Equality Analysis Form

Subject of equality analysis	Intermediate Care – Phase 2 (developing the model)		
Type			**Tick**
	Policy		
	Strategy		
	Business case		
	Commissioning service redesign		X
	Contract / Procurement		
	Event / consultation		
Owner	**Name:**	Karen Tooley & Debbie Aitchison	
	Job Title:	Intermediate Care Leads	
Date	June 2016		
Assessment Summary	Intermediate Care services comprise a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living (National Audit of Intermediate Care 2015, NHS Benchmarking). NHS Doncaster Clinical Commissioning Group (CCG) has prioritised intermediate care, alongside primary care, as a key transformational workstream forming part of our Care Out of Hospital programme. Doncaster Council has also recognised this as a priority workstream going forwards. A considerable amount of work has already been undertaken locally to understand and identify the intermediate health and social care needs of the Doncaster population. The work, referred to as Phase 1, was primarily focussed around gathering patient experiences and the review of over 1000 patient records using a wide multidisciplinary team that represented the key health and social care organisations in Doncaster. The work has resulted in a documented Case for Change, which has been considered through the Doncaster Health and Social Care Transformation Group and approved at the NHS Doncaster CCG Governing Body meeting in May 2016. There is consensus across health and social care partners that we now need to respond to the issues identified in the Case for Change. The next step, Phase 2, to respond to those issues will be system redesign. Phase 2 is the subject of this equality analysis.		

<table>
<tr><td></td><td colspan="2">A Project Board will be developed to coordinate the redesign of the intermediate care system. The Project Board will be a non-decision making partnership group making recommendations to the lead commissioning organisations for intermediate care services – NHS Doncaster CCG and Doncaster Council.

Four interconnected workstreams are planned in Phase 2:
• Designing the service model
• Financial modelling
• Commissioning and contracting
• Communication and engagement</td></tr>
<tr><td rowspan="7">Stakeholders</td><td></td><td>Tick</td></tr>
<tr><td>Staff</td><td>X</td></tr>
<tr><td>General public</td><td>X</td></tr>
<tr><td>Service users</td><td>X</td></tr>
<tr><td>Partners</td><td>X</td></tr>
<tr><td>Providers</td><td>X</td></tr>
<tr><td>Other</td><td></td></tr>
<tr><td>Data collection and consultation</td><td colspan="2">Data:

Intermediate Care Needs Assessment, 2014-2016
http://www.doncasterccg.nhs.uk/wp-content/uploads/2016/05/DCCG-Case-for-Change-Final-HR.pdf

• The aims of Phase 1 of the intermediate care redesign from 2014 to 2016 was to gather and analyse information to identify future intermediate care service needs by:
  ○ Collecting and analysing evidence relating to the performance of the current intermediate care system
  ○ Clearly identifying local need for intermediate care services.
  ○ Systematically evaluating the evidence base for intermediate care and models from elsewhere.
  ○ Presenting the case for change.
  ○ Identifying key elements required in the future intermediate care model for Doncaster.

• The in depth needs review was completed in early March 2016 which involved patient experience gathering, and an audit of the records of 1,027 people who had travelled through the intermediate care pathways reviewed (a statistically significant sample) by 78 expert panels with over 70 people involved from a range of teams. The results were presented back to stakeholders and the public.

