Equality Impact: Screening and Assessment Form

Section 1: Policy details - policy is shorthand for any activity of the organisation and could include strategies, criteria, provisions, functions, practices and activities including the delivery of our service.	
a. Name of policy or practice (list also any linked policies or decisions)	Implementation of a New Response Model for the Service
b. Name of department	ICT Development
c. Name of Lead	David Kinnaird
d. Equality Impact Assessment Team [names, job roles]	David Kinnaird (Project Manager), Paul Cook (ICT Development Officer), Steph Jones (Paramedic), Project Team
e. Date of assessment	October 2016 – January 2017
f. Who are the main target groups / who will be affected by the policy?	Patients/ Public /ACC Call Takers/ACC Dispatchers/ACC Clinical Advisors /Paramedics/Technicians/ SAS Managers
g. What are the intended outcomes / purpose of the policy?	To more quickly and accurately identify patients with Immediate Life Threatening (ILT) conditions and dispatch the best available resource (both physical and human) to the patients, resulting in more lives being saved. To safely and more effectively identify and send the most appropriate resource first time for patients with non-ILT conditions, resulting in better overall clinical outcomes.

h. Is the policy relevant to the General Duty to eliminate discrimination? advance equality of opportunity? foster good relations?	The model enhances existing capability to deliver Service based exclusively on clinical need by • improving the identification and prioritisation of clinical need • improving the provision of human and physical resource based on that clinical need Basing Service Delivery decisions exclusively on clinical data removes possible bias against any protected characteristic. In so doing, good relations are fostered with all parties – patients, public and staff – as both clinicial and operational benefits are gained.
If yes to any of the three needs complete all sections of the form (2- 7) If no to all of the three needs provide brief detail as to why this is the case and complete only section 7 If don't know: complete sections 2 and 3 to help assess relevance	Yes

Section 2: Evidence, consultation and involvement **Please list the available evidence used to assess the impact of this policy, including the sources listed below. Please also identify any gaps in evidence and what will be done to address this.**			
a. Previous consultation / involvement with community, including individuals or groups or staff as relevant. Please outline details of any involvement / consultation, including dates carried out and protected characteristics			
Details of consultations - where, who was involved	Date	Key findings	Protected characteristics
As part of standard Emergency Call Handling process	2015 - 2016	Patient age is gathered as part of the process of receiving any emergency call. This is used solely to assess clinical risk factors and provide the commensurate clinical response. The Service has partnerships with local Falls Teams where available. The criteria for referral to such teams includes consideration of patient age, and is determined by the Fall Team policy rather than Service policy.	Age
n/a			Disability
n/a			Gender reassignment
As part of standard Emergency Call Handling process	2015 - 2016	Patient gender is gathered as part of the process of receiving any emergency call. This is used solely to assess clinical risk factors and provide the commensurate clinical response.	Gender / sex
n/a			Marriage / civil partnership *
As part of standard Emergency Call Handling process	2015 - 2016	Pregnancy is a consideration in certain clinical situations. In these situations only, this information is gathered and used solely to assess clinical risk factors and provide the commensurate clinical response.	Pregnancy / maternity
n/a			Race

n/a			Religion / belief
n/a			Sexual orientation

The Service carried out an extensive review of clinical data – almost 500,000 records, it was the largest review of its kind undertaken in the UK and builds on similar pilots in Wales and England. Consultations with relevant external stakeholders: Wider NHS - NHS CEOs - GP Out of Hours Group - Medical Directors Group - Cardiovascular Advisory Group - Scottish General Practitioners Committee - All health boards including NHS24 Public Partnerships Forums/Public etc - Scottish Health Council - Shetland / Mull / Iona PPF - Community First Responder	2015 - 2016	The Service is moving to a New Response model which more closely matches the help we send patients with their clinical conditions. SAS have reviewed all clinical triage outcomes and their related response levels to better reflect patient needs. This review was conducted in collaboration with and approved by a variety of stakeholders, independent clinicians, and Scottish Government. Existing equity of access to the Service (free 999 line, technology for access by speech / hearing impaired users, virtually distributed call handling, nationwide mapping and address database technology, etc) is unaffected by the new model.	Cross cutting - e.g. health inequalities - people with poor mental health, low incomes, involved in the criminal justice system, those with poor literacy, are homeless or those who live in rural areas. Other?

