Imogen Blood &
Associates

Proposed National Rehabilitation Centre in East Midlands:

Equality Impact Assessment

June 2019

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Introduction

Our approach

This short report presents the findings and recommendations of a high-level Equality Impact Assessment of the Pre-Consultation Business Case for the National Rehabilitation Centre at Stanford Hall, near Loughborough.

The assessment was conducted during June 2019 by the independent consultancy Imogen Blood & Associates (IBA).

Imogen Blood and Sarah Chalmers-Page of IBA, who have extensive expertise of Equality, Diversity and Inclusion and the NHS – reviewed the following documents:

- Pre-consultation Business Case (PCBC) for the National Rehabilitation Centre (NRC)
- Stage 2 Clinical Assurance Evidence Pack

Telephone meetings were held between senior leaders in the team working on the NRC and Imogen Blood. These allowed clarification of points in the document and the scope of the Equality Impact Assessment (EIA).

At the current time, workforce is outwith the scope of this document.

Purpose and status of Equality Impact Assessment (EIA)

Under the Public Sector Equality Duty (PSED) (S.149 of the Equality Act 2010), a public authority such as a Clinical Commissioning Group, must, in the exercise of its functions, have due regard to the need to:

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

The following characteristics are protected under the Act:

- age;
- disability;
- gender reassignment;
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.

In addition, the NHS Equality Delivery System applies to CCGs and NHS England commissioning decisions. It is a set of outcomes covering patient care, access, and experience which adds to the protected characteristics a number of 'Inclusion Health groups', including (NHS 2013):

- People who are homeless
- People who live in poverty
- People who are long-term unemployed
- People in stigmatised occupations (such as women and men involved in prostitution)
- People who misuse drugs
- People with limited family or social networks
- People who are geographically isolated

What is an EIA and why conduct one?

An Equality Impact Assessment ("EIA") is an analysis of a proposed organisational policy, or (in this case) a change to the way in which services are delivered, which assesses whether plans are likely to have a disparate impact on persons with protected characteristics.(House of Commons Library 2018, p.23).

Although not explicitly required by law, EIAs are one way in which a public authority can demonstrate its compliance with the PSED:

- They can help an authority to evidence that it has considered potential equality impacts systematically and can help it to identify the actions it can take to promote equality of opportunity.
- EIAs allow authorities to pre-empt and mitigate potential 'indirect discrimination', in which a practice, policy or rule which applies to everyone in the same way but has a worse effect on some people than others.

The proposed change

The National Rehabilitation Centre (NRC) aims:

> 'To create the first National Rehabilitation Centre in England, bringing together experts in the field to deliver best practice, train our future workforce and research in the field to maximise the advances in technology and engineering to benefit this patient group'. (PCBC, v2)

The core aims of the service are:

- To reduce delays in accessing care and increase capacity to treat patients. The proposed centre will treat around 800 patients a year.
- To improve outcomes by increasing the intensity of rehabilitation, with improved return to work or other social outcomes.
- To improve facilities, equipment and knowledge through co location with the defence facility.

Patients will be referred to the service based on clinical need, avoiding the current geographical variations in care. Access will widen from neurological patients to include major trauma, complex MSK, traumatic amputees, incomplete spinal cord injury and severely deconditioned patients. These additional patient groups are currently cared for in acute beds but do not benefit from treatment in specialist rehabilitation facilities. Rehabilitation aims to enable people to return as far as possible to their day to day lives and roles.

The centre will share facilities and learning with the UK defence medical services, whose Rehabilitation Centre is co-located at Stanford Hall Rehabilitation estate in state of the art, bespoke new facilities, some of which the NHS patients will be able to share. This includes the hydrotherapy pool, diagnostics equipment such as X ray and MRI, highly sophisticated gait lab and a virtual reality Computer Aided Rehabilitation Environment (CAREN). Such facilities are currently not available on the NHS; currently, defence returns 85% of trauma patients to duty, compared to 35% of people returning to work in the civilian population. Although the populations may not be directly comparable, the UK also lags behind the USA and Europe on return to work (NSCARI report cited in PCBC). This report also acknowledged that rehabilitation provision for patients is not adequate in England.

