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Task Force on Migrant-Friendly and Culturally Competent Healthcare

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Project to Develop Standards for Equity in Health Care for Migrants and other Vulnerable Groups

Preliminary standards for pilot testing in health care organizations

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This document has been developed by Antonio Chiarenza and the International Project Group on Standards for Equity in Health Care for Migrants and other Vulnerable Groups. It has been developed in accordance and in cooperation with the International HPH Secretariat.

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and Culturally Competent Healthcare

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Presentation of the Task Force MFCCH

Introduction

The Task Force on Migrant Friendly and Culturally Competent Health Care is established within the international HPH network with a specific mandate for coordination assigned to the HPH regional network of Emilia-Romagna (Italy) by the General Assembly and the Governance Board of the international HPH network. The provider is the Health Authority of Reggio Emilia, responsible for the Coordinating Centre of the regional HPH network of Emilia Romagna.

The Task Force was set up to continue the momentum created by the MFH project (2002-2005)[1] which involved 12 European countries engaged in the development of models of good practice for promoting health and health literacy of migrants and improving hospital services for these patient groups in selected pilot hospitals. The idea of creating a Task Force originated from the desire to continue working on these themes in a comparative international context after the conclusion of the MFH project, and to build on this experience in order:

- To facilitate the diffusion of policies and experiences and stimulate new partnerships for future initiatives;
- To foster cooperation and alliances between health care organisations and other networks;

[1] The outcomes of the MFH project can be found in the web site: www.mfh-eu.net

- To support member organisations in becoming migrant-friendly and culturally competent health care organisations, as recommended in the Amsterdam Declaration (2004).

The approach of the TF was informed by some initial considerations regarding the dynamics of the migration phenomenon in Europe. Despite the fact that most migrants are healthy when they first arrive in their host country, they risk suffering from poorer health compared to that of the average population, because of the conditions surrounding the migration process (Smedley et al. 2003). These migrant groups are more vulnerable, due to their lower socio-economic status; the conditions of poverty they abandon are often to be re-encountered in their new host countries.

This vulnerability is at times caused by traumatic migration experiences, by the feeling of exclusion in the place of arrival and often by a lack of adequate social support due to the absence of integration and specific socio-health policies (Mladovsky, 2009). This situation is worse still if we take into account not only resident populations who already possess the requisite residence or work permits, but also asylum seekers and undocumented migrants. Social exclusion, discrimination, poor living conditions and poverty in general all impact on the health, mental health and social adjustment of migrants in the host community (WHO, 2010).

This can only be further exacerbated by the lack of access to health services. Experience in recent years show that migrant patients and members of minority ethnic communities and other disadvantaged

groups tend to receive lower levels of health care compared to indigenous patients due to the lack of awareness of services available, the absence of provision for appropriate access to services and the negative attitude of staff in the delivery of health services. Moreover, migrants often lack the necessary information relating to access and to how hospital and clinic services operate as well as relating to health issues generally in the specific local context. Therefore, health organisations are finding themselves increasingly faced with the specific vulnerability of migrants who run a greater risk of not receiving adequate service in diagnosis, care and prevention because of their minority status, their socio-economic position, communication difficulties and lack of familiarity with health systems.

Key challenges are:

- How do we make health care services accessible, responsive and appropriate to all patients?
- How do we ensure that health care services are effectively utilised?
- How do we ensure that health care staff has the right skills and knowledge to deliver sensitive and equitable services?

Here, the role of the Task Force is to support member organisations in this process of developing policies, systems and competences for the provision and delivery of equitable and accessible health care services for migrants and other vulnerable groups.

The conceptual framework

The decision to set up a project aiming at developing standards for equity was taken at the Task Force MFCCH meeting held in Reggio Emilia on 15th October 2010 at the end of the scientific workshop "Redefining the concept of cultural competence". The workshop was jointly organised with the COST Action IS0603 HOME[2] group and aimed at critically discussing the very idea of cultural competence as the most effective way to address and improve access and quality of care for migrants and minority ethnic groups.

The now classical definition provided by Cross et al. (1989) has been adopted by many Western health care systems and translated into strategies aiming at improving services in order to make them more effective for migrants and ethnic minority populations. Many of the efforts to translate cultural competence into practise have resulted in the development of programmes to equip staff with cultural knowledge about various groups and to adapt service delivery to ethnic minorities' characteristics and needs, with the hope that increasing cultural competency at the service frontline will improve equity of access and quality of care for these populations.

This definition of cultural competence, both at individual and organisation level, stresses the importance of culture and knowledge

[2] Group of experts who participated in the Action IS0603 "Health and social care for migrants and ethnic minorities in Europe" (2007-2011)

about cultures, however it is unclear what sense health providers actually make of such concepts in practice.

Although, the idea of cultural competence should be used to address a variety of social groups, identified by age, gender, social-status, physical ability, religion and sexual orientation, when it comes to evaluating professionals' cultural competence, existing models present culture as equivalent of ethnicity and race. Culture is often presented as a concept that pertains only to the other, as if providers had not got a culture. It is the other who is (or has) the problem. The implicit message is that certain people are culturally or ethnically diverse, others are not. On the contrary, health experiences are made up of the interactions between the health service culture, the provider's culture and the patient's culture. Moreover, they occur within a specific socio-economic and political context and time, which partially shapes and influences those experiences.

Cultural incompetence is assumed to be rooted in practitioners' lack of familiarity with the other. As a consequence the other is constructed as the object of a specific knowledge that needs to be taught and learned. These assumptions on cultural competence constitute a worldview where culture is perceived as a "barrier" relating to the other that health providers need to address when interacting with individuals from minority groups. The image that is drawn is that of a western "culturally competent" provider, armed with specific knowledge and skills and thus able to interact with diverse ethnic communities. The underlying assumption of this approach is that the greater the knowledge about another culture, the greater the competence in practice.

However, people are so diverse that developing competence for health and social care professions based on supposed cultural knowledge, or simplified ideas about the health-related beliefs of specific ethnic

groups, does not allow for understanding individual diversity; nor does it take into account historical effects and socioeconomic status. It is important to look beyond culture to examine its intersections with gender, class, race, age and other social distinctions. As multicultural strategies, based exclusively on responding to ethnic differences, may lead to neglect other aspects of individual differences and to exclude more vulnerable groups or newly arrived migrants, so it seems that the logical solution would be to invest in the development of more equitable services for all. Health care organisations, in order to ensure equity, should be encouraged to implement a number of interventions:

- To provide equal opportunities in healthcare and contribute to reducing health inequities through the delivery of sustainable and cost-effective policies. This means ensuring that equity is included in all aspects of the organisation's policy, governance, staff training, actions and performance monitoring systems.
- To ensure equitable access to available care for all individuals, addressing the formal and informal barriers that prevent people from accessing and benefiting from health care services, such as legal barriers; multiple diversity barriers; communication barriers; organisational barriers; financial barriers; geographic and physical barriers.
- To provide high quality, person-centred care for all, acknowledging the unique characteristics of the individual and acting on these to improve individual health and wellbeing. This means, on the one hand, ensuring that individual characteristics, experiences and living conditions are considered during the assessment of health needs, while on the other hand, creating an environment that feels safe for patients, where there is no threat to their dignity or denial of individual identity.

- To engage service users and groups in the community through inclusive outreach activities. Population groups and service users need to be seen as active participants rather then passive recipients. This means identifying the most effective and accessible ways that marginalised groups can engage and participate in involvement activities and processes.
- To promote the principles of equity through integration with other services and across sectors, cooperating with other agencies in the territory through advocacy and intersectoral interventions aimed at reducing inequalities.

These reflections within the Task Force MFCCH group created the conditions for developing further work at re-defining the traditional notion of cultural competence, proposing an alternative approach to cultural competence both at individual and organisational levels, based on the idea of encouraging staff to focus on the uniqueness of the individual, transcending ethnic identity and ensuring equity of treatment for all as the major strategy to reduce disparity in health care.

The project aim

An effective strategy to improve equity in health care is by setting standards. To this purpose the Task Force MFCCH has started a new project aiming at developing a comprehensive framework for measuring and monitoring the capacity of healthcare organizations to improve accessibility, utilization and quality of health care for migrants and ethnic minorities. The final product will be a self-assessment tool that allows all professionals in healthcare organizations to carry out their own equity evaluation against a set of standards and to stimulate development. These standards will provide a real opportunity for staff to question what they do, why they do it, and whether it can be done better. This process is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of an action plan, implementation and subsequent evaluation. The self-assessment process has to be clearly distinguished from external evaluation.

