Improving Community Urgent Care
Equality impact assessment (EIA)
October 2018

About this document

This equality impact assessment (EIA) takes account of the two community urgent care pathway options proposed by Barking and Dagenham, Havering and Redbridge CCGs (BHR CCGs) through a public consultation.

An equality impact assessment (EIA) is the process of assessing the impact of a proposal and its consequences for equality. There is a legal obligation to undertake EIAs to assess the impact of proposals on equality groups identified by the Equality Act 2010 (called protected characteristics):

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation

Equality analysis is a way of considering the effect of a proposal or policy on different groups and serves to:

- consider if there are any unintended consequences for some groups
- consider if the proposal/policy will be fully effective for all target groups.

It involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of functions, contracts, policies or decisions.

Barking and Dagenham, Havering and Redbridge CCGs are subject to the general public sector equality duty required by Section 149 of the Equality Act 2010.

This states that the CCGs must "have due regard to the need to:

1. Eliminate discrimination, harassment, victimisation, and any other conduct prohibited by the Act
2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
3. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it."

This involves:

- Removing or minimising disadvantages experienced by people due to their protected characteristics
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Carrying out an equality impact assessment helps BHR CCGs to make sure it has considered the needs of people with protected characteristics.

This means it can:

- identify unintended consequences and mitigate them as far as possible
- actively consider how the proposed change might support the advancement of equality and fostering of good relations.

This equality analysis should be reviewed in conjunction with the:

- pre-consultation business case document which is located on BHR CCG websites: http://www.barkingdagenhamccg.nhs.uk/Our-work/community-urgent-care-consultation.htm
- full consultation documents which are located on BHR CCG websites: http://www.barkingdagenhamccg.nhs.uk/Our-work/community-urgent-care-consultation.htm http://www.haveringccg.nhs.uk/Our-work/community-urgent-care-consultation.htm http://www.redbridgeccg.nhs.uk/Our-work/community-urgent-care-consultation.htm

Introduction
Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Groups (CCG) are the NHS organisations that plan, design and buy (commission) local health services.

Below are extracts from the pre-consultation business case:
In Barking and Dagenham, Havering and Redbridge (BHR), as with other parts of England, increasing numbers of people are using NHS services every year. The current urgent and emergency care system does not provide a good experience for patients as it can lead to a long wait to see a GP or in accident and emergency (A&E), and also puts increasing pressure on the hard-working frontline staff and clinicians.

The clinical commissioning groups (CCGs) cannot leave the system as it is currently. Doing nothing will not help to resolve the challenges in the urgent and emergency care system and will not ease the pressure on the emergency department, leading to an un-sustainable model of care for the population. There is a need to deliver a simpler, cost-effective system that meets future needs.

Two options have been developed for the future model that has been shared with the public as a formal consultation to determine the best fit for the future *(see boxes below).*

Both options also include a move towards booked appointments for urgent care needs, building on call or click before patients come in. They will utilise NHS 111 as a way to help people get the right care, right place, first time.

Audits have demonstrated that people are attending, and being seen in A&E for conditions that can be managed in an Urgent Treatment Centre (UTC) or in the community. BHR CCGs are currently working with providers in the system to strengthen the streaming in the urgent treatment centres and ensure the maximisation of attendances that can appropriately be seen in this setting. This will reduce the number of patients seen in A&E and ensure that performance is improved.

During BHR CCG engagement work the public has consistently given a clear message that urgent and emergency care services are confusing. BHR CCGs feel both options will help to address this critical issue - and future-proof urgent care.

All sites (including UTCs) would have bookable appointments through NHS 111.

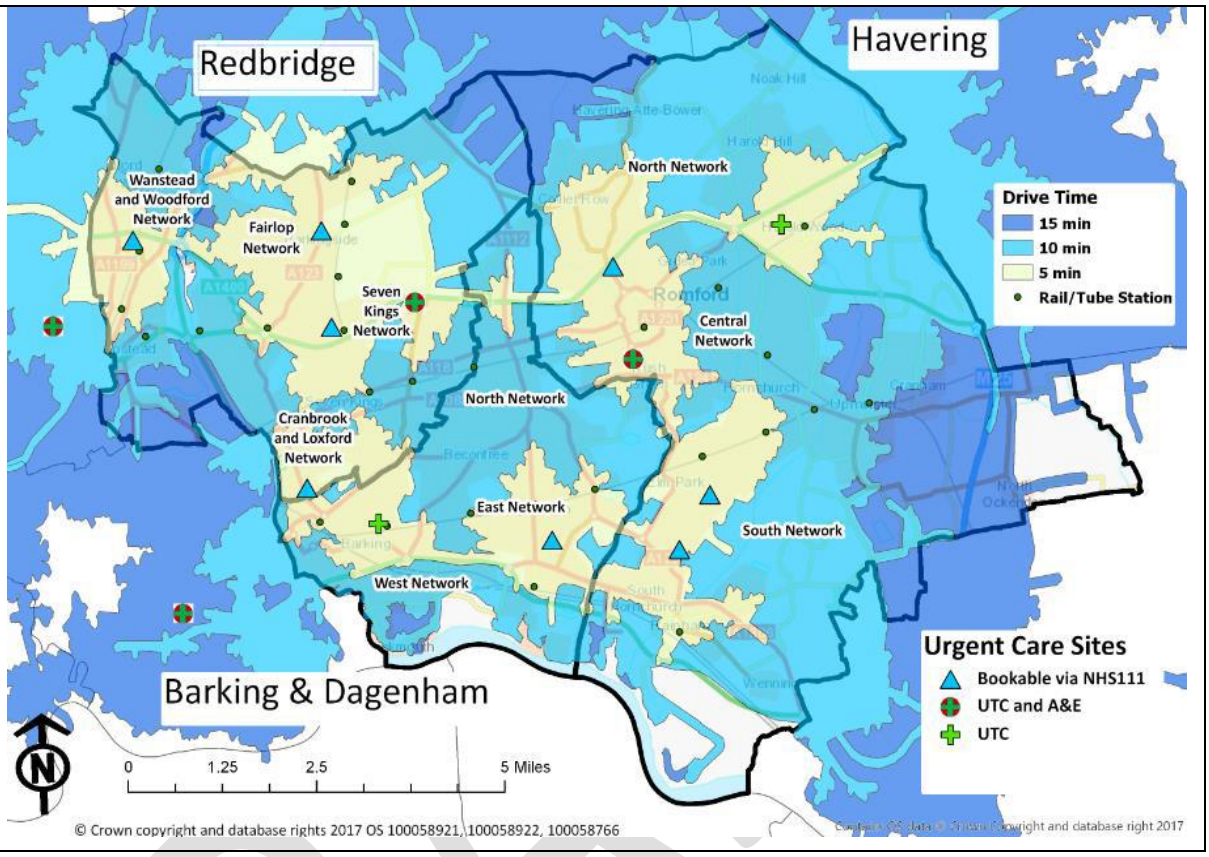
Option 1 would see 12 sites in total, with four Urgent Treatment Centres (UTCs) open within Barking and Dagenham, Havering and Redbridge (2 on hospital sites, and 2 in the community), plus eight locations for booked community urgent care services.

