Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Appendix 6 - BNSSG Stroke Services Reconfiguration - Equality Impact Assessment (EIA)

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Contents

1. Introduction

The Bristol, North Somerset & South Gloucestershire (BNSSG) Stroke Programme, are reviewing the delivery of stroke care across the region to understand how changes to the stroke pathway can bring about improvements to patient outcomes.

Stroke care is typically divided into the following parts of a pathway:

We know there is variation in the ability of services in BNSSG to meet national clinical standards, as evidenced in the Sentinel Stroke National Audit Programme (SSNAP) (appendix 10.1).

There is significant variation in the provision of stroke services depending on where patients live and the time of the week that patients present at hospital with a stroke.

There is strong evidence from elsewhere in the country that the centralisation of hyper acute stroke services, such as brain scanning and thrombolysis, delivered as part of a 24/7 networked service, will improve outcomes for patients.

The NHS Long Term Plan sets out clear ambitions from the delivery of stroke care including increasing access to thrombolysis and thrombectomy, and improving post-hospital rehabilitation services. Changing how services are organised will make it possible to meet these ambitions that will ultimately improve patient outcomes and bring greater equity of services to the local population.

The BNSSG contribution to the national milestones of the Long Term Plan for stroke will be as follows:

- By 2022, we will deliver **thrombectomy** to all the people for whom it is clinically appropriate.
- By 2022, we will have an equitable offer for improved post-hospital stroke **rehabilitation** care.
- By 2025, we will contribute to the aspiration of the UK having amongst the best performance in Europe for delivering **thrombolysis** to all individuals who could benefit from it.

1.1. Proposals for Consultation

A comprehensive new service model is put forward. The proposed model centralises hyper acute care for stroke patients at a single site in Southmead Hospital, which will have a “hyper acute stroke unit” (HASU) and become a “Comprehensive Stroke Centre” under the new National Stroke Service Specification. This means that ambulances would no longer convey people with suspected strokes to Weston Hospital A&E or the BRI A&E.

There are two clinically viable options to consider for acute care following on from the hyper-acute episode shown as option 1b and 2b. Further detail regarding the evaluation process can be found in the PCBC document.

Option 1b	
Hyper Acute Stroke Unit at Southmead Hospital	
Acute Stroke Unit at Southmead Hospital	
Sub-Acute Rehab Unit	Sub-Acute Rehab Unit

Option 2b	
Hyper Acute Stroke Unit at Southmead Hospital	
Acute Stroke Unit at Southmead Hospital	Acute Stroke Unit at BRI
Sub-Acute Rehab Unit	Sub-Acute Rehab Unit

Population health information demonstrates that the population of Weston are at high risk of stroke and Healthier Together partners have therefore confirmed that one of the SSARUs should be located in the Weston area; Weston Hospital is therefore proposed as a fixed location for a SSARU in the South of the BNSSG area. The location of the second SSARU will be determined as part of the consultation process; possible sites are South Bristol Community Hospital and Frenchay Hospital (with an interim location ahead of the completion of this new South Gloucestershire facility).

The rationale for this was based on the demographic of that population, the distance to nearest unit and the importance of having support from relatives and friends in the sub-acute phase of care. Similar rationale was felt to be applicable for residents of South Gloucestershire, although the distance to South Bristol was not felt to be as prohibitive and the population risk factors are not as marked in that area.

Under both options, the new Integrated Community Stroke Service (ICSS) will support stroke survivors to meet their goals and continue their rehabilitation at home. This is a fundamental enabler of delivery of the proposed acute hospital changes. The improvements described have been co-designed with service users and members of the public. The ICSS will also address current inequity in provision of sub-acute stroke rehabilitation.

There are a number of further service improvements proposed as part of the pre consultation business case (PCBC), detail of which is included in the PCBC document and are included as part of the EIA review process.

2. EIA Purpose & Development

This Equality Impact Assessment (EIA) gives an insight into the local population and their health needs, and what we have learnt through our engagement so far.

The equality act 2010, makes it unlawful to directly or indirectly discriminate against people with protected characteristics, we have considered within this document the impact of any changes to stroke services on these 9 protected characteristics listed in section 3.

There is particular focus within the document to:

- Identify groups more affected by stroke and in particular, what it is about these groups that may make it more likely that they will have a stroke. Particular reference to protected characteristics and consideration of health inequalities across BNSSG, also in line with the Public Sector Equality Duty (PSED)
- Consider equity of access to all aspects of the stroke pathway. Identify barriers that make it harder for specific groups to access services, reduce their risk of stroke and recover from it more quickly.
- Identify areas for consideration to address these barriers when designing a future service model.

2.1. COVID-19 Impact

This document acknowledges that the COVID-19 outbreak has affected, and continues to affect, people and their communities differently. For some groups the impact will be more severe than that experienced by the general population as a whole and, as a result, there is the potential of worsening health inequalities.

The Public Health England report 'Disparities in the risk and outcomes of COVID-19'[1] identifies the following groups as being disproportionately impacted – males, those aged 80 or older, those living in more deprived areas and those from Black, Asian and Minority Ethnic (BAME) communities. The PHE report highlights further challenges including language barriers, cultural differences, the link to comorbidities, socio-economic factors (housing, employment, education etc).

This EIA further considers the COVID-19 impact associated with each of the 9 protected characteristics, as well as further aspects where stroke service change may impact the BNSSG population.

COVID-19 presents opportunities to change the way stroke care is delivered across all aspects of the pathway. We have the opportunity to improve stroke outcomes and deliver services that matter to people in a different way, in line with COVID-19 guidelines. It is important to recognise that these changes must not negatively impact groups of people, without adequate mitigations.

[1] Disparities in the risk and outcomes from COVID-19 – Public Health England

3. EIA Summary

The case for change and the benefits of centralising specialist hyper acute care and are well understood. However, it is important to ensure that the proposed changes to stroke services are equitable across the BNSSG population. The table below summarises the impact assessment, across the protected characteristics, and lists the associated mitigations.

