futurefit
Shaping healthcare together

Future Fit Programme
Equality Impact Assessment

November 2018

1.0 Executive Summary

The CCGs in Shropshire and Telford and Wrekin are proposing to transform acute hospital services for patients in Shropshire, Telford and Wrekin and Powys with the aim to improve care for local people (including people from mid Wales). The consultation, which ran from 30 May to 11 September 2018, asked for views on proposed changes to the hospital services provided at the Royal Shrewsbury Hospital in Shrewsbury and the Princess Royal Hospital in Telford. The proposals are that one hospital becomes a Planned Care site and the other hospital becomes an Emergency Care site (including women and children's consultant-led services) with a 24-hour urgent care centre at both sites.

Our approach to developing a final Equality Impact Assessment (EIA) was to create and update a 'living' process. An EIA was developed at the pre-consultation stage and has been updated throughout, with a refresh at mid-point and now a further post-consultation EIA. A further EIA refresh will be considered post decision making.

This Equality Impact Assessment has drawn upon a wide range of existing information, intelligence and previous engagement work. It examines if particular protected characteristic groups or other vulnerable groups are likely to experience any disproportionate impact from the proposals – either negatively or positively.

Our assessment work pays particular attention to equality legislation and to showing how the proposed work is considering the needs and views representative of the nine protected characteristics under the Equality Act 2010 and Public Sector Equality Duty 2011.

Four additional groups that we have made particular efforts to engage with during the consultation have been identified:

- People living in rural areas
- People living in areas of deprivation
- Carers
- Welsh speakers, as a first language

We have also engaged with groups who are either likely to be more impacted on by the proposals or are likely to have more health needs. These have included military personnel and families, asylum seekers and refugees and homeless people.

Local population data has been reviewed as well as local, regional and national evidence in relation to health and prevalence of conditions in the different protected characteristic groups. This gives a picture of which groups might be disproportionately impacted on by the proposed changes.

We have not produced a separate analysis for each of the protected characteristic groups by each of the proposed options. This decision has been made on the grounds that the type of impact – for example, the issues around access – does not change between options for the protected characteristics, although the extent and relative impact may differ. The main difference in impact between the options is geographical - where people live is a greater indicator of the impact rather than their protected characteristic.

1.1 Summary of local demographic data

The data we have reviewed demonstrates a different demographic profile across Shropshire, Telford and Wrekin and Powys although there is some consistency for certain protected characteristic groups. It is important to consider the difference between the percentage of people and the number of people belonging to a particular group in the different geographical areas as the percentage of the local population from a particular protected characteristic group might be higher in one area but the actual number of people higher in a different area.

Protected characteristic	**Demographic profile**
Age	Higher % of older people (aged 50+) living in Shropshire and Powys but higher % aged 30-44 in Telford and Wrekin. Higher % of 0-19 year olds in Telford and Wrekin but higher number in Shropshire. Higher % of 5-9 year olds in Powys than in other areas. Projected increase in older age groups (over 65) across all areas.
Sex	Across all areas, number of men and women similar to national levels. Slightly higher number of women.
Sexual orientation	No specific local data available but between 1.5 and 5.85% of the population is estimated to be lesbian, gay, bisexual or transgender.
Disability	% of people with a long term condition/disability across all areas is similar but slightly higher for Powys and slightly lower for Telford and Wrekin.
Race	All areas are mainly White British. Higher % of BAME groups in Telford and Wrekin.
Religion	High number of Christian people across all areas. Higher number of people of different religions in Telford and Wrekin. Small Amish/Mennonite community in South Shropshire.
Pregnancy/maternity	Although the % of women of child-bearing age in the Telford and Wrekin population is higher, the total number of women aged 16-44 living in Shropshire and Powys is larger than in Telford and Wrekin.
Gender reassignment	No specific local data available but 1% of population is estimated to be transgender.
Marriage/civil	% of married people in Shropshire and Powys is higher than the national rate but lower in Telford and Wrekin. % of

partnership	civil partnerships is slightly higher in Powys.

