

Report on Equality Analysis

Joint Strategy for the Provision of Urgent and Emergency Care for Patients using Services in Wolverhampton to 2016/17

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Summary

Midlands and Lancashire Commissioning Support Unit (CSU) is contracted to provide equality and diversity support to Wolverhampton Clinical Commissioning Group. As part of this support, the Equality and Diversity Team of the CSU was asked to undertake an equality analysis of the 'Joint Strategy for the Provision of Urgent and Emergency Care for Patients using Services in Wolverhampton to 2016/17'. The analysis is focused on the impacts for Wolverhampton residents.

This document presents the analysis along with reasons for the conclusions reached, and makes evidence based recommendations to inform equality approaches in the procurement, operation, and continuous improvement of urgent and emergency care services.

The Equality Analysis considers two distinct, but related areas:

1. The equality impact of the reconfiguration of services, and particularly the relocation of the Walk-in Centre facility from Showell Park to a new Primary Care Centre at New Cross Hospital.

Assessment 1

The relocation of the Walk-in-Centre from Showell Park to New Cross Hospital will benefit some residents and disadvantage others. Although it is not possible to quantify the balance between 'winners' and 'losers', the demographic information available suggests that the health inequality gap between different groups is unlikely to be widened by the proposals. Proxies for deprivation discussed in the report such as no car ownership or receipt of Disability Living Allowance suggest that a greater proportion of low income households with mobility disadvantages may benefit from the re-siting. Furthermore, if the proposed improvements in primary and secondary care are realised, all protected characteristic groups should benefit from more accessible and responsive services. Urgent care for other distinct groups such as homeless people and migrants also has potential to improve.

2. A consideration of how *operationally*, urgent and emergency care services can adopt an equality approach towards different protected characteristic groups.

Assessment 2

Commissioners can ensure that robust equality considerations, sensitive to the particular needs of each protected characteristic group, are built into procurement in pre-qualification questionnaires (PQQs), and service specifications. Contracts can require providers to conduct further equality analyses on their service operations. Contractual information requirements can also be established which consider equality in the provider workforce and in the delivery of services. All NHS Trusts and private sector providers commissioned by the CCG will be required to demonstrate compliance with the general duty under s149 Equality Act 2010 (the Public Sector Equality Duty).

Recommendations are offered in the analysis as part of a specific equality action plan for services as they are developed (**at section 7**).

1. Introduction

Urgent and Emergency Care – the case for change

- 1.1 The increase in demand for urgent and emergency care services, and the pressures this creates in the health economy of Wolverhampton have been clearly articulated in the strategy itself:

“It is understood that there is no single cause to the increased pressure nor is there a single solution. The existing system of providing urgent care in Wolverhampton is unsustainable and was not designed to cope with the significant and unpredicted increased levels of activity. Our patients are experiencing long waits and have told us that they are confused on how and where to access appropriate services. Doing nothing is not an option....The system has become complicated for patients and their expectations have led to immediate demands to be seen and treated for conditions that are not always urgent, with the default often being the ambulance service or the Emergency Department (ED).”

Joint Strategy (Wolverhampton CCG, 2013a; p6)

- 1.2 The intention is set out in the vision for the strategy:

“Our vision is for an improved, simplified and sustainable 24/7 urgent and emergency care system that supports the right care in the right place at the right time for all of our population. Our patients will receive high quality and seamless care from easily accessible, appropriate, integrated and responsive services. Self-care will be promoted at all access points across the local health economies and patients will be guided to the right place for their care and their views will be integral to the culture of continuous improvement.”

Joint Strategy (Wolverhampton CCG; 2013a;p7)

- 1.3 ‘Access points’ will include ‘easy to access’ 24 hours a day, seven days a week services, urgent GP appointments, Walk in Centres, Emergency Department, the Ambulance Service and emergency admissions to hospital. The crux of the reconfiguration is described as:

The new urgent & emergency care system will be improved and simplified for patients with access to general practice, community teams, a walk in centre at the Phoenix Centre, the ambulance service and a new Primary Care Centre and ED at New Cross Hospital. Patients will be encouraged to self-care or seek advice from pharmacy services or to be guided to the right place for their care through telephone access with NHS 111. The out of hours service and the Showell Park Walk in Centre (only the service, the building and GP practice will remain) will be relocated to become fundamental parts of the new Primary Care Centre which will offer care to primary care patients 24 hours a day, 7 days per week whether they walk in or are directed there by a healthcare professional.

Joint Strategy (Wolverhampton CCG, 2013a; p23-24)

- 1.4 The Consultation document '*Plans for Urgent and Emergency Care Services in Wolverhampton*' summarised the proposals for change for residents and invited respondents to indicate if they were supportive of them:

“At the heart of our plans is the move to bring together some of the city's urgent and emergency care services into one building, which is expected to open in early 2016. This will be a brand new purpose-built centre that will be open 24 hours per day and 365 days per year at New Cross Hospital”

Plans for Urgent and Emergency Care Services (Wolverhampton CCG; 2013b)

The timetable for change

- 1.5 The strategy for urgent and emergency care services outlines the 'what', 'where' and 'when', and explains that the 'how' will be detailed within the *implementation plans*. There are 4 distinct phases for implementation:

Phase 1 – December 2013 – December 2014

Consultation, and development of implementation plans. This phase will include a new Emergency Department with a co-located Primary Care Centre, and supporting ambulatory and diagnostic facilities. Subsequent developments are proposed and include a second and third floor housing Emergency Admissions Units for Children (PAU), Medical Patients (AMU), Surgical Patients (SAU) and a proposed Clinical decisions Unit (CDU). The new ED Business case is tightly linked to the emerging Urgent and Emergency Care Strategy and work has been undertaken to provide assurance to the CCG's that the new ED will improve quality.

Phase 2 – November 2013 – December 2016

Improve Primary Care

Phase 3 – November 2013 – December 2016

Improve Secondary Care

Phase 4 – December 2016 – December 2017

Review and amend

Responses to the proposals so far

- 1.6 The methodology for the consultation, and a summary of patient responses are included in a 'Feedback Report' (Wolverhampton CCG; 2013) The consultation was undertaken between 2 December 2013 and 2 March 2014. 94% of respondents to the survey expressed support for the plans for urgent care.
- 1.7 Key themes emerging from patients included issues around access to services: especially GP appointments; transport and parking at urgent care facilities; and reducing confusion about the system through education and communication. Healthwatch Wolverhampton has said it agrees with the principle of creating a simple system with fewer options, layers and improved information, and that this will be better for the people of Wolverhampton. It also stressed the importance of on-going involvement of patients and residents in the development of the service specification.

- 1.8 There was a demand for information on the impact of the proposed changes for the Eye Infirmary, including its connectivity to the new centre. There is an expectation that the services should be linked or co-located in order to make it easier for eye care patients to travel between the two. This should be supported with clear and accessible information.
- 1.9 Healthwatch Wolverhampton has expressed the view that more needs to be done to clarify care pathways for ophthalmology urgent care patients.
- 1.10 Healthwatch Wolverhampton has also expressed the view that the current pharmacy provision is not effective.

Equality and diversity research methodology

- 1.11 204 individuals responded to the consultation survey which was, given the reach of the consultation process, a low response level. Responses to specific equality questions included on the survey form (questions on disability, ethnicity etc) were not well completed, and there are lessons here for improving the confidence of questioners when asking for equality information, and too for the reassurances given to the public about why the information is being collected, and how it is to be used. The minority ethnic completion percentage for respondents was much lower than for the Wolverhampton population overall, suggesting that different venues, and specific outreach approaches need to be identified in the future. Both these points are included in the recommendations arising from this analysis and should help to influence implementation plans.
- 1.12 However there was significant coverage, and a very wide range of stakeholders included in the consultation process, and so it is reasonable to conclude that the vast majority of Wolverhampton residents had an opportunity to access the materials and to respond if desired.

Survey of organisations

- 1.13 A separate short survey was undertaken, targeted at voluntary and community organisations who work with protected characteristic groups as defined by the Equality Act 2010. This survey was kindly distributed by both the Wolverhampton Equality and Diversity Forum (EDF) to their membership list, and by the Wolverhampton Voluntary Sector Council using their organisational database. This survey was designed to be complementary to the consultation questionnaire, and to capture any currency of information, through the knowledge and understanding of representative groups, about how urgent and emergency care services are operating. The questions asked about:
 - Positive experiences of urgent care health services?
 - Any difficulties experienced?
 - Improvements which could be made?
 - Whether services understand (or don't understand) the particular needs of different groups?
 - Whether people feel listened to?
 - Whether privacy and dignity are respected by services?

- 1.14 The survey ran over a six week period from early January through to 21st February 2014. 23 organisational responses were received. The findings from this survey have been used to inform the local issues included in the analysis of protected characteristic groups from **section 4** . In general the responses have been positive and focussed on patient experiences of urgent care. Some concerns were expressed about the needs of people with mental health problems, and patients with learning disabilities. These echo some of the concerns highlighted about Accident and Emergency services by the CQC Quality Report following the recent inspection of New Cross Hospital (CQC, November 2013).
- 1.15. Issues were not raised in this survey concerning the rationale for the proposed changes to urgent and emergency care, nor for the proposed re-siting of urgent care facilities in Wolverhampton.
- 1.16 Wolverhampton CCG will work with provider organisations to ensure that as plans for re-modelled urgent and emergency care services develop and are implemented, that thorough consideration is given to the appropriate collection of equality monitoring information, and that equality analyses (impact assessments) help to inform the receptiveness and sensitivity of services to diverse needs.

2 The Context for Equality Analysis

Strategic Commitment

2.1 There are explicit commitments to equality and diversity in the strategy itself:

“The Urgent and Emergency Care Board is fully committed to promoting equality of opportunity, eliminating unlawful and unfair discrimination and valuing diversity, so that we can remove or minimise disadvantages between people who share a protected characteristic and those who do not. All Urgent and Emergency Care services will ensure that services are appropriate and do not discriminate on the basis of the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or beliefs, sex and sexual orientation...The rights and pledges contained in the NHS Constitution will be upheld at all stages of the patient journey through Urgent and Emergency Care (p9)

Joint Strategy (Wolverhampton CCG, Royal Wolverhampton NHS Trust; 2013; p9)

2.2 To ensure this, a regular Equality report has been considered by the Board (on a bi-monthly basis) submitted by the Midlands and Lancashire Commissioning Support Unit which has sought to identify improvements in the equality approaches adopted by the process – especially to consultation methods, and to data collection systems.

The Public Sector Equality Duty

2.3 Clinical Commissioning Groups (CCGs) are now listed as public authorities in Part 1 of Schedule 19 to the Equality Act 2010. This means that Wolverhampton CCG is subject to the general Public Sector Equality Duty required by s.149 of the Act. S.149 states that the CCG must **“have due regard to the need to:**

- i. Eliminate discrimination, harassment, victimisation, and any other conduct prohibited by the Act;
- ii. Advance equality of opportunity between persons who share a relevant protected characteristic* and persons who do not share it;
- iii. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.”

*Protected characteristic groups’ are described in paragraph 2.7 below.

2.4 Having **due regard** for advancing equality (2nd aim) 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

2.5 In the case of *R (Brown) v Secretary of State for Work & Pensions [2008] EWHC 3158 (Admin)*, the Court set out some principles for public bodies to guide them in

compliance with the duty to give due regard to relevant equality needs. These include that:

- When a public authority makes decisions that do or might affect a protected characteristic group, it must be made aware of its duty to have due regard to the aims in the Equality Duty. An incomplete or mistaken appreciation of the Duty will mean that 'due regard' has not been paid.
- The 'due regard' must be exercised with rigour and with an open mind. It is not a question of 'ticking boxes'. The Duty has to be integrated within the discharge of the public functions of the CCG. **It involves a conscious and deliberate approach to policy-making** and needs to be thorough enough to show that 'due regard' has been paid before any decision is made.
- If the CCG has not specifically mentioned the relevant general Equality Duty when carrying out a particular function, this does not mean that the Duty to have 'due regard' has not been performed. However, it is good practice for the policy itself, or the CCG, to make reference to the Duty and any code or other non-statutory guidance. This will reduce the chance of someone successfully arguing that 'due regard' has not been paid to equality considerations. This is also likely to enable a public authority to ensure that factors relevant to equality are taken into account when developing a policy.
- It is good practice for public organisations to keep an adequate record showing that they have actually considered the Equality Duty and pondered relevant questions. Appropriate record-keeping encourages transparency and will discipline those carrying out the relevant function to undertake their Equality Duties conscientiously.

