West, North & East Cumbria

Equality Impact Analysis Report

July 2016

FINAL

Contents:

1) Introduction

The West, North and East Cumbria Success Regime has been established to help create the right conditions for high quality health and social care to develop in this area. The aim is to secure improvement by introducing new care models where appropriate, developing leadership capacity and capability across the health system and ensuring collaborative working

The vision is to position WNE Cumbria as an area recognised for its expertise in delivering integrated health and care for people living in rural, remote and dispersed communities. This will require our services to be underpinned by a comprehensive approach to public health and prevention and characterised by strong clinical networks across health and social care within WNE Cumbria and beyond.

It is clear that change is needed in order to respond to the challenges of:

- An ageing population with increasingly complex needs
- National shortages of key clinical roles
- Meeting ever increasing external standards
- Significant financial pressure facing all parts of the NHS and social care.

The aim is to deliver more services within the community, protecting and enhancing primary care and strengthening out-of-hospital services, while also encouraging individuals to change their behaviour to prevent poor health and reduce overall demand. The implementation of Integrated Care Communities (ICCs) is seen as a focus for the development of community and primary care, with community hospitals playing a key part. The expectation is that ICCs will strengthen out of hospital care and reduce the need for unplanned hospital admissions. This will enable NCUHT to focus on delivering secure, safe, stable, and high-performing acute hospital services.

The development of mental health services in parity to physical health services (from prevention to treatment and care) is fundamental to these proposals. However as statutory consultation on the wider plans to transform mental health services takes place as part of a related Cumbria-wide process, it does not form part of this analysis.

This Equality Impact Analysis (EIA) is a desk top exercise, focusing on four areas identified as being of concern to the local communities:

- Maternity Services
- Paediatric Services
- Emergency and Acute Medical Care
- Community Hospital Bed Configuration

This EIA should be seen as a starting point, with an ongoing process to engage with representatives covering the protected characteristics, through the consultation process due to start in September. The additional engagement will lead to the production of a EIA covering the WNE Cumbria Strategy.

2) The Equality Act and Public Sector Duty

The NHS Constitution (Principle 1) states that the NHS has "a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population".

The Equality Act (2010)

The Equality Act, which came into force in April 2011, replaces existing anti- discrimination laws with a single act. It aims to help public authorities avoid discriminatory practices and integrate equality into their core business.

The Public Sector Equality Duty

The CCG is also subject to the Public Sector Equality Duty Section 149 of the Equality Act places an additional set of requirements upon public bodies, known as the Public Sector Equality Duty. This is made up of a general equality duty which is supported by specific duties.

The general equality duty requires public authorities, in the exercise of their functions, to have due regard to the need to:

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

The specific duty requires public authorities to publish annually information on the effects of their services and employment on people who share a protected characteristic, these include:

- Age
- Disability
- Gender
- Gender Reassignment
- Marriage & Civil Partnership
- Pregnancy & Maternity
- Race
- Religion & Belief
- Sexual Orientation

Although not classed as protected characteristics carers, rural isolation and deprivation have been included in this analysis due to the specific geography and make up of Cumbria. Further information is available at www.gov.uk/equality-act-2010-guidance

Method

Organisations are free to decide exactly how they do and demonstrate their analysis of equality impact. There is no longer a *specific duty* to produce a document called an 'Equality Impact Analysis', but it is important to record that a genuine and systematic assessment of how significant changes such as those proposed by the PCBC will impact on protected characteristic groups and your duties towards them.

The Equality and Human Rights Commission[1] advises that this analysis:

- Has the buy-in of senior staff
- Draws on relevant equality information and the results of engagement activity

[1] Equality & Human Rights Commission (2009) Equality Impact Assessment Guidance: A step-by-step guide to integrating equality impact assessment into policymaking and review.

- Requires decision makers to consider taking steps to mitigate adverse impacts where they have been identified
- Documents how information about the actual impact of the policy will be used to review the policy in future.

Our method in undertaking this EIA reflect this guidance including:

- A review of the work stream propositions and initial equality screening
- A search for the most recent and relevant local statistics relating to demographics, health issues, service usage, patterns of inequality for each of the protected characteristic groups
- A review of local engagement activities
- A review of relevant national research, literature and good practice to test, support or fill gaps in the local evidence base.

3) Local Demographics & Protected Characteristics

The chart below shows the total population for Cumbria with the locality breakdown. It includes the Better Care Together (Vanguard area) for information but does not form part of this EIA. Any reference to Better Care Together in demographic and protected characteristic data is there for comparison only.

Cumbria	498,100
WNE Cumbria Success Regime Area	
Allerdale	96,200
Carlisle	106,138
Copeland	70,000 (circa 8400 who access services in Vanguard)
Eden	52,600
Better Care Together	
South Lakeland	103,500
Barrow in Furness	67,800

Source JSNA: Office for National Statistics (ONS), Mid-2013 Population Estimates

AGE

The age profile of Cumbria's districts varies considerably. Out of the 348 local authority districts in England & Wales, South Lakeland and Eden have the 5th and 12th lowest proportions of residents aged 0-15 years respectively, while South Lakeland also has the 12th highest proportion of residents aged 65+. (Cumbria JSNA 2015 onwards)[2] Allerdale, Eden and South Lakeland have the smallest proportions of residents in each of the three youngest age groups and the greatest proportions of residents in each of the three oldest age groups.

Between mid-2013 and mid-2014 all of Cumbria's districts, except Carlisle, experienced negative natural change (more deaths than births). In Carlisle there were 200 more births than deaths.

[2] http://www.cumbriaobservatory.org.uk/health/JSNA/2015/homepage.asp

Area	0 to 15	16 – 24	25 – 34	35 – 49	50 & Over
Allerdale	16,202	9,121	9,429	20,067	40,151
Carlisle	18,417	11,577	12,732	22,540	40,872
Copeland	11,968	6,988	7,420	14,957	27,979
Eden	8,538	4,500	4,611	10,980	22,984

Between 2015 and 2020, the number of people aged under 60 years is expected to decrease by 3.4% and those aged 60 years and older is expected to increase by 8%.

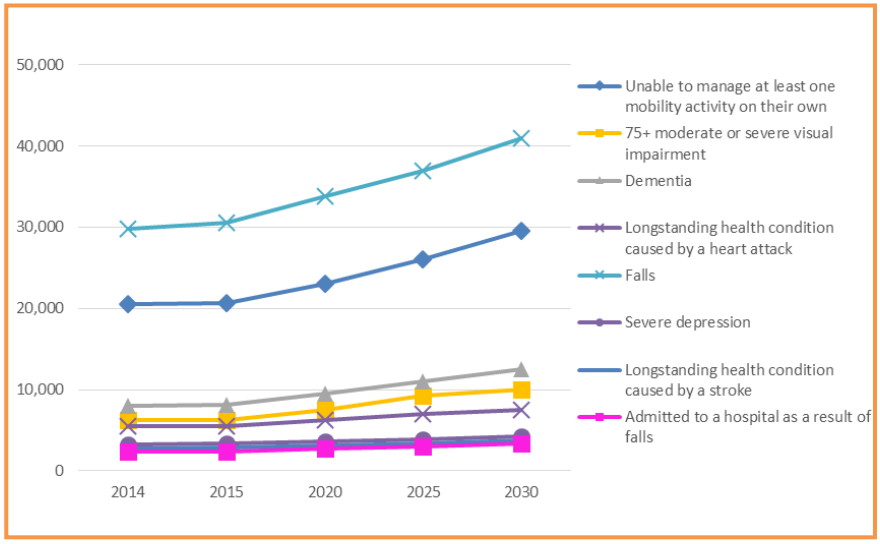
Health Projection (65+Years)

A so-called "super ageing" population increases demand for a number of services, and places particular pressure on social care providers

Nationally, 83% of those aged 85+ and 61% aged between 75 and 84 have at least one disability or limiting long-term condition; many have multiple conditions (2011 Census).

The number of people affected by age related conditions including dementia is predicted to increase significantly and this cohort of patients are also more likely to utilise health and care services.

