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.

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 Head of Partnership & Engagement.

CONSULTATION & ENGAGEMENT

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

INSTRUCTIONS

- Consult the Equality Analysis Demographic Information document on Sharepoint. Consider how your proposal would impact the different groups and what reasonable adjustments need to be made. Make recommendations to adjust or amend the proposal to address any positive or negative impacts. If no impact is predicted, simply state that.

- Include the Summary and the Equality Analysis in all Committee and Governing Body Papers where decisions regarding your proposal are recommended after removing this instruction page.
### SUMMARY OF EQUALITY ANALYSIS for INTEGRATED ‘OUT OF HOSPITAL’ SERVICES

<table>
<thead>
<tr>
<th>EQUALITY GROUP</th>
<th>Negative Impact</th>
<th>Positive Impact</th>
<th>ADJUSTMENTS PROPOSED</th>
</tr>
</thead>
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<tr>
<td></td>
<td>YES / NO</td>
<td>YES / NO</td>
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</tr>
<tr>
<td>Age</td>
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<tr>
<td>Disability</td>
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<td>NO</td>
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<td>Pregnancy &amp; Maternity</td>
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<tr>
<td>Sexual Orientation</td>
<td>NO</td>
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<td>Carers</td>
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<td>YES</td>
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<tr>
<td>Areas of Deprivation/Geographical Location</td>
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<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Vulnerable Groups</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>
**NAME OF THE SERVICE/STRATEGY / SERVICE CHANGE PROPOSAL / PLAN (‘ACTIVITY’)**

**INTEGRATED ‘OUT OF HOSPITAL’ SERVICES**

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

A significant number of older people in hospital need rehabilitation that can safely be provided elsewhere rather than in acute care. The urgent and emergency care system needs to ensure the best use of available services to benefit patients, especially the frail elderly with long term conditions. Avoiding emergency admissions is a major concern because of the increased risks to this patient group of hospital acquired infection, delirium and loss of function that affects independent living and reablement.

The aim of the integrated ‘out of hospital’ services is to reduce non-elective admissions, and includes the continuation and/or development of the proactive, reactive and active work streams in the community setting. This programme builds on the previous scheme of the Integrated Care Partnership programme. For 2017/2018, the aim of this scheme is two-fold:

- to support the integration and development of community based services and
- to reduce avoidable admissions and A/E attendances.

The scheme is made up of the following four work streams that will be monitored throughout the course of the year:

1. Locality development including the continuation of the Proactive Care Service and the Falls Programme.
2. Community Hospital Length of Stay. Work to reduce unnecessary length of stay once patient is ready for discharge.
3. Community Matrons in Care Homes to help prevent patients going to A&E.
4. Interface geriatricians for admission avoidance.

An integrated Proactive and Reactive Service model strengthens multidisciplinary health and social care triage for older vulnerable patients, especially those with long term conditions who frequently present to NHS services, and will strengthen the current Proactive Care Service that is operating across Guildford and Waverley.

The aim of this service is to:

- Ensure experience of care in and out of hospital is amongst the best in the country.
- Reduce avoidable deaths.
• Reduce time spent in hospital.
• Support people living independently at home.
• Improving health related quality of life for people with long term conditions including mental health.
• Secure additional years of life for people particularly in deprived areas.

The Proactive & Reactive Care Service is responsible for contributing to the delivery of the overarching outcomes of the ICP Programme which includes:

• Reduction in A&E (Accident & Emergency) attendances for the > 65 population.
• Reduction in emergency admissions for the >65 population.
• Reduce ambulance conveyances for the >65 population.
• Reduce the reliance on care home placements, contributing to reducing the Continuing Health Care and social care spend.
• Increasing the number of people supported to remain at home.
• Increasing the number of patients who are cared for and die in the place of their place of choice.
• To support patients to maintain emotional wellbeing and independence in their normal place of residence.
• To Support patients under 65 with complex needs.

All teams across health and social care work collaboratively, sharing knowledge and skills. The responsive service teams can provide a time limited support for patients in the community and to develop admission avoidance pathways.

