PURPOSE
Equality Analysis is a best practice method to demonstrate due regard to the general duty under the Equality Act 2010 to eliminate discrimination, advance equality of opportunity and foster good relations between people from different groups.

The purpose of an Equality Analysis (EA) is to examine the extent to which existing or proposed services/policies/strategies may benefit different members of the community and, where appropriate, prompt the consideration of adjustments.

RESPONSIBILITY
Responsibility for compliance with the CCG’s public sector equality duty rests with the author’s lead Director. Specialist guidance and support is, however, available from the Head of Partnership & Engagement.

CONSULTATION & ENGAGEMENT
Please note that early engagement is recommended and in many cases is necessary to develop strategies or service changes. Please ask the Partnership & Engagement Team if you would like help with this.

INSTRUCTIONS
- Consult the Equality Analysis Demographic Information document on SharePoint. Consider how your proposal would impact the different groups and what reasonable adjustments need to be made. Make recommendations to adjust or amend the proposal to address any positive or negative impacts. If no impact is predicted, simply state that.
- Include the Summary and the Equality Analysis in all Committee and Governing Body Papers where decisions regarding your proposal are recommended after removing this instruction page.
## SUMMARY OF EQUALITY ANALYSIS for New Follow-up Models

<table>
<thead>
<tr>
<th>EQUALITY GROUP</th>
<th>Negative Impact YES / NO</th>
<th>Positive Impact YES / NO</th>
<th>ADJUSTMENTS PROPOSED YES/NO</th>
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<td>NAME OF THE SERVICE/STRATEGY / SERVICE CHANGE PROPOSAL / PLAN (‘ACTIVITY’)</td>
<td>REDUCING ROUTINE FACE-TO-FACE FOLLOW-UP APPOINTMENTS AND OFFERING ALTERNATIVE FOLLOW-UP MODELS TO PATIENTS</td>
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**What are the main aims and objectives of the ‘activity’?**

This service change aims to offer patients a greater range of options for how their follow-up care is provided.

A range of published clinical studies have evaluated the impact of shifting to alternative follow-up models, finding that this results in: higher patient and clinician satisfaction, a reduced number of regular follow-up attendances and no negative outcome on psychological or health outcomes for patients.

The proposal looks to alter a proportion of face-to-face follow-up appointments at the local acute trust, by targeting clinically appropriate specialities and identifying patients who do not need to access routine follow-up appointments in the traditional way. It is important to note that patients will only be considered for the new model of follow-up care should their consultant deem them suitable for this method.

Potential follow-up models include the nine models detailed below. This equality analysis will focus on group clinics and telephone follow-ups as these are the models that have been agreed with the Royal Surrey County Hospital as appropriate to develop and have been implemented successfully at other sites across the country. In future further follow-up models will be worked up in conjunction with the local acute trust, the Royal Surrey County Hospital.

1. **Patient-initiated follow-up**
   a. Rather than a patient coming in to the hospital for a routine follow-up appointment when they feel well, patients would be able to initiate a follow-up appointment whenever they needed one. This option would involve clinically appropriate patients being given leaflets and information around how to manage their condition, how to initiate a follow-up appointment and the signs to look out for which would indicate that they need to do so.

2. **Telephone follow-up**
   a. Telephone follow-ups are routinely used in NHS care, and involve a clinician telephoning the patient within an allocated time slot rather than the patient’s appointment taking place at the hospital.

3. **Virtual follow-up**
   a. Virtual follow-ups are often used for the clinician to review the patient’s results, and do not require the patient attending the hospital as a letter is then sent out to the patient following the virtual clinic.

4. **Video follow-up**
   a. Video follow-ups can be implemented so that a patient can have a follow-up appointment from their home/work rather than attending the hospital.
5. Email follow-up  
   a. Where clinicians traditionally would use a face to face appointment to review test results or symptoms with patients, an email clinic may be more appropriate.