The proposed NHS facility at the NRC would contain 63 beds, comprising 40 neurological rehabilitation beds, 19 complex MSK beds and four traumatic amputee rehabilitation beds. It would treat 796 patients per year. Part of the proposal is that 25 beds at Linden Lodge (where the estate is no longer at the required standard and there is no space to expand) are moved to the NRC. 18 beds for MSK rehab may also be relocated to the NRC. It is expected that the proposal will be cost neutral due to the relocation of rehab beds, improved lengths of stay for rehab and better outcomes for patients which in turn, will reduce demand on services over the longer term.

The population of the East Midlands

Life expectancy and healthy life expectancy in the East Midlands are lower than the average for England (Public Health England 2017). In terms of deprivation, levels are lower than the English average (PCBC v2) but there is a significant urban-rural divide (with deprivation higher in the urban areas), which means that this should be included in the equality analysis where possible. In Rutland, males and females live 10.7 and 14.6 years respectively in ill health, whereas in Nottingham City they live 20.1 and 24.2 years in ill health (Public Health England 2017). There are also pockets of significantly poorer health outcomes in the former coalfields in Leicestershire and along the Lincolnshire coast.

The Global Burden of Disease data quoted in Public Health England (2017) indicate the most common risk factors for years lived in disability in the East Midlands are obesity, alcohol and drug use, poor diet, occupational risks and smoking.

Overview of key themes highlighted in the EIA

NB: In the remainder of the report, we have highlighted mitigations, questions and recommendations in italics.

Opportunities to advance equality of opportunity through the NRC

Narrowing inequalities through reducing disability and improving clinical outcomes

The NRC will improve outcomes for patients, which should benefit all groups accessing the centre. The concentrated patient cohort will also allow for research, which will benefit patients across the UK and beyond. The NCASRI final report on the provision of specialist rehabilitation following major trauma found that only 40% of patients in major trauma centres identified as needing specialist rehabilitation received it, but of those who did receive it, 94% showed signs of functional improvement. This indicates that there is a need for the NRC and that it will reduce impairments.

The NRC will aim to return people to their usual activities (such as work or caring), rather than facilitate a safe discharge as soon as it is medically possible. This will draw from the defence model of intensive rehabilitation to facilitate a return to duties. This will reduce long term disability and dependence, and in turn reduce the risk of family members becoming carers.

There is evidence that patients benefit from taking part in research, and that services can be improved by patients being involved in service improvement and development (e.g. NIHR Involve 2019; NICE 2019).

The public involvement on these proposals should include people from a range of backgrounds, and proactively reach out to people who are within the EDS2 Inclusion Groups or who have a protected characteristic, to ensure that their perspectives are included in the development of the services.

Reducing geographical inequalities in care and outcomes

The PCBC indicates that there are currently wide variations in waiting time and service based on the area of the East Midlands that a patient is treated in. These are not clinically justified. The NRC will reduce this unfair variation, and therefore reduce inequality based on location.

Practice learning, research and development

The NRC views the ability to increase the profile of rehabilitation as a medical specialty as a critical success factor. The centre will offer posts, training posts and rotations to doctors, nurses and AHPs. The training posts will not only encourage people to work at the NRC, but will also allow people who choose to work elsewhere after training to take specialist knowledge and understanding out into the wider NHS. This will further raise standards for patients and reduce variation in practice.

Shared learning with defence medical services could improve outcomes for all patient groups, through understanding the more intensive model of rehabilitation and what proportion of the difference between the defence return to duties of 85% and the NHS patients return to work of 35% can be reduced, and what is an artefact of a different population. It is this co-location with and access to some of the specialist defence rehabilitation facilities that should help narrow these inequalities and improve outcomes for civilians.

A concentrated cohort of patients will facilitate research into trauma and rehabilitation, which could benefit patients with all protected characteristics and across the whole UK. For example, there is evidence that men are taken as the norm in research and this can lead to women being misunderstood or under treated (Samulowitz 2018; Wiklund 2016); studies done in the NRC could have large enough sample sizes for women to be treated as a category for analysis and any differences to be explored.

