INITIAL EQUALITY IMPACT ASSESSMENT AND ANALYSIS (EqIAA)

HEALTHWATCH

Please Note:-

This document describes an initial analysis of equalities impacts in relation to proposals concerning Healthwatch South Gloucestershire funding.

The council has a statutory duty to consider the impact of its actions in relation to the following protected characteristic groups:-

Age
Disability
Gender Reassignment
Marriage and Civil Partnership
Pregnancy and Maternity
Race
Religion or Belief
Sex
Sexual Orientation

Therefore, the council wishes to hear and proactively consider any comments in relation to how any aspect of the issues presented may impact on any sections of the community as listed above. Any feedback in relation to equalities and any point raised within this document will inform a full Equality Impact Assessment and Analysis.

You can find out more and tell us your views by:

Online: https://consultations.southglos.gov.uk/consult.ti/Healthwatch

Email: consultation@southglos.gov.uk

Write to: Freepost RTXL-YJXJ-BXEX, South Gloucestershire Council, Corporate Research & Consultation Team, Council offices, Badminton Road, Yate, BRISTOL, BS37 5AF

Phone: 01454 862356 to talk to us or leave a message

Copies of the consultation are available from your local library and one stop shop.

SECTION 1 – INTRODUCTION

Healthwatch South Gloucestershire acts as a consumer champion for the patients and the public of South Gloucestershire. The service hears the views of the local population and promotes the views to the relevant decision makers.

Healthwatch was created by Part 5 of the Health and Social Care Act 2012. There is a national body, Healthwatch England, and a local organisation for each local council in England with social care responsibilities, which is local Healthwatch, or in our area Healthwatch South Gloucestershire.

Due to increasing demands on Council budgets, from April 2019 the Council is proposing to reduce Healthwatch South Gloucestershire funding by approximately 50% and jointly commission the service in partnership with Bristol City Council. This proposal is being considered as there is potential to improve efficiency through joint commissioning and by reflecting more closely the new Clinical Commissioning Group's commissioning footprint. Also to prevent funding reductions to other services where a greater negative impact on individuals may be experienced.

SECTION 2 –RESEARCH AND CONSULTATION

This section will be updated post consultation in order to present consultation feedback.

Bristol City Council have already undertaken a reduction in Local Healthwatch funding in collaboration with the current service provider. The proposed commissioning route for South Gloucestershire has been developed in partnership with Bristol City Council, drawing upon their learning so far.

Other Councils across the UK have made varying levels of funding reductions to their Local Healthwatch service, many reducing by 30-50%. Of these Councils, some have explored joint commissioning with neighbouring Councils taking advantage of economies of scale and common local issues.

Heathwatch England have been helpful in advising South Gloucestershire Council on consultation planning and effective operating models within limited funds.

The existing provider of Healthwatch South Gloucestershire has been consulted and will be consulted again with other providers to develop a service which continues to meet statutory requirements in a sustainable manner.

As part of the consultation process, the Council will be reviewing the unsolicited feedback that Healthwatch South Gloucestershire has received from protected characteristic groups so that we are clear about the exact impact of the proposed changes.

This section of the EqIAA will be updated by examining the quantity and type of consultation feedback in respect of Protected Characteristic groups.

Some examples of how Healthwatch has impacted on people with protected characteristics:

- Healthwatch South Gloucestershire heard from people with learning difficulties that the annual health check that they should receive doesn't always happen. Healthwatch told South Gloucestershire CCG who started monitoring this more closely and encouraging GPs to do more.
- Healthwatch heard that the public feel there is a lack of information about GP based minor injury services in South Gloucestershire. Healthwatch told South Gloucestershire CCG who encouraged GP surgeries to ensure this information is on their websites and known to GP reception staff.
- Healthwatch South Gloucestershire heard from people in a care home that said they have two local GPs visiting regularly, but arranging for a dentist to visit could be difficult. To help tackle this staff were provided with some training from a dental nurse.
- Healthwatch South Gloucestershire challenged a care home to provide a greater and more diverse range of activities, including outdoor activities and especially those suited to male residents. They returned to the home to see if the recommendations had been acted upon and they found a bingo game underway, someone being supported with knitting and a gentleman colouring. They also observed a notice board of planned activities for the week.

