NHS
Wolverhampton
Clinical Commissioning Group

The Royal Wolverhampton NHS
NHS Trust

Report on Equality Analysis

Joint consultation on proposals to deliver some planned care at Cannock Chase Hospital

November 2014

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Summary

Wolverhampton CCG and The Royal Wolverhampton NHS Trust have undertaken a joint consultation on proposals to deliver some planned care at Cannock Chase Hospital for Wolverhampton patients. This equality analysis focuses on the impact of these changes for patients in Wolverhampton

This document presents the analysis along with reasons for the conclusions reached, and makes evidence based recommendations to inform equality approaches in the transfer of some planned care services to Cannock chase Hospital for Wolverhampton patients

The Equality Analysis considers two key areas:

1. **The equality impact of the new clinical model which sees the transfer of planned care from New Cross Hospital to Cannock Chase Hospital for some patients**

The transfer of service to Cannock Chase Hospital will benefit some residents and disadvantage others. The demographic information available suggests that the health inequality gap between different groups is unlikely to be widened by the proposals however responses to the survey highlight a perception that older people and people with a long-term limiting disability feel disproportionately affected 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 be impacted by these changes. The proposed benefits described in the consultation document should deliver an improved quality of service for all patients including all protected characteristic groups. In response to the most significant concern relating to transport the Trust has already commissioned a dedicated bus service as described elsewhere in this report.

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

Commissioners can ensure that robust equality considerations, sensitive to the particular needs of each protected characteristic group, are built into the commissioning contract. Contractual information requirements can also be established which consider equality in the provider workforce and in the delivery of services. The operational impact for each of the different protected characteristic groups will be considered as part of the detailed service planning and is referenced in the Action Plan accompanying the final report.

Recommendations are offered in the analysis as part of the overarching action plan in response to the consultation and are shown at section 7.

1. Introduction

Delivering some planned care at Cannock Chase Hospital – the case for change

The Trust's priority is to deliver safe and effective services for its patients and to increase the certainty for delivery of routine elective surgery. Over the last couple of years the Trust has faced increasing pressure on all services due to the rise in unscheduled care including admissions from A&E and other emergency portals. This has resulted in an increase in cancellations of patients about to undergo elective surgery. As part of its bid for the services from MSFT RWT proposed a clinical model which will enable the Trust to more effectively schedule elective care and prevent cancellations resulting from unscheduled admissions. The Trust presented its clinical model to the National Clinical Advisory Group (comprising the chairs of all the Royal Colleges and Associations). The proposals that have been included in the consultation were approved by this Group as being clinically safe.
The Trust has presented to the Health Scrutiny Panel and other forum on a number of occasions regarding the pressures on its services. Most recently the Panel has heard about the City wide Urgent & Unscheduled Care Strategy. WCCG has discussed the Trust's plans and agree that the proposed model seeks to address the current pressures on elective care and give patients a better experience.

The current constraints on capacity at New Cross Hospital driven by a number of factors including increasing demand on unscheduled (emergency and unplanned) care have resulted in the need to implement a clinical model that separates elective (planned surgery and medical treatment) and unscheduled/ complex care. The Trust is unable to make suitable changes on the New Cross site due to the financial cost and space constraints therefore delivering this model on the New Cross site is not an option. The consultation document and presentation material describe the current situation with continuing uncertainty for patients arising from:

- Delays in admission from the Emergency Department
- Moves between wards
- Delays in discharge
- Cancellation of operation
- Delays in having planned operations including after admission to hospital
- And, sometimes the Trust doesn't get it right leading to poor care and experience

The Trust has clearly stated that for the majority (c.90%) of patients there will be no change for outpatient and day case surgery, unless patients choose to go to Cannock Chase Hospital, as these services have little impact on the inpatient bed stock. Introducing this element of choice means that patients who live equidistant to the two hospitals can go to the most convenient. Additionally there will be some patients who choose Cannock Chase Hospital for personal reasons.

The Trust has undertaken analysis to show the number of patients likely to be impacted by the change. This information was included in the joint consultation document and is shown in the table below. These numbers represent around 1.3% of the Wolverhampton population (assumes that every patient in each category is a "new" contact ie no patient has an appointment in more than 1 category and that no patients choose to go to Cannock under Choice)

	Total Activity at New Cross 2013/14	Proposed Transfer to Cannock	Remaining activity at New Cross	% proposed to transfer
A&E attendances	109305	0	109305	0
Inpatient/Daycase	45835	9849	35986	21.5
Unplanned admissions	47419	0	47419	0

Outpatient attendances (including procedures)	519592	22766	496826	4.4

The Consultation document summarised the proposals for each element of planned care and invited respondents to indicate if they were supportive of them

The Trust and CCG have stated that the provision of services at Cannock Chase Hospital will be to the same standards as the rest of the Trust with the same policies and procedures and the same staff on rotation between the Trust sites. Regulators such as the Care Quality Commission will assess Cannock Chase Hospital as part of any inspection of the Trust's services and will expect it to be delivering services to a consistent standard. This should provide assurance to patients

The Trust and CCG identify two main benefits related to elective service transformation:

1. A target of no last minute cancellations by hospitals for non-clinical reasons due to separation of elective and emergency activity (there have been no cancellations for non clinical reasons at CCH since 2003)

2. There will be a reduction in waiting times, meeting the pledge to patients in the NHS constitution. The Trust is currently breaching the 18 week target for orthopaedics and general surgery (including urology and breast) due to pressures at New Cross Hospital.

