Appendix 6

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Clinical Commissioning Group

Equality Impact Analysis Update: Better Care Fund Plan 2019/20

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 2017/19 BCF plan.

Key beneficiaries of the 2019/20 iteration of the BCF plan will be:

- All of Hillingdon's residents aged 85 and over
- Frail older people aged 75 and over with one or more long-term conditions
- Older people who are at risk of dementia
- Older people who are at risk of falling for a first time;
- Older people who are socially isolated;
- Children and young people with special educational needs (SEN);
- Adults with learning disabilities and/or autism; and
- Carers of all ages.

There are eight schemes within the 2019/20 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 and the intermediate tier.
- ***Scheme 5*** - Improving care market management and development.
- ***Scheme 6*** - Living well with dementia.
- ***Scheme 7*** - Integrated therapies for children and young people.
- ***Scheme 8*** - Integrated care and support for people with learning disabilities and/or autism.

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: 14th August 2019

Relevant documents:

Name of document	Year	Owner(s)	Public document
Better Care Fund Planning Template	2019	HCCG/LBH	Yes
Better Care Fund Annex 1: Integration Vision	2019	HCCG/LBH	Yes
Better Care Fund Annex 2: 2019/20 Delivery Plan	2019	HCCG/LBH	Yes

Responsible Clinical Lead

Dr Kuldhir Johal HCCG Governing Body and Older People's Model of Care Delivery Group co-chair
Dr Simira Tanvir Clinical lead for Children and Young People

Supporting team

Kate Kelly-Talbot - Assistant Director, Adult Social Work, LBH
Joe Nguyen - Deputy Managing Director, HCCG

Section 2: Data gathering

What are the aims of the policy?

By 2023/24 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, integration of health and social care and on the wider role played by the third sector;
- 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 maximum of 2,435 emergency admissions (also known as non-elective) to hospital attributed to the 65 and over population with ambulatory care sensitive conditions, i.e. cases where effective community care and case management can help prevent the need for hospital admission, such as chronic hepatitis B; asthmas; congestive heart failure; diabetes; chronic obstructive pulmonary disease; hypertension; epilepsy; and dementia;

b. A maximum of 170 permanent admissions of people aged 65 + and over to care homes;

c. 90% of older people (65 + and over) discharge from hospital into the Reablement Service in quarter 3 of 2019/20 who are still at home 91 days after discharge;

d. The number of delayed transfers of care to be no more than 13.6 daily delays (4,964 delayed days for 2019/20);

e. In respect of CYP:

   - **Prevention & Early Intervention** - *"A CYP, their families and carers are able to access wellbeing support before it becomes an issue.*"
   - **Identification** - *"A CYP's needs are identified as early as practically possible."*
   - **Triage** - *"A CYP is signposted to the necessary intervention shortly after referral."*
   - **Assessment & Individual Care Planning** - *"A CYP's needs are assessed and clear recommendations are made around the provision they require."*
   - **Review & Transition** - *"Therapy delivery provides targeted intervention that enables CYP to make good progress."*

f. In respect of people with learning disabilities and/or autism:

- People with a learning disability and/or autism are able to lead happy and fulfilling lives as independently as possible in the least restrictive environment feasible;

- People with a learning disability and/or autism have a positive experience of care and support.

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

The following are factors that could impact on these outcomes being achieved:
a. 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. Adaptability of providers to deliver new models of care;
f. Lack of available providers who can support people with complex needs.

What relevant quantitative and qualitative data do you have?

Hillingdon's Population

Hillingdon's Joint Strategic Needs Assessment (JSNA) shows that based on the Greater London Authority (GLA) estimates the population of the borough in 2019 is 312,567. Table 1 below shows the projected growth by age group for the period 2019 to 2030.

