

Pain Service Equality Impact Assessment

1. Aim of pain service

The aim of the pain service is to enable those with chronic pain to be able to live with their pain which gives them the highest possible quality of life.

2. Background

2.1 Current pain services

Pain expertise is currently provided through both acute hospital trusts in Bristol, serving the NHS Bristol population. Many pain specialist services offered are based in the acute hospitals. This makes some services difficult to access for large sections of the Bristol community.

GPs already manage a lot of patients suffering from chronic pain within a community setting. However, with a combination of effective triage to ensure that patients receive the most appropriate help at the most appropriate time, and good communication, the long-term management of patients in the community setting will be better supported

The current model of care does not entirely address several of the objectives from national policy and guidance. This is particularly evident in terms of providing care closer to home. There are initiatives to provide some elements of the service outside of the two acute hospitals but, these are currently limited.

Analysis of the referrals into the pain services in Bristol, and review of the patient pathway showed:

1. The GP referral rates across Bristol ranged from less than 1 per 1000 patients to 11.5 per 1000 patients per practice¹ (practice population weighted for according to practice weighting indexes²)
2. Disparity in referral rates do not appear to be dependant on socioeconomic status
3. Pain services tend to be the last option in the patient's pathway. Most patients surveyed (67%) had been referred to at least two other specialities before being referred to the pain service.

The Pain Service model described below has been developed to implement the recommendations of national and local policy and guidance, and to support patients to more effectively manage their pain. Specific work groups developed the service model with input from a range of practitioners and stakeholders (including patients) to reflect the needs of the local population.

¹ Based on referrals during years 2005/06, 2006/07 & 2007/08

² Practice weighting indexes are based on six criteria: age and sex; care home population; length of time registered; patient postcode ward; rurality; and market forces factor.

2.2 New pain service

The new pain service is a community based service, which will be delivered to aid patients with chronic pain to achieve the highest quality of life possible. It is planned to be operational in 2011.

The service treats patients with chronic pain through a number of interventions and self management techniques. This includes:

1. Pain specialist physiotherapy
2. Pain specialist psychology
3. Pain clinical nurse specialist
4. Pain Consultant
5. Pain procedures (normally as day cases)
6. Pain Management programme (for patient with severe chronic pain)
7. Self management programme (for patients with less severe chronic pain – delivered through the co-creating health programme, and back pack programme)
8. Acupuncture

The new pain service has a number of key elements:

1. Hub and spoke model of care: The hub will be the administrative and coordination function, with the spokes being the service delivery points in the community
2. Team triage process: All referrals will be assessed by competent clinicians, who have the necessary skills and experience to effectively triage patients to see the right professional(s) at their first visit
3. Advice and guidance service: GPs will be able to e-mail pain service professionals for advice and guidance on the management of their patients' chronic pain
4. Education and training programme: A programme of ongoing training and support for GPs and other front line staff about how best to support people who live with chronic pain will be developed and delivered by the pain service
5. Multi disciplinary working model: The pain service will offer patients the opportunity to be treated by the appropriate range of professionals at a one-stop appointment where this has been defined in the team triage process
6. Partnership working: The pain service will work collaboratively, particularly with organisations for hard-to-reach patients to deliver pain services which are accessible for these groups
7. Self management model of care: The self-management model of care is an important part of the pain service model both in terms of the delivery of discreet self-management programmes and in the diffusion of self management techniques for all pain practitioners through internal development and training, and as part of the education and training programme to other health practitioners

The pain service model of care, corresponding business case, and service specification has been approved by the NHS Bristol professional executive committee. This service is planned to be operational in 2011.

3. Equality information and intelligence

The new pain service is not yet operationally live. The implementation of the service is expected to take place in 2011. However, there are currently two pain services which provide pain expertise for Bristol patients. Data from these services and also other available and relevant qualitative data will be reviewed to inform the development and implementation of the new service, and to highlight any possible inequalities.

Qualitative data source:

1. Equity of access report for pain services in Bristol: This report was developed by speaking to a wide range of stakeholders in pain services including Pain Specialists, charities for the elderly, sheltered housing, community nursing, hospice services, primary care etc.... The report gives insights into the potential problems with accessibility to the pain service.
2. Learning difficulties access to service report: This report was developed to summarise the outputs from a workshop held with a group of individuals who have learning difficulties. The workshop reviewed experiences with health and healthcare, and accessibility to services.

Quantitative data source:

1. Outpatient data – Covers outpatient data for services for both NBT and UHB. This data has been obtained from SUS data, and also directly from the relevant secondary care trusts.
2. Inpatient data – Covers all inpatient data (day case procedures) for both NBT and UHB. This has been obtained directly from the relevant secondary care trusts.

3.1 Ethnicity

Ethnicity data is available from both secondary care trusts who deliver pain services. For the benefit of this analysis the ethnicity data is cross matched against other items such as age, to highlight any significant outcomes which may be relevant to the equality impact assessment. The data is presented for NBT and UHB separately. Due to the way in which data is reported by both trusts, there are some minor differences in the presentation of data from both trusts.

