

## Equality Impact Assessment

<b>Title of policy, project or service</b>	Young Parents Support	
<b>Service Area</b>	Maternity (city wide)	
<b>Name and role of people completing the assessment</b>	Liz Wigley Maternity Commissioning Manager	
<b>Date assessment started/completed</b>	December 2016	

Equality impact assessment is a way of systematically analysing a new or changing policy, strategy, process etc to identify what effect, or likely effect it could have on ‘protected groups’ to ensure appropriate decisions, which reduce health inequalities, address discriminatory consequences and maximise opportunities to promote equality, are made.

This toolkit has been developed to meet our obligations under the Equality Act 2010 general duty to;

- **eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Act;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not share it
- **foster good relations** between people who share a protected characteristic and people who do not share it.

Public bodies have to demonstrate **due regard** to the general duty. Due regard means active consideration of equality must influence the decision/s reached – as employers; in policy development, evaluation and review; in the design, delivery and evaluation of services, commissioning and procurement.

Having **due regard** to the need to **advance equality of opportunity** involves considering the need to:

- remove or minimise disadvantages suffered by people due to their protected characteristics;
- meet the needs of people with protected characteristics; and
- encourage people with protected characteristics to participate in public life or in other activities where their participation is low.

**Fostering good relations** involves tackling prejudice and promoting understanding between people who share a protected characteristic and others.

Following a recent judicial review (costing Birmingham City Council a reported £600k) due regard was described as ‘creating a decision making process that links the policy design, macro or micro, with the details of the impact of policy on individuals’. Before making policy decisions, even high level decisions about allocation of resources, an organisation must understand the potential impact of its decision on individuals (not necessarily named individuals, but a suitable range of typical service users) and ensure that this is explicitly factored into its decision-making.

This assessment process therefore aims to ensure we have;

- evidence of consultation and other engagement activities that elicit sufficient information to enable it to identify the impact of a proposed decision on individuals;
- informed the decision-makers of the potential impact and expressly considered how this can be reconciled with the organisations equalities duties;
- informed decision-makers how adverse impacts of a decision might be mitigated and whether there are alternatives to the proposed decision that could be taken that would avoid or reduce adverse impact.

**Please delete the section above in completed version**

<b>1. Outline</b>	
<p><b>Give a brief summary of your policy, project or service</b></p> <ul style="list-style-type: none"> <li>• Aims</li> <li>• Objectives</li> <li>• Links to other policies, including partners, national or regional</li> </ul>	<p>The Maternity Strategy for Leeds 2015-2020 was developed based on extensive consultation with women and families in Leeds, using a detailed health needs assessment and the latest and best evidence of what works well in maternity services, taking into consideration national and local drivers. The strategy outlines 9 priorities which aim to improve maternity services by providing safe, high quality maternity care, meeting the needs of all families in the city:</p> <ol style="list-style-type: none"> <li>1. Personalised Care – All women will receive care that is personal to their needs, where professionals work with them to plan and deliver care throughout pregnancy, birth and after the baby is born.</li> <li>2. Integrated Care – We will ensure that every woman feels that each stage of her care is coordinated, consistent and delivered in an integrated way.</li> </ol>

	<p>3. Access – Services will be easy to access to help women have their first midwife appointment early in pregnancy and to continue to receive all the care and support that they need throughout their pregnancy.</p> <p>4. Emotional Health – We will support the emotional and mental wellbeing of women who are pregnant and ensure that those who experience any emotional problems during and after their pregnancy are well supported and offered the best care.</p> <p>5. Preparation for Parenthood – We will support all parents to have a healthy pregnancy and to feel well prepared and confident for the birth and subsequent care of their baby.</p> <p>6. Choice – Women and their partners will have all the information that they need to make informed choices about their pregnancy and care.</p> <p>7. Targeted Support – We will ensure that those families, who need it, receive targeted support during their pregnancy and after the baby is born.</p> <p>8. Quality &amp; Safety – We will strive to ensure that all women receive high quality, safe and responsive maternity care throughout their pregnancy, birth and post-natal care.</p> <p>9. Staffing – We will work in partnership to provide well-prepared, trained and confident staff in all our services to meet the needs of women and families.</p> <p>As part of the targeted support project, work has already been completed to improve services for women and partners using maternity services who have learning difficulties. The programme board has now agreed that young parents will be the next group which we will focus on as part of the targeted support project.</p>
<p><b>What outcomes do you want to achieve</b></p> <ul style="list-style-type: none"> <li>• Desired outcomes</li> <li>• Benefits</li> <li>• Who for</li> </ul>	<p>Improved and enhanced service for young parents.</p>

