Appendix 5

Equality Impact Analysis Update: Better Care Fund Plan 2017/19

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 2016/17 BCF plan, which updated the assessment undertaken in respect of the first plan for 2015/16. The focus of the 2017/19 BCF plan, as for the last two years, 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. The HIA that was undertaken for the 2016/17 plan still applies to the new plan and this assessment focuses on the changes for 2017/19. There are six schemes within the 2017/19 BCF plan and these are: • ***Scheme 1*** - Early intervention and prevention. • ***Scheme 2*** - An integrated approach to supporting Carers. • ***Scheme 3*** - Better care at end of life. • ***Scheme 4*** - Integrated hospital discharge. • ***Scheme 5*** - Improving care market management and development. • ***Scheme 6*** - Living well with dementia

Appendix 1 provides a summary of each of the schemes.

Responsible officer completing this assessment:

Gary Collier - Health and Social Care Integration Manager

Date completed:

25th August 2017

Relevant documents:

Name of document	Year	Owner(s)	Public document
Better Care Fund Plan Narrative	2017	CCG/LBH	Yes
Better Care Fund Planning Template	2017	CCG/LBH	Yes
Better Care Fund Annex 1: Delayed Transfers of Care (DTOC) Action Plan	2017	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 Health Integration and Voluntary Sector Partnerships, LBH*
Nina Durnford - *Assistant Director, Older People & Physical Disabilities, LBH*
Joan Veysey - *Deputy Chief Operating Officer, HCCG*
Jane Walsh - *Older People Commissioner, HCCG*

Section 2: Data gathering

What are the aims of the policy?

By 2019/20 we expect to have in place a model of care and supporting enablers:

- Where residents have easy access to information and advice about services, including care and support services;
- That has a focus on improving health outcomes for residents with one or more health conditions or care needs, a personalisation of service provision and a collaborative approach between providers;
- Where there is systematic early identification of susceptibility to disease or exacerbation in the population, alongside integrated management of conditions and a consistent approach to care provision;
- Where better coordination of services are configured around Hillingdon's residents, including a much stronger focus on case management and prevention and integration of health and social

care;

- Where residents and carers are actively involved in the planning of their care and recognised as expert partners in care;
- Enablement of self-care and preventative services and promotion of independence for as long as possible
- Where people are only admitted to Hillingdon Hospital when they are acutely ill;
- Where a hospital admission is necessary and unavoidable their lengths of stay are reduced;
- That enables people to be treated at or close to their home wherever possible;
- A reduction in the number of people living in residential care;
- The most effective use of health and care resources is made to achieve best value for the Hillingdon £ by allowing for a flexible use of collective resources and reduction in transaction costs; and
- Enablers such as IT interoperability, development of a sustainable workforce and a vibrant market offering residents/patients quality choices.

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 975 during 2017/18. This is a contribution to the overall CCG target for 2017/18;
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?

<u>Overview</u>

Although nearly 42% (10,049) of our non-elective activity in 2016/17 was attributed to the 65 and over population, this population group accounted for 58% (£27.3m) of the total health emergency admission spend in that year. In 2016/17 34% (£16.1m) of emergency admission spend was on the 80 and over population, which accounted for nearly 23% (5,495) of admissions in 2016/17. We estimate that some 28% (1.553) of emergency admission for the 80 and over population group were avoidable or deferrable, which is based on the proportion of admissions resulting in a length of stay of between 0

and 1 days.
Nearly 46% of the Council's gross spend on care for older people in 2016/17 was on care homes (residential and nursing). This made Hillingdon the 15th lowest in London (18 boroughs have a higher proportion spend than Hillingdon). However, the desired trajectory would be towards the 40% level, focusing on people who can be better supported in their usual place of residence.

Population 65 +

Hillingdon's Joint Strategic Needs Assessment (JSNA) shows that in 2017 there are a total of 40,355 people over the age of 65 in Hillingdon, out of which 40,355 (46%) are men, and 21,881 (54 %) are women. Older People's (65+) population is predicted to increase by 6% (2,470) by 2020 and 10% (4,440) by 2022.