Table 1: Patients accessing outpatient pain services by Ethnic group (compared against local population ethnic mix) – NBT

Broad Ethnic Group	% of total accessing OP pain management (based on number of people)	% of total population of Bristol (2007 ONS estimate)
White British	79.5	82.5
White Irish	0.7	1.0
White Other	3.4	4.6
Mixed	1.2	2.3
Black / Black British	4.8	3.0
Asian / Asian British	3.7	4.6
Chinese	0.0	1.4
Other	0.7	0.7
Not stated	5.9	0.0

Table 2: Patients accessing Inpatient pain services by Ethnic group (compared against local population ethnic mix) – NBT

Broad Ethnic Group	% of total accessing IP pain management (based on number of people)	% of total population of Bristol (2007 ONS estimate)
White British	86.7	82.5
White Irish	1.0	1.0
White Other	2.7	4.6
Mixed	1.0	2.3
Black / Black British	3.6	3.0
Asian / Asian British	2.9	4.6
Chinese	0.0	1.4
Other	0.5	0.7
Not stated	1.7	0.0

Table3: Patients accessing outpatient pain services by Ethnic group (compared against local population ethnic mix) – UHB

Broad Ethnic Group	% of total accessing OP pain management (based on number of people)	% of total population of Bristol (2007 ONS estimate)
Asian or Asian British	5.38%	4.56%
Black or Black British	4.95%	2.95%
Chinese or Other Ethnic Group	1.51%	2.11%
Mixed	2.80%	2.28%
White	78.49%	88.09%
Unknown	6.88%	0.00%

No significant disparity is highlighted in the ethnicity profile of patients accessing either pain service compared to local population profile. The figure for NBT service for Asian/Asian British is lower than expected. However, this is most likely to be affected by the population that this service is principally being delivered to. This may warrant further consideration with the implementation of the new pain service, to see if this inequality is sustained.

Neuropathic pain prescriptions from GPs

Map 1 shows the rates of prescribing among GPs for two neuropathic pain drugs; pregabalin, and gabapentin. These are mapped against the BME levels for Bristol.

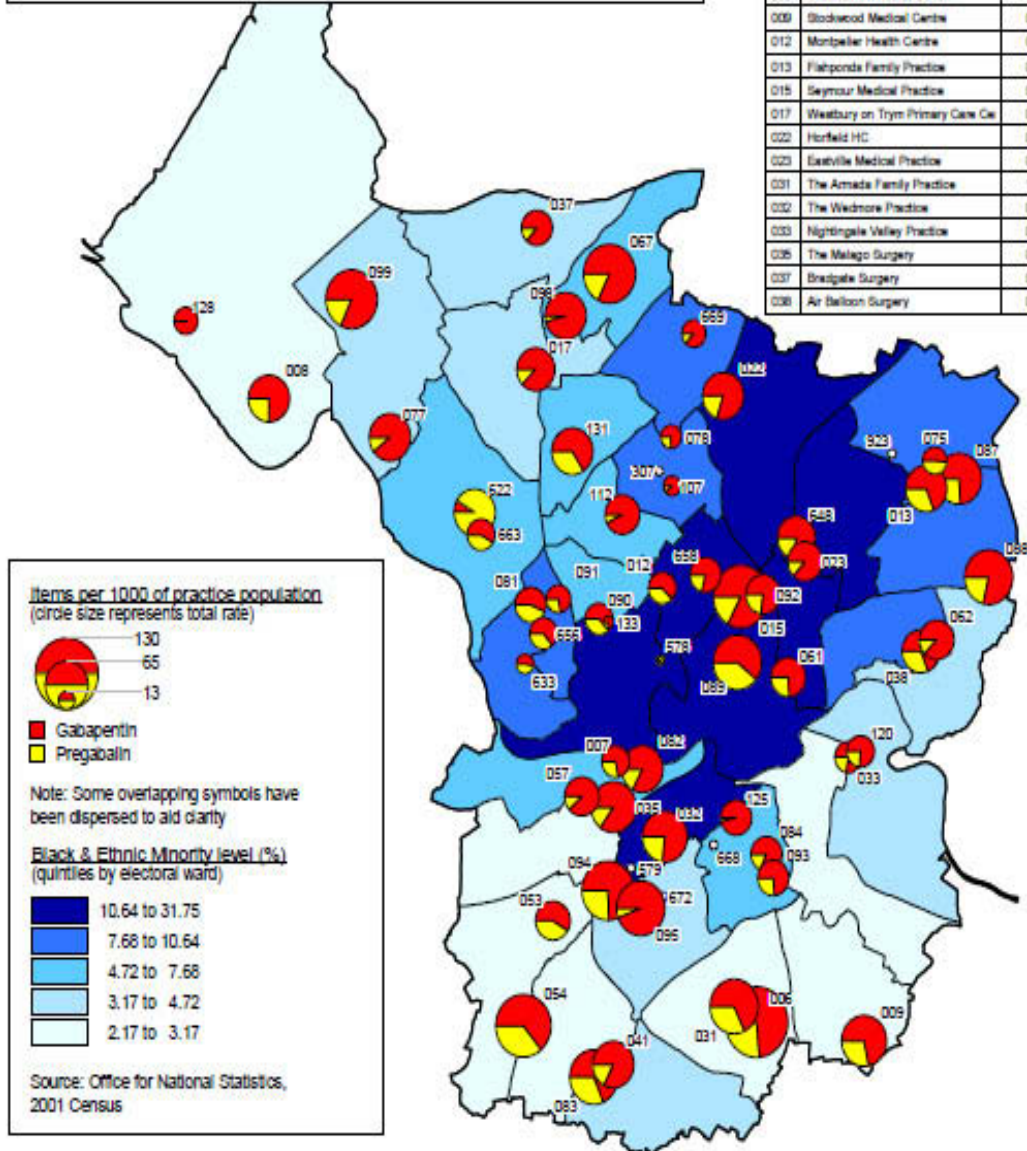
The prescribing patterns of GPs vary greatly, from a low of less than 13 items per 1000 registered population, to a high of 130 items per 1000 registered population. This demonstrates a large variance in prescribing patterns for the treatment of pain, but not necessarily any inequality along ethnic lines.