The role of Midlands and Lancashire Commissioning Support Unit

2.6 Midlands and Lancashire Commissioning Support Unit (MAL CSU), as part of its support to Wolverhampton Clinical Commissioning Group, was asked to help facilitate an Equality Analysis on the Joint Strategy for Urgent and Emergency Care services. The aims in producing this report were to:

- i. Establish a baseline on current usage of urgent and emergency care services within Wolverhampton with regard to **protected characteristic groups**.
- ii. Assess the equality impact on the local population of potential changes as part of the plans in Wolverhampton.
- iii. To use the process of Equality Analysis, as guided by the route map (Appendix 1) to inform decision-making.
- iv. Identify opportunities to promote equality
- v. Recognise the potential risks to the strategy from not addressing inequalities.
- vi. To suggest ways to mitigate these risks

2.7 The '**protected characteristic groups**' are defined in Part 1 of the Equality Act 2010 and cover people who are specifically offered protection by the Act. Before the Equality Act, all NHS organisations already had to demonstrate that they were treating people of different races, people with a disability, and men and women fairly and equally. The 2010 Act has added groups of people to the equality duty. These are set out in Table 1 below:

Table 1: Definition of Protected Characteristics

Protected Characteristic	Definition
Age	This refers to a person having a particular age (for example, 52 years old) or being within an age group (eg 18-30 year olds; 'older people' or 'children and young people'. Specific discussions about age will usually be given context by the nature of the services under consideration.
Sex	Someone being a man or a woman
Disability	A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.
Race	Race refers to a group of people defined by their colour, nationality (including citizenship), ethnic, cultural or national origins. 'Ethnic group' is another descriptive term often used. This may refer to a long, shared history and common cultural traditions; a common geographical origin, language, literature, or religion may also be factors to consider.
Sexual Orientation	Whether a person's sexual attraction is towards their own sex (homosexuality), the opposite sex (heterosexuality), or to both sexes (bisexuality). The terms 'Lesbian', 'Gay', 'Bisexual' (LGB) are commonly used when describing the particular health experiences, prejudices, and challenges encountered by people whose sexuality differs from the majority heterosexual state.
Gender reassignment	People who are transitioning from one gender to another. A person who is Transgender is someone who expresses themselves in a different gender to the gender they were assigned at birth. Although the legislation covers gender reassignment, the term 'trans' better encompasses the wider community and has wide currency. Gender reassignment may also include people who are considering a sex change, but an intention to change sex is not a necessary requirement to be considered as trans.
Religion or belief	People with a religious or philosophical belief, (or people without a religion or belief e.g. Atheism). Generally a belief should affect your life choices or the way you live for it to be included in the definition. Political beliefs are not afforded protected characteristic status.
Pregnancy and maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in an employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.
Marriage and Civil Partnership	People who are in a civil partnership or are married. Marriage is currently defined as a 'union between a man and a woman'. Same-sex couples can have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same way as married couples on a wide range of legal matters

Scope of the Equality Analysis

- 2.8 The Equality Analysis considers two distinct but related areas:
- i. The equality impact of the reconfiguration of services, and particularly the relocation of the Walk-in Centre facility from Showell Park to a new Primary Care Centre at New Cross Hospital.
 - ii. A consideration of how operationally, urgent and emergency care services can adopt an equality approach towards different protected characteristic groups as users of services.
- 2.9 The focus of the analysis has been on the impact for residents of Wolverhampton, but not for visitors from neighbouring CCG areas seeking healthcare within Wolverhampton. Each CCG should consider the equality impact for its own population.
- 2.10 The impact on staff working for provider organisations has not been considered as part of this analysis. This work would need to form part of the equality analysis of specific implementation plans for each provider.

Method

- 2.11 Wolverhampton CCG at its inception in April 2013, adopted a process for Equality Analysis for many key areas of its work. This includes an equality analysis tool comprising a template and guidance. The CCG's Equality and Diversity Strategy and Action Plan (available at this [link](#)) sets out in detail how the CCG seeks to comply with its Public Sector Equality Duty.
- 2.12 For the Joint Strategy, in anticipation that a much wider group of stakeholders would be engaged in the process, an equality analysis 'route map' was produced by the CSU to illustrate how each stage could progress. A summary of this route map is attached at Appendix 1. The case for change set out in the Joint Strategy is focused on the issues which necessitate a reconfiguration of urgent care services and facilities. This equality analysis has therefore considered the potential impact of the case at an early stage and considers the information from the listening exercise carried out early in 2013, the formal public consultation held in early 2014, and a targeted survey of voluntary and community organisations which deal with protected characteristic groups (early 2014) [Discussed more fully in section 4]
- 2.13 A wide range of reports, statistical information, and transferable learning from equality analyses of urgent care services in other parts of the country were used as part of this analysis. A full list of these appears at the end of this document. In addition, equality information statistical returns from provider organisations were compiled, and additional service information was requested from those organisations directly involved in providing urgent and emergency care. These were used to try to understand the provision for protected characteristic groups as well as for non-statutorily protected groups who have significant healthcare needs (eg: homeless people; migrants; travelling communities). The conclusions and inferences made in this analysis have been made using these materials.

Assumptions

2.14 We have assumed:

- i. No planned diminution of service has been identified either by withdrawing services, or restricting eligibility for existing services. The drivers for change emphasise the intention to enhance services and improve efficiencies by reducing unnecessary duplication, and offering clinicians and patients alike greater clarity along the treatment pathway.
- ii. Provider organisations, in pursuance of meeting their own Public Sector Equality Duty under s149 Equality Act 2010 will conduct their own equality analyses to cover workforce and service impacts arising from implementation plans. These will form an important part of the implementation phase.
- iii. Further engagement opportunities for patients and their families, and other stakeholders will continue throughout the strategy period (to 2017) and be effected through the joint partners to the strategy. These opportunities will be receptive to the perspectives of different protected characteristic groups.

3. Equality Impact of the reconfiguration of services

Relocation of Showell Park

3.1 Evidence considered by the Joint Urgent and Emergency Care Strategy Board found that:

“Further to the analysis of Walk-in-Centre use by patients, based on their registered GP Practice, it is clear that the proximity of the Walk-in-Centre to a patient’s home or GP Practice has a significant impact on their use of walk-in-centre – ie the closer they are based to the walk-in-centre, the more significant their use”

(Wolverhampton City Council, 2012)

3.2 As well as high use from people living close to the walk-in-centre, the evidence also showed that the walk-in-centre was in higher demand when GP Practices are shut (evenings and weekends), and that for Showell Park walk-in-centre in particular, activity is localised around the physical location of the services. However there is also a significant duplication of Accident and Emergency use where patients visit Showell Park and then go on to visit A&E. This pattern of activity is shown in Figures 1 and 2 below

Figure 1: Showell Park activity in 2011/12 (Wolverhampton City Council, Public Health Intelligence Team 2013) – figures in brackets refer to the number of geographical ‘lower super output areas’ (LSOAs) that demonstrate each level of activity.

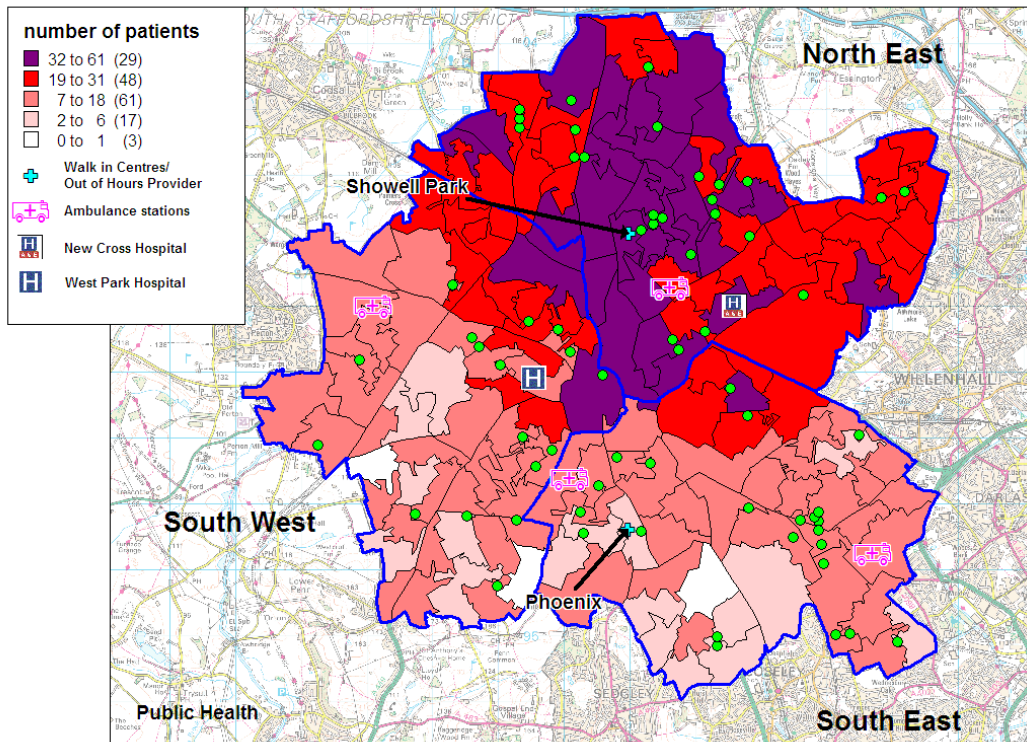
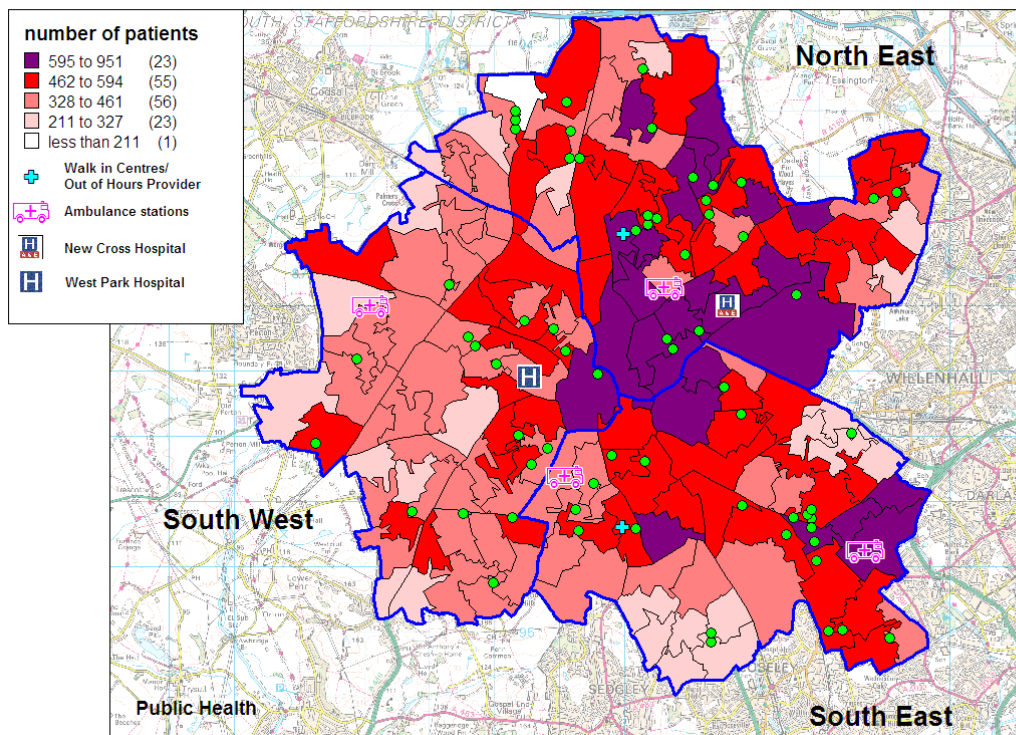


Figure 2: A&E attendances in 2011/2012 (Wolverhampton City Council Public Health Intelligence Team 2013)