Option 2 would see 12 sites in total, with two UTCs within our area on our hospital sites, although local people may still use those in our neighbouring boroughs (Newham and Whipps Cross). Plus there will be 10 places to be booked when your own GP practice is closed and you have an urgent health need.

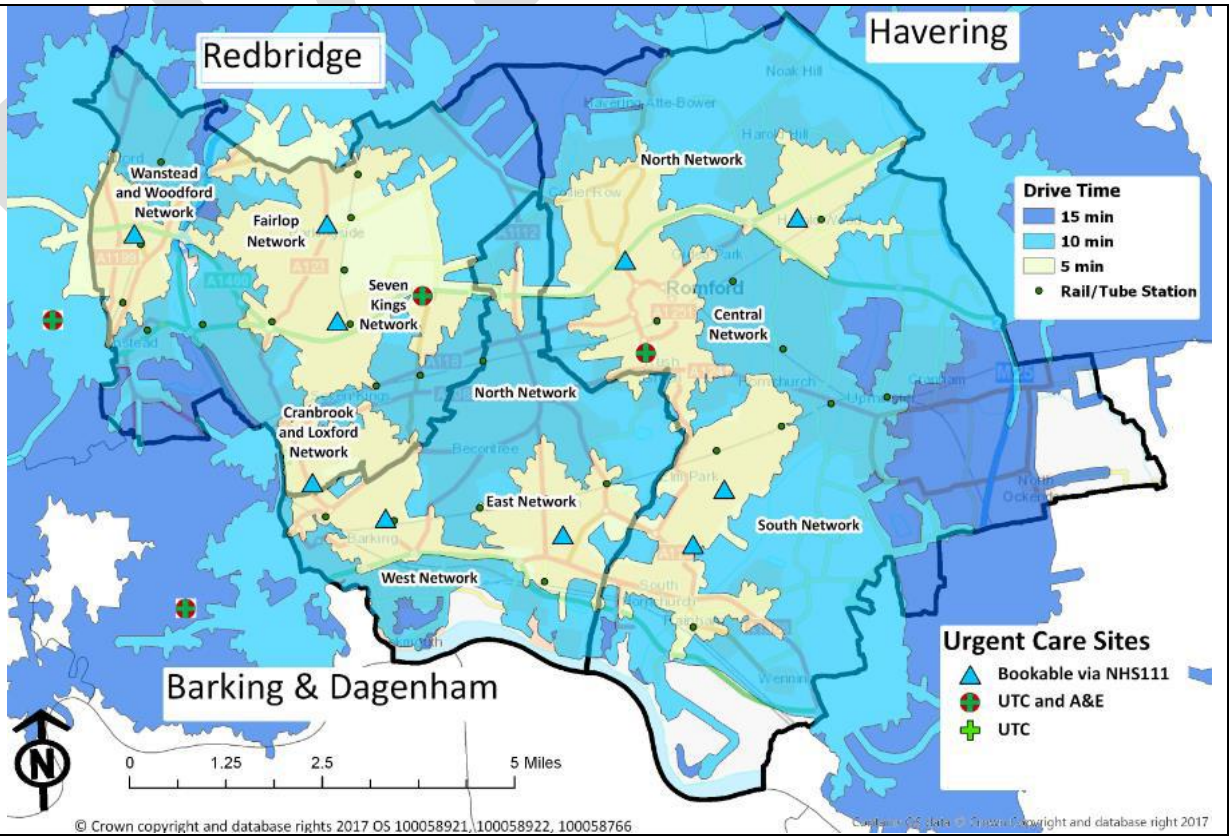
Transport consideration for both Options

BHR travel analysis shows that the vast majority of local residents are currently and will be within a 15 minute drive of a community urgent care service.

