PURPOSE
Equality Analysis is a best practice method to demonstrate due regard to the general duty under the Equality Act 2010 to eliminate discrimination, advance equality of opportunity and foster good relations between people from different groups.

The purpose of an Equality Analysis (EA) is to examine the extent to which existing or proposed services /policies/strategies may benefit different members of the community and, where appropriate, prompt the consideration of adjustments to ensure that all equality groups benefit equally from what is being analysed.

RESPONSIBILITY
Responsibility for compliance with the CCG’s public sector equality duty rests with the author’s lead Director. Specialist guidance and support is, however, available from the Policy & Engagement Manager and the Director of Governance & Compliance.

Equality analysis must be carried out for all policies, strategies and service change proposals. Existing services can also be the subject of an equality analysis to ensure the activity is having intended benefits for all equality groups.

CONSULTATION & ENGAGEMENT
Please note that early engagement is recommended and in many cases is necessary to develop policies, procedures, strategies or service changes. Please ask the Communications & Engagement Team if you would like help with this.

INSTRUCTIONS
- Complete the equality analysis
- Insert the Summary at the front of all Policies and append the Equality Analysis, not including this page, at the end.
- Insert the Summary and the Equality Analysis, not including this page, into Committee and Governing Body Papers between Front Cover and Main Report to inform decision making.

Note: Different impact does not necessarily mean adverse (or negative) impact.
Equality Analysis/The Locality Model in Guildford and Waverley/28th October 2015
### SUMMARY OF EQUALITY ANALYSIS for the Locality Model in Guildford and Waverley

<table>
<thead>
<tr>
<th>EQUALITY GROUP</th>
<th>Negative Impact YES / NO</th>
<th>Positive Impact YES / NO</th>
<th>ADJUSTMENTS PROPOSED YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Disability</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ethnicity / Race / Ethnic Group</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Gender</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Religion &amp; Beliefs</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Marriage &amp; Civil Partnership</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Pregnancy &amp; Maternity</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Carers</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Areas of Deprivation/Geographical Location</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Vulnerable Groups</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
CONCLUSION:
The establishment of the five localities in Guildford and Waverley will result in greater coordination between health and social care services meaning that services as a whole will be better at identifying and caring for the needs of the frail population who live with multiple long term conditions. However, steps will need to be proactively taken to ensure that this service serves the different majority and minority groups within the community. Further, the service will need to continue to be a needs-based service rather than purely an age-based service if it is to meet the needs of those within the community who need this type of care.

For the locality model to continue to meet the needs of different majority and minority groups within the Guildford and Waverley community, it will need to:

- Improve involvement of patients and carers in the evolving locality model.
- Review the demography of the local area to ensure service provision is tailored to the local community.
- Undertake further equality analyses when building on the current service provided by the respective localities.
- Ensure that it continues to provide a needs-based service.
- Communicate effectively to all relevant groups who would benefit from the new service change.
- Ensure that the health and social care workforce, involved in the new service, are appropriately trained so that they can cater for those who require reasonable adjustments to access services.
- Ensure that the needs of carers are understood and provided for.
- Ensure that the impact of deprivation in causing the early onset of frailty is understood and provided for.
- Undertake equality monitoring to ensure no group is excluded or adversely affected by the new model.
- Ensure that reasonable adjustments are made so that majority and minority groups are offered fair access to the service.

RECOMMENDATIONS: Summarise the amendments that need to be made to prevent any identified health inequalities from arising or continuing with this activity.

1. Improve involvement of patients and their carers in evolving locality model

   1.1. Commissioners need to identify patient and carer representatives for membership of the ICP Steering Group to ensure that the appropriate feedback and discussions begin as early as possible (adjust Terms of Reference to accommodate this recommendation).

   1.2. Commissioners and providers need to consider engagement plans within each locality to ensure that the locality will engage with their own communities.
1.3. Providers to routinely collect patient and carer feedback to identify whether there are any differences in experience across different majority and minority groups.

2. Demography

2.1. The analysis shows that some localities have an older demographic than others. This indicates that some localities within this model will experience greater demand than others due to this disparity. Although, it should be noted that frailty is not solely related to age. The ICP Steering Group needs to provide assurance that resources are allocated across the localities according to need.

2.2. Commissioners and providers will review the demand for the service on a frequent basis to ensure that integrated working is delivering for local people. Due to increased life expectancy, projections forecast that the over-65 population will grow significantly in the coming years and so correspondingly the demand for support for frail people is also expected to grow.

3. Locality Development

3.1. To continue with equality monitoring, when/if further service changes building on the locality model are implemented; for example, the development of a Proactive Care Service (the East Waverley pilot). This will ensure that future service changes do not negatively impact or exclude any relevant majority or minority groups.

4. Needs-Based Criteria

4.1. This equality analysis of the locality model reinforces the decision to utilise referral criteria based on need rather than age. Certain equality groups present at a younger age with frailty, for example, people with disabilities and people from the Gypsy, Roma and Traveller communities.

4.2. Providers need to be mindful of the locality provision of integrated care being available to different age groups and not solely for people aged 65 years and over as was initially proposed.

5. Communication with Patients and Carers

5.1. To meet the needs outlined in this equality analysis, providers need to ensure patient materials can be made available in accessible formats that cater to a wide range of needs including braille, audio and different languages.

5.2. Providers need to ensure that information materials are inclusive to a variety of different minority groups including those who identify as Lesbian, Gay, Bisexual or Transgender.

5.3. Providers need to make reasonable adjustments to ensure that their communications are accessible to the patient. For example, offering SMS or email as an option if the patient has a hearing impairment.
5.4. Language needs should be accommodated for via the usual interpreter processes in place within all providers.

5.5. Care planning will ensure that religious beliefs and sexual orientation are noted by professionals, for patients who have a plan. This is important during end of life care, when religious and spiritual beliefs and support from partners should be considered.

6. Workforce

6.1. Providers need to ensure that health and social care staff are appropriately trained so that they can support people with a disability. This will ensure that staff can make reasonable adjustments to services for the needs of those with a disability. Staff training can include general awareness training or more specialised training to cater to the needs of those with a disability, such as guiding training for those with a severe visual impairment.

6.2. Providers need to provide appropriate levels of training to ensure that their staff are aware of the needs of the different ethnic minority groups in the local community. Surrey County Council provides Gypsy, Roma and Traveller Awareness Training and could be asked to provide this training on a locality-wide basis.

7. Carers

7.1. Providers should encourage carers they come into contact with to register as a carer with their GP. This will provide carers with greater access to carer support services and the carer prescription.

7.2. All localities should maintain active links with carer support organisations, for example, Carer Support Surrey.

7.3. It is recommended that the ICP Steering Group includes a Carer as well as a Patient to ensure carer needs are continuously provider for in the development of integrated care.

8. Areas of Deprivation and Geographical Location

8.1. In order to encompass all circumstances that impact on frailty, including deprivation, it is recommended that the ICP Steering Group discusses whether or not the model of integrated care requires greater clarity across all localities.

8.2. To ensure non-clinical impacts on frailty are routinely discussed, the MDTs should consistently include social and voluntary care professionals, as outlined in the agreed operating model.
9. **Equality Monitoring**

9.1. The Locality GP representatives should continue to attend the monthly Locality GP representative meeting. This enables representatives to discuss how the localities are functioning and provides an opportunity to discuss any potential adverse impacts on different groups that spans multiple localities.

9.2. Commissioners and providers need to ensure that there is a methodology for monitoring equality when implementing Key Performance Indicators (KPIs) and metrics for various pieces of work associated with the localities.

9.3. It is recommended that the ICP Steering Group advises localities on the equality monitoring methodology to be adopted by all localities.

9.4. Represented providers to undertake regular equality monitoring of patients referred to the ICP Locality Multi-Disciplinary Teams (MDTs).

