Manchester Health & Care Commissioning
A partnership between Manchester City Council and the NHS

MANCHESTER CITY COUNCIL

NHS Manchester Clinical Commissioning Group

NHS Pathways Directory of Service Policy Manchester Health and Care Commissioning

Version: **1.0**

Date Approved: **29/01/2018**

Document Control Sheet

Title of document:	NHS Pathways Directory of Services Governance Policy		
Supersedes:	N/A		
Placement in Organisation:	MHCC		
Consultation/Stakeholders	Directory of Services Lead MHCC DoS Leads		
Author(s) name:	Joseph Corbett		
Department/Team:	MHCC Commissioning		
Approved by:	MHCC Governance Committee		
Approval date:	29/01/2018	Review date:	26/07/2020
Implementation Date:	29/01/2018		
Implementation Method:	**This document will be used by the DoS lead to inform the implementation of correct procedures whilst amending the DoS system.**		
N/A			

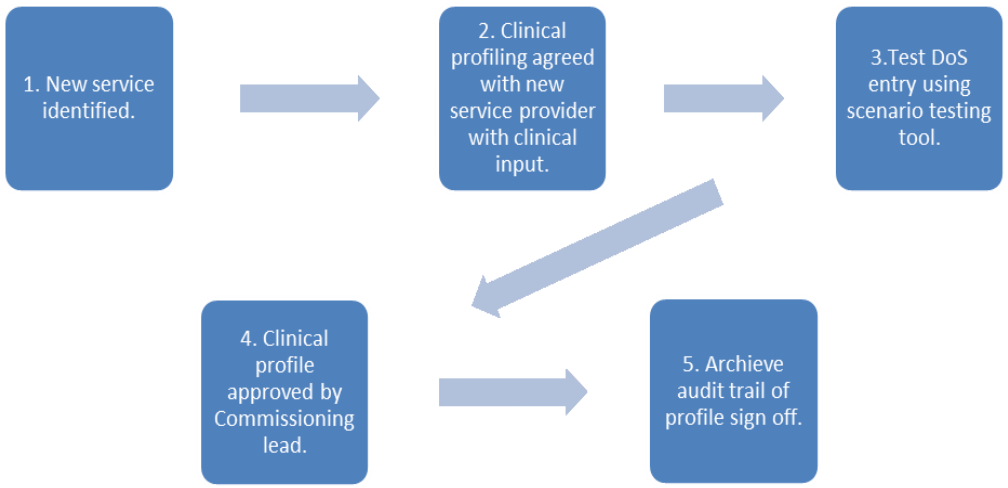
Contents

Appendices

1.0	Definitions of Terms Used
1.1	DoS – Directory of Service – The repository of services nationally which are added locally by the local DoS lead to support the 111 service. 111 – The national number for the Out Of Hours access for patients to contact for further triage that is not immediately deemed by the patient/caller as life threatening. IUC – Integrated Urgent Care – 24/7 access for patients to for both treatment and clinical advice. NWAS – North West Ambulance Service and the North West regions provider for NHS 111.
2.0	Introduction
2.1	The NHS pathways Directory of Services (DoS) underpins the NHS 111/IUC service in providing the call handler and in turn the patient, a selection of clinically appropriate services which the patient can choose to be referred or sign posted to following assessment via the Pathways Triage system. The DoS system is not restricted to NHS 111/IUC and there are numerous reason as to why existing DoS profiles may need to be amended. Further to the above use of the DoS system, other stakeholders including clinicians in both the community and acute settings have access to the DoS system so this information must be controlled and updated appropriately to ensure appropriate uptake of available services. DoS profiles must be carefully considered and the impact on the health economy is managed and monitored.
3.0	Purpose
3.1	This document aims to set out the roles and responsibilities in relation to the management of DoS and the change procedures which are to be followed to ensure best utilisation of available services via the NHS 111 service.
4.0	Responsibilities

4.1	There are various stakeholders both in and outside of MHCC which the DoS Lead must be aware of to fulfil its remit. Below are the main DoS users: • DoS Lead • MHCC 111/IUC Commissioning Leads • Service Providers • Other DoS Users (e.g. GP's, NWAS) The above list is not exhaustive and may be added to where appropriate as DoS develops.
4.2	**DoS Lead** The DoS Lead encompasses the following requirements: • Maintain the DoS, ensuring all provider demographics are accurately recorded and new services are added. • Maintain a robust and accurate audit trail of DoS profiles changes. • Review and improve clinical profiling of the services on the directory in line with software upgrades. • Create DoS training material for stakeholders as appropriate and tailoring to user level. • Support the DoS user community for MHCC including maintaining, updating and developing DoS user accounts. • Develop/amend service profiles to respond to changing demands on services. • Make improvements to MHCC DoS ranking strategies based on service availability and demand via systems such as IDT and RAIDR. • Supporting testing and auditing of DoS.

	• Support the Investigation to resolution of any DoS issues reported via the various mediums including Health Care Professional Feedback. • Develop policies in line with other national DoS policies. • Provide DoS/111 data analysis to inform gaps in service provision. • Represent MHCC at national and regional meetings and events.
4.3	**MHCC 111/IUC Commissioning Leads** • Inform DoS strategy (e.g. ranking strategy) and aid in issue resolution. • Partake in review of local DoS documentation and training materials. • Sign off of services from commissioner perspective following clinical sign off. • Alert the DoS lead to changes in capacity of services and other commissioning service provision changes.
4.4	**Service Providers** • Alert the DoS lead to any changes in their service profile (e.g. demographics and clinical changes) which must be cleared with commissioners and clinical leadership). Alert the DoS lead and commissioners to any inappropriate referrals received via NHS 111/IUC. • Services with a ITK end point on the DoS are responsible for configuring their systems to receive specific dispositions and working with their local 111/IUC/DoS lead for testing.
4.5	**Other DoS Users** • DoS users should contribute to the overall accuracy of the DoS system and notify their local DoS lead with any amendments or errors they find.
5.0	DoS User Levels

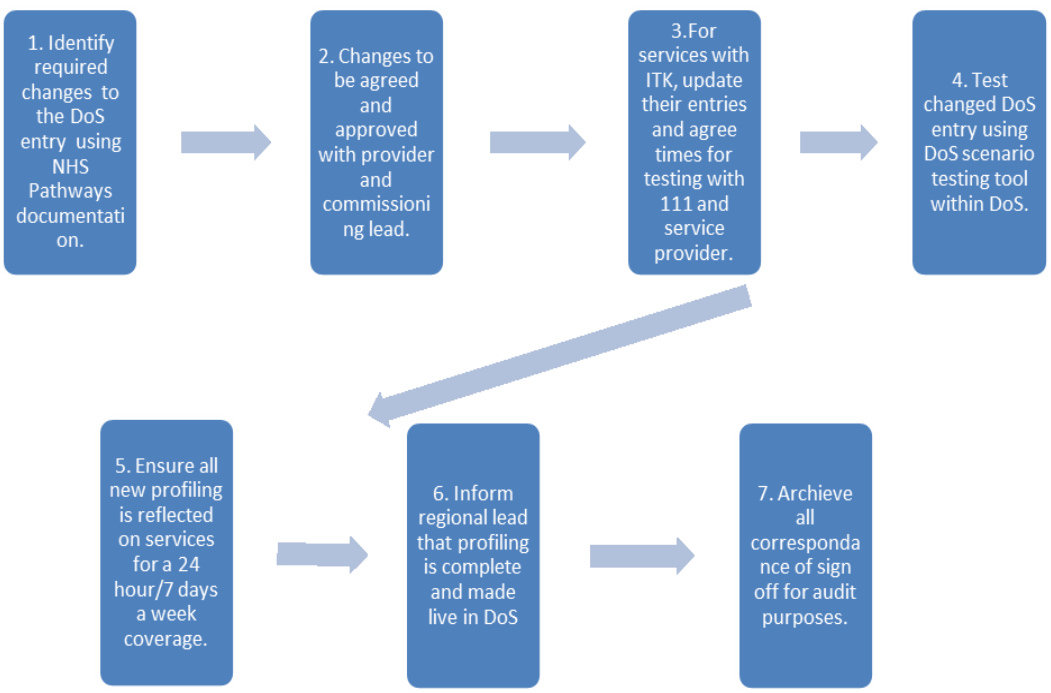
5.1	To ensure only appropriate amendments are made on the DoS there are different user levels which can be granted to a user. The main groups are: - Add details - Edit details - Approve changes - View the system Depending on what the user is doing on the system will determine what level of access they have. For example a clinician may only have viewing access so they can view available services in their local area, and a commissioner may have approval rights to have final sign off of a clinical service profile.
6.0	Change Management Procedure
6.1	The below processes outline the stages which services need to pass through to be added, amended or removed from the DoS.
6.2	**New additions** The below process is undertaken for services which are new to DoS. If the service is a local initiative conversations with NHS 111 take place to ensure appropriate uptake of the service. 