• The analysis demonstrated that the majority of service users who have required intermediate care are unsurprisingly over</td></tr>
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	the age of 65 (92%) which is similar to the national average. In 2013/14 intermediate care service users appear to reside in areas with above average rate of deprivation, whereas there appears to be less demand in areas containing higher a proportion of older people. The age profile is increasing with as much as 22.39% increase in the over 85 years estimated by 2019. The latest data from the Health and Social Care Information Centre demonstrates that Doncaster is in the worst 20% for a number of indicators and the GP Quality Outcome Framework demonstrated high prevalence of Respiratory disease, Diabetes and Chronic Kidney disease. • A chart in the Case for Change (p.15) shows the demographics of the sample reviewed by the multidisciplinary team panels, alongside national and local population data. In general the sample was representative particularly in terms of age, gender and residential status. Although the sample was not representative of the ethnicity of the Doncaster population it is not yet clear if it was representative of those who use intermediate care services. The low percentage could indicate that people from BME backgrounds are underrepresented in intermediate care services or it could be due to difficulties collecting ethnicity data for at certain touch points. It will be important to investigate this further to ensure that future services are designed to meet the needs of everyone in Doncaster. ***Intermediate Care Case for Change, May 2016*** • A case for change was produced and this was approved by NHS Doncaster CCG's public Governing Body meeting in May 2016. No conflicts of interest were identified because all information was placed into the public domain. A summary of the case for change is: o Intermediate care services are too complex and difficult to access o The service model could be more efficient. o Too heavily weighted towards bed based services to step people down from hospital. o Not enough emphasis on maintaining people at home and avoiding admissions. o People who use intermediate care services have complex, often fluctuating health & social care needs and require an integrated service response. o A significant number of people have medium to very high cognitive impairment - the majority of current intermediate care services don't work with people with this level of need and we know this will increase. o Low level mental health needs, psychological needs and social isolation are not routinely addressed in

intermediate care services but these are often the reason why it is difficult to discharge someone or has a longer term impact on health and level of functioning.

- The case for change resulted in the following recommendations for future intermediate care services:
    - Intermediate care needs to be simpler and more efficient
        - Single point of access
        - Single assessment process
        - Shared recording system
        - Fewer teams
    - Integrated physical, mental health and social care teams.
    - Flexible access to range of skills/ expertise based on need not service.
    - Less bed based services and more home based.
    - More emphasis on maintaining people in their own homes and avoiding admissions.
    - Rapid, reactive home based response needs to be developed along with more intensive options for short term support.
    - Commissioned and led as one integrated service.
    - Future intermediate care services will need to deliver 4 types of service response:
        - A rapid / urgent response
        - A short term / intensive community response
        - Medium term community response
        - Bed based response-short and medium term
        - Longer term interventions

Doncaster population:

Age: The age profile in Doncaster is broadly similar to the national picture with a slightly higher proportion of older people (65+) and slightly lower proportion of working age people (16-64). The number of younger people (0-15) from the 2011 Census was 57,493 (19% of population), working age people (16-64) was 193,768 (64.1%) and older people (65+) was 51,141 (16.9%). The national age profile of people using intermediate care services is 65+ and our Doncaster service user profile matches this.

Disability: In Doncaster 21.7% (65,535) of people have some form of disability compared to the national average of 17.9%. Of these 33,644 (11.1%) residents in Doncaster indicated that their day to day activities were limited a lot and 31,891 (10.5%) residents indicated that day to day activities were limited a little. Doncaster is predicted to have a similar proportion of people with learning disabilities as the national average at 1.85% of the population. People accessing intermediate care services will be doing so because they have a disability. The services are aimed at older

people, frailty, and long term conditions. The services cater for co-morbidities. There are some emerging themes around the need for intermediate care services to support people with dementia, and there are links to loneliness and social isolation associated with age and/or long term conditions.

Gender: The gender ratio in Doncaster is very similar from birth up until 65+. From the 2011 Census the ratio between the ages 0-17 are Male 50.51% and Female 49.49%. Between the ages of 18-64 the ratio is Male 50.31% and Female 49.69%. However at 65+ the ratio becomes Male 44.37% and Female 55.63%. The national gender profile of intermediate care service users has more women than men, because women generally live longer. The national picture is mirrored in Doncaster.

