Cover page	
Meeting	Trust Board
Agenda Item No.	20
Paper Title	Equality and Diversity – Annual Report 2018 (Service Delivery)
Date of meeting	4 April 2019
Date paper was written	17 January 2019
Responsible Director	Deirdre Fowler, Director of Nursing, Midwifery and Quality
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Executive Summary

The Trust Board is asked to receive the Annual Equality and Diversity Report (Service Delivery) for 2018, approve the objectives and action plan relating to Service Delivery and note that this is in addition to the Workforce report submitted in November 2018.

The report covers the period from the 1 April 2017 to 31 March 2018.

The paper provides an overview of progress set out against the equality objectives set in 2017 and includes the relevant information in order to meet compliance with the Equality Act 2010 which is for the Trust to publish and act on equality data for our patients, staff and the local communities which SaTH serves.

There is evidence to suggest there is a direct connection to equality and diversity being embedded within every level of the organisation to better outcomes for both patients and staff.

Previously considered by	Quality and Safety Committee Patient and Carer Experience Panel

The Board is asked to:			
☑ Approve	☐ Receive	☐ Note	☐ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☐ Effective	☑ Caring	☐ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☑ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☐ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☐ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	RR 1186 If we do not develop real engagement with our community we will fail to support an improvement in health outcomes and deliver our service vision

Equality Impact Assessment	○ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	○ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	There is no established budget allocation for Equality and Diversity (Service Delivery).
Appendices	Appendices available in Information Pack

Main Paper

Situation

Under legislation the Trust is required to publish an annual report which demonstrates its compliance with the Public Sector Duty as outlined in the Equality Act 2010. The Trust is required to demonstrate that it has considered how the decisions we make and services we deliver affect people who share different protected characteristics.

The protected characteristics as defined in the Equality Act 2011:

- Age
- Race
- Religion or belief
- Gender
- Sexual orientation
- Marital Status
- Disability
- Pregnancy and maternity
- Gender reassignment

NHS organisations are required to demonstrate compliance with legal requirements and improvement in Equality and Diversity practice through the Equality Diversity System (EDS2). It is designed to be used in partnership with patients, the public, staff and the communities served by the Trust.

Background

Previous reports have acknowledged that whilst being transparent in assessments and involvement of patient experience groups and volunteers, the Trust had not fully consulted with the broad diversity of service users to inform completion of the EDS2.

In December 2018 to enable full engagement with assessment of the EDS2 Service Delivery outcomes the Trust held an Equality and Diversity stakeholder event.

Assessment

An organisation which embraces equality and diversity is viewed by patients and the local the community as one which addresses individual needs in an inclusive manner.

Whilst it is recognised that the Trust has continued to build upon foundations, it is acknowledged that there is work to be done to make further improvements, break down barriers and foster relationships with the diverse communities which we serve. To deliver this the Trust needs to:

- Ensure our patients, carers, partners and stakeholders are effectively engaged in service provision
- Raising awareness of diversity monitoring of patients with staff
- Ensure that patients feel free from discrimination, treated fairly with dignity and respect
- Establish an Equality, Diversity and Inclusivity Group

Recommendation

The Committee are asked to receive this Annual Equality and Diversity Report for 2018, approve the objectives relating to Service Delivery and note that this is in addition to the Workforce report submitted in November 2018.

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1. Legal Requirements

As a public sector organisation, SaTH is required to publish an annual report that demonstrates its compliance with the Public Sector Duty as defined by the Equality Act 2010. The Equality Act 2010 contains measures which have direct implications for our functions and underpins the legal framework in which we operate. It informs our approach as an employer and a provider of public services.

The report examines the composition of patients against each of the 9 protected characteristics, where data is available, comparing these with the local demographics, in order to try and identify gaps and trends in service provision. Where gaps are identified, these will be converted into the development of an action plan and objectives for the Trust to deliver on in 2019/20.

The Equality Act 2010 identified nine Protected Characteristics, these are:

- Age
- Disability (including learning disabilities, physical disabilities, sensory impairment and mental health problems)
- Sex (gender)
- Race (ethnicity)
- Religion, belief and non-belief
- Sexual orientation
- Marital status
- Pregnancy and maternity
- Gender reassignment

In addition to these key characteristics NHS organisations are required to consider equality and diversity in relation to other disadvantaged groups which may include but are not restrictive to: living in poverty, geographical isolation, limited family or social networks and homeless.

In respect of the nine Protected Characteristics, section 149 of the Equality Act 2010 requires us to have due regard to:

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

The General Equality Duty focuses on advancing equality and involves:

- Removing or minimising disadvantages suffered by people due to their Protected Characteristics
- Taking steps to meet the needs of people from the protected groups where these are different from the needs of other people
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The Trust is also required to demonstrate that it has considered how the decisions that we make, the services we deliver and our employment practices affect people who share different Protected Characteristics.

In addition, NHS organisations are required to demonstrate compliance with legal requirements and continuous improvement in Equality and Diversity practice through the Equality Delivery System (EDS2), Accessible Information Standard and Sexual Orientation Monitoring Standards.

2. Governance and Reporting

In SaTH responsibility for Equality and Diversity is split between the Workforce Director for Workforce E&D matters and the Director of Safety and Quality for patient services matters. There is no single reporting point for combined oversight and scrutiny until papers get to the Trust Board as some papers go to Workforce Committee and others to Quality and Safety Committee.

Previous reports have acknowledged that the Trust is not fulfilling its obligations to consult with service users to inform completion of the patient services aspects of EDS2.

In a paper to the Workforce Committee in September 2018, it was proposed to establish a Committee to provide a focus for proper scrutiny, monitoring and direction of this area of work in the Trust.

SaTH is almost unique in the NHS in not having such a single oversight Committee for E&D and the Workforce Committee agreed the establishment of an Equality, Diversity and Inclusivity Committee to be chaired by the Non-Executive Director responsible for Equality and Diversity.

During the past 12 months, the following E&D reports have been made to the Workforce Committee and Quality and Safety Committee:

Gender Equality Pay Gap Report	March 2018
Workforce Race Equality Scheme	September 2018
Equality and Diversity Paper	September 2018
Equality and Diversity Annual Report (Workforce)	November 2018

3. Equality Delivery System (ESD2)

NHS organisations are required to complete the Equality Delivery System (NHS2) framework and assessment and to review it annually. This provides a comprehensive approach to demonstrating commitment to, and compliance with, legal requirements and continuing improvement in genuine involvement and participation of our service users and staff in the equality and diversity agenda.

SaTH completed an annual review of its EDS2 assessment in November 2017 and this was approved by Workforce Committee and Trust Board and published on the Trust website.

The Trust has identified that it needs a more systematic way of consulting with service users and listening to both patient and staff experiences to be able to provide more culturally competent services. The 2017 EDS2 Report, therefore, represented an honest and transparent assessment of where SaTH was against the standards required and proposed an Action Plan to address some of the key findings.

In late 2017, to avoid delaying our EDS2 publication, and in line with good governance we took the step of publishing our EDS2 assessment showing that we had not had external ratings of our performance indicators. Patient Access and Experience Indicators 1.1 to 2.4 were given preliminary ratings by Corporate Nursing before going to Trust Board for ratification. Those preliminary ratings were based upon an internal assessment of our progress informed by feedback from a range of patient experience groups and contacts including Volunteering and Patient Engagement.

The Board approved the preliminary ratings, recognising that these were transparent and honest and to be used as a starting point for improvement.

4. Action Plan - Equality Objectives 2017-19

The following Equality Objectives were approved by Trust Board in November 2017.

Objective	Responsibility	By When	Status
Objective			
Identify data sets that need to be collected for 2017-18 for evaluation and monitoring.	Associate Director of Nursing	March 2018	Outstanding - In progress to be completed February 2019 after first meeting of EDI Committee
Complete EDS2 self-assessment and external assessments related to patient experience, identifying 3 priority areas for action	Associate Director of Nursing	Sept 2018	Complete - disability, accessible information and embedding diversity are identified as priority areas from engagement event and other feedback.
Improved Patient Access and Experience			
Form appropriate forums for patient engagement with focus groups to identify issues and record experiences and implement priority actions, including consideration of the needs of hard to reach groups.	Associate Director of Nursing/Director of Assurance and Governance	July 2018	Complete – Equality and diversity engagement event held Dec 2018 with patient and carer representatives, community groups and key stakeholders.
A Representative and Supported Workforce			
Review staff appetite for Diversity Forum – especially amongst BME staff, older staff and staff with disabilities and support as required.	Head of Education	Jan 2018	Complete – although this will be reviewed again in Nov 2018 after BME staff listening event with a view to establishing a Shropshire BME forum.
Revise Equality and Diversity Policy and Guidance through Trust	Head of Education	Mar 2018	Outstanding - In progress to be

Objective	Responsibility	By When	Status
consultation and approval process			completed January 2019 after first meeting of EDI Committee
Complete EDS2 related to workforce experience, identifying 3 priority areas for action	Head of Education	Sept 2018	Complete. Disability, Age (older workers) and BME identified as priority areas from Staff Survey and other feedback.
Equality and Diversity training compliance to reach 90%	Head of Education	Nov 2018	Outstanding – has risen to 85% from 80% in November 2017
Complete Gender Equality Pay Audit	Head of Education	May 2018	Complete – published March 2018
Inclusive Leadership			
Review Diversity and Inclusivity responsibilities and reporting arrangements to the Board and implement new arrangements as required, including consultation and membership.	Director of Workforce and Director of Safety & Quality	September 2018	Complete - Paper approved by Workforce Committee September 2018. Executive Directors to agree implementation.
Secure appointment of Executive Director (NED) Equality and Diversity lead	Director of Workforce	immediate	Complete - Chris Weiner appointed.
Trust Board to undertake Equality, Diversity and Inclusivity training	Director of Workforce	May 2018	Outstanding
Monitor take-up of Equality, Diversity and Inclusivity for Managers and Leaders training	Head of Education	September 2018	Complete - will be reported in Trust Annual Education Report

5. Summary of Stakeholder Consultation Event

A key objective relating to Service Delivery in 2018 was to hold our first Equality and Diversity Stakeholder Consultation Event with a wide range of organisations and community groups taking part, including Commissioners, Social Care partners, Healthwatch and partner healthcare organisations. This was to facilitate community feedback on our services and to build Equality Objectives for Service Delivery that our stakeholders identify as important to them in accessing high quality healthcare. It is also an important element of the step-change in the way we involve our service users in the design and delivery of our services.

The day included a number of presentations on specific services within the Trust, each relating to an EDS2 outcome. Ten outcomes were presented and facilitators at each table captured the discussion and scoring, ensuring that all in attendance had an opportunity to have their voice heard. Capturing their views on access to health services and better health outcomes for all.

Scoring was undertaken in accordance with the EDS2 framework (eg Excelling, Achieving, Developing or Undeveloped).Following the event all feedback was collated verbatim onto a template for each outcome (Appendix 1).

There was a lot of positive energy on the day and valuable feedback was given which will be used to support planning future engagement events. The engagement of a diverse range of local groups and representatives enriched the event, feedback will be given to individuals and organisations who attended and these links will be used for further engagement and service improvement. The feedback obtained will be shared at the Equality, Diversity and Inclusivity Committee to support development of an improvement plan for 2019/20.

6. EDS2 Update Following Stakeholder Consultation Event

The standards are identified below.

1.0 Better health outcomes for all	**Lead Director - Director of Nursing, Midwifery and Quality**	**Lead Director - Director of Nursing, Midwifery and Quality**
Standard	**Assessment Grading 2017**	**Assessment Grading 2018**
1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Developing	Developing
1.2 Individual people's health needs are assessed and met in appropriate and effective ways	Developing	Developing
1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed	Underdeveloped	Developing
1.4 When people use the NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	Developing / Excelling	Developing
1.5 Screening, vaccination and other health promotion services reach and benefit all local communities	Developing	Achieving
2.0 Improved patient access and experience	**Lead Director - Director of Nursing, Midwifery and Quality**	**Lead Director - Director of Nursing, Midwifery and Quality**
Standard	**Assessment Grading 2017**	**Assessment Grading 2018**
2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Developing / Excelling	Developing / Achieving
2.2 People are informed and supported to be as involved as they wish to be in decisions about their care	Underdeveloped	Developing

2.3 People report positive experiences of the NHS	Underdeveloped	Developing
2.4 People's complaints about services are handled respectfully and efficiently	Underdeveloped / Developing	Developing

The provisional grades remained the same in two outcomes and were graded less favourably in two outcomes, however in five outcomes the grading improved.

