HILLINGDON
LONDON

NHS
Hillingdon
Clinical Commissioning Group

Appendix 7

Equality Impact Analysis: Better Care Fund Plan 2016/17

Equality Impact Analysis is the method used by the Hillingdon Clinical Commissioning Group (HCCG) and Hillingdon Council (LBH) to demonstrate that it is giving due regard to equality when developing and implementing changes to services, strategy, policy and/or practice.

The purpose of this equality analysis is to:

1. Identify unintended consequences and mitigate them as far as is possible,
2. To actively consider how the CCG and LBH can support the advancement of equality and fostering of good relations
3. Reduce health inequalities across the Borough of Hillingdon

Section 1: General information

Background:

The Better Care Fund (BCF) Plan is a mechanism for providing better outcomes for residents and patients through closer integration between health and social care. This assessment updates the one undertaken for the 2015/16 BCF plan.

The focus of Hillingdon's plan in 2016/17, as in 2015/16, is the 65 and over population and there is a specific focus on:

- All of Hillingdon's residents aged 85 and over
- Frail older people aged 75 and over with two or more conditions
- Older people who are at risk of dementia
- Older people who are at risk of falling for a first time.

However, there are aspects of the 2016/17 plan that are extended to a broader population, e.g. scheme 6, which is intended to address the needs of all adults in supported living and scheme 7 which considers the needs of Carers of all ages.

There are eight schemes within the 2016/17 BCF and these are:

- ***Scheme 1*** - Proactive early identification of people with susceptibility to falls, dementia, stroke and/or social isolation
- ***Scheme 2*** - Better care for people at the end of their life
- ***Scheme 3*** - Rapid response and integrated intermediate care
- ***Scheme 4*** - Seven day working initiative
- ***Scheme 5*** - Integrated community-based care and support

- ***Scheme 6*** - Care home and supported living market development
- ***Scheme 7*** - Supporting Carers
- ***Scheme 8*** - Living well with dementia

Annex 1 provides a summary of each of the schemes.

Responsible officer completing this assessment:

Gary Collier - Better Care Fund Programme Manager

Date completed:

10th March 2016

Relevant documents:

Name of document	Year	Owner(s)	Public document
Better Care Fund Plan Narrative	2016	CCG/LBH	Yes
Better Care Fund Annex 1	2014	CCG/LBH	Yes
Better Care Fund Planning Template	2014	CCG/LBH	Yes

Responsible Clinical Lead

Dr Kuldhir Johal HCCG Governing Body and Older People's Model of Care Delivery Group co-chair

Supporting team

Kevin Byrne - Head of Policy and Partnerships, LBH
John Higgins – Head of Safeguarding, Quality and Partnerships, LBH
Joan Veysey - Deputy Chief Operating Officer, HCCG
Jane Walsh - Commissioner Older People's Services, HCCG

Section 2: Data gathering

What are the aims of the policy?

The following aims and objectives of the BCF Plan have been agreed with service users and partners:

1. We will build on our present initiatives around admissions avoidance and supported discharge.
2. Hillingdon's residents will experience a shared set of responsibilities exhibited by all the organisations working in health and care.
3. Residents will be able to access the services appropriate to their needs on each day of the week.
4. Our workforce will be better equipped and better skilled to face this challenge: to residents, they will appear as a single system, with an open culture that celebrates success.

5. We will work together to proactively identify the health and care needs of older frail residents and will aim to better manage the care needs of younger people who may be susceptible to frailty as they get older.

6. We will aim to reduce levels of health inequality in Hillingdon.

7. We will be better at predicting future health and care needs – both across the population and for individual residents.

What health and social care outcomes do HCCG and the Council hope to achieve?

a. A reduction in the number of non-elective admissions (NELs) attributed to the 65 and over population by 663 during 2016/17. This is a contribution to the overall CCG target for 2016/17;
b. A reduction in the number of permanent admissions of older people (65 + and over) to care homes, per 100,000 population;
c. Increase in the proportion of older people (65 + and over) who were still at home 91 days after discharge from hospital into reablement services;
d. Reduction in delayed transfers of care (delayed days) from hospital per 100,000 population (18 +).

Are there any factors that might prevent these outcomes being achieved?

The following are factors that could impact on these outcomes being achieved:
a. Continuing increase in the level of NEL activity;
b. Impact of severe weather;
c. Lack of suitably qualified staff;
d. Private care provider business failure.
e. Lack of available providers who can support people with complex needs.