Table 1: Population Growth by Age Group 2019 - 2030

Year	0-19	20-64	65 +	80+	All Ages	% of Total Population			
						0-19	20-64	65+	80+
2019	83,560	187,386	41,634	12,100	**312,580**	26.7	59.9	13.3	3.8
2024	88,246	192,897	47,516	13,300	**328,273**	26.8	58.7	14.4	4.0
2030	87,750	193,300	53,650	16,300	**334,800**	26.2	57.7	16.0	4.8

Ethnicity

According to the Greater London Authority in 2018, in Hillingdon 41.7% of the population are White British, 8.3% are White Other and 50% are from Black & Minority Ethnic groups. Ruislip and Northwood is least ethnically diverse part of the borough with just over 30% identifying themselves as coming from non-White households, compared to 51% in Hayes and Harlington.

The GLA Ethnic Group Population Projections data suggests that in the period to 2030 Hillingdon's population will become increasingly diverse, e.g. 51.6% of the population is projected to be non-White by 2024 and 54% by 2030. It is noteworthy that the older the population group in Hillingdon is the less diverse it is. For example, 23% of the 65 and over population is projected to be from non-White groups compared to 15.6% of the 80 and over population group. These groups are projected to become more diverse over time so that by 2030 33.8% of the 65 and over age group and 23.6% of the 80 and over age group will be from non-White groups. The older people population from Black and Minority Ethnic Groups (BAME) is concentrated in the south of the borough.

Older People: Dementia

Public Health England shows that in 2018 Hillingdon had a dementia diagnosis rate of 66.7%, which compares to 70.5% for London and for England. The Projecting Older People Population Information System (POPPI) estimates suggest that the number of older people living with dementia in 2019 is

2,970. This is projected to increase to 3,404 by 2025 and 3,939 by 2030. For the 85 and over population POPPI estimates suggest that the number living with dementia is 1,334 in 2019 and that this will rise to 1,562 by 2025 and 1,808 by 2030.

Older People: Social Isolation

An older person living on their own is a risk indicator of social isolation. POPPI projections suggest that in 2019 there are 13,399 people aged 65 and above living on their own, 7,973 of whom are aged 75 and over. This is projected to increase to 15,359 (9,345 aged 75 and over) in 2025 and 17,433 (10,401 aged 75 and over) by 2030.

Older People: Deprivation

Income Deprivation Affecting Older People Index (IDAOPI) 2015 identified that the percentage of older people in Hillingdon experiencing deprivation was in line with the general level of deprivation in the borough and at 15.7% was relatively low in comparison with the average for England of 16.2%. However, IDAOPI data applied to GP practices shows that older people experiencing the greatest levels of deprivation are concentrated in practices in the south of the borough.

Older People: Long-term Conditions

Table 2 shows estimates of the prevalence of older people living with long-term conditions.

Table 2: Prevalence of Long-term Conditions within Older People Population

Borough Estimate	Stroke	Cardio Vascular Disease	Chronic Heart Disease	Hypertension	Diabetes	Mental Health Conditions
2016	3,067	12,299	6,532	26,616	7,098	4,502
2021	3,312	13,271	7,047	28,688	7,662	4,816

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.

Frailty

Frailty is a clinically recognised state of increased vulnerability which results from ageing associated with a decline in the body's physical and psychological reserves. Older people with frailty are at risk of unpredictable deterioration in their health resulting from minor stressor events. A 2015 Institute for Fiscal Studies report suggests a prevalence rate of 6.5% for the population aged 60 to 69 and 65% for the population aged 90 and over.

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 2018/19 there were 921 falls-related admissions to Hillingdon Hospital of people aged 65 and over at a cost of £3.4m, which compares to 868 admissions at a cost of £3.1m in 2017/18.

Life Expectancy

Public Health England's 2018 Local Authority Health Profile for Hillingdon shows that life expectancy for both men and women is higher than the England average. However, it is 6.8 years lower for men and 5.2 years lower for women in the most deprived ward in Hillingdon compared to the least deprived, i.e. Botwell ward compared to Eastcote and East Ruislip.

