Workstream Equality Impact Assessments

Title of policy or service	Stroke – HASU Transformation	
Name and role of officers completing the assessment	Mandy Philbin Transformation Programme Lead Helen Stevens Communications and Engagement Lead	
Date assessment started/completed	8 September	Reviewed post NHSE Level 2 Assurance

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	Using a structured approach, developed to bring together a range of both quantitate and qualitative methodologies to develop a clear understand of current provision and potential opportunities to improve the quality and safety of services developing a clinical and economic case for change. The **aims** in **phase one** of Stroke (HASU) has been to: • Engage with key stakeholders • Develop an understanding of the issues across the priority areas • Gain clinical consensus of the issues to be resolved • Explore willingness of providers to collaborate and to work differently on potential new clinical service options • Develop high level clinical options to support a case for change and wider engagement A key **objective** is to develop a baseline assessment of the priorities areas for all providers individually and as a whole to build a landscape map of the current state which included: The collective outputs of all the intelligence will be consolidated in to provide case for change. Where the impact of this change is significant and require further wider engagement particularly patients and the public, this will be undertaken in phase two of Working Together. Where the impact of change was less significant and where gains in service quality could be achieved through adjustments in existing contracts with provider business cases have been developed for consideration and implementation as part of wave one of new models in 2015/16.The standards will ensure the delivery of the following key objectives:

	• Skilled timely assessment • Dedicated facilities and staff • Access to an appropriate range of investigations and any subsequent appropriate treatment In **Phase 2** the aim has been to • Gain clinical consensus and priority setting within the option appraisal matrix • Explore willingness of providers to collaborate and to work differently on potential new clinical service options across the key provider organisations • Application of knowledge gained from the Yorkshire and Humber Strategic Clinical Network "Blueprint" • Achieve assurance at NHSE Level 2 process • Follow guidance as provided by the Clinical Senate (post Stage 1 Assurance) A key objective has been to rationalise current service delivery and undertake an options appraisal to ensure safe, sustainable high quality services for HASU **Links to other policies and change programmes;** • Pre-existing change programmes; • Decision-making and governance structures within each commissioning organisation; • Collaborations with other commissioning bodies in adjoining sub-regions • NHS England national change programmes, including the implementation of national specialised service specifications • Yorkshire and the Humber Strategic Clinical Networks Blueprint for the Yorkshire &Humber Clinical Commissioning Groups (June 2016) **Policies –** DH. Cardiovascular Disease Outcomes Strategy. Improving outcomes for people with or at risk of cardiovascular disease. (2013). The British Cardiovascular Society (BCS) Commissioning of cardiac services. (2011). Local Standards for: 'Emergency and urgent admissions for non-specialised cardiology and routine admissions which subsequently require emergency or urgent care'. (2012).

	Royal College of Physicians (RCP) Concise guide to stroke. (2012). RCP. National Clinical guidelines for Stroke. (4th edition 2012). DH. National Stroke Strategy. (2007). The National Institute for Health and Care Excellence (NICE) guidelines and quality standards Guidelines: MI secondary prevention. CG172 (2013). MI with ST segment elevation. CG 167 (2013). Stroke CG 68 (Reviewed 2012). Quality Standards: Stable angina QS21 (2012). Stroke QS2 (2010).

2. Gathering of Information

This is the core of the analysis; what information do you have that indicates the policy or service might *impact on protected groups, with consideration of the General Equality Duty*.

	What key impact have you identified?			**What action do you need to take to address these issues?**	**Considerations for stroke services**
	Positive Impact	**Neutral impact**	**Negative impact**		
Human rights		X		Will not be adversely affected	

Age		X		Patients should be repatriated to their local hospital within approximately 72 hours of their stroke. Accessible Information should be produced for patients to ensure that they are able to understand why they are being sent to the hyper acute unit . Making sure the information is available in accessible formats on request. As per Accessible information standard Review service information to ensure that the needs of younger people who suffer a stroke are not neglected.	The proposed model is intended to improve the quality of services for stroke patients, a large number of who are elderly. Centralisation will, however, mean that more elderly, frail patients receive their first few days of care further away from home (for the initial element of Hyper Acute care). If these patients are cared for by an elderly partner, it may be more difficult for those living further away from the three hyper acute centres to visit, with longer journeys and increased costs. Older people who have a stroke are more likely to die from it than younger people, and although for over 75s, a higher proportion of men have had a stroke than women, the proportion dying is higher for women (EIA of NHS Outcomes Framework) It is important not to neglect the needs of the younger and more active stroke survivor with current provision focused on the older stroke survivor.
Carers			X	Accessible Information should be produced for patients to ensure that they are able to understand why they	The centralised model is intended to improve the quality of services for stroke patients, a large number of whom are elderly. Centralisation will, however, mean that more elderly, frail patients receive their first few days of care further away from home. If these patients are cared for by an elderly partner, it may