This publication presents a set of preliminary standards that have been developed on the basis of an extensive critical literature review, several expert workshops and consultations. This set of preliminary standards will be piloted in a number of hospitals and health services. To support the assessment of standards, a review form has been developed, that includes measurable elements and evidence to assess the compliance with standards. The review form and guidelines for the implementation of the pilot test are available in the third part of this document.

The project group

The preliminary standards presented in this publication have been developed thanks to the active contribution of the following members:

Antonio Chiarenza, project coordinator (Italy)
James Glover and James Robinson (Scotland)
Bernadette Nirmal Kumar, Ragnhild Spilker and Christopher Le (Norway)
Conny Seelemann and Marie-Louise Essink-Bot (The Netherlands)
Manuel Fernandez Gonzales (Sweden)
Manuel García-Ramírez (Spain)
Elizabeth Abraham and Marie Serdynska (Canada)

With the contribution of the following experts:
David Ingleby (The Netherlands); Dagmar Domenig and Sandro Cattacin (Switzerland)

In developing these preliminary standards the TF MFCCH has established effective partnership with the COST Action HOME. Future steps will be conducted in cooperation with the new COST Action ADAPT (2012-2015) chaired by David Ingleby and together with the programme "Public Health Implications of Migration" coordinated by Santino Severoni of the WHO European Regional Office.

The project roadmap

Step 1. To develop the conceptual model in order to identify and organise standards and measurable elements. (February 2011)

Step 2. To identify the main standards (Domains) for measuring and monitoring equity in healthcare. (April 2011)

Step 3. To identify, for each main standard, a set of sub-standards (May 2011)

Step 4. To present and discuss the 1st draft of the preliminary standards at the International HPH Conference in Turku, Finland (June 2011)

Step 5. To revise the proposed standards and sub-standards and break these down into their principle components, (October 2011)

Step 6. To develop the measurable elements for each sub-standard (November 2011-March 2012)

Step 7. To present and discuss the 2nd draft of the preliminary standards at the International HPH Conference in Taipei, Taiwan (April 2012)

Step 8. To validate the preliminary standards through a consensus process addressed to WHO and other key players. (April-May 2012)

Step 9. To pilot test the preliminary standards in order to assess their clarity and ensure they meet the actual needs of people and services. (April-July 2012)

Step 10. To collect and analyse the findings of the pilot test (September 2012)

Step 11. To discuss the findings of the Pilot-test and Consensus Process at the Task Force meeting in Reggio Emilia (October 2012)

Step 12. To produce the final standards, develop indicators for each substandard and implement the final self-assessment tool in pilot organisations. (January 2013)

Step 13. To present and discuss the final self-assessment tool at the international HPH conference in Sweden (May 2013)

Structure of the standards

Five standards have been developed addressing the following issues:

Standard 1: Equity in Policy
Standard 2: Equitable Access and Utilisation
Standard 3: Equitable Quality of Care
Standard 4: Inclusive User and Community involvement
Standard 5: Promoting Equity

The standards for equity use the same format, terminology and development process adopted by the HPH standards (see the triple level structure of standards). Each standard has a set of sub-standards, and each sub-standard has one or more measurable elements, which require an answer of 'yes, partly or no'. Demonstrable evidence is required to show compliance with the sub-standards. Examples of evidence against which sub-standards may be evaluated have been added in square brackets. A box for comments is located next to the measurable elements where problems, goals, responsibilities, details on evidence and follow-up actions must be documented. This qualitative information will provide important background for the development of quality improvement plans.

The following graph illustrates the components of the standards.

1 Standard
Equity in policy

The organisation promotes equity by providing fair opportunities in healthcare and contributes to reducing health inequitier through the delivery of sustainable and cost effective policies.

Standard definition

Objective of the standard

To define how the organisation should develop policies, governance and performance monitoring systems which promote equity.

Sub-standard

Substandard definition

1.1. **The organisation can ensure that its plans, policies and decisions promote equity at all aspects of its activities.**

Measurable element

1.1.1 **The organisation has procedures in place to review the impact of its plans, policies and decisions on equity.**
[Evidence: Document setting out its process and tools for carrying out equity audit or impact assessment (e.g. Health Equity Audit; Equity Impact Assessment tool).]

Demostrable evidence

Comments:

Yes ☐ Partly ☐ No ☐

Text box for comments, problems, goals, responsibilities, details on evidence and follow-up actions.

1. **Level one** is the level of the **main standards**. The main standards address the main domains identified: Equity in Policy; Equitable Access and Utilisation; Equitable Quality of Care; Inclusive User and Community Involvement; Promoting Equity.

2. **Level two** is the level of the **sub-standards**. Sub-standards operationalize the main standard and break it down into its principle components. The number of sub-standards per standard may vary (from 1 to 5).

3. **Level three** are the **measurable elements**. Measurable elements are those requirements of the sub-standard that will be reviewed and assessed to be not, partly or fully fulfilled. The measurable elements simply list what is required to be in full compliance with the standard. Listing the measurable elements is intended to provide greater clarity to the standards and help organizations educate staff on standards and prepare for the self-assessment process.

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Standards for Equity in Health Care

Framework of the standards

The project aim is to develop and implement standards for equity in health care organisations that:

- acknowledge that inequities in health care must be redressed; these inequities are determined by power imbalances that exist in the dynamics between diverse populations and the health care system;
- support the values of the international conventions on Human Rights and Social Justice, as well as Codes of Professional Ethics, etc.;
- promote the principle of universal coverage;
- focus on prevention and health promotion as well as treatment across the continuum of care;
- ensure the sustainability of interventions to promote equity;
- acknowledge and value multiple diversity typical of contemporary societies with a complex migration history and the existence of differences as well as commonalities across all populations;
- support work to eradicate all forms of individual and institutional discrimination based on gender, age, ethnicity, race, socio-economic status, aboriginal status, disabilities, religious beliefs, language, and sexual orientation, transgender status;
- acknowledge the uniqueness of all individuals, the right to self-determination and respect for individual identity;
- acknowledge that equity in health is one of the main aspects of social, economic and political inclusion (WHO 2010);
- aim at reducing inequity in access to services and quality of care.

Definitions:

Equity in Health: is concerned with creating equal opportunities for health and with bringing health differentials down to the lowest possible. (M. Whitehead, 2000, p. 7)

Equity in Health Care: is defined as equal access to available care for equal need; equal utilization for equal need; equal quality of care for all. (M. Whitehead, 2000, p. 8)

Health inequality and inequity

Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes. It is important to distinguish between inequality in health and inequity. Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case it may be impossible or ethically or ideologically unacceptable to change the health determinants and so the health inequalities are unavoidable. In the second, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair, thus the resulting health inequalities also lead to **inequity in health**. (WHO, Glossary)

1 Standard
Equity in policy

The organisation promotes equity by providing fair opportunities in healthcare and contributes to reducing health inequities through the delivery of sustainable and cost effective policies.

Objective of the standard

To define how the organisation should develop policies, governance and performance monitoring systems, which promote equity.

Substandards

1.1. The organisation can ensure that its plans, policies and decisions promote equity in all aspects of its activities.

1.1.1 The organisation has procedures in place to review the impact of its plans, policies and decisions on equity. [Evidence: Document setting out its process and tools for carrying out equity audit or impact assessment (e.g. Health Equity Audit; Equity Impact Assessment tool).]

Comments:

Yes ☐ Partly ☐ No ☐

1.1.2 The organisation monitors the extent to which its plans, policies and decisions address equity issues for patients and staff. [Evidence: Report showing the extent to which equity issues are addressed by its management (e.g. The report shows that the organisation acts on the findings of impact assessments).]

Comments:

Yes ☐ Partly ☐ No ☐

1.1.3 The organisation's leaders and decision makers actively promote equity in their work. [Evidence: Equity is included in performance management arrangements for all leaders and decision makers (e.g. Guidance for managers requires them to have at least one performance indicator which addresses equity).]