What relevant quantitative and qualitative data do you have?

Overview

40% of our non-elective activity in 2014/15 and 39% during Quarters 1 to 3 2015/16 was attributed to the 65 and over population, this group accounted for 56% of the total health emergency admission spend (54% Q1 to 3 2015/16). In 2014/15 the 42% (39% Q1 to 3 2015/16) of emergency admission spend was on the 75 and over population, which accounted for 29% of admissions in 2014/15 (27% Q1 to 3 2015/16). We estimate that some 35% of emergency admission for the 75 and over population group are avoidable or deferrable, which is based on the proportion of admissions resulting in a length of stay of between 0 and 2 days.

Population 65 +

Hillingdon's Joint Strategic Needs Assessment (JSNA) shows that in 2016 there are approximately 39,400 people aged 65 and over in Hillingdon, out of which 17,730 (45%) are men, and 21,670 (55%) are women. Older People's (65+) population is predicted to increase by 7.3% in the next 4 years to 2020, which compares with a 5% overall increase in Hillingdon's population. This is approximately the same increase as the neighbouring boroughs of Hounslow and Harrow, but slightly higher than Ealing where there is a projected increase of 5% over the next 5 years. In addition the projected increase for Hillingdon is also in line with the projected increase for the London region.

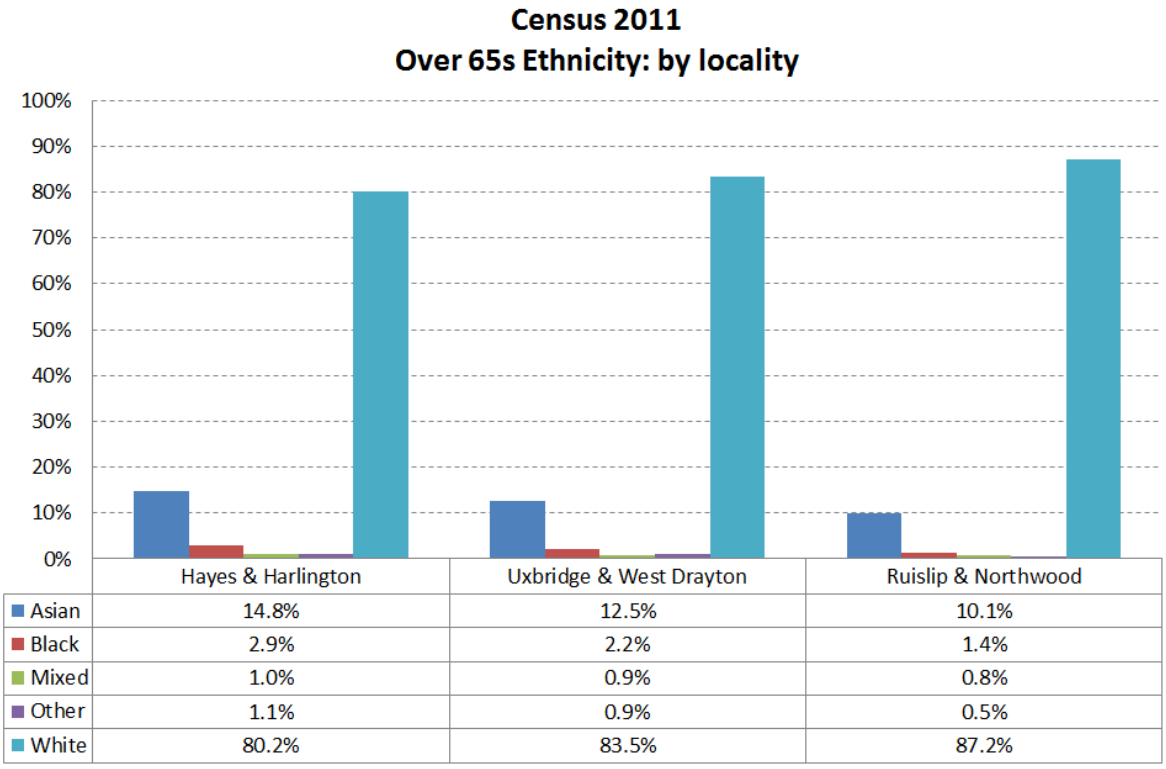
Population 85 +

The biggest percentage increases in Hillingdon is expected to occur in those aged between 65 - 69 and 85 and over. The projected overall increase in the population of people aged 85 and over is 17% between 2016 and 2021 from 5,443 to 6,561. 37.6% (2,049) of the 85 and over population are males and 62.3% (3,933) are females.