These projections are depicted in the graph below; *Source: POPPI, Cumbria Health and Wellbeing Strategy 2016-19*



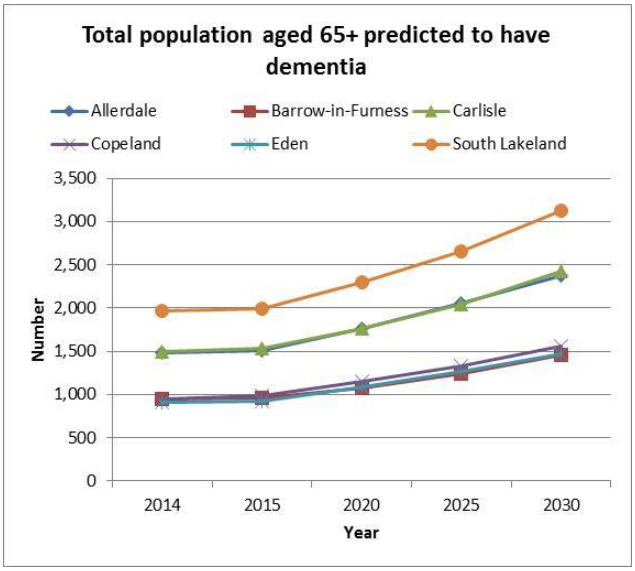
The majority of carers in WNE Cumbria are older people, many of whom have health and disability issues themselves: the number of older carers is likely to increase, given the demographics (JSNA 2012; Older People: Health & Social Care)

Unintentional injuries, particularly falls, are the most frequent type of injury suffered among older people in the UK. NWAS (North West Ambulance Service) data indicates that falls comprise approximately 88% of all injuries serious enough to warrant an ambulance call out for people aged 50 years and over. (Cumbria JSNA 2015 onwards) Falls can precipitate admission to long-term care and people aged 65 and over spend four million days in hospital each year as a result of falls and fractures (Royal College of Physicians, 2011)

Excess winter deaths (EWDs) are considered preventable and it is important to protect those who are most vulnerable during cold winter month. In a bad winter, more than 300 people die in Cumbria due to the effects of the cold weather and the elderly are among the most vulnerable (Source: PHOF)

Dementia

There are an estimated 7,721 people living with dementia in Cumbria (source: POPPI, 2015, Ref: 043) however, it is recognised that numbers are underestimated. The number of people with dementia is expected to rise substantially as our population ages. Over the next 5 years, numbers of people with dementia are predicted to increase by 17.7%; by 2030 numbers are projected to increase significantly by 60.7%, from 7,721 to 12,410. People with dementia stay far longer in hospital than other people who are admitted for the same procedure. The longer people with dementia are in hospital, the worse the effect on the symptoms of dementia and the individual's physical health; discharge to a care home becomes more likely and antipsychotic drugs are more likely to be used[3].



Population aged 65+ predicted to have dementia, 2014 – 2030, by district (Source: POPPI, 2015)- Extracted from JSNA draft carers chapter

Children & Young People

During 2014/15 there were over 16,000 A&E attendances by children aged 0-18 years at WNE Cumbria hospitals, 45 children per day (60% at CIC and 40% at WCH). The rate of attendance varies considerably across localities: 780 attendances for children on practice lists in Eden; 3975 for those in Copeland; 3995 for those in Allerdale; and 6108 in Carlisle. This suggests that those living closest to an acute hospital have the highest attendance rate. 86% of children attending A&E are discharged home without admission.

In under 19s in 2013/14 there were 385 observed unplanned hospitalisations for asthma, diabetes and epilepsy; this equates to a rate of 381.4 per 100,000 registered patients under 19 (higher than the national average of 311.4), with under 19s admissions for epilepsy in the area being in the highest quartile of all areas nationally. Hospital admissions for 0-14 year olds are higher for unintentional and deliberate injuries than they are nationally. Hospital admissions for those under 18 related to alcohol is almost 70% higher. (Cumbria JSNA 2015 onwards)

GENDER

Between the 2001 and 2011 Census data, numbers of male residents increased across all but one of Cumbria's localities; the exception being Barrow-in-Furness where the number of males fell by 2.6%. The greatest increase in numbers of males was seen in Carlisle (+7.7%). Numbers of female residents also increased across all but one of Cumbria's districts between 2001 and 2011; with the exception again being Barrow-in-Furness where the number of females fell by 5.4%. Once more, the greatest increase in numbers of females was seen in Carlisle (+5.8%).

[3] The Alzheimer's Society (2009) Counting the Cost: Caring for people with dementia on hospital wards

	% Persons	
Area	**Males**	**Females**
Allerdale	49.1	50.9
Carlisle	48.8	51.2
Copeland	50.2	49.8
Eden	49.5	50.5

Women have a higher life expectancy than men in Cumbria for males is 78.8 years and females 82.4years which are lower than the national average of 79.2 years and 83 years respectively. Older women are more likely than their male peers to: live alone, be poor, have dementia (Blood 2010[4]).

The Cumbria JSNA 2015 identified that in 2010, men smoked a higher number of cigarettes a day than women, with men smoking on average 13.3 cigarettes a day, compared with 12.1 for women.

33% of men and 50% of women are unlikely to get enough physical activity and around 66% of adults are overweight and obese. Physical activity declines with age to the extent that by the age of 75 years only one in ten men and one in 20 women are active enough for good health and due to the ageing population within Cumbria this presents a considerable risk.

Based on the profile of Cumbria's residents, the county has slightly greater estimated proportions of women who consume more than 3 units of alcohol per day (Cumbria 30.1% vs. UK 28.8%) and men who consume more than 4 units of alcohol per day (Cumbria 42.4% vs. UK 41.4%). In Allerdale the rate of alcohol specific mortality in females of 12.9 per 100,000 was significantly worse than England at 7.5 per 100,000.

Older women have a much higher risk of osteoporosis than their male peers and of subsequent fractures as a result of falls, which are a major cause of older people needing support. One in two women and one in five men will suffer a fracture after the age of 50, mainly due to osteoporosis (National Osteoporosis Society).

ETHNICITY

Numbers of residents from BME groups increased considerably across all of Cumbria's districts between 2001 and 2011, with the greatest increases seen in Carlisle (+143.4%) and Eden (+104.1%), particularly in relation to migration from eastern Europe. While Cumbria has a smaller proportion of residents from BME groups than the national average, as numbers of BME residents have increased more rapidly in Cumbria than nationally in recent years, the ethnic profile of Cumbria is changing to become more representative of the rest of England & Wales. National research suggests that less than a third of those migrating to the UK register with a GP. Older people, asylum seekers and refugees; and women whose circumstances make them 'vulnerable' (e.g. domestic violence) are least likely to register[5]. Barriers include: language, lack of understanding of the system or their entitlements, not having relevant documentation to register, fears about having to pay or being reported to the Home Office. BME people

[4] Blood, I (2010) Older people with high support needs: a Round-up of the evidence, Joseph Rowntree Foundation
[5] Maternity Action/ Women's Health & Equality Consortium (2012) Guidance for Commissioners of Health Services for Vulnerable Migrant Women

living in predominately white British areas can also face particular challenges in terms of accessing culturally appropriate services and being 'invisible' to provider.

	% Persons					
Area	**White British**	**White Other**	**Mixed/multiple Ethnic Group**	**Asian/ Asian British**	**Black/African /Caribbean/Black British**	**Other Ethnic Group**
Allerdale	97.6	1.3	0.4	0.5	0.1	0.1
Carlisle	95.0	3.1	0.5	1.2	0.1	0.1
Copeland	97.3	1.2	0.5	0.9	0.1	0.1
Eden	97.0	1.9	0.4	0.6	0.0	0.1

In 2009, NHS Cumbria completed a Health Needs Assessment for Cumbria Gypsy Travellers. The assessment found that:

- As highlighted in other studies, Gypsies and Travellers have significantly poorer health status and more self-reported symptoms of ill-health than both other UK resident English-speaking ethnic minority groups and economically disadvantaged white UK residents.
- Travellers did express specific concerns about their health as an ethnic group, particularly in relation to high levels of anxiety and stress, smoking, alcohol and drug use.
- Gypsy and Traveller children are likely to need greater access to paediatric care as they have lower immunisation levels and are less likely to be registered with a GP Practice

(source:http://www.cumbriaobservatory.org.uk/elibrary/Content/Internet/536/671/4674/5359/5360/40723111743.pdf)

DISABILITY

When compared to England & Wales, Cumbria has a similar proportion of residents with bad or very bad health (Cumbria: 6%, England & Wales: 5.6%). Of Cumbria's six districts, Barrow-in-Furness had the greatest proportion of residents with bad or very bad health (8.4%), while Eden and South Lakeland had the smallest proportions of residents with bad or very bad health (both 4.5%).

3 neighbourhoods in West, North and East Cumbria rank within the 1% most deprived in the country for health and disability: these neighbourhoods are in Harbour (Copeland), Moss Bay (Allerdale), and Sandwith (Copeland) wards.

2011 Census: Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?				
	No. Persons	% Persons		
	All people	Day-to-day activities limited a lot	Day-to-day activities limited a little	Day-to-day activities not
England & Wales	56,075,912	8.5	9.4	82.1
Cumbria	499,858	9.7	10.6	79.7
WNE Cumbria Success Regime				
Allerdale	96,422	10.1	10.7	79.2
Carlisle	107,524	9.2	10.0	80.8
Copeland	70,603	10.7	10.7	78.7
Eden	52,564	7.8	10.2	82.0
Better Care Together				
South Lakeland	103,658	8.0	10.8	81.2
Barrow-in-Furness	69,087	13.0	11.7	75.4

Almost two million people in the UK are living with sight loss that has a significant impact on their daily lives. The Cumbria JSNA 2015 estimates 17,760 people living with sight loss in Cumbria, of those 2,150 are living with severe sight loss (blindness). The estimated prevalence of sight loss in Cumbria is 3.6%, compared to 2.9% in the UK. By 2020, the number of people living with sight loss in Cumbria is projected to increase to 21,660; while the number of people with severe sight loss are projected to increase to 2,710. The older you are the more likely you are to be living with sight loss and are more likely to have other health conditions or disabilities.