SECTION 3 - IDENTIFICATION & ANALYSIS OF EQUALITIES ISSUES AND IMPACTS

This section will be updated post consultation.

If the proposed reduction in funding goes ahead, the nine protected characteristic groups will still be heard in some form. However, a reduction to service funding at the proposed level will impact on all of the nine protected characteristic groups, as the service that represents these groups will have much less resource. There are a significant number of differences between groups in respect of health and social care outcomes and a range of these are shown in Appendix 1; a significant number of differences are also highlighted within the South Gloucestershire Joint Strategic Needs Assessment (JSNA). Overall, this means that throughout the protected characteristic groups, a negative impact is anticipated and in particular, the protected characteristics of Age (older age in particular) and Disability may experience greater negative impact as people from these groups are proportionately more likely to be impacted by health services and issues.

It is proposed that impacts will be minimised by looking for creative approaches to providing the service, in order that the statutory functions are maintained sustainably.

The creative models referred to above could be to put a greater focus on the most seldom heard groups, by maximising digital opportunities for feedback to free up outreach resource for only those groups that cannot engage online, or by targeting the work of Healthwatch on a very small number of key local issues. These and other service models need to be explored and developed as part of this consultation with existing Local Healthwatch providers, the results of which will form part of the concluding consultation report and EqIAA that in turn informs any procurement plans that follow.

SECTION 4 - EqIAA OUTCOME

This section will be updated post consultation.

Outcome	Response	Reason(s) and Justification

Outcome 1: No major change required.	☐	
Outcome 2: Adjustments to remove barriers or to better promote equality have been identified.	☐	
Outcome 3: Continue despite having identified potential for adverse impact or missed opportunities to promote equality.	☐	
Outcome 4: Stop and rethink.	☐	

SECTION 5 - ACTIONS TO BE TAKEN AS A RESULT OF THIS EqIAA

This section will be updated post consultation.

The existing provider of Healthwatch South Gloucestershire will be consulted again alongside other providers of Local Healthwatch elsewhere in the country to develop the best possible service for South Gloucestershire.

The public voice is clearly very important for this consultation. Feedback from Heathwatch England taught us that open public consultation events are perhaps not the most ideal platform for hearing feedback as these events were poorly attended elsewhere. Therefore in South Gloucestershire we plan to visit several GP surgeries to actively consult patients on our proposals. We will also provide a phone number for people to leave a message such that they will receive a phone call later to discuss their feedback.

All nine protected characteristic groups will be keenly targeted during this consultation for their views. Existing user groups will be approached, such as the Disability Equality Network and the Race Equality Network and broader groups such as the Independent Patient Experience Forum for South Gloucestershire will also be approached for feedback.

We will continue to work closely with Healthwatch England to benefit from their guidance and expertise.

SECTION 6 - EVIDENCE INFORMING THIS EqIAA

This section will be updated post consultation.

South Gloucestershire Joint Strategic Needs Assessment (JSNA)
Race Disparity Audit (2017)
"*Is Britain Fairer?*", the Equality and Human Rights Commission (EHRC), 2015
Bristol City Council feedback
Healthwatch England feedback
The Care Forum feedback

Appendix 1

Race Disparity Audit

The Government's "Race Disparity Audit" report was published in October 2017.

Overall, the audit shows that there are disparities between ethnic groups in all areas of life affected by public organisations. Some are more pronounced than others or have a greater impact on people's life chances and quality of life. In some areas, disparities are reducing, while in others, they are static or increasing.

Key findings include:-

Health

There are differences between ethnic groups across a range of health-related behaviours and preventable poor outcomes, and each ethnic group exhibits both healthy and unhealthy behaviours. More than half of adults in all ethnic groups other than the Chinese group were overweight (having a Body Mass Index of 25 and over), and this was particularly so among the White and Black ethnic groups, affecting 2 out of 3 White and Black adults. Adults in the Mixed group were the most likely to be physically active but also the most likely to smoke.

Most Asian groups express lower levels of satisfaction and less positive experiences of NHS General Practice services than other ethnic groups and there are differences in the prevalence of mental ill-health, its treatment and outcomes between ethnic groups.