				are being sent to the hyper acute unit . Discuss with public transport providers the accessibility of their services and current routes. Review the current car parking costs at the proposed sites and evaluate against local hospital costs.	be more difficult for those living further away from the three hyper acute centres to visit, with longer journeys and increased costs. There is the potential for the increase in travel for carers to attend alternative HASU. Pre consultation feedback regarding "the need to be seen by trained specialist staff" has been taken into consideration and has been developed within the option appraisal
Disability		X		Ensure that staff employed in stroke services have received disability awareness training in general and more specifically in meeting the needs of users with a learning disability Ensure the receiving organisations have hearing loops installed, British Sign Language interpreters are available, independent advocates	It can be difficult to diagnose stroke in people who have certain pre-existing conditions. Some clinicians may fail to realise if a person with a learning disability has had a stroke. The proposed changes will raise the profile of stroke as a disease, and will also remove the relative current complexity of the pre-hospital pathway, which may have a positive impact the correct diagnosis and early action for stroke patients. (Equality Impact Assessment for Stroke Pathway Review, Care Quality Commission (2011))

				are available and written information can be provided in easy read or braille. Ensure all communications needs are met and shared appropriately with receiving. Referring organisations as per Accessible Information Standard	
Sex		X		No adverse impact is expected	No adverse impact anticipated although attitudes to, and experience of caring, also tend to be different for men and women ,may be cultural / religious differences in what is appropriate for different sexes to undertake for partners or relatives) . For example some men may need more support and encouragement to care for a partner who has previously taken on these roles. Staff employed in the centralised model should already have an understanding of this potential need for additional support. Stroke incidence is approximately 25% higher in men than in women, but although stroke incidence is higher for men, there are more strokes in women because women generally live longer than men (Coronary heart disease statistics 2012 edition. British Heart Foundation: London.) The planned centralisation is intended to improve stroke services

					for all patients, regardless of gender.
Ethnicity			X	Review patient and carer information to ensure that it is culturally appropriate and informative and accessible Ensure interpreters are available	The centralisation of hyper acute stroke services is not anticipated to have an adverse impact on people with this protected characteristic. However, the DH EIA for the National Stroke Strategy noted that there is some international evidence to suggest that factors such as lack of translational facilities and cultural misunderstandings can lead to disparities in the management of stroke between ethnic groups and this should be considered as part of the programme . However also evidence that there can be misconceptions around expected support from extended families, and there needs to be safeguards around discharge. Family attitudes towards caring for a relative who has had a stroke vary between ethnic groups. In some communities family members tend to be more willing to take on the role of carer, which may mean someone can go home from hospital sooner, and/or avoid having to go into a nursing home. (Equality Impact Assessment for Stroke Pathway Review, Care Quality Commission (2011)) Variation is observed in prevalence of stroke amongst different ethnic groups. For men the standardised risk ratios were highest for Bangladeshi and Irish men, and lowest for Black Africans. For women the standardised risk ratios were highest for Pakistanis and Bangladeshis, and lowest for Chinese. However due to the limited sample size most of these differences were not

					statistically significant. NAO reports that incidence rates of first ever stroke adjusted for age and sex have been found to be twice as high in black people compared with white people. Health Survey for England 2004: The health of minority ethnic groups (ONS and IC, 2006) Reducing Brain Damage: Faster access to better stroke care (National Audit Office, 2005) Page 8 of 12 There is some evidence of differences in stroke mortality outcomes for different ethnic groups. A 2005 British Medical Journal study reported that black patients in a south London population with first ever stroke are more likely to survive than white patients, the exception being those <65.
Religion or belief		X		No adverse impact is expected	The Department of Health Equalities Impact Assessment for the National Stroke Strategy states that the needs of people who have had a stroke can be different for different communities. Examples include information about rehabilitation and action to reduce the risk of further stroke being provided in different languages, and the need to provide food that is culturally appropriate in health and social care settings where meals are provided. It notes that certain groups such as some Asian women may require rehabilitation therapies to be delivered in a way that takes account of their religious or cultural beliefs. Services should be aware that there may be cultural differences, but consider each person as an individual rather than assume that everyone within a cultural group has the same needs and preferences. These considerations will be applicable within the management of the HASU service delivery as well as the greater “stroke pathway”.

