Walsall Clinical Commissioning Group

Report on Equality Analysis

Urgent and Emergency Care in Walsall – short term/long term plans

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Walsall Urgent Care Equality Analysis vF October 2014
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Summary

Midlands and Lancashire Commissioning Support Unit (CSU) is contracted to provide equality and diversity support to Walsall 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 short-term and medium/long term proposals for urgent and emergency care. The analysis is focused on the impacts for Walsall 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 three distinct, but related areas:

1. The equality impact of the reconfiguration of services in the short term (by April 2015), requiring the re-siting of the current Walk In Centre to an alternative location in the Borough of Walsall.

Assessment 1

The relocation of a single facility Walk-in-Centre – wherever it is sited - will benefit some residents and disadvantage others. It is not possible to quantify the balance between ‘winners’ and ‘losers’. The demographic information available suggests that the health inequality gap overall between different groups is unlikely to be significantly widened or narrowed by the proposals. Patterns of deprivation and health, discussed in the analysis, suggest that a greater proportion of low income households with mobility disadvantages will benefit from the re-siting within the town centre or co-locating with the Manor Hospital site but this will be at the expense particularly of residents in the North and East where use of these facilities is disproportionately low. On balance however, locating the Walk-in-Centre at a central location close to a public transport hub makes for a compelling argument to maximise accessibility.

2. The equality considerations for the longer term (by 2018-2019)

Assessment 2

If the proposed improvements in primary, community, and hospital 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. At this stage however the proposals are substantially aspirational and so it is not possible to determine the equality impact on different protected characteristic groups. This should be considered further as plans progress - especially the emerging age differential between a ‘younger’ west of Borough and an ‘older’ east of Borough. Specific recommendations for the medium/long term plans are made in this document.

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

Assessment 3

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, as well as GP Practices and other primary care services, will be required to demonstrate compliance with the general duty under s149 Equality Act 2010 (the Public Sector Equality Duty).
Recommendations

DATA

1. The CCG works with its provider organisations to improve on the routine collection of equality information from patients using urgent and emergency care services across all protected characteristic groups and other significant minority groups.

2. CCG works with local partners and provider organisations to harmonise collection methodologies for equality data 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 appropriate staff training and the joint promotion (across health and social care agencies) of equality monitoring with users of services.

3. Equality monitoring progress reports becomes a standing item at data quality review meetings between the CCG and provider organisations.

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.

4. CCG to ensure that robust equality considerations are built into pre-qualification questionnaires (PQQs); service specifications; and by requiring providers to conduct equality analyses on their service operations in consultation with local interest groups.

5. CCG to establish contractual information requirements which require providers to report on equality in the workforce and in the delivery of services, to demonstrate compliance with s.149 of the Equality Act 2010. Action plans to be published which allow for discernible improvement in equality approaches. [NB This is consistent with adoption of the Equality Delivery System (EDS2) which NHS England intends to become mandatory from 2015]

CONSULTATION AND ENGAGEMENT

6. All agencies should develop mechanisms to engage meaningfully across the protected characteristic groups and other minority groups as the implementation phase of the urgent care strategy progresses - including specific outreach work where response rates show low engagement with particular groups.
PARTNERSHIP WORK

7. All agencies seek to involve social housing providers and homelessness organisations as part of an integrated approach to implementation plans for urgent and emergency care. 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.

8. The CCG and Public Health Department of Walsall Metropolitan Borough Council consider an analysis of patient registration data to understand current processes for the GP, Walk-In-Centre and EUCC registration for migrants, and for asylum seekers, and how these statistics can be effectively and economically collated at regular intervals.

9. All agencies - the emerging age polarity between a ‘young’ west of Borough and an ‘ageing’ east of Borough should be monitored and the findings used to plan for appropriately located services consistent with the local demographic pattern.

10. The Health and Wellbeing Partnership to explore ways to better understand the health needs of the Walsall 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.

OPERATIONS and STANDARDS

11. Provider organisations 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.

12. Provider organisations 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.

13. 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.

14. 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.

15. 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 and equality analyses.
16. The Health and Well-Being Board consider specific support being identified within the suicide prevention strategy for Lesbian, Gay, Bisexual and Transgender people.

17. Provider organisations should review and seek to improve the current access to interpreters for people whose first language is not English. This should include the access that deaf people have to BSL (British Sign Language) interpreters when attending urgent and emergency health care services.

18. NHS and social care organisations in Walsall should review the effectiveness of the systems in place to effectively treat people with a learning disability in urgent care settings. These reviews should seek the advice and guidance of the Acute Liaison Nurse. 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. The long term strategy should include measures to improve the number of health checks for people with a learning disability. The NDTi (2013) produces a toolkit to assist organisations review their services so that they are more effective for people with learning disabilities, and with autism.

STAFF TRAINING

19. 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.

20. 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.
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 Walsall have been set out in a series of published documents over the course of the last few months. In March 2014 the Health and Well-Being Board was advised:

“The review of local urgent and emergency care services is essential to improve the quality of care we provide across the borough and is being undertaken in partnership with Public Health and our local authority partners and through active engagement with stakeholders and the public.”

(Update Report Development of an Urgent and Emergency Care Strategy for Walsall Health and Wellbeing Board 3rd March 2014; p1)

1.2 The context for the review, and the need for this to be carried out speedily, was also summarised:

“Delay in reviewing the current arrangements could lead to unsustainable pressure on existing services, in particular Accident and Emergency (A&E)...The existing location (the building) that houses the walk in centre at 19-20 Digbeth Street in Walsall, has been identified as a location that may be regenerated. Plans to mitigate any risk to service provision are currently being developed by the CCG. The outcomes of the urgent care review will be fundamental in identifying what future service provision is required and the required location...Timescales for delivery of the programme of work are limited to ensure that we have a Strategy that is agreed for implementation prior to next winter.

(Update Report, Health and Wellbeing Board 3rd March 2014; p3)

1.3 The aim of the review was stated as:

“Our aim is to improve access and integration across services for people with urgent healthcare needs, by ensuring the system is well communicated and simpler to navigate. We want to ensure that services are available at the right place, the right and first time for all patients using our services.”

(Update Report, Health and Wellbeing Board 3rd March 2014; p3)

1.4 This aim was extended in April 2014 as part of a developing longer term strategy for urgent care in Walsall:

“The aim of this strategy is to ensure that the future system provides patients with high quality, accessible and affordable urgent care across the local health economy.”

(‘Development of an Urgent and Emergency Care Strategy for Walsall’ Walsall CCG Governing Body Public Meeting - 24th April 2014)
1.5 This report also set out some guiding principles for the urgent care strategy which were later reported to (and accepted by) Walsall Council’s Health Scrutiny and Performance Panel (24th April 2014) and the Health and Well Being Board (28th April 2014). The principles are:

- Greater levels of self-care of patients
- Clearer, streamlined access to Urgent Care services
- Enhanced opening of GP Practices across the borough of Walsall
- Joined up Urgent and Emergency Care Services
- On-going consultation with the public.

The timetable for change

1.6 There is to be a phased approach to delivering the strategy. **Phase 1** concerns immediate-short term solutions which includes the redesign of the two walk in services in the Borough. This is because there “is an immediate issue regarding the two existing walk in centres (the Walk in Centre (WIC) in Walsall Town Centre and the Emergency and Urgent Care Centre at the Manor Hospital (EUCC)) because the current contractual arrangements for these services are due to end in March 2015. There is also a need to review existing services from the Walk In Centre due to the town centre regeneration”

1.7 **Phase 2** (Mid-longer term vision) which includes a proposal for a co-ordinated Urgent and Emergency Care system developed over the next 5 years.

1.8 This Equality Analysis considers the potential Phase 1 changes (relocation of the Walk-in-Centre) in detail and offers an early indication for issues to be considered as part of Phase 2, including a detailed consideration of service issues for each of the protected characteristic groups listed in the Equality Act 2010.

