Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Policy for the use of Liposuction in A. Lymphoedema B. Lipoedema

Before completing this equality analysis it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

NHS Birmingham and Solihull Clinical Commissioning Group
NHS Sandwell and West Birmingham Clinical Commissioning Group

1. Background

EA Title	**Policy for the use of Liposuction in** **A. Lymphoedema** **B. Lipoedema**		
EA Author	David King	**Team**	Equality and Diversity Team
Date Started		**Date Completed**	
EA Version	1	**Reviewed by E&D**	

What are the intended outcomes of this work? Include outline of objectives and function aims

Liposuction

Liposuction is normally deemed to be a cosmetic procedure used to remove unwanted body fat.

It involves sucking out small areas of fat that are hard to lose through exercise and a healthy diet. It's carried out on areas of the body where deposits of fat tend to collect, such as the buttocks, hips, thighs and tummy.

The aim is to alter body shape, and the results are generally long-lasting, providing you maintain a healthy weight. It works best in people who are a normal weight and in areas where the skin is tight.

Liposuction carried out for cosmetic reasons is not normally available on the NHS. However, liposuction can sometimes be used by the NHS to treat certain health conditions.

Liposuction is usually carried out under general anaesthetic, although an epidural anaesthetic may be used to enable treatment on lower parts of the body.
The surgeon would mark on your body the area where fat is to be removed. He or she would then:

inject this area with a solution containing anaesthetic and medication, to reduce blood loss, bruising and swelling
break up the fat cells using high-frequency vibrations, a weak laser pulse or a high-pressure water jet
make a small incision (cut) and insert a suction tube attached to a vacuum machine (several cuts may need to be made if the area is large)
move the suction tube back and forth to loosen the fat and suck it out
drain any excess fluid and blood
stitch up and bandage the treated area
It usually takes one to three hours. Most people need to stay in hospital overnight.

Afterwards

After the procedure, you would be fitted with an elasticated support corset or compression bandages. This helps to reduce swelling and bruising and should be worn constantly for several weeks after the operation.
You may need to take antibiotics straight after the procedure to reduce the risk of infection. Most people also take mild painkillers to ease any pain and swelling.

Recovery

It usually takes about two weeks to make a full recovery.
If you had a general anaesthetic, someone would need to drive you home and stay with you for the first 24 hours. You would not be able to drive for a few days.

If a small area was treated, you may be able to return to work within a few days. If it was a large area, you may need up to 10 days off work to recover.The bandage or corset can be taken off while you shower. You would need to avoid strenuous activity for up to four weeks (but walking and general movement should be fine).

The results of the procedure are not always noticeable until the swelling has gone down. It can take up to six months for the area to settle completely.

After about a week: Stitches would be removed (unless you had dissolvable stitches).
At four to six weeks: You should be able to resume any contact sports or strenuous activities you would normally do.

Side effects to expect

It is common after liposuction to have:
bruising and swelling, which may last up to six months
numbness, which should go away in six to eight weeks
scars
inflammation of the treated area, or the veins underneath
fluid coming from the cuts
swollen ankles (if the legs or ankles are treated)

What could go wrong? Liposuction can occasionally result in:

lumpy and uneven results
bleeding under the skin (haematoma)
persistent numbness that lasts for months
changes in skin colour in the treated area
a build-up of fluid in the lungs (pulmonary oedema) from the fluid injected into the body
a blood clot in the lungs (pulmonary embolism)
damage to internal organs during the procedure
Any type of operation also carries a small risk of:

excessive bleeding
developing a blood clot in a vein
infection

an allergic reaction to the anaesthetic

The surgeon should explain how likely these risks and complications are, and how they would be treated if they occurred.
Occasionally, people find the desired effect wasn't achieved and feel they need another operation.

Section A: Liposuction in Lymphoedema: Category: Restricted

Lymphoedema is a long-term (chronic) condition that causes swelling in the body's tissues. It can affect any part of the body, but usually develops in the arms or legs.
It develops when the lymphatic system does not work properly. The lymphatic system is a network of channels and glands throughout the body that helps fight infection and remove excess fluid.

There are two main types of lymphoedema:

primary lymphoedema – caused by faulty genes that affect the development of the lymphatic system; it can develop at any age, but usually starts during infancy, adolescence, or early adulthood

secondary lymphoedema – caused by damage to the lymphatic system or problems with the movement and drainage of fluid in the lymphatic system; it can be the result of an infection, injury, cancer treatment, inflammation of the limb, or a lack of limb movement.

Lymphoedema is thought to affect more than 200,000 people in the UK.

Primary lymphoedema is rare and is thought to affect around 1 in every 6,000 people.