In Cumbria in 2015 there estimated to be 49,346 people aged 65 years and over with a moderate, severe or profound hearing impairment. This is predicted to increase to almost 71,000 in 2030, with the majority (32,719) aged 75-84 years. (Source: POPPI)

Some people have dual sensory loss –both hearing loss and sight loss, but there are no figures available to show the numbers of people in Cumbria with dual sensory loss.

RELIGION

Cumbria has a higher proportion of Christian residents (71.9%) compared to the national average (59.3%). Of Cumbria's six districts, Copeland had the greatest proportion of Christian residents (78.9%), the smallest proportion of residents with no religion (14.4%), and the smallest proportion of residents who did not state a religion (5.9%). In contrast, South Lakeland had the smallest proportion of Christian residents (68.1%), the greatest proportion of residents with no religion (23.1%), and the greatest proportion of residents who did not state a religion (7.7%). South Lakeland and Carlisle had the joint greatest proportion of residents with a religion other than Christian (both 1.2%), while Allerdale had the smallest proportion of residents with a religion other than Christian (0.7%).

Muslims can be particularly vulnerable to religious discrimination: research conducted by the Joseph Rowntree Foundation in 2008[6] found that nearly a third of British Muslims had experienced religious discrimination.

The Department of Health's (2009) *Religion or belief: a practical guide for the NHS* identifies a number of considerations for healthcare providers, including:

- Dietary needs (including some issues with prescribed drugs, e.g. those which contain porcine products);
- Respect for the Sabbath, fasting, prayer times and holy days;
- Modesty in dress/ the requirement to be treated by a doctor or nurse of the same sex;
- Issues around the receipt of blood products/ organ donation;
- Spiritual needs in relation to palliative care/ end of life (including access to religious leaders, priests or ministers; beliefs and customs around death; dealing with grieving relatives);
- Cultural differences in attitudes to mental health/ dementia and the use of psychotropic drugs to treat them

[6] Joseph Rowntree Foundation (2008) Immigration, Faith and Cohesion, Centre on Migration, Policy and Society, University of Oxford

SEXUAL ORIENTATION

Nationally it has been estimated that 5 to 7% of the population is lesbian, gay, or bisexual (LGB) if this percentage was applied to WNE Cumbria it would equate to between approximately 15,000 and 21,000 LGB people in WNE Cumbria. Those registered in the 2011 Census as in a registered same sex civil partnership was approximately 800 across Cumbria. However, The Office of National Statistics (2010) found that 1.4% of people in the general population identified themselves as lesbian, gay or bisexual; 94.2% as heterosexual or straight; the remaining 4.4% either refused to identify, said they did not know or described themselves as 'other.' Concerns around confidentiality or receiving a negative reaction, confusion about what is being asked or the categories offered, embarrassment or uncertainty can mean that some people will not feel comfortable identifying themselves as lesbian, gay and bisexual during a telephone interview with a stranger. Those who did feel comfortable enough to do so, were more likely to be younger, white and work in managerial or professional roles: lesbian, gay and bisexual people in these groups are more likely to be 'out' about their sexual orientation. However, it is important for organisations commissioning and providing health and social care to be aware of the existence and needs of 'hidden' lesbian, gay and bisexual people who are older, from black and minority ethnic or working class backgrounds.

GENDER RE-ASSIGNEMENT

Based on research by the Gender Identity Research and Education Society, 600 per 100,000 people have some degree of gender variance. An estimated 20 per 100,000 have sought medical care for this issue. In WNE Cumbria, this would mean that approximately 1,700 people have some degree of gender variance, of whom 55 have sought medical care. Mitchell and Howarth[7] reviewed the available research evidence on trans people's health needs and access to health care for the Equality and Human Rights Commission in 2009. In addition to needs directly related to gender reassignment treatment, trans health needs may be derived from experiences of isolation and discrimination, with trans men and women at greater risk of alcohol and drug abuse, depression, suicide/ self-harm or violence than the general population. There is however limited information relating to this group in Cumbria.

PREGNANCY AND MATERNITY.

In 2014/15 there were 3036 births in NCHUT with 1,703 deliveries in Cumberland Infirmary Carlisle, 1264 in West Cumberland Hospital and 69 in the midwifery led unit in Penrith. A small number of women also required very specialist tertiary services outside Cumbria due to complications of mother or baby usually provided by Newcastle Upon Tyne Hospitals NHS FT for tertiary and level 3 neonatal facilities.

In 2010 Cumbria had a lower proportion of women of childbearing age (15 and 44)34% as compared to the North West (39% and England (40%). This proportion is expected to fall to around 30% by 2031.
Cumbria had a slightly higher proportion of births to teenage mothers in 2010 compared to England and Wales (8% and 6% respectively). The proportion of births to older mothers (aged 40 and over) was similar to national figures. From 2006 to 2010, the number of births to mothers aged 40 and over decreased by 6%, the largest percentage decrease of all the age groups. The largest percentage increase was seen in the 25 – 29 year old group (13%).

The proportion of babies born at low birthweight (less than 2,500 grams) is increasing in Cumbria; however it remains lower than that seen in the North West and England and Wales. In 2010 6.8% of

[7] Mitchell, M. & Howarth, C. (2009) Trans Research Review, NatCen/ Equality and Human Rights Commission, Research Report 27

babies born in Cumbria were of a low birthweight compared to 7.2% in the North West and 7.3 % in England and Wales. There were variations in method of delivery in Cumbria during the five year period 2005 to 2009. For example, 10.3% of deliveries in Cumbria were by elective caesarean, but at local authority level this proportion ranged from 8.2% in Carlisle to 11.2% in Copeland. During this time almost two-thirds of all deliveries in Cumbria were conducted by a midwife (64.5%), while hospital doctors conducted just under a third of deliveries (31.0%).

The table shows the number of live births and crude birth rate (per 1,000 population) for Cumbria and the localities.

Area	2006		2007		2008		2009		2010	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Cumbria	4,917	9.9	4,998	10.1	5,118	10.3	5,068	10.3	5,068	10.3
WNE Cumbria Success Regime										
Allerdale	891	9.5	1,001	10.6	983	10.4	983	10.4	1,012	10.8
Carlisle	1,170	11.1	1,123	10.6	1,225	11.7	1,255	12.0	1,275	12.2
Copeland	774	11.1	735	10.5	747	10.7	715	10.3	745	10.7
Eden	476	9.2	454	8.8	472	9.1	478	9.2	452	8.7
Better Care Together										
South Lakeland	810	7.8	889	8.5	876	8.4	886	8.5	842	8.1
Barrow in Furness	796	11.2	796	11.2	815	11.5	763	10.8	742	10.5

CARERS

As set out in the Care Act 2014, an adult carer is someone who helps another person, usually a relative or friend, in their day-to-day life. A young carer is a child or young person under the age of 18 who takes on a level of practical and emotional caring responsibilities that would generally be expected of an adult.

The number of carers is thought to be significantly underestimated; despite existing services and support networks already in place many carers remain hidden. Male carers are less likely to be identified as they may not be accessing help or support.

Provision of unpaid care, county and district

	Provides unpaid care		Provides 1 to 19 hours unpaid care a week		Provides 20 to 49 hours unpaid care a week		Provides 50 or more hours unpaid care a week	
	All ages	**% of total pop**	**All ages**	**% of all carers**	**All ages**	**% of all carers**	**All ages**	**% of all carers**
Cumbria	56,495	11.3	35,927	63.6	7,265	12.9	13,303	23.5
Allerdale	10,774	11.2	6,632	61.6	1,436	13.3	2,706	25.1
Carlisle	11,305	10.5	7,233	64.0	1,418	12.5	2,654	23.5
Copeland	7,981	11.3	4,695	58.8	1,179	14.8	2,107	26.4
Eden	5,962	11.3	4,208	70.6	620	10.4	1,134	19.0
England	5,430,016	10.2	3,452,636	63.6	721,143	13.3	1,256,237	23.1

(Source: Census 2011)

The report made a number of recommendations and identified six options to address the ongoing issues. Of the six options only three were recommended to be taken forward subject to a detailed feasibility report exploring the cost, viability and risk associated with each one, considering working in very different ways to try and improve long term safety through different configurations and working practices of staff.

As a result of the work to date, three possible service models are being considered and tested in terms of deliverability and sustainability. It is recognised that the model for maternity services must also take account of the key interdependencies with other key services, specifically paediatrics and anaesthetics, both of which are experiencing significant pressures associated with workforce availability.

Potential models for maternity services in WNE Cumbria:

The high-level service implications for the maternity options are summarised below. It is important to note that for all options, local antenatal and post-natal care will continue to be provided across WNE Cumbria.

- **New ways of working** will retain a CLU at WCH with risk stratification such that women assessed as higher risk will be advised to have their intrapartum care at CIC. This option also proposes an MLU is established at WCH & CIC. Based on current estimates, between 200-300 women would be impacted by this change – specifically women expecting twins, with a BMI greater than 35, women who have had a previous section and where the expected foetal weight is over 4.5kg. If planned inductions and caesarean sections would have transferred this would further reduce the number of women delivering in Whitehaven by 30% (330).

- **Partial consolidation** would consolidate a single CLU at CIC, with a maternity-led unit at WCH & CIC providing an option for women assessed as low risk and suitable for maternity led care. Based on current data 489 would be advised to have consultant led care, however given the geographic distance some lower risk women may choose to deliver their babies at CIC.

