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Path to Excellence Phase 2: Preliminary impact assessment.

Headline findings for the project team

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Executive Summary

This report presents some of the key evidence underpinning any future integrated impact assessment of future proposals to reconfigure services within Phase 2 of the Path to Excellence transformation project.

The report presents a preliminary equality assessment of the various vulnerable groups and those with protected characteristics and explores some of the health and care challenges facing these groups.

This preliminary work shows that those groups which are more likely to be impacted by any changes to location or working arrangements are those which:

1. Are more likely to need or use the health services
2. Are known to experience discrimination in health care
3. Have financial difficulties relating to travel / transport
4. Face difficulties travelling to new places particularly alone or at night, (for a variety of reasons including stress, discrimination, violence)
5. Have communication or cognitive difficulties affecting NHS access or use-
6. Provide care or are in need of care / social support -
7. Face social exclusion compromising effective engagement

These details for each of the services under consideration are presented are summarised in Tables 1-3 and further detail and evidence is provided in Tables 4-6.

The information can be used to inform engagement and consultation plans and activity.

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1 Introduction

Path to Excellence is a five-year transformation of healthcare provision across South Tyneside and Sunderland.

The transformation has been set up to secure the future of local NHS services and to identify new and innovative ways of delivering high quality, joined up, sustainable care that will benefit the population of Sunderland and South Tyneside both now and in the future.

Following phase 1 of the transformation programme, the project team is now exploring possibilities relating to reconfiguration of the following services:

- Planned care - outpatient clinics, elective and day case surgery, planned investigations and procedures,
- Urgent and Emergency care - A&E, emergency and acute medical assessment and admissions
- Emergency surgery – acute surgical assessment, admission and surgery

This preparatory work entails widespread consultation with the various communities likely to be impacted by any changes to the way these services are organised.

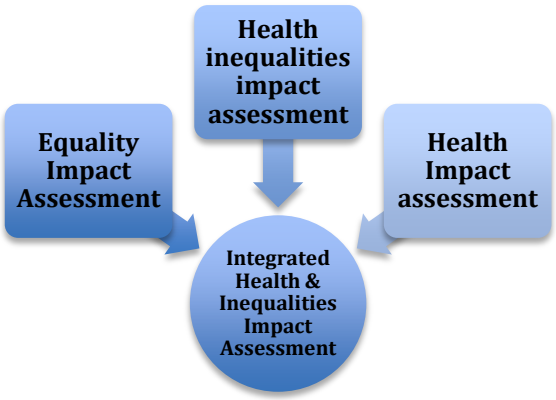
The purpose of this report is to highlight those communities which, on the basis of an evidence review, are likely to be impacted in relation to an integrated impact assessment which examines:

- Equality
- Health
- Health inequalities

This information can be used to inform project plans for engagement and consultation.

2 Overview of the commissioned integrated impact assessment (IIA)

The project team has commissioned an Integrated Impact Assessment (IIAs) which will examine the range and scale of impacts – positive, negative or neutral - which changes to the services could have on the equality, health and health inequalities of the population.



The IIA will be conducted once the various proposals for change have been developed. It will consider the impact of the proposals in relation to the following populations

- Staff working in the services
- The population for whom these services are commissioned by South Tyneside and Sunderland CCGs
- The families, carers and friends (service users) of any patients using these services
- The residents of South Tyneside and Sunderland Local Authorities.

The approach will be consistent with that used in Phase 1 of the Path to Excellence programme, using the same assessment methods, scoring tools, concepts and definitions [1],[2],[3]:

- Equality Impact Assessment (EqIA)[4];
- Health Inequalities Impact Assessment (HIIA);
- Health Impact Assessment (HIA) [5]

2.1 Equality impact assessment (EqIA)

The EqIA will focus on those groups with protected characteristics i.e.:

1. Age
2. Disability[6]

[1] Gray J. Independent Integrated Equality, Health and Health Inequalities Impact Assessment. Urgent and Emergency Paediatrics Services. Strata Nostra Ltd: March 2017

[2] Gray J. Independent Integrated Equality, Health and Health Inequalities Impact Assessment. Acute Stroke Services. Strata Nostra Ltd: March 2017.

[3] Gray J. Independent Integrated Equality, Health and Health Inequalities Impact Assessment. Maternity and Gynaecology. Strata Nostra Ltd: March 2017

[4] The NHS Centre for Equality and Human Rights. A toolkit for carrying out Equality Impact Assessment accessed here Sept 2019

[5] DH (2010) Health Impact Assessment Tools. Simple tools for recording the results of the Health Impact Assessment. accessed here Sept 2019

[6] The term disability covers physical disability, emotional and mental illness, learning and cognitive difficulties and sensory impairments

3. Gender
4. Gender reassignment
5. Pregnancy and maternity (including breastfeeding)
6. Race
7. Religion or belief
8. Sexual orientation
9. Marriage and civic partnership (but only in regards to eliminating discrimination and harassment)

It will also extend to other groups:

- Those vulnerable as a consequence of social deprivation (see below)
- Families and carers

2.2 Health (HIA) and Health Inequalities (HIIA) Impact Assessments

The HIIA and HIA will focus at a population level on those groups whose health outcomes and access are most likely to be impacted by the services affected.

As a consequence of deprivation, the following, often co-occurring, groups have been identified as being most vulnerable to health inequalities[7]:

- people with learning disabilities
- people with co-occurring mental health and alcohol/drug use conditions
- homeless groups
- people who have experienced or witnessed abuse or violence, including women with experience of domestic abuse
- women who are pregnant or have recently given birth
- children and young people
- people who are parents or carers who may fear the consequences of contact with statutory services - for example young carers may fear speaking out in case they are taken into care
- people involved in selling sex
- lesbian, gay, bisexual and transgender (LGBT) people and black, Asian and minority ethnic groups (BAME)
- refugees and asylum seekers
- people without recourse to public funds
- gypsies travellers and roma

[7] Equality and Human Rights Commission (2016) England's most disadvantaged groups: Is England Fairer? accessed here July 2019

2.3 Impact scores

The impact scores will be calculated according to a NHS recommended approach which combines an assessment of the level of available evidence (A score) and the likely scale of impact (B score) [8]

- The level of available evidence (A score) is rated between 1 and 3 according to the criteria in the tables below
- The scale of potential impact (B score) is calculated with reference to the extent of any proposed changes, the numbers of people who may be affected and scored either positively between 0 and + 3 or negatively between 0 and -3 using the criteria in the tables below
- The final impact scores are calculated as the product of the relevant A score and B score i.e. Impact score = A score x B score

Criteria for A scores - (level of) available evidence

Criteria for A scores	Score
Existing data/research	**3**
Anecdotal / awareness data only	**2**
No evidence or suggestion	**1**

Criteria for B scores - impact on community equality, health or health inequalities

Criteria underpinning the Equality assessment B scores	Criteria underpinning the Health or Health Inequalities assessment B scores	B Score
HIGH POSITIVE Evidence indicates: • the proposal supports the organisation in meeting its statutory duties under equality and human rights legislation • there is a positive and/or proportionate impact on staff, service users and/or the community	**HIGH POSITIVE** Evidence indicates: • A significant benefit to the health / health inequalities of the community, service users or staff	**+ 3**
MEDIUM POSITIVE Evidence indicates: • the proposal supports the organisation in meeting its statutory duties under equality and human rights legislation • there is a positive and/or proportionate impact on staff, service users and/or the community	**HIGH POSITIVE** Evidence indicates: • A medium benefit to the health / health inequalities of the community, service users or staff	**+2**
LOW POSITIVE Evidence indicates: • there is little or no relevance regarding the equality legislative requirements • there is a positive and/or proportionate impact on staff, service users and/or the community	**LOW POSITIVE** Evidence indicates: • A minor benefit to the health / health inequalities of the community, service users or staff	**+1**

[8] NHS Centre for Equality and Human Rights. A toolkit for carrying out Equality impact assessment. (Page 132) accessed here Sept 2019

NO IMPACT	**NO IMPACT**	**0**
LOW NEGATIVE Evidence indicates: • there is little or no relevance regarding the equality legislative requirements • there may be some differential impact, but this does not have disproportionate or inequitable outcome and can be reasonably justified	**LOW NEGATIVE** Evidence indicates: • A minor risk to the health / health inequalities of the community, service users or staff	**-1**
MEDIUM NEGATIVE Evidence indicates: • the proposal may adversely impact on some elements of the equality legislative requirements, but the impact will not affect compliance • there is potential for some adverse impact which may affect groups differently.	**MEDIUM NEGATIVE** Evidence indicates: • A medium risk to the health / health inequalities of the community, service users or staff	**-2**
HIGH NEGATIVE Evidence indicates: • the organisation will/may not meet its statutory requirements under equality and human rights legislation • there is/may be disproportionate and/or unjustifiable adverse impact on staff, service users and/or the community.	**HIGH NEGATIVE** Evidence indicates: • A significant risk to the health / health inequalities of the community, service users or staff	**-3**

3. Preliminary findings and evidence

Some of the key findings in the evidence base along with a preliminary equality impact assessment, are outlined in the following Tables:

- Table 4 outlines how each of the protected or vulnerable groups could be impacted by any changes to service organisation on the basis of equality with reference to relevant health and health inequalities information.

- Table 5 presents some of the key health outcomes and health inequalities which affect the populations served by the services under consideration.

- Table 6 summarises evidence for key protected groups and the health and health care challenges for other vulnerable groups including carers are summarised below.

Table 4 shows that except for marriage, **all groups** with protected characteristics and vulnerable groups **could** be impacted by the changes however, **some of the groups might be more vulnerable (negative or positive) to change than others**.

Those groups which are more likely to be impacted by any changes to location or working arrangements are those which:

- Are more likely to need or use the health services - NEED
- Are known to experience discrimination in health care - DISCRIMINATE
- Have financial difficulties relating to travel / transport -FINANCE
- Face difficulties travelling to new places particularly alone or at night, (for a variety of reasons including stress, discrimination, violence) - TRAVEL
- Have communication or cognitive difficulties affecting NHS access or use- COMMUNICATE
- Provide care or are in need of care / social support - CARE
- Face social exclusion compromising effective engagement - EXCLUDE

The findings are summarised in Table 1 (Planned care), 2 (Emergency care) and 3 (emergency surgery) below

Subgroups are described and the symbols represent the availability of evidence to support the findings.
✓ = evidence
X = no identified evidence.

The summaries do not consider populations with multiple vulnerabilities although combinations are common. For example, older people are commonly disabled and socially deprived.