There is research suggesting that separating emergency and elective services can prevent the admission of emergency patients, both medical and surgical, from disrupting planned activity and vice versa, thus minimising patient inconvenience and maximising productivity for the Trust (The Royal College of Surgeons of England 2007). This research suggests that health outcomes may be enhanced by the transformation of noncomplex inpatient elective procedures by removing the possibility of emergency patients disrupting planned activity.

Separating emergency and elective services can also lead to a reduction in healthcare acquired infections through avoiding admissions from the emergency department and transfers from within/outside the hospital (The Royal College of Surgeons of England 2007).

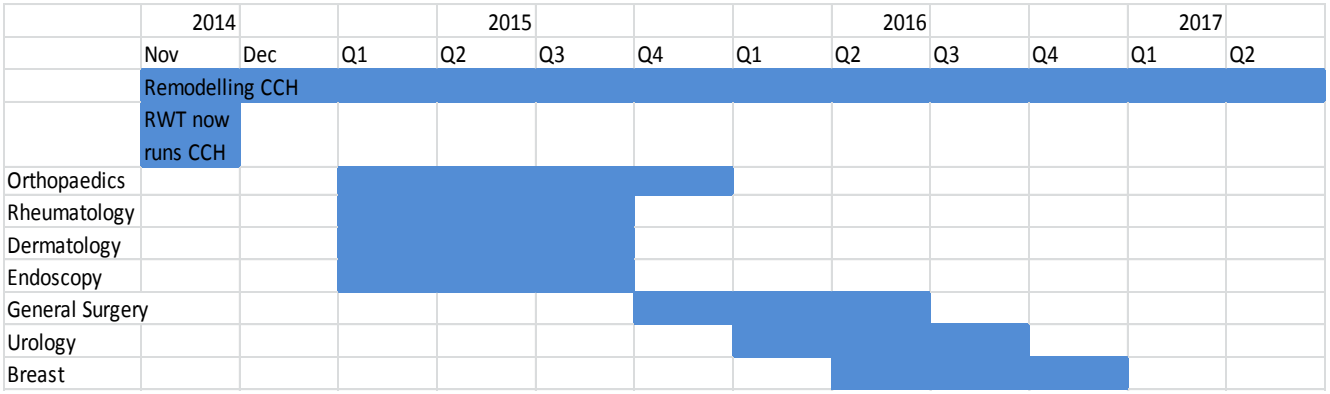
Recent evidence is demonstrated by the South West London Elective Orthopaedic Centre (SWLEOC) which has developed as a centre of excellence, and analogous to the proposed model, is associated with improvements to health and patient outcomes.

There are also some anticipated impacts on patient experience resulting from the proposed transformation of elective services. Research suggests there are potential improvements to patient experience from establishing a non-complex elective inpatient centre. The proposed transformation impacts three distinct components of the NHS Patient Experience Framework (NHS 2012).

- Welcoming the involvement of family and friends. There are proposals to review the car parking arrangements at CCH. This could facilitate the involvement of family and friends of patients undergoing non-complex inpatient elective procedures. Particularly, the proposed changes will make it easier for friends and family to come and visit patients. In doing so, the changes could enhance patient experience.
- Access to care. Lower waiting times and fewer cancellations both enhance patient access to care and thus patient experience. Testimonials from patients using SWLEOC have highlighted that it provides a good patient experience, as they are able to meet with their consultant locally but receive an efficient and high quality service for their operation (EOC 2010). The plans described by the Trust offer outpatients and preoperative assessment at both sites which increases the choice for patients.
- Physical comfort. The Trust has embarked on an extensive remodelling and refurbishment programme at CCH which will improve physical comfort for patients and visitors and support easy navigation of the hospital.

The timetable for change

The Trust takes over the management of Cannock Chase Hospital on 1st November 2014 and will continue to deliver care for the Wolverhampton patients who currently go there. The indicative timeline is shown in the table below:



Responses to the Consultation

The consultation was undertaken between 18 July and 17 October 2014. The methodology for the consultation and a summary of the responses will be presented in a final report to Wolverhampton Health Scrutiny Panel at its meeting in November.

Key themes emerging from the responses include:

- Transport – how will people get to and from Cannock Chase Hospital, and the cost of public transport and taxis. This was the main concern of around 50% of responders. The Trust has already taken steps to address this with the provision of a shuttle bus.
- Standards of care – will they be the same as New Cross
- Staff – will there be enough staff and will patients see the same team
- Improved experience – reducing delays and cancellations

The Trust and the CCG have stressed the importance of on- going involvement of patients in the detailed development of the service changes.

In addition to the individual responses the Trust and CCG received a petition of c.8000 signatures collected by Wolverhampton Breast Care Support Group. A formal response was also received from Healthwatch Wolverhampton which focused primarily on the consultation process

Equality and diversity research methodology

664 individuals responded to the consultation survey which was, given the reach of the consultation process and some of the publicity, a low response level. Equality questions were included on the survey form (questions on disability, ethnicity etc). Analysis shows a slight under representation of young people and those over the age of 80. There was also under representation from ethnic minorities with 89% of the sample being White British compared to 65% of the Wolverhampton population. Concern was also expressed by some responders regarding the provision of their postcode. There are lessons here for providing clarity and reassurances to the public about why the information is being collected, and how it is to be used and the benefit of undertaking targeted work in parallel to the main consultation process.

However there was significant coverage through a range of media, and a very wide range of stakeholders included in the consultation process in efforts to ensure that the vast majority of Wolverhampton residents had an opportunity to access the materials and to respond if desired.