Local engagement

Your place, your well-being – Spring 2012

1.9 The ‘Your Place, Your Well-being’ Survey was undertaken jointly by Walsall Council and NHS Walsall (the Primary Care Trust) in Spring 2012. Questionnaires were completed by a random sample of over 3,000 households across the borough. The research built on previous work such as the Place Survey, and asked about well-being, perceptions of the borough and lifestyle choices. It specifically asked residents for thoughts on their local area, their priorities for improvement, satisfaction with local neighbourhoods and public services and explored some of the key health and well-being issues that they may experience. Part of the survey asked residents to indicate how important they considered different services to be in their lives – including health services – and then to indicate to what extent they felt each service was in need of improvement. The results indicated that although residents rate health services as very important – they are consistently ranked in the top 4 alongside other services – a substantially smaller number of residents consider that health services are in need of improvement. Relative to other services such as highway maintenance, policing, and access to local amenities for example, health services scored very low for ‘need to improve’ considerations as Figure 1 summarises.
Figure 1: Health services – perceptions of importance and of need to improve. 
(Walsall Intelligence Network, January 2013)

<table>
<thead>
<tr>
<th>Area Partnership</th>
<th>Health services Important?</th>
<th>People saying Health services need improving?</th>
<th>People saying Road and Pavement services need improving (as comparator)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area</td>
<td>%</td>
<td>(%)</td>
<td>%</td>
</tr>
<tr>
<td>1</td>
<td>Brownhills Pelsall Rushall-Shelfield</td>
<td>50 2nd</td>
<td>10 Traffic congestion 26</td>
</tr>
<tr>
<td>2</td>
<td>Aldridge and Beacon</td>
<td>46 3rd</td>
<td>10 Public transport 19</td>
</tr>
<tr>
<td>3</td>
<td>North Walsall</td>
<td>40 3rd</td>
<td>15 40%</td>
</tr>
<tr>
<td>4</td>
<td>Walsall South</td>
<td>37 3rd</td>
<td>15 49%</td>
</tr>
<tr>
<td>5</td>
<td>Darlaston and Bentley</td>
<td>32 4th</td>
<td>8 38%</td>
</tr>
<tr>
<td>6</td>
<td>Willenhall and Short Heath</td>
<td>48 3rd</td>
<td>11 54%</td>
</tr>
</tbody>
</table>

1.10 This survey was completed nearly two years after the publication of the Health white paper in June 2010 and following Royal Assent for the Health and Social Care Act 2012 (in March 2012) – a period of considerable national debate and media attention about the future of the NHS and the structural changes required by the new legislation.

1.11 Although over two years ago the survey remains an important indicator of the level of concern Walsall people have about their local health services relative to other issues. It is quite low. However, perceptions can change, and particularly on “the three issues most likely to excite local opinion – money, transport and emergency care” (Independent Reconfiguration Panel, 2010). The plans considered here have all three elements.

Walsall Urgent Care Research Report – December 2013

1.12 This report (Central Midlands CSU (2013)), commissioned by Walsall CCG comprised over 275 face to face interviews at each of the three main urgent care centres: the Walk-in-Centre (WIC); the Emergency and Urgent Care Centre (EUCC); and at Accident and Emergency (A&E). In total, information was collected from some 846 respondents and diversity monitoring was included as part of the survey. The research offered useful findings which have informed the proposals for urgent and emergency care. Detailed findings are referenced in the discussions about Phase 2 plans (section 3), and in ‘Equality considerations for services (section 4).
Reviewing Walsall’s urgent care services - The Listening Exercise
(6 January – 31 January 2014)

1.13 The listening exercise built on the research already undertaken at urgent care centres. The specific aim of this exercise was ‘To understand the views of people and organisations on what works well, what doesn't work so well and how services could be improved.’ Over 400 people responded to a mix of surveys and face-to-face interviews.

1.14 Key findings in report included concern about access to GPs and problems in navigating through the NHS and social care. Specific findings are referenced in the discussions below.

1.15 Diversity questions, based on the protected characteristics of the Equality Act 2010, were asked as part of the Listening Exercise, but secured a low response rate. Reflecting on this, the CCG identified three areas of improvement:

1. To ensure that systems are in place to capture the information consistently at different venues where surveys/face-to-face interviews are conducted.
2. To fully brief and/or train staff engaged to conduct the surveys/interviews so that they understand the reasons why such information is being requested, and can converse confidently with respondents about this.
3. Respondents are also reassured about the anonymity of such responses and explanations offered about how the information they provide will be used.


1.16 This report summarises the outcome of the 12 week consultation period carried out by the CCG. 562 survey responses were received. The report offers a statistical analysis of the total replies to each of the consultation questions, as well as breakdowns by age, gender, sexuality, ethnicity, and disability. This report has helped to inform the assessments made in this equality analysis.

Equality Survey of organisations

1.17 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 Walsall Voluntary Action to organisations listed on their database, and by compiling a list of organisations extracted from the ‘Local Organisation’ database maintained by Walsall Council at https://www.walsall.gov.uk/libraries/localorganisations/search. 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?

1.18 The survey ran over a six week period from early June through to 25th July 2014. 26 organisational responses were received, but only a dozen surveys were fully completed. The findings from this survey have been used to inform the local issues included in the analysis of protected characteristic groups at section 4. In general the responses have focussed on patient experiences of urgent care rather than any comment on the proposals. There is general satisfaction with the quality of treatment but dissatisfaction about lengthening waiting times, including anecdotal information that families with young children or with a family member with a disability will turn to A&E if they can’t get a GP appointment within a reasonable time. Particular concerns from the survey include (in no particular order):

• Access to GPs on the phone and an increase in automated answering services rather than ‘real people’
• Elderly residents in Shelfield and High Heath not having a local GP.
• Language barriers – not having access to interpreters
• Helping people who are isolated and not socially active as a key preventative investment to offset demand on urgent care services.
• No parking facilities at the Walk-in-Centre in town and no wheelchair access.
• The cost of parking facilities at Manor Hospital
• Greater understanding required of children with complex needs and of those with palliative care needs.
• For chronic pain in people with ME/Chronic Fatigue Syndrome or Fibromyalgia to be taken more seriously by GPs, by nurses, and by hospital consultants.

1.19 Walsall CCG has committed in its equality strategy to work with provider organisations to ensure that as plans for re-modelled urgent and emergency care services develop and are implemented, 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. These processes are a necessary part of the Equality Delivery System (EDS2).
2 The Context for Equality Analysis

Strategic Commitment

2.1 There are explicit commitments to equality and diversity in the CCG’s Equality and Diversity Strategy:

“We are committed to equality and diversity in all aspects of employment and service delivery... As part of the Public Sector Equality Duty contained in the Equality Act 2010, we will show due regard to ensuring that individuals do not receive less favourable treatment on the grounds of race; disability; gender; age; religion and belief; sexual orientation; pregnancy and maternity; marriage and civil partnership and gender reassignment... We will work towards eliminating discrimination, advancing equality of opportunity, and fostering good relations in the course of developing policies and delivering services.

(Chairman’s Foreword, Equality and Diversity Strategy 2013-2017)

2.2 In addition there are clear accountabilities set out in the CCG’s Constitution; and an equality action plan is received on a quarterly basis by the CCG’s Safety, Quality and Performance Committee for assurance that the strategy is being progressed. The action plan is part of the CCG’s Equality Strategy which is published on the CCG’s website at this [link](#).

2.3 In consideration of short term proposals (Phase 1) an options appraisal process was adopted which included an ‘inequalities and social justice’ criterion. This was weighted highly as shown by the table below (Figure 2). This methodology was applied to a ‘long list’ of different possible options for Walk-in-Centre re-design or re-siting.

Figure 2: Options Appraisal Issues and Methodology

<table>
<thead>
<tr>
<th>Category</th>
<th>Weightings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Access – patients, visitors, staff</td>
<td>3 (essential)</td>
</tr>
<tr>
<td>2 Integration and proximity to other healthcare services</td>
<td>2 (Very important)</td>
</tr>
<tr>
<td>3 Clinical quality and safety</td>
<td>3 (essential)</td>
</tr>
<tr>
<td>4 Ease of delivery</td>
<td>3 (essential)</td>
</tr>
<tr>
<td>5 Sustainability</td>
<td>2 (very important)</td>
</tr>
<tr>
<td>6 Patient choice &amp; satisfaction</td>
<td>3 (essential)</td>
</tr>
<tr>
<td>7 Strategic fit</td>
<td>2 (very important)</td>
</tr>
<tr>
<td>8 Indicators of success</td>
<td>3 (essential)</td>
</tr>
<tr>
<td>9 Cost and affordability</td>
<td>2 (very important)</td>
</tr>
<tr>
<td>10 Inequalities and social justice</td>
<td>3 (Essential)</td>
</tr>
</tbody>
</table>

2.4 Each criterion was defined, had an attendant rationale, and a set of questions for the review team to consider before offering a score for each option out of 5, prior to it being multiplied by the weighting. The definition, rationale and questions for the inequalities criterion were:
Inequalities and social justice

Definition: Has the proposal the potential to improve or widen health inequalities?

Rationale: Link to the equality and diversity impact assessment (equality analysis) and Health impact assessment.

Questions: Does the option widen health inequalities? Does the option have the potential to narrow health inequalities? If an adverse effect is likely, is mitigation clear? Is this likely to improve social cohesion?

2.5 The ‘long list’ of options (prior to scoring) was tested with GP Locality Boards and the Urgent Care Working Group during February 2014 to ensure that no additional options had been missed. 16 possible scenarios were identified before being appraised to form a proposal which could be put to a wider public, patient and stakeholder consultation.

The Public Sector Equality Duty

2.6 Clinical Commissioning Groups (CCGs) are now listed as public authorities in Part 1 of Schedule 19 to the Equality Act 2010. This means that Walsall 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 Figure 3 below.

