**Equality Impact Assessment including Fairer Scotland Duty and Children’s Rights and Wellbeing Impact Assessment**

Discrimination is usually unintended, for example, in the design of a new policy a one size fits all approach may be applied with the intention to be fair to everyone but what this actually does in practice is apply differential impacts on different groups of people.

The **Equality Impact Assessment (EQIA)** process is an evidence based approach designed to help organisations ensure that policies, practices, procedures, service change or redesign and decision-making processes are fair, equitable and that they don’t present barriers to participation or disadvantage to any protected groups. The equality impact assessment is used to identify any disadvantage and take appropriate steps to mitigate, or at least minimise, this. You should start the EQIA process at the outset and continue throughout the process; don’t wait until the end when a decision has been made. Below are steps to consider to support filling in your EQIA.

**Step 1 - Identify what is being assessed.** You need to be clear what is being assessed and consider what impact this will have and on which groups.

**Step 2 -** **Give details about the policy.** You need to be clear of the purpose at this stage, what are the benefits and who are the stakeholders.

**Step 3 - Gather and analyse data and information and engagement.** You will need to gather evidence to inform your Equality Impact Assessment. This may come from your stakeholder group(s).

**Step 4 –** **Assess Impact.** You need to think about what impact it will have on different groups in our community/workforce. Continue to work with your stakeholders to gain ‘lived experience’ impacts.

**Step 5 – Have you identified any adverse impacts.** You need to think about what can be done to mitigate or minimise the adverse impacts.

**Step 6 – Send EQIA to Equality and Diversity Adviser for publication**. NHS Ayrshire & Arran has an obligation to publish the results of all our equality impact assessments.

In 2018, the **Fairer Scotland Duty** became law and this looks at the impact of socio-economic disadvantage. NHS Ayrshire & Arran have incorporated this into our equality impact assessment process. It should be borne in mind that some minority groups, such as disabled people, ethnic minority people, women, are at a higher risk of facing socio-economic disadvantage and this should be considered when completing the equality impact assessment. This should be considered under each of the area in section 2 with a specific section at 2.16.

In March 2021, the Scottish Parliament unanimously passed the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Bill. This incorporates children’s rights into law and places a duty on us as a public authority to ensure children’s rights are protected and promoted in all areas of their life. NHS Ayrshire & Arran are building the **Children’s Rights and Wellbeing Impact Assessment** into our existing EQIA process. This is woven through the document with a specific section at 2.17.

##### EQUALITY IMPACT ASSESSMENT

**This is a legal document stating you have fully considered the impact on the protected characteristics and is open to scrutiny by service users/external partners/Equality and Human Rights Commission**

**If you require advice on the completion of this EQIA, contact** **elaine.savory@aapct.scot.nhs.uk**

**‘Policy’ is used as a generic term covering policies, strategies, functions, service changes, guidance documents, other**

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| **Name of Policy** | Integrated Care Record (ICR) Programme |
| **Names and role of Review Team:** | Kay Austin, Project ManagerAbigail Smith, Digital FacilitatorIntegrated Care Record Working Group (Appendix 1) | Date(s) of assessment: | 18/01/2023 |
| **SECTION ONE** |  AIMS OF THE POLICY |
| * 1. **Is this a new or existing Policy: Existing**

