Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Reference Number: FOI202324/234
From: Other

Date: 18 August 2023

Subject: Cardiology Lab Performance, Cardiothoracic Theatre Performance and length of stay for Cardiology Patients

Q1 Cardiology Labs – see attached document for full question: *FOI 234 Response - Questions 1, 2 and 3*

A1 Information not held – the Trust does not routinely collate or hold this information centrally as part of its management or performance data. In order to ascertain the data, the Trust would be required to access personal data of the individuals and as such the data is exempt under Section 40: Personal data.

Q2 Cardiology Labs Performance and Cardiothoracic Theatre Average Performance – see attached document for full question: *FOI 234 Response - Questions 1, 2 and 3*

A2 Information not held – the Trust does not routinely collate or hold this information centrally as part of its management or performance data. In order to ascertain the data, the Trust would be required to access personal data of the individuals and as such the data is exempt under Section 40: Personal data.

Q3 Length of Stay – see attached document for full question: *FOI 234 Response - Questions 1, 2 and 3*

A3 Information not held – the Trust does not routinely collate or hold this information centrally as part of its management or performance data. In order to ascertain the data, the Trust would be required to access personal data of the individuals and as such the data is exempt under Section 40: Personal data.

Q4 Cardiology Consultants

a. Number of Cardiology Consultants with job planned PAs for lab sessions
b. Number of Cardiothoracic Consultants with job planned PAs for Theatre sessions
c. Total number of job planned lab sessions per year
d. Total number of job planned cardiac theatre sessions per year

A4

a. 29
b. 15
c. 2834
d. 845

Q5 If available, please also share any operational policies or SOPs relating to Cardiothoracic Theatre and Cardiology Lab day to day running.

A5 Please see attached documents:

- operating-list-changes-sop-v20
- operating-theatres-cancellations-on-the-day-10
- tor-theatre-scheduling-v11

Question 1

	Definition in place for Cardiology Labs	Definition in place for Cardiology Labs
	Please also provide methodology and/or calculation where relevant	*Please also provide methodology and/or calculation where relevant*
Capped Utilisation (%)	Information not held – the Trust does not routinely collate or hold this information centrally as part of its management or performance data. In order to ascertain the data, the Trust would be required to access personal data of the individuals and as such the data is exempt under Section 40: Personal data.	Information not held – the Trust does not routinely collate or hold this information centrally as part of its management or performance data. In order to ascertain the data, the Trust would be required to access personal data of the individuals and as such the data is exempt under Section 40: Personal data.
On the day cancellations		
On the day non-clinical cancellations		
On the day clinical cancellations		
Start time	*How does Trust define start time in this area i.e. Team Brief start time, Needle to skin etc*	
Late start	*How does Trust define a late start i.e. 15 minutes after scheduled start time (defined above)*	
Finish Time	*How does Trust define finish time in this area i.e. Patient out of lab, Patient out of Recovery*	
Late finish	*How does Trust define a late finish i.e. 15 minutes after scheduled finish time (defined above)*	
Turnaround time	*How does Trust define turnaround time i.e. from first patient out of OR to second patient needle to skin?*	
Early finish	*How does Trust define an early finish i.e. 15 minutes before scheduled finish time (defined above)*	

Question 2

	Cardiology Lab Performance					Cardiothoracic Theatre Average Performance				
	May 2023 - Jul 2023 Monthly Average	**Feb 2023 - Jul 2023 Monthly Average**	**Jul 2022 - Jul 2023 Monthly Average**	**1 April 2022 - 31 March 2023 Total**	**1 April 2021 - 31 March 2022 Total**	**May 2023 - Jul 2023 Monthly Average**	**Feb 2023 - Jul 2023 Monthly Average**	**Jul 2022 - Jul 2023 Monthly Average**	**1 April 2022 - 31 March 2023 Total**	**1 April 2021 - 31 March 2022 Total**
Number of late starts	Information not held – the Trust does not routinely collate or hold this information centrally as part of its management or performance data. In order to ascertain the data, the Trust would be required to access personal data of the individuals and as such the data is exempt under Section 40: Personal data.									
Late start durations of 30 - 44 mins										
Late starts durations of 45 - 59 mins										
Late starts durations of 60 - 89 mins										
Late starts durations of > 90 mins										
Average duration of late start (mins)										
Number of late finishes										
Late finish durations of 30 - 44 mins										
Late finish durations of 45 - 59 mins										
Late finish durations of 60 - 89 mins										
Late finish durations of > 90 mins										
Average duration of late finish (mins)										
Number of turnarounds 31 – 45 mins										
Number of turnarounds 46 – 60 mins										
Number of turnarounds 61 – 90 mins										
Number of turnarounds in excess of 91 mins										
Consultant scrub % time										
For how much of ease case is the Consultant scrubbed in?										
Average underrun/early finish										
Unallocated sessions *Please confirm whether session is defined as AM/PM or full day session*										
Allocated sessions *Please confirm whether session is defined as AM/PM or full day session*										

