Out of Hospital Health & Social Care
(Outcomes Based Commissioning)
EINA

Adult Social Care

27 January 2017
1. Summary of the key findings

The integrated out of hospital health and social care model is one that incentivises providers to work together to meet the needs of the whole person and for the borough population. The model is underpinned by a new outcomes based commissioning contract for adult physical health and social care.

This equalities impact needs assessment was carried out to examine the potential impacts on the nine protected characteristics of the out of hospital health and social care model as proposed in the “invitation to submit detailed solutions (ISDS) – the opportunity and submission requirements” document for the Coordinating Providers (CPs).

All groups were considered but the groups with the highest potential impact were age, disability, race/ethnicity and carers as set out in section 6. We assessed the impact on carers as they were identified as a specific population group for consideration in the development of the outcomes framework to support the new OBC contract.

The following positive impacts of the model were identified:

- Services with an increased emphasis on prevention, early identification and self-management of conditions.
- The potential to improve access to services through increasing delivery of services out of hospital and the development of integrated services/teams.
- The development and integration of patient pathways, to provide joined up care for patients, ensuring that they do not have to repeat their story; supporting them and their carer (if they have one) to better navigate the care available.
- Removing the existing fragmentation, variation and duplication in the local health and care system. Supporting the effective use of resources and high quality care available for all.

The following negative impacts were identified:

- Where services may be redesigned and/or provided from a different location, travel and access for the groups identified above may become an issue. In terms of patient’s ability to travel to a different location and the support required to do this. (It is noted that if changes to a service result in shorter distances to travel or easier travel options then this would be a positive impact)
- Accessing services in an unfamiliar environment can cause anxiety for these groups.
negatively impacting their wellbeing and experience of care.

- Any change programme will raise concerns about access to services being disrupted. Concerns have been expressed about new services in the community needing to be established first before any changes to hospital based services are made.
- Changes to pathways of care: there may be confusion about the changes and how to access services. This could potentially hamper or deter people from accessing services which could lead to their condition deteriorating.
- The feasibility of implementing the new model of care due to capacity and resources (staffing, information management and technology [IM&T]). This could have implications for patients within the groups identified if ongoing care is disrupted or placing additional barriers to accessing care.

Increased collaborative working across organisations and between services and professionals may have a positive impact on staff satisfaction and could improve staff retention and support staff recruitment. The focus on joined up care through multidisciplinary teams has the potential to support staff to develop and share learning and good practice. The proposed model of care requires sufficient staff resources and it is recognised that both local and national challenges in recruitment and retention may have an adverse impact on delivery.

The new contract will include the requirement for the CPs to comply with equality legislation and to ensure that they are able to meet the needs of all of Richmond’s population: in particular that they are meeting the needs of protected groups. The CPs will need to agree a consistent approach to collation and monitoring of equalities information. The CPs will be required to undertake further specific equality analysis and engagement to inform any resulting service/pathway redesign.

2. Briefly describe the service/ function/ policy:

In April 2014 Richmond CCG and the London Borough of Richmond upon Thames (LBRuT) undertook a case for change to examine the provision of health and social care community services in Richmond. The report uncovered a number of key problems in the way in which the services are currently delivered and commissioned:

- The public experiences a fragmented system and service that does not focus on improving outcomes for service users in a holistic way. This was noted as a particular problem for elderly people with complex needs – a population group forecast to increase significantly over the next decade;
- Staff do not feel the way the services are commissioned and managed enables them to do their best for patients; rather it forces them to work in ‘silos’ when they would rather be working in integrated teams;
- General Practitioners (GPs) experienced an unexplained variability in access to and engagement with community services and felt this had the potential to impact negatively on patient care, service quality and efficiency;
- The report noted that the current contracts are poorly designed and not effectively managed. Key performance indicators (KPIs) focus on inputs and processes, rather than improvements to patient health. The current contracting arrangements do not give Commissioners the leverage they require to hold providers to account in order to deliver value for money and the outcomes that matter to service users.

