NHS

Nottingham City CCG Nottingham North and East CCG Nottingham West CCG Rushcliffe CCG

Equality and Quality Impact Assessments (EQIAs)

1. Introduction

The Greater Nottingham Financial Recovery Plan for 2017/18 includes a wide range of schemes that cover different services and it is recognised that these may affect different people to differing degrees across the Greater Nottingham population. As such, impact assessments and patient and public engagement activities will need to be managed on a scheme-by-scheme basis, using a consistent, pre-defined approach in order to ensure that the individual and collective impact of proposed schemes are fully understood prior to any decision-making.

Impact assessments and engagement plans are inter-dependant, and as such, need to be developed at the same time. Therefore, the approach to this work, as adopted by all four Greater Nottingham CCG Governing Bodies, ensures that both activities are simultaneously considered as part of the Financial Recovery Gateway Approvals Process.

The purpose of this paper is to provide assurance to the Governing Body in relation to the robustness of this process and to set out a summary of progress to date in completing this work.

2. Background information

Previously the South Nottinghamshire CCGs adopted the approach of having separate Quality and Equality Impact Assessments (QIA and EIA). These were completed by scheme leads and submitted to the quality team (QIA) or governance lead (EIA) for review. QIAs required leads to make a judgment about the risk impact and likelihood with schemes attracting a score of 8 or above in any area requiring a stage 2 assessment and consideration at the Quality and Risk Committee (QRC). A number of issues emerged as a result of this approach as follows:

- Duplication of effort (as this required two documents and overlapped in terms of information required e.g. nature of scheme being assessed, CCGs involved and leads)
- The separate assessments and review by different teams encouraged quality and equality to be considered in isolation which could lead to overall impacts being inaccurately assessed
- The requirement to provide a risk score with only those with scores greater than 8 being subject to stage 2 assessment and consideration at QRC could lead to individuals artificially deflating scores
- In addition a scheme could score just under 8 across a number of areas in the QIA and therefore not reach the threshold for stage 2 assessment but due to the number of factors impacted result in significant risk overall

- The EIA in use did not sufficiently addresss the impact on health inequalities
- There were issues with timeliness and phasing of completion of both assessemnts
- The previous assessment tools did not adequately link with engagement activity and requirements thereby not recognising the interdependent nature of both processes
- The previous approach encouraged schemes to be viewed in isolation and did not take account of collective impact of a number fo schemes
- Leads had little training/ experience or support in developing impact assessments which impacted on the quality of those produced
- The role of QRC was unclear with some members feeling unqualified to assess the appropriateness of stage 2 assessments

3. EQIA/Engagement Screening

An initial screening process will be undertaken for each individual scheme within the financial recovery plan. This will determine whether a full impact assessment and engagement activities are required. The process will consider:

- The **scale** of any potential change to commissioned services
- Whether any potential changes are likely to have an **impact** on patients (i.e. changes

  to the manner in which services are delivered or to the range of health services available)
- How likely it is that any potential changes would be considered to be **controversial**.

Whilst the initial screening process will be considered on an individual scheme basis, the collective impact of schemes affecting the same people/services will also be considered.

In line with the outcome of the initial screening process, individual impact assessments and engagement plans will be developed for each relevant scheme. These will take account of the specific populations/people affected by the changes being considered. See **appendix 1** for a copy of the EQIA screening tool.

4. EQuality Impact Assessments

A process has been introduced that brings together equality and quality impact considerations into a single EQuality Impact Assessment (EQIA). This provides a streamlined process and prevents equality and quality risks from being considered in isolation.

The EQIA is an assessment of whether proposed changes could have a positive, negative or neutral impact on people’s different protected characteristics, as defined by the Equality Act 2010. It also considers the impacts on people from relevant inclusion health groups (e.g. carers, homeless people, people experiencing economic or social deprivation).

The EQIA also assesses impacts in line with the CCGs’ duty to maintain and improve the three elements of quality (patient safety, patient experience and clinical effectiveness) and considers the following:

- Access to services (including patient choice)

- Transfers between services (whether between specialities, care settings, or during a person's life course)
- Safeguarding adults
- Safeguarding children
- Dignity and respect (including privacy)
- Person-centred care
- NICE requirements
- Shared decision-making
- Health inequalities

EQIAs will be treated as 'live' documents and will be revisited at key stages of scheme development and implementation, particularly following the conclusion of any engagement and consultation activities to inform decision-making.