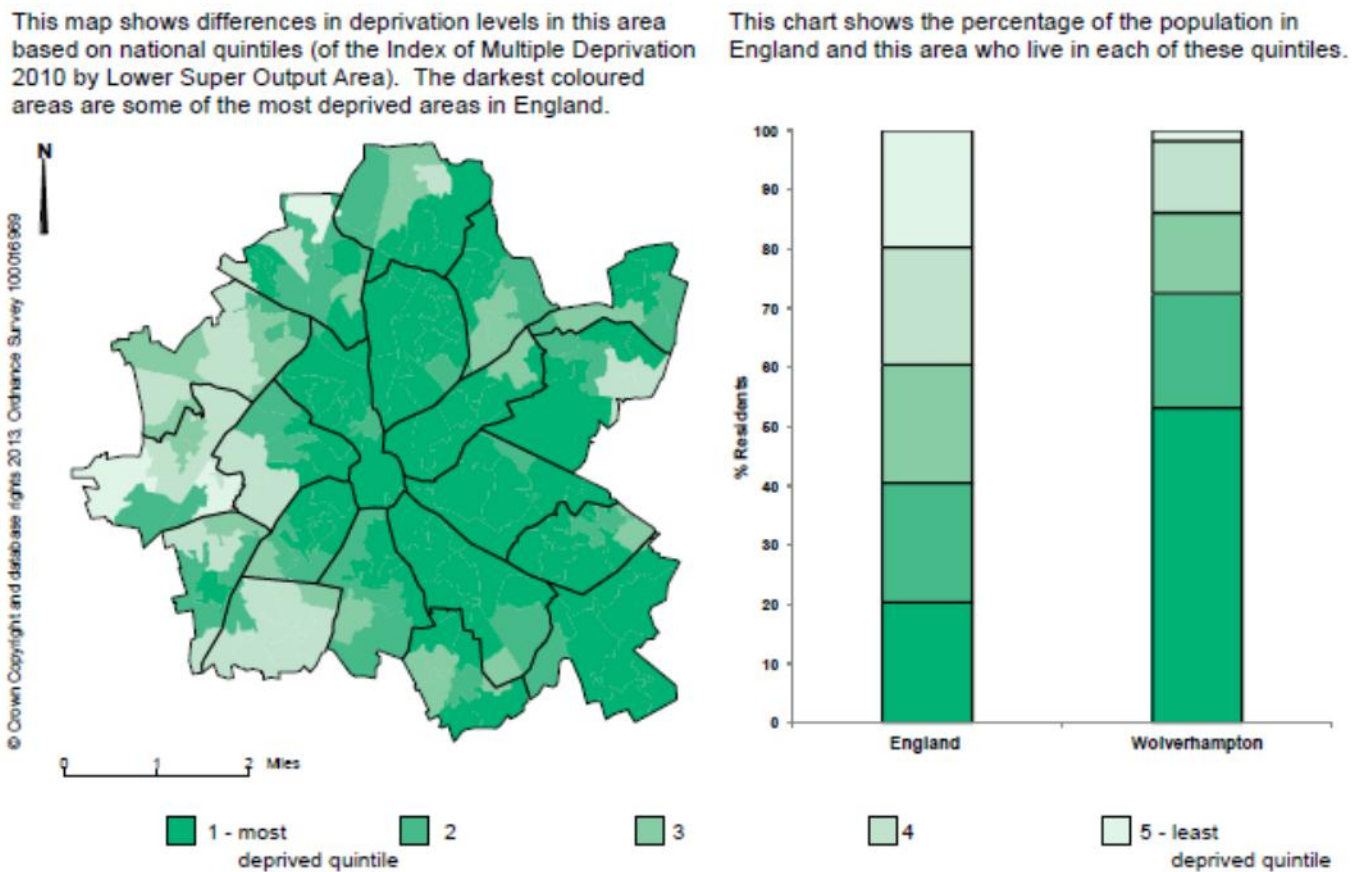


3.3 This suggests that the relocation of Showell Park walk-in-centre to a facility at New Cross (also shown on the map) will have a disadvantageous impact on residents living in the vicinity, and to the immediate North and West of Showell Park. Residents living to the South and East of Showell Park will be closer to the new facility. The question then arises, what is the magnitude of this impact? A definitive answer can not be given, but we can look for some clues in the demographic information we have available.

Demographic Information

3.4 The use of urgent and emergency healthcare services is inextricably linked to socio-economic factors and particularly to deprivation. Wolverhampton has high numbers of people living in deprived areas when compared to the figures for England – Figure 3.

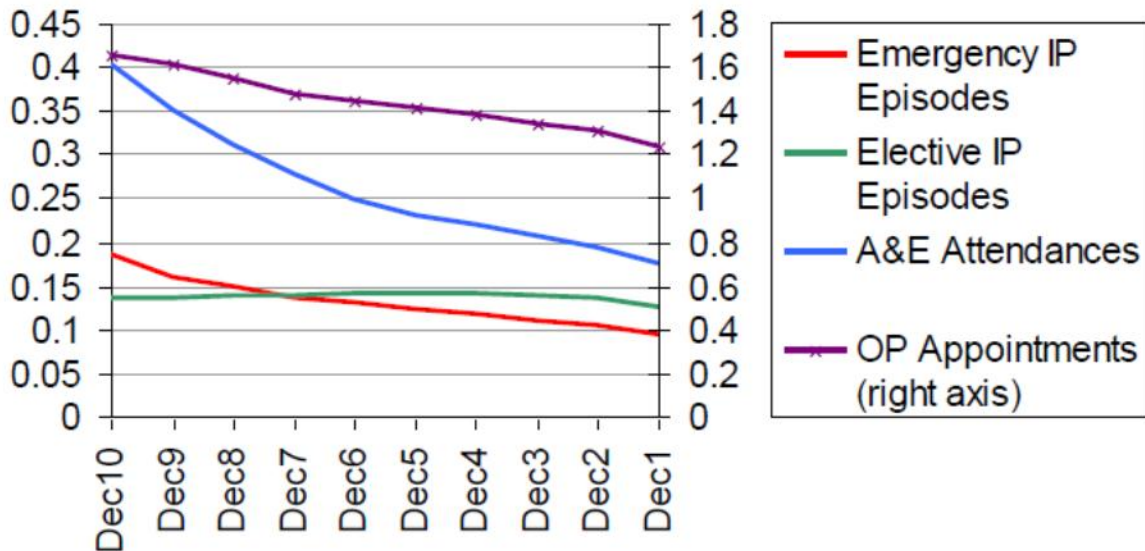
Figure 3 – Map of Deprivation in Wolverhampton (Public Health England 2013)



3.5 Figure 4, below, shows that while the number of elective admissions per head is broadly similar across all deprivation deciles, more deprived areas have more emergency inpatient admissions per head than less deprived areas. In this national study, A&E attendances from Decile 10 were more than double that from Decile 1 and show a steeper incline from Deciles 6 through to 10. Although these figures are for England in 2012 the authors contend that this finding is stable year on year, and

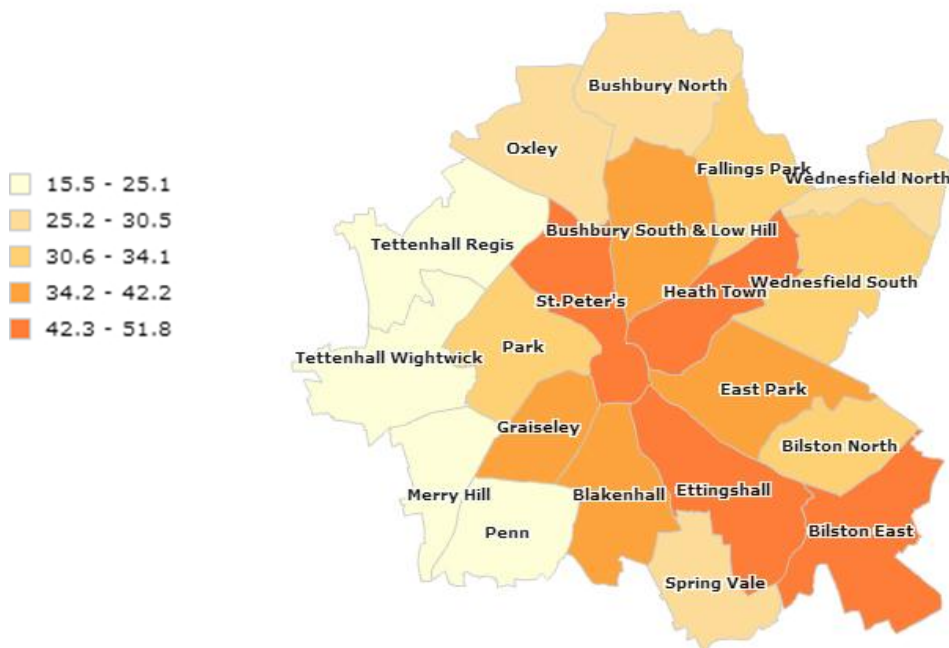
it is reasonable to conclude that the pattern in Wolverhampton is highly likely to be similar. Monitor (2014;p39) has found from primary research that “people from lower socio-economic groups tend to be the most common users of walk-in centres”. The significance for the analysis is that geographic variation in deprivation will influence the use, not only of A&E, but the new Primary Care Centre and the retained Phoenix Walk-In-Centre.

Figure 4
Emergency and elective inpatient episodes for England, A&E attendances and outpatient appointments per head of population by deprivation decile (10 is most deprived, 1 is least deprived), patients of all ages (McCormick et al; 2012)



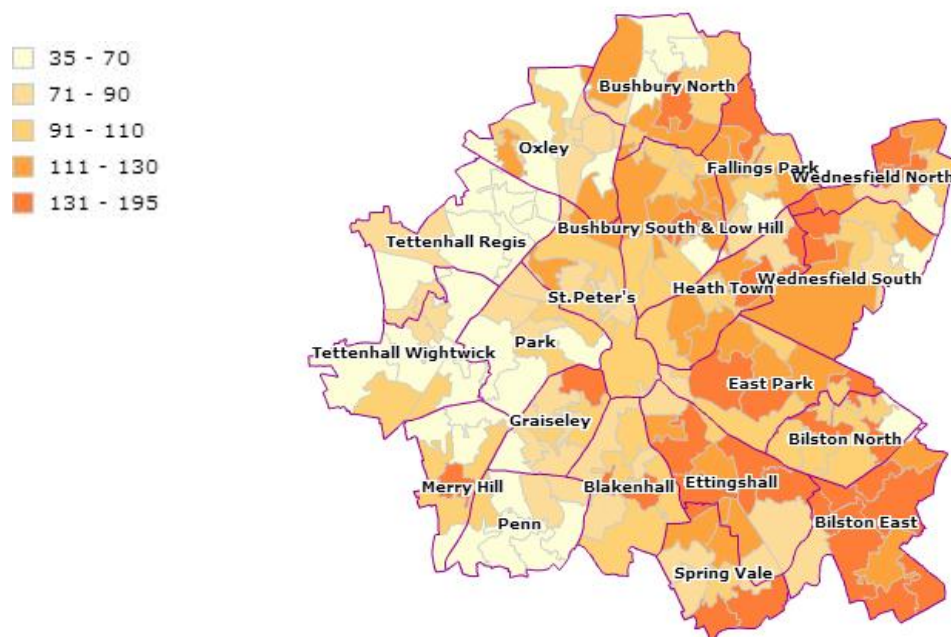
3.6 The following maps highlight some of the indicators of health and wellbeing which may have a contributory effect on the impact of relocating Showell Park.

Figure 5: % of households with no car or van – 2011 (Wolverhampton City Council 2013)



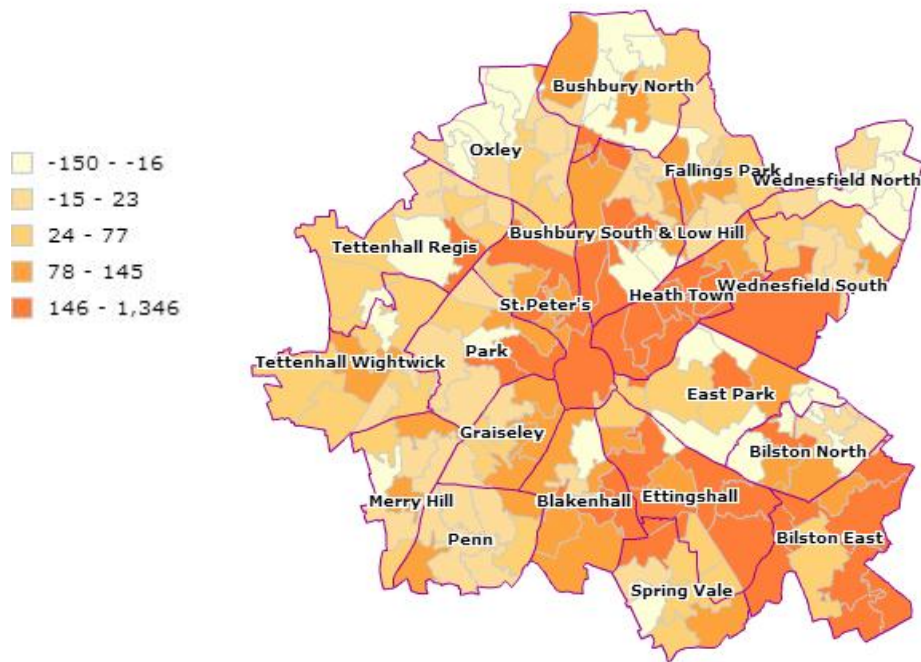
- 3.7 Figure 5 patterns of car ownership suggests that people living in St Peter's, Bushbury South and Low Hill wards are likely to experience most disbenefit because of an apparent reliance on other people for their transport needs – either public transport or lifts from friends, relatives. People in Heath Town and Wednesfield South (where car ownership is low) will be closer to the new Primary Care Centre at New Cross. Implementation plans should consider access to public transport networks for those people who need to travel further from these and other wards in the North of the City, particularly during the transition to discernible improvements in primary care.

