Equality analysis: Specialist cancer and cardiovascular services in north and east London

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Introduction

The public sector equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

These are sometimes referred to as the three aims of the general equality duty. The Act explains that having **due regard** for advancing equality involves:

- Removing or minimising disadvantages suffered 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.

NHS England, together with a number of CCGs, is proposing a reconfiguration of specialised cancer and cardiovascular services in north and east London. The details of the reconfiguration are more fully described in the business case that accompanies this document, and in the first section of this document ‘What are the intended outcomes of this work’.

This report is intended to highlight to stakeholders, patients and the public the groups of patients that will be affected by the proposed changes and suggest the impact that the changes will have. The report is slightly limited by the availability of data about the patients that currently use the services.

Equality analysis

Title: Specialist cancer and cardiovascular services in north and east London

1. What are the intended outcomes of this work? *Include outline of objectives and function aims*

Cancer and cardiovascular disease cause two-thirds of early deaths in London. If the NHS in north and east London were to improve local survival rates for heart disease and all cancers in line with at least the rate for England, it is estimated that over 2,000 lives a year would be saved. The document Improving specialist cancer and cardiovascular services in north and east London: The case for change sets out the case being made to introduce these changes. This proposes that fewer specialist high volume units would improve clinical outcomes, accelerate the uptake of new technologies, achieve greater quality and optimise efficiency.

North and east London has some of the best cancer and cardiovascular experts in the country, but specialist services are not organised in a way that gives patients the best chance of survival and the best experience of care.

NHS England has examined how these services are provided in north and east London and has developed a vision for how they could be improved.

Cardiovascular services
The proposal is to consolidate services currently at the Heart Hospital to the new unit being developed at St Bartholomew's Hospital, to create a single integrated cardiovascular centre. With The London Chest Hospital closing next year and The Heart Hospital having limited capacity, clinicians have recommended consolidating into a centre in the new building at St Bartholomew's Hospital (which is 2.5 miles from The Heart Hospital). The Royal Free Hospital and the integrated cardiovascular centre at St Bartholomew's Hospital would act as heart attack centres for the area.

Specialist cancer services
For the following five complex or rare cancers:

- Brain cancer
- Head and neck cancer
- Urological cancers (kidney, bladder and prostate)
- Acute myeloid leukaemia
- Oesophago-gastric cancer

The proposal is to provide specialist treatment in four centres of excellence across the area with a hub at University College London Hospital. In all cases it is only the specialist element of the treatment pathway that is affected by these proposals. For other types of cancer and general cancer services, diagnostics, outpatients, chemotherapy, radiotherapy and non-specialised surgery would be unaffected by these proposals.

Through engagement to consider these proposals, NHS England has heard that patients want to have health services that are locally accessible where possible, but when they are critically ill they want the best specialists, with the best equipment, to give them the best chance of recovery.

The primary aim of the changes is to improve health outcomes for patients. This will have a positive impact on all patients and by helping to reduce early deaths caused by heart disease and cancer should also have a positive impact on the inequalities in mortality rates between London and the rest of England.

2. Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc

The NHS recognises that cardiac and cancer services concern all communities. Under the NHS Act 2006 the NHS has a duty to improve equality in accessing services and in clinical outcomes, and to ensure that services offer the same outcomes and the same experience to patients regardless of their backgrounds.

Under the public sector equality duty (PSED), when a public sector organisation is planning to re-configure a service it must give ‘due regard’ to equality. The Equality Act 2010 mandates an integrated Equality Duty on all public bodies and those discharging a public function to consider how they can:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and those who do not share it.

Due regard is demonstrated by considering the likely impact of the change on different groups in the community, in particular the protected characteristics as defined under the Equality Act 2010. These characteristics include race, gender, age, disability, gender reassignment, marriage and civil partnership, sexual orientation and pregnancy and maternity.

In addition to the protected groups highlighted in the Equality Act, the NHS is also concerned that inequalities are reduced between groups from different social backgrounds. This is of particularly relevant to the NHS in north and east London where there are areas with high levels of social deprivation that correlate strongly to populations with high incidence of heart disease and shorter life expectancy.

Through equality analysis the organisation must ensure there is no negative or disproportionate impact on equality; and all measures have been considered to eliminate or at least minimise any likely negative impact of the reconfiguration.

‘Due regard’ is not only a legal duty, it can help the services make good business decisions and provide services in an equitable manner which will advance equality and foster good relations between groups as well as good health outcomes.

From the NHS Constitution:
The NHS provides a comprehensive service, available to all *irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to diagnose, treat and improve both physical and mental health. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.*

This analysis is intended to highlight to stakeholders, patients and the public the groups of patients that will be affected by the proposed changes and suggest the impact that the changes will have. The report is constrained by the limited availability of data about the patients that currently use the services.

The area covered by this proposed service reconfiguration includes the London Boroughs of Barnet, Enfield, Haringey, Camden, Islington, City of London, Tower Hamlets, Hackney, Newham, Waltham Forest, Redbridge, Barking & Dagenham, and Havering.

Estimates of the population of this area vary. The Greater London Authority (GLA) estimates the population to be 3.3m, however the number of people registered with General Practitioners (GPs) in the area is 3.5m.

The area is ethnically diverse; of the seven London Boroughs only Havering has less than 20% of its population from a non-white Black and Minority Ethnic (BME) group.

There are seven NHS trusts in the area providing specialist cancer and cardiovascular services from a number of hospital sites. In addition some of these hospitals are the designated provider of some specialised cancer services for West Essex.

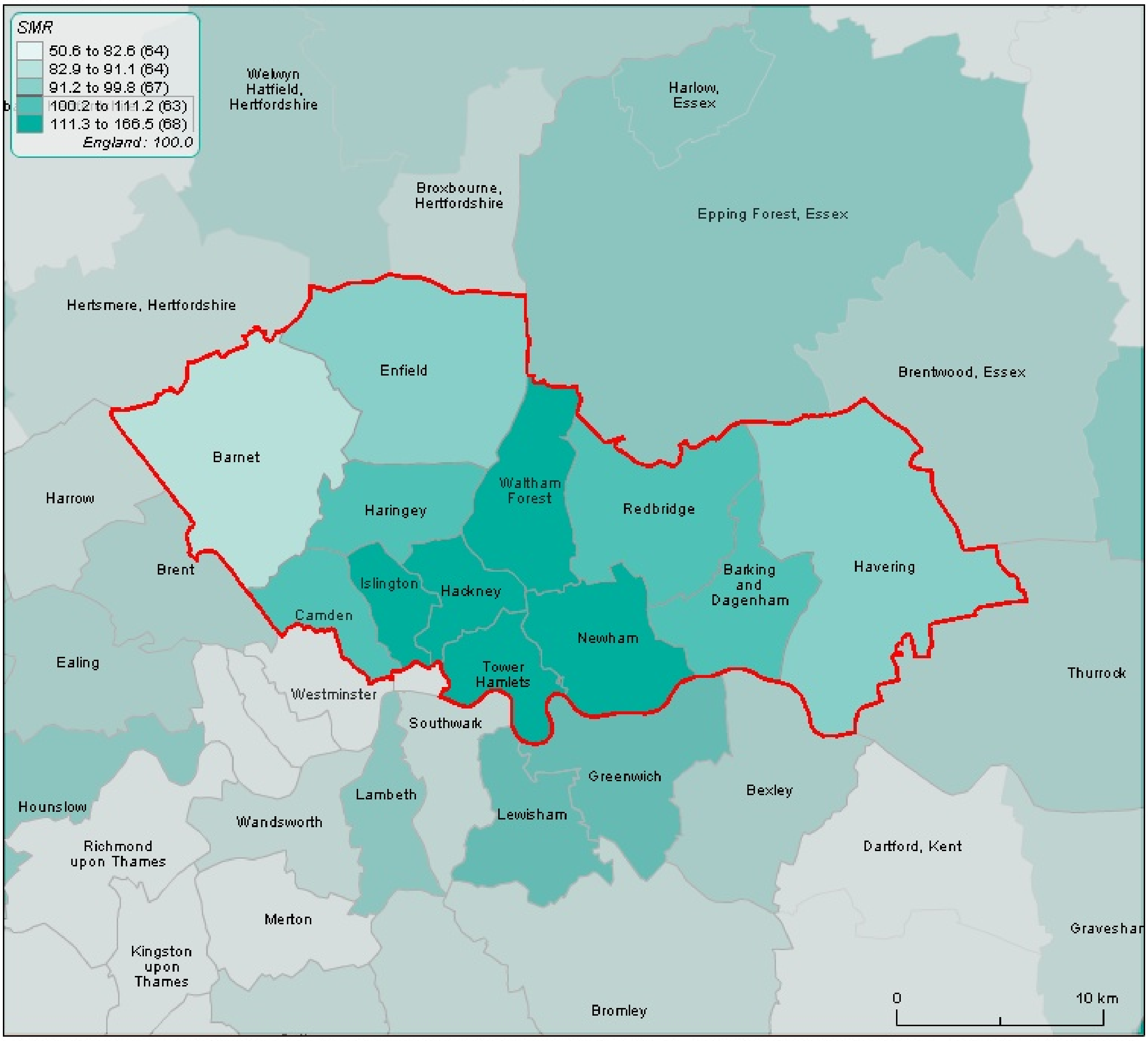
The inequalities report describes the population in north and east London, including areas of deprivation.