**2. Consideration of relevant information – what do we know about peoples and groups access, experience or outcomes?**

<b>Protected group</b>	<b>2a.Evidence, data or research and patient experience data available</b>
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Protected group	2a.Evidence, data or research and patient experience data available
<b>Generic issues</b>	<p>Women and babies from some groups are at increased risk poorer birth and perinatal outcomes. However, this 'risk' is not necessarily inherent within women's cultural practices, ethnicity, age or any other single characteristic. Rather, it is related to an intersection of multiple disadvantage which results in structural barriers to accessing appropriate services and leads to unequal health outcomes.</p>
<b>Age</b>	<p>Despite a downward trend, the teenage maternity rate remains above the England and Wales average.</p> <p>Conversely, births to women aged 18 to 20 years and 16 to 18 years have declined slightly. In 2008/09 births to women aged 16 – 18 years accounted for 2.8% of births. In 2013/14 this has reduced to 1.4%. Births to women aged 18-20 years old accounted for 9.3% of births in 2008/09. This had decreased to 6.3% in 2013/14.</p> <p>Outcomes for young parents are worse than for the general population. The Centre for Maternal and Child Enquiries (CEMACH) published a perinatal mortality report in 2009 which found links between stillbirths/neonatal deaths and age. The youngest mothers (less than 20 years old) were 1.4 times more likely to have a stillbirth and 1.2 times more likely to have a neonatal death than mothers of 25-29.</p> <p>Mothers under the age of 20 were nearly four times as likely to smoke before or during pregnancy, than mothers aged 35 or over (57% compared with 15%). As well as being more likely to smoke in the first place, younger mothers were less likely to quit before or during pregnancy: 38% of mothers under the age of 20 did so compared with 58% of mothers aged 35 or above<sup>1</sup></p> <p>A recent piece of insight (2014) carried out by Women's Health Matters reported that young women do want to breastfeed and 'do the best for their babies' but that they experience barriers –printed materials not aimed at them, low literacy, or the perception from health professionals that young women won't want to breastfeed. In addition, they lack the confidence to ask for help when they need it.<sup>2</sup></p>

<sup>1</sup> Health and Social Care Information Centre, Infant Feeding Survey 2011

<sup>2</sup> Women's Health Matters (2014) *Young, white working class and breastfeeding in Leeds: My influences, my choices*

Protected group	2a.Evidence, data or research and patient experience data available
	<p>There is very strong evidence to suggest that young parents prefer group based antenatal provision that is designed specifically with and for young parents. This provision is not currently available in the city.</p> <p>Teenage mums are 3 times more likely to experience postnatal depression than older mums and more likely to experience poor mental health for three years after birth.</p> <p>The British Crime Survey (2009/10) found that 16- 19 years olds were the age group most likely to suffer from domestic abuse, so this risk is likely to be higher amongst young pregnant people.</p>
<b>Carers</b>	
<b>Disability</b>	
<b>Sex</b>	
<b>Race</b>	
<b>Religion or belief</b>	
<b>Sexual orientation</b>	
<b>Gender reassignment</b>	
<b>Pregnancy and maternity</b>	
<b>Marriage and civil partnership</b> (only eliminating discrimination)	
<p><b>Other relevant group</b>  a group identified as relevant ie, rural communities, asylum seekers and refugees, students</p>	<p><b>Children that are Looked After:</b> Care leavers are a particular group who are of significant concern both locally and nationally. There is evidence to suggest that young women who are looked after are more likely to become young mothers than the general population and are more than twice as likely to have their own children taken into care<sup>3</sup>.</p> <p>Whilst the teenage maternity rate within Leeds has fallen over the last five years, it has remained consistently above the national average. The number of pregnant women who are either in care, or who have recently left care is not recorded by the maternity service, but the Leeds Health Needs Assessment (2014) estimated that in that in 2012, there were 18 care leavers/children who were looked after (aged 15 – 18 years) who had babies.</p>

<sup>3</sup> Barn and Mantovani (2007) Young mothers and the care system, contextualising risk and vulnerability

