

Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Policy for Hysteroscopy

Before completing this equality analysis it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

1. Background

EA Title	Policy for Hysteroscopy		
EA Author	David King	Team	Equality and Diversity
Date Started		Date Completed	
EA Version	1	Reviewed by E&D	

What are the intended outcomes of this work? Include outline of objectives and function aims

Heavy Menstrual Bleeding (HMB/ Heavy Periods)

Heavy Menstrual Bleeding is common but can have a big effect on a woman's everyday life. HMB does not always have an underlying cause but can result from problems such as fibroids or endometriosis.

It's difficult to define exactly what a heavy period is because it varies from woman to woman. Heavy for one woman may be normal for another. Most women will lose less than 16 teaspoons of blood (80ml) during their period, with the average being around 6 to 8 teaspoons.

Heavy menstrual bleeding is defined as losing 80ml or more in each period, having periods that last longer than 7 days, or both.

However, it's not usually necessary to measure blood loss. Most women have a good idea of how much bleeding is normal for them during their period and can tell when this changes.

A good indication that your periods are heavy is if you:

- are having to change your sanitary products every hour or two
- are passing blood clots larger than 2.5cm (about the size of a 10p coin)
- are bleeding through to your clothes or bedding
- need to use two types of sanitary product together for example, tampons and pads

In about half of women with heavy menstrual bleeding, no underlying reason is found. But there are several conditions and some treatments that can cause heavy menstrual bleeding.

Some conditions of the womb and ovaries can cause heavy bleeding, including:

- fibroids – non-cancerous growths that develop in or around the womb and can cause heavy or painful periods
- endometriosis – where the tissue that lines the womb (endometrium) is found outside the womb, such as in the ovaries and fallopian tubes (although this is more likely to cause painful periods)

- adenomyosis – when tissue from the womb lining becomes embedded in the wall of the womb; this can also cause painful periods
- pelvic inflammatory disease (PID) – an infection in the upper genital tract (the womb, fallopian tubes or ovaries) that can cause symptoms like pelvic or abdominal pain, bleeding after sex or between periods, vaginal discharge and fever
- endometrial polyps – non-cancerous growths in the lining of the womb or cervix (neck of the womb)
- cancer of the womb – the most common symptom is abnormal bleeding, especially after the menopause
- polycystic ovary syndrome (PCOS) – a common condition that affects how the ovaries work; it causes irregular periods, and periods can be heavy when they start again

Other conditions that can cause heavy periods include:

- blood clotting disorders, such as Von Willebrand disease
- an underactive thyroid gland (hypothyroidism) – where the thyroid gland does not produce enough hormones, causing tiredness, weight gain and feelings of depression
- diabetes

Medical treatments that can sometimes cause heavy periods include:

- an IUD (intrauterine contraceptive device, or "the coil") – this can make your periods heavier for the first 3 to 6 months after insertion
- anticoagulant medication – taken to prevent blood clots
- some medicines used for chemotherapy
- some herbal supplements, which can affect your hormones and may affect your periods – such as ginseng, ginkgo and soya

Hysteroscopy

A hysteroscopy is a procedure used to examine the inside of the womb (uterus). It is carried out using a hysteroscope, which is a narrow telescope with a light and camera at the end. Images are sent to a monitor so your doctor or specialist nurse can see inside your womb.

The hysteroscope is passed into your womb through your vagina and cervix (entrance to the womb), which means no cuts need to be made in your skin.

In deciding whether to offer the woman a hysteroscopy or ultrasound scan NICE Guidance 88 should be taken into consideration:

Women with suspected submucosal fibroids, polyps or endometrial pathology

Offer outpatient hysteroscopy to women with HMB if their history suggests submucosal fibroids, polyps or endometrial pathology because:

- they have symptoms such as persistent intermenstrual bleeding or
- they have risk factors for endometrial pathology

Women with possible larger fibroids.

Offer pelvic ultrasound to women with HMB if any of the following apply:

- their uterus is palpable abdominally
- history or examination suggests a pelvic mass
- examination is inconclusive or difficult, for example in women who are obese.

