NHS
Wolverhampton
Clinical Commissioning Group

Equality Analysis Form

Name of Project/Review	**Domestic Violence Project – addition of Read codes to clinical system**
Project Reference number	**N/A**
Project Lead Name	**Liz Corrigan**
Project Lead Title	**Primary Care Quality Assurance Coordinator**
Project Lead Contact Number & Email	**liz.corrigan@nhs.net 01902 444275**
Date of Submission	**16th May 2018**
Version	**1.0**

Is the document:	
A proposal of new service or pathway	**NO**
A strategy, policy or project (or similar)	**YES**
A review of existing service, pathway or project	**NO**

Who holds overall responsibility for the project/policy/ strategy/ service redesign etc

Wolverhampton Safer Partnership, Wolverhampton Domestic Violence Project and Wolverhampton CCG

Who else has been involved in the development?

Jo Reynolds - Primary Care Development Manager Wolverhampton CCG
Kathy Cole-Evans – Wolverhampton Domestic Violence Forum
Karen Samuels – Head of Community Safety Wolverhampton City Council
Annette Lawrence – Designated Adult Safeguarding Lead Wolverhampton CCG
Sonia Sanghera – IM&T Project Manager Wolverhampton CCG

Equality Analysis Form

Section A - Project Details

Preliminary Analysis – *copy the details used in the scoping report*

Wolverhampton Safer Partnership, Wolverhampton Domestic Violence Forum, alongside Wolverhampton CCG safeguarding team, have been working to improve the way domestic violence incidents are dealt with across primary care. Primary care support services have been introduced, and referral pathways have been refreshed so that it is easier for practice staff to report concerns and incidents.

A Multi Agency Risk Assessment Conference (MARAC) is a local, multi agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies. Primary Care are often the first agency to have contact, or multiple contact, with an individual experiencing domestic violence, so it is important that risks and concerns are recorded within the patient notes so a true reflection of all risks are presented to MARAC.

Part of the development work taking place improving reporting, and identifying incidents on patient notes is a vital part of this. It is known that if there is a repeat incident within a 12 month period, there is a high and serious risk of imminent death. Previous domestic homicide reviews have indicated that the majority of cases are known to MARAC and have been repeat incidents.

In order to accurately track and identify any repeat incidents, patient records need updating with any incidents that have occurred over the last 12 months. These have already been identified, and need including on the patient records at the patients practice.

By including this information on the patient records, safeguarding duty is being realised, and support to MARAC is being provided.

This is a preparatory piece of work to enable all agencies concerned to have the information required over the next 12 months, while this work is embedded. It will be part of safeguarding duty that this practice of coding on patient records will occur as incidents occur as part of business as usual.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

Practice staff who will enter the data.
Patients who will have the data entered onto their records.

Section B – Screening Analysis

Equality Analysis Form

Equality Analysis Screening
It is vital that the CCG ensures that it demonstrates that it is meeting its legal duty, as the responsible manager you will need to identify whether a Full Equality Analysis is required. A full EA will only not be required if none of the following aspects are identified and you are confident there is no impact. *E.g. 'This report is for information only' or 'The decision has not been made by the CCG' or 'The decision will not have any impact on patients or staff'. (Very few decisions affect all groups equally and this is not a rationale for not completing an EA.)*

Screening Questions	YES or NO
Is the CCG making a decision where the outcome will affect patients or staff? *For example will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.*	No
If the CCG is enacting a decision taken by others, e.g. NHS England or Local Authority - does it have discretion to change, modify or mitigate the decision?	No
Is the board/committee being asked to make a decision on the basis that this proposal will have a consequential effect on any change? e.g. Financial changes	No
Will this decision impact on how a **provider** delivers its services to patients, directly or indirectly?	No
Will this decision impact on any third parties financial position (i.e. Provider, Local Authority, GP Practices)? *For example are you removing funding from theirs or any contract?*	No
If you have answered **NO** to **ALL** the above questions, please provide supporting narrative to explain why none of the above apply. (*Advice and guidance can be sought from the equality team if required).*	
Practices will be asked to add a code to the clinical notes of patients who have been referred to MARAC in the last 12 months and a discreet alert that does not put the survivor at risk from any perpetrators who may attend the surgery with them and may see the alert. There are no financial costs to the CCG from this specification funding has come from the Home Office and is handled by the council. There is unlikely to be significant impact on patients they will have a code added to their notes which will highlight if they have had a previous referral to MARAC in the last 12 months and this will aid GP staff in making a risk assessment and judgement and enable repeat referral if that person presents again. The aim is to reduce risk by ensuring on-going services for DV survivors. Care has been taken in the specification to provide assurances around patient safety. Although the majority of	

DV survivors are female, this issue does affect men and members of the LGBTQ community and there will be no different measures employed for different groups when adding codes. This is a time limited programme that will end when practices have added retrospective data.

If the answer to ALL the questions in the screening questions is "NO", please complete the below section only and do not complete a full assessment.

Please forward the form with any supporting documentation to Blackcountry.Equality@ardengemcsu.nhs.uk

These initial assessments will be saved and retained as part of the CCG's audit trail. These will also be periodically audited as part of the CCG's Quality Assurance process and the findings reported to the Chief Nurse, PMO Lead and the CCG's Governance team.

Please ensure you are happy with the conclusion you have made, advice and guidance can be sought from: David.king17@nhs.net or Equality@ardengemcsu.nhs.uk

Sign Off / Approval (Section A and B)

Title	Name	Date
Project Lead	Liz Corrigan	16th May 2018
Equality and Inclusion Officer		
Equality and Inclusion Comments		
Programme Board Review		
Programme Board Chair		

If any of the screening questions have been answered "YES" then please forward your initial assessment to David.king17@nhs.net or Equality@ardengemcsu.nhs.uk

And complete the next section of the Equality Form Assessment, once you are ready to request approval of the change from the appropriate approval board.

