NEW Devon CCG

Equality Impact Assessment

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Author(s)	Helen Brown
Quality Assurance by	Lucy Farrow
Main point of contact	Lucy Farrow
Telephone	0207 042 8000
Email	lfarrow@opm.co.uk

If you would like a large text version of this document, please contact us.

OPM Group

252B Gray's Inn Road
London
WC1X 8XG

+44 (0)20 7042 8000
www.dialoguebydesign.co.uk
info@dialoguebydesign.co.uk

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1. Introduction: the context for this Equality Impact Assessment

1.1. Changes to healthcare in NEW Devon

NEW Devon is located in the South West of England and covers a population of 883,000 people. This large geographical area (2,330 square miles) includes many smaller towns and villages and rural areas including the Dartmoor National Park. Health and social care spending on the residents of NEW Devon was £1.9bn in 2014/15. Health services in NEW Devon are commissioned on behalf of local people by Northern, Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) and NHS England. NEW Devon CCG is the largest CCG in England, by the size of the local population. In 2014/15, in NEW Devon, there were around 5.5 million consultations at GP surgeries, 838,000 contacts with community staff, 190,000 attendances at A&E, 105,000 planned operations performed and 83,000 emergencies that required hospitalisation[1]. There is a complex range of organisations providing these health and social care services in NEW Devon.

A case for change was published as part of the *Transforming Community Services* Strategic Framework in October 2014. This has been updated as part of the work of the Success Regime in NEW Devon. The updated case for change was developed by local clinical and operational leaders across health and social care with involvement from the public and patients. They agree that local services are not keeping pace with the changing needs of local people and it is becoming increasingly difficult to make sure local people have access to consistently high quality care that is affordable and sustainable. This is because:

- People in NEW Devon are living longer, with increasingly more complex care needs that require more support from health and social care services.
- There are 280,000 local people, including 13,000 children, living with one or more long-term condition such as asthma, diabetes, hypertension, cancer and mental illness.
- Local health and social care services are under severe financial pressure and likely to be £384m in the red by 2020/21 if nothing changes.

While there have been some local successes in changing the way services are delivered, there are still many challenges facing local services:

- Care needs to be more person-centred and co-ordinated especially for people with more than one long-term health condition.

[1] Success Regime Trust data returns, Carnall Farrar analysis, 2015

- There are too many people in hospital beds who don't need to be there. Every day 500 people are in local acute hospitals and 150 are in community hospitals when they could be cared for elsewhere.
- When people are ready to leave hospital, local services are often not ready to look after them, so they have to stay in hospital longer.
- Staying longer than necessary in hospital cause harm to patients in reducing muscle function and diminishing the likelihood of returning to live independently at home, as well as exposing them to the risk of infection
- It is expensive - there is a lot of space in community hospitals that is not being used (up to half the space in some hospitals) and the average cost per day is £200 to £300.
- While significant changes have already been made to the pattern of usage of community beds in the North already, the East in particular has double the level of community beds, many of which are occupied by people who are medically fit for discharge.

1.2. The New Model of Care (NMOC) for Eastern Devon

Local clinical experts have been meeting to refresh the vision and model of care developed as part of *Transforming Community Services*, particularly focusing on those patients who are likely to benefit most. *Your Future Care* is an important first step in in the programme of change that will create services which provide the best care for people and are financially sustainable. The model of care is built on a set of principles that include prevention, health and well-being, individual accountability and support; organising care around the needs of the individual; treating people in the lowest intensity setting possible, and using in-patient beds only for those who most need them. The intention is to improve outcomes, improve access and deliver a better patient experience.

The new model of care addresses in particular the needs of those people who have greatest contact with health and social care services, including frail and elderly people, people with dementia, and people with chronic conditions affecting both physical and mental health. The intended benefits of the new model of care are:

- **Improved clinical outcomes for patients**: less harm caused by bed based care; patients healed faster and more effectively: improved targeting of investigations; better and faster clinical decisions.
- **Improved experience for patients and carers**: many more people treated at or closer to home; need for travel removed or drastically reduced for many patients and carers; provision of care from the best facilities (*PCBC Figure 17*)

In practice this will mean:

- **Putting in place a care plan** for all frail or pre-frail people who are at risk of hospital admission
- Providing **a single point of access** to support people to remain at home

- Where hospital admission is unavoidable provide **coordinated discharge** from hospital with **additional support at home**

These stated intentions have informed the **scope of this Equality Impact Assessment.** Both patients and their carers, who generally share a similar demographic, have been considered in relation to the likely impact of the proposed changes in services. In terms of protected characteristics, we have reviewed the likely impact on patients and carers in terms of **age, disability, sex, race, and religion or belief** as far as available data permit. Other protected characteristics have not been considered.

3. The Equality Act 2010 and the Public Sector Equality Duty

3.1. Public Sector Equality Duty (PSED)

Under the Equality Act 2010 a public authority (and a person exercising public functions) is subject to the PSED. This requires public bodies to have due regard to three aims:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

The Equality Act explains that the second aim in particular involves having due regard to the need to:

- Remove or minimise disadvantages affecting people due to their protected characteristics.
- Take steps to meet the needs of people with certain protected characteristics where they are different from the needs of other people.
- Encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

In addition, the Equality Act 2010 requires decision-makers to make reasonable adjustments in certain circumstances, particularly in relation to disabled people. The Act makes it lawful to treat a disabled person more favourably that a non-disabled person.

3.1.1. **Protected characteristics and protected groups**

The list below outlines each protected characteristic relevant to the PSED and provides a short definition.

Age: This refers to persons defined either by a particular age or range of ages. For example, pre-school 0-4; very old people 75+

Disability: A disabled person is defined as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities

Sex: this refers to a man or to a woman or to a group of people of the same sex, (while **gender** refers to the wider social roles and relationships that structure men's, women's, boys' and girls' lives).

Race: The Equality Act 2010 defines race as encompassing colour, nationality (including citizenship) and ethnic or national origins

Religion or belief: Religion means any religion a person follows. Belief means any religious or philosophical belief and includes people who have no formal religion or belief. ONS uses defined terminology to identify major religious affiliations.