The prescribing rates seem to be in the upper bracket for inner city, East and North East of the city, areas that have proportionally higher density of ethnic minority groups. This does not, from the data available, appear to be related to ethnicity. In areas predominantly populated by those from a white ethnic background, such as Bishopsworth in the South or Lawrence Weston in the North, there are similarly high levels of prescribing for neuropathic pain.

Allison et al (2002) reported that some ethnic minorities experience higher levels of pain than populations from a white ethnic background. The causes of this are not described, but this is certainly something that the pain service will need to be aware of. The research of Allison et al, suggests that pain services need to work to be more accessible to ethnic minority groups. There are two elements of the new model of care which will help to ensure this is addressed: Partnership working, and Education and communication. It is important that both of these areas focus on the increased prevalence of pain in ethnic minority groups.

Both services also have access to translator and interpreter service on site for any patients where English is not their first language. It is important that all staff receive mandatory equality and diversity training in order to ensure all patients are treated with respect and dignity regardless of their race, religion, belief or sexual orientation.

Bristol PCT: Prescribing patterns for neuropathic pain
(November 2008 to October 2009)



ID	Prescriber Name	Gab cost/pt	Pre cost/pt
006	The Green Practice, Whitchurch HC	0.51	1.03
007	The Southville Surgery	0.23	0.25
008	Shirhampton Health Centre	0.40	1.01
009	Stockwood Medical Centre	0.95	1.42
012	Montpelier Health Centre	0.25	0.86
013	Flatponds Family Practice	0.61	1.14
015	Seymour Medical Practice	0.67	0.67
017	Westbury on Trym Primary Care Cn	0.43	0.64
022	Horfield HC	0.34	0.81
023	Eastville Medical Practice	0.31	0.43
031	The Arncliffe Family Practice	1.52	1.50
032	The Widmore Practice	0.29	0.73
033	Nightingale Valley Practice	0.38	0.32
036	The Malago Surgery	0.49	0.90
037	Stratgate Surgery	0.13	0.31
038	Air Balloon Surgery	0.30	0.93

ID	Prescriber Name	Gab cost/pt	Pre cost/pt
041	Hillview Family Practice	0.30	0.92
053	The Leonard Surgery	0.62	1.43
054	Grange Road Surgery	0.64	2.16
057	Gaywood House Surgery	0.52	0.39
061	The Wellspring Surgery	0.25	0.69
062	St George Health Centre	0.42	0.33
067	Southmead & Hanbury Family Practic	0.35	0.56
075	The Old School Surgery	0.09	0.58
077	See Milk Surgery	0.34	0.77
078	Gloucester Road Medical Centre	0.15	0.41
081	Pembroke Road Surgery	0.38	1.29
082	Bedminster Family Practice	0.40	0.88
083	Harwood Health Care	0.67	0.80
084	Pitney Surgery	0.64	0.53
087	Beechwood Medical Practice	0.28	0.65
088	Lodgepole Surgery	0.37	1.12
089	Lawrence Hill Health Centre	0.46	0.93
090	The Family Practice	0.42	0.67
091	Whiteleaves Medical Group	0.31	0.90
092	The Easton Family Practice	0.10	0.39
093	St Martine Surgery	0.26	0.52
094	The Merrywood Practice	0.60	1.35
095	The Crest Family Practice	0.60	0.34
096	Greenway Community Practice	0.42	0.17
099	Ridgeway Medical Centre	0.53	0.77
107	Nevill Road Surgery	0.15	0.08
112	The Spence Group Practice	0.24	0.43
120	Birchwood Medical Practice	0.30	0.60
125	233 Wells Road	0.87	0.14
128	Avonmouth Medical Centre	0.23	0.00
131	Falloon Way Medical Centre	0.33	1.49
133	Student Health Service	0.04	0.12
622	Helico Medical Centre	0.03	1.92
633	52 Clifton Down Road	0.04	0.47
646	The Maytrees Practice	0.33	0.33
656	56 Pembroke Road	0.20	1.01
658	Sussex Place Surgery - FRIENDOC	0.31	0.43
663	Sneyd Park Surgery	0.23	1.60
668	St Peters Hospice		
669	Monks Park Surgery	0.18	0.34
672	BRISDOG Service		
623	Bristol Specialist Drugs Service		
307	HMP Bristol		
576	Stratmead Medical Centre	0.00	0.03
579	GP Walk In Health Centre Service		

(Cost/pt = Practice cost / Practice list size)

Avon IM&T Consortium

Kathryn Wright - 09 March 2010
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3.2 Religion or Belief

Information on religion or belief was only available for inpatients appointments at NBT, and outpatient appointments at UHB. The absence of this information across elements of both services signifies an area for further development, particularly in light of the outcomes framework for 2011/12.

