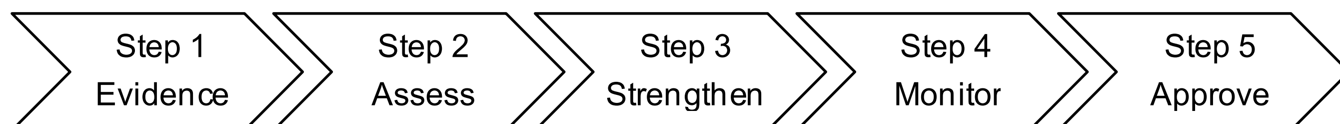
Equality Impact Assessment

Cardiac Service Change

March 2026

EQUALITY IMPACT ASSESSMENT



<table>
<tr><td colspan="4">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 disadvantage, propose steps to strengthen against that disadvantage and record and monitor the success of those strengthening actions.</td></tr>
<tr><td>Name of your policy/plan/project</td><td colspan="3">Cardiac Integration Programme</td></tr>
<tr><td>Person completing the assessment</td><td colspan="3">Elliot Shuttleworth (August 2021)
Sam Burnett (March 2026)</td></tr>
<tr><td>Date your policy, plan or project is designed</td><td colspan="3">2020/21 & 2023/24</td></tr>
<tr><td>Date your equality analysis is completed</td><td colspan="3">August 2021 and updated Feb 2025.
Further update in March 2026.</td></tr>
<tr><td>Does this template form part of a business case or investment proposal submission?</td><td>Yes</td><td>No</td><td>Unsure</td></tr>
<tr><td>Are you completing this because of organisational change?</td><td>X</td><td></td><td></td></tr>
<tr><td>Is there another reason for you completing this template – e.g. renewal of a current service/change to current service – please specify:</td><td colspan="3">As part of the Single Hospital Service, the Cardiac Integration programme is a key programme of work to be undertaken in line with the MFT Clinical Service Strategy. Documentation is required to seek commissioner approval.</td></tr>
</table>

Please read the accompanying guidance paper before you complete this form. Where you see **(Refer to guidance document)**, there is a relevant section in the guidance to help you.

Initial screening assessment

What are the main aims, purpose of your policy, plan or project?
The main aims of the integration work are to create a single service for cardiology and cardiac surgery, working across multiple sites with rapid progress to develop Wythenshawe as the "hub" for cardiac surgery, TAVI and EP in particular.
Who will benefit? The proposed change will benefit patients across a broad spectrum of safety, patient experience. There are also benefits to the Cardiac workforce to work more consistently across sites as one service.

It is part of a wider programme or strategy (for example, the locality plan or MHCC operational plan)?

The Integration programme is part Single Hospital Service, the Cardiac Integration programme is a key programme of work to be undertaken in line with the MFT Clinical Service Strategy. In the short term, this means bringing the teams from Wythenshawe, MRI and (in time) NMGH together to develop a one-team culture and implementing common standards, pathways and protocols across all locations. Moreover, a single cardiac surgery, TAVI and EP hub at Wythenshawe will provide economies of scale to help enable delivery of GIRFT standards and better on-call rotas along with other benefits. Benefits also include the reduction in service delivery costs as part of the GM strategy to improve the financial position. The Cardiac Integration Programme has now been concluded and ratified as business as usual.

(Refer to guidance document) 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 BAME men with diabetes)

Service changes are aimed at promoting improved patient outcomes. Greater Manchester (GM) has significantly worse cardiovascular outcomes than the North West and the rest of the country: Manchester ranked 386th out of 386 UK local authorities in 2014-16 for age-standardised death rates from cardiovascular disease. The early mortality rate for coronary heart disease was 84.8 per 100,000 in Manchester in 2014-16, compared to 39.4 in England. GM continues to have some of the UK's highest levels of health inequalities in 2025.

