APPENDIX 1

NHS Cumbria Clinical Commissioning Group

Name of the Document	Equality Impact Analysis and Workshop Report
Date Completed	23 February 2017
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Summary of the Document

NHS Cumbria Clinical Commissioning Group (CCG) is fully committed to meeting its duties to relating to equality and diversity, including the requirements of the Equality Act 2010 (the Public Sector Equality Duty).

Throughout the process of developing and considering options, the CCG has ensured that appropriate Equality Impact Analysis have been undertaken as a continuous, dynamic process. This included:

- An Equality Impact Analysis was undertaken in July 2016[1] which assessed the potential impact of the significant changes proposed within the Pre Consultation Business Case (PCBC)
- In November 2017, further analysis was undertaken which resulted in an addendum to the original EIA focusing on proposals for the Hyper Acute Stroke Services and Emergency Surgery, Trauma & Orthopaedic Services[2]

In December 2016 a series of workshops were held to review the Equality Impact Analysis. These were attended by a range of stakeholders and representatives of groups of the population with protected characteristics. A copy of the report from the workshops is attached as an Appendix A.

Informed by the process outlined above, and including the feedback received during the December workshops, a fuller Equality Impact Analysis was finalised in February 2017 which updated the work previously undertaken. This document is attached as an Appendix B. The document does not repeat the demographic information provided in the earlier document from July 2016.

While focussing on the potential service changes subject to the Public Consultation, the report also records a number of improvements that could be made to existing services.

The Equality Impact Analysis demonstrates how the CCG, working with our partners, has considered the potential impact of the service changes consulted upon, the potential mitigation of any negative impact, and our collective commitment to comply with our responsibilities under the Public Sector Equality Duty Section 149 of the Equality Act.

[1] http://www.wnecumbria.nhs.uk/wp-content/uploads/2016/11/West-North-and-East-Cumbria-Equality-Impact-Analysis-Report-Jul-2016.pdf

[2] http://www.wnecumbria.nhs.uk/wp-content/uploads/2016/09/West-North-and-East-Cumbria-Equality-Impact-Analysis-Report-Addendum-Nov-2016.pdf

Appendix A

Healthcare for the Future in West, North & East Cumbria

Equality Impact Assessment Workshop Report

December 2016

Feedback from the Equality Impact Analysis Workshop – 6th December 2016

The workshop was organised in partnership with the Action for Health Network with the aim of gathering feedback directly from those with a protected characteristic or those who specifically support those with a protected characteristic, across all of the proposed changes in the Healthcare for the Future Consultation.

There were 28 people who attended the workshop, all of the protected characteristics were represented other than the Lesbian, Gay, Bisexual, transgender (LGBT) community. To strengthen the input into the EIA process and to ensure that every effort has been made to cover as many of the protected characteristics and 'hard to reach' groups as possible a further 3 deliberative events were held, one for representatives of the Neurological Alliance and one for representatives from the deaf community (both in west Cumbria) and one for the LGBT community (held in Carlisle). Feedback from all of these events is included in the following information

Although not part of the formal consultation, the workshop also provided an opportunity for people to comment on changes to Public Health, General Practice and Integrated Care Communities and the status quo. The feedback for each section is split across each of the protected characteristics.

Representatives were asked to consider how the proposals would affect people under each of the protected characteristics and any possible mitiagations.

Some general concerns were raised and are reflected in the feedback. Some issues relating to access to health services in general, rather than specifically to the consultation were also raised. These have been contained in the feedback to ensure they available for in a future planning and can be found in the section 'General Feedback on Status Quo.'

There was a discussion about how many people need to be affected to justify a small or a large impact, as this is a subjective process this was not resolved during this process.

There was a general feeling looking at the overall impact of the proposals that there is a negative impact on women as a whole. This was due to the maternity issues and that women take on a greater caring role be in for children or older people.

Concerns over recent extreme weather and the impact on travelling around the county, as well as the general road and travel conditions were expressed as a general concern affecting any proposal.

General Feedback on Status Quo

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Race	There is already a lack of understanding among health and social care staff of different cultural issues in Black & Minority Ethnic (BME) communities. Some immigrant communities (Bengali was mentioned) tend not to register with GP, but make use of hospital services. This is believed to be mainly due to lack of understanding of the system, need to raise awareness. BME increase in elderly population from those who settled in the 80's tend not to access services. Needs to be greater awareness of cultural issues, specifically during pregnancy, birth and postnatal care. Gypsy and Traveler children are likely to need greater access to acute paediatric care as they have lower immunisation levels and are less likely to be registered with a GP Practice. Higher incidence of stroke in some ethnic groups?	Improve cultural awareness and attitudes, with better understanding of different cultures, identifying and working with available support networks. Clarify place based – identify community of identity and interest and how to reach them rather than a geographic community.
Religion & Belief	Staff going in to support people within their homes will be less able to seek advice from colleagues on cultural issues – particularly relevant to end of life care.	
Gender	Concerns over services being less likely to be accessed by men at present Staff: lone working and related issues may affect women more (more vulnerable, higher proportions of staff are female). Shift patterns have bigger impact on women as more likely to have other caring responsibilities.	Target marketing at publicity at men, and develop specific services for men where they are identified at being at risk of higher health inequalities

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Disability	Wider range of staff working with less support – increased need for training around disability issues, need for a broader knowledge base. Mental health issues and the impact on physical health Care in a different community may cause care to be less connected – at moment, GP with detailed knowledge of patient will often visit in CH, unlikely to happen if outside of area. Wheelchair access is poor at CIC – rooms too cramped Children with disabilities or long term medical conditions may require more frequent visits to hospital services which has significant cost and time implications for families People with disabilities suggested they may not feel their conditions are fully understood, within the context of their disability Learning difficulties – capacity and communications issues bring added implications – out of normal routines Cuts in social care – end up in healthcare as social care collapses	
Sexual Orientation	Some people may prefer a more anonymous service in acute hospital rather than a community setting if they do not wish their sexual orientation to be known. Lifestyle and vulnerable groups – homeless young people and how to access this group. Cumbria can be more of a closed community Concerns raised that there may be risks associated with pregnancy in lesbian couples – e.g. higher likelihood of IVF, and perhaps higher risks from that. Possibly more likely artificial insemination, and unlikely to have higher risks at birth. Discrimination against women in same sex relationships (links to paediatrics). Despite improvements in legislation national research over the last few years shows that discrimination can still be an issue.	Ensure choice is available for accessing particular services. Grassroots work in schools

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Age	Older adults who experience social isolation will not be included fully if they do not have support and encouragement to access local health and care services Dementia is more common in older people, and can place heavy demands on carers (also often older people). Lots of people retired here so no family support – some communities all of a similar age. Community hospital beds are more likely to be used by older adults, and given there are already concerns regarding loneliness and isolation in the over 80's population – this could be exacerbated in the areas where beds are removed as there will be less opportunity for families and friends to visit (especially when those friends are also older adults) As the system is already under strain, there are concerns that it will not really be resolved and older adults will be considered to be 'bed blocking'. Older people perceived to be more susceptible to the stress of being in an unfamiliar environment. Growing needs of those with dementia not being met Ageing population with more complex needs – don't recover as quick	Ensure good signposting and referrals between services, designed with all providers (including 3rd sector)
Pregnancy & Maternity	Babies on paediatric ward can't be left alone (or at least not encouraged), so hard for mum to get meals, shower etc. (don't get hospital meals) if other parent isn't there – which is more likely the further unit is from home	Parents are encouraged to say on children's ward (preferably one parent but two can stay) – fold out camp beds on the ward
Gender Reassignment	Concern over lack of understanding of the issues within local health services. Can take a long time to get a referral, then waiting long time for an appointment	Availability of choice Raise awareness within local health services

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Rural Isolation & Deprivation	Difficulty recruiting home care staff in rural areas because of contract terms (often not paid for travel time, which is significant in rural areas), whereas there is a belief that it is comparatively easy to recruit staff to work in care home or community hospital. No or poor phone / broadband reception so issues of poor internet services Problems in accessing rural areas in poor weather / floods Transport costs less affordable for those in deprived wards which may be a barrier to them accessing services Not all home environments are suitable – e.g. old house, fuel poverty, too cold. Tourists – tourists tend to use A&E instead of other health services, less likely to be informed about the best place to attend.	Funding of social care staff, contracts Improve Adult Social Care workforce and what is needed – allow separate travel time (not part of care time). Potential for access to services to be improved Infrastructure is critical – broadband, roads, mobile phone coverage etc. Need to consider in wider resilience context. Is it better to bring people to one place where it's easier to see them than visiting everyone at home
Carers	Identify difference between paid care workers and unpaid carers. Young Carers may find it difficult to support the person they care for, to access health and care services, within school hours Carers may find it difficult to support the person they care for, to access health and care services, within work hours There is a risk that if people have less contact with their GPs that Carers are not identified and do not receive appropriate support. Respite Care is already a considerable problem for unpaid Carers, and if it is not provide then Carers are more likely to have failing health. Community Hospital beds provide essential respite care.	Develop focus groups with young Carers and link with schools to publicise support available for Carers locally Ensure good levels of knowledge regarding Carers Assessments for example, throughout the health and care system. This will help to ensure Carers are at least encouraged and signposted to available support.

Public Health, General Practice and Integrated Care Communities

While not formally part of the consultation these 3 areas are what underpins the proposed changes so it was important to give people an opportunity to give some feedback on these proposals. Generally these areas are seen as a positive step in improving health and social care across the area, initially to relatively small groups of people but expanding to take in more of the population.

The biggest area of concern is related to social care and its possible impact on the success or failure of all of the Integrated Care Communities.

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Race	Lack of understanding among health and social care staff of different cultural issues in BME communities including: • Lifestyle and working patterns • Access and understanding information • Alternative issues – not just smoking cigarettes other things worse for health i.e. pan, gutka, spari • Assumption that everyone has friends and family – there is some social integration Some immigrant communities (Bengali was mentioned) tend not to register with GP, but make use of hospital services. This is believed to be mainly due to lack of understanding of the system, need to raise awareness. How to ensure that the generic and/or localised provision (within the 8 ICC's) does not affect access to more specialised services such as interpreters, which may make them less accessible to people where English is not their first language. Gypsy & Traveller community – difficult to promote self-care when people are moving between areas. Could be difficult to provide services in own home. Lack of understanding of the issues affecting the community and poor engagement.	Improve cultural awareness and attitudes, with better understanding of different cultures, identifying and working with available support networks. Clarify place based – identify community of identity and interest and how to reach them rather than a geographic community. Ensure a good understanding of relevant services that may be able to support ICC's to be more accessible (for example working with groups that support BME groups) by using existing networks Good engagement from ICC team could have a positive impact here. Follow Accessible Information Standard to ensure access to translation services and information in an understandable format across all ICC's, and community based services ensuring that they are meeting relevant legislation. Provision of information in an accessible format available on sites, use of social / visual media and available networks.
Religion & Belief	Staff going in to support people within their homes will be less able to seek advice from colleagues on cultural issues – particularly relevant to end of life care.	Develop protocols and minimum standards for all ICC's, ensuring that they are required to ensure provision is in place to meet the needs of people that are from minority ethnic groups Training & support Central point of contact for both staff and families
Gender	Concerns over services being less likely to be accessed by men, both at present and in the future. Dignity – care for people in own home may make it more difficult to offer people a choice of carer (particularly men who would prefer a male carer, when the majority of staff are female) Men in rural areas and of a certain age seem to disappear – medication which means they can't drive so disappear from usual activities. Staff – Increased lone working and related issues may affect women more (more vulnerable, higher proportions of staff are female). Shift patterns may change and bigger impact on women as more likely to have other caring responsibilities.	Target marketing at publicity at men, and develop specific services for men where they are identified at being at risk of higher health inequalities Appropriate training and support

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Disability	Identify difference between paid care workers and unpaid carers. ICC facilities, GP surgeries and other place based services may be based for convenience and economic reasons rather than easy access for the general public. This may mean they are less accessible for people who have mobility problems. Wider range of staff working with less support – increased need for training around disability issues, need for a broader knowledge base. Earlier supported discharge home – home may be adapted if long term disability, but if new disability (e.g. amputation, stroke) then home may not be ready. Unsuitable facilities (toilets, hoists etc.) Transport – providing services more locally doesn't necessarily mean they're easier to access if don't have own transport. Changes to benefits system means that many people have lost their mobility care and are now reliant on others for transport. Cuts to bus subsidies, and so loss of services, make this worse. Learning Difficulties – issues in accessing information on line – need accessible format	Work with disability/access groups to ensure that locations are accessible not only for people who use wheelchairs but also people who have limited mobility, and those who require additional support/carers Recruit champions' within ICC's, Public Health provision and GP Surgeries who have greater awareness of specific needs, for example Dementia Champions, Mental Health Champions and Veterans Champions Other agencies – housing, social care – need to be involved, and adequately funded HAWCS need to be trained to work with people with communication issues
	3rd sector staff (Mencap) trained to very high level – training costs high – cover community nurse roles (tracheotomy management) – could become an issue in the future. Mental health issues and the impact on physical health	Feed into CLIC re access to training for 3rd Sector (could use as funding in kind)
Sexual Orientation	Some people may prefer a more anonymous service in acute hospital rather than a community setting if they do not wish their sexual orientation to be known. Lifestyle and vulnerable groups – homeless young people and how to access this group. Cumbria can be more of a closed community	Ensure choice is available for accessing particular services. Grassroots work in schools

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Age	Older adults who experience social isolation will not be included fully if they do not have support and encouragement to access local health and care services ICC model may rely heavily on volunteers, and many of these will be older adults – e.g. volunteer drivers Many carers are older people, and ICC model/care in home may increase demands on carers. Could be positive, but the worry is that services won't be in place in community before community hospital beds are lost. Dementia is more common in older people, and can place heavy demands on carers (also often older people). Older people who live alone may find it very isolating to be cared for at home. Difficult to provide same continuity of care (e.g. checking that an individual is eating adequately). Public transport is limited in North Cumbria and this may have an additional impact on young people and older people who do not drive Young carers? Single parents with no family support Why are we losing our young people? Lots of people retired here so no family support – some communities all of a similar age. PH – not everyone has access to online services	Ensure good signposting and referrals between services, designed with all providers (including third sector) Ensure suitable, affordable transport provision (that covers the ICC footprint) for those who do not drive, to access services Planning, support and training Adequate support, respite care and escalation procedures (when carer is unable to cope) ICC should involve social care, schools and 3rd sector
Pregnancy & Maternity	Better births talks of "maternity hubs" – will these be part of ICC model?	Perinatal mental health – opportunity for a positive impact if services are provided well at a community level, as destigmatises
Gender Reassignment	May prefer anonymous service Concern over lack of understanding of the issues within local health services. Can take a long time to get a referral, then waiting long time for an appointment	Availability of choice Raise awareness within local health services

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Rural Isolation & Deprivation	Additional transport costs for those who live in rural areas ICC footprints are developing based on population size, not the distance people have to travel to access services. This means that those in rural areas will have poorer access to support. Care in own home means more travel for care staff. This might be an issue in rural areas in winter & severe weather – e.g. gritting of rural roads. Difficulty recruiting home care staff in rural areas because of contract terms (often not paid for travel time, which is significant in rural areas), whereas relatively easy to recruit staff to work in care home or community hospital. No or poor reception so issues of poor internet services Difficulty in getting to village halls, no public transport Mental health issues and access to physical health services Problems in accessing rural areas in poor weather / floods Losing young people – lack of affordable housing No workforce to provide care More chance of seeing GP than pharmacy Transport costs less affordable for those in deprived wards which may be a barrier to them accessing services Not all home environments are suitable – e.g. old house, fuel poverty, too cold.	Work with local, specialist organisations to capture their knowledge of local need. Utilise very local facilities (consider village halls etc. as in The Bolton Village Exchange where they have space for people to get flu jabs for example) to deliver services, wherever possible, close to those who have highest levels of need. Potential for access to services to be improved Infrastructure is critical – broadband, roads, mobile phone coverage etc. Need to consider in wider resilience context. Funding of social care staff, contracts Is it better to bring people to one place where it's easier to see them than visiting everyone at home Improve ASC workforce and what is needed – allow separate travel time (not part of care time).
Carers	Young Carers may find it difficult to support the person they care for, to access health and care services, within school hours Carers may find it difficult to support the person they care for, to access health and care services, within work hours ICC footprints/areas may be outside of peoples natural communities, so Carers may have to travel elsewhere to access support Personal contact with Carers may be lost if services are delivered via digital methods	Develop focus groups with young Carers and link with schools to publicise support available for Carers locally Good community engagement when developing ICC's to ensure that they reflect the needs and (as much as practically possible) the preferences of people who use the services, and their Carers Ensure that there are choices available in terms of how people receive information and support (offer other means to digital)

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
	GPs are the main point of contact for most people experiencing problems with their health; it is also an important point of contact when identifying unpaid Carers. There is a risk that if people have less contact with their GPs that Carers are not identified and do not receive appropriate support. End of life care – assumption that people want to die at home, but this places significant demands on carers. Risk that carers are less likely to be identified, and so not get appropriate support. 85% of carers have a chronic illness themselves, so support for carers is vital. Increased costs on family when care is provided at home. Assumption that everyone has friends and family Access to GP – ring at half 8 – can't get through – have to take kids to school – have to get to work Need to assess wider family needs, not just the patient, and identify the stress points.	Use the development period of ICC's to develop public and patient participation groups, thus ensuring that the level of support meets the needs of local people, and those with additional support needs Ensure good levels of knowledge regarding Carers Assessments for example, throughout the health and care system. This will help to ensure Carers are at least encouraged and signposted to available support. ICC needs to provide adequate professional support – but could be positive impact if done well. Live in one area, work in another – arrange to have (blood test) in work area