Question 3

	May 2023 - Jul 2023 Monthly Average	**Feb 2023 - Jul 2023 Monthly Average**	**Jul 2022 - Jul 2023 Monthly Average**	**1 April 2022 - 31 March 2023 Monthly Average**	**1 April 2021 - 31 March 2022 Monthly Average**
Preoperative length of stay for Cardiothoracic patients who go on to have surgery	Information not held – the Trust does not routinely collate or hold this information centrally as part of its management or performance data. In order to ascertain the data, the Trust would be required to access personal data of the individuals and as such the data is exempt under Section 40: Personal data.				
Postoperative length of stay for Cardiothoracic patients following surgery					
Preoperative length of stay for Cardiology patients who go on to have a procedure					
Postoperative length of stay for Cardiology patients following a procedure					

Operation List Changes
Standard Operating Procedure

Policy and Procedure

For completion by Author			
Author(s) Name and Title:	Lucy Kilgallon, Deputy Divisional Head of Operations, Surgery		
Scope:	Trust Wide	Classification:	Clinical
Version Number:	2.0	Review Date:	01/06/2022
Replaces:	V1.0		
To be read in conjunction with the following documents:	Patient Access Policy Theatre Scheduling Terms of Reference		
Document for public display:	No		
Executive Lead	Hayley Kendall, Chief Operating Officer		

For completion by Approving Committee			
Equality Impact Analysis Completed:		No	
Endorsement Completed:	Yes	Record of Changes	No
Authorised by:	Ian Wilson & Fiona Altintas	Authorisation date:	12/05/2021

For completion by Document Control					
Unique ID No:	TC94(15)	Issue Status:	Approved	Issue Date:	02/07/2021
After this document is withdrawn from use it must be kept in archive for the lifetime of the Trust, plus 6 years.					
Archive:	Document Control		Date Added to Archive:		
Officer responsible for Archive:	IG and Document Control Facilitator				

Contents

Document Statement

The aim of this document is to outline the process for the management of the Operation List used for the listing of procedures within the theatres department.

The Operation List provides details of each patient listed for surgery within the theatre department. Incorrect listings can impact on patient flow and patient safety. It is therefore imperative that all information detailed on the list is correct and up to date.

1. Roles and Responsibilities

Outlined below is the process required for any amendments (additions, removals or changes) to the Operation List.

1. It is the responsibility of the Consultant to inform his/her Secretary or, if Out of hours (17.00-08.00) the Hospital Coordinator regarding additions or changes to the Operation List.

2. Details to be included for every patient should include:

    - patient name
    - date of birth
    - patient number
    - ward, including POCCU/HDU for thoracic patients/DOSA
    - breach date
    - risks ®
    - cancellation ©
    - Urgency of patient (if required)
    - Procedure
    - P Code

3. The users of the system who can make additions or changes to this list are the consultant secretaries and the hospital coordinators. An email should be forwarded with confirmation of changes via operation changes. Other members of staff should use the operation list to view the information only.

4. Elective TCI's should be scheduled two weeks ahead to enable adequate theatre planning and scheduling. Urgent and Cancer cases should be listed as soon as allocated to individual consultants. When this is not possible the consultant operating should be added to the operating list and TBA added.

5. List changes and amendments should be kept to a minimum. List changes will be audited quarterly.

6. Within office hours, additions and changes will be made by the secretary responsible for the consultant named on the Operation List. In the event of the consultant's secretary being unavailable on that day, another secretary providing cover for that consultant will make the necessary additions or changes to the list. The Hospital Co- ordinators are responsible for changing the list out-of-hours and will primarily add last minute urgent cases

or amendments where no secretary is available. An email should be forwarded with confirmation of amendments via operation changes.