A copy of the EQIA template is attached as **appendix 2.**

5. Framework for informing, engaging and consulting with patients and the public

Engagement plans will broadly fall into one of the following three approaches:

- Informing – Communicating changes to affected people and the wider public
- Engaging – Undertaking targeted engagement with affected people and/or their representatives
- Consulting – Formal consultation with affected people and the wider public

Engagement plans will be developed in line with the following framework. It is important to note that these different approaches to engagement are not mutually exclusive, and depending on the scale and complexity of proposals, engagement plans may include all three approaches. Engagement plans will be proportionate to the scale, complexity and potential impact of proposals.

Definition	Key elements
Inform	
To communicate with relevant stakeholders to raise awareness and/or provide information on scheme proposals.	A stakeholder analysis will be completed to identify people/groups with an interest Clear, simple messaging will be used that is tailored to the needs of the relevant audiences A range of communication mechanisms will be used
Engage	
To engage relevant stakeholders in a two-way dialogue to obtain a better understanding of need and/or to gather views and opinions. These are then taken into account when completing EQIAs and developing scheme proposals.	An 'issue paper' will be produced to identify the purpose of engagement – i.e. a description of the problem we are seeking to resolve (the clinical case for change). In some instances this may also describe possible courses of action. The engagement activities will explore these

Definition	Key elements
	possibilities and potential impacts in support of further scheme development. A stakeholder analysis will be completed to identify people/groups with an interest. Engagement activities will then be designed to ensure that they reach the right people and meet their specific needs (also taking account of the EQIA). Engagement will start as soon as possible to enable people to have the greatest opportunity to shape the development of proposals. The output from engagement activities will be carefully analysed and considered in scheme/EQIA development, with clear feedback provided to participants
Consult	
A formal, structured process to seek stakeholder feedback on possible options under consideration and about which a decision needs to be made. This approach is adopted when: • There is a statutory requirement to consult – i.e. when a proposed change is 'significant' (whether it is likely to have a substantial impact on access to services or service delivery) • Where there is a legitimate expectation that stakeholders should be consulted (e.g. when a 'promise' has been made to do so, or where a legal precedent has been set).	Pre-consultation engagement will take place, in line with the approach described above, to scope and develop options on which consultation will take place. A stakeholder analysis will be completed to identify people/groups that may be affected. This will take account of any pre-consultation engagement work and the EQIA outcome. Those most affected will be actively targeted for consultation. Consultation exercises will: (a) Be undertaken at a time when proposals are at a formative stage (b) Provide sufficient information to satisfy the needs of consultees (c) Allow sufficient time to enable a considered response (proportionate to the scale, complexity and potential impact of the proposal) (d) Ensure careful consideration of consultation outcomes prior to any decisions being taken, with clear feedback provided to consultees.

6. EQIA/Engagement Panel

An EQIA/Engagement Panel has been established to support the development and quality assurance of EQIAs for all relevant schemes within the Financial Recovery Plan.

The Panel is comprised of relevant Directors from across the Greater Nottingham CCGs with equality and quality expertise and knowledge of the different CCG populations.

Decisions on whether schemes will be implemented, amended or stopped will be taken in line with impact assessment, engagement and consultation outcomes.

The Panel has meetings scheduled on a fortnightly basis, but only meets as and when necessary to consider completed impact assessments and engagement plans.

QRC will receive regular reports detailing which schemes have had EQIA screening, which have proceeded to full EQIA/ engagement/ consultation and the outcomes. The QRC will no longer be expected to consider EQIAs in full. The role of QRC will be to obtain assurance in relation to the robustness of the process and that this is being complied with.

7. EQIA Process for Schemes/ Policies not Associated with the Financial Recovery Plan

In order to simplify the process for staff it has been agreed that the same EQIA full assessment document will be used to impact assess schemes and policies that are not part of the financial recovery plan. However these will not be required to undergo review by the cross CCG panel. These will be completed by the scheme or policy lead and submitted to the quality team for review. The previous EIA and QIA policies will therefore become obsolete. A Greater Nottinghamshire EQIA policy will be developed when the proposed joint management team and committee are established. In the interim the processes and documentation outlined in this paper will be followed.