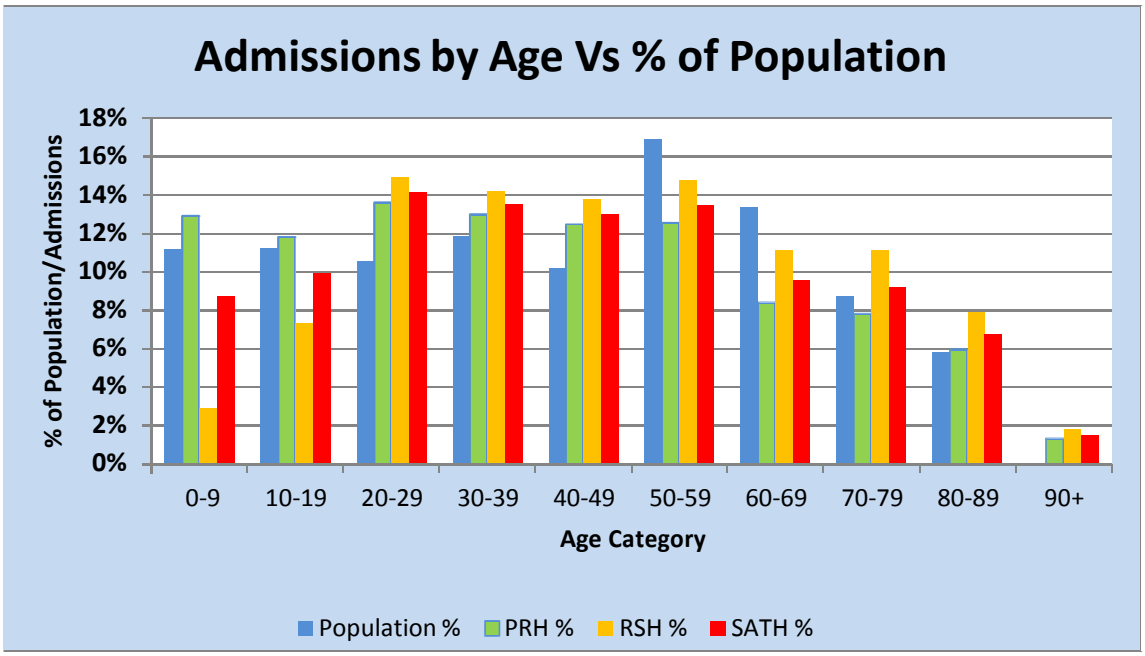
7. Service User Equality and Diversity Profile

The following points should be noted:

- Patient data has been taken from SemaHelix (both inpatient and outpatient) for the period from the 1st April 2017 to the 31st March 2018
- Translation and interpreting data has been taken from the Trust's service providers for the period from the 1st April 2017 to the 31st March 2018
- Workforce data (not including Bank Staff) for the period from the 1st April 2017 to the 31st March 2018
- Comparison data has been taken from the Office for National Statistics, Public Health England, Powys Unity Authority and Public Health Wales Observatory
- The data from different sources is not always collated in the same format

The Trust's Equality and Diversity profile for Service Users can be found in Appendix 2.

Age

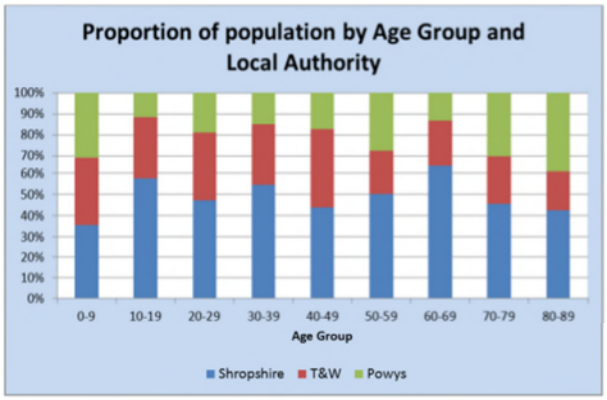


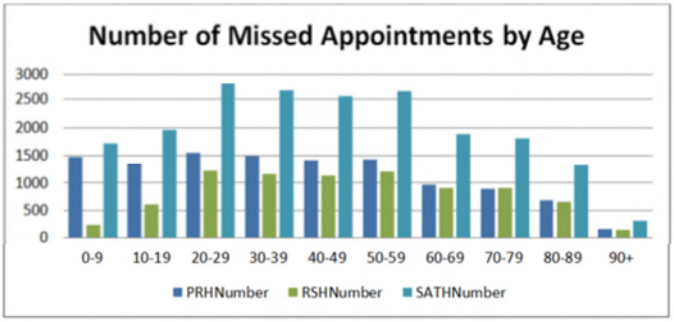
The highest percentage of patients accessing services at SaTH by age are those aged 20 - 29 years, followed by those aged 50 – 59 years, 30 – 39 years and 40 – 49 years which is statistically disproportionate to the population profile.

The largest admission group by age for RSH was jointly the 20-29 and 50-59 age group, with again more presenting in the 20-29 than population proportion but under represented for the 50-59 age group.

Although lower numbers, the proportion of over 70's presenting at RSH exceeded the population represented but in line for PRH, this represents that overall, Shropshire County and Powys has a higher proportion of older residents than Telford & Wrekin, which is a theme across the data.

PRH has a greater admission figure for the 0-9 and 10-19 age groups due to the location of the Children's Department and also the younger demographic of Telford & Wrekin.

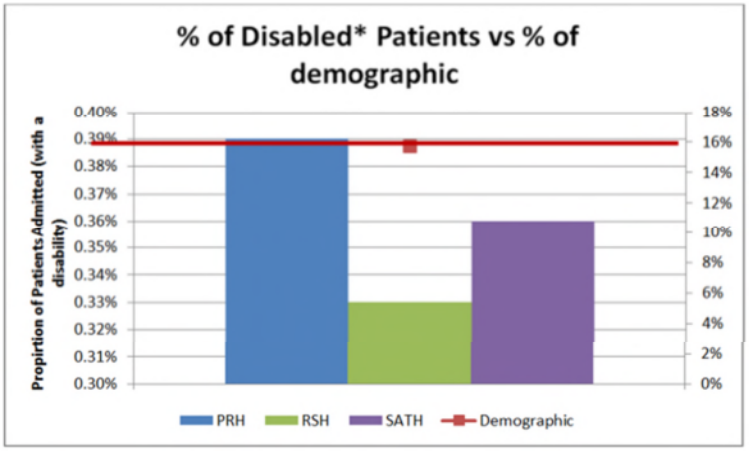




The data demonstrates that Shropshire County and Powys have the highest number of over 50's in their population and that Telford & Wrekin's demographic shows a higher proportion in the 0-9 and 40-49 age groups.

The number of missed hospital appointments is highest in the 20–29 age range however this age range only reflects 8.22% of Out Patient attendance. The largest Out Patient group by age are 70-79 years (16.72%) however this group are less likely to miss an appointment.

<u>Disability</u>

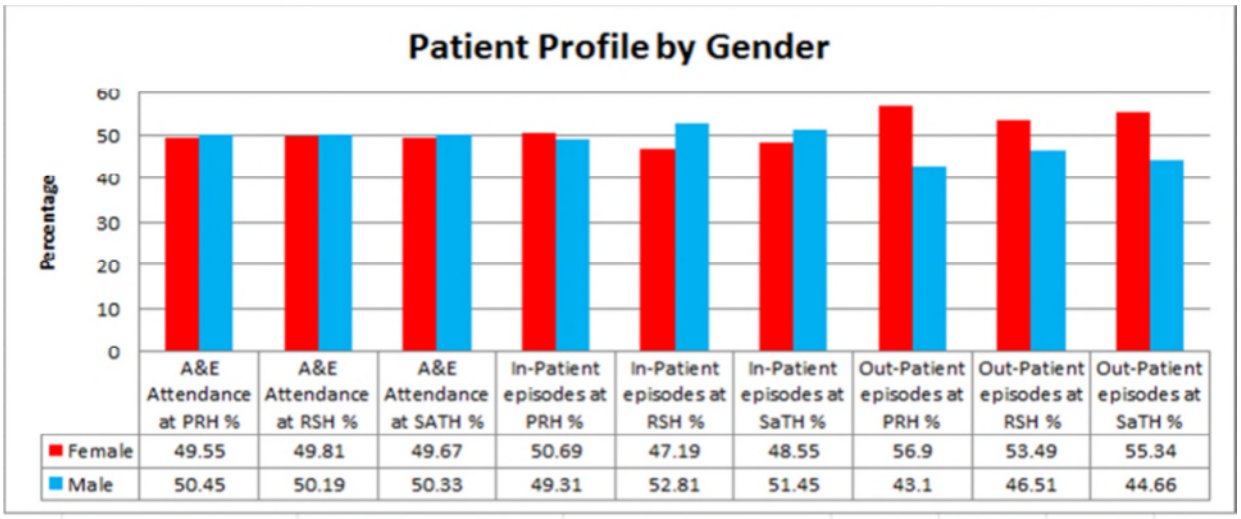


Disability data is presented in the various local authority census reports differently. Shropshire County definition covers any long-term illness, health problem or disability which limits daily activities or work.

SaTH data was split into: Disabled (1.14%), Not Disabled (98.33%) or unrecorded (0.52%). For the purposes of this report the unrecorded numbers have been incorporated in the Not Disabled category, but there is likely to be a small proportion of disabled patients who have not been categorised. The proportion of disabled patients recorded across SaTH does not

reflect the proportion of patients recorded as disabled in the county/local authorities and therefore no discernable outcomes can be construed.

Sex (gender)



	A&E Attendance at PRH %	A&E Attendance at RSH %	A&E Attendance at SATH %	In-Patient episodes at PRH %	In-Patient episodes at RSH %	In-Patient episodes at SaTH %	Out-Patient episodes at PRH %	Out-Patient episodes at RSH %	Out-Patient episodes at SaTH %
Female	49.55	49.81	49.67	50.69	47.19	48.55	56.9	53.49	55.34
Male	50.45	50.19	50.33	49.31	52.81	51.45	43.1	46.51	44.66

A lower percentage of males (44.66%) access SaTH Out Patient services when compared to the local population (of 49.5%) and a higher percentage of females (55.34%) use SaTH Out Patient services compared to the local population at 50.5%.

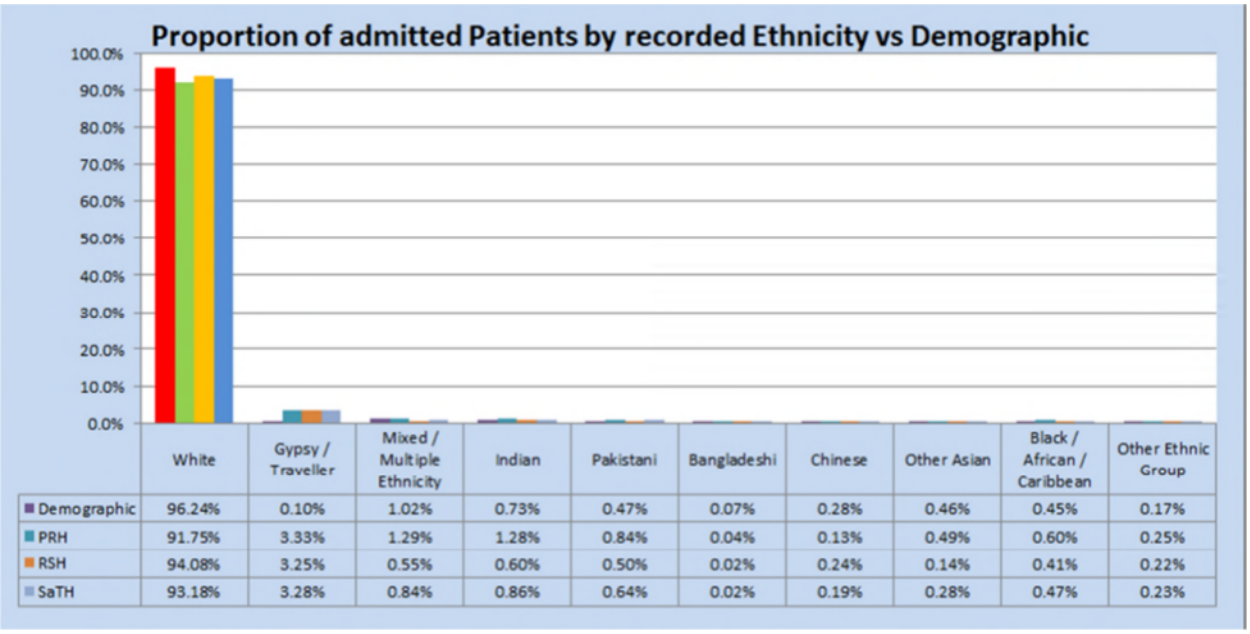
In-Patient episodes across SaTH are slightly higher for males (51.54%) than females (48.55%) however PRH has a slightly higher number of female In-Patient (50.69%) episodes due to the location of the Womens and Childrens Centre. Similarly Out Patient activity across SaTH is higher for females at 55.34% with a higher level of activity at PRH (56.9%) which is likely to reflect the location of services.