Option 1 - map of services and drive time analysis for services within the BHR geography:



Option 2 - map of services and drive time analysis for services within the BHR geography:



Accessing centres without a car

BHR CCGs will ensure that alternative methods of reaching the centres are publicised on their websites and this will be included in the communications and engagement plan put into place during mobilisation to support change. Below are examples of the information that will be available:

All three boroughs have access to the London Taxi Card Scheme which provides subsidised door to door journeys in licensed taxis and private hire vehicles for London residents who have serious mobility or visual impairments. https://www.londoncouncils.gov.uk/services/taxicard

Transport for London operate a 'Hopper fare' that allows passengers to have unlimited bus and tram journeys in one hour for the price of one fare. This scheme keeps the cost of travel to the centres to a minimum if patients need to use more than one bus to reach a centre or if they are sign-posted to an alternative centre within one hour. https://tfl.gov.uk/campgn/hopper-fare

Each councils website transport section:
http://careandsupport.lbbd.gov.uk/kb5/barkingdagenham/asch/adult.page?adultchannel=4_1
https://www.havering.gov.uk/info/20027/travel
https://www.redbridge.gov.uk/roads-and-pavements/transport-services/passenger-transport-service/

TFL Public Transport Access Level (PTAL) scores for each of the centres
The PTAL is a measure of access to the public transport network calculated by transport for London (TfL). For any given point in London, PTALs combine walk times from a chosen point (the building) to the public transport network (e.g. stations and bus stops) together with service frequency data at these locations. This provides an overall access score. There are 9 accessibility levels between 0 and 6b (6b would be achieved by the most accessible sites in London). PTAL 2015 is the most recent year published and PTAL 2021 is the projected rating for 2021 after planned transport enhancements.

The current BHR urgent care sites PTAL scores are in the table below - the highest score is 4 and the lowest is 1b. This demonstrates BHR has accessibility as would be expected for outer London.

Site	Postcode	PTAL 2015	PTAL 2021
Queens Hospital	RM7 0AG	2	2
King George Hospital	IG3 8YB	2	2
Harold Wood Polyclinic	RM3 0FE	1b	1b
Barking Community Hospital	IG11 9LX	2	3
Loxford Polyclinic	IG1 2SN	2	2
South Hornchurch	RM13 7XR	2	2
Broad St	RM10 9HU	1b	1b
Rosewood	RM12 5NJ	1b	1b
Southdene	E18 1BD	4	4
Newbury Park	IG2 7LE	3	3
Fulwell Cross	IG6 2HG	3	3
North St	RM1 4QJ	3	3
Grays Court	RM10 9SR	2	2

Consultation process

Included the following:

- A 14 week, three-borough consultation, running, running from 29 May to 4 September 2018
- Online consultation in line with previous successful Spending Money Wisely consultations
- Consultation promoted through social media and other established channels, through media releases, posters, and advertisements, and via newsletters, stakeholders and existing forums
- Printed copies of a flyer (written in plain English) promoting the consultation to be widely circulated throughout the three boroughs
- Presented at the BHR patient engagement forums (PEF)
- Actively engaged with Healthwatch and other local stakeholders
- Attended meetings with local stakeholders as requested
- Proactively engaged the voluntary and community sector
- Key stakeholders identified, with a targeted focus on hard to reach groups, parents of young children and young adults as high or frequent users of UEC services

A large number of groups were proactively approached and offered CCG representatives to present on the proposals to their members. A number of those contacted responded inviting us to do so. Other groups contacted the CCGs asking us to present on the proposals. The CCGs were also asked to present to two groups by representatives who had attended the Havering Compact meeting.

The format of these meetings usually involved a presentation, followed by a question and answer session. Attendees discussed the proposals, asked questions and then some submitted responses.

The meetings at which the clinical leads and CCG representatives presented were as follows:

Date	**Borough**	**Name of meeting**
11 June	Redbridge	Age UK
14 June	Barking and Dagenham	Barking and Dagenham Council for Voluntary Services
18 June	Redbridge	Redbridge Gujarati Welfare Association
18 June	All three boroughs	North East London Local Pharmaceutical Committee
19 June	Redbridge	Redbridge Asian Mandal
21 June	Redbridge	Redbridge Older Carers – coffee morning
25 June	Barking and Dagenham	The Learning Disabilities Advisory Partners
26 June	Havering	Havering Compact Forum
28 June	Barking and Dagenham	Somali Women's Association
2 July	Redbridge	Redbridge Pensioners Forum
3 July	Barking and Dagenham	Barking and Dagenham Carers' Forum
4 July	Havering	Havering CCG's Patient Engagement Forum
9 July	Barking and Dagenham	Barking and Dagenham Diabetes Support Group
10 July	Havering	Havering Over 50s Forum
10 July	Havering	Independent Living Association
11 July	Havering	Havering Health and Wellbeing Board

Date	Borough	Name of meeting
11 July	Redbridge	Redbridge Council for Voluntary Services
16 July	Havering	Havering Dementia Carers Support Group
17 July	Redbridge	Redbridge Patient Engagement Forum
18 July	Redbridge	Redbridge Children and Young People's Network
18 July	Redbridge	Redbridge Health Overview and Scrutiny Committee
24 July	Redbridge	Redbridge Faith Forum
24 July	Barking and Dagenham	Barking and Dagenham CCG's Patient Engagement Forum
26 July	All three boroughs	Joint Health Overview and Scrutiny Committee
31 July	Havering	Havering Hub Carers Forum

Demographic profiles

Barking and Dagenham

The overall population of Barking and Dagenham is currently 190,560 people (based on 2012 ONS figures). And 225,327registered with a GP as at 1 October 2018 (NHS Digital https://app.powerbi.com/view?r=eyJrIjoiNjQxMTI5NTEtYzlkNi00MzljLWE0OGItNGVjM2QwNjAzZGQ0IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9)

Age

Since 2001, Barking and Dagenham has seen rapid population growth, linked to both new housing development and birth rate changes. The population structure has changed significantly with particularly large increases in the numbers of younger people living in the borough. The main component of population change across the London boroughs over the last decade has been and remains natural increase which is the result of having more births than deaths.

Children and young people place particular demands on urgent and emergency care services as do older and frail elderly people.

0 – 19

Barking and Dagenham has a young population, with the highest proportion of 0–19s in the UK (32%). More than one in four (26%) residents is aged 0–14, compared with 18% across England and 25% in London, and this proportion has increased from 22% in 2001.

Barking and Dagenham had the highest birth rate in England and Wales in 2016; there were 3,973 live births - a rate of 86.5 live births per 1,000 women aged 15–44[1].

Older people

12.03% of the patients registered with a local GP are aged between 60 and 90+ years. This is the lowest percentage of older adults in the BHR region.