Incidence of cancer and heart disease in north and east London

From local and national evidence it can be shown that there are serious health issues and health inequalities in north and east London which are closely linked to poverty and deprivation and which impact on life expectancy. Cancer and cardiac conditions are predominantly issues of poverty, age and lifestyle i.e. smoking and drinking alcohol. We have highlighted some key facts about cancer and cardiovascular health from local Joint Strategic Needs Assessments (JSNA) and national organisations:

- Smoking is the leading cause of premature deaths in all communities but more so amongst minority communities and working class populations. Smoking accounts for nearly one-fifth of all deaths from cardiovascular disease.
- Much of the area has poor survival and high mortality from cancer. Evidence suggests that late diagnosis is a significant contributor to this.
- Lack of physical exercise and poor diet increase the risks of cancer and cardiovascular diseases.
- Prostate cancer is one of the top causes of cancer death in men.
- Cancer occurs predominantly in older people, and therefore as life expectancy increases so the number of cancers diagnosed each year is expected to increase.
- Evidence suggests that people with learning disabilities, mental health issues and those who are housebound have high risks of developing cancer and cardiovascular conditions due to life style and socio-economic factors.
- The prevalence of Coronary Heart Disease (CHD) is higher amongst Indian, Pakistani and Bangladeshi men. From those who are dying in England and Wales but born in South East Asia, CHD accounts for about a quarter of all deaths.

Deaths from coronary heart disease, all ages, standardised mortality ratio, 2006-2010 - *source: PHOs (now part of Public Health England), produced from ONS data © Copyright 2011*



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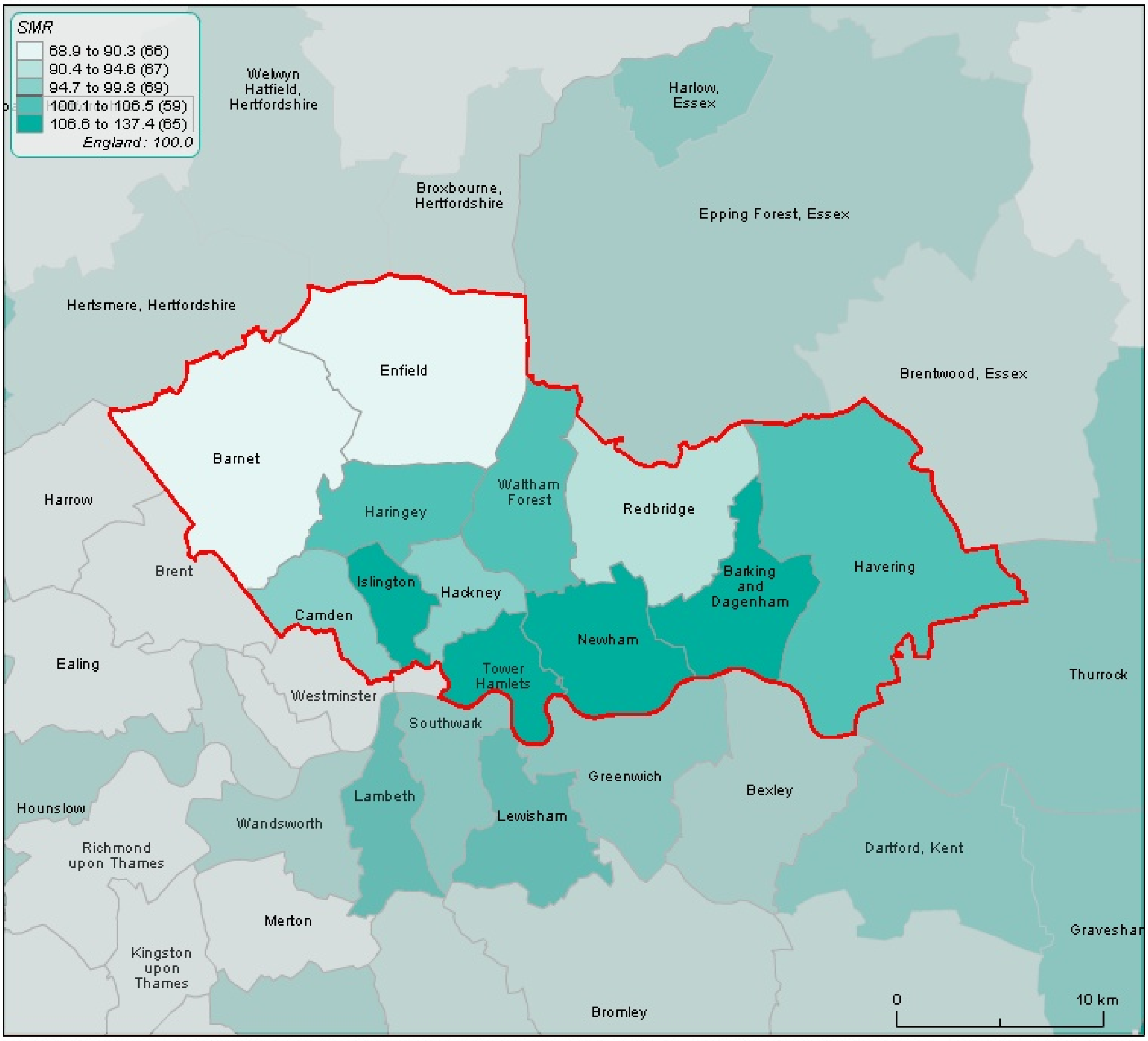
The map above shows deaths from CHD across the north and east London area, standardised for the age of the population. The map shows that CHD deaths are higher than average in all areas except Barnet, Enfield and Havering. CHD deaths are particularly high in Islington, Hackney, Tower Hamlets, Waltham Forest and Newham.