Population 65 + and Ethnicity

A key feature of Hillingdon's demography is that ethnic diversity is concentrated in the younger age groups. For each of the five year age bands for people aged 65 and over there is an increasing proportion of White British. It is expected that the lack of diversity within these older age groups will change over the coming decades as the younger age groups grow older.

The graph below shows the distribution by ethnicity of Hillingdon's older people population.



	Hayes & Harlington	Uxbridge & West Drayton	Ruislip & Northwood
Asian	14.8%	12.5%	10.1%
Black	2.9%	2.2%	1.4%
Mixed	1.0%	0.9%	0.8%
Other	1.1%	0.9%	0.5%
White	80.2%	83.5%	87.2%

Long-term Conditions

Within the next 5 years, there is a projected increase of 9% in the number of people aged 65 and over with a limiting long-term illness. This figure is slightly higher than the projections for Ealing and the London region, but close to the percentage increases projected for Hounslow and Harrow. Overall Hillingdon has the highest projected increase in relation to the London region and the forenamed neighbours.

The latest official data on dementia prevalence data (Joint Commissioning Panel for Mental Health, 2013) suggests that at mid-year 2014 there were 2,574 people in the borough living with dementia. This is projected to grow by 13.5% to 2,975 by 2021. The Projecting Older People's Population Information (POPPI) service developed by the Institute of Public Care (IPC) in partnership with Oxford Brookes University suggests that there are currently 2,670 people living with dementia and predicts an increase of 12% to 3,037 by 2020.

The Royal Society of Psychiatrists' 2009 study *Dementia and People with Learning Disabilities: Guidance on the assessment, diagnosis, treatment and support of people learning disabilities who develop dementia* shows that there is an increased susceptibility amongst this population group to develop dementia once they reach the age of 50. The following figures suggest that the risk is up to four times greater than the general population:

- 1 in 10 of those aged 50 to 64
- 1 in 7 of those aged 65 to 74
- 1 in 4 of those aged 75 to 84
- Nearly three-quarters of those aged 85 or over.

Research undertaken in partnership with the Alzheimers' Society estimates that 1 in 10 people with a learning disability will go on to develop dementia between the ages of 50 and 65 and approximately 50% of those aged 85 and over. For people living with Down's syndrome 1 in 50 are estimated to develop dementia in their 30s and 50% of those aged 60 and over will develop it. The Projecting Adult Needs and Service Information (PANSI) suggests that there are currently 5,393 adults in Hillingdon with a learning disability and that this will increase by 6% to 5,749 in the period up to 2020. There are approximately 117 people who have Down's syndrome in Hillingdon.

POPPI projections suggest that the number of people aged 65 and over with a body mass index of 30 + was 10,094 in 2015 and that this will increase by 8% to 10,943 by 2020. The numbers of older people living with types 1 & 2 diabetes are projected to increase by nearly 10% from 4,805 in 2015 to 5,307 in 2020.

Stroke

In 2013/14 there were 3,246 people who had been diagnosed with a stroke in Hillingdon. In the same period there were 310 admissions recorded on the Sentinel Stroke National Audit Programme. Atrial fibrillation is a known risk factor for stroke. The diagnosed prevalence in Hillingdon is 1.1% and the estimated prevalence is 2.0%. There could be an additional 2,500 people with undiagnosed atrial fibrillation in Hillingdon.

Falls and Fractures

The consequences of falls have a significant impact on both NHS and social care services. Falling can precipitate loss of confidence, the need for regular social care support at home, or even admission to a care home. Fractures of the hip require major surgery and inpatient care in acute and often rehabilitation settings, on-going recuperation and support at home from NHS community health and social care teams. In addition, hip fractures are the event that prompts entry to a care home in up to 10% of cases. Indeed, fractures of any kind frequently require a care package for older people to support them at home.

In the UK, 35% of over-65s experience one or more falls each year. About 45% of people aged over 80 who live in the community fall each year. Between 10% and 25% of such fallers will sustain a serious injury.

757 patients aged 65 years or over were admitted as an emergency admission to The Hillingdon Hospital (THH) as a result of a fall in 2012/13. The total cost was £1,767,175. The average cost per patient for the acute inpatient stay was £2,334. 146 patients aged 65 years or over were admitted to THH with a fractured neck of femur as a result of a fall in 2012/13. The average cost of the acute inpatient stay was £5,762.

