NHS
Greater Manchester

Appendix B

Equality Analysis Template Document

Step 1 Evidence | Step 2 Assess | Step 3 Strengthen | Step 4 Monitor | Step 5 Approve

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Step 1 Evidence

If you are unsure about any part of this template, please read the accompanying guidance paper before you complete. ALL sections must be completed – N/A is not applicable in this template as it is used to inform legal compliance. If you need to explain your bespoke approach further, please do so in the text boxes.

This equality analysis is being undertaken to prevent my policy, plan or project from adversely affecting people with different protected characteristics or at known disadvantage.

I am using this template to identify potential discrimination or disadvantage, propose steps to strengthen against those and record and monitor the success of those strengthening actions.

Name of your strategy/policy/plan/project: ADULT ADHD Services

Contact details for the person completing the assessment:

Scott Williams
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07388956280

Design date for the plan/project: August 2024

Date your equality analysis is completed: 3/07/2024,
reviewed February 2025 and
August 2025

Does this template form part of a business case or investment proposal submission? YES

Are you completing this as a result of organisation change? NO

Is there another reason for you completing this template – e.g. renewal of a current service/change to current service – please specify: Change to current service

Initial screening assessment

What are the main aims, purpose of your policy, plan or project?
Service Redesign for Adult ADHD Services

What is your expected outcome?

To move through the stages of engagement and formal consultation with recommendations for adult ADHD services to lead to service change.

Who will benefit?

Patients
Services
System

Is your project part of a wider programme or strategy (for example, the locality plan)?

No

2. Are there any aspects/activities of the policy, plan or project that are particularly relevant to equality, socio-economic disadvantage, or human rights?

We have carried out engagement and consultation on the proposed service changed for Adult AHDD services.

We are aware there are elements of the service changes that are relative to Equality and Socio-economic disadvantage and we will use this document and reports to identify mitigations where we can.

3. What existing sources of information will you use to help you identify the likely impact on different groups of people? (For example, statistics, JSNA's, stakeholder evidence, survey results, complaints analysis, consultation documents, customer feedback, existing briefings, comparative data from local or national external sources).

   - Current service evidence
   - Comparative data
   - Stakeholder evidence from the pre-consultation engagement
   - Options Appraisal information
   - Consultaiton Report

Evidence gaps

Are there gaps in information that make it difficult or impossible to form an opinion on how your proposals might affect different groups of people? If so, what are the gaps in the information and how and when do you plan to collect additional information? Note this information will help you to identify potential equality stakeholders and specific issues that affect them - essential information if you are planning to consult as you can raise specific issues with particular groups as part of the consultation process. EIAs often pause at this stage while additional information is obtained.

No: Please go on to question 5. (Be sure to have fully considered all communities and parts of communities – e.g. have you considered the needs of gypsies, travellers and Roma communities, other transient communities, do you need to better understand take up of your service by Muslim women or Orthodox Jewish men, for example.)

Yes: Please explain briefly how you will fill any evidence gaps. You might want to start with contacting research or policy colleagues to see whether they can point you in the right direction. Our third sector colleagues will also be pleased to offer support and direction.

Evidence gap	**How will the evidence be collated**	**Individual or team responsible and timeframe**
Lived experiences.	Lived experience panel, Engagement Report	Scott Williams initiated between 12/2-24/3

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Family test and provider feedback	Service feedback to be collated and shared to form part of report evidence	Sandy Bering, Scott Williams Throughout Pre-Engagement process

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Patient demographics	To be established through provider services , programme leads and task and finish groups	Sandy Bering

Involvement and consultation

Note: You are required to involve and consult stakeholders during your assessment. The extent of the consultation will depend on the nature of the policy, plan or project.

(Don't forget to involve trade unions and inclusion staff groups if staff are affected and consider socio-economic impact as well as community and third sector groups for different protected characteristics. If there is potential for different impact across different neighbourhoods, consult your neighbourhood leads)

Consultation and involvement that has taken place, who with, when and how?

We did a wide range of engagement throughout our pre-consultation work including that detailed below. This model will be repeated in the consultation phase which we hope to launch in July/August 2024.

Focus Group Sessions – 21st February 202410am and 6pm
Prebooked phone calls – March and April 2024
Lived experience group meetings – Monthly through Engagement Phase and bi monthly during Consultaiton phase. The LEAG also met to support the development sof the documents and survey
Case study filming of a lived experience member – 19th June 2024
Consultaiton commenced 23rd April
Focus Group meetings x 5
Over 30 Locality based engagement events

All information and evidence of the above can be found within the Engagement and Consultation reports available on our Get Involved Site: https://getinvolved.gmintegratedcare.org.uk/projects/adult-adhd-consultation

Key feedback from consultation:

For significant or large strategies and programmes, please provide a link to any written record of the consultation to be published alongside this assessment here:
https://getinvolved.gmintegratedcare.org.uk/projects/adult-adhd-consultation

How engagement with stakeholders will continue:
Here you need to explain how you continue to engage throughout the course of the delivery to ensure the measures you take to address any disparity are working.

