Greater Manchester Health and Social Care Partnership

# Equality Analysis Template v1.0

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

## Step 1 Evidence

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.

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| **Name of your strategy/policy/plan/project** | The Provision of Vascular Services for Greater Manchester and East Cheshire - A pre consultation business case | | |
| **Contact details for the person completing the assessment** | Stuart Moore, Director of Strategy, MRI & WTWA | | |
| **Design date for the strategy/policy/plan/project** | Design ongoing since 2018.<br>Estimated implementation date : August 2026 | | |
| **Date your equality analysis is completed** | December 2025 | | |
| **Does this template form part of a business case or investment proposal submission?** | Yes | No | Unsure |
| **Are you completing this as a result of organisation change?** | Yes | No | Unsure |
| **Is there another reason for you completing this template – e.g., renewal of a current service/change to current service – please specify:** | Reconfiguration of the current vascular services. | | |

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.

### 1. Initial screening assessment

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**What are the main aims, purpose of your policy, plan or project?**
The primary purpose of this business case is to establish a sustainable, high-quality vascular service network in Greater Manchester that meets national standards and local healthcare needs. By further reconfiguring services, this proposal seeks to enhance patient outcomes through streamlined access to specialist care, improve recruitment and retention of skilled professionals, and build capacity for future demand driven by demographic changes. Additionally, it aims to ensure consistency in service delivery across the region, optimise resource allocation, and expand opportunities for research and clinical training, ultimately creating a resilient, integrated vascular service model for Greater Manchester.

**What is your expected outcome?**
The intended outcome is a streamlined, regionally integrated vascular service that reduces health disparities, provides improved patient outcomes, and supports a sustainable, high-standard healthcare model within the region.

**Who will benefit?**

- **Patients:** Across Greater Manchester and East Cheshire, patients will benefit from more accessible, comprehensive care.
- **Organisation and Staff:** Through streamlined operations, staff will work within a consistent, standardized framework.
- **Communities:** Addressing the unique needs of communities with specific socio-economic and health challenges.

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

The case for change is aligned with the Greater Manchester strategic direction and ambitions – it is to an extent an updating and refresh of substantial work undertaken by the former Greater Manchester Integrated Healthcare Partnership which was paused as a result of the Covid pandemic – and has been developed with and on behalf of the GM system partners:

- Lead commissioner: NHS England Specialised Commissioning NW);
- Local commissioner: GM Integrated Care Board (ICB);
- Arterial centre providers: Manchester University NHS Foundation Trust (MFT) and Northern Care Alliance NHS Foundation Trust (NCA);
- Network hospital providers: Bolton NHSFT, Stockport NHSFT, Tameside & Glossop Integrated Care NHSFT

Vascular Surgery – GIRFT Programme National Specialty Report, 2018 Provision of Interventional Radiology Services (PIRS), 2019 Specialised vascular services (adults) – NHS England service specification

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

At this stage, you do not have to list possible impacts, just identify the areas. (E.g. we are commencing a new programme of health care aimed at Caribbean men with diabetes)

Co-locating specialties that might be impacted are interventional radiology, cardiology, stroke services, operating theatres, critical care, outpatient clinics, vascular laboratory, vascular wards, Limb Fitting services, diabetes, and renal clinics would enable integrated, multidisciplinary care like rehabilitation and physiotherapy/OT for complex vascular patients.

National Service Specifications for Vascular Services

https://vascularsociety.org.uk/_userfiles/pages/files/povs/povs-2021.pdf
https://vascularsociety.org.uk/_userfiles/pages/files/povs/povs-2024-final-update-202224-with-links-for-web.pdf

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).

To assess the likely impact on different groups of people, several existing sources of information will be utilized:

**Travel Analysis**: This will examine the impact of service centralization on patients' travel times and accessibility, particularly for those in more deprived or geographically distant areas. Travel analysis can provide insights into the barriers posed by long travel distances and identify vulnerable groups who may face difficulty accessing care. There has been an externally commissioned travel analysis.

**Consultation Documents:** These include official consultation responses from local stakeholders, healthcare professionals, and patient groups. They provide valuable feedback on how the proposed changes might affect different communities, highlighting concerns or areas of support.

**Patient Feedback**: Direct input from patients who currently use the vascular services will be gathered through surveys, interviews, and patient satisfaction data. This feedback will provide insights into how the changes may impact their access to care, and any issues they anticipate, particularly related to service delivery or access challenges.

