Appendix 1

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Proposals to improve older people's healthcare and adult community services

Equality Impact Assessment

This is a live document that is worked on throughout the life of the procurement and contract

Post Public Consultation
2 July 2014

Index

Executive Summary

Introduction & Purpose of Equality Impact Assessment

Section A : Screening

Form 1: Preparation

Form 2: Information Gathering

Form 3: Assessment of Relevance and Priority

Section B: Full Equalities Impact Assessment

Form 4: Examine the Information Gathered So Far

Form 5: Judge/Assess the Potential Impact of the Policy across the Protected Characteristics

Form 6: Consider Any Alternatives which will Reduce or Eliminate any Negative Impact

Section C : Outcome

Form 7: Outcome Report

Form 8: Action Plan

Executive Summary

Introduction

The purpose of an Equality Impact Assessment (EIA) is to establish the evidence for the extent to which the Integrated Older People's Services and Adult Community Services Procurement impacts in either a positive or negative way upon groups with protected characteristics and patients as a result of the proposals. This EIA is a work in progress. Some information gaps in the original EIA were identified. Further information became available through the public consultation (17 March – 16 June 2014) and this version of the EIA includes pertinent feedback from that consultation. An Equality and Diversity Report from the Public Consultation is at Annex A to this EIA. This describes how the consultation process was designed to reach specific groups with visual and hearing impairment, learning disabilities, ethnic minority groups and gypsy and traveller groups.

The EIA will continue to evolve further through the procurement process and during the life of the contract with the Lead Provider.

Section A Screening: Forms 1-3

The purpose of this section is to prepare and gather relevant information in relation to the protected characteristics and to assess the relevance and priority in terms of the evidence against each protected characteristic. The document sets out a description of, and the national and local context for, the Programme as well as setting out the range of external and internal stakeholders who will be affected by the Programme. Since Summer 2013, a number of public engagement events have already taken place. The Programme is deemed relevant to the public duties relating to the following protected characteristics: Age, Disability, Race/ethnicity or nationality, Religion or belief. In addition the Programme is relevant to several of the Human Rights Act Articles including numbers 2, 3, 5 and 6.

The evidence is set out against each of the above protected characteristics. Information sources include feedback gathered during the Proposals to Improve Older People's Healthcare and Adult Community Services public consultation (17 March to 16 June 2014), the Joint Strategic Needs Assessments (JSNAs) for Peterborough and Cambridgeshire, national guidance, locally derived data such as patient and GP surveys and anecdote. An assessment of relevance and priority is then made based upon the nature of the evidence and the potential impact and by this means a score is derived for each protected characteristic. Using this method there were positive impact scores (i.e. a beneficial impact) for each of the above protected characteristics, with Age having the highest positive impact.

Section B Full Equality Impact Assessment: Forms 4-6

This section of the EIA considers the evidence gathered thus far, its adequacy, information gaps and the likely impact of the proposals on the protected characteristics. Finally any actions to reduce or eliminate any negative impact are considered. There is considerable evidence against multiple protected characteristics and age, though not quite so much specifically in relation to disabilities, religion and ethnicity and the potential impact of the Programme on these areas. There are thus some information gaps.

Section C Outcome Report: Forms 7-8

The decision to proceed to full EIA is recorded here. The reasons for proceeding to full EIA are due to the large number of older people and adults who will be impacted by the new services. Further, the current inequalities experienced by hard to reach groups and people with disabilities, in terms of access to services and health outcomes, need to be countered within the new service and this needs to be monitored. Apart from the positive impact reported for those with protected characteristics, and in general on the community, it is viewed that there could be a negative impact on the public and media and existing community staff who may fear the future and these negative impacts need to be mitigated and managed. Finally, an action plan sets out the necessary actions in terms of gathering more information from hard to reach groups and ethnic minorities, the mechanisms for monitoring performance of the new NHS Standard contract, under which the Lead Provider/s will be held to account, with particular reference to equity of access to health services and equalities monitoring.

Introduction & Purpose of Equality Impact Assessment

The preparation of an EIA is not, in itself, a legal requirement. However, its use lies in the extent to which it will assist the CCG to comply with its duties under:

1. Section 149 of the Equality Act 2010 (the public sector equality or PSED); and
2. Section 14T of the NHS Act 2006 (the duty to have regard to the need to reduce inequalities between patients with respect to their ability to access health services and the outcomes achieved for them by those services – the Section 14T Duty).

The purpose of an EIA is therefore to:

- contain an outline of the means by which the CCG has gathered evidence in relation to groups with protected characteristics and patients who may face inequalities in either access to, or outcomes from, the proposals
- describe the positive and negative impacts in respect of those groups and patients arising from the proposals; consideration of how the CCG's proposals in relation to the reconfiguration of services for older people could be amended to improve the experience of people with protected characteristics or those patients who have a lower ability to access, or receive lower outcomes from, those services
- contain a robust discussion as to whether or not the CCG is going to continue with its proposals in their current form and why.

The EIA needs to provide a summary of all of the above. This is the document that contains the detailed evidence that the CCG has so far considered.

This EIA is complete as far as the available information allows. However, it needs to continue to evolve when the new Lead Provider is appointed. It will therefore be subject to continued review and will be updated as necessary throughout the life of the procurement through to the service delivery phase. The consultation process (17/3/14 – 16/6/14) was one of the principal mechanisms by which the CCG set out to gather further equalities information. For this reason, the full detail of the equalities discussion was published alongside the consultation documents in order to obtain public feedback on the bidders' proposals. Within the context of the EIA, the CCG will pay particular attention to issues of equalities raised by the public.

The CCG will consider equalities issues when making decisions on final solutions, who is chosen as preferred bidder and the final form of the services to be delivered. Equalities information will be considered by the Governing Body.

Form 1: Preparation

1. What are you equality impact assessing (EIA)?	
	The Integrated Older People's Services and Adult Community Services Procurement ('the Procurement')

2. Brief Aims and Description and Outcomes	
	Description:
	This Procurement aims to address two of the CCG's top priorities which are to improve older people's services and end of life care. To this end, the CCG plans to commission integrated care for older people that achieves the overall ambitions of improving outcomes and improving older people's experiences of services. As many community services for older people are also provided for adults below the age of 65, those with long term conditions for example, most adult community services are also included in this Procurement.
	Specific Aims:
	To commission an integrated hospital and community service for older people in line with the vision and critical success factors.
	Service vision for Older People and Adult Community Services:
	• for people to be proactively supported to maintain their health, well-being and independence for as long as possible, receiving care in their home and local community wherever possible;
	• for care to be provided in an integrated way with services organised around the patient;
	• to ensure that services are designed and implemented locally, building on best practice;
	• to provide the right contractual and financial incentives for good care and outcomes; and
	• to work with patients and representative groups to design how the CCG commissions services.
	How Programme Aims will be achieved:
	Our current system of care does not achieve our vision as it is fragmented, with some patients being admitted to hospital when they do not need to be, or remaining in hospital longer than they should, or not receiving the level and type of community care we aspire to.

	This programme is about joined up service transformation in how care is provided and commissioned for older people in Cambridgeshire and Peterborough. It is about delivering better outcomes, and will contribute to the Health & Well-Being Strategies priorities for older people by organising services around the patient, not around organisational structures, to ensure older patients get the right support to keep healthy and to maintain independence. To do this we will improve the way different services (hospitals, GPs, mental health and community services) work together to coordinate patient care. Over several years we have attempted to achieve this through the existing NHS providers but with limited success. With the rapid growth in 65 years and over and the CCG's increasing financial pressures we need to find new ways to provide better services for older people while achieving financial sustainability. Recent NHS legislation provides a mandate for CCGs to consider a range of providers in the development of new services. For these reasons the CCG decided to go out to tender in order to identify a Lead Provider to develop new services for older people.
	A set of programme outcomes has been determined and are articulated within the following outcomes framework:
	Outcomes:
	The CCG is focussing strongly on outcomes to ensure patients are seen and treated by the most appropriate professional to meet their clinical needs in the most convenient and cost effective way, to achieve the best clinical outcome. This means that the CCG will look to reduce all clinically unnecessary contacts and admissions where we have evidence of unnecessary contact or admission. We will look to the successful provider/s to act as strategic partners in managing demand for services within our very constrained financial environment where we have to make the money go as far as possible. We will work with the Lead Provider as a key partner in ensuring we have a clinically safe and cost effective system which delivers equitable access and outcomes. This is both innovative and transformational. Therefore within this Procurement the CCG will develop outcome based contracts within an 'Outcomes Framework'. This Framework has been developed specifically for this Procurement based on seven domains as follows:
	• **Better experience of care.** Ensuring people have an excellent and equitable experience of care and support, with care organised around the patient. Within this domain, we will also monitor access to services from all groups and from across the CCG in order to ensure equity of access to the new services.
	• **Safe care.** Treating and caring for people in safe environment and protecting them from avoidable harm.
	• Well organised care. Developing an organisational culture of joined-up working , patient-centred care, empowered staff and effective information sharing.
	• **Keeping healthy**. Early intervention to promote health, well-being and independence.
	• **Treatment during acute illness or injury.** Treatment and / or support during an acute episode of ill health.
	• **Recovering from illness or injury.** Long term recovery and sustainability of health.

	• **End of Life Care.** Caring for people in the most appropriate way and place in last stages of life.