There are several GM initiatives and programmes aimed at improving the quality of cardiac care in the region. Devolution Manchester has an objective to reduce the number of individuals dying from heart disease by 600 by 2021. Although progress towards this objective has proved challenging, aims such as these that are key to driving positive momentum and inspiring system collaboration.

Manchester has a high population and huge variances in terms of equality specifically in terms of socio-economic discrepancies.

(Refer to guidance document) What existing sources of information will you use to help you identify the likely equality 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).

- MFT consultation documents – Single Hospital Service
- MFT Cardiac Clinical Service Strategy
- Health Innovation Manchester – Cardiovascular research domain
- Devolution Manchester
- Local/national data comparisons
- Trust internal data regarding Cardiac waiting list
- Improved access to care from all protected groups

(Refer to guidance document) 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. EAs' 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 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
Information is collected on the Trust PAS system. From review of this data, gaps are noted with information not captured in the following protected characteristic groups; • Disability • Gender reassignment • Pregnancy and maternity • Sexual orientation • Carers In addition, whilst information is provided in the remaining protected characteristic groupings there are a significant number of lines where information has not been provided – we are unsure if this may have been an intentional response to the question and it would be helpful to understand this.	More robust data is required to support the analysis at a detailed level but some data is available through health inequalities measures and more generic data collection.	Data to be examined where possible for granular measures.

Involvement and consultation

(Refer to guidance document) 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 if staff are affected, and consider socio-economic impact as well as community and third sector groups for different protected characteristics. If there potential for different impact across different neighbourhoods, consult your neighbourhood leads).

Consultation and involvement that has taken place, who with, when and how?
The changes within the Cardiac Integration Programme have always been planned as part of the Single Hospital Strategy, however some of this work has been accelerated during the Covid pandemic. An EQIA engagement session was held to discuss the changes with VCSE representatives on 13 September 2021. Further engagement work has been carried out throughout 2023/24 & 24/25 for single surgical site moves. Patient engagement work carried out and captured in PCBC.

Summary of the feedback from consultation:
 	
The feedback supporting the Single Hospital Strategy supported the move to offer single managed services with cross site working and flexibility across site for patients.
 	
Key feedback points from the EQIA session:
• Benefits were noted in respect of the merger and service changes having helped to reduce variations in quality of care, high volume centres lead to improved outcomes, better recruitment and retention of staff and 7-day services
• Transfers and Transport
    o Potential for additional travel costs were noted – previously patients / families / careers would have attended MRI and they will now attend at Wythenshawe for their surgery / procedure
    o However, it was acknowledged this is an inpatient service and much of the outpatient activity will still take place at the patient's local hospital
• Impact on dementia patients
• Impact on patients, families where English is not their first language – need multiple languages and can use symbols, access to interpreters needed

For significant 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 • EQIAs to incorporate feedback from the session and be shared with attendees for review and amendments as necessary • Complaints/compliments – review of feedback received and engagement as required • Representation from all hospital sites across governance and hospital boards Via the ongoing commissioner approval process

Step 2 - Assessing impact and opportunities to promote equality

and human rights

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.

N/A

What barriers have you identified as being potentially disadvantaged by your proposals? Add the impacts in the box next to the group. (E.g. we have found that working age people in particular are not taking up our services because of our opening hour restrictions)

The barriers / potential adverse impacts will need to be identified through the relevant programme workstreams and products. Neighbourhood statistics and COVID-19 analysis will help inform this analysis, along with the programme involvement and consultation work that takes place. The table below highlights some high-level considerations which will be important to take account of across the programme.