Gender reassignment: this refers to persons who are proposing to undergo, are undergoing, or have undergone a process for the purpose of reassigning their gender identity

Pregnancy and maternity: Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after birth. In the non-work context protection against maternity discrimination is for 26 weeks after giving birth

People who are **Married or in a Civil Partnership,** compared to those who are not

Sexual orientation: a person's sexual orientation relates to their emotional, physical and/or sexual attraction and the expression of that attraction.

3.1.2. Purpose of an Equality Impact Assessment (EIA)

An EIA assesses a strategy, project or scheme to identify whether people with protected characteristics are likely to be affected disproportionally or differentially by impacts arising as a result of (in this case) changes in the pattern of provision of health services in Eastern Devon.

In this case **disproportionate equality effects** may arise:

- in the impact on people in the area in question where people sharing a protected characteristic make up a greater proportion of the affected resident population than their representation in the wider area, in this case Devon as a whole and/or England,
- where an impact is predicted on changes to a community resource predominantly or heavily used by people sharing a protected characteristic (e.g. primary schools, care homes), in this case community hospital beds.

A **differential equality effect** is one which affects members of a protected group differently from the rest of the general reference population because of specific needs, or a recognised sensitivity or vulnerability associated with their protected characteristic (e.g. a disabled person's need to travel further because services have been relocated).

In some cases, members of a protected characteristic group could be subject to both disproportionate and differential equality effects.

4: Scope of this Equality Impact Assessment

4.1 Devon's response to the Equality Act

Devon County Council's Joint Strategic Needs Assessment 2015 states that: 'In terms of health and wellbeing, our response to the Equality Act should lead to a healthier population because it includes:

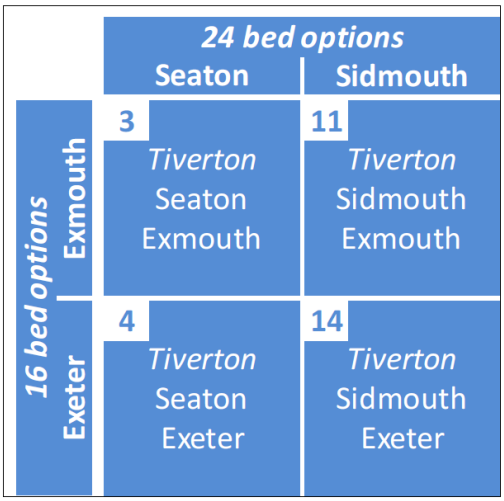
- Ensuring no-one is discriminated against in the delivery of services (including the provision of health information). Discrimination includes indirect discrimination which is a 'provision, criteria or practice' that puts a person at a disadvantage and cannot be justified. This means ensuring that people feel they have equal access to and quality of healthcare treatment, which may mean they are treated differently in order to meet a particular need or overcome a barrier to accessing the service
- Having a better understanding of people's needs by analysing and publishing information about health outcomes for different protected characteristic groups
- Considering the duty to advance equality by setting specific and measurable objectives and targets to reduce health inequalities between protected characteristic groups.

4.2. Options for community hospital beds in Eastern Devon

This Equality Impact Assessment has been carried out in relation to proposed changes to the provision of community hospital beds in Eastern Devon. This will further inform and be informed by the forthcoming stakeholder consultation.

To develop a set of preferred options the CCG, working with clinical leads and other stakeholders, first used an agreed set of 'hurdle criteria' (*set out in PCBC 1.11*) to identify an initial set of options. Tiverton was established as a fixed point due to the high quality estate with its PFI commitment and its large scale.

Further evaluation criteria including **patient access** (average travel times and longest travel times) and **access for carers** (average and longest travel times, parking availability) were applied, resulting in four viable options for consultation, shown below. This Equality Impact Assessment considers only the four viable options.



In all cases Tiverton will continue to provide community beds. Under the viable options there will be a removal of community inpatient beds in Honiton and Okehampton and at two other sites, depending on which option is finally selected (*PCBC 1.13*).

4.3 Protected characteristics in scope

Based on the demography of those patients and carers who are likely to be affected by the proposed changes, the following protected groups and characteristics have been considered in conducting this EIA:

- **Disability,** the incidence of long term health problems or disability which limits day-to-day activities. This therefore includes both physical and mental disabilities, particularly dementia which affects many of those in the relevant population
- **Age,** specifically elderly people (70+) and very elderly people (85+), since the community hospital beds under consideration are used very substantially (over 90% of bed days) by older people
- **Sex:** 71% of people over 90 in Devon are women and so we may reasonably assume that there will be more women among the patients who may be affected by the proposed changes.
- **Race.** While the population of Devon is predominantly White several BME groups are represented across the whole population, and in greater concentration in some urban areas, particularly Plymouth and Exeter. Devon's Joint Strategic Needs Assessment 2015 reports some differences in overall health/ ill heath patterns in different ethnic populations.
- **Religion or belief** Devon is not an area where religions or beliefs other than Christianity are very prevalent in the population. However, there is a Muslim community in Exeter, and a range of religions represented across the population. This may have implications for the nature of health care facilities and cultural awareness in the ways in which services are delivered.

Other protected groups and characteristics have not been considered:

- **Gender reassignment**: Gender reassignment affects very small numbers of people and is not a component of census data, nor are gender reassignment services affected by the proposed changes.
- **Pregnancy and maternity**: pregnancy and maternity are transient states which can, to an extent, be inferred from the gender and age profiles, and are not relevant in relation to the current scope. No maternity services are affected by the proposed changes.
- **Marriage and civil partnership**: not considered likely to be a basis for differential treatment in relation to the scope of this EIA and have not been considered here.

- **Sexual orientation**: gathering information about sexual orientation usually requires specific surveys which have not been undertaken in this instance. There is no immediate evidence that proposed changes will have an impact.

Within the protected characteristics in scope – age, disability, sex, race and religion or belief - we considered two populations who could be affected by the proposed changes: patients and carers

4.2.1. Patients

Current and future users of the community bed services in the affected locations. In the last calendar year there were approximately 1,250 overnight admissions to community hospitals in Eastern Devon –without intervention it is expected that the future number of patients would be at least this number - the expected growth in the number of older people in Eastern Devon will mean more people with health needs such as diabetes, heart disease, stokes and cancer. This means more people are likely to need care and treatment as they get older.