Protected Characteristic	Analysis + / N / -	Impact Assessment Summary	Suggested Mitigation
Age	+	• People are having strokes earlier in their lives • Aging population within North Somerset • The risk of a stroke increases significantly as people get older • The ability to travel may prove more challenging with older age, particularly increased reliance on public transport	• Awareness of increased dependence on technology (as a result of covid-19 restrictions – particularly post stroke / rehabilitation. Digital guidance and training processes to be implemented • Local access to rehabilitation facilities / services • Travel time analysis to consider impact of changes – review of patient transport services (inter hospital transfers)
Disability	+	• The benefits of centralising specialist hyper acute care and are well understood (see case for change) - early intervention and treatment can prevent long term disability • Challenges associated with communication as a result of a stroke	• Consideration should be given to ensuring that there is equitable opportunity to express need, this may be through specific adaptations to enable effective communication – particularly through the consultation phases
Gender Reassignment	N	• There are risks associated with defined male or female specific acute bed provision. This may have an impact on inpatient stroke care.	• Training and education, embedding equality and diversity through the implementation of service change - alongside ensuring staff confidence in

Protected Characteristic	Analysis + / N / -	Impact Assessment Summary	Suggested Mitigation
			discussing transgender issues.
Marriage and civil partnership	N	• It is expected that changes to stroke services will have a limited impact on people based on their marital or civil partnership status.	• Although not limited to marriage and civil partnerships - Need to be aware that there may be considerable effects on a partner who has a stroke, particularly if this leads to new or increased carer responsibilities.
Pregnancy / maternity	N	• There is no evidence to suggest the proposed changes to stroke services will disproportionately affect this group.	• No mitigation required at this stage. If new information becomes available this will be reviewed.
Race/Ethnicity	N	• Evidence suggests that COVID-19 may have a disproportionate impact on people from Black, Asian and minority ethnic (BAME) groups. • Studies show that black people are more likely to have a stroke than white people (in part due to stroke risk factors)	• Consideration of preventative strategies to address the risk factors associated with stroke – in particular high blood pressure and diabetes
Religion	N	• People with different religious beliefs access healthcare in different ways. • Important that we understand access points in the context of any service change.	• Consideration that people who have different regions / beliefs access healthcare in different ways. This will need to be reviewed as part of the public consultation, particularly in relation to listening to what matters most to patients with different religious beliefs.
Sex	N	• Men are at a higher risk of having a stroke at a younger age than women - generally due to a combination of	• Differences in stroke prevalence for both men and women should be

Protected Characteristic	Analysis + / N / -	Impact Assessment Summary	Suggested Mitigation
		behavioural and medical factors. • However, more women than men die of stroke. This is because women tend to live longer than men, and the risk of stroke increases with age.	incorporated into acute and sub-acute bed modelling assumptions, particularly in relation to specific gender based bed or ward provision.
Sexual Orientation	N	• There is limited evidence to suggest the proposed changes to stroke services will disproportionately affect this group.	• We must consider gender sensitivity in care settings, particularly where people who have suffered a stroke struggle with the ability to communicate.

Overall, the provision of access to a single centralised HASU enhances equity of stroke care across BNSSG. This change in provision means that people can access the very best care and treatment opportunity regardless of where they live and the time of day that their stroke occurs. Early intervention and treatment can prevent long term disability and the new service model will ensure that more people benefit from highly specialised interventions (such as thrombectomy) that Southmead Hospital provides.

Coupled with this the BNSSG Stroke Clinical Reconfiguration Programme has heard that people want (and need) to be able to return to home (or close to home if their treatment needs preclude homecare) as quickly as possible. The enhancements to the community provision will enable this and ensure that people affected by a stroke have a short length of stay in hospital and are brought home, or to a locally based rehabilitation centre, with the right support as early as possible in the care pathway. This will be supported by enhanced use of technology to make interventions and treatment more accessible remotely. It will also help ensure that specialised stroke support can be accessed by local clinicians as and when needed so that they can provide the best care possible for patients, wherever they are based or working from – including in peoples' home.

4. Overview of engagement

It is vital that any review of stroke services incorporates the needs and views of those with lived experience of these services, as well as those working within them.

As part of the development of the consultation proposals the BNSSG Stroke Programme has undertaken initial public and stakeholder engagement in order to understand what is most important to those recovering from stroke. The process that has been used to date can be seen in **Error! Reference source not found.**. Stakeholders including clinicians; patient, carer and public representatives and those from the third sector have been involved in a wide range of engagement activities so far.

To date, this public engagement has taken place over three distinct phases:

- February / March 2020 – Exploratory phase of public engagement
- June / July 2020 – Building and testing ideas
- September / October 2020 - Feedback on draft proposals for consultation

The specific findings from the three phases of activity are described in the PCBC document. The intention is to continue this iterative engagement throughout the coming months. Any larger public engagement work conducted by Healthier Together will also be influenced by the patient and public involvement groups specifically linked to stroke and to wider groups, such as the BNSSG CCG Patient and Public Involvement Forum. The information gained through the consultation will continue to build on the initial sample to ensure fair representation which reflects the population in Bristol, North Somerset and South Gloucestershire who are most at risk of stroke.

4.1. Patient and Public Involvement

Between 4th February and 11th March 2020, an initial phase of engagement was conducted involving clinicians, members of the public, carers and those from the third sector. The primary purpose of this phase of engagement was to explore what matters most to those with lived experience, carers and staff in relation to stroke recovery and rehabilitation.

In order to explore this, the programme has conducted its own engagement sessions and has attended numerous support groups across Bristol, North Somerset and South Gloucestershire.

During each session, attendees were asked to consider four questions:

- When thinking about stroke services, what matters to you?
- What are the future aspirations of those with lived experience and those working within stroke services?
- How did stroke services help meet your aspirations and what matters to you?
- How could stroke services improve to meet some of these needs?

The second phase of public engagement, which was delayed due to the COVID-19 pandemic, took place in June and July 2020. These pieces of work were performed remotely, and details of these pieces of work can be found below:

- **'Zoom' Co-Design Group**

In July 2020, we involved a small group of individuals in the co-design of solutions in response to previous feedback around stroke services. This group met remotely, and participants provided detailed feedback and ideas on a range of topic areas related to immediate stroke care and rehabilitation.

- **COVID-19 telephone interviews**

Temporary changes to service provision took place as a result of COVID-19, and until July 2020 this presented a large gap in our understanding in relation to stroke support people had received in recent months. The primary aim of this work was to understand how remote rehabilitation support met or exceeded the expectations of people accessing it.

- **Online quantitative survey**

Following the telephone interviews and co-design group, there was a need for quantitative feedback in order to ensure ideas and solutions proposed during the first stage were reliable across a larger number of people. This resulted in a short, focused survey to explore ideas and feedback received in February and March. The list of engagement opportunities conducted in this initial is listed in appendix 10.3.