Community Hospitals

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

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Workshop Feedback - Race	BME increase in elderly population from those who settled in the 80's tend not to access services. Often run business with little support so if someone is ill have to close business because no family support. Nepalese bringing in parents. Brexit new situation, no longer an attractive place to be – community care has a huge immigrant workforce. Some dementia suffers revert back to original language	CCG to work with the Allerdale, Carlisle, Copeland and Eden District Councils and CPFT to: • identify current Gypsy and Traveler sites/resident numbers across the WNE Cumbria area • Assess possible health need in relation to community hospitals • If health need is identified, carry out specific consultation with Gypsies and Travelers who may be affected by the proposed options • Facilitate accessible communication
Workshop Feedback – Religion & Belief	End of life care – may be harder to be aware of, and/or accommodate religious beliefs in community hospital rather than acute hospital. Mixed sex wards in community hospitals may be unacceptable to some faiths	Multi-faith chaplain service – skype facilities (wouldn't work for everyone)

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Workshop Feedback – Gender	Carers are disproportionately female (70 %?); closure of community hospital beds will have large impact on carers, and by implication, on women. Details under Carers section.	
Workshop Feedback – Disability	Concerns that provision of support in peoples own homes (away from community hospitals) don't address the issue of the suitability/accessibility of a person's own home. In cases where a person is temporarily/short term disabled it is less appropriate (or economically sensible) to install accessibility aids and adaptations - so this could have additional negative impact on those people. Closure of some community hospital beds and care in a community hospital in another community will make it more difficult for people in those areas to see their families, increasing their isolation. This is especially relevant where people have existing vulnerabilities around their mental health. Equipment provided in people's own homes is not always easy to use, so even when it is provided it's not always useful Patients often receive transport to community hospital bed (e.g. from acute hospital) but rarely from Community Hospital to home. Arranging this from a CH in a different community is more challenging, and disproportionately so for people with some disabilities (sight problems, learning disabilities, dementia). Care in a different community may cause care to be less connected – at moment, GP with detailed knowledge of patient will often visit in CH, unlikely to happen if outside of area. Family members with disability will find it harder and more expensive to travel and visit relative in CH if this is more distant. People with learning difficulties find it more difficult to visit parents in hospital if out of area. Can't visit because of their disability Where does mental health fit into this Complex disability – what happens when things go wrong, don't need acute but need a bit of extra support – where do they go – removing safety net	• Ensure suitable transport is affordable as well as adequate. • Provide training in the use of equipment, in the persons own home

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Workshop Feedback – Age	Community hospital beds are more likely to be used by older adults, and given there are already concerns regarding loneliness and isolation in the over 80's population – this could be exacerbated in the areas where beds are removed as there will be less opportunity for families and friends to visit (especially when those friends are also older adults) Where it is not appropriate for someone to receive support in their own home (because of the level of care needed), and where there are no local community hospital beds – people may be more likely to stay in local residential care homes. Given the uncertainty around the future of residential care homes this could create issues for older adults who require complex end of life care. (There are links with Carers section) Respite Care, often provided within community hospitals, and especially where there are co-dependent couples, is essential to maintaining independence and living at home in the long term. Removing this in proposed areas could increase pressure elsewhere on the system in future. Proposals are removing beds from areas of highest deprivation (West) and great rural disadvantage (East) therefore having the greatest impact on those older adults who are already experiencing disadvantage. As the system is already under strain, there are concerns that it will not really be resolved and older adults will be considered to be 'bed blocking'. If community beds are removed, what is there to fall back on? The future of residential care is also in question, so adds to concerns. Intergenerational links likely to be broken (e.g. grandchildren less likely to visit if further away) End of life care – partner likely to be older, and less likely to be able to travel to visit if beds further away. Older people perceived to be more susceptible to the stress of being in an unfamiliar environment. Older volunteers – e.g. volunteer drivers – likely to be under more pressure. Community hospitals work well for children, out of school to physio and back to school Removing support networks Family moved away / or moved away from family Implications re workforce and issues of having enough care workers to visit people in own homes. Young disabled what does parent do if care given further away.	• Links to other beds in locality – e.g. social care beds • Much improved discharge processes

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Workshop Feedback – Rural Isolation & Deprivation	The proposals suggest the closure of beds in deprived and/or rural areas – in some cases the most deprived and the most rural. The proposals therefore have the greatest impact on the people who are least able to cope with them. The proposals remove hospital beds from The Solway Plain – so essentially putting the burden of bed closures on a very specific community (along with Alston). This means that it has a greater impact upon single communities rather than sharing the burden across the North of Cumbria. Alston – the road from Alston to Brampton (which is where beds would move to) is gritted by Northumbria (loops out of Cumbria and back again) – rarely seen as a priority route. Moves the risk to patient & relatives – travel in poor weather Staff access to patients in poor weather – more challenging if cared for at home rather than in Community hospital. None of the options improve things for elderly in rural areas Loss of rural bus services – not everyone can access mini bus services - No provision for transport in plans Having to travel further is difficult for people who have dual responsibilities (farmers, etc.). Community Hospital should be focus for ICC Clarify viability of hospital if beds close. Shift may be bigger than anticipated – e.g. Alston used to do a lot of end of life care, but if not possible due to staffing, tends to go to hospice in Carlisle rather than Brampton CH.	Transport routes into Keswick make it an ideal site to be developed
Workshop Feedback – Carers (Carers were added as a separate category for the workshop due to a number of concerns raised beforehand)	Respite Care is already a considerable problem for unpaid Carers, and if it is not provide then Carers are more likely to have failing health. Community Hospital beds provide essential respite care. There are high levels of trust regarding Community Hospital staff, where beds are planned to close, Carers will be put under increased strain as they will not have the same levels of reassurance. Carers will have to travel further (where bed closures are planned) putting increased time and money pressure on to them. This could lead to a decline in their own health and wellbeing. Placing people 'out of reach' of their unpaid care and support could potentially put more strain on the health system, as Carers will not be filling gaps in unmet need.	• Ensuring Carers are part of care planning, to ensure that their needs are also met when decisions are being made. • Reassurance for Carers around the joined up working between health and social care, to meet people's needs.

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
	The proposals describe the difficulties in recruiting staff in Alston, for example. There are concerns because this is also the case when recruiting care Workers. If there is a shortage of Care Workers then unpaid Carers may be required to provide greater levels of care. Single parent – difficulties in looking after children and working, while having sick child or adult. Don't necessarily have support networks Pressure of taken away from community and have other responsibilities	• Recruitment should be considered a system wide challenge, not just within the NHS

Maternity Services

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

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Workshop Feedback - Race	Needs to be greater awareness of cultural issues	Multi-faith chaplain service
Workshop Feedback - Religion & Belief	Jehovah's Witness – blood transfusion issues, increased distance to CLU and alternative surgical solutions – may increase likelihood of poor outcome. Likely to be identified in pregnancy as high risk and advised to attend CLU (?) – effectively reduces choice for these women	Identification during pregnancy and advice on choices and risks
Workshop Feedback - Gender	Also some disproportionate impacts on men identified: Driving to hospital during labour (and back home afterwards, often without sleep) – stressful, and some men very traumatized by this – mental health implications – and increased stress as distance increases. Stress of trying to juggle caring responsibilities – partner and older children – again, more of a problem as distance/travel time to place of birth increases Greater risk to women if remove consultant led unit at WCH	Availability of accommodation at/near CIC to avoid need to drive back without sleep

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Workshop Feedback - Disability	Women with a disability may also require more support during labour (particularly if require support with communication – LD, deaf), and arranging this may become more difficult if distance to services increases (particularly if support is provided by partner/family member, and there are other siblings to care for) Wheelchair access is poor at CIC – rooms too cramped. Issue for women giving birth and also partners/visitors. Because women who have disabilities may experience greater difficulties during pregnancy, options which do not include consultant led Maternity services in West Cumbria may have a greater impact on disabled women living in West Cumbria because they are less likely to opt for a home birth because of increased risk Learning difficulties and autism, don't always know what's happening to them so issues may not be identified soon enough	Ensure transport options cater for women who have additional equipment (wheelchairs, scooters etc.) Improve access at CIC/allocate suitable room – not limited to maternity
Workshop Feedback – Sexual Orientation	Perhaps very tenuous – but are there any risks associated with pregnancy in lesbian couples – e.g. higher likelihood of IVF, and perhaps higher risks from that. Suspect not – more likely artificial insemination, and I suspect that's not got higher risks at birth. Discrimination against women in same sex relationships (link to paediatrics)	
Workshop Feedback – Age	Other factors related to teenage pregnancy that increase impact: • Less likely to have own transport • Support networks more fragile • Tend to be higher risk pregnancies – both because of age, and because of increased incidence of other risk factors – smoking, heavy alcohol use, drug use, late access to antenatal care • Danger high risk pregnancies will present at WCH (to MLU, or A&E if no MLU) because of lack of antenatal care (& so knowledge) or simply because of lack of transport • (? Some evidence from other areas this happens)	• Where required, community midwives can offer mental wellbeing advice and reassurance - • Some concern with the wording of this, and suggestion that MW would have to reassure even when they may feel concern is justified
Workshop Feedback – Pregnancy & Maternity	Haven't looked at TIA – but perhaps need to mention that babies born "in transit" have higher chance of poor outcome – and every chance number of babies born before arrival will increase as distance increases? Increased stress from increased travel distance (and parking difficulties at CIC, and lack of dedicated maternity entrance) will have an impact on birth experience, and a cascade of longer term impacts: • Stress shifts body from producing oxytocin to adrenaline – tends to stall labour, and make interventions more likely • Disruption of normal birth process • Consequently, more difficult to establish breastfeeding, and increased incidence of postnatal mental health issues	

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
	Women may choose to set off from home earlier in labour to avoid risk of giving birth before arrival – increased chance of arriving early in labour and being sent home, or offered induction. May lead to increased time spent in hospital during labour – which has knock-on effects for women from other parts of Cumbria (e.g. CIC labour ward full, sent to other units?) (Lack of) Pain relief during long journey Grade 1 section 30 minutes no time to transfer If one (either mother or baby) needs to transfer what happens to the other – additional stress Stand alone midwife unit not safe • Better Births (national doc) requires a family focus – increased travel distance makes this much harder • In options 1 & 2, it'll be the highest/higher risk mums who have to travel further in labour – this seems the wrong way round. What are the options for the highest risk mums – specialist ambulance (twin pregnancies – suggestion that if born on journey, ambulance would have to stop and await second crew as can't transport mum plus 2 babies??), helicopter?	• improved parking arrangements at CIC • Advice on suitable pain relief (e.g. paracetamol OK in labour) • 3 lane decent road for A595 - travel time under 30 mins? • Reviewing hospital services has to improve infrastructure – CIC often full and divert to WCH • Different progression routes – offering GPs opportunity to specialize • Different ways of providing support • Keep consultant led unit and full paediatric service • Stop undermining unit • Speak to ST6 trainees- can't do general paediatrics in many places – mix with research and job swap • None of the options work – urbanized models – not fit for purpose – be more innovative • Can we lobby for the Community Hospitals to have a role?
Workshop Feedback – Rural Isolation & Deprivation	Rural – as above for increased travel distances Deprivation – costs of travel and implications for support during labour and any subsequent hospital stay. Cost of partner travelling to/from Carlisle, and difficulty of caring for other children, is likely to mean less family support Given the three most deprived wards have been identified in West Cumbria, the options will have an increased impact upon those deprived communities – and do not take in to consideration the links between deprivation and problems during pregnancy. Deprivation – low levels of education – people turn up at A&E not knowing they are pregnant. Levels of Literacy some of it hidden Rural areas under threat – losing services all over. People move out community gets older Tourists – do access Cumbrian maternity services, more likely to be doing so in high risk situation (early labour) and less likely to know where the best unit to attend is	• Need rural model • Remove NHS from Government

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Workshop Feedback – Carers (Carers were added as a separate category for the workshop due to a number of concerns raised beforehand)	Fathers/Grandparents/Friends as carers for other children – more necessary and bigger commitment as distance to place of birth increases Impact on family – mental health of parents – extra stress going through this Higher risk of abuse – rates increase with depression and stress Man left at home with children – additional stress levels	Childcare options at/near CIC?

Paediatric Services

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

Protected Characteristi	Issues Raised	Suggestions to address the issues raised
Workshop Feedback - Race	Gypsy and Traveller children are likely to need greater access to paediatric care as they have lower immunisation levels and are less likely to be registered with a GP Practice. Other recent immigrants (Polish & Lithuanian mentioned) – children may also be on different immunization schedule, have missed jabs in move, and less likely to register with GP (due to lack of knowledge of system, language difficulties, etc.) and make more use of acute paediatric services as a result (present to A&E with child who's more ill). Access more difficult as travel distance increases – and danger of present at WCH A&E with no paediatric back up (under various combinations of options) Refugees – concerns raised about immunization, poor general health, etc. [my involvement in refugee work suggests that those being taken under national government schemes are given thorough health screening & immunisations before arrival – so may not be significant issue. May still be more likely to be malnourished, etc., and more need for services as a result? Higher chance of disability? Mental health concerns – outside scope of consultation/EIA?]	CCG to work with the Allerdale, Carlisle, Copeland and Eden District Councils and CPFT to: • identify current Gypsy and Traveller sites/resident numbers across the WNE Cumbria area • Assess possible health need in relation to Paediatric services • If health need is identified, carry out specific consultation with Gypsies and Travellers who may be affected by the proposed options • Identification & education by community teams • Links into communities by AWAZ, etc., as education/information route

Protected Characteristi	Issues Raised	Suggestions to address the issues raised
Workshop Feedback - Gender	Women, as the primary carer for children in most families, are likely to be more affected by increased journey lengths, and consequent difficulties with juggling other commitments (work, other children, caring for older relatives). Teenage mums – will/may still be accessing paediatric services themselves, and so directly affected by the changes	
Workshop Feedback - Disability	Children with disabilities or long term medical conditions may require more frequent visits to hospital services and this will have significant cost and time implications for families if there is a longer travel distance. Travel difficulties may also cause parents to delay access to services (e.g. mum may wait for husband to come home from work before driving child to A&E, particularly if other children to care for) Significant stress of longer travel time with an acutely ill child (e.g. severe asthma attack), and possibility of increased use of 999/NWAS Impact on mental health of young people – especially those who may already have poor mental health, and/or an existing diagnosed MH condition (in particular option 3 puts greater strain on a greater number of young people who may have disabilities inc. MH problems) Greater impact on younger disabled people (including those who are temporarily disabled as part of their medical condition) in west Cumbria, Complex child low risk maintained condition suddenly goes wrong wouldn't be time to transfer Children with learning difficulties can't always explain symptoms and pain levels	Improved education/support for "self" (parent if younger) management Improve awareness and communications skills
Workshop Feedback - Age	Danger children are taken to wrong place if parents transport to A&E – i.e. take direct to A&E at WCH, when at some options no paediatric back up 24/7 Children deteriorate so quickly and often through night	
Workshop Feedback - Pregnancy & Maternity	SCBU – confusion over what is proposed in option 1, conflict between consultation document and EIA. Remote SCBU has number of implications – SCBU has no facilities for mum to stay on site, if attempting to breastfeed need to visit frequently. So increased travel distance makes successful breastfeeding less likely, with long term health (and health service cost) consequences. Particularly difficult if other children to care for. Travel a particular problem if mum has had a C-section and is unable to drive. Babies on paediatric ward can't be left alone (or at least not encouraged), so hard for mum to get meals, shower etc. (don't get hospital meals) if other parent isn't there – which is more likely the further unit is from home	• More support within unit. Access to hospital meals. • Develop alternative staffing structure • Improve staff experience to retain staff

Protected Characteristi	Issues Raised	Suggestions to address the issues raised
	Special care – travelling and expressing and how to get it to hospital More risky to have two people at risk than one – i.e. baby delivered. No professional would consider moving to a department under threat	
Workshop Feedback – Rural Isolation & Deprivation	And increased cost, relative to disposable income. Deprivation ? Higher rates of child abuse. If reduced use of services, reduced chance of abuse being detected? ? Higher incidence of stress, weak support networks – so increased travel time & cost more likely to have negative impact on mental health Greater impact on young people and their families Increased risk and decreased ease of access for parents in West Cumbria travelling to CIC in an emergency situation, outside of daytime hours (in all options) so this disproportionately impacts on those who live further away, in deprived communities Proposals rely on transport solutions… in rural and deprived areas people may become increasingly reliant on these transport solutions, if they do not have public transport available – or they cannot afford public transport. If transport solutions have inadequate provision then this will impact more detrimentally on these communities. Extreme weather may prevent people seeing/visiting their loves ones which will be especially difficult if it's a parent/child relationship that is impacted upon Travel time will impact on families with other children attending school etc. as transport solutions tend to run on their own schedule (rather than based around individual circumstances)	Education to increase knowledge/awareness amongst community teams, schools, etc.
Workshop Feedback – Carers (Carers were added as a separate category for the workshop due to a number of concerns raised beforehand)	Greater impact on carers/parent carers and greater expectations on them to travel to provide support. This will have ongoing impact upon their employment, other family members and their finances Concerns from carers that they will lose the relationship that they have built up with specialists (esp. west Cumbria) and that by centralizing those specialists/services the broader knowledge and awareness will be lost Any statistics for the number of parent/carers in west Cumbria?	