- **Full consolidation** of all intrapartum care at CIC. All deliveries, other than home births would be provided at CIC. Based on current data this would impact on just over 1600 women a year who would receive their care at CIC rather than WCH.

Equality Impact Analysis – Maternity Options

Protected Characteristic	Option 1 New Ways of Working			Option 2 Partial Consolidation			Option 3 Full Consolidation		
Option / area	west	north	east	west	north	east	west	north	east
Race	N	N	N	N	N	N	N	N	N
Religion & Belief	N	N	N	N	N	N	N	N	N
Gender	N	N	N	N	N	N	N	N	N
Disability	-	N	N	-	N	N	-	N	N

	the expected foetal weight is ÀE 4Ìg. Copeland and Allerdale have high obesity levels when compared to the national average. See data below: Excess weight in Adults - % of adults (16+ years) classified as overweight or obese (Source: Active People Survey, Sport England (PHOF) 2012-14 x 71.4% of adults (aged 16+ years) in Copeland are classified as obese or overweight, worse than the England average of 64.6%; and ranked the 3rd worst (out of 39) local authority in the North West. x 68.6% of adults (aged 16+ years) in Allerdale are classified as obese or overweight, worse than the England average of 64.6%; and ranked 10th worst (out of 39) local authority in the North West. Obese adults - % Adults with a BMI greater than or equal to 30kg/m2 (Source: Active People Survey, Sport England (PHOF) 2012-14) x 27.9% of adults (aged 16+ years) in Copeland are classified as obese, worse than the England average of 24%; and ranked the 6th worst (out of 39) local authority in the North West. Women who are obese are more likely to have associated diseases and pregnancy complications and have higher risk pregnancies (source: http://www.acog.org/Patients/FAQs/Obesity-and-Pregnancy). Travel time for intrapartum care is perceived as a significant risk (See travel impact assessment below). dZ¥ZvÃÑPÎ((oÁ number	mitigating actions. x Community midwives provide a high level of advice and support regarding healthy weight and breastfeeding both prior to and following birth. This support will not be impacted on by the proposed changes and will continue to be available to all pregnant women/new mothers, regardless of maternity-related complications.
Gender Reassignment	There is no robust data available for groups with this protected characteristic in Cumbria.	x Based on the assessment carried out, no mitigation required.
Rural Isolation & Deprivation	Considering the large % of residents in West Cumbria who live in a rural or deprived area and may not have access to a car, travel time for intrapartum care is perceived as a significant risk (See travel impact assessment below).	x See travel analysis section for risk and mitigating actions x Consideration needs to given to transport solutions for Carer/family members to aid visiting.

Impact on travel times for maternity (based on average speed of 35 miles per hour)

	Option	Configuration Details	Groups Affected	Total Affected	Estimated additional average travel time
Maternity	New ways of working	WCH low risk CLU CIC CLU and MLU	Mat day case Mat inpatient Neonatal Inpatient Neonatal day case	245 244 6 1	45:05 45:50 46:44 47:37

	Partial consolidation	WCH MLU CIC CLU and MLU	Mat day case Mat inpatient Neonatal Inpatient Neonatal day case	245 244 32 3	45:05 45:50 46:44 47:37
	Full consolidation	WCH Ante and post-natal only CIC CLU and MLU	Mat day case Mat inpatient Neonatal Inpatient Neonatal day case	815 813 32 3	45:05 45:50 46:44 47:37

6.2) Paediatric Services

Current position

Currently NCUHT provides paediatric assessment and inpatient services at both CIC and WCH, with 39 beds across the two sites (24 beds at CIC and 14 bed at WCH) operating as 16 inpatient beds and eight assessment beds from 08.00 to 20.00 hours. The 14 beds in WCH operate as seven inpatient beds and seven assessment beds from 08.00 to 21.00 hours; they function as a 14-bed area overnight.

During the CQC inspection, NCUHT's paediatric services were rated as "good", however longer term sustainability issues in paediatrics have been noted as a challenge to the system for some time and the Royal College of Paediatrics & Child Health (RCPCH) requirements for senior assessment and emergency cover are only partially met on the two sites.

There may by significant scope to change patterns of demand for urgent and emergency care through improved integrated community children's services and encouraging and supporting self-care.

New Models of Care

The aim is to create an evidence-based, sustainable, one-team model focused on integrated services to improve health outcomes and patient experience for children, young people and their families.

The changing nature of childhood illness means that fewer children require an inpatient hospital stay and those that do need to be admitted tend to have a shorter length of stay than in the past. Changing epidemiology also means there has been an increase in children with complex long term conditions and technological developments have enabled a children's health service delivery model that is much more community-based and multidisciplinary.

The new model reflects the fact that 37% of children admitted to hospital stay less than 12 hours and 83% stay just one day. (Nationally the evidence shows that up to 97% of children referred as emergencies can be safely managed through a Short Stay Paediatric Assessment unit (SSPAU) without needing an inpatient admission).

The proposals focus on supporting staff to work as a single team. Specifically:

- An integrated clinical workforce, including a coordinated children's nursing service that will deliver acute care and community-based, multidisciplinary care as close to home as possible including Cumbria's children's hospice as part of the integrated nursing team.

- A place-based approach – ensuring that children can get care they need as close to their home as possible.

- Working seamlessly with SSPAUs delivering rapid assessment and treatment and support for children who require a specialist assessment or period of observation.

The short-listed options for paediatric services are as follows:

- **New ways of working** would see the establishment of a 14-hour SSPAU with nurse-led low-acuity beds at WCH. SCBU and inpatient paediatrics would be consolidated at CIC. In relation to paediatric care, we believe that the establishment of consultant led paediatric assessment units at both CIC and WCH represents the optimal model to provide rapid, expert assessment, diagnosis, treatment and assessment. Based on current activity, this would have an impact on just under 250 episodes of care each year for children in West Cumbria who may need consultant-led inpatient care at CIC.

- **Partial consolidation** would result in all inpatient beds being consolidated at CIC, with a 14-hour SSPAU at WCH. Based on current activity this would have an impact on just over 300 episodes of care each year for children living in West Cumbria who would have their care provided at CIC.

- **Full consolidation** would result in a single SSPAU at CIC, with outpatient paediatric services at WCH to include 9am-5pm hot clinics. Based on current activity this has the potential to have an impact on over 1600 episodes of care each year.

Equality Impact Analysis – Paediatric Options

Protected Characteristic	Option 1 New Ways of Working			Option 2 Partial Consolidation			Option 3 Full Consolidation		
Option / area	west	north	east	west	north	east	west	north	east
Race	N	N	N	N	N	N	N	N	N
Religion & Belief	N	N	N	N	N	N	N	N	N
Gender	N	N	N	N	N	N	N	N	N
Disability	N	N	N	N	N	N	N	N	N
Sexual Orientation	N	N	N	N	N	N	N	N	N
Age	- / +	+	+	-	+	+	- -	-	-
Pregnancy & Maternity	-	N	N	-	N	N	-	N	N
Gender Reassignment	N	N	N	N	N	N	N	N	N
Rural Isolation & Deprivation	-	N	N	-	N	N	- -	N	N

Impact Assessment & Mitigation

Protected Characteristic	Reason for impact assessment rating	Suggested Mitigation
Race	Compared to England & Wales, Cumbria has lower proportions of residents from all broad ethnic groups, therefore all the proposed options for paediatric services are not likely to impact on health and wellbeing linked to ethnicity. Yet we have noted that people from BME groups living in predominately white British areas can face particular challenges in terms of accessing culturally appropriate services and being 'invisible' to providers. It should be noted that between 2001 and 2011, Cumbria experienced a greater proportional increase in numbers of residents from BME groups than the national average; with the greatest increases seen in Carlisle (+143.4%) and Eden (+104.1%); particularly in relation to migration from the eastern Europe. Gypsy and Traveller children are likely to need greater access to paediatric care as they have lower immunisation levels and are less likely to be registered with a GP Practice.	• Regarding broad ethnic groups - No current mitigation is assessed as required, however it is recommended that further advice from AWAZ Cumbria is sought and wherever possible, the ethnicity of patients using Paediatric services in Cumbria is reviewed annually. This would allow any changes in ethnicity profiles to be identified, and service provision and cultural training for staff to be reviewed and amended if required. • CCG to work with the Allerdale, Carlisle, Copeland and Eden District Councils and CPFT to: - identify current Gypsy and Traveller sites/resident numbers across the WNE Cumbria area - Assess possible health need in relation to Paediatric services - If health need is identified, carry out specific consultation with Gypsies and Travellers who may be affected by the proposed options
Religion & Belief	In Cumbria, the reported religion held by residents in each district (as reported in the 2011 census) is not statistically different from the England averages, therefore this indicates that population health and wellbeing linked to religion will not be significantly impacted upon by the proposed changes to Paediatric services.	• Based on the assessment carried out, no mitigation required, although further advice from AWAZ Cumbria is recommended.
Gender	There is limited information regarding the ratio of boys to girls accessing paediatric services across Cumbria. However, in 2012/13, males accounted for 58% of children's and 62% of young people's attendances to A&E.	• Based on the assessment carried out, no mitigation required, although further work to identify causes for A&E admission in children in Cumbria should be carried out, and actions to help prevent admissions prioritised across primary care, public health and early help (e.g. accident prevention advice and promotion of self-care).
Disability	Evidence shows that Copeland and Allerdale do not have a higher than average % of children 0-19 with 'long-term health problems or disability/activities limited'	• Ensure adequate suitable transport options, including parking are available for patients with disabilities who need to travel further to access Paediatric services.