2.7 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.

2.8 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

2.9 Midlands and Lancashire Commissioning Support Unit (MAL CSU), as part of its support to Walsall Clinical Commissioning Group, was asked to help facilitate an Equality Analysis on the proposals for urgent and emergency care. The aims in producing this report were to:

i. Establish a baseline on current usage of urgent and emergency care services within Walsall with regard to **protected characteristic groups**.
ii. Assess the equality impact on the local population of potential changes as part of the plans in Walsall.
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

2.10 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 **Figure 3** below:
Figure 3: Definition of Protected Characteristic Groups

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>Age</td>
<td>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.</td>
</tr>
<tr>
<td>Sex</td>
<td>Someone being a man or a woman</td>
</tr>
<tr>
<td>Disability</td>
<td>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.</td>
</tr>
<tr>
<td>Race</td>
<td>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.</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>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.</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>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.</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>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.</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>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.</td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>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</td>
</tr>
</tbody>
</table>
Scope of the Equality Analysis

2.11 The Equality Analysis considers three distinct but related areas:

i. The equality impact of the reconfiguration of services in the short term (by April 2015) – requiring the re-siting of the current Walk in Centre to an alternative location in the Borough of Walsall.

ii. The equality considerations for the medium term (by 2018-2019)

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

2.12 The focus of the analysis has been on the impact for residents of Walsall, but not for visitors from neighbouring CCG areas seeking healthcare within Walsall. Each CCG should consider the equality impact for its own population.

2.13 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. However, the options appraisal process included criteria for determining some impacts on staff such as staff access; proximity to other healthcare services; clinical quality and safety; and ease of delivery.

Method

2.14 Walsall 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.

2.15 For the urgent care proposals, 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 (see Section 1 above) 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 2014; the formal public consultation held in summer 2014; and a targeted survey of voluntary and community organisations which deal with protected characteristic groups (June-July 2014) [Discussed more fully in section 4]

2.16 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 (e.g. homeless people; migrants; travelling communities). The conclusions and inferences made in this analysis have used these materials.

Assumptions

2.17 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 offering high quality, accessible and affordable urgent care which is simple to navigate.

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 phases of the long term strategy across the health economy.

iii. Further engagement opportunities for patients and their families, and other stakeholders will continue throughout the strategy period (anticipated to be 5 years from 2014) 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

Phase 1: Short-term - relocation of Walk in Centre

3.1 The consultation document published by Walsall CCG in May 2014 – ‘Consultation on urgent and emergency care; How to get involved and have your say – 23rd May – 14th August 2014’ sets out the context and proposals for consideration:

i. Move Walsall Walk-in Health Centre to a new town centre location – this would be open from 8am to 8pm, 7 days per week.

ii. Move Walsall Walk-in Health Centre to a new out of town location in the north of Walsall this would be open from 8am to 8pm, 7 days per week.

iii. Move Walsall Walk-in Health Centre and merge it with the existing Emergency and Urgent Care Centre, which already provides an urgent care walk in service at Walsall Manor Hospital – this would continue to be open 24 hours per day, 7 days per week.

3.2 These options are summarized in Figure 4 below
3.3 The three options each carry a different level of geographic precision. The merger with the existing EUCC at the Manor Hospital is clearly defined. Location within the town centre is less definite, but still quite closely defined because it would necessitate siting the centre within a very limited radius. The third option is very open and could potentially be located in any of the northern Area Partnerships outside of Walsall South (St Matthews, Paddock, Palfrey, and Pleck) making a precise consideration of equality impacts more difficult. Before considering the potential equality impact of each of these different proposals, it is necessary to consider the demography and geography of the Borough.

Demographic Information

3.4 The use of urgent and emergency healthcare services is inextricably linked to socio-economic factors and particularly to deprivation. Walsall has high numbers of people living in deprived areas when compared to the figures for England – Figure 5.

“In 2010, Walsall was ranked as the 30th most deprived of the 326 Local Authorities in England. This position has worsened since the last data release in 2007, where Walsall ranked 45th out of 354. The borough fares particularly badly in terms of education, income and employment deprivation. Central and western parts of the borough are typically more deprived than the east.”

(Walsall JSNA Refresh 2013; page 62)
Figure 6, below, summarises research that looked at emergency and elective activity by deprivation decile for England (ie in tenths – tenth poorest and so on). It 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 (poorest) 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 Walsall 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 of all urgent and emergency care facilities, and therefore the specific locale of facilities may differentially impact on people living in more deprived areas, particularly if the facility is re-sited to a more distant place.

The Walsall Urgent Care Research Report (CMCSU 2013) found that the Walk-in-Centre is used more by people who do not have access to a motor vehicle, and use public transport or walk there.
Figure 6: Emergency and elective inpatient (IP) 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)

3.8 The following maps highlight some of the indicators of health and wellbeing for which relocation of the Walk-in-Centre may have a contributory effect.

3.9 The shading in Figure 7 below - patterns of vehicle ownership – closely resembles that for the deprivation map at Figure 5. It suggests that people living in the North Walsall and Walsall South Area Partnerships are, proportionately, more likely to experience disbenefits regarding transport because of an apparent reliance on other people for their transport needs – either public transport or lifts from friends and/or relatives.

3.10 People in Bloxwich, Blakenhall, Birchills Leamore, St Matthews, Paddock, Palfrey, Pleck, Darlaston and Bentley in particular (where car ownership is low) are relatively close (by travel time) to the existing Walk-in-Centre in the Town Centre and to the Manor Hospital sites, and there are relatively good public transport links to these locations. Re-siting the Walk-in-Centre to an alternative Town Centre location, or merging it at the Manor will directly benefit some people in these wards, and directly disbenefit others. The complexity of winners and losers means that the overall impact is not discernible, but it is unlikely to measurably widen or to reduce health inequalities.

3.11 However there is also evidence, from the map, of pockets of low vehicle ownership to the North East of the Borough – particularly in the southern part of the Brownhills ward, in Rushall-Shelfield, and in Aldridge North and Walsall Wood. Figure 16 (below) shows that of those people seeking urgent care services, the proportion using the Walk-in-Centre from Brownhills is the lowest %, with Aldridge North and Walsall Wood the next lowest %. An out-of-town-centre re-location further North, or
North-East would directly benefit residents in these wards by reducing their distance of ‘dependency’. Clearly this would also place the facility further away from where the pivotal central areas of deprivation in the Borough are. Implementation plans should therefore consider access to public transport networks for those people who need to travel further from these and other wards in the East of the Borough and particularly during the longer term transition to discernible improvements in primary care. This is included as a recommendation in this report.

Figure 7: % of households with no car or van – 2011 (compiled by Walsall Council 2014, from Census 2011 data)
Figure 8: Number of people who claim Disability Living Allowance (DLA) November 2013 (compiled by Walsall Council, July 2014)

3.12 **Figure 8** 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 - generally - 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 West and North of the Borough is consistent with the map of deprivation and proxy indicators for low income such as Figure 7 above. Again this suggests that the relocation of the Walk-In-Centre facility to another town centre location will mean that it would still be relatively more accessible to the majority of those in the Borough receiving DLA, (including Darlaston and Bentley and Willenhall and Short Heath to the West) than if located in the North, although more remote from the areas of claimants in parts of Brownhills, Aldridge North and Walsall Wood, and Rushall-Shelfield.

3.13 **Figure 9** shows the pattern of minority ethnic groups in the Walsall borough area, based on Census 2011 information and using the descriptor of ‘the % of residents who are ‘other than White British’. The pattern is very similar to Figure 14 below
which illustrates English language needs. The larger minority ethnic populations - particularly in the wards of St Matthew’s, Palfrey, Pleck, Paddock, and the southern part of Birchills Leamore means that a town centre location for the Walk-in-Centre or co-location at the Manor hospital site would, on balance, be more readily accessible to a larger number of residents from minority ethnic communities than a more northerly location in the Borough. These areas are also the wards exhibiting the highest deprivation in the Borough (Figure 5), and, proportionately, the highest activity at both the existing Walk-in-Centre and the EUCC. Both the deprivation factors (aggravating poor health), and proximity factors (offering ease of accessibility) contribute to these higher than average activity levels but it has not been possible in this analysis to determine the magnitude of impact of each one.