TABLE 1: Planned care equality impact summary

	NEED	DISCRIMINATE	FINANCE	TRAVEL	COMMUNICATE	CARE	EXCLUDE
Age	Older people Working age	Older people	Older people	Older people	Older people	Older people	Older people
Disability	✓	✓	✓	✓	✓	✓	✓
Gender	X	X	Women	Women	X	Women	X
LGBT	✓	✓	✓	✓	X	X	✓
Maternity/breastfeed	X	X	✓	✓	X	✓	X
Race/ethnicity	✓	✓	✓	✓	✓	X	✓
Religion	X	? Staff	X	? Staff	X	X	X
Marriage	X	X	X	X	X	X	X
Families or carers	✓	X	✓	✓	X	✓	✓
Social deprivation	✓	Some groups	✓	✓	✓	X	✓

TABLE 2: Emergency care equality impact summary

	NEED	DISCRIMINATE	FINANCE	TRAVEL	COMMUNICATE	CARE	EXCLUDE
Age	Older people	Older people	Older people	Older people	Older people	Older people	Older people

Disability	✓	✓	✓	✓	✓	✓	✓
Gender	X	X	Women	Women	X	Women	X
LGBT	✓	✓	✓	✓	X	X	✓
Maternity/breastfeed	X	X	✓	✓	X	✓	X
Race/ethnicity	✓	✓	✓	✓	✓	X	✓
Religion	X	? Staff	X	? Staff	X	X	X
Marriage	X	X	X	X	X	X	X
Families or carers	✓	X	✓	✓	X	✓	Possible
Social deprivation	✓	X	✓	✓	✓	X	✓

TABLE 3: Emergency surgery equality impact summary

	NEED	**DISCRIMINATE**	**FINANCE**	**TRAVEL**	**COMMUNICATE**	**CARE**	**EXCLUDE**
Age	Older people Young adults	Older people	Older people	Older people	Older people	Older people	Older people
Disability	✓	✓	✓	✓	✓	✓	✓
Gender	X	X	Women	Women	X	Women	X
LGBT	X	✓	✓	✓	X	X	✓
Maternity/breastfeed	X	X	✓	✓	X	✓	X
Race/ethnicity	X	✓	✓	✓	✓	X	✓
Religion	X	? Staff	X	? Staff	X	X	X
Marriage	X	X	X	X	X	X	X
Families or carers	✓	X	✓	✓	X	✓	Possible
Social deprivation	✓	✓	✓	✓	✓	X	✓

Table 4: Preliminary Equality Assessment

Could any of the following vulnerable[9] or groups with protected characteristics be affected disproportionately by changes to the way services are organised?

Protected characteristics or vulnerable groups	**Planned care services i.e.** • **Elective surgery** • **Outpatient assessment and follow up** • **Planned investigations**	**Urgent and Emergency Care i.e.** • **A&E services** • **Emergency medicine**	**Emergency surgery**
Age A heterogenous group Adults main users Health needs increase with age. Many older people also have disabilities Older people, now constitute the main users of the NHS[10],[11] - particularly those	Yes - All adults (any age) use or need planned health services Likelihood of using services varies with age and specialty. Older people are most likely to use these services and to benefit in any improvements in access, safety, experience, or effectiveness. Evidence shows older people already face risks of discrimination in health care and are therefore at higher risk of negative equality impact.	Yes - All adults (any age) use or need urgent and emergency care Likelihood of using thse services varies with age and condition. Admissions are more common in older people who will benefit most by any improvements in access, safety, experience, or effectiveness	Yes - All adults (any age) use or need emergency surgery. Likelihood of using services varies with age and specialty. Older people are most likely to use these services and to benefit in any improvements in access, safety, experience, or effectiveness Evidence shows older people

[9] See list of vulnerable groups in Section 2.2

[10] Centre for policy on ageing (2015) Briefing: The health and care of older people in England 2015 accessed here July 2019

with co-morbidities. Frailty becoming increasingly common in emergency services	Working age adults in certain roles (self employed, zero hours contracts) are more likely than others to be negatively impacted if location is less convenient. Staff and users with young families are more likely to be negatively impacted if location or working patterns are less convenient Older people in general are more likely to face social exclusion and, including those in care homes, this (combined with disabilities – see below) can affect their ability to participate in engagement / consultation about changes to these services	Evidence shows older people already face risks of discrimination in health care and are therefore at high risk of negative equality impact. Working age adults in certain roles (self employed, zero hours contracts) are more likely to be negatively impacted if location is less convenient. Staff and users with young families are more likely to be negatively impacted if location or working patterns are less convenient Older people in general are more likely to face social exclusion and, including those in care homes, this (combined with disabilities – see below) can affect their ability to participate in engagement /	already face risks of discrimination in health care and are therefore at high risk of negative equality impact. Working age adults in certain roles (self employed, zero hours contracts) are more likely to be negatively impacted if location is less convenient. Staff and users with young families are more likely to be negatively impacted if location or working patterns are less convenient Older people in general are more likely to face social exclusion and, including those in care homes, this (combined with disabilities – see below) can affect their ability to participate in engagement / consultation about changes to these services

[11] Age UK (2011) Older people and human rights. A reference guide for professionals working with older people. accessed here July 2019

		consultation about changes to these services	
Disability[12] A heterogenous group with a large health burden and inequalities in health care outcomes.	People with a disability are more likely to use or need planned care services. They are therefore likely to benefit most from any improvements in access, safety, experience or effectiveness. Disabled people already face risks of discrimination in health care and are therefore at higher risk of negative equality impact. Staff with disabilities are more likely to be negatively impacted by any change in working arrangements – stress, convenience, support. Any changes in location will generate particular challenges for this group as users or staff. Any communication or cognitive difficulties could compromise the	Some disabilities can increase need for urgent and emergency services. Disabled people are therefore likely to benefit most from any improvements in access, safety, experience or effectiveness Disabled people already face risks of discrimination in health care and are therefore at higher risk of negative equality impact Staff with disabilities are more likely to be negatively impacted by any change in working arrangements - stress, convenience, support Any changes in location will	Some disabilities can increase need for general surgery. Disabled people already face risks of discrimination in health care and are therefore at higher risk of negative equality impact Staff with disabilities are more likely to be negatively impacted by any change in working arrangements - stress, convenience, support Any changes in location will generate particular challenges for this group as users or staff. Any communication or cognitive difficulties could compromise the ability of this group to participate in engagement / consultation

[12] The term disability is inclusive of any physical or mental disability or illness, any learning or cognitive difficulty or impairment, and sensory impairment

	ability of this group to participate in engagement / consultation about changes to these services. People with some disabilities, such as learning disability, serious mental illness, and sensory impairment experience social exclusion creating further problems for engagement / consultation about these services	generate particular challenges for this group as users or staff. Any communication or cognitive difficulties could compromise the ability of this group to participate in engagement / consultation about changes to these services. Such problems could also create greater problems accessing care in an emergency leading to delays with subsequent negative impacts. People with some disabilities, such as learning disability, serious mental illness, and sensory impairment experience social exclusion creating further problems for engagement / consultation about these services	about changes to these services. Such problems could also create greater problems accessing care in an emergency leading to delays with subsequent negative impacts. People with some disabilities, such as dementia, learning disability, serious mental illness, and sensory impairment experience social exclusion creating further problems for engagement / consultation about these services

Gender	Both men and women are likely to use planned care. Evidence shows that women are more likely to act as unpaid carers and may therefore be more likely to use these services in that capacity. Evidence relating to the gender pay gap means that women might be more likely to be negatively impacted by any additional financial burden generated by the changes. Women are also more likely to act as Primary care givers in families such that changes in convenience and working patterns might affect women more than men. Women might also be likely to face greater distress due to travel alone or at night.	Both men and women are likely to use urgent and emergency care Evidence shows that women are more likely to act as unpaid carers and may therefore be more likely to use these services in that capacity Evidence relating to the gender pay gap means that women might be more likely to be negatively impacted by any additional financial burden generated by the changes. Women are also more likely to act as Primary care givers in families such that changes in convenience and working patterns might affect women more than men. Women might also be likely to face greater distress due to travel alone or at night.	Both men and women are likely to use emergency surgery. Evidence shows that women are more likely to act as unpaid carers and may therefore be more likely to use these services in that capacity Evidence relating to the gender pay gap means that women might be more likely to be negatively impacted by any additional financial burden generated by the changes. Women are also more likely to act as Primary care givers in families such that changes in convenience and working patterns might affect women more than men. Women might also be likely to face greater distress due to travel alone or at night.

Gender reassignment / sexual orientation (The evidence base often relates to LGBT communities with common experiences therefore they have been grouped together here)	LGB&T people need and use planned care services. There is evidence to suggest that they might be at greater risk of developing some LTCs and cancer requiring planned care. They might therefore benefit more from any improvements in access, experience, safety or effectiveness. Evidence highlights that LGBT communities – especially trans people – experience discrimination in accessing health care. Any changes to services which negatively affect access might further impact negatively on this group Previous stigma and discriminatory experiences with health services might affect meaningful participation in engagement / consultation about changes to these services LGBT people are more likely to be represented in the homeless community. Therefore any financial implications will fall disproportionately	LGB&T people need and use urgent and emergency care services. There is evidence indicating that they are more likely to use emergency services than traditional primary care. They might therefore benefit more from any improvements in access, experience, safety or effectiveness. Evidence highlights that LGBT communities – especially trans people – experience discrimination in accessing health care. Any changes to services which negatively affect access might further impact negatively on this group Previous stigma and discriminatory experiences with health services might affect meaningful participation in engagement / consultation	LGB&T people need and use emergency surgery. Evidence highlights that LGBT communities – especially trans people – experience discrimination in accessing health care. Any changes to services which negatively affect access might further impact negatively on this group Previous stigma and discriminatory experiences with health services might affect meaningful participation in engagement / consultation about changes to these services LGBT people are more likely to be represented in the homeless community. Therefore any financial implications will fall disproportionately on them.

	on them.	about changes to these services LGBT people are more likely to be represented in the homeless community. Therefore any financial implications will fall disproportionately on them.	
Pregnancy and maternity (including breastfeeding)	Although maternity and gynaecology services are not included in the Phase 2 changes, this group may still use/ need planned care. Breastfeeding is a key determinant of population health and health inequalities and should be supported as much as possible. For staff, patients or other users in this group, any changes to location or convenience or working arrangements might have a negative impact on family life, or breastfeeding arrangements.	Although maternity and gynaecology services are not included in the Phase 2 changes, this group may still use/ need urgent and emergency care Breastfeeding is a key determinant of population health and health inequalities and should be supported as much as possible For staff, patients or other users in this group, any changes to location or	Although maternity and gynaecology services are not included in the Phase 2 changes, this group may still use/ need emergency surgery Breastfeeding is a key determinant of population health and health inequalities and should be supported as much as possible For staff, patients or other users in this group, any changes to location or convenience or working arrangements might

	The time demands on this group could mean that they cannot fully contribute to consultation / engagement arrangements for changes to these services	convenience or working arrangements might have a negative impact on family life, or breastfeeding arrangements The time demands on this group could mean that they cannot fully contribute to consultation / engagement arrangements for changes to these services	have a negative impact on family life, or breastfeeding arrangements The time demands on this group could mean that they cannot fully contribute to consultation / engagement arrangements for changes to these services
Race A heterogenous group. Some groups are at increased risk of very poor health outcomes. – especially: • Gypsy or Irish Travellers • Bangladeshi • Pakistani • Migrants, refugees and asylum seekers	All races / ethnic backgrounds are likely to use or need planned care services There is evidence to suggest that they might be at greater risk of developing some LTCs requiring planned care. They might therefore benefit more from any improvements in access, experience, safety or effectiveness. Evidence shows that minority ethnic groups are at greater risk of discrimination in accessing health care so any changes to services which affect access might further impact negatively	All races / ethnic backgrounds are likely to use or need urgent and emergency care. The most vulnerable groups are more likely to use emergency care services due to difficulties accessing primary care. They might therefore benefit more from any improvements in access, experience, safety or effectiveness.	All races / ethnic backgrounds are likely to use or need emergency surgery Evidence shows that minority ethnic groups are at greater risk of discrimination in accessing health care so any changes to services which affect access might further impact negatively on this group. Any language difficulties or lack of understanding about available health care could compromise

	on this group. Any language difficulties or lack of understanding about available health care could compromise their ability to participate in engagement / consultation about changes to these services Some ethnic minorities are more likely to face social exclusion which will affect their ability to participate in engagement / consultation about changes to these services	Evidence shows that minority ethnic groups are at greater risk of discrimination in accessing health care so any changes to services which affect access might further impact negatively on this group. Any language difficulties or lack of understanding about available health care could compromise their ability to participate in engagement / consultation about changes to these services or to access timely care in an emergency. Some ethnic minorities are more likely to face social exclusion which will affect their ability to participate in engagement / consultation about changes to these services	their ability to participate in engagement / consultation about changes to these services Some ethnic minorities are more likely to face social exclusion which will affect their ability to participate in engagement / consultation about changes to these services or to access timely care in an emergency.