Patients can be referred in to this service by their General Practitioner or a Paramedic/Practitioner.
Referral Criteria:

- Long term condition
- Change/deterioration
- Cognitive impairment
- History of Falls
- Care/Community Breakdown
- Admission to or risk of admission to hospital in last 12 months
- Medication Issues
- Primary chronic physical health condition where a secondary mental health condition may be suspected

Describe the current situation

The four elements of the Out of Hospital Service have been established and this project aims to strengthen the outcomes. The development of the Reactive Care aspect of the Proactive Care Service is being scoped to help support patients in the community with their health needs, with the aim of keeping them at home, instead of in hospital.

What engagement, including with different equality groups, has taken place to inform this equality analysis?

Various engagement events took place in the initial establishment of the Integrated Care Partnership (ICP). These were listed in the previous Equality Analysis that can be found on the Guildford and Waverley CCG website or by clicking [HERE](#).

Community services were discussed at Practice Council meetings throughout 2016/17.

**January 2016**

- Pre Market Engagement Event for Adult Community Health Services
April 2016
- Interested Bidders Event for Adult Community Health Services

September 2016
- Forward View
- Practice Council

November 2016
- Practice Council
- Frailty Forum
- Proactive Care Service Workshop

January 2017
- Frailty Forum

For each of the Equality Groups detailed below, consider how your proposal will affect or address health needs relevant to that group. Refer to demographic information about people living in Guildford and Waverley CCG and consider who will be affected.

AGE

The total Guildford and Waverley CCG population is 207,772 and consists of approximately 102,725 (49.4%) men and 105,047 (50.6%) women. Approximately one quarter (24%) are children and young people aged 0-19 years. Almost 60 per cent (58%) are adults of working age (20-64 years). Approximately a fifth (18%) are older adults, aged 65 years and over, with 3% of the population the very old, aged 85 years and over.

Equality Analysis / INTEGRATED ‘OUT OF HOSPITAL’ SERVICES / February 2017
Mid 2013 Estimate of Guildford and Waverley Population by broad age group and gender

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>% Total</th>
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<tbody>
<tr>
<td>0-19</td>
<td>25,915</td>
<td>24,188</td>
<td>50,103</td>
<td>24</td>
</tr>
<tr>
<td>20-64</td>
<td>59,792</td>
<td>59,962</td>
<td>119,754</td>
<td>58</td>
</tr>
<tr>
<td>65 and over</td>
<td>17,018</td>
<td>20,897</td>
<td>37,915</td>
<td>18</td>
</tr>
<tr>
<td>85 and over</td>
<td>2,071</td>
<td>3,958</td>
<td>6,029</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>102,725</td>
<td>105,047</td>
<td>207,772</td>
<td>100</td>
</tr>
</tbody>
</table>

The proportion of people aged 65 years and older is projected to increase and therefore sustainable systems designed to meet the needs of the frailest members of the community are needed. This service will be primarily targeting the over 65 population; however it is recognised that there should be flexibility for patients with complex conditions under the age of 65 that may benefit from this service.

**Conclusion & Recommendations**  Is there positive, negative or no impact? How will negative impact be addressed?

There is a positive impact. Providers will need to focus on the complex needs of the patients referred and although the service is only for adults, it will be needs-based rather than age-based.

**DISABILITY (mental, physical, learning disability, dementia)**

**Physical disability**

People with physical disabilities are a very diverse group with a variety of causes and severity of disability. What they do have in common is that they are more likely than able-bodied people to suffer from falls, have poorer measured quality of life and health related quality of life, and be more likely to suffer from respiratory and urinary tract infections. Depending on the level and nature of their disability, they are more likely to live in poverty or to be economically inactive, less likely to have educational qualifications and more likely to experience problems with hate crime, harassment or sexual violence and transport.

It is estimated that 10.8% of the adult population in Great Britain are disabled, which equates to 22,000 people in Guildford and Waverley CCG. The CCG was estimated to have 1078 people aged 18 – 64 with a serious personal care disability in 2015. This is projected to
increase by 6% in the next ten years.

Learning Disability

The Confidential Enquiry into Premature Deaths of People with Learning Disabilities (2013) found that men with learning disabilities died, on average, 13 years earlier than the general population, while women with learning disabilities died 20 years earlier. While some of the causes of learning disabilities are associated with health problems leading to lower life expectancy, 42% of deaths investigated in the Confidential Enquiry were assessed as potentially avoidable, due to inferior healthcare or lack of reasonable adjustments to enable people with learning disabilities to access healthcare appropriately. Additionally, virtually all those investigated had at least one long term health condition including epilepsy, cardiovascular disease, hypertension, dementia and osteoporosis.