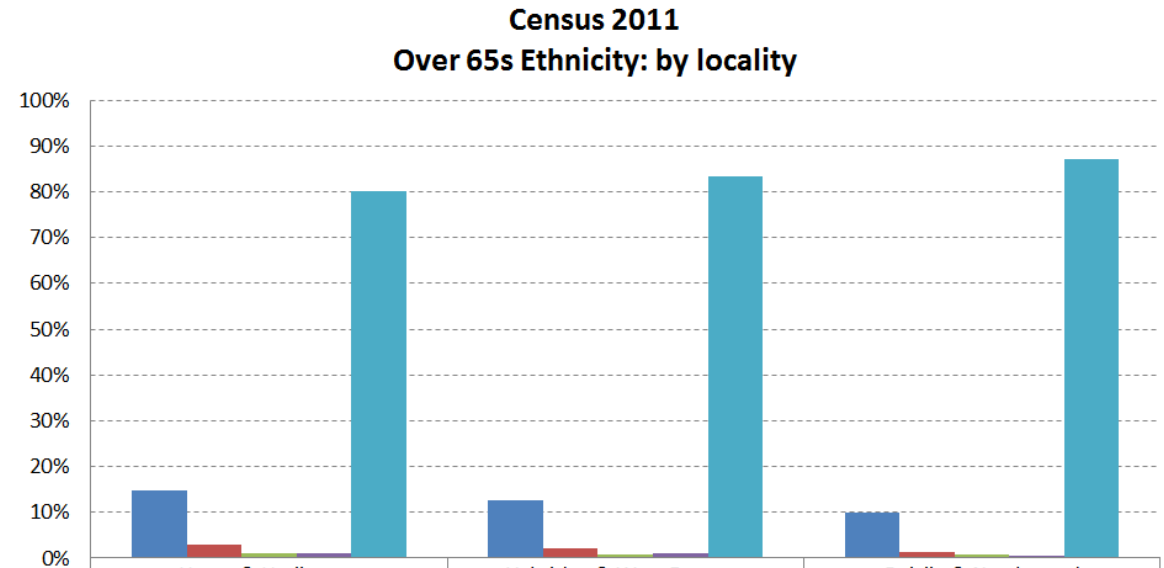
Population 85 +

The projected overall increase in the population of persons aged 85+ is 8% in the next five years compared with 5% in Hillingdon's total population. Currently, the total number of people aged 85+ is 5,616, out of which 2,172 (39%) are men and 3,444 (61%) are women.

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, but this is likely to little impact during the period of the 2017/19 BCF plan.

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

It is estimated that 2% of the most complex patients (all ages), e.g. people living with two or more long-term conditions, comprise 16.2% of CCG spend. 57% of these complex patients are people aged 65 and over; 35% are aged 75 and over and 14% aged 85 and over. In 2016/17 the local health spend on people aged 65 and over living with multiple health conditions was £9.1m.

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 dementia diagnosis rate increased to 69.3% in Hillingdon at the end of 2016/17 compared to 41% in 2014/15.

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) service 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.

In 2016/17 there were 816 falls-related admissions to Hillingdon Hospital at a cost of £2.8m.

Life Expectancy

The latest data (2013-15) shows that a male child born in Hillingdon can expect to live for 80.4 years and females for 83.7 years, which is higher than the England average (79.5 years for males and 83.1 for females). 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. Men in Hillingdon aged 65 now can expect to live to the age of 84.3 years and females 86.4 years.

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.

Sedentary 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 per 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. Projections from the Projecting Older People Population Information System (POPPI) suggest that by 2020 36% (15,580) of the 65 and over population will be living on their own and 64% (9,980) of this number will comprise of people aged 75 and over.

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.

At the end of 2016/17 there were 5,769 active Adult Carers registered with the Hillingdon Carers' Partnership, which represents nearly 23% of total Carer population in Hillingdon based on 2011 Census data. During 2016-17 there were 750 new adult referrals. At the end of 2016/17 there were also 690 Young Carers, e.g. Carers aged under 18, registered with the Partnership and of these 254 were new referrals during 2016-17.

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.

The review of the experience of the discharge process within Hillingdon Hospital undertaken by Healthwatch Hillingdon in 2016 called *Safely "home" to the right care: The experiences of Older People being discharged from Hillingdon Hospital and the onward care they received in the community* (HWH 2016) showed the importance of timely information about the discharge process as well as good communication and better integration and coordination between organisations and services involved in supporting people back home.