XX**Please state which:** **Policy** **Strategy** **Function** **Service Change** **Guidance** **Other**   |
| **1.2 What is the scope of this EQIA?**X**NHS A&A wide** **X** **Service specific**  **Discipline specific** **Other (please detail)**  |
| **1.3c. What are the intended outcomes?** * On-going development of an integrated care record (derived from agreed datasets shared from multiple patient/citizen record digital applications) across Ayrshire for all disciplines and partners delivers improved continuity of care, safety and quality for all patients.
* Improved collaboration and data sharing across the entire system making the Board future ready for the National Care Service.
* Improved user experience and streamlined digital processes, including increasing clinical/nursing time to care and improving the productivity and efficiency of operational areas, e.g. clinic efficiency, saved hours.
* Releasing time to care as live note taking and integrated monitoring is captured electronically.
* Discharge planning and access to an integrated care record will support system partners in accessing patient/citizen information and managing care end to end.
* Widening access to an integrated care record to a wider range of health and care professionals, e.g. community pharmacy, potentially reduces the demand on primary and acute care services.
* Improved safety and transformation of live patient care with insightful, accurate and up-to-date data, as patients are mapped and tracked digitally throughout their entire care journey.
* Reduction in usage of paper, storage, administration and transport costs of paper health records.
* Improved access to data for research and service planning.
* Although the adoption of an integrated care record will provide many benefits, the digital solution will be complementary and existing processes will remain for those who require it.
 |
| **1.4. Who are the stakeholders?** Ayrshire wide: health and care practitioners, administrative personnel, patient/citizens and potentially third-sector staff, etc. |
| **1.5. How have the stakeholders been involved in the development of this policy (this should include children and young people where appropriate)?**Integrated Care Record Working Group. A Communication and Engagement Plan has been developed for the programme. A refreshed programme vision and roadmap will be shared with strategic digital governance groups and wider stakeholder group thereafter.Following a communication sent out to all staff, several volunteers put themselves forward to be involved in the Integrated Care Record Programme. Further interested staff were also identified at drop-in sessions arranged to review current documentation and plans to move to digital. These volunteers were invited to take part in a survey to provide their feedback on priorities of the integrated care record and identify any anticipated benefits and challenges. The results of the survey were collated and compiled into a report which was disseminated to the participants. In addition to this, consultation has taken place through a number of vision & roadmap presentations to various groups across the organisation (listed below) to seek their feedback.This engagement will continue as we continue to develop the integrated care record. |
|  **1.6 Examination of Available Data and Consultation?**Data/evidence gathering is getting underway as the programme progresses. |
| **Name any experts or relevant groups / bodies you should approach (or have approached) to explore their views on the issues.** * Integrated Care Record Working Group
* Clinical Portal Programme Board
* Digital Champions Network
* Health Records and Clinical Administration Service
* Corporate Management Team
* Strategic Digital Delivery Group
* Digital Services EMT
* Caring for Ayrshire Professional Reference Group
* TEC Steering Group
* Equality & Diversity Forums
* Comms & Engagement Team
* Clinical Networks (Meds, NMAHP, etc.)
* Patient Focus Public Involvement Forum
* External – DHI Equality & Inclusion Advisory Group
* Survey of interested ‘volunteers’, Aug/Sept 2023
* Strategic Digital Delivery Group, 3rd July 2023
* ICR Programme Board, 4th July 2023
* I&SS EMT, 3rd August 2023
* Acute Services Directorate Management Team, 9th August 2023
* Nursing Directorate Professional Reference Group, 28th Sept 2023
* Primary Care & Community Digital Group, 9th October 2023
* NMAHP Digital Group, 25th October 2023
* AHP Extended Leadership Team, 29th November 2023
* East Ayrshire HSCP Senior Leadership Team, 30th November 2023
* AHP Professional Committee, 30th November 2023
* Area Clinical Forum, 1st December 2023
* Mental Health Digital Transformation Group, 9th January 2024
 |
| **What do we know from existing in-house quantitative and qualitative data, research, consultations, focus groups and analysis?**Digital literacy levels amongst staff, UX / usability of digital systems, challenges with paper-based patient documentation, e.g. human factors report.The survey of interested volunteers for the ICR Programme and the documentation drop-in awareness sessions highlighted several themes to consider as we continue to develop the integrated care record. These themes included digital inclusion/literacy, infrastructure, workforce & leadership. Many staff identified that duplication is an issue due to lack of integration between systems, with clinicians having to document multiple times on different systems and repeating information. Infrastructure needs to be improved, with staff reporting reduced connectivity, lack of WIFI and access to sufficient technology/devices. Providing training and education to staff so that they have confidence and competence in basic IT skills and to ensure they can use a digital system. Making sure that digital platform is simple and easy to use and is accessible to all. Ensuring we involve all key stakeholders and engage with staff and users of the systems in development, we take a whole system approach and have clear leadership and listen to the service users' voice. |
| **What do we know from existing external quantitative and qualitative data, research, consultations, focus groups and analysis?**Equity of Access, e.g. to digital technology, fragmented digital systems and information landscape across organisations/sectors to support care journeys. |
| **1.7. What resource implications are linked to this policy?**Investment in digital infrastructure (connectivity and devices) and applications, investment in digital innovations, securing clinical leadership to review and modernise clinical administration processes, engage and secure commitment from clinical teams to drive the programme forward. |