9.5. Commissioners and providers to ensure that minutes and actions will be taken at locality meetings and will be reviewed every quarter to understand the impact the meeting is having in caring for the needs of the local population.

9.6. Commissioners and providers to review the list of attendees for each meeting to ensure that all appropriate services are represented. For example, if a mental health professional is not represented, this could have an adverse impact on those referred who are suffering from a mental health condition as there would be no represented practitioner who specialises in caring for their needs.

9.7. Commissioners to consider how equality impact can be monitored through pre-existing programme management framework that is in place.

9.8. Commissioners to repeat the equality analysis after two years to gain an understanding of how the demographics in each of the localities has changed and to reassess the impact of the locality model on minority groups.
Who is this ‘activity’ aimed at? Please delete and explain further if relevant.

This activity is aimed at the frail over-65 population in Guildford and Waverley who are at increased risk of acute hospital admission if they do not receive the right care within their community. Those who present with similar needs, but are below the age of 65 will equally be a priority. Therefore it is a needs-based service and not an age-based service.

What are the main aims and objectives of the ‘activity’?

The aim is to integrate health and social care services in five distinct localities across Guildford and Waverley to improve the community-based care of frail people who have been identified as being at increased risk of an unplanned hospital admission. This initiative is part of a programme called the Integrated Care Partnership (ICP). All projects that are a part of this programme are branded with ‘My Care My Choice’ so that patients, carers, professionals and local people can more easily identify the integrated care projects that are going on in Guildford and Waverley.

The objectives are to:

- Improve health outcomes for patients, their family and carers
- Create access to better, more integrated care outside of hospital
- Reduce avoidable hospital admissions
- Facilitate discharge for patients from acute care with appropriate communication and support for patients, their family and carers
- Enable effective working of professionals across provider boundaries
- Engage and enable health and social care professionals to deliver the right care at the right time in a joined up approach
- Empower people with long-term conditions including frail and older people to feel supported to manage their own health and care needs and live independently in their own homes with the right support for their families and carers
- Support carers in their caring role and in having a life outside of caring
- Ensure best use of resources by enabling better communication between different health and social care personnel
- Develop the role of the local voluntary sector through collaboration with current services  
- Recognise and address the significant challenge of social isolation for people living alone in their homes

The model of integrated care is delivered through a forum that meets every month. Outside of the meeting, this model will also facilitate better cooperation between services through improved working relationships developed at these monthly meetings. Each forum includes a group of GP practices that have come together due to their geographical proximity and is attended by health and social care representatives working within that respective local area. These forums are called: ‘localities’ and there are five localities in Guildford and Waverley. Each GP practice sends a GP representative to the monthly meeting and the care coordinator from the hosting GP practice typically attends. Below are the five localities and the GP practices that belong to each of them:

**East Waverley locality**  

**Haslemere locality**  
- Chiddingfold Surgery, Grayshott Surgery, Haslemere Health Centre, Witley Surgery  

**Guildford Central locality**  

**Guildford East locality**  
- East Horsley Medical Centre, Merrow Park Surgery, New Inn Surgery, Shere Surgery, Villages Medical Centre  

**North Guildford locality**  
- Fairlands Practice, Guildowns Group Practice, Woodbridge Hill Surgery

Other organisational representatives involved with the locality meetings include:  
- NHS Guildford and Waverley Clinical Commissioning Group (CCG)  
- Surrey County Council  
- Royal Surrey County Hospital NHS Foundation Trust  
- Virgin Care Services Ltd.  
- Surrey and Borders Partnership NHS Foundation Trust  
- Age UK Surrey  
- Other public sector and voluntary sector organisations send representatives when appropriate.
These monthly locality meetings consist of a locality development section and a Multi-Disciplinary Team (MDT) section.

The locality development section of the meeting is attended by clinicians and non-clinicians and focuses on how services are generally functioning in the local area. This generally involves:

- An update from each of the organisations that are represented
- An update on any significant issue that is affecting service delivery in the local area
- An update on any significant service change that will affect the area
- Any other issue that an attendee would like to raise

The MDT section of the meeting is attended by clinicians and focuses on particular patients who have a range of complex health and social care needs. The aim is to identify how professionals from different organisations can work together in cases where a patient’s needs are particularly challenging. Each represented health and social care organisation is encouraged to bring their own challenging patient cases to the meeting in order to facilitate wider learning. Through this process, professionals can learn about how other services work and so learn about the wider care system in their local area. This will facilitate the development of working relationships, within the health and social care sector, as services will learn to work in a unified way to meet the complex needs of their patients. The intention is for these working relationships to extend outside of the meeting so that health and social care services have a coordinated approach to the needs of local people with complex needs.

Some localities have chosen to use their MDT sections to focus on particular themes such as dementia, self-neglect, cardiac problems or alcoholism. These themes allow for clinicians to examine their approach in dealing with particular health issues. Local specialist clinicians are invited and provide specialist knowledge regarding how to improve the collective clinical approach within the community.

**Summary of the Integrated Care Partnership**

The Integrated Care Partnership (ICP) is Guildford and Waverley’s local health and social care system integration programme aimed at supporting frail older people in the community. The model of care is based upon the needs of frail older adults for two reasons:

- Frail older adults account for high volume use of social care, acute and community health services
- Frail older adults are more likely to have complex needs and the system redesign will support them in regaining or retaining independence in their local community
The vision is to have more intensive management of the frail older population over time with more resources focused on supporting this group of patients in the community and preventing acute hospital admission. Currently, the patient and carer experience of services can be confusing and disjointed resulting in a poor overall experience. The ICP will bring together services in a more streamlined manner, and improve experience for patients and carers. This will support easier navigation for professionals working with the frail and older population. It will also improve the coordination with which services respond to complex patient needs.

It will generally have a positive effect on the local population as no frontline service is being reduced or changing its location as part of this service change. This significantly minimises any adverse effects that might impact patients.

By implementing the service change, the aim is to promote, restore or maintain health and wellbeing by making sure that every person and their family in Guildford and Waverley can access the care that they need, when and where they need it.

However, it is important that service providers note the recommendations above to ensure that all equality groups benefit from this new model of care. Providers should be asked to report progress against these recommendations to the ICP Steering Group to demonstrate their commitment to narrowing health inequalities amongst the most frail and vulnerable members of our community.

Describe the current situation:

Previously within Guildford and Waverley, there were GP practice-based meetings of health and social care professionals. However, there was no formal locality-based meeting in which providers would discuss local system wide issues and complex patients. The practice based meetings were generally less well attended as there were a large number of GP practice-based meetings that providers would be expected to attend. Meetings were often lacking input from important contributors and so the coordinated approach was more limited. This resulted in less effective joint working in meeting the needs of the frail over-65 population within the local area. This fragmentation of services contributed to avoidable hospital admissions as well as patients not receiving the best care possible.

The Five Year Forward View identifies the integration of health and social care services as a vital way to improve outcomes for patients and generate necessary savings for local health economies. This has led to health and social care providers pursuing integration by working together to implement new models of care. Likewise, the NHS England Vanguard Programme supporting new models of care has identified sites to pilot a variety of new ways of delivering integrated care. As such, this is a pivotal time for integration as this national strategy will inform how providers in Guildford and Waverley will work together in establishing the five localities.
Clarify what exactly is being analysed:

The new locality model will mean new ways of working for community based health and social care services. This equality analysis examines the impact of these service changes on different local groups. The analysis will address:

- accessibility of services;
- communications;
- service capacity;
- the care services provide for patients;
- service location;
- staff training;
- the impact of coordinated working.

Please describe what ENGAGEMENT AND/OR CONSULTATION that has taken place to inform this equality analysis?

Consider internal and external routes. If you would like assistance with identifying particular groups to consult with please liaise with the Communications & Engagement team.