6. Text follow-up  
   a. Where clinicians traditionally would use a face to face appointment to review test results or symptoms with patients, a text clinic may be more appropriate.

7. Telehealth follow-up  
   a. Telehealth monitoring is the remote exchange of physiological data between a patient at home and medical staff at hospital to assist in diagnosis and monitoring. It includes units to measure and monitor vital signs for clinical review at a remote location.

8. Telecare follow-up  
   a. Telecare is the continuous, automatic and remote monitoring of real time emergencies and lifestyle changes over time in order to manage the risks associated with independent living.

9. Other pathway changes  
   a. Group clinics have been proposed by one of the specialties that involve a longer appointment that is facilitated by a nurse with an educational interest, and covers a different educational topic each time from a CNS or a member of the MDT team, as well as a micro-consultation with the consultant.

Describe the current situation

Currently, routine face-to-face follow-up appointments are offered at regular time intervals from the CCG’s acute providers. Some specialties are already using telephone follow-ups, such as cardiology, and others are using virtual follow-ups or patient-initiated follow-ups successfully. This programme involves engaging with specialties to understand their existing follow-up models and look to expand or create clinically appropriate new models of follow-up care in that specialty.

What engagement, including with different equality groups, has taken place to inform this equality analysis?

Discussions with the Royal Surrey County Hospital’s Patient Panel and the CCG’s Patient & Public Engagement group were held regarding New Follow-up Models on the 19th September 2017 and 7th November 2017 respectively. Further engagement with service users is planned following agreement of which specialties and follow-up models will be in scope. This agreement is based on discussions with the leadership triumvirates at the local acute trust (the senior manager, consultant and specialist nurse for each clinical area).

Accordingly, this equality analysis is not examining how different conditions affect different equality groups. Instead, it examines the logistics of different potential follow-up models as they may be experienced by different equality groups. The impact of follow-up models for particular conditions will be considered by patient panels and by discussing patient views with those affected by those conditions.
For each of the Equality Groups detailed below, consider how your proposal will affect or address health needs relevant to that group. Refer to demographic information about people living in Guildford and Waverley CCG and consider who will be affected.

**AGE**

**Telephone follow-ups**

- Telephone follow-ups may not be appropriate for direct use with children who are very young and are deemed not to have Gillick competency\(^1\). In this situation other hospitals have offered telephone follow-ups whereby they discuss the child’s care with the parent on the phone\(^2\) in lieu of the child being competent to discuss their own care. This is expected to be the same as a young child attending a face-to-face appointment where the doctor will direct information towards the parent who is responsible for the child’s wellbeing.

- Overall, patient satisfaction on the accessibility of care and compliance with treatment is higher when telephone follow-up care has been implemented\(^3\). This is therefore likely to have a positive impact on all age groups.

- Around 1.45 million over-65s in England struggle to get to hospital, with issues being exacerbated in rural areas with lack of access to a vehicle and poor public transport alternatives\(^4\). Telephone follow-ups will provide another route to access care without the need to travel outside the home, and thereby is expected to have a positive impact for over-65 year old patients who may struggle to attend hospital, especially for those living in the more rural areas of Guildford and Waverley.

- Telephone follow-ups are also likely to have a positive impact for those who are considered as frail and elderly and/or who might have limited mobility as this cohort of patients may find it harder to attend hospital.

**Group clinics**

- Group clinics are not being considered for paediatric care as this was deemed not clinically appropriate by the Chief of Service. Group clinics are unlikely to be appropriate for younger children due to safeguarding concerns and the group clinic nature being distracting for a young child.