Survey of Organisations

A separate short survey ran from 22 September to 17 October targeted at voluntary and community organisations who work with protected characteristic groups as defined by the Equality Act 2010. This survey was distributed by the Trust to 25 organisations or individuals using their Equality and Diversity database. It was also made available to individuals and groups through an online survey. This survey was designed to be complementary to the consultation questionnaire, and to capture any information, through the knowledge and understanding of representative groups, about how the current provision of planned care services are viewed. The questions, a summary of which is attached at appendix 1, were focused on planned care and asked about:

- Positive experiences of 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

Two specific issues which arose during the consultation and in the survey responses:

1. Concerns of people with a long-term or limiting disability and how those reliant on 3rd party transport will be affected
2. The under-representation of Indian and Pakistani respondents

Actions to address these issues have been described elsewhere in this report

2 The Context for Equality Analysis

2.1 Strategic Commitment

The Trust and CCG are 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.

The clinical model the Trust will implement mirrors that in place in a number of places across the country and 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 fact that outpatient and daycase surgery will be available on both sites means that there will be no negative impact for any of the groups with protected characteristics in terms of entering the secondary care system (first outpatient appointment) and day case surgery. Those patients who, on clinical assessment are deemed to be complex, will continue to be treated at New Cross and therefore there is no negative impact arising from these proposals.

2.2 The Public Sector Equality Duty

The **Public Sector Equality Duty** (PSED) is made up of a general overarching equality duty supported by specific duties intended to help performance of the general equality duty. The general equality duty is set out in section 149 of the Equality Act 2010.

In the exercise of functions, healthcare providers and commissioners have to give due regard to the need to:

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

These are often referred to as the three aims of the general equality duty.

Advancing equality of opportunity involves in particular, having due regard to the need to:

- Remove or minimise disadvantages suffered by people due to their protected characteristics.
- Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people.
- Encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

This includes taking into account the needs of disabled people and treating some people more favourably.

Personal Protected Characteristics

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 were required 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 the table below

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 recognised between same sex couples as well as the '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

2.3 Scope of the Equality Analysis

The Equality Analysis considers two distinct but related areas:

1. The equality impact of the new clinical model which sees the transfer of care from New Cross Hospital to Cannock Chase Hospital for some patients

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

The focus of the analysis has been on the impact for residents of Wolverhampton. The impact for residents of Staffordshire was covered within the extensive work undertaken as part of the Trust Special Administrator's consultation into changes for the provision of services at Mid Staffordshire Foundation Trust

The impact on staff working for the Trust will be considered internally within the existing framework for

Method

Both the Trust and the CCG have published documents outlining how they will seek to comply with its Public Sector Equality Duty. Both organisations have action plans in place and local tools to support Equality Impact Assessments for all change including clinical services. Further information can be accessed via the links below:

- WCCG
- RWT

This equality analysis has considered the potential impact of the transfer of some services to Cannock Chase Hospital and considers the information from the public consultation and a targeted survey of voluntary and community organisations which deal with protected characteristic groups

A wide range of information and transferable learning from equality analyses of similar service changes 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. The conclusions and inferences made in this analysis have been made using these materials.

Assumptions

In undertaking this work it is assumed that:

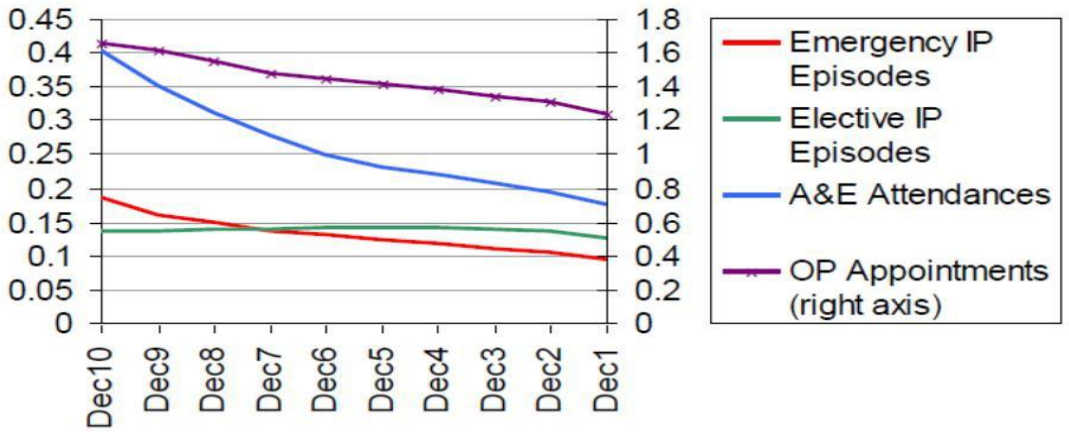
- No planned diminution of service has been identified either by withdrawing services, or restricting eligibility for existing services. The drivers for change emphasise the intention to enhance services and improve efficiencies by reducing unnecessary duplication, and offering clinicians and patients alike greater clarity along the treatment pathway.
- The Trust, in pursuance of meeting its own Public Sector Equality Duty under s149 Equality Act 2010 will conduct further analysis to cover workforce and service impacts arising from implementation plans.
- Further engagement opportunities for patients and their families, and other stakeholders will continue throughout the transition phase and the detailed service planning. These opportunities will be receptive to the perspectives of different protected characteristic groups, including targeted outreach work where relevant