Life Expectancy

Life expectancy in Hillingdon is estimated at 79.4 years for males and 83.5 years for females (data from 2008-12). This is similar to the averages for London and England & Wales.

There are inequalities within the Borough at ward level. The gap in male life expectancy between Eastcote and East Ruislip and Botwell is 6.7 years and the gap in female life expectancy between Eastcote & East Ruislip and Botwell is 8.5 years.

Sedantary Lifestyle

Health Survey for England 2008 Volume 1 Physical activity and fitness shows that approximately 50% of Hillingdon's population aged 65 - 74 year olds spend 6 or more hours sedentary time day during the week and over 50% at weekends. For the over 75s it is 62% for both week days and at weekends.

Older People Living Alone

The 2011 census identified that 31% of older people lived alone. POPPI projections suggest that there are currently 14,094 older people living alone and that this will increase by approximately 10% to 15,580 by 2020. This does not necessarily mean that an older person living on their own is socially isolated but it can act as an indicator.

The study *Preventing Suicide in England - a cross-governmental outcomes strategy to save lives* (DH 2012) shows that living alone and becoming socially isolated and experiencing bereavement are contributory factors that can lead to suicide. Available figures show that the number of suicides amongst the 65 + age group in Hillingdon is small, e.g. 5 in 2010, 4 in 2011 and 3 in 2012, but they predominantly occur amongst men.

Carers

Carers are people who provide care and support to vulnerable relatives or friends for no financial payment and should not be confused with care workers, who are paid for the work they do.

The 2011 census shows that there were at least 25,702 Carers in Hillingdon; in fact, this figure was and is probably much higher when taking into consideration the fact that some people who are providing care to their partner or other relatives do not identify themselves as Carers. These ‘hidden Carers’ may not be accessing the support and advice that is available to them.

The table below provides a breakdown of the age of Carers as identified by the 2011 census.

Age Breakdown of Carers in Hillingdon	
Carer Age Group	**Number**
0 - 24	2,450
25 - 64	18,609
65 +	4,643
TOTAL	**25,702**

The census showed that 11,158 Carers were male and of these 2,264 were aged 65 and over. This compares to 14,544 Carers who were female, 2,379 of which were aged 65 and over.

The census also showed that 36% of the Carers aged 65 and above were providing 50 hours a week or more unpaid care and of those 17% identified themselves as having bad or very bad health.

According to estimates within the Institute of Public Care's 2009 Estimating the prevalence of severe learning disability in adults - working paper 1, there should currently be approximately 400 people living with parents and this should rise to approximately 440 in 2020. Of the 220 people with learning disabilities currently being supported by the Council who live with parents or other relatives who are identified as their main Carers. 77 of these Carers are aged 65 and over and of these 11 are aged 75 and over. This illustrates both the importance of supporting older Carers and the need to plan for a time when they will be unable to continue their caring role because of the effects of old age.

What Older People Want

The 2006 Wanless review, *Securing Good Care for Older People*, showed that only 11% of older people wished to have their care needs met in a care home should these arise, with the preferred options either being to remain in their own home cared for by relatives or friends (62%) or trained care workers (56%). An analysis of Strategic Housing Market Assessment (SHMA) surveys of over 13,500 households aged 50 and over suggests that up to 20% of all older households would consider moving to retirement housing and the application of the Retirement Housing Group (RHG) model suggests that up to 20% of people aged 75 and over would do so if it was available. The key messages from national studies are reinforced by messages received from our local older people population through fora such as the Older People's Assembly.

Supported Living Schemes

There are currently 15 schemes comprising of 106 self-contained flats for people with learning disabilities and a further scheme comprising of 14 self-contained flats due to open in 2018. There are an additional 60 rooms in 12 shared houses with the objective being to step-down people to the least restrictive environment.

There are also 48 self-contained flats in four supported living schemes for adults of working age with mental health needs and a further scheme comprising of 12 self-contained flats is due to open in 2018.

Two extra care sheltered housing schemes for the 55 and over population comprising of 95 self-contained flats for rent were opened in 2011 and 2012 respectively and two further schemes comprising of a total of 146 self-contained flats are due to open in 2018.

Did you carry out any consultation or engagement as part of this assessment or previously?

Yes

Who was consulted or engaged?