Involvement group	Consultation dates	Strengthening actions
Survey Focus Groups	**To be planned for throughout the engagement period in August/ September** **Consultation took place between 23rd April and 17th July**	
Lived Experience Panel	**A meeting to be planned ahead of the consultation launch in July/August, and a catch up meeting during the engagement phase of August/September** **Consultation took place between 23rd April and 17th July**	
Provider Meeting	**Took place Wednesday 10th July, to support providers to engage with their stakeholders**	
GP Newsletter	**An update for primary care colleagues was issued in July to ensure GP's are sighted on the plan of action and can be relay this to their patients**	

Step 2 - Assessing impact and opportunities to promote equality and human rights

4. If you have piloted a project you want to roll out, add here what you learnt about communities not taking up, accessing or having poorer outcomes from it and what you have done to address those disparities.

No piloting was considered or carried out during this process

5. What barriers have you identified for the different groups listed by your proposals?

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Following a criteria setting and options appraisal exercise, we have 2 options (decided with stakeholders) to consult the public on – both of which could have different considerations for the public.

Option A) Clinical triage with wider support offer (*recommended*): Introducing a clinical threshold, with all patients triaged and prioritised based on their clinical need. Patients who don't meet the threshold will get offered support to manage symptoms. Patients who meet the threshold will go forward for diagnosis.
Option B) Universal offer, followed by clinical triage: Provide everyone who comes forward with an offer of support to help manage symptoms. Patients who then request further support will be triaged against a clinical threshold and prioritised based on their clinical lead, with those who meet the threshold going forward for diagnosis.

We undertook an 8 week consultation phase. The below information pulls together information shared by people who engaged with the process, shared thoughts and identified potential impacts on protected characteristic groups.

These will need to be considered and where applicable mitigations should be identified and considered in the implementation of the new services

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Age • Young • Middle age • Older age	However, there is an increase in young people with ADHD or/and autism who are also Emotional School Based Avoiders (EBSA) and this is a factor to consider when assessing wider impact of change It is important to note that Children who have both autism and attention-deficit/hyperactivity disorder (ADHD) are also more likely to experience anxiety, depression, developmental delays, learning disabilities and other mental health conditions than are children with only autism or ADHD. University aged adults and CYP going through exams may be impacted if can't access service Working age adults seeking employment and other activity can have challenges accessing support during working hours and or evidencing their need without a diagnosis. Increase in adults and children seeking diagnosis. 6x increase in children since 2019. We recognise there are challenges when transitioning between services and also when children transition to adult services given tht the age bracket changes dependant on need and the service being accessed. In Heywood, Middleton and Rochdale – there has been a rise in referrals at ages where children transition through education settings i.e Early Years to primary and Primary to High school **Consideration following Engagement/Options Appraisal Phase** Both options include a support offer, which will need to be of appropriate reading age for adults in Greater Manchester. This includes the use of plain English and simple language which is no complicated for people living with ADHD. **Updated information following public Consultation** There is a **moderate to high perceived impact** for older adults. People reported experiences of being dismissed by GPs, with comments such as "you've managed this long" used to justify lack of referral or support. This was felt to minimise the difficulties faced by older people seeking an ADHD assessment or diagnosis.

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	Several participants highlighted that the requirement to evidence childhood symptoms creates a particular barrier for older adults, who may struggle to recall earlier experiences or have limited access to childhood records. Diagnostic criteria based on childhood presentation were therefore seen as disadvantaging this group. Some also described feeling “left behind” by services, both in terms of access to diagnosis and in the availability of appropriate support once diagnosed. Feedback also highlighted that both current and proposed systems risk missing people who have managed for many years often older adults yet are now struggling with significant impacts in later life. This reflects a wider concern that the system does not adequately recognise the lifelong impact of undiagnosed ADHD. A strong and recurring theme was the gap between children’s and adult services. People reported waiting several years on the children’s list, only to transition to adult services and face being placed at the bottom of a new waiting list. These delays were described as particularly damaging during key transition periods, such as starting higher education or work. University students were specifically highlighted as facing barriers to timely and accessible support, with calls for flexible provision and links to student mental health hubs.

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Disability Types of impairment can be categorised as physical, sensory, psychosocial, and intellectual. There are several types of barrier that cause exclusion including • Physical • Social/attitudinal • Institutional • Communication Complete which *barriers* you will need to consider in your programme.	The potential impact of service change is There may be potential for the programme of work to adversely impact on particular groups within the SEND cohort. This is due to the potential for service change. There is a challenge that change for people with ADHD and Autism leads to confusion, concern and potentially disengagement form services. There are a number of related conditions identified by the autistic society which include: • ADHD • Hearing Impairment: • Some autistic people have sensory differences • Downs Syndrome • Dyspraxia • Dyslexia • Epilepsy • About one in every 100 people have epilepsy. Autistic people are at heightened risk, with between 20% and 40% having epilepsy. This rate increases steadily with age. • Fetal Anti-Convulsant Syndrome (FACS) • Fragile X Syndrome • Hyperlexia • Learning Disabilities • Social Communication Disorder • Visual Impairment • When visual impairment and autism occur together, …the impact is much greater because the difficulties arising from each disability interact with each other Further information available: Related conditions - a guide for all audiences (autism.org.uk) We also recognise the challenges partners such as schools face with a growing number of Emotional Based School avoiders. This project will target respondents across GM who currently live with ADHD, and children with Autism. **Consideration following Engagement/Options Appraisal Phase** The support offers will be online, which, providing patients are able to access the internet, should not impact on a person with a disability