Comments:

Yes ☐ Partly ☐ No ☐

1.2. The organisation's research, monitoring and evaluation systems can measure equity performance.

1.2.1 The organisation collects data on the way people access its services to understand how service utilisation patterns reflect the demography and meet the needs of the catchment area.. [Evidence: Data are available about who is and who is not using its services according to the same need (e.g. Compare data on access of service users with statistics about social stratification, gender, nationality, origin, religion, aboriginal, ethnicity, disability and age breakdown of the population).]

Comments:

Yes ☐ Partly ☐ No ☐

1.2.2 **The organisation collects data on the health status and inequalities in its catchment area**. [Evidence: Data or information collection about the health needs of relevant populations which allow health inequalities to be identified (e.g. Epidemiological and socio-demographic data in relevant areas/districts and target population groups; Quantitative and qualitative information).]

Yes Partly No

Comments:

1.2.3 **The organisation uses this data to continually improve equity in the accessibility and quality of health care.** [Evidence: Evidence-based outcomes showing service equity improvements (e.g. Documented variation in the number and range of individuals accessing a diabetes or asthma clinic).]

Yes Partly No

Comments:

1.3. The organisation has a plan, resources and budget to promote equity. This plan is integrated with existing performance management and accountability systems.

1.3.1 **The organisation has an equity plan or strategy, which is reviewed regularly**. [Evidence: Written strategy or plan, which sets out the actions it will take to address equity issues (e.g. The equity plan includes mission statement, objectives, allocation of resources, duration, responsibilities).]

Yes Partly No

Comments:

1.3.2 **Implementation of the organisation's equity plan is included in the overall strategy of the organisation**. [Evidence: The overall strategy makes specific reference to the equity plan (e.g. The equity plan has equal weight to quality improvement and risk management objectives and is integrated with them).]

Yes Partly No

Comments:

1.3.3 **The organisation includes progress on equity in its mainstream performance reports.** [Evidence: Mainstream reports include specific equity measures (e.g. Equity measures in patient satisfaction, complaints and patient safety reports).]

Comments:

Yes Partly No

1.4. The organisation ensures that staff at all levels has awareness and competence to address inequities in health care.

1.4.1 **The organisation has a comprehensive programme for equity training and challenging attitudes towards equity issues for all staff.** [Evidence: Training plans show appropriate training is delivered to all staff, including senior staff (e.g. The plan sets out which staff should receive basic awareness training, and which should receive more advanced training on specific equity issues).]

Comments:

Yes Partly No

1.4.2 **The organisation's mainstream training includes learning about equity.** [Evidence: Mainstream training is reviewed for inclusion of equity issues where this is appropriate (e.g. Equity is part of the core induction training and training updates).]

Comments:

Yes Partly No

1.4.3 **The organisation monitors and evaluates the effectiveness of its equity training.** [Evidence: Data is available on the number of staff who has completed equity training. Mechanisms are in place to evaluate changes in staff attitudes, knowledge and skills (e.g. Credit system for ongoing learning and professional development; Pre and post-assessment of training; Mystery shoppers; Patient feedback, Complaints or other similar sources to evaluate training).]

Comments:

Yes Partly No

2 Standard
Equitable access and utilisation

The organisation ensures equitable access to and utilisation of services.

Objective of the standard

To encourage the health organisation to address barriers which prevent or limit people accessing and benefiting from health care services.

Substandards

2.1. The organisation ensures that accessibility and availability of health services are equitable.

2.1.1 The organisation continually seeks to identify and monitor access barriers to its services. [Evidence: Data collection to identify and monitor barriers, which prevent or discourage people from making use of services (e.g. Access or architectural audits for buildings; Language needs assessments; Information material audits; Findings from impact assessments).]

Comments:

Yes | Partly | No

2.1.2 The organisation has minimised architectural, environmental and geographical barriers to its facilities. [Evidence: Formal procedures or policy for ensuring that buildings and facilities are assessed for their accessibility and geographical distribution (e.g. Clear signs and directions; Welcoming environments; Diversity friendly; Wheelchair accessible; Facilities are close to public transport; Services are provided to rural areas).]

Comments:

Yes | Partly | No

2.1.3 The organisation ensures access to care for disadvantaged groups. [Evidence: Formal procedures for ensuring access to available services for the more disadvantaged people or people at risk of discrimination (e.g. Drop-in primary health care unit based in hospital, Care pathways for HIV/AIDS patients or disabled patients; Access to AE services for alcoholic patients, homeless people; Use of case management workers).]

Comments:

Yes | Partly | No

2.1.4 The organisation evaluates the impact of interventions and programmes targeting reduction of access barriers. [Evidence: Quantitative and qualitative evaluation of intervention' outcomes; Assessment criteria are identified (e.g. Pre and post evaluation of implemented measures; Enhanced satisfaction experienced by patients and carers).]

Comments:

Yes | Partly | No

2.2. The organisation develops initiatives to reduce communication and information barriers.

2.2.1 **The organisation takes into account health literacy needs when communicating with people and providing information**. [Evidence: Policy and/or standards for information and communication with patients and the public (e.g. Procedures for involving users in developing written materials; Guidelines for written communication; Information about preventive services and health education programmes; Navigation support services; Use of Community Health Educators).]

Comments:

Yes | Partly | No

2.2.2 **The organisation has a clear policy setting out how it will ensure that patients can communicate with services where language may be a barrier**. [Evidence: Written policy on interpretation, translation, intercultural mediation and communication support (e.g. Guidelines for staff in organising interpreters or communication support; Eligibility criteria for accessing interpreting or intercultural mediation services).]

Comments:

Yes | Partly | No

2.2.3 **The organization makes professional interpreting services available and widely promotes this**. [Evidence: Explicit forms of financing for medical interpreters or intercultural mediators; Interpreting services available on request; Inclusion of interpreting services in the organizational routine (e.g. Scheduling system; Distribution of language identification chart; Flyers to inform patients and staff about how to access service; Assessment for interpreting needs in admission procedures).]

Comments:

Yes | Partly | No

2.2.4 **The organization monitors and evaluates the performance and quality of interpreting services**. [Evidence: Documentation for tracking volume increase; Performance records of interpreting provision; Qualification criteria for interpreters; Defined criteria for interpreting quality; Defined interpreting code of conduct (e.g. Patient and staff surveys addressing awareness, satisfaction, resources, and perceived needs; Evaluate the advantages and disadvantages of using the service; Competence standards for interpreters).]

Comments:

Yes | Partly | No

2.2.5 **The organisation ensures staff ability to work with interpreters.** [Evidence: Training for staff about how to work with interpreters (e.g. Pre-post assessment to evaluate impact of training; Involving an interpreter in induction training for new staff; Promoting the interpreting service in internal communications).]

Yes | Partly | No

Comments:

2.3. The organisation develops initiatives to increase user trust.

2.3.1 **The organisation provides outreach communication to disadvantaged populations.** [Evidence: Relevant information about available outreach services; Evidence of how well these are used (e.g. Meetings with hard to reach groups; Information on services for refugees, and asylum seekers, aboriginal peoples, sex workers, homeless people, LGBT... ; Mobile clinics).]

Yes | Partly | No

Comments:

2.3.2 **The organisation is able to ensure that complaints and feedback on equity issues are identified and addressed in a transparent manner.** [Evidence: Complaints process allows for collection and monitoring of perceived discrimination (direct or indirect) and unequal treatment (e.g. The organization complaints process includes equity categories; Procedures are in place to take action on identified inequalities; The staff who deal with complaints are trained to address equity issues).]

Yes | Partly | No

Comments:

2.4. The organisation is able to ensure that healthcare is provided where eligibility rules compromise human rights.

2.4.1 The organisation monitors situations where people are unable to access services because of lack of eligibility. [Evidence: Information and data collection about people who are ineligible for health care (e.g. System to identify and keep track of people who are ineligible for financial or legal reasons, such as non-insured people; undocumented migrants; asylum seekers).]

Yes	Partly	No

Comments:

2.4.2 The organisation is able to ensure that people who are ineligible for health care receive appropriate support. [Evidence: Concrete solutions to ensure that ineligible people receive appropriate information, care and support (e.g. Informal provision of health care; Referral to local civil society groups or NGOs; Services for irregular migrants where legislation permits this).]

Yes	Partly	No

Comments:

3 Standard
Equitable quality of care

The organisation provides high quality, patient-centred care for all, acknowledging the unique characteristics of the individual and acting on these to improve individual health and wellbeing.