Emergency & Acute Care,

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

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Workshop Feedback – Religion & Belief	Jehovah's Witnesses – longer travel distance to A&E may mean patients arrive in worse condition, and so be more likely to be considered to need blood transfusion on arrival.	
Workshop Feedback – Gender	Are men more likely to attend A&E, and more likely to suffer serious injuries – farm & industrial injuries, sporting injuries, road traffic accidents (and so be affected by changes in some options) Women – more likely to be victims of domestic violence – less likely to attend A&E for injuries if travel distance greater due to practical difficulties, so less likely to be identified and offered support? Increasing numbers due to nuclear industry	Better training for other professionals in contact with women

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Workshop Feedback – Disability	Travel tends to be more difficult for people with disabilities than for the general population, so options that increase travel distances may make access more difficult. Wheelchair access is poor at CIC People with disabilities suggested they may not feel their conditions are fully understood, within the context of their disability and this may be increased if they are not able to go to familiar points of contact Communication difficulties (Learning difficulties) Using respite beds for issues with people with disability rather than resolving ongoing support issues.	Cultural shift required through the whole health and care system that address the reasons that people access A&E rather than other means of getting the support/advice /treatment required Improved awareness of the role of pharmacies, and improved trust in that support Education to help people be better informed of where to go for support, and engagement with the frequent attenders to identify reasons why
Workshop Feedback – Age	Children – families where abuse takes place may be less likely to access A&E if travel distance increases (partly due to concern about leaving other children with the abuser). This may both lead to injuries being untreated, and abuse being undetected. If families do attend A&E, lack of paeds back up (and access to specialist opinion) may make it less likely abuse is detected. Children – more likely to be separated from main carer for a significant length of time if they or a family member is injured or acutely ill – stress Children – if parents transport direct to A&E, rather than calling ambulance, may not attend most appropriate hospital (i.e. no paeds back up, or reduced A&E hours) and so need to be transferred – increase in time spent travelling. Older people – falls – if end up travelling further, may be more likely to need admission, and so prolonged recovery [not clear if evidence supports this?] No local provision for complex care (in west Cumbria) so concerns things may be missed, or people will be reluctant to access services as they're concerned they will be taken further away from home, their families and codependent partners (esp. for older people) Elderly care been seen in GP surgeries Growing needs of those with dementia not being met	Education of public Increase in carers salaries Urgent care GP part of A&E Better use of interim care beds Improve access to GPs and out of hospital services.

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Workshop Feedback – Pregnancy & Maternity	Assumption was disputed – it was believed that women will use A&E as their first point of contact for unusual events during pregnancy – e.g. baby stops moving, or vaginal bleeding. Unidentified pregnancy was also identified as an issue – women of childbearing age with abdominal age presenting to A&E (perhaps most impact if A&E on site, but no obstetric back up for a specialist opinion) Unstable ectopic pregnancy is a particular concern, as will require emergency surgery, but patient should not be transported (land or air) Centre for Research in Midwifery & Childbirth recommendation – all pregnant women who attend A&E (for any reason, not just pregnancy issues) should be screened by a maternity specialist (midwife may be acceptable). Could be difficult if A&E on site, but not obstetrics.	Staff training and access to remote specialist support Ability to transfer surgical team to patient
Workshop Feedback – Rural Isolation & Deprivation	Attendance at wrong site as well as non-attendance (i.e. attend site from which A&E has been removed). Cost of increased travel – danger of non-attendance, or increased use of 999 • Tourists – tourists tend to use A&E instead of other health services, less likely to be informed about the best place to attend. • Danger this is the "thin end of the wedge" – A&E services at WCH hospital perceived to be very fragile, and danger of services being gradually withdrawn.	
Workshop Feedback – Carers (Carers were added as a separate category for the workshop due to a number of concerns raised beforehand)	Same issues as earlier sections of IA Increased pressure on carers when the person they care for is transferred a longer distance away – more travelling, more time taken, harder to balance life/care and family and more cost. Given this will impact more on West Cumbria, where deprivation is a bigger issue it was felt this is a significant impact on carers in the west (options 2 b& 3) Carers identified that a lack of '5pm to 9am' services present greater challenges for them if they're in work (options 2 b& 3) Travel issues if caring for more than one person	A&E for many is a place of safety where people are sure they will be seen, over reliance on A&E was felt (by some carers) to be because they are frustrated at not getting the care and support needed (for them or the person they care for) so it is important to ensure that trust is built, and culture changed before services are removed in the west.

Urgent Care, Trauma & Orthopaedics

Protected Characteristic	Changes made on Safety Grounds February 2014			Consultation Proposal		
Option / area	west	north	east	west	north	east
Race	N	N	N	N	N	N
Religion & Belief	N	N	N	N	N	N
Gender	N	N	N	N	N	N
Disability	- N	N	N	-	N	N
Sexual Orientation	N	N	N	N	N	N
Age	- N	N	N	- /+	- /+	- /+
Pregnancy & Maternity	- N	N	N	N	N	N
Gender Reassignment	N	N	N	N	N	N
Rural Isolation & Deprivation	-	N	N	- /+	- /+	- /+
Carers	- N	N	N	- /+	- /+	- /+

Hyper-Acute Stroke

Protected Characteristic	Option 1			Option 2		
Option / area	west	north	east	west	north	east
Race	- N	- N	N	- N	N +	N +
Religion & Belief	N	N	N	N	N	N
Gender	N	N	N	N	N	N
Disability	-	N	N	-	N	N
Sexual Orientation	N	N	N	N	N	N
Age	-	N	N	-	+	+
Pregnancy & Maternity	N	N	N	N	N	N
Gender Reassignment	N	N	N	N	N	N
Rural Isolation & Deprivation	-	N	N	-	+	+
Carers	-	N	N	-	+	+

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Workshop Feedback - Race	Higher incidence of stroke in some ethnic groups?	
Workshop Feedback - Gender	Young men more likely to involved in serious trauma (e.g. road traffic accidents) that require trauma & orthopaedic services.	
Workshop Feedback - Disability	Poor wheelchair access at CIC Accessing services that are some distance away may be more difficult for those who have disabilities, considering the additional transport and support requirements thus making it more challenging to attend appointments very early in the morning, for example or when they do not have an BSL interpreter available to support them Learning difficulties – capacity and communications issues bring added implications – out of normal routines Cuts in social care – end up in healthcare as social care collapses	Ensure people who have disabilities are offered flexibility in terms of appointment times and days Ensure facilities are accessible not only for those who use wheelchairs but also those who have limited mobility and choose to walk/use walking aids – and those who experience hearing loss, reduced sight etc. Make best use of new hospital Raise awareness of issues Better partnership working across all services
Workshop Feedback - Age	Both ends of the age spectrum are more affected by long travel distances Young men more likely to involved in serious trauma (e.g. road traffic accidents) that require trauma & orthopaedic services. Ageing population with more complex needs – don't recover as quick Elderly disabled – taken further away from support networks Social isolation and systems not working properly	Utilising ICC's as centres for support and daytime respite – especially when people require shorter term support and significant care planning is not cost effective and quick solutions are required. This also provides opportunities for people to access wider health and care support – improving overall health and wellbeing which is vital for good and speedy recovery
Workshop Feedback - Pregnancy & Maternity	Higher incidence of stroke during pregnancy? – check figures	
Workshop Feedback - Rural Isolation & Deprivation	Stroke – population living south of Whitehaven will be disadvantaged under proposals due to long travel time to Hyper acute unit – and many in this population have risk factors for stroke. Delayed access to care for these patients is likely to have long term consequences for patients are recovery is likely to be less complete. 3 hour window for stroke – 2 hours travelling will impact on outcome Tourists make up a significant proportion of trauma surgery & orthopaedics – to the extent that services are noticeably less busy during winter months. As before – less likely to know where best to attend to access correct services, and harder to reach in advance to educate them about this.	

Protected Characteristic	Issues Raised	Suggestions to address the issues raised
Workshop Feedback – Carers (Carers were added as a separate category for the workshop due to a number of concerns raised beforehand)	Stroke – extent of recovery from stroke will have significant impact on carers. Proposals that have a positive impact on recovery will benefit carers, but if there are parts of the population that are disadvantaged by proposals (those south of Whitehaven), there are likely to be bigger demands on carers in these areas. Stroke may result in people becoming new carers (so relatives etc. may be unfamiliar with the role and the type of support they will need to offer). Because of the increased distance for those in West Cumbria to travel to see the person they will be/are supporting – this results in additional time and resource pressures on them. (Also included in Age section) Increased impact on older adults who are carers/co-dependent due to the increased risk of stroke – both financially and in terms of mental health (less contact between those involved if services are wholly shifted to Carlisle)	"Drip & ship" model should be considered for this population in addition options proposed – or other models such as a "stroke ambulance" able to scan. Important to recognise 'new carers' and ensure that they are able to be included in care planning, and have access to support. Consider offering unpaid carers financial reimbursement for travel (if they are on low income/benefits etc.) would be cost effective in the long term and ensure better levels of support for people who have had stroke, emergency surgery etc. and encourage better use of personal health budgets. Ensure Care Navigators work with and include carers (including those who may be 'short term' carers as a result of stroke, trauma, emergency surgery etc. to mitigate the impact on their lives and enable people to 'return to normal' as speedily as possible

Appendix B

Healthcare for the Future in West, North & East Cumbria

Updated Equality Impact Analysis Report

February 2017

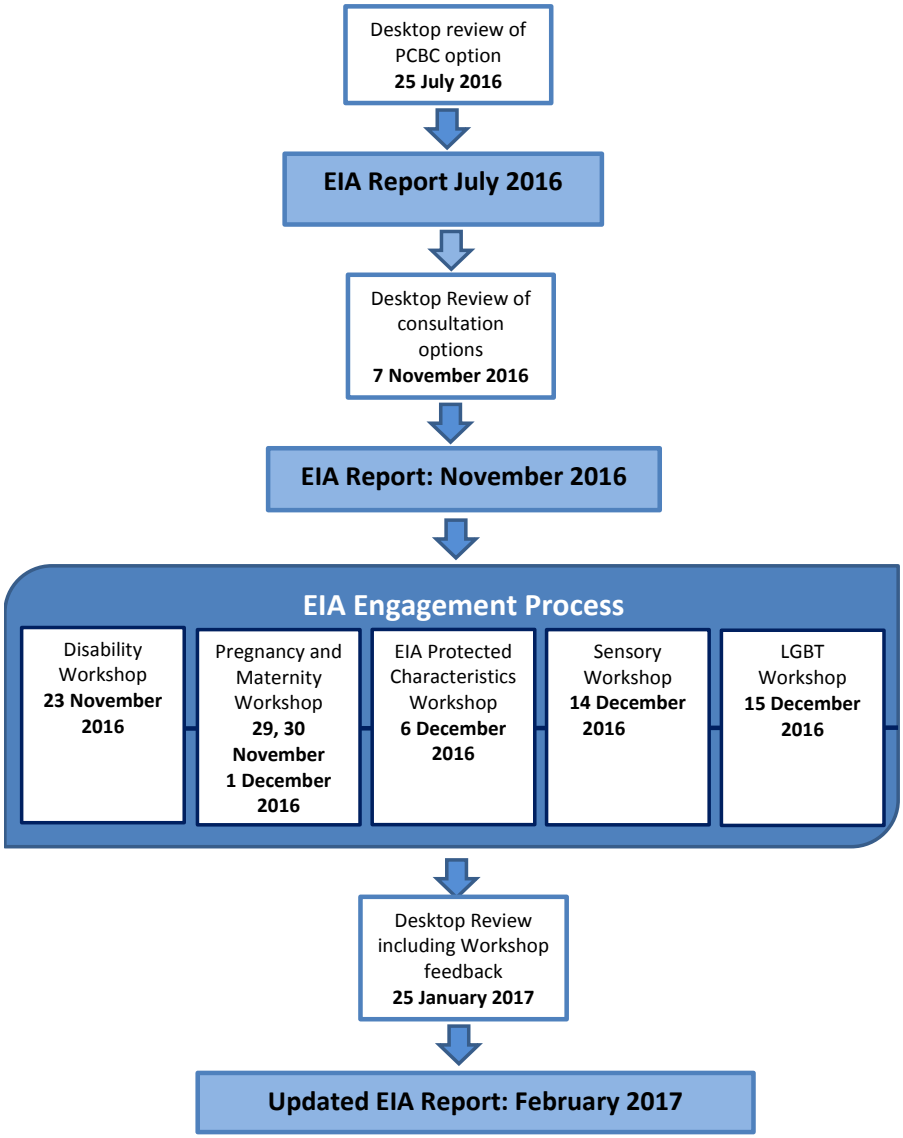
Contents

1) Introduction

The Equality Impact Analysis (EIA) undertaken in July 16[1] assessed the potential impact of the significant changes proposed within the Pre Consultation Business Case (PCBC). Following the publication of 'The Future of Healthcare in West, North and East Cumbria Public Consultation Document'[2] further analysis was undertaken which resulted in an addendum to the original EIA focusing on proposals for the Hyper Acute Stroke Services and Emergency Surgery, Trauma & Orthopaedic Services[3].

This further report updates previous Equality Impact Analyses and includes feedback from the EIA Engagement events which was held in November and December but does not include any additional feedback as part of the consultation process which closed on 19th December 2016.

The Flow Chart below depicts the ongoing process to develop the EIA including engagement with representatives with protected characteristics, in line with Public Sector Equality Duty Section 149 of the Equality Act.



[1] http://www.wnecumbria.nhs.uk/wp-content/uploads/2016/11/West-North-and-East-Cumbria-Equality-Impact-Analysis-Report-Jul-2016.pdf
[2] http://www.wnecumbria.nhs.uk/consultation-document
[3] http://www.wnecumbria.nhs.uk/wp-content/uploads/2016/09/West-North-and-East-Cumbria-Equality-Impact-Analysis-Report-Addendum-Nov-2016.pdf

Our considerations in undertaking this addendum, relating to Equality Legislation, Local Demographics & Protected Characteristics are concurrent with those used in the EIA from July 2016; as a result they have not been reproduced here. For the detailed information, please refer to pages 2 – 12 of EIA July 2016.

2) Impact Analysis Methodology

The aim of the engagement events was to gather feedback directly from those with a protected characteristic or those who specifically support those with a protected characteristic, across all of the proposed changes. They were supported by Action for Health, a third sector network of organisations with an interest in health and social care, and part of Cumbria Council for Voluntary Service.

The workshop on 6th December covered all of the protected characteristics, a report detailing this workshop and its outcomes is detailed in Appendix A. Additional work was also carried out to ensure that the traditional 'hard to reach' groups were specifically targeted and offered an opportunity to contribute, over 50 organisations were contacted as part of that process. In addition specific events to consult with Lesbian, Gay, Bisexual, transgender (LGBT) community and sensory disability community which had not been overtly represented at the workshop were undertaken.

As previously the options were scored using a matrix (table 1) and were broken down to West – Allerdale & Copeland, North – Carlisle Area, East – Eden, as it was recognised that for the protected groups in these areas the impact may be different. As well as the original addition of Rural Isolation and Deprivation to the list of protected characteristics, carers have also been added as a specific group for consideration, following feedback on protected characteristic groups. The protected groups and this report also gives consideration to developments relating to Integrated Care Communities, Health and Wellbeing and General Practice, which are key components of the plans in delivering integrated health and care for people living in rural, remote and dispersed communities and have been included for completeness.

The feedback and the matrix scores from the events is attached in Appendix A, (all issues from the events were captured and are reflected in the feedback. Issues relating to access to health services in general and these have been contained captured within 'General Feedback on Status Quo.'). Using this feedback a further desk top screening exercise was undertaken for each of the proposed options to give an updated analysis of the potential equality impacts that could occur. The actual impact will be dependent on which option is implemented – it will be vital to make sure that the diverse needs of patients and the families and carers are at the very heart of this process.

High Impact	Medium Impact	Neutral	Medium Impact	High Impact
++	+	N	-	- -
Significant positive impact on a large proportion of protected characteristic groups	Medium positive impact on a large proportion of protected characteristic groups. Significant positive impact on a small proportion of protected characteristic groups.	no change / no assessed significant impact of protected characteristic groups	Medium adverse impact on a large proportion of protected characteristic groups. Significant adverse impact on a small proportion of protected characteristic groups.	Significant adverse impact on a large proportion of people with protected characteristics

3) Public Health, General Practice and Integrated Care Communities

Although not part of the formal consultation process Public Health, General Practice and Integrated Care Communities underpin many of the proposed changes within the consultation. As a result and part of the ongoing development of the EIA, the workshop groups were additionally asked to consider the developments being implemented and to give an indication of the equality impacts that could occur.

The detail of these developments can be found in the Pre Consultation Business Case, but have been summarised below for ease.

The focus for Public Health is to reduce social isolation, prevent illness and disease and enable citizens to live healthy and independent lives. It will be achieved by creating a health and wellbeing system to support and empower the population to stay healthy and includes; The development of universal and targeted prevention services, enabled through 'health and well-being coaches', Better targeting of lifestyle services towards those who will benefit the most from them, Mechanism for connecting socially isolated people to local communities and opportunities.

For General Practice, initiatives are in progress to help stabilise and sustain primary care, which is nationally and locally in an increasingly fragile position. For example the role played by community pharmacies is being extended; practices are being supported to benefit from technology enablers, infrastructure investment, increased collaboration and new models of care. The maintenance of high standards of general practice is fundamental to the success of the development Integrated Care Community model (ICCs). The ICCs will wrap care around patients by bringing together public health, general practice, social care, community services, mental health services and community assets, including community hospitals to act as single integrated hubs, with active support from key secondary care specialists, such as geriatricians, as well as providing access to timely and appropriate acute based diagnostics. With the intention that, wherever possible, care will be provided as close to home as possible.

Feedback from the EIA Engagement Events

Generally the feedback during the EIA engagement events were that the plans were a positive step in improving health and social care across the area, initially to relatively small groups of people but expanding to take in more of the population. Concerns were raised in relation to social care and its possible impact on the success or failure of all of the Integrated Care Communities.

The general view was that Public Health can make a big impact on a small number of people which would roll out over time, whereas General Practice is usually the first point of contact for most people accessing healthcare so is likely to have a bigger impact on a larger number of people.

Integrated Care Communities (ICCs) were seen as a key to delivering joined up care involving the NHS, social care providers and the voluntary sector. It is however recognised that there are organisational and cultural barriers to overcome before true partnership working can be achieved, and the challenges facing social care may have an effect on ICCs.

The matrix below was scored at the workshops and the further desktop review made no adjustments.