In the general adult population, Black women were the most likely to have experienced a common mental disorder such as anxiety or depression in the last week, and Black men were the most likely to have experienced a psychotic disorder in the past year. However, White British adults were more likely to be receiving treatment for a mental or emotional problem than adults in other ethnic groups. Of those receiving psychological therapies, White adults experienced better outcomes than those in other ethnic groups. Black adults were more likely than adults in other ethnic groups to have been sectioned under the Mental Health Act.

Equality and Human Rights Commission (EHRC) Research Findings

In 2010, the Equality and Human Rights Commission (EHRC) produced its first progress report on equality, entitled *How Fair is Britain?* In October 2015, the EHRC published its follow-up report on both equality and human rights, entitled *Is Britain Fairer?*

The following information shows the findings of the 2015 report in relation to 'Health and Care'.

Health and Care

Health status Bad health particularly affected women, disabled people, those in 'Routine' occupations or who had never worked, Gypsies and Travellers, and homeless people.	– A higher proportion of women than men in England reported having bad or very bad health in both 2008 and 2012. – In England, the proportion of disabled people who reported bad or very bad health increased between 2008 and 2012, whereas there was a reduction for non-disabled people – Lower proportions of people with 'Higher managerial, administrative and professional' occupations reported bad health, as compared with other occupations. Those in 'Routine' occupations or who had never worked reported the highest levels of bad or very bad health. – Bad health also particularly affected Gypsies and Travellers: In all three countries, a greater proportion of Gypsies and Travellers rated their health as bad or very bad compared with people from other ethnicities. – An ONS report noted that, while the variability in general health among people from different ethnic minorities could sometimes be explained by their differing age structures (that is, an older age profile), this was not the case for Gypsies and Travellers. – Gypsies and Travellers were known to have low child immunisation levels, higher prevalence of anxiety and depression, chronic cough or bronchitis (even after smoking is taken into account), asthma, chest pain and diabetes, as compared with the general population. – Evidence from England showed the health problems of homeless people to be considerable, including physical trauma, skin problems, respiratory illness, mental ill health, infections and drug/alcohol dependence. Reported incidents of physical ill health, depression and substance misuse were higher among those sleeping rough or living in precarious accommodation.
Premature death Overall life expectancy rose and the gender gap narrowed. However, some people, such as those with learning disabilities and serious mental illness, Gypsies and Travellers, and homeless people had lower life expectancy rates than the general population.	– Life expectancy was highest in England and lowest in Scotland (a difference in life expectancy at birth in 2011/13 of 2.4 years for men and 2.1 years for women). – Men experienced a greater increase in life expectancy than women. The gap in life expectancy between men and women narrowed in all three countries between 2007/09 and 2011/13, with the greatest decrease in Scotland. – White people are estimated to have among the highest life expectancies in England. However, the life expectancy of Gypsies and Travellers is lower, and below that of other ethnicities. – People with serious mental illness have substantially lower life expectancies compared with the general population, with reductions in life expectancy of 7–24 years. In 2012, people with a learning disability had a median life expectancy of 58 years, compared with life expectancies of closer to 80 (or more) for the general population.