Religion or belief[13]	It is possible that staff & patients & users with different religious beliefs might be affected if the changes affect facilities / arrangements for worship, dietary requirements, spiritual support or religious holidays	It is possible that staff & patients & users with different religious beliefs might be affected if the changes affect facilities / arrangements for worship, dietary requirements, spiritual support or religious holidays	It is possible that staff & patients & users with different religious beliefs might be affected if the changes affect facilities / arrangements for worship, dietary requirements, spiritual support or religious holidays
Marriage and civic partnership	Individuals will use these services regardless of marital or partnership status There is no evidence that marital / partnership status will affect the impact of any changes to these services.	Individuals will use these services regardless of marital or partnership status There is no evidence that marital / partnership status will affect the impact of any changes to these services.	Individuals will use these services regardless of marital or partnership status There is no evidence that marital / partnership status will affect the impact of any changes to these services.
Families and carers	Unpaid care for older and disabled family members is becoming increasingly common. Carers will often accompany patients to attend planned care appointments. They might therefore benefit more from any improvements in access, experience, safety or effectiveness.	Unpaid care for older and disabled family members is becoming increasingly common. Lack of time for their own preventive care can lead to them needing emergency care	Unpaid care for older and disabled family members is becoming increasingly common. Carers will often accompany patients in need of emergency surgery.

[13] For staff, to promote equality need worship facilities on all sites, and provision for religious holidays in terms of working arrangements – rotas etc

	Staff affected by the changes might also be carers at home. Relatives and friends will visit planned medical or surgical inpatients Evidence shows that carers are more likely to neglect their own health and this "neglect" might be exacerbated by changes which create any further barriers to access. Changes in location or convenience or working patterns could disproportionately and negatively impact on the health, wellbeing, employment opportunities and finances of those visiting loved ones, staff, and especially carers juggling family life and/or work with caring responsibilities. The time demands on carers juggling work and family alongside caring responsibilities could mean that they cannot fully contribute to consultation	more often. They might therefore benefit more from any improvements in access, experience, safety or effectiveness. Carers will often accompany patients in need of urgent and emergency care. Staff affected by the changes might also be carers at home. Relatives and friends will visit emergency medical inpatients Changes in location or convenience or working patterns will disproportionately and negatively impact on the health, wellbeing, employment opportunities and finances of those acting as carers, staff or family/friends visiting loved ones. Carers juggling family life and/or	Staff affected by the changes might also be carers at home. Relatives and friends will visit emergency surgical inpatients Changes in location or convenience or working patterns will disproportionately and negatively impact on the health, wellbeing, employment opportunities and finances of those visiting loved ones, staff and especially carers juggling family life and/or work with caring responsibilities. The time demands on carers juggling work and family alongside caring responsibilities could mean that they cannot fully contribute to consultation / engagement arrangements for changes to these services

	/ engagement arrangements for changes to these services	work with caring responsibilities will be especially affected. The time demands on carers juggling work and family alongside caring responsibilities could mean that they cannot fully contribute to consultation / engagement arrangements for changes to these services	
Social deprivation - Vulnerable groups The worst health outcomes and health inequalities are experienced by the following groups: • homeless people, • sex workers, • gypsies, travellers and roma • people with serious mental illness • people with co-	Strong evidence shows that social deprivation is linked to ill health and an increased need for planned care. However, there is also strong evidence showing that social deprivation is linked to inequalities in access to and outcomes from health services. Changes in the way services are organised or located might therefore be more likely to have a disproportionately negative impact on this group. They might benefit more from any improvements in access,	Social deprivation is linked to ill health and an increased demand for emergency care However, there is also strong evidence showing that social deprivation is linked to inequalities in access to and outcomes from health services. Changes in the way services are organised or located might therefore be more likely to have a disproportionately	Social deprivation is linked to ill health. However, there is also strong evidence showing that social deprivation is linked to inequalities in access to and outcomes from health services. Changes in the way services are organised or located might therefore be more likely to have a disproportionately negative impact on this group. They might benefit more from any

occurring mental health and substance/alcohol misuse • migrants, refugees and asylum seekers	experience, safety or effectiveness or be more vulnerable to any negative impacts. If changes result in any additional financial implications of travel for their own care, as carers or when visiting families/friends they will fall disproportionately on this group. Social deprivation is often linked to social exclusion affecting effective participation in engagement / consultation about changes to these services	negative impact on this group. They might benefit more from any improvements in access, experience, safety or effectiveness or be more vulnerable to any negative impacts. If changes result in any additional financial implications of travel for their own care, as carers or when visiting families/friends they will fall disproportionately on this group Social deprivation is often linked to social exclusion affecting effective participation in engagement / consultation about changes to these services or knowledge regarding how to access timely care in an emergency	improvements in access, experience, safety or effectiveness or be more vulnerable to any negative impacts. If changes result in any additional financial implications of travel for their own care, as carers or when visiting families/friends they will fall disproportionately on this group. Social deprivation is often linked to social exclusion affecting effective participation in engagement / consultation about changes to these services or knowledge regarding how to access timely care in an emergency

Table 5: Key themes relating to population health outcomes and health inequalities

	Planned care services i.e. • **Elective surgery** • **Outpatient assessment and follow up** • **Planned investigations**	**Urgent and Emergency Care i.e.** • **A&E services** • **Urgent and Emergency medicine – assessment and admission**	**Emergency surgery** • **Urgent and Emergency Surgery assessment, surgery, and admission**
In these populations, poor health outcomes and health inequalities are strongly related to wider social deprivation and population lifestyles: • Smoking • Xs alcohol • Poor diet • Low levels of physical activity In relation to adults and health services, South Tyneside and Sunderland Health and	The key health outcomes are: • Preventing people from dying prematurely • Enhancing quality of life for people with long term conditions including cancer • Helping people to recover from episodes of ill health or injury On the basis of JSNA data, population health needs and local Health & Wellbeing	The key health outcomes are: • Preventing people from dying prematurely • Helping people to recover from episodes of ill health or injury On the basis of JSNA data, population health needs and local Health & Wellbeing Strategies the main emergency health care challenges in these populations relate to:	The key health outcomes are: • Preventing people from dying prematurely • Helping people to recover from episodes of ill health or injury • Enhancing quality of life for people with long term conditions including cancer On the basis of JSNA data, population health needs and local Health & Wellbeing Strategies the main emergency

Wellbeing Boards are prioritising: • the needs of people with long-term conditions and their carers[14],[15] • Integrated and coordinated care • Healthy behaviours • Self care In South Tyneside, additional priorities include: • Delivery of care closer to home for adults • Ensuring prevention is part of health and care pathways and delivery models • Reducing the prevalence of, and harm, caused by smoking • Reducing the inequality gap for people with	Strategies the main "planned care" health challenges in these populations relate to: • Cancer • Circulatory disease • Respiratory disease especially COPD • Mental health problems • Digestive problems including liver disease and diabetes • MSK - joint, back and mobility problems • Multiple morbidity	• Acute Exacerbations of LTCs – COPD, CVD, osteoporosis, liver disease • Alcohol related harm, disease, mental and behavioural disorders, • Self harm • Substance misuse • Violence • Falls • Dementia • Injuries Chronic Ambulatory care sensitive conditions i.e. • Asthma • Congestive heart failure • Diabetes complications • Chronic obstructive pulmonary disease (COPD)	health care challenges in these populations relate to: Acute Ambulatory Care Sensitive Conditions: • Falls • Injuries • Hip fractures • Dehydration and gastroenteritis • Pyelonephritis • Perforated/bleeding ulcer

[14] South Tyneside Health & Wellbeing strategy 2017-21 accessed here Oct 2019
[15] Sunderland City Council Health and Wellbeing Strategy accessed here Oct 2019

mental illness • Reducing Sickness absence • Implementing a local alcohol strategy • Reduce the inequality gap for people with mental illness In Sunderland additional priorities include: • Promoting understanding between communities and organisations • Supporting and motivating everyone to take responsibility for their health and that of others • Supporting everyone to contribute • Supporting individuals and their families to recover from ill-health and crisis		• Angina • Iron deficiency anaemia • Hypertension • Nutritional deficiencies Acute Ambulatory Care Sensitive Conditions: • Dehydration and gastroenteritis • Pyelonephritis • Perforated/bleeding ulcer • Cellulitis • Pelvic inflammatory disease • Ear, nose and throat infections • Dental conditions • Convulsions and epilepsy • Gangrene	

The relevant interventions which could have the greatest impact on reducing health inequalities include:

- Promoting healthy lifestyles
- Integrating physical and mental health services
- Personalised care - tailored support for self care, patient activation, health literacy,
- Perioperative medicine including geriatric medicine input as appropriate
- Promoting appropriate health seeking behavour

Table 6: A summary of the evidence highlighting inequalities in health and health care for key protected groups

	Ethnicity	LGB&T	Old age	Disability
Evidence for health inequalities	Ethnic inequalities in health are well documented in the UK[16]. There is a plethora of evidence highlighting that people from minority ethnic groups experience poorer physical and mental health than the overall UK population[17], and that ill health among minority ethnic groups starts at a younger age than among the white British[18]. Furthermore, when people from BME communities have a disability, they are more likely than other people to experience poor outcomes[19]	There is a substantial body of qualitative evidence demonstrating that LGB&T people experience significant health inequalities, which impact on their health outcomes and their experiences of health care. Such inequalities are compounded if LGB&T individuals are young, come from a BME, disabled or from a socio-economically deprived background. Additional focus on LGB&T communities is necessary to avoid widening the inequality gap[20]. LGB&T individuals have an increased risk of developing long term health problems and suffering late diagnoses (especially cancer, cardiovascular, liver and respiratory diseases)[21].	Older people - The likelihood of being disabled and/or experiencing multiple chronic and complex health conditions increases with age.[22],[23] . In general, older people who live in socially disadvantaged communities have poorer physical and mental health than those who live in more advantaged communities.[24] Older people, now constitute the main users of the NHS[25],[26] and all types of hospital activity for older people have been increasing - both routine and elective care as well as emergency care[27].	Disabled people - Compared to the general population, disabled people experience a greater burden of health problems[28] and inequalities in health outcomes[29]. This burden is greater in deprived areas.[30] ○ People living with SMI experience some of the worst health inequalities, with a life expectancy of up to 20 years less than the general population[31]. ○ People with learning disabilities have more physical and mental health and health care needs than the general population[32], they face a

[16] Evandrou, M. et al. Ethnic inequalities in limiting health and self reported health in later life revisited. Journal of Epidemiology & Community Health 2016; 70: 653-62 accessed here July 2019

[17] PHE (2018) Local action in health inequalities: understanding and reducing ethnic inequalities in health. accessed here July 2019

[18] Better Health Briefing 6. Tackling health inequalities for minority ethnic groups: challenges and opportunities. Race equality foundation 2007. accessed here July 2019

[19] Pocklington (2008) People from Black and Minority Ethnic Communities and Vision Services: A Good Practice Guide accessed here July 2019