Figure 9: Population % of residents by ethnicity (Census 2011) (compiled by Walsall Council, July 2014)
There are over 350 separate maps of Walsall which can be constructed from Census 2011 information. The six Figures (10-15) on this and the following pages are a small selection sourced from the University of Liverpool (Alex-Singleton - Open Atlas) used to illustrate both the complexity of the Borough’s population, but also where there are some intriguing patterns. On this page for example, the almost mirror contrast of the very young (infants of 0-4 years) and the elderly, post retirement age generation of 65-74 years showing a definite West to East split (although note particularly the contrast in Short Heath and Bloxwich which makes this simple divide more complex. This makes simple assessments for the location/re-location of an existing facility impossible – any location is likely to benefit one group at the expense of another. In such circumstances, choosing a central location close to a transport hub offers a compelling rationale.
A similar contrast is offered by the two patterns displayed here, and is perhaps challenging to our pre-conceptions. Again there is a distinct skew to the East and North for residents aged 75 years and over, many of whom we may expect to be experiencing long term conditions. But people self-defining as in very bad health shows an apparent skew to the West. Distinct overlaps between the two are apparent in Rushall-Shelfield and the immediately adjacent area in Aldridge Central and South, and in Bloxwich East, and Brownhills.
Figure 14 - Household language – No people in household have English as a main language

Figure 14 illustrates the area of need for interpreting is likely to arise from the cluster of electoral wards close to the Manor Hospital and to a Walk-in-Centre co-located at the Manor site, or within the Town centre; and so for this population, a central location would be beneficial as long as the attendant language support services are in place to meet patient and carer needs. Figure 15 shows another distinct Western and North skew for elementary occupations. These are defined for the Census as jobs requiring simple and routine tasks but sometimes with considerable physical effort. This will include cleaners, labourers, street and related sales workers and refuse workers. Predominantly these will be low paid jobs, increasingly offered on zero-hours contracts. It coincides with the deprivation maps Figs 5, 7 and 8 above.
### Walsall Urgent Care Equality Analysis vF

**October 2014**

Colour Key – in each column:
- is the highest value;
- the second highest value;
- is the lowest value

<table>
<thead>
<tr>
<th>Wards</th>
<th>Activity (Individual requests) for urgent care (A)</th>
<th>% (A) using Manor Hospital</th>
<th>% (A) using EUCC</th>
<th>% (A) using Walsall Walk in Centre</th>
<th>% (A) using Out of Hours</th>
<th>% (A) using Other Out of Borough</th>
<th>Total % (A) Out of Borough</th>
<th>Activity expressed as % of ward population (Census 2011 figures)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>194,696</td>
<td>36%</td>
<td>22.6%</td>
<td>30.7%</td>
<td>5.0%</td>
<td>3.5%</td>
<td>2.2%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Pelsall</td>
<td>5325</td>
<td>42.9%</td>
<td>23.4%</td>
<td>23.1%</td>
<td>6.5%</td>
<td>3.2%</td>
<td>0.9%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Brownhills</td>
<td>7306</td>
<td>46.2%</td>
<td>22.4%</td>
<td>15.0%</td>
<td>6.8%</td>
<td>2.8%</td>
<td>7.0%</td>
<td>9.8%</td>
</tr>
<tr>
<td>Rushall-Shelfield</td>
<td>6225</td>
<td>40.6%</td>
<td>22.4%</td>
<td>26.7%</td>
<td>7.1%</td>
<td>2.1%</td>
<td>1.1%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Aldridge North &amp; Walsall Wood</td>
<td>3509</td>
<td>42.2%</td>
<td>21.5%</td>
<td>18.8%</td>
<td>6.6%</td>
<td>2.3%</td>
<td>8.7%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Aldridge Central &amp; South</td>
<td>6900</td>
<td>42.1%</td>
<td>18.1%</td>
<td>23.7%</td>
<td>9.5%</td>
<td>2.4%</td>
<td>4.1%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Pheasey Park Farm</td>
<td>1196</td>
<td>18.1%</td>
<td>11.5%</td>
<td>25.4%</td>
<td>12.5%</td>
<td>0.6%</td>
<td>31.9%</td>
<td>32.5%</td>
</tr>
<tr>
<td>Streetly</td>
<td>1084</td>
<td>23.8%</td>
<td>10.9%</td>
<td>25.2%</td>
<td>15.4%</td>
<td>0.5%</td>
<td>24.2%</td>
<td>24.7%</td>
</tr>
<tr>
<td>Bloxwich East</td>
<td>7357</td>
<td>40.9%</td>
<td>22.4%</td>
<td>25.0%</td>
<td>8.5%</td>
<td>2.8%</td>
<td>0.4%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Bloxwich West</td>
<td>9069</td>
<td>40.5%</td>
<td>23.7%</td>
<td>27.2%</td>
<td>5.9%</td>
<td>2.4%</td>
<td>0.3%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Blakenall &amp; Birchills Leamore</td>
<td>26,750</td>
<td>34.3%</td>
<td>26.2%</td>
<td>33.1%</td>
<td>4.7%</td>
<td>1.5%</td>
<td>0.3%</td>
<td>1.8%</td>
</tr>
<tr>
<td>St Matthews and Paddock</td>
<td>25,185</td>
<td>27.2%</td>
<td>17.0%</td>
<td>49.9%</td>
<td>3.8%</td>
<td>1.6%</td>
<td>0.5%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Palfrey</td>
<td>16,303</td>
<td>25.4%</td>
<td>18.1%</td>
<td>50.7%</td>
<td>3.8%</td>
<td>1.2%</td>
<td>0.8%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Pleck</td>
<td>11,695</td>
<td>32.3%</td>
<td>28.8%</td>
<td>33.3%</td>
<td>3.9%</td>
<td>1.5%</td>
<td>0.2%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Darlaston South; Bentley and Darlaston North</td>
<td>22,880</td>
<td>38.5%</td>
<td>25.8%</td>
<td>27.4%</td>
<td>4.1%</td>
<td>3.2%</td>
<td>1.0%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Willenhall North and Short Heath</td>
<td>12,241</td>
<td>33.6%</td>
<td>24.0%</td>
<td>23.8%</td>
<td>6.5%</td>
<td>11.9%</td>
<td>0.4%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Willenhall South</td>
<td>8391</td>
<td>30.3%</td>
<td>23.8%</td>
<td>22.8%</td>
<td>6.6%</td>
<td>16.1%</td>
<td>0.5%</td>
<td>16.6%</td>
</tr>
</tbody>
</table>

**Figure 16** – urgent care activity by Ward (figures from Walsall CCG (2014) and Census 2011)
3.14 **Figure 16** above uses activity figures taken from the Health Market Analysis carried out by Walsall CCG in July 2014, along with population information from the 2011 Census to present some comparative information by electoral wards in the Borough. Activity can include several visits by the same person. This will help to give context to the discussions above concerning deprivation and the impact of re-locating the existing walk-in-centre.

[NB – Data for the postcodes WV11 2 and WV11 3 have not been included because they fall outside of the Borough. The postcode WS2 8 bridges the wards of Pleck and Blakenhall & Birchills Leamore. For the purposes of this analysis it has been included with the latter. The separate wards of St Matthews and Paddock; of Willenhall North and Short Heath; of Darlaston South and Bentley & Darlaston North; and of Blakenhall and Birchills Leamore have been combined because of the cross-boundary nature of the postcode sectors on which the data has been gathered.]

3.15 The colour coding in the table is used to highlight the highest, second highest and lowest values. The final column – activity as a % of the ward population offers a comparative set of figures to understand the demand arising from each ward. The table offers some interesting figures which can be used as further cues for exploration:

- **Brownhills** has the highest proportion of people using Manor Hospital yet the lowest (at 15%) using the Walk in Centre suggesting that travel distance may be a less significant factor to influence access for more urgent medical needs. Activity as a proportion of ward population is below the Borough average at 57.6% (72.3% average). Activity at out of Borough facilities is markedly higher than the average at 9.8% (5.7% average).
- **Streetly** has a very low overall use of urgent care services at 7.8% when expressed as a proportion of the ward population (the lowest in the Borough), but of those that do use urgent care, many use the out of hours service (15.4%) (the highest proportion in the Borough). A high proportion also use services outside of the Borough – 24.7% (compared to a 5.7% average). Streetly residents also have the lowest proportion of activity at the EUCC – 10.9% (22.6% average), and at New Cross – 0.5% (3.5% average).
- **Pheasey Park Farm** similarly has a very low proportion of activity for its population (at 10.9% the second lowest), and the lowest proportion in the Borough of those using A&E at Manor Hospital -18.1% (36% average) Residents here have the highest proportion of their service users – nearly a third of those who use urgent care - using out of Borough services – 32.5% (5.7% average)
- **Palfrey and St Matthews & Paddock** have the highest proportion using the Walk-in-Centre (50.7% and 49.9% respectively), and this is from a high overall activity as a percentage of population (98.6% - highest, and 89.6% - third highest respectively). However both wards have the lowest proportion of their service users accessing the GP Out of Hours service. Whether this reflects patient choice or awareness of services is not discernible from this data.
- **Pleck** has the highest proportion of its service users accessing the Emergency and Urgent Care Centre (EUCC) at the Manor Hospital – 28.8% (22.6% average)
- The high figures for activity expressed as a percentage of population in **Palfrey, Blakenhall & Birchills Leamore, St Matthews and Paddock, Darlaston and Bentley, and Pleck**; and the low figures for **Streetly, and Pheasey Park Farm** correspond with the findings by Monitor (February 2014) and by McCormick and others (March 2012) which together show that people living in more deprived
areas are more likely to use urgent care services. This offers some credence to the application of other national data on similar themes to the Walsall context.