	– The mean age of death for homeless men and women was around 26 and 37 years lower than for the general population of men and women respectively.
Infant mortality Infant mortality particularly affected some ethnic minority people, mothers of different ages and socioeconomic groups.	– The infant mortality rate went down in England/Wales between 2007/08 and 2012 for White, Pakistani/Bangladeshi and African/Caribbean groups. – In England/Wales (in both 2008 and 2013) and Scotland (2008–12), the infant mortality rate was higher for mothers aged below 20 years old than for other age groups. The second highest rate was among mothers aged 40 and over. – In England/Wales in 2011 and 2013, infant mortality rates were highest for the 'Routine, never worked and long-term unemployed' socioeconomic group; this was also the case for mothers in the most deprived areas in Scotland in 2012.
Lifestyle factors The key drivers of ill health and premature death included smoking, excessive alcohol consumption and being overweight or obese. These saw some decreases, but men and disabled people remained particularly affected.	– In England, the proportions of both men and women who currently smoke decreased between 2008 and 2012. – In England and Wales, the proportions of men who exceeded lower-risk drinking guidelines decreased between 2008 (2009 in Wales) and 2012; there was a decrease for women in England and Scotland between 2008 and 2012. – The percentages of overweight or obese individuals were higher among men and disabled people in all three countries.
Suicide Suicide rates increased in England and Wales, but decreased in Scotland (although its suicide rate remained the highest in Britain). The gap between men and women widened in the UK as a whole, with middle-aged men having the highest suicide rates.	– Between 2008 and 2013, the overall suicide rate increased slightly in England (from 10.0 per 100,000 inhabitants to 10.7) and to a greater extent in Wales (from 10.7 to 15.6 per 100,000 – most visibly among the 35–64 age groups). – The male suicide rate increased in both countries resulting in a widening of the gap between males and females in Wales and England. – In the UK, the suicide rate of males aged 45–49 increased significantly between 2007 and 2013 from 19.4 to 26.8 deaths per 100,000 population, while that of the overall population (counting both men and women) increased from 10.6 to 11.9 per 100,000 over the same period. – The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH, 2014) highlighted the continued high risk of suicide by patients with mental health issues, within 12 months of mental health service contact. Patients at particularly high risk were those who were recently discharged from hospital (especially in the first one or two weeks) and those who were under crisis resolution and home treatment who were also living alone.
Access to healthcare Evidence suggests that some groups such as Gypsies and Travellers, transgender people and migrant communities can experience problems accessing healthcare services.	– Many Gypsies and Travellers remained unregistered with GPs. In Scotland, some GP practices refused to register Gypsy Travellers on the grounds that they had no fixed address or photographic ID, or could not guarantee that they would stay in the area for at least three months (Scottish Parliament, 2012). – Transgender people experienced a range of barriers in accessing NHS gender reassignment services, resulting from a lack of knowledge on the part of GPs on referring patients to gender identity services or, at worst, GPs allegedly being obstructive and discriminatory. – Little formal evidence is available about access to healthcare services for transgender children and young people.

	– Concerns were raised that confusion over eligibility to access healthcare in England meant that migrants with complex immigration histories, and/or those who entered the UK prior to the introduction of the new rules, could be unfairly refused access to free healthcare, regardless of how long they had lived in the UK. – The Children's Society (2015) stated that charging undocumented migrant children for secondary healthcare threatened the health and wellbeing of the child, posed risks to public health, and prevented health professionals from identifying child protection and safeguarding concerns.
Access to end of life and palliative care End of life care helps those with advanced, progressive or incurable illness to live as well as possible until they die. There was evidence of inequality in outcomes at the end of life for people sharing particular characteristics:	– People from more disadvantaged socioeconomic positions had worse outcomes at the end of life including a higher proportion of hospital deaths, lower proportion of home and hospice deaths, and increased emergency department attendance in the last month of life. – A study using records from all deaths in England between 2001 and 2010 showed that overall a larger proportion of men died at home and in hospital compared with women, while a larger proportion of women died in care homes. – Although dying at home became less likely with increasing age across the period 1984–2010, age-based inequality narrowed over time. – Evidence suggests that children with cancer who needed palliative care often did not receive it owing to lack of provision and lack of awareness and acceptance. – A recent review of UK-based literature found that studies reported lower access to palliative and end of life care services for ethnic minorities when compared with White British people. There was also concern that the Christian origins of the hospice movement may have led to some incompatibility within hospice care and palliative care more broadly in relation to other religions. – Specific challenges were faced by lesbian, gay, bisexual and transgender (LGBT) people, owing to a lack of recognition of their relationships by other family members and healthcare professionals.
Access to mental health care Risk of poor mental health rose in England with some ethnic minorities, LGB people, and disabled people particularly at risk.	– In England, the proportion of adults at risk of poor mental health increased from 13.4% in 2008 to 15.0% in 2012. – The gap between disabled and non-disabled people in England widened between 2008 and 2012. (However, a number of disabled people would have classified themselves as such owing to a mental health condition.) – Among ethnic minority respondents in England, the highest proportions of people at risk of poor mental health in 2012 were among Pakistani/Bangladeshi and African/ Caribbean/Black respondents (22.9% and 19.9% respectively). The higher rate among Pakistani/Bangladeshi people was primarily among women. There was an increase in the risk of poor mental health among White women between 2008 and 2012. – People identifying as 'gay/lesbian/bisexual/ other' in England in 2012 were at greater risk of poor mental health compared with those identifying as heterosexual. – Mental health problems accounted for 23% of the total 'burden of disease' in the UK but only a quarter of all those with mental ill health received treatment, compared with the vast majority of those with physical health problems. – The Health and Social Care Act 2012 introduced a principle of 'parity of esteem' in England, whereby mental health must be given equal priority to physical health. – In England, there has been an increase in the rate of involuntary admissions for mental illness over the period 1988 to 2008 which appears to be associated with a decrease in provision of mental illness beds in the NHS. – Mental health inpatient provision decreased by 10% in the four years between December 2010 and December 2014, falling to 21,446.