7. It is the responsibility of the secretary or, in the case of overnight transfers, the Hospital Co-ordinator to ensure that patient details are accurate, and the patient listing is kept up to date.

8. All changes must be completed by 07.30 on the day of surgery, at which point the list will be considered locked down for the day with no further changes to be made. After this time, manual changes will be made via the Theatre Co-ordinator (bleep 2306).

9. All patients should be on the operating list and on PAS based on the above

Any errors found on the list should be reported on the incident reporting system Datix.

The Datix incident is then sent to the Patient Access and Administration Manager to investigate

2. Controlled Document Standards

Any errors should be recorded and kept to identify improvement or deterioration of the quality of the listing and to identify training issues where required for particular users where recurrent errors occur

3. Procedure

In the absence of a secretary, other members of the team must provide cross cover for the consultants to ensure service continuity. In the event of the operation list becoming unavailable online, paper copies must be used as a reference for the day's proceedings, confirmed by information on EPR and PAS.

4. Policy Implementation Plan

In the absence of a secretary, other members of the team must provide cross cover for the consultants to ensure service continuity. In the event of the operation list becoming unavailable online, paper copies must be used as a reference for the day's proceedings, confirmed by information on EPR and PAS.

This SOP should be read in conjunction with the Patient Access Policy and Theatre Scheduling Terms of Reference.

5. Monitoring of Compliance

Compliance will be monitored through the Theatre Scheduling Meeting and any areas of concern raised directly to the Patient Access and Administration Manager.

6. Endorsed By:

Name of Lead Clinician / Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date
Ian Wilson & Fiona Altintas	Surgical Divisional Board	12th May 2021

7. Record of Changes

Section No	Version No	Date of Change	Description of Amendment	Description of Deletion	Description of Addition	Reason

Cancellations on the day Policy
Operating Theatres

For completion by Author			
Author(s) Name and Title:	Lisa Edwards (Deputy Divisional Head of Operations, Surgery) Patricia Routledge (Theatre Business Manager) Cecilia Marchant (Service Line Manager for Cardiothoracic Surgery)		
Scope:	Trust wide	Classification:	Non-Clinical
Version Number:	1.0	Review Date:	17/03/2026
Replaces:	New		
To be read in conjunction with the following documents:	Scheduling policy, Patient Access Policy, Operation Changes Policy		
Document for public display:	Yes		
Executive Lead	Jonathan Matthews		

For completion by Approving Committee			
Equality Impact Analysis Completed:		No	
Endorsement Completed:	Yes	Record of Changes	No
Authorised by:	Divisional Board	Authorisation date:	17/03/2023

For completion by Document Control					
Unique ID No:	TW23DC(149)	Issue Status:	Approved	Issue Date:	26/07/2023
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Officer responsible for Archive:	Information Governance and Document Control Facilitator				

Contents

Document Statement

As NHS providers, we commit to plan a patient's operation and take all the necessary steps to avoid the operation being cancelled due to resource capacity or other organisational constraints.

Avoiding cancellation on the day of surgery is a high priority for our Trust. Impacts include poor patient experience, increased administration workloads, negative impact on staff, wasted theatre time, productivity, and financial losses.

Efficient capacity planning of elective operations combined with appropriate intervention before surgery could avoid some cancellations.

1. Roles and Responsibilities

- Chief Operating Officer is responsible for implementation of this policy
- Medical Director is responsible for ensuring all medical staff adhere to this procedure.
- Director of Nursing is responsible for ensuring all staff that assist in operational procedures within the Liverpool Heart and Chest Hospital adhere to this procedure.
- Theatre Matron is responsible for ensuring that this procedure is implemented within all departments where operation procedures occur.
- Clinical Lead for Cardiac, Thoracic and Aortic surgery is responsible for making the final decision to cancel patients, ensuring all options have been considered
- It is responsibility of the patients' surgeon to inform the patient of the decision to cancel.
- Surgical Management Team is responsible for prioritising patients on operating list

2. Controlled Document Standards

- The standard from April 2003 is when a patient's operation is cancelled by the hospital at the last minute for non-clinical reasons, the hospital will have to offer another date within a maximum of the next 28 days.