**Figure 6 – Number of people who claim Disability Living Allowance (DLA) (Feb 2013)
(Wolverhampton City Council 2013)**



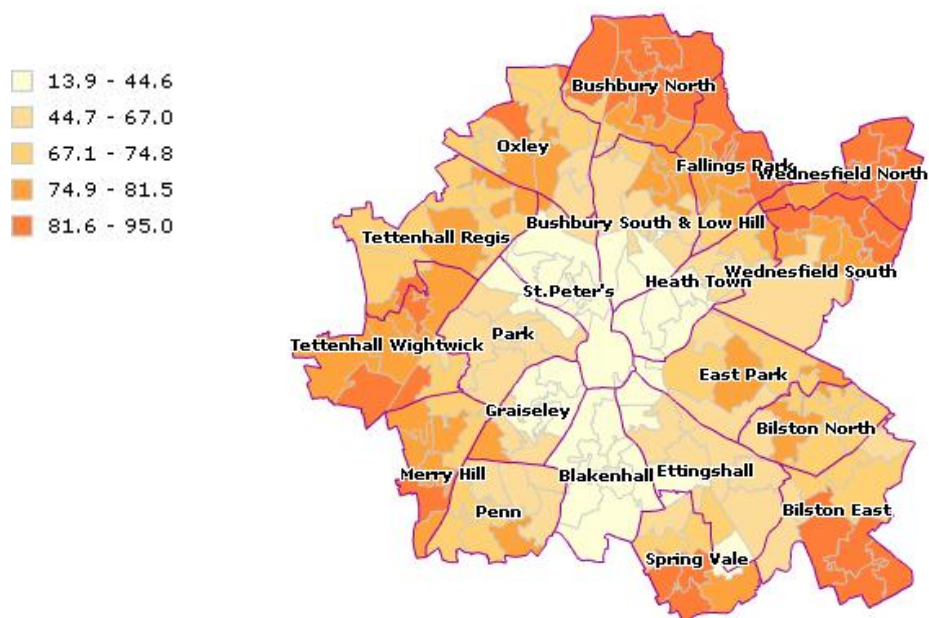
- 3.8 Figure 6 shows that the pattern for people who claim DLA (now being replaced by Personal Independence Payment (PIP) for over 16s and under-65s). DLA provides some money to eligible claimants as a contribution to extra costs caused by long term ill-health or disability. People needing DLA are less likely to be independently mobile, and more reliant on carers. The distinct skew of the pattern for higher levels of DLA claimants in the East of the Borough suggests that the relocation of the Walk-In-Centre facility to New Cross will be closer to a greater proportion of people with mobility difficulties and their carers.
- 3.9 Figure 7 below shows the total change in population in the 10 years between the last two censuses (in 2001, and 2011) and indicates significant increases in the south-east and the east of the City. The relocation and siting of Urgent and Emergency Care services at a new purpose built centre at New Cross is consistent with the strategic intention to increase accessibility for patients – certainly if the proximity to the changing demographic of Wolverhampton residents is taken into account.

Figure 7: Change in total population between 2001 and 2011 (Censuses 2001, 2011)



3.10 Figure 8 shows the pattern of minority ethnic groups in the City area, based on Census 2011 information and using the descriptor of 'the % of residents who are White British'. In this map therefore, the **darker** the shaded area, the greater the proportion of White British people who are resident in the area. The pattern for minority groups correlates closely to the map of deprivation in Figure 3 above. The relocation of the Walk-In-Centre from Showell Park will mean that the facility is further away from patterns of residence for minority ethnic groups and there are likely to be people in these groups who are inconvenienced because of the move. It has not been possible to quantify this disbenefit however, nor to estimate any compensating benefits – eg those arising from the reduced duplication between Showell Park and A&E patient visits. Residency analysis also ignores any in-borough mobility for work, volunteering, or social visits.

Figure 8: Population % of residents who are White British (Census 2011)



Conclusion on the relocation of Showell Park

- 3.11 Because of the complexity of variables arising in the statistics and data available, it is difficult to make a cogent and assured assessment of the overall impact on protected characteristic groups and whether, on balance, the impact is differentially negative, or positive. There are competing claims – eg the closure of Showell Park will definitely inconvenience some people and extend travel times. Patterns of residency suggests that this will impact more negatively on poorer and minority ethnic groups in the City. However, it has not been possible to quantify this. Furthermore patterns of residency do not offer information about where people are located day-to-day – in work for example – and where they are most likely to access urgent care facilities from? The discussion above has also offered some possible arguments for benefits for some groups. And the apparent reduction in duplication between sites (which impacts negatively on other patients through less available consultation/treatment time) is an obvious benefit of co-locating facilities.
- 3.12 Offering conclusions on the magnitude of benefits and disbenefits would be speculative. Disbenefits may well be out-weighted by improvements in the system – especially if primary care improvements mean that people will be able to access their GP and attendant primary care services more easily, in their own locality and with a wider range of services available.
- 3.13 **Conjecture and uncertainty in modelling means that it can not be argued that there is any discernible differential impact overall (positive or negative) on any protected characteristic groups. Because of limited data collected by providers about usage patterns [see section 6 below] it is not possible to detect any spikes or gaps in service reach. If the vision for urgent and emergency care (including primary care improvements) is realised then all patients should benefit from improvements.**

4. Equality considerations for services

Introduction

- 4.1 Urgent and emergency care services should be prepared to provide for all citizens. Because services here are often provided at a time of heightened distress, and imminent danger to the wellbeing of patients, it is right that the focus of attention should be on the immediate health care needs of each person, and that healthcare staff (and patients) do not feel encumbered by unnecessary burdens of bureaucracy and form-filling, or in undertaking equality assessments which prove to be irrelevant to the 'core business' of patient care.
- 4.2 This section of the report – set out in **Table 2** below - considers the operation of services and how these impact distinctly on different protected characteristic groups to demonstrate how a consideration of diverse needs in planning and organising urgent and emergency healthcare can offer much improved experiences and outcomes for patients, as well as improving the working environment for staff.
- 4.3 Following a consideration of the challenges for service provision for each protected characteristic group in an urgent care context, this section then considers the challenges in the care of other groups not covered by the Equality Act 2010, and the key structural challenges to service reconfiguration which have an impact on all patients.

Key to Table 2

Protected Group = Group as defined by the Equality Act 2010	
Potential Impact	Opportunity/Risk Mitigation
<i>Impact as discerned from available evidence. Full reference list given at back of this document.</i>	<i>The opportunities available in service design and operations, and the potential for reducing risks through acknowledgement of the needs of different protected characteristic groups.</i>
Local Issues	
<i>The issues arising from the consultation, the equality survey of organisations, local research or studies, and stakeholder comments received.</i>	

Table 2 - Protected Characteristic Groups

Protected Group	AGE – Older People
<p>Potential Impact</p>	<p>Opportunity/Risk Mitigation</p>
<p>The number of older people (65 year and above) living in the city has increased to 40,600 from 40,000 in 2001, a +1.5% increase. This represents 16.2% of the population, close to the English average of 16.5% but lower than that for the West Midlands (17.2%).</p> <p>The growing elderly population and the prevalence of long term conditions represents a significant challenge to health and social care services. Older people are significantly high users of A&E.</p> <p>No discernible negative impact, but important issues to consider at implementation for improvements in service delivery. Positive impacts are contingent on improvements to primary/secondary care.</p>	<p>Opportunity to consider accessibility to specific facilities as they are developed for older people; and to consult. NHS 111 pilots’ usage data indicates high use of the service for patients aged over 80 when compared to the average use (DH 2012; p18). This is a potential beneficial use of technology as part of the overall integration of services. However please note that Older people also appear to be reluctant to use the telephone to access out-of-hours care (DH 2012; p20).</p> <p>Standards and recommendations for the care of older people in urgent care settings are set out in the ‘Silver Book’ (2012) along with specific recommendations for primary care, Emergency Departments and Urgent Care units. Example recommendations from the Silver Book are:</p> <p>Rec 15. There should be a distinct area in Emergency Departments which is visibly and audibly distinct, that can facilitate multidisciplinary assessments.</p> <p>Rec 16 All units should have ready access to time critical medication used commonly by older people such as Levo-Dopa.</p> <p>Rec 17 If a procedure is required for a person who is confused, two health care professionals should perform the procedure, one to monitor, comfort and distract, and the other to undertake the procedure; carers and/or family members should be involved if possible; cutaneous anaesthetic gel should be considered prior to cannulation, particularly if the person is confused.</p> <p>Rec 18. All urgent and emergency care units should have accessible sources of information about local social services, falls services, healthy eating, staying warm, benefits and for carers of frail older people.</p> <p>Recommendation: Provider organisations should consider adoption of the Silver Book recommendations as appropriate for their areas of service.</p>
<p>Local Issues</p>	
<p>Feedback from respondents to the Urgent Care Equality Survey (Appendix 2) offered issues for consideration by provider organisations. These include – Long waits for ambulances (sometimes two arrive); Triage phone management for access to ambulances needs to be more responsive to the needs of older people; Some issues of dignity – overly familiar use of first names without seeking permission first; concerns over inadequate facilities for the care of elderly patients; concerns that elderly people are not given appropriate priority and appropriate, timely care; long waiting times in A&E are particularly difficult for elderly patients, especially when having to sit for long periods when they need to lie down; communication with community services requires improvements; a suggestion that understanding of palliative care in A&E would help to ensure a safe discharge for patients; generally recognition that staff are caring but that time constraints force a focus on the presenting problem without seeing the whole picture for patients.</p>	

Protected Group	AGE – Younger People
<p>Potential Impact</p>	<p>Opportunity/Risk Mitigation</p>
<p>Monitor (2014, p39) found that younger people are the predominant users of Walk-in Centres, with people between 16 and 45 attending at higher rates than other age groups and those in the 25 to 34 year age bracket (23%) and the 16 to 24 age bracket (16%) were the most commonly attending patients. (Monitor patient survey report)</p> <p>Local figures for Showell Park in 2011/2012 show that the 0-5 age group were the largest group of users. Walk-In-Centre analysis in 2012 showed a significant increase in use by the 0-5 and 21-25 age groups.</p> <p>No discernible negative impact, but important issues to consider at implementation for improvements in service delivery. Positive impacts are contingent on improvements to primary/secondary care.</p>	<p>Opportunity to consider accessibility to specific facilities as they are developed for young people and parents with young children and to consult. NHS 111 pilots' usage data indicates high use of the service for patients aged 0 to 4, when compared to the average use (DH 2012; p18). This is a potential beneficial use of technology as part of the overall integration of services.</p> <p>The Royal College of Paediatrics and Child Health RCPCH (2012) have published 'Standards for Children and Young People in Emergency Care Settings' developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings. Example standards set are:</p> <p>Section 6 - Staffing and Training issues</p> <p>Standard 1: Nurses working in emergency care settings in which children are seen require a minimum level of knowledge, skill and competence in both emergency nursing skills and in the care of children and young people.</p> <p>Standard 9: Emergency care settings seeing more than 16,000 children per annum employ a consultant with sub-specialty training in paediatric emergency medicine</p> <p>Section 4 - Environment in emergency care settings</p> <p>Standard 1: Emergency care settings accommodate the needs of children, young people and accompanying families and comply with DH 'You're welcome' and HBN 22 standards' (NB now superceded by HBN 15-01: Accident and Emergency Departments Planning and design guidance (Department of Health, April 2013)</p> <p>Recommendation: Provider organisations should consider adoption of the Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings (as appropriate) for their areas of service</p>
<p>Local Issues</p>	
<p>Difficulties reported in obtaining same-day GP appointments for young people; some young people reporting that they feel that they are not listened to by their GP, and that some issues are pre-judged (eg: self-harm); privacy and dignity is not always respected. Suggestions for improvements include: more accessible appointments with GPs; more support for issues such as self-harm; and an idea for specific surgeries once a month for young people to discuss issues and access treatment. View expressed that it is a myth that young people do not want to access services. This needs to be broken.</p>	