	– The number of formal detentions in NHS and independent hospitals increased from 46,600 in 2009/10 to 53,176 in 2013/14. – Of people with an inpatient stay in a mental health unit in 2013/14, over a third were compulsorily detained under the Mental Health Act 1983. – The reduction in inpatient bed numbers resulted, at least in part, from policies to introduce a more community-based model of services. – The Commission on Acute Adult Psychiatric Care in England noted that Trusts that focus on improving the overall acute care pathway had fewer difficulties with their acute care bed base. It also suggested that investment in community services, both as an alternative to and following acute admissions, was needed. – In England and Wales, governments have provided substantial funding for Improving IAPT. Scotland was the first nation in the UK to introduce a target to ensure faster access to psychological therapies for patients of all ages. There were annual increases in the numbers of people treated under the IAPT programmes, and improvements in levels of anxiety and depression. There was, however, considerable variation between areas, with long waiting times for treatment in some places. – Data on contact with mental health services in England showed some differences by ethnicity. – 4.4% of Black/African/Caribbean/Black British adults had contact with NHS-funded specialist mental health services in 2013/14; for the Mixed/multiple ethnic group the rate was 3.3% and for the Asian/Asian British population it was 2.9%, compared with 3.5% for White adults. – Among Black or Black British people with an inpatient stay in a mental health unit in 2013/14, 48.8% were compulsorily detained under the Mental Health Act 1983 (including 50.6% of people of African ethnicity). – For people of Asian or Asian British ethnicity, the percentage with an inpatient stay in a mental health unit in 2013/14 who were compulsorily detained under the Mental Health Act 1983 was 45.8% (49.4% for people of Pakistani ethnicity). Among White people, the figure was 33% (with the highest rate, 40.4%, being for those of 'Other White' ethnicity). – The use of police custody-based 'places of safety' for people with mental health problems decreased in England by 24% between 2012/13 and 2013/14, while the use of hospital-based 'place of safety' orders increased by 21%. – In England, Wales and Scotland there were no changes in the proportions of children and young people at risk of poor mental health between 2008 (2009 in Wales) and 2012. In 2012, these proportions were in the range of 5% to 10% of all young people aged 13 to 15. However, children and young people with mental health conditions have sometimes experienced high referral thresholds or long waiting times for specialist services, and have in some cases been admitted to hospitals a long way from home (House of Commons Health Committee, 2014). As a result, the UK Government stated that it was making improvements to child and adolescent mental health services (CAMHS) and improving access to therapies for children.
Quality of health and social care	Integration between health and social care – The number of people in England with health problems requiring both health and social care increased. In the next 20 years there are likely to be more people with 'complex health needs' (more than one health problem) who require a combination of health and social care services. For example, the percentage of people over 85 will double.
Vulnerable groups	Learning disabilities