The proposals suggest that care will be delivered differently for patients, depending on their particular needs. Bed days will be reduced for those patients who would benefit from returning home relatively quickly, sicker patients who are admitted will probably stay longer in hospital. The present assumption is that all 1,250 potential patients are within the scope of this assessment.

4.2.2. Carers

That is those supporting and visiting users of the community beds services in the affected locations. It is generally true that people with long term conditions are likely to have an informal carer who is a spouse or adult child and these carers also need to be supported.

No data is collected by NEW Devon about the incidence of visitors to community hospitals, their demographic mix, or the proportion of community hospital patients who have one or more carers. For the purposes of this assessment it has been estimated that each patient will have one main visitor/carer who will visit around 4 times in a week. As discussed under recommendations in chapter 6, additional data should be collected to enable the equality impacts of these changes to be considered more fully.

Based on the assumptions of NMOC, with an anticipated reduction in the number of patients admitted to community hospitals overnight and with longer lengths of stay for fewer patients, we can estimate that fewer than 1,250 carers/visitors will be affected by the removal of beds. As it cannot be accurately predicted how many patients will not be admitted at all, and how many discharged more quickly, this might be better calculated as a reduction in visits of around 30% (corresponding to the reduction in bed days). This suggests up to 2/3 of visitors/ carers (some 875 individuals) may be affected by a change in the location of care in the future, once the agreed changes have been implemented. The remaining 1/3 (or 375 individuals) will be affected by a change in the setting of care from the community hospital to the home.

5. Overview of population characteristics of the area

2.1 Age[2]

More than 1 in 5 people in NEW Devon are over 65, which is higher than the national average, and this will be almost to 1 in 4 people by 2021[i]. The number of very elderly people is also high, with 3.1% people in NEW Devon over the age of 85 compared to 2.3% on average across England. More of these older people live in Eastern Devon and fewer in Western Devon but all areas are seeing growth in the number of older people, in common with the rest of England.

- In **Western Devon**, people mainly live in and around the city of Plymouth and are relatively young (near the England average), more deprived and more urban than the people in the east and the north.
- The people in **Eastern Devon** are comparatively much older, more affluent and live in more rural locations. Eastern Devon has a higher proportion of very old people (aged 85+) than almost anywhere else in England.
- The people in **Northern Devon** are also comparatively old (although with a lower proportion of very old people than in the east) with pockets of deprivation, especially in Barnstaple. People in Northern Devon tend to live in more rural locations.

2.2 Disability characteristics of the area

Devon County Council's Joint Strategic Needs Assessment 2015 reports that:

> *"According to the 2011 Census, 8.6% of Devon residents reported having a long-term health problem or disability that limits their day-to-day activities a lot and has lasted, or is expected to last, at least 12 months (including problems related to old age), with 10.9% reporting their day-to-day activity were limited a little, a total of just under one in five (19.5%).[3]"*

This is comparable with the national figure of 8.3% of people reporting that their day-to-day activities are limited a lot.

[2] Data reported in PCBC

[3] Accessed via http://www.devonhealthandwellbeing.org.uk/jsna/overview/ 15/9/2016

Across Devon as a whole there are over 45,000 people who are blue badge holders[4] although the prevalence of disability varies substantially between sub areas. The chart below shows the distribution of disability by age and sex in the NEW Devon area, based on 2011 census data. It shows that disability increases significantly with age, and becomes more prevalent in males from age 75 onwards.