The organisations concluded that there was a case for change and set out a long term vision to improve the quality of care for individuals, unpaid carers, and families living in the borough of Richmond. The CCG and LBRuT want to deliver the outcomes that matter to local people.
by encouraging providers to break down organisational boundaries to deliver health and social care in a way that is seamless, proactive, efficient, and centred on the service users.

It was therefore decided to move to the delivery of an integrated out of hospital health and social care service model that: incentivises providers to work together to meet the needs of the whole person; treats people as close to home as possible; keeps people living independently in the community; prevents avoidable hospital admissions; reduces length of stay in hospitals and avoids delays to discharge; risk stratifies the population and matches prevention according to need; invests in prevention and home based care; evidences user and carer satisfaction; addresses co-morbidities and provides access to urgent care in the community.

The issues identified through the case for change, are not limited to any one community health or social care service provider or associated contract. It is acknowledged that part of the underlying cause of the system failures are partly due to the current commissioning models which do not encourage provider organisations to work in an integrated way.

In order to address this fragmented way of working it was agreed to move to outcomes based commissioning (OBC). As commissioners both organisations see OBC as the means to significantly improve health and wellbeing outcomes by driving efficiency and promoting the integration of the delivery of out of hospital health and social care services.

To enable the commissioning of an OBC contract an outcomes framework has been developed.

Using the outcomes above, a future model of care was developed (see diagram at appendix.
1). Commissioners have focused on physical health and social care as a starting point for system transformation but recognise the need for parity between physical and mental health and wish to bring community mental health within scope as soon as possible. A similar outcomes framework has been developed for community mental health.

Reflecting the vision of out of hospital care being delivered in a fully integrated and joined up way commissioners decided to follow the Most Capable Provider assessment process. The coordinating providers selected to participate in the MCP process are: Richmond General Practice Alliance (RGPA); Hounslow and Richmond Community Healthcare NHS Trust (HR CH); Kingston Hospital NHS Foundation Trust and West Middlesex University Hospital NHS Trust.

The intention is to award an OBC contract for adult out of hospital health and social care from April 2016. The services in scope for the contract are:

- Community health services
- Any qualified provider
- Locally commissioned services (primary care)
- Continuing healthcare (assessment)
- End of life care
- Urgent care pathway
- Planned care
- Other non-acute transport and NHS 111

3. **Why is the equality impact and needs analysis being undertaken?**

The proposed out of hospital health and social care model and outcomes based approach to commissioning is about proactively maintaining and managing the health of the borough’s population. To achieve this consideration must be given to the protected characteristics identified with the Equality Act 2010 i.e. age, disability, gender, race, religion/belief, sexual orientation, marriage/civil partnership, maternity and gender reassignment.

The equality analysis provides assurance on the equality impact of the proposed out of hospital health and social care model and will therefore inform the CCG and Council’s out of hospital commissioning process. It will also inform any resulting changes to service specifications or service/pathway redesign undertaken by commissioners and the coordinating providers.

4. **Has this service/ function/ policy undertaken a screening for relevance?**

The assessment of the impact of the protected characteristics is detailed in section 6. All the protected groups were considered but the groups with the biggest potential impact i.e. high and medium impact were age, disability, gender, race/ethnicity, sexual orientation and carers.
5. **What sources of information have been used in the preparation of this equality impact and needs analysis?**