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	differently. **Updated information following public Consultation** There is a **very high perceived impact** for disabled people. The majority of respondents self-identified as disabled, with conditions including ADHD, autism, mental health difficulties such as anxiety and depression, and physical disabilities such as fibromyalgia and chronic pain. Many people described how both the current and proposed systems create additional barriers for disabled people. These include challenges linked to executive dysfunction, memory difficulties, problems with organisation, and the need to attend repeated appointments or engage in self-advocacy. It was also highlighted that the process can be particularly disadvantageous for individuals with “invisible” disabilities or for those who mask their symptoms, as their needs may be underestimated or overlooked. In addition, some feedback noted that support services themselves are not always accessible. Barriers include physical access issues as well as digital exclusion, which can prevent disabled people from fully engaging with available support. **Co-occurring conditions was also a focus of the potential challenges faced** There is a **significant equality impact** perceived in relation to people with co-occurring conditions. It was highlighted that ADHD frequently co-exists with other neurodevelopmental and mental health conditions such as autism, anxiety, and depression. They emphasised the need for assessments to be holistic and trauma-informed, in order to reduce the risk of misdiagnosis, exclusion, or inequitable treatment. A particular concern was the proposed requirement for individuals to have “other severe mental or physical health problems” before being considered for referral or assessment. Many respondents felt this criterion would unfairly disadvantage people with ADHD as a primary condition, effectively excluding them from timely access to diagnosis and support. This was perceived as discriminatory and inconsistent with principles of equitable access to care. The issue of “diagnostic overshadowing” was repeatedly raised, with respondents noting that ADHD is often overlooked when other conditions are present. Participants stressed that ruling out ADHD on the basis of another diagnosis is inappropriate and risks disproportionately affecting those with complex needs. In particular,

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	individuals with autism reported being less likely to be referred for ADHD assessment because their existing diagnosis was seen as sufficient, despite experiencing unmet needs relating specifically to ADHD. The potential consequences of misdiagnosis or delayed recognition were described as severe. One individual shared their lived experience of being misdiagnosed with schizophrenia and psychosis for many years, which contributed to repeated suicide attempts. They explained that receiving an accurate ADHD diagnosis transformed their quality of life, enabling them to rebuild family relationships and sustain employment. These concerns point to a risk of systemic inequality in access to assessment and support for people with ADHD, particularly those with co-occurring conditions. Without adjustments to assessment criteria and processes, individuals may continue to experience exclusion, inappropriate treatment pathways, and poorer long-term outcomes compared with other groups.

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Sex Identify any potential adverse impact to men or women.	Prevalence of ADHD In adults is estimated at 3 to 4% with a ratio of male to females being 3:1 https://cks.nice.org.uk/topics/attention-deficit-hyperactivity-disorder/background-information/prevalence/ …recent local and national reviews confirm increasing CYP MH inpatients are frequently Autistic females attending services in crisis with comorbid self-harm/disordered eating. Following feedback from the engagement, it would be beneficial if the support offer was tailored towards men / women specifically. **Updated information following public Consultation** There is a **high perceived impact** for women and gender minorities. Many felt that ADHD diagnostic criteria and service pathways are biased towards male or hyperactive presentations, which means that women, girls, and people with inattentive-type ADHD are at risk of being overlooked. Concerns were raised that criteria and assessment tools focus on hyperactivity and impulsiveness, which are more typical of boys and men and more visible forms of ADHD. Women in particular described being missed or misdiagnosed because of masking behaviours or inattentive symptoms. Several highlighted that this often results in alternative diagnoses such as depression or anxiety, rather than ADHD being recognised. People also expressed concern that triage systems risk excluding women who do not present as being “in crisis,” even though they may be severely affected by their symptoms. Additional factors such as menopause and hormonal changes were also reported as exacerbating ADHD in women, further complicating recognition and access to support. In contrast, there were few comments identifying unique barriers for men. Male respondents more commonly noted that diagnostic tools were overly rigid or not inclusive of all ADHD presentations, but no significant or specific disadvantages were identified in relation to male experiences, There were considerable less men who took part in the consultation phase.

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Race Identify any adverse potential impact on different ethnic groups and identify which ethnic groups you may need to specifically consider.	According to gov.uk there is no meaningful difference between ethnic groups when screening positive for ADHD or autism in children. There are barriers to accessing Autism/ADHD services as an ethnic minority, delays in diagnosis, cultural differences impacting experience when interfacing with healthcare services Autism and BAME people Autism and BAME people ; Autism rates have increased and show differences in ethnic minorities and links to social disadvantage | University of Cambridge To consider throughout what the impacts of the service redesign of ethnic minority communities and if their engagement with services is lower than would be anticipated how will that be addressed in service redesign. Certain ethnic groups are more likely to have an education, health and care plan (EHCP) than others. Based on data published in January 2022, the highest percentage of pupils with an EHCP were Travellers of Irish heritage (5.7%) and the second highest were Black Caribbean pupils (5.4%). Chinese pupils had the lowest percentage of pupils with an EHCP, at 2.3%. The overall percentage of pupils with an EHCP plan was 4% Equalities impact assessment: area SEND framework and handbook - GOV.UK (www.gov.uk) **Consideration following Engagement/Options Appraisal Phase** When tailoring the support offer, we could look into any specific support requirements around race. **Updated information following public Consultation** There is a **low to moderate perceived impact** for people from minority ethnic backgrounds. A minority of respondents raised concerns about cultural barriers, language barriers, and the risk of being misunderstood by services. It was stressed that adult ADHD services do not adequately account for cultural and ethnic diversity, with particular reference to the lack of culturally competent practice within current pathways. Several participants highlighted that ADHD is often underdiagnosed or misdiagnosed in certain ethnic groups, particularly among women and people from Black, Asian, or other minority ethnic backgrounds. This was attributed to cultural differences in symptom presentation, masking, and limited awareness among both professionals and patients. It was also noted that current diagnostic criteria and assessment tools are based largely on white, male, hyperactive presentations of ADHD, which can exclude inattentive-type presentations more common among women and some minority