4.2. Higher Risk and Seldom Heard Groups

Initial analysis uncovered a higher incidence rate of stroke in areas of North Somerset, and so far the outreach engagement work has reflected this, by actively seeking engagement from individuals in this area. Geographic and demographic monitoring has and will continue to be used throughout the engagement activity to identify possible themes by groups or localities that need further investigation.

People from black or minority ethnic groups are almost twice as likely to suffer a stroke as white people and, as well as people with South Asian background, tend to have a stroke ten years earlier than white people. These people, as well as the generally ageing population, those with modifiable existing health risk factors and those from disadvantaged and deprived areas, represent a wider group at higher risk of having a stroke and of being more likely to be impacted by changes to services. It is vital that the voice of people from within these groups is heard, to contribute to development of proposals of services that they may need.

Work to target these groups for engagement activity has already been conducted in partnership with public health bodies and this process will continue throughout the reconfiguration process, specifically within the consultation period. The public consultation plan (Appendix 7 of the PCBC document) describes in more detail the approach to targeting these groups.

Two examples of how successful engagement with some of these groups is being planned and conducted are: 1) Collaborative links with research being planned and conducted by researchers at the University of the West of England (UWE) into the information and support needs of BME groups following a stroke, and 2) Discussions with colleagues working in Public Health teams as to existing networks and how best to initiate engagement with people with learning disabilities.

Following stroke, many people have communication or cognitive difficulties which make communication more difficult (such as aphasia) and as such this group are potentially at risk of being less included in engagement. Specific engagement approaches have been undertaken to ensure that engagement with these people is successful in identifying issues, concerns and comments. An advanced Speech and Language Therapist is a member of the programme team and has led on communication approaches with this group of people and maintains a regular co-design meeting with several members. Written communication for engagement has and will continue to be screened by her for accessibility to people with communication difficulties and, if necessary, more accessible versions of the documents produced.

During the second phase of engagement, a range of remote approaches were used in response to COVID-19, particularly given that those at risk from stroke are possibly more susceptible to COVID-19. These methods include online public engagement activity through platforms such as 'Zoom', as well as telephone interviews with those who are less digitally enabled. The public consultation plan will include, where possible regarding COVID-19 restrictions, socially distanced face-to-face communication to ensure that the voices of those with less access to or ability to use technology are not missed.

Demographic monitoring has also been in place for our short 'pulse' survey into some of the key issues which emerged from our initial pieces of engagement in February and March. While the sample size from this particular piece of work is not sufficient to draw significant conclusions at this stage, the results will provide indicators in relation to which demographic groups may experience particular issues in accessing stroke support or hold particular opinions which will need to be followed up on during later phases of engagement.

Upon further development of the Equality Impact Assessment, efforts will be undertaken to ensure that we have heard from those who are more likely to be impacted by changes to stroke care and those who are more disadvantaged within Bristol, North Somerset and South Gloucestershire. Further work will also be done with those most at risk of a stroke according to predictive indicators.

4.3. Engagement with staff

Throughout this initial phase of engagement, staff working within stroke services and those in the voluntary sector have been involved. They have played key roles in facilitating engagement with those who have had a stroke, while the programme has also considered their views in terms of what matters to them.

GP leadership has been combined within the programme from the outset and wider engagement with Primary Care has been undertaken through a number of different mechanisms. These have included attendance of the Programme Team at a 'Primary Care Strategy Group' meeting, presentation of feedback through the CCG GP Members Event, and through the Primary Care Providers Board members undertaking a desktop review of the draft Pre Consultation Business Case document. Work continues with primary care and other service providers in each locality area through the "Locality Integration Meetings" (or similar) that are held between local partner agencies in the six Localities across BNSSG.