48.86% of patients accessing SaTH are male compared to 49.5% of the male population and 19.93% of the workforce. 80.07% of the workforce are female which appears to be an over-representation of females as they represent 50.5% of the local population and 51.13% of the total number of patients.

There is no information held on gender reassignment available.

Race (ethnicity)

The largest ethnicity group is “White” at over 90% representative, this is inclusive of patients from different backgrounds and is not exclusively British. Telford and Wrekin local authority (and PRH) has the largest proportion of other ethnic groups recorded with the next largest group being Indian and mixed ethnic groups respectively.

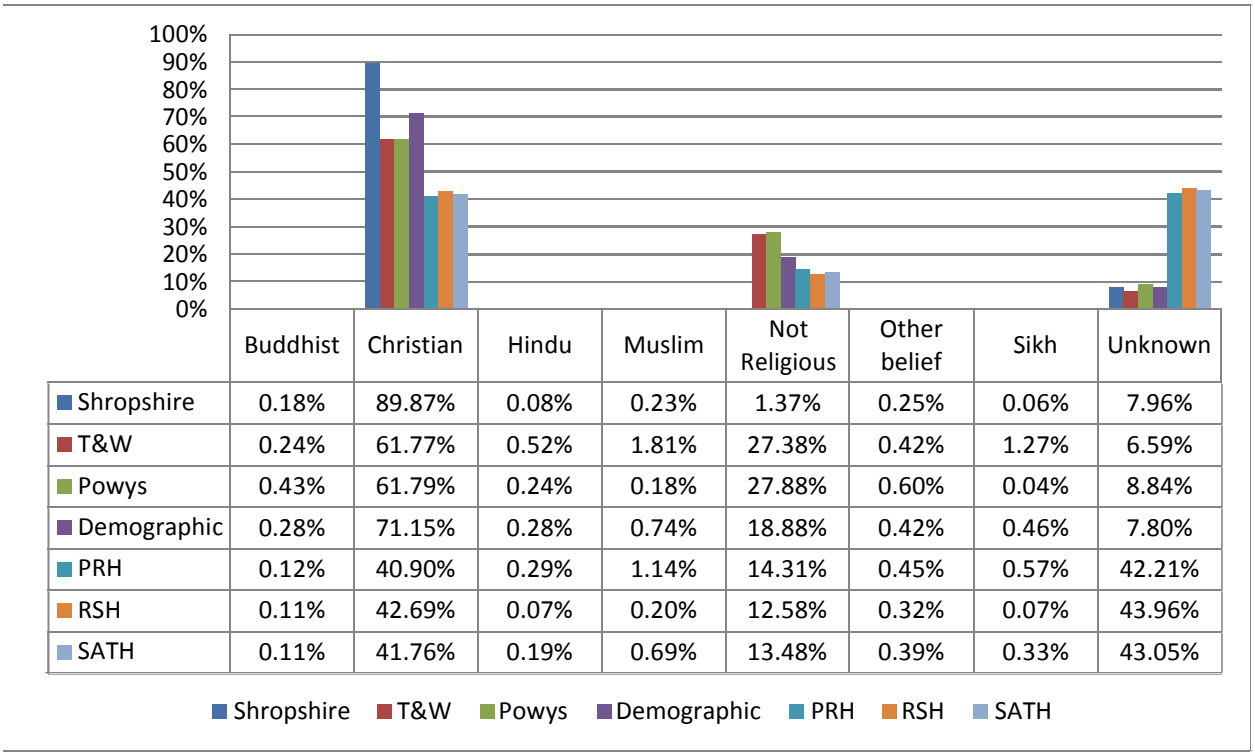


	White	Gypsy / Traveller	Mixed / Multiple Ethnicity	Indian	Pakistani	Bangladeshi	Chinese	Other Asian	Black / African / Caribbean	Other Ethnic Group
Demographic	96.24%	0.10%	1.02%	0.73%	0.47%	0.07%	0.28%	0.46%	0.45%	0.17%
PRH	91.75%	3.33%	1.29%	1.28%	0.84%	0.04%	0.13%	0.49%	0.60%	0.25%
RSH	94.08%	3.25%	0.55%	0.60%	0.50%	0.02%	0.24%	0.14%	0.41%	0.22%
SaTH	93.18%	3.28%	0.84%	0.86%	0.64%	0.02%	0.19%	0.28%	0.47%	0.23%

The ethnicity proportion admitted broadly matched that of the demographics with the exception of the classification gypsy / traveller where hospital admissions exceed the local demographic.

The largest ethnic group for missed hospital appointments is White British (84.44%) followed by Other White (2.73%), Indian (0.96%) and Pakistani (0.84%)

Religion, belief or non-belief

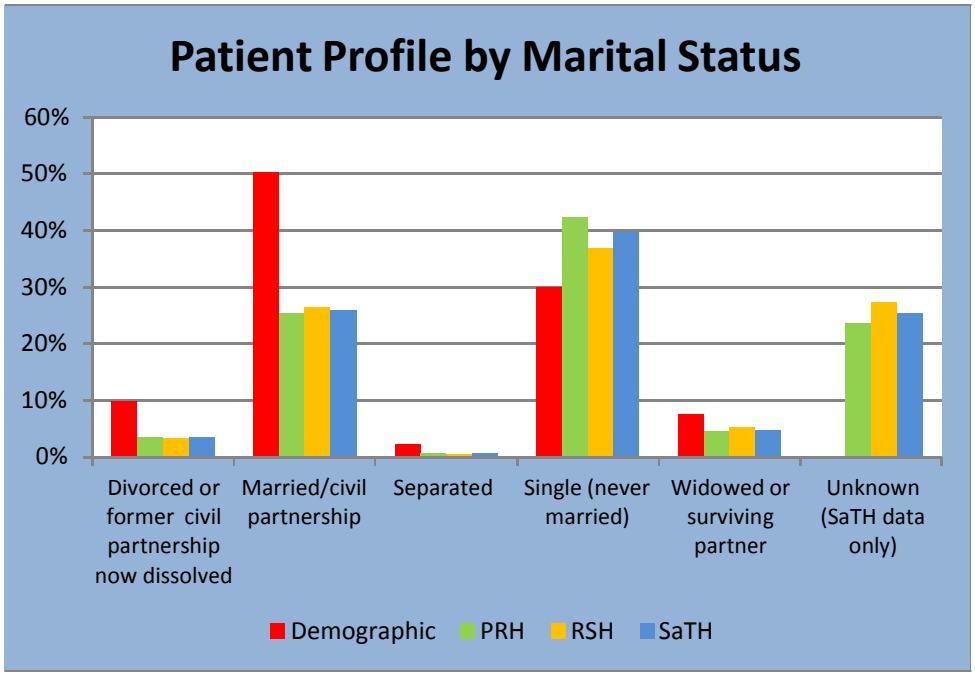


	Buddhist	Christian	Hindu	Muslim	Not Religious	Other belief	Sikh	Unknown
Shropshire	0.18%	89.87%	0.08%	0.23%	1.37%	0.25%	0.06%	7.96%
T&W	0.24%	61.77%	0.52%	1.81%	27.38%	0.42%	1.27%	6.59%
Powys	0.43%	61.79%	0.24%	0.18%	27.88%	0.60%	0.04%	8.84%
Demographic	0.28%	71.15%	0.28%	0.74%	18.88%	0.42%	0.46%	7.80%
PRH	0.12%	40.90%	0.29%	1.14%	14.31%	0.45%	0.57%	42.21%
RSH	0.11%	42.69%	0.07%	0.20%	12.58%	0.32%	0.07%	43.96%
SATH	0.11%	41.76%	0.19%	0.69%	13.48%	0.39%	0.33%	43.05%

It is difficult to ascertain whether the religious or belief needs of service users are being met at SaTH as 43.05% of this information is not available.

From the local population percentages, it is evident that there is more work to be carried out to improve this data to enable the Trust to ascertain if the diverse local ethnic groups have equal access to its services.

Marital Status



PRH has a higher proportion of single patients admitted than RSH (which is still higher than the representative demographic), and overall has a slightly higher proportion of single (never married) residents.

25.4% of SaTH patients have an 'unknown' marital status, it is therefore hard to draw any useful conclusions from this data as it is incomplete. The high percentage of missing data on marital status may include that for children.

Sexual Orientation

The Trust has no patient demographic data available on sexual orientation, it is therefore difficult to assess whether the Trust is meeting some of the health inequality data for these groups. Through the demographic data which was returned with the National In-Patient Survey it is possible to identify that the majority of respondents thought of themselves as heterosexual (93.54%) with a smaller group identifying as gay / lesbian (1.02%), a number of respondents preferred not to disclose the information (4.59%) with 43 respondents opting not to respond to this question.

Key Areas of Note

A concern is the limited availability of data for patients by the 9 protected characteristics, as it is necessity under the Equality Act 2010. This means the Trust is not able to fully address any gaps in service provision, or identify who is accessing our services, and which groups might be less likely to engage with services. This is recognised nationally as a challenge across many NHS organisations.

Protected Characteristic	Data Available (%)
Age	100
Disability	1.63
Learning Disability	98.23
Sex (gender)	100
Race (ethnicity)	94.93
Religion, belief or non-belief	56.95
Sexual orientation	0
Marital Status	74.6

We do not presently capture data information on disability, gender reassignment or sexual orientation. The protected characteristic of pregnancy is not required for patients and Service Delivery, however it is required for Workforce. Religion is captured within SEMA however this was only captured for 56.95% of patients during this period.

A key action for the 2018-20 plan will be the improvement of Equality and Diversity monitoring throughout the admission and booking process to establish a more robust patient profile to support patient access to information and services.

8. Community Equality and Diversity Profile

Shropshire County (23.6%) and Powys (22.75%) has a higher proportion of residents over 65 years of age than Telford & Wrekin (16.6%) and the national average across England (17.9%).

Across England there are 13.6% of people from ethnic minority groups, this is significantly lower in Powys (1.62%), Shropshire (1.8%) and Telford and Wrekin (5.3%).

Within Shropshire around 12% of children live in low income families compared to 20% in Telford and Wrekin. Deprivation within Telford and Wrekin is higher than the national average whilst across Shropshire the level of deprivation is considerably lower.

Within Powys 3.05% of the population only speak Welsh and 1.57% only speak and read Welsh. In addition to this 15% of Powys households have no transport such as a car which could lead to social isolation.

Both inpatient and outpatient services are accessed by a diverse range of service users. There are a number of non-attendances for appointments within each of the data sets and the information available does not identify with a particular group which suggests that there is no group experiencing increased difficulty accessing services within the Trust.

9. Available Health Inequalities Data

It is recognised that many rural communities face challenges which impinge upon health including poor employment opportunities, low income, lack of affordable housing and difficulty accessing healthcare services due to the decline in rural public transport links.

Across Shropshire the under 75 mortality data for heart disease and stroke remains consistently below the national average. In Telford and Wrekin the local average is above the national data however over recent years the gap of inequality has reduced.

The number of hip fractures in older people (aged 65 plus) is significantly worse than the national average in Telford and Wrekin whilst Shropshire is not significantly different to the average across England.

There are significantly more pregnant women who continue to smoke at the time of delivery within both Shropshire and Telford and Wrekin than the national average however the number is considerably higher within Telford and Wrekin. It is recognised that rates of smoking in pregnancy is linked to levels of deprivation and disadvantage (Smoking in Pregnancy Challenge Group).

Life expectancy is lower than the English national average in Telford and Wrekin (by 8.7 years for men and 5.1 years for women) and higher than the national average in Shrewsbury (3.7 years for men and 2.5 years for women). Life expectancy in Powys is higher (2 years for men and 1.5 years for women) than the Welsh national average.

Whilst overall the health status for Shropshire is above the national average conversely Telford and Wrekin is below the national average with a larger amount of deprivation within the community.

10. Accessible Information Standards

The Accessible Information Standards define a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. The standards are of specific significance to individuals who are blind, deaf, deafblind or who have a learning disability, however they should support anyone with information or communication needs relating to disability, impairment or sensory loss.

The Trust's compliance with Accessible Information Standards which requires staff to record patient's disability and the format information needs to be provided in remains a challenge to the NHS. Although data available to SaTH on interpreting and translation indicates support is accessed, this is not consistently reflected upon SEMA and there may be groups of patients who are missed leaving gaps to be addressed.

In the next SemaHelix upgrade to support the Accessible Information Standard, there will be a requirement to record and flag the communication support needs of patients, service users, carers and parents, where the needs relate to a disability, impairment or sensory loss. The upgrade is anticipated to be completed in summer 2019.