**April 2014**
- Public and Patient Engagement Forum- focused on older people, integrating services and 7-day working.

**July 2014**
- Provider Engagement for the Integrated Care Organisation (later replaced by the Integrated Care Partnership; much of the feedback is still applicable as many of the features of the service change have remained the same through the transition)

**October 2014**
- Public and Patient Engagement Forum- focused on older people, integrating services and 7-day working

**January 2015**
- Practice Council
- Frailty Forum
- Executive Briefing- Guildford and Waverley Clinical Commissioning Group

**March 2015**
- Frailty Forum

**April 2015**
- ICP Launch Event for all Health and Social Care
- Meeting with Guildford Borough Council
- Meeting with Surrey and Borders Partnership NHS Foundation Trust

**May 2015**
- Frailty Forum
- Patient and Public Engagement Group
- Presentation to Guildford Borough Council
- GP Practice Participation Group

**June 2015**
- Practice Council
- Better Care Fund event

**July 2015**
- Frailty Forum
- Meeting with GP Trainees
- Meeting with Frailty Coordinators from local GP practices

**September 2015**
- Talking about Commissioning Intentions 2016/17 - Engagement Event
- Annual General Meeting - Engagement Event
- Care Home Forum

**October 2015**
- Patient and Public Engagement Forum - 2016/17 Commissioning Intentions

Engagement has also taken place through a variety of meetings with the Guildford Diocese, Voluntary Action South West Surrey and Park Barn Day Centre. These were arranged to discuss the on-going agenda of integration.
Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years (British Geriatrics Society, *Fit for Frailty*, June 2014.). In a recently published longitudinal study of just under 5,500 older people, prevalence of frailty rose with increasing age, from 6.5% in those aged 60-69 years to 65% in those aged 90 or over (*Prevalence of frailty and disability: findings from the English Longitudinal Study of Ageing*, Gale, C et al, 6th January 2015, Age & Ageing Vol. 44(No.1), pp162-5).

Among the over-65 age group, there are a number of patients who are both frail and have long term health conditions, but frailty can exist in isolation with presentation to health care services being limited, until a minor illness causes a break down in health. These patients require a range of different services in order to meet their health and social care needs. The likelihood of a patient requiring this kind of support increases as they grow older and so a significant proportion of these patients are also older than 85.

Frail individuals are at a substantial risk of being admitted to an acute hospital if the care they receive in the community is not holistic and effective. This service change will result in improved communication by health and social care professionals leading to a more coordinated approach to patient care. Greater coordination will improve the ability of health and social care providers to provide care within the community and will improve their ability to meet the needs of this cohort of patients who have a range of complex needs.

---

2 [https://gp-patient.co.uk/surveys-and-reports](https://gp-patient.co.uk/surveys-and-reports)
No additional funding has been allocated towards integrating health and social care in this locality model; it is being developed and delivered within existing resources through changes in provider working practices. There are no changes in the location of services, but instead an improvement in the capacity to meet needs by approaching care in a more coordinated way. For these reasons, the service is expected to have a significant positive impact for patients who are frail and have multiple long term conditions requiring this kind of support.

The table above shows that there are clear differences in age demographic for the different localities. East Waverley and Haslemere localities have a higher proportion of patients who are aged over 65 and a higher proportion of patients who are aged over 85 compared with the other localities. Guildford East has a similar proportion of patients who are aged over 65 compared with East Waverley and Haslemere, but has a lower proportion of patients who are aged over 85. North Guildford and Guildford Central are the localities with the lowest proportion of patients who are over 65 and over 85 respectively.

East Waverley locality has the highest population of patients aged over 65 and over 85 respectively. Haslemere follows with more than 2000 fewer patients in the over 65 category and more than 400 fewer in the over 85 category. The Guildford localities each have significantly fewer patients in both age categories. The overall range across the five localities is 13% to 22% of the locality population being aged 65yrs and over with East Waverley having almost twice as many people in this age group than North Guildford. Due to the strongly age-related presentation of frailty, it would therefore be expected for the health and social care resource allocated to these different localities to reflect this difference in age-related need to meet frailty-related demand.

Due to increased life expectancy, projections forecast that the over-65 population and over-85 population will grow significantly in the coming years. Given the positive correlation between age and presenting with frailty, this will mean an increase in the number of frail patients in Guildford and Waverley.

Due to the increasing health and social care needs associated with frailty, the CCG is launching the Proactive Care Service Pilot in East Waverley. This will look to build on the coordination developed by localities by developing a single point of access for the pilot alongside a joint assessment process. The outcomes from this pilot will help to inform the future staffing of the remaining localities.

For those who do not require this type of care, there will be neither a positive nor a negative impact. No other service change is being proposed under the parameters of this equality analysis.
What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

- Represented providers to review their processes for referring patients to the MDT section of the meeting for discussion. This will need to focus on the complex needs of the patients referred and whether the process is needs based rather than purely age based.

DISABILITY

The GP Survey data 2013/14 provides data on a number of disabilities including learning disability, visual impairment and hearing impairment. The survey does not contain data on other disabilities.

The sample size may contribute to inaccuracies as only a relatively small proportion of patients filled in a questionnaire. It is also important to acknowledge that patient questionnaires may be less accessible for those with a disability. Estimates from the Guildford and Waverley CCG Health Profile 2015 have been included to provide some context to these figures.

People with a Learning Disability

Population and prevalence of people with a learning disability sorted by locality/CCG (GP Survey data 2013/14)

<table>
<thead>
<tr>
<th>Location</th>
<th>Patients with a Learning Disability 18+ who filled in GP questionnaire</th>
<th>Prevalence among patients who filled in GP questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Guildford</td>
<td>8</td>
<td>2.3%</td>
</tr>
<tr>
<td>Guildford East</td>
<td>11</td>
<td>2.3%</td>
</tr>
<tr>
<td>Guildford Central</td>
<td>2</td>
<td>0.4%</td>
</tr>
<tr>
<td>Haslemere</td>
<td>19</td>
<td>4.0%</td>
</tr>
<tr>
<td>East Waverley</td>
<td>6</td>
<td>1.0%</td>
</tr>
<tr>
<td>Guildford and Waverley CCG</td>
<td>46</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

3 https://gp-patient.co.uk/surveys-and-reports

Equality Analysis/The Locality Model in Guildford and Waverley/28th October 2015
There were 46 people with a learning disability who filled out a patient questionnaire in Guildford and Waverley in 2013/14. The results indicated that Haslemere locality has the highest prevalence of people with a learning disability with 4%. North Guildford and Guildford East localities follow up with each having a prevalence of 2.3%. East Waverley locality and Guildford Central locality have the lowest prevalence with 1% and 0.4% respectively.

National estimates suggest that 2% of the general population have a learning disability. The entire Guildford and Waverley area has an indicated prevalence of 1.9% from the information gathered from the GP Survey 2013/14. The national estimate suggests that the data gathered by the GP Survey is an underestimation of the size of the population of people with a learning disability. This is supported by the fact that Guildford and Waverley provided a significant number of residential homes for people with a learning disability in the past and so is expected to have a higher prevalence of people with a learning disability than the rest of the country.

Across Guildford and Waverley, 3,911 adults (age 18+) are estimated to have a learning disability, according to the Guildford and Waverley Health Profile 2015. This is projected to increase to a total number of 4,169 by 2025. The number of adults aged 65 and over with a learning disability is predicted to increase from 820 to 973 in the same period. Therefore it is likely that the localities will experience an increase in the number of frail people with learning disabilities.

People with a learning disability as a group suffer from worse health outcomes than those without a learning disability. This is partially due to long term conditions that are associated with having a learning disability such as epilepsy. However, these worse outcomes are also caused by people with a learning disability being less able to access the right care. These problems with accessing care can be mitigated by making reasonable adjustments to how services are provided. This includes training for staff, health checks and easy read communications.