Protected group	2a.Evidence, data or research and patient experience data available
	<p><b>Homeless people:</b> Very little literature specifically related to the issue of young homeless women and pregnancy is currently available, however the issues in this group are closely related to the issues of young parents who are in care<sup>4</sup>. The Independent Inquiry into Inequalities in Health<sup>5</sup>, made specific mention of homeless or runaway teenagers having higher rates of pregnancy than the population average. A research study exploring mental health among young homeless people in London found that in the intervening year between two interviews 40% of the young women in the study had become pregnant<sup>6</sup>.</p>

Protected group	2b. Consultation and engagement
<b>Generic issues</b>	
<b>Age</b>	<p>Virtual meetings can encourage participation by more young people, who have been traditionally under-represented in engagement and participation activity. Commissioners should use approaches that enable wider access such as considering educational commitments when planning the timing of activities. Commissioners should consider working with networks and organisations that already engage with young people.<sup>7</sup></p>
<b>Carers</b>	<p>Consideration should be given to creating flexible approaches to engagement which enable carers to participate in a way that works with their caring responsibilities. This may include virtual meeting approaches and organising activities at times which fit around other commitments. Consideration should be given to offering alternatives to face-to-face participation, including online or telephone surveys, which may encourage participation by people with caring responsibilities as it negates the need to travel or make alternative arrangements to support the cared for person. However, many older carers may be digitally excluded, so their participation in online activities should not be assumed.</p>
<b>Disability</b>	<p>People with disabilities ('disabled people') experience a range of barriers to participation, including those associated with physical, financial and societal factors. These barriers include, but are not</p>

<sup>4</sup> <http://www.crisis.org.uk/data/files/publications/YoungWomenPregnancy.pdf>

<sup>5</sup> Sir Donald Acheson (1998) An Independent Inquiry into Health Inequalities, HMSO.

<sup>6</sup> Craig, TKJ. et al (1996) Off to a Bad Start, Mental Health Foundation.

<sup>7</sup> <https://www.england.nhs.uk/wp-content/uploads/2016/04/equality-hlth-inequalities.pdf>

Protected group	2b. Consultation and engagement
	<p>limited to, the following:</p> <p>Disabled people may experience difficulties and barriers to participating in ‘face-to-face’ meetings, workshops and events due to the inaccessibility of venues, including a lack of ‘level floor’ or ‘step free’ access, an absence of lifts or accessible toilets, inaccessible transport or travel facilities, a lack of communication or other support.</p> <p>Disabled people may experience barriers to virtual engagement due to being digitally excluded. Inaccessible websites and electronically published information can result in users being unable to access websites and documents which are not compatible with assistive technologies such as ‘screen-readers’. These convert text to speech for people who are blind, deafblind or have visual loss.</p> <p>Disabled people may experience barriers to engagement due to inaccessible information (in both printed formats and that published online). This includes barriers to accessing ‘standard’ printed English documents and/or a need for information in alternative formats such as braille, audio or ‘easy read’.</p> <p>Disabled people continue to experience stigma, disadvantage and poorer health outcomes as well as, often, poorer care. Such negative experiences may also pose barriers to their active engagement.</p> <p>Registration processes for events and meetings, and application processes for recruiting lay voices, should include questions about access and communication needs, to enable actions to be taken to ensure that such needs can be met.</p> <p>Consideration should also be given to identifying, recording and making provision for accommodation of carers, support workers or personal assistants, who may support some disabled people at events or meetings. Commissioners should also seek to create an inclusive environment which enables people to participate in the way which works best for them. This should include both considering the environment itself and also the provision of alternative means of engaging.</p> <p>Virtual meetings should be considered where this will help to improve access for people who may not be able to attend in person. However, virtual approaches may not be suitable for everyone. Commissioners should consider working with existing organisations and networks of people with disabilities.</p>
<b>Sex</b>	<p><b>Women</b></p> <p>Travelling to face-to-face meetings could have negative impact for women, as evidence suggests they are more likely to have caring responsibilities. Virtual meeting approaches should be considered alongside more traditional approaches to ensure that opportunities for engagement are</p>