Protected Group	DISABILITY GENERAL ISSUES
<p>Potential Impact</p>	<p>Opportunity/Risk Mitigation</p>
<p>The coherent integration of pathways across health and social care is a recurring concern nationally for patients with a disability and for carers.</p> <p>Physical access to facilities, and the availability of suitable equipment to meet the specific needs of people with different disabilities (particularly when emergency treatment is required) also figures prominently.</p> <p>No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase.</p>	<p>There is an opportunity to consult people with disabilities – both directly and through representative organisations as part of the continuing consultation and particularly during the implementation phase; to consider accessibility improvements for people who have mobility problems, and/or who use mobility aids; for visually impaired people (colour schemes, and signage); Hearing impaired people and communication options generally.</p> <p>Recommendation: Both commissioner and provider organisations should ensure that representatives from the Wolverhampton People’s Parliament (part of the Changing Our Lives charity which supports people with disabilities of all ages) see www.changingourlives.org</p>
<p>Local Issues</p>	
<p>There was a demand during the consultation for information on the impact of the proposed changes on the Eye Infirmary, including its connectivity to the new emergency centre. There is an expectation that the services should be linked or co-located in order to make it easier for eye care patients to travel between the two. This should be supported with clear and accessible information. Healthwatch Wolverhampton expressed the view that more needs to be done to clarify care pathways for ophthalmology urgent care patients.</p> <p>CQC (2013) commented “We found that the Trust had recently introduced good systems so that most patients could now be treated in A&E without having to be sent to the eye department to access specialist eye care for treatment. This is an example of effective treatment for patients in the A&E department.”</p>	

Protected Group	DISABILITY – LEARNING DISABILITY
Potential Impact	Opportunity/Risk Mitigation
<p>Having a learning disability can increase anxiety and distress (adding to the patient’s vulnerability) as the individual may not understand why they are there or what to expect. Therefore it helps to make the situation as predictable as possible for the person – always letting them know what is happening. Consideration should be given to the appropriate reception and treatment for patients with a learning disability who arrive at an urgent care facility and to whether staff are sufficiently trained to safely discern the person’s needs; to communicate effectively with the patient and their carer(s); and to ensure the best possible patient experience.</p> <p>No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase, and specific consideration given to pathways for people with a Learning Disability.</p>	<p>Royal College of Nursing (2013); Dignity in Health Care for People with Learning Disabilities (2nd edition) [London]</p> <p>“I was in a ward and a patient was screaming. Nobody did anything. I was scared” p14</p> <p>The RCN publication offers excellent and useable examples of good practice. Commonly reported experiences for people with learning disabilities include:</p> <ul style="list-style-type: none"> • Discrimination • Assumptions being made about individuals with no assessment • Lack of communication with the individual and their carers • Difficulty in accessing services • Staff with a lack of knowledge and skills in learning disabilities • Abuse and neglect <p>This document can be used to pose questions for the urgent and emergency care pathways for people with a learning disability and to consider scenario testing.</p> <p>GAIN (Guidelines and Audit Implementation Network, June 2010): Guidelines on Caring for people with a Learning Disability in General Hospital Settings (Northern Ireland)</p> <p>This document proposes that: ‘Staff within emergency care departments should develop a specific care pathway/protocol for identifying and caring for patients with a learning disability.</p> <p>Bradley and Lofchy (2005) ‘Learning Disability in the accident and emergency department Advances in Psychiatric Treatment 2005, 11:45-57</p> <p>“An A&E department is generally a strange and unfamiliar environment for anyone. For people with learning disabilities, the experience may be particularly frightening because they may understand even less what is happening around them. Getting to A&E may also have been traumatic, for both the person and the family or care providers. Waiting can be anxiety provoking and contribute to behavioural disturbance” (p 47)</p>

Protected Group	DISABILITY – LEARNING DISABILITY - CONTINUED
Potential Impact	Opportunity/Risk Mitigation
<p>No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase, and specific consideration given to pathways for people with a Learning Disability</p>	<p>Work undertaken in Lincolnshire in 2011 demonstrated that people with learning disabilities, although a small percentage of the population (0.3%), accounted for 6% of the Accident and Emergency budget. Over the next 20 years we will see a doubling in the number of people with learning disabilities. (ADASS 2013; p6)</p> <p>Public Health England (2013a) Learning Disabilities profile for Wolverhampton</p> <p>This document explains (at page 3) that the emergency hospital admissions (in 2009) for people with a learning disability were significantly worse than the England average. Identification of people with a learning disability in general hospital statistics was similarly poor. Administrative changes in access to hospital episode statistics means that PHE were unable to update these indicators for 2013. Adults with a learning disability known to GPs was significantly higher than the national average however the proportion having a GP health check was significantly worse.</p> <p>Recommendation: Commissioner, and Provider organisations should work collaboratively to improve the data collection mechanisms for use of emergency care by people with Learning Disabilities and publish these regularly. Providers should consider using the RCN and the GAIN publications (particularly where these offer recommendations for emergency settings) as part of their equality analysis of facility design and pathway development.</p>
<p>Local Issues</p>	
<p>The lack of current, accurate statistical information about emergency care for people with a learning disability means that further exploration is required, with the objective of improving data collection mechanisms. At the time of preparing this report the local Learning Disability Self Assessment Framework (LD SAF) for Wolverhampton 2013 was not available.</p> <p>CQC (2013) refer (p18) to a listening event conducted with patients during the September 2013 inspection of New Cross Hospital: “..people spoke to us about delays in treating family members with learning difficulties and autism.” This echoes the feedback received from the equality survey of organisations. The hospital has recognised this and the CQC reported that staff now prioritise these patients to reduce any distress caused by waiting.</p> <p>Recommendation: Commissioner and Provider should monitor the effectiveness of this prioritisation and evaluate through further listening events to inform improved practice.</p>	

Protected Group	DISABILITY – MENTAL HEALTH
Potential Impact	Opportunity/Risk Mitigation
<p>Concern has been expressed in a number of reports regarding national reconfigurations about mental health emergency care and the joint working between services not receiving adequate attention – please see this link.</p> <p>No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase, and specific consideration given to pathways for people with mental health problem.</p>	<p>The College of Emergency Medicine (Feb 2013); ‘Mental Health in Emergency Departments – A toolkit for improving care’ [College of Emergency Medicine, London]</p> <p>The core principle of Mental Health in the Emergency Department: “A patient presenting to ED with either a physical or mental health need should have access to ED staff that understand and can address their condition, and access to appropriate specialist services, regardless of their postcode, GP, or time of arrival.” (p2)</p> <p>“Does the education and clinical knowledge of your staff in mental health match that for major trauma, cardiac arrest...?” (p2)</p> <p>CEM standards for mental health are set out at page 15 and include: 1. Patients who have self-harmed should have a risk assessment in the ED; 2. Previous mental health issues should be documented in the clinical record; 6. From the time of referral, a member of the mental health team will see the patient within one hour...”. Plus strong links with Community Mental Health Teams are advocated including “Involvement in each other’s induction programme really helps to improve response times and flow of service. For the pure psychiatry trainees or staff grades, they may have no knowledge of the ED’s clinical standards or time requirements. Equally, we need to understand the competing pressures that exist in mental health” (CEM, p11).</p> <p>Care plan management involving multi-disciplinary teams for substance and mental health for patients who will benefit from a consistent response.</p> <p>Recommendation: Commissioner and providers consider a planned move towards adoption of the CEM standards over an agreed and realistic period of time.</p>
<p>Local Issues</p>	
<p>CQC (2013) expressed concern about the safety of mental health patients at New Cross Hospital and the deprivation of liberty. There were also concerns about the delays in mental health trust staff reaching A&E.</p> <p>The Equality Survey of organisations identified concerns about practitioners being unable to “differentiate between psychosis and being under the influence” (ie of drugs or alcohol, particularly following self-medication). Requests for better mental health training for front line staff, but also timely follow up through after care services are seen as wanting.</p> <p>Bishop (2013) recommends that the Local suicide prevention strategy needs to include specific support for Lesbian, Gay, Bisexual and Transgender people</p> <p>Survey response from The Haven (which supports individuals who have been victims of violence and abuse) strongly advocating the long term funding of an Independent Domestic Violence Advisor to be based within the local emergency department and offer valuable preventive and cost effective support.</p>	

Protected Group	RACE
Potential Impact	Opportunity/Risk Mitigation
<p>Wolverhampton’s Black and Asian Minority Ethnic (BAME) population has increased significantly since the 2001 Census and now represents over one third of the population at 35.5%.</p> <p>Nationally, the Afiya Trust suggests that “many minority ethnic communities have poor access to health and social care services for a variety of reasons including language barriers, lack of awareness/information, social isolation, lack of culturally sensitive services and negative attitudes about communities”. (Afiya Trust 2010)</p> <p>Impact analysis is hampered by the lack of good equality monitoring information for ethnicity.</p> <p>No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase..</p>	<p>Hull, S; Mathur,R; Boomla,K (May 2011):</p> <p>“For general practice this means developing robust counts of ethnicity at practice level and using the data to monitor access and service utilisation. This is particularly important in urban areas which tend to be most ethnically diverse and where population mobility is greatest...At the local level one of the primary purposes of collecting ethnic category data about patients is to establish whether services are meeting the needs of different ethnic groups in the community and to assist future planning of service provision.”</p> <p>Monitoring of ethnicity locally, in Wolverhampton, is poor and can be improved.</p> <p>The figures for minority ethnic respondents to the urgent care consultation were low and so there are opportunities to consult different minority ethnic groups as part of the urgent and emergency care implementation phase – both in ‘mainstream’ consultation events and through dedicated outreach work. This should include a review to consider if appropriate interpreting facilities are available at some consultation events for patients whose first language is not English. Commissioner’s service specifications and procurement process may wish to highlight public sector equality duty and set contractual information requirements on providers to demonstrate how they comply with statutory provisions. Provider opportunities to consider workforce development and talent management, recruitment , and promotion of equal opportunity policies.</p> <p>DH (June 2011) A&E Clinical Quality Indicators; Best Practice Guidance for Local Publication</p> <p>“25. Organizations are also encouraged to use the richness of their A&E data to analyse and present data that can be disaggregated by the equality protected characteristics defined by the Equality Act 2010 (for example, presenting data for different age, gender and ethnic groups where available); and to explore presenting their data in a way that aids understanding of the issues affecting particular clinical groups (for example, investigating attendances for patients with mental health issues).”</p> <p>NHS Scotland Information Services Division (ISD) in their AE2 ‘A&E data recording reference manual (October 2013 v2.0) includes as potential data items: ethnicity, religion, sexual orientation.</p> <p>Butler, Christina, Hatzidimitriadou, Eleni and Psinos, Maria (2010) put a cogent case for the benefits of ethnic monitoring.</p>

Health inequalities: ethnicity

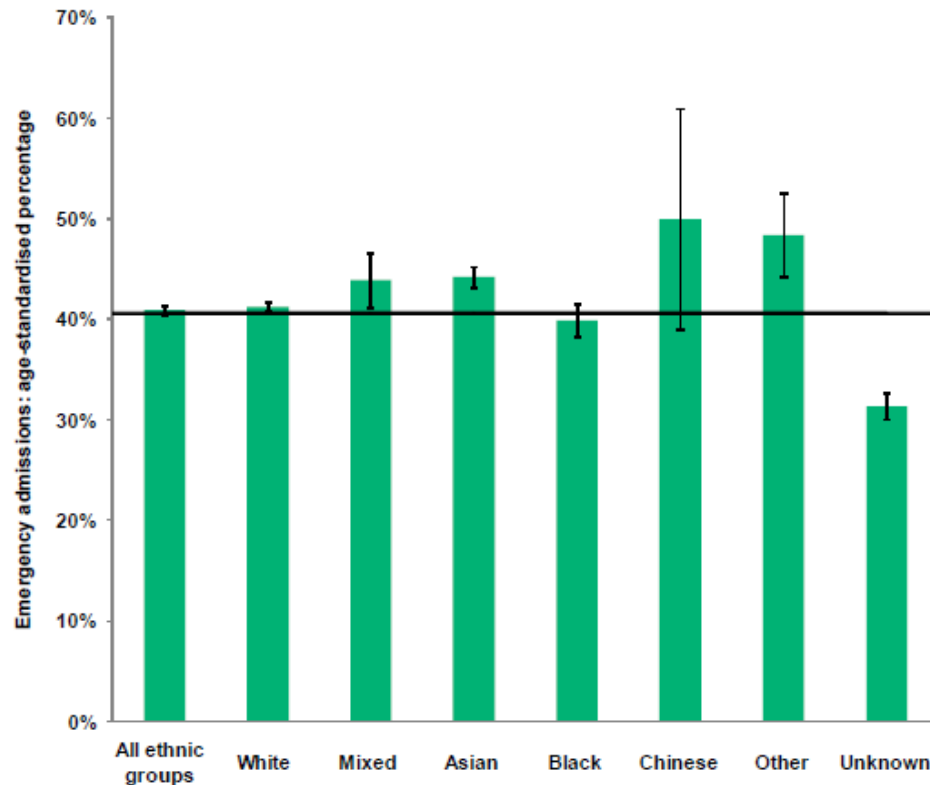
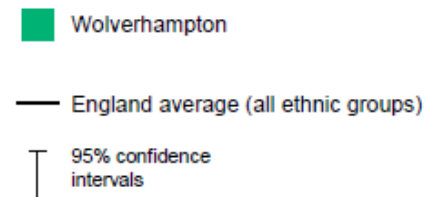


Figure 9: emergency hospital admissions in Wolverhampton 2011/2012.