5. Population and demographics

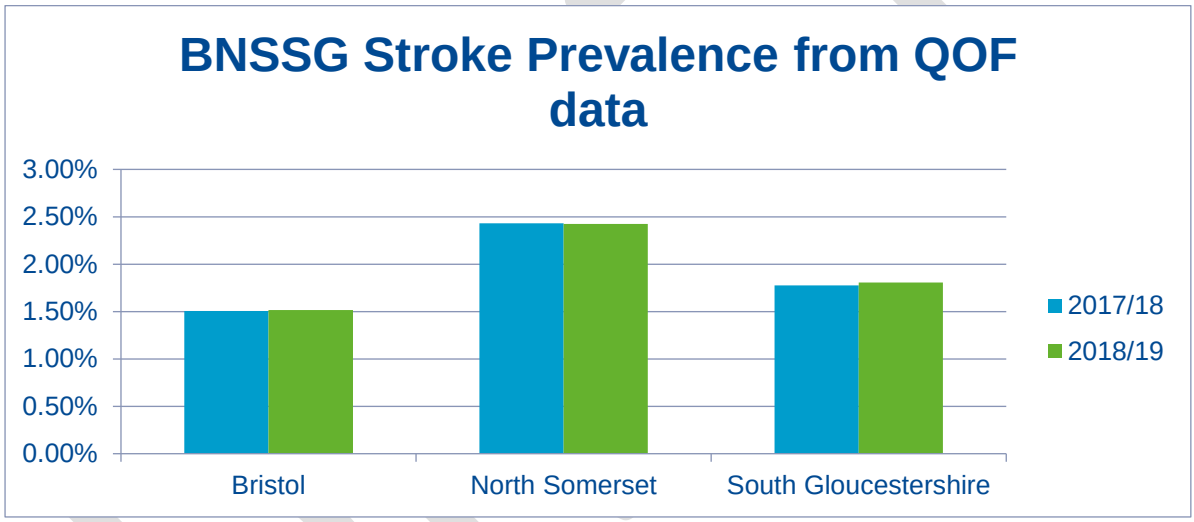
5.1. Local Population

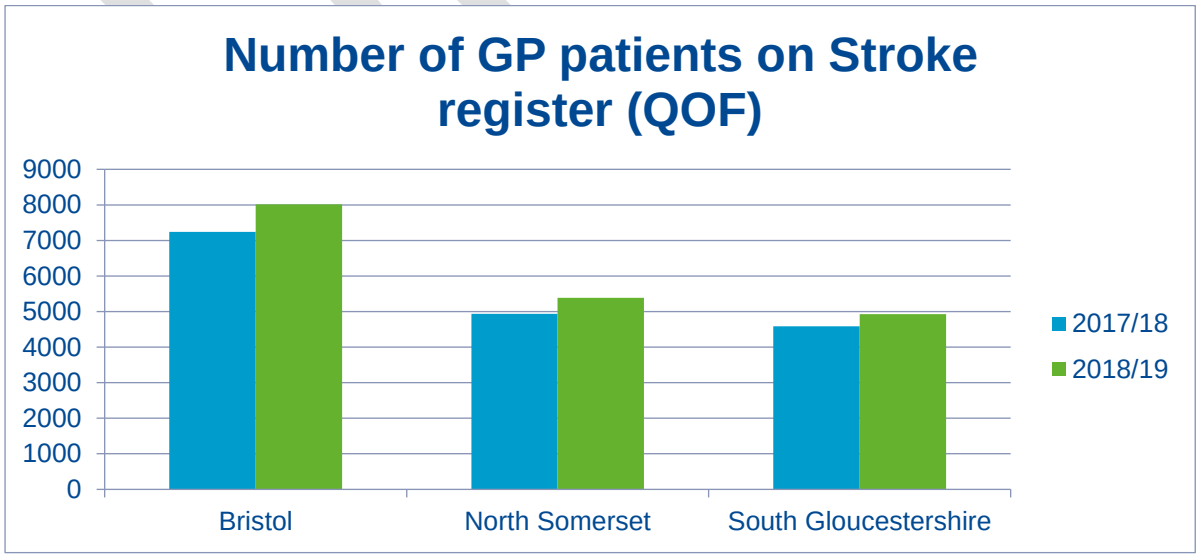
Our population is growing, getting older, living with more long-term conditions and there are significant inequalities in health. There is an increasing, but changing, demand on health and care services.

The population of BNSSG is almost one million. 48% live in Bristol, 23% in North Somerset and 29% South Gloucestershire Local Authorities (LAs).

There are more than 100,000 strokes in the UK each year and over 1,347 in BNSSG in 2018/19.

The prevalence of stoke is highest in the North Somerset area however when represented as total numbers the number of patients having had a stroke is higher in Bristol.

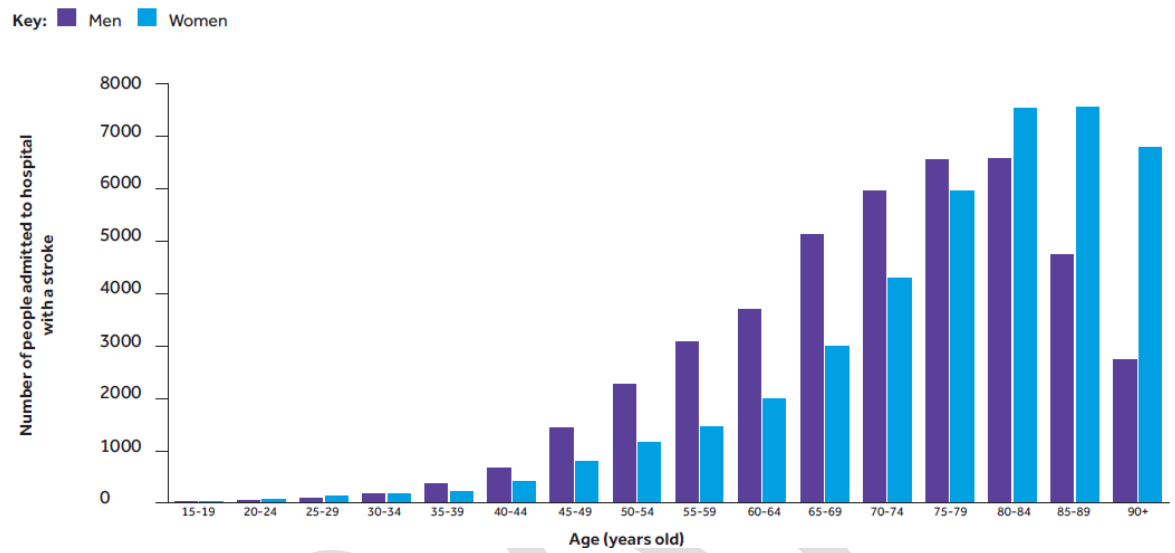




5.2. Age

The risk of a stroke increases significantly as people get older, as a result, the number of people admitted to hospital with a stroke increases with age.

Figure 1 Stroke Hospital Admissions in England, Wales and Northern Ireland



In England, Wales and Northern Ireland the average age for someone to have a stroke is 72 for men and 78 for women.[2] People are most likely to have a stroke after the age of 55.[3]

Across BNSSG, we project that for the next two decades, those groups aged over 65 and 85 years will continue to grow at the fastest rate. This is particularly relevant as 17% of our BNSSG population are now over 65 years old.

Despite the aging population, people are having strokes earlier in their lives. In 1990 only a quarter of all strokes occurred in people aged 20-64. In 2010, a third of all strokes happened to people in that age group.[4]

Early mortality rates (under 75 years of age) for stroke in BNSSG were 10.6 per 100,000 people. This was significantly lower than the England rate (12.8). Later mortality rates (over 75 years of age) from stroke in BNSSG were 459.6 per 100,000 people which is significantly lower than the England rate (506.3). However, it is anticipated that this can be further improved by reconfiguring services in particular reducing the levels of long-term disability.

With age being a significant contributing factor linked to the probability of having a stroke, we must consider the areas within BNSSG with an older or aging population.

[2] Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP). National clinical audit annual results portfolio March 2016-April 2017. Available: http://bit.ly/1NHYlqH
[3] Wang Y, Rudd AG, Wolfe CD (2013). Age and ethnic disparities in incidence of stroke over time: the South London Stroke Register. Stroke 44:3298-3304.
[4] Feigin VL, et al. (2013). Global and regional burden of stroke during 1990-2010: findings from the Global Burden of Disease Study 2010. Lancet 383: 245-255.

Within the North Somerset area, 20% of people are expected to be over the age of 70 by 2025. In addition, over half of the total population increase between 2018 and 2025 will be in the 70+ group. The predicted prevalence of stroke in North Somerset has an annual growth rate of 4.4% in the 75+ population[5]

Increased consideration must be given to the North Somerset area in terms of ensuring there are appropriate mitigations to address this demand on all aspects of stroke services.

COVID-19 has a significant effect on the older population. Among people already diagnosed with COVID-19, people who were 80 or older were seventy times more likely to die than those under 40. Coupled with this, COVID-19 diagnosis rates increased with age for both males and females.[1]

Older people may have multiple heath and care needs, they might not speak English or limited English and live alone or in care homes or environments where they are at greater risk. This group might find it difficult to cope with change and adhere to COVID-19 restrictions due to poor memory or lack of understanding.