3. Equality Impact of the reconfiguration of services

Accessing Services

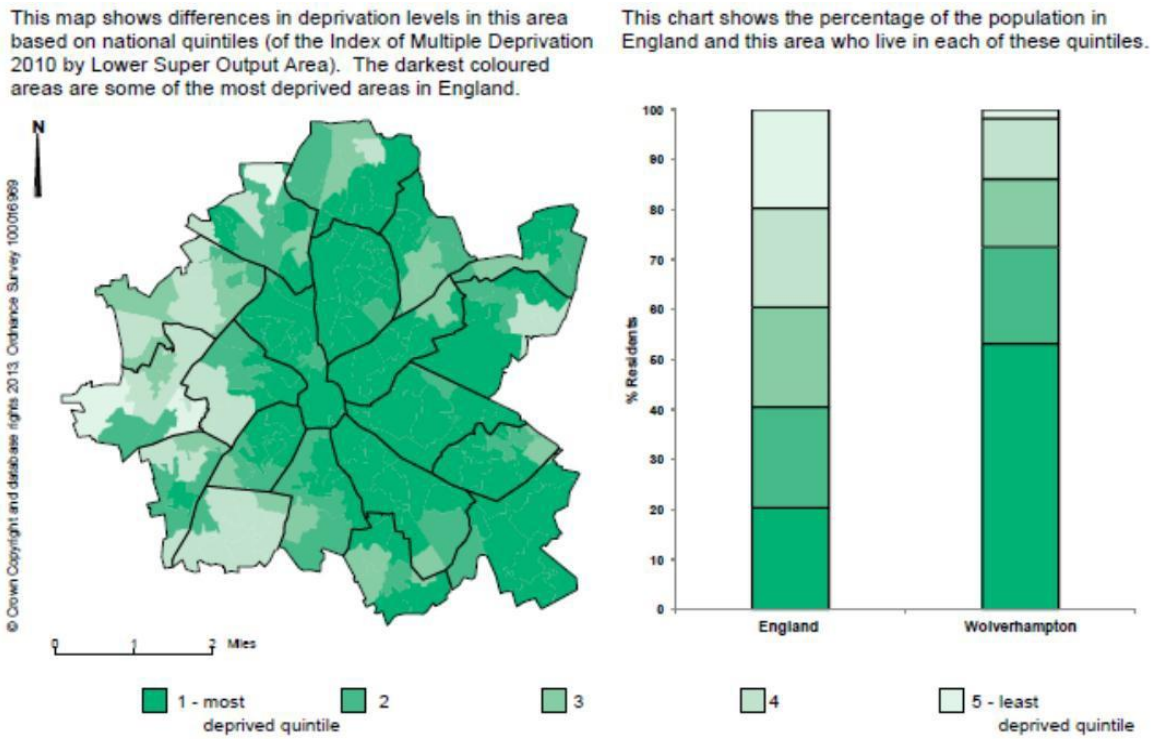
The figure below shows that the number of elective admissions per head is broadly similar across all deprivation deciles. Although these figures are for England in 2012 the authors contend that this finding is stable year on year, and it is reasonable to conclude that the pattern in Wolverhampton is highly likely to be similar.

Figure 1: 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)



Demographic Information

Figure 2: Map of Deprivation in Wolverhampton (Public Health England 2013)



The following maps highlight some of the indicators of health and wellbeing which may have a contributory effect on the impact of transferring some planned care to Cannock Chase Hospital

Figure 3: Percentage of households with no car or van – 2011 (Wolverhampton City Council 2013)

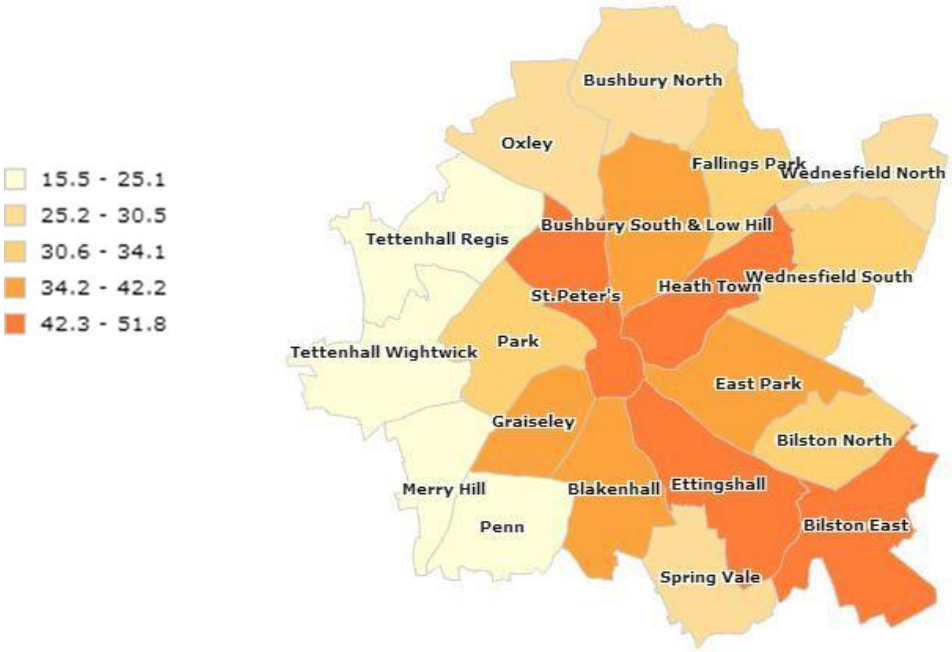


Figure 3 shows the percentage of households with no car or van. People in areas with greatest reliance on others for transport are likely to have been those who expressed most concern about the proposals. As the current service provision for outpatients and daycase surgery remains unchanged this is unlikely to have a negative impact on people accessing services.