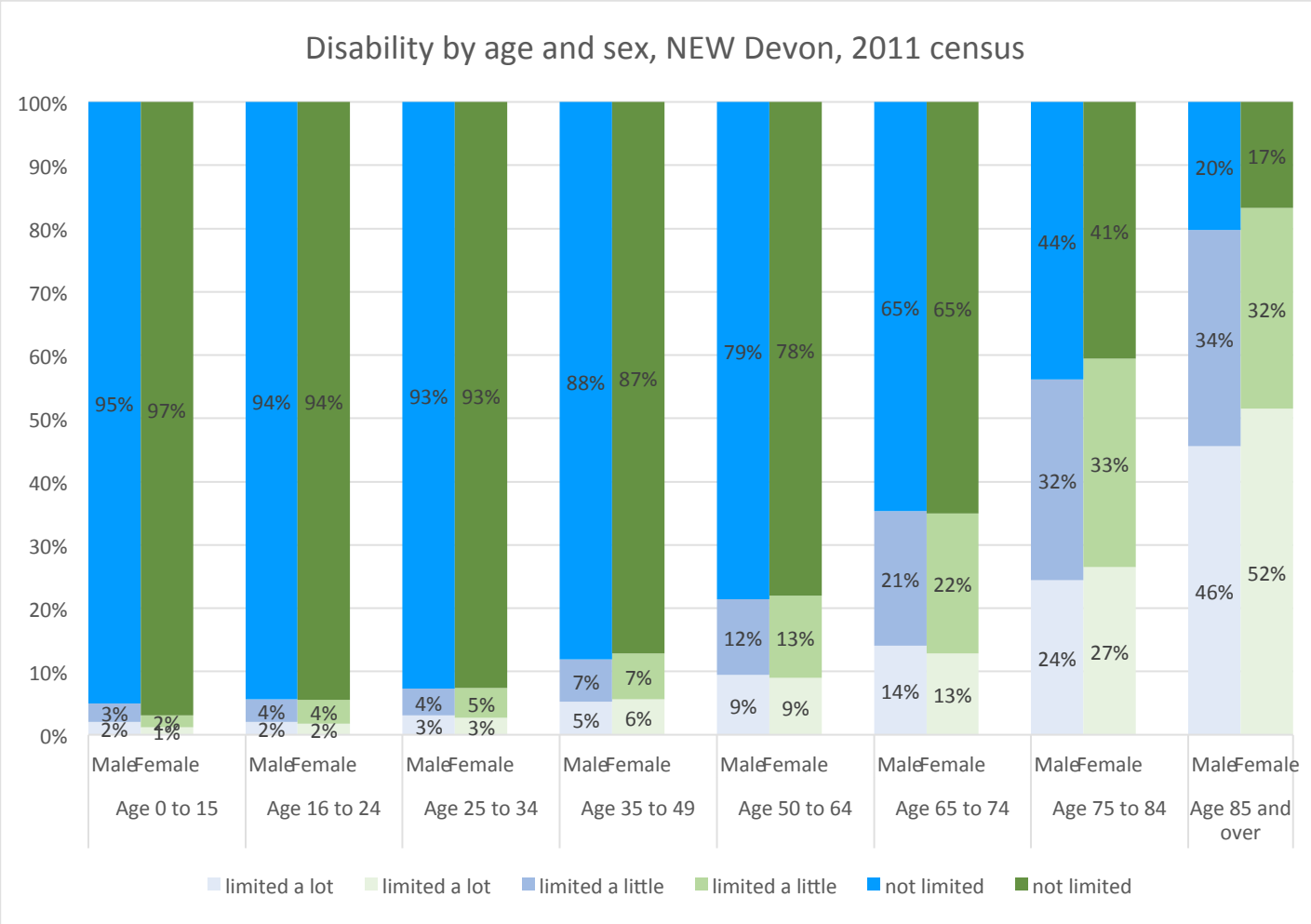


Figure 1

2.3 Profile of the area by sex

2011 census data for the NEW Devon geographical area shows that overall women make up 51.2% of the population, but that for people aged 85 and over this percentage rises to 68%, as shown in figure 3 below. These proportions are very similar to the more recent Devon County

[4] Information provided by Devon County Council, September 2016

Council Joint Strategic Needs Assessment 2015 with 51.4% women overall rising to 71.0% for people aged 90 and over.

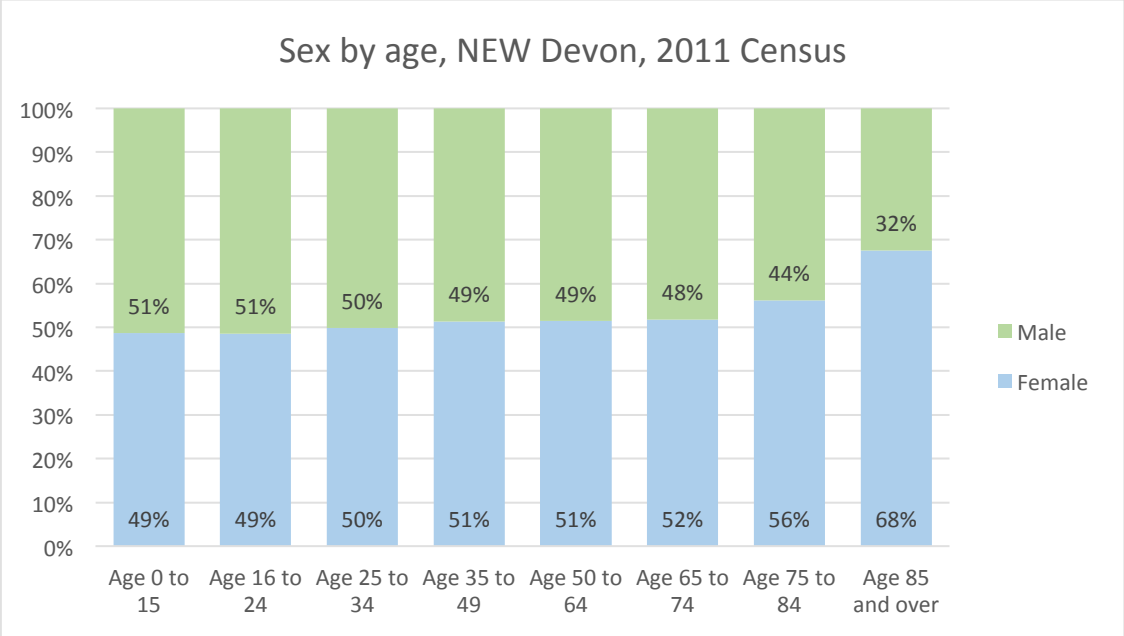
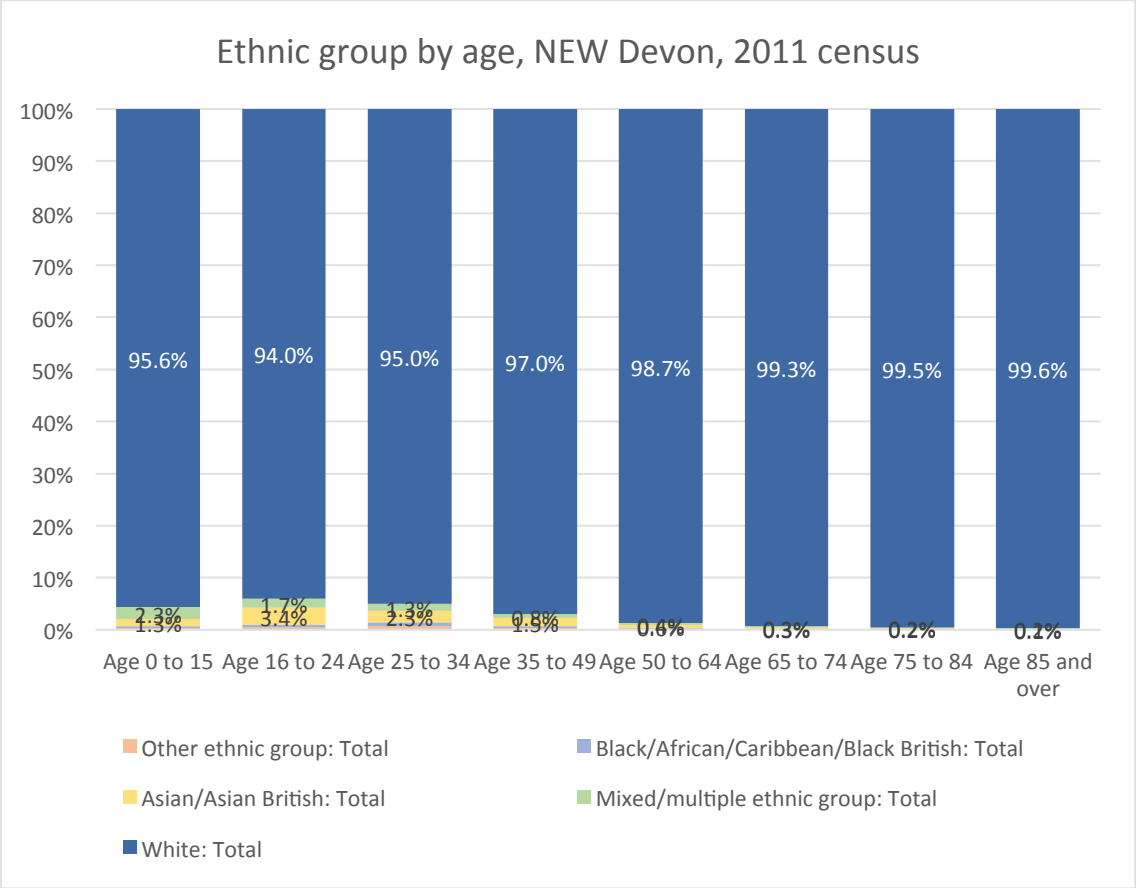