8. Reporting

A log of EQIA activity associated with the Greater Nottinghamshire Financial Recovery Plan will be maintained by the City CCG engagement team. A log of EQIA activity not associated with the Financial Recovery Plan will be maintained by the relevant Quality Teams. These will be presented to the CCGs' respective Quality Committees, Equality and Diversity Groups and Patient and Public Engagement Groups.

9. Recomentations

The Governing Body is requested to:

- **APPROVE** the revised process.

Appendix 1: EQuality Impact Assessment (EQIA) and Engagement Screening Tool

Introduction

This screening tool has been designed to identify proposals that require completion of an EQIA and development of an engagement plan. Proposals that, through this screening, are identified as not having a tangible impact on patients or quality do not require an EQIA or engagement. The screening tool also captures information that tells us about the scale of the proposal and the risk of controversy i.e. reputational impact.

Where an impact on patients is identified through the screening a full EQIA template and engagement scoping template should be completed. A panel has been established to support the development and assurance of EQIAs and engagement plans.

Scheme title:
Scheme lead:
Date screening completed:
Projected savings 2017/18:
Projected savings 2018/19:
CCG(s) affected:
Summary description of QIPP scheme being assessed: *Please embed the scheme overview/scoping document or other relevant papers that provide a summary of the scheme*

SECTION 1: QUESTIONS ON THE IMPACT OF THE CHANGE ON PATIENTS

Will the proposal: • **have an impact on who is eligible to access the service e.g. by changing referral criteria and/or** • **affect how people access the service e.g. where or when it will be delivered?** ● Positive impact ○ Negative impact ○ No impact ○ N/A
Comments/rationale: *Please explain briefly your response*

Will the proposal have an impact on patient safety, patient experience or clinical effectiveness? ○ Positive impact ○ Negative impact ● No impact ○ N/A
Comments/rationale: *Please explain briefly your response*

Will the proposal have any other impact that will be noticeable to patients or carers?

● Positive impact ○ Negative impact ○ No impact ○ N/A

Comments/rationale:

Please explain briefly your response

SECTION 2: QUESTIONS ON THE LIKELY LEVEL OF CONTROVERSY

Is the proposal likely to result in controversy due to:

- **The nature of the service**
- **The nature of the patients or carers affected**

● Positive impact ○ Negative impact ○ No impact ○ N/A

Comments/rationale:

Please explain briefly your response

Has there been previous controversy around the service resulting in:

- **Complaints**
- **Media coverage**

● Positive impact ○ Negative impact ○ No impact ○ N/A

Comments/rationale:

Please explain briefly your response

Are you aware of any controversy (complaints or media coverage) when this scheme was introduced elsewhere?

● Positive impact ○ Negative impact ○ No impact ○ N/A

Comments/rationale:

Please explain briefly your response

Appendix 2: EQuality Impact Assessment (EQIA) Template

Introduction

The EQIA template has been introduced to bring together equality and quality impact considerations into a single systematic assessment process.

An EQIA should be completed whenever the initial screening process on each scheme in the Financial Recovery Plan indicates that one is required.

The EQIA Panel will oversee the development and quality assurance of EQIAs.

To support understanding and completion of the EQIA process, this document is hyperlinked to a glossary of key terms.

Purpose

The EQIA is designed to:

- Enable details of supporting evidence to be recorded
- Assess the impact of proposed changes on health inequalities.
- Assess the impact of proposed changes to services in line with the CCGs' duty to maintain and improve the three elements of quality (patient safety, patient experience and clinical effectiveness)
- Assess whether proposed changes could have a positive, negative or neutral impact, depending on people's different protected characteristics defined by the Equality Act 2010
- Identify any unlawful discrimination or negative effect on equality for patients/service users, carers and the general public
- Consider the impacts on people from relevant inclusion health groups (e.g. carers, homeless people, people experiencing economic or social deprivation)
- Identify where any information to inform the assessment is not available, which may indicate that patient engagement is required
- Provide a streamlined process and prevent equality and quality risks from being considered in isolation
- Determine whether a scheme can proceed, proceed with identified action or not be progressed

Decisions on whether schemes will be implemented, amended or stopped will be based on a combination of EQIAs, engagement findings and consultation outcomes.