Deaths from all cancer, all ages, standardised mortality ratio, 2006-2010 - *source: PHOs (now part of Public Health England), produced from ONS data © Copyright 2011*



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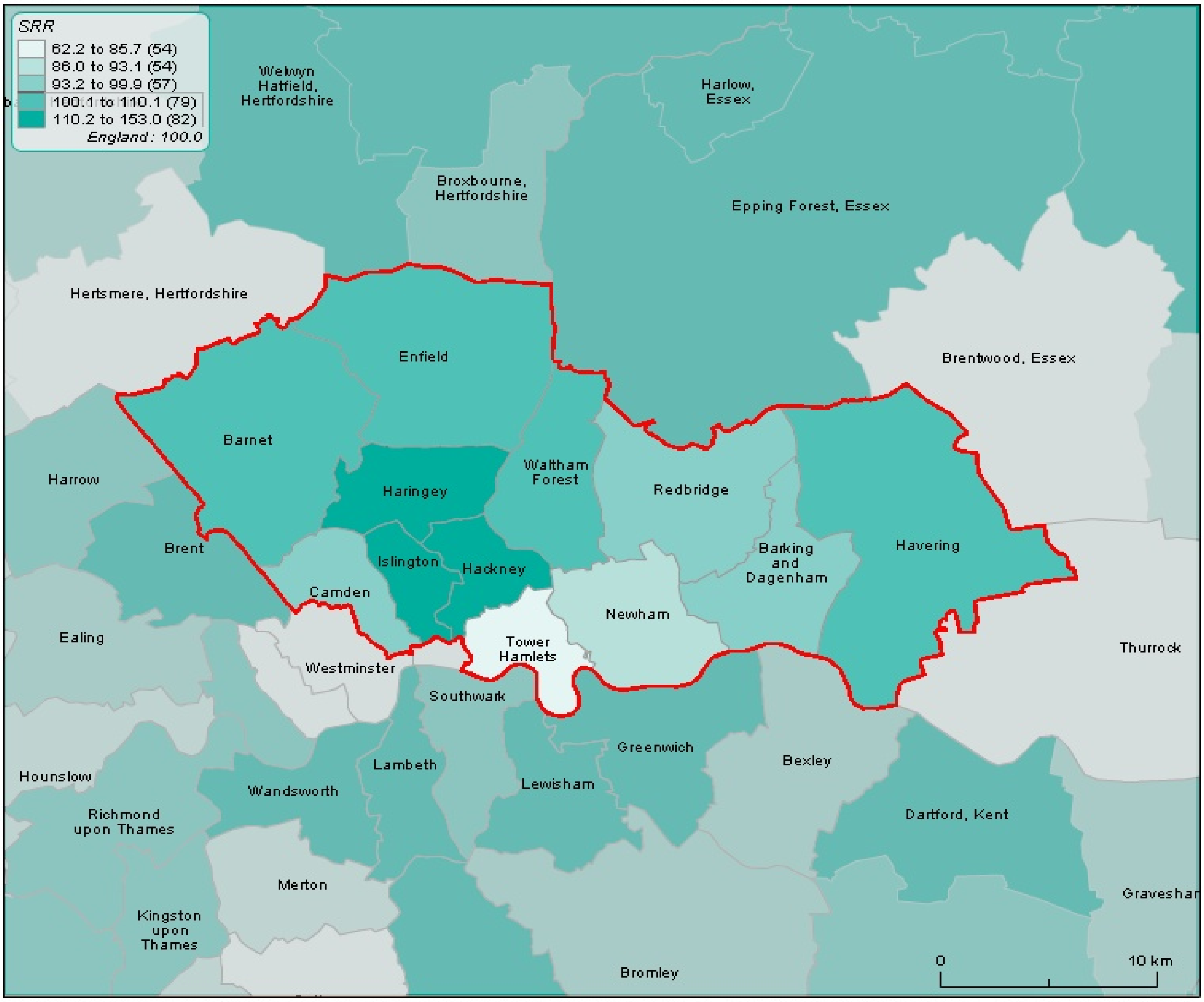
The map above shows deaths from all cancers across the north and east London area standardised for the age of the population. The map shows higher than average numbers of deaths across much of the area, with the highest numbers of deaths in Islington, Tower Hamlets, Newham and Barking & Dagenham. However this is data for *all* cancers, each tumour type can have a different pattern of incidence.

Of the tumour types covered by this programme (brain cancer, head and neck cancer, renal cancer, bladder cancer, prostate cancer, acute myeloid leukaemia and oesophago-gastric cancer) only prostate cancer data was readily available. The map below shows the incidence of prostate cancer in north and east London. This shows that there is higher than average incidence across much of the area with the highest incidence in Islington, Haringey and Hackney.

New cases of prostate cancers, standardised registration ratio, 2005-2009 - *source: UK Association of Cancer Registries (now part of Public Health England), National Cancer Data Repository*



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Evidence

3. What evidence have you considered? List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other Equality Analyses. If there are gaps in evidence, state what you will do to mitigate them in the Evidence based decision making section on the last page of this template.

In addition to the general profile of the area, as shown above. There was a three staged approach to developing this analysis:

Stage 1: scoping. To decide where the focus of the impact analysis should be. This took account of:

- The proposed changes
- Initial view of the communities likely to be most impacted
- The availability of data: there are some equality groups where there is little or no data available to reach any conclusions as to the impact of changes on that group

Stage 2: impact assessment: the aim of this analysis was to provide an assessment of the impact on equality of the proposed changes and to support decision making on the preferred options. This informed the engagement exercise. This analysis looked at the profile of the patients most affected by the changes proposed. The summary of the analysis is included in section 5.

The scoping exercise concluded that of the protected characteristics:

- The changes proposed would have the greatest effect on the elderly as cancer and cardiovascular disease most commonly affect older people
- There was likely to be no impact on marriage/civil partnerships or pregnancy
- It is difficult to measure the impact on equality in the areas of disability, religion/belief, sexual orientation or gender reassignment as data was not collected by the Trusts on these groups.

Stage 3: engagement: the findings were tested with stakeholders. Every effort was made to get views on the proposals from groups identified as likely to be the most impacted by the proposals prior to final decision making on the preferred service model. The engagement process was an opportunity to obtain views from groups where the analysis in the report was limited by a shortage of information (information on people with disabilities, religion, sexual orientation and gender reassignment).

The focus of the analysis in this document has focused mostly on race, gender and age, as there is existing data from the former PCTs on these characteristics.

Analysis undertaken

The analysis that follows has looked at recorded data by the hospitals affected over the last three years. The hospitals record the age, gender and ethnicity of the patients treated. Using this data a profile has been created of the patients that are currently being seen at the hospitals where the proposal is to decommission a service. This represents the patients that will be most affected by the proposals.

In each case the profile of the affected group has been contrasted against patients treated at a wider range of centres. The analysis seeks to address the following issues:

- What is the nature of the patients affected by the proposed changes:
  - How many patients are affected?
  - Where do they come from?
  - What is the age, ethnicity and gender profile of the group?
- Is the profile of the group of patients affected by the changes any different from the profile of patients in general? If so the changes could have an impact on equality of service provision or access to services.

The preliminary proposals to improve specialist cancer and cardiovascular services in north and east London and west Essex formed part of NHS England's drive to improve equality and reduce the disparities in life expected between residents within the area and in the context of London-wide life expectancies.

The impact assessment found that the proposals would not impact any of the groups disproportionately, but did show that some services would be moving out of communities that are more ethnically diverse. Hospitals providing specialist services under the proposals would need to make sure that people in those communities would not be unduly affected. Should the proposals be approved, this is an area that will continue to be monitored as part of the assurance process. Providers will need to ensure that the needs of diverse populations are met under their public sector duties.

3.1 Age Consider and detail age related evidence. This can include safeguarding, consent and welfare issues.

Cancer occurs predominantly in older people, and therefore as life expectancy increases so the number of cancers diagnosed each year will also increase. For the proposals for specialist cancer services, it is only the specialist element of the treatment pathway that is affected by these proposals. Some people may have to travel slightly further for the specialist element of their treatment, which could have a disproportionate impact on older people.

See relevant age profile sections in the Cardiovascular and Cancer services impact analysis below (section 5). The second phase of engagement for the programme was used to reach out to groups with protected characteristics, including Age UK.