Protected group	2b. Consultation and engagement
	<p>accessible to those who do not wish to travel due to caring commitments. Telephone and online survey approaches can also be used.</p> <p>Creche facilities or support with childcare/carer costs can support participation, as can avoiding school holiday times.</p> <p>Demographic information including on gender should be collected for people involved in health services.</p> <p>Women are at greater risk of poverty than men and are more likely to suffer recurrent and longer spells of poverty (22 per cent of women have a persistent low income compared to 14 per cent of men, and the current gender pay gap for full time workers is 19.7%). Offering to reimburse travelling expenses will help to avoid excluding women living in poverty.</p> <p>Commissioners should consider working with and supporting women’s voluntary and community organisations that can enable women to participate and have a voice. In particular, specialist services for minority groups of women and women only services are often able to reach women who would not otherwise engage with services.</p> <p>Some groups, such as women from some faith or ethnic minority communities may find it easier to attend meetings that are women-only. However, lesbians from these and other communities (including young women and girls) may find it impossible to speak out in open meetings at all, and may require separate, anonymised modes of engagement, such as focus groups held by representative organisations.</p> <p>Groups that speak for particular sections of the community may be led by men, excluding women’s voices, and special care needs to be taken to reach women in those communities. Dedicated spaces for women offer opportunities for women to find their voice, develop collective understanding of the challenges women face, and develop confidence to participate and contribute on the basis of their experience and needs.</p> <p>Access should be considered, as women are less likely to have access to private transport than men, and therefore are disproportionately reliant on public transport. Venues should be convenient to public transport and meetings held at times when public transport is running. Research shows that many women do not leave their homes in the evening for safety reasons, and this should be taken into account.</p> <p>Differential access to and skills to use technology can limit participation for some women. For example, many consultations and other participation exercise depend on effective use of technologies, not available across all social groups of women.</p> <p><b>Men</b></p>

Protected group	2b. Consultation and engagement
	<p>Especially during working age, men are less likely to engage with health services. Some health issues are more stigmatised for men.</p> <p>Commissioners need to consider a varied range of participation approaches such as engagement via social media, outreach into workplaces, surveys, focus groups, and working through organisations that support men.</p>
<b>Race</b>	<p>Some ethnic groups have poor experiences of services resulting in lack of trust, for Black, Asian and Minority Ethnic (BAME) groups with mental health services and Gypsy Traveller groups experiencing discrimination. This may make them reluctant to take part in mainstream engagement such as public meetings. Commissioners need to consider a range of engagement approaches such as outreach and working through community organisations.</p> <p>For some minority ethnic communities, levels of literacy may be lower and English will not be spoken or read by all. Communication support needs to be considered by commissioners to support participation including access to translation services and availability of easy read documents.</p>
<b>Religion or belief</b>	<p>Commissioners should consider religious diversity when planning for participation including ensuring that events are accessible and inclusive. This should include consulting a multi faith calendar and considering other faith specific needs such as dietary requirements.</p> <p>Commissioners should take steps to ensure that choice of venues for meetings or events are not exclusive or off-putting for people of different faiths, and ensure that registration processes ask questions about dietary requirements.</p> <p>Religious diversity can be overlooked when targeting engagement activity. This can have specific relevance in some healthcare settings. Commissioners should therefore consider the potential impact of their work on different religious groups when planning participation activity to ensure that the right people are engaged, for example many religions have different practices that have to be performed during labour and on the birth of a child. Midwives and maternity ward staff should ask pregnant women from the first appointment whether there are any religious requirements or ceremonies that need to be considered during the birth, so that planning can take place in advance<sup>8</sup>.</p> <p>Faith communities often provide community based support and can be a useful conduit for engaging with excluded groups.</p>
<b>Sexual orientation</b>	<p>An increasing number of lesbian women are choosing to become mothers. NICE Guidance on Fertility Treatment (February 2013) now recommends free intrauterine insemination for same sex</p>

<sup>8</sup> [http://www.nhs-chaplaincy-spiritualcare.org.uk/NationalHealthService/dh\\_ReligionOrBelief.pdf](http://www.nhs-chaplaincy-spiritualcare.org.uk/NationalHealthService/dh_ReligionOrBelief.pdf)