Women with suspected adenomyosis

Offer transvaginal ultrasound (in preference to transabdominal ultrasound or MRI) to women with HMB who have:

- significant dysmenorrhoea (period pain) or
- a bulky, tender uterus on examination that suggests adenomyosis.

If a woman declines transvaginal ultrasound or it is not suitable for her, consider transabdominal ultrasound or MRI, explaining the limitations of these techniques.

Be aware that pain associated with HMB may be caused by endometriosis rather than adenomyosis (see NICE's guideline on endometriosis).

Other diagnostic tools

Do not use saline infusion sonography as a first-line diagnostic tool for HMB.

Do not use MRI as a first-line diagnostic tool for HMB.

Do not use dilatation and curettage alone as a diagnostic tool for HMB

Evidence Review

In reviewing the evidence NICE 2018 considered the following requirements:

- that the correct identification of the cause of HMB is important as this can impact the treatment options offered to women.
- If a test is sensitive, it may help the clinicians to choose the right initial treatment to be offered to women.
- It is important to avoid false positives because unnecessary treatment, especially surgical treatment, can cause harm.

- The evidence on diagnostic accuracy was assessed using adapted GRADE methodology. GRADE is a systematic approach to rating the certainty of evidence in systematic reviews and other evidence syntheses.
- The evidence on patient satisfaction or acceptability was assessed using Cochrane Collaboration's tool for assessing risk of bias.

NICE in their evidence review accepted that the quality of evidence in these reviews ranged from very low to moderate with most evidence being of very low quality. The NICE committee recognised that the evidence was fragmented and with several limitations. The NICE committee agreed that the quality of evidence was most often downgraded because of unclear sampling, unclear inclusion and exclusion criteria, unclear diagnostic criteria, and at times, considerable number of drop-outs.

However, national clinical consensus under NG 88 has recommended the use of hysteroscopy as a first line intervention in a limited number of clinical circumstances:

The patient must have suspected submucosal fibroids OR polyps OR endometrial pathology **AND** The patient has one of the following symptoms:

- persistent intermenstrual bleeding OR
- risk factors for endometrial pathology

Due to this national clinical expertise, the use of hysteroscopy will be commissioned in specified clinical circumstances in line with the clinical consensus achieved through NICE NG 88.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

Eligibility Criteria: Restricted

Hysteroscopy for Heavy Menstrual Bleeding is commissioned as a first line investigation in the following clinical circumstances:

The patient must have suspected submucosal fibroids OR polyps OR endometrial pathology **AND**

The patient has one of the following symptoms:

- persistent intermenstrual bleeding OR
- risk factors for endometrial pathology

Risk factors for endometrial pathology are defined as:

- the patient has persistent intermenstrual or persistent irregular bleeding, and the patient has infrequent heavy bleeding and is obese or has polycystic ovary syndrome
- the patient taking tamoxifen

- the patient for whom treatment for HMB has been unsuccessful.

In other clinical circumstances diagnostic hysteroscopy is commissioned in the following clinical circumstances:

- First -line investigation using ultrasound scan has provided inconclusive results. For example, hysteroscopy is clinically required to determine the exact location of a fibroid or the exact nature of the abnormality.

N.B. investigation for suspected or proven malignancy is outside the scope of this policy and should be investigated in line with the relevant cancer pathway.