<table>
<thead>
<tr>
<th>Information source</th>
<th>Description and outline of the information source</th>
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<tbody>
<tr>
<td>Richmond OBC Invitation to submit detailed solutions – the opportunity and submission requirements (V1 August 2015)</td>
<td>The document sets out the opportunity for the delivery of outcomes based commissioning for out of hospital health and social care for the adult population of Richmond and the submission requirements for the coordinating providers in order to complete the MCP assessment.</td>
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<tr>
<td>Outcomes that matter community engagement and research report (October 2014)</td>
<td>Summarises the engagement undertaken and how this was developed into the outcomes framework.</td>
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<tr>
<td>Outcomes that matter community services in Richmond development report (October 2014)</td>
<td>Outlines the process undertaken to develop the OBC framework for adults in the borough.</td>
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<tr>
<td>Community services case for change (June 2014)</td>
<td>Case for change put forward by Richmond CCG for a move to outcomes based commissioning.</td>
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<tr>
<td>Joint strategic needs analysis (JSNA) and The Richmond Story</td>
<td>The Richmond Story is a snapshot of the local needs identified through the JSNA process. It is developed to inform commissioning intentions.</td>
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<tr>
<td>Better care closer to home strategy and EINA</td>
<td>A joint CCG and LBRuT strategy to improve health and social care closer to home for adults from 18 years of age. The strategy focuses on care provided out of hospital.</td>
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<tr>
<td>Promoting wellbeing and independence, a framework for prevention 2015 – 18.</td>
<td>A joint framework for the CCG and Council, which sets out plans for meeting the future health prevention needs of Richmond residents.</td>
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<tr>
<td>NHS SWLCC equalities analysis (October 2015)</td>
<td>An initial equality analysis of the ideas for change outlined within SWLCC’s issues paper Help us build a new NHS in south west London</td>
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<tr>
<td>Joint health &amp; wellbeing strategy 2016 – 2021 EINA</td>
<td>An equality analysis of the potential impacts of the new joint health and wellbeing strategy 2016 – 2021. The strategy sets out a high level and overarching strategy that will enable Richmond’s health and wellbeing board to take action by championing key principles and selected initiatives across the local health and social care system.</td>
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### ANALYSING IMPACT, NEEDS AND EFFECTS

6. **It is important that the analysis addresses each part of the duty assessed as relevant to the area being examined** (see further Guidance on RIO).

<table>
<thead>
<tr>
<th>Protected Group</th>
<th>Impact</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Age</td>
<td>H</td>
<td>The population of Richmond borough is growing; by 2016 the population is expected to rise from 187,000 to 191,200 reaching 194,000 by 2021. Around 75% of community health services and 68% of social care services are used by people aged 65+. Analysis of Richmond’s demographics forecast suggests that demand on community health services will grow over future years. Richmond is facing significant growth in its older population. While the overall population is expected to grow by 8% over the next decade, residents aged 65 and over will grow by 21% and those 85+ by 28% by 2024. Richmond’s over 65 age group are key users of adult community services so the problem themes which emerged from the case for change are likely to be exacerbated by rising demand. There is a risk that even though at this time the current service/model is able to withstand these issues, it will not have the capacity to do so as the population continues to increase. The older population are also likely to have more complex needs which cannot be met by single service providers, for example in social care and mental health, highlighting the importance of good integration with other services. Therefore the model has the potential to deliver benefits for this population group improved care coordination, case management, risk stratification, multidisciplinary working and sharing patient information has the potential to deliver benefits through joined up care for these groups. For some older people or those who do not have access to private transport being able to access care in a community setting or in your own home may be more convenient and beneficial. For some older people and those who rely on the support of unpaid carers improving discharge arrangements and reablement support provided by an</td>
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</table>
integrated service including social care would be particularly important for them.

The impact of the outcomes framework on people with this protected characteristic has been estimated as **high** due to the high percentage of people requiring health and social care by age together with the increase in the number of people over 65 over the next 10 years.