	groups. Concerns were raised that ethnicity or cultural background may influence how symptoms are perceived and whether they are taken seriously by professionals. Respondents from Black British, Asian British, Pakistani, Jewish, African, Latin American, and Romany backgrounds shared experiences of being overlooked or misinterpreted by services. This issue was echoed in focus groups, where one participant described her son being expelled from school due to “bad behaviour” but not receiving an ADHD diagnosis until adulthood. Language barriers, stigma within communities, and the lack of culturally appropriate information and resources were also cited as obstacles to access. Respondents called for greater investment in professional training on diversity in ADHD presentation, alongside the development of inclusive resources. They stressed the importance of making information available in multiple languages to ensure equitable access to diagnostic services and support. It was also noted that cultural expectations, such as gender roles, family structures, or social stigma, may contribute to masking behaviours or different symptom expression. For example, in a focus group with an ESOL class in Rochdale, Pakistani women described how cultural norms made it harder to be recognised as having ADHD.

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Religion/ belief Identify any adverse potential impact on different religious groups and identify which you may need to specifically consider.	Through previous engagement activity and working with faith groups across GM we are aware that some religions and belief are less likely to access health services and screening. We are also aware that this is a factor in wider health determinants and choices. **Consideration following Engagement/Options Appraisal Phase** When tailoring the support offer, we could look into any specific support requirements around religion. **Updated information following public Consultation** There was **no noted perceived impact** on religion, there were many reflections, in the race/ethnicity characteristic on background, expectation and norms that may need consideration.
Sexual Orientation Identify any adverse potential impact on different sexual orientations and identify which sexual orientations you may need to specifically consider.	It is not perceived that their will be any undue disadvantage based on sexual orientation. There has been no evidence found of any connections between ADHD and Autism and Sexual Orientation. We do however know from other work that the LGBTQQIA community face challenges in accessing health services. **Consideration following Engagement/Options Appraisal Phase** During the consultation phase, we plan to engage specifically with LGBTQ+ organisations to deliver some focus groups. Emails were sent in June to try and build a relationship. **Updated information following public Consultation** There is a **low perceived impact** overall for people who identify as LGBTQ+. A small number of respondents from LGBTQ+ communities contributed to the consultation and generally reported that their experiences of ADHD services reflected issues common to all service users. Some respondents noted intersectional barriers, particularly in relation to feeling less able to advocate for themselves or being misunderstood by services. A small number also expressed a preference for LGBTQ+

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	inclusive support groups, observing that generic services may not always meet the specific needs of gay men, women, or other LGBTQ+ people. However, it was emphasised the importance of inclusive, person-centred care that recognises intersectionality and ensures that services are accessible and welcoming to people of all sexual orientations and gender identities.

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Transgender Identify any adverse potential impact on transgender or non-binary people.	Autistic children are 4 times more likely to be transgender or gender questioning. Transgender and gender questioning children are 5 times more like to have autism or ADHD (1). Some intersex variations, like Klinefelter Syndrome and Turner's Syndrome, are also linked to higher rates of neurodiversity (2) [1] Thrower, E., et al. Prevalence of Autism Spectrum Disorder and Attention-Deficit Hyperactivity Disorder Amongst Individuals with Gender Dysphoria: A Systematic Review. *J Autism Dev Disord.* 2020; 50: 695–706. [2] de Vries, A. L., et al. Mental Health of a Large Group of Adults With Disorders of Sex Development in Six European Countries. *Psychosomatic Medicine.* 2019; 81(7), 629-640. **Consideration following Engagement/Options Appraisal Phase** During the consultation phase, we plan to engage specifically with trans organisations to deliver some focus groups. **Updated information following public Consultation** Non-binary and trans respondents identified further barriers, noting that diagnostic tools and services often do not reflect their experiences. They emphasised that male-focused criteria, the effects of masking, and intersectionality with other forms of neurodivergence contribute to being overlooked or dismissed. Some expressed concern that Option B could disproportionately disadvantage gender minorities, particularly those whose symptoms are more internalised or who may find it harder to self-advocate within systems designed around cisgender norms. This feedback highlights the need for more inclusive assessment processes, improved staff training on gender diversity, and a broader range of support options.