Secondary lymphoedema is much more common.

Secondary lymphoedema affects around 2 in 10 women with breast cancer, and 5 in 10 women with vulval cancer. About 3 in every 10 men with penile cancer get lymphoedema.

People who have treatment for melanoma in the lymph nodes in the groin can also get lymphoedema. Research has shown around 20-50% of people are affected.

Treating lymphoedema

There is no cure for lymphoedema, but it's usually possible to control the main symptoms using techniques to minimise fluid build-up and stimulate the flow of fluid through the lymphatic system.

These include wearing compression garments, taking good care of your skin, moving and exercising regularly, having a healthy diet and lifestyle, and using specialised massage techniques.

The recommended treatment for lymphoedema is decongestive lymphatic therapy (DLT).

DLT isn't a cure for lymphoedema, but it can help control the symptoms. Although it takes time and effort, the treatment can be used to bring lymphoedema under control.
Decongestive lymphatic therapy (DLT)

There are four components to DLT:

- **compression bandages** – to complement exercise by moving fluid out of the affected limb and minimise further build-up
- **skin care** – to keep the skin in good condition and reduce the chances of infection
- **exercises** – to use muscles in the affected limb to improve lymph drainage
- **specialised massage techniques** – known as manual lymphatic drainage (MLD); this stimulates the flow of fluid in the lymphatic system and reduces swelling.

DLT is an intensive phase of therapy, during which you may receive daily treatment for several weeks to help reduce the volume of the affected body part.
This is followed by a second phase called the maintenance phase. You will be encouraged to take over your care using simple self-massage techniques, wearing compression garments, and continuing to exercise.
This treatment phase aims to maintain the reduced size of the affected body part.
Surgery

In a small number of cases, surgery may be used to treat lymphoedema. There are three main types of surgery that may be useful for the condition:

- removal of sections of excess skin and underlying tissue (debulking)
- removal of fat from the affected limb (liposuction)
- restoration of the flow of fluid around the affected section of the lymphatic system – for example, by connecting the lymphatic system to nearby blood vessels (lymphaticovenular anastomosis)

These treatments may help reduce the size of areas of the body affected by lymphoedema, but some are still being evaluated – particularly lymphaticovenular anastomosis – and aren't in widespread use.

Liposuction

The accumulation of fat is a significant feature of lymphoedema swelling.
Liposuction is where a thin tube is inserted through small cuts (incisions) in the skin to suck fat out of tissue. It can be used to remove excess fat from an affected limb to help reduce its size.
After surgery, you'll have to wear a compression garment on the affected limb day and night for at least a year to help keep the swelling down.

Evidence Review

Searches in the Cochrane Database and the identification of a number of systematic reviews show, good quality of evidence, which support the use of liposuction in patient diagnosed with lymphoedema in certain clinical circumstances.

The evidence demonstrated clear prevention of future illness, due to the nature of lymphoedema and the reduction in the likelihood of serious infections.

Moderate to large health improvement using this procedure was supported within the evidence review by long term follow up which demonstrated on-going clinical benefit to patients.

Current evidence on the safety and efficacy of liposuction for chronic lymphoedema is adequate to support the use of this procedure provided that standard arrangements are in place for clinical governance, consent and audit.

However, patient selection should only be done by a specialist lymphoedema multidisciplinary team as part of a lymphoedema service pathway.

Section B: Liposuction in Lipoedema: Category: Not Routinely Commissioned

Lipoedema is a long-term (chronic) condition where there's an abnormal build-up of fat cells in the legs, thighs and buttocks, and sometimes in the arms.
The condition usually only affects women, although in rare cases it can also affect men.

In lipoedema, the thighs, buttocks, lower legs, and sometimes the arms, become enlarged due to a build-up of abnormal fat cells. Both legs and/or the arms are usually enlarged at the same time and to the same extent.
The feet and hands are not affected, which creates a "bracelet" effect or "band-like" appearance just above the ankles and wrists.
Leg and arm size can vary between individuals with lipoedema, and the condition can gradually get worse over time.

As well as becoming enlarged, affected areas of the body may:

- feel soft, "doughy" and cold
- bruise easily
- ache or feel painful or tender
- have small broken veins under the skin

Someone with lipoedema may eventually get fluid retention (lymphoedema) in their legs. This type of swelling can worsen by the end of the day and may improve overnight, whereas the fatty swelling of lipoedema is constant.

Treatments for lipoedema

There's been little research into lipoedema, so there is some uncertainty about the best way to treat the condition.