Age	There were 8,628 catheter lab procedures completed between 1st January 2025 and 31st December 2025, of these 7,476 (86.65%)were aged 50 or over which again reflects older patients more likely to be affected. Furthermore, there were 350 TAVI procedures for the same period and 55.14% were over 50.Cardiac disease is significantly more prevalent in older populations. Local service data shows that the majority of cardiac procedures are undertaken in patients aged 50 and over, reflecting national evidence that cardiovascular disease risk increases with age. The consolidation of cardiac surgery, including TAVI, onto a single site at Wythenshawe may result in some older patients travelling further for surgery compared to the previous dual-site model. Travel time analysis undertaken as part of the Pre-Consultation Business Case shows that the increase in car travel time is modest, with a median increase of just over three minutes for patients who previously accessed Manchester Royal Infirmary. Older patients may also be more likely to have mobility issues, frailty or cognitive conditions such as dementia, which could make travel more challenging. To mitigate this, patients will continue to be contacted in advance of surgery to confirm attendance arrangements and identify any support needs. Patients undergoing surgery or TAVI are also allocated a named nurse during the pre-operative process who can support patients and families with planning for admission and travel arrangements where required. Overall, while travel may present a practical consideration for some older patients, the consolidation of cardiac surgery into a larger specialist centre is expected to improve service resilience, reduce variation in care and support better outcomes for all patients, including older people. The adoption of a single surgical site has not identified any negative impact to this group.

Disability	
	Complete disability data is not consistently recorded within existing patient datasets, which limits the ability to undertake detailed quantitative analysis for this group. Due to limitations in the current dataset, disability status is not consistently recorded, which restricts the ability to undertake detailed equality analysis for this protected characteristic. However, it is recognised that people with disabilities may experience additional barriers when travelling to hospital services. To address this, the service will develop improved approaches to recording disability status and individual access needs within patient administration systems. This will include promoting the consistent use of the Reasonable Adjustment Flag in line with the Accessible Information Standard set out by NHS England, ensuring that patients' communication and accessibility needs are identified, recorded and shared appropriately across services. Improved recording will enable the service to better understand the needs of patients with disabilities and to monitor any potential impacts arising from the service change. Data will be reviewed through service governance processes to ensure that any emerging barriers to access are identified and addressed, and that appropriate reasonable adjustments are made to support equitable access to cardiac surgery services. The proposed model may result in some patients with disabilities travelling further to access cardiac surgery. Travel analysis demonstrates that the increase in car travel time is generally minimal, although public transport journey times may be longer. To mitigate potential impacts, the service will continue to provide individualised support through the pre-operative pathway. Patients are assigned a named nurse prior to surgery who can identify access requirements and ensure appropriate arrangements are in place before admission. The Heart Centre at Wythenshawe Hospital provides accessible facilities including designated disabled parking spaces close to the entrance. Patients will also be contacted before their procedure to ensure there are no access barriers and to discuss transport or support needs where required. Based on the available evidence, no disproportionate negative impact on disabled patients has been identified, although access considerations will continue to be monitored through service governance processes.

Gender	Cardiac conditions statistically affect more men than women. • Of the 1,345 cardiac surgery patients Jan 2025 – Dec 2025, 1,007 (74.87%) were male and 338 (25.13%) female • Of the 350 TAVI procedures between Jan 2025 – Dec 2025, , 193 were male (55.14%) and 157 female (44.86%) A focus will be placed on supporting national campaigns to support any gender inequalities i.e. the Cardiovascular Disease Prevention programme within the NHS Long Term Plan. Cardiac conditions are known to affect men more frequently than women. Local service data shows that a higher proportion of cardiac surgery patients are male, which reflects national epidemiology of cardiovascular disease. The proposed service change relates to the location of cardiac surgery rather than the eligibility criteria, referral pathways or treatment protocols. These elements of the patient pathway remain unchanged. As a result, the consolidation of cardiac surgery onto a single site is not expected to create differential access or outcomes between men and women. The service will continue to support wider NHS programmes aimed at addressing gender inequalities in cardiovascular disease prevention and treatment.
Race	Of the 2723 patients submitted for Cardiac Surgery during a 3 years period 2018-2020, 137 of these patients were from Asian/African heritage. Of the 1211 cardiac surgery patients between September 20 – August 21, there are noticeable gaps in the race / ethnicity information with over 50% of patients being either unknown, not stated or specified. Ethnicity data within the current patient dataset is incomplete, with a significant proportion of records recorded as “unknown” or “not stated”. To strengthen the analysis and ensure potential differential impacts are appropriately monitored, the service will work to improve the completeness and accuracy of ethnicity coding within patient administration systems. This will enable the service to monitor access, waiting times and clinical outcomes disaggregated by ethnicity to identify and respond to any emerging inequalities. In addition, the service will ensure that patient communication and language needs are identified at the earliest possible stage in the referral and pre-operative pathway. Where language needs are identified, interpretation and translation services will be arranged in advance of attendance to support equitable access to information and care. This approach will align with the guidance set out by NHS England in the Improvement Framework: Community Language Translation and Interpreting Services. Given current limitations in service-level ethnicity data, the programme will also consider available population-level data relating to race, ethnicity and language needs within the catchment population to inform equality monitoring. This may include use of the NHSE Language Barrier Population Tool to better understand the prevalence of language barriers across local communities and to help assess whether changes in travel

