**Equality Analysis and Engagement Template 2018: Rotherham CCG**

1. **Guidance**

1.1 Engaging with patients and the public is a **statutory duty**. Clinical Commissioning Groups have a duty under Section 14Z2 of the NHS Act 2006 (as amended) to ‘make arrangements’ to involve the public in commissioning.

This planning template has been developed to support the process. It will also make sure that any planned activity is meaningful, and includes fair and proportionate involvement. We need to:

* Show that we have considered the impact our activities will/may have on patients and the public;
* Identify changes we can make to reduce/remove any negative impacts**.**

This form is a tool to help commissioners identify whether there is a need for patient and public participation in their commissioning activity, and if required help them plan for a level of participation which is ‘fair and proportionate’ to the circumstances.

* 1. **The equality analysis (EIA) in this plan forms the initial stage of the equality impact assessment process.**

The purpose of this is to ensure that we:

* Don’t discriminate
* Promote equality
* Think carefully about the likely impact of our work and plans on service users
* Take action to address inequalities, where appropriate, considering the protected characteristics.
* Systematically assess and record the likely equality impact of an activity or policy.

The EIA is carried out by completing a form, drawing on existing research, monitoring information, and consultation. Once this has been completed, an action plan can be drawn up and any decisions to change the delivery of an activity or policy can be made. Completed EIAs will be presented to the Equality and Diversity Steering Group:

* To give advance notice of a significant service change (a level 3 or 4 change).
* To present the equality analysis and engagement plan.
* To provide an update on an engagement project that has previously been taken to CP.

**1.3 Both parts – the Engagement Assessment and Equality Impact Assessment should be completed at the start of the planning process for any commissioning activity and before operational commissioning decisions are taken which may impact on the range of commissioned services and/or the way in which they are provided.**

***Completed forms may be used as evidence in the event of a legal challenge. Please retain a copy within your system.***

If you have any questions please speak to Alison Hague, Corporate Services Manager and Helen Wyatt, Patient and Public Engagement Manager.

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| **Diagram 1; What you need to do** |
| **Stage** | **Planning** | **Reporting** | **Updating** |
| Actions Required | Fill in the **Equality analysis and engagement plan** | Write your **Assessment of Equality impact and engagement report** | Write your **Equality and engagement update** |
| Detail | **Carry out your equality analysis** and use intelligence to understand who is using the service, who should be using services; prevalence of illness/condition within certain communities etc. And highlight any gaps. This information will help inform who you need to engage with.**Plan your engagement** and outline the change and how you will engage. | **Write up the findings of your engagement.**Who did you talk to and what did they tell you? Theme your findings and make recommendations. **Outline the impact of the change on people with protected characteristics.** Will people from certain groups be impacted upon? (These could be positive or negative) Make recommendations that could remove/reduce any negative impacts. | **Outline how you have addressed the recommendations in the report.** Feedback on each recommendation. Outline why you have not actioned any recommendations. **Outline what action you have taken and how you have made changes to reduce any negative impacts on people with protected characteristics and explain why actions have not been possible.** |
| Checks and challenges | Is the engagement robust?Are you confident that we are engaging with the right people? Have all protected groups been considered? | Have we carried out the plan well?Are the findings and recommendations fair?Have all protected groups been considered? | To what extent have we met the recommendations?Are there any gaps/concerns?Is there evidence being taken in relation to identified negative impacts?  |