Opportunity to design a new-build, purpose-built facility

The fact that the NRC will occupy a purpose-built facility creates a number of opportunities to promote equality of access and experience for different protected characteristic groups, *assuming these are fully considered at the design stage*. The centre should be designed to the highest access standards (including staff and research spaces as well as public-facing spaces), and should also consider acoustics, dementia-friendliness, lighting and psychologically informed approaches in layout, signage, interior design, etc. Making sure that free and/or disabled parking, multi-faith prayer spaces, single rooms, visiting family/ breast-feeding spaces, etc are designed in from the outset should promote equality for a range of protected characteristics amongst the patients, visitors and workforce.

Access to the parkland and other facilities on the site will allow patients from across the East Midlands to experience the benefits of green space, which has been shown to improve recovery outcomes (Houses of Parliament 2016). This will particularly benefit patients from urban areas, and those who do not have access to transport to the countryside.

Possible risks for equality of opportunity through the NRC

NB: Mitigations and considerations moving forwards are included in italics.

Understanding of Vocational or Occupational Benefit

One of the criteria for referral to the service is based on vocational and occupational benefit. It is essential that referring hospitals are clear that this does not just refer to paid employment, but also to wider life, including social roles and leisure pursuits. If referring hospitals mistakenly or unconsciously take a narrower definition, this could potentially discriminate against people who are undertaking unpaid work (carers, people raising children, retired adults who are volunteering and living independently in the community and who are in good physical health), or people who are not currently employed (homeless people, unemployed people, people in the “gig economy” whose work is irregular and hard to document), and others perceived, albeit unconsciously, to have lower social status.

Referring hospitals should be offered advice in how to avoid making broad assumptions about who will benefit, all staff should be trained in equalities and unconscious biases, and supervision and mentorship should include reflection about how referral decisions are made and what unconscious biases could be affecting decisions.

Risk of increased travel

Although patients will not be making repeated journeys to the new centre, because they will be inpatients, their families may be affected by changes to travel. In some cases they will benefit from the centre being closer. In others, such as patients who live close to the existing Linden Lodge at Nottingham City Hospital, they may be travelling further. Nottingham City Hospital is served by public transport. The NRC will have ample free car parking and is served by a bus route which runs between Nottingham and Loughborough every 20 minutes. We understand that there are plans to explore an additional bus route with the Highways Authority.
The NHS should continue to negotiate with public transport providers and the Highways Authority, in response to the forthcoming findings of the travel analysis to maximise ease of access for those visitors dependent on public transport.

However, the Linden Lodge cannot be refurbished to provide the clinical benefits of the NRC, and so staying in the current location without substantial capital investment is not an option. The NRC will be providing some facilities for families to stay on site, and arrangements with public transport providers should enable people who do not have a car to visit their family or friends who are patients.

Equality Considerations for Protected Characteristics and Health Inclusion Groups

Gender

Seventy percent of major trauma patients are men. This is based on case mix and will not need to be mitigated.

Historically, women may not have had their needs understood or met in areas such as pain management (Samulowitz 2018; Wiklund 2016) and as such may have been under treated.
The National Centre could use its expertise and large patient cohort to develop protocols that would prevent this, work with referring units to ensure that unconscious biases are addressed and potentially commission research into whether women experience rehabilitation in a different way from men.

Women are more likely than men to be working part time, or to be working as unpaid carers or providing unpaid childcare.
As vocational and occupational benefit is part of the referral criteria, it must be made very clear to referring hospitals that caring responsibilities are a vocation and an occupation.
This, combined with the male majority case mix for the centre, means that women are more likely to be visiting the centre and may be at more risk of becoming carers, depending on the outcomes of rehabilitation. These issues are picked up in more detail under the section on carers below.

Sexual Orientation, Gender Re-assignment and Gender Identity

Sexual Orientation and Gender re-assignment are protected characteristics and non-binary people are protected from discrimination regardless of whether they have had, are undergoing, or plan to make a medical and legal transition, or not.

Long hospital stays can be a stressful time for people who identify as trans or non-binary, and for gay, lesbian and bisexual patients. It is positive that all patients at the new facility will be in single rooms, as this should reduce the risk of harassment by other patients, or the risk of people being placed in a ward that does not fit with your gender identity, and should afford privacy to trans people and to patients with visiting same sex partners. This will be an improvement over staying in a traditional bay in a local hospital.