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| **SECTION TWO** |  IMPACT ASSESSMENT |
| **Complete the following table, giving reasons or comments where:****The Programme could have a positive impact by contributing to the general duty by –*** **Eliminating unlawful discrimination**
* **Promoting equal opportunities**
* **Promoting relations within the equality group**

**The Programme could have an adverse impact by disadvantaging any of the equality groups. Particular attention should be given to unlawful direct and indirect discrimination.****If any potential impact on any of these groups has been identified, please give details - including if impact is anticipated to be positive or negative.** **If negative impacts are identified, the action plan template in Appendix C must be completed.** |
| Equality Target Groups – please note, this could also refer to staff |
|  | Positive impact | Adverse impact | Neutral impact | Reason or comment for impact rating |
| **2.0 All** | X |  |  | **Repeat information -** People often have to retell their story due to a lack of information sharing across the sector. To address this, the ICR aims to ensure that the right information is shared with those who need it. The ICR will require clear guidance on data handling and sharing to enable staff to access and share data whilst ensuring the appropriate safeguards are in place to protect the data that is held. **Access to devices/wifi** - many people may not have access to a digital device or connectivity in the home in their area. Work has been undertaken in collaboration with partners, particularly libraries, to allow patients/citizens to access free private space, devices and connectivity to support people to check their digital record. Support through the [Connecting Scotland](https://connecting.scot/) Programme can also be sought by individuals who struggle with the cost of devices/wifi and skills to use digital information.**Mitigation**Existing processes for accessing health and social care services/information will remain in place and those who do not wish to engage digitally can choose to use that medium. |
| **2.1. Age** * **Infants, children and young people (IC&YP)**

Any impact on IC&YP requires additional completion of section 2.17 below. | X |  X |    | See section 2.0* While almost all young people use the internet, there are still many who lack good digital skills or access to resources such as home computing, data and broadband.
* Younger children most likely wouldn’t have access to their personal health records and this would be managed by their parent/guardian.
* Older children/teenagers may want to access their health records independently – they have rights to confidentiality from their parents, in a number of scenarios e.g. when it comes to sexual health etc.
* Important to consider that in order for children to access digital health records either independently or through their parent/guardian, they need access to technology, Wi-Fi connection etc. Children may not have their own devices or neither may their parents have devices/Wi-Fi connectivity.
* Children and/or their parents/guardians will be able to access their health records easier by having it in a digital format, more accessible information instead of having to contact their GP surgery for results, appointments, can access clinical correspondence for health care consultations and encounters Can keep track of appointments better, have an digital record of their children’s health plan, easier management for children who require a lot of medical care.
 |
| * Adults
 |  X |  X |   | * Socio-economic barriers:
	+ some adults may not be able to access technology or be able to afford devices or
	+ may not have a network connection at all in their homes or poor connectivity.
* Some adults may not know how to use technology.
* Limited literacy skills and digital skills.
* Unable to use and/or understand digital records.
* Easier access and manageability of personal health records and plan.
* Patients/citizens are better informed concerning their medical history, investigations and management plan so better prepared for clinical consultations and encounters with clinical staff.
* Reduction of time spent contacting GP’s surgeries for information or waiting for results/appointments
* Reduction of clinical letters sent out to patients.