3.	Who is responsible for the work?
	1. The Older People's Programme Board is accountable to the CCG Governing Body for the programme delivery of the Older People's Services and Adult Community Services Procurement, which includes the ongoing development of the EIA. Specifically its role is to:
	• oversee delivery of older people's service transformation, taking forward further development of the CCG outcome specification for urgent care for older people, and the CCG medium term strategy
	• take into account and ensure that the work of the Board is consistent with the Health & Well-Being Board strategies as they develop
	• be a facilitator for the programme giving the programme management team the mandate to continue at various points in the programme
	• be held to account indirectly by LCG Boards through their representatives on the Governing Body
	• ensure that clear outcomes for the programme and associated projects are agreed, monitored and delivered, including evaluation and links to research where applicable. This will include the trajectory for reduction of emergency bed days predicated on improving out of hospital care for older people, and improving patient satisfaction with their care
	• enable and support LCGs to deliver the Older People's services transformation programme locally
	• provide leadership and coordination on projects or CCG wide issues where it is efficient to 'do once' across the organisation
	• identify innovation and good practice, and ensure effective diffusion across the CCG
	The Programme Board provides a vehicle for partnership working with other relevant agencies and patients. Its membership is thus wide ranging and includes:
	• From the CCG: GP Clinical Champion (Chair), Chief Operating Officer (Deputy Chair), Senior Responsible Officer (Deputy Chair), Programme Management, Clinical Leads, Performance & Delivery, Local Strategic Leads, Public Health, Contracting/Commissioning/Community Services, Communications, Engagement & Membership, Procurement support, Finance, IM&T, Quality, Safety, Administrative support.
	• For Patients: patient experience representative and the executive of Healthwatch Peterborough.

	• Local Authority Representatives: Cambridge City Council: Executive Director: Children and Young People's Services and Adult Social Care; Service Director: Older People's Services; Assistant Director strategic commissioning.
	• Peterborough City Council: Assistant Director strategic commissioning.
	• South Cambs District Council (on behalf of District Councils): Director Health & Environmental Services.
	Gaps
	It is considered that the Programme Board membership covers all the relevant areas of interest. Although there is only one patient representative, this voice is supported and listened to during the meetings.
	2. Governing Body: The Cambridgeshire and Peterborough Clinical Commissioning Group's Governing Body is the accountable body for the EIA within the CCG. The Governing Body membership is as follows:
	Chief Operating Officer, Director of Corporate Affairs, Director of Commissioning & Contracting, GP Member; Peterborough, CCG Lay Member, CCG Chair, GP Member; Cam Health, CCG Secretary, Director of Quality, Safety & Patient Experience, GP Member; Hunts Care Partners; GP Member; Isle of Ely, CCG Lay Member, Deputy Chair, CCG Chief Clinical Officer, GP Member; Hunts Health, Director of Public Health, Secondary Care Doctor, Director of Performance & Delivery, CCG Lay Member, GP Member; Wisbech, GP Member; Borderline, Chief Finance Officer.
	Gaps
	The membership of the Governing Body covers all relevant areas of interest in order to fulfil its statutory duties. Further, an element of all meetings are held in public thus members of the public are able to hear and comment on CCG policy.

4.	Who is involved in undertaking this EIA?
	1. The CCG Equity and Diversity Group
	2. Older People's Programme Management Team members together with communications and engagement and programme management colleagues have been involved in the EIA development. This Team is accountable to the Programme Board.
	Full membership of the Programme Management Team includes: GP Clinical Champion (Chair), Senior Responsible Officer (Deputy Chair), Programme Management, Social Care Commissioners, Performance & Delivery Local Strategic Leads, Public Health, Contracting/Commissioning/Community Services, Communications, Engagement & Membership, Procurement support, Legal support, Financial support, IM&T, Information/analytical, Medicines Management, Quality, Safety & Patient Experience,

	Administrative support.

5.	Is the Programme related to other policies/areas of work?
	1. National Guidance & Programmes
	The *NHS Outcomes Framework* incorporates much of the Government's mandate to NHS England. This has been translated in the national planning guidance into seven outcome ambition measures which inform the CCG's plans.
	The *National Planning Guidance* issued by NHS England in December 2013: sets out the ambitions for the NHS and the planning agenda for the next five years. Much of the Government's mandate to the NHS is contained in the NHS Outcomes Framework which has now been translated into seven ambitions. The CCG's plans need to cover the fundamentals – i.e. Outcomes, Patient services , Access, Quality, Innovation and Delivering Value.
	Safe Compassionate Care for Older People Using an Integrated Care Pathway - NHS England, South - February 2014: sets out guidance for commissioners to transform older peoples services within an integrated care pathway. It also provides evidence of the harm suffered by older people who receive care in an acute hospital when not absolutely necessary and from long waits in A&E Departments.
	Safeguarding Vulnerable People in the NHS - NHS England's accountability and assurance framework is a key source of reference and guidance to safeguarding arrangements. These are considered whenever services are being planned or redesigned. Each new or redesigned service will have safeguarding requirements within the contract; performance against safeguarding requirements is monitored by the safeguarding team. There is a requirement for safeguarding to be taken account of within the Equality Impact Assessments undertaken for all local plans, policies and projects.
	2. Local Policies/Programmes
	Over-arching Themes from Joint Strategic Needs Assessments (JSNAs): See Peterborough's JSNAs at : http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assesmen.aspx
	and Cambridgeshire's JSNAs at: http://www.cambridgeshireinsight.org.uk/jsna
	Several over-arching themes are apparent from the intelligence provided in Joint Strategic Needs Assessments and bespoke health needs profiles as follows:
	• The population for Cambridgeshire and Peterborough is increasing and growing older.
	• There are significant levels of deprivation that need to be addressed.
	• Lifestyle has an important bearing on the prevention of ill-health and premature mortality.

	• People are living longer but there are significant health inequalities.
	Further detail is provided below.
	i) Cambridgeshire & Peterborough CCG's Five Year Plan 2014/15 – 2018/19
	The Five Year Plan is under development. It is rooted within the national guidance and is cognisant of the local health needs and demographic context. The plan reviews the local demographic, health, service and financial status and sets out an ambitious programme of service transformation in order to achieve better outcomes for local people within a sustainable financial framework.
	CCG values establish it will operate in an integrated way, putting patients' best interests at the heart of all decision making to achieve the best care outcomes for patients, their carers and the population. By working together in an open and transparent way, commissioners and providers of care, aim to maximise the wellbeing of the population and provide the safest, highest quality care outcomes for patients in our system. It aspires to commission and provide the safest, highest quality care and best patient experience within the resources available. The CCG will seek to maximise the amount of care provided outside hospital as close to the patient's home as possible.
	Guiding principles governing the way the CCG will work together with Social Care have been agreed to :
	• Organise services around the patient's clinical needs and not around organisational and professional specialties.
	• Integrate care to maximise continuity and safety for patients across separate facilities and organisations.
	• Expand the geographic/population reach for specialties to ensure clinical and financial sustainability.
	• Measure costs and outcomes for each patient and, where possible, develop local pricing to reflect local costs.
	• Build enabling information flows and IT platforms to maximise efficiency and continuity of care.
	• Work together effectively, openly and transparently in best interests of patients and public.
	• Maximise focus on prevention and anticipatory care to avoid unnecessary admissions and costs.
	• Allocate resources across time, place and person in a way that maximises sustainability and reduce inequalities.
	Focus for change: Within the Plan eight clinical areas for change have been identified, the first two being Older People's and End of Life Services. For each of these services seven key delivery areas have been identified including improving access and patient experience and engagement.

	ii) Better Care Fund (BCF)
	The BCF is intended to provide an opportunity to transform care so that people receive better integrated care and support. It encompasses a substantial level of funding and it will help deal with demographic pressures in adult social care. The BCF is an important opportunity to take the integration agenda forward at scale and pace. It is a significant catalyst for change and comes into full effect in 2015/16, but locally planning and engagement has already started and this will continue. The CCG is actively working with Peterborough City Council, and Cambridgeshire County Council (and other Local Authority and wider partners), to develop a shared vision and principles for the use of the Fund, as well as priorities for funding.
	iii) CCG Obligations
	The CCG is also obligated to fulfil all the requirements of the NHS Constitution and the Government's Mandate to NHS England.
	3. Strategic Fit of the Older Peoples Procurement within the National and Local Context
	The Older People's Project sits centrally within national policy, sets out to meet the needs identified in the JSNA, is identified as a service priority within the CCG's five year plan, and fits within the plans for further service integration between health and social care. Specifically this project relates to the CCG Strategic Priority of improving care for older people. It is relevant to the CCG Assurance Framework strategic aims 1, 2 and 3 in particular (Quality, finance, and transformation). It relates to Equality & Diversity (EDS) goals 1 and 2 (improved health outcomes for all, improved patient access and experience).

6.	Stakeholders – who is involved with or affected by this Programme ?
	There is a range of internal and external stakeholders – identified as follows:
	Internal (CCG) Parties:
	CCG staff, Local Commissioning Groups, GPs and primary care staff, CCG Board, CCG Board Lay Representative for Public Engagement.
	Other NHS Parties:
	Providers – Cambridgeshire Community Services NHS Trust, Peterborough and Stamford Hospitals NHS Foundation Trust, Cambridgeshire and Peterborough NHS Foundation Trust, Cambridge University Hospitals NHS Foundation Trust, Queen Elizabeth Hospital, Kings Lynn NHS Trust, Hinchingbrooke Healthcare NHS Trust, Trust Development Agency (TDA), NHS England, Department of Health, East of England Ambulance Service NHS Trust, Public Health England, Health Education