	requirements could disproportionately affect particular population groups. These actions will support ongoing monitoring through programme governance processes to ensure that any potential inequalities relating to race, ethnicity or language needs are identified and addressed. Evidence from organisations such as the British Heart Foundation indicates that people from some ethnic minority groups, particularly Asian and African heritage communities, have a higher risk of developing cardiovascular disease. The proposed change does not alter referral pathways or eligibility for cardiac surgery and therefore is not expected to create a differential impact based on ethnicity. Cardiac care will continue to be delivered through the established network model, meaning that most elements of the pathway remain local to patients. The service will continue to provide interpretation and translation services to support patients whose first language is not English, helping to ensure equitable access to information and care.
Religion/ belief	Of the 1211 cardiac surgery patients between September 20 – August 21, there are noticeable gaps in the religion data information with over 60% of patients being either marked as 'not specified' or no information provided. Available patient data on religion or belief is incomplete, with a high proportion of records recorded as "not specified" or missing. This limits the ability to fully assess potential impacts for this group. The service will work to improve the completeness and accuracy of recording of religion and belief information within patient administration systems. Improved data quality will enable the service to monitor patient access, experience and clinical outcomes disaggregated by religion or belief through routine governance processes, helping to identify and address any potential differential impacts over time. However, we have not identified and adverse impact for patients and the service will continue to accommodate religious and cultural beliefs e.g. provision of multi faith prayer rooms. There is no evidence to suggest that the consolidation of cardiac surgery onto a single site would negatively impact individuals based on religion or belief. The service will continue to accommodate religious and cultural needs where possible, including access to multi-faith prayer spaces and support for patients observing religious practices during their hospital stay. The adoption of a single surgical site has not identified any negative impact to this group.
Sexual Orientation	Sexual orientation data is not routinely recorded within the available patient datasets for cardiac surgery services, meaning that detailed analysis for this protected characteristic is not possible.

	However, the proposed service change relates only to the physical location of surgery and does not change referral criteria, clinical decision-making processes or access to treatment. No evidence has been identified to suggest that the proposal would adversely affect individuals based on sexual orientation.
Transgender	Information relating to gender reassignment is not routinely captured within the available patient datasets. As a result, detailed analysis for this protected characteristic is not possible. The proposed service change relates solely to the location of cardiac surgery and does not alter the way in which patients are referred, assessed or treated. There is therefore no evidence that the proposal would result in differential treatment or access for individuals who are transgender or undergoing gender reassignment. The adoption of a single surgical site has not identified any negative impact to this group.
Carer	The proposed service change may result in some carers needing to travel further to support patients attending for surgery. This may create additional practical or financial considerations for a small number of families. To support carers, the service will provide clear information about the location of the service, travel options and key contacts for support. Patients will also be contacted in advance of admission to ensure arrangements are understood and to identify any potential barriers to attendance. As cardiac surgery is typically an inpatient procedure that occurs relatively infrequently within a patient's lifetime, the impact on carers is expected to be limited.
Socio-economic status	Patients with a disadvantaged socio-economic status may be financially more disadvantaged if they must travel further to Wythenshawe for elective surgery rather than this being offered at both sites. However, the benefits of a single site outweigh this potential impact and alternative arrangements are available for those with hardships and travel to hospital. Greater Manchester has significant levels of socioeconomic deprivation, which is strongly associated with higher rates of cardiovascular disease and poorer health outcomes. Travel analysis undertaken as part of the business case examined the impact of the service change across deprivation groups. This analysis found that increases in car travel time were broadly similar across all deprivation deciles, indicating that the change does not disproportionately affect more deprived communities. While some patients may face additional travel costs if they previously attended Manchester Royal Infirmary, the overall increase in travel time by car is relatively small. The benefits of a single specialist centre include improved workforce resilience, reduced variation in care and better compliance with national standards, which are expected to improve outcomes for the population overall.