Previous national engagement around the Protect Scotland App was was undertaken. That EQIA highlighted that more people had grown familiar with technology during the Covid pandemic. However, issues were still found for those over the age of 85 or with dementia. |
| * Older People (also consider impact on IC&YP such as kinship care)
 |  X |  X |   | Although age is not in itself a barrier to using digital devices and services, many of the factors that can make this difficult are more common for older people (confidence familiarity, access to internet, disability). When they do use it they may not benefit to the same degree.* May not be able to afford technology/Wi-Fi, may not want to have devices or internet out of personal choice, have grown up without it.
* Older people may be more resistant to change, used to having clinical letters sent to them.
* Not as confident/competent with technology as younger people, particularly for those over the age of 85.
* Lack of digital knowledge.
* Easier access and manageability of personal health records and plan.
* Patients/citizens are better informed concerning their medical history, investigations and management plan so better prepared for clinical consultations and encounters with clinical staff
* Reduction of time spent contacting GP’s surgeries for information or waiting for results/appointments
* Reduction of clinical letters sent out to patients.
 |
| **2.2. Disability** (incl. physical/ sensory problems, learning difficulties, communication needs; cognitive impairment, mental health) |  X |  X |   | See section 2.0* People with physical, sensory or learning difficulties or cognitive impairments may have inability to access digital records, may not be able to view or understand information.
* Some people may need additional support to assist them such as text to speech for blind people.
* For any videos/audio, interpretation for people with hearing impairments, including BSL, would be needed.
* Some people may be able to view and understand information but may have trouble communicating their needs and decisions, so would need support with this.
* It may be difficult for people with mental health conditions to access their health records, their decision making could be affected by their conditions and also viewing their information could pose a risk/could be a trigger for them.
* Guardian rights/next of kin access would need to be considered to protect those who are vulnerable/need support with accessing their information.
* Easier access and manageability of personal health records and plan.
* Patients/citizens are better informed concerning their medical history, investigations and management plan so better prepared for clinical consultations and encounters with clinical staff.
* Reduction of time spent contacting GP’s surgeries for information or waiting for results/appointments
* Reduction of clinical letters sent out to patients.

**A study by the** [Glasgow Disability Alliance](https://mailchi.mp/gdaonline/covid-19-supercharges-existing-inequalities-faced-by-glasgows-150000-disabled-people) **highlighted that digital exclusion is a prevalent factor for disabled people. They reported that only 37% of the disabled people they engaged with reported having home broadband or digital devices and that many lack the confidence or skills to use them. Being disabled can also mean that individuals are more likely to face socio-economic disadvantage which is a defining factor in digital exclusion.****Mitigation** Support through the [Connecting Scotland](https://connecting.scot/) Programme can also be sought by individuals who struggle with the cost of devices/wifi and skills to use digital information.Civtech challenge – Challenge 7.6 will look to resolve key issues related to how people can communicate with health and care services where an impairment or other disability may currently make this challenging with a view to enabling more inclusive access to public services. NHS A&A should keep abreast of any outputs from this work to help inform local practice. |
| **2.3. Gender** **Reassignment** |   |   |  X | See section 2.0* Should not be any change with digital records but important to ensure that records are up to date with chosen identity so that any notifications sent to a person do not call them by the wrong pronoun etc.
* Depending on the surgical procedures undertaken an individual may still require to be called for screening programmes and some consideration to how that is approached needs to be made.
 |
| **2.4 Marriage and Civil partnership** |   | X |   | See section 2.0* Despite being married, people still have rights to individual confidentiality and are not required to share information with their spouse/civil partner if they don’t want to.
* Having digital records may make it easier for perpetrators to commit domestic abuse/coercion as people having more access to health records on devices in their homes makes it easier for a person to force their partner into showing them their records or trying to access their partner’s records without their permission (going on their device without them knowing) etc.
 |
| **2.5 Pregnancy and Maternity** |  X |   |  X | See section 2.0* Easier for pregnant people to keep track of their appointments, their care plan, their baby’s growth, scans etc.
* Although pregnancy involves two people, the pregnant woman still has the right to individual confidentiality and does not have to tell their partner/other person anything that they don’t want to.
* They may disclose information to their Midwife that they don’t want their partner to know. Alternatively, to that, the other parent may wish to be involved and want to receive information about their baby as well.
 |
| **2.6 Race/Ethnicity** |  X | X |   | See section 2.0* Minority ethnic people whose first language is not English, may not be able to understand any information provided in the ICR or engage fully with other channels. Where an individual’s first language is not English we need to consider if information can be translated into the language required and added to their record to allow the person to be fully engaged and informed in their care.
* Gypsy Travellers – the introduction of an integrated care record is seen to be positive in that due to the nomadic nature of Gypsy / Traveller they will have access to their health and care information regardless of where they are.