Conclusion on Phase 1 – short term relocation of the Walk-in-Centre

3.16 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 of different locations is differentially negative, or positive. We have tried to use indices of deprivation, and proxies for low income, to understand the potential impacts a little better. There are competing claims. The ‘critical mass’ of deprivation is focused on the western half of the Borough, but there are significant pockets of poorer households to the North East in parts of Brownhills, in Aldridge North and Walsall Wood, in Pelsall, and in Rushall-Shelfield.

3.17 Clearly, given the evidence concerning the links between deprivation and demand for urgent care services, it is reasonable to assume that the more distant these areas (in the North East of the Borough) are to service provision, the greater the disbenefits associated with trying to access services. However, it has not been possible to quantify this, other than to notice that the activity as a proportion of ward population in these areas is well below the average for the Borough, the proportion using the Walk-in-Centre is well below the average for the Borough, but the proportion using A&E is higher. Furthermore the balance of the magnitude of activity attributable to deprivation factors, or to proximity factors as indicated in the Keogh Review (NHS England 2013b) is difficult to disentangle. Also, 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 potential 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, but the benefit reduces the further some residents have to travel.

3.18 Offering conclusions on the magnitude of benefits and disbenefits would be speculative. Disbenefits may well be out-weighed by improvements in the system over time – 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.

3.19 Conjecture and uncertainty in modelling means that it cannot be argued that there is any discernible differential impact overall (positive or negative) on any particular protected characteristic groups from the Phase 1 proposals. Because of limited data collected by providers about usage patterns it is not possible to detect any spikes or gaps in service reach. The demographic information available suggests that the health inequality gap overall between different groups is unlikely to be significantly widened or narrowed by the proposals. Patterns of deprivation and health, discussed in the analysis, suggest that a greater proportion of low income households with mobility disadvantages will benefit from the re-siting within the town centre or co-locating with the Manor Hospital site but this will be at the expense particularly of residents in the North and East where use of these facilities is disproportionately low. On balance however, locating the Walk-in-Centre at a central location close to a public transport hub makes for a compelling argument to maximise accessibility.
Phase 2: Medium-Long Term (5 years) improvements to primary care

3.20 The consultation document published by Walsall CCG (May 2014) sets out a number of proposed improvements as part of the longer term strategy. It states that “…the new service would be supported by improvements in primary, community and hospital care, which would help people to:

- care for themselves at home
- know where best to go for their needs by calling NHS111
- have better access to GP practices
- ensure that all long term condition patients have a care plan and
- experience joined up urgent and emergency care services.”

Consultation on urgent and emergency care; How to get involved and have your say 23rd May – 14th August 2014

3.21 The consultation document also commits to simplifying the urgent care system, but this is not explicit on the question of whether or not, longer term, there will continue to be a separate walk-in-centre distinct from A&E, in addition to the co-located services at Manor Hospital.

3.22 Commissioners have to navigate a difficult path to balance the demands and expectations of people who use services with the need to maintain quality within resource limits – particularly when demand is increasing:

“…attendances at walk-in centres and minor injury centres have increased by around 12% per year since data was first recorded in 2003. Increased demand for walk-in services is part of a larger trend of increased demand for other NHS services. The average number of GP practice consultations per patient rose from 3.9 to 5.5 per year between 1995 and 2008. Attendances at major and single specialty A&E departments have also increased, by about 18 per cent between 2003 and 2011 (or 2% per year).”

Monitor (February 2014; page 41)
Walk-in centre review: final report and recommendations

3.23 Because of the substantially aspirational nature of the long-term plans it is not possible, at this stage to determine the equality impact on different protected characteristic groups. Clearly if the aspirations are realised, and improved access for patients to local primary care facilities are secured evenly across the Borough, then all communities – including disadvantaged groups – should benefit. There are challenges to overcome given the increasing demand, the ageing profile of the Borough, and that recent patient experiences of GP services and out-of-hours have been poor when compared to the England average (Figure 17). In addition the emerging age polarity between a ‘young’ west of Borough and an ageing east of Borough will need to be carefully mapped and the findings used to plan for appropriately located services consistent with the local demographic pattern.
Figure 17 – patient experiences of GP Services (from Outcome Benchmarking Pack – LA Level – Walsall (NHS England and PH England - Jan 2014)

3.24 The Walsall Urgent Care Research Report (December 2013) also identified problems with current access to GP services. Of those that tried to get an appointment with their GP, most reported that they were told there were 'no appointments available at all', or offered an appointment 'next week' or later (Figure 18)

Figure 18 – Patient experience of access to GP services

<table>
<thead>
<tr>
<th>Appointment offered by GP</th>
<th>Total</th>
<th>Walk In Centre</th>
<th>A&amp;E/ EUCC Combined</th>
<th>EUCC (Emergency &amp; Urgent Care Centre)</th>
<th>A&amp;E (Accident &amp; Emergency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base (Those who tried to get appointment)</td>
<td>263</td>
<td>125</td>
<td>138</td>
<td>103</td>
<td>35* Low Base</td>
</tr>
<tr>
<td>Today</td>
<td>10%</td>
<td>3%</td>
<td>16%</td>
<td>11%</td>
<td>31%</td>
</tr>
<tr>
<td>Tomorrow</td>
<td>10%</td>
<td>9%</td>
<td>11%</td>
<td>10%</td>
<td>14%</td>
</tr>
<tr>
<td>In 3 to 5 days time</td>
<td>10%</td>
<td>7%</td>
<td>13%</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>Next week (6 plus days)</td>
<td>16%</td>
<td>23%</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>No appointments available at all</td>
<td>43%</td>
<td>53%</td>
<td>33%</td>
<td>42%</td>
<td>9%</td>
</tr>
<tr>
<td>Didn’t get through to reception</td>
<td>7%</td>
<td>4%</td>
<td>10%</td>
<td>12%</td>
<td>6%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>5%</td>
<td>1%</td>
<td>8%</td>
<td>5%</td>
<td>17%</td>
</tr>
</tbody>
</table>

3.25 The long term strategy will need to consider improvements in areas where performance against national indicators is poor – for example the proportion of eligible adults with a learning disability having a GP health check (Figure 19).

Figure 19: Proportion of eligible adults with a learning disability having a GP health check (Public Health England 2013a)
3.26 People with a learning disability have more difficulty than others in recognising ordinary health problems and getting treatment for them. Each year GPs are supposed to offer regular health checks to make sure important problems are identified and treated. Whilst the situation in Walsall is improving year on year the current position remains significantly worse than the performance across England and in the West Midlands, and this potentially has an impact on urgent care. 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)

3.27 Specific operational considerations for different protected characteristic groups are considered in the next section.
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 Figure 20 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 Figure 20

<table>
<thead>
<tr>
<th>Protected Group</th>
<th>Potential Impact</th>
<th>Opportunity/Risk Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protected Group = Group as defined by the Equality Act 2010</td>
<td>Impact as discerned from available evidence. Full reference list given at back of this document.</td>
<td>The opportunities available in service design and operations, and the potential for reducing risks through acknowledgement of the needs of different protected characteristic groups.</td>
</tr>
<tr>
<td>Local Issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The issues arising from the consultation, the equality survey of organisations, local research or studies, and stakeholder comments received.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Protected Group | AGE – Older People
--- | ---
Potential Impact | Opportunity/Risk Mitigation
National estimates suggest an increase in the number of older people (aged 65 years and over) in Walsall from 45,100 in 2010 to 50,400 in the year 2020. (16.9% of the population; English average 16.6%; West Midlands (17.2%)) The number of people 85 year and older increasing from 5,467 in 2008 to 8,109 in 2021 (48% increase) Figs 11 and 12 (above) illustrate a geographical skew with significantly more older people residing in the East and North of the Borough. **No discernible negative impact in Phase 1 but important issues to consider at implementation for improvements in service delivery. Positive impacts are contingent on improvements to primary/secondary care.**

The growing elderly population and the prevalence of long term conditions represent a significant challenge to health and social care services. **Older people, proportionately, are significantly high users of A&E (25.5% of attendances in 2013/14).** Opportunity to consider access by older people to specific facilities as they are developed, 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 a higher than average proportion of older people appear to be reluctant to use the telephone to access out-of-hours care (DH 2012; p20). Standards & 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:

**Rec 15.** There should be a distinct area in Emergency Departments which is visibly and audibly distinct, that can facilitate multidisciplinary assessments; **Rec 16** All units should have ready access to time critical medication used commonly by older people such as Levo-Dopa; **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; **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. **Recommendation: Provider organisations should consider adoption of the Silver Book recommendations as appropriate for their areas of service.**

Local Issues

Feedback from the Urgent Care Equality Survey (Appendix 2) echoed a key issue identified in the JSNA – “**High levels of older people living alone with no access to their own transport limits their ability to participate in a range of activities and often leads to social isolation. This in turn places added pressure and increased reliability on public transport**”. Anecdotal information includes – Long waits for ambulances; Triage phone management for access to ambulances needs to be more responsive to the needs of older people; Issues of dignity – eg: 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 or timely care; long waiting times in A&E particularly difficult for elderly patients, especially when they may need to lie down; communication with community services requires improvements; understanding of palliative care in A&E would help to ensure a safe discharge for patients.
### Protected Group

<table>
<thead>
<tr>
<th>Potential Impact</th>
<th>Opportunity/Risk Mitigation</th>
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</table>
| 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) | 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. 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:  
**Section 6 - Staffing and Training issues**  
**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.  
**Standard 9:** Emergency care settings seeing more than 16,000 children per annum employ a consultant with sub-specialty training in paediatric emergency medicine  
**Section 4 - Environment in emergency care settings**  
**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)  
**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 |

No discernible negative impact in Phase 1 but important issues to consider at implementation for improvements in service delivery. Positive impacts are contingent on improvements to primary/secondary care.