<table>
<thead>
<tr>
<th>Disability</th>
<th>The model of care relates to all adults (18 years plus) in the local population with a disability/long term condition.</th>
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<tr>
<td></td>
<td>At the last census 21,447 (12%) people living in the borough reported that they have some form of disability or health problem that affects their day-to-day activities.</td>
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<td></td>
<td>There are 1,780 people recorded as having multiple sclerosis, Parkinson’s disease or epilepsy. Long term neurological conditions like these tend to be incurable and progressive in nature, and particularly towards the later stages of the disease impact on quality of life.</td>
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<td></td>
<td>22,000 adults living with a common mental disorder: around 1,700 people are estimated to have some form of severe mental illness. Almost a third of people with long term physical conditions have a concurrent mental health problem such as depression and anxiety.</td>
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<tr>
<td></td>
<td>It is estimated that 2,072 residents have dementia. Around 64% of this number has a formal diagnosis, which is higher than the national average but lower than the London average and below the target of 66%. Of those with dementia, 70% have one or more other long term conditions.</td>
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<td></td>
<td>Based on prevalence of Autism Spectrum Conditions (ASCs) in adults in England it is estimated that the number of people in Richmond over 18 with ASC is 1,423 (male) and 2,228 (female). There are currently around 130 adults with ASC as a presenting need known to the local authority (2013). The majority of which receive a service from the Richmond specialist adult social care team. There are also 41 young people aged between 13 and 18 years of age with ASC who will require transition planning and transfer to adult services over the next 5 years (2015). 451 adults with a learning disability are known to general practice. It is predicted that there are a total of 2,968 people who have some level of learning disability living in Richmond. People with a learning disability generally have higher health needs and more complex health needs that the rest of the population.</td>
</tr>
</tbody>
</table>
The quality of life for those living with both mental and physical long term conditions has been evidenced as being worse compared with the quality of life for people with two or more physical long term conditions (The King’s Fund (2012) Long term conditions and mental health: The cost of co-morbidities.) Integrating pathways offers the potential to improve a patient’s wellbeing and quality of care by ensuring services are able to respond to both physical and mental health needs.

For people with long term conditions, complex needs, as well as those identified to be at the end of life, care coordination, case management, risk stratification, multidisciplinary working and sharing patient information has the potential to provide a positive impact by delivering joined up care.

Many people who are living with more than one long term condition may experience fragmented or duplicated care as a result of the different service providers involved. Therefore there are potential benefits in creating a more joined up and coordinated approach and removing variation for these groups.

Increased access to urgent care services based out of hospital is considered to provide better support to patients with long terms conditions. The provision of rapid access to more appropriate support, enabling people to manage their own conditions has the potential to create positive patient experiences as a result of a coordinated urgent and emergency whole system: likely to provide benefits for people with a disability.

However for individuals who face language or cognitive barriers such as some people with a learning disability or mental health condition such as dementia could be adversely affected by changes to how services are accessed e.g. urgent and emergency care or the provision of more services being delivered out of hospital in a community setting. This could cause confusion and anxiety for some and result in individuals delaying access to treatment or living with conditions that could benefit from early intervention and treatment.

Outcomes based commissioning and the proposed model of care provides mechanisms for putting the outcomes of the patient at the heart of services; providing patients with a joined up experience of care and reducing health inequalities.

| Gender (Sex) | M | Current information shows that the proportion of women 51% and men 49% are roughly equal and |
across age bands until later life. As women experience longer life expectancy than men, by the time people are aged 85 years and over there are more than twice as many women as men. This has implications for the needs of women. For example, the older age profile of women means that they suffer higher rates of chronic disease and require access to appropriate models of chronic disease and elderly care services. They are also more likely to be living alone without a partner or unpaid carer. Women are also more likely to take on a caring role in later life. The last census showed that there are approximately 6 million carers in the UK and the majority of these are women.