People with Learning Disabilities

Table 3 below shows the Projecting Adult Needs and Service Information (PANSI) and POPPI estimates for the numbers of people in Hillingdon with a moderate to severe learning disability who are therefore likely to be accessing or in need of services.

Table 3: Estimates and Projections for People with Moderate to Severe Learning Disabilities 2019 - 2030

	2019	2025	2030
18 - 64	1,095	1,139	1,175
65 +	116	133	152
TOTAL	**1,211**	**1,272**	**1,327**

People with Autistic Spectrum Disorders

Table 4 below shows the PANSI estimates for the numbers of people aged 18 to 64 with autistic spectrum disorders.

Table 4: Estimates and Projections for People with Autistic Spectrum Disorders and Challenging Behaviours 2019 - 2030

	Autistic Spectrum Disorders			Challenging Behaviours		
	2019	2025	2030	2019	2025	2030
18 - 64	1,973	2,054	2,123	88	91	93

Children and Young People with Special Educational Needs

The 2018 Schools Census showed that there were 7,318 children and young people requiring special

educational need (SEN) support or with an Education and Health Care Plan (EHCP) in Hillingdon. Of the total volume 1,822 have an EHCP and 5,496 require SEN support. Table 5 below shows the breakdown between state funded primary, secondary and special schools.

Table 5: Summary Breakdown of Need Across Hillingdon's Schools							
School Type	**Total Pupils**	**Pupils with EHCPs**	**%**	**Pupils with SEN Support**	**%**	**Total SEN & EHCP**	**% of all pupils with SEN**
Primary school	30,690	557	1.8	3,577	11.7	4,134	13.5
Secondary school	20,431	318	1.6	1,911	9.4	2,229	10.9
Special schools	955	947	99.2	8	0.8	955	100
Overall Total	**52,076**	**1,822**		**5,496**		**7,318**	**14.1**

Table 5 shows an increase in the 0 - 19 age group to 2024. As the numbers of people aged 0-19 continue to grow so will the SEN population.

Carers

The 2011 census showed that there were over 25,000 Carers in Hillingdon providing unpaid support. The census also showed that 18% of unpaid carers were aged 65 and over. Additional census information showed that approximately 10% of Carers were aged under 25, which emphasises the continuing importance of supporting Carers of all ages. POPPI data suggests that in 2019 there are 5,612 older people providing unpaid care and nearly 36% (2,017) are providing 50 hours a week or more. The number of older carers is projected to increase to 6,438 in 2025 and 7,342 in 2030. As at 31st March 2019 there were 1,112 Young Carers, i.e. Carers aged between 5 and 24, registered with the Hillingdon Carers' Partnership who were actively providing care to a relative.

PANSI estimates suggest that in 2019 there are 426 adults with learning disabilities living with parents and this is expected to rise to 435 in 2025 and 451 in 2030. As at 31st July 2019 there were 226 people with learning disabilities in receipt of Social Care services with live-in Carers and of these 8% (19) were people 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.

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

Yes

Who was consulted or engaged?

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

- Kevin Byrne - *Head of Health Integration and Voluntary Sector Partnerships, LBH.*
- Sally Chandler - *CEO, Hillingdon Carers on behalf of H4All.*
- Carol McLoughlin - *Senior Commissioning Manager for Children and Young People, HCCG.*
- Turkay Mahmood - *Interim Chief Executive, Healthwatch Hillingdon.*
- Keith Spencer - *Director of Integration and Delivery, HHCP.*
- Vicky Trott - *Equality, Diversity and Inclusion Manager.*

- Jane Walsh - *Commissioner Older People's Services, HCCG.*

The timescale for delivering the EIA did not permit wider consultation to be undertaken. However, the development of the 2019/20 BCF Plan is consistent with feedback from consultation previously undertaken in respect of earlier iterations of the plan. The Strategic Operational Leads Team (SOLT) for Hillingdon Health and Care Partners has been consulted on the content of the 2019/20 plan.

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.