[20] Bachman CL, Gooch B. LGBT in Britain – Health Report Stonewall November 2018 accessed here Sept 2019

[21] Williams H, Varney J et al. The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document. PHE: Equality and Human Rights Commission (2009) Research report 37 – estimating the size and composition of the LGBT population in Britain accessed here August 2019

[22] Age UK (2019) Later life in the United Kingdom 2019. accessed here July 2019

[23] ONS (2018) Living Longer: how our population is changing and why it matters. accessed here July 2019

[24] International Longevity Centre UK (2018) Inequalities matter – an investigation into the impact of deprivation on demographic inequalities in adults accessed here July 2019

	Ethnicity	LGB&T	Old age	Disability
				shorter life expectancy[33] and increased risk of early death when compared to the general population[34] ○ People with sensory impairment suffer from a higher prevalence of other health conditions including heart problems, diabetes, kidney or liver disease and long term neurological conditions including dementia, frequently experiencing two or more such long term conditions.[35] They are also more likely to suffer additional disabilities, generating multiple and complex needs.[36] ○ People with sensory impairment or learning disabilities are more prone

[25] Centre for policy on ageing (2015) Briefing: The health and care of older people in England 2015 accessed here July 2019
[26] Age UK (2011) Older people and human rights. A reference guide for professionals working with older people. accessed here July 2019
[27] Centre for policy on ageing (2015) Briefing: The health and care of older people in England 2015 accessed here July 2019
[28] PHE (2018) Health matters: reducing health inequalities in mental illness accessed here Sept 2019
[29] Health inequalities inquiry. Inclusion Scotland. Health Inequalities and Disabled People accessed here July 2019
[30] PHE (2018) Health matters: reducing health inequalities in mental illness accessed here Sept 2019
[31] Equality and Human Rights Commission (2017) Being disabled in Britain: a journey less equal accessed here Sept 2019
[32] PHE (2018) Learning disabilities: applying All our Health accessed here Sept 2019
[33] Equality and Human Rights Commission (2017) Being disabled in Britain: a journey less equal accessed here Sept 2019
[34] BMA (2014) Recognising the importance of physical health in mental health and intellectual disability. Achieving parity of outcomes
[35] Sense (2016) Equal Access to Healthcare: The importance of accessible healthcare services for people who are deafblind accessed here Sept 2019
[36] Action on hearing loss. Hearing matters. Taking action on hearing loss in the 21st century accessed here Sept 2019

	Ethnicity	LGB&T	Old age	Disability
				to accidents and associated injuries[37],[38],[39]
Evidence of inequalities in access, experience outcomes of health care	There is evidence of persistent inequalities in access, use, experience and outcomes of healthcare for minority ethnic patients.[40]	Heteronormative assumptions as well as experiences and/or fears of discrimination prevent LGB&T people from accessing mainstream services.[41].	There is a large body of evidence suggesting variation in the quality of hospital care provided to older people[42],[43] and inequalities relating to older adults' access to and use of a variety of health-care services[44],[45]. Older people with the greatest need for health care, especially those living in socially disadvantaged communities, do not always have access to appropriate services and treatments. Take-up of services and access to treatment is often lower amongst the most disadvantaged groups[46],[47]	Evidence shows that people with a learning disability or severe mental illnesses receive a poorer standard of care[48] for a range of conditions including diabetes and heart failure, and are less likely to receive medical treatments for arthritis[49]. Disabled people face multiple barriers accessing health services resulting in detrimental effects on their health and wellbeing, [50]. [51],[52]

[37] Truesdale M, Brown M, People with Learning Disabilities in Scotland: 2017 Health Needs Asessment update report Edinburgh Napier University: July 2017 accessed here Sept 2019

[38] Action on hearing loss. Hearing matters. Taking action on hearing loss in the 21st century accessed here Sept 2019

[39] Scuffham, P.A. et al (2002) The incidence and cost of injurious falls associated with visual impairment in the UK. Visual Impairment Research, 4:1-14 accessed here sept 2019

[40] PHE (2018) Local action in health inequalities: understanding and reducing ethnic inequalities in health. accessed here July 2019

[41] NIESR (2016), 'Inequality among lesbian, gay bisexual and transgender groups in the UK July 2016 accessed here August 2019

[42] Nuffield Trust (2016) Using data to identify good quality care for older people accessed here July 2019

[43] Macmillan Cancer Support. The rich picture. Older people with cancer. accessed here July 2017

[44] Council of Europe. (2017) Human rights of older persons and their comprehensive care. accessed here July 2019

[45] Centre for ageing better (2017) Inequalities in later life. accessed here July 2019

[46] Centre for ageing better (2017) Inequalities in later life. accessed here July 2019

[47] ONS (2018) Living Longer: how our population is changing and why it matters. accessed here July 2019

[48] BMA (2014) Recognising the importance of physical health in mental health and intellectual disability. Achieving parity of outcomes

[49] Kings Fund (2016) Bringing together physical and mental health accessed here Sept 2019

	Ethnicity	LGB&T	Old age	Disability
Access problems relating to travel and transport			Travelling to hospital is a challenge for older people affected by ○ physical mobility [53] ○ public transport - Currently, around 25% of bus journeys taken by people aged 65+ are for medical appointments, yet many struggle with inaccessible or irregular bus services[54] ○ Fear of travelling at night to unfamiliar treatment centres[55]	Transport is often cited by disabled people as their biggest challenge.[56] The journey to hospital is therefore a key barrier to access for people with a disability[57]:, the problems relate to[58], [59], [60]: • Transport difficulties • Distance • Needing someone to accompany them For people with visual impairment, new buildings or venues represent a significant challenge because familiar routes and landmarks cannot be used[61].

[50] Truesdale M, Brown M, People with Learning Disabilities in Scotland: 2017 Health Needs Asessment update report Edinburgh Napier University: July 2017 accessed here Sept 2019
[51] London Assembly (2015) Access to health services for deaf people accessed here Sept 2019
[52] Healthwatch Bromley (2016) See hear now – access to health and wellbeing services for people with sensory impairments and learning disabilities accessed here Sept 2019
[53] Centre for Policy on Ageing (2009) Ageism and age discrimination in primary and community health care in the United Kingdom accessed here July 2019
[54] Age UK (2018) Consultation response. Labour party National Policy Forum. Health and social care: tackling health inequalities accessed here July 2019
[55] Centre for Policy on Ageing (2009) Ageism and age discrimination in primary and community health care in the United Kingdom accessed here July 2019
[56] Prime ministers strategy unit (2005) Improving the life chances of disabled people. accessed here July 2019
[57] Mencap. Health inequalities. accessed here Sept 2019
[58] Office for Disability Issues (2008) Experiences and Expectations of Disabled People – Executive Summary accessed here Sept 2019
[59] Winyard S. The costs of sight in the UK. RNIB: 2005
[60] Airedale NHS Foundation Trust. Evidence of health inequalities affecting disabled people. http://www.airedale-trust.nhs.uk/wp/wp-content/uploads/2013/09/Disability.pdf
[61] Sense (2016) Equal Access to Healthcare: The importance of accessible healthcare services for people who are deafblind accessed here Sept 2019

	Ethnicity	LGB&T	Old age	Disability
				For those with learning difficulties, local services can promote independence and access.[62]
Fragmented care The recent national CQC patient survey showed that Patients are reporting poorer experience when it comes to the integration of their care[63]			Multidisciplinary teams achieve better outcomes for people with multiple pathologies and functional problems - more common in older age . Current structure of the NHS, with its focus on 'specialisms', can create barriers to cutting across medical boundaries and care settings.[64,65]	Poor coordination of care is evident across and between different disease pathways resulting in fragmented care for people with disabilities.[66] The importance of coordinating care for people with physical and mental health problems is often challenging[67] but vitally important[68]. The required collaborative approach to service delivery remains a challenge and means people continue to fall through the gaps in current service provision[69]
Accessing information about health services and care Access to information is a key part	BME communities experience more problems accessing information about health services[72,73,74] due to language difficulties, familiarity with health services		Older people also face multiple barriers to accessing information - use mobile phones and access the internet far less than those under 65	Deaf people face more difficulty accessing health information than hearing people[81] and do not have access to incidentally occurring

[62] Healthwatch Bromley (2016) See hear now – access to health and wellbeing services for people with sensory impairments and learning disabilities accessed here Sept 2019
[63] CQC Adult inpatient survey 2018 *******
[64] Oliver D. et al. Making our health and care systems fit for an ageing population. Kings Fund 2014. accessed here July 2019
[65] Centre for Policy on Ageing (2009) Ageism and age discrimination in primary and community health care in the United Kingdom accessed here July 2019
[66] BMA (2014) Recognising the importance of physical health in mental health and intellectual disability. Achieving parity of outcomes
[67] Health inequalities inquiry. Inclusion Scotland. Health Inequalities and Disabled People accessed here July 2019
[68] Kings Fund (2016) Bringing together physical and mental health accessed here Sept 2019
[69] Turning point. Dual Dilemma: the impact of living with mental health issues combined with drug and alcohol misuse. accessed here August 2019

	Ethnicity	LGB&T	Old age	Disability
of health care - appointment letters, information about conditions, treatments and services - enabling informed and shared decision making. Lack of information can lead to missed appointments, reduced privacy, and difficulty understanding or lack of confidence in how to manage a health condition. [70] Information is also vital to understanding, identifying and administering medication properly.[71]			in the UK resulting in digital exclusion.[75] , [76] - more difficulties processing and remembering information than younger people[77] and may, especially if they have dementia, have communication / language difficulties[78] - those over 80 years old are more likely to have poor literacy and numeracy[79] - older people prefer to receive information face to face from Health care professionals than in leaflets or from websites[80]. -	information about health issues on the radio or TV.[82] They are less likely to know or understand about health care issues such as health screening opportunities or appreciate the purpose of prescribed medications or the implications of other medical or surgical interventions[83] People with disabilities may need information in an alternative format eg braille, audio, large print. Evidence shows that disabled people find it difficult to access alternative forms of information, especially in a timely manner.[84]

[72] Better Health Briefing 9. The health and social care experiences of black and minority ethnic older people. Race equality foundation 2008. accessed here July 2019
[73] Pocklington (2008) People from Black and Minority Ethnic Communities and Vision Services: A Good Practice Guide accessed here July 2019
[74] Pocklington (2008) People from Black and Minority Ethnic Communities and Vision Services: A Good Practice Guide accessed here July 2019
[81] Sign health (2014) Sick of it – the deaf health report. accessed here Sept 2019
[70] Sense (2016) Equal Access to Healthcare: The importance of accessible healthcare services for people who are deafblind accessed here Sept 2019
[71] Sense (2016) Equal Access to Healthcare: The importance of accessible healthcare services for people who are deafblind accessed here Sept 2019
[75] ONS (2018) Living Longer: how our population is changing and why it matters. accessed here July 2019
[76] Macmillan Cancer Support. The rich picture. Older people with cancer. accessed here July 2017
[77] Macmillan Cancer Support. The rich picture. Older people with cancer. accessed here July 2017
[78] Age UK (2011) Older people and human rights. A reference guide for professionals working with older people. accessed here July 2019
[79] Macmillan Cancer Support. The rich picture. Older people with cancer. accessed here July 2017
[80] Macmillan Cancer Support. The rich picture. Older people with cancer. accessed here July 2017
[82] Kuenburg A et al. Health care access among deaf people. The Journal of Deaf Studies and Deaf Education 2016; 21(1): 1-10 accessed here Sept 2019
[83] Kuenburg A et al. Health care access among deaf people. The Journal of Deaf Studies and Deaf Education 2016; 21(1): 1-10 accessed here Sept 2019
[84] Healthwatch Bromley (2016) See hear now – access to health and wellbeing services for people with sensory impairments and learning disabilities accessed here Sept 2019