Disability

In Barking and Dagenham the recorded prevalence of dementia (aged 65+) was 4.32% in Barking and Dagenham in 2016, similar to both London and England (4.54% and 4.31% respectively).

It is estimated that 3.9% of adults in the Barking and Dagenham adult population were in contact with secondary mental health services in 2014/15. This is slightly below the London and national averages of 4.7% and 5.4% respectively.

Complex health and social care needs and disability

Barking and Dagenham has the second lowest disability-free life expectancy for women aged 65 in London, which is also significantly lower than the England estimate.

Essentially this means that women over the age of 65 in Barking and Dagenham are more likely to live with limiting longstanding illness or disability at age 65 than women living in other areas of London and some parts of England. Years of living with disability in particular at an old age increases dependence on the health and care system.[2]

Deaf and hearing impairment

Action on Hearing Loss estimate that 1 in 7 of the UK population has some level of hearing impairment, there are likely to be approximately 24,000 people in the borough with hearing loss. 847 people who use adult social services provided by the Council are known to have some level of hearing loss of whom 516 are registered with Barking & Dagenham Council as being Deaf or hard of hearing (19% from BME

[1] https://www.lbbd.gov.uk/sites/default/files/attachments/JSNA-2017-report.pdf

[2] https://www.lbbd.gov.uk/sites/default/files/attachments/JSNA-2017-report.pdf

backgrounds) and 133 are known to use BSL (British Sign Language). This low proportion of people with hearing impairment reaching the Council's register indicates that large numbers of people are not accessing specialist services that could help them.
https://www.lbbd.gov.uk/sites/default/files/attachments/7.5-Sensory-disability-eye-health-and-low-vision-2016.pdf

Ethnicity
49.52%, white population, 50.48% BAME population.

Barking and Dagenham has seen a rapid shift in the proportions of various ethnic groups, with a large decrease in the White British ethnic group and a large increase in the Black African ethnic group.

Languages spoken
81.3% of people living in Barking and Dagenham speak English. The other top languages spoken are 2.3% Lithuanian, 2.0% Bengali, 1.7% Urdu, 1.0% Polish, 0.9% Panjabi, 0.8% Albanian, 0.8% Portuguese, 0.7% French, 0.7% Romanian.[3]

Long term condition prevalence in ethnic groups
Barking and Dagenham has the sixth highest prevalence of diabetes in London. People of Asian ethnic origin are six times more likely to have diabetes, while people of black ethnic origin are four times more likely to have diabetes than the white population.

Traveller population
There is limited evidence on the number, however the local authority aims to provide essential services to the Traveller and Gypsy communities in the borough demonstrating their presence.

Pregnancy and maternity
Barking and Dagenham had the highest birth rate in England and Wales in 2016; there were 3,973 live births - a rate of 86.5 live births per 1,000 women aged 15-44[4]. Urgent care services undertake pregnancy testing as a part of diagnosing minor illness, however pregnancy and maternity care is delivered by specialist maternity / pregnancy services which are not part of the current or proposed urgent care pathways.

Gender
Barking and Dagenham has the second lowest disability-free life expectancy for women aged 65 in London, which is also significantly lower than the England estimate.

Women over the age of 65 in Barking and Dagenham are more likely to live with limiting longstanding illness or disability at age 65 than women living in other areas of London and some parts of England. Years of living with disability in particular at an old age increases dependence on the health and care system[5].

Deprivation
Barking and Dagenham is one of the most deprived boroughs in England. It has the twelfth highest index of multiple deprivation (IMD) score in England (based on 326 local authority districts, where one is the most deprived and 326 is the least deprived) third highest IMD score in London.

Gascoigne, Heath, Thames and Village wards all had neighbourhoods amongst the 10% most deprived in the country. Alibon and Mayesbrook wards were amongst the 20% most deprived in the country. Longbridge was the only ward without any neighbourhoods amongst the 30% most deprived in the country[6]

[3] http://localstats.co.uk/census-demographics/england/london/barking-and-dagenham

[4] https://www.lbbd.gov.uk/sites/default/files/attachments/JSNA-2017-report.pdf

[5] https://www.lbbd.gov.uk/sites/default/files/attachments/JSNA-2017-report.pdf

[6] https://www.lbbd.gov.uk/poverty-and-deprivation

The health of people in Barking and Dagenham is varied compared with the England average. Life expectancy for both men and women is lower than the England average.*

Homelessness
Rates of statutory homelessness are significantly higher in all three boroughs than the national average with Barking and Dagenham, and Redbridge six and seven times the national rates respectively.

Homelessness directly links to health, as homeless individuals and families are likely to be less healthy than the general population. Homelessness is associated with poor health, educational, and social outcomes, especially for children.

Shelter report in December 2016[7] shows homeless figures for three boroughs:

- Barking and Dagenham – 1 in 40 people are homeless
- Havering – 1 in 128 people are homeless
- Redbridge – 1 in 48 people are homeless

Car ownership
According to the 2001 census, 62% of households in the borough have access to at least one car. This compares to 63% and 71% for London and outer London respectively.

The borough also has lower than average households with one, two or more cars. The level of households without access to a car is similar to all of London, though more than Outer London[8].

Havering

There are 256,039 (https://www.haveringdata.net/population-demographics/) people living in Havering and 279,321 people registered with a Havering GP as at 1 October 2018.

Age 0-19
From 2009 to 2014, Havering experienced the largest net inflow of children across all London boroughs, with 4,606 children settling here from another London borough.[9]

As well as increases in the number of births, there has been an increase in the general fertility rate from 54 births per 1,000 women aged 15-44, in 2003 to 66 in 2014. From 2009 to 2014, Havering experienced the largest net inflow of children across all London boroughs, with 4,606 children settling here from another London borough.