	Patients from more deprived backgrounds may be more likely to experience financial barriers when travelling to hospital appointments or procedures. The service will ensure that patients and carers are made aware of available financial support for travel where they may be eligible. This will include providing information about the Healthcare Travel Costs Scheme, which allows eligible patients to claim reimbursement for travel costs to attend NHS treatment. Information about this scheme and other available support will be communicated through appointment letters, pre-operative discussions and patient information materials, and staff will be encouraged to signpost patients who may require assistance. In addition, the service will seek to monitor patient access, experience and clinical outcomes by socio-economic status where possible. This may include analysis of activity and outcomes disaggregated by Index of Multiple Deprivation deciles to identify whether the service change results in any differential impact for patients living in more deprived communities. Findings will be reviewed through service governance processes to ensure that any emerging inequalities are identified and addressed.
Pregnancy or maternity	Patient information is not available to support this analysis, however no negative impact has been identified as described below. Pregnancy places extra strain on the cardiovascular system, so in very rare cases, maternity units may need urgent advice or intervention from a cardiac surgeon. If cardiac surgery is consolidated onto the Wythenshawe site, the main risks relate to time, access and emergency escalation. St Mary's Hospital provides specialised tertiary maternity services for Greater Manchester and is the lead centre for maternity cardiology across the North West. Only a very small number of maternity patients each year require input from cardiac surgery or cardiac anaesthesia. These cases are typically anticipated in advance and are jointly planned to ensure the safest location, clinical team and resources are available. Cardiac surgery teams at MRI provide this specialist support, and this will continue to be maintained through a 24/7 on-call consultant model. Clear transfer protocols, joint pathways and communication structures will be developed to ensure that maternity services retain rapid access to the appropriate expertise.
Marriage /civil partnership	Patient information is not available to support this analysis, however no negative impact has been identified.
Other	Patient information is not available to support this analysis, however no negative impact has been identified.

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.

Despite the option to only have elective surgery at Wythenshawe, this can be justified in terms of the improved patient experience patients will experience by having elective surgery on one site. In terms of the distance between the Wythenshawe site and the MRI site this is an 8-mile difference which by car is a travel time of 20-25 minutes. The site is also well connected by road and public transport, with both bus and tram links supporting ease of access for most patients.

Patients will be contacted in advance of their appointment to confirm they can travel and to ensure they are directed to the right place for their care. Where travel may present a challenge, transport can be coordinated through existing routes such as primary care teams, to minimize barriers to attendance. While this may only be required for a small number of patients, it remains important that such mitigations are available so all patients can access the specialist site when needed.

Overall, a single surgical site offers improved and more efficient care for surgery individual patients may access rarely in their lifetimes. Patient engagement carried out shows that travel time is low on the list of considerations for patients when it comes to cardiac surgery. However, travel implications must still be considered as part of the EQIA to fully understand the potential differential impact on patients who may not have the means to travel easily to the Wythenshawe site.

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 changes mean that all patients experience the same service with a higher quality service. This includes efficient use of resources, with a strong cardiac presence across all sites and therefore the reassurance of expertise across sites and a consistent service to all.

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.