	Ethnicity	LGB&T	Old age	Disability
Health seeking behaviours	Healthcare-seeking behaviours vary between ethnic groups as do expectations about normal health and ageing. This means that some BME communities are less likely to seek help or do so much later in their illness[85].	LGBT individuals report that they avoid treatment for fear of discrimination because they're LGBT[86]	There is evidence that older people are more likely to fail or delay to seek help themselves, possibly due to ○ their own "ageist" perceptions of old age and assumptions that levels of disability and ill health are 'normal for someone my age' or a general lack of awareness of symptoms requiring further investigation[87],[88] ○ Concerns about wasting doctors time [89]	People with mental health problems or cognitive impairment are less likely than other patients to report physical symptoms which can delay help seeking behaviour and reduce the chance of the illness being detected and diagnosed.[90].
Practitioner attitudes and skills	There is evidence of[91] • stereotyped assumptions about the preferences of older people from minority ethnic groups and the availability of other sources of support from within the family • older people from minority ethnic groups feeling that professionals do not always take their concerns seriously • instances of racism from health and social care professionals All of these experiences can lead to BME individuals having a lack of trust and concerns about being able to freely express ideas about	Recent surveys have identified major gaps in the knowledge and training of staff in relation to LGB&T individuals resulting in unfair treatment of both patients and colleagues[93]	There are numerous citations of an identified a shortfall in the capability of many clinical practitioners with respect to managing older patients[94], [95],[96] Older people often find communication difficult with health care staff. There are reports of ○ older people feeling that they are made excessively aware of the costs of treatment and whether they merit the expense of such treatments.[97] ○ older people finding discourse insensitive, patronizing and	There are concerns that health professionals can lack confidence and experience in communicating with and identifying the needs of people with sensory impairment or learning disabilities in health care settings and require further education, training and support.[100],[101]

[85] PHE (2018) Local action in health inequalities: understanding and reducing ethnic inequalities in health. accessed here July 2019

[86] Whittle, S., Turner, L. and Al-Alami, M., 2006. Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination accessed here Sept 2019

[87] Centre for ageing better (2017) Inequalities in later life: the issue and implications for policy and practice accessed here July 2019

[88] Macmillan Cancer Support. The rich picture. Older people with cancer. accessed here July 2017

[89] Macmillan Cancer Support. The rich picture. Older people with cancer. accessed here July 2017

[90] BMA (2014) Recognising the importance of physical health in mental health and intellectual disability. Achieving parity of outcomes

[91] Better Health Briefing 9. The health and social care experiences of black and minority ethnic older people. Race equality foundation 2008. accessed here July 2019

	Ethnicity	LGB&T	Old age	Disability
	ways of self-managing illness which in turn deters them from approaching services [92].		ineffective[98] ○ practitioners being less patient, less respectful, less involved, and less optimistic with older patients compared to younger patients. [99]	
Healthcare outcomes **Co-morbid mental and physical health problems** A combination of physical and mental health problems can result in people being less likely to actively manage their wellbeing. This can lead to reduced energy, motivation and confidence as lead to a diminished capacity to seek and comply with treatment[102]. Co-morbid mental health problems	A number of factors can compromise the effectiveness and safety of care for people from ethnic minority communities, due to [104].,[105] • greater difficulties in obtaining, understanding and acting on health information, particularly for those with limited educational attainment and poor English language skills • poor cultural appropriateness • poor uptake and adherence to treatments **Cultural appropriateness**	**Diagnostic overshadowing** Trans people report their trans status being raised when seeking treatment for entirely unrelated health concerns. The latter has been described as 'trans cold syndrome', where a clinician views gender history as more important than the presenting medical complaint[108] **Person centred care** Extensive research has shown the relevance of sexual orientation to both physical and mental health, but many	**Person centred care** Greater provision of person centred care can help older persons maintain their autonomy and quality of life[111] **Co-morbid mental and physical health problems** Depression and anxiety are frequently under-recognised and under-diagnosed amongst older people.[112]	Accessing information is recognised to be more challenging for disabled people[113] and lack of appropriate information and communication can lead to missed diagnosis, and ineffective treatment.[114] Problems with communication mean that people leave appointments not knowing what was discussed or feeling that their views have been overridden.[115] Challenging behaviours are common within the learning disabled

[93] Somerville C. Unhealthy Attitudes: the treatment of LGBT people within health and social care services. Stonewall: 2015 accessed here August 2019
[94] Council of Europe. (2017) Human rights of older persons and their comprehensive care. accessed here July 2019
[95] Oliver D. et al. Making our health and care systems fit for an ageing population. Kings Fund 2014. accessed here July 2019
[96] Macmillan Cancer Support. The rich picture. Older people with cancer. accessed here July 2017
[97] Macmillan Cancer Support. The rich picture. Older people with cancer. accessed here July 2017
[100] Truesdale M, Brown M, People with Learning Disabilities in Scotland: 2017 Health Needs Asessment update report Edinburgh Napier University: July 2017 accessed here Sept 2019
[101] Kuenburg A et al. Health care access among deaf people. The Journal of Deaf Studies and Deaf Education 2016; 21(1): 1-10 accessed here Sept 2019
[92] Pocklington (2008) People from Black and Minority Ethnic Communities and Vision Services: A Good Practice Guide accessed here July 2019
[98] Wyman M. et al Ageism in the Health Care System: Providers, Patients and Systems. Contemporary perspectives on ageism. 2018: 193-212 accessed here July 2019
[99] Wyman M. et al Ageism in the Health Care System: Providers, Patients and Systems. Contemporary perspectives on ageism. 2018: 193-212 accessed here July 2019
[102] BMA (2014) Recognising the importance of physical health in mental health and intellectual disability. Achieving parity of outcomes
[104] Better Health Briefing 27. High quality health care commissioning: why race equality must be at its heart. Race equality foundation 2013 accessed here July 2019
[105] Evandrou, M. et al. Ethnic inequalities in limiting health and self reported health in later life revisited. Journal of Epidemiology & Community Health 2016; 70: 653-62 accessed here July 2019

	Ethnicity	LGB&T	Old age	Disability
have a number of serious implications for people with long-term conditions, including poorer clinical outcomes and lower quality of life. For example, mortality rates after heart attack or heart bypass surgery are several times higher among people with co-morbid depression[103]	Insensitivity and inappropriateness in service provision is likely to contribute to health inequalities both by leading to poor care (for instance due to poor communication, missed diagnoses and poor adherence to treatment) and by undermining the mental wellbeing of patients through being stressful[106], [107]	LGB&T individuals feel that their specific needs are not considered in their care.[109], [110]		population and can make assessment, care and treatment more difficult within health services. [116] **Diagnostic overshadowing** The effectiveness of care can be undermined by diagnostic overshadowing' (symptoms of physical ill health being mistakenly attributed to a behavioural problem or seen as being inherent in the person's learning disability)[117] **Co-morbid mental and physical health problems** The excess morbidity and premature mortality demonstrated in people with a learning disability. predominantly results from a failure

[108] Equality and Human Rights Commission (2015) Is Britain fairer? Key facts and findings on transgender people accessed here August 2019
[111] Council of Europe. (2017) Human rights of older persons and their comprehensive care. accessed here July 2019
[112] Centre for policy on ageing (2015) Briefing: The health and care of older people in England 2015 accessed here July 2019
[113] PHE (2015) The health equality framework and commissioning guide. Improving the health and wellbeing of people with learning disabilities, accessed here Sept 2019
[114] Signhealth (2014) Sick of it – the deaf health report accessed here Sept 2019
[115] Sense (2016) Equal Access to Healthcare: The importance of accessible healthcare services for people who are deafblind accessed here Sept 2019
[103] Kings Fund (2016) Bringing together physical and mental health accessed here Sept 2019
[106] Better Health briefing 45. Dementia and end of life care for black, Asian and minority ethnic communities Race Equality Foundation: 2018 . accessed here July 2019
[107] Pocklington (2008) People from Black and Minority Ethnic Communities and Vision Services: A Good Practice Guide accessed here July 2019
[109] Somerville C. Unhealthy Attitudes: the treatment of LGBT people within health and social care services. Stonewall: 2015 accessed here August 2019
[110] Bachman CL, Gooch B. LGBT in Britain – Trans Report. Stonewall accessed here Sept 2019
[116] Truesdale M, Brown M, People with Learning Disabilities in Scotland: 2017 Health Needs Asessment update report Edinburgh Napier University: July 2017 accessed here Sept 2019
[117] Equality and Human Rights Commission (2017) Being disabled in Britain: a journey less equal accessed here Sept 2019

	Ethnicity	LGB&T	Old age	Disability
				to adequately diagnose, treat and prevent comorbid physical health conditions. [118]
Patient safety	Communication difficulties and lack of cultural competence can compromise effectiveness and safety of care for BME individuals[119]		Older people are more at risk of some preventable harms of hospital care[120]: ○ falls - Acute illness, particularly in frail older people, increases the risk of a fall in hospital. Older patients are vulnerable to delirium, dehydration and deconditioning, all of which affect balance and mobility, especially in unfamiliar surroundings. The majority of falls occur among medical inpatients during the first few days after admission,[121] ○ pressure sores, ○ hospital acquired infection, ○ medication errors ○ deep vein thrombosis ○ loss of mobility due to bed rest ○ Other potential risks relate to malnutrition and delirium.	Reports have also highlighted major concerns about the quality of healthcare people with a learning disability have received in hospital, sometimes leading to unnecessary deaths. The most common reasons are delays or problems with diagnosis or treatment, and problems with identifying needs and providing appropriate care in response to changing needs.[122] The presence of a physical communication problem (deafness and blindness) is significantly associated with an increased risk of experiencing a preventable adverse event.[123] Falls are common in both formal and non-formal care settings and increase with age in the population of people with a learning disability.[124]

[118] Equality and Human Rights Commission (2017) Being disabled in Britain: a journey less equal accessed here Sept 2019
[119] Better Health Briefing 27. High quality health care commissioning: why race equality must be at its heart. Race equality foundation 2013 accessed here July 2019
[120] Oliver D. et al. Making our health and care systems fit for an ageing population. Kings Fund 2014. accessed here July 2019
[121] Falls workstream. NAIF audit report 2017. RCP London: 2017 accessed here July 2019
[122] Equality and Human Rights Commission (2017) Being disabled in Britain: a journey less equal accessed here Sept 2019
[123] Kuenburg A et al. Health care access among deaf people. The Journal of Deaf Studies and Deaf Education 2016; 21(1): 1-10 accessed here Sept 2019
[124] Truesdale M, Brown M, People with Learning Disabilities in Scotland: 2017 Health Needs Asessment update report Edinburgh Napier University: July 2017 accessed here Sept 2019