Age older people
Havering has the oldest population in London with a median age of 40 years, as recorded in the 2011 census. There is a much older age structure for the population of Havering compared to London but similar to England.

Notwithstanding Havering having oldest population in London, an increasing older population across the UK leads to frail elderly residents who live alone and are often isolated. This can result in patients presenting at A&E and/or requiring ambulance services even if their presenting medical condition could be managed at home if the necessary support was in place in the community.

Disability

[7] https://england.shelter.org.uk/media/press_releases/articles/life_on_the_margins_over_a_quarter_of_a_million_without_a_home_in_england_today

[8] https://www.lbbd.gov.uk/sites/default/files/attachments/Chapter-2.pdf

[9] https://www.haveringdata.net/wp-content/uploads/2018/09/Published-201819_Havering-Demographic-Profile-v4.1.pdf

The prevalence of depression ranges from 53.6 per 1,000 persons aged 17 and over in Upminster - to 111.5 per 1,000 persons aged 17 and over in Gooshays (i.e. more generally more common with increasing deprivation).

Dementia is more common in Havering than London but similar to England; and it will be an increasing problem for Havering because of its ageing population.[10]

Complex health and social care needs, and disability
There is an increasing number of Havering residents living with long term conditions (LTCs) - this has a significant impact on daily lives including the use of urgent and emergency health and social care services. Havering CCG patients with five or more LTCs are five times more likely to attend A&E, 20 times more likely to be admitted for an emergency, and the average number of inpatient bed days will be 37 times greater compared to patients with no LTC.

Deaf and hearing impairment
There is limited data available on deafness and hearing impairment in Havering; however, there are currently 44 people in Havering registered with a dual sensory loss. Out of these, 2 people are registered as severely sight impaired and severe hearing loss. The Centre for Disability Research has estimated that the number of people with deaf blindness will increase by 60% in the next 16 years. (https://www3.havering.gov.uk/Documents/Adults-and-older-people/Disabled-adults/strategy-for-eye-care-and-inclusion-2013-16.pdf)

Ethnicity
86% white population, 14% BAME population.

Havering is one of the most ethnically homogenous places in London, with 83% of its residents recorded as White British, higher than both London and England. About 90% of the population were born in the United Kingdom. It is projected that the Black African population will increase from 3.8% (2015) to 5.2% in 2030.

Languages spoken
The latest School Census (January 2014) reported that 9.4% of school-aged children in Havering speak a language other than English, with 10 most spoken languages (after English) in Havering being: Yoruba, Lithuanian, Urdu, Polish, Bengali, Romanian, Punjabi, Albanian, French & Turkish.[11]

Traveller population
There were 137 caravans occupied by travellers in Havering as at January 2018. This number is an increase of seven from the last six-month count - there has been a steady increase in the total number of travellers over the past four counts. About 83% of the traveller caravans in Havering were on unauthorised sites, as at July 2015.

Long term condition prevalence in ethnic groups
In Havering, the number of people living with diabetes is on the increase. The prevalence of diabetes is lowest in Romford Town (47.5 per 1000 persons aged 17 and over) and highest in South Hornchurch (68.3 persons aged 17 and over) where there is the highest proportion of non-white ethnicities.[12]

Pregnancy and maternity

[10] https://www.havering.gov.uk/download/downloads/id/1533/havering_health_and_wellbeing_strategy_2017.pdf

[11] https://www3.havering.gov.uk/Documents/Equality-and-Diversity/Demographic_and_Diversity_Profile_of_Haverings_Population_Mar-14.pdf

[12] https://www.havering.gov.uk/download/downloads/id/1533/havering_health_and_wellbeing_strategy_2017.pdf

As well as increases in the number of births, there has been an increase in the general fertility rate from 54 (per 1,000 women aged 15-44) in 2003 to 66 in 2014[13]. Urgent care services undertake pregnancy testing as a part of diagnosing minor illness, however pregnancy and maternity care is delivered by specialist maternity / pregnancy services which are not part of the current or proposed urgent care pathways.

Gender
There are no significant statistics on gender to be reported here.

Deprivation
Havering ranks 102 out of 152 upper tier local authorities in England with rank one being the most deprived. Havering is a more affluent area than Barking and Dagenham and Redbridge, being ranked 166th overall out of 326 local authorities for deprivation.

However the borough still has pockets of poverty. Two wards, Gooshays and Heaton, fall into the 20% most deprived areas in England. When compared to Barking and Dagenham, Havering has a relatively small proportion of children living in poverty, however this has risen in recent years, bucking the trend seen in most other London borough of declining levels of child poverty.

Unemployment levels in 2015 were lower than London and national rates (5.3%).

The people of Havering are generally fairly healthy. Life expectancy is long and residents and visitors to the borough benefit from plenty of high quality parks and open spaces.

The borough has a rate of short-term international migrants of 77 per 100,000 population, the lowest of all London local authorities. A short-term international migrant is someone who visits a country other than that of his or her usual residence for a period of between 1 and 12 months, as opposed to a long-term migrant, who changes their country of usual residence for a year or more. (https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/bulletins/shortterminternationalmigrationannualreport/mid2015estimates)

Homelessness
Rates of statutory homelessness are significantly higher in all three boroughs than the national average with Barking and Dagenham, and Redbridge six and seven times the national rates respectively. Homelessness directly links to health, as homeless individuals and families are likely to be less healthy than the general population. Homelessness is associated with poor health, educational, and social outcomes, especially for children.

Shelter report in December 2016[14] shows homeless figures for three boroughs:

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- Redbridge – 1 in 48 people are homeless

Car ownership

[13] https://www.haveringdata.net/wp-content/uploads/2018/09/Published-201819_Havering-Demographic-Profile-v4.1.pdf

[14] https://england.shelter.org.uk/media/press_releases/articles/life_on_the_margins_over_a_quarter_of_a_million_without_a_home_in_england_today

The number of cars and vans available to households in Havering was 117,634 in 2011. 77% of households in Havering have at least one car and compared to other local authorities in London, Havering has the second highest proportion of households (32.8%) with two or more cars.[15]

Redbridge

The overall population of Redbridge is currently 296,800 people (based on 2015 ONS figures), and 324,021 registered with a GP as at 1 October 2018.