EQIAs are 'live' documents, and as such, are required to be revisited at key stages of scheme development and implementation, particularly following the conclusion of any engagement and consultation activities to inform decision-making.

Scheme title:

Assessor name:

Date of assessment:

Summary description of QIPP scheme being assessed:

Details of any supporting evidence:

When completing this section a review of the latest evidence should be undertaken. Use the checklist provided for sources of evidence and trusted websites to visit to find evidence. Describe the key findings from your evidence search and how they have informed this scheme.

Microsoft Word 97 -
2003 Document

If you have been unable to find evidence, please describe what you have based this scheme on instead (e.g. activity data, population data, patient experience or public engagement intelligence, clinical opinion etc.):

The following question should be addressed and responses provided for each of the protected characteristic and inclusion health groups listed below. Highlight where the scheme has (or could potentially have) a positive or negative impact, either directly or indirectly, considering proportionality and relevance.

> **Could the scheme have a positive impact or negative impact on people who may, as a result of being in one or more of the following protected characteristic or inclusion health groups, experience barriers when trying to access or use NHS services?**

In addressing this question, please consider whether the scheme could potentially have a positive or negative impact in any of the following areas:

- The CCGs' duty to maintain and improve the three elements of quality – patient safety, patient experience and clinical effectiveness
- Access to services (including patient choice)
- Transfers between services (whether between specialities, care settings, or during a person's life course)
- Safeguarding adults
- Safeguarding children
- Dignity and respect (including privacy)
- Person-centred care
- NICE requirements
- Shared decision-making

Protected characteristic and inclusion health groups

Impact on the protected characteristic of Age: ● Positive impact ○ Negative impact ○ No impact ○ N/A
Comments/rationale:
Impact on the protected characteristic of Disability: ● Positive impact ○ Negative impact ○ No impact ○ N/A
Comments/rationale:
Impact on the protected characteristic of Gender re-assignment: ● Positive impact ○ Negative impact ○ No impact ○ N/A
Comments/rationale:
Impact on the protected characteristic of Pregnancy and maternity: ● Positive impact ○ Negative impact ○ No impact ○ N/A
Comments/rationale:
Impact on the protected characteristic of Race: ● Positive impact ○ Negative impact ○ No impact ○ N/A
Comments/rationale:
Impact on the protected characteristic of Religion or belief: ● Positive impact ○ Negative impact ○ No impact ○ N/A
Comments/rationale:
Impact on the protected characteristic of Sex: ● Positive impact ○ Negative impact ○ No impact ○ N/A
Comments/rationale:
Impact on the protected characteristic of Sexual orientation: ● Positive impact ○ Negative impact ○ No impact ○ N/A
Comments/rationale:

Impact on people in any of the following Inclusion Health Groups: **Carers** **Homeless people** **People who misuse drugs** **New and emerging communities, including refugees and asylum seekers** **Gypsies, Roma and Travellers** ● Positive impact ○ Negative impact ○ No impact ○ N/A
Comments/rationale (with an indication of which of the above groups have specifically influenced your impact conclusion)**:**
Could the scheme have a positive or negative impact on health inequalities (specific consideration should be given to **people experiencing economic or social deprivation,** including those who are long-term unemployed, have limited family or social networks)**:** ● Positive impact ○ Negative impact ○ No impact ○ N/A
Comments/rationale:

Details of any risks identified and overall comments:
Recommendation: ● Proceed ○ Proceed with action* ○ Stop *Please provide details of action required:

GLOSSARY *The descriptions for the following terms are worded specifically for this EQIA.*