Following the upgrade the Trust will be in a position to:

- Record patient's communication and information needs in a set way
- Ensure patients receive information in an accessible way if and when needed
- Develop a process to ensure that information can be translated into the format required
- Identify gaps in the provision of accessible information
- Develop staff training and information on the SemaHelix upgrade
- Publicity and raising awareness to patients and staff members

11. Translation Services

An interpreting service is available for both in-patients and out-patients at our hospitals where English is not their first language. These appointments can be face-to-face or via the telephone. A large variety of languages are available through the Trusts preferred provider. The provider is contracted on the basis that it can provide qualified interpreters in most languages required by the Trust in the Telford and Shrewsbury region.

The Trust has utilised interpretation services for a range of languages over the time period:

Afghani	Farsi	Latvian	Potwari	Thai
Amoy	French	Lithuanian	Punjabi	Tigrinian
Arabic	Hindi	Malay	Pushto	Turkish
Bengali	Hungarian	Mandarin	Romanian	Twi
BSL	Italian	Mirpuri	Russian	Urdu
Bulgarian	Japanese	Nepalese	Serbian	Vietnamese
Cantonese	Kurdish	Polish	Slovak	
Czech	Kurdish-Southern	Portuguese	Spanish	

There were 15 occasions when written translation was required, 15 occasions when telephone interpreting was required and 2440 occasions during the time period when face to face interpreters were arranged to assist patients with communication barriers. This demonstrates a clear demand for the interpreting and translation service (Appendix 3).

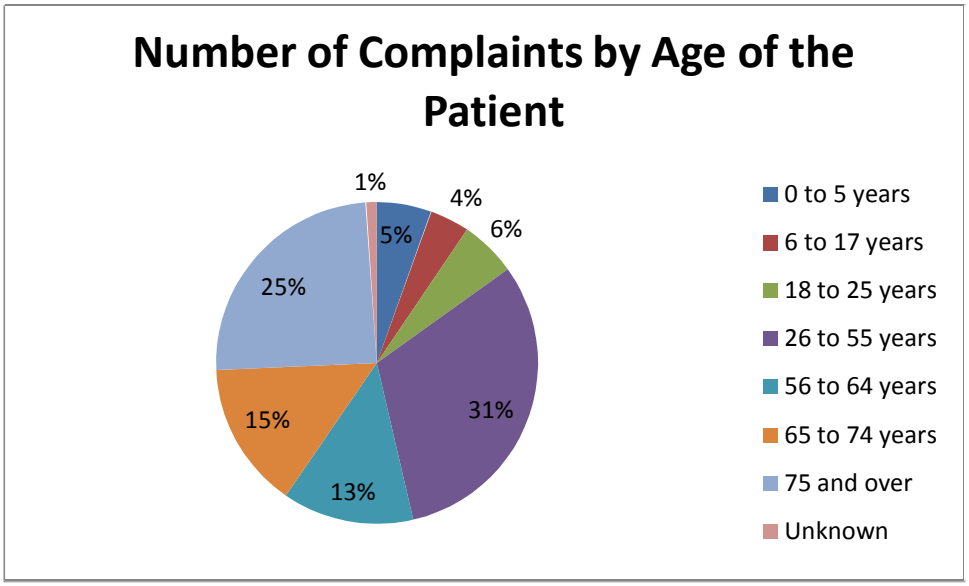
There were 10 occasions when translation had been arranged and the patient did not attend for their appointment.

The highest percentage of language translation services accessed at SaTH is Polish (39%), British Sign Language (9%), Bulgarian (9%), Arabic (7%) and Romanian (7%).

12. Complaints and PALS

The Trust Concern and Complaints Policy sets out a structure for listening, responding and driving developments when patients, service users, their family or carers raise concerns. The Trust promotes a culture of being open and honest, ensuring that patients are treated with respect and do not suffer discrimination if a concern or complaint is raised.

The PALS and Complaints Team provide assistance to any person wishing to raise a concern or complaint, including the provision of interpreter services where the patient's first language is not English. Assistance is also given to any person who has a sensory impairment or learning difficulty.



Whilst age of the patient is gathered as part of the monitoring process further patient demographics and key characteristic data is not presently collated in full. The Team are aware of this and have now started recording details of patient key characteristics where these are available, to enable gaps to be addressed.

13. Patient Surveys

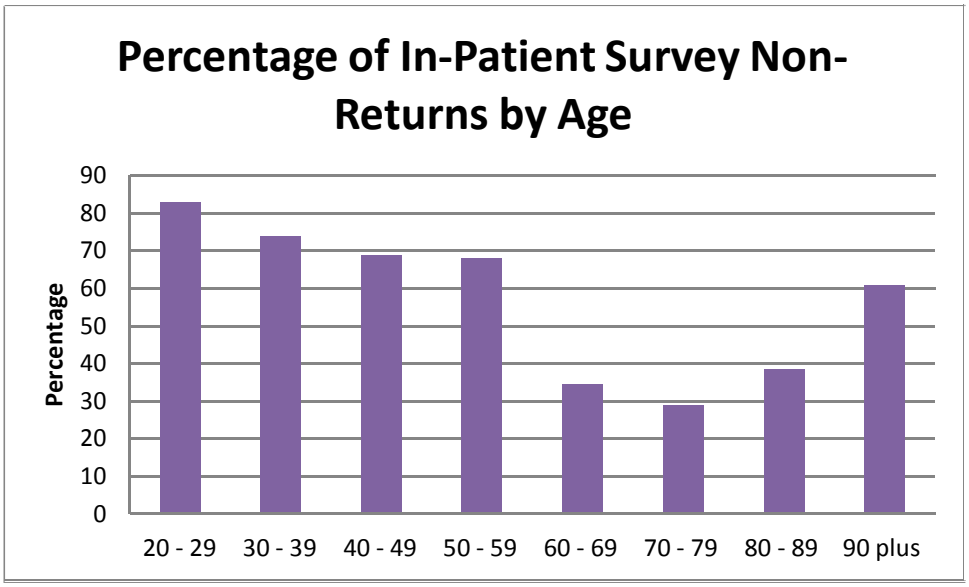
Patient surveys are recognised as a valuable source of feedback on clinical services and identifying areas which require development.

Through capturing diversity data for surveys it is possible to ensure that the sample is reflective of the local population. When required translation services can be used to ensure that non-English speaking patients are not excluded.

Diversity data is not presently collected for all surveys however it is available for a small cross section which includes the National In-Patient Survey (2017) and Maternity Survey (2018). The National In-Patient survey by response rate (Appendix 1) demonstrates that the gender sample was an accurate reflection of admissions with more female (53.41%) responses than male (46.59%) which reflects the patient profile.

There were more responses from patients aged 66–80 years (37.08%), followed by 80 plus years (25.83%) and the 51–65 age group (23.61%). The largest admission group was jointly 20–29 and 50-59 which suggests that the younger group is underrepresented in the results. On comparing the number of surveys from the random selection which were sent to the 20-29 year group this reflects only 6.8%, in addition to this the age group reflected the lowest rate of survey returns (17.1%) which suggests that the group is under represented in the feedback, however admissions due to maternity are not included in the National In-Patient Survey as these are captured separately and this may account for a number of the 20-29 year age group admissions.

The age groups above 60 completed a greater number of survey returns and this may have impacted upon the demographic data which was obtained.



Within the ethnicity response rate the largest group was White (98.34%) which reflects both the local demographic (96.24%) and the patient profile (93.18%). The second largest ethnic groups identified themselves as Mixed (0.66%) and Asian (0.66%) which is reflective of the patient profile.

The response to religion demonstrated the highest return for patients identifying themselves as Christian (78.98%) which is reflective of the local demographic (71.15%) however the patient demographic is significantly lower (41.76%) which will be impacted by the number of patients whose religion is unknown (43%). The second largest group is that of no religion (17.57%) which correlates to both the patient (13.48%) and local demographic (18.88%).

A key action for the 2018-20 plan will be the establishment of Equality and Diversity monitoring throughout the patient survey process to ensure feedback is obtained from under-represented groups. The Clinical Audit Team should access patents preferred communication needs following the SemaHelix upgrade to ensure that patients are provided with accessible information.

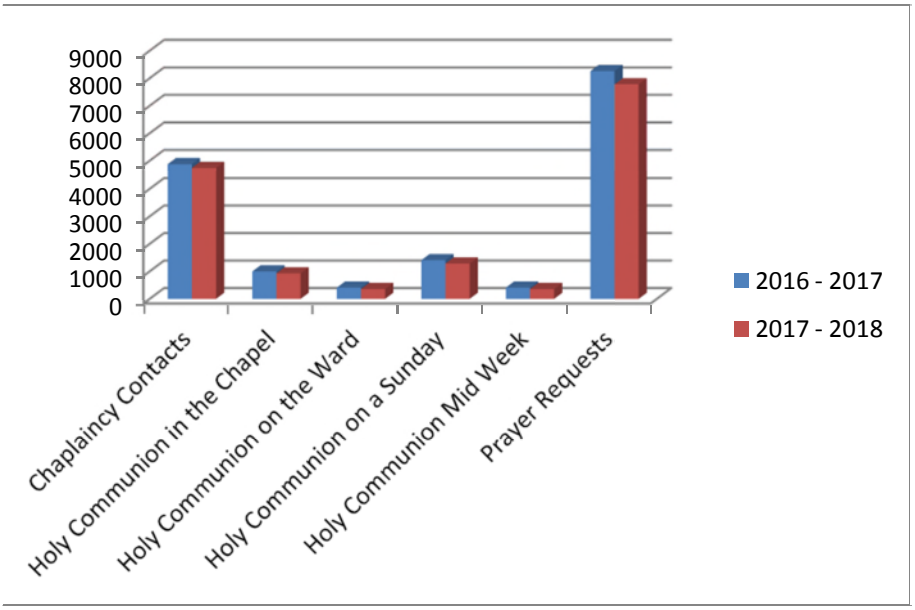
14. Chaplaincy Services

The Chaplaincy Team consists of 1.6 WTE chaplains who are both Church of England. There is an on-call team which consists of chaplains including Anglican, Methodist, Baptist, Imam and a Humanist, with contacts for all other world faiths. The chaplaincy service work generically with people of all faiths and no faith.

The main two faiths within Shropshire are Christian, its many forms including folk religion and Muslim. There are washing facilities and prayer rugs available in both chapels however it is recognised that these are not single sex facilities.

Prayer cards of many different faiths are available in both chapels in addition to humanist thoughts and visual thoughts for patients and staff who do not wish to read, but look at images and use them to meditate upon.

The Chaplaincy Team are working in partnership with their Sikh colleagues and joined in prayers together on the 14th November 2018 at each hospital site.



The Chaplaincy Team are presently exploring the support which is available to patients who have attempted suicide and how this can be improved across the differing faith dimensions. There is currently no training on faith and spirituality provided within the Trust.

The Chaplaincy team are involved in other Trust-wide service initiatives such as the End of Life steering group.

15. Safeguarding Services

Safeguarding training at Level 1 is delivered at Corporate Induction, this includes Adult Safeguarding, Child Protection, Domestic Violence and Prevent.

Safeguarding training at Level 2 remains on the 3 yearly statutory training programme which compromises Child Protection, Domestic Abuse and Adult Safeguarding. Child Protection training is included in the FY1 and FY2 education programme and Junior Medical staff have received bespoke training on Adult Safeguarding.

Level 3 training for Child Protection is delivered to staff within an A&E, Children's Ward and Neonatal Unit setting and Maternity training ids delivered by the Named Midwife for Safeguarding. Level 3 training Child Protection training this year has been on:

- Basic Awareness of Child Protection
- Domestic Abuse
- WRAP (Prevent)
- Female Genital Mutilation (FGM)
- Sexual behaviour in children
- Child sexual exploitation
- Parents as carers

Bespoke training in the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Adult Safeguarding has been delivered within key areas following requests from the Care Groups.

Adult Safeguarding compliance at Level 2 is currently 74% and Child Protection compliance at Level 1 is currently 91%, Level 2 is 74% and Level 3 is 94% within the required staff groups.

Next year's training plan includes Modern Slavery, Trafficking and Mental Health in Children.

16. Key Developments in Service Delivery Equality and Diversity

A number of initiatives have taken place throughout the year to raise awareness of key issues and promote equality and diversity across the Trust.

Dementia Work

The Dementia Team have been working to raise awareness of staff, patients and family members of the importance of ensuring that a person living with end stage dementia takes a high calorie diet as appropriate to their need.

The Dementia Clinical Specialist teamed up with the Trust Catering Department to create small packs of finger food which are available to patients throughout the day and night. Patients and their carers were involved in the development of the packs and the snacks selected are based on their feedback.