	England.
	Interagency Groups:
	Social Partnership Forum, Older People's Programme Board, Academic Health Science Network.
	Health Services Research Organisations:
	King's Fund, Capitated Outcomes Based Incentivised Commissioning (COBIC)
	Private Healthcare Providers:
	The three competing bidders: Virgin Care Ltd., Uniting Care Partnership (UCP) and Care for Life
	Patient and Carer Fora:
	CCG Patient Reference Group (CCG PRG), patients, the wider public, carers – with a focus on older people but this is also relevant to the wider adult population, Huntingdonshire Patients Congress, Peterborough Consultation Forum, Borderline Patient Forum, Patient Groups (via Patient Reference Group members), Carer Forums in Cambridgeshire and Peterborough.
	Voluntary Sector Organisations:
	Senior Citizens fora across the region, Age UK, Cambridgeshire Older People's Reference Group (COPRG)
	Cambridge Older People's Enterprise (COPE), Cambridge, Fenland, East Cambridgeshire, Huntingdon and Peterborough Councils for Voluntary Organisations.
	Speak Out Council (learning disability), CAMTAD drop-in services for people with acquired hearing loss, Arthur Rank House – Hospice, Sue Ryder – Hospice.
	Local Authorities & other Statutory Bodies:
	Peterborough Older People's Partnership Board, Peterborough City Council, Northamptonshire, North Hertfordshire and Cambridgeshire County Councils - Adult Social Care, Northamptonshire and North Herts District Councils, Northamptonshire and North Herts Overview and Scrutiny Committees, LINK /Healthwatch – Peterborough and Cambridgeshire, Cambridgeshire County Council Overview and Scrutiny Committee, Peterborough City Council Overview and Scrutiny Committee, Peterborough and Cambridgeshire Health and Wellbeing Boards, Northamptonshire and Hertfordshire Health and Wellbeing Boards, East Cambs Health and Wellbeing Partnership, South Cambs Health and Wellbeing Partnership, Fenland Health and Wellbeing Partnership, Huntingdonshire Health and Wellbeing Partnership, Hunts Strategic Board, East Northamptonshire Health and

	Wellbeing Partnership, District Councils, Parish Councils, Hunts Forum.
	Other:
	MPs and the Media all have a particular interest in this procurement programme.
	The CCG has held a series of events throughout Cambridgeshire and Peterborough both explaining and answering questions about the process they are going through and finding out people's views on the services. It has attended many meetings of established groups as well as setting up some stalls in the markets of towns and villages to talk to people they wouldn't normally hear from. This is an ongoing process. The CCG has welcomed suggestions for groups for talks about this programme. They are committed to wide ranging engagement throughout the lifespan of this major transformation programme and continue to be keen to listen to patients', carers' and the public's experiences of using health services. Invitations offering groups and organisations a CCG speaker to go to their meetings to talk about the Older People's Programme continue to be popular. Prior to public consultation more than 100 awareness raising events took place since 2013 as follows:
	Summer Roadshows were undertaken at the following venues:
	• Whittlesey market
	• Royston market
	• Oundle market
	• March market
	• Wisbech library
	• Ely market
	• St Ives market
	The following engagement events were also undertaken with the below listed groups of people:
	• Local Councillors via briefings
	• CCG Staff at staff briefings
	• Histon and Cottenham PPG
	• Warboys day care centre

	• Peterborough Salvation Army day centre
	• Arbury Rd PPG
	• Over 60s club – Cotton End Bretton, Peterborough
	• Market Deeping – Welcome Club
	• Stroke Group – Addenbrookes Hospital
	• Ely Patients Forum
	• Burwell Carers Group
	• Care Network AGM
	• Breathe Easy Cambs
	• Lillington Evergreen Club
	• Huntingdon Rd Surgery PPG
	• Burwell over 60s club
	• Ramsey Day Centre
	• Caresco AGM, Sawtry
	• Benwick forget me not group
	• The National Autistic Society Peterborough & District Branch
	• Parkinson's Disease Association
	• Peterborough Area Transgender Alliance
	• Peterborough Disability Forum
	• Headway Cambridgeshire
	• Thorpe Road Surgery - Peterborough Patient Participation Group

	• Peterborough Youth Council
	• Cambridgeshire Independent Advocacy Services
	• Peterborough Association for the Blind
	• Welland Residents Association
	• Park Medical Centre Patient Participation Group
	• Family Voice Peterborough
	• Westgate Surgery PPG
	• Netherton Friendship Club
	• Peterborough Interfaith Council
	• Age Concern
	• Stroke Association
	• Peterborough Rape Crisis Centre
	• Home Instead
	• Golden Age of the Caribbean Society
	• Senior Citizens of Pakistan Group
	• The Italian Association, Peterborough
	• Disabled Living Foundation
	• CAMTAD
	• Cambridgeshire Libraries
	• Punjabi Cultural Society Cambridge
	• One Voice

	• SUN, Engagement Forum for adults & older people who use mental health service, Cambs
	• Pinpoint
	• Falls Assist UK
	• Cambridge Kerala Cultural Association
	• Indian Cultural Society
	• Cambridge Forum of Disabled People
	• Wisbech Matters
	• Speaking Up Youth Parliament
	• Huntingdonshire Community Safety Partnership
	• Fenland Community Safety Partnership
	• Cambridge Community Safety Partnership
	• South Cambridgeshire Community Safety Partnership
	• East Cambs Community Safety Partnership
	• Huntingdon Community Group
	• The Ely Society (Civic Society for Ely)
	• Cambridge Malayalee Association
	• Cambs ACRE
	• Hunts Forum of Voluntary Organisations
	• Diabetes UK Huntingdonshire Voluntary Support Group
	• COPE (Cambridge Older People's Enterprise)
	• Travellers Initiative

	• East Anglia Gypsy Council
	• Young Lives
	• Fenland District Council Housing and Development Services
	• Women 4 Integration
	• Ethnic Minority contacts
	• MENTER (East of England network for black & minority ethnic voluntary organisations & communities)
	• Cambridge Ethnic Community Forum
	• Cambridge African Network
	• Cambridge Pakistan Cultural Association
	• Bangladeshi Welfare Cultural Association
	• Punjabi Cultural Society, Cambridge
	• University of the Third Age – all local groups
	• Rosmini Centre

7.	What might help/hinder the success of the Programme ?
	1. Factors that might contribute to the success of the Programme
	External factors:
	• Public and media support for change – through proactive engagement and communications.
	• Good public engagement - through early, full public consultation on bidder solutions and ongoing programme of engagement.
	Internal/NHS Factors:
	• Robust tendering process with strict adherence to rules to ensure transparency and fairness to all parties and so reduce risk of challenge.

	• Provider staff engagement – through development of engagement and communications strategies.
	• Good engagement from LCGs particularly the GPs through local system engagement plans and events and maximising involvement in the process.
	• Good awareness and engagement from CCG staff.
	• Robust transition plan on contract award to ensure organisation development and staff training/ orientation to new service delivery and principles and application of new integrated ways of working.
	2. Factors that might hinder the success of the Programme
	External Factors:
	• No viable Lead Provider initially identified through tender process.
	• Lead Provider unable to deliver outcomes/scale of transformational change required within financial envelope.
	• Challenge on process from bidder/s leading to judicial review thus significant delays.
	• Inequalities in provision between different parts of CCG.
	• Impact on Cambridgeshire Community Services and service sustainability until successful bidder in place.
	• Further decreases in Social Care funding.
	• Lead Provider experiences staff recruitment difficulties.
	• Mobilisation delays.
	• Funding risks to voluntary sector organisations.
	Internal Factors:
	• Delays in the procurement process.
	• Reluctance of existing providers (acute and community) to helpfully engage with successful bidder.
	• Resistance to a non NHS provider – could lead to staff leaving or unwillingness to embrace changes.
	• CCG Financial constraints affecting the appropriate level of investment into the programme infrastructure – further

	constrained by movement of £47m of CCG resources into the Better Care Fund.
	• Recruitment and retention of community services staff/increased sickness and absence rates and resistance to organisation development work and training.
	• Capacity to deliver the programme within timescales. If the programme is not delivered in the timescales, this could mean a delay in achieving the desired outcomes.
	• Staff resistance to working in a new integrated way.
	• Lack of GP, primary care, community clinical staff engagement leading to services not being as well developed as planned.
	3. How we will know success has been achieved
	i) The Critical Success Factors have been identified as:
	• Improved patient experience and service quality for patients and their carers through care organised around the patient.
	• Delivery of services which are sensitive to local health and service need, as defined in the local health system visions.
	• Older people supported to maintain their independence and reduce avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care).
	• Front-line staff enabled to work effectively and flexibly together to deliver seamless care as delivery has moved beyond traditional organisational and professional boundaries.
	• An organisational solution delivered for older people's care which can demonstrate strong leadership, sound governance, resilience, and the confidence of commissioners and provider partners.
	• A credible approach to engaging patients and representative groups in design and delivery of services demonstrated.
	• A sustainable financial model with the following financial principles provided:
	○ Improved patient outcomes aligned with financial incentives.
	○ Financial gain and risk sharing across the commissioner - provider system.
	○ Recurrent financial balance delivered in a sustainable way.
	○ The conditions for investment and delivering a return on investment are created.

	4. Performance Monitoring
	Through the Key performance indicators within the outcomes framework and standard NHS contract monitoring process

Form 2: Information Gathering

	Age	Disability***	Gender	Gender Reassignment	Pregnancy and Maternity	Race/Ethnicity or Nationality	Religion or Belief	Sexual Orientation	Marriage / Civil Partnership	No Differences Either Position or Negative
Is the Policy you are considering relevant to the public duties relating to each Protected Characteristic (listed to the right)? Place a Tick or a Cross as appropriate	✓	✓	✓	x	x	✓	✓	x	x	x
In other words, does the Policy: eliminate discrimination and eliminate harassment in relation to… promote equality of opportunity in relation to… promote good relationships and positive attitudes in relation to… encourage participation in public life in relation to…										
*** In relation to disability only, as part of your assessment you MUST consider whether there is a need to make reasonable adjustment(s). The law requires this even if it involves treating some individuals more favourably in order to meet their needs										

Form 2: Information Gathering (Human Rights)

Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 3 rights that are particularly relevant to healthcare are listed below. For a fuller explanation of these rights and other rights in the Human Rights Act please refer to Appendix A: The Legislative Framework.

Depending on the Policy you are considering, you may find the examples below helpful in relation to the Articles.