Table 4: Patients accessing inpatient pain services (day case) by religion or belief (compared against local population belief or religion) – NBT

Religion	People attending IP pain management services	ONS Census 2001
Christian	64.7%	62.1%
Buddhist	0.0%	0.4%
Hindu	0.2%	0.6%
Jewish	0.2%	0.2%
Muslim	2.2%	2.0%
Sikh	1.2%	0.5%
Any other religion	2.9%	0.5%
No religion	24.2%	24.5%
Religion not stated	4.3%	9.3%

Table5: Patients accessing outpatient pain services by religion or belief (compared against local population belief or religion) – UHB

Religion	People attending OP pain services	ONS Census 2001
Christian	64.17%	62.10%
Buddhist	1.01%	0.40%
Hindu	0.31%	0.60%
Jewish	0.00%	0.20%
Muslim	6.35%	2.00%
Sikh	0.13%	0.50%
Any other religion	1.45%	0.50%
No religion	22.50%	24.50%
Religion not stated	4.09%	9.30%

The data did not highlight any significant inequalities. Any differences between the local population versus the patient population of the pain services were generally related to very small numbers. It would be interesting to continue to review this information to see if the differences are repeated in subsequent years.

It is worth noting the importance of equality and diversity training being mandatory for all pain service staff to ensure that all patients are treated with respect and dignity, regardless of their religion or belief. For instance, any involvement in inpatient procedures by pain staff should come with an awareness that Jehovah Witnesses will not consent to a blood transfusion. Also, some women find the presence of men or being touched by men unacceptable for religious or other cultural reasons. Hospital wards should not be mixed and patients should be able to request treatment from a female member of staff.

3.3 Disability

There is a strong relationship between chronic pain and the prevalence of an associated disability. Webb et al (2003) in a survey of patients from general practice found that of those patients reporting chronic pain, 40% had a disabling level of pain. It is therefore particularly important that pain services are accessible to patients with a disability, whether or not it is caused by chronic pain.

Sensory Impairment

Patient information needs to be available for people with sensory impairments, for example, available in large print, Braille or in audio for the visually impaired. Visual impairment affects all age groups, but predominantly older people.

The prevalence and severity of hearing loss increases with age, Staff should communicate with hard of hearing patients sensitively and using a means they can understand, i.e. via a British Sign Language (BSL) or in writing. A loop system should be available in the room where patient education is offered

Mobility Impairment

Reduction in mobility can be a significant problem for patients who have suffered chronic pain for long periods of time. Therefore, staff should be trained in moving and handling to assist patients with mobility problems. Accessible parking and wheelchairs should be easily available. All premises would be expected to be Disability Discrimination Act (1995) compliant.

It is particularly important that patients with a physical disability have access to any aids they would usually use to assist them in their activities of daily living to ensure they are able to maintain their independence.

Data on the disabilities of patients and their associated activity is not currently recorded for either service. This demonstrates a significant gap in our understanding of the access of this group (and sub-categories) to pain services. The omission of this data is particularly significant for a pain service as the profile of the patient groups is likely to have significant disabilities, not least because of the effects of chronic pain³.

As part of the preparation for the equality impact assessment a workshop was arranged for individuals with learning difficulties to discuss their experiences with healthcare and also to get their input into how access to services could be improved. The principal messages which the group members reported were:

1. "I should be communicated with in a way that suits me"
3. "My permission should be given before anything happens to me"
4. "Healthcare professionals should make sure that I understand all of the information about my health and healthcare"
5. "Information about my learning difficulty should be recorded and communicated between different healthcare professionals"
6. "My specific needs should be considered when organising my healthcare"
7. "I should be helped to access services that I might not otherwise use or know about"
8. "Time should be taken to understand what stops me going to see someone about my health"
9. "Services should be easy to get to and use"