Figure 2 Sex by age, NEW Devon, 2011 census

2.4 Race

2011 census data shows that within the NEW Devon geographical area the population predominantly identifies as white, at 97%. Of a total population of around 870,000 approximately 26,000 identify with a non-white ethnicity. As shown in figure 3 below this proportion decreases with age – in the 85 and over age group 99.6% of NEW Devon residents are White.

Race is highly unevenly distributed across the NEW Devon geographical area. The BME population is largely concentrated in the two urban centres: Plymouth and Exeter.



2.5 Religion or belief

Across Devon as a whole religions other than Christianity are not very prevalent in the population. As shown below, only Christian is reported by more than 1% of the population in any age group. Prevalence of Christian increases with age, with a corresponding decrease in the proportion of people reporting no religion.

There is some geographical variation in the prevalence of religion or belief across the NEW Devon area. In particular larger cities (Plymouth and Exeter) have relatively larger proportion of residents reporting their religion as Muslim or Other.

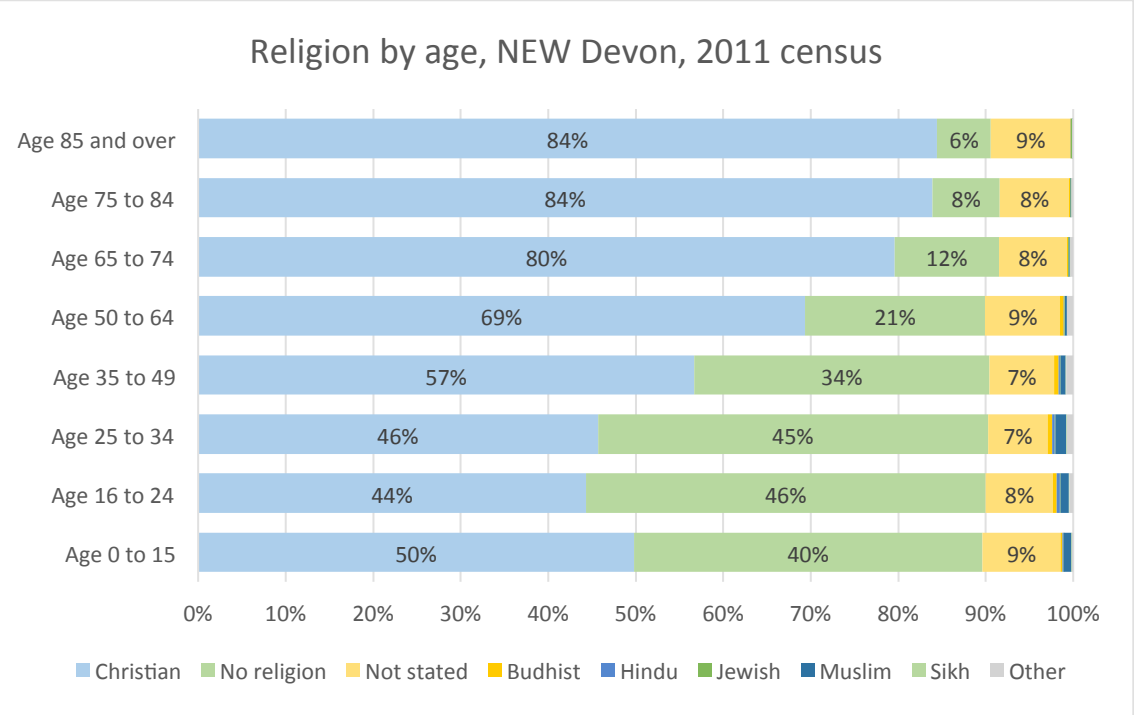


Figure 3 Religion by age, NEW Devon, 2011 census NB: Data labels not shown for values => 1%

6. Assessment

6.1. Nature of the Assessment

The context for and scope of this EIA, described above, leads to the view that one potentially differentiating feature of the options proposed in the move to implement NMOC in Eastern Devon is that of changes to **travel times** for patients and carers. In their deliberations the Clinical Cabinet considered this aspect for older patients and carers and for disabled patients and carers, and their work is reprised in this EIA. They did not, however, examine travel times in relation to the sex, race or religion of patients or carers.

A number of other **indicators** of improved health services and improved health outcomes have been proposed – in relation to the nature of health services in Eastern Devon in the Pre Consultation Business Case, and at a population level in the Joint Strategic Needs Assessment 2015. These are set out above in 1.2 (NMOC) and 4.1 (JSNA) and are briefly summarised here.

- **Improvement in population health** which ensure no one is discriminated against in the delivery of services which are based on an understanding of people's varied needs
- **Improved clinical outcomes for patients** in terms of standard morbidity and mortality measures
- **Improved design and delivery of services** which includes: better experiences for patients and carers; individualised care plans: a single point of access; coordinated discharge, and support for people to remain at home.

Work is underway to develop specific targets and indicators by which to assess progress towards these improved health outcomes, outputs and processes. These may include system measures such as use of services like GPs and new home care services, or provider metrics such as bed occupancy and delayed discharge rates.