Consider, is the Programme relevant to:	Yes	No
Article 2: The right to life		
Example: The protection and promotion of the safety and welfare of patients	✓	
Article 8: The right to respect for private and family life, home and correspondence;		
Example: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life; Issues of patient restraint and control	✓	
Article 11: The right to freedom of thought, conscience and religion		
A person's religion or beliefs may affect their access to healthcare or the way in which they feel comfortable with healthcare being provided.	✓	

Protected Characteristic	List Information Gathered in relation to different protected characteristics
Multiple protected characteristics	**2012 data for patient experience of care in hospitals demonstrates**:
	• Timely discharge is an issue for patients. This is further supported by the CCG's scoping work of national surveys covering the past six years which shows the discharge process needs to be addressed.
	2012 GP Patient Survey demonstrates:
	• Out of hospital care is an area for improvement.
	JSNAs demonstrate:
	• A rapidly growing population (+1.5%pa) with increasing births & inward migration.
	• Increasing inequalities of outcome in most deprived areas.
	• In terms of reducing potential years of life lost (PYLL) from causes amenable to healthcare, Cambs is in the lowest Local Authority quintile and Peterborough is in the highest. This is likely to reflect inequalities in other geographical units across the CCG area.
	• Inequalities exist in terms of improving health related quality of life in people with long term conditions Cambs is faring better than Peterborough.
	The CCG 5 Year Plan highlights:
	• The CCG has a major reduction in resources across the system with the lowest funding per head in the East of England.
	• Some of the most challenged health & social care providers in terms of their financial and clinical sustainability and this pressure is accelerating.
	Better Care Fund (BCF) Review on service integration to inform BCF investment:
	Stakeholders have been involved in the process to determine how the resources should be spent. The following recurring themes were highlighted:

	• The importance of aligning the Older People Programme and the BCF.
	• The need to avoid 're-inventing the wheel' and to optimise care pathways.
	• The need for clarity about how the BCF joint commissioning fund will be deployed and the anticipated impact on the overall CCG commissioning resources.
	The CCG Strategic plan highlights:
	The need to reduce the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital. Admissions in this category are approximately 25% of all emergency admissions. At CCG level, this indicator has a flat trend from 2009/10 to 2012/13 with the CCG consistently in the second best quintile of CCGs, thus demonstrating the potential for improvement.
	Development Process of the Integrated Older People's Services and Adult Community Services Procurement 'Outcomes Framework'.
	The CCG has developed an innovative approach to provider contracting by using a Payment by Outcomes (PBO) methodology which is linked to specific outcomes domains and indicators through the use of evidence and extensive consultation to test the approach as follows:
	Setting specific objectives by which to measure and manage performance is a key step in achieving effective transformation of joined-up, patient centred care for older people. Linking these objectives to contract measures and financial incentives will ensure high quality care, organisational performance and achievement of programme goals.
	Three target groups have been identified within the Older People's Programme: if) frail older people 65 years and over as evidence shows they are particularly vulnerable to hospital admission ii) community services for adults and older people with long term conditions iii) preventive interventions for all 65 years and over to maintain health, wellbeing and independence for as long as possible.
	Desired outcomes for the service were mapped across the clinical pathway of four key stages for all patients incorporating: i) maintaining health and wellbeing ii) treatment and support during acute episode of illness iii) long term recovery iv) end of life care. Three further overarching domains were identified as follows: v) to ensure people have an excellent and equitable experience of care vi) patient safety vii) joined

	up organisational working.
	A scoping review was performed to describe current national benchmarked outcomes or indicators in the NHS Public Health, Social Care and CCG National Outcomes frameworks, national data sets for specific populations (e.g. the Older People's Health and Wellbeing Atlas) or specific diseases (e.g. Stroke Sentinel Audit, National Intermediate Care Audit, End of Life Care Audit, National Bone Audit) and local Commissioning Health data sets including Secondary Uses Service data (SUS). Key aspects of measuring patient experience were reviewed including national reports (e.g. the National Voices survey) and patient reported outcome measurement tools were described. Indicators were then identified for each desired outcome of the programme. Where possible and feasible, indicators have been identified to triangulate information on each outcome using patient and carer experience, staff or provider experience, service process measures and clinical outcomes.
	The guiding principles that have been used to develop the Outcomes Framework are:
	• add value in understanding and monitoring high quality care
	• be innovative and measured as part of the clinical pathway, to improve patient care
	• Triangulate indicators relating to feedback from patients and carers, measurable clinical outcomes, service utilisation with feedback from staff and other providers including primary care.
	Indicators have been tested to ensure they are robust and relevant to all stakeholders and be clear, specific and measurable, defined in a technical specification.
	Each indicator is based upon sound evidence. A variety of information sources were used including National Outcome Frameworks for NHS, Public Health, CCG and Social Care: NICE Quality standards & national audits, NHS Constitution requirements and NHS Standard Contract requirements, Quality reporting measures to ensure national standards are maintained. In addition research from patient experience, patient views from the local population and expert local clinical opinion were used. Full details are provided in the Outcomes Framework document available on
	http://www.cambridgeshireandpeterboroughccg.nhs.uk/pages/older-peoples-programme.htm
	On the basis of the above, a draft Outcomes Framework (‘*Mark 1’*) was produced. This has been tested

	with the bidders through the dialogue stage of the procurement in order to test the appetite for a PBO based methodology, the validity and relevance of the indicators, practicalities of data collection.
	Following the dialogue the Outcomes Framework underwent additional testing/review with patient representatives, the voluntary sector, social care colleagues and GPs to identify local desired outcomes for this programme. In addition, key clinical and managerial subject matter experts were involved including a review conducted by Dr Vienna Raleigh who is a Senior Fellow in epidemiology with the King's Fund.
	In November 2013 the CCG held a patient engagement event whereby >100 patients and organisations that represent patients where invited from across the CCG geography to attend. The focus of the event was to discuss and understand the audience perspectives on what mattered most about their NHS care and why. Over 50 patient representatives attended the workshop and the views captured have been used to inform the indicators in Domain A (Patient Experience). Emerging themes from patients were used to further shape the patient experience domain.
	Further patient engagement involved a patient testing event using the revised 'I' statements in February/March 2014 where patient representatives were asked for their views and feedback on the actual indicators and outcomes proposed and whether these appropriately reflect their needs and priorities. Patient groups were also asked to comment on the entire framework.
	The *Mark 1* Framework was also subject to external review by COBIC (Capitated Outcomes Based Incentivised Commissioning), and is part of the Kings Fund Learning Network support. The outputs from these reviews have been used to inform the revised *Mark 2* document.
	A workshop was convened in February 2014 facilitated by COBIC to review each indicator using clinical scenarios to understand whether they capture elements of good and bad care i.e. whether the list of indicators in the outcomes framework is fit for purpose. Also to explicitly consider potential unintended consequences of attaching payment to the proposed PBO indicators.
	Revisions were made to the technical specifications of the revised list of indicators including new evidence, where available, and detail on what should be reported.
	The list of indicators and technical specifications for the Outcomes Framework 'Mark 2' were finalised for review by LCG Boards during February prior to approval by the Older People's Programme Board (OPPB) on 27 February and approved by the Governing Body on 4th March. The document was then issued to

	providers for further dialogue at the start of ISFS stage on 10 March 2014.
	In the ISFS stage, thresholds and trajectories will be developed and discussed with bidders to define and agree targets for PBO. As a result of this comprehensive review a '*Mark 3'* Outcomes Framework is being issued within the full solution phase of the procurement. This framework will summarise indicators against which it is proposed to add PBO and also list indicators which we want providers to report for further information, as part of the contract. Further work on thresholds for each indicator will be ongoing as part of the contract development work.
Age	**Joint Strategic Needs Assessment (JSNA) & bespoke health needs profiles demonstrate**
	Working closely with partners in Public Health, and through the Improving Outcomes Team within the CCG a wide range of demographic information about population was identified which informs commissioning. This is primarily included in the Joint Strategic Needs Assessments (JSNAs) for both Peterborough and Cambs. The JSNAs' data is one of the sources of evidence of the current situation with reference to the Older People's Procurement. These show growing population and current inequalities between different parts of the CCG, as follows:
	• The population of Cabs and Peterborough is growing older. The population aged 75 years and over is set to increase by 33% between 2011 and 2021 (20,000 people) with increasing health & social care needs.
	• Although life expectancy is increasing over time, there are inequalities between Cabs and Peterborough. The average life expectancy in Cambridgeshire is 80 years for males and 84 years for females. In Peterborough, average life expectancy is 78 years for males and 82 years for females (2008-2010 ONS Life Expectancy).
	• Important differences remain in mortality of the populations between local Authority districts and between areas in both Cambridgeshire and Peterborough, for example in Peterborough the rate of coronary heart disease (CHD) mortality is not falling as fast as in Cambridgeshire, some districts in Cambridgeshire have higher death rates than the county average, e.g. in Fenland, and there are important differentials in premature deaths from CHD. See Peterborough JSNA at:
	http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assesmen.aspx

	and Cambridgeshire's JSNA at: http://www.cambridgeshireinsight.org.uk/jsna
	The Cambridgeshire JSNA : Prevention of ill health in older people – 2013 provides evidence on the following areas in relation to promotion of wellbeing in older people:
	i) 65 years and over within Cambridgeshire use more emergency bed days compared with other PCTs. Evidence shows that by integrating care for older people emergency hospital admissions will be reduced.
	ii) Frailty makes an older person more vulnerable to an acute health or social crisis. There are estimated to be nearly 17,000 frail people 65 years and over (16.8%) in Cambridgeshire. A risk stratification process would identify the frail older people at risk of hospital admission and would thus provide the basis for management and help to prevent avoidable admissions.
	iii) Falls are a major cause of disability and a leading cause of mortality due to injury in over 75 year olds in the UK. In falls related indicators Cambridge City is significantly worse than the England average. Evidence suggests the need for an integrated falls service across Cambridgeshire.
	iv) In terms of mental health, over a third of older people in the UK are likely to experience mental health problems. The mental health needs of older people are often complex due to co-morbidities with mental health and/or physical health conditions or frailty being present at the same time. In 2013 in Cambridgeshire there were estimated to be 7,240 people with dementia, and this number is likely to grow. This will lead to increased demands on social services, primary care and families, as well as increasing pressure on acute hospitals and specialist mental health services.
	v) Loneliness and isolation amongst older people is another key issue which impacts on their health and wellbeing. In Cambridgeshire, approximately 29,000 people aged 65 years and over live alone. Reducing loneliness and isolation can also help to address health inequalities.
	vi) Nationally 65% of older carers (aged 60 to 94) have long-term health problems or a disability themselves and 69% say that being a carer has an adverse effect on their mental health. Carers provide a crucial role in supporting older people to be independent and live in the community, preventing unnecessary hospital admissions and reducing the need for health and social support. Better recognition of a caring role would help people identify themselves as a carer at an earlier stage, and potentially be more likely to access appropriate support services before a crisis. There are 60,000