Objective of the standard

To assist the organisation in developing the following areas so that they respect the uniqueness of patients: patient assessment; staff / patient interactions; safe environment; discharge and continuity of care.

Substandards

3.1. The organisation ensures that individual characteristics, experiences and living conditions are considered alongside the assessment of health needs.

3.1.1 The organisation is able to identify patients' needs according to their individual characteristics and experience. [Evidence: Needs assessment procedures include information about individual characteristics and background of each patient (e.g. Health records explicitly include information such as age, language preference, health literacy level, physical ability, cognitive impairment, ethnicity, aboriginal status, religion, socio-economic status, social context).]

Comments:

Yes Partly No

3.1.2 The organisation is able to recognise the psychosocial needs of individual patients. [Evidence: All patients are asked about psychosocial needs, and these are documented in health records (e.g. Family situation and living conditions; Routine assessment of individual psychosocial functioning and vulnerability; Investigation of individual beliefs and practices).]

Comments:

Yes Partly No

3.2. The organisation's workforce is able to deliver care that takes into account individual patients' ideas and experiences of health and illness.

3.2.1 The organisation takes account of the individual characteristics and experience of each patient in clinical practice. [Evidence: Equity related characteristics are integrated in clinical practice (e.g. Care plans include sensitivity to difference concerning individual patient; Guidelines are subjected to equity impact assessment developed in partnership with diverse patients).]

Comments:

Yes Partly No

3.2.2 Care is considerate and respectful of the patient's dignity, personal values, knowledge and beliefs regarding health and care. [Evidence: Patient experience feedback in the areas of dignity, respect and personal beliefs is routinely requested by staff (e.g. Request for feedback on patient views about nutrition, religion and spiritual help, language assistance, pain management, rituals).]

Comments:

Yes ☐ Partly ☐ No ☐

3.2.3 The organisation has procedures to meet the psychosocial needs of individual patients. [Evidence: Procedures for dealing with patients who are identified as being at risk (e.g. Referral to specific support organisations, such as Counselling services, Social services, NGOs, Mental health services).]

Comments:

Yes ☐ Partly ☐ No ☐

3.2.4 The organisation ensures that staff training includes best practice guidance on how to elicit the patient's story and ideas of illness and health care. [Evidence: Staff training includes learning on how to work across differences, illness narratives, relevance of considering individual characteristics and situation (e.g. Reports into patient satisfaction, adherence to care plans; Follow-up visit attendance; Self-care success rates; Feedback from patients).]

Comments:

Yes ☐ Partly ☐ No ☐

3.3. The organisation is able to create an environment that makes the patient feel safe, where there is no threat to his/her dignity or denial of individual identity.

3.3.1 The organisation strives to create an environment, which is inclusive for all patients regardless of individual identity. [Evidence: Policies to challenge discrimination, bullying, harassment and abuse and widely promotes these (e.g. Publicity materials; Patient information materials are inclusive for diverse patient groups; Facilities' interiors do not contain elements, which could be considered offensive or disrespectful to some individual cultures).]

Comments:

Yes ☐ Partly ☐ No ☐

3.3.2 **The organisation is sensitive to patient needs for privacy during care and treatment.** [Evidence: All patients are informed about their own right to privacy as well as other patients' rights to privacy (e.g. Sensitive information about patient's right to privacy; Patient expectations of needs for privacy are identified and specific needs are recorded in patient records).]

Comments:

Yes Partly No

3.4. The organisation takes into account individual patients' characteristics, experiences and living condition to ensure effective discharge and continuity of care.

3.4.1 **The organisation ensures that the socio-cultural context and individual characteristics of all patients are taken into account at discharge.** [Evidence: Discharge procedures and communication clearly includes reference to the individual characteristics and social context of the patient (e.g. Discharge letter available in different languages; Discharge takes different family circumstances into account).]

Comments:

Yes Partly No

3.4.2 **The organisation has a planned approach to collaboration with other health service providers and organisations in order to ensure continuity of care.** [Evidence: Written plan for collaboration with partners to improve the patients' continuity of care (e.g. Plan for discharge).]

Comments:

Yes Partly No

4 Standard
Inclusive user and community involvement

The organisation ensures equitable involvement and participation of users and/or community groups in how services are planned, delivered and evaluated. Users and community groups are seen as active participants rather then passive recipients.

Objective of the standard

To support the organisation in developing involvement processes sensitive to the needs and preferences of individuals and groups so that everybody has an equal opportunity to benefit from these processes.

Substandards

4.1. The organisation is able to identify and involve users and groups who have an interest in the focus of its involvement process.

4.1.1 **The organisation is able to identify the individuals and groups likely to be excluded from its involvement processes.** [Evidence: Statistical data of service users; List of local community groups; Consultation handbook; Supplement statistical data with information from community based networks or organisations (e.g. Minority Ethnic groups; Aboriginal populations; Young people; Older people; Faith groups; People with disabilities; LGBT).]

Comments:

Yes Partly No

4.1.2 **The organisation promotes the inclusion of disadvantaged groups in mainstream involvement activities.** [Evidence: Recruiting disabled and other groups in consultation bodies and service forums; Outreach work within 'grassroots' (hard-to-reach) groups (e.g. 'Grassroots' consultations; Consultation with equal opportunities or human rights commissions; Disability rights commission).]

Comments:

Yes Partly No

4.1.3 **The organisation monitors and evaluates the extent to which individuals and groups participate in its involvement activities.** [Evidence: Systematic monitoring of the involvement process; Monitoring the level of compliance to involvement activities (e.g. Composition of advisory or consultation bodies; Register of involvement; Register of key stakeholders such as organisations representing patients, carers or community groups).]

Comments:

Yes Partly No

4.2. The organisation identifies and overcomes barriers to effective involvement.

4.2.1 The organisation is able to identify and meet the communication needs of individuals and groups to enhance participation and feedback. [Evidence: Communication methods to improve involvement and participation; Accessible information material for consultation (e.g. Information about involvement opportunities in different languages; Use of plain language; Use of Community Health Educators; Braille; Large print).]

Comments:

Yes | Partly | No

4.2.2 The organisation is able to identify and meet the support needs of involved individuals and groups in order to enhance participation. [Evidence: Systems for recording people's support needs (e.g. Accessible venues; Transport arrangements; General assistance; Provision of food; Sign language and interpretation support; Timing of events).]

Comments:

Yes | Partly | No

4.2.3 The organisation uses methods of involvement that enhance inclusive participation. [Evidence: Participatory approach to consultation; Arrange meeting where target groups normally meet (e.g. Use inclusive methods that effectively outreach to hidden 'sub-groups' such as people who are housebound; in residential care or in rural areas; Involve people in design of tools; Interactive workshops).]

Comments:

Yes | Partly | No

4.2.4 The organisation ensures that staff training on user and community involvement includes best practice guidance on how to engage with disadvantaged people. [Evidence: User and community involvement is part of the core staff training; Staff training includes learning on how to identify and overcome barriers to effective involvement (e.g. Effective communication strategies; Effective consultation and engagement methods).]

Comments:

Yes | Partly | No

4.3. The organisation has an empowering evaluation system of participatory processes in which users and community groups are involved.

4.3.1 The organisation evaluates its methods of involvement including relevant groups in the evaluation process. [Evidence: Evaluation system to assess, prevent and eliminate potential barriers to participation (e.g. Mechanisms to detect with which aspects communities are most and least satisfied; Tools to assess the impact of community participation in future planning).]

Yes Partly No

Comments:

4.3.2 The organisation provides feedback on the results of involvement activities to the community groups and organisations affected. [Evidence: Provide feedback in different formats according to people's needs (e.g. Dissemination of data and reports of involvement activities; Feedback meetings with groups).]

Yes Partly No

Comments:

4.3.3 The organisation has systems to record specific feedback from involved individuals and groups and prioritise any actions arising from feedback addressing inequalities. [Evidence: Users and community groups feedback inform the organisation's Equity plan or strategy (e.g. Assessment tools for evaluating the impact of user and groups participation in service planning).]

Yes Partly No

Comments:

5 Standard
Promoting equity

The organisation understands that it is part of a wider system and is able to promote the principles of equity through integration with other services and across sectors.

Objective of the standard

To support the organisation in promoting equity externally in its wider environment through: advocacy and lobbying; facilitating capacity building; disseminating research; developing education and promotional work.