The following were involved in the assessment process:

- Sally Chandler - CEO, Hillingdon Carers (post meeting input)
- Claire Eves - Head of Adult Services, CNWL
- Graham Hawkes - CEO, Hillingdon Healthwatch
- Jo Manley - Hillingdon ACP Programme Director

- Peter Okali - CEO, Age UK Hillingdon/H4All
- Shikha Sharma - Conslutant in Public Health
- Vicky Trott - Senior Policy Officer (Equalities & Diversity), LBH
- Jane Walsh - Older People's Commissioner, HCCG

The timescale for delivering the EIA did not permit wider consultation to be undertaken. However, the development of the 2016/17 BCF Plan is consistent with feedback from consultation previously undertaken for the development of the 2015/16 plan and feedback from stakeholders through a range of fora. The 2016/17 plan proposals have been raised with the multi-agency Older People's Model of Care Delivery Group, the Disabled Tenants' and Residents' Association and the Older People's Assembly.

From the consultation what feedback did you receive?

Feedback reflected in response to analysis of impact on protected characteristics.

What changes have been made as a result of the feedback you have received?

Feedback reflected in response to analysis of impact on protected characteristics.

Section 3: Impact

Consider the information gathered in section 2 of this assessment form and assess:

1. Where you think that the strategy could have a **NEGATIVE** impact on any of the equality groups, i.e. it could disadvantage them

2. Where you think that the strategy could have a **POSITIVE** impact on any of the equality groups like promoting equality and equal opportunities or improving relations within equality groups

3. Where you think that this strategy has a **NEUTRAL** effect on any of the equality groups listed below i.e. it has no effect currently on equality groups.

The assessing team felt that the comments raised as part of the 2015/16 plan assessment were still valid. Additions have been made to those comments where the team felt that this was appropriate in view of the content of the 2016/17 proposed plan.

Do you think that the policy impacts on people because of their **age?**

1. Age	Positive	Negative	Neutral	Reasons for your decision
Young (Children and young people, working age)			√	The focus of the BCF Plan is older people. The needs of Carers aged under 60 are considered under equalities characteristic 8: Carers.
Older (Working age, 60+, and	√			The key objective of the BCF Plan is to keep older people out of hospital or ensure a reduction in length of stay where an admission is unavoidable. The Plan seeks to promote independence and

retirement age)				maximise the quality of life for Hillingdon's older people population. However, the intention behind scheme 2 is embed the principle of a good death where older people are at the end of life.

Do you think that the policy impacts on **carers**? (e.g. adults providing care for other adults free of charge)

2. Carers	Positive	Negative	Neutral	Reasons for your decision
	√			The BCF Plan recognises the importance of supporting Carers and the majority of the resources committed under *scheme 7* are dedicated to that purpose, the remit of which has been expanded in the 2016/17 plan to include Carers of all ages. The following summarises other key benefits for Carers deriving from the schemes: *Scheme 1*: Early identification and case management support empower Carers to make informed choices, thus preventing decisions being made in crisis situations; *Scheme 2*: better end of life management helps to reduce stress for the Carer and provides continuing support on the passing of the person at end of life, therefore helping to address their mental wellbeing; Scheme 3: short term post discharge support from professionals and/or third sector will provide assurance for Carers and help to build their confidence about being able to manage the needs of the person they are caring for; Scheme 4: by ensuring steady flow of activity should reduce readmissions and the stress that this can cause to Carers; *Scheme 5*: Carers should experience a more seamless service as a result of the more widespread use of care planning and effective, joined up use of services to address needs; *Scheme 6*: Application of *Dignity Challenge* principles will see Carers treated as true partners in care provision; Scheme 8: Carers should benefit from the delivery of the proposed actions with this scheme.

Do you think that the policy impacts on people with a **disability?**

3. Disability	Positive	Negative	Neutral	Reasons for your decision
Visually impaired	√			All schemes should have a positive impact on people with sensory impairments and physical disabilities through the identification of people