Impacts have previously been identified within this document.

The service is aiming to be an improved service with better patient outcomes.

Please provide details of whether or not you will consult on the proposed changes, particularly with disabled people, and if you do not plan to consult, please provide the rationale behind that decision.

The proposed changes have been through an internal consultation and further engagement processes. Additionally, the proposed change will go through a full public engagement if the PCBC moves to stage-3 of the national process.

Step 3 – Strengthening your policy plan or project

Please use the table below to document your strengthening actions.

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
Information gaps – there is no information available in several protected characteristics groupings, furthermore where information is provided on the remaining groupings, there are a significant number of gaps	Improved data gathering Establish a project to implement the improvements identified within the EQIA relating to reporting of information for protected characteristic groups. This will be project managed within the division and monitored via existing governance and operation structures.	Cardiac Divisional Management
Age - Having elective surgery at the Wythenshawe site alone may mean older patients have more difficult or longer journeys to attend for surgery.	Individuals will continue to be contacted prior to attending to ensure patients have access and have the right treatment at the right place- a named nurse is assigned at pre-op stage. Specific signposting, as described within the EQIA, will be communicated to patients to ensure available resources are in place. Transport considerations will be addressed as part of the dialogue.	Cardiac Divisional Management
Disability - Having elective surgery at the Wythenshawe site alone may mean patients with disabilities have more difficult or longer journeys to attend for surgery.	Individuals will continue to be contacted prior to attending to ensure patients have access and have the right treatment at the right place- a named nurse is assigned at pre-op stage. Transport and access considerations will be addressed as part of the dialogue Specific signposting, as described within the EQIA, will be communicated to patients to ensure available resources are in place.	Cardiac Divisional Management

Adverse impact	Proposed action	Person responsible
Gender - Cardiac conditions statistically affect more men than women	There is no current evidence to suggest a single surgical site would negatively impact this category.	N/A
Race - Patients of Asian heritage are more likely to suffer with heart disease	Establish a project to implement the improvements identified within the EQIA relating to reporting of information for protected characteristic groups. This will support with identification of improvements required within the service relating to access, experience and outcomes for patients.	Cardiac Divisional Management
Transgender It is important recognise the increased prevalence of cardiac surgery as identified in the gender analysis above and the potential implications for transgender patients.	There is no current evidence to suggest a single surgical site would negatively impact this category.	N/A
Carers **Costs** - The service change may result in additional travel time and costs for carers. **Information** - The service will need to ensure that carers are fully informed of the new service arrangements	The service will need to ensure that carers are fully informed of the new service arrangements with clear information provided, contact details in case of questions etc. and travel options Specific signposting, as described within the EQIA, will be communicated to patients to ensure available resources are in place.	Cardiac Divisional Management
Socio-economic status - Patients with a disadvantaged socio-economic status may be financially more disadvantaged if they have to travel further to Wythenshawe for elective surgery rather than this being offered at both sites.	Patients will also be contacted prior to attending to ensure patients have access and have the right treatment at the right place. Establish a project to implement the improvements identified within the EQIA relating to reporting of information for	Cardiac Divisional Management

Adverse impact	Proposed action	Person responsible
	protected characteristic groups. This will support with identification of improvements required within the service relating to access, experience and outcomes for patients.	

(Refer to guidance document) Describe how you could further promote equality of opportunity as a result of your analysis. What action/s do you recommend and when? Please provide details.

The service will continue to promote equality of opportunity by ensuring that all patients are able to access cardiac surgery services regardless of protected characteristics or personal circumstances. As part of this, the service will improve the recording of key demographic characteristics, including disability status, ethnicity, religion/belief and language needs within patient administration systems. Improved data quality will enable the service to monitor patient access, waiting times, experience and outcomes across different demographic groups and identify any emerging inequalities. The service will also ensure that patient communication and accessibility needs are identified early in the referral and pre-operative pathway. This includes the use of reasonable adjustments, interpretation services where required and proactive engagement with patients to identify any barriers to attendance. These actions will be implemented through service operational processes and monitored through programme governance arrangements, with periodic review of equality data as part of routine service monitoring.