- In adult services, group clinics have been shown to have most benefit in the management of long-term conditions such as Rheumatology, which can affect patients at any age but is more likely to be first diagnosed from the third to sixth decade\(^5\). Children are predominantly managed under paediatric care for Rheumatology, but under CQC guidance about children transition following between

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2. [http://www.uhs.nhs.uk/Media/Controlleddocuments/Patientinformation/Childhealth/Your childs telephone follow-up outpatients.pdf](http://www.uhs.nhs.uk/Media/Controlleddocuments/Patientinformation/Childhealth/Your childs telephone follow-up outpatients.pdf)
8. [International Longevity Centre, file:///Z:/Downloads/The_Future_of_Transport_in_an_Ageing_Society_FINAL.pdf (June 2015)](file:///Z:/Downloads/The_Future_of_Transport_in_an_Ageing_Society_FINAL.pdf)

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paediatric and adult care indicates that patients should be offered options to participate in group clinics on an individual case by case basis taking into account whether a child is suitable for inclusion in a mixed aged group setting and the child and parent’s opinion on suitability.

- Group clinics should always be offered with an opt-out option so that any patient that did not feel comfortable in this environment could opt-out and continue on their existing follow-up method.
- Group clinics are likely to benefit all adult age groups with patients reporting satisfaction with the group format and the benefits of being able to talk to others who have a similar experience and condition.

### Conclusion & Recommendations

The proposed changes are not being considered for paediatric care as this was deemed clinical unsuitable by the Chief of Service. As children reach a stage of transitioning between paediatric and adult care it is recommended that this decision is made on a case by case basis.

Group clinics are predicted to have a positive impact for all adult age groups. The provider should ensure that group clinics are offered as an opt-out service, allowing a patient who does not feel comfortable in this environment to continue on their existing follow-up method.

Telephone follow-ups are likely to have a positive impact on people from all age groups.

### DISABILITY (mental, physical, learning disability, dementia)

It is estimated that 10.8% of the adult population in Great Britain are disabled, which equates to 22,000 people in Guildford and Waverley CCG. Depending on the level and nature of their disability, they are more likely to live in poverty or to be economically inactive, less likely to have educational qualifications and more likely to experience problems with hate crime and transport. Around 3.2% of the Guildford and Waverley population have a learning disability and around 1.4% have dementia.

**Telephone follow-ups**

- For telephone follow-ups, the service must be configured to be equally accessible to all disability groups. For example, in order to ensure the service is accessible for deaf or hard of hearing individuals the provider should offer a textphone that has the ability to send and receive text.

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• Telephone follow-ups may not be appropriate for individuals with a learning disability or dementia. It should be a clinically led decision on whether a patient is suitable for utilising the model of follow-up care, for example they may be able to be supported by their carer to access this model in the same way they would for a face-to-face appointment. Patients who are not suitable for telephone follow-ups should remain on their existing method of follow-up care.

• Telephone follow-ups are likely to have a positive impact on those with physical disabilities that may find accessing face-to-face care at the hospital more difficult.

Group clinics
• Group clinic areas must be configured to be equally accessible to all disability groups e.g. hearing loops

• Patients with learning difficulties have a range of different needs and capabilities\textsuperscript{11}, which must be considered by the provider and any adjustments must be made where necessary to enable them to benefit from attending a group clinic. For some individuals no adjustments may be needed for them to participate in the group, but for others additional time may need to be spent with the individual patient one-on-one, or make adjustments to the content of the educational session, provide additional materials or alternatives. Liaison with the Learning Disability Specialist Nurse will enable group clinics to be accessible in this respect. Some patients with learning disabilities may prefer not to attend a group clinic for a variety of reasons, and therefore should remain on their existing model of follow-up care. This should be a clinically led decision with involvement from the patient and/or carer.

• Patients with Dementia should be considered, and adjustments made where possible, depending on the severity and type of dementia the patient may be suitable for inclusion, suitable with reasonable adjustments or unsuitable for group clinics and therefore should remain on their existing model of follow-up care. This should be a clinically led decision with involvement from the patient and/or carer.

• The area the group clinics are provided in must be fully compliant with the requirements of the Equality Act 2010 to ensure accessibility for patients with disabilities.