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Carer status	This project will also look to work with carers and their support in particular projects such as the Parent Carer Forums. We are aware from wider knowledge pools that carers can find it harder to access health services when caring or responding to needs of the cared for. The project acknowledges the impact change of service may have to carers and will review the impact throughout the process and update accordingly. Access to funding and benefits can be diagnosis led. **Consideration following the Engagement/Options Appraisal Phase** Although this service is for adults, there may be some considerations around transitioning of services or support that may need to be included. **Updated information following public Consultation** There is a **moderate perceived impact** for carers and families. Several respondents reported that caring responsibilities make it harder to access support, with concerns about being deprioritised or unable to attend multiple appointments. Carers also highlighted that ADHD is often hereditary, meaning that multiple members of the same family may be affected, creating additional strain on households. Carers' often focused on the practical barriers faced by people with ADHD in accessing help, and they were less likely to support pathways involving signposting or self-directed tasks. Particular challenges were identified for parents in vulnerable circumstances, including young or single parents and parents of babies or young children, there is a greater risk of children entering care, difficulties with bonding, and relationship breakdowns. ADHD was also linked to challenges such as attachment difficulties, drug and alcohol dependency, and wider social issues, with carers emphasising that without appropriate intervention, parents may struggle to adequately look after their children. Concerns were also raised about gaps in professional awareness. The consultation highlighted the specific experiences of fathers.

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Socio-economic status Identify any adverse potential impact because of deprived communities and identify which communities you may need to specifically consider.	Financial difficulties, housing tenure, maternal age at birth of child and marital status were significantly associated with an outcome of ADHD, such that families either living in financial difficulty, living in council housing, with younger or single mothers were more likely to have a child with a research diagnosis of ADHD at age 7. Financial difficulties was the strongest predictor of ADHD (OR 2.23 95% CI 1.57-3.16). In the multiple mediation model, involvement in parenting at age 6 and presence of adversity at age 2-4 mediated 27.8% of the association. Socioeconomic Associations with ADHD: Findings from a Mediation Analysis - PMC (nih.gov) **Consideration following Engagement/Options Appraisal Phase** The support offer being online should reduce the need to travel to access support whilst waiting. Access to digital online facilities an whether some printed resources could be made available should b considered as part of the package of support. **Updated information following public Consultation** There is a **high perceived impact** in relation to socio-economic disadvantage. Those unable to afford private care would be left facing long waits and limited support, while those who accessed private provision often reported significant financial hardship as a result. Several people described paying hundreds of pounds per month for private assessments and medication, only to encounter further barriers when NHS services refused to accept shared care arrangements. People with lower incomes were seen as more affected by long waiting lists, as they cannot pay for private assessments, interim therapies, or coping aids such as coaching or digital tools. Some also highlighted additional costs linked to attending appointments, such as transport and taxi fares, which particularly affect people with disabilities or those living far from service locations. It was noted that there is a high prevalence of unemployed or underemployed people with ADHD, many of whom require support but face barriers in accessing it. Without timely diagnosis, individuals are unable to access work-related support schemes such as Access to Work, reasonable workplace adjustments, or disability-related benefits.

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	Delays in diagnosis were therefore directly associated with increased financial hardship and greater risk of job loss. These findings highlight that socio-economic disadvantage compounds the barriers faced by people with ADHD. Long waiting times, high private costs, and the lack of accessible financial support pathways disproportionately affect those on lower incomes, contributing to entrenched inequalities in health, employment, and overall wellbeing.
Pregnancy or maternity Identify any adverse potential impact because of pregnancy or maternity.	There would be no adverse potential impact to note within this programme of work. **Updated information following public Consultation**
Marriage /civil partnership This category is only required for employment discrimination matters.	It is important to note that: Mothers with children with ADHD were less likely to be married than mothers of children with no ADHD diagnosis. Socioeconomic Associations with ADHD: Findings from a Mediation Analysis - PMC (nih.gov) The socioeconomic impact of single parenthood could impact access to services during pregnancy/maternity. **Updated information following public Consultation**

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Other Are there other discriminations or disadvantages that you think you need to address?	Geographical location plays a part in waiting times and diagnostic pathways, across GM there are multiple organisations who are part of the process with no one way for all residents of GM. Tameside also has the largest waiting list for Children. Things we need to consider when reviewing common traits of ADHD. ADHD is more common in people who have: • a sibling or close family member with ADHD • epilepsy • other neurodevelopmental conditions, learning disabilities or learning difficulties. • mental illnesses • a history of alcohol or drug misuse • been involved in the criminal justice system. • an acquired brain injury • been in care. Or who were: • born prematurely • diagnosed with 'oppositional defiant disorder' or 'conduct disorder' as children. • thought to have a mental illness like anxiety or depression as children. **Consideration following Engagement/Options Appraisal Phase** The consultation will ask members of the public which option they would support, and the reasons why they chose A or B. These findings will be analysed as part of the consultation work and fed into shaping the support offer. We will work closely with the lived experience group throughout the communications and engagement phase. **Updated information following public Consultation** **Care Experienced** Care experienced people face particular inequalities in accessing