- All cancellations will be reviewed by 'Cancellations Working Group' to ensure consistent approach to the management of cancellations. Information regarding cancelled operations will be shared at:

- Service Line Business Meetings
- Surgical Divisional Board
- Operational Board

3. Procedure

3.1 Any changes or cancellations made from the day of admission to the day of surgery must be relayed immediately to theatre co-ordinator.

3.2 If a priority order is required on the day due POCCU beds/staffing, the process outlined in Appendix 1 should be followed.

3.3 If there is a requirement to cancel a patient for non-clinical reasons, this should be communicated as soon as possible to the Surgical Management Team and/or Clinical Lead.

3.4 Once a decision has been made to cancel patient, the theatre coordinator escalate information to the following:

- Surgical Management Team
- Nurse in charge, on the patient's ward.
- Theatre Administration team
- POCCU
- Hospital coordinator
- Theatre team
- Surgical PA's

3.5 Following cancellation, a cancellation form is completed and sent to cancelled operations email group.

3.6 This policy does not cover emergency cases.

3.7 This policy does not cover decisions to cancel patients for clinical reasons, this remains the decision of the clinical team responsible for the patient.

3.8 The Theatre Admin team are responsible for recording the patient cancellation on the PAS system.

3.9 The Surgical Management team record cancellations on the Cancelled Operations Spreadsheet. The Surgical Management Team will also check that patients have been added to the RTT pathway if appropriate. Cancellations that have not been added back to a RTT pathway will be escalated to the RTT validation team.

4.0 Cancellations are reviewed on a weekly basis at the Cancelled Ops Review meeting. This meeting is attended by the Clinical Lead of Cardiac Surgery and representatives from Theatres and Management. The group discusses the root

cause of each cancellation which has occurred that week and comes to a general consensus as to whether the cancellations were avoidable or unavoidable. Themes are collated from the meeting to facilitate learning and will be shared in a Quarterly report.

4.1 Cancellations and 28-day concerns are escalated on a weekly basis at Performance meetings.

Escalation process

Based on the reasons of cancellations relevant staff are expected to follow the escalation process in the follow diagram in appendix 1.

4. Policy Implementation Plan

This document will be widely circulated within the Trust, including all consultant staff, heads of departments and ward managers and will be made available on the Trust's Intranet. The Chief Operating Officer for the Trust will be responsible for the implementation of this policy.
Monitoring of the implementation will be reported to Surgical Governance Committee.