### Local Issues

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. A specific concern raised in the equality survey of organisations that a greater understanding is required in emergency and urgent care settings of children with complex needs and of those with palliative care needs.
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 (particularly when emergency treatment is required) also figures prominently.

No discernible negative impact identified in Phase 1. However this will need to be reviewed further at the implementation phase.

<table>
<thead>
<tr>
<th>Protected Group</th>
<th>DISABILITY ISSUES</th>
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</thead>
<tbody>
<tr>
<td><strong>Potential Impact</strong></td>
<td><strong>Opportunity/Risk Mitigation</strong></td>
</tr>
<tr>
<td>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 (particularly when emergency treatment is required) also figures prominently.</td>
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</tr>
<tr>
<td><strong>No discernible negative impact identified in Phase 1. However this will need to be reviewed further at the implementation phase.</strong></td>
<td><strong>No discernible negative impact identified in Phase 1. However this will need to be reviewed further at the implementation phase.</strong></td>
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</table>

Walsall has a higher proportion of residents with a long term health problem or disability than the national average. There is an opportunity to involve people with disabilities – both directly and through representative organisations as part of the continuing consultation and particularly during the implementation phases; to consider accessibility improvements for people who have mobility problems, and/or who use mobility aids; for visually impaired people (colour schemes, and signage); Deaf and Hearing impaired people and communication options generally – especially access to BSL (British Sign Language) interpreters. Key sources of information offering insight into the experience of patients with disabilities include:

- Signhealth (2014) ‘How the Health Service is failing Deaf People (link)
- Watkinson, S; Scott, E.(2003) ‘Managing the care of patients who have visual impairment. Nursing Times 100:1; 40–42. (link)
### Protected Group

#### DISABILITY – LEARNING DISABILITY

<table>
<thead>
<tr>
<th>Potential Impact</th>
<th>Opportunity/Risk Mitigation</th>
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</table>
| Based on information from GPs (Public Health England (2013a)) there are approximately 900 people with a learning disability in Walsall. The proportion of the population this represents is not significantly different to the England average. 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. | Royal College of Nursing (2013); Dignity in Health Care for People with Learning Disabilities (2nd edition) [London]  

“I was in a ward and a patient was screaming. Nobody did anything. I was scared” p14  
The RCN publication 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 the urgent and emergency care pathways for people with a learning disability and to consider scenario testing.  
GAIN (Guidelines and Audit Implementation Network, June 2010): Guidelines on Caring for people with a Learning Disability in General Hospital Settings (Northern Ireland)  
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.  
“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)  
The Parliamentary Health Ombudsman (2009) recommended that “all NHS and social care organisations in England should review urgently: the effectiveness of the systems they have in place to enable them to understand and plan to meet the full range of needs of people with learning disabilities in their areas”.

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Walsall Urgent Care Equality Analysis vF  October 2014
## Protected Group

**DISABILITY – LEARNING DISABILITY - CONTINUED**

<table>
<thead>
<tr>
<th>Protected Group</th>
<th>Opportunity/Risk Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Potential Impact</strong></td>
<td><strong>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)</strong></td>
</tr>
<tr>
<td><strong>Public Health England (2013a) Learning Disabilities profile for Walsall</strong></td>
<td>This document shows that the population of adults with a learning disability known to GPs is slightly less than the English average. For the purposes of urgent care, the significantly poorer performance for GP health-checks (see Figure 18 above) will need to be considered as part of the longer term strategy to improve primary care.</td>
</tr>
<tr>
<td><strong>Recommendations:</strong> 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. The long term strategy should include measures to improve the number of health checks for people with a learning disability. The NDTi (2013) produces a toolkit to assist organisations review their services so that they are more effective for people with learning disabilities, and with autism.</td>
<td></td>
</tr>
</tbody>
</table>

## Local Issues

A respondent to the public consultation was concerned about the quality of care provided to their son who has a **profound learning disability**. It was suggested that staff need to be trained to care for similar patients and have the time and patience to diagnose them effectively. The respondent was worried this might not happen in an overstretched service. This echoes similar concerns expressed nationally by advocacy organisations. Provider organisations are advised to review their services through equality analysis to ensure that the particular needs of such patients. The Learning Disability profile for Walsall (PHE 2013a) indicates that for 2008-2009 (the last year that figures are available), the identification of patients with a learning disability in general hospital statistics was significantly above the England average. This suggests that mechanisms to capture such data were in place and effective then, although it has been difficult to obtain information about Learning Disability for this analysis. The CCG commissions an Acute Liaison Nurse who offers advice and support on learning disabilities and is based at Manor Hospital. Providers are therefore advised to consult written guidance produced by the ALN or contact direct in relation to a person with learning disabilities entering urgent care.
## Protected Group

<table>
<thead>
<tr>
<th>Potential Impact</th>
<th>DISABILITY – MENTAL HEALTH</th>
</tr>
</thead>
</table>
| 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. | The College of Emergency Medicine (Feb 2013); ‘Mental Health in Emergency Departments – A toolkit for improving care’ [College of Emergency Medicine, London]  
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)  
“Does the education and clinical knowledge of your staff in mental health match that for major trauma, cardiac arrest...?” (p2)  
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).  
Care plan management involving multi-disciplinary teams for substance and mental health for patients who will benefit from a consistent response.  
Recommendation: Commissioner and providers consider a planned move towards adoption of the CEM standards over an agreed and realistic period of time. |

<table>
<thead>
<tr>
<th>Local Issues</th>
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<tbody>
<tr>
<td>The Chief Executive at Walsall Manor Hospital reported in January 2014 that “We are about to commence some short-term improvement work to provide 3 extra cubicles for patients and improve facilities for assessing patients with mental health needs in the existing department. We are continuing to work with the CCG on plans for the complete redevelopment of the unit. The exact timing for this will be confirmed as part of the Trust’s updated plan due in June 2014 but is likely to be 2015/16 – 2016/17.” See link</td>
<td></td>
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</table>
### Protected Group

<table>
<thead>
<tr>
<th>Potential Impact</th>
<th>RACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td>The overall figures for minority ethnic respondents to the urgent care consultation were low (14% compared to a population figure of 23%) although significantly higher responses were received from Indian (4.7%); Pakistani (2.8%); and Irish (1.4% respondents). These minority groups were the only groups from all respondents to indicate a majority of those surveyed in favour of the proposals for urgent care.</td>
</tr>
<tr>
<td>Impact analysis is hampered by the lack of good equality monitoring information for ethnicity.</td>
<td>While monitoring of ethnicity locally, in Walsall, is carried out by provider organisations, the information does not appear to be used pro-actively to inform operational or strategic decisions. There is considerable room for improvement and established arguments for why organisations should do this:</td>
</tr>
<tr>
<td>No negative differential impact identified at Phase 1. However this will need to be reviewed further at the implementation phase.</td>
<td>There are opportunities to consult different minority ethnic groups as part of the urgent and emergency care implementation phases – 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 processes may wish to highlight the public sector equality duty and set contractual information requirements on providers to demonstrate how they comply with statutory provisions. Providers have opportunities to consider workforce development and talent management, recruitment, and promotion of equal opportunity policies especially in preparation for NHS England’s introduction of a Race Equality Standard (link)</td>
</tr>
</tbody>
</table>

**Hull, S; Mathur,R; Boomla,K (May 2011):**

“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.”

**DH (June 2011) A&E Clinical Quality Indicators; Best Practice Guidance for Local Publication**

“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).”
These figures offer cues for further exploration to understand where we can improve access to the most appropriate mode of care. Please see also Figure 21 and discussion of migrant health.