Substandards

5.1. The organisation is an active participant in networks, think tanks and research initiatives which promote equitable approaches.

5.1.1 The organisation promotes research on health interventions and health care innovations targeting vulnerability, in order to maximize their impact on the accessibility and the quality of care. [Evidence: Information on inequities in health and health care and in the residential status are included as relevant categories in research (e.g. Equity issues are included among the criteria for prioritising research recommendation).]

Yes Partly No

Comments:

5.1.2 The organisation builds solid relationships with community-based service providers in its area, and develops networks and partnerships to deliver innovative services to disadvantaged populations. [Evidence: Integration plans of health care with social services; Partnerships with NGOs and other agencies for the care of irregular migrants; Targets for the organisation equity strategy relate to the equity activities of collaborative organisations (e.g. One Stop Services; Use of case or care management; Local Strategic Partnerships, Equity monitoring system is compatible with that of other agencies involved in joint working).]

Yes Partly No

Comments:

5.1.3 The organisation builds inter-sectoral collaborations beyond the healthcare system to address the wider determinants of health. [Evidence: Formal links with umbrella agencies of relevant areas/districts (e.g. Co-operation between agencies concerned with social inclusion and those concerned with health promotion and education; Shared social responsibility agreements; Inter-sectoral interventions).]

Yes Partly No

Comments:

5.2. The organisation actively disseminates the results of research and practice which relates to equity.

5.2.1 The organisation promotes dissemination of research outcomes and/or information about existing good practices in the development of health interventions towards people in vulnerable situations. [Evidence: Communication plan concerning the dissemination of research outcomes (e.g. Reports addressed to different stakeholders such as the scientific community, decision makers, experts, and the general population).]

Comments:

Yes ☐ Partly ☐ No ☐

5.3. The organisation ensures that equity is reflected in all partnership agreements and relationships, including contracted services, and partnerships.

5.3.1 The organisation ensures that partnership and sub-contract agreements reflect equity standards. [Evidence: Contractors are required to provide evidence of their equity strategies (e.g. Equity issues explicitly included in official agreements; Staff of sub-contracted services are trained on equity issues).]

Comments:

Yes ☐ Partly ☐ No ☐

5.3.2 The organisation ensures and monitors that sub-contracted services are delivered in an equitable way. [Evidence: Systematic review of sub-contracting processes against the recommended equity standards. Monitoring the performance of contractors in relation to equity duties (e.g. Standards for equity in healthcare; Equity impact assessment reports).]

Comments:

Yes ☐ Partly ☐ No ☐

Pilot-testing the Standards in Health Care Organisations

Guidelines for implementation

Introduction

An initial draft of this set of preliminary standards was developed by a subcommittee[3] and subsequently analysed and revised in the 1st workshop by a working group[4] in May 2011. A project group[5] was then established in September 2011 and a new revision of the standards was developed during a 2nd workshop in Reggio Emilia. Further revision took place in a 3rd workshop in November 2011. Finally, a consensus process has been activated involving key players in WHO. The preliminary standards are now ready for the pilot test.

Purpose of the pilot test

The scope of the pilot test is to assess the standards and not to assess the test organisation. However, information about the actual compliance of the health organisations involved to the standards will give important information about applicability and relevance of the standards themselves. The pilot test is furthermore expected to collect examples of "demonstrable evidence" (effective practices relating to the sub-standard) already in place in pilot institutions. Finally, the pilot test aims to establish if the standards are accessible and understandable.

[3] Members of the sub-committee: Antonio Chiarenza, Sandro Cattacin, Dagmar Domenig.

[4] Antonio Chiarenza, Sandro Cattacin, Dagmar Domenig, James Glover, Bernadette Nirmal Kumar, James Robinson, Ragnhild Spilker.

[5] Members of the project group: Antonio Chiarenza (coordinator), HPH Emilia-Romagna - Italy; James Glover and James Robinson, HPH Scotland - UK; Bernadette Nirmal Kumar, Ragnhild Spilker, Christopher Le, HPH Norway; Conny Seeleman and Marie-Louise Essink-Bot, AMC - The Netherlands; Manuel Fernandez Gonzales, Uppsala University Hospital - HPH Sweden; Elisabeth Abrahams and Marie Serdynska - HPH Canada, Manuel Garcia Ramirez, University of Seville; Sandro Cattacin (expert), University of Geneva; David Ingleby (expert), University of Utrecht and Dagmar Domenig, (expert).

Criteria for evaluating sub-standards and measurable elements:

- COMPREHENSIBILITY: is the formulation sufficiently clear?

- RELEVANCE: is the sub-standard and measurable element related to an important health care issue?

- APPLICABILITY: is the sub-standard and the measurable element applicable to the organisation?

- COMPLETENESS: are important items missing?

Time Schedule

The test period is scheduled from April 15th to June 30th. Results of the test must be returned to HPH TF MFCCH, Reggio Emilia before July 15th. Corrections and amendments that may emerge as a result of the pilot test will be incorporated into the standards and final corrections will be carried out at a workshop to be held in October 2012 before the presentation of the standards at the international HPH conference in Sweden in May 2013.

Roles and Responsibilities

Role of the coordinator of the TF MFCCH

1. To encourage countries and health care organisations to participate in the pilot implementation;
2. To identify coordinators at regional and national levels;
3. To coordinate the pilot test implementation in the participating countries;
4. To provide for instructions and tools for pilot testing: guidelines and a review form.
5. To collect data from national coordinators
6. To support participation and to analyse the results sent to TF MFCCH using the meta-evaluation form;
7. To provide feedback to pilot-test organisations
8. To organise workshops for dissemination of outcomes

Role of the regional and national coordinator

The national/regional coordinators in countries taking part in the pilot test are expected to:

1. Identify and contract with 2 – 4 test hospitals / health services. Institutions of a different size and with an appropriate geographic distribution should be selected.
2. Identify a responsible contact person for each pilot-institution who should take responsibility for the review at a local level.
3. Provide guidance to organisations taking part in the pilot test implementation and to provide feedback on the results.

4. Translate the test material into the national language, where necessary.
5. To collect the completed review forms and send them to the TF coordinator.

Role of the pilot organisations

Each pilot-organisation will have to identify the members of the review team according to their organization. Nevertheless, it is suggested that the following staff should be involved in the multidisciplinary review team:

1. A **contact person** responsible for the local pilot-test
2. Hospital/health service management, and staff representatives (nurses, medical doctors, administrative staff)
3. Specific relevant departments/professionals such as quality management, human resources, communication, community health, social work, health promotion.
4. Representatives of service users and the community, selected to ensure coverage of target vulnerable groups.

It is important to stress that there is very little value in one person completing the standards' assessment without the involvement of relevant stakeholders, as the results would be subjective and prevent staff and users from being involved in the learning process.

Role of the contact person (local project leader)

It is also also crucial that a contact person within the health care organisation is appointed to lead the process and train other staff in carrying out the standards' assessment. Ideally, this person may already be responsible for the 'Equality and Diversity' programme or other 'migrant-friendly' initiatives in the organisation as the project needs to be run as any other equity improvement activity.

Role of the health service management

Essential to the success of this project is the commitment to the project of the chief executive, governing body and senior managers of the health care organisation, to ensure implementation of the pilot test and to release the necessary resources to undertake the task.

Review form for the pilot test

The form below is to be used in the test. Provided the structure of the scheme is unchanged it may be returned in the national language. However, the national test coordinator must translate the comments and suggestions into English before returning the material to the HPH-Task Force MFCCH office.