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	ADHD assessment and support. A reliance on evidence of childhood symptoms or school reports disadvantages this group, who often cannot access such information due to disrupted care histories. This increases the risk of exclusion or misdiagnosis, particularly where trauma is misinterpreted as other conditions such as attachment disorder or PTSD. Even when diagnosed, support is often limited or not tailored to their needs. Group-based or digital-only interventions may be inaccessible due to trauma, social anxiety, or lack of stable networks. Complex referral pathways and requirements for self-advocacy also create barriers for those without strong family or support structures. Overall, the current system risks entrenching health inequalities for care experienced people by failing to recognise their distinct circumstances. Trauma-informed, flexible, and personalised approaches are essential to ensure equitable access and outcomes. **Drug and Alcohol** There is a notable equality impact in relation to ADHD and substance misuse. Respondents highlighted a strong association between ADHD and the use of alcohol or drugs, often as a means of self-medication to manage symptoms, including among those who are undiagnosed. Substance misuse was frequently identified as a priority area for support alongside mental health, anxiety, sleep, and gambling. Barriers were reported where people were required to reduce alcohol or drug use before being referred for assessment or treatment, which risks excluding those most in need. A lack of professional awareness of the link between ADHD and substance misuse was also highlighted, with concerns that ADHD is not always factored into care planning. This creates a risk of poorer outcomes, as individuals may struggle to manage addiction effectively without appropriate recognition and support for underlying ADHD. **Criminal Justice System** There is a significant equality impact in relation to people with ADHD in the criminal justice system. Respondents raised concerns about the high prevalence of ADHD among prisoners and the barriers they face in accessing diagnosis, treatment, and ongoing support. A particular issue identified was the difficulty in continuing medication after release, due to problems with shared care arrangements. This often results in individuals being placed back on lengthy waiting lists, leaving their symptoms unmanaged at a critical point of transition. The lack of timely access to treatment was linked to an increased risk of reoffending, with concerns that some individuals may engage in offending behaviour as a means of obtaining stimulant medication.

	Barriers were also noted for ex-offenders with co-occurring issues such as substance misuse, as well as wider challenges including low literacy levels, insecure housing, and difficulties navigating complex health and benefits systems. Respondents highlighted the need for greater awareness and training among criminal justice staff to ensure ADHD is recognised and appropriately managed. The failure to adequately support this group risks perpetuating cycles of poor health, exclusion, and reoffending. Addressing these barriers was viewed as an opportunity not only to reduce health inequalities but also to deliver wider societal benefits through improved rehabilitation and reduced demand on criminal justice services.

6. Can the adverse impacts you identified be justified and the original proposals implemented without making any adjustments to them? If so, please set out the basis on which you justify implementing the proposals without adjustments.

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Further engagement will be undertaken on the impact and mitigations required

7. Having analysed the initial and additional sources of information including feedback from consultation, is there any evidence that the proposed changes will have a *positive* impact on any of these different groups of people and/or promote equality of opportunity? Please provide details of who will benefit from the positive impacts and the evidence and analysis used to identify them.

Further engagement will be undertaken on the impact and mitigations required.

8. Is there any evidence that the proposed changes have *no* equality impacts? Please provide details of the evidence and analysis used to reach the conclusion that the proposed changes have no impact on any of these different groups of people.

Further engagement will be undertaken on the impact and mitigations required.

9. Please provide details of how you will consult and involve communities on the proposed changes. If you do not plan to consult and involve, please provide the rationale behind that decision.

Engagement Plans

Although dates are TBC of delivery (expected August and September 2024), the activities will consist of:

- **Public Engagement;** at events, delivering focus groups, pre-booking phones or receiving information on voice notes etc.
- **Stakeholder Engagement;** GP newsletter for primary care and a provider meeting planned for July to ensure our stakeholders are updated on our plans and current position. We can discuss at this point how we best support them to engage with their waiting lists and patient population.
- **Comms;** we have had regular meetings with our comms functions to try and plan how we best communicate this engagement and ensure that as many people see it in GM as possible and take part if they are interested. We have secured a budget of £3000 for translated materials including easy read and BSL. We will be working with our lived experience group to 'test' the comms before launch.
- **Social Media;** we have recorded a video case study to try and boost interactions on social media, and have secured a budget of £500 to target demographics which we had a low response from in the pre-consultation.

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Step 3 – Strengthening your policy plan or project

Please use the table below to document your strengthening actions.

10. What changes are you planning to make to your original proposals to minimise or eliminate the adverse equality impacts you have found?

Please provide details of the proposed actions, timetable for making the changes and the person(s) responsible for making the changes.

Adverse impact	**Proposed action**	**Person responsible**
Support offer only being available online	Printed copies of support booklets to be made available to those who are digitally excluded	Programme team and support offer provider
Support offer only being in English	Translations provided	Comms team
The comms we create for consultation is not fit for purpose or easily understood	We will work with our lived experience group to 'test' the comms prepared and ensure it is fit for purpose for someone living with ADHD	Engagement team
Protected Characteristic	Proposed Action(s)	Person Responsible
Age	• Provide information and support materials at an appropriate reading level for all age groups • Ensure pathways consider transitions from child to adult services • Offer flexible appointment times to accommodate students and working-age adults	Service Leads / Providers

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Disability	• Apply reasonable adjustments for neurodiverse and disabled patients • Ensure support materials and assessment tools are accessible (plain English, easy read, BSL, alternative formats) • Train staff in neurodiversity awareness and trauma-informed care	Service Leads / Providers
Sex (Men/Women)	• Tailor communication and support materials to reflect differences in ADHD presentation between men, women, and gender minorities • Review diagnostic tools to ensure they capture inattentive and internalising presentations	Clinical Leads / Service Leads
Race / Ethnicity	• Provide culturally appropriate materials and translation services • Engage community organisations representing ethnic minority groups for outreach and co-design • Train staff in cultural competence and awareness of underdiagnosis in minority groups	Commissioners / Providers
Religion / Belief	• Ensure information and support materials are sensitive to religious or belief-related considerations • Liaise with faith groups where needed to improve awareness and engagement	Service Leads / Engagement Team
Sexual Orientation	• Engage LGBTQ+ organisations for focus groups and consultation • Ensure inclusive language in materials and training to address intersectional	Service Leads / Engagement Team