COVID-19 has meant more services are readily accessible online. Whereas this may be beneficial for some, for others there may be an adverse effect on those who are older do not use digital technology. AgeUK has identified a digital divide in later life, only 33% of adults over 75 use digital technology[6].

It is important to have support from family, carers or the health and care system to help share information, encourage hand hygiene and social distancing and support from voluntary groups who are delivering medicines and groceries. This should be considered as part of the developing stroke community services.

5.3. Disability

The proportion of people with life limiting long term illness or disability make up 17.6% of the population of Bristol, 19.2% of the population of North Somerset, and 18% of the population of South Gloucestershire.

About 250,000 people in the UK live with disability following a stroke at any time.[7] For a person who has experienced a stroke, this may impact on the ability to communicate need or want, particularly those who suffer from aphasia. Consideration should be given to ensuring that there is equitable opportunity to express their needs, this may be through specific adaptations to enable effective communication.

Nationally the number of adults with learning disabilities is increasing and is predicted to increase by 1% each year for the next 15 years.[8] Mental and physical health problems are more common amongst people with learning disabilities, yet

[5] North Somerset JSNA – Disease Prevalence Models Accessed: https://www.n-somerset.gov.uk
[6] AgeUK - Later life in a digital world
[7] Stroke Services – University of Manchester https://www.bmh.manchester.ac.uk/research/impact/stroke-services/
[8] North Somerset JSNA- Learning disabilities. Accessed: https://www.n-somerset.gov.uk

they are less likely to receive regular primary care health checks and access routine screening than the general population,[9] which links back to stroke contributing factors such as high blood pressure.

Following a stroke and as a result of a physical disability, there may be a requirement for physical home environment adaptations. Everyone who requires these changes must have equitable opportunity, proportionate to need. Consideration should be given to the links between health and social care so that a person's needs are met in regard to both aspects. This should be seamless and integrated.

People who are disabled and then have a stroke are likely to have additional needs that need to be recognised in the care that they receive for the stroke. For example, a blind person who becomes unable to talk due to a stroke would have a greater challenge than a sighted person, who is more likely to be able to use alternative modes of communication such as writing.

We know from our engagement with stroke survivors that clear information and guidance throughout all aspects of the pathway is important. This information must be accessible for all patients, along with appropriate support and clear signposting for relatives and their carers in a variety of formats for example braille, larger font, audible.

People with disability may also be disproportionately impacted by the COVID-19 outbreak because of serious disruptions to the services they rely on. This may be across a range of stroke services both in the acute setting as well as in the community.

Changes were made to stroke services in line with the national COVID-19 response. People with learning difficulties or neuro-diversity may not cope well with change and the disruption might cause long-term negative impact to their emotional wellbeing and mental health beyond the pandemic. It is important to recognise the sensitivities of change and to ensure that any changes are communicated in an inclusive and supportive manner.

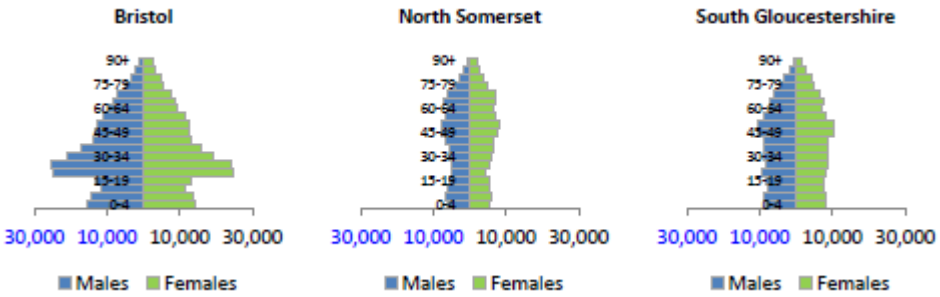
5.4. Sex

The Stroke Association state of the nation statistics[10] document gives particular reference to how stroke prevalence varies according to gender. It references how men are at a higher risk of having a stroke at a younger age than women. This is generally due to a combination of behavioural and medical factors. Diabetes and heart disease, both risk factors for stroke, are more common amongst men. In addition, on average, men consume more alcohol and are more likely to smoke.

However, more women than men die of stroke. This is because women tend to live longer than men, and the risk of stroke increases with age.

[9] Kerr MP, Richards D, Glover G (1996) Primary care for people with a learning disability - a Group Practice survey. Journal of Applied Research in Intellectual Disability
[10] State of the Nation Stroke statistics - February 2018

Figure 2 BNSSG population pyramids, ONS, mid-2017 estimates (Pyramid widths are proportional to population size)



In Bristol, the under 75 death rate from stroke among males is highest in the North and West (outer) locality. Among females the rate is highest in the Inner City locality.[11]

We recognise the important statistical differences between men and women in relation to stroke. These differences should be incorporated into acute and sub-acute bed modelling assumptions, particularly in relation to specific gender based bed or ward provision.

5.5. Ethnicity

Across BNSSG, 10% are from a black or minority ethnic (BME) background though there is considerable variation across the region and within age groups.

In Bristol, 16% are from a BME background, which rises to nearly 60% in one city ward (area of the city), compared with 2.7% in North Somerset.[12] The population of North Somerset is less ethnically diverse than England and Wales with 97% of people living in North Somerset classifying themselves as belonging to a white ethnic group.[13] South Gloucestershire has a BME population of 5%[14]

Evidence suggests that COVID-19 may have a disproportionate impact on people from Black, Asian and minority ethnic (BAME) groups. Death rates from COVID-19 were higher for Black and Asian ethnic groups when compared to White ethnic groups.[1]

PHE note that the relationship between ethnicity and health is complex and likely to be the result of a combination of factors. People of BAME communities are also likely to be at increased risk of poorer outcomes once they acquire the infection. For example, some co-morbidities which increase the risk of poorer outcomes from COVID-19 are more common among certain ethnic groups. Research suggests black people are more likely to have high blood pressure and diabetes than white

[11] JSNA Health and Wellbeing Profile 2019/20. https://www.bristol.gov.uk
[12] BNSSG CCG Long Term Plan Response, 2019/20
[13] North Somerset JSNA – Changing Population
[14] Census 2011 (accessed via South Glos JSNA, 2017)

people, both of which are stroke risk factors.[15] Black people are therefore almost twice as likely to have a stroke than white people.[16]

White people in the UK are more likely to have atrial fibrillation (AF), smoke and drink alcohol than other ethnicities.[17] These are all factors that increase the risk of stroke. Managing aspects of peoples lifestyle smoking and drinking are as modifiable factors and should be considered as part of the stroke prevention aspect of the programme.