Protected group	2b. Consultation and engagement
	<p>couples</p> <p>However, research into the experience of lesbian women in particular, suggests that heteronormative systems and the heterosexist assumptions of practitioners can affect the satisfaction that mothers-to-be and co-mothers have of maternity services<sup>9</sup>.</p> <p>LGBT people report feeling unsafe in certain areas or on certain transport routes because of discrimination and hate crime they have experienced or feel in danger of experiencing. Holding participation events in locations that are not considered to be LGBT friendly may act as a significant barrier. However, some LGBT people who do not wish to be 'outed' may consider entering an LGBT-specific building a barrier to participation. For example this may apply to some trans people or LGBT people of faith. An enabler would be to use localised LGBT-specific expertise and experience from Voluntary and Community Sector (VCS) organisations who can consult with the community on preferable locations and transport routes. Additionally, consider having a budget for alternative modes of transport for particularly vulnerable individuals. Flexible approaches to participation can help to ensure the greatest number of people can participate.</p> <p>LGBT people are less likely to access or engage with mainstream health services because they are more likely to rate their experiences as poor and fear that they will suffer unequal treatment as an LGBT person. Enablers include being visibly and explicitly LGBT inclusive and utilising local LGBT VCS organisations as a method of communicating with the community to advertise and facilitate participation.</p> <p>LGBT people experience higher rates of mental ill health and may not feel confident or comfortable to speak up about their experiences and views. Commissioners should seek to create supportive and inclusive environments, including considering how best to support people to develop their confidence and capacity to engage effectively.</p> <p>Commissioners should consider offering alternatives to face-to-face participation approaches, which may encourage participation by LGBT people who do not wish to be 'outed', including online, telephone or paper surveys which enable people to participate anonymously.</p>
<b>Gender reassignment</b>	<p>Many trans and non-binary people are anxious about disclosing their status and may have distrust in authority figures. Commissioners should ensure that confidentiality is respected and seek to create inclusive and supportive environments.</p> <p>Many trans and non-binary people feel unable to participate in events where they fear they will be misrepresented – referred to by he instead of she, or by she instead of they, for example. This is</p>

<sup>9</sup> Journal of Advanced Nursing. 2013 Jun; 69(6):1269-78. Lesbian co-mothers' experiences of maternity healthcare services)

Protected group	2b. Consultation and engagement
	particularly true for non-binary people. Introducing name badges and normalising the idea of asking someone what their pronouns are rather than guessing their gender based on appearance will make trans and non-binary people feel more included and catered for.
<b>Pregnancy and maternity</b>	Travelling to face-to-face meetings could be more difficult for women in the latter stages of pregnancy or with young children. Virtual meeting approaches should be considered alongside more traditional approaches to ensure that opportunities for engagement are accessible to those who do not wish to travel due to pregnancy or caring commitments. Telephone and online survey approaches can also be used. Consideration should be given as to how to enable participation for people with caring responsibilities. Events should be organised in a way which is accessible to those who are caring for children, for example by providing facilities for children and for women who are breastfeeding.
<b>Marriage and civil partnership</b> (only eliminating discrimination)	No impact identified.
<b>Other relevant groups</b>	<b>Homeless people:</b> Commissioners should work with existing organisations and networks, including the voluntary sector, to develop effective routes to engagement.

### 3. Analysis of impact and action plan

This is the core of the assessment, using the information above detail the actual or likely impact on protected groups, with consideration of the general duty to;

- eliminate unlawful discrimination
- advance equality of opportunity
- foster good relations

	What key issues/impacts have you identified?	What action do you need to take to address these issues/impacts?	How will you review/monitor the impact and effectiveness of your actions?	Lead	Timescale
<b>General issues</b>	Various	The teenage midwifery team will target individual young parents, asking them	We will evaluate the attendees of the engagement events, and the responses to engagement	LW	August 2017

	<b>What key issues/impacts have you identified?</b>	<b>What action do you need to take to address these issues/impacts?</b>	<b>How will you review/monitor the impact and effectiveness of your actions?</b>	<b>Lead</b>	<b>Timescale</b>
		what method would be most beneficial for them to engage with the project, and encouraging them to engage via that method.	surveys, interviews etc, using anonymous equality monitoring assessment forms, to ensure that the sample is representative of all young parents.  If any gaps in consultation are evident, further focussed work will be carried out to gain feedback from young parents in this group.		
<b>Age</b>	Various		As above	LW	August 2017
<b>Carers</b>		Various methods of engagement will be used, including virtual methods. Expenses will be paid.	As above	LW	August 2017
<b>Disability</b>		Registration processes for events will include questions about access and communication needs. Engagement events will take place in accessible locations. Provision will be made for the accommodation of carers, when	As above	LW	August 2017