Extra Care Sheltered Housing

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. These are Cottesmore House and Triscott House. Two further schemes comprising of a total of 148 self-contained flats are due to open in 2018. Two new schemes totalling an additional 148 self-contained flats, Grassy Meadow Court and Park View Court, are due to open in June and September 2018 respectively.

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:

- Graham Hawkes - CEO, Hillingdon Healthwatch
- Jane Walsh - Older People's Commissioner, HCCG

The following partners were consulted on the content of the EIA:

- Trevor Begg - *Lay Member, HCCG Governing Body*
- Kevin Byrne - *Head of Health Integration and Voluntary Sector Partnerships*
- Sally Chandler - *CEO, Hillingdon Carers*
- Claire Eves - *Operational Head of Hillingdon Health Care Partnership*
- Julian Lloyd - *CEO, Age UK Hillingdon*
- Jo Manley - *Hillingdon ACP Programme Director*
- Kam Rai - *Deputy Borough Director, CNWL*
- Shikha Sharma - *Consultant in Public Health*
- Vicky Trott - *Equality, Diversity and Inclusion Manager, LBH*

The timescale for delivering the EIA did not permit wider consultation to be undertaken. However, the development of the 2017/19 BCF Plan is consistent with feedback from consultation previously undertaken in respect of earlier iterations of the plan. The 2017/19 plan proposals have been raised with the multi-agency Clinical Design Group, Carers' Strategy Group 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 2016/17 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 2017/19 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)	√			Although the focus of the BCF Plan is older people the introduction in 2017/18 of an integrated, all age home care dynamic purchase system (DPS) will benefit younger people. The needs of Carers aged under 60 are considered under equalities characteristic 2: Carers.
Older (Working age, 60+, and retirement age)	√			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 maximise the quality of life for Hillingdon's older people population. However, the intention behind scheme 3 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 or people aged under 18 caring for another person 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 2* are

				dedicated to that purpose. 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 1* - 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 3* - 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 4* - 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 6* - Carers should benefit from the development of the Dementia Resource Centre.

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 early identification of residents/patients at risk of moving from lower tiers of risk into higher tiers of risk and facilitating access to preventative pathways (*scheme 1*); possible early provision of major adaptations to address anticipatory needs could improve quality of life for people facing predictable escalation of physical needs (*scheme 1*); provision of rehabilitation and reablement for those experiencing an acute episode (*scheme 4*); 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*);
Hearing impaired	√			
Physically disabled	√			

				preventing admission to hospital from care homes where residents experience an exacerbation by providing professional clinical support to care home staff (*scheme 5*); 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 5*); and addressing safeguarding issues and effectively managing the provider market (*scheme 5*).
Learning disability	√			*Schemes 1 and 4* 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. A key benefit to this user group will come under *scheme 2* 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 6*. *Scheme 5* will have a positive effect by ensuring the sustainability of extra care as an alternative to residential care for older people with learning disabilities.
Mental health	√			*Schemes 1 and 6* - Early identification of people 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 3* - 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. *Schemes 1 and 3* in particular would seek to

				address some of the issues that can lead to suicide. The support to Carers deriving from *scheme 2* 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. *Scheme 5* seeks to ensure the availability of appropriate care home provision to meet the needs of people with more complex needs, including challenging behaviours.
Other (HIV positive, multiple sclerosis, cancer, diabetes, epilepsy)	√			Risk stratification that is reflected in *scheme 1* will identify people with long-term conditions and ensure that they are linked into the appropriate CCT, 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	√			Under *scheme 1* the continued development of the H4All Wellbeing Service will result in links with community groups being established and facilitate more effective sign-posting to appropriate cultural and faith groups. *Scheme 1* - Risk stratification will proactively identify some groups who do not ordinarily access health services whose needs have escalated to the point where they are at risk of a significant loss of independence and high demand on health and care services, e.g. men and particularly men from East African communities. This is a potential positive impact. *Schemes 1 and 4* - Improved linkages between primary care and community services are likely to have a positive benefit for people from seldom seen, seldom heard groups. The use of assistive technology benefits all communities by providing reassurance to service users and patients and their families that there will be a response in a crisis regardless of ethnicity and language. *Scheme 2* - Identification of hidden Carers could particularly benefit people from BAME communities who do not identify themselves as Carers. This could potentially benefit those communities who may not traditionally access health and care services for whatever reason.
Eliminating unlawful discrimination	√			