HPH Task Force MFCCH
AUSL di Reggio Emilia
Via Amendola, 2
I-42100 Reggio Emilia
Phone: +39 0522 335087
Fax: +39 0522 339638
E-mail: antonio.chiarenza@ausl.re.it

The Review Form can be filled in on line at the HPH website:

http://www.hphnet.org/index.php?option=com_content&view=article&id=18&Itemid=95

The Review Form can be downloaded from the TF MFCCH website:

http://www.ausl.re.it/HPH/FrontEnd/Home/Default.aspx?channel_id=38

Questions	Answers/answer categories	Your Comments
Part 1: General information about your institution		
Contact information:	☐ Keep contact information confidential Name of contact person: Postal address: E-mail address: Phone (include country code):	
Please list the name of your institution.		
What HPH network does your institution belong to (if applicable)		
What type does your institution belong to	☐ Regional/strategic Health Authority (corporate organisation) ☐ General hospital (mainly acute) ☐ Specialized hospital (e.g. children's hospital, trauma centre, psychiatric hospital) ➔ *if yes, which specialization:* ☐ University/Teaching hospital ☐ Long stay hospital (e.g. geriatric hospital, rehabilitation clinic) ➔ *if yes, specify:* ☐ Primary care organisation ☐ Specialised outpatient clinic ☐ Nursing home ☐ Hospice ☐ Community health centre ☐ Health promotion centre ☐ Other type ➔ *if yes, specify:*	
Who is the owner / provider of your institution **Multiple answers possible**	☐ Public, state / region ☐ Public, community ☐ Private owner, non-profit ☐ Private owner, for profit ☐ Health / social insurance ☐ Charity organization (e.g. church, monastic order) ☐ Other, which:	
Is your institution part of a formal network	☐ No ☐ Yes, the institution is part of a regional health organisation ☐ Yes, the institution is part of a strategic health organisation ☐ Other type ➔ *if yes, specify:*	
What is the catchment area of your hospital	☐ Rural area ☐ Urban area ☐ Mixed area	
Please describe your organisation in figures:	☐ Number of hospital beds ☐ Number of inpatients treated last year ☐ Number of outpatients treated last year ☐ Number of FTE staff ☐ Population served in the catchment area	

Part 2: Review form

Standard 1. EQUITY IN POLICY

Description of main standard	**The organisation promotes equity by providing fair opportunities in healthcare and contributes to reducing health inequities through the delivery of sustainable and cost effective policies.**											
Objective of standard	**To define how the organisation should develop policies, governance and performance monitoring systems, which promote equity.**											
Comments and suggestions to improve Standard 1												
1.1 Substandard	**The organisation can ensure that its plans, policies and decisions promote equity in all aspects of its activities.**											
Comments and suggestions to improve Substandard 1.1												
Measurable element 1.1.1	The organisation has procedures in place to review the impact of its plans, policies and decisions on equity. [Evidence: Document setting out its process and tools for carrying out equity audit or impact assessment (e.g. Health Equity Audit; Equity Impact Assessment tool).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element				
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐		
Comments on measurable element												
Evidence (Best practice in your organisation)												
Measurable element 1.1.2	The organisation monitors the extent to which its plans, policies and decisions address equity issues for patients and staff. [Evidence: Report showing the extent to which equity issues are addressed by its management (e.g. The report shows that the organisation acts on the findingsof impact assessments).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element				
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐		
Comments on measurable element												
Evidence (Best practice in your organisation)												
Measurable element 1.1.3	The organisation's leaders and decision makers actively promote equity in their work. [Evidence: Equity is included in performance management arrangements for all leaders and decision makers (e.g. Guidance for managers requires them to have at least one performance indicator which addresses equity).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element				
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐		
Comments on measurable element												
Evidence (Best practice in your organisation)												
1.2 Substandard	**The organisation's research, monitoring and evaluation systems can measure equity performance.**											
Comments and suggestions to improve Substandard 1.2												

Measurable element 1.2.1	The organisation collects data on the way people access its services to understand how service utilisation patterns reflect the demography and meet the needs of the catchment area. [Evidence: Data are available about who is and who is not using its services according to the same need (e.g. Compare data on access of service users with statistics about social stratification, gender, nationality, origin, religion, aboriginal, ethnicity, disability and age breakdown of the population).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 1.2.2	The organisation collects data on the health status and inequalities in its catchment area. [Evidence: Data or information collection about the health needs of relevant populations which allow health inequalities to be identified (e.g. Epidemiological and socio-demographic data in relevant areas/districts and target population groups; Quantitative and qualitative information).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 1.2.3	The organisation uses this data to continually improve equity in the accessibility and quality of health care. [Evidence: Evidence-based outcomes showing service equity improvements (e.g. Documented variation in the number and range of individuals accessing a diabetes or asthma clinic).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
1.3 Substandard	**The organisation has a plan, resources and budget to promote equity. This plan is integrated with existing performance management and accountability systems.**									
Comments and suggestions to improve Substandard 1.3										
Measurable element 1.3.1	The organisation has an equity plan or strategy, which is reviewed regularly. [Evidence: Written strategy or plan, which sets out the actions it will take to address equity issues (e.g. The equity plan includes mission statement, objectives, allocation of resources, duration, responsibilities).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 1.3.2	Implementation of the organisation's equity plan is included in the overall strategy of the organisation. [Evidence: The overall strategy makes specific reference to the equity plan (e.g. The equity plan has equal weight to quality improvement and risk management objectives and is integrated with them).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										

Measurable element 1.33	The organisation includes progress on equity in its mainstream performance reports. [Evidence: Mainstream reports include specific equity measures (e.g. Equity measures in patient satisfaction, complaints and patient safety reports).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
1.4 Substandard	**The organisation ensures that staff at all levels has awareness and competence to address inequities in health care.**									
Comments and suggestions to improve Substandard 1.4										
Measurable element 1.4.1	The organisation has a comprehensive programme for equity training and challenging attitudes towards equity issues for all staff. [Evidence: Training plans show appropriate training is delivered to all staff, including senior staff (e.g. The plan sets out which staff should receive basic awareness training, and which should receive more advanced training on specific).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 1.4.2	The organisation's mainstream training includes learning about equity. [Evidence: Mainstream training is reviewed for inclusion of equity issues where this is appropriate (e.g. Equity is part of the core induction training and training updates).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 1.43	The organisation monitors and evaluates the effectiveness of its equity training. [Evidence: Data is available on the number of staff who has completed equity training. Mechanisms are in place to evaluate changes in staff attitudes, knowledge and skills (e.g. Credit system for on going learning and professional development; Pre and post assessment of training; Mystery shoppers; Patient feedback, Complaints or other similar sources to evaluate training).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Final comment. Do you feel that other sub-standards or measurable elements should have been included?										

Standard 2. EQUITABLE ACCESS AND UTILISATION

Description of main standard	**The organisation ensures equitable access to and utilisation of services.**
Objective of standard	**To encourage the health organisation to address barriers which prevent or limit people accessing and benefiting from health care services.**
Comments and suggestions to improve Standard 2	
2.1 Substandard	**The organisation ensures that accessibility and availability of health services are equitable.**
Comments and suggestions to improve Substandard 2.1	

		Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
Measurable element 2.1.1	The organisation continually seeks to identify and monitor access barriers to its services. [Evidence: Data collection to identify and monitor barriers, which prevent or discourage people from making use of services (e.g. Access or architectural audits for buildings; Language needs assessments; Information material audits; Findings from impact assessments).]	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 2.1.2	The organisation has minimised architectural, environmental and geographical barriers to its facilities. [Evidence: Formal procedures or policy for ensuring that buildings and facilities are assessed for their accessibility and geographical distribution (e.g. Clear signs and directions; Welcoming environments; Diversity friendly; Wheelchair accessible; Facilities are close to public transport; Services are provided to rural areas).]	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 2.1.3	The organisation ensures access to care for disadvantaged groups. [Evidence: Formal procedures for ensuring access to available services for the more disadvantaged people or people at risk of discrimination (e.g. Drop-in primary health care unit based in hospital, Care pathways for HIV/AIDS patients or disabled patients; Access to AE services for alcoholic patients, homeless people; Use of case management workers).]	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 2.1.4	The organisation evaluates the impact of interventions and programmes targeting reduction of access barriers. [Evidence: Quantitative and qualitative evaluation of intervention' outcomes; Assessment criteria are identified (e.g. Pre and post evaluation of implemented measures; Enhanced satisfaction experienced by patients and carers).]	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										