6.3 **Planned Amendments to DoS profiles**

NHS Pathways version releases

NHS pathways release bi-annual updates to the pathways assessment tool. As the pathways system is linked to DoS the supporting dispositions and clinical symptom groups and discriminators are affected, leading to changes in clinical profiling of services.

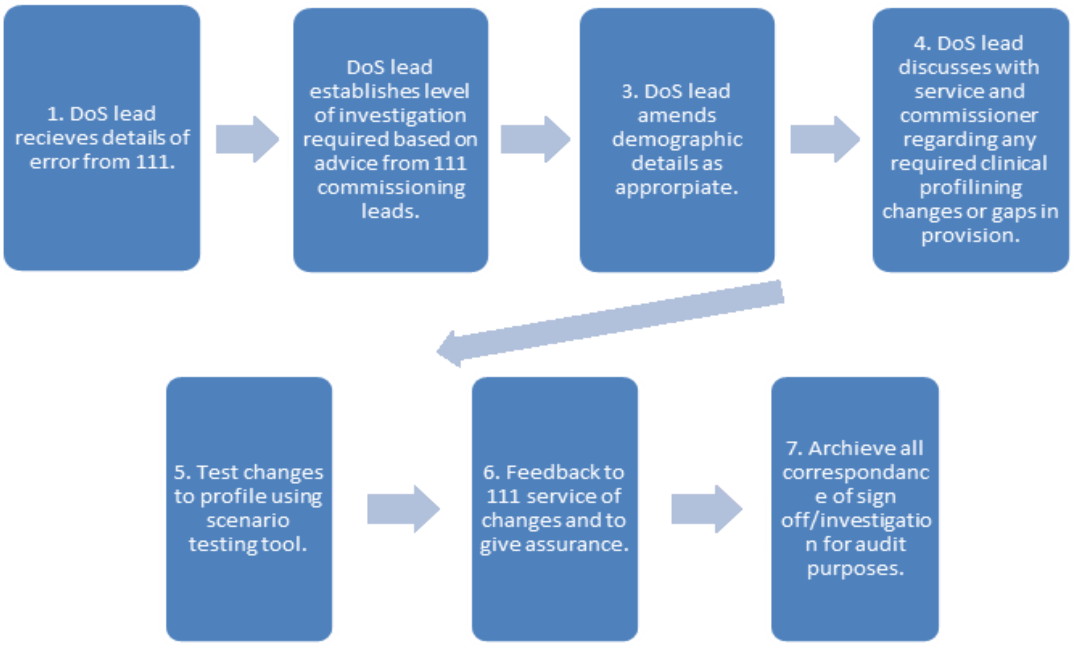
NHS pathways provides documentation including profiling templates including the new, amended or retired dispositions, symptom groups and discriminators and suggested services which will be affected by the changes.



6.4 **Unplanned Amendments to DoS profiles**

Within the 111/IUC providers there are processes in place to notify local DoS leads of any errors or amendments required to profiles during the call handling process. These amendments can include changes to the DoS call handler instruction field to make it clearer for future referrals.

There is the above informal procedure to make DoS changes but the formal approach to DoS changes where there have been issues with the patient care pathway or a serious incident will be logged through Datix by the provider.



6.5	**Service Capacity Changes and Service Closures** The DoS enables the DoS lead to amend individual service profiles capacity status to support the Operational Pressures Escalation Levels (OPEL) process. Please see the Opel Process document (appendix B) for further explanation of capacity management options. The current coverage for amendments to DoS service capacity changes is only In hours.
7.0	DoS Training
7.1	The DoS lead will deliver training where appropriate and access other resources such as the regional lead, NHS Digital and the 111 provider for further training as required. The DoS lead is required to review and amend local training documentation to tailor the delivery to the target audience and user level.
8.0	Process for Approval & Ratification
8.1	This document will be required to be signed off at the MHCC clinical quality committee to formalise the process for clinical and commissioner sign off of additions, amendments and deletions of services on the DoS.
9.0	Dissemination, Training & Advice
9.1	The document will be shared with commissioners and securely saved on the CCG shared drive for anyone involved in the DoS to access.
9.2	Anyone who feels they have involvement with the DoS can contact the developer of the document to seek guidance on implementation. If the information is not contained in the document the DoS lead will seek guidance nationally from NHS England and will update the document accordingly.
10.0	Review, Monitoring and Compliance
10.1	The document will be reviewed by the DoS lead in partnership with the 111 Commissioning leads to ensure it is accurate and up to date with current processes every 3 years. Amendments may happen more frequently where required.

10.2	The DoS lead will be responsible for amending the document with any changes to national guidance or changes to local structures or policies.
11.0	References
11.1	**Legislation** N/A

Version Control

Version	Date	Brief description of change
1.0	26.07.17	Initiation of document

PLEASE NOTE: the most recent version of this document is available on the CCG's website. Printed copies (or saved electronic copies) must be checked to ensure they match the most recent version.

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EQUALITY ANALYSIS

NO: **EQUALITY ANALYSIS**

1. Name of the proposal being analysed	Directory of Services	2. Officer/s responsible for completing the Equality Analysis	Joseph Corbett	3. Senior Responsible officer/s	Helen Speed
4. Date Equality Analysis started	21st August, 2017	5. Date Equality Analysis is completed	23rd August, 2017	6. Date of approval	
7.Is the EA linked to the Operational Plan Y/N	Y	8. Is it linked to Investment? Y/N	N	9. Other	
Please state if the proposal being analysed is: (please tick which one is applicable)					
1. Strategy or Policy		2. New Service		3. Service Redesign	
4. Service Review		5.Decommissioned services		6. Other	✓
Please state from the following which this proposal relates to: (please tick)					

Manchester Health & Care Commissioning (MHCC)	✓	Manchester Clinical Commissioning Group (MCCG)		✓
Local Commissioning Organisation (LCO)	✓	All three organisations		
Single Hospital Service (SHS)	✓	Other		

Section 1 - Your Proposal

Please provide the context and scope of this proposal. Your Equality Analysis is a stand-alone public document, therefore please ensures that it is written without jargon, acronyms and is in plain English. Please briefly explain the proposal (including the scope) being analysed.	
Please briefly explain the proposal being analysed in this EA.	**Please briefly explain the proposal** **Background** The Directory of Services (DoS) is the electronic repository of services. It supports the NHS 111 service to identify appropriate pathways and services for patients and clients. Each CCG has a responsibility to maintain its DoS, to ensure services are profiled appropriately to return correctly when it is interrogated. Each CCG uploads clinically profiled commissioned services onto the DoS. The CCG has no control over the commissioning of the national electronic software that powers the

	DoS. It has no control over the national policies regarding the DoS. There is no national governance policy for the DoS. Instead each CCG has to develop its own as the process to populate the DoS is locally owned. The DoS is not publicly available, as it contains information such as private telephone numbers for use by healthcare professionals The main users currently of the DoS directly are paramedics as well as pharmacists and other healthcare professionals employed by providers of NHS 111 across the country. Indirectly NHS 111's triage system also uses the DoS to produce a list of clinically appropriate services for call handlers to offer to patients dependant on their clinical presentation. It is the DoS that will enable patients to be directed to appropriate local services and ensure that NHS 111 'fits' with each CCGs local clinical assessment approach depending on how these services are locally commissioned. Populating and updating the DoS with the skills and capacity within any given area enables the NHS 111 Service to have a clear view of the capacity within the system to provide the appropriate service for each patient. It also gives NHS 111 oversight of services available locally to the patient. It also enables services to register their capacity in real time, in the form of a red, amber and green indicator. This information can be used by NHS 111 to avoid sending patients to services with restricted capacity and direct them instead to services with more capacity.

	The DoS is held centrally by Health and Social Care Information Centre (HSCIC) on a web server. Data within the DoS is subject to robust governance and sign off by Commissioners to ensure that all parties agree that the listed services are commissioned services and that updates to the Red/Amber/Green status are a true reflection of capacity. NHS Manchester CCG has allocated resources to ensure there is robust management and oversight of the DoS in all areas and that the service offer for each CCG is accurately reflected in terms of the demographic data, clinical profiling and the referral instructions.
	What is being proposed? The DoS contains details of all available services for the NHS 111 Service to refer into. It is the responsibility of the commissioner working with providers of services to ensure that the DoS is continually updated so that callers are referred to the appropriate service and that health professionals have access to the most accurate and up to date information relating to services via NHS 111 or via a web link It is proposed that the governance policy for the Manchester DoS is updated and an EA is completed as part of the process
	Why it is needed? A governance policy should accompany the DoS. This document will set out the roles and responsibilities in relation to the management, profiling and testing of DoS, and the change procedures which are to be followed to ensure best utilisation of available services.