Disability	informal carers in Cambridgeshire, but fewer than 5% are 'known' to GPs. In the 2012 Carers Survey, local carers identified a need for local and accessible information to enable informed decisions and choice, isolation and carer breaks and easily accessible advice on financial benefits. The full report can be found at:
	http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/prevention-ill-health-older-people-2013
	Peterborough
	• Learning disability - it is estimated that there are 339 people in the Peterborough resident population aged 15 to 64 with profound learning disability, and a further 3,803 with a mild to moderate learning disability.
	• There are an estimated 17,774 people aged 16 to 64 with mental health problems in Peterborough, based on the Mental Health National Service Framework prevalence estimates.
	• 388 people with sensory impairments were supported by community based social care services in 2008, covering 26.1% of those registered.
	• Approximately 10% of the population of Peterborough provide unpaid care to family members, friends and neighbours - their role and contribution to society and the people they care for needs to be recognised and valued. Without unpaid carers, formal services would be unable to cope with demand.
	Ref. Peterborough City Council Single Equality Scheme 2011 - 2014
	The Cambs JSNA for physical and learning disabilities 2013 highlights the following:
	• As the Cambridgeshire population grows and ages, the number of people with disabilities is also expected to rise. The proportion of people with a learning disability aged over 55 is expected to increase and parents caring for them are likely to have died or become frail. Social care requirements for people with a learning disability in England are expected to increase by 14%, up to 2030.
	Key inequalities and issues for Cambridgeshire
	Disability and disadvantage :

	• People with disability are more likely to live in poverty and be unemployed. There are differences experienced by people who have had a disability since birth and those who have become disabled later in life.
	• People with learning disabilities are more likely than their non-disabled peers to be exposed to poverty, poor housing conditions, unemployment, social exclusion, violence, abuse and discrimination.
	• As people with learning disabilities are living longer, there are greater numbers transferring to older people's services at 65 years of age. This can cause difficulties if older people's services lack the specialist skills or knowledge to care for people whose primary need may still be a learning disability. The Learning Disability Partnership has agreed a transition process to help smooth the path into older people's services.
	• Those who are already disadvantaged are at a greater risk of becoming disabled later in life.
	Prevention and staying healthy
	Some types of physical disability are related to a number of chronic health conditions. People receiving support from the physical disabilities social care team at Cambridgeshire County Council are most likely to have a disability resulting from Multiple Sclerosis, spinal or skeletal injury or acquired brain injury.
	People with disabilities are subject to the same risk of chronic diseases as the population as a whole, but may be less able to access healthy choices. People with disabilities may be less able to access leisure services, and people with a learning disability and their carers may have poor knowledge of healthy eating.
	People with learning disabilities are more likely to experience ill health and to die younger. In part, this is related to a number of environmental factors, including, poverty, discrimination and unemployment. Preventable causes of death are relatively common, such as pneumonia, which can result from swallowing difficulties and seizures.
	Health checks for adults with a learning disability are important to reduce inequalities in accessing healthcare. 75% of eligible adults received a health check in Cambridgeshire in 2012.
	People with learning disabilities are less likely to take up screening and other health promotion activities. In

	Cambridgeshire, work is underway to ensure screening is signposted at health checks and to look at how information on screening uptake can be obtained from primary care.
	Identifying adults with a learning disability on information recorded during a hospital admission is important to ensure reasonable adjustments are made. This is happening less often in Cambridgeshire than the England average for psychiatric admissions. Learning disabilities specialist nurses, based at two Cambridgeshire NHS trusts, identify when people with learning disabilities are admitted to those Trusts and advise on necessary reasonable adjustments.
	People with learning disability in England are more likely to go into hospital for conditions that could have been treated in the community. Admission rates in Cambridgeshire are not significantly different from the England average, suggesting that this may be a problem in Cambridgeshire as well. Better sharing of information on people with a learning disability across agencies is needed
	People with learning disabilities in Cambridgeshire reported certain shortcomings in the provision of health care services, in 2007. This included a lack of easy read information; poor attitudes from some health staff towards people with learning disabilities and their carers; insufficient care available whilst person with learning disability is in hospital; inadequate hospital facilities, including access and delays in referrals. Local surveys identified that people with autism have unmet needs, such as difficulties with identification and diagnosis, and lack of training amongst staff concerning people with autism with whom they came into contact.
	http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/physical-disabilities-and-learning
	There is also anecdotal evidence via some of the public and voluntary sector events. The feedback was that the CCG needs to ensure the needs of disabled people are considered and met.
	Following feedback during the consultation from Cambridgeshire Learning Disability Partnership Forum, a simplified Easy Read version of the presentation and feedback questionnaire was created. The Easy Read

Learning Disability – feedback from Public Consultation	questionnaire was distributed via both Cambridgeshire and Peterborough Learning Disability Partnerships. The presentation was given to the Leaders of the VoiceAbility Speak Out Council, who each completed a questionnaire. The group asked that the following groups are considered people with learning disabilities, people with Autism or Asperger Syndrome and people with Mental Health difficulties. They requested that reasonable adjustments are made with regards to signage, leaflets and all correspondence, for example if letters for appointments could be produced in Easy Read format, waiting areas and appointment length flexibility
Gender	The older population has more females than males due to the fact that women tend to live longer than men. The CCG has recently engaged upon a project to pilot multi-disciplinary team (MDT) working across the Local Commissioning Groups (LCGs) in order to identify frail older people who may be at risk of hospital admission. A recent evaluation shows that the vast majority of people identified were over 80 years old and around 60% of all those identified were female. It is important that the CCG ascertains the distribution of male versus female patients in order to ensure equity of access to the available services for both genders. The skew towards female gender in the frail elderly population of patients in MDT care is representative of the population in the older age groups. (Evaluation Report on MDT Working across Cambridgeshire and Peterborough, May 2014 P.26) □n 2011, females were notably more likely to be unpaid carers than males; 57.7 per cent of unpaid carers were females and 42.3 per cent were males in England and Wales. Across English regions and Wales, females took on a higher share of the unpaid care burden than males in a similar proportion, regardless of the amount of unpaid care the region's usually resident population provided. The share of unpaid care provision fell most heavily on women aged 50-64; but the gender inequality diminished among retired people, with men slightly more likely to be providing care than women - Source: 2011 Census. This is a situation the CCG wishes to keep under review moving forward. In specific groups and areas of the CCG there is inequity in health outcomes between male and female. Male gypsies and travellers are less likely to access health services early on in illness. 2008-2010 ONS Life Expectancy, JSNAs Peterborough & Cambs. The majority of staff involved in caring for older people are female. In terms of future new employer, TUPE

	will apply to staff which ensures their legal rights are protected irrespective of gender / age or any other protected characteristics.
Gender Reassignment	Not affected
Human Rights	As per age (above)
Pregnancy and Maternity	Not affected
Race/Ethnicity or Nationality	**1.Peterborough's population**
	Ethnically diverse, with 1 in 13 people being members of an Asian ethnic group.
	The largest Asian ethnic group is the Pakistani population, with around 7,400 people.
	• The proportion of residents coming from black and minority ethnic communities is increasing.
	• The ten most common languages spoken in schools are English, Punjabi, Urdu, Polish, Portuguese, Slovakian, Lithuanian, Guajarati, Czech and Chinese.
	• International migration into Peterborough has increased since 2004, People from Eastern Europe now form the largest group migrating into Peterborough, particularly those from Poland, Lithuania, Slovakia and the Czech Republic. This population is estimated to be between 25,000 - 35,000.
	Ref. Peterborough City Council Single Equality Scheme 2011 - 2014
	http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assesmen.aspx
	Immigrants
	The majority of Peterborough's population is white British, but Black and Minority Ethnic (BME) groups including new arrivals and Gypsies and Travellers are more likely to face social exclusion and marginalisation.