If you have lipoedema it is important to avoid significant weight gain and obesity because putting on weight will make the fatty swelling worse.
Compression tights are helpful for some people because they support the fatty swelling and may reduce the pain.

Liposcution is the surgical option for the removal of fat.

Tumescent liposuction

Tumescent liposuction involves sucking out the unwanted fat through a tube. A liquid solution is first injected into the legs to help numb the area and reduce blood loss. Fatty swelling of the legs may return after having the procedure if you subsequently gain weight.

Non-surgical treatments may also be needed for a long period after having tumescent liposuction. For example, you'll need to wear compression garments after surgery to prevent complications such as lymphoedema.

Treatments to prevent lipoedema

Non-surgical treatments can sometimes help improve pain and tenderness, prevent or reduce lipoedema, and improve the shape of affected limbs – although they often have little effect on the fatty tissue.
Several different treatments are designed to improve the flow and drainage of fluid in your tissues, such as:

- compression therapy – wearing bandages or garments that squeeze the affected limbs
- exercise – usually low-impact exercises, such as swimming and cycling
- massage – techniques that help encourage the flow of fluid through your body

<u>Treatments that do not work</u>
Treatments used for some types of tissue swelling are generally unhelpful for lipoedema.

Lipoedema doesn't respond to:

- raising the legs
- diuretics (tablets to get rid of excess fluid)
- dieting – this tends to result in a loss of fat from areas not affected by lipoedema, with little effect on the affected areas

Causes of lipoedema

The cause of lipoedema is not known, but in some cases, there is a family history of the condition. It seems likely that the genes you inherit from your parents play a role. Lipoedema tends to start at puberty or at other times of hormonal change, such during pregnancy or the menopause, which suggests hormones may also have an influence.

Although the accumulation of fat cells is often worse in obese people, lipoedema is not caused by obesity and can affect people who are a healthy weight. It should not be mistaken for obesity and dieting often makes little difference to the condition.

Evidence Review

There is no evidence available which directly compares liposuction with conservative management – where evidence testing the intervention is found, it is applied to patient cohorts that have already received conservative management.

The evidence identified during the evidence review consisted of three trials (totalling 274 patients), along with the NHS website (https://www.nhs.uk/conditions/lipoedema/) which states that this is a relatively new and under researched condition.

The largest study consisting of 164 patients, clearly stated that they had “undergone conservative therapy over a period of years” and as such the benefits stated can be viewed as over and above those offered by conservative treatment.

The results from all of the identified studies, suggests that there are both short and long-term sustained improvements in almost all dimensions around pain and QoL, and one study substantiates this as over and above conservative treatment. However, the number of patients across the research areas are very low and no randomised control trials were identified.

Whilst the three studies seem consistent in their findings, the evidence identified within the review reflects the lack of RCTs (or direct comparison to no treatment on two of the studies) and the need for further research in this area.

Therefore, in light of the paucity of evidence to support this intervention, liposuction for this clinical indication cannot be supported at the present time. However, it is hoped that a commissioning review will take place once further evidence has been published regarding the use of liposuction in lipoedema. If there is available evidence which has not been considered during this review, please do not hesitate to submit this evidence during the engagement period: 2nd September 2019 – 11th October 2019.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

Section A: Liposuction in Lymphoedema: Category: Restricted

For patients with Lymphoedema who have failed conservative management in line with the current patient pathway for the treatment of lymphoedema, patients will be eligible for treatment of their lymphoedema with liposuction.

Patient selection should only be done by a specialist lymphoedema multidisciplinary team as part of a lymphoedema service pathway.

Investigations for suspected or proven malignancy are outside the scope of this policy and should be treated in line with the relevant cancer pathway.

Conservative management of lymphoedema is defined as:

Current conservative treatments for lymphoedema include manual lymph drainage (MLD), which stimulates the movement of lymph away from the affected limb, and decongestive lymphatic therapy (DLT). DLT combines MLD massage techniques with compressive bandaging, skin care and decongestive exercises. Once DLT sessions are stopped the patient is fitted with a custom-made compression garment, which is worn every day.

This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Section B: Liposuction in Lipoedema: Category: Not Routinely Commissioned

For patients with Lipoedema, Liposuction is Not Routinely Commissioned in these clinical circumstances due to a lack of evidence to support this intervention.

Investigations for suspected or proven malignancy are outside the scope of this policy and should be treated in line with the relevant cancer pathway.