<table>
<tr><td rowspan="3"></td><td colspan="6">The Manchester governance policy for the DoS has been updated and an EA is required a part of the policy process.

This EA assessment relates to the Directory of Services</td></tr>
<tr><td colspan="6">What are the desired outcomes?

The desired outcome of the governance policy is that roles and responsibilities for the DoS are clearly articulated for the organisation. The policy will be held by the CCG and available in the public domain.</td></tr>
<tr><td colspan="6">What activity is required to achieve this proposal?

The key activity is to update the governance policy for the DoS.</td></tr>
<tr><td rowspan="5">Please tick who will be affected by this proposal.</td><td colspan="6">Please tick (√)</td></tr>
<tr><td></td><td>Patient</td><td></td><td>Age</td><td></td><td>Disability</td></tr>
<tr><td></td><td>Service Users/Clients</td><td></td><td>Marriage & Civil Partnership</td><td></td><td>Sex</td></tr>
<tr><td></td><td>Employees (MHCC)</td><td></td><td>Religion & Belief</td><td></td><td>Pregnancy & Maternity</td></tr>
</table>

		Disadvantage/Vulnerable Group(s)		Sexual Orientation		Gender Reassignment
	✓	Other please state: The policy is an information document that will be used to inform healthcare professionals and will be available to the general public to view. It is not directed to specific client groups		Race		Carers

Section 2 – Gathering Data for your Equality Analysis – a) what current data is available?

Identify which of the following Equality Group(s) you currently have equality data about, in relation to this proposal: Relevant links: - The Intelligence Hub (http://manchester-ccg-intranet.verseone.com/the-	**Equality Groups**	**Y/N**	**If Yes please state what information has been used for this analysis* If No please state where you will get this information from if applicable.**
	Race	Y	We have data for Manchester residents. The 2011 Census tells us that 33% of people living in Manchester (168,000 residents) were from a black minority ethnic (BME) group background compared to 7% across the UK. This has continued to grow

intelligence-hub) - Equality, Diversity and Human Rights (EDHR) (http://manchester-ccg-intranet.verseone.com/equality-diversity-and-human-rights) - General Population information (http://manchester-ccg-intranet.verseone.com/general-population-information)			in recent years with new economic migrants joining well-established BME communities from Pakistan, Bangladesh, China, Nigeria and Somalia, as well as university students from far-east Asia. The proportion of residents within the White broad ethnic group fell in Manchester from 81% in 2001 to 66.6% in 2011. Furthermore, since 2011 the BME population in the city has seen significant growth and the proportion of the Manchester population who are from ethnic minority groups has increased from 19% to 33.4%, an increase of 14.4% (taken from The State of the City Report – Communities of Interest 2014). This may mean we should anticipate an increasing demand on services from BME communities in the future. Across the city in 2011, 10% of residents lived in households with no English speakers compared to 4% across England. In some of the city's most diverse wards there is a large number of residents who do not speak English well or at all. As only one example, the Cheetham ward for example has a local neighbourhood where only 32% of residents speak English as their main language. We also know from Multilingual Manchester at the University of Manchester that 150 to 200 languages are spoken by long-term residents of Manchester and the Greater Manchester area, making it

			one of the world's most diverse places linguistically. Close to 20% of Manchester's adult population declared a language other than English as their main language in the 2011 census. The Centre on Dynamics of Ethnicity, which is part of The University of Manchester, has produced a national study around health for different ethnic groups in England and Wales. The study showed that most ethnic minority groups have poorer health than the White British group, although ethnic health inequalities vary by gender.
	Gender	Y	We have data for Manchester residents In Manchester we know that there are roughly around 268,000 males and 262,000 females (Manchester Public Health data Public Health England) and that the proportion of males and females in each age group is broadly similar.

	Males	Females	Persons
Manchester (population in thousands)			
Population (2015):	268	262	530
Projected population (2020):	285	270	555
% people from an ethnic minority group:	31.8%	31.3%	31.5%
Dependency ratio (dependants / working population) x 100			42.9%

The health of people in Manchester is generally worse than the England average at all stages of life. Statistics relating to Manchester population's life expectancy are stark. Healthy life expectancy in Manchester is significantly lower than the England average for both men and women. A boy born in Manchester can only expect to live 77% of his life in good health compared with 87% for a boy born in the healthiest part of England. Similarly, a girl born in Manchester can only expect to live 71% of her life in good health compared with 84% for a girl born in the healthiest area of the country.

Furthermore the State of the City Report 2013 states that the average life expectancy for Manchester women is the lowest in the country and remains among the lowest for men. Although female life expectancy remains higher for Manchester women, the gap between male and female life expectancy at birth for Manchester has reduced from five years since 2008–2012 to a gap of 4.3 years in 2010–2012.

	Gender Reassignment	N	There is limited published research into trans health issues outside gender reassignment pathways of care. The Gender Identity Research and Education Society (GIRES) estimates that around 1% of the population is 'gender variant' to some degree, although not all will seek medical treatment. The largest survey of trans people in England found that 20% of trans people identify as heterosexual, and 58% have a disability or chronic health condition, including 8.5% who were deaf and 5% who were visually impaired; 18% were carers with 7% giving significant levels of care. Transgender data collected is at the national level only.
	Pregnancy & Maternity	N	Data is available to some degree in Manchester but not in sufficient amount to fully inform this EA.
	Disability	Y	Data is available to some degree in Manchester. It should be noted that limited information is available from the Manchester Health Profile on all of the possible classifications of disability, such as: cognitive, hearing loss, deafness, invisible disabilities, mobility impairments, psychological disorders, spinal cord injury, and vision disability.

			We do know from the 2011 census, however, that 8.2% of the Manchester population reported being 'not in good health' and 15% that they had a 'limiting long term health problem'. Both of these measures are higher than the England average Poor mental health and wellbeing has a significant impact on individuals, families and communities. The ED strategy informs us that low mental wellbeing among people living in Manchester is associated with employment status, poor general health and a higher prevalence of diagnosed medical conditions. Suicide rates in Manchester remain higher than the national average.
	Sexual Orientation	Y	In comparison to other demographic groups, there is a lack of data relating to the health of LGBT communities. According to the LGBT foundation, there is a substantial body of evidence demonstrating that lesbian, gay, bisexual and trans (LGBT) people experience significant health inequalities, which impact both on their health outcomes and their experiences of the healthcare system. The relationship between sexual orientation and gender identity and health has often been overlooked by the healthcare system, and a lack

			of sexual orientation and trans status monitoring in service provision and population level research means that this area needs exploring in greater detail. The LGBT foundation also believes it is reasonable to extrapolate from the evidence of significantly higher levels of smoking, drug and alcohol misuse, and mental ill health, that LGBT populations will have a shorter life expectancy than their heterosexual and non-trans peers due to their increased risk of cancer, coronary heart disease and suicide. Prolonged exposure to stigma and discrimination is recognised as having a detrimental impact upon physical and mental health outcomes. In our 2011 Exist Survey of LGB people in Greater Manchester, just 12% of the respondents aged over 50 said that they had never experienced a mental health issue. Over half had experienced depression or low self-esteem, and 48% had experienced feelings of isolation. The national Integrated Household Survey included sexual orientation as a dimension in 2010. This found that self-reported health was slightly better among lesbians and gay men than heterosexuals, but much worse among bisexuals and those identifying with another non-heterosexual identity. There are no national trans surveys of health that describe self-reported health status, although almost all population

			based surveys of trans communities report high levels of depression which would suggest that self-reported health will be lower. Compared with heterosexual people, older lesbian, gay and bisexual people are more likely to be single, more likely to live alone and less likely to see a biological family member on a regular basis.89 Evidence presented under indicator 1.7 shows that LGBT older people are likely to experience more social isolation than their heterosexual contemporaries. The national standards on treatment and care to support trans people states that 'trans people suffer enormous social isolation as one of the most marginalised groups in society', acknowledging the extreme potential for social isolation. This statement is supported by a growing body of evidence which demonstrates that social isolation of trans individuals is a significant barrier to seeking health and medical support until crises occur and contributes to serious mental ill health and suicidal intent.
	Age	Y	According to the State of the City report (2016), the number of 20 to 29-year-olds living in Manchester has increased from 86,600 in 2001 to 128,900 in 2015 (MYEs), which in part will be due to increased graduate retention. In 2015, almost a quarter of residents were aged 20 to 29