At this stage of the development of the proposals there is no analysis available to suggest at what level these improvements are anticipated to be. Therefore, the conclusions and recommendations in section 6 encourage the development of data collection and analysis which can be used to assess the equality impact of the changes in relation to protected groups as well as for the affected populations as a whole.

NB: The data below, which is used to set out a baseline from which improvements (or the absence of them) may be judged in this first assessment of equality impact draws on: available information on the demographics of community in-patients provided by North Devon Healthcare Trust for the calendar year August 2015 - 2016; data provided by NEW Devon CCG to inform the PCBC; population data in the 2015 JSNA; and 2011 Census information.

6.2. Age

6.2.1. Older Patients

The PCBC notes that the majority of patients using community beds across all locations in Eastern Devon are elderly. Over 90% of bed days in 2014/15 were occupied by patients who were 70 or older, and 91% of people admitted to Eastern community hospitals in 2015/16 were 70 or older.

An ageing population is significant because older people are more likely to develop long term health needs such as diabetes, heart disease and breathing difficulties, and are more at risk of strokes, cancer and other health problems – which together means people tend to need more care and more treatment as they get older. In NEW Devon almost 40% of health and social care expenditure is used for people aged over 70, even though they make up only 15% of the population. One third of the hospital beds in NEW Devon are occupied by someone over the age of 80 and two thirds of the people staying more than 10 days in hospital are over the age of 70[xix].

Impacts and benefits

The impact of **travel time** on people with protected characteristics who are potentially affected by the proposals was reviewed for older patients as the majority of people in community inpatient beds are older.
However, as all patients requiring bedded care will be conveyed to and from whichever sites are chosen access is not a differentiating criterion for patients. Based on this information the Clinical Cabinet agreed that **there is no difference between the options in terms of access for older patients.**

Improvement in population health – targets and measures to be developed

Improved clinical outcomes for patients – targets and measures to be developed

Improved design and delivery of services – targets and measures to be developed

Although specific measures have not yet been developed the data and evidence presented in the PCBC suggest that outcomes for elderly patients should improve under the new model.

6.2.2. Older carers

The 2011 Survey of Carers in Households suggests that for carers over 65 the majority (58%) are caring for their spouse[5]. 2014/15 data for Devon as a whole shows that 74.8% of carers were aged 65 or over. This is substantially higher than the comparable figure of 41.8% for

[5] http://www.hscic.gov.uk/pubs/carersurvey0910

older carers across England and indicates that the majority of the carer population in NEW Devon is very likely to be elderly, together with some younger carers supporting parents.

Impacts and benefits

People in community inpatient beds are visited by carers, friends and relatives, many of whom are elderly themselves. **Travel time** to the different locations was therefore identified as the most likely differential impact on elderly carers. Analysis was carried out to identify the likely positive or negative effect of the various options on travel time during the period 8am to 6 pm, relative to the whole population of Eastern Devon.

Difference between travel time impact for whole population & selected populations (minutes)

Positive effect relative to whole population — Negative effect relative to whole population

		Option														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Elderly	Public weekend	-2	-1	-1	2	-1	-1	0	-1	3	1	-1	-1	-2	1	-1
	Public weekday	-2	0	-1	2	-1	-1	0	-1	3	1	-1	-1	-2	1	-1
	Road peak	-2	-1	-1	1	-1	-1	-1	-1	2	1	-1	-1	-2	1	-1
	Road off-peak	-1	0	0	1	0	0	0	0	1	0	0	-1	-1	1	-1

Of the four viable options:

- 3: There was a relative beneficial or neutral effect on travel time
- 4: There was a relative negative effect on travel time of between 1 and 2 minutes
- 11: There was a relatively beneficial or neutral effect on travel time
- 14: There was a relatively negative effect on travel time of around 1 minute

We note however that some visitors/ carers will attend hospital during the period 6pm to 8pm and suggest that the analysis be extended to include this time period. While the average difference between travel times does not suggest a differential impact we also recommend that the consultation process actively engage elderly residents to develop a better understanding of how the increase in overall, rather than average, travel time may affect them.

Improved design and delivery of services – providing better experiences for carers – targets and measures to be developed

6.3. Disability

6.3.1. **Disabled Patients**

There is a significant correlation between age and disability, with around 45% of adults of state pension age and above reporting difficulty with day-to-day activities, relative to 17% of

working age adults[6]. For those aged 80 years and older the proportion increases further to 60%. Given that the majority of patients using community beds in Eastern Devon are elderly, disability levels – both mental and physical - are also likely to be high. (At this time Northern Devon Healthcare Trust (*correspondence 08.09.16)* are not able to provide reliable data on the incidence of different forms of disability among their 2015/16 patient population). Extrapolating from the NEW Devon population level data for the over 65 age groups we can estimate that on average 58% of patients will have some level of disability (measured as having a little or a lot of difficulty with everyday activities). This figure is likely to be higher, given that it individuals reporting some level of difficulty with everyday activities may be more likely to require inpatient treatment.

There are an estimated 10,000 people in NEW Devon with dementia, although only half have a formal diagnosis. More than 2 in 5 people admitted in an emergency have dementia and over 45% of the hospital beds in Devon are occupied by someone with dementia. Specifically, in relation to community beds some 34% are occupied by frail and/or elderly patients and 31% by frail and/or elderly patients with dementia *(PCBC Figure 14).*

The PSED covers all types of disability, physical and mental, which affect day-to-day living. However, dementia is a particular concern within an elderly and ageing population, and is relevant here given the demographics of community bed patients. We know, for example, that older patients with chronic conditions and with dementia take up some 65% of current community beds. As the PCBC notes there are an estimated 10,000 people in NEW Devon with dementia, more than 2 out of 5 people over the age of 70 admitted in an emergency have dementia, and over 45% of the hospital beds in Devon are occupied by someone with reported dementia who is medically fit to leave but has not been discharged.

Impacts and benefits

The new model of care is designed to improve outcomes for all patients, including those with disabilities, and there is no evidence to suggest that the location of the community beds will affect outcomes since patients requiring bedded care will be transported between sites.