Feedback from Public Consultation on ethnic minority groups	The consultation documents carry the wording “If you would like this document in another language or format, or if you require the services of an interpreter, please contact us” translated into Urdu, Czech, Italian, Polish, Gujarati, Lithuanian and Portuguese on page 2 and 23 of the document. One of the public meetings was held at the Rosmini Centre, a cultural community centre in Wisbech. Two of the public meetings in Peterborough were held at the Italian Community Association building known as ‘The Fleet’ in Fletton, Peterborough. Based on information received from GP practices and City, County and District Council collegues on common community languages, the consultation summaries and feedback questionnaires were translated into Latvian, Lithuanian, Portuguese, Polish, Urdu and Russian. These were made available through the CCG’s website and emailed to councillors and community groups. Information was distributed to, and offers made for CCG representatives to attend meetings to explain the consultation in more detail through, umbrella organisations (Peterborough Diversity Forum, Cambridge Ethnic Community Forum, Peterborough Racial Equality Council) and groups and through direct email, with addresses sourced from the internet and contact lists held by the CCG and local authorities. Following this, specific contact was received from the following groups: Requests to attend meetings: • Cambridge Punjabi Cultural Society • Peterborough Community Groups Forum (Umbrella group for newly settled residents) Offers to pass on information: • Muslim Council of Peterborough • Club Polonia (Cambridge Polish Community)

Feedback given included that healthcare professionals need to be aware of cultural/faith/religious differences. An example was given where an elderly lady of Asian background had been visited at home by a male nurse. While there was nothing wrong with the care given, the fact that it had been a male and not female nurse had left the elderly lady in state of distress. Peterborough Scrutiny Commission for Health Issues also stated that all community languages should provided within a 'call centre'. Peterborough Community Groups Forum, an umbrella organisation for groups representing newly settled residents, including Lativian, Lithuanian, Polish, Nigerian and Ghanaian communities, offered an avenue for further engagement with these communities. They advised that documents translated into Swahili would be beneficial in future consultations. Ethnicity data from the completed public consultation questionnaires indicates that residents from ethnic minority groups did respond to the consultation. Twelve respondents considered themselves to be of 'mixed multiple ethnic group', 19 stated 'Asian/British Indian', four said 'Asian/British Pakistani', three were 'Asian/Asian British Chinese' and one said they were 'Asian/Asian British – Any other Asian background'. One respondent stated 'Black, African, Caribbean, Black British – Caribbean. Five said they were of 'Other Ethnic Group' and 43 respondents stated 'White – any other white background.
Gypsies & Travellers
Estimates suggest that Peterborough has around 2,000 Gypsies and Travellers
2. Cambs Population
l **Gypsy & Traveller Community**
Gypsies and Travellers make up almost 1% of the population in Cambridgeshire representing the largest ethnic minority in the county. In Cambridgeshire it is estimated that approximately 70% are Romany Gypsies, 20% are Irish Travellers and 10% are others including Scottish and Welsh Travellers and an increasing number of Eastern European Gypsies. The numbers of Gypsies and Travellers in the

	population is difficult to ascertain and there is often significant underreporting of service use and outcomes as organisations may not include Gypsies and Travellers in their ethnic monitoring, coupled with the need for the subjective definition of ethnicity and reluctance to declare ethnicity for fear of discrimination.
	The 2005 CSTNA found that the age distribution of the Gypsy and Traveller population broadly corresponded with findings from other research: there is a higher proportion of children and lower proportion of older people in the Gypsy and Travellers population compared to the general population.
	The Cambridgeshire Gypsy and Travellers JSNA aims to identify the current and future health, care and wellbeing needs of the Traveller population in Cambridgeshire. From this it is clear that the Gypsy and Traveller population face a number of inequalities. These can be summarised as follows:
	Accommodation: Lack of secure accommodation is the biggest issue facing Gypsy and Traveller communities in the East of England and many are homeless. Eviction and enforced mobility are key factors preventing access to education, healthcare, training and work opportunities.
	Health and Wellbeing: Gypsies and Travellers have significantly poorer health status and more self-reported symptoms of ill-health than the rest of the population with reported health problems being between two and five times more prevalent. Poor mental health is a particular concern and has been flagged by the Traveller Health Team (THT) as an issue.
	There are issues with lack of understanding and therefore not complying with treatment and access to healthcare services.
	Male Gypsies and Travellers are reluctant to discuss personal issues with the women in their family network and will not access health services until the problem is severe.
	Early intervention and prevention measures such as screening and immunisation have low uptake among the Gypsy and Traveller population.
	Lifestyle risk factors such as rates of smoking and obesity are higher in the Gypsy and Traveller community than the rest of the general population.
	It is known that Irish Travellers life expectancy is lower than average life expectancy.
	Education and Employment: Gypsy and Traveller children remain highly disadvantaged in terms of access

	to education and achievement. There are many inhibitors to achievement for Gypsy, Roma and Traveller pupils. These children and young people are being excluded from the opportunity to develop the skills and knowledge that will equip them to be able to participate fully and equally in society.
	Economic exclusion: There is evidence of economic exclusion in the Gypsy and Traveller population and locally concern has been raised about access to affordable utilities. Other issues include problems with securing finance due to having no fixed abode or varied employment. In common with other vulnerable groups, lack of literacy and numeracy may impact on household budgeting skills and awareness of rights and benefits.
	Communications and access to services : Poor levels of literacy make it difficult to access services and information and there is a lack of information for Gypsies and Travellers in appropriate formats. Gypsy and Traveller culture and identity receive little or no recognition and are frequently excluded in policy initiatives. There is a lack of access to culturally appropriate support services for people in the most vulnerable situations.
	Travellers Health Team (THT): The THT have reported successes as increasing trust has been placed in the team by the Gypsy and Traveller community and there seems to be increased confidence in the team for issues relating to advocacy, adult learning and general health. Delivering drop in clinics at sites has proved successful. Having a dedicated multi-agency team with differing expertise is working extremely well. Working closely with Children's Centres is opening up pathways for Gypsy and Traveller families to receive additional services as well as fostering better relations with local families. Additional funding has been obtained for specific purposes such as vocational courses, family healthy eating sessions, swimming lessons for children, literacy courses and Health Trainer courses. Partnerships have also been developed with other Professionals to enable the delivery of more acceptable and accessible services.
	The full report can be found at:
	http://www.cambridgeshireinsight.org.uk/currentreports/travellers
	Based on experience from previous consultations and community engagement, the CCG contacted local authority colleagues for assistance in reaching Traveller/Gypsy communities. Information was passed on, or offers to hold focus group sessions were made accordingly through

councils and companies who manage traveller sites.

This included:

- Fenland District Council (five traveller sites in Fenland)
- East Cambs District Council (two traveller sites in East Cambs)
- South Cambs District Council (two traveller sites in South Cambs)
- Luminus Group (one traveller site in Huntingdonshire)
- Hertfordshire County Council
- Peterborough City Council
- AMEY (Paston and Oxney Rd Traveller sites – Peterborough).

Following advice from a community contact, a focus group session with a Czech interpreter was set up for the Roma Community in Peterborough. The session was held at a time and place suggested by the community advisor as appropriate to give the best chance of people from this community to the chance to attend. The community contact advised all his contacts of the session and distributed a flyer advertising the session through them. He felt that those he had spoken too 'didn't seem to be very keen on attending' and no one attended on the day. The interpreter advised that the best way to reach the Roma community in future would be for a person known to the families concerned to approach them and to pass on a flyer in the community's own language.

Feedback given via the questionnaire advised the best way for healthcare to be delivered to Traveller communities is through community outreach work.

Ethnicity data gathered through the public consultation questionnaire shows that two respondents to the consultation consider themselves to be 'White – Gypsy or Irish Traveller'.

ii Migrant Workers

Between January 2008 and April 2013, there was a 14.6% increase in the registered population – source -

Feedback from Public Consultation relating to Gypsies and Travellers	. The CCG's Operational Plan 2014/15–2015/16. The migrant population changes adds to the complexity of commissioning services. International migrants in Cambridgeshire come from all over the world and with different socio-economic backgrounds. Between 2002 and 2011, more than 74,000 foreign nationals registered for a National Insurance Number in Cambridgeshire. The 2011 Population Census indicates that the total number of Cambridgeshire residents who were born outside the UK was 85,700. The most common countries of origin for migrant workers registering in Cambridgeshire and in Peterborough in both 2010 and 2011 were Lithuania, Latvia, and Poland.
	Translations of the Proposals to Improve Older People's Healthcare and Adult Community Services consultation summary and questionnaire were translated into Lithuanian, Latvian and Polish, the native languages of the most common countries of origin for migrant workers registering in Cambridgeshire and Peterborough. These were distributed through community contacts. A Latvian Festival took place during the consultation period and the Latvian translations were taken along. A member of the CCG's Engagement Team attended a meeting of the Peterborough Community Groups Forum (Umbrella group for newly settled residents), where representatives of groups all meet. Copies of the consultation summary and questionnaire in all of the languages available were distributed to the group. Download data from the public consultation page on the CCG website shows that both the translated summary and questionnaire were downloaded in each of the three languages of the most common countries of origin for migrant workers but no completed paper copies were received in any of the languages these documents were translated into. Likewise, no specific equalities issues were raised through the consultation or our other engagement work in relation to Lithuanian, Latvian and Polish residents. However, ethnicity data collected from the questionnaires that were completed shows that 43 respondents considered themselves to be of 'White – Any other background' and as such could be of Latvian, Lithuanian or Polish origin.
Religion or Belief	Peterborough has a large number of different faith groups, with most major faith groups represented and a large Muslim population. The Peterborough Inter-faith Council has over 30 years of history and a newly

	formed Faith and Cohesion Network is working to encourage different faith groups and denominations to work together closely on cohesion matters. A Cohesion Manager works across partners based within the Greater Peterborough Partnership.
	Ref. Peterborough City Council Single Equality Scheme 2011 – 2014
	People with different religious beliefs that impact upon the way that healthcare is delivered need to be understood and respected if barriers to care are to be avoided. The team sent the consultation document to groups with different religious beliefs but we did not receive any specific feedback in this regard.