			compared to 13.4% across England , further highlighting Manchester's rapidly growing younger population profile compared to the national average. The working-age population in the city has also increased (66% to 71% between 2001 and 2011) with the largest increase recorded in the city centre, where 94.4% of people were of working age in 2011 – again strongly linked with the city's broadening economic base. The State of the City Report tell us that older people form a much smaller proportion of the population in Manchester than seen nationally, and although the number is increasing, the proportion is currently decreasing, set against an above-average proportion of young adults. While there are a number of settled communities of older people towards the outskirts of the city, some live in more central areas where they can become isolated. Furthermore, the characteristics of Manchester's older residents mean they are more likely to place high demands on health services and suffer from long-term limiting illnesses at an earlier stage in their life than nationally. Manchester has a very low healthy life expectancy (years living in good health) compared to the rest of England,5 currently one of the lowest in England. Approaches taken by the Council and its partners through Age-Friendly Manchester initiatives aim to improve

			social participation of older residents, and the quality of local communities for older people. These initiatives are key to reducing the high demands on services, together with extending and improving the quality of life for Manchester's older population. Recent data for the period 2012–14 suggests that men and women aged 65 living in Manchester can only expect to live just under two-fifths (39.3% for men and 39.4% for women) of their future life in good health. This is significantly lower than the estimate for England as a whole, where the proportion of remaining life spent in good health for men and women is 56.3% and 54.2% respectively
	Religion or belief (or lack of religion or belief)	Y	The latest information available with regards to this protected characteristic is from the 2011 census which shows that 75.3% of Manchester's population reported as having some religious affiliation, which is down from a total of 84% in 2001. There has been a large decrease in the proportion of people identifying themselves as Christian in Manchester since 2001, falling from 62.4% in 2001 to 48.7% in 2011. Conversely, there has been an increase in those not identifying with any religion, rising from 16% to 25.3% and a rise in the proportion of people identifying themselves as Muslim, rising from 9.1% in 2001 to 15.8% in 2011.

<table>
<tr><td></td><td></td><td></td><td>From the census data we also know that North Manchester in particular remains a key area for the Jewish community and there has also been an increase in people identifying as Muslims across all wards in the city.</td></tr>
<tr><td></td><td>Marriage or civil partnership</td><td>Y</td><td>Limited data is currently available on this protected group.
Nationally, the 2011 Census shows that most people aged 16 years and over are either married, in a civil partnership, divorced or widowed.

<table>
<tr><th></th><th>Single</th><th>Married</th><th>Civil partnered</th><th>Divorced</th><th>Widowed</th><th>Population aged 16 and over</th></tr>
<tr><td>Total number</td><td>15,789,198</td><td>23,837,253</td><td>115,389</td><td>3,802,489</td><td>3,005,928</td><td>46,550,257</td></tr>
<tr><td>Percentage of population aged 16 and over</td><td>33.9%</td><td>51.2%</td><td>0.2%</td><td>8.2%</td><td>6.5%</td><td>100%</td></tr>
</table>

However in Manchester the proportion of people recorded as single or as never been married is much higher than the national average

<table>
<tr><td>Married/Civil Partnership/divorced/widowed</td><td>45%</td></tr>
<tr><td>Single/ never been married</td><td>55%</td></tr>
</table>

Statistics show that Manchester ranks the highest as the city with the most single people; the next city in Greater Manchester is Salford which is ranked as 19th.</td></tr>
</table>

			<table><tr><th>Rank</th><th>City/Town</th><th>% Single</th><th>Number of single people</th></tr><tr><td>1</td><td>Manchester</td><td>54.9</td><td>222,585</td></tr><tr><td>2</td><td>Oxford</td><td>53.8</td><td>68,206</td></tr><tr><td>3</td><td>Cambridge</td><td>52.6</td><td>55,781</td></tr><tr><td>4</td><td>Nottingham</td><td>51.3</td><td>128,363</td></tr><tr><td>5</td><td>Brighton and Hove</td><td>50.1</td><td>114,826</td></tr><tr><td>6</td><td>Liverpool</td><td>49.7</td><td>193,012</td></tr><tr><td>7</td><td>Glasgow</td><td>49.2</td><td>244,831</td></tr><tr><td>8</td><td>Bristol</td><td>47.0</td><td>164,225</td></tr><tr><td>9</td><td>Norwich</td><td>46.9</td><td>51,978</td></tr><tr><td>10</td><td>Belfast</td><td>46.6</td><td>106,568</td></tr></table>
	Carers	Y	The only information currently available for Manchester in relation to this protected group is from the State of the City report. It tells us that statutory return figures for 2015/16 show that there are 3,388 carers receiving a service, caring for 3,510 people. Of these, 0.6% are under 18, 73.8% are 18–64, 23.9% are 65–84, and 1.7% are 85 or older.
	Disadvantage & Vulnerable	N	We have limited information for this group. We know the following categories are disadvantaged and/or vulnerable but the list below is not

	groups		exclusive. **Homeless** In line with the national picture, the prevalence of homelessness in Manchester has seen a steady increase since 2010. In the last year, Manchester City Council has received almost 6,000 approaches for assistance. Of those who make an application, there has been a 14.5% increase in people found to be in priority need over the last year. In addition the number of people known to be rough sleeping in the city has risen from 15 in 2011 to 70 in 2015, this is a higher percentage increase than the national average – Manchester now has the fourth largest rough sleeping problem in the UK, including London. The average age range for a homeless adult is between 25 and 44; this is reflected in the homeless patient population of Manchester. However, in the past 18 months, there has been a large increase in young people aged 18-25 registering as homeless. National data shows that the majority of homeless people are White British males and this is reflected in local data; however there is currently an increase in European Nationals registered as homeless in Manchester **Gypsy and Travellers** A report from the Commission for Racial Equality (CRE) suggests that

			nationally the Gypsy and Traveller population accounts for 0.6% of the population (CRE, 2006). It is, however, not possible to determine how this population is distributed across the country although there are known concentrations of Gypsy and Traveller communities in many parts of the country including Manchester. The population is clearly highly mobile, and any limited information that is available is varied. There is however a settled site for 'retired' travellers in the north of the city. **Victims of Domestic Abuse and Violence (DV)** It is estimated that: • 1 in 4 women and 1 in 6 men will be a victim of DV during their lifetime. • A victim will suffer 20-30 assaults before disclosing DV. • 7 women and 2 men are killed by their current or former partner every month in England and Wales. • DV is a central issue in child protection, being a factor in the family backgrounds of two-thirds of the serious case reviews where a child has died.

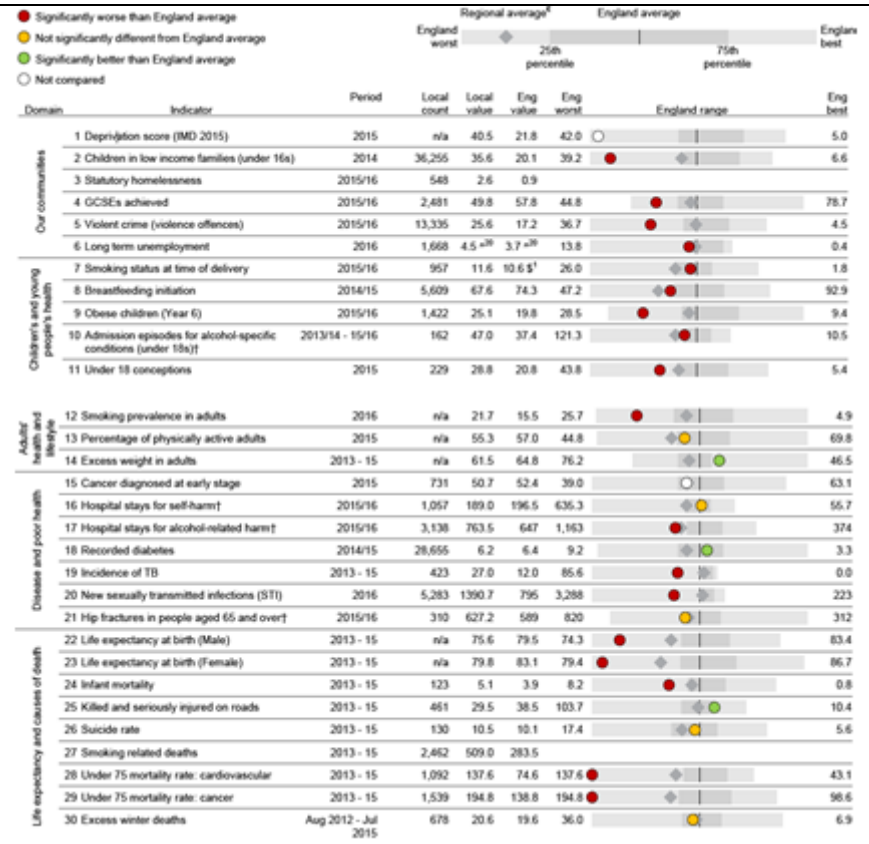
			• A conservative estimate of around 12% of A&E attendances are due to DV • 75% of cases of domestic violence result in physical injury or mental health consequences. • 41% of hospital patients experience high severity physical abuse compared to 32% of non-hospital clients. • More than half of victims attending A&E are likely to also be experiencing poor mental health (54% compared to 31% average presenting to other DV services) • Victims attending A&E are twice more likely to also have substance misuse issues (12% compared to 6% average presenting to other DV services) • The cost of treating physical health of victims of domestic violence, (including hospital, GP, ambulance, prescriptions) is £1,220,247,000, i.e. 3% of total NHS budget. • Aside from the human and emotional costs, DV is estimated to cost the health economy £1.6bn per annum on physical and mental health costs alone. The NHS spend more time dealing with the impact of DV than almost any other agency and are often the first, sometimes the only, point of contact for people who have experienced violence.