| **Diagram 2; The Characteristics to consider in assessing for equality impact** |
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| **Protected characteristic** | **Some questions to ask when considering the equality impact** |
| Age | * How have / will you engage with different age groups: different process and communication?
* Is there data to show any different usage of the service / project by different age groups?
* Do you use inclusive imagery and language?
* Is your this accessible and inclusive to different age groups, considering location and time?
 |
| Disability | * How have/will you engage with disabled people: process and communication methods
* Is there data to show a higher need or usage of the service / project by disabled people?
* Are staff trained on disability awareness, including learning disability?
* Are services accessible to people who have a range of different disabilities?
* Does the service / project / policy give consideration to the Accessible Information Standard?
* Do you communicate a zero tolerance approach to disability related harassment?
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| Gender reassignment | * Are staff aware of the legal requirements affecting the provision of confidential services ?
* Are records fully reflective of the gender identify of a trans patient / service user / employee and are staff empowered to communicate appropriately with trans people?
* Are services appropriate to the gender which people identify?
* Do you communicate a zero tolerance approach to transphobia and harassment?
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| Marriage and civil partnership | * Do information, policies and procedures treat marriage and civil partnership equally?
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| Pregnancy and maternity | * How have / will you engage with pregnant women and parents of young children: what different process and communication methods can you use?
* Do you have data to show if there is a higher need or any different usage of the service / project by pregnant women or families with young children?
* Does your service/ project support breastfeeding mothers or parents with children?
* Do you support pregnant women and parents with children in the workplace through flexible working and job-sharing?
* Does your policies and procedures give equal maternity / paternity rights to staff adopting?
 |
| Religion or belief | * How have / will you engage with people with different religious beliefs: what different process and communication methods can you use?
* Do you communicate a zero tolerance approach to Islamphobia among staff, patients, cares and the local community?
* Is your service / project / policy sensitive to different religious requirements eg the times people may wish to access a service, religious days and festivals, dietary requirements, prayer space etc.
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| Race | * How have / will you engage with people from different ethnic backgrounds: what different process and communication methods can you use?
* Do you have data to show if there is a higher need or any different usage of the service / project by different ethnic groups?
* Do you build positive relationships with ethnic minority community organisations and community advocates to facilitate the involvement of different ethnic groups?
* Do you communicate a zero tolerance approach to racism among staff, patients, cares and the local community; and challenge negative myths and stereotypes about different ethnic groups and new arrivals to the UK?
* Is your workforce representative of the communities where you work in terms of race?
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| Sex | * Is there data to show different need or usage of the service / project by men and women?
* Does the plan consider that different needs and aspirations?
* Are your services accessible to men and women in terms of location but also time?
* Do you consider gender equality in the workplace at all levels?
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| Sexual orientation | * How have / will you engage with lesbian, gay, bisexual (LGB) people: what different process and communication methods can you use?
* Is there data to show if there is a higher need or any different usage?
* Does publicity and information, policies and procedures include reference to LGB and heterosexual people equally?
* Do you communicate a zero tolerance approach to homophobia and biphobia?
* Do you build positive relationships with the LGB community?
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| **Diagram 3 – Assessing the size of change**  |
| **Definitions of reconfiguration proposals and stages of engagement/consultation** |
| **Definition & examples of potential proposals** | **Stages of involvement, engagement, consultation** |
| Informal Involvement | Engagement | Formal Consultation |
| **Major variation or development**Major service reconfiguration – changing how/where and when large scale services are delivered. Examples: urgent care, community health centre services, introduction of a new service, arms length/move to CFT |  |  |  | **Category 4**Formal consultation required (minimum 12 weeks) |
| **Significant variation or development**Change in demand for specific services or modernisation of service. Examples: changing provider of existing services, pathway redesign when the service could be needed by wide range of people |  |  | **Category 3** Formal mechanisms established to ensure that patients/service users/carers and the public are engaged in planning and decision making. In most cases this means 12 weeks engagement period. | Information & evidence base |
| **Minor Change**Need for modernisation of service. Examples: Review of health visiting and district nursing (Moving Forward Project), patient diaries |  | **Category 2**More formalised structures in place to ensure that patients/service users/carers and patient groups views on the issue and potential solutions are sought | Information & evidence base |  |
| **Ongoing development**Proposals made as a result of routine patient/service user feedback: Examples: proposals to extend or reduce opening hours | **Category 1**Informal discussions with individual patients/service users/carers and patient groups on potential need for changes to services and solutions | Information & evidence base |  |  |