Form 3: Assessment of Relevance and Priority

Protected Characteristic	Evidence: Existing Information to suggest some groups affected. Gathered from Step 2. (See Scoring Chart A)	Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score. (See Scoring Chart B)	Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C)
Age	Hard evidence from National Policies and Guidance, JSNAs, Patient Experience data, GP Survey, CCG Five Year Plan, BCF review and CCG strategic plan. Anecdotal from patients and the public on the need to avoid hospital admission where appropriate through better local services and to improve outcomes for older people. Via public consultation 82% of 60 – 74 years and 81% over 75 year olds in the consultation agreed with proposals and the older generation were more confident of the success of the proposals than the younger generation. Score: 3	• Large - and expanding – number of 65 years and over people. • Too many older people being admitted to hospital for care and lack of community alternatives. • Mistrust of new provider by older people, fuelled by media concern. • High profile nature of programme – as one of the first of its kind in the UK. • Payment by Outcomes – mechanism to ensure right outcomes being achieved for target population. Score: 3	By focussing on four key stages of the older people's pathway – promoting wellbeing and independence; rapid response to health problems; rehabilitation and end of]life care and through inclusion of both the secondary and community care spend for older people in the budget there is more capacity for the incoming provider to provide a greater level of appropriate and local service to meet the needs of older people than hitherto. On this basis it is deemed to be a high positive impact. The CCG notes that any incoming provider will need to work hard to establish trust with the public, media and provider organisations and staff. Score 9 – High Positive Impact
Disability	Hard evidence from Cambs disabilities JSNA. Peterborough City Council Single Equality Scheme 2011 – 2014. Anecdotal awareness of importance of	• Increasing number of people with learning and physical disabilities and mental health issues. • Social care requirements for people with learning disability in England are	One of the facets of programme design is to improve access to community services for adults and older people This includes people with disabilities. Through the

	not losing sight of people with disabilities within the Older People's Programme. Score: 3	expected to increase by 14%, up to 2030. • Issues of difficulty of access to services and to healthier lifestyles for people with disabilities – thus poorer health outcomes. • Providing patient centred services closer to home should facilitate access for disabled people • Greater prevalence of co morbidities in the disabled • People more likely to be admitted to hospital if disabled. • Issues with understanding information, care and staff attitudes on hospitalisation. Score: 3	provision of more local community services the CCG aims to increase care in the community and reduce avoidable hospital admission. The focus on outcomes will ensure improved quality of community services for all adults and older people including those with disabilities and hospital care for older people, including those with disabilities. On this basis it is deemed to be a high positive impact However, the CCG does acknowledge the need to clearly articulate the programme benefits specifically for people with disabilities in the light of public feedback and to ensure monitoring access by this group Score 9 – High Positive. Impact
Gender	2008-2010 ONS Life Expectancy, JSNAs Peterborough & Cambs In specific groups and areas of the CCG there is inequity in health outcomes between male and female. Male gypsies and travellers are less likely to access health services early on in illness. Men tend to die earlier than women	The different numbers of female / male, the differential access and health outcomes especially in different ethnic / minority groups needs to be addressed through the programme in order to ensure equity of provision, access and outcomes. . Score 3	The successful Provider is required to design services around specific local needs across the CCG taking into consideration the demographic and ethnic profile of the population and to work in partnership with local voluntary and statutory organisations and carers to ensure reach to diverse and deprived communities in

	More female carers than male but differential is changing (males increasing slightly). Requires monitoring Protected characteristics of paid carers need to be protected via TUPE. Score: 3		culturally sensitive and appropriate ways. Score : 9 High positive impact
Gender Reassignment	Score: 1	Rationale: the CCG has identified no barriers to access on the basis of gender reassignment as a result of its proposals. The service will continue to be available to all irrespective of gender re-assignment. Score 0	Score: 0 No Impact positive or negative
Human Rights	Hard evidence from National Policies and Guidance, JSNAs, Patient Experience data, GP Survey, CCG Five Year Plan, BCF review and CCG strategic plan. Anecdotal information from patients and the public on the need to avoid hospital admission where appropriate through better local services and to improve outcomes for older people. Score: 3	Rationale: There is a need to ensure patient safety and welfare of patients (article 2), ensure that issues of patient restraint and control are treated sensitively and within the law (article 5) and respect the wishes of people to be treated at home or in the community where possible (article 8). Score: 3	More healthcare will be provided on a preventive, community centred basis and appropriate secondary care services will be provided with safety and welfare of patients in mind. Patient and carer experience will be monitored via contract performance and Outcomes Framework. Score: 9 – High Positive impact
Pregnancy and Maternity	One of the Trade Union responses to the public consultation states that they believe there to be a risk to pregnant women and children as the tender poses a risk to the viability of the Cambridge Community Services (CCS) organisation and hence to its remaining services. However, the CCS	Score: 0 Maternity services excluded from scope.	Score 0 – No Impact positive or negative

	Response to the consultation is that the procurement budget amounts to 45% of CCS's service portfolio. Therefore CCS as well as the Trust Development Agency (TDA) believed it remains a viable organisation. For this reason this element has been scored as no evidence / suggestion. Score: 1		
Race/Ethnicity or Nationality	Hard evidence from the 2011 Population Census about migrant population, Peterborough City Council Single Equality Scheme 2011 – 2014. Soft evidence from experience on difficulty of engaging with traveller and gypsy communities. Score : 3	• There is a growing migrant population in both Cambs and Peterborough as well as gypsy and traveller communities. • Migrant / gypsy/traveller communities face poorer educational attainment, greater unemployment, greater deprivation, discrimination, isolation etc Score: 3	The successful Provider/s is required to design services around specific local needs taking into consideration the demographic and ethnic profile of the population and to work in partnership with local voluntary and statutory organisations to ensure reach to diverse communities in culturally sensitive and appropriate ways. Score 9 – Positive Impact
Religion or Belief	Hard evidence from Peterborough City Council Single Equality Scheme 2011 – 2014. Peterborough has a large muslim population. Score: 2	People with different religions and beliefs may have different attitudes towards healthcare practices e.g. attitudes towards single sex accommodation etc. If these issues are not understood and respected they could have a negative impact on access to services and therefore outcomes. Score: 2	The successful bidder will be required to address all issues of inequality raised through the consultation and through the EIA. Score 4 – Positive impact As Score may require adjustment once further evidence gathered.
Sexual	Score: 1	Score: 0	Score 0 – No Impact

Orientation		Rationale: Service will continue to be available to all irrespective of sexual orientation. The CCG has identified no barriers to access on the basis of sexual orientation as a result of its proposals.	
Marriage / Civil Partnership	Score: 1	Score: 0 Rationale: Service will continue to be available to all irrespective of status. The CCG has identified no barriers to access on the basis of marital/civil partnership status as a result of its proposals.	Score 0 – No Impact

Scoring Chart A: Evidence Available			Scoring Chart B: Potential Impact			Scoring Chart C: Impact	
3	Existing data/research		-3	High negative		-6 to -9	High Impact (H)
2	Anecdotal/awareness data only		-2	Medium negative		-3 to -5	Medium Impact (M)
1	No evidence or suggestion		-1	Low negative		-1 to -2	Low Impact (L)
			0	No impact		0	No Impact (N)
			+1	Low positive		1 to 9	Positive Impact (P)
			+2	Medium positive			
			+3	High positive			

Form 4: Examine the Information Gathered So Far

1.	Do you have adequate information? (Refer to Form 2 : Information Gathering for assistance if necessary)	Sufficient on Age, gender, disabilities, race/ethnicity Insufficient on religion. A response has now been obtained via the public consultation on proposed solutions. This feedback will enable bidders to shape final solutions. The consultation process was designed to reach out to the hard to reach groups identified herein.
2.	Can you proceed with the Programme whilst the EqIA is ongoing?	Yes.
3.	Does the information collected relate to all protected characteristics?	Not all just: Age, disabilities, race/ethnicity, religion, gender.
4.	What additional information (if any) is required?	Further hard data required: A continued dialogue with hard to reach groups is required. Some groups were very hard to reach during consultation. Further information required on religion and preferences/issues in relation to access to and experience of healthcare and outcomes.
5.	How are you going to collect the additional information needed? State which representative bodies you will be liaising with in order to achieve this	
		i) Via ongoing targeted outreach to gypsy and traveller communities and other hard to reach groups working with Cambs County Council and Peterborough City Council, THT and other organisations working with this community.
		ii) Via further research into the impact of religion on health choices and experience e.g. Muslims.

Form 5: Judge/Assess the Potential Impact of the Policy across the Protected Characteristics

	Information gathered on Forms 2 and 4	Consider the likely/potential impact of the evidence	Positive	Differential	Negative
Age			✓		
Disability			✓		
Gender			✓		
Gender Reassignment					
Human Rights			✓		
Pregnancy and Maternity				✓	
Race			✓		
Religion/Belief			✓		
Sexual Orientation				✓	

Form 6: Consider Any Alternatives which will Reduce or Eliminate any Negative Impact

1.	Describe any mitigating actions taken to reduce negative impact	
2.	Is there a handling strategy for any unavoidable but not unlawful negative impacts that cannot be mitigated?	
3.	Describe any actions taken to maximise the opportunity to promote equality, ie: changes to the Programme , regulation, guidance, communication, monitoring or review	**Ensuring equity of access to services** Within the CCG's Operational plan, Delivery Objective 1: is to improve access to services to meet the requirements of the NHS Constitution in order to improve access to services for patients, including patients who come from disadvantaged and minority groups. The CCG is aware that there are a range of 'seldom heard' groups in their communities and they are determined to reach out to them to ensure that they are able to benefit from timely access to services. Through their Communications, Engagement and Membership Strategy, the CCG will ensure that all external communications are inclusive and that they take place through a range of channels that reach all groups, taking into consideration all barriers to communication, including language and access to computers. The CCG is committed to engaging with patients, carers and the public in all stages of the commissioning cycle. This is essential and the CCG will ensure they always develop innovative, patient-centred services and are mindful of the need to ensure ease and timeliness of access to those services. The CCG is aware of the need to ensure the views of patients and the public are listened to, heard and acted upon and of the need to ensure that healthcare is delivered in such a way that respects and is sensitive to

	an individual's religious belief. The CCG is particularly focused on accessing seldom heard and vulnerable groups, namely: • Migrant Workers. • Travellers (including those who prefer to be known as Gypsies). • Individuals within the criminal justice system. • Asylum seekers and refugees. • Black and Minority Ethnic (BME) Groups. • People with Learning Disabilities. • People with long-term mental health problems. • Lesbian, Gay, Bisexual and Transgender people. • Homeless and insecurely housed people. • Children and Young People
4. What changes have been / will be made as a result of conducting this EqIA?	1. Add to the above list of hard to reach groups: • People from different religious groups – especially Muslims • People with physical disabilities
	2. Incorporate EIA as a standing item on Older People's Programme Board Agenda and Contract Development and Scrutiny Groups' agendas.
	3. Seek further information on different religious groups in relation to access to services and outcomes.
	4. Conduct Health Equity Audits as part of the Provider contract monitoring (Contract will be the Standard NHS Contract which incorporates the values and principles enshrined within the NHS Constitution).