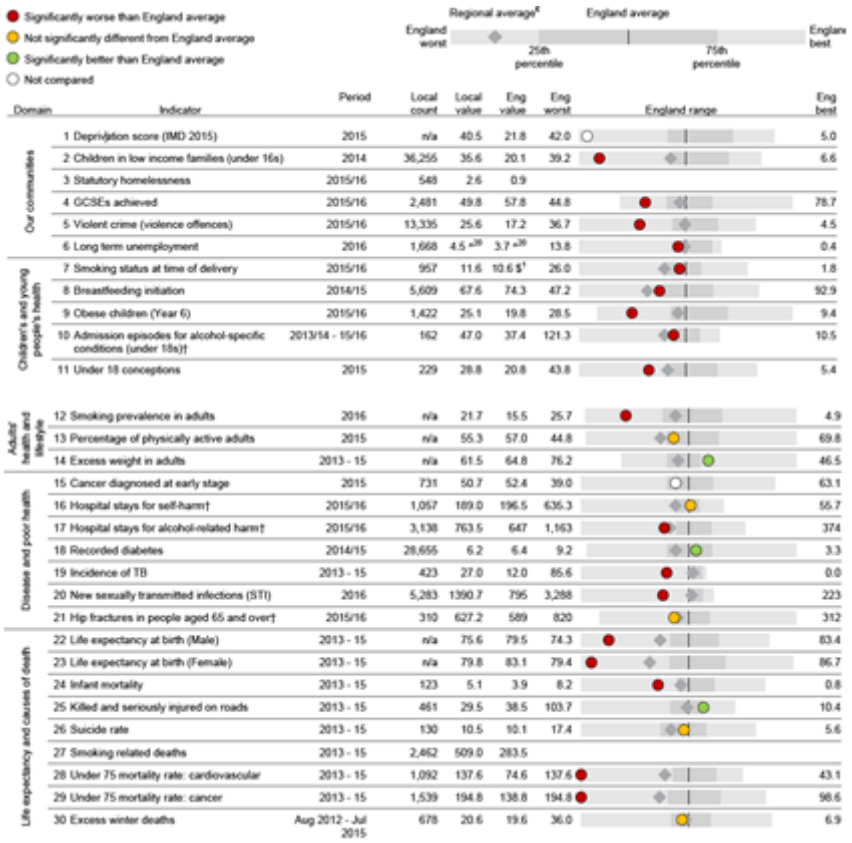
			We know that many victims will have experienced between 20-35 assaults before seeking support. Promoting a zero tolerance approach to DV, raising-awareness of the project and training staff to be able to ask the right questions the service provides opportunity to engage victims in support earlier, reduce re-victimisation and reduce the number of patients requiring the ED. DV patients do not always attend with injury specific presentations. There are significant and strong associations between DV and many illnesses, notably psychiatric complaints; depression, self-harm and substance misuse. Other strong associations exist with termination of pregnancy, sexually transmitted diseases and medically unexplained symptoms. In Manchester, despite an increase in reported incidents, there is still a fear that the true extent of domestic abuse is hidden because of a reluctance to contact the police **Poor Housing and Poverty** Poor housing costs the NHS at least £2.5 billion a year in treating people with illnesses directly linked to living in cold, damp and dangerous homes. Treating children and young people injured by

			accidents in the home costs A&E departments across the United Kingdom around £146 million a year. Among the over 65s, falls and fractures account for 4 million hospital bed days each year in England, costing £2billion. Over 25,000 people die each year in the UK as a result of living in cold temperatures; much of this is due to living in poorly heated homes. The main health conditions associated with cold housing and poverty are circulatory diseases, respiratory problems and mental ill-health. Other conditions influenced or exacerbated by cold housing include the common flu and cold, as well as arthritis and rheumatism. The level to which such conditions rise during the winter months and their relationship with cold housing is harder to measure than for mortality, which is systematically recorded. Low indoor temperatures are associated with poor health, excess winter mortality, as well as a variety of social and economic problems for residents. Based on national estimations for each Health and Wellbeing Board, it is estimated Manchester spends £27,000 each day treating patients with health conditions caused or worsened by living in cold, damp housing. Hospitals are seeing more cases of malnourishment and its effects on health. Food and clothing banks have been set up to help support patients returning to their own homes. Some of those patients are the

			elderly confused, who may or may not have funds to buy food, but need help. Nationally, the number of over-65s has risen by 11% in the last five years, the number of over-80s is rising at its fastest rate ever, yet at the same time fewer of the frail old get any help at all, while many of the most vulnerable get scant 15-minute visits, and no cooking or shopping. **Loneliness and Social Isolation** Loneliness can be understood as an individual's personal, subjective sense of lacking desired affection, closeness, and social interaction with others. Loneliness is not the same as social isolation. Although it has a social aspect, loneliness is also defined by an individual's subjective emotional state. Multi-dimensional exclusion, particularly social detachment, can lead to isolation and loneliness. Loneliness and isolation are negative factors on the mental health and wellbeing of people of all ages and research has shown that loneliness rates tend to be higher amongst older people who live in socially disadvantaged urban communities. Loneliness has a strong relationship with low personal wellbeing ratings.

			The 2011 Census can tell us how many people are living in single households but living alone is not the same as being lonely or socially isolated
	Socio-economic	Y	We have limited data for Manchester only. We have socio economic data for Manchester Residents, this data derived from the Public Health England Health Profile June 2017

			 Significantly worse than England average Not significantly different from England average Significantly better than England average Not compared Regional average[#] England average England worst 25th percentile 75th percentile Englan best Domain Indicator Period Local count Local value Eng value Eng worst England range Eng best Our communities 1 Deprivation score (IMD 2015) 2015 n/a 40.5 21.8 42.0 5.0 2 Children in low income families (under 16s) 2014 36,255 35.6 20.1 39.2 6.6 3 Statutory homelessness 2015/16 548 2.6 0.9 4 GCSEs achieved 2015/16 2,481 49.8 57.8 44.8 78.7 5 Violent crime (violence offences) 2015/16 13,335 25.6 17.2 36.7 4.5 6 Long term unemployment 2016 1,668 4.5 =20 3.7 =20 13.8 0.4 Children's and young people's health 7 Smoking status at time of delivery 2015/16 957 11.6 10.6 ^{1} 26.0 1.8 8 Breastfeeding initiation 2014/15 5,609 67.6 74.3 47.2 92.9 9 Obese children (Year 6) 2015/16 1,422 25.1 19.8 28.5 9.4 10 Admission episodes for alcohol-specific conditions (under 18s)† 2013/14 - 15/16 162 47.0 37.4 121.3 10.5 11 Under 18 conceptions 2015 229 28.8 20.8 43.8 5.4 Adults' health and lifestyle 12 Smoking prevalence in adults 2016 n/a 21.7 15.5 25.7 4.9 13 Percentage of physically active adults 2015 n/a 55.3 57.0 44.8 69.8 14 Excess weight in adults 2013 - 15 n/a 61.5 64.8 76.2 46.5 Disease and poor health 15 Cancer diagnosed at early stage 2015 731 50.7 52.4 39.0 63.1 16 Hospital stays for self-harm† 2015/16 1,057 189.0 196.5 635.3 55.7 17 Hospital stays for alcohol-related harm† 2015/16 3,138 763.5 647 1,163 374 18 Recorded diabetes 2014/15 28,655 6.2 6.4 9.2 3.3 19 Incidence of TB 2013 - 15 423 27.0 12.0 86.6 0.0 20 New sexually transmitted infections (STI) 2016 5,283 1390.7 795 3,288 223 21 Hip fractures in people aged 65 and over† 2015/16 310 627.2 589 820 312 Life expectancy and causes of death 22 Life expectancy at birth (Male) 2013 - 15 n/a 75.6 79.5 74.3 83.4 23 Life expectancy at birth (Female) 2013 - 15 n/a 79.8 83.1 79.4 86.7 24 Infant mortality 2013 - 15 123 5.1 3.9 8.2 0.8 25 Killed and seriously injured on roads 2013 - 15 461 29.5 38.5 103.7 10.4 26 Suicide rate 2013 - 15 130 10.5 10.1 17.4 5.6 27 Smoking related deaths 2013 - 15 2,462 509.0 283.5 28 Under 75 mortality rate: cardiovascular 2013 - 15 1,092 137.6 74.6 137.6 43.1 29 Under 75 mortality rate: cancer 2013 - 15 1,539 194.8 138.8 194.8 98.6 30 Excess winter deaths Aug 2012 - Jul 2015 678 20.6 19.6 36.0 6.9 It shows that Manchester is significantly worse on almost every level than the national average
	Health Inequalities	Y	We have limited data from Manchester only. We have health inequalities data for Manchester Residents, this data derived from the

