will initially be reviewing processes which will improve services within existing resources. 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 any unintended impact on particular protected groups of changes to productivity	On-going EIA and identification of mitigating actions into the reviewed at the productivity and efficiency meeting monthly	Using available intelligence in Tableau and Model Health System

NHS Greater Manchester Integrated Care

Step 5 – Sign off

Strategy, policy, plan, project or service owner or Work Programme Lead*	
Name Vicky Sharrock	Date 14/10/2022
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 Waleed Abdi	Date 14/10/2022
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 David Warhurst	Date 07/11/2022

*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.