This chart shows the percentage of hospital admissions in 2011/12 that were emergencies for each ethnic group in this area. A high percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions. By comparing the percentage in each ethnic group in this area with that of the whole population of England (represented by the horizontal line) possible inequalities can be identified.

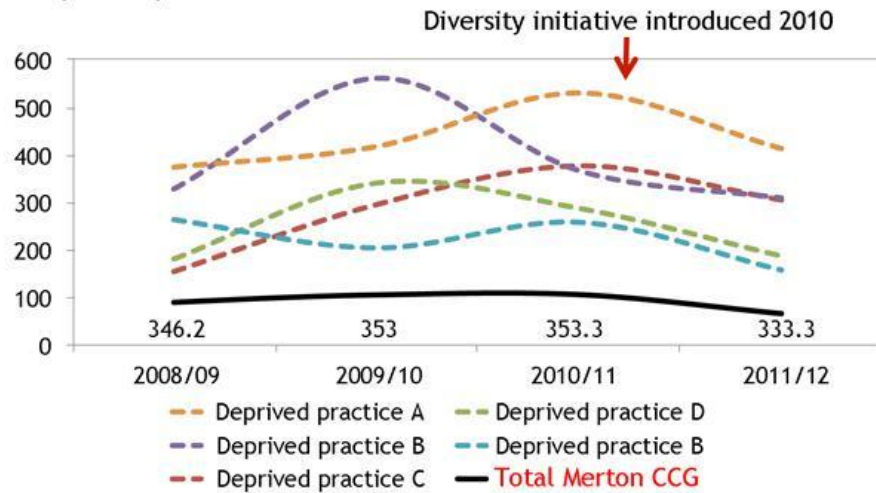


Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

FROM: **Public Health England (2013b) Wolverhampton Health Profile** (published 24th September 2013) available at: <http://www.apho.org.uk/resource/view.aspx?RID=127042>

This chart also emphasises the need for better equality monitoring and work to advance the issues identified by the Joint Urgent and Emergency Care Board around gaps in equality monitoring (**please see the Recommendations for DATA in section 7**)

A&E activity per 1000 people in Merton and in five most deprived practices



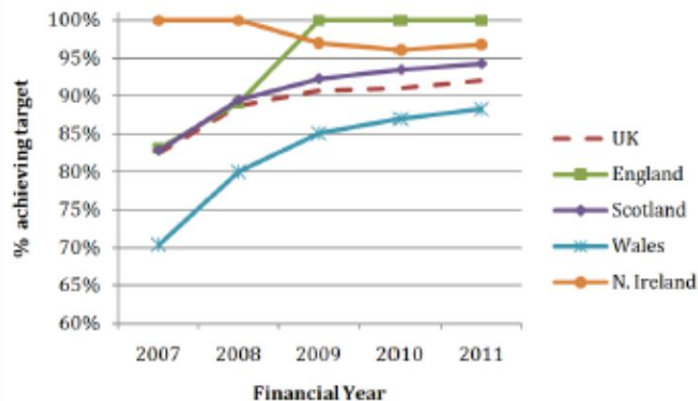
Ford A et al (2013) Cutting A&E use and health inequalities. Nursing Times; 109: 24, 14-16

People from migrant communities may not use primary care because the services, expectations and payment requirements are very different in their country of origin. They may not feel comfortable communicating in English or they may feel embarrassed about health issues. 2 strangers in the room can accentuate these feelings (Health Care Professional and an interpreter). They may think that using A&E or urgent care services is easier or more appropriate without realising that there are other options.

The work in Merton (see adjacent figure) has been successful, breaking into the cycle of inequality and changing the way in which A&E services are used including reduced A&E activity in the 5 most deprived ward areas.

In Wolverhampton, the health profile shows that, at the very least the statistics suggest that there are cues for further exploration.

Figure 1. Proportion of UK practices achieving 100% ethnicity recording for all newly registered patients



*Graph produced using freely available NHS data⁶⁷, Data for UK and Wales missing values for 2010

NCRM – National Centre for Research Methods (March 2013) ‘Availability and use of UK based ethnicity data for health research (Working Paper 1/13)’

P9 ‘When hypothesising about and interpreting the mechanisms through which ethnicity is related to health, it is essential to be clear that health outcomes are determined by factors associated with ethnicity, not ethnicity itself. The distribution of these factors, such as genetic influences, socio economic deprivation, migration status, cultural practices, and lifestyle manifest unequally in different population groups and can be conceptualised, broadly, as ethnic differences.’

P13 The recording of ethnicity was removed from the programme in 2011(QOF under GMS) and now relies on an expectation that this will be recorded by GPs.

Protected Group	RACE - CONTINUED
Potential Impact	Opportunity/Risk Mitigation
	<p>Lawrenson,R et al (1998) offers a useful general conclusion that ethnic origin is recorded but not on every patient; recruitment of staff from ethnic minorities may require positive action; formal training in place for staff to gain an appreciation of issues facing patients from ethnic minorities; interpreters and written materials. Although this paper is from 1998, the issues it identifies are still pertinent to the situation now.</p>
Local Issues	
<p>No specific local issues have been identified around race (ethnicity) and urgent and emergency care services. The Equality Survey of organisations did not express any concerns around discriminatory practice. However equality monitoring of ethnicity for service use is poor, and ethnicity recording for complaints information is similarly weak.</p>	
<p>Recommendation: Equality monitoring mechanisms need to be improved.</p>	

Protected Group	RELIGION
Potential Impact	Opportunity/Risk Mitigation
<p>No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase</p>	<p>Opportunity for providers to consider workforce composition and planning as local populations change, and to consider the cultural sensitivity of services provided.</p> <p>Religion is increasingly being recognised as an important signifier of customs and traditions which may have a bearing on health and prevalence of ill-health (for example dietary habits). It can also help, in consideration alongside data on race (ethnicity), to identify physical, cultural, or behavioural barriers to accessing health and social care services. There are sometimes concerns expressed about the work required to capture and analyse such information and whether or not it is proportionate. However, provider organisations are subject to the public sector equality duty and need to demonstrate that they are eliminating discrimination, and minimising disadvantage across all protected characteristic groups. This information can also usefully be compared to a provider’s workforce data (for race and religion) to demonstrate if the composition of the workforce reflects the communities it serves? The absence of any robust local data here does not allow for any form of analysis.</p> <p>Useful resources include: Northern Ireland inter-Faith Forum (2005) ‘Check up - A guide to the special healthcare needs of ethnic-religious minority communities’ and the guide by the Department of Health (January 2009). The DH guide identifies the important role that Chaplains and spiritual care givers have in the planning (as well as the delivery) of urgent care.</p>
Local Issues	
None identified but caveat that information collection mechanisms are poor.	
Recommendation – included in a general recommendation about equality monitoring and data collection.	

Protected Group	SEXUAL ORIENTATION
<p data-bbox="125 240 638 624">Although no specific issues have been identified with the case for change in Wolverhampton; Issues have been identified nationally with same sex partners not having easy access to loved ones in emergency/urgent circumstances, or not being included in consultations in the same way that heterosexual couples/married partners would.</p> <p data-bbox="125 871 638 1018" style="text-align: center;">No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase</p>	<p data-bbox="674 240 2018 312" style="text-align: center;">Opportunity/Risk Mitigation</p> <p data-bbox="674 240 2018 312">Opportunity to gather further evidence from Lesbian, Gay, and Bisexual and Transgender (LGBT) groups locally/regionally to see if anecdotal reports of poor experiences can be addressed.</p> <p data-bbox="674 333 2078 443">Bishop, M (2013) ‘Out in the City – exploring the experience and needs of Lesbian, Gay, Bisexual and Trans People in Wolverhampton’ [LGBT Network Wolverhampton and Wolverhampton City Council, Wolverhampton]</p> <p data-bbox="674 464 2063 536">Section 2.11- “Just over 34% respondents did not feel Wolverhampton hospitals were meeting the needs of LGB and T people; 11% felt they did, 55% had never used hospital services in Wolverhampton.”</p> <p data-bbox="674 557 2078 667">Section 2.12 – significantly higher numbers of LGB and T people who self harm, contemplated suicide, or attempted suicide. (NB link this finding to the College of Emergency Medicine (2013) p 15 – CEM standards for mental health included 1. Patients who have self-harmed should have a risk assessment (in the ED).</p> <p data-bbox="674 687 2040 759">Stonewall (2008) ‘Serves You right: Lesbian and gay people’s expectations of discrimination [Stonewall, London]</p> <p data-bbox="674 767 2074 839">Stonewall describes staff comments and antagonistic attitudes in response to current affairs stories or radio news openly discussed in front of patients:</p> <p data-bbox="674 860 2107 970">“The surgeon said he thought it ridiculous that gays could now get married and what on earth was the world coming to recognising this type of union. He went on to ask his assistant if she realised gays could adopt as well, he thought it outrageous.”</p> <p data-bbox="674 978 2051 1050">[Conversation overheard by a lesbian patient during treatment to reattach nerves in her finger (Stonewall, 2008;p15).</p> <p data-bbox="674 1058 2051 1168">Stonewall recommendations: dignity and respect. ‘Health providers should inform all staff that discrimination on the grounds of sexual orientation is unlawful and that the GMC can stop Doctors from practising if they discriminate against lesbian and gay people (Stonewall, 2008, p20).</p>
<p data-bbox="125 1177 331 1214">Local Issues</p>	
<p data-bbox="125 1230 2107 1334">The work by Bishop (2013) and the LGBT network offers the most recent and comprehensive survey of LGBT service users although no specific questions are included about urgent and emergency care. There are however important cues for further exploration including treatment of LGBT people in primary care; professional attitudes towards LGBT people; and staff training.</p>	

Protected Group	GENDER REASSIGNMENT
Potential Impact	Opportunity/Risk Mitigation
<p>Patients who have stigmatising conditions can end up in urgent and emergency departments partly because of limited access to other health care services. Therefore inclusive policies, awareness and training are key to all provider operations.</p> <p>No specific issues have been identified in Wolverhampton, but anecdotal issues raised nationally with trans groups around courtesy of treatment, respect and dignity issues for a person's preferred identity.</p> <p>No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase</p>	<p>There are concerns in trans communities about recording gender reassignment status and the potential for identifying people where postcode information is also identified. Opportunity to engage further and for Providers to review policies for reception and treatment for patients and carers; and training for staff.</p> <p>ICD 10 (WHO International Statistical Classification of Diseases and Related Health Problems 10th Revision ICD-10) still lists at F64 Gender identity Disorders including F64.0 Transexualism and F64.1 Dual-role transvestism, whereas the APA DSM-V - the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorders ' which may well influence the release of ICD-11 in 2017 has now moved away from 'disorder' to 'dysphoria'. This may have a positive impact on the treatment of transgendered individuals by removing the stigmatisation of individuals having a 'disorder'.</p> <p>A diagnosis of Gender identity Disorder implies that the problem lies within the patient, suggesting and setting a context for treatment that the patient needs to be cured or 'fixed' emotionally or mentally. The reclassification in DSM-V recognises the mental state that accompanies being transgendered within a society that stigmatises the condition. – ie the problem to be addressed is not the person's identity but rather the distress that is often experienced by those who need access to medical transition care.</p> <p>Transgender Patients: Implications for Emergency Department Policy and Practice (Journal of Emergency Nursing 2005; 31: 405-407)</p> <p>"A young woman trauma patient has arrived in the emergency department. When her clothes are cut off, her breasts and male genitalia are apparent. Will the care she receives be influenced by this discovery? Ideally gender expression and identity should not make a difference in health providers' care delivery. But in reality negative attitudes and lack of knowledge can compromise the care of transgender patients." (p405)</p> <p>This scenario acts as a useful cue to ask an appropriate question of providers – how would such an individual be treated in your organisation? How do you know?</p>
Local Issues	
<p>The work by Bishop (2013) and the LGBT network offers the most recent and comprehensive survey of LGBT service users although no specific questions are included about urgent and emergency care. There are however important cues for further exploration including treatment of LGBT people in primary care; professional attitudes towards LGBT people; and staff training.</p>	

Protected Group	SEX
Potential Impact	Opportunity/Risk Mitigation
No negative differential impact identified	

Protected Group	PREGNANCY AND MATERNITY
Potential Impact	Opportunity/Risk Mitigation
No negative differential impact identified	Recommendation: Access and mobility issues should be considered for visitors and ability for mothers to breastfeed; for parents to change babies as part of Providers' consideration of service use.