Term	Description
Access	Access includes the ability of patients to obtain and understand information about their health and health services, as well as being able to access clinical advice and treatment. Patients' access may be limited by a range of factors such as mobility limitations, cognitive function and language barriers.
Age	The protected characteristic of Age refers to being of a specific age or belonging to a particular age range.
Carers	Carers may be socially excluded and vulnerable, causing them to experience specific disadvantages, leading them to have poorer predicted health outcomes and a shorter life expectancy than the average population.
Clinical effectiveness	Clinical effectiveness is a component of quality in the NHS. It is the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients. The process involves a framework of informing, changing and monitoring practice.
Cost effectiveness	Cost effectiveness is assessed in order to maximise health gain from available resources. If resources are used for interventions that are not cost effective, then less health gain is achievable across the whole population (that is, there is a greater 'opportunity cost'). Opportunity cost is the cost of losing an alternative that would have brought benefit (benefits foregone).
Dignity and Respect	This is one of the values incorporated in the NHS Constitution: "We value every person - whether patient, their families or carers, or staff - as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do." Respect, dignity, compassion and care should be at the core of how patients and staff are treated - not only because that is the right thing to do, but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.
Disability	The protected characteristic of Disability includes people with a physical or mental impairment or illness, which have a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.
Engagement	The range of activities designed and deployed by CCGs to: • gain the views of patients, service users and carers on commissioning and service delivery • include patients, service users and carers in considering their own health, care and treatment.

Term	Description
Equality Act 2010	A single piece of legislation that replaced previous anti-discrimination Acts. It simplified the law, removing inconsistencies and making it easier for people to understand and comply with. The Act outlaws direct and indirect discrimination, harassment and victimisation of people with relevant protected characteristics in relevant circumstances and requires that reasonable adjustments be made for disabled people. The Equality Act includes a public sector equality duty (PSED), which applies to public bodies and others carrying out public functions. It supports good decision-making by ensuring public bodies consider how different people will be affected by their activities, helping them to deliver policies and services that are efficient and effective, accessible to all, and which meet different people's needs.
Evidence	Information from research and other sources e.g. activity data, population data, patient experience or public engagement intelligence, clinical opinion, NICE, national strategies, policy documents and reports, evaluation, clinical audit, etc.
Evidence-based practice	EBP is the integration of clinical expertise, patient values, and the best research evidence into the decision making process for patient care. Clinical expertise refers to the clinician's cumulated experience, education and clinical skills. The patient brings to the encounter his or her own personal preferences and unique concerns, expectations, and values.
Gender re-assignment	A person has the protected characteristic of gender reassignment if s/he is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning her/his sex by changing physiological, behavioural or other attributes of sex.
Gypsies Roma and Travellers	A group of people who may be socially excluded and vulnerable, causing them to experience specific disadvantages, leading them to have poorer predicted health outcomes and a shorter life expectancy than the average population. See also Inclusion Health groups.
Health inequalities	Preventable and unjust differences in health status experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged.
Homeless people	A group of people who may be socially excluded and vulnerable, causing them to experience specific disadvantages, leading them to have poorer predicted health outcomes and a shorter life expectancy than the average population. See also Inclusion Health groups.
Inclusion health groups	Groups of people who may be socially excluded and vulnerable, causing them to experience specific disadvantages, leading them to have poorer predicted health outcomes and a shorter life expectancy than the average population. These include carers, homeless people, people who misuse drugs, asylum seekers and refugees, Gypsies and Travellers, sex workers, people experiencing economic and social deprivation, people who are long-term unemployed, people who have limited family or social networks and people who are geographically isolated.
Negative impact	An effect that could, for example: • decrease or exclude access to a service or activity • be detrimental to treatment outcomes • have an adverse impact on patient experience.

Term	Description
New and emerging communities, including refugees and asylum seekers	A group of people who may be socially excluded and vulnerable, causing them to experience specific disadvantages, leading them to have poorer predicted health outcomes and a shorter life expectancy than the average population. See also Inclusion Health groups.
Patient choice	Informed decision-making by patients over where/how they receive health care.
Patient experience	Patient experience is one of the three components of quality in the NHS. Experience of care, clinical effectiveness and patient safety together make the three key components of quality in the NHS. Good care is linked to positive outcomes for the patient and is also associated with high levels of staff satisfaction. Patient experience means putting the patient and their experience at the heart of quality improvement.
Patient safety	The NHS is expected to treat patients in a safe environment and protect them from avoidable harm. Patient safety is one of the three components of quality in the NHS and is defined as the prevention of errors and adverse effects to patients associated with health care. While health care has become more effective it has also become more complex, with greater use of new technologies, medicines and treatments. Patient safety issues are the avoidable errors in healthcare that can cause harm (injury, suffering, disability or death) to patients.
People experiencing economic and social deprivation	A group of people who may be socially excluded and vulnerable, causing them to experience specific disadvantages, leading them to have poorer predicted health outcomes and a shorter life expectancy than the average population. It includes people who are long-term unemployed, or who have limited family or social networks. To comply with the Equality Act 2010, CCGs are required to consider how their strategic decisions might help to reduce the inequalities associated with socio-economic disadvantage, such as inequalities in employment, education, health, housing and crime rates. It is for individual CCGs to consider which socio-economic disadvantages it is able to influence.
People who misuse drugs	A group of people who may be socially excluded and vulnerable, causing them to experience specific disadvantages, leading them to have poorer predicted health outcomes and a shorter life expectancy than the average population. See also Inclusion Health groups.
Positive impact	An effect that could, for example: • increase access to a service or activity • improve treatment outcomes • enhance patient experience
Pregnancy and maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.
Privacy	Interpreted most broadly, privacy is about the integrity of the individual. It therefore encompasses many aspects of the individual’s social needs – privacy of the person, personal information, personal behaviour and personal communications.