				Scheme 3 - 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 4* - 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 5* - For people who meet the national eligibility criteria for adult social care or the Continuing Health Care criteria personal budgets in the form of Direct Payments or Personal Health Budgets (PHB) respectively, will enable residents to secure more personalised care services. *Scheme 5*: More proactive support for care homes is likely to eliminate discrimination faced by residents based on their race as a result of difficulties in expressing wishes or expressing concerns. *Scheme 6* - The dementia-specific scheme is a positive as it provides the opportunity to address stigma attached to dementia within some ethnic groups, as well as addressing the needs that may arise for people living with the condition who may revert to their mother tongue. This is much more likely to be an issue in the south of the borough, which is much more diverse than the north.
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 other than 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
	√ Schemes 1 & 5		√ Other Schemes	*Scheme 1* could have a positive effect for people because of their religion or faith through sign-posting to more personalised pathways to address their needs. The development of the homecare DPS under *Scheme 5* and expansions of direct Payments and Personal Health Budgets 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 people because of their **marriage or civil partnership** status**?**

10. Marriage or civil partnership	Positive	Negative	Neutral	Reasons for your decision
			√	The assessment identified no benefits of disbenefits attributed to marriage or civil partnership status.

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

11. 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. There are, however, three characteristics that are not recorded as a matter of course on the care management database and these are: pregnancy/maternity, gender reassignment and marriage/civil partnership status.

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. Decisions about any additional data collection will be proportionate to the intended outcome and the ease with which the data can be collected.

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.

Service User Experience Metric

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?

Social Care-related Quality of Life

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 quarterly for the HCCG and the following frequency for the Council is dependent on the size of the contract and associated levels of risk, e.g. quarterly, six monthly or annually.

- Carers Survey - Anonymised data on age, disability, race, religion, gender, sexual orientation reported once every 2 years following national survey.

- User Survey - Anonymised data on age, disability, race, religion, sex, sexual orientation reported once a year following annual survey.
- Performance information to Adult Social Care Senior Management Team - Age (data split between 18-64 and 65+) and disability reported monthly.
- National (NHS Digital) return - Age, disability, gender, and race reported once a year.

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. During the lifetime of the plan there are areas for development that may require specific assessments to support decisions made by either HCCG's Governing Body and/or the Council's Cabinet.

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.

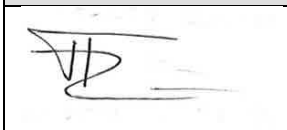
Section 5: Publish Assessment Results

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



Tony Zaman, Corporate Director Adults, Children & Young People's Services
12 September 2017

Caroline Morison, Chief Operating Officer, Hillingdon CCG
13th September 2017

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.

Appendix 1

BCF Scheme Summaries

Scheme Number	Scheme Title	Scheme Aim(s)
1.	Early intervention and prevention.	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.	An integrated approach to supporting Carers.	To maximise the amount of time that Carers are willing and able to undertake a caring role.
3.	Better care at end of life.	To realign and better integrate the services provided to support people towards the end of their life in order to deliver the ethos of a 'good death.' The main goals of the scheme are to: • Ensure that people at end of life are able to be cared for and die in their preferred place of care; and • To ensure that people at end of life are only admitted to hospital where this is clinically necessary or where a hospital is their preferred place of care or death.
4.	Integrated hospital discharge.	This scheme seeks to prevent admission and readmission to acute care following an event or a health 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.

		A further objective of this scheme is to support discharge from mental health community beds in recognition of the impact of these delays on patient flow through Hillingdon Hospital.
5.	Improving care market management and development.	This scheme is intended to contribute to the STP 2020/21 outcomes of achieving: • A market capable of meeting the health and care needs of the local population within financial constraints; and • A diverse market of quality providers maximising choice for local people.
6.	Living well with dementia	The objective of this scheme is that people with dementia and their family carers are enabled to live well with dementia and are able to say: • *I was diagnosed in a timely way.* • *I know what I can do to help myself and who else can help me.* • *Those around me and looking after me are well supported.* • *I get the treatment and support, best for my dementia, and for my life.* • *I feel included as part of society.* • *I understand so I am able to make decisions.* • *I am treated with dignity and respect.* • *I am confident my end of life wishes will be respected. I can expect a good death.*