For both types of follow-up model
• Ensure that training is in place for staff to equip them with the skills needed to provide a quality service to patients and carers with disabilities including people with complex mental health needs and learning disabilities.

• Having a learning disability can increase anxiety and distress (adding to the patient’s vulnerability) as the individual may not understand why they are there or what to expect. Guildford and Waverley CCG expects providers to make the situation as predictable as possible for the person – always letting them know what is happening. Consideration should be given to the appropriate reception and treatment for patients with a learning disability who access either telephone or group clinics and to whether staff are sufficiently trained to safely discern the person’s needs; to communicate effectively with the patient and their carer(s); and to ensure the best

\textsuperscript{10} \url{https://www.btplc.com/Inclusion/HelpAndSupport/DocumentsandDownloads/Communicationchoices/Fordeaforhardofhearingpeople/Communication_Choices_Deaf_Hard_Hearing.pdf}

\textsuperscript{11} \url{http://www.learningdisability.co.uk/learning-disability/}

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possible patient experience.

- Any communications provided to patients regarding their appointments should be provided in an appropriate format and via an appropriate medium, such as Easy Read, Audio or Braille, to ensure that the most vulnerable groups of service users within Guildford and Waverley who access these services are fully informed on what to expect and how to access telephone and group follow-up care.

Conclusion & Recommendations

The proposed changes require the provider to implement accessible technologies for disabled individuals, for example a textphone service must be provided for telephone follow-ups. It may not be possible to make the telephone follow-up model accessible for all patients with dementia or learning difficulties, this will be a clinically led decision with patients who are deemed clinically unsuitable to access this service remaining on their existing model of follow-up.

Telephone follow-ups are likely to have a positive impact on individuals with physical disabilities.

The venue used for Group Clinics must be accessible to all in terms of building access routes and ability to participate e.g. by having a hearing loop fitted and use of resources that are suitable for people with visual impairment. For patients with learning disabilities or dementia reasonable adjustments should be made where possible to include individuals in a group setting. Where this is not appropriate the patient should remain on their existing model of follow-up care.

Materials produced and communications should be sensitive to the needs of those with learning disabilities, and should make the situation and process clear and predictable. Any communications should be available in other accessible formats (especially in the most common languages spoken in this area).

ETHNICITY / RACE / ETHNIC GROUP

Nationally, the Afiya Trust suggests that “many minority ethnic communities have poor access to health and social care services for a variety of reasons including language barriers, lack of awareness/information, social isolation, lack of culturally sensitive services and negative attitudes about communities” (Afiya Trust 2010). There is evidence that groups about whom very little research has been conducted, notably Gypsies and Travellers, asylum seekers and refugees, have particularly low levels of health and wellbeing. Those without fixed addresses, such as Roma, gypsies and travellers, asylum seekers and refugees, have difficulty in accessing services and their needs are often different and unknown.” (EHRC 2010).

Given that the proposals put forward are designed to provide patients with a greater choice regarding how to access follow-up care, there is

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potential for the proposals having a positive impact on different ethnic groups if reasonable adjustments are made. Some patients identifying with certain ethnic groups may feel less comfortable in a group consisting of men and women together; reasons for choosing not to join a group clinic and continue usual follow-up should be monitored and adjustments made if necessary should this trend emerge.

**Telephone follow-ups**
- Discussed below as affects both telephone and group clinics

**Group clinics**
- Discussed below as affects both telephone and group clinics

**Both**
- Providers should ensure that all materials provided to patients, for example appointment letters, are available in other languages (as well as accessible formats) on request.
- The provider must have robust access to high quality, responsive and comprehensive interpreter services for those who speak different languages. Consideration must be given to those patients who will require an access to an interpreter or advocate via the telephone and in group settings.

**Conclusion & Recommendations**

Providers should ensure that patients have access to interpreter services for telephone follow-ups and group clinics if the patient does not understand spoken and written English.