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	barriers	
Transgender / Non-Binary	• Update assessment pathways to be inclusive of gender-diverse experiences • Train staff in gender diversity and intersectional neurodiversity • Provide targeted outreach for trans and non-binary communities	Service Leads / Clinical Leads
Carer Status	• Offer flexible appointment scheduling to accommodate carers • Provide clear guidance and support for carers, including information on hereditary risks and family support	Service Leads / Providers
Socio-Economic Status	• Conduct localised outreach and awareness campaigns in deprived areas • Provide plain English materials and easy-read resources • Engage community organisations for support and advocacy	Commissioners / Service Leads
Pregnancy / Maternity	• No significant adverse impacts identified; continue to monitor	N/A
Marriage / Civil Partnership	• No specific adverse impacts identified; continue to monitor	N/A

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Other (Care Experienced, Criminal Justice, Substance Misuse)	• Develop trauma-informed and flexible pathways for care-experienced individuals • Coordinate with criminal justice services to ensure continuity of ADHD care • Integrate substance misuse support alongside ADHD care where needed	Service Leads / Commissioners / Providers

11. Describe here how you could further promote equality of opportunity. What action/s do you recommend and when?

To further promote equality of opportunity, the following actions are recommended for each protected characteristic. These actions go beyond mitigating disadvantage and actively seek to reduce barriers, increase access, and ensure services are designed inclusively. Responsibilities have been assigned to commissioners, service leads, providers, or clinical leads to ensure accountability and delivery.

The recommended actions should be embedded into the service redesign process from the outset and reviewed regularly as part of contract monitoring and service evaluation. Some actions, such as staff training and accessible communication, should be implemented immediately, while others, such as partnership development and pathway refinement, will be ongoing. Progress should be reviewed quarterly, with adjustments made in response to service-user feedback and equality monitoring data.

Protected Characteristic	Action(s) to Promote Equality of Opportunity	Person Responsible
Age	• Develop flexible service access times (evenings/weekends) • Strengthen transition pathways from children's to adult services with automatic record transfer • Produce age-appropriate support materials for different groups (e.g. university students, older adults)	Service Leads / Commissioners
Disability	• Provide holistic, trauma-informed assessments recognising co-occurring conditions • Offer information in multiple formats (easy read, BSL, large print, audio, printed) • Train staff to reduce diagnostic overshadowing	Providers / Clinical Leads
Sex (Men/Women)	• Adapt diagnostic tools to better capture inattentive-type ADHD presentations (common in women) • Provide resources on ADHD in relation to menopause/hormonal changes • Tailor support for gendered experiences (e.g. parenting, employment)	Clinical Leads / Providers

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Protected Characteristic	Action(s) to Promote Equality of Opportunity	Person Responsible
Race / Ethnicity	• Deliver cultural competence training for staff on ADHD presentation in diverse groups • Translate key materials into community languages • Partner with local organisations to raise awareness in minority ethnic communities	Commissioners / Service Leads
Religion or Belief	• Engage with faith groups to reduce stigma and build awareness • Ensure appointment times are sensitive to religious observances • Provide quiet/prayer spaces within clinics	Service Leads / Providers
Sexual Orientation	• Use inclusive messaging and imagery in service communications • Link service users to LGBTQ+ peer support networks • Train staff on intersectionality of ADHD and LGBTQ+ identities	Service Leads / Providers
Gender Reassignment (Trans / Non-binary)	• Train clinicians on ADHD presentations and masking in trans/non-binary people • Ensure inclusive gender options on forms and systems • Co-design resources with trans-led organisations	Clinical Leads / Commissioners
Pregnancy / Maternity	• Provide guidance for women on ADHD management during pregnancy/postpartum • Offer flexible appointment options (remote, childcare-friendly) • Highlight hereditary risks to support early recognition in families	Clinical Leads / Service Leads
Marriage / Civil Partnership	• Provide information and signposting for partners/carers of people with ADHD • Offer family/relationship support options to reduce risk of breakdown	Providers / Commissioners

12. Describe how you could further promote human rights principles. What action/s do you recommend and when? Please provide details.

To further promote human rights principles within the redesign of Adult ADHD Services, actions should focus on embedding dignity, respect, equality, participation, and fairness into service delivery. These principles underpin the Equality Act and NHS Constitution, and their promotion will help ensure services are safe, inclusive, and person-centred.

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Human Rights Principle	Action(s) to Promote Principle	Person Responsible
Dignity & Respect	• Train all staff in trauma-informed, person-centred care • Provide accessible communication formats (easy read, BSL, large print, translation) • Safeguard privacy during assessments with flexible remote/in-person options	Providers / Clinical Leads
Equality & Non-Discrimination	• Apply reasonable adjustments proactively for people with disabilities and neurodiverse needs • Monitor waiting lists and outcomes by protected characteristic • Collect inclusive demographic data (e.g. gender identity, ethnicity, sexual orientation) with respect and confidentiality	Commissioners / Service Leads
Participation & Voice	• Involve service users with lived experience in co-design of pathways and materials • Establish ongoing feedback mechanisms (surveys, panels, focus groups) • Provide clear routes for appeals or second opinions	Commissioners / Service Leads / Providers
Fairness & Transparency	• Publish eligibility criteria, referral processes, and waiting times in accessible formats • Apply consistent decision-making frameworks to ensure fair access • Share service performance data publicly to build trust and accountability	Commissioners / Service Leads

These actions should be embedded from the start of the redesigned service model and form part of commissioning requirements. Staff training and communication adjustments should be implemented immediately, while co-design, monitoring, and transparency measures should be reviewed and strengthened on an ongoing basis, with formal reviews at least annually.