**Mitigating action** – link with the [Connecting Scotland](https://connecting.scot/) programme and accessing via community hubs/libraries etc. |
| **2.7 Religion/Faith** |  |  | X | See section 2.0* Should not be any specific differences in the way people access their digital records but in certain religions/cultures/faiths it may be that males/husbands are in charge of the family’s affairs, women and/or children may not have devices etc.
* In some religions certain medical practices may not be allowed (i.e., receiving blood), but this shouldn’t affect how digital records are viewed.
 |
| **2.8 Sex (male/female)** |  |  | X | See section 2.0* Similar to religion/faith, should not be any difference to how digital records are viewed but may be differences in certain households of who has access to devices.
* Also similar to gender reassignment, although perhaps not undergone reassignment surgery, transsexual people may identify as a different sex, may want to be called by a different pronoun (he/she/them/mr/mrs) to their biological sex. Ensuring digital records are updated to reflect this.
* Need to consider impacts of GBV/coercion which, evidence shows, is more likely to impact women than men.
 |
| **2.9 Sexual Orientation** * Lesbians
* Gay men
* Bisexuals
 |  |  | X | See section 2.0* Should not be any specific differences to the way digital health care records are viewed.
* May be some considerations to make for certain areas of healthcare, for example in maternity it may not be ‘mum and dad’, it may be ‘mum and mum’ or ‘dad and dad’ or perhaps something else entirely.
* Being considerate about language used on digital records and not making any assumptions.
 |
| **2.10 Carers including young carers**  | X |  |  | See section 2.0* Carers may have the right to access digital records for someone in their care.
* They may care for their mum/dad/grandparent/sibling or somebody else.
* Those they care for may not have capacity to understand their own medical information and/or make decisions regarding their care. Therefore carers (if granted rights) should be able to access digital records, permissions on the system granted to allow them to access records of those they care for, again considerations given to whether they have the technology/connectivity to support this.
* Or if the person they care for does have capacity, they may just need to assist the person they care for to access their own records.
 |
| **2.11 Homeless** |  | X |  | See section 2.0* May move between hostels/sofa surf/live on the streets. Likely to not have internet connection or may be intermittent depending on where they are staying that day.
* Possibly no device to access digital records.

**Mitigating action** – signpost to accessing digital records via community hubs/libraries etc. |
| **2.12 Involved in criminal justice system including youth justice** | X | X |  | See section 2.0* For Health and Social care staff within the prison service they will have access to the same integrated health record as other Health and Social care staff thus making it easier to provide comprehensive information and advice to patients.
* No Access to Digital devices for those in prison.
* Information is provided via paper format or verbal.
 |
| **2.13 Literacy** |  |  | X | See section 2.0* Some people may not be able to read or write so may not understand written information on their digital records. This would be the same for paper health records. Verbal information / results can still be provided.
* May need to consider other ways of receiving information i.e., videos or audio files.
* Digital literacy also a factor, people may need support to develop digital skills and knowledge.
* Carers/Family members may have the right to access personal health records for someone in their care to assist with reading/understanding written information.
 |
| **2.14 Rural Areas** | X | X |  | See section 2.0* Internet connectivity may be limited in these areas so may not be able to access digital records or may be harder.
* Potential positive impact for those on Island communities and more remote and rural areas as could potentially reduce travel etc.
 |
| **2.15 Staff** * Working conditions
* Knowledge, skills and learning required
* Location
* Any other relevant factors
 | X |  |  | * Important for staff to receive training to support digital records as staff may not have good digital knowledge and confidence themselves.
* Considerations of data protection and security – not accessing digital records in inappropriate places i.e., working on a laptop on the bus with patient records on view.
* Easier to access patient/citizen data where they are working, don’t have to go into a clinic, hospital or office to update records, can do this from patient/citizen homes or their own home/another site if working in a distributed way.
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| **2.16. What is the socio-economic impact of this policy / service change? (The** [**Fairer Scotland Duty**](https://www.gov.scot/publications/fairer-scotland-duty-interim-guidance-public-bodies/) **places responsibility on Health Boards to actively consider how they can reduce inequalities of outcomes caused by socio-economic disadvantage when making strategic decisions)** |
|  | **Positive** | **Adverse** | **Neutral** | **Rationale/Evidence** |
| **Low income / poverty** |  | X |  | A - socio-economic disadvantages/barriers. Limited access to technology. Limited WiFi availability. Mitigating action – link with the [Connecting Scotland](https://connecting.scot/) programme and signposting to community hubs/libraries etc. |
| **Living in deprived areas** |  | X |  |
| **Living in deprived communities of interest** |  | X |  |
| **Employment (paid or unpaid)**  |  | X |  |