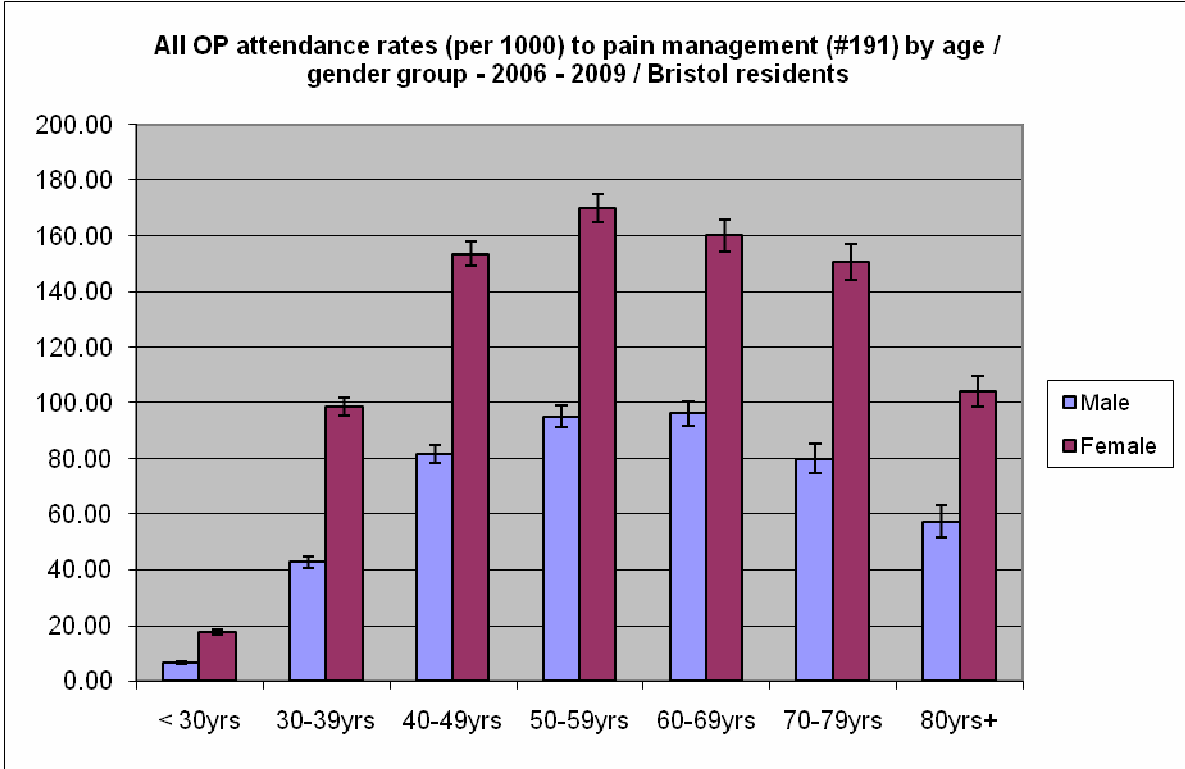
While this feedback is not specific to pain services, the issues are equally relevant and will need to be considered in the implementation of the service and its future development, particularly with reference to the partnership working element of the model of care.

3.4 Gender and Age

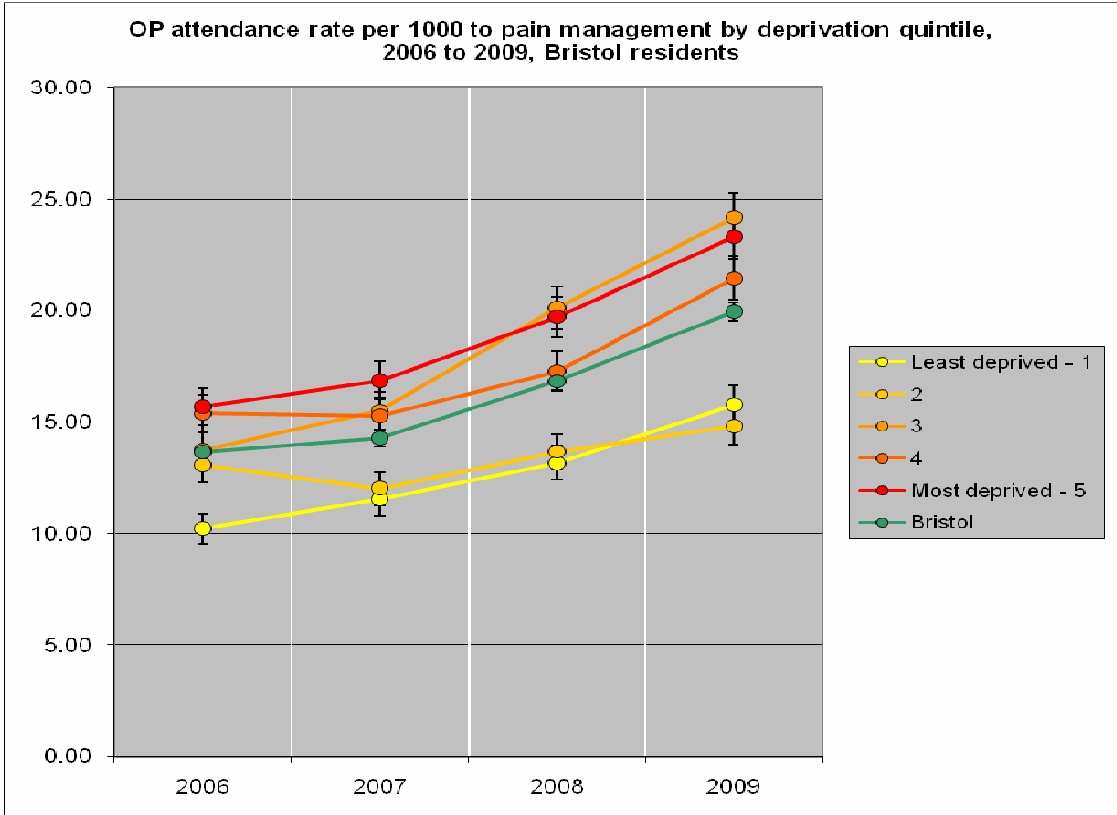
Activity data related to gender and age for both trusts was available and is recorded for both inpatient and outpatient activity. This has been cross tabulated with a range of other factors to highlight any significant differences in service activity and behaviour with regard to age, gender and other equality target areas.