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| **Equality Impact and Engagement Assessment Form** |
| **Complete this section****Please retain one copy, and pass one copy to both the Equalities and Engagement leads** |
| **Section one – Project or plan details** |
| 1.1 | **Project Title:**  |
| DVT in the Community |
| 1.2 | **Project Lead:** | **Contact Details:** |
| David Clitherow - GP | David.clitherow@nhs.net |
| 1.3 | **This activity /project is:** |
| Other |
| 1.4 | **Describe the activity/project**  |
| Proposed DVT Pathway redesign – pilot of community-based assessments. |
| 1.5 | **Timescales** |
| Pilot would take place during 2019/2020 with evaluations informing commission intentions for 2020/2021. |
| 2 | **Equality Impact Assessment** |
| 2.1 | **Gathering of Information:** This is the core of the analysis; how might the project or work impact on protected groups, with consideration of the General Equality Duty.Please add any general information here. |
| It is not envisaged that the community-based assessment would impact upon protected groups negatively. Those experiencing mobility issues, and their carers may need additional support in securing transport if a referral is needed to secondary care. The improved assessment will reduce the number of referrals to secondary care that oreviously were made on a precautionary basis, thus this will be a positive for patients as it eliminates the need for a scan appointment at the Trust in the majority of cases (88% as per Bradford model evaluation) |
| 2.2 | **Screening**  |
| **Please complete each area)** | **What key impact have you identified?** | **Information Source** |
|  | **Positive Impact** - will actively promote or improve equality of opportunity. | **Neutral Impact -** where there are no notable consequences for any group. | **Negative Impact** negative or adverse impact causes disadvantage or exclusion. **If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures.** | What action, if any, is needed to address these issues and what difference will this make? For example: *At this point no action is required. Further EIA screenings will be developed in future once there are recommendations to assess.* |
| Human Rights | **N** | **N** | **N** |  |
| Age | **Y** | **N** | **N** | Patients who have problems with mobility due to old age might require transport to convey them to secondary care for commencement of urgent treatment and investigation under the current model.The proposed new pathway moves the assessment steps from Secondary Care to Primary Care and will therefore allow suspected DVT to be ruled out before the referral to the Acute Trust, thus eliminating this journey in the majority of cases (88% Bradford model evaluation) |
| Carers | **Y** | **N** | **N** | Carers of patients with mobility problems/disability might require transport to convey them to secondary care for commencement of urgent treatment and investigation under the current model.The proposed new pathway moves the assessment steps from Secondary Care to Primary Care and will therefore allow suspected DVT to be ruled out before the referral to the Acute Trust, thus eliminating this journey in the majority of cases (88% Bradford model evaluation). |
| Disability | **Y** | **N** | **N** | Patients with a disability might require transport to convey them to secondary care for commencement of urgent treatment and investigation under the current model.The proposed new pathway moves the assessment steps from Secondary Care to Primary Care and will therefore allow suspected DVT to be ruled out before the referral to the Acute Trust, thus eliminating this journey in the majority of cases (88% Bradford model evaluation). |
| Sex | **N** | **N** | **N** |  |
| Race | **N** | **N** | **N** |  |
| Religion or belief | **N** | **N** | **N** |  |
| Sexual Orientation | **N** | **N** | **N** |  |
| Gender reassignment | **N** | **N** | **N** |  |
| Pregnancy and maternity | **N** | **N** | **N** |  |
| Marriage/civil partnership (only eliminating discrimination) | **N** | **N** | **N** |  |
| Other relevant groups | **N** | **N** | **N** |  |
|  | **NEXT ACTIONS? See 3.4 below** |
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| **3 Engagement Assessment** |
| 3.1 | **What is the level of service change**? – see diagram 3 above**If your project is classed as a ‘significant variation’ (level 3) or ‘major change’ (level 4)** please contact england.yhclinicalstrategy@nhs.net for a preliminary discussion to support planning and agree whether the service change needs to follow the NHS England Service Change Assurance process. The assurance process generally looks at the ‘case for change’ The key players in the process include overview and scrutiny teams, and the clinical senates. You can also refer to the DH guidance: (please note that level 4 changes will require considerable long term planning and this DH guidance is mandatory for all level 4 changes) <http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/nhs_public_involvement_-hempsons_stp.pdf> DH 2013 |
| **Circle or highlight the appropriate level of service change**Level 1 Level 2 Level 3 Level 4 |
| **Add additional information and rationale for this scoring below** |
| Patient intervention & journey remains the same, the boundary of primary care to secondary care referral is being moved to allow community based assessment with those patient who have high probability of DVT and positive D-dimer then being referred on, this will see a decrease in secondary care referrals. |
| 3.2 | **Who are your stakeholders?**Consider using a mapping tool to identify stakeholders - who is the change going to affect and how? Complete below or attach or link to a mapping document |
| TRFT – loss of activityGPs – new activity/LES in placeGP Federation – new activity/LES in place |
| 3.3 | **What do we already know?**What do you already know about peoples’ access, experience, health inequalities and health outcomes? Use intelligence from existing local, regional or national research, data, deliberative events or engagements. |
| The current patient care pathway for acute deep-vein thrombosis (DVT) requires clinicians in primary care to refer patients with suspected DVT to hospital for diagnosis. This can result in a delay in patients receiving treatment in a busy A&E or AMU, with associated cost implications. Where DVT is confirmed patients are discharged on treatment with community monitoring until stable. The diagnosis of DVT relies on clinical suspicion, followed by a combined use of a Wells score, D-dimer assay, sonography and intervention with anticoagulation as soon as possible. There are several models in use around the country where the pathway has moved the patient diagnosis and management from a secondary to a primary care-based model, with few hospital admissions.  |
| **Describe any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight?**How will the insight available to you help to inform your decision? |
| Feedback from the Bradford Model;There was widespread support from both primary and secondary-care clinicians during the development and implementation of this pathway. There was also a strong clinical consensus that the pathway is of high quality, safe, and more convenient than the current model utilising LMWH. It was largely considered that the protocol change would generally improve outcomes for patients. In addition, by implementing a thrombosis clinic follow up 1 month after diagnosis, the continuity of patient care improved. This was associated with the improved IT functionality, ensuring the lead haematologist had access to patient primary-care records. In the previous system, patient follow-up occurred on a rather *ad-hoc* basis.Initial feedback from patients (shared by referrers) suggested that the new DVT pathway was effective and appropriate, enabling patients to remain at home safely with their families. Our first patient was frail, vulnerable to infection and remained in his care home rather than being admitted to hospital; excluding the initial scan, his DVT was managed completely at home. |
| **Briefly describe how the existing or proposed engagement will be ‘fair and proportionate’**, in relation to the activity? |
| There is no specific planned patient engagement for this pilot as the patient intervention & journey remains the same, the improvement comes from reducing the number of secondary care referrals, this will be a positive impact for patients as the need to attend the Acute Trust will be lessened. |
| 3.4 | **Reaching out to overlooked communities**Are additional arrangements for patient and public involvement required for this activity and in particular how will you ensure that ‘seldom-heard’ groups, those with ‘protected characteristics’ under the Equality Act, and those experiencing health inequalities are involved* Seldom-heard groups Yes/No
* Nine Protected Characteristics Yes/No
* Health inequalities Yes/No