**Quantitative and Qualitative Data:** This includes statistical data from sources like the Joint Strategic Needs Assessment (JSNA), which offers an overview of health outcomes across various demographics. Qualitative data from focus groups or interviews will provide deeper insights into the lived experiences of patients and healthcare providers, shedding light on any disparities.

4. **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 |
|---|---|---|
| Detailed analysis around clinical outcomes for Oldham General Integration | Investigate in the same manner as the approach with Wythenshawe integration (MnMs, Patient complaints, incident reporting, Further Quality and safety procedure, access and performance indicators) | The clinical lead for CVS |

## 5. 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?** |
|---|
| Arterial vascular services for GMEC have been included in a number of reviews since 2016 and has included the development of a case for change, outline model of care as an arterial centre and network hospital (hub and spoke) configuration and options for the future delivery of the service.<br><br>**Case for change**<br>• Three workshops were held to develop the case for change and model of care in 2018.<br>• These included the following stakeholders: Vascular Surgeon, GM Health & Social Care Partnership, Patient/Public Rep, GM Director of Finance (CCG), GM Director of Commissioning, Spec Commissioning Lead, Vascular Manager (South, Central and North Network), GM Clinical Transformation lead, VIR, AHP Lead, Nurse Lead, PAT Strategy Manager, Spoke Representative, GM Clinical Lead for Radiology, NHS Hub GM Link<br>• Clinical senate review was completed November 2023<br>• NHSE Stage 1 Assurance was completed December 2023<br><br>**Options appraisal**<br>• A robust options appraisal process has been delivered to identify the preferred way forward. The options appraisal process is the process of defining objectives, examining options and weighing up the costs, benefits, risks and uncertainties of those options before a decision is made. In the PCBC this must be completed for a ranked shortlist of options that will then be consulted on. |

- The face-to-face long list workshop, held on 6 December 2024, used a pre-workshop information pack as a foundation for in-depth discussions. The workshop provided a forum for stakeholders to validate the information presented, identify any omissions or gaps, and scrutinise the merits of each option resulting in an emerging shortlist.
- Key stakeholders in attendance included:
    - Patient rep
    - Strategy Directors (MFT & NCA)
    - Healthwatch
    - Vascular Surgeons
    - Workforce Director
    - Director of Nursing
    - GM Finance Manager
    - Specialised Commissioning Lead
- Following the identification of the emerging shortlist, in January 2025 a structured scoring process was undertaken to evaluate each option against the agreed criteria. A pre-scoring information session was held virtually with scorers to ensure they understood the process and gave an opportunity for questions.
- Once the scores were submitted, a scoring moderation meeting was held virtually to review the scoring results, resolve discrepancies, and confirm the final rankings.
- The scorers included representatives from the following key groups:
    - Patient/Public
    - Providers (MFT and NCA)
    - Specialised Commissioning North West
- An additional option (Two site Model - Manchester Royal Infirmary & Salford Royal) was identified at the longlist workshop and following the moderation meeting it was highlighted that scorers did not feel there was enough information available for them to score it accurately. Work was undertaken collaboratively with NCA and MFT to develop the option and it was re-scored in November 2025.

**Key feedback from consultation:**

The 2018 workshops were to develop the case for change and model of care. The model of care options were:

- Two site model - Arterial vascular surgery to be delivered on two sites
- One site model - Arterial vascular surgery to be delivered on one site

There was not a consensus decision for either option as the preferred model at the time. The main reasons raised for having a two-site model were based around patient access, resilience and finance. The main reasons raised for having a one-site model were around workforce recruitment/attraction/retention, opportunities for research and the support provided by spokes.

Following the robust options appraisal process, the preferred option identified was for a single arterial vascular centre at Manchester Royal Infirmary. This option received a 98.4% positive response rate and low entropy, indicating strong consensus by the group. During the workshops and engagement as part of the options appraisal, the expected benefits and potential impacts were highlighted by stakeholders. Key feedback included:

- Benefits around reduction in variation and improved equity of access to vascular surgery services

- Impacts on patients including travel times and costs
- Impacts on workforce, especially ROH staff

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:

**How engagement with stakeholders will continue**

Every effort will be made to continue to monitor and engage throughout the course of the delivery by regularly assessing any disparities through patient and improvement groups. This involves collecting feedback, analysing data, and observing outcomes to ensure that the strategies are having the desired impact. There will be adjustments as needed, staying proactive to ensure any challenges are addressed promptly and that the approach remains aligned with the goals.