## Protected Group

<table>
<thead>
<tr>
<th>Potential Impact</th>
<th>Opportunity/Risk Mitigation</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>NHS Scotland Information Services Division (ISD) in their AE2 ‘A&amp;E data recording reference manual (October 2013 v2.0) includes as potential data items: ethnicity, religion, sexual orientation.</td>
</tr>
<tr>
<td></td>
<td>Butler, Christina, Hatzidimitriadou, Eleni and Psinos, Maria (2010) put a cogent case for the benefits of ethnic monitoring.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

## Local Issues

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.

On language needs the Equality and Diversity Profile (Walsall Council, 2014) states:

“Levels of English proficiency in Walsall are high, and in line with the national average. Overall 92.6% of residents speak English as their main language; a further 5% do not consider English their main language but speak it well. However this still leaves 3.3% of the borough’s households in which no one speaks English as their main language and over 6,200 residents who cannot speak English well (1,200 of whom cannot speak the language at all).”

The CCG commissions interpreting services for GP Practices, and local provider organisations each commission interpreting services for their own organisations. In preparing this analysis, there appeared to be little evidence of interpreting service information being used regularly to inform strategic planning, or operational business decisions. The CCG, through its Equality and Diversity action plan, intends to review language support and interpreting services in 2014-2015.
<table>
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<tr>
<th>Protected Group</th>
<th>RELIGION</th>
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<tr>
<td>Potential Impact</td>
<td>Opportunity/Risk Mitigation</td>
</tr>
<tr>
<td>No negative differential impact identified at Phase 1. However this will need to be reviewed further at the implementation phase</td>
<td>Opportunity for providers to consider workforce composition and planning as local populations change, and to consider the cultural sensitivity of services provided. 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. Useful resources include: Northern Ireland inter-Faith Forum (2005) ‘Check up - A guide to the special healthcare needs of ethnic-religious minority communities’ 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.</td>
</tr>
</tbody>
</table>

Local Issues

The Walsall Urgent Care Research report (Central Midlands CSU (2013) found that: “Compared to the Walsall census, a high proportion of people in the survey stated they had no religion (37% vs 20%). This may be an effect of the different survey environments; the census seeming to demand to know your ‘official religion’, with the ad-hoc survey perhaps resulting in a more pragmatic response. Similarly in this survey far fewer people claimed to be Christian than in the census.( 46% vs 59%). The proportions of Christians and those with no religion is fairly stable across the three urgent care services, suggesting this may be a research effect rather than a finding that non-religious people use Urgent Care Services more….Focussing just on the differences between the samples taken at the three Urgent Care locations, shows a statistically significantly higher proportion of Muslims using the WIC and EUCC than A&E. The proportion of Muslims who are registered with a GP (95%) is not significantly different to the proportion of the total population (94%), so this is not the cause of their higher usage. Sikhs are significantly more likely to use EUCC than the WIC.” It would be useful to improve the equality monitoring data collected by providers for the protected characteristic of religion to see if these patterns are indeed statistically significant over sustained periods. |
## Protected Group | SEXUAL ORIENTATION

<table>
<thead>
<tr>
<th>Potential Impact</th>
<th>Opportunity/Risk Mitigation</th>
</tr>
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<tbody>
<tr>
<td>Although no specific issues have been identified with the case for change in Walsall; 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.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>No negative differential impact identified at Phase 1. However this will need to be reviewed further at the implementation phase</strong></td>
<td><strong>Bishop, M (2013)  ‘Out in the City – exploring the experience and needs of Lesbian, Gay, Bisexual and Trans People in Wolverhampton’ [LGBT Network and Wolverhampton City Council]</strong></td>
</tr>
<tr>
<td></td>
<td>Although this research was conducted by a group based in Wolverhampton, the respondents to the survey were not necessarily Wolverhampton residents, and some of the findings have more general application.</td>
</tr>
<tr>
<td></td>
<td>Section 2.11 - “Just over 34% respondents did not feel hospitals were meeting the needs of LGB and T people; 11% felt they did, 55% had never used hospital services.”</td>
</tr>
<tr>
<td></td>
<td>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).</td>
</tr>
<tr>
<td></td>
<td><strong>Stonewall (2008)  ‘Serves You right: Lesbian and gay people’s expectations of discrimination</strong></td>
</tr>
<tr>
<td></td>
<td>Stonewall describes staff comments and antagonistic attitudes in response to current affairs stories or radio news openly discussed in front of patients:</td>
</tr>
<tr>
<td></td>
<td>“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.”</td>
</tr>
<tr>
<td></td>
<td>[Conversation overheard by a lesbian patient during treatment to reattach nerves in her finger; p15].</td>
</tr>
<tr>
<td></td>
<td><strong>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).</strong></td>
</tr>
</tbody>
</table>

## Local Issues

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.
### Protected Group

<table>
<thead>
<tr>
<th>Protected Group</th>
<th>GENDER REASSIGNMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Potential Impact</strong></td>
<td><strong>Opportunity/Risk Mitigation</strong></td>
</tr>
<tr>
<td>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.</td>
<td>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 provider organisations to review policies for reception and treatment for patients and carers; and training for staff.</td>
</tr>
<tr>
<td>No specific issues have been identified in Walsall for urgent care, but anecdotal issues raised nationally with trans groups around courtesy of treatment, respect and dignity issues for a person’s preferred identity.</td>
<td>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 Transsexualism 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’. 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.</td>
</tr>
</tbody>
</table>

No negative differential impact identified at Phase 1. However this will need to be reviewed further at the implementation phase. | Transgender Patients: Implications for Emergency Department Policy and Practice (Journal of Emergency Nursing 2005; 31: 405-407) “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) 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? |

### Local Issues

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.
<table>
<thead>
<tr>
<th>Protected Group</th>
<th>SEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential Impact</td>
<td>Opportunity/Risk Mitigation</td>
</tr>
<tr>
<td>No negative differential impact identified</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protected Group</th>
<th>PREGNANCY AND MATERNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential Impact</td>
<td>Opportunity/Risk Mitigation</td>
</tr>
<tr>
<td>No negative differential impact identified</td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protected Group</th>
<th>MARRIAGE AND CIVIL PARTNERSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential Impact</td>
<td>Opportunity/Risk Mitigation</td>
</tr>
<tr>
<td>No negative differential impact identified</td>
<td>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.</td>
</tr>
</tbody>
</table>
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 Rates of statutory homelessness in Walsall are better than the average for England but research shows that homeless people are likely to be high users of urgent care services.

5.3 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)

5.4 Because of the disproportionate impact of homelessness on the costs of health provision – particularly skewed towards urgent and emergency care – future 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**

5.5 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)

5.6 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 2014 suggests that 51 caravans are located within the Borough’s boundary – this includes caravans on authorised and unauthorised sites. Reliable estimates of the number of individuals and their age profile have not been secured for this report.

5.7 It would be useful, through the Health and Wellbeing Partnership to explore ways to better understand the health needs of the Walsall 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

5.8 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)

5.9 From Census 2011 data, 3.7% (9859) of Walsall’s residents were born outside of the UK and arrived in the UK since 2001. The proportion of non-UK born individuals arriving in the past 10 years is comparable to that experienced by authorities such as Telford and Wrekin and Herefordshire, but significantly lower than the West Midlands average of 5.2% for this period (Newall, 2013).

5.10 Newall (2013) further 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 Borough.” He suggests that 1.8% of Walsall’s population arrived from outside the UK in the past 5 years. This compares to 2.9% for the West Midlands Region. In 2011, 22.7% of primary school aged children and 14.8% of secondary school pupils in the Borough have a non-English first language (Regional averages are 18.9% and 13.8% respectively). Walsall has the fifth largest proportion of primary school and secondary school children with a non-English first language in the West Midlands.

Migrants registering for health services

5.11 Newall (2013) provides a useful summary for Walsall:

“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 authority in 2010 were equivalent to 5 per every 1000 of the resident population. This represents 1159 new migrant patient registrations in 2010-11, a reduction of 112 on the previous year. 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 GP patient registration data. Walsall has a lower level of new migrant GP registration per 1000 residents than the West Midlands Region as a whole for which was 8 per 1000 resident population in 2010.”