Age

It is positive that age is not an explicit criterion for referral to the centre, and older adults should not be discriminated against if they could benefit from rehabilitation. However, there is a risk of referring hospitals making assumptions about older people's likely benefit based on stereotypical views of older people as already weaker, less able to stick with an intensive programme or lacking in vocation or occupation.
The Centre should work with referring hospitals to make sure they understand that some older adults may benefit from rehabilitation and be motivated enough and physically fit enough to benefit, on a case by case basis.

Analysis of UK TARN data (Herron et al 2017) has identified the different types of needs which older people – as group – may have for rehabilitation compared to younger people. The findings of this study suggest that older patients with traumatic injuries will often benefit from being managed in an environment that is also capable of dealing with their complex needs. However, they will benefit from early assessment of their needs by senior decision-makers and specialist older people's physicians. The NRC proposal, which should widen choices and ensure that pathways are determined by clinical need stands to benefit this group, provided that the NRC does not have the (unintended) impact of reducing quality in existing acute hospital settings (early thinking is that it should improve quality by reducing patient numbers); and that there is effective, early clinical decision-making, free from unconscious bias about age. We understand that the major trauma centre will have regular input from ortho-geriatricians, and that speciality reviews can be requested as required.

Younger adults are more likely to be in RTAs as pedestrians or cyclists, and this affects injury severity and type (Department for Transport 2018). The co-location with the Defence Medical Rehabilitation Centre (DMRC) may improve services for younger adults (aged under 25), through greater familiarity with the effects of life changing injuries in younger people, and more experience with a model that aims to return younger people to demanding work.

Race/ Ethnicity and migrants

People from Black, Asian and Minority Ethnic (BAME) backgrounds are more likely to derive their household income from work (Cabinet Office 2017), more likely to be in poor quality and overcrowded housing that would be difficult to adapt to the needs of a disabled resident (Cabinet Office 2017), and more likely to experience a severe occupational injury

(Mekkodathil 2016) than people from white ethnic backgrounds. If the degree and impact of impairments and the need for adaptations can be reduced, there may particularly positive impacts for these groups.

One in five people from Pakistani and Bangladeshi backgrounds do not speak English well or at all (Cabinet Office 2017), and this is more likely for women and older adults. This could make it harder to discuss referral and the likelihood of benefitting from rehabilitation with patients in this group, and they may struggle to advocate for themselves if their English is not fluent. *Referring hospitals should ensure that they use appropriate translation services when discussing the option of a referral to the NRC.*

It should also be noted that worldwide, migrants are more vulnerable to occupational injury than other groups (Mekkodathil 2016) and that migrants may be particularly benefited from having a service that aims to return them to work, since they may have reduced eligibility to UK disability benefits.

Religion and Belief

People who have experienced a life-changing injury and who are receiving intensive rehabilitation may need spiritual support, as well as mental health support, especially if they already have a faith that is important to them.
The diverse spiritual needs of patients should be taken into account, and links should be built with local faith communities to help provide appropriate spiritual support those patients that would benefit from this.

Physical disability and sensory impairment

The centre will reduce impairments and their impact through improving clinical outcomes for people with rehabilitation needs, and by reducing variation in treatment. Extending rehabilitation from neurological patients to people who have had traumatic amputations, major trauma or complex orthopaedic surgery will reduce variation in outcomes and provide more people with the chance to avoid long-term disability.

Care must be taken that people with pre-existing disabilities or sensory impairments, who have been living previously independent lives and who could still benefit from intensive rehabilitation, are not excluded from rehabilitation based on inaccurate assumptions about how much they could benefit from it.
Referring hospitals should be offered advice on how to assess whether people with pre-existing disabilities or sensory impairment would benefit from intensive rehabilitation, and avoid unconscious bias about their likely quality of life gains and independence.

Learning Disability

People with learning disabilities may be less likely to be in traditional paid employment and health professionals may make assumptions about their likely benefit and quality of life. This group may also experience barriers in relation to communication and self-advocacy, both when the decision about whether to refer to NRC is being made and within the

unfamiliar environment of the unit. The Centre will have family rooms available, which should enable family members to come and provide support.
As mentioned under other headings, *referring hospitals must be clear that paid employment is not the only occupational or vocational outcome, and that people with learning disabilities must be assessed on a case by case basis to see if they could benefit.*

Mental Health

The provision of mental health support as part of the model of care will help support patients to adapt to life changing injuries and decrease the risk of long term psychological harm preventing people returning to work.