In Dementia Action Week the Trust held two butterfly days and launched the use of blue crockery for patients living with dementia and introduced the garden butterflies. Delirium workshops were also held to raise awareness amongst staff and a top tip leaflet for care of people living with dementia has since been introduced.

End of Life Care

The Trust implemented the Swan Scheme in 2015 to represent end of life and bereavement care. The Scheme is symbolised by a Swan Logo. The League of Friends of RSH and the Friends of PRH continue to support the Swan Scheme, through on-going funding for Swan Boxes. These boxes and their contents, which are used for expected deaths and Swan Bags and contents, which are unique to SaTH, are used for sudden unexpected deaths.

Lanyards with the swan symbol have been introduced and are worn by the staff escorting family members to the Swan Bereavement Suite. The aim of these is to prevent the staff member being disturbed whilst offering the family support at this difficult time

Swan Vouchers have been introduced and they entitle people staying with their loved ones at the end of their life to a free hot drink and a slice of cake to encourage people to take a short break and look after themselves.

Children's nightwear has been donated by the Harry Johnson trust. The pyjamas are for children who have passed away and seriously ill children who need a change of clothes within the Emergency Department.

A sharing event was held for Dying Matters Week and staff from other Trusts were invited to attend and celebrate the achievements of SaTH and plans for the future.

The Trust End of Life Care Lead Nurse presented at a Day of Death Education Conference, in addition to presenting the Trust had a stand to promote the Swan scheme and work being undertaken within SaTH. Other stands at the event included Shropshire Recovery Partnership, SANDS, Designs in Mind and a range of others to reflect the diversity of the local community.

End of Life Volunteers

The End of Life Volunteers give their own time to sit with end of life patients who have few or no family, or allow family members to have a break. The volunteers offer support to patients and families to help them through a difficult time.

At the annual Trust VIP Awards the End of Life Volunteers were recognised for the valuable role which they play in offering companionship to patients and their families when they won the volunteer of the year award.

Smoking Cessation in Pregnancy

A service to support women to stop smoking during pregnancy was established in Telford and Wrekin April 2017. It is recognised that within the local community the number of mothers smoking at the time of delivery is significantly worse that the national average. The impact maternal smoking and second hand smoking have upon an infant is acknowledged as low birth weight, stillbirth, miscarriage, preterm birth, heart defects and sudden infant death.

The service is run by midwives who offer support in the home, hospital and childrens centres. This has increased the level of access, advice and support available to pregnant women and their families to help stop smoking.

There have been a number of improvements delivered which include emphasis on raising awareness and training within the midwifery, health visitors, sonographers and children's services workforce.

The team recognise the importance of educating the community to support women and their families address smoking before, during and after pregnancy. Through engaging with schools, GP Practices, Help 2 Change and the local Council, raising awareness within all generations to signpost mothers, fathers and other family members to support available to them.

Ensuring consistency in the support available to women across the local demographic can be a challenge due to areas of rurality, the Health Promotion Midwives are continuing to work with the local network to explore new ways of reaching pregnant women.

Falls Awareness

A falls awareness day for the general public was held to provide information on how to prevent falls and the services which are available within the hospital.

The Falls Team and Day Hospital staff supported the day with leaflet information on how to get yourself off the floor and keeping steady and balance information. They promoted the service they offer at the hospital, such as a 12-week programme for postural stability and exercise groups. The team also raised awareness amongst staff who have patients who are prone to falls to be signposted to this service.

Watch—a 24-hour response service that assists in providing independent living for vulnerable people of all ages—also supported the day. They displayed personal alarms as assistive technology such as falls detectors. They assist in providing independent living for vulnerable people of all ages, they assist people who are in their home who have had numerous falls this helps give support to family and carers.

From the falls prevention service offered in hospital, the team were able to talk to people about how fall can prevent falls in the home. Falls, and injuries related to fall, are among the most serious and common medical problems experienced by older adults.

Community Engagement

The Trust is committed to meaningful community engagement which will help to deliver services in the best way to meet the needs of local people. Engagement has been undertaken through:

Attending community meetings last year these included: Shropshire Deaf and Hard of Hearing Forum, Shropshire Disability Network, Community Connectors (across Shropshire), Telford Chief Officer group, Telford After Care Team (TACT), Shropshire Voluntary & Community Sector Assembly (VCSA).

Holding Community meetings these are being organised on a quarterly basis in both Telford and Shrewsbury and invitations have been sent to our contacts in the voluntary and community sector.

Attending community events last year these included: Shropshire Flower Show, Shropshire See-Hear event, International Children's Day event organised by our Polish community, Telford 50 Carnival of Giants, Ironbridge Coracle Regatta

The Team target engagement with young people, working with local colleges to provide opportunities through the People's Academy programme.

17. Draft 2018-20 Service Delivery Equality Objectives

Objective	Responsibility	By When	Status
Better health outcomes for all			
Meeting compliance with the Equality Act in terms of diversity monitoring of patients across all service delivery. This has been a challenge and the Trust carries on developing systems and mechanism to meet compliance with the Act.	Director of Safety & Quality and Service Delivery Equality Lead	December 2019	
Develop Equality and Diversity (Service Delivery) Policy and Guidance through engagement with service users the Trust approval process.	Service Delivery Equality Lead	December 2019	
Action plans to be developed for each outcome presented at the Engagement Event utilising feedback from stakeholders for service improvement.	Service Delivery Equality Lead to coordinate	February 2019	
Raise awareness through inviting key stakeholders to present at a Trust Equality and Diversity Conference.	Service Delivery Equality Lead and Workforce Lead to coordinate	September 2019	
Raise awareness through celebrating national equality dates within the Trust.	Service Delivery Equality Lead to coordinate	December 2019	
Improved patient access and experience			
Embed Diversity and Inclusivity responsibilities and reporting arrangements to the Board including implementation of new arrangements as required, including consultation and membership.	Director of Workforce and Director of Safety & Quality	May 2019	
To establish a single post as an Equality and Diversity Lead within the Trust.	Director of Workforce and Director of Safety & Quality	June 2019	
Support development of a diverse group of patient representatives to undertake a PLACE review and identify environmental areas requiring improvement to improve access across the Trust.	Lead for Patient Experience and Head of Facilities	November 2019	

Objective	Responsibility	By When	Status
Ensure that patients, carers, stakeholders and partners are effectively engaged in service provision.	Service Delivery Equality Lead and Community Engagement Facilitator	November 2019	
Development of an easy read version of the PALS and complaints patient information leaflets.	Head of PALS & Complaints	April 2019	
Trust involvement in community engagement and consultation events with patients, carers and community groups on key equality issues.	Community Engagement Facilitator	December 2019	
Ensure that complaints reports include details of complaints broken down by patient key characteristics to enable further analysis by Trust Equality & Diversity Group.	Head of PALS & Complaints and Lead for Patient Experience	April 2019	
Implementation of appropriate sampling techniques to ensure that the sample obtained is representative of our patients.	Clinical Governance Manager	April 2019	

EQUALITY & DIVERSITY ANNUAL REPORT

Collation of Stakeholder Consultation Event Feedback 2018

Collated - Group Comment — Audiology

Good service – nothing but praise.
Online ordering for consumables ordered 3 times and only received once.
Rural services not frequent enough eg Powys. Don't have all the equipment, couldn't do the procedure due to ear wax, to go back to GP for referral – Brecon, Powys – particular problem - wide area covered. Are GP practices paid to do ear syringing? Access from Powys for GP practice appointments. Are telephone consultations with Audiologist available for GP help? Use of technology.
Pilot of working with Care Homes – further details. Promote/raise awareness more to make people aware.
How do they manage language and hearing issues? Support minorities?
Get pink boxes used more. Dementia nurses – community care. More communication in community, general care and hospital. Currently done through volunteers – location specific user focus groups to look at the needs of the service user

How is Audiology linking in with people with protected characteristics in Shropshire? Provision in Powys area? Volunteers in Powys trained by 'Action for Hearing Loss'. Training? Funding? 14 volunteer clinics. ?Accessible. Risks.
Adjustments are made for younger patients – need to publicise this more.
Very accommodating with appointments.
Volunteer service is very helpful eg for battery changes – this service needs to be promoted more in addition to off-site clinics.
Very interesting presentation. AWARENESS. Alternatives to hearing aids used in the hospital – accessible at home.
Provision of audiology services for staff.
Consideration of Welsh language – can Welsh speakers access this service?
Pink box is a good idea.

Lots of stuff – How do we get everyone else to know?
Home visits with other agencies - Can this be collaborative/ partnership working eg on a Audiology visit, could this take place with the fire service and or other teams and pick up home safety issues? (the presenter and a stakeholder agreed to look at joint collaboration)
BSL interpreter – they are finding that some patients do not want to use this service and prefer their family members to do this, however this might not mean the full message from the clinician gets across to the patient. Could an interpreter be booked/offered to the patient without any choice to ensure they have access to the service provision – could this be explored? A family member does not always say everything.
Issues around access to interpreter. Is it possible to have an interpreter over Skype – telemedicine? Sometimes the signal is poor, need a good signal, band width and connectivity.
Send a survey.

Understanding silence – face to face. Pay on the internet – Call name in clinic not fetch you and assist you.
How things are done – I think the Audiology Service is excellent
We need to change – Lots of people use the drop in service in South Shropshire.
Feel burden – Along the border. Rural area close to service users.

Misinformation – Audiology service – guided on ward.
Education in schools – Eye clinic – Inpatients not helped with food
Education not good from technology – training for staff to lead patients.

Hearing – Where do you go for advice in the first instance – coping mechanisms where do you go – Specsavers – How does the service interact?
Disappointed with comments from and support from GP – where is help – layout of rooms and interpreter not introduced and lack of communication, not told what is happening not enough dialogue during appointment.
Tinnitus kept coming up over and over. Not part of annual health check? More use of Makaton?
Hearing loop in library – not tested, not used – staff not aware how to use.
High staff turnover – impact.
Doctors (with English as second language) can be difficult to understand (even for elderly patients not just patients with hearing impairment, eg an elderly patient brought in a family member to help them receive verbal feedback from the Doctor).

Wards don't know where the pink boxes are – staff busy not aware – Education.
Hearing loop in A&E hadn't been working for 3 months – Kate helped. Estates and Maintenance Dept didn't fix it, not their problem, not taking responsibility.
Domestic abuse – what to do with the information once disclosed. Care plans – how linked to Social Care?
Prevention – what does this mean / what's available?

Good links with different organisations and groups – wide engagement.
There to support with an essential skill for life.
Some questions around literacy levels and widening understanding of literacy levels.
Improve – patients often receive more than one letter for the same appointment.
Areas for improvement – training for staff on deaf awareness – in all areas of health.
Where to go to raise awareness of hearing problems – environmental health / HSE inspectorate / Occupational Health.

Potential future actions derived from the group discussion	Grading		Group Grade
Better interconnection between services, eg make sure appointment made for wax syringing if performing a hearing test otherwise this will prevent the hearing test from happening and result in another appointment being made. Advertise these more in the community. Ensure that all staff are aware of services, boxes etc. More promotion of paediatric side of the service, talks etc. Promotion of volunteer services and off –site clinics. Audiology services for Trust staff – provision of services. Translation and lanyards available from Powys Health Board. To grade would want to hear from service users with each of the protected characteristics and the people of Shropshire who are potential service users. Contact detail for interpreter given to deaf patients to build rapport with ✓ IT engagement and being integral as part of early intervention. Ambassadors across services to help deaf people and understand. Not where it needs to be – needs more proactive support. Need wider interpreter understanding. Hearing impairment – new battery offered or changed for patients when they come into hospital to ensure hearing aids are working properly. Offer support and help – don't wait to be asked. Improved inclusion – potentially school ambassadors from main stream and work with children with special needs. NCS – National Citizen Service education. Staff to be trained in helping sight and sound. Challenge patients – with meals and guiding. Makaton and British Sign Language. Introduce – staff to patients. Work around sight loss patients. Awareness training for dementia. How many loops in the Trust – how many work, testing programme annually. Hearing loop training for staff and monitored so that it is effective. Access message needs to be communicated more clearly, link in with other organisations. Some doctors hard to understand for the hard of hearing. Information on contacts to maintain hearing loop – laminate with numbers. Hearing tests for staff Staff training Pink boxes promotion. Batteries for hearing aids in A&E and all Wards – have a box. Are Audiology staff / A&E aware of blows to the head / domestic abuse / women with hearing loss presenting with other symptoms – confident about asking – awareness / training. Joined up services. Whiteboards – to write basic 'hello' in A&E. All Wards and A&E to have remote control device instead of hearing aids. Actioning understanding of literacy in order to – look at the other avenues for communication. Encourage staff in SaTH to actively look for hearing aids / hearing deficits – encourage discussions around hearing loss. Deaf awareness training – basic sign language, lip reading, communication – community, primary care, secondary care. Recognition of service veterans on medical notes – changes to all coding / inform audiologist. What are we doing about other protected groups which will move grading forward?	**Undeveloped** **People from all protected groups fare poorly compared with people overall OR evidence is not available**	☹	(✓ ✓ one group was split and 2 individuals graded as undeveloped)
	Developing **People from only some protected groups fare as well as people overall**	😐	✓ ✓ ✓ ✓ ✓ (✓ ✓ one group was split and 2 individuals graded as developing) (Powys is developing due to access) (Promotion of sources to all age groups. Lack of our knowledge of provision of services to other users with other protected characteristics. Assurance of variability between volunteers.)
	Achieving **People from most protected groups fare as well as people overall**	🙂	✓ (Shropshire and T&W is achieving)
	Excelling **People from all protected groups fare as well as people overall**	😊	

Collated - Group Comment — Gynaecology

Stressful for learning difficulties – more so maybe.
Easy reading information.
Not always aware of patient need before they arrive – how do we handle the unexpected?
More picture information
What is the gold standard – define it!!
Systems not always up to date.