This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Activity data 2018/19

Number of Procedures	BSOL	Sandwell

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	Working Groups	Clinical Experts
<p>Abd Elkhalek 2016 Abd Elkhalek, Y. I., Kamel, O. F., El-Sabaa, H., Comparison of 3 dimensional sonohysterography and hysteroscopy in Premenopausal women with abnormal uterine bleeding, Egyptian Journal of Radiology and Nuclear Medicine, 47, 1117-22, 2016</p> <p>Abdel Hak 2010 Abdel Hak, A. M., Accuracy of sonographic criteria for diagnosis of adenomyosis in perimenopausal women with menorrhagia, Middle East Fertility Society Journal, 15, 35-8, 2010</p>		

<p>Abe 2008 Abe, M., Ogawa, H., Ayhan, A., The use of non-three-layer ultrasound in biopsy recommendation for premenopausal women, <i>Acta Obstetrica et Gynecologica Scandinavica</i>, 87, 2008</p> <p>Alborzi 2007 Alborzi, S., Parsanezhad, M. E., Mahmoodian, N., Alborzi, S., Alborzi, M., Sonohysterography versus transvaginal sonography for screening of patients with abnormal uterine bleeding, <i>International Journal of Gynaecology & Obstetrics</i>, 96, 20-3, 2007</p> <p>Bazot 2002 Bazot, M., Darai, E., Rouger, J., Detchev, R., Cortez, A., Uzan, S., Limitations of transvaginal sonography for the diagnosis of adenomyosis, with histopathological correlation, <i>Ultrasound in Obstetrics and Gynecology</i>, 20, 605-11, 2002</p> <p>Botsis 1998 Botsis, D., Kassanos, D., Antoniou, G., Pyrgiotis, E., Karakitsos, P., Kalogirou, D., Adenomyoma and leiomyoma: differential diagnosis with transvaginal sonography, <i>Journal of Clinical Ultrasound</i>, 26, 21-5, 1998</p> <p>Champaneria 2010 Champaneria, R., Abedin, P., Daniels, J., Balogun, M., Khan, K.S., Ultrasound scan and magnetic resonance imaging for the diagnosis of adenomyosis: systematic review comparing test accuracy, <i>Acta Obstetrica et Gynecologica</i>, 89, 1374–84, 2010</p> <p>Cicinelli 1995 Cicinelli, E., Romano, F., Anastasio, P. S., Blasi, N., Parisi, C., Galantino, P., Transabdominal sonohysterography, transvaginal sonography, and hysteroscopy in the evaluation of submucous myomas, <i>Obstet Gynecol Obstetrics and gynecology</i>, 85, 42-7, 1995</p> <p>Cooper 2014 Cooper, N. A., Barton, P. M., Breijer, M., Caffrey, O., Opmeer, B. C., Timmermans, A., Mol, B. W., Khan, K. S., Clark, T. J., Cost-effectiveness of diagnostic strategies for the management of abnormal uterine bleeding (heavy menstrual bleeding and post-menopausal bleeding): a decision analysis, <i>Health Technology Assessment</i>, 18, 1-201, 2014</p> <p>Critchley 2004 Critchley, H. O. D., Warner, P., Lee, A. J., Brechin, S., Guise, J., Graham, B., Evaluation of abnormal uterine bleeding: Comparison of three outpatient procedures within cohorts defined by age and menopausal status, <i>Health Technology Assessment</i>, 8, iii-77, 2004</p>		
---	--	--