A full workforce communications plan has been developed. Key messages are highlighted below:

- Acknowledging that job security will be one of the first concerns raised by staff will need to be addressed from the onset. Addressing potential concerns and mitigate risks associated with TUPE (Transfer of Undertakings Protection of Employment) implications.
- The hub-and-spoke model will enhance patient safety and quality of care by concentrating specialist expertise in a central hub.
- Inform staff, stakeholders (other services at the Trust, trade union representatives etc) and partners about the proposed changes. The messaging will be designed to primarily communicate the benefits of enhancing the vascular single arterial service for patients.
- Routine and follow-up care will remain accessible locally through spoke sites, reducing unnecessary travel for patients.
- Staff will have opportunities for professional development and access to specialist training within the hub.
- Workforce changes will be managed transparently, with full adherence to employment law and staff engagement principles.
- Ensure meaningful engagement with affected staff groups, including consultation on workforce changes.

## Step 2

## Assessing impact and opportunities to promote equality and human rights

**6.** 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.

This is not a pilot project; this is a review of Vascular Services across Manchester and East Cheshire. The vision is to be an exemplar Vascular Network delivering an equitable service across Greater Manchester (GM), redefining the outcomes for our patients through clinical excellence, innovation and research and promoting professional development for our workforce. The aim is to ensure improved access for patients to an arterial centre/ Hub which delivers clinical volumes and outcomes in line with POVS standards.

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

Add the impacts in the box next to the group. (e.g. we have found that working age people are not taking up our services because of our opening hour restrictions)

Complete the identified barriers for each group and identify which group you have identified
You should complete each category. If you believe there is no adverse impact, you should put an explanation as to why.

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| Age<br>• Young<br>• Middle age<br>• Older age | From the responses receive from the cohort of 227 people<br>Nearly 2/3 of the same were over 66 years of age and a similar number said they were retired.<br>Older adults, who constitute 14% of the GM population (over 400,000 people), are particularly vulnerable due to mobility challenges and reliance on public transportation. Areas like Wigan and Rochdale have limited transport links to Manchester Royal Infirmary (MRI), exacerbating access difficulties. Older adults are also more likely to suffer from vascular conditions such as peripheral arterial disease (PAD) and abdominal aortic aneurysms (AAA), with studies indicating higher surgical needs in this group. For working-age individuals (63% of the population, over 1.7 million), travel time and inflexible service hours are major barriers. Many in this group delay seeking care due to work commitments, potentially worsening disease progression. |
| Disability<br>Types of impairment can be categorised as physical, sensory, psychosocial, and intellectual. There are several types of barrier that cause exclusion including<br>• Physical<br>• Social/attitudinal<br>• Institutional<br>• Communication<br>Complete which *barriers* you will need to consider in your programme. | From the responses receive from the cohort of 227 people- 110 people from this cohort said they had disability<br><br>A significant proportion of patients accessing vascular services are individuals with diabetes, a condition that substantially increases the risk of vascular complications. Diabetes is a leading contributor to peripheral arterial disease (PAD), diabetic foot ulcers, and poor wound healing, often requiring specialized vascular care. Additionally, diabetes-related complications such as neuropathy and retinopathy can result in disabilities, including reduced mobility and impaired vision. Approximately 580,000 residents (21% of GM's population) live with a disability, including physical, sensory, and intellectual impairments. For individuals with physical disabilities, navigating the reconfiguration of vascular services could pose challenges, especially for those requiring specialized transport. Similarly, patients with sensory impairments, such as hearing or vision loss (affecting 6% and 9% respectively), may struggle with inadequate communication support like braille, large print, or sign language interpreters. Intellectual disabilities add another layer of complexity, with many patients needing simplified communication and consistent caregiver support. |
| Sex | From this cohort response of 227 people<br>Male- 153; Females- 69<br><br>Men account for 60% of vascular-related admissions in GM, with |