Welsh language.
Women with learning difficulties die 30 years before their non-learning disabled counterparts – no mention of provision for patients with learning disabilities.
Communication issues are particularly problematic in gynaecology and also examinations.
Isolated individuals may miss out as they don't always have the self-awareness to identify health issues in gynaecology.
Determination and confidence are required to move through the system.
Age differences need to be taken into consideration, technology expectations of younger patients.

Liked approach to women's health.
Family nurse partnership funding.

How do we deal with it FGM is safeguarding.
Transgender needs.

Domestic Violence Constable and Counsellor – How many WTE? Do you give extended appointments? How would you manage extended appointments? Mental capacity needs for internal examination?
Access to PRH from Powys. County hospitals – what's the accessibility of service?
Outreach work – go out into the community – travel.
Consideration around chaperone, management of domestic violence. Difficult.

Improve feedback – qualitative
Presentation didn't give enough incite to discuss impact and groups of people. How are race, religion and ethnicity considered.
Share positive patient experience feedback – give confidence.
Concentrating on youngsters and ignoring older patients.
Small number of beds because of investigations / treatments happening in GATU – consideration for future fit.
Irrelevance of some treatments which are not appropriate for transgender patients.
Service that is accessible but is responsive to certain sectors of the population.
Do we need discussions around culture and gender of interpreters?

Potential future actions derived from the group discussion	Grading		Group Grade
Train staff and give them tools to handle the unexpected need. More picture information – less text. What is the desired 'gold' standard for engagement – define and achieve. System to be checked for accurate data. Visual path scales for non-verbal patients. IT infrastructure to support innovation and new technology. Further links with Consultants with special circumstances – domestic abuse. Sexual health – Safeguarding links – training. Education and schools – prevention. How does the Department work with carers – information and plans? What is available over the weekend – how to access help? FGM – Training. Better understanding. Consultant with this special skill set. Hidden in rural areas. Rural setting travel time? Age and travel profile. Batching people for appointments. More Women's health groups in the community – more engagement. More face2face time of community engagement and challenge More communication of services – via video. Qualitative feedback – why? Adaptive focus groups – solutions for service users, don't handpick – random selection, ask it on friends and family test. Patient stories No blame culture – staff stories, patient stories, temporary staff stories. Action plan/next steps, continual improvement. Womens Services for staff – menopause – improve wider knowledge for staff and patients. Educate men to provide insight and support. Dementia friendly support for women – cancer, gynaecology. How is equality considered? How is dignity presented? Forum to engage women around health needs. Feed into specific patient groups attached to GP services / practices. Improved communication around individuals and their health needs. Transcultural education – choice around gender of GP, interpreters, clinicians Unclear as to what training staff have around protected groups?	**Undeveloped** **People from all protected groups fare poorly compared with people overall OR evidence is not available**		✓ (Straddles developing and underdeveloped)
	Developing **People from only some protected groups fare as well as people overall**		✓ ✓✓✓✓✓✓ (We think developing but need more information please)
	Achieving **People from most protected groups fare as well as people overall**		✓
	Excelling **People from all protected groups fare as well as people overall**		

Collated - Group Comment — Paediatrics

Staff listen, good services. Appear to have a plan to move forwards. Community links and family support. How staff raise concerns – Safeguarding.
Transition between the two services is key – time line between the two.
Choice – giving the choice to the young person – individual choice.
Improve – Ensuring the communication is effective – asking difficult questions.
Individuality of the services were there to support the individual.
Transition is very much a national issue.
Adaptability of the hospitals to where patients are placed.
Agree on what age is a child recognised as across the community – different services quote different ages – eg age 16, age 18 or even age 21
End of life care hospice service between children and adults.
For physical sickness it seems a good service. Mental health and learning disability different ball game. Non engagement can lead you to start from the beginning. Mental health in minorities – need a dynamic service.
Accessibility from Powys when moved to PRH.
An adolescent service – as needs are different – 16 can be too young.
Maybe not enough information to grade.
Child patient with additional needs or accessibility issues.
Communication and listening is not common between staff.
Separation works went well in Hope House by age treating their need?
Should be clinician led on what is needed.
System led classification not hospital decision. When does a Mr become Master or vice versa?
Learning disabilities – leaving at 23 + 24. Derive at 24.
Young person's ward a good idea. Some 'children' adamant at 18 they are an adult!
Paediatric service good. What is a paediatric age difference?
Training for carers.
Key individuals were very good e.g A&E sheets. AMU pathways not always followed.
FFT card given on admission – not appropriate for a child as an emergency by ambulance.
Regular blood tests – family choose to have these at RSH rather than PRH as PRH is too chaotic.
ED is not about treating everyone the same, it is about treating people fairly.
Does paediatrics have an accessible email and text messaging system for patients who come from an entirely deaf family?
Disconnect between patient priorities and 'ward culture'. Policies don't seem to translate into patient care. Some individual practitioners are very good.
Non-verbal patients show path differently – training issues – patients having to attend repeatedly for diagnosis of a fracture.
Patients not able to access key support workers.
What about Welsh language?
Focus on age.
Presented as a critical friend. How can we improve – need to get the whole organisation to do this.
Practical application.

Potential future actions derived from the group discussion

Need to plan a young person unit for 16 – 25 year olds.
Separate teenage area – not appropriate to be on wards with 70 + and dementia patients, not good for Adolescent ward.
Other areas to adapt this approach – critical friend – how can we improve?
Equality Group – standardise approach for all across the Trust – as a checklist for them to reference to – personalise how they implement it. Framework to understand where to start from to help personalisation.
Group – peer review from different areas of focus: LGBT, visual, hearing, ethnic, age. Engage experience.
Ward visit prior to treatment to help paediatric assessment of what to expect and give a level of choice.
Remember to consider the family experience to support children.
Their wellbeing, death on wards – traumatic.
More mental health awareness – self harm, anorexia.
Social media – ask children.
More staff. Faith and Religions training.
Books on wards – library visits, story tellers.
Mermaid's charity for transgender children. Gives information re transgender children.
Equitable access to services whether you are under or over 16 years old.
An adolescent ward which caters for the 'in betweeners'.
Patients to have a choice.
Benchmarking young people to see where they want to be placed.
A focus upon mental health.
Address the age difference issues.
System led decision on classification of child / adult classification – one organisation can't treat as a child and another adult.
Young person's ward.
Classification on learning disability age 24?
Some decisions need to be clinically led.
Look at individual's needs, not based on just age.
Help for parents.
Training for staff – for transgender children.
Cultural change is needed. Need for key support worker / specialist nurse for paediatric patients with learning difficulties – this would help considerably.
Anaesthetist was able to give consideration to son's individual needs.

Grading		Group Grade
Undeveloped **People from all protected groups fare poorly compared with people overall OR evidence is not available**		✓ ✓ ✓ (Mental Health support) (Very complex area)
Developing **People from only some protected groups fare as well as people overall**		✓ ✓ ✓ ✓ (Physical Health) (Best option, we don't know enough to classify confidently)
Achieving **People from most protected groups fare as well as people overall**		✓ ✓ (Continuous improvements and recognising that)
Excelling **People from all protected groups fare as well as people overall**		

Collated - Group Comment — Speech and Language Therapies

Soft food options not available – frozen not good enough, disappointing. Transport delays patients in Radiology, need food if there a long time, Diabetes clinics.

Vegetarian options in the snack box. Aspirational behaviour discussed – not happening based on a table delegate experiences. Mixed messages regarding service levels, some visitors feel they are not welcome at protected mealtimes. Carers should be allowed on Wards and all be given badges.

PRH food comes from New Cross – why? Lots about service, but hard to grade. Dementia snack box is great, how many different minority menu foods? Do staff always feed patients who need it. What steps are in place to ensure Dementia boxes are ordered. SALT Team are responsive in hospital but Community SALT Team very risk averse, nice to identify that they 'go the extra mile'. Food is a massive part of culture, don't underestimate the importance. Where do specialist meals come from – same quality?

Real eye opening session – hidden work which isn't obvious to patients or carers. How often do menus change? Great idea to encourage staff not to be interrupted when delivering food. Important to encourage carers to be more involved and present. Having carer present normalises mealtimes. Sounds like they are still trying to find ways to improve – putting themselves in the shoes of the patients – Trust values in action. It's clear the department is trying to get away from an institutionalised approach. Lots of good work in place. Understand national guidance but needs to balance with patient choice.

Snack boxes – patients can eat when they want. Celebrate success. Talking newspapers info. Awareness. Dysphagia menu.

Potential future actions derived from the group discussion

More ethnic choices – vary menu.
More fruit on Wards.
More information for staff at SaTH about food choices.
Better meals for breastfeeding mothers who need an extra 500 (calories) a day.

Snack box vegetarian options.
Review honestly the service provided – how is feedback incorporated.
Get the message over that carers and family can help at meal times.

Is there a variety of specialist meals as there is for non-Speech and Language therapy Patients? Talk to the patient's families enabling the clinicians to understand the patient's individual needs.

Really celebrate the success you have achieved so far!
Think about changing the menus more regularly and perhaps giving more choice. Be clever about the choices for younger people.

How do people know Halal or Kosher are available?
Children menus need to be reconsidered and potato wedges cooked properly (personal experience – parent of child).
Allergens menu to be placed in staff / public canteen, need to raise awareness, education and choice.

Need education for Women and Children's Services, Public Health, Schools, Catch early. Ask outside providers to change menus.

Grading		Group Grade
Undeveloped **People from all protected groups fare poorly compared with people overall OR evidence is not available**		
Developing **People from only some protected groups fare as well as people overall**		✓ ✓ ✓ (No measurements KPIs given or discussed)
Achieving **People from most protected groups fare as well as people overall**		✓✓
Excelling **People from all protected groups fare as well as people overall**		

Collated - Group Comment — Maternity – Smoking Cessation

Going forward targeting different groups who require support.
Excellent progress from nothing to a service, making tangible positive change.
Reaching hard to reach communities.
Not just linking in and developing ideas but putting plans in action which is really positive.
Differences between Telford and Shropshire.
The work being done is excellent. Responsive.
In community – good work, partnership working.
Social prescribing links – do they work with these?
Greatest need = white working class women – not a protected characteristic, gender is a protected characteristic.
Engagement pre-pregnancy.
How do we engage with hard to reach areas?
Children's Centre closing
Stats compare to national average. Are E-cigarettes counted as smoking? Too early to tell of harm.
Specific to T&W – Shropshire?
Great baby buddy app.
Duel standard.
Good job to aim at family.
The group were surprised by only 20% being quoted on the presentation
Social Work – need more information to make an assessment.
Heart and minds learning – balance this.
Seems much more flexible, coming to you. Preventative approach – could you stop them earlier. Seems very responsive. Aware of assumptions and not allowing it to fit in.
Very good example of responding to community need.
What is engagement with different cultures?
How much technology for appointments? Skype? How do they access people who don't want to engage?
Free app would be a good idea – sizes, warnings and figures.
The 17% quoted in relation to cot deaths shocked one group and a member of the group is aware of an app which will give you these type of facts. An app may raise awareness about cot deaths.
What is the advice on E-cigarettes?
Michelle knows her patient group and is using technology. Fantastic service with user involvement.
Good patient engagement. Is support provided for partners?
Awareness of hearing loss in children due to smoking.
Support continues after birth.
Are there any particular groups the service needs to focus upon?
How does the small team reach the hard to access population – how is support provided to non-English speaking patients? – Interpreters used for non-English speaking patients.