5. Monitoring of Compliance

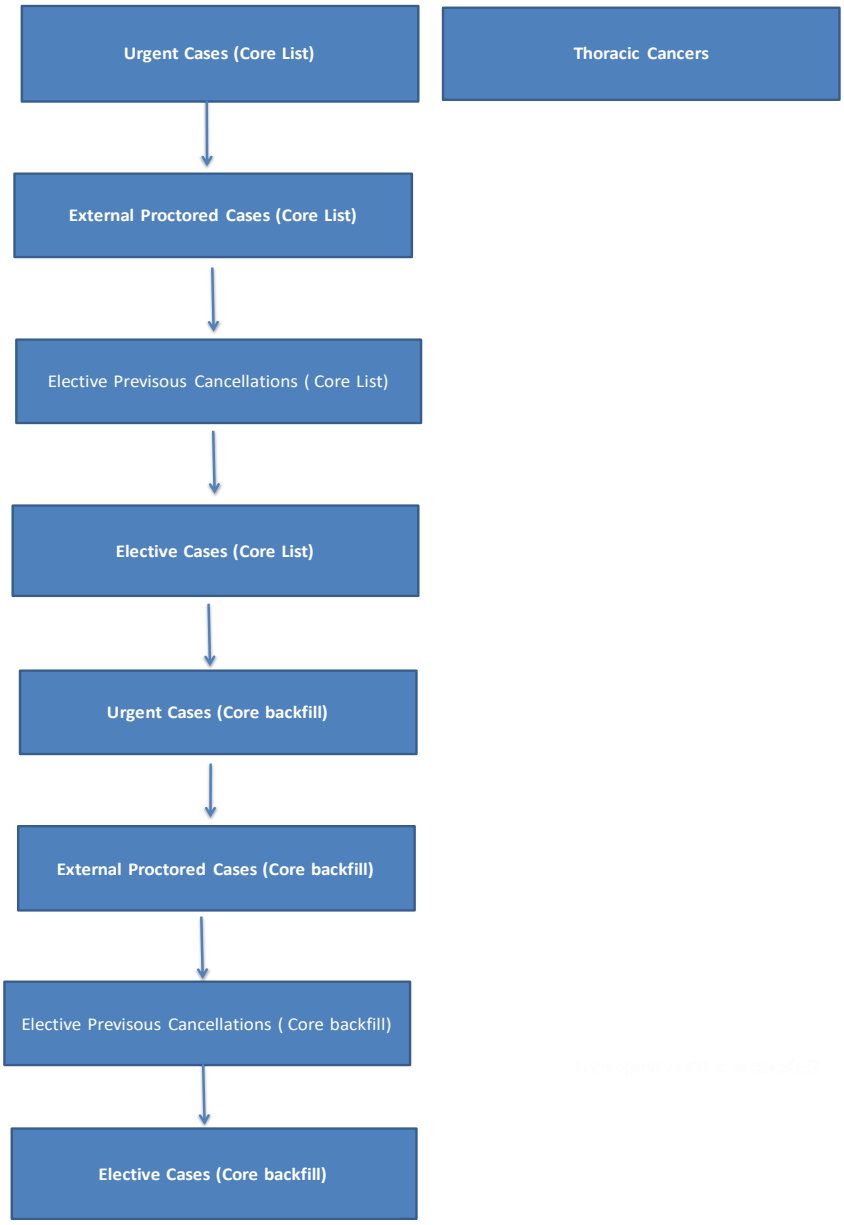
6. References

Cancelled operation Guidance – NHS England
AfPP (Forth Edition) 2016 Standard and Recommendations for Safe Perioperative Practice.

7. Appendices

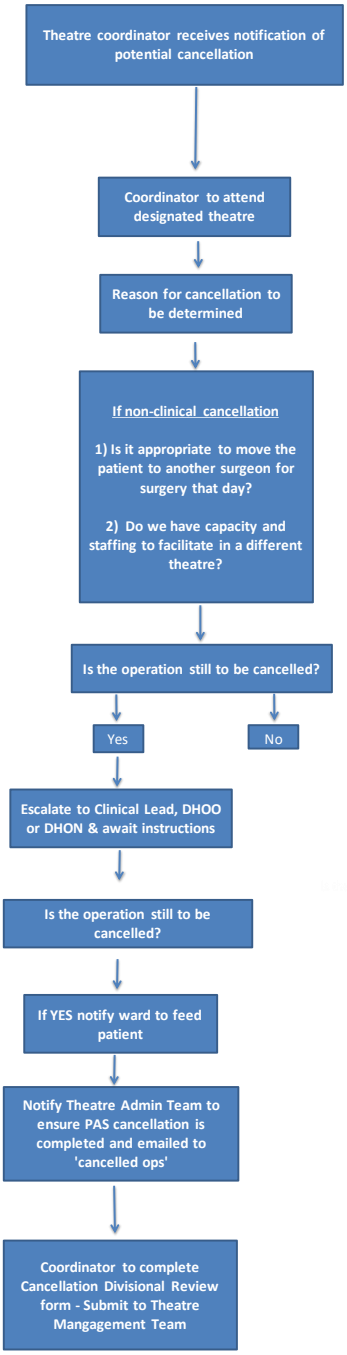
Appendix 1:

Theatre Priority Process - POCCU Beds



Appendix 2:

Theatre Cancellation Process



Appendix 3:

Reasons for cancellation:

Cancellation Reason	Cancellation Type
Pre-existing Medical condition	Clinical
Undiagnosed Condition	Clinical
Acute medical condition – related to Covid	Clinical
Acute medical condition - all other	Clinical
Procedure No Longer Necessary	Clinical
Unsuitable for Surgical Hub/Green site	Clinical
Inadequate Pre-assessment - Incomplete Paperwork	Clinical
Inadequate Pre-assessment - Health problem not fully investigated	Clinical
Inadequate Pre-assessment - Appropriate optimisation / follow up not completed	Clinical
Inadequate Pre-assessment - Appropriate aftercare not arranged	Clinical
Inadequate Pre-assessment - Reasonable adjustments not in place due to disability	Clinical
Treatment/Surgery deferred	Clinical
No Bed Available - General / Ward	Non-Clinical
No Bed Available - ITU/HDU	Non-Clinical
No Bed Available - PACU/POCU/Enhanced Care	Non-Clinical
No Bed Available - Paediatric	Non-Clinical
No Bed Available - Maternity	Non-Clinical
Emergency Admission	Non-Clinical
List Overrun - Booking error	Non-Clinical
List Overrun - Complexity of procedures	Non-Clinical
List Overrun - Theatre inefficiencies	Non-Clinical
List Overrun - Other reason	Non-Clinical
Clinical Staff Unavailable - Surgeon	Non-Clinical
Clinical Staff Unavailable - Anaesthetist	Non-Clinical
Clinical Staff Unavailable - Scrub practitioner	Non-Clinical
Clinical Staff Unavailable - Anaesthetic practitioner	Non-Clinical
Clinical Staff Unavailable - Recovery Practitioner	Non-Clinical
Equipment Unavailable or failed	Non-Clinical
Administrative Change - Booked to incorrect Session	Non-Clinical
Administrative Change - Patient brought forward	Non-Clinical
Essential support unavailable - Perfusionist / Cell Salvage	Non-Clinical
Essential support unavailable - Radiology	Non-Clinical
Essential support unavailable - Manufacturer Rep	Non-Clinical
Essential support unavailable - Interpreter	Non-Clinical
Pre-op Guidance Not Followed	Patient
Appointment Inconvenient	Patient
Unfit for procedure	Patient
Procedure Not Wanted	Patient
Did Not Attend / Was not brought	Patient

Appendix 4:

National Targets

Reportable Cancellations

A cancellation is classed as reportable when an elective patient is cancelled by the hospital at short notice (i.e. on the day of surgery or on the day of TCI) for a non-clinical reason. Urgent inpatients cancelled twice for non-clinical reasons are also reportable.

Non-reportable Cancellations

Urgent inpatients cancelled once (for clinical or non-clinical reasons) are classed as nonreportable cancellations. Elective patients cancelled for clinical or patient related reasons are also non-reportable.

28-day Guarantee

Patients cancelled at short notice should be given a new date for surgery within 28 days of the cancellation. Risks of 28-day breaches are escalated at weekly Performance meetings.

8. Endorsement

Name of Lead Clinician / Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date
Manoj Kuduvalli	Divisional Medical Director for Surgery	17/03/2023

9. Record of Changes

Section No	Version No	Date of Change	Description of Amendment	Description of Deletion	Description of Addition	Reason

Theatre Planning and Scheduling Meeting

Terms of Reference

For completion by Author			
Author(s) Name and Title:	Patricia Routledge, Operational Support Manager – Theatre Lucy Kilgallon, Deputy Head of Ops – Surgery Mark Field, Clinical Lead – Cardiac Surgery		
Scope:	Trust Wide	Classification:	Terms of Reference
Version Number:	V1.1	Review Date:	01/02/2022
Replaces:			
To be read in conjunction with the following documents:	Patient Access Policy		
Document for public display:	Yes		
Executive Lead	Hayley Kendall, Chief Operating Officer		

For completion by Approving Committee			
Equality Impact Analysis Completed:			
Endorsement Completed:		Record of Changes	
Authorised by:	Surgery Divisional Board	Authorisation date:	18/09/20

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Unique ID No:	TOR/T21/ DC047	Issue Status:	Approved	Issue Date:	24/02/2021
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Contents

1. Constitution and Remit

To achieve a multi-disciplinary team (MDT) approach to theatre scheduling ensuring Theatre Scheduling is efficient, accurate and robust. To ensure theatre capacity, staffing, equipment is available and utilised effectively. Reducing the risks associated with patient cancellations for non-clinical reasons.

2. Authority

Monthly Surgical Performance & Governance

3. Objectives and Duties

- The Group will consider and seek assurance in relation to any risks relating to its remit and will identify and escalate any new or emerging risks arising from its work
- The Group will discuss and assess the impact of services eg. Beds, equipment
- Review root cause analysis data in relation to inefficiencies/cancellations to promote pro-active management
- Review utilisation of theatres to ensure all activity is recorded to allow for robust audit

4. Integration

The Group will support the integration and communication of work undertaken to achieve maximum theatre utilisation within resources.