The primary aim of the changes is to improve health outcomes for patients which would have a positive impact on all patients. The changes should also help to reduce early deaths caused by heart disease and cancer that will promote equality in mortality rates between London and the rest of England.

3.2 Disability Consider and detail disability related evidence. This can include attitudinal, physical and social barriers as well as mental health/ learning disabilities.

Evidence suggests that people with learning disabilities, mental health issues and those who are housebound have high risks of developing cancer and cardiovascular conditions due to life style and socio-economic factors. However, it is difficult to measure the impact in the areas of disability, religion/ belief, sexual orientation or gender reassignment as data is not collected by the Trusts on these groups. The second phase of engagement for the programme was used to reach out to groups with protected characteristics, including Age UK, who were invited to engagement events and sent copies of the proposals as part of a survey for feedback.

For the proposals for specialist cancer services, it is only the specialist element of the treatment pathway that is affected by these proposals. Some people may have to travel slightly further for the specialist element of their treatment, which could have a disproportionate impact on people with disabilities.

The primary aim of the changes is to improve health outcomes for patients which would have a positive impact on all patients. The changes should also help to reduce early deaths caused by heart disease and cancer that will promote equality in mortality rates between London and the rest of England.

3.3 Gender reassignment (including transgender) Consider and detail evidence on transgender people. This can include issues such as privacy of data and harassment.

It is difficult to measure the impact in the areas of disability, religion/ belief, sexual orientation or gender reassignment as data was not collected by the Trusts on these groups.

The primary aim of the changes is to improve health outcomes for patients which would have a positive impact on all patients. The changes should also help to reduce early deaths caused by heart disease and cancer that will promote equality in mortality rates between London and the rest of England.

The second phase of engagement for the programme was used to reach out to groups with protected characteristics identified through the stage two impact assessment and for which there was limited data, including contacting a number of local organisations representing LGBT groups.

3.4 Marriage and civil partnership Consider and detail evidence on marriage and civil partnership. This can include working arrangements, part-time working, caring responsibilities.

The NHS recognises that cardiac and cancer services concern all communities. The primary aim of the changes is to improve health outcomes for patients which would have a positive impact on all patients. The changes should also help to reduce early deaths caused by heart disease and cancer that will promote equality in mortality rates between London and the rest of England.

3.5 Pregnancy and maternity Consider and detail evidence on pregnancy and maternity. This can include working arrangements, part-time working, caring responsibilities.

The NHS recognises that cardiac and cancer services concern all communities. The primary aim of the changes is to improve health outcomes for patients which would have a positive impact on all patients. The changes should also help to reduce early deaths caused by heart disease and cancer that will promote equality in mortality rates between London and the rest of England.

3.6 Race Consider and detail race related evidence. This can include information on difference ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers.

The prevalence of Coronary Heart Disease (CHD) is higher amongst Indian, Pakistani and Bangladeshi men. From those who are dying in England and Wales but born in South East Asia, CHD accounts for about a quarter of all deaths. See also relevant Ethnicity Profile sections in Cardiovascular and Cancer services impact analysis below (section 5). During the first phase of engagement the summary Case for Change was translated into Bengali and letters inviting responses to the engagement were sent to 540 stakeholders including local Healthwatch committees, patient groups, community groups and voluntary sector groups representing a wide range of the population.

The primary aim of the changes is to improve health outcomes for patients which would have a positive impact on all patients. The changes should also help to reduce early deaths caused by heart disease and cancer that will promote equality in mortality rates between London and the rest of England.

3.7 Religion or belief Consider and detail evidence on people with different religions, beliefs or no belief. This can include consent and end of life issues.

It is difficult to measure the impact on equalities in the areas of disability, religion/ belief, sexual orientation or gender reassignment as data was not collected by the Trusts on these groups.

The primary aim of the changes is to improve health outcomes for patients. This would have a positive impact on all patients, and by helping to reduce early deaths caused by heart disease and cancer should also have a positive impact on the inequalities in mortality rates between London and the rest of England.

3.8 Sex Consider and detail evidence on men and women. This could include access to services and employment.

See relevant Gender Profile sections in Cardiovascular and Cancer services impact analysis below (section 5).

The primary aim of the changes is to improve health outcomes for patients. This would have a positive impact on all patients, and by helping to reduce early deaths caused by heart disease and cancer should also have a positive impact on the inequalities in mortality rates between London and the rest of England.

3.9 Sexual orientation Consider and detail evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.

It is difficult to measure the impact on equalities in the areas of disability, religion/ belief, sexual orientation or gender reassignment as data was not collected by the Trusts on these groups.

The primary aim of the changes is to improve health outcomes for all patients. This would have a positive impact on all patients, and by helping to reduce early deaths caused by heart disease and cancer, should also have a positive impact on the inequalities in mortality rates between London and the rest of England.

3.10 Carers Consider and detail evidence on part-time working, shift-patterns, general caring responsibilities.

Travel implications also affect family visitors. A number of the engagement events during the first and second phases included patients and their carers, including a specific event focusing on proposals for prostate cancer. However, the primary aim of the changes is to improve health outcomes for all patients. This would have a positive impact on all patients, and by helping to reduce early deaths caused by heart disease and cancer should also have a positive impact on the inequalities in mortality rates between London and the rest of England, and so a positive impact on carers.

3.11 Other identified groups Consider and detail evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include different socio-economic groups, geographical area inequality, income, resident status (migrants, asylum seekers).

This document should be read in conjunction with the Health Inequalities Impact Assessment.

4. Engagement and involvement

How have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?

NHS England and CCG partners undertook two phases of engagement to understand the views of a wide range of stakeholders in relation to the proposals including their views and experience of current services and their aspirations for future health services. These dedicated phases of engagement built on previous pan-London and local engagement exercises, namely: Healthcare for London which engaged across the capital; the London-wide 2010 review of cancer and cardiovascular services (led by the former NHS organisation Commissioning Support for London); and previous engagement on specialist urological cancer services covering north and east London and west Essex undertaken in early 2013.

In developing the clinical recommendations for specialist cancer services in north and east London UCLPartners and London Cancer had previously undertaken an extensive programme of stakeholder engagement (2012). A wide range of stakeholders, including patient representatives, GPs, and clinicians (encompassing a range of professions e.g. Clinical Nurse Specialists, oncologists and radiologists) from every NHS trust currently providing cancer services in the locality, were involved in the development of the clinical recommendations. Likewise, over 100 cardiac clinicians from across the partnership were involved in developing the preliminary specialist cardiovascular proposals following a wider stakeholder workshop in November 2012.

Phase 1

Between 28 October and 4 December 2013 NHS England undertook a 38-day engagement exercise. This process was supported by a commissioner-led case for change document providing key information about existing specialist cancer and cardiovascular services, clinicians' recommendations for the future configuration of these services and the wider context. The 'Case for Change' is available at http://www.england.nhs.uk/london/engmtconsult/

Specific attention was given towards making representatives of affected groups aware of the 'Case for Change'. This included sharing the 'Case for Change' with over 540 stakeholders. The summary document translated into Bengali; a series of drop in sessions for members of the public and a range of meetings with patient, clinical and local authority groups.

NHS England received 130 comments and views during this period. Following this initial phase one engagement period, NHS England compiled a report detailing the feedback. This report, an overview and appendices are available on the programme's dedicated page on NHS England's website: http://www.england.nhs.uk/london/engmtconsult/

Overall, discussions during the first phase of engagement showed broad clinical and public support for the need to improve patient outcomes and experience across the area and the need to bring specialist services together (consolidation). Key issues included travel and transport for patients and their families, how the specialist centres would work with local hospitals, and how/if the proposals would affect any other hospital services such as the Major Trauma Centre at the Royal London Hospital site. These issues were considered in detail at the options appraisal meeting, with clinical leaders at the hospitals in the region, and with commissioners.