Other key groups	Demographic profile
People living in a rural area	The main rural areas are in Shropshire and Powys (although there are some rural areas to the west of Telford.) Rural poverty includes increased costs of housing and fuel, poor access to public transport and low wages. People tend to be older White British. Health is generally better than for people living in urban areas but social isolation can increase with age and long term conditions.
People living in a deprived area	Telford and Wrekin has the highest levels of deprivation, although there are also some pockets of deprivation in Shropshire and Powys. Some residents in Powys suffer from not only financial but also fuel, health, digital and child poverty.
Carers	Higher % of carers across all areas than nationally, with Powys having the highest % of unpaid carers.
Welsh speakers	Highest % of Welsh speakers in Powys is in the north west. The number of Welsh speakers is decreasing and over 80% of the population has no knowledge of Welsh.

For more detail, please go to section 8.

1.2 Summary of health profile by protected characteristic

Protected characteristic	Health profile/risk factors
Age	Certain age groups access A&E more: adults 80+ often due to falls, young children up to age 4, 20-24 year olds and 25-44 year old men (due to higher suicide rates) and are more likely to be impacted on by changes to A&E services. Women of child-bearing age most likely to be impacted on due to changes to women's and children's services. Long term conditions more likely in older people. Higher risk of stroke in over 55 year olds. Higher usage of planned care by older patients e.g. hip and knee surgery, therefore higher impact on older people if planned care site and hyper acute stroke unit move further away from where they can be accessed now. Travel impacts greatest for younger and older people.
Sex	Higher impact on women due to women's and children's services, particularly BAME women (see Race section below) although men may be impacted on as visitors. Young men may have a greater need to access A&E and acute services. Older women are more likely to require joint surgery. Older women and younger men have a higher risk of

	stroke. Fewer women drive than men and more women therefore tend to use public transport.
Sexual orientation	LGBT people have poorer mental and physical health e.g. higher rate of self harm and suicide. LGBT people are more likely to smoke and drink heavily and less likely to have had a smear test, increasing the risk of some cancers and stroke. Lesbian and bisexual women are at higher risk of complications during pregnancy. LGBT people may not be confident that healthcare services understand or meet their needs, which may discourage service usage and lead to late interventions. Higher rates of asthma, arthritis and obesity in lesbian and bisexual women. Some LGBT people may feel unsafe on public transport.
Disability	People with a disability more likely to use health services. Low screening uptake, excluded from sex education and less likely to have weight checks. Possible premature ageing. Higher rates of risky behaviours. Lower life expectancy for people with mental health problems and intellectual impairments. People with a learning disability (LD) have worse physical and mental health. Some ethnic groups have higher disability rates. Women with a LD more likely to access services late in pregnancy. Higher risk of worse outcomes for pregnant disabled women. People who have already had a stroke are at increased risk of another stroke, with a higher risk of disability and death. Barriers include not only transport but also accessing information and communication.
Race	BAME women have a higher risk of still birth, low weight babies, pre-term birth, congenital abnormalities, severe maternal morbidity and maternal death. Higher emergency hospital admission to intensive care for South Asian children. Higher prevalence of certain conditions in Black and South Asian people including diabetes and stroke. Higher number of emergency admissions for gypsies and travellers. Black men and Asian women have higher risk of some cancers.
Religion	Amish/Mennonite communities more likely to have genetic disorders, birth defects and increased infant mortality rate. However, overall, they tend to have better health than the general population due to their healthy lifestyle. They are less likely to seek medical attention for non-urgent conditions and often prefer to use natural or homeopathic remedies.
Pregnancy/maternity	Older mothers more likely to have complications during and after pregnancy. Higher risks for pregnant teenagers and their babies, especially if they live in a deprived area. BAME women have higher rates of maternal mortality and still births. Disabled women are more likely to have a caesarean section and stay in hospital longer. Mental ill health may cause women to miss health checks, which could lead to pregnancy complications. Mental ill health can occur for the first time during pregnancy and women who have severe mental health problems before are at higher risk. Appendicitis, gallbladder disease and ectopic pregnancies can necessitate emergency surgery on pregnant women. Some cancer and stroke risks can be related to pregnancy. Travel impacts greatest for pregnant women without a local support network and young women particularly if they live in a deprived or rural area. Women of child-bearing age and their families most likely to be impacted on due to changes to women's and children's services.

Gender reassignment	No particular risk factors identified except lack of understanding of healthcare staff.
Marriage/civil partnership	No particular risk factors identified.