Improvement in population health – targets and measures to be developed

Improved clinical outcomes for patients – targets and measures to be developed

Improved design and delivery of services – targets and measures to be developed

5.2.2 Disabled Carers

No direct data are available about the prevalence of disabilities among carers in East Devon. However, we can make some assumptions based on available data. Across Devon the proportion of carers who receive self-directed support is 89.4%. This figure rises to 99.7% in Plymouth, and compares with a figure of 79.7% for England as a whole. Given the increased

[6] Family Resources Survey 2014/15 (latest year published) via

prevalence of disability in older people, and the high proportion of elderly carers in the affected population (carers of Eastern Devon community hospital patients), we can assume there are substantial numbers of disabled people among the relevant carer population.

Impacts and benefits

As for the protected characteristic of age, the most likely impact on carers is via increased transport time as patients may be treated or hospitalised in more distant centres. The same analysis was carried out to assess the difference between travel time impact between hours of 8am and 6pm for those carers with disabilities relative to the whole Eastern Devon population.

Difference between travel time impact for whole population & selected populations (minutes)

Positive effect relative to whole population — Negative effect relative to whole population

		Option														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Disability	Public weekend	-1	0	0	2	0	-1	0	0	2	1	-1	0	-1	1	0
	Public weekday	-1	0	0	1	0	-1	0	0	2	1	-1	0	-1	1	0
	Road peak	-1	0	-1	0	0	-1	0	-1	1	0	-1	-1	-1	0	-1
	Road off-peak	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0

In line with the table above, there are no instances where the relative difference for disabled carers relative to the whole population was greater than two minutes.

Of the viable options:

- 3: There was a relative beneficial or neutral effect on travel time
- 4: There was a relative beneficial or neutral effect on travel time
- 11: There was a relative beneficial or neutral effect on travel time
- 14: There was a relative negative effect on travel time of around 1 minute for public transport only

We note however that some visitors/ carers will attend hospital during the period 6pm to 8pm and suggest that the analysis be extended to include this time period.

> **Improved design and delivery of services – improved experiences for carers:** Indicators and targets to be developed

As with age, we recommend that the consultation stage of this programme actively engage with disabled carers to consider whether absolute, rather than average, increase in travel time poses particular challenges which might generate a differential impact.

5.3 Sex

6.3.2. Male and Female Patients

53.3% of patients admitted to Eastern community hospitals in 2015/16 were female. In terms of sex and disability it is also the case that dementia prevalence rates are higher in women and this, together with their longer lives, means that women with dementia outnumber men by

more than 2:1 in Devon. In contrast, general levels of disability are higher amongst men in the over-65 age groups that make up the majority of community hospital inpatients. Therefore, we can reasonably assume that the populations of patients who may be affected by the proposed changes contain more women than men, but that this difference may be small.

Impacts and benefits

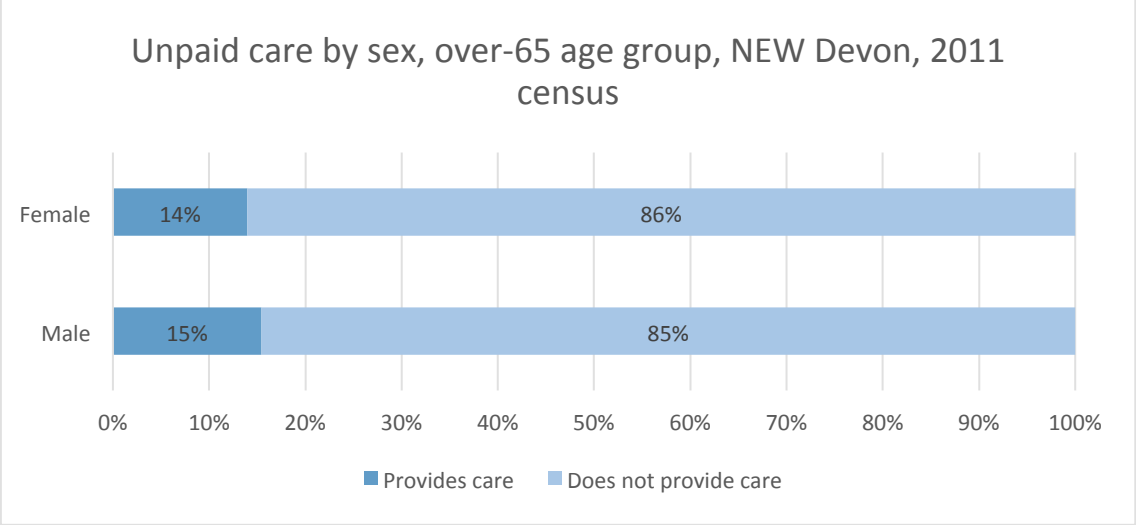
Improvement in population health – targets and measures to be developed

Improved clinical outcomes for patients – targets and measures to be developed

Improved design and delivery of services – targets and measures to be developed

6.3.3. Male and female carers

The prevalence of male and female carers varies according to the age group in question: while women in the 50-64 age group are more likely to be providing care than men, this trend reverses for over the over-85 age group. As shown in the chart below, when calculating based on the NEW Devon population level data for the over-65 age groups, roughly equal proportions of men and women provide care.



Impacts and benefits

Any potential differential impact between male and female carers in terms of travel time was not examined in the analysis conducted by the Clinical Cabinet.

Improved design and delivery of services – improved experiences for carers: targets and measures to be developed

6.4. Race of patients and carers

6.4.1. Race of patients

Patients admitted to Eastern community hospitals in 20115/16 were very substantially White and British, with White patients making up over 99% of all patients for whom ethnicity data was recorded. While we note that ethnicity was not recorded for nearly 10% of patients, extrapolating from the NEW Devon population level data for the over-65 age groups who make up the majority of community hospital inpatients gives a similar figure, with over 99% of patients expected to be White. While this figure may be an overestimate, given evidence of poorer health outcomes for some BME groups[7], the overall figures are likely to remain small, numbering tens of patients.

Improvement in population health – targets and measures to be developed

Improved clinical outcomes for patients – targets and measures to be developed

Improved design and delivery of services – targets and measures to be developed

6.4.2. Race of carers

No data are available on the race composition of carers but we can reasonably assume that it is very similar to that of patients, given that the majority of carers are friends and family. As above the proportion of carers in the affected population (visitors of community hospital inpatients) may be higher than the NEW Devon general population level, the absolute figures are likely to remain small, in the tens of individuals.