Following the first engagement phase, the three Joint Health and Overview Scrutiny Committees (JHOSCs) for the area (North Central London, Inner North East London and Outer North East London) agreed that formal consultation was not required because the proposals did not amount to a substantial change. This was dependent on continued engagement with patients and the wider community in developing the proposals.

Phase two

The second stage of the programme included a further phase of engagement, planning for implementation and the development of a commissioner assurance framework to oversee the safe transition of services, should the proposals be approved. The second period of engagement ran for five weeks, beginning on Friday 23 May 2014 and ended on Friday 27 June 2014. The aim was to seek stakeholder views on the commissioner preferred options and to provide people with the opportunity to contribute to the planning for implementation work, concerning the themes raised in the first phase of engagement, such as travel and transport. A variety of methods were employed during this second phase to seek the widest range of views from the community and our partners including:

- Notifying over 600 stakeholders of the launch of the second phase of engagement
- Producing a summary business case, including a survey to understand support for each of the proposals
- Publishing the business case on the NHS England dedicated web page, with an online feedback form (http://www.england.nhs.uk/london/engmt-consult/)
- Distributing the summary business case to local hospital sites and publishing on trust intranets and CCG websites
- Hosting an online feedback form, allowing respondents to comment on each proposal individually
- Advertising engagement events in local newspapers
- Promoting engagement events in staff meetings and local public/patient workshops
- Facilitating four engagement workshops covering the local area.

NHS England received 254 comments and views on the proposals. A few of the comments, particularly from older people, focused on patient travel. Further detail on the feedback can be found in the phase two engagement report – appendix 2.)

During this phase, the programme team analysed whether the proposals for change would be likely to have an impact on the groups identified in the stage two impact assessment, including older people, people with disabilities and people from more ethnically diverse communities. While the stage two impact assessment demonstrated that there was no evidence of any group being disproportionately affected by the proposals, every effort was made in designing the engagement plan to communicate with groups identified with protected characteristics, such as LGBT groups and Age UK, providing the opportunity to contribute to the proposals. In addition, public documents were approved by the Clear English Standard, and alternative language formats made available on request. The plan also incorporated an offer to attend existing patient groups in local communities, to discuss the proposals.

The engagement plan was developed to ensure that all stakeholders (including patients, the public, clinicians and others) were informed about the proposals, and had ample opportunity to comment on commissioners' preferred options and provider plans to support patients, arising from the equality impact assessment and in the first engagement phase. The plan was based on themes raised during the first phase of engagement (including impact on co-dependent services, travel and the patient pathway), and targeted at groups/ individuals who had previously engaged with the programme and with those identified through the equalities impact assessment. The programme team discussed the proposed approach for engagement with local branches of Healthwatch to agree that the final plan was appropriate for local populations.

Travel

The programme team examined the net impact on travel times for those patients who, under the proposals, would receive care at a different location. The stage two impact assessment showed that under the preferred options, travel time and distance would increase for some patients to access the specialist elements of their care or treatment, particularly those travelling from outer north-east London and west Essex.

It is recognised that travelling can be slower and harder for people who are ill. The patients who require specialist surgery and treatment requiring travel will also benefit from the improved care and outcomes. The stage two impact assessment recommended that providers could consider whether there should be any mitigation for cancer patients with increased long or difficult journeys, which was included in the plan for public workshops. Attendees were asked to comment on trust draft travel and transport plans, to shape development should the proposals be approved, and trusts will be responsible for developing any associated travel plans.

In order to ensure the programme reached out to communities within the protected characteristics identified in this report, contact was made with a range of new stakeholders, who had not previously engaged with the proposals, including local Age UK branches and a number of LGBT charities and organisations. Engagement from the newly identified stakeholders was variable, with requests for information on public events, but limited actual attendance and direct responses. Should the proposals be approved, each trust will develop a plan to ensure comprehensive communication of the changes for all stakeholders.

Contact was also made with all CCG communication or patient leads to make full use of existing events to publicise engagement with their respective populations. This led to discussions at two existing public and patient fora (Whipps Cross and City and Hackney). Dedicated engagement activities and communications targeted groups with an interest in the proposals, and included all those who had previously engaged in the process:

- Members of NHS staff within local providers and commissioning organisations
- Clinical Commissioning Groups
- GPs
- Staff within relevant hospital trusts and stakeholders in trusts outside London
- Patient participation groups and support groups
- Community and voluntary sector organisations
- Local branches of Healthwatch
- JHOSCs
- Local Medical Committees and Royal Colleges
- MPs and Assembly Members
- All respondents from the first engagement phase

4.1 How have you engaged stakeholders in testing the policy or programme proposals?

As above during the two phases of engagement for the programme, and during the options appraisal to help shape preferred options for improving services.

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

Please see communications and activity logs for phases 1 and 2 for full details of all events and responses during the engagement periods (appendices 3 and 4).

5. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impacts, if so state whether adverse or positive and for which groups and/or individuals. How you will mitigate any negative impacts? How you will include certain protected groups in services or expand their participation in public life?

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

5.1 Possible impacts

Whilst the analysis described above goes some way towards identifying whether one group may be affected disproportionately over another it is harder to assess whether the impact could be neutral, positive or negative.

Possible impacts could include:

- Changes lead to better clinical outcomes for the affected group
- The new provider is more difficult for patients from the affected group to access; possibly because of a combination of the age of the patient group affected and the increased distance to travel.
- The new provider is better or worse at responding to the particular needs of a specific patient group; for example if the access to translation services is better under the new provider.

The changes proposed are to tertiary services, so patients have already started on a treatment pathway before they are treated by the specialist centre. By implication, access to the patient pathway is not affected by the proposals.

5.2 Impact on people with disabilities

Currently there is no data collected on the numbers of patients treated with a disability. Consequently it is difficult to assess the numbers of patients with disabilities that might be affected by the proposed changes. However the impact should be negligible because all the hospitals involved in the reconfigurations:

- Are routinely assessed by the Care Quality Commission to ensure that their services are responsive to the needs of patients with a disability
- Operate special transport arrangements for patients with mobility problems.

So it is reasonable to conclude that there should be no material negative impact on patients with a disability. However there remains an onus on all the providers involved in the project to ensure that the implementation of the changes is done in a way that the needs of disabled patients are considered.

The stage one scoping exercise concluded that, of the protected characteristics:

- The changes proposed would have the greatest effect on the elderly as cancer and cardiovascular disease most commonly affect older people.
- There was likely to be no impact on marriage/ civil partnerships or pregnancy.
- It is difficult to measure the impact on equalities in the areas of disability, religion/ belief, sexual orientation or gender reassignment as data was not collected by the Trusts on these groups.

The focus of the analysis that informs the assessment in this report has concentrated broadly on race, gender and age, as there is existing data from the former PCTs on these characteristics.

5.3 Impact analysis: Cardiovascular services

Current service

Currently there are cardiovascular centres in north and east London providing cardiology, catheterisation and cardiac surgery at the Heart Hospital, St Bartholomew's Hospital and the London Chest Hospital.

There are heart attack centres at St Bartholomew's, the Heart and the Royal Free Hospitals.