2.2 Substandard	**The organisation develops initiatives to reduce communication and information barriers.**											
Comments and suggestions to improve Substandard 2.2												
Measurable element 2.2.1	The organisation takes into account health literacy needs when communicating with people and providing information. [Evidence: Policy and/or standards for information and communication with patients and the public (e.g. Procedures for involving users in developing written materials; Guidelines for written communication; Information about preventive services and health education programmes; Navigation support services; Use of Community Health Educators).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element				
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐		
Comments on measurable element												
Evidence (Best practice in your organisation)												
Measurable element 2.2.2	The organisation has a clear policy setting out how it will ensure that patients can communicate with services where language may be a barrier. [Evidence: Written policy on interpretation, translation, intercultural mediation and communication support (e.g. Guidelines for staff in organising interpreters or communication support; Eligibility criteria for accessing interpreting or intercultural mediation services).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element				
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐		
Comments on measurable element												
Evidence (Best practice in your organisation)												
Measurable element 2.2.3	The organization makes professional interpreting services available and widely promotes this. [Evidence: Explicit forms of financing for medical interpreters or intercultural mediators; Interpreting services available on request; Inclusion of interpreting services in the organizational routine (e.g. Scheduling system; Distribution of language identification chart; Flyers to inform patients and staff about how to access service; Assessment for interpreting needs in admission procedures).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element				
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐		
Comments on measurable element												
Evidence (Best practice in your organisation)												
Measurable element 2.2.4	The organization monitors and evaluates the performance and quality of interpreting services. [Evidence: Documentation for tracking volume increase; Performance records of interpreting provision; Qualification criteria for interpreters; Defined criteria for interpreting quality; Defined interpreting code of conduct (e.g. Patient and staff surveys addressing awareness, satisfaction, resources, and perceived needs; Evaluate the advantages and disadvantages of using the service; Competence standards for interpreters).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element				
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐		
Comments on measurable element												
Evidence (Best practice in your organisation)												

Measurable element 2.2.5	The organisation ensures staff ability to work with interpreters. [Evidence: Training for staff about how to work with interpreters (e.g. Pre-post assessment to evaluate impact of training; Involving an interpreter in induction training for new staff; Promoting the interpreting service in internal communications).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
2.3 Substandard	**The organisation develops initiatives to increase user trust.**									
Comments and suggestions to improve Substandard 2.3										
Measurable element 2.3.1	The organisation provides outreach communication to disadvantaged populations. [Evidence: Relevant information about available outreach services; Evidence of how well these are used (e.g. Meetings with hard to reach groups; Information on services for refugees, and asylum seekers, aboriginal peoples, sex workers, homeless people, LGBT,... ; Mobile clinics).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 2.3.2	The organisation is able to ensure that complaints and feedback on equity issues are identified and addressed in a transparent manner. [Evidence: Complaints process allows for collection and monitoring of perceived discrimination (direct or indirect) and unequal treatment (e.g. The organization complaints process includes equity categories; Procedures are in place to take action on identified inequalities; The staff who deal with complaints are trained to address equity issues).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
2.3 Substandard	**The organisation develops initiatives to increase user trust.**									
Comments and suggestions to improve Substandard 2.3										
Measurable element 2.3.1	The organisation provides outreach communication to disadvantaged populations. [Evidence: Relevant information about available outreach services; Evidence of how well these are used (e.g. Meetings with hard to reach groups; Information on services for refugees, and asylum seekers, aboriginal peoples, sex workers, homeless people, LGBT,... ; Mobile clinics).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										

Measurable element 2.3.2	The organisation is able to ensure that complaints and feedback on equity issues are identified and addressed in a transparent manner. [Evidence: Complaints process allows for collection and monitoring of perceived discrimination (direct or indirect) and unequal treatment (e.g. The organization complaints process includes equity categories; Procedures are in place to take action on identified inequalities; The staff who deal with complaints are trained to address equity issues).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
2.4 Substandard	**The organisation is able to ensure that healthcare is provided where eligibility rules compromise human rights.**									
Comments and suggestions to improve Substandard 2.4										
Measurable element 2.4.1	The organisation monitors situations where people are unable to access services because of lack of eligibility. [Evidence: Information and data collection about people who are ineligible for health care (e.g. System to identify and keep track of people who are ineligible for financial or legal reasons, such as non-insured people; undocumented migrants; asylum seekers).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 2.4.2	The organisation is able to ensure that people who are ineligible for health care receive appropriate support. [Evidence: Concrete solutions to ensure that ineligible people receive appropriate information, care and support (e.g. Informal provision of health care; Referral to local civil society groups or NGOs; Services for irregular migrants where legislation permits this).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Final comment. Do you feel that other sub-standards or measurable elements should have been included?										

Standard 3. EQUITABLE QUALITY OF CARE

Description of main standard	**The organisation provides high quality, patient-centred care for all, acknowledging the unique characteristics of the individual and acting on these to improve individual health and wellbeing.**
Objective of standard	**To assist the organisation in developing the following areas so that they respect the uniqueness of patients: patient assessment; staff / patient interactions; safe environment; discharge and continuity of care.**
Comments and suggestions to improve Standard 3	

3.1 Substandard	**The organisation ensures that individual characteristics, experiences and living conditions are considered alongside the assessment of health needs.**										
Comments and suggestions to improve Substandard 3.1											
Measurable element 3.1.1	The organisation is able to identify patients' needs according to their individual characteristics and experience. [Evidence: Needs assessment procedures include information about individual characteristics and background of each patient (e.g. Health records explicitly include information such as age, language preference, health literacy level, physical ability, cognitive impairment, ethnicity, aboriginal status, religion, socio economic status, social).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element											
Evidence (Best practice in your organisation)											
Measurable element 3.1.2	The organisation is able to recognise the psychosocial needs of individual patients. [Evidence: All patients are asked about psychosocial needs, and these are documented in health records (e.g. Family situation and living conditions; Routine assessment of individual psychosocial functioning and vulnerability; Investigation of individual beliefs and practices).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element											
Evidence (Best practice in your organisation)											
3.2 Substandard	**The organisation's workforce is able to deliver care that takes into account individual patients' ideas and experiences of health and illness.**										
Comments and suggestions to improve Substandard 3.2											
Measurable element 3.2.1	The organisation takes account of the individual characteristics and experience of each patient in clinical practice. [Evidence: Equity related characteristics are integrated in clinical practice (e.g. Care plans include sensitivity to difference concerning individual patient; Guidelines are subjected to equity impact assessment developed in partnership with diverse patients).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element											
Evidence (Best practice in your organisation)											

Measurable element 3.2.2	Care is considerate and respectful of the patient's dignity, personal values, knowledge and beliefs regarding health and care. [Evidence: Patient experience feedback in the areas of dignity, respect and personal beliefs is routinely requested by staff (e.g. Request for feedback on patient views about nutrition, religion and spiritual help, language assistance, pain management, rituals).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element				
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐		
Comments on measurable element												
Evidence (Best practice in your organisation)												
Measurable element 3.2.3	The organisation has procedures to meet the psychosocial needs of individual patients. [Evidence: Procedures for dealing with patients who are identified as being at risk (e.g. Referral to specific support organisations, such as Counselling services, Social services, NGOs, Mental health services).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element				
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐		
Comments on measurable element												
Evidence (Best practice in your organisation)												
Measurable element 3.2.4	The organisation ensures that staff training includes best practice guidance on how to elicit the patient's story and ideas of illness and health care. [Evidence: Staff training includes learning on how to work across differences, illness narratives, relevance of considering individual characteristics and situation (e.g. Reports into patient satisfaction, adherence to care plans; Follow-up visit attendance; Self-care success rates; Feedback from patients).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element				
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐		
Comments on measurable element												
Evidence (Best practice in your organisation)												
3.3 Substandard	**The organisation is able to create an environment that makes the patient feel safe, where there is no threat to his/her dignity or denial of individual identity.**											
Comments and suggestions to improve Substandard 3.3												
Measurable element 3.3.1	The organisation strives to create an environment, which is inclusive for all patients regardless of individual identity. [Evidence: Policies to challenge discrimination, bullying, harassment and abuse and widely promotes these (e.g. Publicity materials; Patient information materials are inclusive for diverse patient groups; Facilities' interiors do not contain elements, which could be considered offensive or disrespectful to some individual cultures).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element				
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐		
Comments on measurable element												
Evidence (Best practice in your organisation)												
Measurable element 3.3.2	The organisation is sensitive to patient needs for privacy during care and treatment. [Evidence: All patients are informed about their own right to privacy as well as other patients' rights to privacy (e.g. Sensitive information about patient's right to privacy; Patient expectations of needs for privacy are identified and specific needs are recorded in patient records).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element				
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐		
Comments on measurable element												
Evidence (Best practice in your organisation)												

3.4 Substandard	**The organisation takes into account individual patients' characteristics, experiences and living condition to ensure effective discharge and continuity of care.**										
Comments and suggestions to improve Substandard 3.4											
Measurable element 3.4.1	The organisation ensures that the socio-cultural context and individual characteristics of all patients are taken into account at discharge. [Evidence: Discharge procedures and communication clearly includes reference to the individual characteristics and social context of the patient (e.g. Discharge letter available in different languages; Discharge takes different family circumstances into account).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 3.4.2	The organisation has a planned approach to collaboration with other health service providers and organisations in order to ensure continuity of care. [Evidence: Written plan for collaboration with partners to improve the patients' continuity of care (e.g. Plan for discharge).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Final comment. Do you feel that other sub-standards or measurable elements should have been included?										