Other key groups	Health profile/risk factors
People living in a rural area	Living in a rural community can have positive health benefits but social isolation can be a problem particularly for older people and people with long term conditions. Rural deprivation and increased travel time and cost particularly for young and older people who are less likely to have their own transport are particular challenges.
People living in a deprived area	People living in a deprived area spend fewer years in good health and have a lower life expectancy. Higher prevalence of behavioural risk factors for cardiovascular, cancer and respiratory disease deaths e.g. smoking, poor diet and inactivity. More likely to suffer alcohol-related harm. The risk may be increased for certain ethnic groups living in a deprived area. High infant mortality rate for women in a deprived area, particularly from certain ethnic groups.
Carers	Caring can have a significant impact on physical and mental health. Carers are more likely to have a long term condition and young carers are more likely to have a health condition e.g. back and mobility problems. Carers often lack time to attend a medical check-up, to exercise and eat healthily. Carers of a disabled child are most likely to suffer from depression. Travel impacts particularly high for carers of someone with a disability.
Welsh speakers	No particular risk factors identified except possible anxiety due to having to converse in a language other than Welsh.

For more detail, please go to section 9.

1.3 Summary of impacts by protected characteristic

Overall, the proposed changes would have a positive impact for the whole population including those from the nine protected characteristics due to improved quality of care, waiting times, facilities and staffing. The impacts on the different protected characteristic groups may be lower or higher depending on where people live and also if they belong to multiple protected characteristic groups. Where there is no evidence found to show a different impact on one particular protected characteristic group compared to other groups, this is included as “none identified.”

	Age	Sex	Sexual	Disability	Race	Religion	Pregnancy/	Gender	Marriage

			orientation				**maternity**	**reassignment**	**/civil partnership**
Consultant - led maternity services	Women of child-bearing age and neonates	Women of child-bearing age	Pregnant lesbian and bisexual women	Pregnant women with a disability, partic. learning	Pregnant BAME women BAME babies	*None identified*	Pregnant women - aged 35+ - teenagers, e.g. in deprived areas - BAME women - disabled women e.g. mental illness	*None identified*	*None identified*
Paediatric services	Children and young people (0-16)	*None identified*	*None identified*	Children and young people (0-16) with a disability	South Asian children	Amish/ Mennonite children	BAME babies Babies born to older and teenage mothers Babies living in an area of deprivation	*None identified*	*None identified*
Emergency care	People aged 80+ Children aged 0-4 Men aged 20-24	Young men, particularly under age 30	LGBT people aged 55+ Lesbian and bisexual women Gay men	People with a disability e.g. mental illness	Black and South Asian people with sickle cell disease, thalasse-mia, diabetes,	*None identified*	Pregnant women with - a mental illness - appendicitis or gallbladder disease - an ectopic pregnancy	*None identified*	*None identified*

					stroke Gypsies and travellers				
Planned care	People over 60 People with a long term condition	Women over the age of 50	LGBT adults Lesbian and bisexual women Male to female transgender patients	People with a disability	Black people Asian women	Amish/ Mennonite people	Older pregnant women	*None identified*	*None identified*
Stroke services	People aged 50+ (also children and working age)	Older women, women of child-bearing age, younger men	Gay and bisexual men Lesbian women	People who've already had a stroke	Older BAME people (also children and working age)	*None identified*	Pregnant women with gestational diabetes or hypertension and increased bleeding after birth Pregnant BAME women	*None identified*	*None identified*
Travel	Young people and older people	Women, particularly younger and older women	Young LGBT people	People with a disability e.g. learning, children, wheelchair users and	Young people and older people	*None identified*	Pregnant women, mothers and their families e.g. living in rural and deprived areas Pregnant	*None identified*	*None identified*

				people living in rural and/ or deprived areas			women without family/friends nearby Pregnant BAME women		

For more detail, please go to section 9.

1.4 Summary of consultation participant profile

All feedback received as part of the formal consultation has been collated and analysed by an independent, external organisation - Participate. This organisation provided a factual report to feed into the decision-making process. This includes equalities monitoring data provided as part of the consultation survey as well as equalities monitoring forms circulated at focus groups and meetings, which enabled us to evaluate the response rate from the different protected characteristic groups and identify key themes.