Pregnancy, Maternity and Parenthood

Pregnancy is a protected characteristic. Parenthood is not, but is another potential source of inequality. This service provides some rooms for family to stay on site. This may be particularly beneficial to parents, who would otherwise not see their families as often during their stay, and may help to maintain family bonds. This in turn may reduce familial anxiety, and benefit the children of people who require rehabilitation.

Carers

This service will benefit carers through reducing the long-term dependency of patients.

The main risk for carers, relates to additional travel time to come and visit loved ones. This is likely to impact particularly on those living in poverty, those who do not have access to a car and/or those living in rural areas. A travel analysis is being conducted, and it will be important to use the findings of this to plan mitigations, e.g. seeking to influence public transport providers.

The provision of rooms on site should reduce anxiety for family members who would otherwise not have been able to see patients during their rehabilitation (e.g. adults who live in the East Midlands and whose families live elsewhere; this may be particularly beneficial to younger adults such as students). The provision of free and plentiful accessible parking will benefit carers, especially those who are on low incomes and/or have health problems or impairments themselves.

Socio-economic deprivation

People who live in areas of socioeconomic deprivation are more likely to have road traffic accidents , more likely to be in occupations that have high incidences of occupational injury (World Health Organisation Europe 2009) and more likely to be the victims of violence (World Health Organisation Europe 2009) and therefore may benefit highly from this service. They are also more likely to be casually employed, and therefore not to have sickness pay, critical injury insurance etc. This makes return to work rather than discharge home with ongoing needs a positive outcome for this group.

More socioeconomically deprived families may be disproportionately disadvantaged if transport costs are higher to visit the NRC than to remain in local pathways, and this may

influence them to seek care closer to home even if the outcomes may not be as good. As mentioned above, this can be mitigated with provision of free car parking, negotiating bus routes that include the NRC, and with facilities for families to stay on site where this is needed.

People using alcohol and other drugs harmfully and/or experiencing homelessness

Members of these 'Health Inclusion' groups experience a heightened risk of traumatic injury, due to being victims of crime, involved in RTAs or other accidents while under the influence and/or sleeping rough, and amputation, where they have been injecting.

These groups are at risk of unconscious bias during the assessment process, and there is a risk that NRC is not offered since assumptions are made that the individual will not be sufficiently motivated or does not have enough rehabilitation potential to warrant a referral. Whilst patients in this group may decide that they do not want to undergo an intensive rehabilitation programme, especially at a distance from their current networks, it is important that these options are presented and discussed fairly and honestly. For some, the opportunity to attend NRC may be a turning point.

Conclusions and recommended next steps

The centre has significant potential to improve clinical outcomes, reduce disability and address geographical inequalities in outcome for patients in the East Midlands. There is no evidence that the risks to equality outlined above cannot be successfully mitigated.

Recommendations

1) Develop explicit referral criteria that state that paid employment is not the only form of vocational and occupational benefit, and that unpaid care, family support, volunteering and social engagement must also be considered.

2) Support referring hospitals with training to address unconscious bias so that, on a case by case basis, older adults, people with existing disabilities (physical, sensory and learning) but a high level of motivation and ability to benefit and others who may be vulnerable to being discriminated against (e.g. people who are addicted to drugs) are considered for rehabilitation in a fair and consistent manner.

3) Provide ongoing advice and support for referring hospitals on a case by case basis, so that people who may benefit but have a pre existing disability, older adults and other vulnerable people can be discussed.

4) Proactively reach out to people with protected characteristics and people in EDS2 inclusion groups during the public consultation for the NRC and take action on their concerns.

5) Negotiate public transport access to the site with local public transport providers.

6) Use the patient cohort and research expertise at the NRC to identify and address equality issues, such as concerns raised that women are under treated due to unconscious biases around their pain response or need for rehabilitation, and other equality issues raised in the literature or during consultation.

7) Ensure that the NRC and referring hospitals seek appropriate translation services when necessary.

8) Take steps to address the spiritual needs of patients, where requested, by forming links with local faith communities.

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