13. Describe how you could further reduce socio-economic disadvantage. What action/s do you recommend and when?

To further reduce socio-economic disadvantage, the following actions are recommended. These measures aim to increase awareness, access, and support for people from deprived communities, ensuring that service redesign does not exacerbate existing inequalities. Responsibilities are assigned to commissioners, service leads, and providers to ensure effective delivery and accountability.

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Theme	Action(s) to Reduce Socio-Economic Disadvantage	Person Responsible
Localised Support & Outreach	• Deliver information sessions and engagement events in community centres, libraries, schools, and colleges in deprived areas • Partner with community organisations, youth services, and voluntary groups to raise awareness and guide access to ADHD services • Produce plain English and easy-read resources to improve understanding of referral pathways	Commissioners / Service Leads / Providers
Support for Employment & Education	• Strengthen links with employment services, colleges, and universities to provide reasonable adjustments and vocational support • Offer information on workplace rights and Access to Work funding • Work with local employers to reduce stigma and increase inclusive opportunities	Commissioners / Providers
Addressing Wider Impacts	• Build partnerships with voluntary and community organisations to provide peer mentoring and advocacy, particularly for care-experienced and marginalised groups • Embed signposting to financial advice, housing support, and benefits advice within the ADHD care pathway • Collect and analyse service uptake data by postcode/Index of Multiple Deprivation to ensure equitable access	Service Leads / Commissioners

14. Describe here how you could further promote social value. What action/s do you recommend and when?

To further promote social value, the following actions are recommended. These measures aim to create broader benefits for the local community, including employment opportunities, skills development, and engagement with community-led organisations. Responsibilities are assigned to commissioners, service leads, and providers to ensure that social value objectives are delivered effectively alongside service redesign.

Theme	Action(s) to Promote Social Value	Person Responsible
Employment & Skills Development	• Offer apprenticeships or trainee positions within the ADHD service or partner organisations • Provide volunteering opportunities for local community members, including peer support roles • Encourage recruitment from local job seekers and underrepresented groups	Commissioners / Service Leads / Providers
Engagement with Community-Led Organisations	• Contract community-led social enterprises for delivery of support services or outreach initiatives • Partner with local charities and voluntary groups to co-deliver awareness campaigns and engagement events • Support local networks that provide mentoring,	Commissioners / Service Leads

Theme	Action(s) to Promote Social Value	Person Responsible
	advocacy, or family support for people with ADHD	
Local Economic Benefit	• Prioritise local suppliers and service providers where possible • Support initiatives that strengthen community cohesion and wellbeing • Monitor and report social value outcomes as part of service evaluation	Commissioners / Service Leads / Providers

Step 4 – Monitoring and review

15. You are legally required to monitor and review the proposed changes after implementation of your strategy or programme to check they work as planned and to screen for unexpected equality impacts. Please provide details of how you will monitor, evaluate or review your proposals and when the review will take place.

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What	When	How
Evaluate patient experience to identify any inequalities for at-risk or underrepresented groups.	Initial review at 6 months post-implementation, with ongoing evaluation through annual reviews.	Collect feedback via surveys, focus groups, and engagement with lived experience groups. Analyse responses by protected characteristic to identify emerging disparities.
Monitor service uptake by protected characteristic to identify gaps or unequal access.	Quarterly monitoring through performance dashboards and annual equality audit.	Analyse referral, assessment, and outcome data by age, sex, ethnicity, gender identity, disability, and socio-economic status. Report findings to programme board and commissioners.
Monitor complaints and feedback to screen for differential impacts.	Quarterly review of complaints data and annual summary of themes.	Track complaints by protected characteristic and issue type. Use findings to inform service improvement actions and equality updates.
Review overall equality impacts and effectiveness of mitigations.	12 months post-implementation and annually thereafter.	Programme board and equality leads to review all data sources, update action plans, and publish outcomes through equality and quality reports.

Step 5 – Sign off

Strategy, policy, plan, project or service owner or Work Programme Lead*

Name: Sandy Berring, Greg Vaughan, Chris Pimblott

Date:

EIA Lead (the person completing this form)
This equality analysis has been quality-checked and will be passed to the senior responsible officer for final sign off.

Name: Chris Pimlott

Date: 05/09/2025.

Director or Senior Responsible Owner *
This equality impact assessment has been completed in a rigorous and robust manner and I agree with the actions identified. It will now be progressed and published where required.

Name: Dr Manisha Kumar, Chief Medical Officer, NHS Greater Manchester

Date: 05/09/2025

*By signing off your EIA you are confirming that you are satisfied that the policy/strategy/project/activity/service has been designed with the needs of different equality groups and communities in mind, and that the groups it is intended to serve will be able to access the service and experience similar outcomes from it.

For records, this EIA will also need to be copied to elaine.mills7@nhs.net to ensure we can evidence our legal duties to undertake equality analysis. However, the original version must be kept with the project documents and pro-actively used to inform the progress of the work, alongside budget, risk and health and safety monitoring.

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