Protected Characteristic	Public Health			General Practice			Integrated Care Communities		
Option / area	west	north	east	west	north	east	west	north	east
Race	N	N	N	N	N	N	N	N	N
Religion & Belief	N	N	N	N	N	N	N	N	N
Gender	+	+	+	++	++	++	+	+	+
Disability	N	N	N	N	N	N	N	N	N

Protected Characteristic	Public Health			General Practice			Integrated Care Communities		
Option / area	west	north	east	west	north	east	west	north	east
Sexual Orientation	N	N	N	N	N	N	N	N	N
Age	+	+	+	++	++	++	+	+	+
Pregnancy & Maternity	N	N	N	N	N	N	N	N	N
Gender Reassignment	N	N	N	N	N	N	N	N	N
Rural Isolation & Deprivation	+	+	+	N	N	N	+	+	+
Carers	N	N	N	N	N	N	N	N	N

Impact Assessment & Mitigation

Protected Characteristic	Reason for impact assessment rating	Mitigation
Race	Compared to England & Wales, Cumbria has lower proportions of residents from all broad ethnic groups, therefore the changes in GP Practice, Public Health and ICCs are not likely to impact on health and wellbeing linked to ethnicity. Because of these lower proportions it may be that there is a lack of understanding among health and social care staff of different cultural issues in Black & Minority Ethnic (BME) communities including: • Lifestyle and working patterns • Access and understanding information • Assumption that everyone has friends and family – there is some social integration Between 2001 and 2011, Cumbria experienced a greater proportional increase in numbers of residents from BME groups than the national average; with the greatest increases seen in Carlisle (+143.4%) and Eden (+104.1%); particularly in relation to migration from the eastern Europe. Some BME communities tended not to register with GP, but make use of hospital services. This may be as a result of a lack of understanding of the system. Gypsies and Travellers have significantly poorer health status and more self-reported symptoms of ill-health, particularly in relation to high levels of anxiety and stress, smoking, alcohol and drug use. (source:http://www.cumbriaobservatory.org.uk/elibrary/Content/Internet/536/671/4674/5359/5360/40723111743.pdf) when people are moving between areas it can be difficult to promote self-care and provide services in own home, however there is not enough data available to identify geographical areas where need may be greater. The proposed changes have been assessed as 'neutral'.	• Regarding broad ethnic groups - No current mitigation is assessed as required, although advice from AWAZ Cumbria is recommended particularly in the development of ICCs to ensure that cultural needs are considered. • Ensure a good understanding of relevant services that may be able to support ICC's to be more accessible (for example working with groups that support BME groups) by using existing networks. Ensure access to translation services and information in an understandable format across all ICC's. Develop protocols and minimum standards for all ICC's, ensuring that they are required to ensure provision is in place to meet the needs of people that are from minority ethnic groups. • Wherever possible, the ethnicity of patients accessing GP, Public Health ICC services should be monitored. This would allow ethnicity profiles to be identified, and service provision and cultural training for staff to be reviewed and amended if required. • CCG to work with the Allerdale, Carlisle, Copeland and Eden District Councils and CPFT to:

Protected Characteristic	Reason for impact assessment rating	Mitigation
		identify current Gypsy and Traveller sites/resident numbers across the WNE Cumbria area to Improve cultural awareness and promote self –care
Religion & Belief	In Cumbria, the reported religion held by residents in each district (as reported in the 2011 census) is not statistically different from the England averages, this indicates that population health and wellbeing linked to religion will not be significantly impacted upon by the proposed changes. Thought it is important that Staff going in to support people within their homes are able to seek advice from colleagues on cultural issues – particularly relevant to end of life care. The proposed changes have been assessed as 'neutral'.	• Based on the assessment carried out, no mitigation required, although advice from AWAZ Cumbria is recommended
Gender	The proportion of male and female residents across West, North and East Cumbria are equally split (no significant difference between population %). But increased lone working and related issues may affect women more (more vulnerable, higher proportions of staff are female). The proposed changes have been assessed as 'positive'. Overall these changes have been assessed as positive for women because more services will be offered locally through GPs and ICCs. Women are more likely to have caring responsibilities (Children and Elderly) so will improve access. For men it was felt that with more services provided locally this could increase the opportunity for men to access services.	• Based on the assessment carried out, building links with Health & Wellbeing Coaches (HAWCs) into ICCs to tackle isolation / loneliness will be critical.
Disability	The percentage of residents in Allerdale and Copeland who describe their day-to-day activities as 'limited a lot' is greater than the Cumbria average (10.1% and 10.7% versus 9.7%). Eden has a lower percentage (7.8%). 3 neighbourhoods in West, North and East Cumbria rank within the 1% most deprived in the country for health and disability: these neighbourhoods are in Harbour (Copeland), Moss Bay (Allerdale), and Sandwith (Copeland) wards. It should be noted that changes to benefits system may mean that some people have lost their mobility and are now reliant on others for transport. As disabled people find it easier to access services closer to home, options that improve choice could be beneficial though the wider range of staff working with less support. The proposed changes have been assessed as 'neutral'.	• Work with Cumbria CVS to Recruit champions' within ICC's, Public Health provision and GP Surgeries who have greater awareness of specific needs, for example Dementia Champions, Mental Health Champions and Veterans Champions • Ensure that stakeholder involvement includes other agencies – housing, transport etc. • Disability awareness training for staff to be reviewed and amended if required.
Sexual Orientation	There is no robust data available for groups with this protected characteristic. Public health, ICCs and GPs are accessible to all groups regardless of sexual orientation, therefore the impact of the proposed options have been assessed as 'neutral' with relation to sexual orientation.	• Based on the assessment carried out, no mitigation required – although it is important that organisations commissioning and providing health and social care be aware of the existence LGB groups and 'hidden' LGB people

Protected Characteristic	Reason for impact assessment rating	Mitigation
		who may be older, from BME or working class backgrounds. Ensure choice is available for accessing particular services.
Age	**Population data (source – ONS):** The proportion of the population in Cumbria aged 65+ years, by district (and comparison with Cumbria and England & Wales averages) England & Wales – 17.4, Cumbria – 22.2, Allerdale – 22.3, Carlisle – 19.6, Copeland – 20.5, Eden – 23.8 Between 2012 and 2017, the 65+ years population in likely to increase by the following in each district: Allerdale (2,600), Carlisle (2,200), Copeland (1,700), Eden (1,700). ICCs proposals aim to provide improved care within people's communities, with more integrated working between all sectors, leading to more coordinated care. Particular focus on risk stratifying community should help in providing tailored support and escalation procedures, including older people who may experience social isolation The reduction in public transport services may leave many older people susceptible to isolation this is particularly so in rural areas. The ICC model may rely heavily on volunteers, and many of these will be older adults – e.g. volunteer drivers **Dementia** The number of people with dementia is expected to rise substantially as our population ages. Over the next 5 years, numbers of people with dementia are predicted to increase by 17.7%; by 2030 numbers are projected to increase significantly by 60.7%, from 7,721 to 12,410. Numbers of people with dementia in Copeland are predicted to increase by +63.7% by 2030. The proposed options have been assessed as potentially having a 'positive impact' as more care will be offered closer to home with services becoming more integrated and patient-centred e.g. the development of frailty pathways and paediatric community services	ICC proposals aim to provide improved care within people's communities. Transforming community hospital sites into integrated health and care hubs with support provided into people homes. • Working with the Local Authority to develop sustainable models to improve connectivity of local communities (that covers the ICC footprint) • Ensure adequate and affordable transport options are available for patient, families and carers
Pregnancy & Maternity	The impact of the proposed options have been assessed as 'neutral' though there is opportunity to improve in terms of Perinatal mental health and the possible the development of "maternity hubs" as outlined in Better births.	• Based on the assessment carried out, no mitigation required. Although consideration should be given to the interdependencies with Maternity options, 'Better Births' etc as outlined within the consultation.
Gender Reassignment	There is no robust data available for groups with this protected characteristic in Cumbria. However, GP Practice, Public Health and ICCs should be fully accessible to anyone who proposes to, starts or has completed a process to change his or her gender. Therefore the impact of the proposed options has been assessed as 'neutral'	• Based on the assessment carried out, no mitigation required. Although there may be scope to improve awareness and understanding of the issues within local health services.

Protected Characteristic	Reason for impact assessment rating	Mitigation
Rural Isolation & Deprivation	54% of Cumbria's residents live in rural areas compared to 18% nationally. Of Cumbria's districts, Allerdale and Eden have the greatest proportions of residents living in rural areas (72% and 71% respectively. Some wards within Copeland and Allerdale are identified as having high levels of deprivation compared to the national average. ICC proposals aim to provide improved care within people's communities. The health and wellbeing system also takes a more place based approach which should bring significant benefits to communities. However, ICC footprints vary significantly in size and geography. Careful consideration will need to be given in terms of delivering parity of service with some local flexibility. Transport costs are less affordable for those in deprived wards which may be a barrier to them accessing services however close they are. No or poor phone / broadband reception so there may be issues with care delivery in people's homes and not all home environments are suitable for providing care e.g. old house, fuel poverty, too cold. The proposed options have been assessed as potentially having a 'positive impact' for Public Health and ICC development.	• Based on the assessment carried out, no mitigation required. Although thorough transparent consideration of the interdependencies with Community hospitals options should be given. • ICCs need to work with local, specialist organisations to capture their knowledge of local need. Careful consideration will need to be given in terms of delivering parity of service with some local flexibility. • To investigate a system wide approach to the recruitment and retention of care staff • Focus on improved Infrastructure required to access to services. Work with the Local Authority and other key partners
Carers	In 2011 more than 56,000 residents across Cumbria were providing unpaid care to family members, friends, neighbours or others because of a long-term physical or mental ill-health / disability or problems relating to old age. In addition the estimated number of young carers is around 7,700 (Source: Carers Support Cumbria, 2014) giving an estimated total of 63,700. There are greater proportions of carers in Cumbria compared to the rest of England (11.3% compared to 10.2%). Most carers in Cumbria (around 64%) provide on average 1 to 19 hours of care per week; 1 in 4 carers (around 23.5%) provide 50 or more hours. Numbers of those providing unpaid care are increasing. 28% of carers in Cumbria report that their own activities are limited due to long-term health problem or disability. GPs are the main point of contact for most people experiencing problems with their health; it is also an important point of contact when identifying unpaid Carers and support. The development of ICCs and risk stratified community should enable access to more tailored support for carer and their families The impact of the proposed options has been assessed as 'neutral'	• Good community engagement when developing ICC's to ensure that they reflect the needs and (as much as practically possible) the preferences of people who use the services, and their Carers. • Use the development period of ICC's to develop public and patient participation groups. • Ensure good levels of knowledge regarding Carers Assessments for example, throughout the health and care system.

4) Community Hospitals

Community hospitals have a long history in the area and are strongly supported by their local communities and active League of Friends that contribute significant funds.

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

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

Current Position

There are currently eight community hospitals in WNE Cumbria and an inpatient unit on the WCH site, which are operated by CPFT. The geographical position of the hospitals has, to a large extent, grown up based upon historical development rather than population health needs. Some community hospitals host minor injury and/or primary care assessment services as well as a range of outpatient and therapy services.

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

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

New Models of Care

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

In considering the needs of the population, a review of community hospital inpatient capacity has been undertaken, which suggested that WNE Cumbria currently has a significantly higher number of community hospital inpatient beds compared to most other areas in England. (Based on a population of 330,000, and making a presumption that the beds are used appropriately, the data would indicate the need for 84 community hospital beds, compared with 133 beds currently).

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

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

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

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

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

Feedback from the EIA Engagement Events

The matrix assessment undertaken during the engagement process primarily changed the equality impact from a neutral to medium impact and medium impact to a high impact, (Appendix A) recognising the strength of feeling in communities about their local hospital. These scoring changes were considered in the desktop review and for those relating to race, religion, belief and gender the impacts were not considered different to those of the population as a whole and the numbers involved would be small, as result the medium impact was reduced to neutral. The impact for disability in east was also reduced from high impact to a medium impact, as, whilst it was recognised for the individuals affected the impact would be significant, the numbers would be small. Option 4 for the north, shows a -/+ as it relates to a loss of community hospital in Brampton, but a new build in Carlisle.

	Option 1 Minimal Consolidation of beds (loss of beds at Maryport, Wigton & Alston)			Option 2 Partial Consolidation around 5 sites (loss of beds at Maryport, Wigton, Alston, Workington & Carlisle)			Option 3 Partial Consolidation around 5 sites (loss of beds at Maryport, Wigton, Alston, Carlisle & Cockermouth)			Option 4 Consolidation round 3 sites (only beds in Whitehaven, Penrith & Carlisle)		
Option / area	west	north	east	west	north	east	west	north	east	west	north	east
Race	N	N	N	N	N	N	N	N	N	N	N	N
Religion & Belief	N	N	N	N	N	N	N	N	N	N	N	N
Gender	N	N	N	N	N	N	N	N	N	N	N	N
Disability	- -	N	-	- -	N	- -	-	N	- -	- -	- +	- -
Sexual Orientation	N	N	N	N	N	N	N	N	N	N	N	N
Age	- -	N	- -	- -	N	- -	-	N	- -	- -	- +	- -
Pregnancy & Maternity	N	N	N	N	N	N	N	N	N	N	N	N
Gender Reassignment	N	N	N	N	N	N	N	N	N	N	N	N
Rural Isolation	- -	N	- -	- -	N	- -	- -	N	- -	- -	N	-

-

& Deprivation												
Carers	- -	N	- -	- -	N	- -	- -	N	- -	- -	N	- -

Impact Assessment & Mitigation

Race	Compared to England & Wales, Cumbria has lower proportions of residents from all broad ethnic groups, therefore most of the proposed options for community hospitals are not likely to impact on health and wellbeing linked to ethnicity. It should be noted that some dementia sufferers revert back to original language and people BME people living in predominately white British areas can face particular challenges in terms of accessing culturally appropriate services and being 'invisible' to providers. It should be noted that between 2001 and 2011, Cumbria experienced a greater proportional increase in numbers of residents from BME groups than the national average. As already highlighted, Gypsies and Travellers have significantly poorer health status and more self-reported symptoms of ill-health, particularly in relation to high levels of anxiety and stress, smoking, alcohol and drug use. This suggests that Gypsies and Travellers may be more likely to require inpatient care at a community hospital than other ethnic groups, however there is not enough data available to identify geographical areas where need may be greater. The proposed options have been assessed as 'neutral' with relation to race.	• Regarding broad ethnic groups - No current mitigation is assessed as required, however advice from AWAZ Cumbria is recommended and that wherever possible, the ethnicity of patients using community hospitals in Cumbria is reviewed annually. This would allow any changes in ethnicity profiles to be identified, and service provision and cultural training for staff to be reviewed and amended if required. • CCG to work with the Allerdale, Carlisle, Copeland and Eden District Councils and CPFT to: 1) identify current Gypsy and Traveller sites/resident numbers across the WNE Cumbria area 2) Assess possible health need in relation to community hospitals 3) If health need is identified, carry out specific consultation with Gypsies and Travellers who may be affected by the proposed options
Religion & Belief	In Cumbria, the reported religion held by residents in each district (as reported in the 2011 census) is not statistically different from the England averages, therefore this indicates that population health and wellbeing linked to religion will not be significantly impacted upon by the proposed changes to community hospitals.	• Based on the assessment carried out, no mitigation required, although advice from AWAZ Cumbria is recommended.
Gender	The proportion of male and female residents across West, North and East Cumbria are equally split (no significant difference between population %). There is no evidence to suggest that Community Hospital inpatient bed usage is disproportionate between males and females. Therefore, the proposals related to community hospital beds are	• Based on the assessment carried out, no mitigation required. The potential impact on women is considered in the carers section.

Protected Characteristic	Reason for impact assessment rating	Suggested Mitigation
	unlikely to impact specifically on either males or females. It should be noted, however, that carers are disproportionately female (58%) and the proposals could have an large impact on carers, and by implication, on women, so a potentially 'neutral/medium negative impact' has been indicated for West and East Cumbria	
Disability	The percentage of residents in Allerdale and Copeland who describe their day-to-day activities as 'limited a lot' is greater than the Cumbria average (10.1% and 10.7% versus 9.7%). Eden has a lower percentage (7.8%). 3 neighbourhoods in West, North and East Cumbria rank within the 1% most deprived in the country for health and disability. As disabled people are more likely to require inpatient care, and find it easier to access services closer to home, options that reduce or exclude inpatient provision in west Cumbria could significantly impact on disabled groups both as patients and as visitors of friends and relatives. This refers to all the options proposed. So a potentially 'high negative impact' has been indicated. Lack of inpatient provision in Alston could potentially impact on disabled people living in the East area, both as patients and as visitors of friends and relatives. However the data suggests that the numbers would be lower than in West, so a potentially 'medium negative impact' has been indicated. The workshop also highlighted that the proposals could increase isolation of disabled people from GP, family and friends and would make already challenging transport even more challenging, and disproportionately so for people with some disabilities	• Through the development of integrated care communities, provide support to residents with disabilities in their own homes and communities, in order to reduce the requirement for inpatient care in community hospitals • Ensure adequate and affordable transport options are available for patients with disabilities who need to travel further to access community hospital services, including access to parking. • Disability awareness l training for staff to be reviewed and amended if required.
Sexual Orientation	There is no robust data available for groups with this protected characteristic in Cumbria. However community hospital services (both inpatient and outpatient) are accessible to all groups regardless of sexual orientation, therefore the impact of the proposed options have been assessed as 'neutral' with relation to sexual orientation.	• Based on the assessment carried out, no mitigation required – although it is important that organisations commissioning and providing health and social care be aware of the existence LGB groups and 'hidden' LGB people who may be older, from BME or working class backgrounds.
Age	**Population data (source – ONS):** The proportion of the population in Cumbria aged 65+ years, by district (and comparison with Cumbria and England & Wales averages) England & Wales – 17.4, Cumbria – 22.2, Allerdale – 22.3, Carlisle – 19.6, Copeland – 20.5, Eden – 23.8 Between 2012 and 2017, the 65+ years population in likely to increase by the following in each district: Allerdale (2,600), Carlisle (2,200), Copeland (1,700), Eden (1,700). Community hospital beds are more likely to be used by older adults and sometimes for Respite Care, especially where there are co-dependent couples, to help maintain	• It is important that any proposed changes to community hospital provision are mitigated against through the timely provision of community-based services, particularly specialist dementia and frail elderly support. This is particularly important for people living in West Cumbria and the Alston area.