Sexual orientation		X		No adverse impact is anticipated	We have very little evidence about whether or not lesbian, and bisexual people who have had a stroke face discrimination in the provision of services; but there are wider issues about how people access health care which may be particularly relevant to gay people. Some research has also shown that lesbian, gay and bisexual older people are less likely to have children or contact with other members of their families, so they are more likely to need social care services rather than rely on informal support. The main point of entry to this pathway will be via the ambulance service and therefore discrimination in access to the service is not to be expected.
Gender reassignment		X		Will not be adversely affected	There is very little evidence about whether or not people who have had gender reassignment face discrimination after a stroke in the provision of services. The main point of entry to this pathway will be via the ambulance service and therefore discrimination in access to the service is not expected.
Pregnancy and maternity		X		No adverse impact is anticipated	
Marriage and civil partnership (only eliminating discrimination)		X		No adverse impact is anticipated	
Deprivation			X	Discuss with public transport providers the	People from the most economically deprived areas of the UK are

				accessibility of their services and current routes. Review the current car parking costs at the proposed sites and evaluate against local hospital costs.	around twice as likely to have a stroke than those from the least deprived areas Public Health England: National Cardiovascular Disease (CVD) Profiles. Available: http://www.sepho.org.uk/NationalCVD/NationalCVDProfiles.aspx. Last accessed: 09 January 2015 There may be some increased travel costs Also consider access to wider support services – benefits / CAB / advocacy / housing issues post discharge / debt.

A high level assessment will be made of the options for each service change, and the impact on the protected groups and will be included as part of the options review.

Please provide details on the actions you need to take below.

3. Action plan				
Issues identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**
Age It is important not to neglect the needs of the younger and more active stroke survivor with current provision focused on the older stroke survivor. If patients are cared for by an elderly partner, it may be more difficult for those living further away from the hyper acute centres to visit, with	Review service information to ensure that the needs of younger people who suffer a stroke are not neglected. Patients should be repatriated to their local hospital within approximately 72 hours of their	Patient and public engagement groups for initial feedback to allow consideration by the steering group and Working Together programme board. Wider and formal statutory consultation in advance of any recommendation to Working Together Programme Board	Present information to March WTP Stroke Steering Board	PMO and providers

longer journeys and increased costs.	stroke. Carer information should be produced to help elderly partners describe to their friends / relatives why they need to be transported to the hyper acute centres to visit. Potential for subsidised parking for carers during the patient's 3 day stay at the hyper acute centre should be explored through the individual organisations boards	Review EIA as part of mobilisation developments this will be undertaken by any organisation affected by change.		
Learning disabilities Some clinicians may fail to realise if a person with a learning disability has had a stroke. This is known as diagnostic overshadowing.	Ensure that staff employed in stroke services have received Disability Awareness Training in general and more specifically in meeting the needs of users with a learning disability (or have ready access to specialist knowledge and interventions)		Assurance to be gained at individual organisational level by March 17	Lead Clinician
Carers The centralised model is intended to improve the quality of services for stroke patients, a large number of whom are elderly. Centralisation will, however, mean that more elderly, frail patients receive their first few days of care further away from home. If these patients are cared for by an elderly partner, it may be more difficult for	Carer information should be produced to help elderly partners describe to their friends / relatives why they need to be transported to the hyper acute centres to visit. Discuss with public transport providers the accessibility of their services and current routes.		March 17	Operational Leads

those living further away from the three hyper acute centres to visit, with longer journeys and increased costs. There is the potential for the increase in travel for carers to attend alternative HASU. Pre consultation feedback has been taken into consideration and has been developed within the option appraisal to develop the appropriate options.	Review the current car parking costs at the proposed sites and evaluate against local hospital costs.			
Race Family attitudes towards caring for a relative who has had a stroke vary between ethnic groups. In some communities family members tend to be more willing to take on the role of carer, which may mean someone can go home from hospital sooner, and/or avoid having to go into a nursing home.	Review patient and carer information to ensure that it is culturally appropriate and informative.		March 17, overview by exception to be presented at March 17 Stroke Steering Board	Clinical Lead

4. Monitoring, Review and Publication			
When will the proposal be reviewed and by whom?	**Stroke Steering Board**		
Lead Officer	**Lesley Smith AO**	**Review date:**	**February 2017**