5. Membership

- Operational Support Manager – Chair
- Theatre Co-ordinator or representative
- SLM
- Clinical Lead for Cardiac Surgery
- Clinical Lead for Aortic Surgery
- Clinical Lead for Anaesthesia or representative
- Medical Secretary/Team Leader
- SICU Business Manager /Matron for SICU
- Lead Surgical Care Practitioner or representative

Co-opted Members

- Theatre Matron
- Surgery Matron
- Theatre Business Manager

- Perfusion Manager

6. Attendance

Members or deputies are expected to attend 100% of meeting

7. Quorum and Frequency

75% attendance shall be considered quorate including the Chair or Deputy Chair. The group will meet weekly. Weekly requirement

- Chair
- X1 SLM
- X1 Clinical representative for surgery
- X1 Clinical representative for anaesthesia
- X1 SICU representative
- X1 Theatre Co-ordinator

8. Reporting

The Chair will submit a weekly summary of the meeting to the Group. Monthly reporting of inefficiencies/cancellations will be provided for monthly Performance meeting.

9. Conduct of Committee Meetings

The meeting will follow the following format:

- Apologies
- Minutes
- Matters arising
- Any other business

10. Other Matters

Equality Analysis

Introduction and Guidance

The change in terminology from "equality impact assessment" to "analysis of the effects" is intended to put more focus on the quality of the analysis and how it is utilised in decision making and less on the production of a document. It is not a one-off exercise but an on-going and cyclical process.

It is important that you conduct your equality analysis (EA) from the very beginning of the process of development (be it a strategy, policy, practice, provision or decision). The person who is responsible for the development, or is advising the decision maker, needs to undertake the assessment with appropriate support. If working in partnership a collaborative approach saves time, shares expertise and knowledge and avoids duplication of effort.

You must demonstrate that:

- engagement with the appropriate stakeholders has taken place in **accessible** and **proportionate** ways
- comprehensive equality monitoring of all engagement activities that you have initiated has taken place with all stakeholders (e.g. if a particular provision is targeted at a specific group, e.g. disabled people, it is still important to monitor all equality categories)
- evidence relating to dates and venues and/or methods used to engage is available
- feedback has informed and influenced developments.

In the case of reviewing and updating current practice you must ensure that any lack of engagement or incomplete monitoring in the past is rectified during the updating process.

EA applies to all activities including analysing the cumulative effect of a number of decisions when made together, and the implementation of something that has been developed by an external body e.g. a government department.

The **"protected characteristics"** (PCs) listed in the Equality Act 2010 and covered by the Equality Duty are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Civil partnership and marriage are also covered but not for all aims of the duty. **Protected Groups** (PGs) are based on the protected characteristics. These groups must be considered during the EA process.

Please note that it is not possible to include all the required information in the boxes below. The following is a framework for noting key points within which you must refer to underlying documents and other supporting detail. When completing this you will find it helpful to refer to the "Equality Analysis Checklist" at the end of this document for additional information.

A copy must be kept within your department for audit purposes.

To keep up to date on the latest guidance go to the website of the Equality and Human Rights Commission: www.equalityhumanrights.com

11. **Equality Analysis Framework**

Tick Category (after completion of assessment)	**Not Relevant (NR)**		**Relevant (R)**	
Signature of Manager/Group Responsible				
Date				

Department/Function	
Lead Person	
Contact Details	
Name of Strategy/ Policy/ Procedure/Service to be Analysed (including procurement)	
Is this a new or existing Strategy/Policy/Procedure/Service?	
1. What are the main aims and/or objectives of the strategy/ policy/procedure/service and to what extent is equality a relevant consideration? (e.g. a policy that lists the frequency of checking the temperatures of hospital fridges would have no relevance to equality (NR) but a change or cut back to a current service would have relevance (R)). Take account of the **protected characteristics (PC's)/ groups** and outline your reasons for your chosen category in as much detail as possible. Tick "R" or "NR" at the top of this page. If "NR" has been chosen finish here **once your reasons have been given in the box on the right.**	
1. How will you scope your equality analysis? 2. Fill in details under the headings in the box on the right.	**How do the aims of the development relate to equality?** (Consider purpose, operational context, beneficiaries, intended results and needs including those of PGs.) **Which groups could be usefully engaged?** (Consider