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| Identify any potential adverse impact to men or women. | conditions such as PAD and AAA disproportionately affecting this group. However, men often underutilize preventive care services, which may increase the risk of late-stage presentations requiring urgent intervention. For women, vascular diseases are sometimes underdiagnosed due to atypical symptom presentation or biases in diagnostic criteria. As women make up 51% of GM's population, ensuring gender-equitable service design is crucial, particularly to address conditions like varicose veins or chronic venous insufficiency, which are more common in women. |
| Race<br>Identify any adverse potential impact on different ethnic groups and identify which ethnic groups you may need to specifically consider. | From this cohort response of 227 people-<br>Over 2/3 were male and 93% were white British<br>White British – 202<br>White- Irish – 5<br>Asian or Asian British Indian- 3<br>Asian or Asian British Pakistani- 1<br>Black or Black British- 1<br>Mixed- white and Asian- 1<br>White -Polish-1<br>White- Ukrainian- 1<br>Other- 2<br><br>Ethnic minorities in GM face substantial barriers to accessing vascular services. South Asian communities (10% of the population) and Black communities (4%) experience higher rates of vascular conditions due to a higher prevalence of diabetes and hypertension, key risk factors. Language barriers disproportionately affect non-English-speaking households, which make up 8% of GM's population. Poor health literacy and mistrust of centralized care, shaped by historical inequities, further discourage these groups from seeking timely interventions. Culturally insensitive services, such as a lack of halal dietary options or inadequate provision for religious observances, can also alienate patients. |
| Religion belief<br>Identify any adverse potential impact on different religious groups and identify which you may need to specifically consider. | GM's religiously diverse population includes 59% identifying as Christian and 9% as Muslim. The Muslim community may face barriers if services do not accommodate prayer times, fasting schedules during Ramadan, or halal dietary needs for inpatients. Christian patients, particularly those observing traditional Sabbath days, may encounter scheduling conflicts. Ensuring religious inclusivity in service provision is key to fostering equitable access. |
| Sexual Orientation<br>Identify any adverse potential impact on different sexual orientations and identify which sexual orientations you may need to specifically consider. | An estimated 5–7% of GM residents identify as LGBTQ+, and 1% as transgender or non-binary. These groups may avoid accessing reconfiguring vascular care due to fears of discrimination or inadequate staff training on inclusivity. Misgendering and a lack of understanding of specific health needs could discourage these populations from engaging with vascular services, even when necessary. |
| Transgender<br>Identify any adverse potential impact on | Transgender or non-binary individuals may face discomfort if MRI's staff are not trained in gender-sensitive care, including appropriate use of names and pronouns. |

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| transgender or non-binary people. | |
| Carer status | With 250,000 unpaid carers in GM, many face logistical challenges in supporting patients who require vascular treatment. Reconfiguring vascular services may increase the burden of travel and time management for carers, particularly if appointment scheduling is inflexible. A lack of carer-friendly facilities, such as waiting areas or support services, exacerbates these challenges. |
| Socio-economic status<br>Identify any adverse potential impact because of deprived communities and identify which communities you may need to specifically consider. | GM has stark socio-economic inequalities, with 42% of residents living in the top 20% most deprived areas nationally, including Oldham and Rochdale. These communities often experience poorer health outcomes and higher rates of vascular disease, exacerbated by limited access to preventative care. Financial barriers, such as transport costs to MRI, deter engagement with centralized services, while time off work adds an additional economic strain. |
| Pregnancy or maternity<br>Identify any adverse potential impact because of pregnancy or maternity. | Annually, there are 35,000 births in GM, and vascular complications during pregnancy, such as preeclampsia or varicose veins, require tailored care pathways. Centralising services at MRI could make access difficult for pregnant individuals, who may face travel-related fatigue or increased risks during late pregnancy stages. |
| Marriage/civil partnership<br>This category is only required for employment discrimination matters. | No specific barriers identified beyond standard considerations for employment discrimination, which is not applicable here. |
| Other<br>Are there other discriminations or disadvantages that you think you need to address? | Non-English-speaking patients need interpretation services and materials in commonly spoken languages within Greater Manchester. Patients without digital access or skills must have non-digital pathways for accessing services, such as telephone or in-person appointments. |

**8.** 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.

The proposed reconfiguration of vascular services has been evaluated for equality impacts using public expectations data and local surveys conducted in Greater Manchester (GM) NHS England, Greater Manchester Combined Authority. While the service changes aim to improve clinical outcomes and streamline care pathways, public feedback highlights key areas that minimize adverse equality impacts.

Public Expectations and Patient Priorities

Accessibility and Service Quality:

Surveys conducted by the Greater Manchester Health and Social Care Partnership indicate that residents prioritize high-quality care over proximity to services. For instance, a 2021 GM-wide survey found that 80% of respondents were willing to travel further if it meant receiving specialized care with better outcomes. The reconfiguration of services at MRI aligns with this expectation, as it concentrates vascular expertise and improves care standards.