Form 7: Outcome Report

Organisation:	Cambridgeshire & Peterborough CCG

Proposal Sponsored by:	Name:	Andy Vowles
	Title:	Chief Operating Officer
	Department:	

Programme Title:	The Integrated Older People's Services and Adult Community Services Procurement

Brief Aims and Objectives of Programme :	To commission an integrated hospital and community service for older people in line with the vision and critical success factors. Ref. From 1 No. 2 above.

Was the decision reached to proceed to full Equality Impact Assessment?:	Yes ✓	No
	Record Reasons for Decision: 1. The programme will directly affect a large number of 65 years and over year olds and adults who require community services. 2. There are current inequalities in terms of access, outcomes and experience of health services from hard to reach groups and people with disabilities. It will be important to ensure the Lead Provider/s address the inequalities gaps. 3. There will be a positive impact on service users and the community. 4. There could be a negative impact on staff depending upon which bidder wins the contract. This situation needs to be carefully managed, mitigated and monitored to minimise negative impact on staff. Protected characteristics (age, gender, ethnicity) need to be protected via TUPE on transfer. 5. There could be a negative impact on the public / media depending upon which bidder wins the	

	contract. This situation needs to be carefully managed, mitigated and monitored to minimise negative impact on the public and other organisations.. 6. The Programme will support the CCG to achieve its Equality and Diversity goals in terms of improving access to services to all.	
If no, are there any issues to be addressed?	Yes ☐	No ☐
	Record Details:	
Is the Programme Lawful?	Yes ✓	No
Will the Programme be adopted?	Yes ✓	No
	If no, please record the reason and any further action required:	
Are monitoring arrangements in place?	Yes ✓	No ✓
	Partially. Programme monitoring mechanisms are in place to ensure the Procurement proceeds to time and plan. The contract monitoring mechanism and how this will be implemented is under development . Also Refer to Action Plan (Form 8)	

Who is the Senior Responsible Officer ?	Name:	Matthew Smith
	Title:	Programme Director
	Department:	Strategy & Delivery
Review Date of Programme:	Quarterly	

Signature of all parties:	Name	Title	Signature

Please Note: An Action Plan should be attached to this Outcome Report prior to signature.

Form 8: Action Plan

This template records planned actions following completion of EIA including any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research. **This Action Plan is iterative and as such will be amended in response to new information. It is a work in progress.**

Version 2: Post public consultation – 28 June 2014

	Response	Proposed Actions	Lead Officer Identified	Timescale	Progress
1. Will the Older People's Procurement proceed?	Yes	Continue with Procurement as per plan	Programme Director	Contract signing – October 2014 Service start date to be re-considered in light of public consultation feedback.	On target to achieve revised plan which incorporates public consultation feedback
2. If No please give reasons and any alternative action(s) agreed:	N/A				
3. How will the effects of the Programme be monitored?	The standard NHS contract will be used.	The Lead Provider's final solution will be incorporated within the contract A robust contract monitoring framework is being developed to monitor contract progress. Outcomes will be measured via the	Contract Development Group Contract Scrutiny Group Contracts Monitoring Team LCGs	Performance monitoring start from contract start date	Contact monitoring –process is undergoing ongoing development.

		outcomes framework monitoring process.			
		Equalities monitoring (access and outcomes) across all identified groups will be incorporated via Health Equity Audits as part of the Lead Provider's contract monitoring.			
		The quality of the programme will be assessed through the quality indicators in the contract. This includes review of the Equality and Diversity programme for providers. Other indicators that support the Equality and Diversity agenda include review of safeguarding adults and children's arrangement and training, patient experience feedback and staff engagement programmes.	Quality Team		
		Include EIA in Older People's Programme Board monitoring.	OP Programme Director		
			Contracts Development Group		

4. What monitoring data will be collected?	Contracts monitoring granularity will include monitoring access and outcomes by BME, deprived communities, gypsy and traveller groups.	Identified groups are Traveller and Gypsy groups, Eastern European migrants and Black & Asian groups, people with disabilities and peoples from different religious groups access to, outcomes from and experience of health services. Review access to services and outcomes on the basis of gender Review gender of carers Review the CCG ethnic monitoring system to include Romany Gypsy and Irish Traveller as separate categories and use the resulting data for better planning and commissioning Monitor hospital admissions and outcomes for older people with learning disabilities of health services. Health checks and	Contracts Development Group		

		screening for older people with learning disabilities			
5. How will this data be collected?	Via contract monitoring process	Review / adapt monitoring tools to ensure inclusion of EIA information.	Contracts Monitoring Team Quality Team		
	Via E&D Monitoring Tool		Contracts Monitoring Team		
	Via Quality Dashboard data		Quality Team		
	Surveys		Contracts Monitoring Team		
6. When will the monitoring data be analysed?	Quarterly		Contracts Monitoring Team Quality Team		
7. Who will analyse the data?	E&D Group Contracts monitoring team Incorporate within the Quality Dashboard	E&D Group monitor progress. Quality Team to ensure on Quality Dashboard.	E&D Lead Contracts Lead/s	From contract start date and onwards	
8. What changes have been made as a result of this EIA?	Expanded consultation process to ensure views of hard to reach groups are obtained. Programme start date to be reviewed	Obtain feedback on programme from gypsy and traveller groups, older people with disabilities, Muslims and different religious groups, plus the housebound and illiterate.	Engagement Team working with appropriate agencies who already have inroads with these groups e.g. Peterborough Muslim Community	March – June 2014 – during public consultation	

	EIA – standing agenda item on Programme Board and Contract Development and Contract Scrutiny Groups Greater granularity of contract monitoring process to monitor access by specific groups including gypsies and travellers and people with disabilities and learning disabilities Better communcations with disabled and learning disabled people around the programme Call centres to contain information in all the community languages Improve access for		Network, AGE UK, Alzheimers Society, Traveller Health Team etc Programme Director Contracts Monitoring group Engagement Team Lead Provider		

	travellers and gypsies to healthcare using community outreach workers Letters to people with learning disabilities to be in Easy Read format Training for health care providers to incorporate cultural awareness of different preferences arising from different cultural practices, norms and belief		Lead Provider Lead Provider Lead Provider		
9. Where a Policy may have differential impact on certain groups, state what arrangements are in place or are proposed to mitigate these impacts	May initially lead to better quality urgent hospital care for older people when compared with adults due to the Lead Provider's scrutiny of the older people's urgent care pathway in the acute hospital setting (e.g. more appropriate	To be monitored via acute contracts monitoring process.	Contracts Monitoring Team Quality Team		

	admissions, and quicker discharge process better secondary / community care pathways etc)				
10. Justification: for when a policy may have a negative impact on certain groups, but there is good reason not to mitigate, state those reasons here	Existing Cambridge Community Services (CCS) staff who may fear employment implications of a new provider.	1. Establish CCS Transition Steering group to address comms, engagement, HR and TUPE issues and all aspects of mobilisation. 2. Include CCS staff and Unions as part of engagement process with particular reference to timescales and HR issues. 3.	Programme Director Engagement Team		
	2. Public and media.	2. Launch early consultation with potential lead providers' outline proposals.	SPT		

		3. Make process as open and transparent as possible within the bounds of tendering rules e.g. publish tender documents on CCG website, early press releases etc.	Programme Director		
11. Provide details of any actions planned or taken to promote equality	1. We do not have sufficient knowledge of the views of and issues for hard to reach groups including the housebound, illiterate, Muslims, Italian population (Peterborough), Eastern European communities, Travellers, people with Alzheimers and dementia.	Use existing resources / groups who are already in-reaching to hard to reach communities (via Councils or voluntary organisations eg. AGE UK or Alzheimers Society or the THT Team) to obtain views from hard to reach groups as part of public consultation.	Engagement Team		
	2. We need to put bespoke measures in place to promote equity of access and outcomes for all ethnic and religious minority groups and all hard to reach groups.	1. Explore options for monitoring access to services and outcomes for identified hard to reach groups for example: • older travellers with mental health problems • male health specialist support services to	Contract Development Group Contracts Monitoring Team		

		ensure male travellers are able to access primary and community services.			
		• other groups/ issues to be ascertained through consultation.			
		2. Raise health care staff awareness of the particular issues for hard to reach groups.	Lead Provider/s		
		3. Identify potential health champions from the various communities.	Lead Provider/s		
	3. Some groups will be unable to read consultation materials due to illiteracy, visual impairment or language difficulties.	A summary of the consultation document will be published in Polish, Portuguese, Russian, Latvian, Lithuanian and Urdu. Interpreters and signers can be made available for public meetings. Documents will be provided in HTML and rich text versions to assist people with visual impairment to access the materials. Announcements regarding public meetings will be made via print, radio and through community	Engagement Team	17 March onwards	

		group. There is a day time consultation phone line to the CCG if people want to talk through the proposals.			
12. Describe the arrangements for publishing the EIA Outcome Report	EIA published as a working document with full detail.	EIA published on CCG Website as part of the suite of consultation materials from 17 March to 16 June 2014.	Communications Team	17 March 2014 and onwards	
13. When will the EIA be subject to further Review?	It will be subject to ongoing review, post public consultation.	EIA to be kept under regular scrutiny in response to new equalities information.	Programme Strategic Lead + Engagement Team	Ongoing	

Lockton House
Clarendon Road
Cambridge
CB2 8FH
30 June 2014
For more information about NHS Cambridgeshire and Peterborough Clinical Commissioning Group please:
Visit: www.cambridgeshireandpeterboroughccg.nhs.uk
Call: 01223 725304
Email: engagement@cambridgeshireandpeterboroughccg.nhs.uk