Consultation survey

The demographics of the respondents to the consultation survey are broadly representative of the local population except for their age and gender, with more women and people in older age groups completing the survey. This is regarded as normal in consultations and we recognised this at the midpoint review and targeted younger, male groups specifically in the second half of the consultation.

Focus groups and meetings for seldom heard groups

The completion of equalities monitoring forms by people attending focus groups and meetings, during the consultation, was optional. This data is therefore not reflective of the profile of all participants and should be regarded with caution. Some focus group/meeting participants may also have completed the consultation survey and therefore their equalities monitoring data will also have been collected via this route.

1.5 Summary of themes from consultation feedback – meetings and events

Where it has been possible to identify themes from the consultation survey feedback from a particular protected characteristic group, these have been highlighted below.

Some particular groups have specific themes based on their potential level of access to specific services or their particular needs and therefore the potential level of impact the changes might have on them. For example, young people sometimes show a lack of interest as they don't see the changes as affecting them and working age people like the convenience of having all services on one site. Older people commented on non-emergency patient transport and voluntary transport as well suitable appointment times for people living a long way away, as these are most likely to have an impact on this age group.

People with a mental illness or people who work in this field commented about the need for staff to understand mental health issues and the need for links to psychiatric assessments. The possible increased anxiety for patients who need to travel further and out of their familiar area was also mentioned by this group. Similar travel challenges were also mentioned in relation to people with a learning disability and people with dementia.

Feedback also told us that people with autism don't like to access GP services until something serious is wrong suggested that hospitals should have a support team for people with autism.

Although travel and transport is a common theme across all protected characteristic groups, feedback highlighted the possible additional negative impact on older and younger people who don't drive, people with a learning disability, people with a visual impairment and carers/visitors, particularly if they need to travel on public transport, on a Sunday and on a regular basis. It could also have a negative impact on a patient's mental health if carers, friends and family are unable to visit them or not regularly. Carers in particular fed back about transport issues and that they can't travel with the person they are caring for on community transport.

Women tend to be more focussed on the quality of maternity services than men as we would expect. Younger women also expressed concerns about how they would travel to hospital if they were in labour and if they had to visit a sick child who needed to stay in hospital overnight, particularly if this is further to travel than it is now. For female gypsies, there was a concern about travelling further to hospital as they often don't drive and wouldn't be able to travel on public transport due to low levels of literacy.

For the different religious and race groups we spoke to at meetings, the feedback was broadly similar to that from other protected characteristic groups. People of the Sikh religion were the only group that mentioned a concern about language issues particularly for older Sikh women who don't have family nearby to translate for them.

Welsh people felt that bi-lingual signage, Welsh TV channels and easily identifiable Welsh-speaking staff were important. They also seemed to prefer to go to the Royal Shrewsbury Hospital due to its proximity to Powys and the perceived likelihood of there being more Welsh speakers there.

There are also lots of similarities in the feedback themes from many or all groups. These include (in no particular order):

- Why can't we stay as we are
- The decision has already been made
- Travel time and cost
- Travel between sites and on discharge
- Availability of public transport
- Parking – cost and availability
- Risk of increased travel in an emergency
- Cost of making the changes
- Waste of money building women's and children's unit at PRH
- Need clear explanation of the difference between the ED and a UCC and where patients need to go in different situations
- Pressure on ambulance service
- Availability of GP appointments
- More local community services
- Capacity of one site to take more patients
- Condition of buildings/facilities
- Different demographics of different areas

It should be noted that people of the same protected characteristic can frequently give contradictory feedback for a variety of reasons. For example, some feedback was more related to where a person lives than their protected characteristic or they might have a number of different protected characteristics.

Further details on feedback from the consultation engagement work with seldom heard groups can be found in Appendix 5.

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1.6 Summary of considerations

The disproportionate impacts on certain protected characteristic groups are largely in relation to increased travel and transport, and cost. This impact is increased for groups who are more likely to need to access the services we are proposing to change:

- Women of child-bearing age and pregnant women, particularly older and younger women, women with a disability (especially a learning disability), BAME women, lesbian and bisexual women
- Young men (under the age of 30)
- Babies and young children (aged 0-4), particularly neonates, and their parents/carers
- People with a disability, particularly children and young people and their carers
- BAME people including women and babies, South Asian and Mennonite children, Black and South Asian adults
- Gypsies and travellers
- Older people (particularly over the age of 80)
- People with a long term condition
- LGBT people

The impacts could be further increased if these groups live in rural and/or deprived areas.