<p>Dakhly 2016 Dakhly, D. M. R., Abdel Moety, G. A. F., Saber, W., Gad Allah, S. H., Hashem, A. T., Abdel Salam, L. O. E., Accuracy of Hysteroscopic Endomyometrial Biopsy in Diagnosis of Adenomyosis, Journal of Minimally Invasive Gynecology, 23, 364-71, 2016</p> <p>Dasgupta 2011a Dasgupta, S., Chakraborty, B., Karim, R., Aich, R. K., Mitra, P. K., Ghosh, T. K., Abnormal uterine bleeding in peri-menopausal age: Diagnostic options and accuracy, Journal of Obstetrics and Gynecology of India, 61, 189-94, 2011a</p> <p>Dasgupta 2011b Dasgupta, S., Sharma, P. P., Mukherjee, A., Ghosh, T. K., Ultrasound assessment of endometrial cavity in perimenopausal women on oral progesterone for abnormal uterine bleeding: comparison of diagnostic accuracy of imaging with hysteroscopy-guided biopsy, The journal of obstetrics and gynaecology research, 37, 2011b</p> <p>Dueholm 2001a Dueholm, M., Forman, A., Jensen, M. L., Laursen, H., Kracht, P., Transvaginal sonography combined with saline contrast sonohysterography in evaluating the uterine cavity in premenopausal patients with abnormal uterine bleeding, Ultrasound in Obstetrics and Gynecology, 18, 54-61, 2001a</p> <p>Dueholm 2001b Dueholm, M., Lundorf, E., Hansen, E. S., Sorensen, J. S., Ledertoug, S., Olesen, F., Magnetic resonance imaging and transvaginal ultrasonography for the diagnosis of adenomyosis, Fertility and Sterility, 76, 588-94, 2001b</p> <p>Erdem 2007 Erdem, M., Bilgin, U., Bozkurt, N., Erdem, A., Comparison of transvaginal ultrasonography and saline infusion sonohysterography in evaluating the endometrial cavity in pre- and postmenopausal women with abnormal uterine bleeding, Menopause, 14, 2007</p> <p>Exacoustos 2011 Exacoustos, C., Brienza, L., Di Giovanni, A., Szabolcs, B., Romanini, M. E., Zupi, E., Arduini, D., Adenomyosis: three-dimensional sonographic findings of the junctional zone and correlation with histology, Ultrasound in obstetrics & gynecology : the official journal of the International Society of Ultrasound in Obstetrics and Gynecology, 37, 471-9, 2011</p>		
--	--	--

<p>Fakhar and Mahmud 2010 Fakhar, S., Mahmud, G., Validity of hysteroscopy and histopathology in patients with menstrual irregularity, Journal of Ayub Medical College, Abbottabad: JAMC, 22, 129-32, 2010</p> <p>Gkrozou 2015 Gkrozou, F., Dimakopoulos, G., Vrekoussis, T., Lavasidis, L., Koutlas, A., Navrozoglou, I., Stefos, T., Paschopoulos, M., Hysteroscopy in women with abnormal uterine bleeding: a meta-analysis on four major endometrial pathologies, Arch Gynecol Obstet, 291, 1347-54, 2015</p> <p>Krampl 2001 Krampl, E., Bourne, T., Hurlen-Solbakken, H., Istre, O., Transvaginal ultrasonography sonohysterography and operative hysteroscopy for the evaluation of abnormal uterine bleeding, Acta Obstetrica et Gynecologica Scandinavica, 80, 616-622, 2001</p> <p>Meredith 2009 Meredith, S. M., Sanchez-Ramos, L., Kaunitz, A. M., Diagnostic accuracy of transvaginal sonography for the diagnosis of adenomyosis: systematic review and metaanalysis. American Journal of Obstetrics and Gynecology, 201:107, e1-6, 2009</p> <p>Mukhopadhyay 2007 Mukhopadhyay, S., Bhattacharyya, S. K., Ganguly, R. P., Patra, K. K., Bhattacharya, N., Barman, S. C., Comparative evaluation of perimenopausal abnormal uterine bleeding by transvaginal sonography, hysteroscopy and endometrial biopsy, Journal of the Indian Medical Association, 105, 2007</p> <p>Najeeb 2010 Najeeb, R., Awan, A. S., Bakhtiar, U., Akhter, S., Role of transvaginal sonography in assessment of abnormal uterine bleeding in perimenopausal age group, Journal of Ayub Medical College, Abbottabad : JAMC, 22, 2010</p> <p>Nanda 2002 Nanda, S., Chadha, N., Sen, J., Sangwan, K., Transvaginal sonography and saline infusion sonohysterography in the evaluation of abnormal uterine bleeding, Australian and New Zealand Journal of Obstetrics and Gynaecology, 42, 530-4, 2002</p> <p>NHS 2018 NHS. 2018 Hysteroscopy. Last reviewed 05.12.2018. https://www.nhs.uk/conditions/hysteroscopy/</p>		
--	--	--