The forming of localities will improve how health and social care services work together to meet the needs of the local population. The result will be a more coordinated approach to meeting the needs of different local groups, including people with a learning disability. There is also potential for learning disabilities to be raised as a theme in the MDT section of the meeting. This will create a focused time in which community based health and social care professionals can discuss how to provide care for people with a learning disability. This ability to share best practice in the locality model will improve care for this group.

The focus of localities is providing coordinated support for frail elderly patients with multiple long term conditions. This means that for people with a learning disability who are not frail and do not have multiple long term conditions, the service change that has been undertaken will not significantly impact the care they receive- either positively or negatively. Other services that provide care and support for this group are not being changed under this service change. No service is being reduced or moving location, and so it is not projected to generate a negative impact.
However, if a patient is younger than 65 and has multiple long term conditions, then they will be considered for support from the locality. Given the links between having a learning disability and the likelihood of suffering from long term conditions, it seems likely that people with a learning disability, who are younger than 65, will be discussed at MDT meetings. This type of discussion will improve the care that this group receive as it will lead to a more coordinated approach to the treatment of their range of health and social care needs.

**People with Blindness or a Severe Visual Impairment**

Population and prevalence of people with blindness or a severe visual impairment sorted by locality/CCG (GP Survey data 2013/14)

<table>
<thead>
<tr>
<th>People with Blindness or a Severe Visual Impairment who filled in GP questionnaire</th>
<th>Prevalence among patients who filled in GP questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Guildford</td>
<td>4</td>
</tr>
<tr>
<td>Guildford East</td>
<td>4</td>
</tr>
<tr>
<td>Guildford Central</td>
<td>7</td>
</tr>
<tr>
<td>Haslemere</td>
<td>9</td>
</tr>
<tr>
<td>East Waverley</td>
<td>7</td>
</tr>
<tr>
<td>Guildford and Waverley CCG</td>
<td>30</td>
</tr>
</tbody>
</table>

There were 30 people with blindness or a severe visual impairment who filled out a patient questionnaire in Guildford and Waverley in 2013/14. The results indicated that Haslemere locality has the highest prevalence of people with a severe visual impairment with 2%. North Guildford, Guildford Central and East Waverley localities follow up with a prevalence of 1.1%, 1.2% and 1.1% respectively. Guildford East locality has the lowest prevalence of people with a severe visual impairment with 0.7%.

The GP Survey 2013/14 indicates that 1% of the population in England suffers from a severe visual impairment. The fact that this figure is lower than the proportion of patients with a severe visual impairment in Guildford and Waverley is likely due to Guildford and Waverley’s aging demography. The likelihood of severe visual impairment increases in old age with conditions such as age related macular degeneration, glaucoma and diabetic retinopathy becoming more prevalent. This means that localities with a larger elderly population are likely to encounter more patients with a severe visual impairment.
Less severe forms of sight loss also need to be considered when assessing the impact of this service change. Research indicates that 3.3% of the national population suffer from some kind of sight loss\(^4\). The likelihood of this health issue increases in old age with: 1 in 5 people who are aged 75 and over and 1 in 2 who are aged 90 and over suffering from sight loss\(^5\).

The GP Survey 2013/14 suggests a prevalence of people with a severe visual impairment for Guildford and Waverley of 1.2%. The Guildford and Waverley Health Profile 2015 estimates that there are 4,511 people, aged 65 and over, with a moderate/severe visual impairment in Guildford and Waverley. This amounts to a prevalence of 11.3% within this age group, given the population estimate of 39,700. Within the 18-64 age group in Guildford and Waverley, there are 104 people with a severe visual impairment.

Visual impairment is a risk factor for falls, which is one of the five presenting syndromes of frailty.

Blindness or a severe visual impairment can negatively impact how patients with these conditions access services. Accessing information, communicating with clinicians, and booking and attending appointments are more challenging for those with this disability. Health and social care services have a responsibility to make reasonable adjustments so that people with a severe visual impairment are able to access the care they need. This includes providing information in braille or audio format; training staff to understand the needs of people with a severe visual impairment; and ensuring the physical environment is not prohibitive to access.

The five localities in Guildford and Waverley have been created to provide more coordinated support for frail elderly people with multiple long term conditions. This service change will improve the support for all people in this group including people with a severe visual impairment who are frail and have multiple long term conditions. For people with a severe visual impairment that are not frail and do not have multiple long term conditions, this service change will not impact them- either positively or negatively. No service is being reduced or moving location under the parameters of this service change.

Given the increased likelihood of having a severe visual impairment as you become elderly, the service will be working with a relatively high proportion of people with a severe visual impairment.

---


\(^5\) Ibid.
People with Deafness or a Severe Hearing Impairment

Population and prevalence of people with deafness or a severe hearing impairment sorted by locality/CCG (GP Survey data 2013/14)

<table>
<thead>
<tr>
<th>Locality</th>
<th>People with Deafness or a Severe Hearing Impairment who filled in GP questionnaire</th>
<th>Prevalence among patients who filled in GP questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Guildford</td>
<td>23</td>
<td>6.7</td>
</tr>
<tr>
<td>Guildford East</td>
<td>18</td>
<td>3.1</td>
</tr>
<tr>
<td>Guildford Central</td>
<td>12</td>
<td>2.7</td>
</tr>
<tr>
<td>Haslemere</td>
<td>27</td>
<td>5.6</td>
</tr>
<tr>
<td>East Waverley</td>
<td>30</td>
<td>4.9</td>
</tr>
<tr>
<td>Guildford and Waverley CCG</td>
<td>110</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

There were 110 people with deafness or a severe hearing impairment who filled out a patient questionnaire in Guildford and Waverley in 2013/14. The results indicated that North Guildford locality has the highest prevalence of people with a severe hearing impairment with 6.7%; followed by Haslemere locality with 5.6%; then East Waverley locality with 4.9%; after that Guildford East Locality with 3.5%; and lastly Guildford Central locality with 2.3%

National estimates suggest that 17% of the general population suffer from some form of hearing loss\(^6\). The likelihood of hearing loss increases with age with more than 70% of 70 year olds being affected by hearing loss and 90% of over 80 year olds\(^7\). It is estimated that more than 1.2% of the general population suffer from severe hearing loss. The ageing demographic of Guildford and Waverley and the fact that GP Practices are more frequently supporting older people are the main factors behind why the hearing loss prevalence is higher in the GP Survey 2013/14 than national estimates for the general population.

The GP Survey 2013/14 suggests a prevalence of people with a severe hearing impairment for Guildford and Waverley of 4.4%. The Guildford and Waverley Health Profile 2015 estimates that there are 22,048 people, aged 65 and over, with a moderate/severe hearing impairment in Guildford and Waverley. This amounts to a prevalence of 55.5% within this age group, given the population estimate of 39,700. Within the adult population in Guildford and Waverley, there are 28,320 people with a moderate/severe hearing impairment; 6,272 of this group are aged between 18 and 64.

---

Equality Analysis/The Locality Model in Guildford and Waverley/28\(^{th}\) October 2015
Deafness or a severe hearing impairment can negatively impact how patients with these conditions access services. Accessing information, communicating with clinicians, and booking appointments are more challenging for those with this disability. Health and social care services have a responsibility to make reasonable adjustments so that people with a severe hearing impairment are able to access the care they need. This includes arranging for a sign language interpreter; providing information in other formats such as SMS and email; using a hearing loop where needed; and training staff to understand the different needs of people with a severe hearing impairment.

The five localities in Guildford and Waverley have been created to provide more coordinated support for frail elderly people with multiple long term conditions. This service change will improve the support for all people in this group including people with a severe hearing impairment who are frail and have multiple long term conditions. For people with a severe hearing impairment that are not frail and do not have multiple long term conditions, this service change will not impact them - either positively or negatively. No service is being reduced or moving location under the parameters of this service change.