For some services gender may provide a barrier to access and use of services. For example, in primary care, research has found that on average men are less likely to consult with their GP than women between the ages of 16-60 years which can lead to men presenting with a serious disease at a later (and less treatable) stage. (Wang Y et al (2103) Do men consult less than women? An analysis of routinely collected UK general practice data)

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Impact</th>
<th>Evidence</th>
</tr>
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<tbody>
<tr>
<td>Gender reassignment</td>
<td>L</td>
<td>At present there is no official estimate of the trans population. The UK’s largest survey of trans people found that 34% of adult trans people have attempted suicide. The same survey found that 65% of trans people had experienced negative interactions/discrimination when accessing health services. (National Mental Health Development Unit (2013) Transgender) The collection of local data for protected groups is dependent on services completing monitoring information.</td>
</tr>
<tr>
<td><em>Marriage and civil partnership</em> (<em>only in relation to first part of the duty: eliminate discrimination and harassment</em>)</td>
<td>L</td>
<td>The outcomes framework is estimated to have <strong>low</strong> impact on this protected characteristic.</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>L</td>
<td>The proposed model of care does not cover pregnancy and maternity services specifically and therefore the impact on this protected characteristic has been estimated as <strong>low</strong>.</td>
</tr>
<tr>
<td>Race/ethnicity</td>
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<td>From the 2011 census shows 160,725 (86%) of Richmond residents identify as belonging to a white ethnic group, and 26,265 (14%) to a black and minority (BME) group. 75.7% of the population were born in the UK therefore almost a quarter of residents were born</td>
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</table>
outside the UK with 14.3% born outside Europe.

Richmond’s BME population is made up of 13,607 (7.3%) Asian/British Asian, 6,780 (3.6%) missed/multiple ethnic groups, 3,062 (1.6%) other ethnic groups, and 2,816 (1.5%) black groups. Data suggests that there is likely to be an increase in older people from BME backgrounds due to the higher proportion of people age 55 – 64 from black or ethnic minority background.

In order to achieve against all the outcomes providers must give due care to a patient’s specific ethnic and/or cultural requirements and in particular for outcomes such as A1:I need to trust the system and services and A2: I want to feel I am a full partner in my care, as set out in Outcomes that matter community services in Richmond (Cobic) October 2014.

Those who face language barriers such as some BME groups as well as some people with a learning disability or mental health condition such as dementia could be adversely affected by changes to how services are accessed e.g. urgent and emergency care or the provision of more services being delivered out of hospital in a community setting. This could cause confusion and anxiety for some people and result in individuals delaying access to treatment or living with conditions that could benefit from early intervention and treatment.

The percentage of the population reporting as Christian is declining and the percentage reporting as not having a religion is increasing. Compared to London as a whole, Richmond continues to have a higher proportion of Christian 55% v 48% a higher proportion reporting no religion 28% v 21% and lower proportions of other religions.

Faith groups and organisations are seen to be significant contributing factors in the health and wellbeing of many older people and especially those from minority ethnic groups.

Little evidence is available on the particular health needs of people of different religions and belief. Most specific health issues that might be associated with people of different religions are actually associated with their race or ethnicity.

In order to achieve against all the outcomes providers must give due care to a patient’s specific religious and spiritual beliefs and in particular for outcomes A1 and A2 as set out within the full outcomes framework. Outcomes that matter community services in
Lesbian, gay and bisexual people (LGB) often have the same health and social care needs as their heterosexual counterparts. However, research acknowledges that the LGB community often also has particular additional or different needs (e.g. sexual, reproductive and mental health) including access to services which are not accepting and sensitive to their sexuality, preferences and needs.

Estimates of the LGB population in Richmond vary. Given personal sensitivity regarding sexual orientation, limited reliable information is available and estimates are likely to under-estimate true numbers. A conservative estimate of 5% equates to 9,500 people in Richmond. Although the 2011 census did not have a specific question regarding sexual orientation, 665 people (0.35% of the borough’s population) reported being in a same sex civil partnership.

LGB people are statistically as likely as the general population to use alcohol and other drugs and to misuse substances when young, but are more likely to maintain that level of use in later life.

In order to achieve against all the patient outcomes it is important that the CPs are aware of the sexuality, preferences and needs of patients and in particular for outcomes A1 and A2 as set out within the full outcomes framework. Outcomes that matter community services in Richmond (Cobic) October 2014.