Protected Group	MARRIAGE AND CIVIL PARTNERSHIP
Potential Impact	Opportunity/Risk Mitigation
No negative differential impact identified	No specific issues with plans for change. Issues have been identified nationally with same sex partners not having easy access to loved ones in emergency/urgent circumstances, or being included in consultations in the same way that heterosexual couples/married partners would.

5. Groups not protected by the Equality Act 2010

- 5.1 There are some key groups which are not covered by the Equality Act but are vulnerable, often marginalised, and have a significant impact on health services.

Homeless people

- 5.2 Wolverhampton City Council's Homelessness Strategy 2011-2014 identified that:

- 1 in 5 people suffer from mental health problems
- The suicide rates of homeless people are 34 times greater than the population as a whole.
- 80% of street homeless people are addicted to drugs or alcohol
- The life expectancy of someone who is street homeless is 42.
- Rough sleepers are 13 times more likely to be a victim of violent crime.

- 5.3 The number of homeless households in Wolverhampton is significantly worse than the England average (Public Health England Community Mental Health and general Health profiles 2013) despite successful homelessness intervention strategies adopted by the City Council.

- 5.4 Homeless people attend A&E up to six times as often as the general population; are admitted four times as often and once admitted, tend to stay three times as long in hospital as they are invariably more sick. As a result, acute services are four times, and unscheduled hospital costs are eight times those of general patients. Nearly 90% of all 'NFA – No Fixed Abode' admissions are emergency admissions compared to around 40% for the general population. (Deloitte Centre; p5)

- 5.5 Because of the trend in homelessness in Wolverhampton and the disproportionate impact of homelessness on the costs of health provision – particularly skewed towards urgent and emergency care – the implementation plans should involve social housing providers and homelessness organisations as part of an integrated approach. Further work may be required to identify any geographical disparities in the location of homelessness people; to research the health experiences of homeless people; and to explore the potential for more effective and earlier interventions to prevent or reduce ill-health and to respond more appropriately to their healthcare needs.

Travelling Communities

- 5.6 The Equality and Human Rights Commission has stated:

“There is evidence that groups about whom very little research has been conducted, notably Gypsies and Travellers, asylum seekers and refugees, have particularly low levels of health and wellbeing. Those without fixed addresses, such as Roma, gypsies and travellers, asylum seekers and refugees, have difficulty in accessing services and their needs are often different and unknown.”

(EHRC 2010)

- 5.7 Statistics for 'gypsy or travelling communities' are difficult to estimate. The Department of Communities and Local Government count of 'Gypsy and Traveller Caravans' from January 2013 suggests that 58 caravans are located within the City boundary – 40 are 'socially rented' and 18 are on land owned by traveller's themselves. Reliable estimates of the number of individuals and their age profile have not been secured for this report.
- 5.8 It would be useful, through the Health and Wellbeing Partnership to explore ways to better understand the health needs of the Wolverhampton based travelling communities and how they access healthcare. However, any such work and the resource commitment will need to be proportionate. Anecdotal information about healthcare demands may offer an appropriate starting point.

Migrants and Asylum Seekers

- 5.9 The Faculty of Public Health briefing (2008) states that:

“Asylum seekers are one of the most vulnerable groups within our society, with often complex health and social care needs. Within this group are individuals more vulnerable still, including pregnant women, unaccompanied children and people with significant mental ill-health” (p1)

- 5.10 Newall (2013) explains that information on migrant populations can be obtained from a range of data sources, “however no one source is able to provide a detailed picture of all new migrants to the UK that have settled in the City.” He suggests that 3.8% of Wolverhampton's population arrived from outside the UK in the past 5 years. This compares to 2.9% for the West Midlands Region. In 2011, 22.9% of primary school aged children and 18.5% of secondary school pupils in the City have a non-English first language (Regional averages are 18.9% and 13.8% respectively).

Migrants registering for health services

- 5.11 Newall provides a useful summary for Wolverhampton:

“Migrant patients who have never previously registered with the NHS are given a marker for their first patient registration, known as a flag 4. Flag 4 registrations in the City are equivalent to 13 per 1000 of the resident population for 2010. This represents 3228 new migrant patient registrations in 2010-11, a negligible change from of from 2009-10 (3224), however it is an increase of over 700 new registrations per year from 2008-9. The Clinical Commissioning Group or Public Health department may be able to break this information down further into nationality, gender and age profiles by analysing patient registration data. The City has a higher level of new GP registration per 1000 residents than the West Midlands Region as a whole for 2010, which was 8 per 1000 of the resident population.”

- 5.12 Understanding the process of GP registration for migrants, and for asylum seekers, and collating the statistics can offer useful information about the likely demands on primary care, and on urgent and emergency care. As Newall suggests, the CCG or Public Health Department may analyse patient registration data, and obtain more contemporary figures than those presented in this summary.

- 5.13 The Social Care Institute for Excellence (2010) publication 'Good Practice in social care for asylum seekers and refugees' though targeted at social care, has a useful set of principles from which urgent and emergency health care services could learn:
- A humane, person-centred, rights-based and solution-focused response to the [health] care needs of asylum seekers and refugees
 - Respect for cultural identity and experiences of migration.
 - Non-discrimination and promotion of equality
 - Decision-making that is timely and transparent and involves people, or their advocates, as fully as possible, in the process.

6. Data Considerations

- 6.1 The collation of equality data is a pivotal stage in developing any equality analysis work in support of strategic decision making because from this, we can begin to build a picture of how responsive urgent and emergency care services are to patients from the different protected characteristic groups. Initial concerns were raised by the lack of equality information returned to Wolverhampton CCG (See **Table 3 below**), and so a letter was sent out to key provider organisations on 23rd October 2013, seeking replies by 25th November 2013. The tone of the letter acknowledged that there would undoubtedly be gaps in equality information but sought at this stage to explore with each provider organisation what was available, and any barriers they felt there were to collecting information. The letter (and its purpose) was discussed at the Joint Urgent and Emergency Care Strategy Board on 8th November 2013.
- 6.2 From the replies received from 3 provider organisations we have identified specific difficulties in the collection and analysis of equality information The main issues can be summarised as:
- i. Partial information only about protected characteristics is collected – typically for age, gender and ethnicity only – although some limited information is available on Learning Disability. High 'not stated' returns (ie where patients have chosen not to state ethnicity) render analysis of some of this information as unreliable.
 - ii. No consistency in the type of equality questions being collected (eg for ethnicity one provider simply asks 'White', 'Black', 'Asian' 'Other').
 - iii. Providers have tended to be guided by the contractual requirements set by previous commissioners, rather than by any conviction that such information offers useful business or strategic information. Historically, Wolverhampton PCT did not ask for equality information returns as part of the contractual information requirements. This has led to a situation where minimal equality information is collected by rote, and analysis is very rarely undertaken.
 - iv. Where information is collected, it resides in several different systems, which makes collation and analysis, and consideration of 'whole system' services time consuming.
 - v. Concerns by Providers that a move to collect information about a wider range of protected characteristic groups will impinge on precious staff time and impact on waiting times for patients.

- vi. Where there has been consistently high 'not stated' numbers from patients, there has not been any promotion among patients (or indeed healthcare staff) to explain to patients the rationale for collection, and to offer assurances about anonymity of information and use of aggregated (not individual) data. Among staff the value of equality monitoring does not appear to have been discussed, nor any support in helping staff to feel confident about asking for such information in a sensitive manner, and at an appropriate time.

6.3 In short, it appears that equality monitoring information is not being used, and is not considered, organisationally, to be useful.

6.4 Providers have valid concerns about the potential resource commitment required to collect, collate and analyse equality monitoring data and the impact on waiting times. It is also the case however that NHS Trusts, and 3rd party suppliers are bound by the public sector equality duty in s149 Equality Act 2010 which requires them to eliminate discrimination and show due regard to minimising disadvantage for the protected characteristic groups: age; disability; race; religion/belief; sex; sexual orientation; gender reassignment; pregnancy and maternity; and marriage and civil partnership. In order to demonstrate compliance with these provisions, each organisation will need to understand something about the different patients it serves, and so collection of equality information is a necessary first step. As stated in the letter to providers:

“Wolverhampton CCG and the Joint Urgent and Emergency Care Board ... recognise that such information may not be readily available and that a number of information repositories may need to be interrogated in a variety of ways. We also understand that extracting such information may be considered to require disproportionate effort when compared to how useful it is. We do not wish to create unnecessary burdens on our partner organisations. If you consider that acquiring some information would be too onerous, then please share with us what these barriers are.”

6.5 To develop these issues further, the Senior Equality and Diversity Manager of Midlands and Lancashire Commissioning Support Unit is working with the Head of Contracting and Procurement at Wolverhampton CCG on the following:

- i. Reviewing the equality information and assurances offered by intending providers in PQQs (Pre Qualification Questionnaires); service specifications, and contractual information requirements.
- ii. A standing item of 'equality monitoring' at each Data Quality Review Meeting.
- iii. Once barriers have been addressed - seeking to secure an agreement across Joint Commissioning partners and Provider organisations to collect equality information in a consistent way which offers comparative analysis between organisations, and with population data (for example using Census 2011 categories as a starting point, but adapted to reflect local needs and demands

Table 3 - Summary of equality data received by WolverhamptonCCG from providers

	Admissions	A & E	Phoenix Centre	Showell Park	Primecare	PALS	111	WMAS
Age	Y	Y	Y	Y	Y	N	N	N
Sex	Y	Y	Y	N	Y	N	N	N
Race/Ethnicity	S	S	S	N	N	N	N	N
Religion or Belief	N	N	N	N	N	N	N	N
Sexual Orientation	N	N	N	N	N	N	N	N
Gender Reassignment	N	N	N	N	N	N	N	N
Pregnancy and Maternity	N	N	N	N	N	N	N	N
Marriage and Civil Partnership	N	N	N	N	N	N	N	N
Disability	N	N	N	N	N	N	N	N

Non-Statutory

Homeless people	N	N	N	N	N	N	N	N
Sex workers	N	N	N	N	N	N	N	N
Travellers	N	N	N	N	N	N	N	N
Migrant workers	N	N	N	N	N	N	N	N
Asylum seekers	N	N	N	N	N	N	N	N

PALS – Patient Advice and Liaison Service
 WMAS – West Midlands Ambulance Service

Key	
Y	Yes, available
S	Yes, available but not well completed
N	Not available in current data

Data it would have been helpful to consider

- 6.6 The Public Health Observatory (PHO) creates a “deprivation score” for each lower super output area (LSOA) from 1-10 with 1 being the most deprived and 10 being the least deprived. It would be useful to organise the geographical location of GP Practices into each of these deciles and to identify usage of urgent and emergency care services by decile and by GP Practice. We would expect to find higher use from more deprived areas. Unfortunately this data has not been collated.
- 6.7 Further analysis of the trends in deprivation scores (as evidenced by IMD figures) for example for health, income and employment, were outside the scope of this analysis but could yield useful information to advise partnership approaches – through the health and wellbeing Board, which are receptive, say, to housing and regeneration challenges; changes in the welfare system, and to patterns of employment.

Summary of usage data

- 6.8 Because of the significant gaps in data collected, it is difficult to draw any reliable conclusions about the use of Urgent Care facilities in Wolverhampton, and in some cases, no analysis is possible. Establishing a baseline in line with our first aim (**see paragraph 2.6 (i)**) has therefore not proved to be possible at this stage in the project. However it has been very useful to discover that there are data gaps. Wolverhampton CCG has already begun work with its provider organisations to improve on the routine collection of equality information, and to harmonise the collection methodologies so that comparative statistics are available. We understand that this will need to be proportionate, and may need to be accompanied by appropriate training for staff so that questions are asked confidently, with sensitivity to patients’ circumstances (not when a person is in pain, discomfort or anxious about waiting to be seen), and with promotion among patients so that they can be reassured of the reasons why data is being collected, how it will be used, and the anonymous nature of aggregated data.

7. Recommendations

DATA

- 1. The CCG works with its Provider organisations to improve on the routine collection of equality information from patients, and by staff, and to harmonise the collection methodologies between providers so that comparative statistics are available (eg by using Census 2011 classifications but with flexibility to enable patients to self-define where this is possible). This should include staff training approaches (see Recommendation 21), and the joint promotion (across health and social care agencies) of equality monitoring with users of services.**
- 2. The CCG explores the availability of benchmark data for similar services in other CCG areas. to help establish baseline positions.**
- 3. The CCG and provider organisations work collaboratively to improve the data collection mechanisms for the use of emergency care by people with a learning disability and publish these regularly. Providers should consider using the RCN (2013) and the GAIN (2010) publications, particularly where these offer recommendations for emergency settings, as part of their equality analysis of facility design and pathway development.**
- 4. 'Equality monitoring progress' becomes a standing item at each Data Quality Review Meeting.**

CONTRACTS

NB: all NHS Trusts and private sector providers commissioned by the CCG will be required to demonstrate compliance with s149 (the Public Sector Equality Duty), and this requirement is included within the standard form of NHS Contract.