Given the increased likelihood of having a severe hearing impairment with ageing, the service will be working with a relatively high proportion of people with a severe hearing impairment.

**Other Disabilities**

There are a range of other disabilities that impact how patients can access services including disabilities that affect mobility and disabilities that impact verbal communication (aphasia). Aphasia is one of the most common communication disorders to affect the brain. Although there are no official figures, the Stroke Association estimates more than 376,000 stroke survivors in the UK are living with aphasia. Aphasia can affect people of all ages, including children. It's most common in people over 65 years old as stroke and common progressive neurological conditions tend to affect older adults. Hence, the ICP localities will be caring for a population with a higher prevalence of aphasia when compared with the national average.

Health and social care services have a responsibility to make reasonable adjustments so that people impacted by these disabilities can access services. This includes providing support to access services and providing support with communication where needed. There are national guidelines to assist health and social care services in instances where a patient has very particular needs. Providers are advised to ensure all staff are aware of these guidelines and know how to access assistance to provide the care required.
Conclusion: Positive? YES  Negative? NO

What amendments should be made to eliminate or reduce any adverse impact to this equality group identified by the analysis?
- Providers to continue to apply needs based referrals to the MDT meetings rather than age-based to ensure that those with early onset frailty are catered for under the new service.
- Providers need to ensure patient materials can be made available in accessible formats that cater to a wide range of needs including braille, audio, written, etc.
- Providers need to make reasonable adjustments to ensure that their communications are accessible to the patient. For example, using SMS or email rather than a phone call if the patient has a hearing impairment.
- Providers need to ensure that health and social care staff are appropriately trained so that they can support people with a disability. This will ensure that staff can make reasonable adjustments to the needs of those with a disability. Staff training can include general awareness training or more specialised training to cater to the needs of those with a disability, for example, guiding training.
<table>
<thead>
<tr>
<th>GP Practice</th>
<th>Locality</th>
<th>White British</th>
<th>Black</th>
<th>Asian</th>
<th>Chinese</th>
<th>Mixed</th>
<th>Other Non-White Ethnic Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairlands Practice</td>
<td>North Guildford Locality</td>
<td>94.5%</td>
<td>x</td>
<td>1.6%</td>
<td>x</td>
<td>1.6%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Guildowns Group Practice</td>
<td>North Guildford Locality</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Woodbridge Hill Surgery</td>
<td>North Guildford Locality</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>East Horsley Medical Centre</td>
<td>Guildford East Locality</td>
<td>99.1%</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>0.9%</td>
</tr>
<tr>
<td>Merrow Park Surgery</td>
<td>Guildford East Locality</td>
<td>98.4%</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>1.6%</td>
</tr>
<tr>
<td>New Inn Surgery</td>
<td>Guildford East Locality</td>
<td>91.6%</td>
<td>1.9%</td>
<td>1.9%</td>
<td>x</td>
<td>x</td>
<td>4.6%</td>
</tr>
<tr>
<td>Shere Surgery</td>
<td>Guildford East Locality</td>
<td>99.1%</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>0.9%</td>
</tr>
<tr>
<td>The Villages Medical Centre</td>
<td>Guildford East Locality</td>
<td>97.4%</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>2.6%</td>
</tr>
<tr>
<td>Austen Road Surgery</td>
<td>Guildford Central Locality</td>
<td>98.5%</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>1.5%</td>
</tr>
<tr>
<td>Dapdune Surgery</td>
<td>Guildford Central Locality</td>
<td>93.3%</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>1.9%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Guildford Rivers Practice</td>
<td>Guildford Central Locality</td>
<td>92.5%</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>1.9%</td>
<td>5.6%</td>
</tr>
<tr>
<td>St. Luke’s Surgery</td>
<td>Guildford Central Locality</td>
<td>92.8%</td>
<td>x</td>
<td>2.7%</td>
<td>1.8%</td>
<td>2.7%</td>
<td>x</td>
</tr>
<tr>
<td>Chiddingfold Surgery</td>
<td>Haslemere Locality</td>
<td>99.1%</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>0.9%</td>
</tr>
<tr>
<td>Grayshott Surgery</td>
<td>Haslemere Locality</td>
<td>95.1%</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>4.9%</td>
</tr>
<tr>
<td>Haslemere Health Centre</td>
<td>Haslemere Locality</td>
<td>99.1%</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>0.9%</td>
</tr>
<tr>
<td>Witley Surgery</td>
<td>Haslemere Locality</td>
<td>98.4%</td>
<td>x</td>
<td>1.6%</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>The Mill Medical Practice</td>
<td>East Waverley Locality</td>
<td>94.9%</td>
<td>x</td>
<td>x</td>
<td>1.7%</td>
<td>1.7%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Binscombe Medical Centre</td>
<td>East Waverley Locality</td>
<td>98.4%</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>1.6%</td>
</tr>
<tr>
<td>Cranleigh Medical Centre</td>
<td>East Waverley Locality</td>
<td>98.3%</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>1.7%</td>
</tr>
<tr>
<td>Wonersh Surgery</td>
<td>East Waverley Locality</td>
<td>96.7%</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>3.3%</td>
</tr>
<tr>
<td>Springfield Surgery</td>
<td>East Waverley Locality</td>
<td>96.7%</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

Ethnicity breakdown of the population in the Guildford and Waverley Clinical Commissioning Group area (ONS Census, 2011 OR Health Profile):

86% white British
7% other white- Eastern European, Gypsy Roma Traveller;
3% other Asian-likely to be Nepalese;

Equality Analysis/The Locality Model in Guildford and Waverley/28th October 2015
1% Indian; 
1% Black African Caribbean.

An x indicates that the proportion of people who identify as this ethnicity is sufficiently small as to not be registered in the summary of the GP Survey 2013/14 for that respective area. In the case of Guildowns Group Practice and Woodbridge Hill Surgery, there was insufficient data provided for the curators of the GP Survey 2013/14 to generate an ethnicity breakdown.

People from different ethnic groups have different patterns of health behaviours and disease which may affect requirements for service provision. In certain cases, this can lead to some of the long term conditions that the establishment of localities is attended to care for. Below is an overview of the health issues facing the two largest ethnic minority groupings in Guildford and Waverley: the Gypsy, Roma and Traveller (GRT) community and the Nepalese community. With respect to the other ethnic minorities in Guildford and Waverley, clinicians are trained to be aware of particular health problems facing particular groups and commissioners continue to engage with the communities to ensure that their needs are catered for in health and social care.

One of the largest ethnic minority groups in Guildford and Waverley is the Gypsy, Roma and Traveller Community. Whilst many people who identify as GRT live in designated traveller sites others live in ‘bricks and mortar’ housing.

Below are the number of traveller sites in the vicinity of the locality’s GP practices to indicate the potential demand from this ethnic minority grouping in each locality:

<table>
<thead>
<tr>
<th>Locality</th>
<th>Number of Traveller Sites in the Vicinity of the locality’s GP practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Guildford Locality</td>
<td>2</td>
</tr>
<tr>
<td>Guildford East Locality</td>
<td>2</td>
</tr>
<tr>
<td>Guildford Central Locality</td>
<td>2</td>
</tr>
<tr>
<td>Haslemere Locality</td>
<td>4</td>
</tr>
<tr>
<td>East Waverley Locality</td>
<td>4</td>
</tr>
</tbody>
</table>

8 Surrey County Council 2010
Equality Analysis/The Locality Model in Guildford and Waverley/28th October 2015
The two largest Gypsy, Roma Traveller sites in the vicinity of the 5 localities are:

- The Hatchingtan in Worplesdon, which is closest to North Guildford Locality
- The Willows in Runfold, which is closest to Springfield Surgery in the East Waverley Locality.