Data from the 2011 census estimates that the White Gypsy or Traveller population is approximately 270 (0.1%) in South Gloucestershire, the same percentage as both England and the South West.**Error! Bookmark not defined.** Bristol has a substantial Gypsy, Roma and Traveller (GRT) population; however, the exact population of these communities are unknown. The poor health outcomes of GRTs can often be linked to a lack of access to health care services when they are on the move and the difficulties this presents in registering with a GP.[18] This may have a particular impact on stroke prevention and the early diagnosis of contributing factors such as high blood pressure or AF.

We must consider that across all ethnic groups, there may be barriers to accessing health care services. These barriers are more likely to affect each end of the pathway (Prevention and rehabilitation). From a healthcare professional side there may be a lack of cultural understanding and there may also be poor access to health information, particularly where English may not be the commonly used language. For particular groups of patients or certain ethnic groups, there may be stigma associated with seeking medical attention, this should be explored as part of the wider consultation and engagement process to determine where these gaps may be.

5.6. Religion and Belief

Christians represent the largest religious group in Bristol (46.8%), North Somerset (61%) and South Gloucestershire (59.6%). The second largest group stated that they have no religion making up 37.4% of the population of Bristol, 30% of North Somerset and a third of the South Gloucestershire population.

We must consider that people who have different regions beliefs access healthcare in different ways. We recognise this will need to be reviewed as part of the public consultation, particularly in relation to listening to what matters most to patients with different religious beliefs.

[15] Banerjee S., Biram R., Chataway J., Ames D.(2009) South Asian Strokes: lessons from the St Mary's Stroke database. QJM: An International Journal of Medicine, Volume 103, Issue 1, 1 January 2010, Pages 17–2

[16] Wang Y, Rudd AG, Wolfe CD (2013). Age and ethnic disparities in incidence of stroke over time: the South London Stroke Register. Stroke 44:3298-3304. Accessed via Stroke association 'state of the nation'

[17] Gov.uk (2017) Ethnicity fact and figures. Available: https://www.ethnicity-facts-figures

[18] JSNA Health and Wellbeing Profile 2019/20. Theme: Population. Available: https://www.bristol.gov.uk

5.7. Sexual Orientation

The Bristol Quality of Life (QoL) survey found that 6.6% of the Bristol adult population identified as LGB in 2018.[19] We aim to determine the percentage within North Somerset and South Gloucestershire.

Whereas it is not expected that changes to the stroke services across BNSSG will have a specific impact on this particular protected characteristic, future commissioned services must include appropriate consideration.

We must consider gender sensitivity in care settings, particularly where people who have suffered a stroke struggle with the ability to communicate. Recent research studies indicate that care home staff in England and Wales receive little or no training on working with residents from gender and sexual orientation diverse groups, despite increasing numbers of older LGBT+ adults needing care.[20]

We must ensure that civil and same sex partnerships respected in care settings and their homes, particularly around next of kin experiences.

We must be aware of the rates of discrimination and harassment in the health service against people who identify as, or are perceived to be, LGBT. In a 2016 Healthwatch survey 68% of people said they had felt discriminated against because of their gender identity and / or their sexual orientation.[21]

The LGBT community report differential experiences of the community as they get older; we must ensure awareness and to mitigate against this.

It is important that we are also 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.

5.8. Gender Reassignment

Gender reassignment refers to people who have either undergone, intend to undergo or are currently undergoing gender reassignment (the medical and surgical treatment to alter their body) and also individuals who do not intend to undergo surgery but wish to live as a different gender than their gender at birth. These people self-identify as transgender or trans. Transgender people are protected under the Equality Act 2010 on the basis of gender reassignment or disability.

Transgender people face health inequalities and have poor health outcomes when compared to the non-transgender population. According to The Lancet Journal[22] inequalities faced by transgender individuals in societal aspects and policy making

[19] Bristol Quality of Life survey - https://www.bristol.gov.uk/statistics-census-information/the-quality-of-life-in-bristol

[20] Creating inclusive care home environments for older LGBT+ people https://www.diversitytrust.org.uk/

[21] Evidence for Change - Bristol LGBT and Wellbeing Research Report http://healthwatchbristol.co.uk/Diversity-Trust-Report-2016

[22] The Lancet - Health care and mental health challenges for transgender individuals during the COVID-19 pandemic, May 20

based on binary gender norms could increase the risk of illness and mortality during the COVID-19 pandemic.

During 2017-18 Healthwatch Bristol worked with the Diversity Trust and other partners to identify health inequalities, and discrimination, experienced by Trans and Non-Binary people and communities across the South West.[11]
The project worked with over 200 Trans and Non-Binary people, aged from 16 to 80. Headline figures / findings noted that:

- 60% of participants have felt discriminated against because of their gender identity
- 30% of participants felt discriminated against in the health care system

BNSSG developed a 'trans gender toolkit'. This guidance is designed to support health practitioners to improve the care and experience of transgender people, who we know can face challenges in accessing services. There has been some reported challenge to this. Pending the outcome of a national review relating to this particular issue, we will consider any learning points in designing an inclusive stroke service across BNSSG.

There are risks associated with defined male or female specific acute bed provision. This may have an impact on inpatient stroke care.

Monitoring the impact of any service changes on this characteristic will continue throughout the entire process. Training and education of all staff on equality and diversity and embedding equality and diversity through the implementation of service change alongside ensuring staff confidence in discussing transgender issues.

5.9. Pregnancy and Maternity

There is limited evidence to suggest that the changes to stroke services will disproportionately affect this group.

We do however need to consider that transportation may prove more challenging for this group in relation to visiting friends or family. Particular consideration needs to be given to the location of acute stroke unit beds and sub-acute rehab beds to not disproportionally affect those that may have issues traveling longer distances.

5.10. Marital Status

It is expected that changes to stroke services will have a limited impact on people based on their marital or civil partnership status. We will however need to be aware that there may be considerable effects on a partner who has a stroke, particularly if this leads to new or increased carer responsibilities.

It should also be noted that a quarter of all stroke survivors in England, Wales and Northern Ireland live alone after their stroke.[10]

The financial implications of having a stroke must also be considered. Although it is difficult to estimate the financial burden of stroke to the family, as each case is unique. State of the Nation Stroke statistics - February 2018 notes that one report

estimates the average cost of stroke to a family in the UK is £22,377.126. Marital status may affect a social care financial assessment (means test) and could lead to a partner having to incur the costs of a stroke.