Figure 4: Number of people who claim Disability Living Allowance (DLA) (Feb 2013) (Wolverhampton City Council 2013)

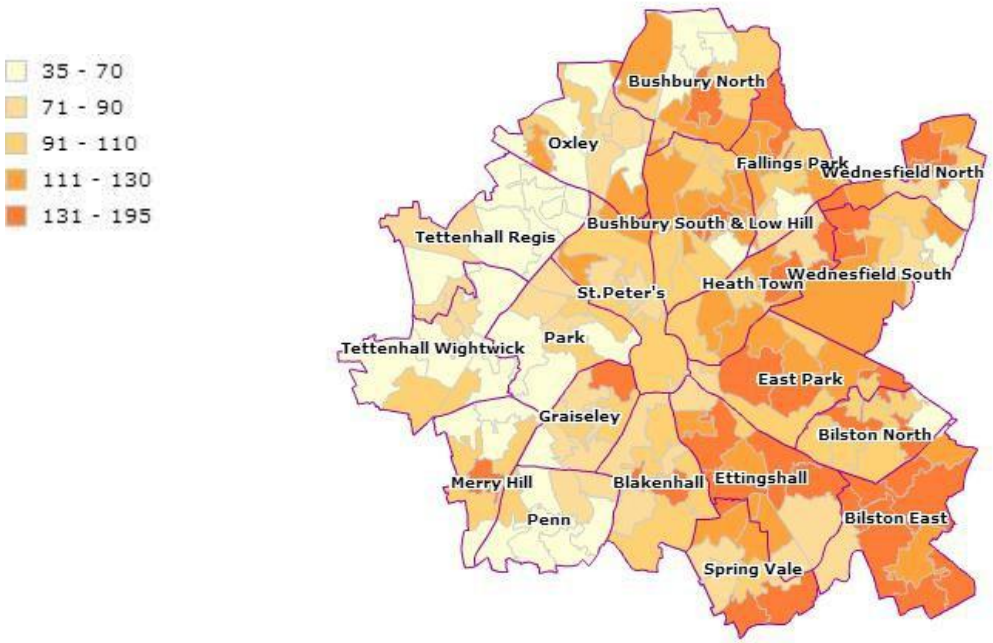
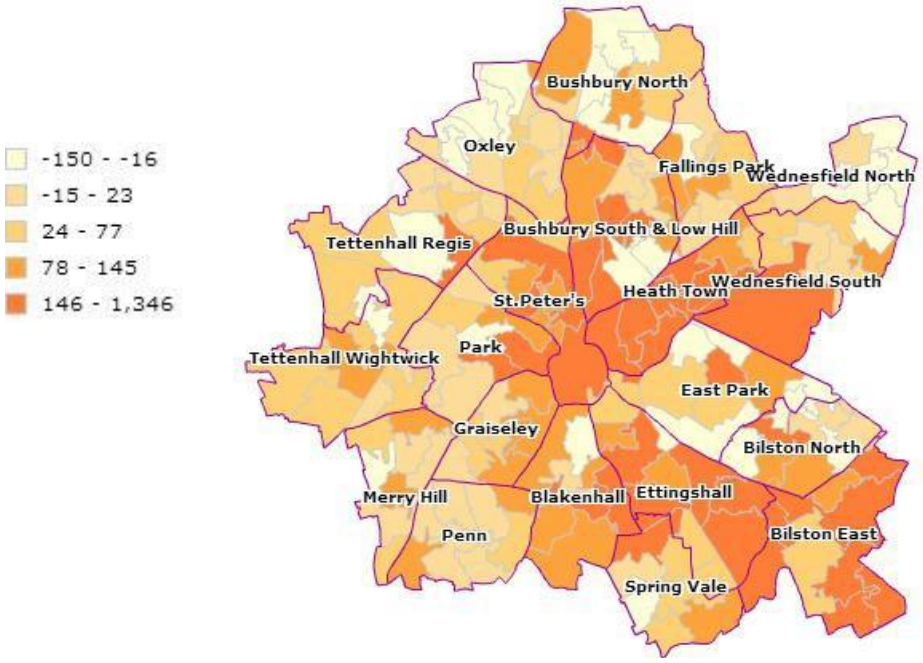


Figure 4 above shows the pattern for people who claim DLA (Personal Independence Payment (PIP) for over 16s and under-65s). DLA provides some money to eligible claimants as a contribution to extra costs caused by long term ill-health or disability. People needing DLA are less likely to be independently mobile, and more reliant on carers.