Many of the comments raised as part of the 2017/19 plan assessment were still considered to be valid and have consequently been retained. Additions have been made to those comments where it was felt that this was appropriate in view of the content of the 2019/20 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 early intervention therapy model for CYP with special educational needs proposed under scheme 7 will offer early assessment and advice and should assist in maximising independence by reducing dependence on services in the future. A robust integrated triage process that directs children and young people to the most appropriate therapy and support without delay, thus preventing an escalation of needs that is avoidable. The key changes that the new model will introduce can be summarised as: • Increasing Occupational Therapy (OT)

				provision in schools to provide therapy and training; • Developing a pathway for those without an Education, Health and Care Plans (EHCP) using a screening tool called Speech Link; • Delivering a triage facility that ensures that all referrals are reviewed by a qualified therapist within two weeks of a referral; • Introducing and formalising the consultation model for stakeholders involved in the assessment of a CYP; • Increasing the focus on transition to primary school and using a system called Language link to assess and inform therapy provision for children aged 4 to 8. • Using the support planning document called My Support Plan and the Team Around the Child (TAC) process to inform transition to primary and to secondary school with information shared regarding planned therapy input in schools. • Introducing social skills groups to support CYP and their parents. • Introducing a Development/Facilitator role to build and support cross-agency working through training and sharing best practice, etc. 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 or people aged under 18 providing care for an adult 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. • *Scheme 8* - The provision of case management support by the Council for CCG for people qualifying for NHS funded Continuing Healthcare funding should help support continuity of care and seamless service provision, which will benefit Carers.

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

Hearing impaired	√			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*); 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*).
Physically disabled	√			
Learning disability	√			*Scheme 8:* The integrated case management service will ensure continuity of service for people where funding responsibility changes, i.e. between the Council and the CCG and vice versa. Actions within the scheme will help to support the scope for people with learning disabilities and/or autism living in the least restrictive setting. *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 8*. *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, 6 and 8* - 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 Neighbourhood Team, 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 people whose social isolation may relate to their gender identity but other schemes are considered to be neutral.

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 significant impact on this protected characteristic.

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
Eliminating unlawful discrimination	√			

				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. *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. *Scheme 7* - Early intervention model for integrated therapies is likely to have positive benefits where cultural and/or language issues linked to race prove a barrier to the identification of need and access to appropriate services.
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, 7 & 8		√ 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. Schemes 7 and 8 provide opportunities through the assessment process to identify preferences related to religion or faith 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, 7 & 8		√ 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. A similar point applies with schemes 7 and 8.
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 or 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. It may be necessary to undertake specific assessments to support decisions made by either HCCG's Governing Body and/or the Council's Cabinet. Any such decisions will be reflected in the 2020/21 iteration of the BCF plan.

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.

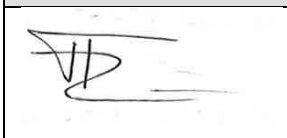
Section 5: Publish Assessment Results

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



28/08/19

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

28/08/19

Caroline Morison, Managing Director, Hillingdon CCG

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

Education, Health and Care Plans (EHCPs)
This is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHC plans identify educational, health and social needs and set out the additional support to meet those needs.

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.

Team Around the Child (TAC)
The TAC brings together a range of different practitioners from across the children and young people's workforce to support an individual child or young person and their family. TAC places the emphasis firmly on the needs and strengths of the child or young person, rather than on organisations or service providers.

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 and the intermediate tier.	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.*
7.	Integrated therapies for children and young people.	This scheme seeks to: • Provide early intervention therapy services that offer early assessment and advice, support self-care and reduce dependence on services in future years. • Provide a robust integrated triage process that directs children and young people to the most appropriate therapy and support without delay.
8.	Care and support for people with learning disabilities and/or autism.	This scheme aims to: • To improve the quality of care for people with a learning disability and/or autism;

		• To improve quality of life for people with a learning disability and/or autism; • To support people with a learning disability and/or autism down pathways of care to the least restrictive setting; • To ensure that services are user focused and responsive to identified needs.