Schemes Political - Scottish Government - All MSPs - Relevant MPs - Scottish Parliament Information Centre Third sector - British Heart Foundation Scotland - Chest Heart & Stroke Scotland Emergency Services - Police Scotland - Scottish Fire & Rescue Service Review by external multi-disciplinary clinical advisory group, consisting of specialist consultants, professors etc.			

	The Service carried out an extensive review of clinical data from historical calls, the analysis informed the business case for this project. The Clinical team manage and publish all the evidence. Extensive consultation with internal and external stakeholders was conducted using this evidence base.
b. Research and relevant information	See above
c. Knowledge of policy lead	Neil Sinclair / Steph Jones, Paramedics, working under Dr Jim Ward, Clinical Director.
d. Equality monitoring information -- including service and employee information	
e. Feedback from service users, partner or other organisations as relevant	Feedback actively sought from staff during training sessions, via dedicated email address and open conference call Q&A sessions. Feedback from consultations with patient groups (such as Mull & Iona, Shetland). Feedback following media release on social media and through conventional channels. Scottish Government heavily involved from the start.
f. Other	-
g. Are there any gaps in evidence? Please indicate how these will be addressed	
Gaps identified	1. As this project involves the first example worldwide of this type of data analysis, the reliability of the modelling carries a degree of uncertainty. 2. The current lack of clinical data available to the Service after transfer of patients to a definitive care environment (no external Information Services Department links) means modelling is based solely on outcome at handover. Ideally a full patient journey could be analysed.

Measure to address these; give brief details. Further research? Consultation? Other	1. Continual review of the clinical data throughout the pilot phase and beyond the potential permanent model acceptance, in consultation with aforementioned external parties. 2. The Service is currently working with ISD to build a system that transfers information between hospital and SAS systems, allowing the future analysis of end-to-end clinical data.
Note: specific actions relating to these measures can be listed at section 5	

Section 3: Analysis of positive and negative impacts **Please detail impacts in relation to the three needs specifying where the impact is in relation to a particular need - eliminating discrimination, advancing equality of opportunity and fostering good relations**			
Protected characteristics	**i. Eliminating discrimination**	**ii. Advancing equality of opportunity**	**iii. Fostering good relations**
Age	**Yes**		
Positive impacts			
Negative impacts			
Opportunities to enhance equality	The new model reinforces the Service's commitment to providing timely, appropriate responses based solely upon the clinical need of the patient. Use of e.g. Falls Pathways enhances Service provision for vulnerable age groups.		
Disability	**Yes**		
Positive impacts			
Negative impacts			
Opportunities to enhance equality	The new model reinforces the Service's commitment to providing timely, appropriate responses based solely upon the clinical need of the patient.		
Gender reassignment	**Yes**		
Positive impacts			
Negative impacts			
Opportunities to enhance equality	The new model reinforces the Service's commitment to providing timely, appropriate responses based solely upon the clinical need of the patient.		
Gender / sex	**Yes**		
Positive impacts			
Negative impacts			
Opportunities to enhance equality	The new model reinforces the Service's commitment to providing timely, appropriate responses based solely upon the clinical need of the patient.		
Marriage / civil partnership	**Yes**		
Positive impacts			