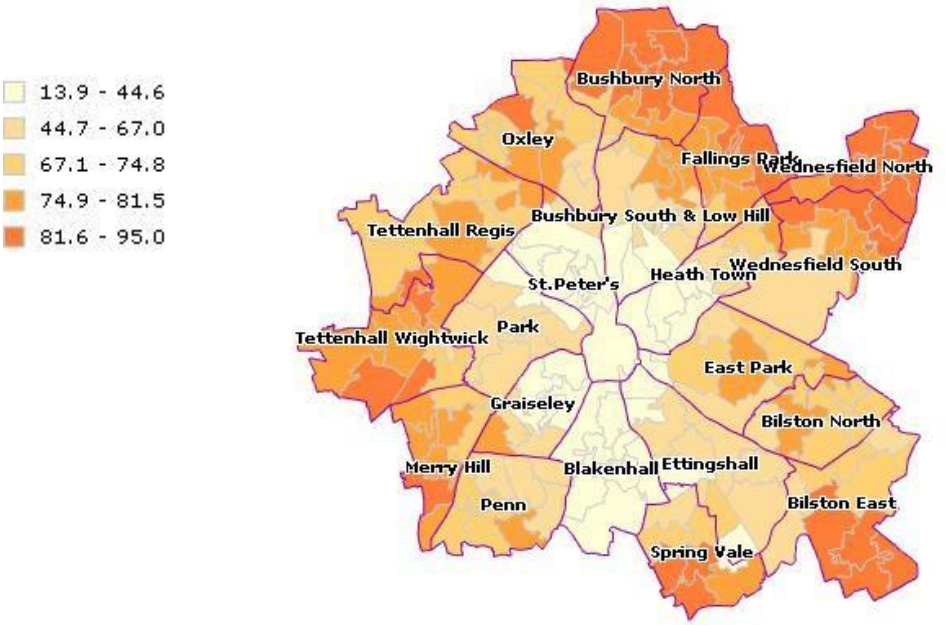
The figure below shows the total change in population in the 10 years between the last two censuses (in 2001, and 2011) and indicates significant increases in the south-east and the east of the City. This would suggest that the current pressure on services at New Cross will continue to rise.

Figure 5: Change in total population between 2001 and 2011 (Censuses 2001, 2011)



The figure below 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 1 above.

Figure 6: Population percentage of residents who are White British (Census 2011)



Travel times

There are no nationally established databases of journey times to hospital or recognised standards for what length of journey should be regarded as safe or reasonable. In the absence of a clear indication on thresholds the measure of the median distance to a District General Hospital which nationally is 12 km, with a maximum of 50 km and a corresponding travel time of 13 – 48 minutes was used. The distance between New Cross Hospital and Cannock Chase Hospital is about 13.5km (8.7 miles) with an average drive time of 19 minutes (AA Routeplanner).

Given the elective nature of the service, adverse health outcomes are not identified as a result of potentially increased travel time. People know in advance that a certain procedure is required and they book the procedure for a certain date. As such, whilst there may be an increase in travel time for some patients and the resulting inconvenience, this may suggest a less material impact on accessibility for the majority of patients travelling by public transport

Whilst physical and geographical barriers have been discussed, the main focus has been on journey times. However, stakeholders also noted the potential impact of service transformation on journey complexity. Complexity involves the route that patients have to take to reach a certain hospital, the number of changes that have to be made and the walking distance from a bus stop and train station to a hospital.

In response to early concerns during the consultation about travel to and from Cannock Chase Hospital the Trust has already committed to providing a regular bus service which will make it much easier for patients living in those wards where there is an apparent reliance on other people for their transport needs – either public transport or lifts from friends, relatives. In addition there are a number of public bus routes details are shown at appendix 3. Implementation plans will include a review of the proposed bus route and its connections with public transport across the city. The proposed service will run at sufficient frequency to enable patients to get to CCH in time for scheduled appointments including admission for surgery. The buses that the hospital will run are easy access, low-floor type buses with kneeling mechanism making easy access for people with walking difficulties and wheelchair users. There is also an open out ramp to assist with boarding and alighting which the teams of drivers are fully trained in using. The Trust has also commenced discussions with the respective council departments on the use of bus passes across borders.

Although travel time would increase for patients going to CCH for surgery/ day case treatments there would be no increase in travel time for outpatient/daycase surgery unless the patient chose to go to CCH. As previously described the Trust has plans to reduce journey complexity through the provision of a shuttle bus and through work with the council on the reorganisation of car parking outside the hospital. These actions are included within the overarching action plan.

Equality considerations for services

This section of the report set out in **Table 2** below considers the impact of the service changes on different protected characteristic groups to demonstrate how a consideration of diverse needs in preparing the detailed service plans can offer much improved experiences and outcomes for patients, as well as improving the working environment for staff.

Following a consideration of the challenges for service provision for each protected characteristic group in an planned 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**
Impact as discerned from available evidence. Bibliography is given at back of this document.	*The opportunities available in service design and operations, and the potential for reducing risks through acknowledgement of the needs of different protected characteristic groups.*