(Refer to guidance document) Describe how you could further promote human rights principles as a result of your analysis. What action/s do you recommend and when? Please provide details.

The service will continue to uphold human rights principles, including fairness, dignity, respect and equitable access to healthcare. Patients will be supported to access services through clear communication, appropriate interpretation and translation services and the identification of any individual accessibility requirements prior to attendance. Where patients may experience barriers to access, for example due to disability, language needs or travel considerations, the service will work with patients and carers to identify reasonable adjustments and appropriate support to enable them to receive care safely and with dignity. The service will continue to work with equality and diversity leads and follow organisational policies to ensure that the delivery of cardiac surgery services aligns with wider NHS commitments to equality, inclusion and human rights. Compliance with these principles will be monitored through programme governance and quality assurance processes.

(Refer to guidance document) Describe how you could further reduce socio-economic disadvantage as a result of your analysis. What action/s do you recommend and when? Please provide details.

The service recognises that patients from more deprived communities may face additional barriers when accessing hospital services, including travel costs or logistical challenges. To mitigate this, patients will be provided with information about available financial support for travel where they may be eligible, including the Healthcare Travel Costs Scheme. Patients and carers will also be supported through pre-operative communication to identify and address any potential barriers to attending appointments or procedures.

In addition, the service will seek to monitor patient access, experience and clinical outcomes by deprivation levels where possible. This may include analysis of service activity using the Index of Multiple Deprivation to ensure that the service change does not result in disproportionate impacts on patients living in more deprived communities.

These actions will be implemented through service processes and reviewed through programme governance and quality monitoring arrangements.

(Refer to guidance document) Describe how you could further promote social value as a result of your analysis. What action/s do you recommend and when? Please provide details.

The cardiac integration programme aims to improve population health outcomes by strengthening specialist cardiac services and ensuring consistent standards of care across the region. By developing a single, resilient surgical service with shared clinical standards, the programme will support improved patient outcomes, workforce sustainability and more efficient use of healthcare resources.

The service will also continue to engage with patients, carers and community stakeholders to understand their experiences and identify opportunities for improvement. Feedback from patient experience data, complaints, compliments and engagement activities will be used to inform ongoing service development.

Promoting transparent communication, inclusive engagement and equitable access to services will help ensure that the programme delivers wider social value for the communities served by the organisation.

Step 4 – Monitoring and review

You are legally required to monitor and review the proposed changes after implementation 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.

[The identification of potential adverse impacts and of actions to remove or mitigate these impacts will need to take place throughout the relevant parts of the programme (see section 4). This strategic EIA will be used as a mechanism to guide the consideration of equality, diversity and inclusion throughout the programme. It will be used as a reference point to regularly review progress of the various equality assessments, impacts arising and associated mitigations through the lifetime of the strategy. At key points (e.g. Outline Business Case, Full Business Case) the strategic EIA will be updated to illustrate what mitigating actions have been identified in the programme and the actions taken in response.

What	When	How
Cardiac integration programme	TBC – programme governance arrangements are being reviewed	Actions monitoring
The governance arrangements for the cardiac integration programme are currently being reviewed – the quality impacts associated with these service changes and the wider integration programme will be monitored through the revised structures.		

Step 5 – Sign off

Please note that this sign off relates to the endorsement of the final working draft of the strategic EIA being taken through programme governance (NM Programme Board). The strategic EIA may be revised following the NM Programme Board, at which time a final version will be produced.

Policy, plan, project or service Owner or Work Programme Lead*	
Elliot Shuttleworth / Nicola Lyons	Divisional Directors, Cardiac
EA 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.	
Heather Done	Business Support Manager
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.	
Elliot Shuttleworth / Nicola Lyons	Divisional Directors, Cardiac

*By signing off your EA 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 EA will also need to be copied to hrtransactions.manchester@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.