Potential future actions derived from the group discussion

Continue the progress and a really excellent job.
Directing education potentially to new mums of school age.
Developing the trust with the hard to reach groups to continue to develop future plans.
How to join up the pregnant mums and work with partners to encourage smoking cessation.
Financial incentives – vouchers to give up smoking.
Target vulnerable groups – Teenagers.
Where does it tie up with other plans – consolidate.
Mot told how they are reaching hard to reach areas.
Auto referral we need to know basic data, how many smoke and hence how many take up the support and the number that don't to judge success.
Staff should not smoke – transferred to patients. Smell of smoking.
Education.
Offer nicotine patches.
Should people be refused treatment?
Increase information and educate younger people – preventative approach
Consideration for different cultures, eg do certain nationalities smoke more
Demographics profiling to understand who falls into 2% - to support and target. Ward support, school support.
How many continued to stop smoking after pregnancy? 70% relapse and go back to smoking.
Why do 70% relapse? Social economic factors – understanding this.
Maternity data.
Pilot study from monitoring data.
Peer learning and taking ideas from other Trusts.
Ambassadors – Individuals who have been a success.
Increase for more and graduate younger – preconception advice.
Considerations for different cultures eg do some groups smoke more?
Psychological considerations.
Awareness of hearing loss in children due to smoking – Add this information to patient information.
Smoking and middle ear problems in children.

Grading		Group Grade
Undeveloped People from all protected groups fare poorly compared with people overall OR evidence is not available	☹	✓ (Not able to say, no evidence supplied) (✓ ✓ one group was split and 2 individuals graded as undeveloped)
Developing People from only some protected groups fare as well as people overall	😐	(✓ ✓ ✓ ✓ one group was split and 4 individuals graded as developing)
Achieving People from most protected groups fare as well as people overall	☺	✓ ✓ ✓✓
Excelling People from all protected groups fare as well as people overall	☺	

Collated - Group Comment — Outpatients

Good service in outpatients, it could not have been better. Awareness for Learning Disabilities.
Process 3 letters, why? Standardising letter to GP and yourself happen.
Process every six weeks will post it to your booking appointment for repeat appointments online no letters. Letter comes and you panic. Had nine letters for one appointment.

Buzzer system a good idea.
Disappointed that Welsh language not mentioned (active offer). Very pleased to see email contact being provided.
Voicemail appointment reminders – would be more appropriate as a text message.
Flexibility and approachability of call centre staff.
Timing of appointment reminders – some choice of timing is needed for dementia patients. Limited space in waiting area – accessibility issues for wheelchair users.

Hand held buzzers very helpful and very welcome for particular patient groups.
Less words on letters for some groups and text reminders are good. 8 to 8 is good.
Change appointments online.

Transgender – difficult when attending appointments, fearful of reactions from staff.
Positive – reviewed the service and moving things forward with the obvious but not stopping. Travelling community now classed as permanent residents so improved services is positive. Have stopped passports previously used by the travelling community – perhaps national passport for health conditions.

Liked hand buzzer.
Easy read letters.
Texts = not all areas have mobile phone signal. Bus passes after 9:30 am making people aware they can change the time of appointment.

Keep informed on how long until appointment, buzzer good idea – countdown buzzer.
Good for Learning Disability – number in the queue – managing expectation – ensure no misinformation. Keep info up to date. Booking letters working quiet well and transport. Clinics – not knowing what comes next- too complex.
Postage costs – email and text communication – like buzzers. Easy read letters would be a big improvement, simplify, bullet points. Waiting times for their convenience not patients. How do they ensure language is correct? Register with GP – preferred language – letter translated.

Good for visual and hearing impairment. Reception staff deliver support but need support themselves to help balance this. How do we identify people with special needs if which are not obvious? If English is not the first language, excellent, how is this identified? Patient experience.

Potential future actions derived from the group discussion

Instant bookings. Text messages. Hand held buzzers.

Obligation to provide active offer regarding Welsh language to patients (active offer of support provided by stakeholder). Two way communication.

Handheld buzzers asap please.
Progress letters and content please.
Future development plan shared with groups.
Calendar link on emails to add to diaries.
Change appointments online.

Treat people as individual human beings despite being old / transgender.
Continue to have the dialogue with patients.
Training to start at the bottom and work up. Think about transcultural education and training.

Training frontline staff to recognise signs of domestic abuse and who / where to signpost and refer.
Text to alert staff if running late / cancel appointment.
Park and ride – Council and NHS need to work bus company jointly.
Refunds – cashiers office opening.

Keep informed during appointments and waiting times. Buzzer and easy read letters excellent.

Texting – keep it brief, not long sentences. How can you respond back to text?
Visual – leave message on coloured paper. Consider non obvious needs – dyslexia
Barcoded letters – easy read.
Colour coded waiting zones.
What next – do a deep dive to grade – quality impact assessments.

Grading		Group Grade
Undeveloped People from all protected groups fare poorly compared with people overall OR evidence is not available		✓ (Making good progress)
Developing People from only some protected groups fare as well as people overall		✓ ✓ ✓ ✓ (Some areas developing)
Achieving People from most protected groups fare as well as people overall		✓ ✓ ✓ (Others achieving)
Excelling People from all protected groups fare as well as people overall		

Collated - Group Comment — Dementia Care

Ward 10 key entry not explained, upsetting
'This is me' not being used enough – encourage patients / family.
Liked attitude to older people – staff are caring.

Dementia growing in volume of diagnosis.
Question asked around the resource available to support 3 nurses.
Too slow within hospital – to get information – personal experience.
Dementia and learning disabilities combined – 2 big issues.

Dementia Team exemplar service. Not enough of them. They provide extra help eg hearing aid boxes, contribute to the hospice team.
How can they cope when people revert to their first language?
Never had negative feedback.

Working with the Team.
Need support.
People are younger.
No down time.
SaTH seems to be a path finder.

Not everyone wants a butterfly above the bed – respectful to those who don't want a butterfly.
Some condescension around dementia in the older person. How do you identify dementia otherwise – you need a visual trigger, butterflies are good for advice and guidance.
Not enough advertisement or publicity for Karen and her team – they do a fantastic job but not enough of them.
Do wards inform Karen's team about dementia patients and do they inform carers of Karen and her team?

If someone has dementia living on their own ☹
How to support them.

Potential future actions derived from the group discussion

More blue cups – raise money for all Wards – not good enough coverage.
Not big enough team, more staff needed – focus on long term conditions, use social media.
Educate staff, more commitments across staff.
GPs practices and nurses to work more help with 'This is me'
More resource is needed to deal with relative.
Plan for ethnic group engagement.
Future proof service.
Hospital passport needs to be in its own place to be accessed by more people.
Care homes encouraged to keep hospital passports up to date.
An excellent service, increase the Team to provide a wider service.
Can this support be offered within community hospitals.

Travelling community.
Numbers of people – resource issue, funding.
Reactive.
Need another nurse and HCA
Outpatients.
Stretched with both sites. Call for help.

Further investment in this team.
Further exposure and publication for Karen and her team.
Link in with care homes who have a high percentage of dementia patients – if they had Karen's details they would be able to pre-warn services of dementia patient, provide support – could link in with other services such as GP.

How to promote dementia care – opportunity to pre-plan, add onto appointment letter or pre-op discussion to ensure a referral is made.
Ward support to take adjustment for patients with dementia, guidelines for Wards.
Recruit volunteers to support.
Designated person or access for dementia support – signposting.
Post-op hospital support for dementia patients.

Grading		Group Grade
Undeveloped **People from all protected groups fare poorly compared with people overall OR evidence is not available**		✓ (Needs more investment.)
Developing **People from only some protected groups fare as well as people overall**		✓ ✓ ✓ ✓✓ (But under resourced holding the service back.) (Needs significant investment to be able to move to achieving.) (Not across all or every Ward.)
Achieving **People from most protected groups fare as well as people overall**		✓
Excelling **People from all protected groups fare as well as people overall**		

Collated - Group Comment — Corporate

What do we do already that we could make more of?
Feeding back the services into the community – relate to how they can access the services.
Car parking causes problems for patients – expensive.

Feedback – social media, schools, I pads + smiles or cross face like service stations.
Who can help us? Mixture negative / positive to recruit, third party groups, charities.

Gathering feedback from service users. Develop! Help us!
National survey feedback is received locally. Used to draw up action plans.
National Companion – benchmarking against other Trusts.
Integral improvements.
I  SaTH page+ need to make if it is to share
Good patient and staff experience.

Face to face conversation, leaflets not always available.
Not aware of all portals available on line.
How are comments acted upon to make positive change
Do we celebrate positive comments?
Feedback directly like a restaurant 'Is everything OK with your care?'

Ensure nurses speak more to patients and families.
1 page discharge form from hospital (you were in for, we did this, going forward, information).
Anonymised feedback from patient – detailed feedback from patients and carers.
Pass on more information.

Potential future actions derived from the group discussion

What do we need to develop?
Transparent service that relates to people's expectations.
Reduce car parking fees – introduce parking incentives
Office on both sites containing a library of leaflets on community services, manned by people with local knowledge.
Feedback forms for community services allowing patients to give feedback at any time.
Put information / leaflets in publically used spaces – back of toilet doors / by car park ticket machines.
Breakdown by area – Radiology, Maternity, identify areas – recommended or not, why
Develop wellbeing – more perks for staff.
Balance of quality Improvement with resourcing and finance is evidently needed to be re addressed from staff survey V patient survey.
Patient groups. GP liaison groups. Community care coordinator.
It is not just about feedback - lack of service promotion to community leaders, disability groups. They then act as ambassadors to feedback – who do they feedback to in the Trust? Advertise on Trust website, posters, advert on Kate's car.
Loop feedback.

Headline on emails.
Not 20 pages?
NHS website to (say) something (about) fantastic results
Shout about the good things.
Social media. Use Facebook, Comms Team to use Twitter.
Morris Dancers go on the back of the followers. Shrewsbury Morris Dancers.
VMI Work.

More personal follow-up to gain quality feedback – and then act upon it. Its time consuming so needs to add value.
Volunteer arm to PALS to collect information.

Have anonymised feedback from patients.
Meetings with patients support group eg Stroke Group, Parkinsons Society – attend and present.
Community leaders / identify a group
Focus groups
Talk to the people / ask the people.

Grading		Group Grade
Undeveloped **People from all protected groups fare poorly compared with people overall OR evidence is not available**		✓✓ (Lots of work to be done.) (Need)
Developing **People from only some protected groups fare as well as people overall**		✓ ✓✓
Achieving **People from most protected groups fare as well as people overall**		✓
Excelling **People from all protected groups fare as well as people overall**		

Collated - Group Comment

PALS and Complaints

Monitoring complaints by protected characteristics is essential.
Examples good – try to accommodate mixed feedback from family carers. 50/50 great / useless.
Ensure people understand the difference between PALS and Complaints.
Seem to be proactive.
PALS office PRH – not very welcoming or if someone is there.
Do they have an outreach facility? PALS can make things happen very quickly.
Ask people who use the service.
PALS are very helpful but no TEETH
For resolution needs to be escalated eg Chief Exec.
Some patients are passing PALS.
Office not always staffed. It is difficult to access PALS for outpatients – outpatients are not given priority – patients on the Wards seem to get priority of response from PALS.
What proportion of complaints are raised after a stay in hospital rather than during?
PALS information – is this available on TV screens?
Perceived lack of awareness of PALS.
Ensure resources are available to staff the office.
2 years ago PALS was not a good experience – hope things have improved.
Learning from complaints – how is this done?
Comprehensive. 3 elements – bereavement (more work to be done), Complaints (how well is it promoted?) and PALS.
The glass in PRH office stops lip readers from reaching deaf – difficult to hear.
Privacy and confidentiality – invite people in.
The PALS group is developing.
Very respectful.
Office hours – is it a 24 hour 7 day service?
Do they have enough resource?
What does good look like?
How are we monitoring?
Timescales
Lots of examples – terminology around protected characteristics used.
How do complaints and bereavement work under the ‘same umbrella’?
PALS has been out and educated as well as ‘done’ – Peoples Academy.
Great to have examples of each protected characteristic.
Visual awareness of the service – is it always clear what the acronym stands for?

Potential future actions derived from the group discussion

Monitor complaints by protected characteristic.
Consider outreach facility. Consider set times on Wards – Increase accessibility and increased opening times.
Help with parking fees while making a complaint.
Consider technology.

PALS info on every locker for patients – in different languages.
Text message service – to be able to text into PALS from the Wards.

More signposting to PALS – education.
Information for staff.
Services at weekends. Text service out of hours.
Autism needs – action plan for hospital and staff.

How can a deaf or visually impaired person make complaints.
Dementia training – for bereavement, this would need to be repeated – what do they remember or have understanding.
Council has one service desk/single access point – link into that such as a one stop shop– is it offered?
PALS – is it open for improvements in addition to complaints?
PALS – opening hours – could this be extended?
A family member should be able to take the complaint on the (patient's) behalf.
Volunteer training – is consistent to front facing staff like reception.
Improvements – promote this element and feedback.