Any materials provided to patients, for example appointment letters should be offered in other languages and accessible formats (especially in the most common languages spoken in this area\(^\text{13}\)).

**GENDER**

**Telephone follow-ups**
- The proposed changes are likely to have a positive impact on men, who have been reported as less likely to access healthcare services\(^\text{14}\). Some of the reasons stated were difficulty in making an appointment outside working hours and the cost of the visit in terms of loss of earnings, which is likely to be circumvented by reduced overall time taken out for an appointment.


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- No impact is expected on women.

**Group clinics**
- For the same reasons as above i.e. men being less likely to attend an appointment during working hours, it may be beneficial for the provider to provide group clinics outside normal working hours as well as in-hours.
- No impact is expected based on gender

**Both**
- The providers must utilise methodologies that ensure that men (who are typically least likely to access healthcare services) are aware of the services available and feel welcome to approach the services as part of any care that they may need.
- The provider must monitor demographic information of patients accessing the follow-up models in order to understand any trends, for example in the proportion of each gender accessing group clinics, and to address any concerns as a result.
- Any materials produced that include photographs should include images of men and women and the leaflet should be written in a gender neutral format.

<table>
<thead>
<tr>
<th>Conclusion &amp; Recommendations</th>
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<tbody>
<tr>
<td>The proposed telephone follow-ups may have a positive impact on men, as this may increase accessibility to services around work that has been reported as a barrier to men accessing care.</td>
</tr>
<tr>
<td>Regular reviews of the equality monitoring information recorded by providers may reveal a gender difference in preference for different follow-up models; it is not necessary for equal proportions of men and women to utilise each model of follow-up but for overall outcomes to improve as a result of a greater range of follow-up methods being available. Any materials produced with images should include images of men and women and the leaflet should be written in a gender neutral format.</td>
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**GENDER REASSIGNMENT**

**Telephone follow-ups**
- No impact is expected based on gender reassignment
### Group clinics

- Patients who may be concerned about stigma based on their gender reassignment status may be put off attending a group clinic. Some actions taken to reduce this impact could be to indicate a non-discrimination policy on the information leaflet provided to patients. Opportunities to provide information confidentially to the consultant or nurse should be provided, either in a written or one-to-one basis in the micro-consultation.

### Conclusion & Recommendations

The proposed changes will have a neutral impact on people who are undergoing or have undergone gender reassignment for telephone follow-ups.

The proposed changes may have a negative impact on those who are undergoing or have undergone gender reassignment who may be concerned about stigma based on their gender reassignment status. Some actions taken to reduce this impact could be to indicate a non-discrimination policy on the information leaflet provided to patients. Opportunities to provide information confidentially to the consultant or nurse should be provided, either in a written or one-to-one basis in the micro-consultation.

### RELIGION & BELIEFS

#### Telephone follow-ups

- No impact is expected based on religion or belief specifically for telephone follow-ups.

#### Group clinics

- People with certain religious beliefs may feel less comfortable in a group environment but not necessarily so. Consideration needs to be given regarding alternative arrangements e.g. a micro-group clinic with the consultant may be more appropriate taking into account preference for other females being present.

#### Both

- The provider will need to consider ways of engaging faith forums in service design to ensure that any changes made meet the needs of these groups and do not have a negative impact in areas such as access e.g. group or telephone follow-ups only being available on a Friday would not be best practice.

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## Conclusion & Recommendations

The provider should consider ways of engaging faith forums in service design to ensure the needs of these groups are met. Access should be provided flexibly e.g. group or telephone clinics only being available on a Friday would not be best practice. Consideration should also be given to Muslim women attending group clinics in the set-up of the micro-consultation.