Standard 4. INCLUSIVE USER AND COMMUNITY

Description of main standard	**The organisation ensures equitable involvement and participation of users and/or community groups in how services are planned, delivered and evaluated. Users and community groups are seen as active participants rather then passive recipients.**									
Objective of standard	**To support the organisation in developing involvement processes sensitive to the needs and preferences of individuals and groups so that everybody has an equal opportunity to benefit from these processes.**									
Comments and suggestions to improve Standard 4										
4.1 Substandard	**The organisation is able to identify and involve users and groups who have an interest in the focus of its involvement process.**									
Comments and suggestions to improve Substandard 4.1										
Measurable element 4.1.1	The organisation is able to identify the individuals and groups likely to be excluded from its involvement processes. [Evidence: Statistical data of service users; List of local community groups; Consultation handbook; Supplement statistical data with information from community based networks or organisations (e.g. Minority Ethnic groups; Aboriginal populations; Young people; Older people; Faith groups; People with disabilities; LGBT).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 4.1.2	The organisation promotes the inclusion of disadvantaged groups in mainstream involvement activities. [Evidence: Recruiting disabled and other groups in consultation bodies and service forums; Outreach work within 'grassroots' (hard-to-reach) groups (e.g. 'Grassroots' consultations; Consultation with equal opportunities or human rights commissions; Disability rights commission).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 4.1.3	The organisation monitors and evaluates the extent to which individuals and groups participate in its involvement activities. [Evidence: Systematic monitoring of the involvement process; Monitoring the level of compliance to involvement activities (e.g. Composition of advisory or consultation bodies; Register of involvement; Register of key stakeholders such as organisations representing patients, carers or community groups).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
4.2 Substandard	**The organization identifies and overcomes barriers to effective involvement.**									
Comments and suggestions to improve Substandard 4.2										

Measurable element 4.2.1	The organization is able to identify and meet the communication needs of individuals and groups to enhance participation and feedback. [Evidence: Communication methods to improve involvement and participation; Accessible information material for consultation (e.g. Information about involvement opportunities in different languages; Use of plain language; Use of Community Health Educators; Braille; Large print).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element			
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐	
Comments on measurable element											
Evidence (Best practice in your organisation)											
Measurable element 4.2.2	The organisation is able to identify and meet the support needs of involved individuals and groups in order to enhance participation. [Evidence: Systems for recording people's support needs (e.g. Accessible venues; Transport arrangements; General assistance; Provision of food; Sign language and interpretation support; Timing of events).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element			
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐	
Comments on measurable element											
Evidence (Best practice in your organisation)											

Measurable element 4.2.3	The organization uses methods of involvement that enhance inclusive participation. [Evidence: Participatory approach to consultation; Arrange meeting where target groups normally meet (e.g. Use inclusive methods that effectively outreach to hidden 'sub-groups' such as people who are housebound; in residential care or in rural areas; Involve people in design of tools; Interactive workshops).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element			
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐	
Comments on measurable element											
Evidence (Best practice in your organisation)											

Measurable element 4.2.4	The organization ensures that staff training on user and community involvement includes best practice guidance on how to engage with disadvantaged people. [Evidence: User and community involvement is part of the core staff training; Staff training includes learning on how to identify and overcome barriers to effective involvement (e.g. Effective communication strategies; Effective consultation and engagement methods).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element			
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐	
Comments on measurable element											
Evidence (Best practice in your organisation)											
4.3 Substandard	**The organization has an empowering evaluation system of participatory processes in which users and community groups are involved.**										
Comments and suggestions to improve Substandard 4.3											

Measurable element 4.3.1	The organisation evaluates its methods of involvement including relevant groups in the evaluation process. [Evidence: Evaluation system to assess, prevent and eliminate potential barriers to participation (e.g. Mechanisms to detect with which aspects communities are most and least satisfied; Tools to assess the impact of community participation in future planning).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 4.3.2	The organisation provides feedback on the results of involvement activities to the community groups and organisations affected. [Evidence: Provide feedback in different formats according to people's needs (e.g. Dissemination of data and reports of involvement activities; Feedback meetings with groups).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 4.3.3	The organisation has systems to record specific feedback from involved individuals and groups and prioritise any actions arising from feedback addressing inequalities. [Evidence: Users and community groups' feedback inform the organisation's Equity plan or strategy (e.g. Assessment tools for evaluating the impact of user and groups participation in service planning).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Final comment. Do you feel that other sub-standards or measurable elements should have been included?										

Standard 5. PROMOTING EQUITY

Description of main standard	**The organisation understands that it is part of a wider system and is able to promote the principles of equity through integration with other services and across sectors.**										
Objective of standard	**To supportthe organisation in promoting equity externally in its wider environment through: advocacy and lobbying; facilitating capacity building; disseminating research; developing education and promotional work.**										
Comments and suggestions to improve Standard 5											
5.1 Substandard	**The organisation is an active participant in networks, think tanks and research initiatives which promote equitable approaches.**										
Comments and suggestions to improve Substandard 5.1											
Measurable element 5.1.1	The organisation promotes research on health interventions and health care innovations targeting vulnerability, in order to maximize their impact on the accessibility and the quality of care. [Evidence: Information on inequities in health and health care and in the residential status are included as relevant categories in research (e.g. Equity issues are included among the criteria for prioritising research recommendation).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element											
Evidence (Best practice in your organisation)											
Measurable element 5.1.2	The organisation builds solid relationships with community based service providers in its area, and develops networks and partnerships to deliver innovative services to disadvantaged populations. [Evidence: Integration plans of health care with social services; Partnerships with NGOs and other agencies for the care of irregular migrants; Targets for the organisation equity strategy relate to the equity activities of collaborative organisations (e.g. One Stop Services; Use of case or care management; Local Strategic Partnerships, Equity monitoring system is compatible with that of other agencies involved in joint working).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element											
Evidence (Best practice in your organisation)											
Measurable element 5.1.3	The organisation builds inter-sectoral collaborations beyond the healthcare system to address the wider determinants of health. [Evidence: Formal links with umbrella agencies of relevant areas/districts (e.g. Cooperation between agencies concerned with social inclusion and those concerned with health promotion and education; Shared social responsibility agreements; Intersectoral interventions).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element											
Evidence (Best practice in your organisation)											
5.2 Substandard	**The organization actively disseminates the results of research and practice which relates to equity.**										
Comments and suggestions to improve Substandard 5.2											

Measurable element 5.2.1	The organisation promotes dissemination of research outcomes and/or information about existing good practices in the development of health interventions towards people in vulnerable situations. [Evidence: Communication plan concerning the dissemination of research outcomes (e.g. Reports addressed to different stakeholders such as the scientific community, decision makers, experts, and the general population).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
5.3 Substandard	**The organisation ensures that equity is reflected in all partnership agreements and relationships, including contracted services, and partnerships.**									
Comments and suggestions to improve Substandard 5.3										
Measurable element 5.3.1	The organisation ensures that partnership and sub-contract agreements reflect equity standards. [Evidence: Contractors are required to provide evidence of their equity strategies (e.g. Equity issues explicitly included in official agreements; Staff of sub-contracted services are trained on equity issues).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Measurable element 5.3.2	The organisation ensures and monitors that sub-contracted services are delivered in an equitable way. [Evidence: Systematic review of sub-contracting processes against the recommended equity standards. Monitoring the performance of contractors in relation to equity duties (e.g. Standards for equity in healthcare; Equity impact assessment reports).]	Measurable element is clear		Measurable element is relevant		Measurable element is applicable		Your organisation fulfils demands in this element		
		yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	yes ☐	no ☐	partialy ☐
Comments on measurable element										
Evidence (Best practice in your organisation)										
Final comment. Do you feel that other sub-standards or measurable elements should have been included?										

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