A recent Healthwatch consultation with LGBT groups in Merton (part of south west London) identified current challenges in service provision. As well as identifying gaps in service provision, (Hepatitis A, B and C testing and vaccination for example) LGBT awareness was considered to be poor. Specific issues also raised included clarity about next of kin and nearest relative, as for many health conditions many LGBT community members would prefer the contact not to be their nearest relative. It was acknowledged this was better for planned admissions but still a contentious issue (Merton Healthwatch (2015) Merton lesbian, gay, bisexual and transgender (LGBT) community engagement workshop.)

Carer refers to an individual who is in an unpaid caring role for a family member, friend, neighbour or someone in their local community.

The 2011 census showed that there are 15,802 unpaid carers (8.5% of all residents) in the London Borough of
Richmond upon Thames. This is similar to London, and lower than the average in England (10.2%). Most frequently cited reasons for caring are: physical disability (58% of carers), long-standing illness (37%), sight or hearing loss (20%), problems connected to ageing (17%), mental health problem (13%), a learning disability (11%) and dementia (10%).

The number of unpaid carers identified in the 2011 Census is higher than the number of carers that is registered as using health and social care services. GPs and other providers have an important role to play in identifying carers and signposting them to existing services.

As the population is ageing and many more people are living into their 80s and 90s, an increasing number of carers are aged 65+ and caring for elderly family members. The negative impacts on a person’s health and wellbeing as a result of caring are well documented; increased social isolation, unhealthy eating habits and limited physical activity are seen amongst carers.

Carers were one of the four population categories identified in the development of the outcomes framework. The impact on carers has been estimated as high as the main groups using community services are older people and those with a long term condition who are more likely to have someone caring for them. This is reflected in the inclusion of a set of carer-specific outcomes. Outcomes that matter community services in Richmond (Cobic) October 2014.

7. **Have you identified any data gaps in relation to the relevant protected characteristics and relevant parts of the duty?**

<table>
<thead>
<tr>
<th>Gaps in data</th>
<th>Action to deal with this</th>
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<tbody>
<tr>
<td>Health and social care do not systematically collect information on all protected characteristic and if collected are not in the same format. Additionally some people choose not to disclose specific information, particularly in relation to sexual orientation, religion and belief, including non-belief</td>
<td>• Ensure full adoption of equality requirements in service specifications and monitoring processes as part of contracting requirements for new out of hospital contract.</td>
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<tr>
<td></td>
<td>• Ensure full adoption of equality requirement in service specifications and monitoring processes as part of wider health and social care contracts.</td>
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<tr>
<td></td>
<td>• Include training for staff on collecting equalities information as part of patient care planning.</td>
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</table>
CONSULTATION ON THE KEY FINDINGS

8. What consultation have you undertaken with stakeholders or critical friends about the key findings? What feedback did you receive as part of the consultation?

The outcomes framework has been defined by the CCG, LBRuT, service users, carers and the public through engagement and reflects what patients and carers want from their health and care services. The framework aligns with the strategic objective of the CCG and Council which is to improve the quality of care for individuals, carers, and families living in the borough and to deliver the outcomes that matter to them by encouraging providers to break down organisational boundaries to deliver health and social care in a way that is seamless, proactive, efficient, and centred on the patient.

The development of the high level outcomes and their goals were drawn up and defined by working with members of the public, service users and clinicians/practitioners delivering services, using the following process:

- A wide ranging literature review to identify common themes and areas that would enable a platform from which the development of the outcomes could be launched;
- Working with service users and the public to develop an Outcomes Framework that represents outcomes that matter to service users and residents in Richmond;
- Facilitating various working groups of key participants to enable detailed review, challenge and discussion of the outputs from public engagement events; and
- Additional engagement with key stakeholders including Clinicians (Geriatricians, Primary Care Teams), General Practitioners, Social Care staff, Business Intelligence teams in the Council, CCG and CSU and Public Health to gain a wider input on the outputs from the working groups from a number of perspectives.