Surrey had large numbers of long stay hospitals and the placement of large numbers of people into these during the last century and their subsequent closure has artificially increased the proportion of people with a learning disability in the general population. Those who remained are aging so that the population with learning disabilities in Surrey is believed to be older than those with learning disabilities in other areas. In the long term these numbers will gradually reduce returning the number of people in Surrey with a learning disability towards the national average for the indigenous population.

In Guildford and Waverley CCG, 3,091 adults (aged 16 -64) are estimated to have a learning disability, which is projected to increase to 3,196 by 2025. The number of adults aged 65 and over with learning disabilities is predicted to increase from 820 to 973 in the same period. In Surrey 21,239 adults are estimated to have a learning disability, which represents 2.37% of Surrey’s adult population.

Disability is a protected characteristic under the Equality Act (2010), so the CCG must have regard to this population in the services they commission. Additionally, Indicator 1.7 of the NHS Outcomes Framework monitors the CCG’s progress in reducing the excess under-60 mortality in this particular group. It is worth noting that almost 40% of those with moderate or severe learning disabilities under 65 live with their parents. As they and their parents age there is a risk that parents may no longer be able to support their children, requiring substantial additional input by health and social care services.

If more care is provided at home, it will prevent admissions that will benefit people with certain disabilities whose conditions may worsen with hospital admission. For a patient who has a Personal Assistant, they may not be able to keep their PA whilst in hospital due to funding as this is not covered by existing funding arrangements. By preventing admission, we will enable more people with disabilities to maintain existing personal assistant arrangements, which helps improve dignity and care for this group.
Conclusion & Recommendations  Is there positive, negative or no impact?  How will negative impact be addressed?

There is a positive impact but the following recommendations will enhance the service further for this equality group:

- Providers to continue to apply needs based referrals rather than age-based to ensure that those with early onset frailty are catered for under this service.
- Providers need to ensure patient materials can be made available in accessible formats that cater to a wide range of communication needs including braille, audio, written, etc.
- Providers need to make reasonable adjustments to ensure that their communications are accessible to the patient. For example, ensuring SMS text services are available 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.

ETHNICITY / RACE / ETHNIC GROUP

The largest ethnic group in Guildford and Waverley CCG is Gypsy, Roma and Travellers. Surrey has the 4th largest GRT community in the country whilst Guildford and Waverley is home to just under 1,000 people who identify with this ethnic group. Local research with this community identified high levels of smoking (48%), high blood pressure (52%) and anxiety/depression (48%). This poorer health could lead to a greater prevalence of the long term conditions. 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.
(1) The average number of persons per pitch is four. This has been used to estimate the population numbers at local authority level.

(2) To meet IG requirements around small counts, the data has been colour coded on the map in terms of quintiles with the first quintile having the highest number of pitches and the fifth quintile the lowest (< 12 pitches) at Lower Super Output Area (LSOA).

* It should be noted that LSOAs have a population of around 1,500 people.
No impact. There is potential for a negative impact but full provisions will mitigate.

- 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.
- Language needs should be accommodated for via the usual processes in place within all providers.

**GENDER**

National life expectancy statistics show women having a significantly higher life expectancy than men. These differences mean that it is likely that more women than men will receive support, as women will generally be living longer than men and require this kind of support.

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. Women as a whole are generally more likely to approach health and social care at an earlier stage.

Research indicates that more women than men suffer with frailty nationally and in particular within elderly people who live in their own home.

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 to note that this service is targeted equally at both genders that are elderly and have multiple long term conditions.
Providers and commissioners need to engage with relevant voluntary groups to ensure that both genders benefit equally and 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 Lesbian, Gay, Bisexual and Transgender (LGBT) community. For the impact on the LGBT community, see the sexual orientation section.

This service will not impact either positively or negatively on a patient who has had gender reassignment.

Conclusion & Recommendations  Is there positive, negative or no impact?  How will negative impact be addressed?

No impact.

RELIGION & BELIEFS

GP Practices work with frail and elderly patients to put together a 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 expected outcome of this approach is better communication around PACe plans so that a patient’s wishes around religious beliefs are followed even in an emergency situation.

Conclusion & Recommendations  Is there positive, negative or no impact?  How will negative impact be addressed?

No impact.