The Gypsy, Roma and Traveller Community comprises of travellers of Irish heritage, Gypsies, European Roma, Fair Ground and Circus Families, and New Travellers. The GRT Community have significantly poorer health than any other disadvantaged UK residents. Local research with this community identified high levels of smoking (48%), high blood pressure (52%) and anxiety/depression (48%). In a number of cases, the stressful nature of moving from place to place can amplify high blood pressure and anxiety levels. This poorer health could lead to a greater prevalence of the long term conditions that require the kind of support provided by the localities. Also, the general poorer health of this community could lead to persons presenting with the long term conditions and the associated frailty at an earlier age. Localities will include patients based on clinical need rather than purely age-based. Those who present with these long term conditions and frailty at a younger age will be reviewed by localities on a case by case basis.

The Gypsy, Roma and Traveller Community encounter a range of different barriers to accessing health and social care services. Much of the community continues to travel from place to place and so are less likely to register with a GP. This movement also makes it difficult for other health and social care services to identify the needs of the GRT Community and to provide the necessary support. Increasingly, however, the Gypsy, Roma and Traveller Community are living in settled locations. This helps health and social care services to provide the needed health and social care to this community. In spite of this, the community still encounters barriers to accessing the right support from health and social care. For example, literacy skills are worse within the community and so literacy-based registration to services can be a barrier to access. Many of the community also report poor experiences when presenting to GP practices for treatment.

The introduction of localities will result in better communication between individual health and social care services leading to a greater ability to identify needs. This will be an improvement on the current situation and means that the Gypsy, Roma and Traveller Community will be more able to access the right care to meet their health and social care needs along with other local groups in Guildford and Waverley. This improved coordination is supplemented with the need for all services to make reasonable adjustments so that members of the Gypsy, Roma and Traveller Community can access the right care. The improved coordination and the need for services to make reasonable adjustments should improve the care provision for the Gypsy Roma and Traveller community.
**The Nepalese community** is another significant ethnic minority group in Guildford and Waverley. The Nepalese have higher rates of diabetes and coronary heart disease than the general population. This could lead to a greater admission rate of Nepalese people into the service when compared with the general population, as long-term conditions can be associated with frailty (although not always).

Generally, across all ethnic groups, service provision will improve if providers make reasonable adjustments to the services that they each provide. The improved coordination that results from the service change and the reasonable adjustments that all services are required to make will mean that care is more accessible for minority ethnic groups. This will lead to a positive impact for these local groups and in particular for those who are frail and live with multiple long term conditions.

<table>
<thead>
<tr>
<th>Conclusion:</th>
<th>Positive? YES</th>
<th>Negative? NO</th>
</tr>
</thead>
</table>

**What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?**

- Providers to continue to apply needs based referrals to the MDT meetings rather than age-based to ensure that those with early onset frailty are catered for under the new service.
- Providers need to ensure that patient materials are made available in accessible formats e.g. easy read; different languages
- Providers need to provide appropriate levels of training to ensure that their staff are aware of the needs of the different ethnic minority groups in the community which they operate in. Surrey County Council provides GRT Awareness Training and could be asked to provide this training on a locality-wide basis.
- Language needs should be accommodated for via the usual processes in place within all providers.

**GENDER**

Research indicates that more women than men suffer with frailty nationally and in particular within elderly people who live in their own home. For example a UK study from 2010 using the phenotype approach to defining frailty found a prevalence of **8.5% in women** and **4.1% in men** aged 65 –74 years (*Fit for Frailty, BGS, 2014*).
### Gender Breakdown of Patients (general population)- GP Survey Data 2013/14

<table>
<thead>
<tr>
<th>Locality:</th>
<th>Male population</th>
<th>Female population</th>
<th>Total population</th>
<th>Prevalence of Men</th>
<th>Prevalence of Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Guildford</td>
<td>23161</td>
<td>23191</td>
<td>46352</td>
<td>50.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Guildford East</td>
<td>17646</td>
<td>18176</td>
<td>35822</td>
<td>49.3%</td>
<td>50.7%</td>
</tr>
<tr>
<td>Guildford Central</td>
<td>17834</td>
<td>17300</td>
<td>35134</td>
<td>50.8%</td>
<td>49.2%</td>
</tr>
<tr>
<td>Haslemere</td>
<td>21757</td>
<td>22619</td>
<td>44376</td>
<td>49.0%</td>
<td>51.0%</td>
</tr>
<tr>
<td>East Waverley</td>
<td>26852</td>
<td>27917</td>
<td>54769</td>
<td>49.0%</td>
<td>51.0%</td>
</tr>
<tr>
<td>Guildford and Waverley CCG</td>
<td>107250</td>
<td>109203</td>
<td>216453</td>
<td>49.5%</td>
<td>50.5%</td>
</tr>
</tbody>
</table>

For North Guildford locality, Guildford East Locality, Haslemere Locality and East Waverley Locality, there is a slightly higher proportion of women than men within the general population. Guildford Central is the only locality with a slightly higher proportion of men than women within the general population. Guildford and Waverley as a whole reflects the majority of localities with a slightly higher proportion of women than men.

### Gender Breakdown of Patients (Over 65s)- GP Survey Data 2013/14

<table>
<thead>
<tr>
<th>Locality:</th>
<th>Male population</th>
<th>Female population</th>
<th>Total population</th>
<th>Prevalence of Men</th>
<th>Prevalence of Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Guildford</td>
<td>2575</td>
<td>3320</td>
<td>5895</td>
<td>43.7%</td>
<td>56.3%</td>
</tr>
<tr>
<td>Guildford East</td>
<td>3089</td>
<td>3654</td>
<td>6743</td>
<td>45.8%</td>
<td>54.2%</td>
</tr>
<tr>
<td>Guildford Central</td>
<td>2451</td>
<td>3030</td>
<td>5481</td>
<td>44.7%</td>
<td>55.3%</td>
</tr>
<tr>
<td>Haslemere</td>
<td>4046</td>
<td>5035</td>
<td>9081</td>
<td>44.6%</td>
<td>55.4%</td>
</tr>
<tr>
<td>East Waverley</td>
<td>5075</td>
<td>6448</td>
<td>11523</td>
<td>44.0%</td>
<td>56.0%</td>
</tr>
<tr>
<td>Guildford and Waverley CCG</td>
<td>17236</td>
<td>21487</td>
<td>38723</td>
<td>44.5%</td>
<td>55.5%</td>
</tr>
</tbody>
</table>

If you look at the proportion of men compared to women in only the 65 and over age group, the difference between the proportion of men and women widens. The highest proportion of men in any single locality is 45.8% with the lowest proportion of women being significantly higher at 54.2%. Looking at the Guildford and Waverley for the over 65 age group, the difference in the gender proportions is 11% with the prevalence of women at 55.5% and the prevalence of men at 44.5% and this gender balance is consistent across the five different localities.
This difference reflects national life expectancy statistics with women having a significantly higher life expectancy than men. These differences mean that it is likely that more women than men will receive support from the locality service change, as women will generally be living longer than men and require this kind of support. However, it is important to note that this service is targeted equally at both genders that are elderly and have multiple long term conditions.

There is also anecdotal evidence that men and women access health and social care services differently. It is known that men are less likely to visit their GP than women, even when feeling unwell. In a study reported in the BMJ in 2013, the crude consultation rate was 32% lower in men than women. The greatest gender gap in primary care consultations was seen among those aged between 16 and 60 years; these differences are only partially accounted for by consultations for reproductive reasons. Differences in consultation rates between men and women were largely eradicated when comparing men and women in receipt of medication for similar underlying morbidities.