There are some service issues associated with the current service:

- Patients are waiting unacceptably long for treatment
- Too many patients are having their surgery cancelled
- Hospitals cannot deliver 24/7 care by specialist teams without sufficient patient numbers

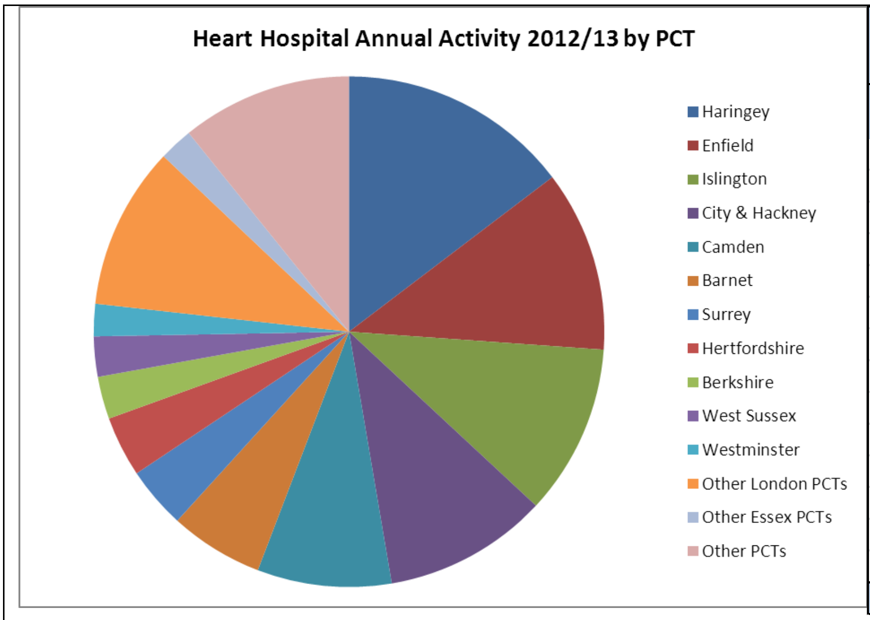
Not all of the services are delivering the national standards for care and patient outcomes could be improved.

Proposed service

All services currently at the Heart Hospital will be consolidated to the new development at St Bartholomew's, thereby creating one world-class integrated cardiovascular centre and two heart attack centres for the north and east of London.
The aim is to develop a comprehensive, joined-up network of care spanning from prevention and earlier diagnosis through to treatment of disease.
The majority of care would continue to be provided close to people's homes.

Patients affected

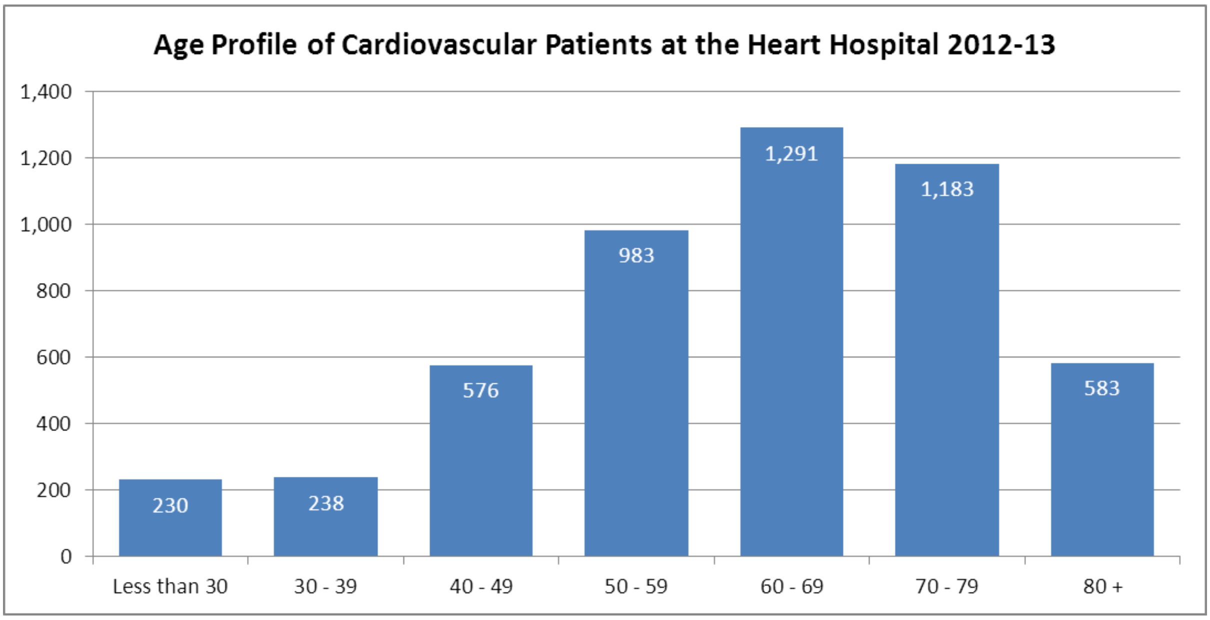
The patients using the Heart Hospital predominantly come from the North Central London area and Hackney. The table and pie chart below show that around 60% of patients come from this area. Within this area, the public health analysis shows that Islington and Hackney are areas of high mortality for CHD. However there are patients using the Heart Hospital from across London and south east England. The current assumption is that 95% of the activity currently going to the Heart Hospital would in future transfer to St Bartholomew's Hospital.



Heart Hospital Annual Activity 2012/13 by PCT		
PCT	**Value**	**Proportion**
Haringey	739	14.7%
Enfield	578	11.5%
Islington	545	10.8%
City & Hackney	524	10.4%
Camden	428	8.5%
Barnet	299	5.9%
Surrey	197	3.9%
Hertfordshire	193	3.8%
Berkshire	136	2.7%
West Sussex	128	2.5%
Westminster	103	2.0%
Other London PCTs	520	10.3%
Other Essex PCTs	108	2.1%
Other PCTs	545	10.8%
Total	**5,044**	**100.0%**

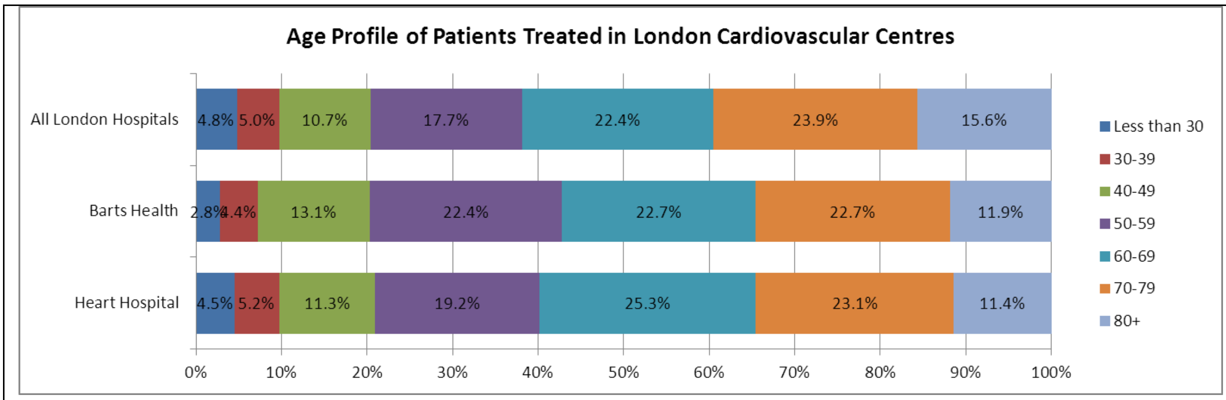
Age Profile

The tables below show the age profile of the patients using the Heart Hospital in 2012-13. This shows that the patients using the Hospital tend to be middle-aged or elderly, which reflects the profile of cardiac heart disease.



This profile has been contrasted to the age profile of patients using cardiovascular services across all the units in London and at Barts Heath. This analysis indicates that the Heart Hospital has a younger mix of patients than London as a whole but that it is broadly the same as patients treated at the two units in Barts Health. A number of factors are contributing to this:

- The Heart Hospital focuses on interventional cardiac services where the patients tend to be younger and fitter. Patients requiring non-interventional cardiology are treated at UCLH rather than the Heart Hospital.
- The congenital heart service at the Heart Hospital has a younger case mix than conventional cardiovascular service.
- Demographic factors effecting the boroughs served by the Heart Hospital


Age Profile of Patients Treated in London Cardiovascular Centres

Ethnicity

The table and graphs below show the ethnic mix of patients using the Heart Hospital[1]. The information is contrasted with the ethnic mix of patients at Barts Health (St Bartholomew's Hospital and the London Chest Hospital) and all cardiovascular centres across London. Each of these show a different profile that to a large extent reflects the ethnic mix of the local population served. In particular it is worth noting that the 63.5% of the patients at the Heart Hospital are classified as "White British" compared to 52.8% for London providers as a whole. It is also worth noting that the number of patients seen in some of the ethnicity categories is small so it is difficult to reach definitive conclusions about these groups.