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| **2.17. What is the impact of this policy / service change on infants, children and young people (IC&YP)? (The** [**United Nations Convention on the Rights of the Child (UNCRC)**](https://www.gov.scot/policies/human-rights/childrens-rights/) **places a compatibility duty on public authorities to ensure the rights of children are protected and promoted in all areas of their life).** **Kathleen Winter** **or** **Ruth Mellor** **can be contacted for further support.** |
|  | **Yes** | **No** | **Not applicable** | **Rationale/Evidence** |
| **Will this policy impact on the best interests of IC&YP?** |  X |  |  | Benefits are that children and/or their parents/guardians will be able to access their health and care records easier by having it in a digital format, more accessible information instead of having to contact their GP surgery for results, appointments, can read summaries of what was discussed in appointments. Can keep track of appointments better, have a digital record of their children’s health plan, easier management for children who require a lot of medical care. |
| **Will this policy impact on the developmental needs of the IC&YP?** | X |  |  | Has the potential to reduce delay in receiving verbal or written feedback from services. |
| **Will this policy impact on IC&YP being able to express their views in relation to the service and have that view taken into account?** | X |  |  | Should allow young people to be better represented and allow for increase in independence.  |
| **Will the policy have any direct or indirect impacts on IC&YP?** | X | X |  | Younger children most likely wouldn’t have access to their personal health records and this would be managed by their parent/guardian.Older children/teenagers may want to access their health records independently – they have rights to confidentiality from their parents when it comes to sexual health, etc. Important to consider that in order for children to access digital records either independently or through their parent/guardian, they need access to technology, wifi connection etc. Children may not have their own devices or neither may their parents have devices/wifi connectivity.Benefits are that children and/or their parents/guardians will be able to access their health records easier by having it in a digital format, more accessible information instead of having to contact their GP surgery for results, appointments, can read summaries of what was discussed in appointments perhaps. Can keep track of appointments better, have a digital record of their children’s health plan, easier management for children who require a lot of medical care. |
| **Have you considered the impact of the policy across the wide range of IC&YP, e.g. preschool children; children in hospital; children with additional support needs; care experienced children; children living in poverty?** | Y |  |  | Important to consider that in order for children to access digital records either independently or through their parent/guardian, they need access to technology, wifi connection etc. Children may not have their own devices or neither may their parents have devices/wifi connectivity.Benefits - Join of up services, streamline care and better communication & information sharing across the various services that IC&YP may be involved with. |

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| **SECTION THREE** |  **CROSSCUTTING ISSUES** |
| **What impact will the proposal have on lifestyles? For example, will the changes affect:**  |
|  | Positive impact | Adverse impact | No impact | Reason or comment for impact rating |
| **3.1 Diet and nutrition?**  | X |  |  | Easier to access and share readily available information.  |
| **3.2 Exercise and physical activity?** | X |  |  | Easier to access and share readily available information. |
| **3.3 Substance use: tobacco, alcohol or drugs?**  | X |  |  | Easier to access and share readily available information. |
| 3.4 Risk taking behaviour? | X |  |  | Easier to access and share readily available information. |