Negative impacts	
Opportunities to enhance equality	The new model reinforces the Service's commitment to providing timely, appropriate responses based solely upon the clinical need of the patient.
Pregnancy / maternity	**Yes**
Positive impacts	
Negative impacts	
Opportunities to enhance equality	The new model reinforces the Service's commitment to providing timely, appropriate responses based solely upon the clinical need of the patient.
Race	**Yes**
Positive impacts	
Negative impacts	
Opportunities to enhance equality	The new model reinforces the Service's commitment to providing timely, appropriate responses based solely upon the clinical need of the patient.
Religion / belief	**Yes**
Positive impacts	
Negative impacts	
Opportunities to enhance equality	The new model reinforces the Service's commitment to providing timely, appropriate responses based solely upon the clinical need of the patient.
Sexual orientation	**Yes**
Positive impacts	
Negative impacts	
Opportunities to enhance equality	The new model reinforces the Service's commitment to providing timely, appropriate responses based solely upon the clinical need of the patient.
Cross cutting - e.g. health inequalities people with poor mental health, low incomes, involved in the criminal justice system, those with poor literacy,	**Yes**

are homeless or those who live in rural areas. Other	
Positive impacts	**Eliminate discrimination** Healthcare Professional calls for a given diagnosis previously gained a different clinical response from a patient with the same diagnosis calling on 999. The new model delivers equity of Service regardless of the method by which the patient contacted the Service. Previously, the success or failure of the Service was measured on response times. This creates the risk of introducing bias to patients within reach (rather than patients in need), and of introducing focus on response time improvements rather than person-centred improvements. The new model removes the risk of such discrimination by using clinical outcomes. By defining response characteristics (priority, resource etc) based upon a combination of consensus and inherited protocol, there was a risk of introducing unintentional cultural bias (American protocol) or personal bias (personal experience of consensus committee). In the new model, response characteristics are defined solely by clinical data, removing any such possible bias. The automation inherent with pre-determined attendance functionality eliminates a degree of human factors from resourcing decisions, enhancing equity of Service across and within regions. **Fostering good relations** • for all – due to faster identification of Immediately-Life-Threatening situations • for all – now a more clearly person-centred Service, focus on clinical need • for all – due to a realignment of Standard Operating Procedures as part of this project, particularly those relating to Rest Period and End of Shift, availability of resources has

	been more effectively balanced with patient need • with patients – due to better availability of resource for Immediately-Life-Threatening situations • with patients – due to reduced waiting times for the right resource • with patients – due to increased availability of the right resources giving increased access to alternative care pathways • with patients – due to reduction in inappropriate hospital admissions • with staff – due to better resource allocation, fewer diverts and stand downs, fewer occasions where backup needs to be requested
Negative impacts	Where appropriate, the arrival of a response where patients do not have immediately life-threatening conditions may take a little longer, in order to ensure the right resource attends. This change in intial response time will however result in quicker arrival at a place of definitive care - i.e. a net time saving, as the best resource will be chosen. Public communications have included this element as part of a wider picture of faster responses for Immediately-Life-Threatening situations. An identified requirement for a specific resource type or clinical skill-set may prove challenging in rural locations. Mitigation for this is embedded in both the 20:20 Workforce Vision (under which, for example, a Paramedic should be present on every resource) and in the Pre-Determined Attendance requirements themselves which describe permissible alternative resource provision. Communication of the new model in the media bears risk of misrepresentation, where the perception of risk is different to the proven clinical risk. For example, where clinical data shows a diagnosis to be low risk but that diagnosis is familiar to the public by emotive terminology such as ‘chest pain’. Media communications have been thoroughly reviewed to ensure such

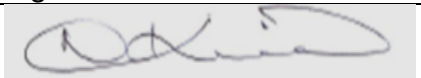
	misunderstanding or misrepresentation is minimised.
Opportunities to enhance equality	**Advance equality of opportunity** Call prioritisation and resource choice is now entirely based on a foundation of clinical data, stripped of any demographic information or protected characteristics. More patients will receive the clinical care they personally require in the necessary timeframe. One example of this is where a patient is experiencing chest pain after taking cocaine. Previously, such a patient received a lower priority than another patient experiencing the same chest pain without given cause, without clinical data to support this grading. Clinical data is now available to give all such patients the response level which meets their clinical need. Implementation of the project means we now have the framework within which to better understand patient demographics and alternative care pathways on a geographical basis. This can be refelected in our future fleet requirements.
Note: specific actions relating to these measures can be listed at section 5	