6. Public Sector Equality Duty (PSED)

In addition to the importance of considering the equality impact of any changes, relating to the 9 protected characteristics of the Equality Act 2010, NHS organisations must also demonstrate "Due regard to the need to":

- Eliminate conduct that is prohibited by the Act, including discrimination, victimisation and harassment.
- Advance equality of opportunity between persons who share a relevant protected characteristics and those who do not share it and to
- Foster good relationships between persons who share a protected characteristic and those who do not (particularly to the need to tackle prejudice and promote understanding).

The following section builds upon this 'due regard' in additional equality areas that may be affected by changes to stroke services across BNSSG.

6.1. Inequality

In general, people from more deprived areas have an increased risk of stroke.[23] We also know that those from deprived areas are more likely to be disproportionally affected by COVID-19.

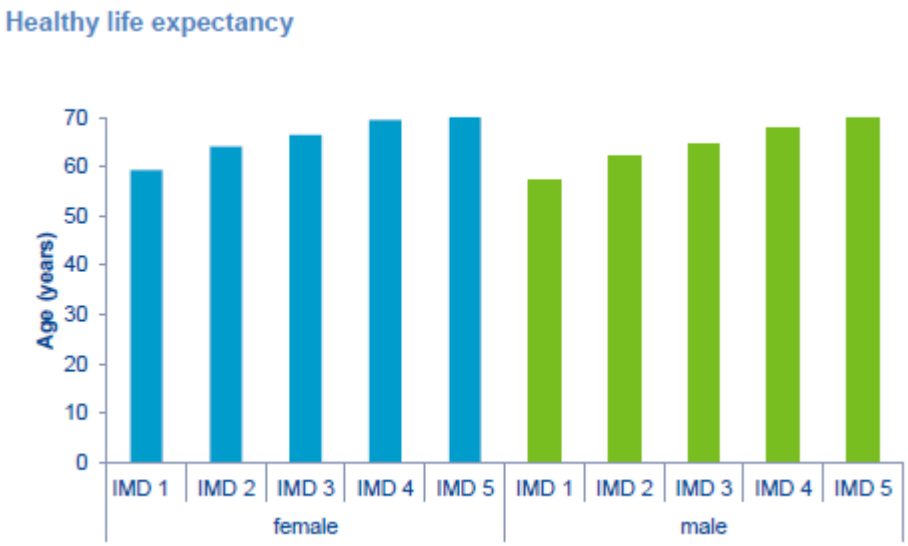
Deprivation in BNSSG is generally lower than the national average however there are significant differences between areas. People living in more deprived areas experience comparatively poor health, with a life expectancy considerably lower than those living in the more affluent areas. The difference in life expectancy between the most and least deprived areas of BNSSG is 6.3 years.

16% live in the most deprived national quintile for the Index of Multiple Deprivation (IMD). However, there is considerable variation within and between local authority areas and localities.

Bristol is relatively more deprived, followed by North Somerset. IMD remains just one measure of deprivation; if just looked at by access to services then rural North Somerset and South Gloucestershire become the most deprived areas. This must be given consideration in relation to access to a range of health and social care services associated with stroke care.

[23] Marshall IJ, et al (2015). The effects of socioeconomic status on stroke risk and outcomes. Lancet Neurology 14: 1206-1218

Figure 3 Healthy life expectancy by deprivation quintile.



Healthy life expectancy (the number of years expected to be lived in self-reported good or very good health) is associated with a strong deprivation gradient within BNSSG.

The main contributing factors to disability/poor health are:

- Musculoskeletal disease
- **Cardiovascular disease (CVD) and stroke**
- Respiratory diseases including COPD
- Depression and mental health problems
- Cancers and particularly lung cancer
- Alcohol and drug misuse

We know from patient and public involvement that having a stroke can lead a significant financial burden for the individual, family or carer. COVID-19 has presented challenges for a number of people financially. The health and wellbeing of people in deprivation are negatively impacted by the wider determinants of health including housing, employment, education, access to social networks and lifestyles. Smoking, higher level of alcohol consumption, obesity and chronic health conditions are risk factors.

It should also be noted that people with more limited financial means may use more public transport, and may therefore be at greater risk of contracting and spreading the virus.

6.2. Location / Travel Impact

It is important that travel analysis is considered as part of the evaluation process to ensure equity of access to BNSSG stroke services across the region. We must consider driving times and public transport times, at both peak and off peak times of day.

Specific analysis has been conducted by the ambulance service (SWASFT) in relation to centralising hyper-acute stoke provision to ensure safety.

The benefits of centralised hyper-acute care are well documented, however in listening to patients and members of the public affected by stroke the importance of local rehabilitation. This has been taken into account in determining sub-acute rehab provision and community rehab services, particularly in relation to location and ease of access.

COVID-19 has meant a number of travel restrictions are in place. Changes to public transport in line with COVID-19 guidance will affect patients' ability to attend clinics and appointments, as well as affect family visiting. This further emphasises the need for local sub-acute and community based provision, coupled with the use of technology to avoid unnecessary travel where possible.

6.3. Carers

As the population ages and medical therapies advance, more individuals are living in the community with complex health conditions. These individuals, as well as their clinicians, often assume their family members and friends will be capable of, and willing to, provide the caregiving work necessary to continue living at home. There is an ethical problem in this assumption that unpaid community care will be provided by family or friends.

Family members are often the primary source of support for older adults with chronic illness and disability.

Two thirds of patients who have suffered a stroke leave hospital with a disability and therefore high assistive complexity. This generates a significant burden on the carers.

Through the engagement process we must engage with carers groups in relation to stoke and recognise the significant impact associated. This will be particularly important during the co-design phase.

The proportion of the population who are carers in North Somerset is 11.1%, slightly higher than the national average of 10.3%. We aim to investigate the percentages for Bristol and South Glos to understand the proportional impact.

COVID-19 is likely to have an impact on carers looking after stroke survivors. They may have added pressure because of reduced access to support systems (E.g. (family, health professionals, care assistants) It is important that care is integrated across health and social care services to mitigate the carers burden.

7. Relevance to the Public Sector Equality Duty

There is a general duty which requires the system to have due regard to the need to:

Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010?

Does this proposal address risk in relation to any particular characteristics? (Yes)

- It is acknowledged that each equality group has been impact assessed, where differential experience or impact is noted mitigation or objective justification has been made.