<p>NHS 2018 NHS. 2018. Heavy Menstrual Bleeding. Last updated 07.06.2018. https://www.nhs.uk/conditions/heavy-periods/</p> <p>NICE 2018 NICE 2018 NICE Guidelines: Heavy menstrual bleeding: Assessment and Management. Published: 14 March 2018 nice.org.uk/guidance/ng88</p> <p>NICE 2018 NICE 2018 NICE Guideline 88: Evidence Reviews. March 2018. https://www.nice.org.uk/guidance/ng88/evidence/a-diagnostic-test-accuracy-pdf-4782293101</p> <p>Pennant 2017 Pennant, M. E., Mehta, R., Moody, P., Hackett, G., Prentice, A., Sharp, S. J., Lakshman, R., Premenopausal abnormal uterine bleeding and risk of endometrial cancer, BJOG, 124, 404-11, 2017</p> <p>RCOG and BSGE 2016 Royal Coll Royal College of Obstetricians and Gynaecologists, British Society for Gynaecological Endoscopy, Management of Endometrial Hyperplasia, Green-top Guideline No. 67, London: RCOG, 2016</p> <p>RCOG and BSGE 2011 Royal College of Obstetricians and Gynaecologists, British Society for Gynaecological Endoscopy, Best Practice in Outpatient Hysteroscopy, Green-top Guideline No. 59, London: RCOG, 2011</p> <p>Soguktas 2012 Soguktas, S., Cogendez, E., Kayatas, S. E., Asoglu, M. R., Selcuk, S., Ertekin, A., Comparison of saline infusion sonohysterography and hysteroscopy in diagnosis of premenopausal women with abnormal uterine bleeding, European Journal of Obstetrics, Gynecology, & Reproductive BiologyEur J Obstet Gynecol Reprod Biol, 161, 2012</p> <p>Taylor 2001 Taylor, S., Jones, S., Dixon, A. M., O'Donovan, P., Evaluation of ultrasound in an outpatient hysteroscopy clinic: Does it alter management in premenopausal women?, Gynaecological Endoscopy, 10, 173-8, 2001</p> <p>Vercellini 1998 Vercellini, P., Cortesi, I., De Giorgi, O., Merlo, D., Carinelli, S. G., Crosignani, P. G., Transvaginal ultrasonography versus uterine</p>		
--	--	--

<p>needle biopsy in the diagnosis of diffuse adenomyosis, Human Reproduction, 13, 1998</p> <p>Vercellini 1997 Vercellini, P., Cortesi, I., Oldani, S., Moschetta, M., De Giorgi, O., Crosignani, P. G., The role of transvaginal ultrasonography and outpatient diagnostic hysteroscopy in the evaluation of patients with menorrhagia, Human Reproduction, 12, 1768-71, 1997</p> <p>Williams and Marshburn 1998 Williams, C. D., Marshburn, P. B., A prospective study of transvaginal hydrosonography in the evaluation of abnormal uterine bleeding, Am J Obstet Gynecol American journal of obstetrics and gynecology, 179, 292-8, 1998</p> <p>Yildiz 2009 Yildiz, A., Koksal, A., Ates, P. F., Ivit, H., Keklik, A., Cukurova, K., Hysteroscopy in the evaluation of intrauterine cavity. Is it more valuable than dilatation and curettage?, Turkiye Klinikleri Journal of Medical Sciences, 29, 2009</p>		
--	--	--

<p>3. Impact and Evidence:</p>
<p>In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.</p>
<p>Age: Describe age related impact and evidence. This can include safeguarding, consent and welfare issues:</p> <p>Although, if clinically required Hysteroscopy can be performed once a person is menstruating the most common reasons to perform the investigative procedure is due to fibroids which usually appear in women between 30 and 50 years old, however, they can be present at any age.</p>
<p>Disability: Describe disability related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/ learning disabilities, cognitive impairments:</p> <p style="text-align: center;">No impact identified</p>