This means the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	Working Groups	Clinical Experts
Section A: Liposuction in Lymphoedema		

Stuiver Martijn M, ten Tusscher Marieke R, McNeely Margaret L. Which are the best conservative interventions for lymphoedema after breast cancer surgery? BMJ 2017; 357 :j233

Carl, H. M., Walia, G., Bello, R., Clarke-Pearson, E., Hassanein, A. H., Cho, B.Sacks, J. M. (Accepted/In press). Systematic Review of the Surgical Treatment of Extremity Lymphedema (. Journal of Reconstructive Microsurgery. https://doi.org/10.1055/s-0037- 1599100

Schaverien MV, Munnoch DA, Brorson H. Liposuction Treatment of Lymphedema. Semin Plast Surg. 2018;32(1):42–47. doi:10.1055/s- 0038-1635116

Greene AK and Maclellan Reid A (2016) Operative treatment of lymphedema using suction-assisted lipectomy. Annals of Plastic Surgery 77: 337-340.

Lamprou DAA, Voesten HG, Damstra RJ et al. (2017) Circumferential suction-assisted lipectomy in the treatment of primary and secondary end-stage lymphoedema of the leg. The British journal of surgery 104, 84-89.

Hoffner M, Bagheri S, Hansson E et al. (2017) SF-36 Shows Increased Quality of Life Following Complete Reduction of Postmastectomy Lymphedema with Liposuction. Lymphatic Research and Biology 15, 87-9

https://www.nhs.uk/conditions/Lymphoedema/

https://www.mayoclinic.org/diseases-conditions/lymphedema/symptoms-causes/syc-20374682

Section B: Liposuction in Lipoedema

Lipoedema (2017) - https://www.nhs.uk/conditions/lipoedema/

Liposuction in the Treatment of Lipedema: A Longitudinal Study (2017) - https://www.ncbi.nlm.nih.gov/pubmed/28728329

Tumescent liposuction in lipoedema yields good long-term results (2017) - https://www.ncbi.nlm.nih.gov/pubmed/21824127

Long-term benefit of liposuction in patients with lipoedema: a follow-up study after an average of 4 and 8 years (2015) - https://www.ncbi.nlm.nih.gov/pubmed/26574236

3. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

Age: Describe age related impact and evidence. This can include safeguarding, consent and welfare issues:

Lymphoedema

Primary: For those with the condition of primary lymphoedema this is more commonly witnessed in infancy, adolescence or early adulthood however it can start at any age.

Secondary: No impact

Lipoedema

No data available on patient ages having the procedure, however there may be a link to the condition resulting to hormone change which occurs at the start of puberty, during pregnancy or those reaching the menopause.

Disability: Describe disability related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/ learning disabilities, cognitive impairments:

Lymphoedema

Primary: There is no data available to suggest a link to disability as this is a genetic and, in most cases, an inherited condition. Those who have the condition of primary Lymphoedema can be anything from mild to a severe disability.

3. Impact and Evidence:

Secondary: Whilst there is no data available on whether the patients who have undergone this procedure have a disability, there may be a link to those who suffer from a disability connected to lack of limb movement such as a degenerative condition which results in problems arising in the lymphatic system and the drainage of fluid.

Lipoedema

There is no available data to suggest disability has an impact on this condition.

Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment:

Lymphoedema
Primary/Secondary: No impact identified

Lipoedema
No impact identified

Marriage and civil partnership: Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part-time working, and caring responsibilities:
No impact identified

Lymphoedema
Primary/Secondary: No impact identified

Lipoedema
No impact identified

Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities:

Lymphoedema

Primary: Depending on the type of primary Lymphoedema diagnosed there may be a link to conditions worsening at the time of hormone changings such as pregnancy.

3. Impact and Evidence:

Secondary: No available data to suggest an impact however with primary Lymphoedema the changing to hormone levels may have an effect on this condition.

Lipoedema

No available data to determine impact. However, there may be a correlation to those at the start of pregnancy when hormone levels are changing acquiring the condition, if they may already be genetically susceptible and if the condition is already prevalent within their family history.

Race: Describe race related impact and evidence**.** This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers:

Lymphoedema
Primary/Secondary: No impact identified

Lipoedema
No impact identified

Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues:

Lymphoedema
Primary/Secondary: No impact identified

Lipoedema
No impact identified

Sex: Describe any impact and evidence on men and women. This could include access to services and employment:

Lymphoedema

Primary: No impact identified based on available data however females may be at more risk of having this genetic disorder.

Secondary: No data available as the condition is a result of damage or problems to the lymphatic system rather than genetics. However, there is a relationship to those who have already undergone cancer treatment for cancers which are gender specific then acquiring the condition. Approximately, around 2 in 10 women with breast cancer, and 5 in 10 women with vulval cancer. About 3 in every 10 men with penile cancer get lymphoedema.