Race/Ethnicity: Based on Census 2011 data, the proportion of total population in Doncaster classified as 'White British' equates to 91.8% (4.7% less than in 2001), and the national average is 80.45%.Those from Black & Minority Ethnic (BME) backgrounds represent 8.2% of the total population. Young people from BME backgrounds represent 10.2% of the total 0-19 population. The working age population from a BME background represent 8.8%, and Older People from BME backgrounds represent 2.9%.
The 6 largest ethnic groups in Doncaster in order of size are a) White British, b) White Polish, c) Pakistani or British Pakistani, d) Indian or British Indian, e) White and Black Caribbean, f) African.
There are currently 4,484 Polish people living in Doncaster, this equates to 1.5% of the population and is the largest single ethnic group aside from 'White British'.
Although it appears from the census data that the ethnic group 'Gypsy or Irish Traveller' accounts for only 0.2% of the population, local analysis has estimated that the population of this group is closer to 4000 with a number of sites within the borough and also an estimated 900 permanent households.
The proportion of people in Doncaster who speak English as their main language is 95.9% compared to the national figure of 92%. Other main languages spoken in Doncaster are Polish 1.6%, Urdu 0.3%, Chinese 0.2% and Punjabi 0.2%.
The random sample of patients from the intermediate care needs assessment was not representative of the population. Only 1% of patients were from a black or minority ethnic group in the statistically significant sample, and yet our local demographic data suggests that 2.9% of our older population are from a black or minority ethnic group. It is not yet clear if this was representative of those who use intermediate care services.

Religion & Belief: Doncaster's breakdown (2011 Census):

No religion / Atheism	24.4%
Christianity	65.9%
Buddhism	0.2%

Hinduism	0.3%
Judaism	0.03%
Islam	1.7%
Sikhism	0.4%
Any other religion	0.3%
Not stated	6.9%

What does the religion & belief profile of intermediate care service users look like in Doncaster? How do the services cater for religious needs?

National Audit of Intermediate Care (NAIC) 2015:
http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/Reports/NAICReport2015FINALA4printableversion.pdf

- In NAIC 2015, over 90% of service users were aged 65 and over in all service categories. Bed based services have an older profile with 51% over the age of 85 compared to 39% in home based and 43% in re-ablement services. Bed based services are admitting an increasing proportion of people aged over 90 who now comprise 25% of the sample compared to 23% in 2014 and 19% in 2013. Reflecting this changing profile, the mean age for people in bed based services has increased from 82 years (NAIC 2014) to 83 years (NAIC 2015). The mean age of home based services users has remained unchanged at 80 years. The mean age for re-ablement services is also 80 years (NAIC 2015, data not available for NAIC 2014).

- Women make up around two thirds of the service user population (64% in home based, 66% in bed based and 64% in re-ablement services).

Consultation:

- The CCG's strategic plan was developed based on a range of data available to the CCG including information on patient needs, information on activity and outcomes, stakeholder engagement, and patient experience feedback. Intermediate care was prioritised alongside primary care as a as a key transformational workstream forming part of our Care Out of Hospital programme. The prioritisation of intermediate care services for transformation was undertaken in partnership with our stakeholders.

- Patient engagement with patients in the service was undertaken as part of the Needs Assessment.

- There is a specific workstream under the Intermediate Care Project Board focussing on Communication & Engagement.

- Consultations are planned over the coming months to develop

	a BME Health Needs Assessment, and also to look at Long Term Conditions. These consultations will also provide further data to support this assessment.

Protected characteristic	Positive	Neutral	Negative	Negative: What are the risks? Positive: What are the benefits / opportunities?
Age	Benefits: Older people are generally the highest users of intermediate care services and should benefit from the development of a new model. Risks: Younger people will also access services - it is unclear whether the design of traditional services is appropriate to meet the needs and goals of younger adults e.g. regaining full independence by returning to employment or participating in social activities. Opportunities – building the needs of all age groups into the redesign, focussing particularly on the needs of older people. Overall – positive impact.			
Disability	Benefit: Those accessing intermediate care service do so because they have a disability and will benefit from a redesigned service to better respond to their needs. Benefit: A prolonged stay in an A&E department or admission to hospital can be traumatic if someone has dementia, due to the noisy environment and stress of separation from familiar people, places and routines. With a suitable intermediate care package, they may be able to avoid hospital admission or leave hospital sooner. This is likely to be better for their wellbeing, potential for recovery and longer term independence. Opportunities – building the needs of people with all disabilities into the redesign. Overall – positive impact.			
Gender	Benefits: services are gender neutral, but there may be a small benefit for women over men because there are more women than men in our over 65 population – the main users of intermediate care services. Risks: Some people may prefer that professionals involved in their care are of the same gender and it is unclear whether intermediate care services will be able to accommodate such			