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| **SECTION FOUR** |  **CROSSCUTTING ISSUES** |
| **Will the proposal have an impact on the physical environment? For example, will there be impacts on:**  |
|  | Positive impact | Adverse impact | No impact | Reason or comment for impact rating |
| **4.1 Living conditions?**  |  | X |  | More requirement for living conditions to have access to Internet and have technology within the home.Mitigating action – link with the [Connecting Scotland](https://connecting.scot/) programme and signposting to community hubs/libraries etc. |
| **4.2 Working conditions?**  | X |  |  | Access to records online should hopefully reduce time away from work for appointments/test results. Staff – reduces time and travel to work base to update records/notes as work can be completed remotely. Increases productivity.  |
| **4.3 Pollution or climate change?** | X | X |  | A - Increase in technology – Wi-Fi.P - Reduces paper / print costs.P - Reduces travel to appointments/work. |
| **Will the proposal affect access to and experience of services? For example:**  |
|  | Positive impact | Adverse impact | No impact | Reason or comment for impact rating |
| **Health care**  | X |  |  | Join up of services. Faster results. Improve access. |
| **Social Services** | X |  |  | Join up of services. Faster results. Improve access. |
| **Education**  |  |  | X |  |
| **Transport**  |  |  | X |  |
| **Housing** |  |  | X |  |

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| **SECTION FIVE** | **MONITORING** |
| **How will the outcomes be monitored?** Benefit management plan for the Integrated Care Record Programme as a whole & on a per project basis. RAID log.ICR Working Group for reporting and governanceNHS A&A Corporate Management Team (CMT) reportingFeedback from staff/patients. |
| **What monitoring arrangements are in place?**Monthly meetings of ICR Programme Board.Monthly NHS A&A CMT meetings. |
| **Who will monitor?**Project team / SRO.ICR Working Group.Digital Services Executive Management Team.NHS A&A CMT. |
| **What criteria will you use to measure progress towards the outcomes?****Staff –** Feedback surveys, adoption of new digital systems, e.g. track usage data, PDR, formal employee relation processes, for example, complaints and grievances, calls to helpdesk.**Patients –** Feedback surveys, Care Opinion, Public meetings/events, Complaints procedures.  |
| **PUBLICATION** |
| Public bodies covered by equalities legislation must be able to show that they have paid due regard to meeting the Public Sector Equality Duty (PSED). This should be set out clearly and accessibly and be signed off by an appropriate member of the organisation. Once completed, send this completed EQIA to the **Equality & Diversity Adviser** |
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| **Authorised by** |  | **Title** |  |
|  |  |  |  |
| **Signature** |  | **Date** |  |

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| **Identified Negative Impact Assessment Action Plan** |

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| **Name of EQIA:** |  |

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| **Date** | **Issue** | **Action Required** | **Lead (Name, title, and contact details)** | **Timescale** | **Resource Implications** | **Comments** |
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| Further Notes: |  |

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| Signed: |  | Date: |  |

**Version Control**

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| --- | --- | --- | --- |
| **Date** | **Version Number** | **Comments** | **Name** |
| 25/07/2023 | 1.0 | Version 1.0 published. | Kay Austin, Abi Smith, David Dougan |
| 25/01/2024 | 2.0 | Reviewed and updated. | Abi Smith |
| **25/07/2024** | **-** | **For review** | **-** |

**Appendix 1**

**Integrated Care Record Programme Working Group Members**

Director of Infrastructure & Support Services, Nicola Graham

Director of Acute Services, Joanne Edwards

Medical Director, Crawford McGuffie

Chief Nurse, Jen Pennycook

QI Lead Nurse, Nina McGinley

QI Lead, Lorna Copeland

Nurse Consultant Digital Services, Mark Fleming

Director of Allied Health Professions, Alistair Reid

Lead Nurse Surgical Directorate, Emma Smith

Head of Health Records Services, Robert Bryden

Programme Manager Digital Services, David Dougan

Programme Manager Digital Services, Lindsay McLachlan

Principal Pharmacist Digital Health and Electronic Prescribing, Richard Cottrell

Head of Information Governance & Data Protection Officer, Ann Wilson

Interim Assistant Director of Digital Services, Derek Gemmell

Head of Infrastructure Services, Ian Sey

Head of Systems, Development & Implementation, Michelle McLuckie

Head of Service Delivery, Karen Lambert

Head of Primary and Urgent Care Services, Vicki Campbell

Senior Accountant, Ian Ferris

Deputy Medical Director, Primary Care and Urgent Care Services, John Freestone

Digital Services Project Manager, Kay Austin

Digital Services Project Manager, Murray Howat

Digital Services Facilitator, Abi Smith