3. Impact and Evidence:
<p>Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment:</p> <p style="text-align: center;">No impact identified</p>
<p>Marriage and civil partnership: Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part-time working, and caring responsibilities:</p> <p style="text-align: center;">No impact identified</p>
<p>Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities:</p> <p style="text-align: center;">Hysteroscopy cannot be performed during pregnancy.</p>
<p>Race: Describe race related impact and evidence. This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers:</p> <p style="text-align: center;">No impact identified</p>
<p>Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues:</p> <p style="text-align: center;">No impact identified</p>
<p>Sex: Describe any impact and evidence on men and women. This could include access to services and employment:</p> <p>Due to the nature of the condition this procedure is only available to those who require uterus investigative work.</p>
<p>Sexual orientation: Describe any impact and evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers:</p> <p style="text-align: center;">No impact identified</p>

3. Impact and Evidence:
<p>Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities:</p> <p style="text-align: center;">No impact identified</p>
<p>Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive)</p> <p style="text-align: center;">No impact identified</p>

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	This condition is not linked to a health inequality.
Is there any impact for groups or communities living in particular geographical areas?	No	No impact identified
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	No	No impact identified
How will you ensure the proposals reduce health inequalities?		

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	Yes, this decision has been made in line with clinical recommendation and NICE guidance.
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	No evidence of impact from this policy
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	No discrimination identified

	How will this affect a person's right to freedom of thought, conscience and religion?	N/A
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	Policy will be applied with due regard to this consideration.
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	An individual can discuss the impact with their GP and has the option for an IFR request to be made
Right to Life	Will or could it affect someone's right to life? How?	No evidence of impact from this policy
Right to Liberty	Will or could someone be deprived of their liberty? How?	No evidence of impact from this policy

6. Social Value	
Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.	
Marmot Policy Objective	What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?
Enable all people to have control over their lives and maximise their capabilities	None
Create fair employment and good work for all	None
Create and develop health and sustainable places and communities	None
Strengthen the role and impact of ill-health prevention	None

7. Engagement, Involvement and Consultation		
If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:		
Engagement Activity	Protected Characteristic/ Group/ Community	Date
For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us So we will):		
As part of the process further targeted engagement is planned with representative groups from among Sandwell, Birmingham and Solihull Patients. In addition, it has		

been identified that patient and clinician information is key in ensuring that the harmonised treatment policies review delivers effective outcomes. To this end an information briefing sheets on each procedure will be developed to give more information on the procedure, eligibility criteria and signposting to further information sources, such as NHS Choices. These information sheets are also designed to help facilitate discussions between GPs and patients. Information briefing sheets have already been tested and uploaded onto the GP systems for the first 45 harmonised treatment policies for Birmingham and Solihull. Due regard will be given to both the accessible information standard and the potential need to translate such leaflets into relevant local languages.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

The restriction of this policy will have limited impact on those who would wish to receive the treatments as the procedure is commissioned as a first line investigation if they meet the eligibility criteria. The opportunity for any exceptional cases to be considered via IFR remains and will ensure treatment is available.

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

None identified

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

This policy is not linked to a contract however, prospective providers remain bound by their contracts with the CCG.

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):
N/A

12. Publication
How will you share the findings of the Equality Analysis?
This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages. All Equality Analysis should be recommended for publication unless they are deemed to contain sensitive information.
Publication on the CCG's website.
Following approval all finalised Equality Analysis should be sent to the Communications and Engagement team for publication: bsol.comms@nhs.net

13. Sign Off		
The Equality Analysis will need to go through a process of quality assurance by the Senior Manager for Equality and Diversity, Senior Manager for Assurance and Compliance or Equality and Human Rights Manager and signed-off by a delegated committee		
	Name	Date
Quality Assured By:		
Which Committee will be considering the findings and signing off the EA?		
Minute number (to be inserted following presentation to committee)		

Please send to Balvinder Everitt or Michelle Dunne, Equality, Diversity and Inclusion for Quality Assurance.



Once you have committee sign off, please send to Caroline Higgs, Communications & Engagement Team for publication: bsol.comms@nhs.net