We note that Exeter is the only potential site for the removal of community beds that has a significant local non-white population and suggest that the potential for this to generate a differential impact is explored at the consultation stage.

6.5. Religion or belief of patients and carers

6.5.1. Religion or belief of patients

Of those community hospital overnight patients for whom religion was recorded nearly 97% describe themselves as Christian. Other religions present in small numbers are Hindu, Jewish, Pagan and Muslim. However, we note that for over 35% of patients' religion is recorded as 'none' (24%) or 'other' (12%), figures which are inconsistent with the available data about the NEW Devon population as a whole, and in particular the over-65 age groups which make up the majority of the community hospital inpatient population. This suggests that there may be some degree of error in data collection, with 'none' and 'other' being over-reported. Extrapolating from the population level data we can estimate that over 99% of patients fall

[7] See for example http://www.devonhealthandwellbeing.org.uk/temp-page/aphr-2014-15/where-are-our-health-inequalities/ethnicity/

into the categories Christian, no religion or none stated, with less than 1% identifying another religion or belief.

Improvement in population health – targets and measures to be developed

Improved clinical outcomes for patients – targets and measures to be developed

Improved design and delivery of services – targets and measures to be developed

6.5.2. Religion or belief of carers

No data are available for carers' religions or beliefs but we can reasonably assume that the overall composition is very similar to that of patients.

As above, Exeter is the only site where community beds may be removed where there is a significant non-Christian/atheist population and we suggest that the potential for this to generate a differential impact via increased travel times is explored at the consultation stage.

6.6. Other equality considerations

There are a number of other characteristics which, while not covered by the PSED, may be relevant when considering the potential for health care service changes to disproportionately impact on particular groups. NEW Devon typically considers:

- **Asylum seekers and refugees**: accurate data about the number of refugees and asylum seekers is difficult to obtain, however national figures for 2015 estimate 1 asylum seeker per 10,000 residents[8]. Applying this to the patient population considered here the number of asylum seekers/refugees is negligible. However, there are known health inequalities affecting traveller communities, and the population is not evenly distributed across Devon, so our recommendation is that any potential location specific issues are considered at the next stage of the development of these proposals.
- **Travellers**: accurate estimates of traveller numbers within a geographical area are difficult to obtain, the most recent service report of the Devon County Council Gypsy and Traveller Liaison[9] service estimated the prevalence at 0.07% for Devon as a whole. Applying this to the patient population considered here this implies that the number of travellers in the community hospital inpatient population annually is negligible (less than 1). However, there are known health inequalities affecting traveller communities, and the population is not evenly distributed across Devon, so our recommendation is

[8] http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN01403

[9] Annual service report 2014/15 https://new.devon.gov.uk/educationandfamilies/family-support/gypsies-and-travellers

that any potential location specific issues are considered at the next stage of the development of these proposals.

- **Social deprivation**: Although overall deprivation levels in NEW Devon are lower than the national average there are significant differences between areas such as Plymouth which have very high levels of deprivation, and Eastern Devon which has lower levels. The PCBC travel time analysis calculated that there was no more than a 3-minute difference in travel time for the most deprived population in the affected area. However, as with other characteristics, we recommend that further assessment is carried out to identify any other impacts as part of the development of the proposals. In particular it will be important to engage with people in areas with high social deprivation, who can be hard to hear in consultations.
- **Rural isolation**: Devon is one of the largest and most sparsely populated counties in the UK, and Eastern Devon in particular has a very low population density (estimated in 2014 at 1.7 persons per hectare, compared with an average for England of 4.1). Not all residents of rural areas are isolated, living alone makes isolation more likely, and the picture is complicated by age. Rurally isolated populations can experience differential health outcomes, and may have particular difficulties in accessing services. While patient transport should ensure that patients can access the remaining community hospital sites this may pose challenges for visitors/carers in some settings, despite the lack of a differential average travel time increase. We recommend that the next stage of development of these proposals explores the potential impacts on rural communities, actively engaging them in the consultation and considering whether there are specific measures or indicators which could demonstrate the impact.

7. Outcome of Equality Impact Assessment

7.1. Conclusions

This Equality Impact Assessment concludes that none of the evidence which has been considered at this point identifies differential or disproportionate impact on people and groups with the protected characteristics within the scope of this Assessment.

Equality Group (Protected Characteristics)	**Conclusions**
Sex	No evidence found
Religion and belief	No evidence found
Age	No evidence found
Disability	No evidence found
Ethnicity & Race	No evidence found
Marriage and Civil Partnership	Not considered
Sexual Orientation	Not considered
Gender reassignment	Not considered
Pregnancy/ maternity	Not considered

7.2. Recommendations

As noted above there as limitations in the evidence which is currently available to inform this Equality Impact Assessment. Here we make a number of recommendations and suggestions for future data collection and analysis which can be used to inform a more detailed and robust consideration of the impact of the proposed changes and your response to the Public Sector Equality Duty under the Equality Act 2010.

1. Establish a good understanding of **the prevalence of people in protected groups** in the local area who may be affected by the impact of these changes, and ensure they are enabled to contribute their perspectives through the public consultation process

2. Collect, analyse and consider **full information about patients** – wherever treated - in terms of their membership of protected groups. Given the missing data and overuse of the 'other' category in relation to some protected characteristics at present we suggest that relevant staff may benefit from training in this respect. This could be linked to a programme of cultural awareness-raising for staff involved in designing and delivering care.
3. It will also be helpful to develop a better understanding of **the profile and needs of visitors/ carers** although we suggest this may be done initially in a less formal manner through, for example local voluntary organisations and support groups
4. The NMOC group is encouraged to reflect on the **changes in morbidity and mortality indicators** that they can reasonably expect to see once the new service patterns are implemented, and consider whether they may indicate any evidence of disproportionate or differential impact, working with Public Health colleagues.
5. As more specific targets and indicators are developed we recommend that they are subject to **a sense check**, so that, for example as we have noted, examination of travel times includes the times of day when visits may be made. We recommend that this EIA be reviewed and updated once such indicators are developed to consider whether they are likely to occur at differential levels for protected groups.