3. Impact and Evidence:

Lipoedema

Occurs almost exclusively in females and there is evidence that it is a genetic and inherited condition.

Sexual orientation: Describe any impact and evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers:

Lymphoedema
Primary/Secondary: No impact identified

Lipoedema
No impact identified

Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities:

Lymphoedema
Primary/Secondary: No impact identified

Lipoedema
No impact identified

Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive)

Lymphoedema
Primary/Secondary: No impact identified

Lipoedema
No impact identified

4. Health Inequalities	Yes/No	Evidence

Could health inequalities be created or persist by the proposals?	No	This condition is not linked to a health inequality.
Is there any impact for groups or communities living in particular geographical areas?	No	No impact identified
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	No	No impact identified
How will you ensure the proposals reduce health inequalities?		

5. FREDA Principles/ Human Rights	**Question**	**Response**
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	Yes, this decision has been made in line with clinical recommendation.
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	No evidence of impact from this policy
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	No discrimination identified
	How will this affect a person's right to freedom of thought, conscience and religion?	N/A
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	Policy will be applied with due regard to this consideration.
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	An individual can discuss the impact with their GP and has the option for an IFR request to be made
Right to **Life**	Will or could it affect someone's right to life? How?	No evidence of impact from this policy
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	No evidence of impact from this policy

6. Social Value

Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.

Marmot Policy Objective	What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?
Enable all people to have control over their lives and maximise their capabilities	None
Create fair employment and good work for all	None
Create and develop health and sustainable places and communities	None
Strengthen the role and impact of ill-health prevention	None

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	Protected Characteristic/ Group/ Community	Date

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

As part of the process further targeted engagement is planned with representative groups from among Sandwell, Birmingham and Solihull Patients. In addition, it has been identified that patient and clinician information is key in ensuring that the harmonised treatment policies review delivers effective outcomes. To this end an information briefing sheets on each procedure will be developed to give more information on the procedure, eligibility criteria and signposting to further information sources, such as NHS Choices. These information sheets are also designed to help facilitate discussions between GPs and patients. Information briefing sheets have already been tested and uploaded onto the GP systems for the first 45 harmonised treatment policies for Birmingham and Solihull. Due regard will be given to both the accessible information standard and the potential need to translate such leaflets into relevant local languages.

If any further available evidence has been submitted which has not been taken into consideration during this review will be looked at during the engagement period: 2nd September 2019 – 11th October 2019.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:
Lymphoedema Primary/Secondary: The restriction of this policy will have limited impact on those who would wish to receive the treatments as the procedure is available where conservative management in line with the current patient pathway has not worked. Moderate to large health improvement using this procedure was supported within the evidence review by long term follow up which demonstrated on-going clinical benefit to patients. This must be balanced against the need to adhere to the clinical effectiveness evidence and services being commissioned continue to be safe and clinically effective to patients. The opportunity for any exceptional cases to be considered via IFR remains and will ensure treatment is available. Investigations for suspected or proven malignancy are outside the scope of this policy and should be treated in line with the relevant cancer pathway. **Lipoedema** The restriction of this policy will have limited impact on those who would wish to receive the treatments as a result of the limited clinical evidence to support this intervention as a clinically effective procedure. There is no evidence available which directly compares liposuction with conservative management. However, it is hoped that a commissioning review will take place once further evidence has been published regarding the use of liposuction in lipoedema. If there is available evidence which has not been considered during this review, please do not hesitate to submit this evidence during the engagement period: 2nd September 2019 – 11th October 2019. The opportunity for any exceptional cases to be considered via IFR remains and will ensure treatment is available. It is noted that investigations for suspected or proven malignancy are outside the scope of this policy and should be treated in line with the relevant cancer pathway.

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

None identified

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):
This policy is not linked to a contract however, prospective providers remain bound by their contracts with the CCG.

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):
N/A

12. Publication

How will you share the findings of the Equality Analysis? This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages. All Equality Analysis should be recommended for publication unless they are deemed to contain sensitive information.
Publication on the CCG's website.
Following approval all finalised Equality Analysis should be sent to the Communications and Engagement team for publication: bsol.comms@nhs.net

13. Sign Off		
The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality Diversity and Inclusion or the Manager for Equality Diversity and Inclusion prior to approval from the delegated committee		
	Name	**Date**
Quality Assured By:		
Which Committee will be considering the findings and signing off the EA?		
Minute number (to be inserted following presentation to committee)		

Please send to Balvinder Everitt or Michelle Dunne, Equality, Diversity and Inclusion for Quality Assurance.

Once you have committee sign off, please send to Caroline Higgs, Communications & Engagement Team for publication: bsol.comms@nhs.net