Our local demographic profile tells us that there is a higher percentage of people (aged 50+) living in Shropshire and Powys and a higher percentage of 0-19 year olds living in Telford and Wrekin (however, the actual number of 0-19 year olds is higher in Shropshire.) There is also a higher percentage of women of child-bearing age in Telford and Wrekin but the total number of women aged 16-44 in Shropshire and Powys is higher.

The higher number of older people living in Shropshire who may have a greater need to access planned care may be negatively impacted on if they had to travel further to PRH under option 1 but there would be a positive impact under option 2 as planned care would be closer to where they live. The opposite would be true if they needed to access emergency care.

As the women's and children's centre is currently based in Telford, there would be no change in the impact on children and young people from Shropshire and Powys if this remains at PRH under option 2, but there would be a positive impact if the centre was moved to RSH under option 1. Although there is a smaller number of children and young people living in Telford and Wrekin, there are some protected characteristic groups that are more prevalent in this area, for example BAME babies, children and young people, particularly those living in a deprived area, who may have an increased need to access paediatric services and they may be negatively impacted on if the services are moved to Shrewsbury.

Similarly as the women's and children's centre is currently based in Telford, there would be no change in the impact on women of child-bearing age and pregnant women from Shropshire and Powys if this remains at PRH under option 2 but there would be a positive impact if the

centre was moved to RSH under option 1. Although there is a smaller number of women of childbearing age living in Telford and Wrekin, there are some protected characteristic groups that are more prevalent in this area, for example BAME women and pregnant teenagers, particularly those living in a deprived area, who may have an increased need to access consultant-led maternity services and they may be negatively impacted on if the services are moved to Shrewsbury.

We do not have any specific local demographic data in relation to the LGBT community but this group could have an increased need to access emergency, stroke and some planned care services. Lesbian and bisexual women are also more likely to have more complications during pregnancy which may increase their need to access the consultant-led maternity unit. Depending on where they live, changing the location of these services may have a negative or positive impact on this protected characteristic group.

The percentage of people with a disability across Shropshire, Telford and Wrekin and Powys is broadly similar but this group could have an increased need to access emergency, stroke and some planned care services. Women with a learning disability may have the need to access consultant-led maternity services more. Depending on where they live, changing the location of these services may have a negative or positive impact on this protected characteristic group. Through our engagement work and the consultation, travel and transport has been raised as a particular challenge for people with a physical disability, a vision impairment or a learning disability, as well as for their carers, and they may therefore be more impacted on by increased travel, particularly if they live in a rural or deprived area. We have also identified concerns that people with a learning disability or with dementia are very reliant on support from carers and they may be negatively impacted on if carers are unable to visit due to transport challenges.

As there is a larger BAME population in Telford and Wrekin than in Shropshire and Powys and this group may have a higher need to access emergency and stroke services, this group may be impacted on under option 1 if the main emergency centre is moved to Shrewsbury. Older Sikh women in Telford and Wrekin who don't have relatives living nearby have raised concerns about travelling outside their local area and about language barriers. Gypsies and travellers across all three areas may have an increased need to access emergency services and travel for gypsy and traveller women has been highlighted as a particular challenge if they have to travel further.

The demographic profile of our local area tells us that the most rural areas are in Powys and Shropshire. There are already significant transport challenges for young people and older people, particularly those who don't drive, in these areas. The higher number of older people living in Shropshire and Powys, who may have a greater need to access planned care, may be negatively impacted on if they have to travel further to PRH under option 1 but there would be a positive impact under option 2 as planned care would be closer to where they live. We have, however, been told that generally it's easier to organise transport for planned care and so the greatest negative impact would be likely to be if older and young people from Shropshire and Powys needed to access emergency care in Telford under option 1.