	There is no robust evidence to indicate that families with disabled children are more likely to access paediatric A&E, than families with children who do not have disabilities. However the literature suggests that families with disabled children might actually avoid taking them to A&E, due to a perception that the staff may not understand the needs of the child. Parents with disabilities however, may find it more challenging to travel longer distances, especially if they do not own their own transport.	• Carry out specific consultation with groups who may be affected by the proposed options to feedback during the consultation.
Sexual Orientation	There is no robust data available for groups with this protected characteristic.	• Based on the assessment carried out, no mitigation required
Age	During 2014/15 there were over 16,000 A&E attendances by children aged 0-18 years at WNE Cumbria hospitals, 45 children per day (60% at CIC and 40% at WCH). The rate of attendance varies considerably across localities: 780 attendances for children on practice lists in Eden; 3975 for those in Copeland; 3995 for those in Allerdale; and 6108 in Carlisle. This suggests that those living closest to an acute hospital have the highest attendance rate. 86% of children attending A&E are discharged home without admission. Options that involve consolidating paediatric services to CIC, may impact on children and families living in the Allerdale and Copeland districts e.g. if a child requires urgent care during the night, the family may take the child to Carlisle, which would mean a longer distance to travel and a longer time period before accessing services	• Based on the assessment carried out, no mitigation required, although further work to identify causes for A&E admission in children in Cumbria should be carried out, and actions to help prevent admissions should be prioritised across primary care, public health and early help (e.g. accident prevention advice and promotion of self-care). • Nationally the evidence shows that up to 97% of children referred as emergencies can be safely managed through a SSPAU without needing an inpatient admission. Therefore options that include SSPAU provision at WCH are preferable to those that do not.
Pregnancy & Maternity	All the options propose consolidating SCBU to CIC. As this service is used by the youngest of children, all the proposals could potentially have a negative impact on the very young (e.g. premature babies) and their families resident in West Cumbria e.g. longer distances to travel could create anxiety amongst family members.	• A thorough analysis of the risks involved in having no SCBU facility at WCH needs to be carried out and the findings used to support additional consultation with stakeholders, the public and representative groups in order to identify the best possible service configuration in the future. • Ensure all relevant maternal care pathways are updated and tested to ensure that they maintain optimal levels of care for babies who require SCBU and whose families would have used the service at WCH if it was still present.
Gender Reassignment	There is no robust data available for groups with this protected characteristic in Cumbria	• Based on the assessment carried out, no mitigation required.

Rural Isolation & Deprivation	Considering the large % of residents in West Cumbria who live in a rural or deprived areas and may not have access to a car, travel time for children requiring paediatric services is a risk, especially for families living in West Cumbria. (See travel impact assessment). Levels of child poverty are below the national average across West, North and East Cumbria. However, there are notable pockets of child poverty e.g. Sandwith ward in Copeland (42.2%); and Moss Bay ward in Allerdale (33.6%). As children from deprived areas are more likely to access paediatric services, any consolidation of services to CIC (from WCH) may have a negative impact on families in parts of Whitehaven and Workington, due to reduced accessibility. (Source: Child Poverty Needs Assessment (February 2014 update), Cumbria Intelligence Observatory)	• See travel analysis section for risk and mitigating actions. • Consideration needs to given to transport solutions for Carer/family members to aid visiting. Consider providing additional resources to support health improvement work (for 0-19 year olds and their families) through primary care, public health and early help in Workington and Whitehaven

Impact on travel times for paediatric options (based on average speed of 35 miles per hour)

	Option	Configuration Details	Groups Affected	Total Affected	Estimated additional average travel time
Paediatrics	New ways of working	WCH: 14 hr SSPAU low acuity beds CIC: 14 hr SSPAU & inpatient	NEL Non-complex inpatient NEL complex inpatient Elective inpatient	49 44 2	46:58 46:58 35:11
	Partial consolidation	WCH: 14 hr SSPAU CIC: 14 hr SSPAU & inpatient	NEL inpatient Elective inpatient	291 11	46:58 35:11
	Full consolidation	WCH: Outpatient only & 9–5 hot clinic CIC SSPAU & inpatient	Elective day case NEL inpatient NEL day case Elective inpatient	53 291 1323 11	48:06 46:58 46:27 35:11

6.3) Future Models of Care - Emergency & Acute Care

Current Position

Many aspects to improve emergency and acute medical care are being progressed as part of the commitment to continuous improvement, a number of changes have been made to develop a single-service model across the two acute hospital sites with the aim of improving outcomes for patients.

Following pubic consultation (undertaken since June 2013), the majority of operative trauma provision has been provided at CIC. Although the major stimulus for that change was associated with improved outcomes, an important local factor was the lack of resources to provide a robust service on both sites.

Some trauma services were maintained at the WCH site to minimise travelling as well as the burden on the ambulance service and the infrastructure at Carlisle. This comprised an on-call rota, two trauma lists per week for minor trauma procedures, new patient fracture clinics for minor injuries and local admission of patients requiring conservative management. In February 2014 a number of changes to the service at WCH were made on safety grounds. These changes reflected a clinical audit of activity undertaken between July 2013 and February 2014.

The changes resulted in the cessation of on call and inpatient trauma care at WCH. It also included a reorganisation of consultant input to fracture clinics and revised protocols in A&E. In June 2014, the decision to cease minor trauma operations at WCH was made due to extremely low numbers (1-2 per week) and consequent inefficiency.

In addition there was a review of the high-risk surgical pathways that were transferred as part of the wider changes to emergency surgery. There are three pathways that could be treated effectively and efficiently at WCH within the new WCH facility, providing care closer to home for some lower risk patients, allowing more efficient use of lists for CIC inpatient emergencies that will improve patient flow.

New Models of Care

Option 1 – New Ways of Working	
CIC	**WCH**
24/7 A&E with UCC streaming. Integrated emergency floor, including hot clinics. Minor increase in ICU, EAU and inpatient specialty beds. Hyper acute stroke unit and ASU. Frailty assessment unit and rehab including specialist rehab.	Integrated emergency floor with UCC streaming. Including hot clinics & day time specialty support. Selected admissions for complex patients where no advantage to transfer. Limited provision of low risk non elective surgery and trauma. A small ICU. Frailty Assessment unit and rehabilitation.

New ways of working with more emphasis on anticipatory and ambulatory care alongside innovative workforce models is a significant departure from previous attempts to work differently and solve the workforce problems, particularly at WCH. Based on current activity levels we would expect this option to affect 1092 patients (each year who would have their care provided at CIC rather than WCH.

Option 2 – Partial Consolidation	
CIC	**WCH**
Increased capacity in 24/7 A&E with UCC streaming. Integrated emergency floor, including hot clinics. An increase in ICU, EAU and inpatient specialty beds. Hyper acute stroke unit and ASU. Frailty assessment unit and rehab including specialist rehabilitation.	Daytime A&E with UCC 24/7, including hot clinics and day time specialty support. Selected blue light admissions and GP referrals during day time. Limited provision of low risk non elective surgery and trauma. No ICU, but day time intensivist support. Frailty assessment, non-complex admissions and rehabilitation.

Volumes of acute medical patients at the WCH site would be reduced by diverting all blue lights and all acute admissions (including GP and self-referrals) to CIC at night time, e.g. 8pm to 8am. Between these hours, WCH would operate as an Urgent Care Centre (UCC), utilising the composite workforce model described above.

Based on current activity levels we would expect this option to affect up to 4,083 patients each year who would have their care provided at CIC rather than WCH.

Option 3 – Full Consolidation	
CIC	**WCH**
Significant increase in capacity in 24/7 A&E to take all blue light ambulances, with UCC streaming; Increase in transfers requiring 10 – 20% additional paramedics. Integrated emergency floor, including hot clinics. Increase in ICU, EAU and inpatient specialty beds. Hyper acute stroke unit and ASU. Frailty assessment unit and rehab including specialist rehabilitation.	UCC only with access to hot clinics and day time specialty support. Ambulatory and "step up" inpatient care only, no acute admissions. No ICU. Frailty assessment, noncomplex admissions and rehabilitation.

An UCC will operate 24/7 at WCH. CIC would have a 24 A&E department with a dedicated UCC to ensure appropriate streaming.

All acute admissions would be directed to CIC, with selected GP referrals for step up or end of life care only at WCH. The UCC would be staffed by GPs and Advanced Nurse Practitioners to triage patients correctly into pathways based on risk and presentation, and to expedite their passage through the system.

Based on current activity levels we would expect this option to affect 11048 patients (100% of Type 1 A&E patients) each year who would have their care provided at CIC rather than WCH.