Protected Characteristic	Reason for impact assessment rating	Suggested Mitigation
	independence and living at home in the long term. Consideration should be given to the social impact of any changes in terms of access to respite, loneliness and isolation for older people and carers. In End of life care as the partner is likely to be older, and less likely to be able to travel to visit if beds further away. Public Transport services have been significantly reduced, leaving many older people isolated this is particularly so in rural areas. **Dementia:** Patients with dementia may be more likely to use community hospital inpatient beds (e.g. for respite care). The number of people with dementia is expected to rise substantially as our population ages. Over the next 5 years, numbers of people with dementia are predicted to increase by 17.7%; by 2030 numbers are projected to increase significantly by 60.7%, from 7,721 to 12,410. Numbers of people with dementia in Copeland are predicted to increase by +63.7% by 2030. Therefore, any reduction in locally available community hospital inpatient beds is likely to have a significant impact on the health and wellbeing of the population (particularly older residents, people living with dementia, carers and family members). Options 1 and 2a would improve accessibility to inpatient community hospital beds for older people living in Cockermouth area (and option 3 would see improved provision in Carlisle), however these options would also see reduced provision in more deprived areas, such as Workington and rurally isolated areas, such as Alston. The proposed options have been assessed as potentially having a 'high negative impact' in west and east Cumbria**.**	• Ensure adequate and affordable transport options are available for patient, families and carers who need to travel further to access community hospital services, including access to parking. Working with the Local Authority to develop sustainable models to improve connectivity of local communities. • Investigate the potential of any social impact of any changes in terms of access to respite care, loneliness and isolation for older people.
Pregnancy & Maternity	For general pregnancy and maternity care, women are not more likely to use community hospital beds in Cumbria.	• Based on the assessment carried out, no mitigation required.
Gender Reassignment	There is no robust data available for groups with this protected characteristic in Cumbria. However, community Hospital services (both inpatient and outpatient) are fully accessible to anyone who proposes to, starts or has completed a process to change his or her gender. Therefore the impact of the proposed options has been assessed as 'neutral' with relation to gender reassignment.	• Based on the assessment carried out, no mitigation required.
Rural Isolation & Deprivation	54% of Cumbria's residents live in rural areas compared to 18% nationally. Of Cumbria's districts, Allerdale and Eden have the greatest proportions of residents living in rural areas (72% and 71% respectively. The proposals do have a disproportionate impact upon in deprived and/or rural areas. Some wards within Copeland and Allerdale are identified as having high levels of deprivation compared to the national average.	• It is important that any proposed changes to community hospital provision are mitigated against through the timely provision of community-based specialist services that support people to remain at home during their care. This is particularly

Protected Characteristic	Reason for impact assessment rating	Suggested Mitigation
	There is some evidence to suggest that people living in deprived areas are more likely to access community hospital beds at present (i.e. due to poorer lifestyles/support networks). Any options that involve the closure of beds in deprived areas have been assessed as having a potentially negative impact due to the additional travel (and therefore additional costs) of attending community hospitals further away. Considering the loss of rural bus services and the large % of residents in West and East Cumbria who live in a rural area, and may not have access to a car, changes to community hospital services could significantly impact on accessibility for vulnerable patients and carers and relatives. In addition the provision of alternative community services and care in rural areas can be challenging particularly in poor weather The proposed options have been assessed as potentially having a 'high negative impact' in west and east Cumbria.	important for people living in West Cumbria and the Alston area. For option 3, this also includes residents in the Brampton area. • Investigate the potential for the disproportionate impact on deprived areas. • Ensure adequate and affordable transport options are available for patient, families and carers who need to travel further to access community hospital services, including access to parking. Working with the Local Authority to develop sustainable models to improve connectivity of local communities. • ICC proposals aim to provide improved care within people's communities. Transforming community hospital sites into integrated health and care hubs would further mitigate travel issues for people from low income households.
Carers	In 2011 more than 56,000 residents across Cumbria were providing unpaid care to family members, friends, neighbours or others because of a long-term physical or mental ill-health / disability or problems relating to old age. In addition the estimated number of young carers is around 7,700 (Source: Carers Support Cumbria, 2014) giving an estimated total of 63,700. There are greater proportions of carers in Cumbria compared to the rest of England (11.3% compared to 10.2%). Most carers in Cumbria (around 64%) provide on average 1 to 19 hours of care per week; 1 in 4 carers (around 23.5%) provide 50 or more hours. Numbers of those providing unpaid care are increasing. 28% of carers in Cumbria report that their own activities are limited due to long-term health problem or disability. Access to local Respite Care is essential for unpaid Carers to maintain health and wellbeing. Carers find it easier to access services closer to home; options that reduce or exclude inpatient provision in west and east Cumbria could significantly impact on carers both as carers for others and on their own health and wellbeing. As a result the proposed options have been assessed as potentially having a 'high negative impact' in west and east	• Ensure adequate access to respite care • As part of the ICC developments ensuring Carers are part of care planning, to ensure that their needs are also met when decisions are being made.

Protected Characteristic	Reason for impact assessment rating	Suggested Mitigation
	Cumbria.	

5) Maternity Services

For further information, please see the Maternity Services Section of 'The Future of Healthcare in West, North and East Cumbria Public Consultation Document'[4]

Current position

In autumn 2014 the CCG commissioned a review of Maternity Services, by the Royal College of Obstetricians and Gynaecologists (RCOG). The purpose of the review was to provide independent and expert advice on the best way to arrange high quality, safe and sustainable maternity services in the future. The review took place in November 2014 and reported in March 2015. The report made a number of recommendations and identified six options to address the ongoing issues. Of the six options only three were recommended to be taken forward subject to a detailed feasibility report exploring the cost, viability and risk associated with each one, considering working in very different ways to try and improve long term safety through different configurations and working practices of staff. As a result of the work to date, three possible service models are being considered and tested in terms of deliverability and sustainability. It is recognised that the model for maternity services must also take account of the key interdependencies with other key services, specifically paediatrics and anaesthetics, both of which are experiencing significant pressures associated with workforce availability.

Potential models for maternity services in WNE Cumbria:

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

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

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

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

[4] http://www.wnecumbria.nhs.uk/consultation-document

at CIC rather than WCH.

	Option 1		Option 2		Option 3	
	CIC	WCH	CIC	WCH	CIC	WCH
Consultant-led unit	✔	✔	✔	✘	✔	✘
Alongside midwife-led unit	✔	✔	✔	✘	✔	✘
Standalone midwife-led unit	✘	✘	✘	✔	✘	✘
Antenatal and postnatal care	✔	✔	✔	✔	✔	✔
Special care baby unit	✔	✔	✔	✘	✔	✘

Feedback from the EIA Engagement Events

There was some question over provision of a Special Care Baby Unit at both Carlisle and West Cumberland Hospitals in Option 1. For clarification Option 1 includes provision of a Special Care Baby Unit at both hospitals in the event that Option 1 in paediatrics is chosen.

Again feedback from the group related to changing from a medium impact to a high impact for the west of the county due to the strength of feeling in the community relating to removing services from an area with high levels of deprivation. The further desktop review made no adjustments.

The desktop review identified possible positives to the north and east relating to an improvement in choice due to the provision of a midwife led unit and a consultant led unit, moving to -/+ for option 3 because of the possible impact to access and availability if all services are moved to CIC.

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

Impact Assessment & Mitigation

Protected Characteristic	Reason for impact assessment rating	Suggested Mitigation
Race	Compared to England & Wales, Cumbria has lower proportions of residents from all broad ethnic groups, therefore all the proposed options for Maternity services are not likely to impact on health and wellbeing linked to ethnicity. Yet we have noted that people from BME people living in predominately white British areas can face particular challenges in terms of accessing culturally appropriate services and being 'invisible' to providers. It should be noted that between 2001 and 2011, Cumbria experienced a greater proportional increase in numbers of residents from BME groups than the national average; with the greatest increases seen in Carlisle (+143.4%) and Eden (+104.1%); particularly in relation to migration from the eastern Europe. Gypsies and Travellers have significantly poorer health status and more self-reported symptoms of ill-health. This suggests that Gypsies and Travellers may be more likely to have higher risk births, however there is not enough data available to identify geographical areas where need may be greater There is need for greater awareness of cultural issues, specifically during pregnancy, birth and postnatal care. The proposed options have been assessed as 'neutral.'	• Regarding broad ethnic groups - No current mitigation is assessed as required, although advice from AWAZ Cumbria is recommended and wherever possible, the ethnicity of patients using Maternity services in WNE Cumbria is reviewed annually. This would allow any changes in ethnicity profiles to be identified, and service provision and cultural training for staff to be reviewed and amended if required. • CCG to work with the Allerdale, Carlisle, Copeland and Eden District Councils and CPFT to: - identify current Gypsy and Traveller sites/resident numbers across the WNE Cumbria area - Assess possible health need in relation to Maternity services - If health need is identified, carry out specific consultation with Gypsies and Travellers who may be affected by the proposed options
Religion & Belief	In Cumbria, the reported religion held by residents in each district (as reported in the 2011 census) is not statistically different from the England averages, therefore this indicates that population health and wellbeing linked to religion will not be significantly impacted upon by the proposed changes to Maternity services.	• Based on the assessment carried out, no mitigation required although advice from AWAZ Cumbria is recommended.
Gender	For women this is assessed in the maternity and pregnancy section For men some disproportionate impacts were identified including the stress of driving to hospital during labour and increased stress as distance increases. The stress of trying to juggle caring responsibilities partner and older children was deemed more of a problem as distance/travel time to place of birth increases. Hence the 'negative' score for west.	• Consideration needs to be given to transport and accommodation solutions for family members.
Disability	The percentage of residents in Allerdale and Copeland who describe their day-to-day activities as 'limited a lot' is greater than the Cumbria average (10.1% and 10.7% versus 9.7%). Eden has a lower percentage	• Ensure adequate suitable transport options, including parking are available for patients with disabilities (e.g. may have additional equipment) who need

<table>
<tr><th>Protected Characteristic</th><th>Reason for impact assessment rating</th><th>Suggested Mitigation</th></tr>
<tr><td></td><td>(7.8%).

3 neighbourhoods in West, North and East Cumbria rank within the 1% most deprived in the country for health and disability. As people with disability are more likely to have high risk pregnancies and find it easier to access services closer to home, options that reduce or remove provision in west Cumbria could significantly impact on disabled groups. Women with a disability may also require more support during labour (particularly support with communication – Learning disability, deaf, autistic), and arranging this may become more difficult if distance to services increases (particularly if support is provided by partner/family member, and there are other siblings to care for)

Wheelchair access is poor at CIC – rooms are cramped and may be an issue for women giving birth and also partners/visitors. The proposed options have been assessed as mainly ‘negative.’</td><td>to travel further to access Maternity services.

• Work with Cumbria CVS to carry out ongoing specific consultation with disability groups who may be affected by the proposed options.

• Undertake a full assessment of the limitations of access to CIC for people with disabilities and explore all options to maximise ease of access for people with disabilities

• Ensure Accessible Information Standard is used to highlight and individual’s specific communication needs. Disability awareness training for staff to be reviewed and amended if required.</td></tr>
<tr><td>Sexual Orientation</td><td>There is no robust data available for groups with this protected characteristic. Although national research suggests that there is discrimination against women in same sex relationships. Consideration should also be given that there may be risks associated with pregnancy in lesbian couples – e.g. higher likelihood of IVF</td><td>• Based on the assessment carried out, no mitigation required – although it is important that commissioners and providers of health and social care consider the needs of LGB groups.</td></tr>
<tr><td>Age</td><td>Evidence suggests that older women are more likely to have complications and pregnancy risks are higher for mothers age 35 and older. The Table below shows the number of births in Cumbria by mother’s age between 2006 and2010.

<table>
<tr><th>Age group</th><th>2006</th><th>2007</th><th>2008</th><th>2009</th><th>2010</th><th>% change 2006-10</th></tr>
<tr><td>All ages</td><td>4,917</td><td>4,998</td><td>5,118</td><td>5,080</td><td>5,068</td><td>3.1</td></tr>
<tr><td>Under 20</td><td>374</td><td>348</td><td>378</td><td>400</td><td>392</td><td>4.8</td></tr>
<tr><td>20 - 24</td><td>947</td><td>998</td><td>1,029</td><td>1,072</td><td>1,019</td><td>7.6</td></tr>
<tr><td>25 - 29</td><td>1,326</td><td>1,350</td><td>1,492</td><td>1,426</td><td>1,500</td><td>13.1</td></tr>
<tr><td>30 - 34</td><td>1,351</td><td>1,334</td><td>1,224</td><td>1,248</td><td>1,283</td><td>-5.0</td></tr>
<tr><td>35 - 39</td><td>749</td><td>810</td><td>815</td><td>766</td><td>714</td><td>-4.7</td></tr>
<tr><td>40+</td><td>170</td><td>158</td><td>180</td><td>336</td><td>160</td><td>-5.9</td></tr>
</table>
Source: NWPHO from Office for National Statistics

Allerdale and Copeland have higher teenage pregnancy rates (2.1%) than the national average, (1.5%) as result options for consolidation of Maternity services could significantly impact on accessibility for teenagers, because they are less likely to have access to transport, their support networks may be more fragile.

The proposed options have been assessed as mainly ‘negative’ for west</td><td>• It is important that consideration is given to ambulance capacity for maternity transfer of maternity cases between sites as well as transport solutions for appointments and transport and accommodation solution carer/family members to aid visiting.

• Community midwives will need to be aware that pregnant women (and their families) living in West Cumbria may be anxious as a result of having to travel further to give birth (even when pregnancies are classified as low risk). Where required, community midwives can offer mental wellbeing advice with appropriate escalation plan.

• Disability awareness l training for staff to be reviewed and amended if required.</td></tr>
</table>

Protected Characteristic	Reason for impact assessment rating	Suggested Mitigation
Pregnancy & Maternity	All the proposals have the development of a Maternity Led Unit at both sites, which will potentially give more choice. With Option 1, the proposed change relates to higher risk pregnancies, specifically women expecting twins, with a BMI greater than 35, women who have had a previous section and where the expected foetal weight is over 4kg. Copeland and Allerdale have high obesity levels when compared to the national average. See data below: Excess weight in Adults - % of adults (16+ years) classified as overweight or obese (Source: Active People Survey, Sport England (PHOF) 2012-14 • 71.4% of adults (aged 16+ years) in Copeland are classified as obese or overweight, worse than the England average of 64.6%; and ranked the 3rd worst (out of 39) local authority in the North West. • 68.6% of adults (aged 16+ years) in Allerdale are classified as obese or overweight, worse than the England average of 64.6%; and ranked 10th worst (out of 39) local authority in the North West. Women who are obese are more likely to have associated diseases and pregnancy complications and have higher risk pregnancies (source: http://www.acog.org/Patients/FAQs/Obesity-and-Pregnancy). Travel time for intrapartum care is perceived as a significant risk, which may disrupt the normal birth process. Women may choose to set off from home earlier in labour to avoid risk of giving birth before arrival and as result may have an increased chance of arriving early in labour and being sent home. In options 1 & 2, it'll be the highest/higher risk mums who have to travel further in labour.	• Carry out specific ongoing engagement with groups who may be affected by the proposed options. • It is important that consideration is given to ambulance capacity for maternity transfer of maternity cases between sites as well as transport solutions for appointments and transport and accommodation solution carer/family members to aid visiting • Ensure adequate and affordable transport and accommodation options are available for patients, carers and family members who need to travel further.
Gender Reassignment	There is no robust data available for groups with this protected characteristic in Cumbria.	• Based on the assessment carried out, no mitigation required.
Rural Isolation & Deprivation	Considering the large % of residents in West Cumbria who live in a rural or deprived area (particularly people south of Whitehaven) and may not have access to a car, travel time, for intrapartum care is perceived as a significant risk. The cost and difficulty of caring for other children is also a consideration. The proposals have a disproportionate impact upon deprived communities in west Cumbria Tourists – do access Cumbrian maternity services, more likely to be doing so in high risk situation (early labour) and less likely to know where the best unit to attend is.	• Consideration needs to be given to transport and accommodation solutions for Carer/family members to aid visiting. • Ensuring appropriate birthing/escalation plans are in place for all expectant mothers.

Protected Characteristic	Reason for impact assessment rating	Suggested Mitigation
Carers	In 2011 there was an estimated total of 63,700 carers in Cumbria. There are greater proportions of carers in Cumbria compared to the rest of England (11.3% compared to 10.2%). Fathers/Grandparents/Friends as carers for other children – is a bigger commitment as distance to place of birth increases	• Consideration needs to be given to transport and accommodation solutions for Carer/family members to aid visiting.

6) Paediatric Services

Current position

Currently NCUHT provides paediatric assessment and inpatient services at both CIC and WCH, with 38 beds across the two sites (24 beds at CIC and 14 bed at WCH) operating as 16 inpatient beds and eight assessment beds from 08.00 to 20.00 hours. The 14 beds in WCH operate as seven inpatient beds and seven assessment beds from 08.00 to 21.00 hours; they function as a 14-bed area overnight.