As there is a higher number of areas of deprivation in Telford and Wrekin than in Powys and Shropshire and evidence shows that people living in these areas may be more likely to need to access emergency services, there could be a negative impact on this group if the emergency centre were in Shrewsbury under option 1 but a positive impact if the centre was in Telford under option 2. Travel costs are a high consideration for people living in a deprived area and this would particularly impact on women of child-bearing age and pregnant women, parents of 0-4 year olds, young men, older people and BAME people living in a deprived area.

Through our engagement and consultation work, carers have raised particular concerns about travel and transport for themselves and for the people they care for, as there is often a particular need for them to travel together and to visit regularly if people need to stay in hospital. Depending on where they live, changing the location of emergency and planned care services may have a negative or positive impact on this group.

Our engagement and consultation work tell us that people living in Powys whose first language is Welsh, particularly those with a learning disability or dementia, would prefer to go to a hospital where there are more likely to be Welsh speakers and they perceive this to be in Shrewsbury due to its proximity to Wales. RSH would also be nearer for their family/friends/carers to visit, particularly in view of the transport challenges for people living in a rural area.

1.7 Conclusions

In conclusion to determine whether the Future Fit Programme and the CCGs have met the general duty of the Equality Act, we need to ask ourselves three questions:

- Does this policy help eliminate discrimination?
- Does this policy help promote equality of opportunity?
- Does this policy help foster good relations between people possessing the protected characteristic and those that do not?

The analysis and evidence presented in this document have highlighted a number of potential impacts that people with protected characteristics may experience both in accessing and providing the health services under consideration within the reconfiguration proposals. In recognition of the risk of potential indirect discrimination against some protected characteristic groups, the Future Fit Programme has already begun the process of identifying appropriate mitigation options, and these are outlined in the recommendations below and in other more detailed mitigation plans that will be set out as part of the Decision-Making Business Case (DMBC).

The Programme recognises that some protected characteristic groups may face additional difficulties in accessing the reconfigured services. These challenges will be greatest for those individuals that have more than one protected characteristic – for example, disabled children, older

people on low income. However, it is also worth noting that the reconfiguration of services for some protected characteristic groups will in fact improve their access to these services as specialist sites are relocated more locally to them.

Additionally, reconfiguration will ensure that when our sickest patients do use these services better access to senior clinicians will mean they will get the right diagnosis, start the right treatment quicker and get better faster, meaning their clinical outcomes will improve.

While potential negative impacts on people's equality of opportunity have been identified options to mitigate these have been proposed and continued to be developed.

The public consultation process provided a public forum for people to share their experiences of accessing health services. It is hoped therefore that this process has in itself promoted better relations between people possessing protected characteristic and those that do not by raising awareness of the range of challenges each section of society may experience. PAVO, Impact and RCC have been engaged in supporting the consultation process. The Programme will continue to engage with these and other advocacy groups for the protected characteristic groups in the next phase of developing the business case, so they can help ensure the needs of all members of the public are given due consideration.

1.8 Recommendations

In considering this equality impact assessment on the options set out in the public consultation, the Future Fit Programme must now conscientiously take into account the views expressed by those who may be affected by proposed service changes. This is achievable because of the extensive engagement through the consultation process, in particular the engagement with those defined as having one or more protected characteristics, but also what was already known from the original impact assessment work done in 2016 and 2017 and this EQIA. They will all contribute to this conscientious consideration phase of the programme.

The programme has over the last 2 years included through all the impact assessments it has carried out, used national evidence, Public Health data, Census data, travel times and distances to hospitals, and public and staff views to identify issues. These impact assessments have identified the issues common to the whole population as well as specific protected characteristic groups.

Central to the equality impact assessment is the consideration of actions to mitigate adverse impacts. Consideration must now be given to whether separate or combined actions are necessary to lessen any negative impact for any relevant group and better promote equality of opportunity.

The Future Fit Programme has reached stage three of its equality impact assessment, the post consultation pre-decision stage. In examining this evidence and analysis and the detailed findings from the consultation response, the Future Fit Programme Board through their conscientious consideration will need to consider any necessary and relevant mitigation plans to address impacts or issues raised for

protected characteristic groups and for the wider population, prior to making any final recommendations to the Joint Committee of the CCGs. The suggested initial mitigations are described below, and these will need to be worked through together with any further issues and mitigations once a decision about the way forward has been made. This will be the focus of stage four of the equality impact assessment process.