Equality Impact Analysis – Emergency & Acute Care

Protected Characteristic	Option 1 New Ways of Working			Option 2 Partial Consolidation			Option 3 Full Consolidation		
Option / area	west	north	east	west	north	east	west	north	east
Race	N	N	N	N	N	N	N	N	N
Religion & Belief	N	N	N	N	N	N	N	N	N
Gender	N	N	N	N	N	N	N	N	N
Disability	-	N	N	-	N	N	- -	-	-
Sexual Orientation	N	N	N	N	N	N	N	N	N

Age	-	N	N	-	N	N	- -	-	-
Pregnancy & Maternity	N	N	N	N	N	N	N	N	N
Gender Reassignment	N	N	N	N	N	N	N	N	N
Rural Isolation & Deprivation	-	N	N	-	N	N	- -	N	N

Impact Assessment & Mitigation

Protected Characteristic	Reason for impact assessment rating	Mitigation
Race	Compared to England & Wales, Cumbria has lower proportions of residents from all broad ethnic groups, therefore all the proposed options for Emergency & Acute services are not likely to impact on health and wellbeing linked to ethnicity. Yet we have noted that people from BME groups living in predominately white British areas can face particular challenges in terms of accessing culturally appropriate services and being 'invisible' to providers. It should be noted that between 2001 and 2011, Cumbria experienced a greater proportional increase in numbers of residents from BME groups than the national average; with the greatest increases seen in Carlisle (+143.4%) and Eden (+104.1%); particularly in relation to migration from the eastern Europe As already highlighted, Gypsies and Travellers have significantly poorer health status and more self-reported symptoms of ill-health, particularly in relation to high levels of anxiety and stress, smoking, alcohol and drug use. (source:http://www.cumbriaobservatory.org.uk/elibrary/Content/Internet/536/671/4674/5359/5360/40723111743.pdf) This suggests that Gypsies and Travellers may be more likely to require Emergency & Acute Services than other ethnic groups, however there is not enough data available to identify geographical areas where need may be greater.	• Regarding broad ethnic groups - No current mitigation is assessed as required, although further advice from AWAZ Cumbria is recommended and wherever possible, the ethnicity of patients using Emergency & Acute services in Cumbria is reviewed annually. This would allow any changes in ethnicity profiles to be identified, and service provision and cultural training for staff to be reviewed and amended if required. • CCG to work with the Allerdale, Carlisle, Copeland and Eden District Councils and CPFT to: - identify current Gypsy and Traveller sites/resident numbers across the WNE Cumbria area - Assess possible health need in relation to Paediatric services - If health need is identified, carry out specific consultation with Gypsies and Travellers who may be affected by the proposed options
Religion & Belief	In Cumbria, the reported religion held by residents in each district (as reported in the 2011 census) is not statistically	• Based on the assessment carried out, no mitigation required,

	different from the England averages, therefore this indicates that population health and wellbeing linked to religion will not be significantly impacted upon by the proposed changes to Emergency & Acute Services.	although further advice from AWAZ Cumbria is recommended
Gender	The proportion of male and female residents across West, North and East Cumbria are equally split (no significant difference between population %). There is no evidence to suggest that the changes proposed will disproportionately affect males or females.	• Based on the assessment carried out, no mitigation required.
Disability	The percentage of residents in Allerdale and Copeland who describe their day-to-day activities as 'limited a lot' is greater than the Cumbria average (10.1% and 10.7% versus 9.7%). Eden has a lower percentage (7.8%). 3 neighbourhoods in West, North and East Cumbria rank within the 1% most deprived in the country for health and disability: these neighbourhoods are in Harbour (Copeland), Moss Bay (Allerdale), and Sandwith (Copeland) wards. As disabled people are more likely to require Emergency & Acute Services, and find it easier to access services closer to home, options that reduce or exclude provision in Cumbria could significantly impact on disabled groups. This refers to all the options proposed. Options that do not include A&E or ICU provision could potentially impact on disabled people living in the west, although these numbers are likely to be small.	• Through the development of integrated care communities, provide support to residents with disabilities in their own homes and communities, in order to reduce the requirement for Emergency & Acute Services admissions • Ensure adequate suitable transport options are available for patients with disabilities who need to travel further to access Emergency & Acute Services.
Sexual Orientation	There is no robust data available for groups with this protected characteristic. Emergency & Acute Services are accessible to all groups regardless of sexual orientation, therefore the impact of the proposed options have been assessed as 'neutral' with relation to sexual orientation.	• Based on the assessment carried out, no mitigation required – although it is important that organisations commissioning and providing health and social care be aware of the existence LGB groups and 'hidden' LGB people who may be older, from BME or working class backgrounds.
Age	Between 2008/09 – 2012/13 the rate of emergency hospital admission (all causes) across Copeland and Allerdale was significantly lower than the England average, however rates for CHD, stroke and MI were significantly higher than the England average (COPD – no significant difference). Between 2012 and 2017, the 65+ years population is likely to increase by the following in each district: Allerdale (2,600), Carlisle (2,200), Copeland (1,700), Eden (1,700). The number of people affected by age related conditions including dementia is predicted to increase significantly and this cohort of patients are also more likely to utilise Emergency	• It is important that any proposed changes to Emergency & Acute Services are mitigated against through the timely provision of enhanced community-based services. This is particularly important for people living in West Cumbria. • It is important that consideration is given to ambulance capacity

	& Acute Services. A reduction in locally available Emergency & Acute Services is likely to have a significant impact on the health and wellbeing of the population (particularly older residents carers and family members). There is strong evidence that there are improved outcomes for stroke patients if they have access to timely specialist stroke care.	for the transfer of patients between sites as transport solutions for Carer/family members to aid visiting. • Discharge planning that proactively takes into consideration transport issues and support to get people home.
Pregnancy & Maternity	Women are not likely to access Emergency & Acute Services services for general pregnancy and maternity care. Most women will go directly to community midwives or hospital-based maternity units.	• Based on the assessment carried out, no mitigation required.
Gender Reassignment	There is no robust data available for groups with this protected characteristic in Cumbria. However, Emergency & Acute Services are fully accessible to anyone who proposes to, starts or has completed a process to change his or her gender. Therefore the impact of the proposed options has been assessed as 'neutral' with relation to gender reassignment.	• Based on the assessment carried out, no mitigation required.
Rural Isolation & Deprivation	54% of Cumbria's residents live in rural areas compared to 18% nationally. Considering the large % of residents in West Cumbria who live in a rural area and may not have access to a car, changes to Emergency & Acute Services could significantly impact on accessibility for vulnerable patients, carers and relatives. Consolidation of A&E could result in non-attendance by those living furthest from the service, posing a significant risk.	• See travel analysis for risk and mitigating actions • It is important that any proposed changes to Emergency & Acute services are mitigated against through the provision of enhanced community-based specialist services that support people to remain at home when they are unwell and/or living with a long-term condition. • Consideration needs to given to transport solutions for Carer/family members to aid visiting.

Travel Analysis for Emergency & Acute Medical Care

Option 1: New ways of working

This option includes a 24/7 A&E at both sites. However, it involves transferring 10% of A&E attendances from West Cumberland Hospital and reducing complexity at this site. This equates to 16 people per day travelling to a new hospital (13 to Cumberland Infirmary and 3 to West Cumberland Hospital).

Summary	To CIC	To WCH	Total
Est total no. of people affected	4737	1264	6001
Additional Miles Travelled	127311	25347	152658

Additional Time (Hours) Travelled	3637	724	4362

Detailed breakdown is available in the full report.

Option 2: Partial consolidation

This option retains non-complex maternity work at West Cumberland Hospital but involves a daytime A&E with an urgent care centre 24/7. For modelling purposes, it has been assumed that A&E will operate at West Cumberland Hospital between 8am and 6pm and deals with all cases during that time. Approximately 57.8% of A&E attendances occurred during these times in 2015/16. According to one document quoted (Fin v6.1WCH Med Staff Clin Strategy Props'n.doc), if there was no A&E at WCH, 69% of attendances would still take place at WCH via a minor injuries / illness unit. Therefore, 31% of A&E is deemed complex and this proportion of attendances are moved from those taking place between 6pm and 8am. This equates to 20 people per day travelling to a new hospital (17 to Cumberland Infirmary and 3 to West Cumberland Hospital).

Summary	**To CIC**	**To WCH**	**Total**
Est total no. of people affected	5973	1264	7237
Additional Miles Travelled	161502	25347	186850
Additional Time (Hours) Travelled	4614	724	5339

Detailed breakdown is available in the full report

Option 3: Full consolidation

All complex A&E attendances, 50% of non-elective day cases and non-complex inpatients would transfer to Cumberland Infirmary. Complex A&E attendances are defined as 31% of activity (see (Fin v6.1WCH Med Staff Clin Strategy Props'n.doc). All maternity, neonatal and paediatric inpatients would also transfer. However, a higher proportion (20%) of elective day cases and non-complex inpatients would move from Cumberland Infirmary to West Cumberland Hospital. This equates to 63 people per day travelling to a new hospital (49 to Cumberland Infirmary and 14 to West Cumberland Hospital.