	Ethnicity	LGB&T	Old age	Disability
				Medicines management is another concern for people with learning disabilities. Polypharmacy is common and effective recording, monitoring and review is required.[125] Sometimes medication is prescribed inappropriately.[126]
Patient experience The biggest improvement are needed for the following patients groups[127]: ○ Those who are vulnerable or frail ○ Those with dementia and mental illness ○ Those who are deaf and/or blind	There is a wealth of qualitative and quantitative evidence that patients of minority ethnic identity frequently have poorer service experiences than majority white British patients[128][129] [130].	Dissatisfaction with health services is higher amongst LGB people than heterosexual people. [131] Evidence shows that discrimination continues to have an adverse impact on LGB&T people's access, needs and experience of services[132] . In recent surveys, 13% of LGBT respondents reported experiencing unequal treatment from healthcare staff because they are LGBT and 7% of trans people reported that they had been refused care because they are LGBT[133].	Numerous reports have documented failings in older people's experience of care in hospital.[136] Evidence suggests that across secondary care in England, NHS, there is evidence of ageism and age discrimination, ranging from patronising attitudes or language, to older people being denied treatment on the grounds of age alone, to common conditions of ageing being neglected in service planning, priorities and training of staff[137], [138] [139], [140] [141] [142]	There have been several reports of the continuing institutional discrimination faced by disabled people as service users, While many disabled people receive an excellent service from the NHS, many others have experienced discriminatory assumptions about their quality of life, stigmatisation, or even abuse . [143] [144],

[125] Truesdale M, Brown M, People with Learning Disabilities in Scotland: 2017 Health Needs Asessment update report Edinburgh Napier University: July 2017 accessed here Sept 2019

[126] Equality and Human Rights Commission (2017) Being disabled in Britain: a journey less equal accessed here Sept 2019

[127] NHS England (2015) Action Plan on Hearing Loss accessed here Sept 2019

[128] PHE (2018) Local action in health inequalities: understanding and reducing ethnic inequalities in health. accessed here July 2019

[129] Nazroo J (2014) Ethnic Inequalities in Health: Addressing a Significant Gap in Current Evidence and Policy' in L Newby and N Denison (eds) "If you could do one thing…" Nine local actions to reduce health inequalities. London: The British Academy: London; 91 – 101 accessed here July 2019

[130] Better Health Government Ethnicity facts and figures service accessed here July 2019

[131] NIESR (2016), 'Inequality among lesbian, gay bisexual and transgender groups in the UK July 2016 accessed here August 2019

[132] CQC (2016) Lesbian, gay, bisexual or transgender people. A different ending. accessed here Sept 2019

[133] Bachman CL, Gooch B. LGBT in Britain – Trans Report. Stonewall accessed here Sept 2019

	Ethnicity	LGB&T	Old age	Disability
		Discrimination is most marked in relation to trans people who encounter significant problems in using general NHS services, due to the attitude of some clinicians and other staff who lack knowledge and understanding and in some cases are prejudiced[134],[135].		
Emotional distress				Some people with learning disabilities may have relatively little capacity to understand what is happening to them or why. They may become confused or frightened by unfamiliar surroundings, or simply not understand what they are being asked to do. Staff may not always recognise that people have learning disabilities or be able to judge the extent to which patients understand what they are being told or asked[145].

[136] Oliver D. et al. Making our health and care systems fit for an ageing population. Kings Fund 2014. accessed here July 2019
[137] Macmillan Cancer Support. The rich picture. Older people with cancer. accessed here July 2017
[138] Council of Europe. (2017) Human rights of older persons and their comprehensive care. accessed here July 2019
[139] Centre for Policy on Ageing (2009) Ageism and age discrimination in primary and community health care in the United Kingdom accessed here July 2019
[140] Centre for policy on ageing (2013) Achieving equality in health and social care for older people: opportunities and challenges. Evidence of age discrimination accessed here July 2019
[141] . House of Lords Library Briefing (2017) Human rights of older persons and their comprehensive care accessed here July 2019
[142] Royal College of Surgeons of England, Age UK. *Access all ages: Assessing the impact of age on access to surgical treatment.* London: RCS; 2012. accessed here July 2019
[143] Health inequalities inquiry. Inclusion Scotland. Health Inequalities and Disabled People accessed here July 2019
[144] BMA (2014) Recognising the importance of physical health in mental health and intellectual disability. Achieving parity of outcomes
[134] The Equality and Human Rights Commission (the Commission) Trans Research Review published in Autumn 2009 accessed here Sept 2019
[135] House of Commons women and Equalities Committee First report of session 2015-16 Published January 2016 Transgender Equality accessed here August 2019
[145] PHE (2016) Learning disability observatory. People with learning disabilities in England 2015. accessed here Sept 2019

	Ethnicity	LGB&T	Old age	Disability
Spoken language communication problems	Written and spoken levels of fluency in English vary across ethnic groups and difficulties are especially evident amongst Chinese, Vietnamese, Somali, Pakistani and Bangladeshi older people[146].		Older people report ○ difficulties seeking help over the phone – due to an increased risk of sensory impairments and a preference for face to face contact.[147] ○ Older people being excluded from conversations or 'talked over' as though they do not exist[148]	Communication is recognised as a significant barrier when people with learning disabilities access healthcare and contributes to their ability to share information regarding their health concerns and health needs. [149] Many studies report that deaf patients encounter severe communication barriers when accessing health services.[150] Communication difficulties for deaf blind people can be so great that they can lead to people avoiding accessing health care, even in emergencies.[151] Deaf and deaf blind people often feel that health professionals do not appreciate just how stressful it is to engage in a healthcare setting; this problem primarily results from inadvertent barriers that prevent effective communication.[152],[153] Simple examples include not hearing their

[146] Better Health Briefing 9. The health and social care experiences of black and minority ethnic older people. Race equality foundation 2008. accessed here July 2019

[147] Centre for Policy on Ageing (2009) Ageism and age discrimination in primary and community health care in the United Kingdom accessed here July 2019

[148] Centre for Policy on Ageing (2009) Ageism and age discrimination in primary and community health care in the United Kingdom accessed here July 2019

[149] Truesdale M, Brown M, People with Learning Disabilities in Scotland: 2017 Health Needs Asessment update report Edinburgh Napier University: July 2017 accessed here Sept 2019

[150] Kuenburg A et al. Health care access among deaf people. The Journal of Deaf Studies and Deaf Education 2016; 21(1): 1-10 accessed here Sept 2019

[151] British Deaf Association (2014) Report on Access to Health Services for Older Deaf People in England and Wales accessed here Sept 2019

[152] Middleton A, Niruban A, et al. Communicating in a healthcare setting with people who have a hearing loss. BMJ 2010; 341: 726–29 accessed here Sept 2019

[153] Sense (2016) Equal Access to Healthcare:The importance of accessible healthcare services for people who are deafblind accessed here Sept 2019

	Ethnicity	LGB&T	Old age	Disability
				name called out whilst awaiting their appointment.[154]

[154] Sense (2016) Equal Access to Healthcare:The importance of accessible healthcare services for people who are deafblind.accessed here Sept 2019

Key evidence relating to inequalities in health and care for deprived communities

Socioeconomic deprivation - There is a plethora of evidence linking poor health outcomes with socioeconomic deprivation. It is widely recognised that most inequalities in health are caused by the conditions in which people are born, grow, live, work and age.[155], [156], [157]

Inequalities affecting the North of England are largely explained by socioeconomic differences with higher unemployment, lower incomes, adverse working conditions, poorer housing and high unsecured debts evidenced in the North. [158]

There are many forms of deprivation in England, but the following, often co-occurring, groups have been identified as being most vulnerable to health inequalities[159]:

- People with learning disabilities
- people with co-occurring mental health and alcohol/drug use conditions
- homeless groups
- people who have experienced or witnessed abuse or violence, including women with experience of domestic abuse
- women who are pregnant or have recently given birth
- children and young people
- people who are parents or carers who may fear the consequences of contact with statutory services - for example young carers may fear speaking out in case they are taken into care
- people involved in selling sex
- lesbian, gay, bisexual and transgender (LGBT) people and black, Asian and minority ethnic groups (BAME)
- refugees and asylum seekers
- people without recourse to public funds
- gypsies travellers and roma

Those at highest risk of socioeconomic deprivation may be particularly at risk of losing contact with services, whilst also being at risk of greater harm.[160]: Difficulties

[155] Marmot M et al (2010) Fair society, healthy lives. (The Marmot Review.) Strategic review of health inequalities in England post 2010 accessed here Sept 2019

[156] WHO Commission on Social Determinants of Health (2008) "Closing the gap in a generation: Health equity through action on the social determinants of health. accessed here Sept 2019

[157] WHO Regional Office for Europe (2013) Review of social determinants and the health divide in the WHO European Region: final report accessed here Sept 2019

[158] Inquiry panel on Health Equity for the North of England. (2014) Due North accessed here Sept 2019

[159] Equality and Human Rights Commission (2016) England's most disadvantaged groups: Is England Fairer? accessed here July 2019

reaching these groups can result in multiple unmet needs and greater risks due to poor access to preventive services such as health promotion and screening. [161], [162], [163], [164]

In health and social care, ensuring the safeguarding needs of all people with coexisting severe mental illness and substance misuse, and their carers and wider family, is a key priority.[165]

Migrants, refugees and asylum seekers

Migrants, refugees and asylum seekers are a diverse group and experience a range of distinct problems and inequalities due to their immigration status. They can experience discrimination on multiple grounds, including socio-economic factors[166]

Vulnerable migrants have poorer access to employment, income, housing and education, important determinants of health and wellbeing, and face significant barriers to health care[167].

Mental health problems include post-traumatic stress disorder (PTSD), anxiety, depression and phobias, with rates up to 5 times higher than in the general population. [168]

In addition to poor health outcomes, there are a range of barriers that prevent vulnerable migrants accessing healthcare including language barriers; a lack of trust in people outside the migrant community; suspicions of officials and government supported services; and limited availability for appointments for reasons such as shift work or caring responsibilities.[169]

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[160] PHE (2017) Better care for people with co-occurring mental health and alcohol/drug use conditions. A guide for commissioners and service providers accessed here August 2019

[161] Equality and Human Rights Commission (2009) Research Report 12. Inequalities experienced by Gypsies and Traveller communities: a review accessed here July 2019

[162] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[163] Inclusion Health (2013) Commissioning inclusive services.accessed here July 2019

[164] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[165] NICE (2016) Coexisting severe mental illness and substance misuse: community health and social care services. NG58 accessed here August 2019

[166] Equality and Human Rights Commission (2016) England's most disadvantaged groups: Is England Fairer? accessed here July 2019

[167] Inclusion Health (2013) Commissioning inclusive services.accessed here July 2019

[168] Inclusion Health (2014) Hidden needs: identifying key vulnerable groups in data collections - vulnerable migrants, gypsies and travellers, homeless people and sex workers. accessed here July 2019

[169] Inclusion Health (2013) Commissioning inclusive services.accessed here July 2019

Many health professionals believe that specific groups of healthcare users are less aware of available health- care services and their entitlement to use them. This barrier was explicitly mentioned in relation to migrant status, ethnic background, age and disability, as well as a combination of these characteristics[170].

The Joint Committee on Human Rights highlight that people with life-threatening illnesses or disturbing mental health conditions being denied, or failing to seek, treatment [171]

Migrants experience barriers to health care which include,[172],[173] :

- lack of access to reliable transport for accessing services;
- inadequate information on availability of health services or how to access health services,
- inadequate language and other support ;
- cultural insensitivity on the part of some health care providers.

A number of smaller research reports highlight the stigma and stigmatising treatment experienced by migrants, refugees and asylum seekers in England[174]

People with co-occurring mental health and alcohol/drug use conditions

In England, a key group of people experiencing the most severe and multiple disadvantage are those with mental health problems combined with substance use, homelessness or criminal justice involvement[175] . Predominantly, this group comprises white men aged 25-44 years[176] however there is a growing body of evidence describing how women exposed to violence or sexual abuse use substances to cope with the psychological and physical consequences[177].