In the patient forum it was identified that access to high quality care was of greater concern than locality especially if for major surgery.

Transport and Connectivity:

Public consultations identified transport as a potential concern but highlighted that Greater Manchester's well-connected transport network, including bus and Tram link services, mitigates this for the majority of the population. GM has committed to improving transport accessibility as part of its Integrated Care System strategy, ensuring equitable access to centralized facilities.

Perceptions of Specialist Care:

Public engagement indicates strong support for specialized hubs like MRI. A 2019 consultation found that 74% of respondents valued having expert teams and advanced technology concentrated in one location, even if it meant longer travel times.

Digital Accessibility:

GM has invested in digital health initiatives, such as remote consultations and telemedicine services, addressing accessibility for individuals unable to travel. Over 90% of GM residents have access to broadband, reducing barriers for those in rural or deprived areas.

From the cohort of 227 responses, it is interesting to note that while travel time scored lowest in terms of satisfaction, it was not regarded as highly important by patients in earlier questions. This indicates that, despite lower satisfaction ratings, travel time does not significantly influence patients' overall priorities or perceptions of care, further suggesting it may not need to be a primary focus in service improvements.

**9.** 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.

The reconfiguration of vascular services at is expected to benefit a wide range of individuals and groups

Patients with Vascular Diseases: Patients requiring specialized care for conditions such as aneurysms, peripheral arterial disease, and diabetic vascular complications. Data shows a 17% reduction in mortality rates in centralized vascular services compared to non-centralized models NHS England.

Ethnic Minority Groups: South Asian and Black communities, who experience higher rates of diabetes and hypertension, which are major contributors to vascular disease.

Residents of Deprived Areas: Populations in Greater Manchester's deprived areas, where 45% of the population resides. These areas face significant health inequalities and higher rates of vascular disease where access to improved services is key driver in the case for change.

Healthcare Professionals and System Efficiency: Medical professionals, including vascular surgeons and radiologists, benefit from enhanced training and research opportunities. A centralized system at MRI fosters standardized practices and promotes the retention of skilled staff. Studies show that workforce satisfaction improves by 20% in centralized hubs due to increased peer support and advanced facilities NHS England.

1. 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.

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It must be noted that the proposal is for the centralisation of surgery at MRI, to ensure sufficient patient volume in key procedures to improve clinical outcomes. A vascular service remains at Royal Oldham Hospital with supporting services. There is no definitive evidence that the proposed centralization of vascular surgical services at MRI will have no equality impacts. However, several measures suggest that potential impacts are mitigated effectively. Public surveys conducted in Greater Manchester also show significant support for specialized hubs, with over 80% of respondents prioritizing quality care over proximity, indicating public confidence in the proposal's inclusivity NHS England.

Additionally, MRI's robust safeguarding policies further reduce equality impacts. These policies address issues of accessibility, safety, and tailored care, ensuring protection for vulnerable groups, including children, disabled individuals, and those at risk of exploitation or abuse. MRI's infrastructure supports this by incorporating wheelchair-friendly facilities, sensory aids, and telehealth services, which mitigate barriers faced by individuals with physical or sensory disabilities. Safeguarding training for staff ensures sensitivity to diverse needs, promoting equitable access and reducing adverse outcomes related to communication or institutional barriers.

While these factors suggest minimal risk of negative equality impacts, ongoing consultation and targeted interventions for underrepresented or vulnerable groups will remain vital to ensuring fairness and inclusion.

2. 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.

The proposed reconfiguration of vascular services will involve a robust consultation and engagement process to ensure community input and alignment with patient needs. Patient surveys will be conducted across Greater Manchester, focusing on those currently using vascular services, particularly high-risk groups, to understand preferences, barriers, and support for the changes. Engagement with the Integrated Care Board (ICB) will ensure a coordinated approach that reflects regional health priorities. Additionally, hospital staff, including clinicians and support teams, will be actively involved to gather insights on operational improvements and implementation challenges.

## Step 3 – Strengthening your policy plan or project

Please use the table below to document your strengthening actions.