Summary	**To CIC**	**To WCH**	**Total**
Est total no. of people affected	17867	5056	22923
Additional Miles Travelled	484946	101399	586344
Additional Time (Hours) Travelled	13856	2897	16753

Detailed breakdown is available in the full report

6.4) Future Models of Care - Community Hospitals

Community hospitals have a long history in the area and are strongly supported by their local communities and active League of Friends that contribute significant funds. Overall they deliver a high standard of nursing care and excellent patient experience.

Community hospitals will be a significant asset in the delivery of integrated out-of-hospital care particularly in the context of the development of ICCs.

Engagement involving a wide range of health and social care stakeholders makes it clear that thriving, sustainable community hospitals can support rural communities and provide centres for the delivery of integrated health and social care with facilities for diagnostics and ambulatory care.

Current Position

There are currently eight community hospitals in WNE Cumbria and an inpatient unit on the WCH site, which are operated by CPFT. The geographical position of the hospitals has, to a large extent, grown up based upon historical development rather than population health needs.

The number of inpatient beds in each hospital ranges from seven to twenty-eight. Some community hospitals host minor injury and/or primary care assessment services as well as a range of outpatient and therapy services.

Where community hospitals have a small number of beds, there have been significant challenges associated with recruitment and safe staffing levels. Some of our units are very small and often only have 1 registered nurse on duty, recruitment and sickness issues in small units can lead to crisis situations where no registered staff are available to work which results is unplanned bed closures putting pressure on the whole system. This can lead to existing staff working long hours, double shifts for prolonged periods of time. The CQC report in autumn 2015 highlighted that staff often felt isolated and vulnerable

The cost of community hospital inpatient beds is comparatively high, with significant variation between sites ranging from £288- £454 per bed night (correct August 2015). Admission criteria is variable across sites, and there have been a number of quality and safety issues – which are a concern given the increased pressure on a depleted workforce who may not always have the most appropriate skill sets to provide optimum care (depending on the complexity of need). There is considerable variation in the condition of community hospital estates and the ongoing ability to meet national standards.

New Models of Care

In considering the options for community hospital inpatient beds, it has been recognised that these must be seen in the context of the changing needs of the population and the wider changes being considered to support safe and sustainable health and care services in WNE Cumbria. While community hospitals are considered primarily as having beds, as strengthened out of hospital care is developed, they have a much broader role in the context of ICCs – acting as natural hubs to provide a focus for the delivery and co-ordination of care.

In considering the needs of the population, a review of community hospital inpatient capacity has been undertaken, which suggested that WNE Cumbria currently has a significantly higher number of community

hospital inpatient beds compared to most other areas in England. (Based on a population of 330,000, and making a presumption that the beds are used appropriately, the data would indicate the need for 84 community hospital beds, compared with 133 beds currently).

- **Option 1** - Focus the future bed bases onto fewer sites within West Cumbria, Eden and Carlisle (minimum 16 bed units)
- **Option 2** - Focus the future bed bases onto fewer sites within West Cumbria, Eden and Carlisle, with some specialisation (minimum 16 bed units)
- **Option 3** - Create capacity to deliver 102 community bed equivalents (such as through hospital at home model, commissioning capacity through nursing homes etc.)

'In relation to operational deliverability, the initial judgement regarding suitability of current community hospital sites for future sustainability is that:

- It would be prohibitive to expand two of the current sites to support the minimum of 16 beds (Maryport Community Hospital and Alston Community Hospital);
- Wigton is assessed as no longer being suitable for long-term provision of inpatient beds, with minimal scope to address current issues given the estates condition.

The remaining options pass the hurdle criteria and have been confirmed as the short list of options to be taken forward for detailed appraisal. There is recognition that the opportunity of creating 'virtual beds' capacity will need to be considered at a local level as the development of ICCs is progressed, and this therefore should be progressed differentially across WNE Cumbria

For all options, the expectation is that the implementation of ICCs will strengthen out of hospital care and reduce the need for unplanned hospital admissions and enable a significant reduction in length of stay. As a result, the financial plans are assuming a reduction in the total number of inpatient beds across the system over time. For example, to mitigate the impact of additional travel for the three hospitals without in-patient beds (Alston, Wigton and Maryport), we are proposing to reinvest 50% of the savings to greatly strengthen local primary and community nurse and therapy teams aimed at supporting more people to stay in their own homes.'

Equality Impact Analysis – Community Hospitals

	Option 1 Minimal Consolidation of beds			Option 2a Partial Consolidation around 5 sites (incl Cockermouth)			Option 2b Partial Consolidation around 5 sites (incl Workington)			Option 3 Consolidation round 3 sites		
Option / area	west	north	east	west	north	east	west	north	east	west	north	east
Race	N	N	N	N	N	N	N	N	N	N	N	N
Religion & Belief	N	N	N	N	N	N	N	N	N	N	N	N
Gender	N	N	N	N	N	N	N	N	N	N	N	N
Disability	--	N	-	--	N	-	-	N	-	--	-/+	-
Sexual Orientation	N	N	N	N	N	N	N	N	N	N	N	N
Age	-	N	--	-	N	--	-	N	--	--	-/+	--

Pregnancy & Maternity	N	N	N	N	N	N	N	N	N	N	N	N
Gender Reassignment	N	N	N	N	N	N	N	N	N	N	N	N
Rural Isolation & Deprivation	-	N	--	--	N	--	-	N	--	--	N	--

Impact Assessment & Mitigation

Protected Characteristic	Reason for impact assessment rating	Suggested Mitigation
Race	Compared to England & Wales, Cumbria has lower proportions of residents from all broad ethnic groups, therefore all the proposed options for community hospitals are not likely to impact on health and wellbeing linked to ethnicity. We have noted that people BME people living in predominately white British areas can face particular challenges in terms of accessing culturally appropriate services and being 'invisible' to providers. It should be noted that between 2001 and 2011, Cumbria experienced a greater proportional increase in numbers of residents from BME groups than the national average; with the greatest increases seen in Carlisle (+143.4%) and Eden (+104.1%); particularly in relation to migration from the eastern Europe As already highlighted, Gypsies and Travellers have significantly poorer health status and more self-reported symptoms of ill-health, particularly in relation to high levels of anxiety and stress, smoking, alcohol and drug use. This suggests that Gypsies and Travellers may be more likely to require inpatient care at a community hospital than other ethnic groups, however there is not enough data available to identify geographical areas where need may be greater.	• Regarding broad ethnic groups - No current mitigation is assessed as required, however further advice from AWAZ Cumbria is recommended and that wherever possible, the ethnicity of patients using community hospitals in Cumbria is reviewed annually. This would allow any changes in ethnicity profiles to be identified, and service provision and cultural training for staff to be reviewed and amended if required. • CCG to work with the Allerdale, Carlisle, Copeland and Eden District Councils and CPFT to: 4) identify current Gypsy and Traveller sites/resident numbers across the WNE Cumbria area 5) Assess possible health need in relation to community hospitals 6) If health need is identified, carry out specific consultation with Gypsies and Travellers who may be affected by the proposed options
Religion & Belief	In Cumbria, the reported religion held by residents in each district (as reported in the 2011 census) is not statistically different from the England averages, therefore this indicates that population health and wellbeing linked to religion will not be significantly impacted upon by the proposed changes	• Based on the assessment carried out, no mitigation required, although further advice from AWAZ Cumbria is recommended.

	to community hospitals.	
Gender	The proportion of male and female residents across West, North and East Cumbria are equally split (no significant difference between population %). There is no evidence to suggest that Community Hospital inpatient bed usage is disproportionate between males and females. Therefore, the proposals related to community hospital beds are unlikely to impact specifically on either males or females.	• Based on the assessment carried out, no mitigation required.
Disability	The percentage of residents in Allerdale and Copeland who describe their day-to-day activities as 'limited a lot' is greater than the Cumbria average (10.1% and 10.7% versus 9.7%). Eden has a lower percentage (7.8%). 3 neighbourhoods in West, North and East Cumbria rank within the 1% most deprived in the country for health and disability As disabled people are more likely to require inpatient care, and find it easier to access services closer to home, options that reduce or exclude inpatient provision in west Cumbria could significantly impact on disabled groups. This refers to all the options proposed. Options that to not include inpatient provision in Alston could potentially impact on disabled people living in the East area, however the data suggests that the numbers would be lower than in West, so a potentially 'medium negative impact' has been indicated.	• Through the development of integrated care communities, provide support to residents with disabilities in their own homes and communities, in order to reduce the requirement for inpatient care in community hospitals • Ensure adequate suitable transport options are available for patients with disabilities who need to travel further to access community hospital services, including access to parking.
Sexual Orientation	There is no robust data available for groups with this protected characteristic in Cumbria. However community hospital services (both inpatient and outpatient) are accessible to all groups regardless of sexual orientation, therefore the impact of the proposed options have been assessed as 'neutral' with relation to sexual orientation.	• Based on the assessment carried out, no mitigation required – although it is important that organisations commissioning and providing health and social care be aware of the existence LGB groups and 'hidden' LGB people who may be older, from BME or working class backgrounds.
Age	**Population data (source – ONS):** The proportion of the population in Cumbria aged 65+ years, by district (and comparison with Cumbria and England & Wales averages) England & Wales – 17.4, Cumbria – 22.2, Allerdale – 22.3, Carlisle – 19.6, Copeland – 20.5, Eden – 23.8 Between 2012 and 2017, the 65+ years population in likely to increase by the following in each district: Allerdale (2,600), Carlisle (2,200), Copeland (1,700), Eden (1,700). **Dementia** Patients with dementia may be more likely to use community hospital inpatient beds (e.g. for respite care).	• It is important that any proposed changes to community hospital provision are mitigated against through the timely provision of community-based services, particularly specialist dementia and frail elderly support. This is particularly important for people living in West Cumbria and the Alston area. • Ensure adequate suitable