			Public Health England Health Profile June 2017  It shows that Manchester is significantly worse on a number of indicators than the national average

*The information could be considered as Y/N (*Please see Guidance)

Section 2 Gathering Data for your Equality Analysis – b) Consultation and Engagement Activities

Please list details of any consultation or engagement that was carried out in support of this Equality Analysis. Consultation and Engagement Activities can be found by following this link. Communication and engagements (http://manchester-ccg-intranet.verseone.com/communications-and-engagment) Equality Analysis Case Law https://www.equalityhumanrights.com/en/advice-and-guidance/relevant-case-law	Please respond to the following: **List what consultation or engagement has been undertaken in support of this EA. List the name of groups/organisations etc** No patient engagement or consultation has been undertaken No clinical engagement or consultation has been undertaken **Which Equality Groups did you engage or consult with**: No equality groups have been consulted **What changed as a result of consultation or engagement?** Not applicable **Are there any groups that you have not engaged with or consulted with that can assist with your EA**? Not applicable

Section 2 Gathering Data for your Equality Analysis - c) Data Sources

What information has been analysed to inform the content of this EA? Think of any data compiled by the service, any research that has been undertaken. Additional information can be found by following the links below:, - Equality, Diversity and Human Rights (EDHR) (http://manchester-ccg-intranet.verseone.com/equality-diversity-and-human-rights) - The Intelligence Hub (http://manchester-ccg-intranet.verseone.com/the-intelligence-hub) - Equality Analysis Case Law https://www.equalityhumanrights.com/en/advice-and-guidance/relevant-case-law	**List data sources here:** 2011 Census Manchester Compendium of Statistics (2016) Health Profile Manchester; Public Health England (June 2017) Manchester Joint Strategic Needs Assessment (JSNA)

Section 3 - Analysing the Data (see Section 5 of guidance and Appendix A for further clarification)

RACE		**Tick** √	**Please provide your response and explain why the impact is positive, neutral or negative?**
Does your analysis indicate an **Positive, Neutral or Negative** impact relating to **Race**? Please tick one or more. You must consider: You need to think carefully about the local demographics of the population/employees that will be accessing service/policy/function etc. Think of all the different racial groups Think about cultural issues, languages, support to access, staff training on cultural awareness	Positive		
	Neutral	√	Analysis has been undertaken of national data and research and of the local community based on the protected characteristics. Updating the governance policy for the DoS has no impact on this patient group
	Negative		
Please indicate the actions which will be taken to address impacts identified.	No action		

Which action plans will these impact(s) been transferred to?			
DISABILITY			
Does your analysis indicate a **Positive, Neutral or Negative** impact relating to **Disability** (including military veterans)? Please tick one or more. Think outside the box, you may not be able see the disability. It could be physical, hearing, seeing or a learning disability. You must consider: Accessibility, location, location, signage access to services, getting around. Disability awareness training, Accessible Information Standards	Positive		
	Neutral	√	Analysis has been undertaken of national data and research and of the local community based on the protected characteristics. Updating the governance policy for the DoS has no impact on this patient group
	Negative		

Involving service users Hearing loops/interpreters Referral System/Partnership working Accessible Information Standards Plain English/Easy Read Visual Impaired Service users			
Please indicate the actions which will be taken to address impacts identified. Which action plans will these impact(s) been transferred to?	No action		
GENDER			

Does your analysis indicate a **Positive, Neutral or Negative** impact relating to **Gender**? Please tick one or more. Consider the impact of the service/policy on both men and women. Same sex accommodation, same sex groups/activities Timing of services/projects – shift workers, location in general men do not access health services as much as women, could location of service/project improve access e.g. workplace?	Positive		
	Neutral	√	Analysis has been undertaken of national data and research and of the local community based on the protected characteristics. Updating the governance policy for the DoS has no impact on this patient group
	Negative		
Please indicate the actions which will be taken to address impacts identified.	No action		

Which action plans will these impact(s) been transferred to?			
GENDER REASSIGNMENT			
Does your analysis indicate a **Positive, Neutral or Negative** impact relating to **Gender Reassignment**? Please tick one or more. Please consider the following: Thinking about creating an environment within the service/policy	Positive		
	Neutral	√	Analysis has been undertaken of national data and research and of the local community based on the protected characteristics. Updating the governance policy for the DoS has no impact on this patient group .

or function that is user friendly and non- judgemental. If the policy/function/service is specifically targeting this equality group, think carefully about training, confidentiality and communication skills.	Negative		
Please indicate the actions which will be taken to address impacts identified. Which action plans will these impact(s) been transferred to?	No action		
PREGANCY AND MATERNITY			
Does your analysis indicate a **Positive, Neutral or Negative** impact relating to **Pregnancy/ Maternity?**	Positive		

Please tick one or more. Please consider the following: The policy/function/service must be accessible for all, e.g. example opening hours. Are the chairs appropriate for breast feeding is there a private area? Are there baby changing and breast feeding facilities available Is there space for buggies?	Neutral	√	Analysis has been undertaken of national data and research and of the local community based on the protected characteristics. Updating the governance policy for the DoS has no impact on this patient group
	Negative		
Please indicate the actions which will be taken to address impacts identified. Which action plans will these impact(s) been transferred to?	No action		
AGE			

Does your analysis indicate a **Positive, Neutral or Negative** impact relating to A**ge**? Please tick one or more. Please consider the following: Think about different age groups and think about the policy/function/service and the way the user would access, it user friendly for that age?	Positive		
	Neutral	√	Analysis has been undertaken of national data and research and of the local community based on the protected characteristics. Updating the governance policy for the DoS has no impact on this patient group
	Negative		
Please indicate the actions which will be taken to address impacts identified. Which action plans will these impact(s) been transferred to?	No action		
SEXUAL ORIENTATION			

Does your analysis indicate a **Positive, Neutral or Negative** impact relating to S**exual Orientation**? Please tick one or more. Please consider the following: Don't make assumptions about this equality group may not be visibly obvious. Providing an environment that is welcoming for example visual aids, posters, leaflets. Using language that respects LGT people and acknowledges same sex relationships is needed for person-centred care. Communication – LGBT people should be able to disclose their sexual orientation and/or gender identity to	Positive		
	Neutral	√	Analysis has been undertaken of national data and research and of the local community based on the protected characteristics. Updating the governance policy for the DoS has no impact on this patient group
	Negative		

their health provider without fear or prejudice. Respects rights Using language that respects LGBT people Staff training on how to ask LGBT people to disclose their sexual orientation without fear or prejudice			
Please indicate the actions which will be taken to address impacts identified. Which action plans will these impact(s) been transferred to?	No action		
RELIGION OR BELIEF			
Does your analysis indicate a **Positive, Neutral or Negative** impact relating to R**eligion or Belief** (including lack of religion or belief)?	Positive		

Please tick one or more. Please consider the following: You should ensure that the service/project is accessible to all individuals/communities with a religion or belief. Do you know what these are in the communities that your service/project is targeting Think about local population and what religion or belief they may have. Have you thought about prayer ties, meal times, food (some religions do not eat meat) holidays, e.g. Ramadan, flexibility. Religious beliefs, e.g. blood transfusions	Neutral	√	Analysis has been undertaken of national data and research and of the local community based on the protected characteristics. Updating the governance policy for the DoS has no impact on this patient group
	Negative		

Think about, staff training on respecting differences, religious beliefs. Are you trying to implement during a time of religious observation Is there any area for prayer times?			
Please indicate the actions which will be taken to address impacts identified. Which action plans will these impact(s) been transferred to?	No action		
MARRIAGE AND CIVIL PARTNERSHIP			
Does your analysis indicate **Positive, Neutral or Negative** impacts in relation to **Marriage and Civil Partnership**?	Positive		