	The Heart Hospital	All London Units	Barts Health	The Heart Hospital	All London Units	Barts Health
British	2,642	32,399	4,164	63.5%	52.8%	53.5%
Irish	122	1,630	100	2.9%	2.7%	1.3%
Any other White background	478	7,835	509	11.5%	12.8%	6.5%
African	101	1,750	175	2.4%	2.9%	2.3%
White and Black African	12	136	14	0.3%	0.2%	0.2%
Caribbean	127	2,569	232	3.1%	4.2%	3.0%
White and Black Caribbean	18	172	29	0.4%	0.3%	0.4%
Any other Black background	28	1,459	76	0.7%	2.4%	1.0%
Indian	164	3,452	587	4.0%	5.6%	7.5%
Pakistani	42	1,534	430	1.0%	2.5%	5.5%
Bangladeshi	97	2,089	740	2.3%	3.4%	9.5%
Chinese	19	272	34	0.5%	0.4%	0.4%
White and Asian	16	142	12	0.4%	0.2%	0.2%
Any other Asian background	114	2,701	383	2.7%	4.4%	4.9%
Other Mixed, Mixed Unspecified	31	252	20	0.7%	0.4%	0.3%
Any other ethnic group	150	2,995	278	3.6%	4.9%	3.6%
Sub-Total	**4,162**	**61,386**	**7,782**	**100.0%**	**100.0%**	**100.0%**

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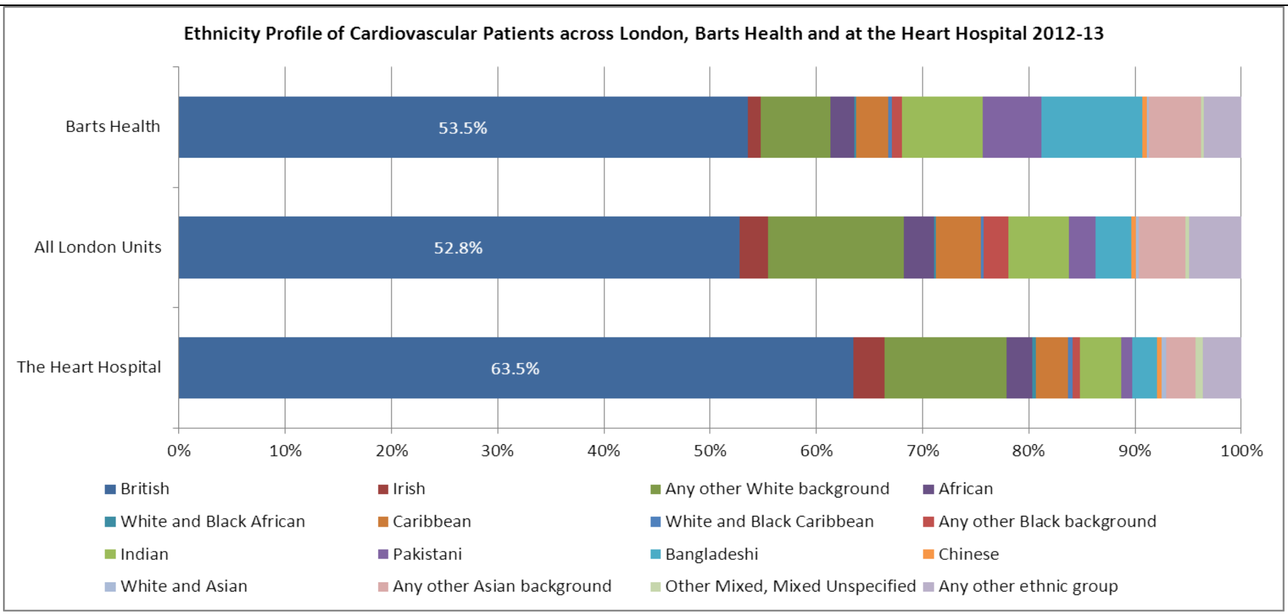
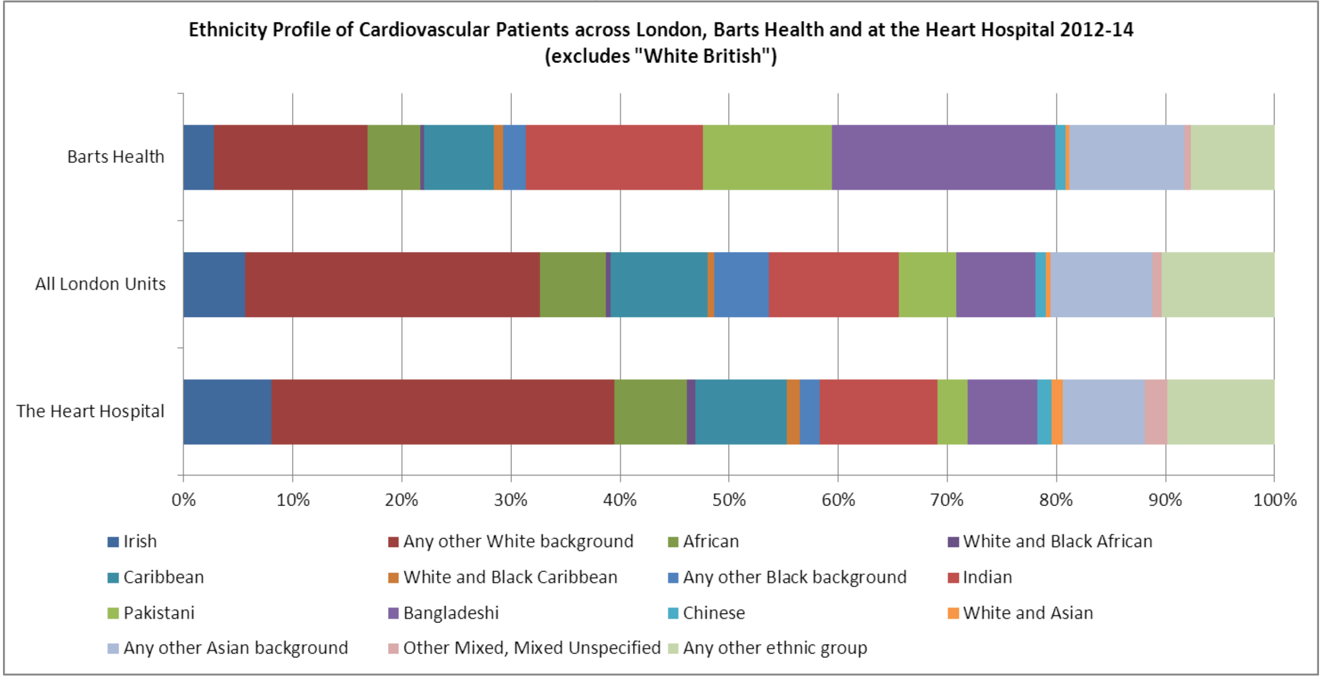
[1] The source of this is the data collected by trusts and where a patient's details have not been collected this has been excluded.


Ethnicity Profile of Cardiovascular Patients across London, Barts Health and at the Heart Hospital 2012-13

The table below shows the same information but without the “White British” Category. This allows the mix of other ethnicities to be seen more clearly.