MARRIAGE & CIVIL PARTNERSHIP

Equality Analysis/ INTEGRATED ‘OUT OF HOSPITAL’ SERVICES /February 2017
This service will not impact either positively or negatively on people who are married or in a civil partnership.

**Conclusion & Recommendations**

Is there positive, negative or no impact?  How will negative impact be addressed?

There is no perceived impact on marriage and civil partnerships.

**PREGNANCY & MATERNITY**

This would be managed by the maternity services.

**Conclusion & Recommendations**

Is there positive, negative or no impact?  How will negative impact be addressed?

No Impact.

**SEXUAL ORIENTATION**

The health needs of people may vary depending on their sexual orientation.

Members of the lesbian, gay, bisexual and transgender communities (LGBT) have been found to have higher levels of certain health behaviors such as excess alcohol consumption, drug use and smoking, as well as lower uptake of screening programmes. This could contribute to disproportionately more members of the LGBT community developing long term conditions, which can exacerbate frailty and therefore require the coordinated support offered by the locality model.

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.

It is estimated that the LGBT population is 5-7% of the population (assumed to mean the adult population). For Guildford and Waverley CCG, this equates to between 8,430 and 11,800 people identifying as LGBT, in the absence of specific population data for this equality group in the CCG area.
Table 10: 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>
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<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>
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</table>

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.

Conclusion & Recommendations

<table>
<thead>
<tr>
<th>Is there positive, negative or no impact?</th>
<th>How will negative impact be addressed?</th>
</tr>
</thead>
</table>
| No impact.                              | - 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**

Carers play an important role in keeping the ill or frail out of hospital. One study found that problems with the carer contributed to hospital readmission in 62% of cases while another found that 20% of those requiring care were admitted to hospital after their carer could no longer cope.

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. The Carers Prescription Service provides GP’s with an easy solution to support
Carers they come into contact with. Across Surrey there are a number of organisations that GP’s can refer Carers to. The Carers Prescription is a secure mechanism for GP’s to make a referral. The team will then make arrangements for the referral to be processed quickly and efficiently.

**Conclusion & Recommendations**  
Is there positive, negative or no impact?  
How will negative impact be addressed?

<table>
<thead>
<tr>
<th>Positive impact.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Positive impact on patient and carer, keeping them home together.</td>
</tr>
<tr>
<td>• Providers need to actively promote support services available to carers in order to improve awareness and uptake.</td>
</tr>
<tr>
<td>• Providers should encourage local people who identify as a carer to register with their GP so that they can access support via that channel.</td>
</tr>
</tbody>
</table>

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

Surrey as a whole is the fifth least deprived county in England ranking 144th out of 149, with 60.9% of the population falling into the least deprived quintile. The most deprived area within Guildford and Waverley CCG is in the ward of Westborough but there are other small pockets including Shalford which sits within an area which is one of the least deprived. The five most deprived LSOAs within Guildford and Waverley CCG are in the wards of Westborough, Godalming Central, Ockford and Stoke.

**Conclusion & Recommendations**  
Is there positive, negative or no impact?  
How will negative impact be addressed?

| No impact. This service will not impact either positively or negatively on people from areas of deprivation and geographical location. There is equal access to Guildford and Waverley patients for this service. |

**VULNERABLE GROUPS e.g. ex-military, homeless, looked-after children, those seeking asylum**

Guildford and Waverley CCG has very low rates of statutory homelessness compared to London and the rest of England. The provider must ensure that homeless people can access their services. Homeless people attend A&E up to six times as often as the general population; are admitted four times as often and once admitted; tend to stay three times as long in hospital as they are invariably...
sicker. As a result, acute services are four times, and unscheduled hospital costs are eight times those of general patients. Nearly 90% of all ‘NFA – No Fixed Abode’ admissions are emergency admissions compared to around 40% for the general population. (Deloitte Centre; p5)

Conclusion & Recommendations  Is there positive, negative or no impact?  How will negative impact be addressed?

No impact.

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.

OVERALL CONCLUSIONS & RECOMMENDATIONS: Summarise your findings for all equality groups

Overall, the Out of Hospital services for G&W CCG will have a positive impact on all equality groups.

<table>
<thead>
<tr>
<th>Name of person completing EA</th>
<th>Job Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracey Rowland</td>
<td>Commissioning Support Officer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of lead Manager / Director</th>
<th>Signature</th>
<th>Date completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Williams</td>
<td></td>
<td>13/02/17</td>
</tr>
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