Redbridge has a growing and mobile population. In 2014 the population was estimated to be 293,055 (ONS mid-year estimate). It is predicted that the population will grow by another 40,000 (13.5%) by 2021, with the greatest growth being in numbers of children. By 2021 it is predicted that 28% of the population will be aged under 20 years.

Age 0-19

There are is a greater proportion of children and young people aged under 19 years (27.6%) than in comparison to London (24.7%) and England (23.7%). https://redbridge.gov.uk/media/3496/jsna-in-breif.pdf

There was a 34% increase in births between 2004 and 2014 although the rate of increase appears to be levelling off.

Age over 65 / older adults

There is projected to be a 19% increase in the numbers of people aged over 85 years by 2021, with a consequent effect on demand for services for this age group

Extract from Redbridge Pharmaceutical Needs Assessment 2010:
Many users of urgent care are from the more vulnerable members of society, such as children under five years of age, older people, people living in deprivation, and individuals with complex health needs.

Social deprivation and age related vulnerability are considered to be two of the most important determinants of the demand for urgent care out-of-hours. *(Shah and Cook 2008, NJ Mclellan 2004).*[16]

Disability

Mental health

There is limited data to demonstrate the mental wellbeing of Redbridge residents.

An estimated 18% of the population, around 46,000 people, are affected by a common mental disorder like depression and anxiety, with more women (56%) affected than men (44%). Estimated prevalence rates of severe mental illness, including schizophrenia are 0.7%, equivalent to 1,138 people; estimated prevalence of Post Traumatic Stress Disorder is 3%, personality disorders 0.4%, eating disorders 6.4%. An estimated 10,000 people in Redbridge will have had an episode of self harm in their lifetime.

Risk factors for mental illness include black ethnicity, unemployment, low educational level, low income, insecure or poor housing, living alone, experiencing domestic violence. In general the levels of these risk factors are lower in Redbridge than in London as a whole. Mental and physical illnesses often co-exist and can result in higher mortality. Physical illness can make people more prone to depression, and people with mental disorders may take less care of themselves.

On average people with mental illness die 5-20 years younger than the general population.
• Redbridge has a higher rate of admission for mental health conditions than England but not significantly different to London.

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[15] https://www.haveringdata.net/wp-content/uploads/2018/09/Published-201819_Havering-Demographic-Profile-v4.1.pdf
[16] https://redbridge.gov.uk/media/2199/pharmaceutical-needs-assessment.pdf

• In 2012/13 44% of mental health admissions in adults were due to mental and behavioural disorders due to the use of alcohol. This represents a very considerable burden.
• Analysis of admissions by ethnicity show that there may be under-representation of admissions among people with Bangladeshi, Pakistani and Indian backgrounds.
(https://www.redbridge.gov.uk/media/2189/jsna-executive-summary.pdf)

Complex health and social care needs, and disability
There are increasing numbers of residents who experience long term and sometimes complex conditions such as diabetes and dementia which significantly impact use of health and social care services.

Deaf and hearing impairment
There is predicted to be a 12% increase in numbers of adults who have a moderate or severe hearing impairment, from 20,855 in 2012 increasing to 23,487 in 2020.There are 1,293 adults and children who have registered as having deafness or hearing loss. This includes 198 residents who are deaf without speech. (https://www.redbridge.gov.uk/media/2189/jsna-executive-summary.pdf)

Ethnicity
37.58%, white population, 62.42% BAME population.

Languages spoken
75.4% of people living in Redbridge speak English. The other top languages spoken are 3.8% Urdu, 3.1% Panjabi, 2.6% Tamil, 2.5% Bengali, 2.3% Gujarati, 1.0% Lithuanian, 0.9% Polish, 0.7% Hindi, 0.7% Romanian.[17]

Traveller population - Redbridge
There is limited evidence on the Traveller population in Redbridge, however, in 2018 Travellers have attempted to settle in the borough only twice since a temporary injunction was introduced during the summer by Redbridge Council, according to official reports.

Long term condition prevalence in ethnic groups
People of Asian ethnic origin are six times more likely to have diabetes, while people of black ethnic origin are four times more likely to have diabetes than the white population. A higher proportion of residents have diabetes than the average for London or England - with an estimated 12% of residents projected to have type 2 diabetes by 2030. Type 2 prevalence is related to a higher risk of diabetes among South Asian communities and increasing numbers of residents who are overweight or obese. In addition, it is very likely that there is a high level of undiagnosed/unreported diabetes among Redbridge residents as levels of recorded diabetes are lower than predicative models would suggest[18].

Pregnancy and maternity
Between 2005-2015 Redbridge saw a large percentage rise in the number of births, although the rate of increase appears to be levelling off. (https://files.datapress.com/london/dataset/birth-trends-in-london/2016-12-01T15:26:00/update-08-2016-birth-trends-london.pdf). Urgent care services undertake pregnancy testing as a part of diagnosing minor illness, however pregnancy and maternity care is delivered by specialist maternity / pregnancy services which are not part of the current or proposed urgent care pathways.

Gender
There are no significant statistics on gender to be reported here.

Deprivation

[17] http://localstats.co.uk/census-demographics/england/london/redbridge

[18] https://redbridge.gov.uk/media/3496/jsna-in-breif.pdf

Redbridge ranks 138th out of 326 local authorities on 2015 Index of Multiple Deprivation (with one being the most deprived), but there is wide variation across the borough with some wards predominantly in the lowest two quintiles for deprivation and some in the highest two quintiles.
Overall the borough has a deprivation score or ranking (see above) of 5.2 compared with 4.8 for London and 5 for England, implying slightly less deprivation than in other areas. There is variation across the borough with Cranbrook and Loxford with a score of 3.9 indicating more deprivation, and Wanstead and Woodford with a figure of 6.9 indicating a less deprived area[19].