Hearing impaired	√			susceptible to falls, dementia and/or stroke and assisting in preventing these occurring (*scheme 1*); provision of rehabilitation and reablement for those experiencing an acute episode (*scheme 3*); reducing length of stay and therefore avoiding hospital acquired infections (*scheme 4*); supporting people locally with an integrated response to their health and wellbeing needs (*scheme 5*); preventing admission to hospital from care homes where residents experience an exacerbation (*scheme 6*) by providing professional clinical support to care home staff; promoting greater independence in the least restrictive care setting through the development of supported living models with appropriate wrap-around care and support provision (including medical) (scheme 6); and addressing safeguarding issues and effectively managing the provider market (*scheme 6*).
Physically disabled	√			
Learning disability	√			*Schemes 1, 3, 4* and *5* could lead to the identification of older people with learning disabilities not known to services, i.e. people with learning disabilities from Black, Asian and minority ethnic communities, where there can be stigma attached to having this type of disability. *Scheme 6* will have a positive effect by ensuring the sustainability of the supported living model. A key benefit to this user group will come under *scheme 7* through identification and the provision of support to older Carers. The susceptibility of people with learning disabilities to develop dementias at a much younger age than the general population will be addressed through *scheme 8*.
Mental health	√			*Scheme 1*: Early identification of living with dementia can help to ensure timely access to treatment that may arrest the progress of the condition. Access to advice about changes in lifestyle habits that may contribute to and accelerate progress could also have the same effect. Engaging with people who are socially isolated can help prevent adverse health impacts, such as depression, that can also lead to other physical health problems. *Scheme 2*: Better management of the end of life pathway should relieve some of the stress

				experienced both by the person at the end of their life and also their family. The study *Preventing Suicide in England - a cross-governmental outcomes strategy to save lives* (DH 2012) shows that living alone and becoming socially isolated and also bereavement are contributory factors in leading to suicides. Available figures show that the number of suicides amongst the 65 + age group is small, e.g. 5 in 2010, 4 in 2011 and 3 in 2012, and these predominantly occur amongst men. *Schemes 1 and 2* in particular would seek to address some of the issues that can lead to suicide. The support to Carers deriving from *scheme 7* should help to address stress and anxiety that they face as a result of their caring role. The specific dementia scheme is intended to address the needs of people will organic mental health conditions to maximise their independence for as long as possible.
Other (HIV positive, multiple sclerosis, cancer, diabetes, epilepsy)	√			Risk stratification that is reflected in *scheme 5* will identify people with long-term conditions and ensure that they are linked into the appropriate GP network, which should ensure access to appropriate treatment and information and advice about self-care. This means that the Plan as a whole should have a beneficial impact

Do you think that the policy affects **men and women** in different ways?

4. Gender	**Positive**	**Negative**	**Neutral**	**Reasons for your decision**
Male	√			As men tend to be more reticent about discussing health needs or problems, *scheme 1* has the potential to be of particular benefit to them.
Female	√			More women than men are likely to benefit from the BCF Plan but this is largely due to the fact that they live longer rather than there being anything intrinsically discriminatory about the nature of the schemes.

Do you think that the policy impacts on people because of their **Gender identity (e.g. People in pre or post operation stage and/or where a person/s identify themselves as one gender but require**

access to their biological gender?

5. Gender Identity	Positive	Negative	Neutral	Reasons for your decision
Pre operation	√ Scheme 1		√ Other Schemes	*Scheme 1* may have a positive impact by identifying older people whose social isolation may relate to their gender identity but other schemes are considered to be neutral at this stage.

Do you think that the policy impacts on people because of **pregnancy or maternity?**

6. Pregnancy or maternity	Positive	Negative	Neutral	Reasons for your decision
			√	None of the schemes were considered to have a positive or negative impact on this characteristic, especially as the focus of the plan is the 65 and over population.

Do you think that the policy impacts on people on the grounds of their **race/ethnicity**?

7. Race	Positive	Negative	Neutral	Reasons for your decision
Promoting equality of opportunity	√			The principle behind *scheme 1* of making every visit count will enable risks relating to the needs of the seldom seen, seldom heard groups to be identified and addressed that may not be the case now. The implementation of the Health and Wellbeing Service in particular will establish links with community groups and facilitate more effective sign-posting to appropriate cultural and faith groups. *Scheme 2*: Identification of preferred place of care (PPC) at end of life and aligning workforce to provide seamless care will prevent distress occurring during handover periods and eliminate any de facto discrimination that may currently be occurring. Identification of PPC also recognises that for some cultures this may actually be hospital. Early identification of people within the last year of life will enable more personalised advanced planning arrangements to either avoid crises or to be able to respond to them in a way that is more sensitive to the needs and wishes of the person at end of life and their families. *Scheme 3*: Neutral as there are no identifiable features of this scheme that would have a positive or negative effect on the population based on their race or ethnic origin. *Scheme 4*: Neutral as there are no identifiable features of this scheme that would have a positive or negative effect on the population
Eliminating unlawful discrimination	√			

Promoting good race relations			√	There may be positive benefits for the promotion of good race relations emanating from positive impacts on *Promoting equality of opportunity* and *Eliminating unlawful discrimination* but there is no evidence to suggest that the schemes will otherwise have a neutral impact at this stage.