Please tick one or more. Please consider the following: Think about access and confidentiality, the partner may not be aware of involvement or access to the service. Consider staff training.	Neutral	√	Analysis has been undertaken of national data and research and of the local community based on the protected characteristics. Updating the governance policy for the DoS has no impact on this patient group
	Negative		
Please indicate the actions which will be taken to address impacts identified. Which action plans will these impact(s) been transferred to?	No action		
CARERS			
Does your analysis indicate a **Positive, Neutral or Negative** impact relating to **Carers**?	Positive		

Please tick one or more. Please consider the following: Does your policy/function/service impact on carers? Ask them. Do you need to think about venue, timing? What support will you be offering?	Neutral	√	Analysis has been undertaken of national data and research and of the local community based on the protected characteristics. Updating the governance policy for the DoS has no impact on this patient group
	Negative		
Please indicate the actions which will be taken to address impacts identified. Which action plans will these impact(s) been transferred to?	No action		

OTHER DISADVANTAGE AND VULNERABLE GROUPS (including socio-economic issues)

Does your analysis indicate a **Positive, Neutral or Negative** impact relating to **other Disadvantage or Vulnerable groups**?	Positive		

Consider the how this policy/function/service may impact on the wider community and socio-economic factors.	Neutral	√	Analysis has been undertaken of national data and research and of the local community based on the protected characteristics. Updating the governance policy for the DoS has no impact on this patient group
	Negative		
Please indicate the actions which will be taken to address impacts identified. Which action plans will these impact(s) been transferred to?	No action		

HEALTH INEQUALITIES

How will this policy/function/service support reduction in health inequalities and improve health outcomes?	Based on the 2015 Indices of Multiple Deprivation which combine a number of indicators chosen to cover a range of economic, social and housing issues, into a single deprivation score for each area in England, Manchester is England's **fifth** most deprived local authority (rank of average scores). Greater Manchester has 348 of the 3,284 top 10% most deprived areas in England. Other areas in Manchester with high levels of deprivation include Rochdale, Salford, Bolton and Oldham. The Manchester Compendium informs us that people with higher well-being have lower rates of illness, recover more quickly and for longer and generally have better physical and mental health. Based on the latest data for 2014/15 it is possible to estimate that around 5.7% of people in Manchester had the lowest levels of life satisfaction compared with 4.8% in England, suggesting that more people in Manchester are less satisfied with their life at present than in

	the country as a whole. Furthermore, in 2015/16, citizens are reporting that they are less satisfied with their care and support, do not find it as easy to find information, and feel generally less safe. Furthermore, the 'Marmot indicators for core cities in England 2015' (key indicators of social determinants of health, health outcomes and social inequality) show us that the average healthy life expectancy of a person living in Manchester is just 55 years. Nationally the average is around 64 years. Helping older people to remain independent in their own homes, keep healthy and improve their wellbeing will help to reduce this significant health inequality. Poorly managed health and difficulties access healthcare at the right time in the right place can have a devastating impact on the physical, psychological, social and financial aspects of patient's lives. Some patients report becoming socially isolated as a result of their condition, experiencing depression, anxiety, loneliness and anger. Analysis has been undertaken of national data and research and of the local community based on the protected characteristics. Updating the governance policy for the DoS has no impact on this patient group
Please indicate the actions which will be taken to address impacts identified. Which action plans will these impact(s) been transferred to?	No action

HUMAN RIGHTS (FREDA Principles)

Consider how Human Rights (**FREDA** Principles) Impacts on this proposal Please provide details which **FREDA**	**Fairness (Right to fair trial):** Not applicable in the context of a governance policy for the DoS **Respect (Right to respect for family and private life):**

Principles is applicable to this analysis and why?	Not applicable in the context of a governance policy for the DoS **Equality (Right not to be discriminated against in the enjoyment of other human rights)**: Not applicable in the context of a governance policy for the DoS **Dignity(Right not to be tortured or treated in an inhuman or degrading way) :** Not applicable in the context of a governance policy for the DoS **Autonomy (Right to respect for private life):** Not applicable in the context of a governance policy for the DoS
Which action plans have these been transferred to?	No action plan.

4. What Course of Action

Taking the equality and the engagement information into consideration and the duties around the **Public Sector Equality Duty**, what action(s) will be taken? What are the impacts and mitigating actions? Please incorporate this section into the Business Case Template **4.3** (include in executive summary) or report front cover.

Actions	**Tick** √
1, Continue unchanged – the business change does not cause any disproportionate impacts and can proceed with no major change required.	✓
2. Justify and continue – decide that some adjustment is required to avoid disproportionate impacts arising	
3. Change– This involves making changes to the business to ensure it does not adversely affect certain groups of people, or miss opportunities to affect them positively.	

4. Stop and remove – the business change will cause a sustainable risk to equality.	

Summary of EA Activity	Overall Response
Brief Summary/Conclusion of EA Analysis (including course of actions):	There is no impact on any protected group. The proposal is to produce and update a governance policy for the DoS.
Impacts (Positive, Neutral or Negative) **and Outcomes, including** identifying protected groups:	The EA analysis shows that there is neutral impact on protected characteristics.
Mitigating Actions in support of Negative Impacts:	No action
Positive Impacts and Outcomes:	No impact

5. Equality Analysis Action Plan

Actions identified from EA to be taken forward	Target completion date	Responsible officer/s	Governance / monitoring arrangements	Timescales for review and evaluation

Office Use Only:

Date EA Submitted:	**EA No:**
QA Provided:	**QA Confirmation Date:**
Final Signature and Approval:	**Publication Date:**

Once the EA is completed you will need to go through a Quality Assurance. Please send to hr.manchester@nhs.net. The normal turnaround time is **four weeks**; if this does not meet with your timeline, can you ensure you contact to hr.manchester@nhs.net. asap, so that we can look for an alternative time that meets with your timetable. Thank you.

6. Sign off and Approval Process (Please ensure that sign off and approval process is completed)

Sign off - Line Management

Name:	**Helen Speed**
Date:	**23rd August, 2017**

Line Manager Signature:	

Business Case Panel

Chair Name:	
Date:	
Chair Signature:	

Approval Sign Off

Chair Board/Committee/Executive Name:	
Date:	
Chair Signature:	

Equality Analysis Checklist

An Equality Analysis (EA) is a tool for identifying the potential impact of the CCGs policies, services and functions. EAs should be actively looking for negative or adverse impacts on policies, services and functions on any of the nine protected characteristics and other disadvantage and vulnerable groups. This section contains a number of questions/prompts to ensure everything is completed for an Equality Analysis before submission.

Checklist Area/Question	Yes/No
Front Sheet - Details	
Have you completed all the boxes in this section?	Y
Section 1 – Your Proposal	
Is your proposal clear and understandable to other people outside of your service area?	Y
Have you answered all the prompt questions in this section in a clear manner?	Y
Section 2 – Gathering Data for your Equality Analysis	
a) **What current data is available?** Have you identified all the current equality group data available to support the Equality Analysis(qualitative, quantitative including engagement activity) b) **Consultation and Engagement Activities** – Ensure you have included any feedback from any consultation or engagement activities c) **Data Sources –** Have you identified all the data sources used to support your Equality Analysis?	Y Y
Section 3 – Analysising the Data	
Have you considered the impact of each equality group based on the data from section 2? - ensure you justify your response to your selected. Have you completed all the relevant questions in full and identified actions where relevant?	Y
Section 4 – What course of Action	
Have you considered the course of action to take based on the analysis from Section 3?	Y

Ensure you provide a sound rationale for your course of action, including impacts/actions. Move these into your Business Case template or report front cover.	Y
Section 5 – Action Plan	
Have you moved all actions/impacts to the action plan template?	Y
Have you identified how the action plan will be monitored and when it will be reviewed and by who?	Y
Section 6 Sign off and Approval Process	
Have you completed all sections of the equality analysis template?	Y
Has the Equality Analysis gone through quality assurance	
Has the equality analysis been through the sign off and approval process? – see sign off and approval process	

Appendix A

Table 1 - Equality Analysis Impacts Criteria

Positive (Low)	Neutral (Medium)	Negative (High)
Positive impact is one in which a person or people will experience an advantage or benefit, this includes P**ositive action** to overcome a disadvantage, meet needs or encourage participation (e.g. a service sets up a disability service user forum to help design and plan service provision so that disabled people's needs are taken into account).	A **Neutral impact** is one where there is no disadvantage; experience will be the same for everyone (e.g. everyone can access the service including disabled people).	A **negative impact** is one in which a person or people will **experience a disadvantage** (e.g. a wheelchair user can't get into the building to access the service).Are there any changes which could be made to the policy to remove (or minimise) **the Negative impact**? **Example**: A policy that will only accept

Example: A targeted health improvement campaign for young men between the ages of 15-21 would have a positive differential impact on this age group, compared with its impact on other age groups and women. It would not, however, necessarily have an adverse impact on the other age groups or on women.		complaints in writing would have a negative or adverse impact on some people. This may include people with learning disabilities, people who do not use English as their first language and people for whom written communication is not a strong cultural norm, such as British Sign Language users. **Some Negative impacts** may be justified on the basis of a legal requirement or applicable exemption including where positive action is undertaken or where there is a conflict with other legislation e.g. health and safety.