- 5. CCG to ensure that robust equality considerations are built into pre-qualification questionnaires (PQs); service specifications; and by requiring providers to conduct further equality analyses on their service operations.**
- 6. Provider organisations to implement and publish internal reviews of their use of equality information for services, and for their workforce and to assess their compliance with the Public Sector Equality Duty (s.149 Equality Act 2010). Action plans to be published which allow for discernible improvement in equality approaches.**
- 7. CCG to establish contractual information requirements which consider equality in the provider workforce and in the delivery of services, with a requirement to report on these and demonstrate compliance with s.149 of the Equality Act 2010.**

CONSULTATION AND ENGAGEMENT

8. All agencies - opportunities to engage across the protected characteristic groups should be built in to proposed engagement and consultation as the implementation phase of the urgent care strategy progresses including specific outreach work where response rates show low engagement with particular groups.
9. CCG and Provider organisations should ensure that representatives from the Wolverhampton People's Parliament (part of the Changing Our Lives charity which supports people with disabilities of all ages see www.changingourlives.org) and the Wolverhampton Equality and Diversity Forum are consulted and involved in any planned engagement work.

PARTNERSHIP WORK

10. All agencies - because of the trend in homelessness in Wolverhampton and the disproportionate impact of homelessness on the costs of health provision – particularly skewed towards urgent and emergency care – the implementation plans for urgent and emergency care should involve social housing providers and homelessness organisations as part of an integrated approach. Further work may be required to identify any geographical disparities in the location of homelessness people; to research the health experiences of homeless people; and to explore the potential for more effective and earlier interventions to prevent or reduce ill-health and to respond more appropriately to their healthcare needs.
11. The Health and Wellbeing Partnership to explore ways to better understand the health needs of the Wolverhampton based travelling communities and how they access healthcare. However, any such work and the resource commitment will need to be proportionate. Anecdotal information about healthcare demands may offer an appropriate starting point on which to build more targeted studies.
12. The CCG and Public Health Department of Wolverhampton City Council should consider an analysis of patient registration data to understand current processes for the GP registration for migrants, and for asylum seekers, and how these statistics can be effectively and economically collated at regular intervals.

OPERATIONS and STANDARDS

13. Provider organisations should consider adoption of the Silver Book (2012) recommendations - 'Quality Care for Older People with Urgent and Emergency Care Needs - as appropriate for their areas of service
14. Provider organisations should consider adoption of the Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings - RCPCH (2012) - (as appropriate) for their areas of service.

15. **The CCG and Royal Wolverhampton NHS Trust should monitor the ongoing effectiveness of the prioritisation plans reported to CQC in September 2013 for people with learning difficulties and autism, and evaluate through further listening events to inform improved practice.**
16. **The CCG and Provider organisations consider a planned move towards adoption of the College of Emergency Medicine (2013) standards for mental health in a phased manner over an agreed and realistic period of time.**
17. **Providers to conduct equality analyses (equality impact assessments) on the proposed operations of their services at an early stage of planning, and to include user groups in this planning. CCG to require evidence of these contractually.**
18. **As informed by Recommendation 17 - Access and mobility issues should be considered for all visitors to urgent care facilities including the topography of the area (eg to avoid inclines for people with mobility difficulties); internal colour schemes (to enable visually impaired users of services to discern between different surfaces); internal fire doors (to enable wheelchair users to move independently through public areas of a building); appropriate signage; facilities for parents to change babies and ability for mothers to breastfeed – all as part of a Provider’s consideration of service use.**
19. **The Health and Well-Being Board consider specific support being identified within the suicide prevention strategy for Lesbian, Gay, Bisexual and Transgender people.**

STAFF TRAINING

20. **All agencies to ensure that equality and diversity training is included in the mandatory training elements for each organisation. Where possible, agencies are recommended to share training opportunities, particularly where patient pathways necessitate involvement with different organisations. This would allow for consistency of approach, and highlight areas of complementary (or dissonant) practice. For all, training content should include information about all the protected characteristic groups; the public sector equality duty and the three aims; the significance and importance of equality monitoring; and the values, principles and pledges within the NHS Constitution as a minimum.**
21. **Staff involved in the design of surveys or questionnaires; in their distribution or completion with respondents should receive a comprehensive and timely briefing beforehand which covers: the significance and value of equality questions; the importance in ensuring a high % of completion from respondents; and how to confidently respond to respondents’ questions in a way which is tactful, sensitive, and reassures people about the confidentiality of the information they share.**

8. Conclusion

- 8.1 Marmot's (2010a; 2010b) concern was with the 'social determinants' of ill-health or the 'causes of the causes' of health inequalities – those fundamental social and economic conditions which have been shown to have an impact on how healthy a person will be during the course of their life. This includes the conditions in which people are born, grow, live, work and age. It includes an individual's education and employment opportunities in life and their earning potential; it can include belonging to a minority group or being socially excluded from mainstream society. Inequalities in the social determinants of health act as barriers to addressing health disparities. The equality approaches identified in this analysis, and explicitly included in the 21 recommendations above, are crucial complementary elements to any Health and Well Being strategy which is concerned with a person's 'life course', and in minimising the disadvantages each citizen may encounter during this life course.
- 8.2 The clinical case for a change in urgent and emergency care services in Wolverhampton has been clearly articulated. The strategy is designed to improve health outcomes for residents and visitors to Wolverhampton. The intention to rehabilitate facilities, improve access and navigability for patients, to remove unnecessary duplication and significantly enhance patients' experiences of urgent care (including primary care) should offer a positive and beneficial impact for all patients, including the statutorily protected characteristic groups. There is no planned diminution of existing services. In this context there are no negative differential impacts identified at this stage for any of the protected characteristic groups covered by the Equality Act 2010.
- 8.3 A more detailed assessment of urgent care services **operationally** can be made by ensuring that equality considerations are built into pre-qualification questionnaires (PQs), and specifications, and by requiring providers themselves to conduct further equality analyses on their service operations where these are not already a systemic part of service planning. Contractual information requirements can also be established which consider equality in the provider workforce and in the delivery of services, with regular (eg quarterly) reports submitted to the commissioner which are required to demonstrate statutory compliance with s.149 of the Equality Act 2010. All NHS Trusts and private sector providers commissioned by the CCG will be required to demonstrate compliance with s149 (the Public Sector Equality Duty).

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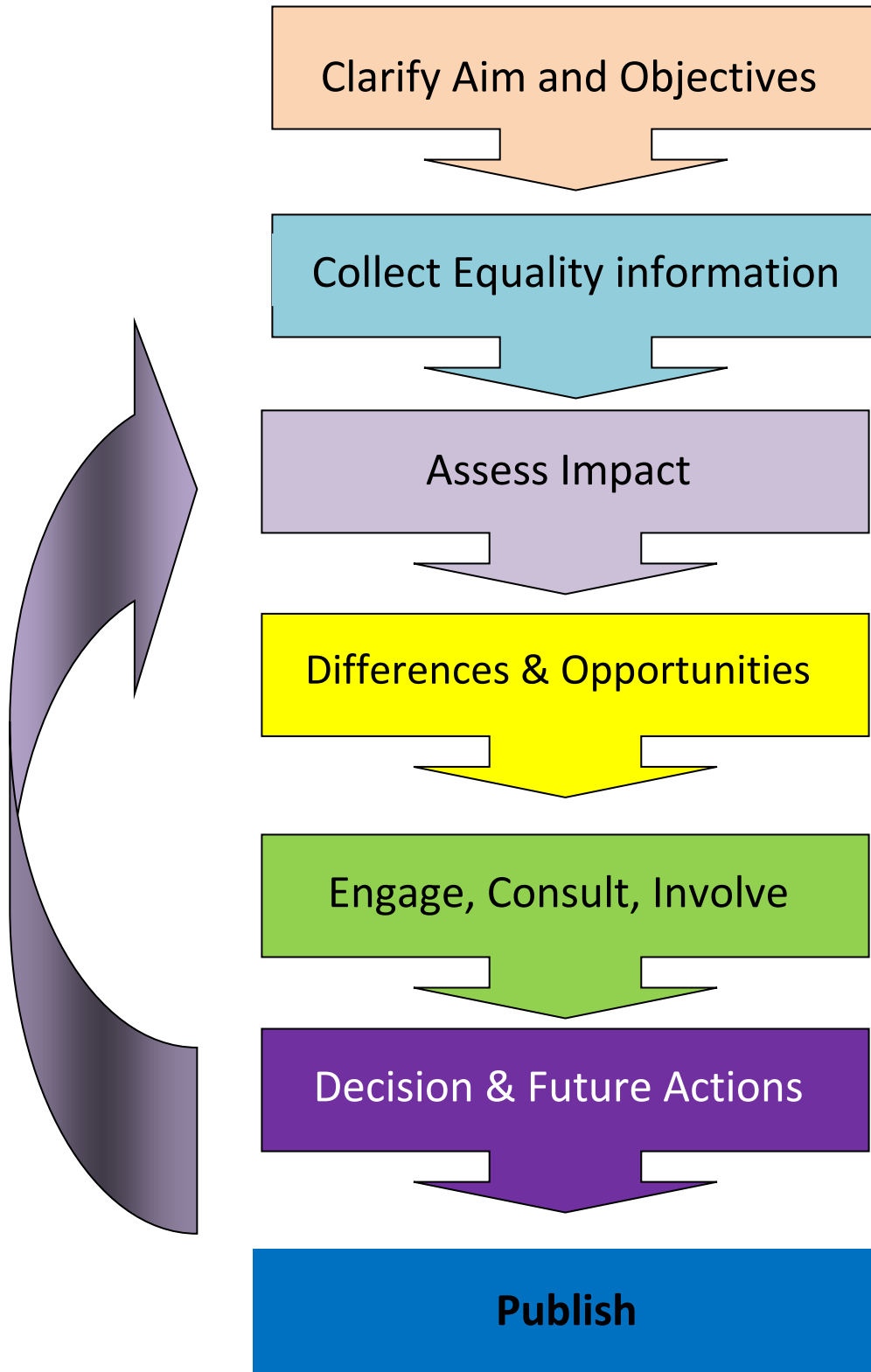
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**Wolverhampton CCG
Plans for Urgent and Emergency Care Services 2014
Route Map for Equality Analysis**



Summary of Questions asked in the Urgent Care Equality Survey January – February 2014

NB. These are shortened forms of the questions asked. The original survey was piloted with several organisations before wider distribution.

- Q1: Name and address of your organisation (please include website if any).**
- Q2: Contact details for someone we can keep informed of progress**
- Q3: Please tell us a little about what your organisation does and who it helps?**
- Q4: Which protected characteristic groups do you work with/represent?**
- Q5: Positive experiences of urgent care health services provided in Wolverhampton?**
- Q6. Difficulties experienced?**
- Q7. Improvements you would wish to see?**
- Q8. Do providers of services understand the needs of the people you work with?**
- Q9. Does the group/community feel that their views are listened to by providers?**
- Q10. Does the group feel that their privacy/dignity as patients is respected**
- Q11. Please tell us three things you would like the NHS in Wolverhampton to change for the better for this group?**

Three things? (from the equality survey, Q11 – see Appendix 2)

Please tell us three things you would like the NHS in Wolverhampton to change for the better for this group/community?

Group providing support to recipients of direct payments

- Gender specific support on A&E
- Safe space to come down if high or drunk
- Quicker access to mental health support while in urgent care

Counselling and support group for children and young people aged 6-25

- Appointments at GPs more accessible – same day
- More support for issues such as self harm
- Specific surgeries once a month for young people to discuss issues and access treatment, break the myth that young people do not want to access services.

A hospice

- Improved communication with community services
- Access to health care professional that has an understanding of palliative care patients.
- Better discharge planning

A nursery and children's centre

- More community based provision

A residents and tenants association

- Keep the local walk-in-centre

Residents in the vicinity of Prestwood Road

- [The Hospital] to be concerned about being a better neighbour to us
- Try looking at the issues from our viewpoint too
- Realise that by trying to put a quart in a pint pot something gets spilled [reference to traffic congestion]

A community association

- Better care for the elderly
- More support in the community
- Better support for carers

A support agency for people with mental health problems

- Educate GPs in mental health awareness
- Educate hospitals/A&E in mental health awareness

An organisation which supports victims of violence and abuse

- To fund the posts of [currently] volunteer Domestic Violence staff in place
- To advertise the [Domestic Violence Advice] service within their own departments and literature
- To integrate Domestic Violence training with Safeguarding Training and make it compulsory attendance.

A church based welfare project

- Support services
- More staff
- Time management [context not explained]

A church

- Improved facilities at New Cross for elderly patients
- Speedier access to ambulance care – triage phone management needs to be more responsive to the particular needs of older people.
- 24 hour GP care.