Do you think that the policy impacts on people because of their **religion or faith?**

8. Religion or Faith	**Positive**	**Negative**	**Neutral**	**Reasons for your decision**
	√ Scheme 1		√ Other Schemes	Scheme 1 could have a positive effect for people because of their religion for the reasons set out above. Scheme 4 provides opportunities to work more flexibly to reflect religious beliefs but other schemes are likely to be neutral.

Do you think that the policy impacts on people because of their **sexual orientation?**

9. Sexual Orientation	**Positive**	**Negative**	**Neutral**	**Reasons for your decision**
Lesbian	√ Scheme 1		√ Other Schemes	*Scheme 1* may have a positive impact by identifying older people whose social isolation may relate to their sexual orientation but other schemes are considered to be neutral at this stage.
Gay				
Heterosexual				
Bisexual				
Transsexual				

Do you think that the policy impacts on any **other** people? (e.g. Homeless, veterans, ex-offenders, substance abuse)

10. Other (Please list)	**Positive**	**Negative**	**Neutral**	**Reasons for your decision**
				No benefits or disbenefits for other groups were considered as part of the assessment.

Section 4: Evaluation / On-going monitoring

If the service this policy refers to already exists please fill out sections 4A and then proceed to section 5. If the service in this policy is a new service please complete section 4B and then proceed to section 5.

Section 4A: Better Care Fund: Existing service

What systems are currently in place to monitor/ record the profile of service users? [e.g. patient or user survey that collects ethnic background]
Community providers collate information in relation to the profile of patients as well as from a patient satisfaction survey.

Equalities information against the protected characteristics are mandatory fields within the Adult Social Care case management system and all providers are required to report against these.

How often is this information collected?
For each episode of care

As a result of this policy will you monitor any additional equality profile information? If yes what additional information will you gather?
The information currently collated will be reviewed and if there are any gaps these can be addressed. Appropriate data collection will be ensured for schemes in development.

As a result of this policy will the CCG and/or the Council increase the frequency of which it collects the above data? If yes, what will the increase be? [e.g. monthly to weekly]
No

Who in the CCG and the Council reviews the data collected? Will they continue to review the data? If not who will monitor the information?
The data is reviewed by the HCCG, included in quarterly reports, during provider contract meetings.

Data is reviewed in the Council by the Performance and Intelligence Team and also the Category Management Team for providers.

Section 4B [Better Care Fund Plan: New Services]

What equality information will be collected that will assist in evidencing that the service is being accessed and meeting the needs of protected groups identified in section 3?

Equalities information and patient satisfaction surveys are required from providers of services and the data is reviewed by the HCCG, included in quarterly reports from the provider.

Equalities information against the protected characteristics are mandatory fields within the Adult Social Care case management system and all providers are required to report against these.

The information below is also collected as part of the BCF Plan metrics.

<u>Service User Experience Metric</u>
Adult Social Care Survey Q12 - In the past year, have you generally found it easy or difficult to find information and advice about support services or benefits?

<u>Social Care-related Quality of Life</u>
Social care-related quality of life. Adult Social Care Survey:

- ***Control - Q3a***: Which if the following statements best describes how much control you have over

your daily life?

- ***Personal care - Q4a***: Thinking about keeping clean and presentable in appearance, which of the following statements best describes your situation?
- ***Food and nutrition - Q5a***: Thinking about the food and drink you get, which of the following statements best describes your situation?
- ***Accommodation - Q6a***: Which of the following statements best describes how clean and comfortable your home/care home is?
- ***Safety - Q7a***: Which of the following statements best describes how safe you feel?
- ***Social participation - Q8a***: Thinking about how much contact you've had with people you like, which of the following statements best describes your situation?
- ***Occupation - Q9a***: Which of the following statements best describes how you spend your time?
- ***Dignity - Q11***: Which of the following statements best describes how the way you are helped and treated makes you think and feel about yourself?

Each question has four possible answers, which are equated with having:

- No unmet needs
- Needs adequately met
- Some needs met
- No needs met

How often will this data be collected?

Equalities information is reported six monthly for the Council and quarterly for the HCCG.
The Adult Social Care Survey is undertaken annually and the audited results issued by the Department of Health in June of the following financial year. This means for BCF Plan purposes this information will not be available until June 2016.