Any problems are compounded by ethnicity, LGBT, homelessness, older people, co-morbidities such as LTCs or communicable disease. Also, substance misuse can affect capacity to make

[170] European Union Agency for Fundamental Rights. (2013) Inequalities multiple discrimination in access to and quality of health care. accessed here July 2019
[171] Equality and Human Rights Commission (2016) England's most disadvantaged groups: Is England Fairer? accessed here July 2019
[172] UK Race equality foundation 2010. Better Health Briefing 19. Health and access to health care of migrants in the UK accessed here July 2019
[173] European Union Agency for Fundamental Rights. (2013) Inequalities multiple discrimination in access to and quality of health care. accessed here July 2019
[174] Equality and Human Rights Commission (2016) England's most disadvantaged groups: Is England Fairer? accessed here July 2019
[175] Lankelly Chase (2015) Hard edges: Mapping severe and multiple disadvantage in England. accessed here Sept 2019
[176] Lankelly Chase (2015) Hard edges: Mapping severe and multiple disadvantage in England. accessed here Sept 2019
[177] Lankelly Chase (2015) Hard edges: Mapping severe and multiple disadvantage in England. accessed here Sept 2019

decisions. Common amongst mental health problems, sex workers, veterans. Men outnumber women but women with childcare responsibiltis,. Pregnant women and their unborn babies. .

Alcohol abuse is a key predictor of suicide, premature death and illness from accidental, violent or self inflicted injuries, cancer, liver and pancreatic disease. More than half (54%) of suicides occur among patients with a history of alcohol or drug misuse (or both). [178]

People with co-occurring conditions have a heightened risk of other health problems and early death[179]

Some groups of people with co-occurring mental health and substance misuse may be particularly at risk of losing contact with services, whilst also being at risk of greater harm. These groups include[180]:

- people who are homeless
- people who have experienced or witnessed abuse or violence, including women with experience of domestic abuse
- women who are pregnant or have recently given birth
- children and young people
- people who are parents or carers who may fear the consequences of contact with statutory services - for example young carers may fear speaking out in case they are taken into care
- people involved in selling sex
- lesbian, gay, bisexual and transgender (LGBT) people and black, Asian and minority ethnic groups (BAME)
- refugees and asylum seekers
- people without recourse to public funds

Difficulties reaching these groups can result in multiple unmet needs and greater risks due to poor access to preventive services such as health promotion and screening

Current NHS services are not always equipped to deal with more than one problem at the same time. Instead, the system has been set up only to support someone's primary need: drugs, alcohol or mental health It is generally agreed that integrated services are the best way to address problems relating to addiction and mental health but they remain the exception rather than the rule. The required collaborative approach to service delivery remains a challenge and means people continue to fall through the gaps in current service provision[181]

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[178] Lankelly Chase (2015) Hard edges: Mapping severe and multiple disadvantage in England. accessed here Sept 2019

[179] Turning point. Dual Dilemma: the impact of living with mental health issues combined with drug and alcohol misuse. accessed here August 2019

[180] PHE (2017) Better care for people with co-occurring mental health and alcohol/drug use conditions. A guide for commissioners and service providers accessed here August 2019

[181] Turning point. Dual Dilemma: the impact of living with mental health issues combined with drug and alcohol misuse. accessed here August 2019

Other barriers to care include lack of capacity, divisions between mental health and physical health services, and strict access and exclusion criteria for specialist mental health services[182].

People with co-occuring substance misuse and mental health problems often lead chaotic lives creating problems attending attending scheduled appointments or even engaging with mainstream services[183].

Co-occurring alcohol use conditions with mental health issues feature prominently in relation to A&E attendances[184], hospital admissions, premature death and suicide[185]. People often attend A&E at a time of mental health crisis, due to self harm, GP referral or because there is nowhere else to go[186]. Except for people with dementia, most people with a mental health condition are admitted to hospital via A&E in the evenings (outside of 9am and 5pm). In particular, the peak hours for self-harm admissions are between 11pm and 5am when it accounts for 6% of all people admitted via A&E. For this reason, many hospitals have introduced liaison psychiatry teams which provide patients who are in distress in hospital with assessment and short-term care, and link with the follow-up support they need[187].

The lack of appropriate services in the community means that A & E staff are often the ones treating people with co-existing issues who have reached a crisis point.[188]

GYPSIES, TRAVELLERS & ROMA

The Traveller identity is often used as an umbrella definition for all populations coming from a nomadic cultural background, including Romany, Welsh, Irish, English and Scottish Gypsies, Roma, as well as fairground and boating communities[189]

[182] PHE (2017) Better care for people with co-occurring mental health and alcohol/drug use conditions. A guide for commissioners and service providers accessed here August 2019

[183] Turning point. Dual Dilemma: the impact of living with mental health issues combined with drug and alcohol misuse. accessed here August 2019

[184] CQC (2015) Right here right now. People's experiences of help, care and support during a mental health crisis. accessed here August 2019

[185] PHE (2017) Better care for people with co-occurring mental health and alcohol/drug use conditions. A guide for commissioners and service providers accessed here August 2019

[186] CQC (2015) Right here right now. People's experiences of help, care and support during a mental health crisis. accessed here August 2019

[187] CQC (2015) Right here right now. People's experiences of help, care and support during a mental health crisis. accessed here August 2019

[188] Turning point. Dual Dilemma: the impact of living with mental health issues combined with drug and alcohol misuse. accessed here August 2019

[189] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

The health status of Gypsies and Travellers is much poorer than that of the general population, even when controlling for confounding factors such as variable socio-economic status and/or ethnicity[190] This group have some of the worst health outcomes of any ethnic minority group, with studies showing that they have significantly lower life expectancy than the general population[191]. It is frequently reported that Gypsy and Traveller women live 12 years less than women in the general population and Gypsy and Traveller men 10 years less than men in the general population[192]

They have poorer general health, high rates of limiting long term illness, substantially elevated smoking rates, high infant mortality rates, high maternal mortality rates, low child immunisations levels, elevated rates of measles, whooping cough, and other infections, mental health issues[193], substance misuse issues and diabetes.[194], [195] [196]

Men and women often experience chronic ill health, frequently suffering from more than one condition[197]

The reasons for such poor health outcomes amongst this population are numerous and include severe deprivation, high levels of illiteracy; lack of good quality health supporting accommodation; lack of knowledge of mainstream services; and a mistrust of authority[198].

These factors can also be compounded by a sense of fatalism and low expectations about their own health and health services – ill health is seen as normal, an inevitable consequence of adverse social circumstances. [199], [200], [201]

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[190] Better Health Briefing 12. The health of Gypsies and Travellers in the UK. Race equality foundation 2008. accessed here July 2019

[191] House of Commons Library (2019) Briefing Paper Number 08083 Gypsies and travellers accessed here July 2019

[192] Equality and Human Rights Commission (2009) Research Report 12. Inequalities experienced by Gypsies and Traveller communities: a review accessed here July 2019

[193] House of Commons Library (2019) Briefing Paper Number 08083 Gypsies and travellers accessed here July 2019

[194] Inclusion Health (2013) Commissioning inclusive services.accessed here July 2019

[195] Inclusion Health (2014) Hidden needs: identifying key vulnerable groups in data collections - vulnerable migrants, gypsies and travellers, homeless people and sex workers. accessed here July 2019

[196] Equality and Human Rights Commission (2009) Research Report 12. Inequalities experienced by Gypsies and Traveller communities: a review accessed here July 2019

[197] Better Health Briefing 12. The health of Gypsies and Travellers in the UK. Race equality foundation 2008. accessed here July 2019

[198] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[199] Inclusion Health (2013) Commissioning inclusive services.accessed here July 2019

[200] Better Health Briefing 12. The health of Gypsies and Travellers in the UK. Race equality foundation 2008. accessed here July 2019

Despite high levels of anxiety and depression, internal stigma means that mental health issues are often kept hidden increasing the burden on individuals and families.[202],[203],[204]

The poor housing and neighbourhood conditions for Gypsy and Traveller groups are a serious concern[205],[206],[207]

Low levels of literacy, together with stigma, poor access to health information and some widespread health-beliefs increase the likeliness that they will not seek treatment, or will underestimate the seriousness of the condition[208].

Cultural norms may prevent some Roma people from accessing services for support with mental health, sexual health, and drug and alcohol misuse

Cultural concerns and an intense fear of particular health conditions (particularly cancer) result in a reluctance to attend for preventive health care such as cancer screening[209],[210].

They believe that professionals are unable to significantly improve patients' health status and make limited use of health care provision.[211],[212]

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[201] Equality and Human Rights Commission (2009) Research Report 12. Inequalities experienced by Gypsies and Traveller communities: a review accessed here July 2019

[202] Equality and Human Rights Commission (2016) England's most disadvantaged groups: Is England Fairer? accessed here July 2019

[203] PHE (2018) Local action in health inequalities: understanding and reducing ethnic inequalities in health. accessed here July 2019

[204] Better Health Briefing 12. The health of Gypsies and Travellers in the UK. Race equality foundation 2008. accessed here July 2019

[205] Equality and Human Rights Commission (2016) England's most disadvantaged groups: Is England Fairer? accessed here July 2019

[206] PHE (2018) Local action in health inequalities: understanding and reducing ethnic inequalities in health. accessed here July 2019

[207] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[208] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[209] Better Health Briefing 12. The health of Gypsies and Travellers in the UK. Race equality foundation 2008. accessed here July 2019

[210] Equality and Human Rights Commission (2009) Research Report 12. Inequalities experienced by Gypsies and Traveller communities: a review accessed here July 2019

[211] Better Health Briefing 12. The health of Gypsies and Travellers in the UK. Race equality foundation 2008. accessed here July 2019

Poor access to, and uptake of, health services is a major factor in Gypsy and Traveller health.[213] Lack of access is not simply an issue pertaining to nomadism: it also applies to sedentary Gypsies and Travellers. It is caused in part by a complex relationship of multiple issues to do with discrimination, marginalisation, lack of trust and low expectations on the part of other agencies[214]

Negative attitudes towards Gypsy, Roma and Traveller communities were still widely held[215]. A number of studies have reported Gypsies' and Travellers' fear of hostility or prejudice from healthcare providers and the ways in which this can impact on accessing or utilising services [216]

Procedures for registering and accessing primary care services are a significant barrier, as well as a lack of cultural awareness and cultural competency amongst health staff which can cause misunderstanding and tension, and can deter some from seeking health care until there is an emergency. [217] Many are denied GP registration being deemed to be problematic users[218]

Poor familiarity with healthcare provisions and literacy language barriers may make it difficult for them to access health services. This is compounded by a lack of trust leading to a lack of engagement with public health campaigns[219]

A lack of awareness and sensibility from staff, can further discourage users from accessing services [220],[221]

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[212] Equality and Human Rights Commission (2009) Research Report 12. Inequalities experienced by Gypsies and Traveller communities: a review accessed here July 2019

[213] Equality and Human Rights Commission (2009) Research Report 12. Inequalities experienced by Gypsies and Traveller communities: a review accessed here July 2019

[214] Better Health Briefing 12. The health of Gypsies and Travellers in the UK. Race equality foundation 2008. accessed here July 2019

[215] Equality and Human Rights Commission (2016) England's most disadvantaged groups: Is England Fairer? accessed here July 2019

[216] Equality and Human Rights Commission (2009) Research Report 12. Inequalities experienced by Gypsies and Traveller communities: a review accessed here July 2019

[217] Inclusion Health (2013) Commissioning inclusive services.accessed here July 2019

[218] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[219] House of Commons Library (2019) Briefing Paper Number 08083 Gypsies and travellers accessed here July 2019

[220] House of Commons Library (2019) Briefing Paper Number 08083 Gypsies and travellers accessed here July 2019

[221] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

There is a lack of suitable intermediate care solutions following discharge from hospital generating a negative impact on patient outcomes. There is a need to ensure that patients are linked up with the appropriate supporting services. [222]

This group is more likely to have a poorer experience of health services due to direct or indirect discrimination.[223]

Carers experience a high level of stress[224].