Men are less likely to access services until their needs have escalated to the point where they need significant health and social care interventions. There are efforts within Guildford and Waverley to address this pattern with Guildford Borough Council and Age UK Surrey running a support programme called ‘Men in Sheds’ based in Ash. The service aims to reduce male social isolation and develop a more effective support network for this group. Men who present late to health and adult social care may likely be a particular focus for localities as they will likely have a range of complex needs that need to be responded to quickly. Women as a whole are generally more likely to approach health and social care at an earlier stage.

Due to gender-related prevalence of frailty, fewer men than women will be cared for by the integrated care model and being a minority can lead to needs being overlooked. It is important that services as a whole are able to meet their needs; men can state a preference for male carers and service providers are encouraged to ensure recruitment practices that encourage more men to work in the caring professions.

<table>
<thead>
<tr>
<th>Conclusion:</th>
<th>Positive? YES</th>
<th>Negative? NO</th>
</tr>
</thead>
</table>

**What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?**

- Providers and commissioners need to engage with relevant voluntary groups to ensure that both genders have fair access to the coordinated services that the localities provide.
GENDER REASSIGNMENT

There are no gender specific gender reassignment statistics for Guildford and Waverley. Those who have undergone gender reassignment have been found to have similar health outcomes to the LGBT community. For the impact on the LGBT community, see the sexual orientation section.

Conclusion: Positive? No  |  Negative? No

What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

None

RELIGION & BELIEFS

A person’s religion can impact how they interact with care services and affect the kind of care that they ask for. Health and social care staff undertake equality awareness training and aim to cater to these beliefs where possible in providing care. These wishes can be of particular importance in the case of end of life care. GP Practices have been working with frail and elderly patients to put together Proactive Anticipatory Care (PACe) plans so that there can be a clear understanding regarding the patient’s end of life care wishes. This plan provides a patient with the opportunity to express their religious/spiritual beliefs and gives them the opportunity to plan their care in accordance with these beliefs. The establishment of localities aims to improve how health and services work together in providing care. An expected outcome of this new approach is better communication around PACe plans so that a patient’s wishes are followed even in an emergency situation. This includes any religious/ belief based requirement that might be included in the PACe plan.

Religious Breakdown of Guildford and Waverley- Health Profile 2015

<table>
<thead>
<tr>
<th>Area</th>
<th>Christian</th>
<th>Buddhist</th>
<th>Hindu</th>
<th>Jewish</th>
<th>Muslim</th>
<th>Sikh</th>
<th>Other religion</th>
<th>No religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guildford Number</td>
<td>82,621</td>
<td>842</td>
<td>1,301</td>
<td>322</td>
<td>2,713</td>
<td>206</td>
<td>469</td>
<td>38,108</td>
</tr>
<tr>
<td>Prevalence in Guildford</td>
<td>60.2%</td>
<td>0.6%</td>
<td>0.9%</td>
<td>0.2%</td>
<td>2.0%</td>
<td>0.2%</td>
<td>0.3%</td>
<td>27.8%</td>
</tr>
<tr>
<td>Waverley Number</td>
<td>79,220</td>
<td>432</td>
<td>321</td>
<td>228</td>
<td>786</td>
<td>69</td>
<td>525</td>
<td>30,745</td>
</tr>
<tr>
<td>Prevalence in Waverley</td>
<td>65.2%</td>
<td>0.4%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.6%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>25.3%</td>
</tr>
</tbody>
</table>
The Guildford region and the Waverley region are relatively similar in their religious breakdown. In both regions, the highest proportion of people identify as Christian with around two thirds of people in each region identifying as such. The next highest proportion in both regions is no religion with around a quarter of people in each region saying they have no religion. In both regions, no other religion has more than 2% of people identifying as a belonging to any specific religion. One noteworthy difference between the two areas is that Guildford has a higher proportion of people who identify as Muslim with 2.0% when compared with Waverley which only has 0.6% of people identifying as Muslim.

There are instances where local people are less willing to engage with a service because of their religious or spiritual beliefs. The locality model will provide professionals with the opportunity to coordinate with other services so that they can offer the patient another type of support that may be permissible to the patient.

### Conclusion

**Positive? YES**

| Negative? NO |

What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

- The introduction of care planning will ensure that religious beliefs are noted for all professionals involved in care going forward. This becomes much more important towards the end of life, where religious and spiritual beliefs of a person may inform their decision-making.

### MARRIAGE & CIVIL PARTNERSHIP

#### Breakdown of Marital Status- Health Profile 2015

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Married</th>
<th>Same-sex civil partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Guildford</strong> %</td>
<td>35.2</td>
<td>49.4</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Guildford Number</strong></td>
<td>39,639</td>
<td>55,650</td>
<td>174</td>
</tr>
<tr>
<td><strong>Waverley</strong> %</td>
<td>26.9</td>
<td>55.3</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Waverley Number</strong></td>
<td>26,219</td>
<td>53,874</td>
<td>161</td>
</tr>
</tbody>
</table>

Localities will offer support for frail patients with long term conditions regardless of whether they are single, married or in same-sex civil partnership.

Spouses and civil partners have a higher likelihood of being carers. **For how this service change impacts carers, see the carers section.**
Conclusion: Positive? NO  Negative? NO

What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

There is no perceived impact on marriage and civil partnerships.

PREGNANCY & MATERNITY

It is very unlikely that a frail patient with multiple long term conditions would be in a position to become pregnant. However, it may be the case that a carer for a frail patient could become pregnant. For how the service change will impact carers, see the carers section.

Conclusion: Positive? NO  Negative? NO

What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

None

SEXUAL ORIENTATION

It is estimated that the lesbian, gay, bisexual and transgender population nationally is 5-7% of the population; this equates to between 8,430 and 11,800 people identifying as Lesbian, Gay, Bisexual or Transgender (LGBT) in Guildford and Waverley. Extrapolating the age demographics of the CCG area, the following can be approximated:

Estimated numbers of people who identify themselves as LGBT in Guildford & Waverley - Health Profile 2015

<table>
<thead>
<tr>
<th>Age</th>
<th>%</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-18yrs</td>
<td>16.6</td>
<td>1,679</td>
</tr>
<tr>
<td>19-49yrs</td>
<td>41.1</td>
<td>4,157</td>
</tr>
<tr>
<td>50-64yrs</td>
<td>18.7</td>
<td>1,892</td>
</tr>
<tr>
<td>65+</td>
<td>18.4</td>
<td>1,861</td>
</tr>
</tbody>
</table>

Members of the lesbian, gay, bisexual and transgender communities (LGBT) have been found to have higher levels of riskier health behaviours such as excess alcohol consumption, drug use and smoking, as well as lower uptake of screening programmes. They have also been found to have higher levels of anxiety and depression, attributed to experiences of homophobia, domestic abuse and bullying. There is
also variation within the LGBT community with those from ethnic minority groups suffering greater health inequalities than those with White British ethnicity. There is little information on life expectancy by sexual orientation but recent evidence on self-reported health status suggests that lesbians and gay men may have better self-rated health than the general population while bisexual and trans people have worse health.

Higher levels of riskier health behaviours such as excess alcohol consumption, drug use and smoking, as well as lower uptake of screening programmes could contribute to the LGBT community developing long term conditions, which can exacerbate frailty and therefore require the coordinated support offered by the locality model.

Although awareness is improving, research shows that older people are still the least likely age demographic to be open about their sexuality due to continuing stigma. This is likely to contribute to riskier health behaviours and higher rates of mental health issues within this group.

<table>
<thead>
<tr>
<th>Conclusion:</th>
<th>Positive?</th>
<th>Negative?</th>
</tr>
</thead>
</table>

**What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?**

- Providers need to ensure that information materials are inclusive to a variety of different minority groups including those who identify as Lesbian, Gay, Bisexual or Transgender.
- Providers must ensure that sexual orientation is accommodated within the care planning process and that patients can arrange the end of life care plans in the way they see fit, where clinically appropriate.