The health of people in Redbridge is generally better than the England average. About 14% (8,900) of children live in low income families. Life expectancy for both men and women is higher than the England average. However, life expectancy is 7.8 years lower for men and 4.3 years lower for women in the most deprived areas of Redbridge than in the least deprived areas.[20]

Extract from Redbridge Pharmaceutical Needs Assessment 2010:
Social deprivation and age related vulnerability are considered to be two of the most important determinants of the demand for urgent care out-of-hours. *(Shah and Cook 2008, NJ Mclellan 2004).*[21]

Homelessness
Rates of statutory homelessness are significantly higher in all three boroughs than the national average with Barking and Dagenham, and Redbridge six and seven times the national rates respectively. Homelessness directly links to health, as homeless individuals and families are likely to be less healthy than the general population. Homelessness is associated with poor health, educational, and social outcomes, especially for children.

Shelter report in December 2016[22] shows homeless figures for three boroughs:

- Barking and Dagenham – 1 in 40 people are homeless
- Havering – 1 in 128 people are homeless
- Redbridge – 1 in 48 people are homeless

Car ownership
Average cars per house in Redbridge in 2011 was 1.1, which is unchanged since 2001. There was in fact little change in the proportions of households who had no car, one car, two cars, or three or more cars[23].

[19] https://www.redbridge.gov.uk/media/4392/redbridge-draft-pna-report-2018-for-consultation.pdf
[20] *Public Health England Health Profiles 2018*

[21] https://redbridge.gov.uk/media/2199/pharmaceutical-needs-assessment.pdf

[22] https://england.shelter.org.uk/media/press_releases/articles/life_on_the_margins_over_a_quarter_of_a_million_without_a_home_in_england_today

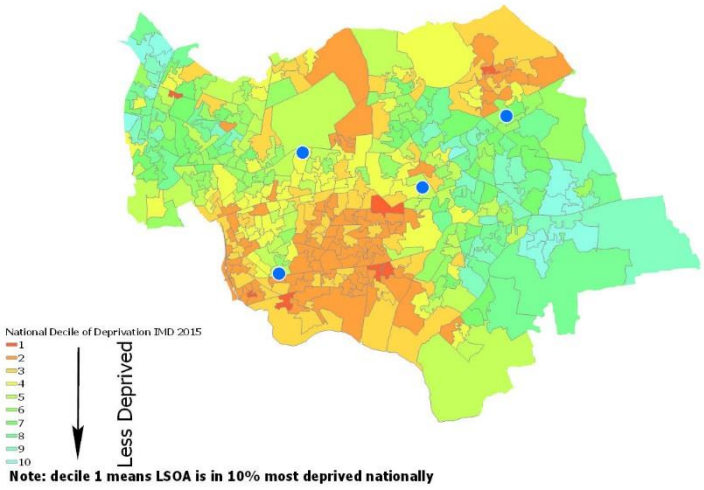
[23] https://www.redbridge.gov.uk/media/2319/draft-redbridge-borough-profile_reduced.pdf

Updated equality impact assessment (EIA)
The following tables set out EIA considerations of the two community urgent care pathway options proposed by BHR CCGs in a recent public consultation. The first table sets out potential EIA considerations and how the proposed urgent care pathway changes will respond or mitigate them, the second table sets out positive impacts of the proposed urgent care pathway changes.

The two options have been analysed against the protected characteristics to understand any unequal impacts on particular groups. The table sets out the findings of that analysis, identified themes from consultation responses, and potential mitigating strategies.

Protected groups	Initial EIA recommendations/ mitigating actions	Potential EIA considerations	EIA impact – response / mitigations
Age	No impact - telephone and online access will be available	Accessibility for older people and children	NHS 111 clinical advice service (or CAS) - allows NHS 111 health advisors to fast-track transfer children aged under one and people aged 65 and older to a GP or other health professional for advice and assessment. NHS 111 provides training for staff regarding patients with specific issues such as: • The elderly and confused patients • Calls relating to under fives Care home staff have priority access to the NHS 111 clinical advice service through the *5 advice line Equality impact is equal for both option one and option two of BHR CCGs proposals for community urgent care pathways.
Disability	No impact - as NHS 111 has access to a BSL interpreter for those unable to and in the future a public on-line NHS 111 clinical assessment tools service	Accessibility for: • Mental health • learning disabilities • Anxiety disorders • Autism • Deaf or hearing impaired	NHS 111 staff are trained to ensure call handlers manage patients in line with local mental health crisis plans when they are available and are aware of the specialist services available in BHR for mental health patients. The local NHS 111 service has enhanced links with the local mental health crisis line so patients calling 111 can safely be transferred to a local mental health professional. NHS 111 requires providers to have systems, technology and procedures in place to enable access for persons with hearing impairment or requiring interpretation services and the provider will be monitored on their adherence to standards set regards access for these services. NHS 111 also has processes in place to improve access to callers who may other communication challenges for example learning disabilities, anxiety disorders, autism. This is achieved by appropriate training for front line staff to recognise these issues quickly and pass the call to a clinician who will have