Impacts and Mitigating Actions

Differential Impact

It is important to consider whether a service experience is different if the patient/resident is disabled, from a Black Minority Ethnic (BME) community, identifies as transgender, and aged 60 or perhaps a combination of multiple protected groups. Identifying differential impact is about the different experiences different people may have because of their identity or characteristics. Collecting and analysing evidence and engagement will assist with understanding what impact each group will experience by this new proposed care model.

Positive Impact

Not all impact is negative and some services and policies can treat particular groups more favourably to address disadvantage. This is encouraged by the Equality Act 2010 and the EA process should acknowledge this and develop actions to protect this, thus ensuring positive impacts remain safe and sustainable. This is a safeguarding measure.

Mitigating Negative Impact

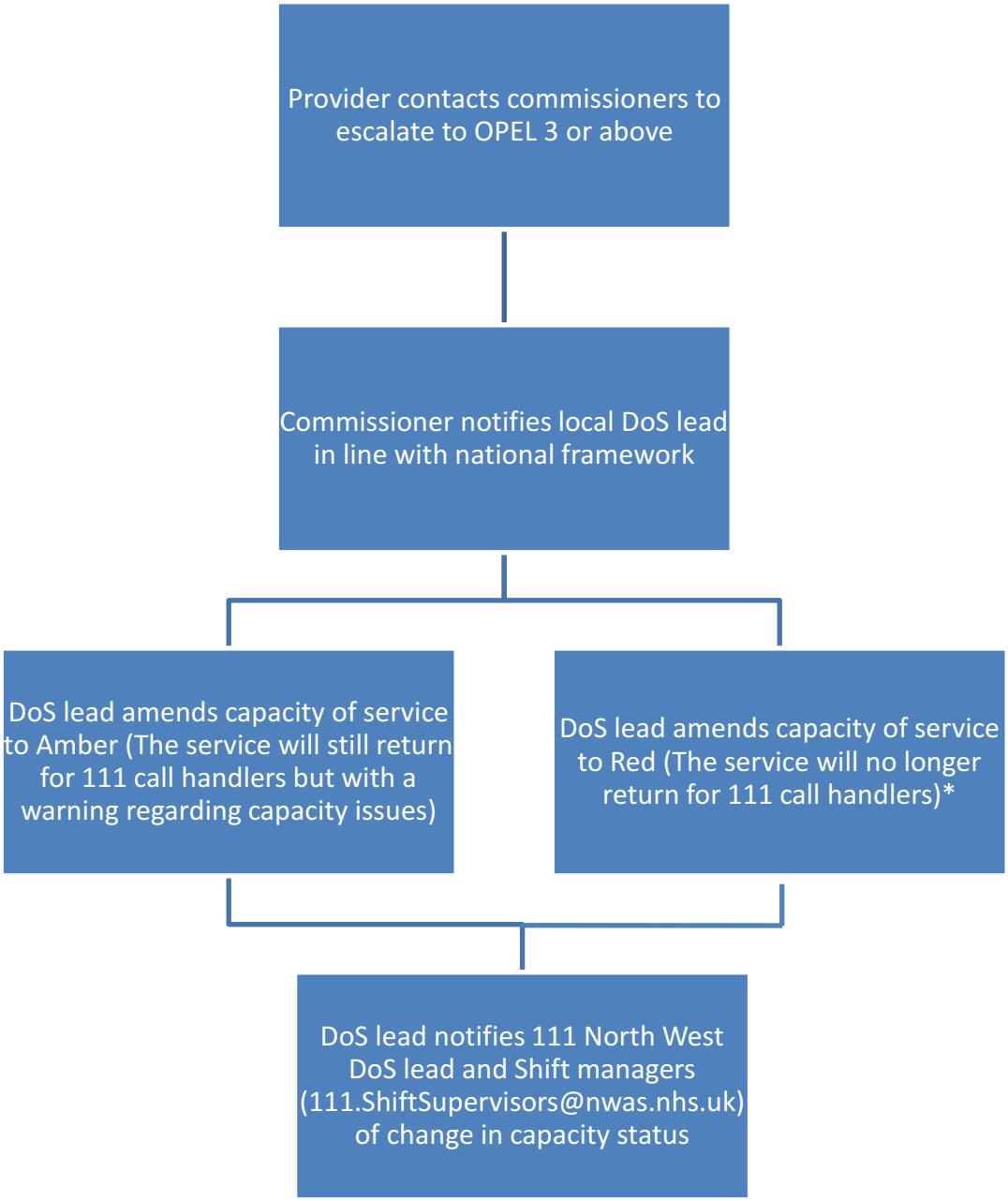
Analysis may have concluded that there are barriers or the potential for adverse impacts. Changes will need to be made in order to remove the adverse impact and to mitigate it. Actions will need to be identified that will produce practical solutions to mitigate these adverse impacts.

If the analysis reveals some negative impacts but they can be objectively justified, the Equality Analysis will need to include all evidence relating to this. If the Equality Analysis identifies adverse impacts that cannot be justified and that cannot be mitigated, urgent advice will be required as this could lead to unlawful discrimination or increasing health inequalities.

This process will also ensure that general conclusions in the analysis is reduced as the EA should not make statements that will universally benefit all patients and service users without any evidence to support that statement.

OPEL Escalation
DoS and 111

The purpose of the document is to advise the options available to commissioners following notification of a provider being at OPEL 3. Commissioners will be expected to give guidance to the DoS lead on the course of action to be taken. The below actions can only be taken inside of normal working hours. In the OOH period contact must be made to 111 via NWAS colleagues but amendments will not be able to be made to DoS.



*The DoS lead will need to be updated every 4 hours to amend the DoS before the system automatically reverts the service back to normal capacity status as per the below text.

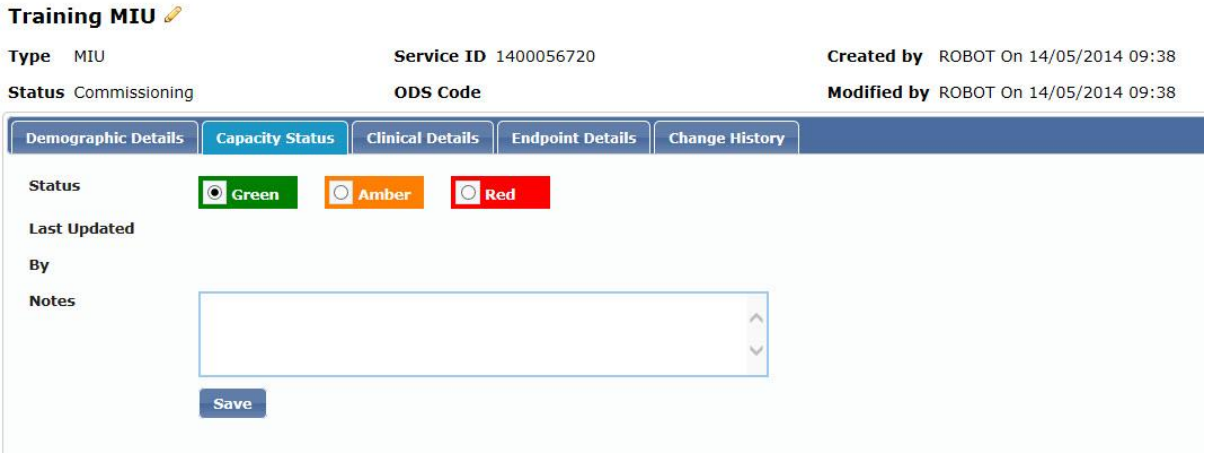
* If a SG/SD and Dx combination is not profiled elsewhere on the DoS, the system will default to the closest ED department (ED catch all) regardless of capacity status.

Capacity Status (extract from DoS guidance)

Capacity status is used to indicate the service's level of availability. The capacity status indicators available are Green, Amber and Red.

Setting the capacity status to Red indicates that the service is temporarily unable to accept any new patients/clients, and as a consequence the service will not return in a search. If the status is set to Amber, it will be returned in a search, but the limited availability will be highlighted. If the capacity status is not restored to Green, the system will automatically revert to green every 4 hours. When the system automatically updates capacity it will also delete any notes.

The Notes field is present on the Capacity Status tab for all services and is used to indicate the reasons for current status.



DoS Lead Details

~~Joe Corbett~~

~~josephcorbett@nhs.net~~

~~07773959179~~