If yes, please provide a brief outline of your approach and objectives for any additional patient participation targeted at these groups |
| Any leaflets & health advice already prepared for these groups will require update. |
| Do you need to make any of your resources accessible (i.e. for people with learning disabilities, sight impairments, or alternative languages?) |
| Any leaflets & health advice already prepared for these groups will require update. |
| 3.5 | **What resources do you need for this?**Consider the sections above* The timescales
* The need to reach overlooked communities
* Accessible materials
* Gaps in knowledge
 |
| Any leaflets & health advice already prepared for these groups will require update. |
| 4 | **Feedback and Evaluation** |
| 4.1 | How will you use the feedback – who does it need to be shared with? |
| Feedback from the Bradford model has been used to inform the decision to pilot a primary care assessment model. The Bradford model is recognised as best practice. |
| 4.2 | Provide a brief outline of how the information collected through patient and public participation will be used to influence the plan/activity. |
| The pilot itself will include a feedback monitoring form for both health professions (GPs) and patients/carers. |
| 4.3 | How will the outcomes of participation be reported back to those involved?  |
| The evaluation of the pilot will inform the commissioning intentions for 2020/2021 |
| 4.4 | How will you assess the ongoing impact of the change on patients and the public after it has been completed? |
| The evaluation of the pilot will inform the commissioning intentions for 2020/2021 |
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| 5 | 1. **Engagement and Equality Impact Plan**
 |
|  | **Action** | **Approx.** **Timescale** | **Lead** | **Deadline** | **Comments/****progress** |
|  | 1. Feedback monitoring form
 | 1. During Pilot
 | 1. CCG
 | 1. Pilot end
 | 1. Will inform commissioning intentions for 2020/2021
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| 6 | Form details |
|  | Completed by:  | Beverley Futia |
|  | Job title: | Project Management Support |
|  | Date | 11th January 2019 |
|  | Reported to | David Clitherow |