Advance equality of opportunity between people who share a protected characteristic and those who do not?

Will this proposal facilitate equality of opportunity in relation to particular characteristics? (Yes)

- Project proposes to improve access to equality groups who might experience negative differential impact; mitigations have been put in place including further engagement or objective justification provided.

Foster good relations between people who share a protected characteristic and those who do not

Will this proposal foster good relations between people who share a protected characteristic and those who do not? (Yes)

- Education and engagement have been used to foster good relations between one group and another, and between the patient/population and providers.

Is a FULL Equality Impact Assessment required?
Yes – to be undertaken at a later date.

8. EIA Impact Assessment Approver(s)

Full Name
Sharon Woma

Comments from Equality Lead
Thorough impact assessment, screening EIA approved.

Date Approved
27 August 2020
Email this document to the inclusion lead Sharon.woma@nhs.net for approval

9. Next Steps

This is an iterative document, further work to understand the impact of any proposed changes will continue to develop.

We anticipate there being at least a further phase to the EIA development process. A final version full EIA will be drafted, drawing upon all learning, knowledge and lived experience from our full engagement process either through formal consultation or other routes. This assessment will present equality impact risks and mitigations associated with the final model that is being recommended to the Clinical Commissioning Group (CCG) Governing Body.

The impacts identified so far will be further considered as part of the contextualised consultation process going forward where the consultation approach and methods must reflect the needs of our diverse populations. Any findings identified through the consultation process will be added to existing themes identified and used to inform the decision making process going forward.

We will continue to actively engage with protected groups and incorporate this into the consultation plan going forward.

10. Appendices

10.1. SSNAP Data

	Number of patients		Overall Performance				Patient Centred Data										
Trust	Admit	Disch	SSNAP Level	CA	AC	Combined KI Level	D1 Scan	D2 SU	D3 Throm	D4 Spec Asst	D5 OT	D6 PT	D7 SALT	D8 MDT	D9 Std Disch	D10 Disch Proc	PC KI Level
North Bristol NHS Trust	243	228	B	A	A	B	A	C	C↓	B↑	A	B	C↓	C↑	B	A	B
University Hospitals Bristol NHS Foundation Trust	124	130	C	A	B	C	A	E↓	D	C↑	A↑	C	C	C↑	B	B↓	C
Weston Area Health NHS Trust	67	76	D	A↑↑	A	D	B↑	E	B	B↑	C	D	D↑	D	B	C	D

10.2. Equality legislation

The main Public Sector Equality Duties 2011, set out in section 149(1) of the Equality Act 2010 ("the Act") applies in three ways:

- It applies to "public authorities" including the National Health Service in respect of all of their functions, unless the authority is specified in respect of only certain functions;
- Where a public authority is specified in Schedule 19 of the Equality Act 2010 in respect of only certain functions, the Duty applies to the authority in respect of only those functions;
- Where persons are not public authorities but exercise public functions, the Duty applies in respect of the exercise of those functions.

A public authority must, in the exercise of its functions, have due regard to the need to:
(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act, but not age, so far as relating to persons who have not attained the age of 18, or marriage and civil partnership.
(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; in particular, to the need to:

- Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it. In the context of this limb, public authorities need to: tackle prejudice, and promote understanding between person who share a relevant protected characteristic and persons that do not share it.

These are known as the three sections of the "general duty". In addition to the "general duty", NHS organisations also need to evidence compliance against the specific equality duty, and under this section of legislation, NHS organisations are required to:

(a) Set specific, measurable equality objectives;
(b) Analyse the effect of our policies and practises on equality and consider how they further the equality aims;
(c) Publish sufficient information to demonstrate that we have complied with the general duty on an annual basis. This compliance is in respect of the effect of their services and employment on the protected characteristics: Age, Disability, Gender Reassignment, Race, Religion or Belief, Sex, Sexual Orientation, Pregnancy & Maternity and Marriage and Civil Partnership.

10.3. Engagement Groups and Summary

Stroke Services Pre-Engagement meeting - Public Session	04/02/2020	12:00-14:00	New Room, Horsefair	Bristol
Stroke Services Pre-Engagement meeting - Clinical Session	04/02/2020	15:00-17:00	New Room, Horsefair	Bristol
Bristol After Stroke (Fishponds Group)	19/02/2020	10:00-11:00	Colliers Gardens	Bristol
Bristol After Stroke (Bedminster Group)	20/02/2020	10:30-12:30	St Monica Wills House	Bristol
UWE ReVoice Choir drop-in	26/02/2020	14:00-15:00	Glenside Campus, Frenchay	South Gloucestershire
Weston Speakability Group	02/03/2020	11:00-12:00	Seventh Day Adventist Church	North Somerset
Weston Active Stroke Group	03/03/2020	10:00-12:00	Worlebury Golf Club	North Somerset
South Gloucestershire Conversation Group (Yate)	05/03/2020	10:30-12:00	Ridgewood Centre, Yate	South Gloucestershire
Nailsea Stroke Survivors Club	11/03/2020	10:00-11:00	Nailsea Methodist Church	North Somerset
Different Strokes - Bristol Exercise Group	11/03/2020	11:30-12:30	Bristol Lawn Tennis Club, Redland	Bristol

Version	Date	Reviewer	Description
0.1	10/02/20	Jeremy Westwood	First draft
0.2	11/02/20	Jeremy Westwood	Updates following discussion with CCG Inclusion Coordinator
0.3	28/02/20	Jeremy Westwood	Further review and updates
0.4	09/03/20	Simon Moss	Engagement section added
1.0	24/03/20	Stroke Programme Board	Stroke programme board sign off
1.1	07/07/20	Jeremy Westwood	EIA review / content update to include Covid-19 impact
1.2	10/07/20	Simon Moss	Overview of engagement section added
2.0	15/07/20	Becca Dunn	Content review / submission to CCG Quality Committee
2.1	26/08/20	Jeremy Westwood	Feedback incorporated from Stroke Programme Board, CCG Quality Committee and suggested amends from Sharon Woma (inclusion co-ordinator)
2.2	28/09/20	Jeremy Westwood / Becca Dunn	Summary paragraphs added
2.3	11/01/21	Jeremy Westwood	Proposals for consultation context added to introduction section Updated engagement section to include phase 3 (September / October 2020)
2.4	11/02/21	Jeremy Westwood	Updated proposals for consultation to show only options 1b and 2b - including additional context for Weston SARU