	– The Care Quality Commission (CQC), the health and social care regulator in England, consistently reported that inpatient treatment services for adults and children with learning disabilities admitted and retained people for too long, and often too far away from their family homes. The CQC recommended that Clinical Commissioning Groups, the NHS and local authorities work more closely together to deliver person-centred services at the local level for adults and children with learning disabilities and/or autism. – However, despite pledges by DH and its partners to improve the situation, a review into the issue in 2014 (Transforming Care and Commissioning Steering Group, 2014; House of Commons Committee of Public Accounts, 2015) found that people with learning disabilities and/ or autism had been, and continued to be, placed in inappropriate settings for too long and a long distance from family and home due to a lack of good-quality alternatives in the local community. Mental health – Reports from Scotland and England noted positive developments in the availability of high-quality mental health care, including units where patients were engaged in activities, thinking about recovery and focusing on the future. However, some concerns were expressed about variations in the quality of mental health services. – The use of overly restrictive practices, lack of therapeutic activities and the use of control and restraint (Schizophrenia Commission, 2012; NHS Quality Improvement Scotland, 2010). – In England, concerns have been raised about the inappropriate use of blanket rules (such as access to the internet, outside areas and rigid visiting times) and inadequate regard for patients' privacy (CQC, 2013; 2014a). The CQC specifically criticised 'controlling practices that only seem to serve the hospital's needs' as infringing patients' human rights, particularly the right to dignity (CQC, 2013, p. 33). – HM Chief Inspector of Prisons (HMCIP) for England and Wales stated in its *Annual Report 2013–14* that the care of prisoners with mental health needs was inconsistent across different prison establishments. – Speaking generally about prisoner peer support, HMCIP stated that although peer-based support schemes, such as the Listener scheme, were available, access was limited in some prisons and many prisoner peer supporters lacked oversight, sufficient training or support from staff (HMCIP, 2014). – Concerns were expressed during the consultation process for the revised code of practice of the Mental Health Act 1983 about the vulnerability of women in mental health wards when single-sex accommodation was not available (DH, 2014a). The DH draft code of practice states that there should be separate facilities for men and women and that female inpatients should not be placed in mixed-gender environments because of the increased risk of sexual and physical abuse and because of the risk of trauma for women who have previous experience of sexual abuse. Older people and people with dementia – An overview of trends in social care in England during the previous Parliament (2010–15), projects that spending on social care fell by 13.4% over the period. Older people were particularly affected – overall, fewer older people were in receipt of social care at a time of growing demand. – Despite an increase of 10.1% between 2009/10 and 2013/14 in the population aged 65 and over, spending on older people fell faster than for adult social care as a whole (by 17.4% between 2009/10 and 2013/14).

	– Although data is not directly comparable across the three countries, it indicates that, between 2009–10 and 2012–13, total gross expenditure on adult social care decreased by 5.5% in England. This compares with falls of 2.1% in Wales and 3.4% in Scotland. – In England in 2012, 28.3% of older people did not receive practical support that met their needs: – those aged 75 plus were far more likely to be in this situation than those aged 65–74 – over half of disabled older people did not get the support they needed. This compares with fewer than one in 10 non-disabled people, and – a higher proportion of women than men reported that they did not receive the support they needed. – A number of inquiries and reviews have found serious shortcomings in the care and treatment of some older people, with key risk groups including people with dementia. The Commission's Inquiry into Older People and Human Rights in Homecare (EHRC, 2011b) identified areas of concern in England in the treatment of some older people and significant shortcomings in the way that local authorities commissioned care. The Inquiry found: – Legal safeguards provided by the HRA to prevent inhuman or degrading treatment were not as widely used as they should be. – Neglect and ill-treatment identified included: older people not being given adequate support to eat and drink (in particular those with dementia); neglect due to tasks in the care package not being carried out, often caused by lack of time; financial and physical abuse; and chronic disregard for privacy and dignity. – A significant legal loophole which meant that the majority of older people who received care at home – that is, if they paid for all or part of it themselves or if it was delivered by a private or voluntary sector organisation – were not protected by the Act. The Care Act 2014 closed the loophole for people receiving publicly commissioned homecare from private and third sector providers.
Access to childcare Data for England from analysis of the Childcare and Early Years Survey of Parents indicates that there was little change between 2010 and 2012 in the proportion of parents saying that they had problems finding flexible childcare. Parents from some ethnic minorities, and of disabled children, were particularly affected by such problems:	– The picture for people from different ethnic minorities was mixed: in 2012, 43.2% of parents of African/Caribbean/Black children and 34.5% of parents of Indian children had problems finding flexible childcare, compared with 24.6% of parents of White children. – Parents with a disabled child also found it harder to find flexible childcare: 32.0%, compared with 25.7% of parents of a non-disabled child. – Other problems in accessing childcare provision include lack of availability in the early morning or overnight, inflexibility, prohibitive costs and a poorer supply of childcare provision in rural areas