Ethnicity Profile of Cardiovascular Patients across London, Barts Health and at the Heart Hospital 2012-14 (excludes "White British")

This shows that Barts Health already treats a wide ethnic mix of patients. The one group that features at the Heart Hospital that is less represented at the two Barts Health sites is the “Other White” category. Barts Health should investigate whether there are any special arrangements that should be put in place to accommodate this group.

Travel implications

The Heart Hospital and St Bartholomew’s Hospital are around 2.5 miles apart. Both are located close to underground stations and both are within two underground stops from the main rail termini for north London (Kings Cross, St Pancras & Euston). The travel times analysis that for the large majority of patient that currently use the Heart Hospital journey times would be unaffected by the move to the Barts site.

A similar conclusion was reached regarding emergency ambulance journeys in discussion with the

London Ambulance Service.

Conclusions

Key points:

- The proposals will result in care for a significant number of patients (c 5,000 per annum) shifting from the Heart Hospital to St Bartholomew's Hospital.
- The patients affected predominantly come from north central London and Hackney, although 40% of patients are spread across the rest of London and the South East.
- There is no evidence of any group being disproportionately affected by the proposals.
- The improved outcomes forecast for these changes will contribute to closing health inequalities for deprived populations that have higher mortality rates for CHD.
- The location of the two sites is such that there are unlikely to be any access implications from the change of site. This will be tested further in the transport impact report.
- The ethnic mix of patients currently seen in the Heart Hospital is different from that seen at the two Barts Health sites; with the Heart Hospital having a smaller proportion of patients from black and minority ethnic (BME) groups

5.4 Specialised cancer services in general

Proposed changes

The changes proposed are concerned with:

- The treatment of rarer cancers (with the exception of prostate cancer)
- Specialised treatments or operations that are not appropriate or necessary for the majority of patients that are diagnosed with the specific type of cancer
- One element of a patient's treatment pathway. Much of the patient's care (outpatients, chemotherapy, radiotherapy) will take place in a more local unit

As a consequence the number of patients affected by these changes is small when considered next to the total number of patients being treated for each type of cancer.
The sections that follow describe in more detail the impact of the proposed changes to each specialised cancer pathway.

In each pathway, the proposal is to reduce the number of sites that provide specialised cancer services and consolidate these into one or two centres. These consolidations will allow specialist centres to develop where the best clinical outcomes can be achieved. The map shows that specialised cancer services are currently provided at a number of sites across north and east London and west Essex.

Hospitals in north and east London and west Essex providing specialised cancer services

Barnet and Chase Farm Hospitals NHS Trust

- 1 Chase Farm Hospital
- 2 Barnet Hospital

North Middlesex University Hospital NHS Trust

- 3 North Middlesex University Hospital

Barts Health NHS Trust (Barts Health)

- 4 Mile End Hospital
- 5 Newham University Hospital
- 6 The London Chest Hospital
- 7 The Royal London Hospital
- 8 St Bartholomew's Hospital
- 9 Whipps Cross University Hospital

Princess Alexandra Hospital NHS Trust

- 10 Princess Alexandra Hospital

University College London Hospitals NHS Foundation Trust (UCLH)

- 11 University College Hospital
- 12 The National Hospital for Neurology and Neurosurgery (NHNN)

Royal Free London NHS Foundation Trust

- 13 Royal Free Hospital

Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)

- 14 Queen's Hospital
- 15 King George Hospital

Homerton University Hospital NHS Foundation Trust

- 16 Homerton University Hospital

Age profile

The graph below shows the patient numbers receiving these specialised treatments in age bands.

6.1 Eliminate discrimination, harassment and victimisation Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation).

The primary aim of the changes is to improve health outcomes for patients which would have a positive impact on all patients. The changes should also help to reduce early deaths caused by heart disease and cancer that will positively impact the inequalities in mortality rates between London and the rest of England.

6.2 Advance equality of opportunity Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation).

The primary aim of the changes is to improve health outcomes for patients which would have a positive impact on all patients. The changes should also help to reduce early deaths caused by heart disease and cancer that will positively impact the inequalities in mortality rates between London and the rest of England.

6.3 Promote good relations between groups Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation).

The primary aim of the changes is to improve health outcomes for patients which would have a positive impact on all patients. The changes should also help to reduce early deaths caused by heart disease and cancer that will positively impact the inequalities in mortality rates between London and the rest of England.

7. Evidence based decision-making

Please give an outline of what you are going to do based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to eliminate discrimination issues, partnership working with stakeholders and data gaps that need to be addressed through further consultation or research.

7.1 Conclusions and recommendations

Cardiovascular services

Key findings:

- The proposals will result in care for a significant number of patients (c 5,000 per annum) shifting from the Heart Hospital to St Bartholomew’s Hospital.
- The patients affected predominantly come from north central London and Hackney, although 40% of patients are spread across the rest of London and the South East.

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[2] Data used is the number of new *patients* treated in a year. Elsewhere *spells* have been used as the units of data, however treatment for blood cancers can often involve several spells in hospital for each patient.

[3] Data used is the number of new *patients* treated in a year. Elsewhere *spells* have been used as the units of data, however treatment for blood cancers can often involve several spells in hospital for each patient.

[4] Numbers shown are for the last calendar year rather than the average of three years that has been used for the other tables. Numbers of patients treated changed significantly in 2011-12 when the new unit in Colchester opened. Prior to that patients from Essex formed a large proportion of the patients treated at the Royal London.

- There is no evidence of any group being disproportionately affected by the proposals.
- The improved outcomes forecast for these changes will contribute to closing health inequalities for deprived populations that have higher mortality rates for CHD.
- The location of the two sites is such that there are unlikely to be any access implications from the change of site.
- The ethnic mix of patients currently seen in the Heart Hospital is different from that seen at the two Barts Health sites; with the Heart Hospital having a smaller proportion of patients from black and minority ethnic (BME) groups.

7.2 Specialised cancer services

Key findings:

- The changes will result in fewer providers of services.
- The numbers of patients affected are relatively small.
- The patients affected by these proposed changes are spread across London and Essex. For those services that involve moving the provider from an outer London provider (Queen’s Hospital, Chase Farm Hospital) to an inner-London provider (UCLH, Royal Free) there will be a travel impact on patients. However the numbers of patients affected are small.
- Most of the patients affected are in the age band 50 to 80 years of age.
- For most of the patients pathways the group of patients affected have a greater proportion from BME groups although this reflects the different populations served.
- There is no evidence of any group being disproportionately affected by the proposals.

7.3 Recommendations

Every effort was made to get views on the proposals from groups identified as likely to be the most impacted by the proposals. The engagement process was used as an opportunity to obtain views from groups where the analysis in this report has been limited by a shortage of information (impact on people with disabilities, religion, sexual orientation and gender reassignment). If the proposals are approved, providers will need to ensure that the needs of diverse populations are met under their public sector duties.

7.4 How will you share the findings of the Equality analysis? This can include corporate governance, other directorates, partner organisations and the public.

The stage two equality impact assessment was produced in February 2014 to inform the engagement plan for phase 2 and to help identify groups with protected characteristics who had not previously engaged with the programme. Every effort was then made to reach out to these groups in the second phase of engagement. This equality analysis has been produced since the completion of the second phase of engagement to support NHS England in its decision-making process; to understand the potential impact on the population of the proposals, and to decide whether to proceed to the next phase of the programme.

For your records

Name of person(s) who carried out this analysis:

Geoff Sanford, NEL CSU (original analysis) and Sarah Mcilwaine, NEL CSU (revised document) on behalf of NHS England

Name of Sponsor Director:

Will Huxter, Director of Specialised Commissioning, NHS England

Date analysis was completed:

Initial EqIA produced for programme in Feb 2014. Document updated in September 2014 to support NHS England decision-making process.

Review date: tbc