If you required any support to complete the FULL Equality form, please contact the Equality Manager.

The Completed EA will then require a final sign off as per section 10.

Section C - Full Equality Analysis Section

If at an initial stage further information is needed to complete a section this should be recorded and updated in subsequent versions of the EA. An Equality Analysis is a developing document, if you need further information for any section then this should be recorded in the relevant section in the form and dated.

1. Evidence used *What evidence have you identified and considered in determining the impact of this decision e.g. census demographics, service activity data, consultation responses*

Corporate Assurance Impact	
State overarching, strategy, policy, legislation this review or service change is compliant with	
Will this review or service change fit with the CCGs Boards Assurance Framework Aim and Objectives? If yes, please indicate which ones *(see notes page for guidance)*	
What is the intended benefit from this review or service change?	
Who is intended to benefit from the implementation of this review or service change?	
What are the key outcomes/ benefits for the groups identified above?	
Will the review or service change meet any statutory requirements, outcomes or targets?	

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*
2.1 Age *Describe age-related impact and evidence. This can include safeguarding, consent and welfare issues.*
2.2 Disability *Describe disability-related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/learning disabilities, cognitive impairments.*
2.3 Gender reassignment (including transgender) *Describe any impact and evidence in relation to transgender people. This can include issues such as privacy of data and harassment.*
2.4 Marriage and civil partnership *Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.*
2.5 Pregnancy and maternity *Describe any impact and evidence in relation to Pregnancy and Maternity. This can include working arrangements, part time working and caring responsibilities.*
2.6 Race *Describe race-related impact and evidence. This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures and language barriers.*
2.7 Religion or belief *Describe any impact and evidence in relation to religion, belief or no belief on service delivery or patient experience. This can include dietary needs, consent and end of life issues.*
2.8 Sex *Describe any impact and evidence in relation to men and women. This could include access to services and employment.*
2.9 Sexual orientation *Describe any impact and evidence in relation to heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.*

2. Impact of decision
In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.

2.10 Carers
Describe any impact and evidence in relation to part-time working, shift-patterns, general caring responsibilities. (Not a legal requirement but a CCG priority and best practice)

2.11 Other disadvantaged groups
Describe any impact and evidence in relation to groups experiencing disadvantage and barriers to access and outcomes. This can include socio-economic status, resident status (migrants, asylum seekers), homeless people, looked after children, single parent households, victims of domestic abuse, victims of drug/alcohol abuse. This list is not finite. This supports the CCG in meeting its legal duties to identify and reduce health inequalities.

3. Human rights
The principles are Fairness, Respect, Equality, Dignity and Autonomy.

Will the proposal impact on human rights?	Yes	☐	No	☐
Are any actions required to ensure patients' or staff human rights are protected?	Yes	☐	No	☐

If so what actions are needed? *Please explain below.*

4. How will you measure how the proposal impacts health inequalities?

<u>The CCG has a legal duty to identify and reduce health inequalities.</u>

e.g. patients with a learning disability were accessing cancer screening in substantially smaller numbers than other patients. By revising the pathway the CCG is able to show increased take up from this group, this a positive impact on this health inequality.

5. Engagement/consultation What engagement is planned or has already been done to support this project?		
Engagement activity	**With who?** *e.g. protected characteristic/group/community*	**Date**
Please summarise below the key finding / feedback from your engagement activity and how this will shape the policy/service decisions e.g. patient told us, so we will… (If a supporting document is available, please provide it or a link to the document)		

6. Mitigations and changes *If you have identified mitigations or changes, summarise them below. E.g. restricting prescribing over the counter medication. It was identified that some patient groups require high volumes of regular prescribing of paracetamol, this needs to remain under medical supervision for patient safety, therefore an exception is provided for this group which has resolved the issue.*

7. Is further work required to complete this EA? *Please state below what work is required and to what section e.g. additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g. disability)*			
Work needed	**Section**	**When**	**Date completed**
e.g. Further engagement with disabled service users to identify key concerns around using the service.	*2 - Disability*	*June to July'17*	*September 2017*

8. Development of the Equality Analysis *If the EA has been updated from a previous version please summarise the changes made and the rationale for the change, e.g. Additional information may have been received – examples can include consultation feedback, service Activity data*		
Version	**Change and Rationale**	**Version Date**
e.g. Version 0.1	*The impact on wheelchair users identified additional blue badge spaces are required on site to improve access for this group.*	*26 September 2017*

9. Preparation for Sign off	
	Please Tick
1) Send the completed Equality Analysis with your documentation to Equality@ardengemcsu.nhs.uk and David.king17@nhs.net for feedback prior to Executive Director (ED) sign-off.	
2) Make arrangements to have the EA put on the appropriate programme board agenda	
3) Use the Action / version section to record the changes you are intending to make to the document and the timescales for completion.	

10. Final Sign off The Completed EA forms must be signed off by the completing manager. They will be reviewed as part of the decision making process. The completed form should also be sent to PMO so that the CCG can maintain an up to date log of all EAs.	
Version approved:	
Designated People	
Project officer* (Senior Officer responsible including action plan) Name: Date:	
Equality & Inclusion Review and Quality Assurance Name: Date:	
Executive Director Review: Name: Date:	
Name of **Approval Board** (*e.g. Commissioning Committee; Governing Body; Primary Care Commissioning Committee*) at which the EA was agreed at: Approval Board: Approval Board Ref Number: Chair: Date: Comments: Actions from the Approval Board to complete:	
Review date for action plan (section 7):	