	What key issues/impacts have you identified?	What action do you need to take to address these issues/impacts?	How will you review/monitor the impact and effectiveness of your actions?	Lead	Timescale
		required.			
<b>Sex</b>		<p>Women: Support with childcare and travel costs will be offered. Engagement events will not take place during school holidays, nor evenings, and will take place in venues which are easily accessible via public transport. Existing groups for young female parents will be used to increase engagement. Virtual meetings and one-to-one engagement opportunities will be used alongside group engagement activities. Existing women-only groups will be engaged with via Leeds Involving People, and women-only groups for young parents will be directly invited to participate in the engagement.</p>	As above	LW	August 2017

	<b>What key issues/impacts have you identified?</b>	<b>What action do you need to take to address these issues/impacts?</b>	<b>How will you review/monitor the impact and effectiveness of your actions?</b>	<b>Lead</b>	<b>Timescale</b>
		Men: Groups which are already engaging with Young Dads will be used to ensure representation from this group.			
<b>Race</b>		A range of engagement approaches such as outreach via community midwives will be used to increase participation. Through Leeds Involving People, the project will increase engagement by working through community organisations.	As above	LW	August 2017
<b>Religion or belief</b>		A multi-faith calendar will be consulted before confirming the dates of any engagement events. Questions will be asked about dietary requirements to ensure	As above	LW	August 2017

	<b>What key issues/impacts have you identified?</b>	<b>What action do you need to take to address these issues/impacts?</b>	<b>How will you review/monitor the impact and effectiveness of your actions?</b>	<b>Lead</b>	<b>Timescale</b>
		these are catered for. We will work with Leeds Involving People to ensure that engagement activity takes place through faith groups.			
<b>Sexual orientation</b>		A variety of engagement methods will be used. We will engage with local community groups using Leeds Involving People. The term co-parent will be used throughout engagement literature, rather than "father" or "dad".	As above	LW	August 2017
<b>Gender reassignment</b>		Name badges will be used at group engagement events. Equality monitoring forms will be confidential.	As above	LW	August 2017
<b>Pregnancy and maternity</b>		Engagement events will allow funding to cover childcare costs, and will be breastfeeding friendly.	As above	LW	August 2017

	<b>What key issues/impacts have you identified?</b>	<b>What action do you need to take to address these issues/impacts?</b>	<b>How will you review/monitor the impact and effectiveness of your actions?</b>	<b>Lead</b>	<b>Timescale</b>
		Virtual meetings, telephone and online approaches will be used alongside face to face methods.			
<b>Marriage and civil partnership</b> (only eliminating discrimination)		No particular actions identified as required.	As above	LW	August 2017
<b>Other relevant group</b>	Homeless people and CYP who are Looked After may be more difficult to engage with, but may have a very different experience of maternity services to contribute to the engagement.	Work with existing voluntary sector organisations to ensure that these groups are represented.	As above	LW	August 2017

<b>4. Monitoring and Review</b>			
<b>Lead Officer</b>	<b>Liz Wigley</b>	<b>Review date discuss monitoring of the effectiveness of actions detailed in no. 3</b>	<b>31/08/17</b>

<b>5. Sign off</b>	
<b>Lead Officer</b>	

<b>Director</b>		<b>Date approved:</b>	
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For any advice or assistance in relation to the completion of the equality impact assessments please contact your Equality lead;

Sharon Moore - [sharon.moore9@nhs.net](mailto:sharon.moore9@nhs.net) Tel.no. 07534406236 . Once completed please send a copy to Sharon Moore.

## Guidance

This guidance has been put together to support completion of the equality impact assessment process.

Equality impact assessment is an integral part of our commissioning processes. It involves looking at what steps could be taken to advance equality, eliminate discrimination and promote good relations. Case law has demonstrated that we need to ensure that we give full consideration to the impact our decisions have on protected groups to avoid both risks in terms of litigation and reputation. We also need to ensure that those we commission deliver on equality improvements.

As a public authority we are subject to the General and Specific Public Sector Equality Duties. Using EQIA is one way of demonstrating that we are compliant with the Equality Act 2010.

### 1. Project outline

- What is the purpose of the policy
- In what context will it operate
- Who is it intended to benefit
- What results are intended
- Why is it needed
- Are there any implications for partners, or national or regional policy

### 2. Consideration of relevant information

#### 2a. Evidence, data or research and patient experience data available

You will be required to detail relevant data such as monitoring, take up rates, census statistics, regional or national data or research. You can utilise evidence obtained from PALS, complaints or recommendations from inspections or audits, or any good practice in the area which could be drawn on.