**Other categories relevant to CCG’s statutory duty to reduce health inequalities:**

**CARERS**

There are approximately 19,220 carers in Guildford & Waverley including 2,400 young carers (13%). The more detailed age breakdown of carers in the CCG area is not known.

**Estimated Carer Population in Guildford and Waverley- Health Profile 2015**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number of Carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-18yrs</td>
<td>2400</td>
</tr>
<tr>
<td>19yrs and over</td>
<td>16820</td>
</tr>
<tr>
<td>Total</td>
<td>19220</td>
</tr>
</tbody>
</table>
Carers are often the key to ensuring frail people can live at home for longer and their needs as carers must be identified and addressed if such arrangements are to continue. Not looking after carers will result in increased numbers of frail people being admitted to hospital as an emergency.

When discussing patients at locality meetings, the represented health and social care organisations discuss the patient’s situation comprehensively. This includes any support that a patient may receive from a carer or whether the patient is a carer themselves. As a result, the locality meetings will provide represented health and social care services with the opportunity to discuss any support that they can provide any carer/s in the particular case. The strain of caring can lead to a range of negative health impacts including: stress and anxiety, high blood pressure, depression, back problems and the carer putting off going to the doctor themselves. Health and social care provide a range of different services to meet the needs of carers and options for support will be reviewed at the locality meeting. These options include GP carer breaks, carer assessments, the carer’s allowance and respite services for carers.

More broadly, the locality model aims to improve how health and social care services coordinate in meeting the needs of local people. Cases that are discussed at the locality meetings will be used to develop examples of best practice in terms of coordination and integration. This will mean that services can develop a more coordinated approach when providing care for local people and carers. Improved information sharing will also mean that local people will not have to identify as a carer with each individual service to access support, rather they will only need to identify once and then this information will be circulated to other services following the patient’s consent to for health and social care organisations to share this information.

The result of the locality model will be improved support for carers. No frontline service will be reduced or move location under this equality analysis and so this service change will generate no negative impact for carers.
Conclusion: Positive? YES  Negative? NO

What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

- Providers need to actively promote support services available to carers in order to improve awareness and uptake. This could potentially include displaying leaflets or posters or discussing support services with someone who has identified as a carer.
- Providers should encourage local people who identify as a carer to register with their GP so that they can access support via that channel.
- All localities should maintain links with carer support organisations including: Carer Support Surrey.
- It is recommended that the ICP Steering Group includes a Carer as well as a Patient to ensure carer needs are continuously included in the development of integrated care.

AREAS OF DEPRIVATION and GEOGRAPHICAL LOCATION (urban, rural, isolated)

Despite Guildford and Waverley being a relatively affluent area, there are pockets of deprivation across the region. Below are the deprived wards in Guildford and Waverley as evaluated by the Deprivation Indices 2010 and linked to particular localities:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Borough</th>
<th>Locality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friary and St. Nicholas</td>
<td>Guildford</td>
<td>Guildford Central</td>
</tr>
<tr>
<td>Merrow</td>
<td>Guildford</td>
<td>Guildford East</td>
</tr>
<tr>
<td>Stoke</td>
<td>Guildford</td>
<td>North Guildford</td>
</tr>
<tr>
<td>Westborough</td>
<td>Guildford</td>
<td>North Guildford</td>
</tr>
<tr>
<td>Worpleston</td>
<td>Guildford</td>
<td>North Guildford</td>
</tr>
<tr>
<td>Farnham Upper Hale</td>
<td>Waverley</td>
<td>East Waverley</td>
</tr>
<tr>
<td>Godalming Binscombe</td>
<td>Waverley</td>
<td>East Waverley</td>
</tr>
<tr>
<td>Godalming Central and Ockford</td>
<td>Waverley</td>
<td>East Waverley</td>
</tr>
</tbody>
</table>

People living in deprived communities have more risky health behaviours and experience more long term conditions at earlier ages, with consequent impact on the individuals and the health service. These health outcomes mean that is likely that a significant proportion of people in these deprived communities will become frail and develop multiple long term conditions from a younger age. There is emerging evidence that frailty increases in the presence of obesity particularly in the context of other unhealthy behaviours such as inactivity, a poor diet and smoking (Fit for Frailty, BGS, 2014). Such behaviours are associated with lower socioeconomic status and so localities that include...
the most deprived wards are likely to experience increased presentation of frailty linked to deprivation. Services need to be adept at adopting a cohesive model of care that links social situations with health outcomes. The integrated care model is ideally placed to enable such considerations to happen more routinely due to the closer working relationships of staff from both health and social care organisations.

Social deprivation can also impact presentation and recovery. Those living in more deprived conditions are more likely to encounter fuel poverty, poor diet and increased risky behaviours. Integrated care offers the opportunity to meld the medical model of care with the social model of care that should lead to such risks being more quickly identified and addressed.

The new locality model will coordinate health and social care resources to more effectively meet the needs of this group within the community. Although this service change is targeted at providing support for the over 65 age group, locality meetings will discuss patients who are under 65 if they have multiple long term needs and the MDT judge that this is a case that requires greater coordination. In general, the greater coordination that arises from locality meetings will benefit all patients with multiple long term conditions even if they are not discussed specifically at an MDT.

For patients who live in deprived communities, but do not require this kind of care, there will be no negative impact. No frontline service will be reduced or move location under this equality analysis and so this service change will generate no negative impact.

<table>
<thead>
<tr>
<th>Conclusion:</th>
<th>Positive? NO</th>
<th>Negative? NO</th>
</tr>
</thead>
</table>

What amendments are required to eliminate or reduce any adverse to this equality group impact identified by the analysis?

- In order to encompass all needs that impact on frailty, including deprivation and its impact, it is recommended that the ICP Steering Group discusses whether or not the model of integrated care adopted by the Providers requires greater clarity.
- To ensure non-clinical impacts on frailty are routinely discussed, the MDTs should consistently include social and voluntary care professionals, as outlined in the agreed operating model.
VULNERABLE GROUPS e.g. ex-military, homeless, looked-after children, those seeking asylum

Ex-military – Around 2,500 members of the armed forces live in Surrey with 600 of these living in communal establishments, mainly in Guildford (441 in Pirbright Barracks). There is no source of routine information regarding the number of ex-services men and women living locally but given the history of military presence there are likely to be greater numbers in Guildford and Waverley than other parts of the country. Ex-service personnel experience significantly more mental illness and are more likely to have life-changing injuries that require care. The Armed Forces Covenant enables NHS care to be delivered efficiently to this group.

Refugees – the disbursement of refugees from the Syrian crisis, as per the Government’s commitment in September 2015, had not been clarified at the time of writing. Guildford and Waverley borough councils have indicated their willingness to assist. A detailed demographic analysis of the refugees that could be settled in Guildford and Waverley is therefore not yet available. However, it is known that the majority will be Syrian, of Arabic ethnic origin and of Muslim religious faith. All services will need to meet the needs that may arise depending upon the asylum arrangements/refugee status that would be applied.

The locality service change will benefit all patients who are frail and have multiple long term conditions. Patients from vulnerable groups are likely to have worse health than the general population due to the impact of their circumstances. Those who become frail and develop multiple long term conditions will benefit from the improved coordinated working of the locality model.

Conclusion: | Positive? NO | Negative? NO
---|---|---

What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?
- Each locality should maintain robust links with Surrey County Council and their local borough council (Guildford or Waverley) to ensure local intelligence regarding different vulnerable groups is incorporated into the model of care.

Name of person completing Equality Analysis | Job Title
---|---
James Courtney | Commissioning Support Officer

Name of lead Manager / Director | Signature | Date completed: 28/10/2015
---|---|---
Leah Moss | |