The initial outcomes framework for Richmond is outlined on page 27 of the ISDS document and aimed to set out high level categories of outcomes, more detailed outcome goals, and suggested measures or indicators for capturing progress in meeting those outcomes across the whole of the local population. The final iteration of the outcomes framework considers outcomes for two groups: people with clinical needs (such as long term conditions, disability or frailty) and carers. The framework was then further developed and commercialised for the purposes of translating into a contract and linking to the OBC capitated payment approach.

The process of developing the outcomes framework was overseen by the outcomes reference group (ORG) a task and finish group with a membership of clinical and engagement leads from CCG, Council, community involvement group representatives, patient and carer members and Healthwatch. Following the engagement the ORG highlighted that there insufficient meaningful engagement had been possible with children and young people to ensure their ownership of any outcomes and indicators suggested in the framework. As a result children and young people were taken out of scope for this programme for the time being.

The ORG was keen to have a continued role in ensuring that use of the outcomes was not diluted once the framework entered the more contractual elements of the programme thereby ensuring the patient and carers’ views consistently remained central to the
Commissioning process.

As the OBC programme has progressed we have worked with Healthwatch who have hosted two public events to provide an opportunity for local people to find out how the project is developing and ask questions of both commissioners and the coordinating providers.

If the contract is let the coordinating providers will be required to undertake further specific engagement and equality analysis to inform any resulting service or pathway redesign.

**ACTION PLANNING**

9. What issues have you identified that require actions? What are these actions, who will be responsible for them and when will they be completed?

<table>
<thead>
<tr>
<th>Issue identified</th>
<th>Planned action</th>
<th>Lead officer</th>
<th>Completion Date</th>
</tr>
</thead>
</table>
| Gaps in data collection for protected groups. Clarity is needed about what data the CPs routinely collect on patients and carers and whether it includes information on all protected characteristics. | • Include requirement in contract and monitor for CPs to routinely collect and monitor information relating to all relevant protected characteristics  
  • Ensure full adoption of equality requirements in resulting service specifications and monitoring processes for new OBC contract (service change/pathway redesign)  
  • Ensure full adoption of equality requirements in service specifications and monitoring processes for new health and social care contracts.  
  • Quality leads from CCG and CPs to agree annual equalities assurance session as part of CQRG                                                                 | Contract and CQRG leads | April 2016       |
|                                                                                |                                                                                                                                                                                                                                                                                                                                                  | Contract/CQRG leads   |                |
|                                                                                |                                                                                                                                                                                                                                                                                                                                                  | Quality leads         | April 2017       |
|                                                                                |                                                                                                                                                                                                                                                                                                                                                  | Contract and CQRG leads| April 2017       |
|                                                                                |                                                                                                                                                                                                                                                                                                                                                  | Contract/CQRG leads   | April 2017       |
|                                                                                |                                                                                                                                                                                                                                                                                                                                                  | Quality leads         | July 2016        |
| Outcome indicators to include evidence of due regard for protected characteristics | Include requirement in contract and monitor for CPs to provide evidence in relation to protected characteristics when taking account of patient’s specific requirements in order to achieve relevant outcomes.                                                                                                      | Contract and CQRG leads| April 2016       |
| Provision of clear and accessible communication and                            | Include requirement in contract for and monitor CPs to:                                                                                                                                                                                                                                                                                           |                      |                 |
|                                                                                |                                                                                                                                                                                                                                                                                                                                                  |                      |                 |
MONITORING AND REVIEW

10. How will the actions in the action plan be monitored and reviewed? For example, any equality actions identified should be added to business, service or team plans and performance managed.

The completion of the actions in this EINA will be monitored through the CCG’s contract and quality performance arrangements with the CPs to be established from 1 April 2016.

PUBLISHING THE COMPLETED ANALYSIS

Approved by Richmond CCG Quality & Safety Committee

Date of approval 14 June 2016

DECISION-MAKING PROCESS

To OBC programme board, CIG and CCG’s Quality and safety committee.
Appendix 1 - Future model of care