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. Some information is available (see Figure XX below), although there are further cues for exploration here (highlighted in yellow) including the high % of ‘not stated and not recorded’ activity.
Figure 21 A&E data for attendances and non-GP registered attendance in Walsall by ethnic group 2013/14 (data source Midlands and Lancashire CSU & NOMIS 2011 census data)

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>% of Walsall’s Population by ethnic group (2011 census)</th>
<th>Number of attendances for GP registered patients</th>
<th>% of attendances for GP registered patients of total for ethnic group</th>
<th>Number of attendances for non-registered patients</th>
<th>% of attendances for non-registered patients</th>
<th>% of all A&amp;E attendance by ethnic group</th>
</tr>
</thead>
<tbody>
<tr>
<td>British</td>
<td>76.9</td>
<td>57,996</td>
<td>99.26</td>
<td>434</td>
<td>0.74</td>
<td>72.31</td>
</tr>
<tr>
<td>Irish</td>
<td>0.5</td>
<td>182</td>
<td>96.3</td>
<td>7</td>
<td>3.7</td>
<td>0.23</td>
</tr>
<tr>
<td>Any other White background</td>
<td>1.4</td>
<td>1,152</td>
<td>90.64</td>
<td>119</td>
<td>9.36</td>
<td>1.57</td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>1.6</td>
<td>502</td>
<td>98.82</td>
<td>6</td>
<td>1.18</td>
<td>0.63</td>
</tr>
<tr>
<td>White and Black African</td>
<td>0.1</td>
<td>82</td>
<td>97.62</td>
<td>2</td>
<td>2.38</td>
<td>0.1</td>
</tr>
<tr>
<td>White and Asian</td>
<td>0.7</td>
<td>211</td>
<td>99.06</td>
<td>2</td>
<td>0.94</td>
<td>0.26</td>
</tr>
<tr>
<td>Any other mixed background</td>
<td>0.3</td>
<td>293</td>
<td>96.38</td>
<td>11</td>
<td>3.62</td>
<td>0.38</td>
</tr>
<tr>
<td>Indian</td>
<td>6.1</td>
<td>4439</td>
<td>98.95</td>
<td>47</td>
<td>1.05</td>
<td>5.55</td>
</tr>
<tr>
<td>Pakistani</td>
<td>5.3</td>
<td>3976</td>
<td>99.08</td>
<td>37</td>
<td>0.92</td>
<td>4.97</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>1.9</td>
<td>806</td>
<td>99.38</td>
<td>5</td>
<td>0.62</td>
<td>1.0</td>
</tr>
<tr>
<td>Any other Asian background</td>
<td>1.5</td>
<td>914</td>
<td>98.17</td>
<td>17</td>
<td>1.83</td>
<td>1.15</td>
</tr>
<tr>
<td>Caribbean</td>
<td>1.2</td>
<td>810</td>
<td>98.3</td>
<td>14</td>
<td>1.7</td>
<td>1.02</td>
</tr>
<tr>
<td>African</td>
<td>0.7</td>
<td>523</td>
<td>96.14</td>
<td>21</td>
<td>3.86</td>
<td>0.67</td>
</tr>
<tr>
<td>Any other Black background</td>
<td>0.4</td>
<td>219</td>
<td>97.77</td>
<td>5</td>
<td>2.23</td>
<td>0.28</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.4</td>
<td>63</td>
<td>92.65</td>
<td>5</td>
<td>7.35</td>
<td>0.08</td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>0.8</td>
<td>531</td>
<td>90.61</td>
<td>55</td>
<td>9.39</td>
<td>0.73</td>
</tr>
<tr>
<td>Not stated/recorded</td>
<td>0.2</td>
<td>7114</td>
<td>97.2</td>
<td>203</td>
<td>2.8</td>
<td>9.06</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>79,813</td>
<td>98.77</td>
<td>990</td>
<td>1.23</td>
<td>100%</td>
</tr>
</tbody>
</table>
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.

5.14 Work in London- Ford A et al (2013) – Figure 22 - looked at cutting A&E use and health inequalities. The research found that 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. Two 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. This work in Merton 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.

5.15 Anecdotally, in Walsall there is a suggestion that some new migrants & refugees are in lower skilled manual type labour. Evidence from other research on migration indicates that working hours and issues relating to agency work and short contracts create barriers to normal GP access and may result in individuals putting off access to health care until the condition is more acute. Data on the ethnicity and country of origin of walk in centre users and a more complete picture for primary care use would be helpful in providing an indication of over or under use by migrant communities.

Figure 22 – Cutting A&E use (from Ford, A (2013)
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 Walsall CCG (See Figure 23 below).

6.2 From discussions with provider organisations there are recurring issues which tend to impede the collection of equality monitoring data:

   i. Partial information only about protected characteristics is collected – typically for age, gender and ethnicity – although some limited information is available on Learning Disability. Public Health England (2013a) reports a good level of recording for learning disability but it is not clear how this information is effectively used at local level. Furthermore there are high numbers of ‘not stated’ returns (ie where patients have chosen not to state ethnicity) which renders 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.

   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 effectively. 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:

“Walsall CCG recognises 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.”

6.4 To develop these issues further, the Senior Equality and Diversity Manager of Midlands and Lancashire Commissioning Support Unit is working with Walsall CCG to review the equality information and assurances offered by intending providers in PQQs (Pre Qualification Questionnaires); service specifications, and contractual information requirements.
Figure 23 – Summary of equality data received by Central Midlands CSU for Walsall CCG from providers (source – CSU; 2014)

<table>
<thead>
<tr>
<th></th>
<th>Admissions</th>
<th>A &amp; E</th>
<th>Urgent Care Centre</th>
<th>Walk in Centre</th>
<th>Out of Hours</th>
<th>PALS</th>
<th>111</th>
<th>WMAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Sex</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Religion or Belief</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Pregnancy and Maternity</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Disability</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

Non-Statutory

<table>
<thead>
<tr>
<th></th>
<th>Admissions</th>
<th>A &amp; E</th>
<th>Urgent Care Centre</th>
<th>Walk in Centre</th>
<th>Out of Hours</th>
<th>PALS</th>
<th>111</th>
<th>WMAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless people</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Sex workers</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Travellers</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Migrant workers</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Asylum seekers</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

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

6.5 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.

6.6 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

6.7 Because of the significant gaps in data collected, it is difficult to draw any reliable conclusions about the use of Urgent Care facilities in Walsall, and in some cases, no analysis is possible. Establishing a baseline in line with our first aim (see paragraph 2.9 (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. Walsall 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. Conclusion

7.1 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 20 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.

7.2 The clinical case for a change in urgent and emergency care services in Walsall has been clearly articulated. The proposed strategy will be designed to improve health outcomes for residents and visitors to Walsall. 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 in Phase 1 for any of the protected characteristic groups covered by the Equality Act 2010.

7.3 No negative implications for patients regarding their rights under the NHS Constitution have been identified by this analysis.

7.4 A more detailed assessment of urgent care services operationally can be made by ensuring that equality considerations are built into pre-qualification questionnaires (PQQs), 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). Furthermore, at the time of writing this analysis, NHS England are due to begin consultation on making the Equality Delivery System (EDS2) mandatory, and for this to form part of the Standard NHS Contract provisions. The recommendations here offer an early start towards these measures.
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Many Thanks to Liz Connolly at Walsall Council who compiled the mapped information used in Figures 7 (no vehicle ownership); Figure 8 (DLA recipients); Figure 9 (minority ethnic population).


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

Clarity Aim and Objectives

Collect Equality information

Assess Impact

Differences & Opportunities

Engage, Consult, Involve

Decision & Future Actions

Publish
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 Walsall?
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 Walsall 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 Walsall to change for the better for this group/community?

A support agency supporting the empowerment of people with a learning disability
- Educate GPs in learning disability awareness

A church group based in Shelfield
- Better access to NHS services in Shelfield and High Heath.
- More people to answer the phone – less automated answer services

A Carer support group
- Reduce GP waiting times
- Extend GP hours at the weekend
- Improve tele-care and telephone consultations

A Housing Association
- Have interpreters on hand
- Have a separate room available (which could be charged) for families with members who are at the end of life.
- Improve coverage of same-sex consultations for women patients.

A community association in Rushall area
- NHS advice worker made available to community groups where older people meet.
- Bespoke transport service for older people for essential medical appointments
- Support volunteer Befrienders or Community link workers through training and ongoing support.

A counselling organisation
- To continue to be able to offer services in the Town Centre (Walk-in-Centre)
- Shorter waiting times for referral services (counselling and psychotherapy)
- Continuity of consultancy provision

Patient representative group in Aldridge
- Wheelchair access to Walk-in-Centre
- Parking facilities at the Walk-in-Centre (and cheap prices)
- Facilities for older and frail patients.

A Community and Welfare Centre supporting Asylum seekers and refugees
- More information about NHS services and accessibility allowed for migrants
- Better understanding of the needs of people whose first language is not English.
- Reduce the car parking charges at the Manor Hospital.
A hospice for children
- Better communication skills for NHS staff to communicate with people who are non-verbal
- Attention to the particular needs of adolescents
- Better understanding of and training to deal with children with palliative care needs.

A support organisation for people with ME and Chronic Fatigue Syndrome
- Appoint a trained Specialist Nurse for ME/CFS and fibromyalgia
- Improve care for long-term chronic health, including neurological conditions so that it is a whole condition, and not a piecemeal approach.
- Take chronic pain seriously – from the GP consultation up.