For this reason, any issues and mitigations described at this stage must be considered preliminary, not exhaustive. The Programme has also shared the content of the Draft EIA with the Directors of Public Health from Shropshire and Telford & Wrekin Councils and Powys Health Board and sought their input to inform the final EIA Report.

In conclusion, it is recommended that mitigation plans will need to include but not be limited to:

1. **Developing an effective communications and engagement strategy**, looking to address continued confusion from the public including those within protected characteristics, of the differences between emergency care, urgent care and planned care. The use of various tools such as on-line video, talking stories of services now and the proposed changes, emphasising that there will be urgent care on both sites where the majority of people will be able to go as before. Advertising and materials should be in different languages and formats where appropriate.
2. **Developing a strong public awareness campaign** about the correct service to access in the case of an urgent or emergency medical need. Consider different tools and languages/formats to reach the widest possible audience and the nine protected characteristics. Target in particular those groups most likely to access A&E services, for example, young men, parents of young children, older people and new migrants.
3. **Incorporating findings into the work of the Travel and Transport Group** the potential impacts for access and travel on protected characteristics groups as set out in this EIA into the Travel and Transport Mitigation Plans. As the impact is likely to be greatest on people living in an area of deprivation or a rural area, older people and young people, people with a disability and homeless people particular attention should be paid to the needs of these groups. This should include a Review appointment times by the Acute Trust and how these could be adjusted to take increased travel times and costs into account, particularly for groups who are more likely to travel by public transport such as people living in deprived areas, older people and younger people and people who are likely to have to travel further, for example, people living in rural areas.
4. **Considering how the Out of Hospital Care Strategies and Neighbourhood Developments** for Shropshire, Telford& Wrekin and Mid Wales might mitigate some impacts in looking at avoiding the need for hospital admission, the need to travel to hospital for appointments and for any other opportunities for enhancing local services for some groups. Particular consideration given for groups who are more likely to travel by public transport such as people living in deprived areas, older people and younger people and people who are likely to have to travel further, for example, people living in rural areas. Example of developments under consideration would including tele-medicine.

5. **Addressing the areas of mitigation in the W&C Integrated Impact Assessment in 2017**, that were set out in three broad areas to address the anticipated impacts relating to a consolidation of women's and children's services including:
    i. **Reducing unnecessary journeys** and transfers for young children
    ii. **Safe care pathway** agreements for children
    iii. **Reducing risk factors** before, during and after pregnancy (particularly for young women, BAME women and women living in deprived areas. This will include the work within the LMS Programme
6. **Ensuring the on-going review of midwife led services** considers findings and analysis in this EIA feeds into the developing model of care for midwife led services and in particular in the design, location and scope of community hubs under consideration.
7. **Ensuring the provision of appropriate accommodation** for parents/carers whose child is an inpatient to mitigate the impact of longer journey times and increased costs.

Post final decision making and in the next phase of the reconfiguration programme the CCGs, the Acute Trust and the wider STP Partners should:

8. continue to work collaboratively to build on existing and planned public health interventions and a more proactive system-wide approach to prevention, bridging deprivation and other health equalities gaps
9. continue to work collaboratively with the voluntary sector, community groups, Healthwatch and patient reference groups to carry out more detailed assessments of potential impacts in future phases of the development including the design phase and through to implementation.
10. continue to improve the volume and diversity of patient views and increase future opportunities for on-going engagement and establishing long term relationships with the protected characteristic groups as a result of the links developed through the Future Fit consultation.
11. continue to consider an inclusive approach to language barriers through fair access to information, services and premises supported by embedding equality and inclusion compliance for all sections of our local community
12. consider the translation, interpretation and other services available to people whose first language isn't English in delivering any newly configured service to ensure that it is effective and that speakers of other languages are not being negatively impacted on when they access services.
13. noting the limited activity data breakdown available, consider how the collection and analyse of data and information can be improved to better understand patient flows and experience of the protected characteristics.
14. continue to share with the groups that have been engaged with developing the EIA and particularly the voluntary sector and others

representing seldom heard groups, the EIA report and the outcomes of the consultation to ensure that they are aware of how their feedback is utilised in any decision-making process.