### MARRIAGE & CIVIL PARTNERSHIP

#### Telephone follow-ups
- No impact is expected based on marriage or civil partnership status

#### Group clinics
- No impact is expected based on marriage or civil partnership status

### PREGNANCY & MATERNITY

#### Telephone follow-ups
- The service is predicted to have a positive impact on parents with young children, due to a reduced requirement for parents to arrange childcare around hospital appointments or have to take leave from work to attend hospital.
- This is also predicted to have a positive impact for pregnant women who may find it harder to travel into hospital for their appointment

#### Group follow-ups
- Premises and facilities must accommodate the needs of pregnant and breastfeeding mothers and provide facilities for parents to change babies.
- Due to the increased time of the group clinic compared to a normal face-to-face appointment, parents of young children who have arranged childcare may find it harder to attend. The flexibility of attending for only part of the session should be promoted to all
patients, which may help support those that can only attend for the core elements of the session.

**Conclusion & Recommendations**

The proposed changes will have a positive impact on people who are pregnant or have young children who utilise telephone follow-ups.

Group follow-up settings must be designed to accommodate the needs of pregnant and breastfeeding mothers and provide facilities for parents to change babies. The flexible nature of attendance for group clinics should be promoted so that patients understand that they need only stay for the core elements of the session.

**SEXUAL ORIENTATION**

**Telephone follow-ups**
- No impact is expected based on sexual orientation.

**Group clinics**
- The proposed changes may have a negative impact on individuals who are concerned about experiencing stigma based on their sexual orientation. This has been reported as a potential barrier to individuals accessing healthcare, or revealing information that may benefit their care. Providers need to ensure that information materials are inclusive to a variety of different minority groups including those who identify as Lesbian, Gay, Bisexual or Transgender. Opportunities to provide information confidentially to the consultant or nurse should be provided, either in a written or one-to-one basis in the micro-consultation.

**Conclusion & Recommendations**

The proposed changes may have a negative impact on people who are concerned about stigma associated with their sexual orientation accessing group clinics. These individuals may be less likely to initiate a follow-up appointment when it is required.

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leading to delays in clinical advice or treatment. Some actions taken to reduce this impact could be to indicate a non-discrimination policy on any communications provided to patients, and to use images that include LGBT individuals. Opportunities to provide information confidentially to the consultant or nurse should be provided, either in a written or one-to-one basis in the micro-consultation.

Other categories relevant to CCG’s statutory duty to reduce health inequalities:

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<th>CARERS</th>
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**Telephone follow-ups**
- The service will mean that patients do not have to travel into hospital for their appointment. This is likely to have a positive impact on carers, whether the carer looks after the patient or is the patient themselves. This is because they will not have to take time out of their lives to attend a hospital appointment.

**Group clinics**
- More responsibility may sit with the carer in terms of assisting the patient with their follow-up appointment if required
- Carers should be invited to attend group clinics with the patient, and this should be made clear on the appointment letters that carers are welcome to attend.

**Conclusion & Recommendations**

Telephone follow-ups may have a positive impact on people who are caring for others or on the patient’s carer(s).

Group clinics may have a negative impact on carers who may find it harder to arrange alternative care for the person they care for whilst attending a longer session.

It should be made clear that carers of patients invited to a group clinic are welcome to attend, and a discussion should be had with the patient and carer about the right follow-up model for them.

**AREAS OF DEPRIVATION and GEOGRAPHICAL LOCATION (urban, rural, isolated)**

**Telephone follow-ups**

- Telephone follow-ups are likely to be of benefit to those in geographically isolated locations, especially those who access hospital via public transport, as they will have fewer attendances to hospital
- This is likely to be of benefit to those in areas of deprivation as they will not have to pay for travel and/or parking to attend their hospital appointments

**Group clinics**

- No impact is expected as a result of a patient living in an area of deprivation or based on their geographical location if the clinic is held in the current location. If the group clinic is moved to a different location, the provider needs to consider access via public transport and any additional time it may take for patients to travel.