You may want to involve other key people and organisations at this stage and you may find that you need to change your plans as you work through the questions.	ways by which you can engage with stakeholder groups and seek out new sources of information to help fill gaps.)
	What aspects are relevant to equality? (Consider each part of the development and any related issues.)
	Which PCs are relevant? (If potential impact on PCs could vary you may need to prioritise.)
	What equality information is available? (Consider local, regional and national data, other related information e.g. Joint Strategic Needs Assessment (JSNA), Community Strategy and anecdotal information.)
	What are your information gaps? (There is a shortage of information regarding some PCs)
3. How will you analyse your equality information? Fill in details under each heading in boxes to right	**Using information to understand the effect on equality.** (Take an overview of the information but be wary of drawing general conclusions e.g. "this benefits everyone". It may be that outcomes will differ between PCs or targeted interventions are required.)
	Findings of your analysis. (This can result in 4 decisions: no major change / adjust what was proposed / continue as planned / stop and re-think or remove. If there is a need for an action plan at this stage develop one.)
	Documenting your analysis. (It is important to record details of your assessment and analysis. Public authorities subject to the specific duties must publish their analysis.)
	Next steps. (When you have decided on your course of action you may consider it helpful to invite views on your findings. It is important that you can validate the conclusions that you have arrived at.)
4. How will monitoring and review be carried out? EA is an on-going process that does not end once implementation has begun. **Plan a review timetable taking into account any specific requirements that have been identified and enter in box to right.** (NB Ensure that procurement activity of any size identifies the equality, diversity and human rights requirements, including evaluation, monitoring and review arrangements, within tender and contract documents)	

5. Are you ready to have the development signed off and publicised? Although EA is an on-going process there is a stage when adoption and signing off can occur. Fill in details under each heading in boxes to right	Decision makers must be clear about how the EA has informed and influenced content and have due regard to the findings when giving final approval. The specific duties require that equality information is published and recommend that the EA is published alongside the development, policy or decision that it relates to.
6. List the additional supporting evidence and sources of information that have informed this EA in box to the right.	

Equality Act 2010 – Background Information

Protected characteristics (PCs) are: age, disability, gender reassignment, pregnancy & maternity, race, religion or belief, sex and sexual orientation. **Marriage and civil partnership** are only covered by the first aim of the general duty outlined within the Equality Act 2010.

Those covered by the general duty must in the exercise of their functions have regard to the 3 "aims" or "arms" of the duty:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the act *(i.e. removing or minimising disadvantage suffered by people due to their PCs)*
- Advance equality of opportunity between people who share a protected characteristic and those who do not *(i.e. taking different steps to meet the needs of people from protected groups (PGs) where these are different from the needs of other people)*
- Foster good relations between people who share a protected characteristic and those who do not *(i.e. encouraging people from PGs to participate in public life or in other activities where their participation is disproportionately low.)*

Disabilities must be catered for and meeting the above requirements may involve treating some people more favourably than others.

The **general duty** applies to all Schedule 19 listed bodies e.g. health bodies, police and transport authorities, government departments. Other organisations that carry our public functions are also covered by the general duty e.g. voluntary sector or private bodies that carry out public functions. There are a few exceptions – if in doubt seek legal advice.

The **specific duties** apply to virtually all bodies listed in Schedule 19 and require the listed body to:

- Publish sufficient information to demonstrate compliance with the general duty across all functions including: information on the effect that its policies and practices have had on people who share relevant PCs, to demonstrate the extent to which it furthered the aims of the general duty for employees and for others with an interest in its functions. *(Public authorities with fewer than 150 employees are exempt from the employee provision)*

- All public authorities must **publish**: evidence of analysis that they have undertaken; details of the information considered; details of engagement they undertook; **prepare** and **publish** equality objectives that must meet one or more aims of the general duty.

- The published information must also be considered before preparing objectives that are specific and measurable; how progress will be measured must be stated. **Information on objectives must be published at least every 4 years** in an accessible format either separately or as part of another document. **Progress must be reported on annually** and it is recommended that this is done incrementally throughout the year.

To keep up to date on the latest guidance go to the website of the Equality and Human Rights Commission: www.equalityhumanrights.com

12. Endorsed By:-

Name of Lead Clinician/ Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date

13. Record of Changes

Section No	Version No	Date of Change	Description of Amendment	Description of Deletion	Description of Addition	Reason