Who in the CCG or Council will monitor this information?
Information will be monitored by the HCCG's Patient Public Involvement Equality Committee and by the Quality, Safety and Clinical Risk Committee.

Performance and Intelligence Team in the Council.

Section 5: Assessment

From your responses gathered in section 3 what actions will be taken to reduce inequalities identified in this EIA?

No inequalities were identified as a result of the assessment. However, particular attention will need to be given to how schemes develop to address the greater diversity in the south of the borough. The 2016/17 does contain areas for development in-year and these may require specific assessments to support decisions during the year.

Is the policy directly or indirectly discriminatory under the equalities legislation?
No

If the policy is indirectly discriminatory can it be justified under the relevant legislation?

Not applicable.

Section 5: Publish Assessment Results

In order demonstrate openness about the way Hillingdon Clinical Commissioning Groups policies, services and partnerships and those of the Council are developed and our commitment to promoting equality and diversity, results of the impact assessment will be published on to the public facing website. www.hillingdonccg.nhs.uk . The assessment will also be available on the Council's website with all the BCF plan-related documents.

Is there any reason why this Equality Impact Assessment should not be published, please use this space to state your reasons:

None known

Section 6: Sign off

Section 7: Glossary

Listed below are definitions of key words that will provide additional guidance in relation to meeting requirements of an Equality Impact Assessment.

Adverse Impact
This is a significant difference in patterns of representation or outcomes between equalities groups, with the difference amounting to a detriment for one or more equalities groups.

Definition of Disability
The Equality Act, 2010 defines Disability as being:

“an impairment which has a substantial, long term adverse effect on person’s ability to carry out normal day-to-day activities”.

Differential Impact
Suggests that a particular group has been affected differently by a policy, in either a positive, neutral or negative way.

Direct Discrimination
That is treating people less favourably than others as it would apply to age, disability, gender, race, religion and belief, sexual orientation. There is no justification for direct discrimination

Ethnic monitoring
A process for collecting, storing and analysing data about individuals' ethnic (or racial) background and linking this data and analysis with planning and implementing policies.

Functions
The full range of activities carried out by a public authority to meet its public sector equalities duties.

Indirect discrimination
Applying a provision, criterion or practice that disadvantages people as applies to age, disability, gender, race, religion and belief, sexual orientation and can’t be justified as a proportionate means of achieving a legitimate aim. The concept of 'provision, criterion or practice' covers the way in which an intention or policy is actually carried out, and includes attitudes and behaviour that could amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and stereotyping. To find discrimination it will be sufficient to show that a practice is likely to affect the group in question adversely.

BCF Scheme Summaries

Scheme Number	Scheme Title	Scheme Aim(s)
1.	Proactive early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.	To manage demand arising from demographic pressures by reducing the movement of Hillingdon residents/patients from lower tiers of risk into higher tiers of risk through proactive early identification and facilitating access to preventative pathways.
2.	Better care for people at the end of their life	To realign and better integrate the services provided to people towards the end of their life. To develop the ethos of 'a good death' for people and for their families and carers within the provision of adult services.
3.	Rapid Response and integrated intermediate care	Prevention of admission to acute care following an event or exacerbation and enabling recovery through intermediate care interventions with the aim of maximising the person's independence, ability to self-care and remain in their usual place of residence for as long as possible.
4.	Seven day working	To improve quality and patient safety through reducing inconsistent care provision by: • Enabling discharge from the acute trust seven days a week for people admitted for either planned or unplanned procedures; • Enabling access to community services seven days a week thereby preventing unnecessary emergency department attendances and admission

		and reducing length of stay for people admitted to hospital for either planned or unplanned procedures; • **Reducing the uneven rate of hospital discharge across the week.**
5.	**Integrated Community-based Care and Support**	**To ensure that community based resources work as effectively and as efficiently as possible with primary care for the benefit of patients.**
6.	**Care Home and Supported Living Market Development**	**Through market reshaping secure:** • **A vibrant, quality care home market that meets current and future local need; and** • **An appropriate mix of supported living provision that provides people with a realistic alternative to care home admission.**
7.	**Supporting Carers**	The aims of this scheme are that Carers are able to say: • "I am physically and mentally well and treated with dignity" • "I am not forced into financial hardship by my caring role" • "I enjoy a life outside of caring" • "I am recognised, supported and listened to as an experienced carer"
8.	**Living well with dementia**	The aim of this scheme is that people with dementia and their family carers are enabled to live well with dementia.