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

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

New Models of Care

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

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

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

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

- An integrated clinical workforce, including a coordinated children's nursing service that will deliver acute care and community-based, multidisciplinary care as close to home as possible including Cumbria's children's hospice as part of the integrated nursing team.
- A place-based approach – ensuring that children can get care they need as close to their home as possible.
- Working seamlessly with SSPAUs delivering rapid assessment and treatment and support for children who require a specialist assessment or period of observation.

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

- **New ways of working** would see the establishment of a 14-hour SSPAU with nurse-led low-acuity beds at WCH. SCBU and inpatient paediatrics would be consolidated at CIC. In relation to paediatric care, we believe that the establishment of consultant led paediatric assessment units at both CIC and WCH represents the optimal model to provide rapid, expert assessment, diagnosis, treatment and assessment. Based on current activity, this would have an impact on just under 250 episodes of care each year for children in West Cumbria who may need consultant-led inpatient care at CIC.
- **Partial consolidation** would result in all inpatient beds being consolidated at CIC, with a 14-hour SSPAU at WCH. Based on current activity this would have an impact on just over 300 episodes of care each year for children living in West Cumbria who would have their care provided at CIC.
- **Full consolidation** would result in a single SSPAU at CIC, with outpatient paediatric services at WCH to include 9am-5pm hot clinics. Based on current activity this has the potential to have an impact on over 1600 episodes of care each year.

The table below summarises which types of services would be delivered at Cumberland Infirmary Carlisle and West Cumberland Hospital in each of the options described above.

	Option 1		Option 2		Option 3	
	CIC	WCH	CIC	WCH	CIC	WCH
Short Stay Paediatric Assessment Unit	✔	✔	✔	✔	✔	✘
Full inpatient service	✔	✘	✔	✘	✔	✘
Low risk inpatient service only	✘	✔	✘	✘	✘	✘

Feedback from the EIA Engagement Events

The feedback from the groups related to changing from a medium impact to a high impact for the west of the county and the possible changes to services due to the strength of feeling in the community relating to removing services from an area with high levels of deprivation. The further desktop review made no adjustments.

Disability in west was changed from N (neutral) to a medium impact as the group are more likely to be considered complex so less likely to be seen in WCH. Disability groups worked in partnership with the NHS to ensure the new build at WCH was as fully accessible, CIC is relatively poor in terms of access for people with disabilities. The further desktop review made no adjustments.

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

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

Impact Assessment & Mitigation

Protected Characteristic	Reason for impact assessment rating	Suggested Mitigation
Race	Compared to England & Wales, Cumbria has lower proportions of residents from all broad ethnic groups, therefore all the proposed options for paediatric services are not likely to impact on health and wellbeing linked to ethnicity. Yet we have noted that people from BME groups living in predominately white British areas can face particular challenges in terms of accessing culturally appropriate services and being 'invisible' to providers. It should be noted that between 2001 and 2011, Cumbria experienced a greater proportional increase in numbers of residents from BME groups than the national average; with the greatest increases seen in Carlisle (+143.4%) and Eden (+104.1%); particularly in relation to migration from the eastern Europe. As a result children may also be on different immunization schedule and maybe less likely to registered with GP (due to lack of knowledge of system, language difficulties, etc.) Refugees may initially need more access to services, for treatment and follow-up. Gypsy and Traveller children are likely to need greater access to paediatric care as they have lower immunisation levels and are less likely to be registered with a GP Practice. However in all the above cases numbers are likely to be small and as a result the proposed options have been assessed as 'neutral.'	• Regarding broad ethnic groups - No current mitigation is assessed as required, however it is recommended that advice from AWAZ Cumbria is sought and wherever possible, the ethnicity of patients using Paediatric services in Cumbria is reviewed annually. This would allow an understanding of ethnicity profiles to be identified, and service provision and cultural training for staff to be reviewed and amended if required enabling identification & education by community teams • CCG to work with the Allerdale, Carlisle, Copeland and Eden District Councils and CPFT to: - identify current Gypsy and Traveller sites/resident numbers across the WNE Cumbria area and assess possible health need in relation to Paediatric services
Religion &	In Cumbria, the reported religion held by residents	• Based on the assessment carried out, no

Protected Characteristic	Reason for impact assessment rating	Suggested Mitigation
Belief	in each district (as reported in the 2011 census) is not statistically different from the England averages, therefore this indicates that population health and wellbeing linked to religion will not be significantly impacted upon by the proposed changes to Paediatric services.	mitigation required, although advice from AWAZ Cumbria is recommended.
Gender	There is limited information regarding the ratio of boys to girls accessing paediatric services across Cumbria. However, in 2012/13, males accounted for 58% of children's and 62% of young people's attendances to A&E. In addition as women, are the primary carer for children in most families, they are more likely to be more affected by increased journey lengths, and consequent difficulties with juggling other commitments (work, other children, caring for older relatives). However in all the above cases the numbers are likely to be small as a result the proposed options have been assessed as 'neutral.'	• Based on the assessment carried out, no mitigation required, although further work to identify causes for A&E admission in children in Cumbria should be carried out, and actions to help prevent admissions prioritised across primary care, public health and early help (e.g. accident prevention advice and promotion of self-care). • Consideration needs to be given to transport and accommodation solutions for family members.
Disability	Evidence shows that Copeland and Allerdale do not have a higher than average % of children 0-19 with 'long-term health problems or disability/activities limited' There is no robust evidence to indicate that families with disabled children are more likely to access paediatric A&E, than families with children who do not have disabilities. However the literature suggests that families with disabled children might actually avoid taking them to A&E, due to a perception that the staff may not understand the needs of the child. The development of the SSPAU on both could be an opportunity to improve awareness and relationships. Parents with disabilities may find it more challenging to travel longer distances for inpatient care, especially if they do not own their own transport. The proposals have a greater impact on younger disabled people (including those who are temporarily disabled as part of their medical condition) in west Cumbria. Hence the medium negative impact score for west Cumbria.	• Ensure adequate suitable transport options, including parking are available for patients with disabilities who need to travel further to access Paediatric services. • Consideration needs to be given to transport and accommodation solutions for family members. • Undertake a full assessment of the limitations of access to CIC for people with disabilities and explore all options to maximise ease of access for people with disabilities • Raise awareness of disability with staff in the proposed SSPAU • Improved education/support for "self" (parent if younger) management
Sexual Orientation	There is no robust data available for groups with this protected characteristic.	• Based on the assessment carried out, no mitigation required
Age	During 2014/15 there were over 16,000 A&E attendances by children aged 0-18 years at WNE Cumbria hospitals, 45 children per day (60% at CIC and 40% at WCH). The rate of attendance varies considerably across localities: 780 attendances for children on practice lists in Eden; 3975 for those in	• Based on the assessment carried out further work to identify causes for A&E admission in children in Cumbria should be carried out, and actions to help prevent admissions should be prioritised across primary care, public

Protected Characteristic	Reason for impact assessment rating	Suggested Mitigation
	Copeland; 3995 for those in Allerdale; and 6108 in Carlisle. This suggests that those living closest to an acute hospital have the highest attendance rate. 86% of children attending A&E are discharged home without admission. Options that involve consolidating paediatric services to CIC, may impact on children and families living in the Allerdale and Copeland districts e.g. if a child requires urgent care during the night, the family may need to take the child to Carlisle, which would mean a longer distance to travel and a longer time period before accessing services. Hence the negative score for west. The negative score for east and north relates to potential impact on assess and capacity for people in North and East should services be consolidated to CIC. However the development of the SSPAU at both sites in Option 1 & 2 is seen as having a positive impact.	health and early help (e.g. accident prevention advice and promotion of self-care). • It is important that consideration is given to ambulance capacity for transfer of paediatric cases between sites and transport and accommodation solution carer/family members to aid visiting • Nationally the evidence shows that up to 97% of children referred as emergencies can be safely managed through a SSPAU without needing an inpatient admission. Therefore options that include SSPAU provision at WCH are preferable to those that do not.
Pregnancy & Maternity	All the options propose consolidating SCBU to CIC. As this service is used by the youngest of children, all the proposals could potentially have a negative impact on the very young (e.g. premature babies) and their families resident in West Cumbria e.g. longer distances to travel could create anxiety amongst family members, increased travel distance makes successful breastfeeding less likely. There are two rooms for parents to stay on SCBU. Maternity can also help accommodate and Parents are encouraged to say on children's ward. All options propose consolidating SCBU to CIC this will have a disproportionate impact of children and families west hence the negative impact score for west Cumbria.	• A thorough analysis of the risks involved in having no SCBU facility at WCH needs to be carried out and the findings used to support additional consultation with stakeholders, the public and representative groups in order to identify the best possible service configuration in the future. • Ensure there are adequate transport and accommodation solutions to enable carer/family members to stay close by. • Ensure all relevant maternal care pathways are updated and tested to ensure that they maintain optimal levels of care for babies who require SCBU and whose families would have used the service at WCH if it was still present.
Gender Reassignment	There is no robust data available for groups with this protected characteristic in Cumbria	• Based on the assessment carried out, no mitigation required.
Rural Isolation & Deprivation	Considering the large % of residents in West Cumbria who live in a rural or deprived area and may not have access to a car, travel time for children requiring paediatric services is a risk, especially for families living in West Cumbria. Levels of child poverty are below the national average across West, North and East Cumbria. However, there are notable pockets of child poverty e.g. Sandwith ward in Copeland (42.2%); and Moss Bay ward in Allerdale (33.6%). As children from deprived areas are more likely to access paediatric services, any consolidation of services to CIC (from	• Consideration needs to be given to transport and accommodation solutions for Carer/family members to aid visiting. • Consider providing additional resources to support health improvement work (for 0-19 year olds and their families) through primary care, public health and early help in Workington and Whitehaven. Including GPs who specialise in general paediatrics

Protected Characteristic	Reason for impact assessment rating	Suggested Mitigation
	WCH) may have a negative impact on families in parts of Whitehaven and Workington, due to reduced accessibility, particularly out of hours. (Source: Child Poverty Needs Assessment (February 2014 update), Cumbria Intelligence Observatory) There is concern that safeguarding issues might be missed if travelling further and seeing a wider range of staff. All options will have a disproportionate impact of children and families in the west who live further away, in deprived communities. Hence the negative impact score for west Cumbria.	.
Carers	In 2011 there was an estimated total of 63,700 carers in Cumbria. There are greater proportions of carers in Cumbria compared to the rest of England (11.3% compared to 10.2%). The centralisation of services has a greater impact on carers/parent carers and greater expectations on them to travel to provide support and may impact on continuity of care. Hence the negative score for west. The negative score for east and north relates to potential impact on assess and capacity for people in North and East should services be consolidated to CIC	• Consideration needs to be given to transport and accommodation solutions for Carer/family members to aid visiting.

Other Secondary Care Services

In the first EIA Emergency & Acute Care covered a range of services that were, during the process, separated out. The services are now covered under the following headings:

- Emergency and Acute Care
- Urgent Care, Trauma and Orthopaedics
- Hyper Acute Stroke Services

7) Emergency & Acute Care

Current Position

Acute services at Cumberland Infirmary Carlisle and West Cumberland Hospital face serious challenges for a number of reasons. Providing care across two sites stretches available staffing and is expensive, particularly because it requires more doctors to run two sets of emergency rotas. Small teams and low volumes of activity on each site make roles less attractive and skills difficult to maintain. There are also difficulties providing the right sort of supervision and training for junior staff. The challenges are made more difficult by the fact that health regulation, professional standards and the expectations of the Royal Colleges are becoming more exacting.

Currently the middle tier of acute medicine doctors working overnight are ALL locums and just 3 of the 11 consultants slots are filled by permanent staff. The geographical location of West, North and East Cumbria is a challenge to recruitment and retention, as is professional isolation. Health Education North East forecasts that the current recruitment issues are likely to continue into the future.

In 2015 the Care Quality Commission judged general medical services at West Cumberland Hospital to be inadequate. This was largely due to the workforce difficulties and the lack of a plan to address these.

The hospitals in West, North and East Cumbria are facing rising levels of activity. A&E attendances have risen almost 10% over the past four years and emergency admissions have risen 20%. In 2014/15, the number of A&E attendances resulting in admission was more than 43%, compared to a national average of under 25%.

There are workforce gaps on both sites in A&E and emergency medicine (40% staff vacancies in total) but these are most severe at West Cumberland Hospital.

New Models of Care

Health and care organisations in West, North and East Cumbria agree the need to develop the two acute hospitals in Carlisle and Whitehaven in ways which comply with national standards for the best clinical care, seven days a week. During the process of developing ideas for improved services at these hospitals, it was agreed that certain core services should remain on both sites, specifically:

- 24/7 urgent care services providing walk-in minor illness and minor injury services
- Elective surgical care
- Full outpatient services
- Comprehensive diagnostic services
- The necessary services to support inpatient and outpatient activity

Option 1 involves a 24/7 A&E at Cumberland Infirmary Carlisle along with acute medical inpatient services, including for the most complex cases. There would be assessment and inpatient beds for the frail elderly, as well as specialist rehabilitation. The number of intensive care beds currently on site would increase slightly, as would the number of emergency assessment unit beds. There would also be a 24/7 A&E at West Cumberland Hospital along with acute medical inpatient services and rehabilitation. There would also be a small intensive care unit but some of the most seriously ill patients would be transferred to Carlisle if it was felt they would benefit from the extra support available there.

Option 2 involves a 24/7 A&E at Cumberland Infirmary Carlisle and acute medical inpatient services with extra capacity at night and for more complex cases. There would be assessment and inpatient beds for the frail elderly, as well as specialist rehabilitation. The number of inpatient beds and intensive care beds would increase, as would the number of emergency assessment unit beds. At West Cumberland Hospital there would be a daytime only A&E service and a 24/7 urgent care centre which would see patients overnight with less serious injuries and conditions. Selected patients would be admitted by emergency ambulance and through referral from their GP during the day. There would be no intensive care unit at Whitehaven but there would be support from specialist clinicians for any very sick patients in order to provide immediate care prior to transfer. There would a number of assessment and in-patient beds including beds for the frail elderly who are medically stable and for rehabilitation.

Option 3 involves a significantly expanded 24/7 A&E at Cumberland Infirmary Carlisle equipped to care for all West, North and East Cumbria patients brought in by emergency ambulance. It would also care for the majority of GP referrals. The number of emergency assessment unit, inpatient, and intensive care beds would increase to manage all acutely ill patients in this area. There would also be inpatient beds for the frail elderly, as well as specialist rehabilitation. At West Cumberland Hospital there would be no A&E unit and no intensive care unit but there would be a 24/7 urgent care centre which would see patients with less serious injuries and conditions. The urgent care centre and outpatient services for those not requiring admission would be supported by specialist clinicians in the daytime but there would be no overnight care for acutely unwell patients. Medically stable frail elderly patients

could be admitted as inpatients, and there would also be assessment services for the frail elderly along with rehabilitation beds. This option would also require more paramedics and ambulances.

The table below summarises which types of services will be delivered at Cumberland Infirmary Carlisle (CIC) and West Cumberland Hospital (WCH) under each of the emergency and acute care options.

	Option 1		Option 2		Option 3	
	CIC	WCH	CIC	WCH	CIC	WCH
24/7 Accident and Emergency	✔	✔	✔	✘	✔	✘
Daytime Only Accident and Emergency	✘	✘	✘	✔	✘	✘
24/7 urgent care centre	✔	✔	✔	✔	✔	✔
Very complex medical services	✔	✘	✔	✘	✔	✘
Emergency care for less complex cases	✔	✔	✔	✔	✔	✘
Assessment and rehabilitation for frail elderly	✔	✔	✔	✔	✔	✔
Step-up beds for the frail elderly	✔	✔	✔	✔	✔	✔
Outpatient care	✔	✔	✔	✔	✔	✔

Feedback from the EIA Engagement Events

Feedback from the events was for services to be maintained at the highest level possible. In line with the desktop review it was considered that the nature of accident and emergency treatment would not have specific impact on race/religion, gender, sexual orientation so is largely neutral. Full consolidation was felt to have a medium negative effect on East and North and high negative for west for disability because of capacity issues at CIC and the better disabled facilities at WCH. Similar impacts were felt in age, carers and rurality as more patients will have to travel and there would be a greater burden on individual and families. The further desktop review made no adjustments.

Protected Characteristic	Emergency & Acute Option 1			Emergency & Acute Option 2			Emergency & Acute Option 3		
Option / area	west	north	east	west	north	east	west	north	east
Race	N	N	N	N	N	N	N	N	N
Religion & Belief	N	N	N	N	N	N	N	N	N
Gender	N	N	N	N	N	N	N	N	N
Disability	- N	N	N	- -	N	N	- -	-	-
Sexual Orientation	N	N	N	N	N	N	N	N	N
Age	- N	N	N	- -	N	N	- -	- N	- N
Pregnancy & Maternity	N	N	N	N	N	N	N	N	N
Gender	N	N	N	N	N	N	N	N	N

Protected Characteristic	Emergency & Acute Option 1				Emergency & Acute Option 2				Emergency & Acute Option 3			
Option / area	west		north	east	west	north	east		west	north	east	
Reassignment												
Rural Isolation & Deprivation	-	N	N	N	- -	N	N		- -	-	N	-	N
Carers	-	N	N	N	- -	N	N		- -	-	N	-	N

Impact Assessment & Mitigation

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

Protected Characteristic	Reason for impact assessment rating	Mitigation
Religion & Belief	In Cumbria, the reported religion held by residents in each district (as reported in the 2011 census) is not statistically different from the England averages, therefore this indicates that population health and wellbeing linked to religion will not be significantly impacted upon by the proposed changes to Emergency & Acute Services. The proposed options have been assessed as 'neutral'	• Based on the assessment carried out, no mitigation required, although advice from AWAZ Cumbria is recommended
Gender	The proportion of male and female residents across West, North and East Cumbria are equally split (no significant difference between population %). There is no evidence to suggest that men are more likely to attend A&E than women, but they are more likely to suffer injuries resulting from accidents e.g. farm, sports and road traffic accidents. However numbers are small. As a result it is not anticipated changes proposed will disproportionately affect males or females. The proposed options have been assessed as 'neutral'	• Based on the assessment carried out, no mitigation required.
Disability	The percentage of residents in Allerdale and Copeland who describe their day-to-day activities as 'limited a lot' is greater than the Cumbria average (10.1% and 10.7% versus 9.7%). Eden has a lower percentage (7.8%). 3 neighbourhoods in West, North and East Cumbria rank within the 1% most deprived in the country for health and disability: these neighbourhoods are in Harbour (Copeland), Moss Bay (Allerdale), and Sandwith (Copeland) wards. As disabled people are more likely to require Emergency & Acute Services, and find it easier to access services closer to home, both as patients and as visitors of friends and relatives options that reduce or exclude provision in west Cumbria could significantly impact on disabled groups. This refers to all the options proposed. Wheelchair access is poor at CIC compared to WCH. WCH was designed in conjunction with disabled people. People with disabilities have suggested they may not feel their conditions are fully understood, within the context of their disability and this may be increased if they are not able to go to familiar points of contact. Options that do not include A&E or ICU provision could potentially impact on disabled people living in the west, although these numbers are likely to be small. The proposed options have been assessed as having	• Through the development of integrated care communities, provide support to residents with disabilities in their own homes and communities, in order to reduce the requirement for Emergency & Acute Services admissions • Ensure adequate and affordable transport options are available for patients with disabilities who need to travel further to access Emergency & Acute Services. • Undertake a full assessment of the limitations of access to CIC for people with disabilities and explore all options to maximise ease of access for people with disabilities.