Graph 1: Rate of attendance (per 1000) for outpatient appointment by age and gender for all Bristol residents

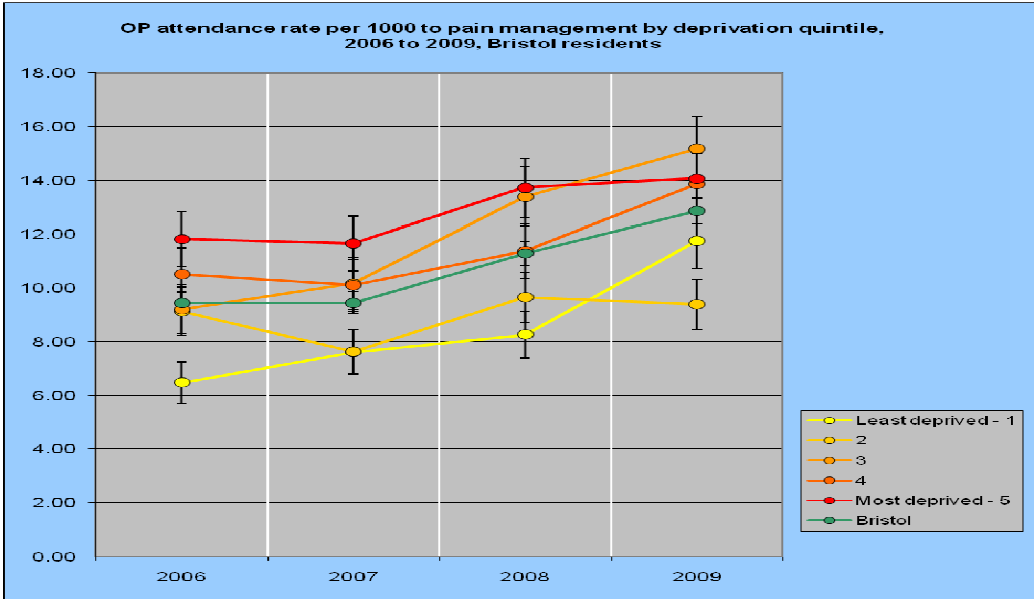
³ Arnsteinabc et al (1999), Self efficacy as a mediator of the relationship between pain intensity, disability and depression in chronic pain patients, Journal for the international association for the study of pain, volume 80, issue 3, Pages 483-491 (1 April 1999)



Graph2: Outpatient attendance rate (per 1000) for pain service by deprivation for all Bristol patients



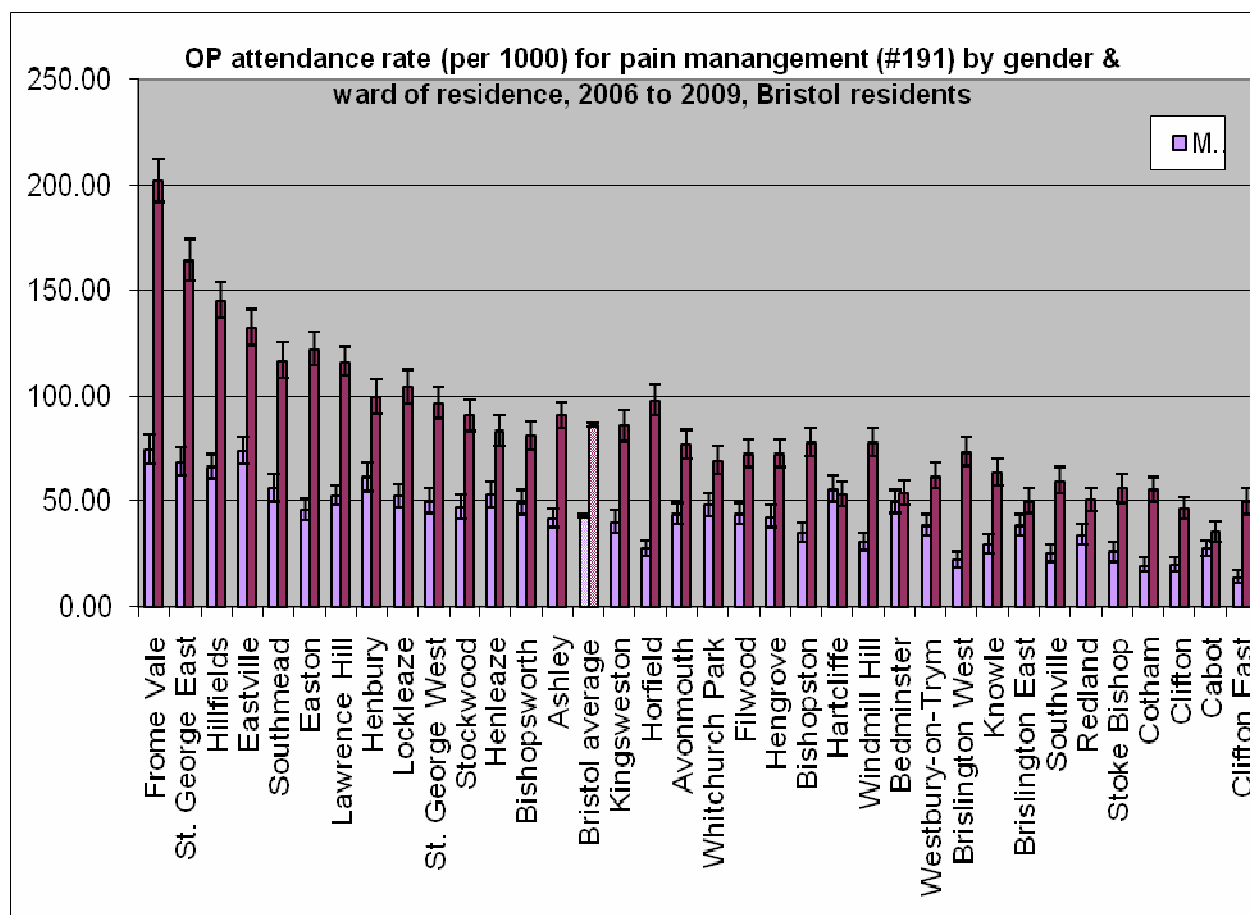
Graph 3: Outpatient attendance rate (per 1000) for pain service by deprivation for all Bristol male patients