	The number of people with dementia is expected to rise substantially as our population ages. Over the next 5 years, numbers of people with dementia are predicted to increase by 17.7%; by 2030 numbers are projected to increase significantly by 60.7%, from 7,721 to 12,410. Numbers of people with dementia in Copeland are predicted to increase by +63.7% by 2030. Therefore, any reduction in locally available community hospital inpatient beds is likely to have a significant impact on the health and wellbeing of the population (particularly older residents, people living with dementia, carers and family members). Options 1 and 2a would improve accessibility to inpatient community hospital beds for older people living in Cockermouth area (and option 3 would see improved provision in Carlisle), however these options would also see reduced provision in more deprived areas, such as Workington and rurally isolated areas, such as Alston.	transport options are available for patient, families and carers who need to travel further to access community hospital services, including access to parking.
Pregnancy & Maternity	For general pregnancy and maternity care, women are not likely to use community hospital beds in Cumbria.	• Based on the assessment carried out, no mitigation required.
Gender Reassignment	There is no robust data available for groups with this protected characteristic in Cumbria. However, community Hospital services (both inpatient and outpatient) are fully accessible to anyone who proposes to, starts or has completed a process to change his or her gender. Therefore the impact of the proposed options has been assessed as 'neutral' with relation to gender reassignment.	• Based on the assessment carried out, no mitigation required.
Rural Isolation & Deprivation	54% of Cumbria's residents live in rural areas compared to 18% nationally. Of Cumbria's districts, Allerdale and Eden have the greatest proportions of residents living in rural areas (72% and 71% respectively. Considering the large % of residents in West and East Cumbria who live in a rural area and may not have access to a car, changes to community hospital services could significantly impact on accessibility for vulnerable patients and carers and relatives. See travel analysis section for further information.	• See travel analysis section for risk and mitigating actions • It is important that any proposed changes to community hospital provision are mitigated against through the timely provision of community-based specialist services that support people to remain at home during their care. This is particularly important for people living in West Cumbria and the Alston area. For option 3, this also includes residents in the Brampton area.

Travel Analysis for Community Hospitals

Option 1: Minimal consolidation of beds to six sites across WNE Cumbria

This option maintains community hospitals at Workington, Keswick, Penrith, Brampton, Copeland and Cockermouth. This is the least change option. This option affects 472 people with an estimated 1680 additional miles to travel to the nearest community hospital (estimate 48 hours). The greatest impact relates to patients who previously would have been cared for in Wigton Hospital.

Option 2a: Consolidation around 5 sites, including Cockermouth

This option maintains community hospitals at Copeland (32 beds), Cockermouth (16 beds), Penrith (24 beds), Brampton (16 beds) and Keswick (16 beds). This option affects 747 people with an estimated 3698 additional miles to travel to the nearest community hospital (estimate 106 additional hours). There is a substantial impact for the people who would have used Workington due to the relatively large numbers using this site. The average travel times for people who would have used Maryport Hospital also increases compared to option 1 as many would have moved to Workington.

Option 2b: Consolidation around 5 sites, including Workington

This option maintains community hospitals at Copeland (32 beds), Workington (16 beds), Penrith (24 beds), Brampton (16 beds) and Keswick (16 beds). This option affects 738 people with an estimated 2858 additional miles to travel to the next nearest community hospital (estimate 81.7 hours). When compared with option 2, it can be seen to have a detrimental effect for those who would have previously been admitted to Wigton Hospital (an average increase of 1.3 miles). However, the average travel times for people who would have used Maryport Hospital reduces by a similar amount and, overall, this model incurs a lower travel impact than option 2.

Option 3: Consolidation around 3 sites

This option maintains community hospitals at Copeland (increasing to 48 beds) and Penrith (24 beds), and involves a new 32 bed unit at either Cumberland Infirmary or the Carleton Unit. For this model, it has been assumed that the new unit will be sited at the Carleton Unit. This option has the greatest impact on travel, affecting 1,361 people and involving 5,105 additional miles with an estimated 145.9 hours of additional travel time. Travel time is reduced for many of those who previously used Brampton Hospital as a substantial proportion were Carlisle residents.

7) Travel Mitigations

The work of the Success Regime work has enabled engagement with a wide range of professionals and lay people so that fundamental issues of transport, physical access and associated requirements are being considered.

The focus is on making sure that adequate transport provision is built into service proposals. Efforts must be made to address significant transport challenges currently experienced by patients (and to a lesser extent our staff).

The following key issues have been identified which will need mitigating:

- Emergency transport and staffing capacity: demand outstrips capacity, but there are opportunities to reduce this through new ways of working.
- Concerns regarding emergency transfers between sites – experience and perceived safety.

- Parking difficulties – patients, carers and staff.
- Perceived gaps in public transport provision, patient transport services and information to support patients and carers in accessing health and social care sites.
- Impact on staff of greater cross-system working.
- Changes to clinical service configuration with potential significant transport impact

8) Conclusions & Recommendations

There is potential here to reduce the barriers which marginalised groups currently experience in relation to accessing health care and improve the quality of care and life for people through system re-design. However, the actual impact will depend on how these different initiatives are implemented – it will be vital to make sure that the diverse needs of patients are at the very heart of this process if the potential gains for different groups are to be realised.

Some of the risks have been highlighted under each of the protected characteristics. There are also significant potential gains for different groups and an opportunity to narrow inequality in the provision of heath care and in health outcomes, through providing a more person-centred (rather than service-lead) approach through the Integrated Care Communities. This will, however, require significant culture change and a clear understanding of equality and diversity must lie at the heart of that change.

Action planning and next steps

The partner organisations in WNE Cumbria are asked to review the contents and conclusions of this report. This EIA should be seen as a starting point, with an ongoing process to engage with representatives covering the protected characteristics, through the consultation process due to start in September. The additional engagement will lead to the production of a full EIA covering the full WNE Cumbria Strategy. We would advise that key voluntary, community sector and engagement workers are given an opportunity to review this draft and add to the evidence base where information or feedback has been missed. This report should be viewed as a 'snapshot' and a living document – to be added to, revisited and updated as more engagement is undertaken and more evidence collected.

This Equality Impact Analysis (EIA) has been undertaken as a desk top exercise, focusing on four areas identified as being of concern to the local communities:

- Maternity Services
- Paediatric Services
- Emergency and Acute Medical Care
- Community Hospital Bed Configuration

The impact of the proposed changes on the protected groups (as specified by the Public Sector Equality Duty Section 149 of the Equality Act) have been assessed. The following table summarises the recommendations made throughout this assessment.

Model	Recommendation
All models of care - Maternity Services, Paediatric Services, Emergency & Acute Medical Care, Community Hospitals.	• Carry out specific consultation with groups who may be affected by the proposed options to feedback during the consultation e.g. - Seek further advice from AWAZ Cumbria regarding the potential impact of the proposals on race, ethnicity, religion and belief.

	- Work with Cumbria CVS to carry out specific consultation with disability groups who may be affected by the proposed options. • Through the development of integrated care communities, enhance community service provision and support residents to access support/self-manage conditions in their own homes and communities, in order to reduce the requirement for hospital services. • Wherever possible, review the ethnicity of patients using health services in WNE Cumbria annually. • CCG to work with the Allerdale, Carlisle, Copeland and Eden District Councils and CPFT to assess the potential health care needs of Gypsy and Traveller Groups. • Ensure adequate suitable transport options are available for patients who may have difficulty accessing hospital services that are further away (e.g. residents in West Cumbria and rural parts of Eden, who do not have access to a car) as highlighted in the travel impact analysis.
Women and Children's Services/Maternity	• Assess the need for ambulance capacity for transfer of maternity cases between sites.
Paediatrics	• Identify causes for A&E admissions in children and identify actions to help prevent admissions through primary care, public health and early help initiatives (e.g. accident prevention advice and promotion of self-care). • A thorough analysis of the risks involved in having no SCBU facility at WCH needs to be carried out and the findings used to support additional consultation with stakeholders, the public and representative groups in order to identify the best possible service configuration in the future. • Ensure all relevant maternal care pathways are updated and tested to ensure that they maintain optimal levels of care for babies who require SCBU and whose families would have used the service at WCH if it was still present.
Community Hospitals	• It is important that any proposed changes to community hospital provision are mitigated against through the timely provision of community-based services, particularly specialist dementia and frail elderly support. This is particularly important for people living in West Cumbria and the Alston area.

Overall, the recommendation is made that the information in this report is used by the NHS Cumbria CCG and partners to inform:

- the consultation process
- the preferred models of care

Once feedback from the consultation process has been considered, and the final preferred options identified, it is recommended that this EIA be reviewed and further analysis undertaken if required.