3. 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 |
|---|---|---|

| | | |
|---|---|---|
| Travel Distance | Exploring possibilities to address any disparity by reviewing currently SLA with NWAS and current provider costs to ensure.<br><br>Travel Analysis undertaken | Mark Drury |
| Vulnerable Patients | Actively seek out most vulnerable patients: targeted outreach or communication strategies to ensure that all communities are equally informed and able to engage. | Mark Drury |

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

The Proposal is for inpatient surgical activity to be undertaken at an Arterial Hub to enable a concertation of activity to improve clinical outcomes and patient experience. Routine and regular access to Vascular Services in line with the GMEC network patient pathways will continue to be provided at Royal Oldham Hospital in line with other local network Hospitals working with the Arterial Centre.

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

To promote human rights principles during the planned delivery, a Human Rights Impact Assessment will be conducted. A commitment will be to ensure inclusive and accessible communication and providing mandatory training for staff on human rights and equality. Additionally, establishing support systems for vulnerable populations and implementing ongoing monitoring and evaluation will help identify and address any potential impacts. These actions should be initiated prior to and continue throughout the integration of the Services.

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

The Office for National Statistics has this week released its latest report on smoking prevalence. It reveals that 14.3% of adults (equivalent to around 316,000 people) in Greater Manchester were smoking in 2022 – an estimated 24,000 fewer smokers compared to 2021.

The data also shows that Greater Manchester continues to close the regional and national smoking prevalence gap, and now sits just 0.9 percentage points above the Northwest (13.4%) and 1.6 percentage points above England (12.7%) – the narrowest the gap has ever been.

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These figures reflect the success of the Greater Manchester Integrated Care Partnership's Making Smoking History programme, which brings together partners from across all 10 local authorities, the NHS and the voluntary sector to tackle the harms of tobacco and offer support for smokers to quit.

Be Smoke Free is a nurse-led Tobacco Addiction treatment service for adults and young people aged 12+ living in Manchester or with a Manchester GP. We provide evidence-based behavioural support and direct supply Nicotine Replacement Therapy (NRT) and Champix – without the need for a prescription or GP visit.

Across GM, there are numerous targeted smoke-free campaigns aimed at addressing the harms of smoking and providing support to smokers, which will have a positive impact on reducing the incidence of vascular illness-related cases.

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

For example, you might be able to offer new jobs or apprenticeships to people struggling to get employment or offer contracts to community led social enterprises to deliver your services.

Manchester University NHS Foundation Trust (MFT) takes a positive and proactive approach to working with members of our local communities and offers vocational placements, pre-employment programmes and internships. These programmes of work aim to help (MFT) attract and recruit local people to our vacancies, working closely with local schools, colleges and organisations to widen participation and increase access to our educational and career opportunities. The Manchester Royal Infirmary will actively engage with programme leads to engage and offer opportunities to local people.

In addition, the new model for vascular services will attract and create employment opportunities and a key focus will be to attract local people into these opportunities. MFT, and the MRI can maximise on it's role as an anchor institution to boost local economies and reduce socio-economic and health inequalities. And given that employment is vital to good health, increasing the amount of hiring an NHS organisation does locally may be an opportunity to increase the impact that it has on the wellbeing of communities.

## Step 4 – Monitoring and review

8. 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.

| What | When | How |
|---|---|---|

| | | |
|---|---|---|
| **Equality Impact Assessments** | Quarterly | Conduct periodic assessments to identify any unexpected equality impacts, particularly for vulnerable or underserved groups. Use this information to adjust strategies as needed |
| **Collect Data and Feedback** | Ongoing monthly reporting | Continuously gather quantitative and qualitative data from key stakeholders, including patients, staff, and community members, to assess the impact of the changes. This can be done through surveys, interviews, or focus groups |
| **Key stakeholder engagement** | Through GMEC Vascular Network and Patient Forums – Alternate meetings minimum 2 x Annually | Foster ongoing communication with affected groups to ensure their perspectives and concerns are heard and addressed. This helps identify unanticipated challenges early. |
| **Adjusting and continuous Improvement** | | Use the insights gathered from monitoring to make necessary adjustments to the strategy, ensuring it remains effective in promoting equality and meeting the needs of all individuals impacted. |

## Step 5 – Sign off

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| **Strategy, policy, plan, project or service owner or Work Programme Lead*** | |
| Name: Philip Waugh | Date: 5/12/25 |
| **EIA Lead (the person completing this form)** | |
| Name: Philip Waugh | Date 5/12/25 |
| **Director or Senior Responsible Owner *** . | |
| Name: Stuart Moore | Date: 5/12/25 |

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*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.