Graph 4: Outpatient attendance rate (per 1000) for pain service by deprivation for all Bristol female patients



Graph5: Outpatient attendance by gender and ward of residence for Bristol residents



The data on age and gender suggests that some of the largest inequities exist based on gender. Women are far more likely to attend a pain outpatient appointment than a man. While women tend to live longer than men, this inequity is repeated at all age brackets. This could be related to male treatment of chronic pain or genuine access the services. The differences do not appear to be related to socio-economic situation or geographic proximity to service locations, as the difference in male and female attendance is significant across all Bristol wards of residence. In Weir et al's (1996) investigation of gender differences in relation to adjustment to chronic pain and relative expenditure on healthcare services, found that "Women used specific health care services more than men..."⁴.

This suggests that there is a possible development opportunity for reducing inequalities. This will need further investigation to properly understand the relationship between chronic pain and gender.

⁴ Weir R, Browne G, Tunks E, Gafni A, Roberts J.(1996), Gender differences in psychosocial adjustment to chronic pain and expenditures for health care services used, Clin J Pain. 1996 Dec;12(4):277-90.

3.5 Sexual Orientation

Jowett and Peel (2009) in their study of lesbian, gay and bisexual people living with non-HIV related chronic illness, suggest that LGB groups need targeted support groups and services. This will ensure better engagement and access to services.

The sexual orientation of patients accessing pain services is currently not recorded by either of the pain services. This is a significant gap in knowledge about equitable service access. The recording of this should be taken forward as an action in the equality impact assessment.

In the meantime, it is important that all staff receive mandatory equality and diversity training in order to ensure all patients are treated with respect and dignity regardless of their race, religion, belief or sexual orientation.

4. Consultations with stakeholders

There was a wide range of consultation on the development of the service model. The consultation included the following groups:

1. General Practitioners
2. Residential Care Home
3. Nursing Care Home
4. Very Sheltered Housing
5. Palliative Care
6. Specialist Deaf and Refugee Mental Health Services
7. District Nurses
8. Secondary Care Pain Specialists
9. Services for refugees and Asylum Seekers (The Haven)
10. GP services for hard to reach groups (Broadmead Medical Centre)
11. Patients
12. Age Concern Members
13. Secondary care Management
14. University of the West of England

This consultation led to the development of a series of recommendations, which directly influenced the design of the pain service model of care. These included:

1. Service provision in the community
2. Direct access to pain specialist advice by GPs
3. Implementation of standards to support hard-to-reach groups e.g. non-speakers of English, deaf etc...
4. Package of education and communication to include:
 - a. Services offered
 - b. Referral management
 - c. Management of pain in primary care
 - d. Awareness raising for hard-to-reach groups
 - e. Training and education for pain service professionals regarding access for hard-to-reach groups
 - f. Partnership working with organisation for hard-to-reach groups

There was also a workshop held for people with learning difficulties to understand their experiences and problems with accessing healthcare. While this was not specific to pain service, the findings are equally applicable. The main messages received were:

1. "I should be communicated with in a way that suits me"
2. "My permission should be given before anything happens to me"
3. "Healthcare professionals should make sure that I understand all of the information about my health and healthcare"
4. "Information about my learning difficulty should be recorded and communicated between different healthcare professionals"
5. "My specific needs should be considered when organising my healthcare"
6. "I should be helped to access services that I might not otherwise use or know about"
7. "Time should be taken to understand what stops me going to see someone about my health"
8. "Services should be easy to get to and use"

5. Identified information gaps

While access to current pain services appears to be largely equitable (excluding significant differences in access based on gender), there are significant gaps in data and also inconsistency in how it is collected and collated. The most significant gap is the omission of any data around sexual orientation or Disability, for inpatient or outpatient. This makes judgements impossible for these groups and any potential cross reference against other equality strands.