Term	Description
Protected characteristics	The Equality Act 2010 outlines nine protected characteristics - Age, Disability, Gender re-assignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion or belief (including no religion or belief), Sex and Sexual orientation. The Equality Act outlaws direct and indirect discrimination, harassment and victimisation of people with relevant* protected characteristics. *Marriage and civil partnership is not a ‘relevant’ protected characteristic. (This distinction applies only in relation to work, not to any other part of the Equality Act 2010) We all have at least five of the nine protected characteristics - age, race, religion or belief/no religion or belief, a sex and a sexual orientation.
Quality	The definition of quality in health care, enshrined in law, includes three key components: patient safety, clinical effectiveness and patient experience. The NHS aspires to the highest standards of excellence and professionalism in the provision of high quality care – ie care that is safe, clinically effective and focused on providing as positive an experience to service users as possible.
Race	This protected characteristic refers to groups of people defined by their colour, nationality (including citizenship), ethnic or national origins.
Religion or belief	This protected characteristic includes any religion and any religious or philosophical belief. It also includes a lack of any such religion or belief. A religion need not be mainstream or well-known but it must be identifiable and have a clear structure and belief system. Denominations or sects within religions may be considered a religion. Cults and new religious movements may also be considered religions or beliefs. Belief means any religious or philosophical belief and includes a lack of belief. Religious belief goes beyond beliefs about and adherence to a religion or its central articles of faith and may vary from person to person within the same religion. A belief need not include faith or worship of a god or gods, but must affect how a person lives their life or perceives the world.
Dignity and respect	This is one of the values incorporated in the NHS Constitution: “We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.” Respect, dignity, compassion and care should be at the core of how patients and staff are treated – not only because that is the right thing to do, but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.
Safeguarding adults	The Care Act 2014 defines adult safeguarding as protecting an adult’s right to live in safety, free from abuse and neglect with people and organisations working together to prevent and stop both the risks and experience of abuse or neglect. Safeguarding balances the adults right to be safe with their right to make informed choices, whilst at the same time making sure that their wellbeing is promoted including, taking into consideration their views, wishes, feelings and beliefs in deciding on any action (s). The Care Act 2014 defines an adult at risk of harm as: ‘someone who has needs for care and support, and is experiencing, or at risk of, abuse or neglect and is unable to protect themselves’.

Term	Description
Safeguarding children	Safeguarding children and young people means the actions that are taken to promote their welfare and protect them from harm, abuse and maltreatment. This includes preventing harm to their health or development, ensuring that they experience safe and effective care as they grow up and enabling them to have the best outcomes. Child protection is part of the safeguarding process and focuses on protecting individual children identified as suffering or likely to suffer significant harm. Safeguarding children and child protection guidance and legislation applies to all children up to the age of 18.
Self-care	Also known as self-management. Refers to the key role that individual people have in protecting and managing their own health, choosing appropriate treatments and managing long-term conditions. They may do this independently or in partnership with the healthcare system.
Sex	This protected characteristic refers to whether a person considers that they are a man or a woman.
Sexual orientation	This protected characteristic refers to whether a person's sexual orientation is towards their own sex, the opposite sex or to both sexes.
Shared decision-making	Shared decision-making is a process in which patients, when they reach a decision crossroads in their health care, can review all the treatment options available to them and participate actively with their healthcare professional in making that decision.