Detail the data that is known about the area, what data we have from providers, what gaps there are in the data we ask to be recorded, what levels of use there are and if there are any gaps in the representation of our local communities.

It will also be useful to access data and information about our communities, public, staff and epidemiology to determine if there are any gaps in representation, or differentials in access and outcomes that may relate to equality.

National and regional data can be used to predict expected patterns/outcomes where data is not available locally. Comparisons should be made with expected use and against known community data, such as the census or local profiles.

#### Data collection and monitoring

Data can be routinely collected on age, gender, disability and ethnicity; however there may be more difficulty with sensitive data monitoring of sexual orientation, religion and belief or gender reassignment. Different approaches may be used for this monitoring such as anonymous survey work to gather views or snapshots of users. The integration of such monitoring is implicit in the Equality Act 2010.

Types of data you may wish to consider include;

- JSNA
- Demographic data
- Census findings
- Recent research finding
- Studies of deprivation
- Results of recent consultations and surveys
- Information from groups and agencies across Leeds
- Comparisons between similar policies and functions
- Complaints and public enquires
- Information analysis of audit reports and reviews.
- Health Equity Audits
- Health Needs Assessment

**Please note** - Ensure you provide the links to any reports or data you reference.

### **Consultation and engagement**

This could be any evidence of existing consultation or engagement from meetings, focus groups, satisfaction or patient experience surveys, staff surveys or others. It could be work done previously or undertaken for the purposes of the analysis – this could be from local, regional or national data.

The findings from **section 2a** help to inform engagement and consultation plans by identifying gaps in information relating to particular communities and/or by identifying particular communities that are more likely to use a service more, for example.

Outline the main points from the consultations and then provide a link to the report/document for further information.

In the event of a service change the NHS may need to undertake a statutory consultation. This is called Section 242, this means that NHS organisations are required to make arrangements to involve and consult patients and the public in:

- Planning of the provision of services;
- The development and consideration of proposals for changes in the way those services are provided, and decisions made by the NHS organisation affecting the operation of services.

The duty applies if implementation of the proposal, or a decision (if made), would have impact on -

- a) the manner in which the services are delivered to users of those services, or
- b) the range of health services available to those users.

### **3. Analysis of impact and action plan**

Now the data has been gathered together in one place it now needs to be considered for its likely impact, positive or negative, on people's experiences, outcomes or opportunities. The first column asks what are the identified issues, the second – 'what are you going to do about it'; this forms the core of the analysis.

Some people can belong to more than one protected group, attention needs to be paid to issues which may affect across groups, such as learning disabled people who are gay or older Irish people etc. .

Detail what the likely issues could be, using the information already considered and other intelligence.

Some of the significant issues that may be relevant to our service users and staff are detailed below, this is not an exhaustive list but should be a good start;

- What equality data do ask for from Providers to support that all people who are potential users of the service are able to, or do access them, ie is their service user data representative of the community as a whole, or of the proportion of the population eligible for it? Are there any representation/data gaps?
- How is the service advertised and promoted– is it in accessible formats, with representative images, in locations likely to be seen by people not being reached or who are under-represented have we ensured providers are required do this?
- What timing has the service been commissioned for; is this when the service is needed or can be accessed by people who may have different needs, parents of school age children, people of different religions and older and younger people?
- Have you required the provider to consider any different needs people may have, interpreters, accessible information, suitable catering and locations that are accessible by public transport and have accessible parking bays?
- When commissioning services have you incorporated the requirement to involve service users in service design, delivery and feedback mechanisms.

To be able to measure progress in equality for our communities and staff we need to appreciate the outcomes, rather than the input, so the ‘what difference will this make’ column allows for consideration of the likely outcomes.

## **Action Plan**

### **Action planning for improvement**

Give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Include here any action to address specific equality issues and data gaps that need to be addressed through consultation or further research. Ensure the actions are specific, measureable, achievable, realistic and have a timescale.

## **4. Monitoring and review**

Detail how and who will monitor this action plan and review this equality analysis.

## **5. Sign off**

The completed equality analysis must be forwarded to your local equality support, for review and once approved signed by the relevant Director. If the assessment is to be used as part of a decision making process it must be recorded as such in the minutes or notes of the meeting held and those making the decision must be fully informed as to their legal responsibilities in regards to equality.