While gender is currently collected, this only includes male and female. For this to be representative of the Bristol population, it needs to also include transgender.

The other gap in our knowledge is specific information about the propensity for certain equality strands to be susceptible to the development of chronic pain, and therefore what their relative demand for pain specialist input should be. While it appears that access to pain services is approximately equitable, this assumes that all strands have the same incidence of chronic pain. This is not the case and will require further investigation, particularly through the partnership working element of the new service model.

6. Service specific equality questions

A. What is known about groups who are currently under or over represented in service provision?

The information collected through the equality impact assessment shows that the service is generally a good match with the population of Bristol. There is substantial disparity in service access across genders. This will require more investigation to understand what may be causing this. It is probable that there is some difference in how each gender treats pain.

While it appears that the pain service population is a good match to the wider Bristol population, this might be misleading. More evidence needs to be collected to understand the incidence of chronic pain across the strands of equality. It is likely that chronic pain is more common in certain groups, and that different groups respond to pain in different ways. This was borne out in conversations during the development of the report 'Equity of access report for pain services in Bristol'. It was reported that services needed to be delivered in locations and formats that responded to the cultural backgrounds and attitudes to healthcare of the target groups.

B. What are the likely known or additional health needs that need to be considered for particular groups?

There are none that are applicable from the equality impact assessment. However, a key function of the new service will be 'Partnership Working'. This will involve working closely with groups and organisations in partnership to better understand the issues, problems and behaviours of specific groups, and to develop services in a way which makes them accessible to the individuals represented by these groups.

C. What is known about the staff group with regards to equality or inequality?

The current staff group for the pain service is relatively small. Any breakdown based on strands of equality would be identifiable.

D. What is known about contractors other providers with regards to equality or inequality?

N/A – There are no other providers

E. Are there any gaps in data or information that would have improved this process?

The report has highlighted several gaps in information, which would have improved this process.

Reporting information:

- Inclusion of transgender in all reporting data
- Inclusion of Sexual orientation in all reporting data
- Inclusion of disability (with sub-categories) in all reporting data
- Inclusion of Religion or faith for both inpatient and outpatient appointments
- Inclusion of ethnicity in all reporting data (inpatient and outpatient)

A major gap in the information is a more complete understanding of the incidence of chronic pain across difference patient groups. An understanding of this would help to contextualise whether the service's patient population is actually representative of an equitable service.

F. Can you identify any aspects of the proposal, including how it will be delivered or accessed, which could inadvertently contribute to inequality?

The new service model will help to ensure greater equality of access through greater partnership working with groups who traditionally have problems accessing health services.

However, the equality impact assessment has highlighted some issues with data recording and reporting, that could inadvertently lead to inequalities. Without a comprehensive dataset, the service may be hiding inequalities that limit access to population groups in Bristol.

7. Equalities Action Plan

Issue Identified	Action to be taken	Expected Outcome	Officer Responsible	Deadline	Monitoring arrangements	Data required
Disparity in gender access to pain services	Suggest gender access as a service development for the Partnership Working aspect of the new service model	Trust plan to review gender access to service	Provider service lead	April, 2012	Through reporting of KPIs	TBC
Absence of transgender from the reporting dataset	It is important to include Trans as one of the gender fields fro the providers to collect and report on	Inclusion of trans as a gender data capture field for service provider	Provider service lead	April, 2012	Through reporting of KPIs	Gender data fields

<p>Absence of disability and subcategories from reporting dataset</p>	<p>There is currently no data capture or reporting of disability for chronic pain service users. It is important that this is included as part of the data set for service provider collection and reporting.</p>	<p>Inclusion of disability and subcategories (as defined by NHS Bristol) as part of the data capture and reporting requirements of service providers</p>	<p>Provider service lead</p>	<p>April, 2012</p>	<p>Through reporting of KPIs</p>	<p>Disability data fields</p>
<p>Absence of sexual orientation from the reporting database</p>	<p>There is currently no data capture or reporting of sexual orientation for chronic pain service users. It is important that this is included as part of the data set for service provider collection and reporting.</p>	<p>Inclusion of sexual orientation and subcategories (as defined by NHS Bristol) as part of the data capture and reporting requirements of service providers</p>	<p>Provider service lead</p>	<p>April, 2012</p>	<p>Through reporting of KPIs</p>	<p>Sexual orientation data fields</p>

<p>Gaps in data capture and reporting for outpatient and inpatient appointments of the following strands of equality: - Ethnicity - Religion or belief</p>	<p>Across the current providers there are gaps in the capture of 'Ethnicity' and 'Religion or belief' for patient appointments in outpatients and/or inpatients (including day-cases). This needs to be captured and reported on by the provider throughout inpatients and outpatients</p>	<p>Inclusion of 'ethnicity' and 'Religion or belief' as part of the data capture and reporting requirements of service providers across outpatient and inpatient appointments</p>	<p>Provider service lead</p>	<p>April, 2012</p>	<p>Through reporting of KPIs</p>	<p>Ethnicity and religion or belief</p>
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