Table 2 - Protected Characteristic Groups

Protected Group	**AGE – Older People**
Potential Impact	**Opportunity/Risk Mitigation**
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%). The growing elderly population and the prevalence of long term conditions represents a significant challenge to health and social care services. Older people are higher users of orthopaedic and rheumatology services Additionally, the older people are high users of elective services and the impact of changes to these services on this group is of particular relevance. **Potential impact related to travel which may be greater than in other groups. This needs to be considered during the detailed service planning**	Choice of outpatient appointment, diagnostics and daycase at both sites will reduce the impact for this group. There is the opportunity to create better packages of care in a calmer environment for this group. The refurbishment of the site will improve accessibility as will the ground level entrance at each floor. The smaller site and calmer environment may also be beneficial for patients who are confused. Travel can cause additional anxiety for patients which will be mitigated to some extent by being on a Hospital bus rather than public transport. Discussions are also taking place about the use of bus passes across county boundaries for those who choose public buses.
Protected Group	**AGE – Younger People**
Potential Impact	**Opportunity/Risk Mitigation**
Younger people may find it difficult to take additional time off work to attend appointments. Those with young children could experience difficulties with travel on public transport. **No negative differential impact identified at this stage. However this will need to be reviewed further during service planning to determine any specific requirements**	Choice of outpatient appointment, diagnostics and daycase at both sites will reduce the impact for this group. There is the opportunity to create better packages of care in a calmer environment for this group. The refurbishment of the site will improve accessibility as will the ground level entrance at each floor. The Rheumatology Unit will offer an enhanced service for this group of patients including access to a hydrotherapy pool
Protected Group	**DISABILITY - General Issues**
Potential Impact	**Opportunity/Risk Mitigation**
The coherent integration of pathways across health and social care is a recurring concern nationally for patients with a disability and for carers. Physical access to facilities, and the availability of suitable equipment to meet the specific needs of people with different disabilities also figures prominently. For people with disabilities, the change in travel time and distance is particularly relevant and may act as a barrier to access for elective services. Depending on the nature	Choice of outpatient appointment, diagnostics and daycase at both sites will reduce the impact for this group. There is the opportunity to create better packages of care in a calmer environment for this group. The refurbishment of the site will improve accessibility as will the ground level entrance at each floor The buses that the hospital will run are easy access, low-floor type buses with kneeling mechanism making easy access for people with walking difficulties and wheelchair

of the impairment, people with disabilities may rely on family and carers to transport them to the hospital where the procedure will be performed. However, pre- and post-operative care could be provided in locations close to the home and this should entail a reduction in travel time and cost. As described for race and age, patients, carers and relatives of people with disabilities may benefit from the development of further parking at CCH **Potential impact related to travel which may be greater than in other groups. This needs to be considered during the detailed service planning**	users There is also an open out ramp to assist with boarding and alighting which the teams of drivers are fully trained in using. There is an opportunity to consult people with disabilities – both directly and through representative organisations as part of the detailed service planning to consider specific requirements for visually impaired people (colour schemes, and signage already provided for to a great extent as there is an ophthalmic unit on site); Hearing impaired people and communication options generally.
Protected Group	**DISABILITY – Learning Disability**
Potential Impact	**Opportunity/Risk Mitigation**
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 are undergoing planned treatment 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. **No negative differential impact identified at this stage. However this will need to be reviewed further during service planning to determine any specific requirements**	The RCN publication Dignity in Healthcare for People with Learning Disabilities (2nd edition) offers excellent and useable examples of good practice. Commonly reported experiences for people with learning disabilities include: • 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 This document can be used to pose questions for people with a learning disability and to consider specific scenarios relating to this group. The Trust has made a number of changes to the ways in which it supports this group of patients and their carers and should ensure that this work is replicated at CCH Choice of outpatient appointment, diagnostics and daycase at both sites will reduce the impact for this group. However, there is the opportunity to create better packages of care in a calmer environment for this group. Travel can cause additional anxiety for patients which will be mitigated to some extent by being on a Hospital bus rather than public transport
Protected Group	**Mental Health**
Potential Impact	**Opportunity/Risk Mitigation**
Based on the proposals 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	
Protected Group	**Race**
Potential Impact	**Opportunity/Risk Mitigation**

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%. 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) Impact analysis is hampered by the lack of good equality monitoring information for ethnicity. **No negative differential impact identified at this stage. However this will need to be reviewed further during detailed service planning**	Choice of outpatient appointment, diagnostics and daycase at both sites will reduce the impact for this group. There is the opportunity to create better packages of care in a calmer environment for this group. Travel can cause additional anxiety for patients which will be mitigated to some extent by being on a Hospital bus rather than public transport. The survey sample under represented ethnic minorities. 89% of the sample was White British compared to only 65% of the Wolverhampton population. The Indian, Pakistani and Black populations of Wolverhampton were not well represented on the survey. The Trust should take steps to engage with these groups during the detailed service planning to ensure that their views are considered
Protected Group	**Religion**
Potential Impact	**Opportunity/Risk Mitigation**
No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase	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.
Protected Group	**Sexual Orientation**
Potential Impact	**Opportunity/Risk Mitigation**
Although no specific issues have been identified with the case for change in Wolverhampton; Issues have been identified nationally with same sex partners not being included in consultations in the same way that heterosexual couples/married partners would. **No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase**	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.
Protected Group	**Gender Reassignment**
Potential Impact	**Opportunity/Risk Mitigation**
Based on research the Gender Identity Research and	There are concerns in trans communities about recording

Education Society (GIRES), it is estimated that 12,500 adults have presented for medical treatment of gender dysphoria with around 7,500 having now undergone transition in the UK (Gender Identity Research and Education Society 2011). GIRES also notes that there is an upward trend with the number of people presenting doubling every six and a half years 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. **No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase**	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**.** **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 stigmatism of individuals having a 'disorder'. 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.
Protected Group	**Sex**
Potential Impact	**Opportunity/Risk Mitigation**
No negative differential impact identified	
Protected Group	**Pregnancy & 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 & 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 being included in consultations in the same way that heterosexual couples/married partners would.

5. Groups not protected by the Equality Act 2010

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

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.

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.

Detailed planning of the service changes should ensure that the specific requirements of this group are considered.

Travelling Communities

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)

Detailed planning of the service changes should ensure that the specific requirements of this group are considered.

Migrants and Asylum Seekers

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)

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).

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 which should be considered in the detailed service planning:

- 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.