**Conclusion & Recommendations**

**Telephone follow-ups may have a positive impact on people who are geographically isolated or in areas of deprivation. No impact is expected for those patients attending group clinics.**

**VULNERABLE GROUPS e.g. ex-military, homeless, looked-after children, those seeking asylum**

**Telephone follow-ups**

- This is likely to have a positive benefit for homeless individuals, and other vulnerable groups that have little access to transportation. Because the service is predicted to reduce outpatient attendances, the patient will not have to make travel arrangements for their hospital appointment.
- The proposed changes may have a negative impact on homeless individuals and those seeking asylum that may not have easy access to telephone equipment in order to initiate their appointment. If the patient does not have access to these facilities they should not be transferred onto a telephone follow-up model.

**Group clinics**

- Homeless individuals have been known to experience stigma\(^\text{18}\) as a result of their housing situation. The provider should signpost patients to support services that can aid where practical facilities are required e.g. wash facilities or clothing stores. The patient’s wishes must be taken into account when looking at the appropriate model of follow-up care, with the patient remaining on their existing model if this is most appropriate.

**Conclusion & Recommendations**

\(^{18}\) [Link to source](http://www.jstor.org/stable/2787093)
Telephone follow-ups may have a positive impact on people who are from vulnerable groups that may have reduced access to transportation. However, there may be a negative impact on homeless individuals and those seeking asylum that may not have easy access to telephone equipment in order to initiate their appointment. If the patient does not have access to these facilities they should not be transferred onto a telephone follow-up model.

Homeless individuals concerned about experiencing stigma by attending a group session should be signposted to support services. Individual preference should be supported when selecting the appropriate model of follow-up for the patient.

OVERALL CONCLUSIONS & RECOMMENDATIONS: Summarise your findings for all equality groups

Overall the service is likely to have neutral or positive impacts on the majority of equality groups. Where negative impact could be felt, amendments and reasonable adjustments have been suggested.

Further work is needed with different equality groups to inform the operational delivery of the proposed changes should they be approved.

The main recommendations from the equality analysis are as follows:

- A patient engagement session should be run following the clinical specialties and follow-up models being considered for each specialty being agreed
- The provider should consider children transitioning into adult services on a case by case basis regarding their inclusion in the model of follow-up care
- Group clinics should be offered with an opt-out option so that any patient that did not feel comfortable in this environment could opt-out and continue on their existing follow-up method.
- The telephone follow-up model must include a textphone service that has the ability to send and receive text
- Group clinic areas must be fully compliant with the requirements of the Equality Act 2010 to ensure accessibility for patients with disabilities e.g. hearing loops and wheelchair access
- Materials produced and communications should be sensitive to the needs of those with learning difficulties, and should make the situation and process clear and predictable. Any communications should be available in other accessible formats (especially in the most common languages spoken in this area19).
- The provider must have robust access to high quality, responsive and comprehensive interpreter services for those who speak different languages. Consideration must be given to those patients who will require an access to an interpreter or advocate.
- A non-discrimination policy should be included on information provided to patients about group clinics.

• Opportunities to provide information confidentially should be built into the group clinic model, for example in the micro-consultation.
• Group clinic areas must be designed to accommodate the needs of pregnant and breastfeeding mothers as well as facilities for parents to change babies.
• Materials provided to the patient regarding group clinics should make it clear that carers are welcome to attend, and discussions with the patient and carer should be had to agree the appropriate follow-up model for them.
• Demographic information about patients accessing new models of follow-up care should be monitored to ensure that representative proportions of patients from equality groups are accessing these services.
• Appropriate training should be available to clinical staff to ensure that they are able to work with patients with learning disabilities, dementia, and those patients that may have a reduced inability to communicate.

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<thead>
<tr>
<th>Name of person completing EA</th>
<th>Job Title</th>
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<tbody>
<tr>
<td>Genevieve Ryan</td>
<td>Senior Commissioning Manager – Planned Care</td>
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<table>
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<tr>
<th>Name of lead Manager / Director</th>
<th>Signature</th>
<th>Date completed</th>
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