Section 4: Addressing impacts **Select which of the following apply to your policy and give a brief explanation - to be expanded in Section 5: Action plan**	
	Reasons
a. **No major change** - the EQIA shows that the policy is robust, there is no potential for discrimination or adverse impact and all opportunities to promote equality have been taken	Due to the mitigation arrangements noted above, at this stage no adverse impact has been identified and the impact of this change will be reviewed closely and a lessons learned and benefits realisation report/meeting will take place.
b. **Adjust the policy –** the EQIA identifies potential problems or missed opportunities and you are making adjustments or introducing new measures to the policy to remove barriers or promote equality or foster good relations	
c. **Continue the development and implementation of the policy without adjustments –** the EQIA identifies potential for adverse impact or missed opportunity to promote equality. Justifications for continuing without making changes must be clearly set out, these should be compelling and in line with the duty to have due regard. See option d. if you find unlawful discrimination. Before choosing this option you must contact the Equalities Manager to discuss the implications.	
d**. Stop and remove the policy** - there is actual or potential unlawful discrimination and these cannot be mitigated. The policy must be stopped and removed or changed. Before choosing this option you must contact the Equalities Manager to discuss the implications.	

Section 5: Action plan **Please describe the action that will be taken following the assessment in order to reduce or remove any negative / adverse impacts, promote any positive impacts, or gather further information or evidence or further consultation**					
Action	Output	Outcome	Lead responsible	Date	Protected characteristic / cross cutting issue*
ACC Training & Awareness	2-hour classroom session covering clinical, operational and technical elements	All ACC staff trained before working under new model.	S Jones, Clinical Effectiveness Lead; L Watters, National Systems Training & Development Manager	6-weeks prior to go live in November 2016	All
Communications – Internally	Information videos, leaflets, Q&A conference calls, presentations at Senior, Operational and Divisional Management team meetings, etc	All Operational staff aware before working under new model.	B Supple, Communications Manager	6-weeks prior to go live in November 2016	All
Communications - Externally	Information videos, leaflets, Press Releases, Annual Review presentation, etc.	All Stakeholders aware of new model before Go Live.	B Supple, Communications Manager	6-weeks prior to go live in November 2016	All
Ongoing Clinical	Evidence base	Clinical outcomes	Clinical Directorate	Ongoing	All

Review	created, modelm built based on clinical need, reviewed before pilot, continual monitoring after go-live , throughout pilot and after potential permanent adoption of model.	from Electronic Patient Reports, feedback from stakeholders, etc.			
External Project Report	Independent Clinical and operational review of project preparation, roll-out, impact, etc	To ratify substantive implantation of NRM for future use	Stirling University through Clinical Directorate	Winter 2017	All
* list which characteristic is relevant - age, disability, gender reassignment, gender / sex, marriage and civil partnership, pregnancy and maternity, race, religion / belief, sexual orientation or cross cutting issue e.g. poor mental health, illiteracy etc					

Section 6: Monitoring and review **Please detail the arrangements for review and monitoring of the policy**	
	Details
a. How will the policy be monitored? Provide dates as appropriate	Ongoing Clinical Review of outcomes by Clinical Directorate via exisiting mechanisms and as a special focus of the clinical team.
b. What equalities monitoring will be put in place?	Will continue to be a fundamental element of SAS operations
c. When will the policy be reviewed? Provide a review date.	Before go-live, ongoing throughout pilot; November 2017 final report date; SAS Clinical Directorate holds responsibility for ongoing patient safety, governance and clinical effectiveness as part of regular processes.

Section 7: Sign off **Please provide signatures as appropriate**			
Name of Lead	Title	Signature	Date
David Kinnaird	**Head of ICT Projects**		**27/01/2017**
Completed form: copy of completed form to be retained by department and copy forwarded to Equalities Manager for publication on Service website			
Provide date this was sent	**27/01/17**		