Lack of cultural awareness, including racism, perceived judgemental behaviours, or inability to 'explain things properly' often contributes to the poor patient experience[225] (14)

Poor provision for visiting family members, cultural clashes with staff and other patients, distress experienced by people with limited literacy skills, and unfamiliarity with being inside bricks and mortar, all contribute to Gypsies and Travellers frequently choosing to discharge themselves early from hospital[226]

The admission and length of stay patterns for members of socially excluded groups show that these patients are admitted more often, stay longer and are re-admitted more frequently.
They are more likely to present at A&E because of the challenges of registering with a GP[227]

There is increasing evidence that the needs of terminally ill Gypsies and Travellers are being overlooked by hospitals and GPs in the UK. [228]

HOMELESSNESS

[222] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019
[223] House of Commons Library (2019) Briefing Paper Number 08083 Gypsies and travellers accessed here July 2019
[224] Better Health Briefing 12. The health of Gypsies and Travellers in the UK. Race equality foundation 2008. accessed here July 2019
[225] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019
[226] Equality and Human Rights Commission (2009) Research Report 12. Inequalities experienced by Gypsies and Traveller communities: a review accessed here July 2019
[227] Better Health Briefing 12. The health of Gypsies and Travellers in the UK. Race equality foundation 2008. accessed here July 2019
[228] Better Health Briefing 12. The health of Gypsies and Travellers in the UK. Race equality foundation 2008. accessed here July 2019

Homelessness is a broad concept that includes a number of different categories, ranging from rough sleepers to those temporarily sheltered in homeless hostels, to hidden groups like 'sofasurfers',who are seeking temporary accommodation from friends and families following the loss of their own lodging, to those in overcrowded and unsuitable accommodation.[229]

Homeless people have significantly more complex, severe health needs than the rest of the population, and the experience of homelessness often further exacerbates existing health conditions, as well as placing people at severe risk of developing new health problems.[230]

Evidence shows that the health problems of homeless people in England are considerable, and their life expectancy is well below the national average. Studies suggest the average age at death of a homeless man is 47 years, compared to 77 for the general population and 43 years for a homeless woman.[231]

About a third of deaths among homeless people are directly connected to substance problems. In addition, homeless people are also much more likely to die due to 'external factors', such as various infections and traffic accidents[232]

The homeless often have one or more physical health condition and many have mental health conditions; a considerable proportion have multiple health needs, including one or more mental health problem[233]s and a problem with drugs and/or alcohol. Estimates of the prevalence of dual diagnosis among homeless people vary from 10 to 50 per cent.[234]

A high prevalence of communicable diseases such as tuberculosis and hepatitis can be found among those living on the streets or in hostels. There are particular challenges in screening and treating this group for such illnesses. The number of cases of tuberculosis in the UK is rising, with homeless people particularly affected[235]

The reasons for such poor health outcomes are numerous and include chaotic lifestyles; perception of social stigma; a low awareness of their own personal health needs; barriers to registering with a GP; and accessing health and other services.[236]

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[229] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[230] Inclusion Health (2013) Commissioning inclusive services.accessed here July 2019

[231] Equality and Human Rights Commission (2016) England's most disadvantaged groups: Is England Fairer? accessed here July 2019

[232] Inclusion Health (2013) Commissioning inclusive services.accessed here July 2019

[233] Inclusion Health (2014) Hidden needs: identifying key vulnerable groups in data collections - vulnerable migrants, gypsies and travellers, homeless people and sex workers. accessed here July 2019

[234] Inclusion Health (2013) Commissioning inclusive services.accessed here July 2019

[235] Inclusion Health (2013) Commissioning inclusive services.accessed here July 2019

[236] Inclusion Health (2013) Commissioning inclusive services.accessed here July 2019

Access to healthcare remains problematic for homeless people. Barriers include poor staff attitudes and the fear of being judged or experience of being passed between agencies and receiving help from none, for example for people with dual diagnosis (substance misuse and mental health problems)[237]

Due to a combination of factors, including more immediate needs such as food and shelter, poor staff attitudes, fear of being judged and others, homeless people find it generally quite difficult to access health services, particularly when trying to use mainstream general practice.

Homeless people can fall into two distinct groups: those that do not engage with services at all, and those with a much higher than average A&E and emergency service . Patients with dual diagnosis have historically been facing increased difficulty in accessing health services, as substance misuse problems have often been a reason for passing the responsibility for these patients on to other parties.[238] Homeless patients are admitted more often, stay longer and are re-admitted more frequently. This highlights a number of issues further upstream: that these patients struggle to access other services, and therefore they turn to secondary care, and that they are sicker and do not receive the same quality of care as other patients, particularly when looking at discharge arrangements.[239]

One of the key areas of concern across the different groups is the lack of suitable intermediate care solutions following discharge from hospital. In fact, the absence of appropriate step-down solutions has a negative impact on patient outcomes and there is a need to ensure that patients are linked up with the appropriate supporting services.[240]

For many of these patients, previous negative experiences with health professionals, complex needs and chaotic lifestyles can make it difficult to access services and navigate the health system. This, coupled with a lack of awareness and sensibility from staff, can further discourage users from accessing services.[241]

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[237] Equality and Human Rights Commission (2016) England's most disadvantaged groups: Is England Fairer? accessed here July 2019

[238] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[239] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[240] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[241] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical

Homeless people are heavy users of acute health services. Their use of hospital services, including Accident and Emergency, is between three and six times that of the general population. [242] Studies suggest they are five times more likely to attend A&E, three times more likely to be admitted and are likely to stay three times as long.[243],[244]

SEX WORKERS

Historically, sex workers have been one of the most socially excluded groups. Sex workers can be categorised into two groups: street workers and off street workers. The health and social needs of the two groups are quite distinct, requiring services tailored to meet these needs, rather than a one size fits all approach.245

Street-based sex-work, accounts for about a third of the total volume, and substance addiction and chaotic lifestyles are key influences among street-based workers, [246]

The other two-thirds of total volume relates to indoor 'parlour-based' activity. Financial difficulties are often the key motivation for indoor-based prostitution.[247]

Most female, and some male, street work is driven by the drug economy. Chronic addiction is common, resulting in complex and multiple health and care needs, compounded by other socio-economic factors, such as poverty, family breakdown, poor educational attainment, lack of alternative employment opportunities and

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Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[242] Equality and Human Rights Commission (2016) England's most disadvantaged groups: Is England Fairer? accessed here July 2019

[243] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[244] Inclusion Health (2014) Hidden needs: identifying key vulnerable groups in data collections - vulnerable migrants, gypsies and travellers, homeless people and sex workers. accessed here July 2019

[245] Inclusion Health (2013) Commissioning inclusive services.accessed here July 2019

[246] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[247] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

persistent contact with the criminal justice system[248] 85% of street sex workers report using heroin and 87% using crack cocaine. [249]

Many sex workers have poor mental health, relating to a complex set of factors including their childhood, use of drugs, and social circumstances (including homelessness).[250]

The lack of stable accommodation is recognised as both a risk factor for entry and a barrier to exit from sex work, and about a quarter of sex workers are reporting no fixed abode', with another quarter living in hostels[251]

Sex workers experience multiple barriers to accessing healthcare. For many of these patients, previous negative experiences with health professionals, complex needs and chaotic lifestyles can make it difficult to access services and navigate the health system. This, coupled with a lack of awareness and sensibility from staff, can further discourage users from accessing services.[252]

The criminalisation of sex work leaves sex workers distrustful of statutory services, fearful that information about them will be shared with the police or that they will be deported. This means that they often do not report as sex workers to health services.[253]

Real and perceived barriers, such as low levels of self-esteem and fear of being stigmatised or treated judgmentally by staff when attempting to access a service make contact more difficult and sensitive[254]

Substance misuse problems often represent a barrier to accessing health care, as health professionals sometimes use this as a reason to push-back , particularly in mental health[255]

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[248] Inclusion Health (2013) Commissioning inclusive services.accessed here July 2019

[249] Inclusion Health (2014) Hidden needs: identifying key vulnerable groups in data collections - vulnerable migrants, gypsies and travellers, homeless people and sex workers. accessed here July 2019

[250] Inclusion Health (2014) Hidden needs: identifying key vulnerable groups in data collections - vulnerable migrants, gypsies and travellers, homeless people and sex workers. accessed here July 2019

[251] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[252] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[253] Inclusion Health (2013) Commissioning inclusive services.accessed here July 2019

[254] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

These patterns are the same as for homeless people – see above

Key evidence relating to carers

Introduction

A carer is anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid.[256]

Women represent 51% of the population but make up 58% of carers. The majority of carers are aged between 50-64 years and are most likely to provide between 1-19 hours of care per week. They may also have care needs and long term conditions. [257]

There are concerns that there may not be sufficient numbers of unpaid carers in the future to meet demand, particularly from older people. Factors such as increasing female employment, fewer children, and higher divorce rates amongst men over 60 years may affect the future availability of children to provide unpaid care[258]

Health needs

Caring responsibilities can have an adverse impact on the physical and mental health, education and employment potential of those who care, which can result in significantly poorer health and quality of life outcomes. These in turn can affect a carer's effectiveness and lead to the admission of the cared for person to hospital or residential care[259]

83 per cent of carers stated that caring has had a negative impact on their physical health and 87 per cent of carers stated that caring has had a negative impact on their mental health[260]

Typically, carers neglect their own health, [261] and in one large survey, over one third had had to cease work because of their caring responsibilities.[262] Some are living in

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[255] Gill, P, Macleod, U, Lester, H and Hegenbarth, A. Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence- based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards. 2013. The Royal College of General Practitioners. accessed here July 2019

[256] NHS England Carers facts - why investing in carers mattersaccessed here Sept 2019

[257] House of Parliament (2018) Postnote Number 582. Unpaid Care

[258] House of Parliament (2018) Postnote Number 582. Unpaid Care

[259] NHS England Carers facts - why investing in carers mattersaccessed here Sept 2019

[260] Carers UK (2012) In sickness and in health

[261] Carers UK (2012) In sickness and in health

[262] Carers UK (2012) In sickness and in health

poverty, or making financial adjustments, as a consequence of taking on their caring role. [263]

Evidence has shown that, providing unpaid care may have an adverse effect on young carers' general health. There is growing evidence pointing to the adverse impact on the health, future employment opportunities and social and leisure activities of those providing unpaid care, particularly in young carers[264]

There is an increasing prevalence of 'sandwich carers' (2.4 million in the UK) – those looking after young children at the same time as caring for older parents. It can also be used much more broadly to describe a variety of multiple caring responsibilities for people in different generations[265]

Increasingly, as the numbers of older and disabled people increase, unpaid carers are juggling work and care. [266]

[263] Carers UK (2012) In sickness and in health
[264] NHS England Carers facts - why investing in carers mattersaccessed here Sept 2019
[265] NHS England Carers facts - why investing in carers mattersaccessed here Sept 2019
[266] Carers UK (2019) Juggling work and unpaid care