Protected Characteristic	Reason for impact assessment rating	Mitigation
	a 'medium to high' impact for people with disabilities in west. Option 3 having a 'medium to high' impact in west, north and east Cumbria	
Sexual Orientation	There is no robust data available for groups with this protected characteristic. Emergency & Acute Services are accessible to all groups regardless of sexual orientation, therefore the impact of the proposed options have been assessed as 'neutral' with relation to sexual orientation.	• Based on the assessment carried out, no mitigation required – although it is important that organisations commissioning and providing health and social care be aware of the existence LGB groups and 'hidden' LGB people who may be older, from BME or working class backgrounds.
Age	Between 2008/09 – 2012/13 the rate of emergency hospital admission (all causes) across Copeland and Allerdale was significantly lower than the England average, however rates for CHD, stroke and MI were significantly higher than the England average (COPD – no significant difference). Between 2012 and 2017, the 65+ years population is likely to increase by the following in each district: Allerdale (2,600), Carlisle (2,200), Copeland (1,700), Eden (1,700). The number of people affected by age related conditions including dementia is predicted to increase significantly and this cohort of patients are also more likely to utilise Emergency & Acute Services. A reduction in locally available Emergency & Acute Services and consolidation of A&E is likely to have a significant impact on the health and wellbeing of the population (particularly older residents, carers and family members) including non-attendance and increased use of 999. The proposed options have been assessed as having a 'medium to high' impact for older people in west. Option 3 having a 'high to neutral/medium' impact in west, north and east Cumbria	• It is important that any proposed changes to Emergency & Acute Services are mitigated against through the timely provision of enhanced community-based services. Including care plans and escalation procedures. This is particularly important for people living in West Cumbria. • It is important that consideration is given to ambulance capacity for the transfer of patients between sites as transport solutions for Carer/family members to aid visiting. • Discharge planning that proactively takes into consideration transport issues and support to get people home.
Pregnancy & Maternity	Women are not likely to access Emergency & Acute Services for general pregnancy and maternity care. Most women will go directly to community midwives or hospital-based maternity units. However in a small number of cases women may use A&E as their first point of contact for unusual events during pregnancy – e.g. baby stops moving, or vaginal bleeding or as result of an unidentified pregnancy or unstable ectopic pregnancy. The proposed options have been assessed as 'neutral'	• Based on the assessment carried out, no mitigation required. Although consideration will need to be given to the Centre for Research in Midwifery & Childbirth recommendation – all pregnant women who attend A&E (for any reason, not just pregnancy issues) should be screened by a maternity specialist.
Gender Reassignment	There is no robust data available for groups with this protected characteristic in Cumbria. However, Emergency & Acute Services are fully accessible to anyone who proposes to, starts or has completed a process to change his or her gender. Therefore the	• Based on the assessment carried out, no mitigation required.

Protected Characteristic	Reason for impact assessment rating	Mitigation
	impact of the proposed options has been assessed as 'neutral' with relation to gender reassignment.	
Rural Isolation & Deprivation	54% of Cumbria's residents live in rural areas compared to 18% nationally. Considering the loss of rural bus services and the large % of residents in West Cumbria who live in a rural area and may not have access to a car, changes to Emergency & Acute Services could significantly impact on accessibility for vulnerable patients, carers and relatives. Some wards within Copeland and Allerdale are identified as having high levels of deprivation compared to the national average. There is some evidence to suggest that people living in deprived areas are more likely to access acute services (i.e. due to poorer lifestyles). Consolidation of A&E could result in non-attendance or increased use of 999 by those living furthest from the service, posing a significant risk and increased pressure on ambulance services. The proposed options have been assessed as having a 'medium to high' impact for people in west. Option 3 having a 'high to neutral/medium' impact in west, north and east Cumbria	• Impact and capacity mapping for increased ambulance provision. • It is important that any proposed changes to Emergency & Acute services are mitigated against through the provision of enhanced community-based specialist services that support people to remain at home when they are unwell and/or living with a long-term condition. • Consideration needs to be given to transport and accommodation solutions for Carer/family members to aid visiting. • Transparency of the interdependencies of acute services and any likely implications that changes to one service might have on others.
Carers	In 2011 more than 56,000 residents across Cumbria were providing unpaid care to family members, friends, neighbours or others because of a long-term physical or mental ill-health / disability or problems relating to old age. In addition the estimated number of young carers is around 7,700 (Source: Carers Support Cumbria, 2014) giving an estimated total of 63,700. There are greater proportions of carers in Cumbria compared to the rest of England (11.3% compared to 10.2%). Most carers in Cumbria (around 64%) provide on average 1 to 19 hours of care per week; 1 in 4 carers (around 23.5%) provide 50 or more hours. Numbers of those providing unpaid care are increasing. 28% of carers in Cumbria report that their own activities are limited due to long-term health problem or disability. Some wards within Copeland and Allerdale are identified as having high levels of deprivation compared to the national average. Carers find it easier to access services closer to home; options that reduce or exclude Emergency & Acute Services in west Cumbria could significantly impact on carers both as carers for others and on their own health and wellbeing in some of the county's most deprived areas. The proposed options have been assessed as having a 'medium to high' impact for people in west. Option 3 having a 'high to neutral/medium' impact	• As part of the ICC developments ensure carers are part of care planning (for them or the person they care for)

Protected Characteristic	Reason for impact assessment rating	Mitigation
	in west, north and east Cumbria	

8) Emergency Surgery, Trauma & Orthopaedics

Current Position

Currently West Cumberland Hospital provides inpatient, day case and outpatient services for planned orthopaedic surgery. Fracture clinics are provided five days a week by trauma consultants. Cumberland Infirmary Carlisle provides a similar service but with seven day a week fracture clinics. It also manages the higher risk cases for all of West, North and East Cumbria and it undertakes all emergency orthopaedic operations along with weekend emergency assessment. The previously agreed centralisation of emergency complex trauma and orthopaedic surgery at the Cumberland Infirmary in Carlisle took place in June 2013. The decision to cease minor trauma operations, emergency admissions and the on-call service at West Cumberland Hospital was made in early 2014 on safety grounds. Since June 2014 there have been no minor trauma operations, emergency admissions, or out of hours assessment service at West Cumberland Hospital. Out of hours advice to A&E staff at West Cumberland Hospital is now provided by the orthopaedic team based at Cumberland Infirmary Carlisle. It is also important to note that more planned orthopaedic operations than ever before are now taking place at West Cumberland Hospital as surgeons work across both hospital sites to treat as many patients as possible locally. Recently the NHS further increased the number of orthopaedic operations taking place in Whitehaven in order to fully utilise the state-of the-art operating theatres in the new hospital which opened in October 2015.

Proposals for Emergency Surgery, Trauma and Orthopaedics in WNE Cumbria:

The proposal is that that the arrangements previously made on safety grounds are now made permanent BUT with some further changes which allow additional emergency surgery and trauma care to take place at West Cumberland Hospital. Specifically

- Additional minor trauma surgery will take place on some days each week at West Cumberland Hospital with any displaced planned surgery being managed in an additional weekly list at West Cumberland Hospital.
- Some non-complex day case general surgery is returned to West Cumberland Hospital including key-hole gall bladder operations, surgical treatment of abscesses, and investigation of abdominal pain (with key hole procedure if necessary).
- Single 'Professional Point of Access' communication arrangements are used to allow the referrer (often the patient's GP) to discuss directly with the hospital based surgeon the best place to see and assess individual patients.
- Additional outpatient fracture clinics at West Cumberland Hospital.

Feedback from the EIA Engagement Events

Feedback from the session was that because some surgery would be returning to WCH there is the potential for improvement in access to services closer to home, however for some very seriously ill patients it may mean travelling greater distances to access services. The further desktop review made no adjustments.

Protected Characteristic	Changes made on Safety Grounds February 2014			Consultation Proposal		
Option / area	west	north	east	west	north	east
Race	N	N	N	N	N	N
Religion & Belief	N	N	N	N	N	N
Gender	N	N	N	N	N	N
Disability	- N	N	N	-	N	N
Sexual Orientation	N	N	N	N	N	N
Age	- N	N	N	- /+	- /+	- /+
Pregnancy & Maternity	- N	N	N	- N	N	N
Gender Reassignment	N	N	N	N	N	N
Rural Isolation & Deprivation	-	N	N	- /+	- /+	- /+
Carers	- N	N	N	- /+	- /+	- /+

Impact Assessment & Mitigation

Protected Characteristic	Reason for impact assessment rating	Mitigation
Race	Compared to England & Wales, Cumbria has lower proportions of residents from all broad ethnic groups, therefore the changes proposed to Emergency Surgery, Trauma & Orthopaedic services are not likely to impact on health and wellbeing linked to ethnicity. Yet we noted in the EIA July 2016 that people from BME groups living in predominately white British areas can face particular challenges in terms of accessing culturally appropriate services and being 'invisible' to providers. It should be noted that between 2001 and 2011, Cumbria experienced a greater proportional increase in numbers of residents from BME groups than the national average; with the greatest increases seen in Carlisle (+143.4%) and Eden (+104.1%); particularly in relation to migration from the eastern Europe Gypsies and Travellers have significantly poorer health status and more self-reported symptoms of ill-health, particularly in relation to high levels of anxiety and stress, smoking, alcohol and drug use. (source:http://www.cumbriaobservatory.org.uk/elibrary/Content/Internet/536/671/4674/5359/5360/40723111743.pdf) This suggests that Gypsies and Travellers may be more likely to require Emergency Surgery, Trauma & Orthopaedics than other ethnic groups, however there is not enough data available to identify geographical areas where need may be	• Regarding broad ethnic groups - No current mitigation is assessed as required, although advice from AWAZ Cumbria is recommended and wherever possible, the ethnicity of patients using Emergency Surgery, Trauma & Orthopaedics in Cumbria is reviewed annually. This would allow any changes in ethnicity profiles to be identified, and service provision and cultural training for staff to be reviewed and amended if required. • CCG to work with the Allerdale, Carlisle, Copeland and Eden District Councils and CPFT to: - identify current Gypsy and Traveller sites/resident numbers across the WNE Cumbria area - Assess possible health need in relation to Emergency Surgery, Trauma & Orthopaedics

Protected Characteristic	Reason for impact assessment rating	Mitigation
	greater. The proposed options have been assessed as 'neutral'	- If health need is identified, carry out specific consultation with Gypsies and Travellers who may be affected by the proposed options
Religion & Belief	In Cumbria, the reported religion held by residents in each district (as reported in the 2011 census) is not statistically different from the England averages, therefore this indicates that population health and wellbeing linked to religion will not be significantly impacted upon by the proposed changes to Emergency Surgery, Trauma & Orthopaedics.	• Based on the assessment carried out, no mitigation required, although advice from AWAZ Cumbria is recommended
Gender	The proportion of male and female residents across West, North and East Cumbria are equally split (no significant difference between population %). There is no evidence to suggest that men are more likely to attend suffer from serious injury than women. As a result it is not anticipated changes proposed will disproportionately affect males or females. The proposed options have been assessed as 'neutral'	• Based on the assessment carried out, no mitigation required.
Disability	The percentage of residents in Allerdale and Copeland who describe their day-to-day activities as 'limited a lot' is greater than the Cumbria average (10.1% and 10.7% versus 9.7%). Eden has a lower percentage (7.8%). 3 neighbourhoods in West, North and East Cumbria rank within the 1% most deprived in the country for health and disability It is difficult to assess the impact of a Minor Trauma Surgery and non-complex day case general surgery changes to individuals or groups with disabilities due to the wide range of conditions these services cover. However it is important to consider any additional distance to assess services and the poor wheelchair access at CIC. Which is more likely to impact on people with disability e.g. challenges with public transport and the additional stress this causes. The proposed options have been assessed as 'neutral' and 'neutral –medium' impact for the west	• Through the development of integrated care communities, provide support to residents with disabilities in their own homes and communities. • Ensure adequate and affordable transport options are available for patients or carers or family members with disabilities who need to travel further. • Undertake a full assessment of the limitations of access to CIC for people with disabilities and explore all options to maximise ease of access for people with disabilities.
Sexual Orientation	There is no robust data available for groups with this protected characteristic. Emergency Surgery, Trauma & Orthopaedics are accessible to all groups regardless of sexual orientation, therefore the impact of the proposed options have been assessed as 'neutral' with relation to sexual orientation. The proposed options have been assessed as 'neutral'	• Based on the assessment carried out, no mitigation required although it is important that organisations commissioning and providing health and social care be aware of the existence LGB groups and 'hidden' LGB people who may be older, from BME or working class backgrounds.
Age	Between 2012 and 2017, the 65+ years population is likely to increase by the following in each district: Allerdale (2,600), Carlisle (2,200), Copeland (1,700), Eden (1,700). The number of people affected by age related conditions is predicted to increase significantly and this cohort of patients are also	• It is important that any proposed changes to Emergency Surgery, Trauma & Orthopaedic Services are mitigated against through the

Protected Characteristic	Reason for impact assessment rating	Mitigation
	more likely to utilise Emergency Surgery, Trauma & Orthopaedic Services. For example hip fractures generally occur in elderly patients who are often frail and have other health problems. It is difficult to assess the impact of a Minor Trauma Surgery and non-complex day case general surgery changes to individuals or groups due to the wide range of conditions these services cover. However it is important to consider any additional distance to assess services which is more likely to impact on older people and younger people e.g. challenges with public transport and the additional stress this causes. Elderly disabled – taken further away from support networks Social isolation and systems not working properly. The proposed options have been assessed as 'neutral' and 'medium' for west.	timely provision of enhanced community-based services to enable them to return to their homes/communities. • It is important that consideration is given to ambulance capacity for the transfer of patients between sites as transport solutions for Carer/family members to aid visiting. • Early discharge planning that proactively takes into consideration transport issues and support to get people home. • Ensure adequate and affordable transport options are available for patients and relatives who need to travel further.
Pregnancy & Maternity	The impact of the proposed options have been assessed as 'neutral' however it should be noted that If the changes meant that women with ectopic pregnancies or bleeding travelled the impact would be negative.	• Based on the assessment carried out, no mitigation required. Although the impact of changes in 2014 is unknown.
Gender Reassignment	There is no robust data available for groups with this protected characteristic in Cumbria. However, Emergency Surgery, Trauma & Orthopaedics are fully accessible. Therefore the impact of the proposals has been assessed as 'neutral' with relation to gender reassignment.	• Based on the assessment carried out, no mitigation required.
Rural Isolation & Deprivation	54% of Cumbria's residents live in rural areas compared to 18% nationally. Injuries resulting from accidents e.g. farm, sports and road traffic accidents are more likely to be experienced by younger men often in rural communities for example the rates of people killed or seriously injured on roads in Eden and Allerdale are significantly higher than the national average at 48 per 100,000 for Eden and 50 per 100,000 (2014). All major trauma cases are currently taken at CIC or transferred to a tertiary centre e.g. Newcastle. There is a potential negative impact that transfer times from rural west may be effected due to adverse weather conditions and road closures which may be problematic in the transfer for emergency trauma and orthopaedic cases. The current proposal to return and expand some Minor Trauma Surgery and non-complex day case to West Cumberland Hospital whilst beneficial for people with protected characteristics in West Cumbria may mean that some people from North & East may need to travel to West Cumbria for some complex day case general surgery.	• It is important that any proposed changes to Emergency Surgery, Trauma & Orthopaedics is mitigated against through the provision of enhanced locally community-based specialist services • Consideration needs to be given to transport solutions for Carer/family members to aid attending appointments and visiting.
Carers	In 2011 more than 56,000 residents across Cumbria were providing unpaid care to family members, friends, neighbours or others because of a long-term physical or	• As part of the ICC developments ensure carers are part of care

Protected Characteristic	Reason for impact assessment rating	Mitigation
	mental ill-health / disability or problems relating to old age. In addition the estimated number of young carers is around 7,700 (Source: Carers Support Cumbria, 2014) giving an estimated total of 63,700. There are greater proportions of carers in Cumbria compared to the rest of England (11.3% compared to 10.2%). Most carers in Cumbria (around 64%) provide on average 1 to 19 hours of care per week; 1 in 4 carers (around 23.5%) provide 50 or more hours. Numbers of those providing unpaid care are increasing. 28% of carers in Cumbria report that their own activities are limited due to long-term health problem or disability. Because of the increased distance for those in West Cumbria to travel to see the person they will be/are supporting – this results in additional time and resource pressures on them.	planning including escalation (for them or the person they care for) . • Ensure ICCs include carers (including those who may be 'short term' carers as a result of Emergency Surgery, Trauma & Orthopaedics. to mitigate the impact on their lives and enable people to 'return to normal' as speedily as possible.