Carers

Carers are not a specific equality characteristic but are considered given their importance to overall patient experience where relevant. The impacts on this group are considered particularly in relation to their ability to continue to provide support to patients as travel times could increase for some patients. Also, the support of carers can be critical to the fast recovery of patients from procedures and illnesses. It is important to note that carers are not considered in the same detail as each of the protected groups.

6. Data Considerations

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 planned care services are to patients from the different protected characteristic groups. In preparing this report it is apparent that a limited amount of information is currently available about protected characteristics.

NHS Trusts 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 the Trust will need to understand something about the different patients it serves, and so collection of equality information is a necessary first step.

7. Recommendations

There are a number of recommendations arising from the responses received during the consultation. Some of these have already been translated into actions and are included in the overarching action plan. The recommendations are listed below:

1. The Trust should establish a mechanism for measuring patient experiences of cross site journeys that will complement existing patient surveys such as the Friends and Family Test.
2. The Trust should establish a mechanism for evaluating the impact of the service changes on those patients with mobility issues and therefore a greater reliance on carers to support them and those without a car or van who have a greater reliance on others for transport
3. The Trust should ensure that it makes specific reference to these service changes and the consultation and subsequent actions in both its Annual Report and Quality Account

In addition to the recommendations arising from this survey there are a number of additional recommendations linked to the joint work on the provision of Urgent & Unscheduled Care services which have been endorsed by the relevant Boards and are relevant to these service changes and should be taken account of by both the Trust and CCG. These are:

DATA - to improve on the routine collection of equality information from patients, and by staff, using collection methodologies that ensure 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. 'Equality monitoring progress 'is now a standing item at each Data Quality Review Meeting.

CONTRACTS - The Trust should 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 (this work has commenced)

CONSULTATION AND ENGAGEMENT - Opportunities to engage across the protected characteristic groups should be built in to any engagement and consultation work and should form part of the detailed service planning

The CCG and the Trust 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.

OPERATIONS and STANDARDS - The Trust should ensure that it can provide appropriate assurance that the same standards in relation to quality of care and access to services are in operation on all its sites. The CCG and the 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. The Trust should include user groups in the detailed service planning

Access and mobility issues should be considered for all visitors to Cannock Chase Hospital 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 users.

STAFF TRAINING - The CCG and Trust should 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.

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 percentage 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

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 included in the 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.

The clinical case for a change for planned care services at Cannock Chase Hospital has been clearly articulated. The intention to separate routine planned 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.

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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Appendix 1

Summary of questions in the Equality Survey September – October 2014

NB. These are shortened forms of the questions asked.

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 planned care services provided by RWT?

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?

Appendix 2

Access Facilities at Cannock Chase Hospital

- **Braille Translation service** – same provision as other RWT sites
- **Disabled parking** – provision at all levels of the Hospital and in the adjacent car parks. Drop of points and 30 minute parking at Level 1 of the Hospital. *The Trust has confirmed that it will make plans available as soon as they are agreed with the Council*
- **Disabled WC** – provision throughout the hospital
- **Signing service** – same provision as other RWT sites
- **Translation services -** same provision as other RWT sites
- **Wheelchair access** – at all levels of the Hospital
- **Step free access** – at all levels of the Hospital

Appendix 3

Bus routes – Wolverhampton to Cannock

All buses go via New Cross Hospital

ROUTE NUMBER	DAY OF SERVICE	OPERATING SERVICE	DEPARTURE POINT WOLVERHAMPTON	ARRIVING IN CANNOCK	TIMES OF DEPARTURE	LENGTH OF JOURNEY
*67	MON - FRI	Select Bus Service	Salop Street	Town Centre, Bus Station	0950 1140 1405	1 hour “
67	SAT	SBS	Salop Street	Town Centre, Bus Station	0950 1140 1405	1 hour “
*68	MON - FRI	Arriva Midlands	University of W’ton, Stafford St.	Town centre, Bus Station	On the hour between 0835-1835, and then 2055 2255	1 hour 1 hour
68	SAT	Arriva Midlands	University of W’ton, Stafford St.	Town Centre, Bus Station	On the hour between 0835- 1835 and then 2055 2255	1 hour 1 hour
70	MON - FRI	Arriva Midlands	Art Gallery, Lichfield Street (Stop2) Wulfrun Centre (Stop1)	Town Centre, Bus Station Town Centre, Bus Station	0625, 0655, 0803, 0905 Then 5 minutes past each hour 0630, 0700, 0805, 0910, then 10 minutes past each hour 0635, 0705, 0735, 0810,	1 hour 1 hour

			University of W'ton Stafford Street, (Stop 2) University of W'ton Stafford Street, (Stop 2)	Town Centre, Bus Station Town Centre, Bus Station	0845, 0915 and then 15 minutes past each hour Until; 1745, 1815, 1855, 1945. 2035, 2135, 2235	1 hour Approx. 1 hour
70	SAT	Arriva Midlands	Art Gallery, Lichfield Street (Stop 2) Wulfrun Centre (Stop 1) University of W'ton Stafford Street (Stop 2)	Town Centre, Bus Station " " " " "	0735, 0805 then 5 minutes past each hour 0740, 0810 and then 10 minutes past each hour 0745, 0815 then 15 minutes past each hour, until; 1845, 1945, 2035, 2135, 2235	1 hour 1 hour Approx. 1 hour
70	SUN	Arriva Midlands	University of W'ton Stafford Street (stand 5)	Town Centre, Bus Station	0940, 1140, 1340, 1540, 1740, 1940, 2200	Approx. 1 hour