Protected characteristic	Positive	Neutral	Negative	Negative: What are the risks? Positive: What are the benefits / opportunities?
	requests. Opportunities – building the needs of both genders into the redesign. Overall – neutral impact (minor impacts).			
Race	Risk: There is research to suggest that people from an ethnic minority background, recent migrants and people for whom English is not their first language can be disadvantaged when accessing services as they may be unaware of care which is available to them. This issue is particularly relevant to older people from a minority background. We have limited local information on the impact on our ethnic minority communities, and these groups were not particularly represented in the initial patient experience data. Further work is needed to understand impact. Opportunities – building the needs of people from different ethnicities into the redesign. Overall – negative impact because the needs of different ethnicities need to be considered further within the redesign.			
Religion & Belief	Benefits: The conclusion of a study from 2008 was that in older patients with chronic diseases in intermediate care, religious attendance was associated with positive perceptions of health, less severe illness, and fewer pack years. Intrinsic religious activities were associated with less severe depression and lower likelihood of living alone. International Journal of Geriatric Psychiatry, 23(7), July 2008, pp.735-740. Risks: Some people may need to have their religious needs catered for during their intermediate care, and it is unclear whether intermediate care services will be able to accommodate such requests. There may be some need for cultural competency development for the wider workforce. Opportunities – building religious needs into the redesign. Overall – neutral impact.			
Sexual Orientation	Opportunities – building sensitivity to sexual orientation in care services into the redesign. Overall – neutral impact.			

Protected characteristic	Positive	Neutral	Negative	Negative: What are the risks? Positive: What are the benefits / opportunities?
Gender reassignment	Opportunities – building sensitivity to gender identity into the redesign. Overall – neutral impact.			
Pregnancy & Maternity	Not applicable. Neutral impact.			
Marriage & Civil Partnership	Not applicable. Neutral impact.			
Social Inclusion / Community Cohesion	Risk: There is evidence to suggest that lower socio-economic status is associated with poor access to information about care options. Risks: People without a settled residence (e.g. the homeless, gypsies and others with traveller lifestyles) are likely to be excluded from services. Opportunities – communication & engagement on designing the new model. Overall – negative impact because the needs of different groups need to be considered further within the redesign.			

Conclusion & Recommendations including any resulting action plan	1. During Phase 2 of the intermediate care transformation programme the following equality areas should be considered: • Building into the model the needs of people with dementia. • Building into the model the needs of people from black and minority ethnic groups and developing a better understanding of any barriers to access that BME groups may face. • Building into the model the needs of older people accessing intermediate care services. • Building into the model the needs of people who have poor access to information about care options or face barriers to access e.g. people without a settled existence. The needs of different groups who may be

	socially isolated will need to be considered further within the redesign. 2. The intermediate care workforce may need support and development to expand their cultural competencies to more effectively understand and respond to the needs of all groups in a new more personalised intermediate care model. 3. The findings from this analysis should be shared with the Communication & Engagement Workstream so that they can take the recommendations into account in future planned engagement activities, focussing particularly on engagement with BME groups and those without a settled existence to better understand their access to and experience of services to inform the new model. 4. The findings from this analysis should be shared with the Service Design Workstream so that they can take the recommendations into account when designing the future model.
Review date	At the conclusion of Phase 2 and before recommending a new intermediate care model.