9) Hyper-Acute Stroke

Stroke services are measured against a set of national quality standards. Whilst NCUHT has been successful in making some improvements, they report that they are not able to meet a number of the highest standards for stroke care due to limited access to stroke specialist staff and facilities and an inability to provide full services seven days a week on two sites.

Nationally, the NHS is centralising immediate acute stroke care in well resourced, specialist hyper-acute stroke units as research suggests a centralised model of acute stroke care, in which hyper acute care is provided to all patients with stroke, can reduce mortality and length of hospital stay. In addition there is a national shortage in stroke consultants as well as workforce challenges in a number of other key areas.

Despite great strides in improving stroke services in WNE Cumbria the view is that they are still not as good as they should be. The care of stroke inpatients in both Whitehaven and Carlisle is provided in clinical areas not dedicated to stroke, services operate for five days a week and it has proved very difficult to recruit more stroke specialists to extend the available service.

Current Position

Currently patients with suspected stroke are assessed, treated for a blood clot if necessary, and admitted for acute care both at West Cumberland Hospital in Whitehaven and at Cumberland Infirmary Carlisle. Patients also receive early rehabilitation on both sites. Patients in Carlisle can also receive early, intensive rehabilitation services that helps them to leave hospital more quickly and return to their own homes in order to maximise independence as quickly as possible after their stroke.

Outside of normal working hours CT scan images for patients with suspected stroke on both sites are reviewed remotely as part of our 'telestroke' arrangements with other hospitals.

Acute stroke admissions in WNE Cumbria total approximately 700 per year, with 410 in Cumberland Infirmary Carlisle (CIC) and 290 in West Cumberland Hospital. Current services are reported as extremely 'fragile': if one element were to disappear (such as an individual consultant leaving), the service is at risk of collapsing.

Potential models for Hyper Acute Stroke services in WNE Cumbria:

As a result of the work to date, two possible service models are being considered and tested in terms of deliverability and sustainability, outlined below. Further information is contained in 'Acute Stroke Services Briefing Note' available from ***Healthcare for the Future*** consultation website [5]

The short-listed options for hyper acute services are as follows:

Hyper-Acute Stroke - Option 1	**Hyper-Acute Stroke - Option 2**
Option 1 would largely maintain services as they are now but the service would be enhanced by ensuring improved, early supported discharge in both Carlisle and Whitehaven	Option 2 would see all acute stroke cases managed in a single hyper-acute stroke unit based at Cumberland Infirmary Carlisle. Ambulances would take possible stroke patients direct to Carlisle. Patients arriving at West Cumberland Hospital by other means would be transferred by ambulance to Carlisle. On leaving the hyper acute stroke unit patients resident in West Cumbria would be transferred to acute stroke and rehabilitation facilities at West Cumberland Hospital if further hospital care was needed. As with option 1 this service would be complemented by ensuring improved, early supported discharge in both Carlisle and Whitehaven.

Feedback from the EIA Engagement Events

Feedback from the group was that as some people form ethnic groups had a higher risk from strokes any changes would have a medium impact, this was considered by the desktop review but as the numbers were small, a Neutral impact was recorded. For disability, age, rural isolation and carers there was feedback that Option 1 had medium negative impact, The desktop review were of the view that given this option largely maintains services as they are the impact should be assessed as neutral.

Protected Characteristic	Option 1			Option 2		
Option / area	west	north	east	west	north	east
Race	N	N	N	N	N	N
Religion & Belief	N	N	N	N	N	N
Gender	N	N	N	N	N	N
Disability	N	N	N	-	N	N
Sexual Orientation	N	N	N	N	N	N
Age	N	N	N	-	+	+
Pregnancy & Maternity	N	N	N	N	N	N
Gender Reassignment	N	N	N	N	N	N

[5] http://www.wnecumbria.nhs.uk/publications-documents/

Protected Characteristic	Option 1			Option 2		
Option / area	west	north	east	west	north	east
Rural Isolation & Deprivation	N	N	N	-	+	+
Carers	N	N	N	-	+	+

Impact Assessment & Mitigation

Protected Characteristic	Reason for impact assessment rating	Mitigation
Race	Compared to England & Wales, Cumbria has lower proportions of residents from all broad ethnic groups, therefore the proposed options for to Hyper Acute Stroke Services are not likely to impact on health and wellbeing linked to ethnicity. However despite low representation it should be noted that Stroke rates are highest in people of African Caribbean descent and diabetes in the African Caribbean and South Asian population is much higher than in the white population. Between 2001 and 2011, Cumbria experienced a greater proportional increase in numbers of residents from BME groups than the national average; with the greatest increases seen in Carlisle (+143.4%) and Eden (+104.1%); particularly in relation to migration from the eastern Europe Gypsies and Travellers have significantly poorer health status and more self-reported symptoms of ill-health, particularly in relation to high levels of anxiety and stress, smoking, alcohol and drug use with Heart diseases and strokes causing (25%) of deaths[6]. This suggests that Gypsies and Travellers may be more likely to access stroke services than other ethnic groups, however there is not enough data available to identify geographical areas where need may be greater. The proposed options have been assessed as 'neutral' with relation to race.	• Regarding broad ethnic groups - No current mitigation is assessed as required, although advice from AWAZ Cumbria and the Stroke Association West & North Cumbria is recommended and wherever possible, the ethnicity of patients using Stroke Services in Cumbria is reviewed annually. This would allow any changes in ethnicity profiles to be identified, and service provision and cultural training for staff to be reviewed and amended if required. • CCG to work with the Allerdale, Carlisle, Copeland and Eden District Councils and CPFT to: - identify current Gypsy and Traveller sites/resident numbers across the WNE Cumbria area - Assess possible health need in relation to Stroke Services - If health need is identified, carry out specific consultation with Gypsies and Travellers who may be affected by the proposed options
Religion & Belief	In Cumbria, the reported religion held by residents in each district (as reported in the 2011 census) is not statistically different from the England averages, this indicates that population health and wellbeing linked to religion will not be significantly impacted upon by the proposed changes to Hyper Acute Stroke Services.	• Based on the assessment carried out, no mitigation required, although advice from AWAZ Cumbria is recommended
Gender	The proportion of male and female residents across West, North and East Cumbria are equally split (no significant difference between population %). There is no evidence to suggest that the changes proposed will disproportionately affect males or females. The proposed options have been assessed as 'neutral' with relation to race.	• Based on the assessment carried out, no mitigation required.

[6] http://health.gov.ie/blog/publications/all-ireland-traveller-health-study/

Protected Characteristic	Reason for impact assessment rating	Mitigation
Disability	The percentage of residents in Allerdale and Copeland who describe their day-to-day activities as 'limited a lot' is greater than the Cumbria average (10.1% and 10.7% versus 9.7%). Eden has a lower percentage (7.8%). 3 neighbourhoods in West, North and East Cumbria rank within the 1% most deprived in the country for health and disability. As disabled people find it easier to access services closer to home, options that reduce or exclude provision could significantly impact on disabled groups. However there is strong evidence that there are improved outcomes for stroke patients if they have access to timely specialist stroke care. Ongoing care is then provided locally. Wheelchair access is poor at CIC compared to WCH. WCH was designed in conjunction with disabled people. People with disabilities have suggested they may not feel their conditions are fully understood, within the context of their disability and this may be increased if they are not able to go to familiar points of contact The proposed options have been assessed as 'neutral' except in Option 2 for west.	• Ensure adequate and affordable transport options are available for patients with disabilities who need to travel further to access Services. • Undertake a full assessment of the limitations of access to CIC for people with disabilities and explore all options to maximise ease of access for people with disabilities
Sexual Orientation	There is no robust data available for groups with this protected characteristic. Hyper Acute Stroke Services are accessible to all groups regardless of sexual orientation, therefore the impact of the proposed options have been assessed as 'neutral' with relation to sexual orientation.	• Based on the assessment carried out, no mitigation required – although it is important that organisations commissioning and providing health and social care be aware of the existence LGB groups and 'hidden' LGB people who may be older, from BME or working class backgrounds.
Age	Between 2012 and 2017, the 65+ years population is likely to increase by the following in each district: Allerdale (2,600), Carlisle (2,200), Copeland (1,700), Eden (1,700). The number of people affected by age related conditions is predicted to increase significantly and this cohort of patients are also more likely to utilise Hyper Acute Stroke Services. A reduction in locally available Stroke Services could have a significant impact on access to services from those in west Cumbria; however there is strong evidence that there are improved outcomes for stroke patients if they have access to timely specialist stroke care. Ongoing care is then provided locally. Consolidation of service into a single base could improve outcomes for those living in East & North Cumbria. Hence the positive impact assessment in Option 2	• It is important that any proposed changes to Stroke Services ensure that ongoing care is provided as close to home as possible. • This is particularly important for people living in West Cumbria. • It is important that consideration is given to ambulance capacity for the transfer of patients between sites and transport solutions for Carer/family members to aid visiting. • Early discharge planning that proactively takes into consideration transport issues and support to get people home.
Pregnancy & Maternity	The impact of the proposed options have been assessed as 'neutral' however it should be noted that there is a higher incidence of stroke during pregnancy , 25–34 cases per	• Based on the assessment carried out, no mitigation required. Although consideration should be

Protected Characteristic	Reason for impact assessment rating	Mitigation
	100,000 deliveries, whereas the incidence of stroke in non-pregnant woman aged 15–44 is 11 per 100,000 women[7] The proposed options have been assessed as 'neutral'	given to the interdependencies with Maternity options outlined within the consultation.
Gender Reassignment	There is no robust data available for groups with this protected characteristic in Cumbria. However, Stroke Services are fully accessible to anyone who proposes to, starts or has completed a process to change his or her gender. Therefore the impact of the proposed options has been assessed as 'neutral'	• Based on the assessment carried out, no mitigation required.
Rural Isolation & Deprivation	54% of Cumbria's residents live in rural areas compared to 18% nationally. There is a potentially negative impact that transfer times from rural west may be effected due to adverse weather conditions and road closures. Delayed access to care for these patients could potentially have long term consequences for patient's recovery. Consolidation of service into a single base could improve accessibility and outcomes for those living in East & North Cumbria.	• It is important that any proposed changes to Hyper Stroke services are mitigated against through the provision of Early Supported Discharge in both West Cumberland Hospital and Cumberland Infirmary. • Consideration needs to be given to transport and accommodation solutions for Carer/family members to aid visiting.
Carers	In 2011 more than 56,000 residents across Cumbria were providing unpaid care to family members, friends, neighbours or others because of a long-term physical or mental ill-health / disability or problems relating to old age. In addition the estimated number of young carers is around 7,700 (Source: Carers Support Cumbria, 2014) giving an estimated total of 63,700. There are greater proportions of carers in Cumbria compared to the rest of England (11.3% compared to 10.2%). Most carers in Cumbria (around 64%) provide on average 1 to 19 hours of care per week; 1 in 4 carers (around 23.5%) provide 50 or more hours. Numbers of those providing unpaid care are increasing. 28% of carers in Cumbria report that their own activities are limited due to long-term health problem or disability. Proposals that have a positive impact on recovery will benefit carers. Stroke may result in people becoming new carers because of the increased distance for those in West Cumbria to travel to see the person they will be/are supporting – this results in additional time and resource pressures on them.	• As part of the ICC developments ensure carers are part of care planning including escalation (for them or the person they care for) • Ensure ICCs include carers (including those who may be 'short term' carers as a result of stroke to mitigate the impact on their lives and enable people to 'return to normal' as speedily as possible.

[7] James AH, Bushnell CD, Jamison MG, et al. Incidence and risk factors for stroke in pregnancy and the puerperium. Obstetrics & Gynaecology. 2005; 106:509–516. [PubMed]

10) Conclusions & Recommendations

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

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

Action planning and next steps The partner organisations in WNE Cumbria are asked to review the contents and conclusions of this report. This EIA should be seen as part of an ongoing process to engage with representatives covering the protected characteristics.

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

Model	Recommendation
All models of care	• Wherever possible, the ethnicity of patients accessing all services should be monitored with service provision and cultural training for staff to be reviewed and amended if required. In addition it is recommended that advice is sought form AWAZ Cumbria and Cumbria CVS as required. • Through the development of integrated care communities, explore the opportunities to enhance community service provision and support residents to access support/self-manage conditions in their own homes and communities, in order to reduce the requirement for hospital services. • Wherever possible, the Accessible Information Standard should be used to highlight and individuals specific communication needs. • The CCG should work with the Allerdale, Carlisle, Copeland and Eden District Councils and CPFT to assess the potential health care needs of Gypsy and Traveller Groups. • Explore the options for additional adequate and affordable transport and accommodation options for patient, families and carers who need to travel further to services, including access to parking. • Raise awareness within communities of any changes to services so families understand how to access the right service in the right place. • Investigate the opportunity and raise awareness of the need to offer more flexibility in appointment times to accommodate travel and patient/carer needs • Work with the Local Authority to develop sustainable models to improve connectivity of local communities e.g. technology, transport, outreach etc • Investigate the potential for a disproportionate impact on deprived areas. • Investigate the potential for a disproportionate impact on women who have the majority of caring responsibilities. • Explore opportunities to access telemedicine and telehealth services for all services but particularly for younger people.
Public Health, General Practice and ICCs	• Ensure a good understanding of relevant non statutory services that may be able to support ICC's to be more accessible (for example working with groups that support BME groups) by using existing networks. • Explore options to access to translation services and information in an understandable format across all ICC's. • Consider developing protocols and minimum standards for all ICC's, to ensure

Model	Recommendation
	provision is in place to meet the needs of people that are from minority ethnic groups. • Explore opportunities to work with Cumbria CVS to Recruit champions' within ICC's, Public Health provision and GP Surgeries who have greater awareness of specific needs, for example Dementia Champions, Mental Health Champions and Veterans Champions. • Investigate the opportunity to develop communities of interest as well as geography to promote wider health and well-being issues • Consider protocols and minimum standards for all ICC's in terms of delivering parity of service within each ICC with some local flexibility. • Utilise opportunities for community engagement when developing ICC's to ensure that they reflect the needs and (as much as practically possible) the preferences of people who use the services, and their carers. • Consider the utilisation and development of public and patient participation groups. • Explore the benefits of raising awareness of Carers Assessments
Community Hospitals	• Proposed changes to community hospital provision should be mitigated through the timely provision of community-based services, particularly specialist dementia and frail elderly support. This is particularly important for people living in West Cumbria and the Alston area • Promote awareness of cultural issues and identify and how to access different religious support for those in end of life care. • Investigate the potential of the social impact of changes in terms of loneliness and isolation for older people. • Investigate the requirement for access to respite care • As part of the ICC developments ensure carers are part of care planning, to ensure that their needs are also met when decisions are being made. • Raise awareness within communities of any changes to services so family's understand how to access the right service in the right place
Maternity Services	• Assess ambulance capacity for maternity transfer between sites. • Investigate transport options cater for women with additional equipment needs, wheelchair, scooter. • Assess the limitations of access to CIC for people with disabilities and explore all options to maximise ease of access for people with disabilities • Carry out specific ongoing engagement with groups who may be affected by the proposed options. • Consider transport and accommodation solutions for Carer/family members to aid visiting. • Raise awareness within communities of any changes to services so women fully understand the changes to services and what it means for them to ensure they can make an informed. • Assess the preferred option for rural proofing.
Paediatrics	• Identify causes for A&E admissions in children and identify actions to help prevent admissions through primary care, public health and early help initiatives (e.g. accident prevention advice and promotion of self-care). • Consider providing additional resources to support health improvement work (for 0-19 year olds and their families) through primary care, public health and early help in Workington and Whitehaven. Including GPs who specialise in general paediatrics. • Investigate the risks involved in having no SCBU facility at WCH to inform any further additional consultation with stakeholders, the public and representative groups to identify the best possible service configuration in the future. • Assess all relevant maternal care pathways to ensure that they maintain optimal levels of care for babies who require SCBU and whose families would have used the service at WCH if it was still present. • Assess the limitations of access to CIC for people with disabilities and explore all

Model	Recommendation
	options to maximise ease of access for people with disabilities • Review ambulance capacity for transfer of paediatric cases between sites. • Explore the opportunities to involve young people in the development of services including young people with protected characteristics. • Raise awareness within communities of any changes to services so families understand how to access the right service in the right place.
Emergency & Acute Services	• Assess how the proposed changes to Emergency & Acute Services are mitigated against through the timely provision of enhanced community-based services. Including care plans and escalation procedures. This is particularly important for people living in West Cumbria. • Consider ambulance capacity for the transfer of patients between sites as transport solutions for Carer/family members to aid visiting. • Assess the limitations of access to CIC for people with disabilities and explore all options to maximise ease of access for people with disabilities • Explore discharge planning that proactively takes into consideration transport issues and support to get people home • Consider the CEMAC recommendation – all pregnant women who attend A&E (for any reason, not just pregnancy issues) should be screened by a maternity specialist. • Wherever possible, help people to be better informed of where to go for support and engagement with the frequent attenders. • Transparency of the interdependencies of acute services and any likely implications that changes to one service might have on others.
Urgent Care , Trauma and Orthopaedics	**As above (except bullet 5) and** • Review how ICCs/care navigators work will include carers including those who may be 'short term' carers as a result of trauma to mitigate the impact on their lives and enable people to 'return to normal' as speedily as possible.
Hyper Acute Stroke Unit	**As above (except bullet 5) and** • Review how the proposed changes to Hyper Stroke services are mitigated against through the provision of Early Supported Discharge in both West Cumberland Hospital and Cumberland Infirmary. • Utilise 'lessons learned' including patient feedback from the development of the Heart Centre at CIC