			greater ability to identify the issue quickly and determine the course of action needed. NHS 111 is legally required to follow the NHS Accessible Information Standard. Equality impact is equal for both option one and option two.
Race and ethnicity	Ethnicity – No impact – as NHS 111 has access to interpreter services	Accessibility for: Non English speakers or people for whom English is not their first language	NHS 111 has systems, technology and procedures in place to enable access for persons with hearing impairment or requiring interpretation services and the provider will be monitored on their adherence to standards set regards access for these services. This includes a text phone service. There is potential for a disproportionate effect if people for whom English is not their first language are not aware that calling NHS 111 will give access to translation services. It is therefore recommended that engagement with and publicising the change is carried out as widely as possible with BAME and non-English speaking communities. This would be further mitigated by the commitment to explore installing telephone access for residents who walk in to call NHS 111 for health advice and bookable appointments at sites where walk in access is changing to bookable. *Equality impact for languages spoken is equal for both option one and option two.*
		Long term condition prevalence in ethnic groups	**Long term condition prevalence in ethnic groups** Most complications of long term conditions (LTCs) such as diabetes are best managed by primary care; while some of the acute symptoms such as strokes are emergencies and need to be seen in specialist emergency departments such as Queen's Hospital. When calling NHS 111 people with LTCs will be clinically assessed and clinical advice offered. Many people may get all the advice they need through the phone. For those who need to be seen, both options will offer more pre-booked appointments with GPs and nurses in community locations. 111 will dispatch an ambulance for those who have an emergency and need to be seen as an emergency. *Equality impact for LTCs is positive and is equal for both option one and option two*
		Travellers will not be aware of the new model	There is potential for a disproportionate effect if Traveller and Gypsy communities are not aware that some locations have changed from walk-in services to bookable services. This would be mitigated by the commitment to explore installing telephone access for residents who walk in to call NHS 111 for health

			advice and bookable appointments at sites where walk in access is changing to bookable. Equality impact for the Traveller and Gypsy population is greater under option two.
Pregnancy / Maternity	No impact	No negative equality impact identified for this group	
Gender	No impact	No negative equality impact identified for this group	
Sexual orientation	No impact	No negative equality impact identified for this group	
Religion	No impact	No negative equality impact identified for this group	
Gender re-assignment	No impact	No negative equality impact identified for this group	
Marriage/ civil partnership	No impact	No negative equality impact identified for this group	
Deprivation		The proposed sites for UTCs are not located near areas of highest deprivation.	The most deprived parts of BHR are in the south west and north east:  Under option one there are urgent treatment centres (UTCs) proposed near each of these areas. Under option two UTCs are centralised to the two hospital sites and therefore would have a higher equality impact to those in the more deprived areas within Barking and Dagenham, Havering, and Redbridge due to a need to travel further to a UTC for minor injuries. There is potential for a disproportionate effect if communities in areas of deprivation are not aware of the change to bookable services. This would be mitigated by the commitment to explore installing telephone access for residents who walk in to a site where walk in access changes to bookable to call NHS 111 for health advice and bookable appointments.

		Homeless people would have reduced access to urgent care under the new model. Car ownership	There is potential for a disproportionate effect if homeless people are not aware where walk in services change to bookable services; this would be mitigated by the CCGs commitment to explore installing a telephone for residents who walk in to call NHS 111 for health advice and bookable appointments. Under option two UTCs are centralised to the two hospital sites and therefore would have a higher equality impact to those without a car due to a need to travel further to a UTC for injury management. This has potential for a disproportionate effect on people who do not own/have access to a car to take them a 15-minute drive to any of the locations under option two.

Positive Impacts
The following impacts have been identified as positive consequences of implementing the proposed community urgent care services:

Positive impact	**Group(s) impacted**
The current confused model will be simplified to make it easier for people to know where to go for help	ALL
Some people will be supported by NHS 111 on the phone and not need to travel at all	ALL People with mobility issues, people in areas of deprivation, people without access to a car.
Ability for unregistered patients to call NHS 111 and be booked an appointment into all 12 sites (currently they can only access the 4 walk in centres and hospital sites)	ALL Homeless people Traveller communities People new to the borough
Booked appointments accessed via 111 will ensure that those needing to be seen are booked into the right place first time; this will reduce the wasted journeys that happen under the current model due to people accessing services which do not meet their needs and then need to go onto another service.	ALL
Whilst clinical services may currently access language translation services the access hub call centre and receptionists do not, so the translation services available through 111 are a benefit to non English speakers or people for whom English is not their first language	Non English speakers or people for whom English is not their first language

The EIA considers that there is no adverse impact of the proposed changes to the urgent care pathway under Option one: 12 sites in total, with four Urgent Treatment Centres (UTCs) and eight bookable locations. It was identified that Option two would have a small, potentially disproportional impact due to a lower number of community locations being available that can manage injuries for traveller communities and those in areas of deprivation, homelessness and car ownership.

Further recommendations for consideration

The Health and Social Care Act 2012 requires CCGs to reduce heath inequalities, therefore the risk of reducing access or introducing barriers should be avoided.

BHR CCGs should be mindful of the effort that is needed to support positive change in community behaviours/expectations.

It is recommended that BHR CCGs consider options to mitigate this risk, taking into consideration each group's behaviours:

- A commitment from BHR CCGs to carry out community engagement activities, focussing on supporting the local communities to better navigate the chosen community urgent care pathway and effective communication to support a smooth transition to the new model. This should target the impacted groups identified in the EIA.

- During the consultation, BHR CCGs were committed to exploring the potential to installing telephone access for public use in Loxford walk-in centre in order to allow residents who walked in to call NHS 111 for health advice and for those who need to make bookable appointments. This should be extended to any site where walk-in access is changed to a bookable service.

- 'Care Navigators' are an initiative that some CCGs are introducing within A&E departments during busy times to raise awareness of both primary care and community based urgent care services and support registration with a GP. This principle should be considered for the new model, particularly during the mobilisation phase.

- Consider a phased replacement of the walk-in appointments to bookable appointments.

- Ensure that transport options are publicised on CCG websites and be included in the communications and engagement plan put into place during mobilisation to support change.

- Notify Transport for London of the changes to the model so they can take these into account during their planning cycles.

Next steps

This is the updated EIA, taking into account the proposed options and the consultation report. This will be included, along with the report on the consultation feedback, in the business case on making changes to community urgent care services will go to the BHR CCGs' Joint Committee for consideration.