Extend rural communities English not Trust language.
Transient workforce understanding expectations.
Talking newspaper, you can just knock on the door of PALS. Short term workforce.
Fast track for Muslims or other groups?
Report on KPI's at next event to judge grading.
24 hour service. Service customer expectation.
Ensuring the general public understand the acronym PALS and what they are there for.
Information for patients / relatives on where to go to raise complaints – in a format which is easily understandable – trifold leaflet previously produced by the CCG.

Grading		Group Grade
Undeveloped **People from all protected groups fare poorly compared with people overall OR evidence is not available**		✓ (Not enough factual evidence. What is good?)
Developing **People from only some protected groups fare as well as people overall**		✓ ✓ ✓ ✓ ✓ (Bereavement)
Achieving **People from most protected groups fare as well as people overall**		✓ (Complaints)
Excelling **People from all protected groups fare as well as people overall**		

Collated - Group Comment

Workforce – Equal Pay Audits

Goodwill of staff keeps the Trust running. Monitoring of sickness and motivation. Family Friendly Policy. Important. Staff who have the most patient contact paid more – eg HCA.
Why do we not collect information on employees as carers – is it written into leave entitlement, HR policies and consideration for flexible working?
Work is fantastic so far. Workforce has done audits but they are not just going to be left on the shelf and forgotten about. Good that pay scales are published and on the website.
There is always a worry that progression or training isn't offered if disability is declared. 1 Support them. 2. Make reasonable adjustments. Trust does not capture Carer information or non-binary. Good to see it is acknowledged that equality in the workforce is being considered for a number of groups.
Why need to know marital status, sexual orientation – Equality Act. Feels like paper exercise.
What is a disabled?
Great to have data albeit easiest to collect. Gives confidence in the process. Issues seem understood and a plan is in place to understand and move forward. People not willing to openly share characteristics within the Trust - do in survey which is in confidence.

	Grading		Group Grade
Potential future actions derived from the group discussion Family Friendly Policies Capture information about employees identifying as a carer but tie it in to HR Policies - do not collect it for audit's sake. What is the purpose of finding out pay rates for staff with disability. How can roles be given based on merit? Chief Executive Salary – how does this compare to other Trusts? Bonuses? Focus Groups. Why do our staff not declare they are disabled? Lack of ownership by senior leaders. We need to change culture of SaTH. Follow up the analysis and continue to make progress	**Undeveloped** Equal pay audits show that staff members from all protected groups fare poorly compared with the overall workforce OR equal pay audits are not carried out		
	Developing Equal pay audits show that staff members from only some protected groups fare as well as the overall workforce		✓✓✓ (More work to be done to ensure equality in workplace)
	Achieving Equal pay audits show that staff members from most protected groups fare as well as the overall workforce		✓✓✓ (Data supports this)
	Excelling Equal pay audits show that staff members from all protected groups fare as well as the overall workforce		

Appendix 2

Equality and Diversity Profile for Service Users 2017-18

Patient Profile by Age

Number of attendances (% by age group vs census)

Age Group	Population %	PRH %	Var	RSH %	Var	SATH %	Var
0-9	11%	12.93%	2%	2.90%	-8%	8.74%	-2%
10-19	11%	11.83%	1%	7.34%	-4%	9.95%	-1%
20-29	11%	13.62%	3%	14.94%	4%	14.17%	4%
30-39	12%	13.01%	1%	14.23%	2%	13.52%	2%
40-49	10%	12.47%	2%	13.78%	4%	13.02%	3%
50-59	17%	12.56%	-4%	14.79%	-2%	13.49%	-3%
60-69	13%	8.42%	-5%	11.14%	-2%	9.56%	-4%
70-79	9%	7.83%	-1%	11.14%	2%	9.21%	0%
80-89	6%	5.98%	0%	7.92%	2%	6.79%	1%
90+		1.35%	1%	1.82%	2%	1.54%	2%

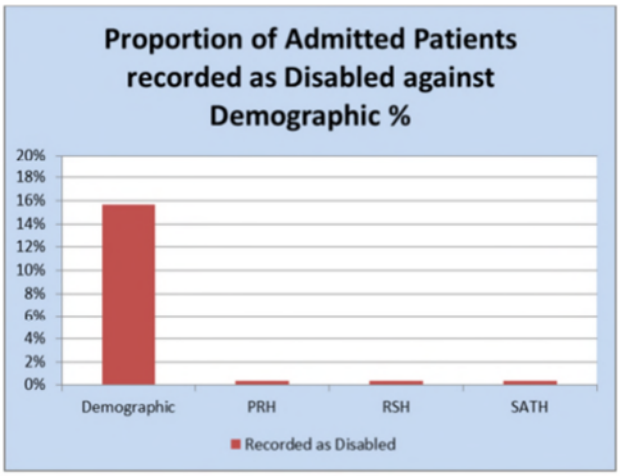
	Shropshire	Shropshire	T&W	T&W	Powys	Powys	Total
age group	No	%	No	%	No	%	No
0-9	24490.32	36%	22800	33%	21169	31%	68459.3
10-19	39796.77	58%	21100	31%	7967	12%	68863.8
20-29	30612.9	47%	21800	34%	12342	19%	64754.9
30-39	39796.77	55%	22000	30%	10909	15%	72705.8
40-49	27551.61	44%	24000	38%	10909	17%	62460.6
50-59	52041.93	50%	22900	22%	28570	28%	103511.9
60-69	52041.93	64%	19000	23%	10864	13%	81905.9
70-79	24490.32	46%	12800	24%	16232	30%	53522.3
80-89	15306.45	43%	6600	18%	14014	39%	35920.5
Total	**306129**	**50%**	**173000**	**28%**	**132976**	**22%**	**612105.0**

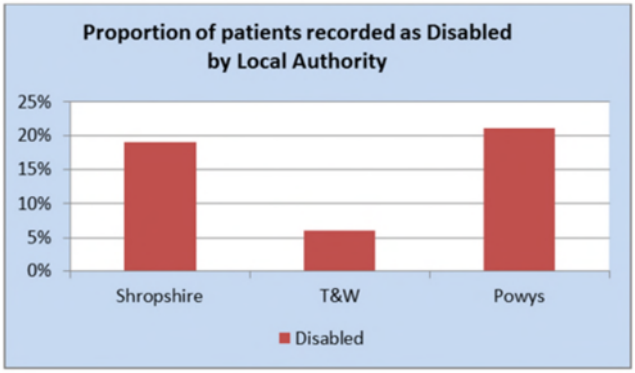
Out Patient Activity by Age Group

Age Group	Out Patient Appointments at PRH (No.)	Out Patient Appointments at PRH (%.)	Out Patient Appointments at RSH (No.)	Out Patient Appointments at RSH (%)	Out Patient Appointments at SaTH (No.)	Out Patient Appointments at SaTH (%)
0-9	8938	9.39	1571	1.96	10509	5.99
10-19	8220	8.64	4174	5.21	12394	7.07
20-29	8180	8.59	6231	7.78	14411	8.22
30-39	9436	9.91	8025	10.02	17461	9.96
40-49	10171	10.68	8861	11.06	19032	10.86
50-59	12966	13.62	12050	15.04	25016	14.27
60-69	12757	13.4	13353	16.67	26110	14.89
70-79	14161	14.88	15141	18.9	29302	16.72
80-89	8561	8.99	8893	11.1	17454	9.96

90+	1802	1.89	1806	2.25	3608	2.06

Patient Profile by Disability





Learning Disability	PRH Number	PRH Percentage	RSH Number	RSH Percentage	SATH Number	SATH Percentage
Yes	694	1.26	937	1.07	1631	1.14
No	54285	98.37	85783	98.3	140068	98.33
Unknown	203	0.37	544	0.62	747	0.52
Total	**55182**	**100**	**87264**	**99.99**	**142446**	**99.99**

Patient Profile by Gender

Gender	A&E Attendance at PRH (No.)	A&E Attendance at RSH (No.)	In-Patient episodes at PRH (No.)	In-Patient episodes at RSH (No.)	Out-Patient episodes at PRH (No.)	Out-Patient episodes at RSH (No.)
Female	25358	23382	27971	41181	54165	42845
Male	25822	23557	27211	46083	41025	37258
Unknown	1	0	0	0	1	2

Gender	A&E Attendance at SATH (No.)	In-Patient episodes at SaTH (No.)	Out-Patient episodes at SaTH (No.)	Total Activity at SaTH (No.)	Total Activity at SaTH (%)
Female	69152	69152	97010	235314	51.13
Male	73294	73294	78283	224871	48.86
Unknown	1	0	3	4	0

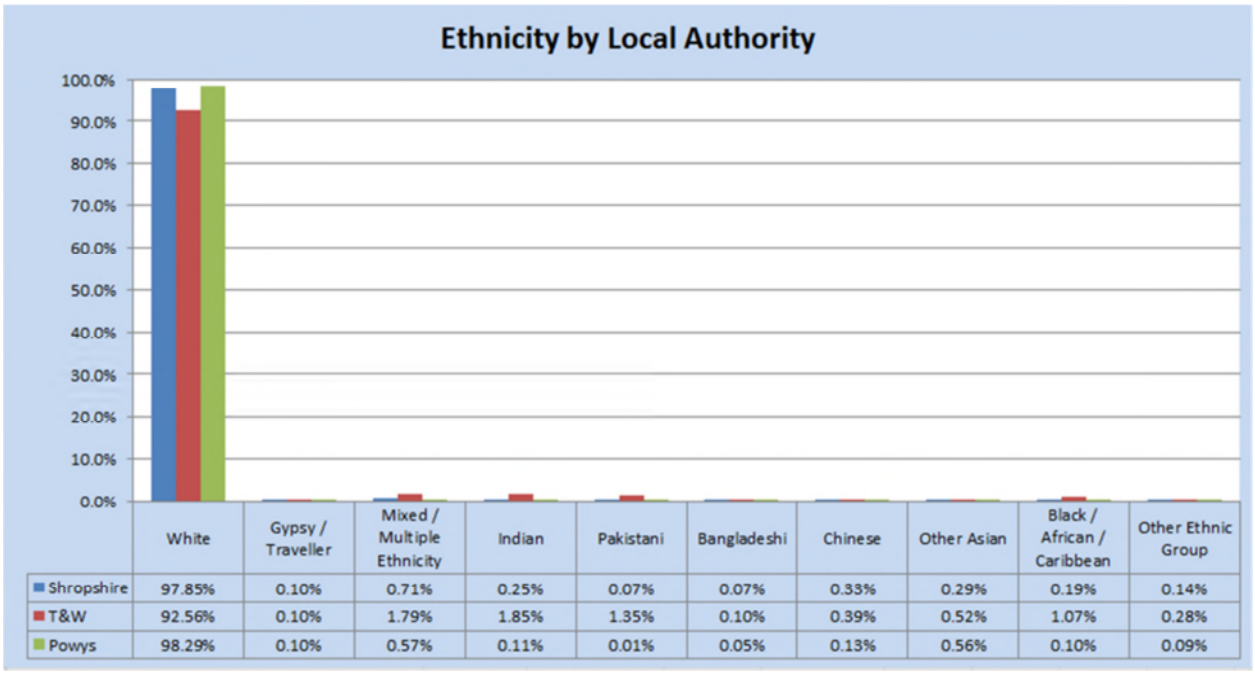
Workforce Profile by Gender (not including Bank Staff) as at 31st March 2018

Gender	Headcount	Percentage
Female	4749	80.07%
Male	1182	19.93%
Grand Total	**5931**	**100.00%**

Patient Profile by Religion

Religion	No.	Shropshire	No.	T&W	No.	Powys	PRH No.	PRH	RSH No.	RSH	SATH No.	SATH
Buddhist	447	0.18%	398	0.24%	567	0.43%	60	0%	50	0.11%	110	0%
Christian	226351	89.87%	102892	61.77%	82120	61.79%	20933	41%	20040	42.69%	40973	42%
Hindu	192	0.08%	872	0.52%	324	0.24%	150	0%	35	0.07%	185	0%
Muslim	589	0.23%	3019	1.81%	235	0.18%	586	1%	92	0.20%	678	1%
Not Religious	3460	1.37%	45599	27.38%	37050	27.88%	7324	14%	5906	12.58%	13230	13%
Other belief	630	0.25%	692	0.42%	798	0.60%	231	0%	150	0.32%	381	0%
Sikh	153	0.06%	2118	1.27%	49	0.04%	291	1%	33	0.07%	324	0%
Unknown	20044	7.96%	10973	6.59%	11753	8.84%	21606	42%	20633	43.96%	42239	43%
Total	**251866**	**100%**	**166563**	**100%**	**132896**	**100%**	**51181**	**100%**	**46939**	**100.00%**	**98120**	**100%**

Patient Profile by Ethnicity

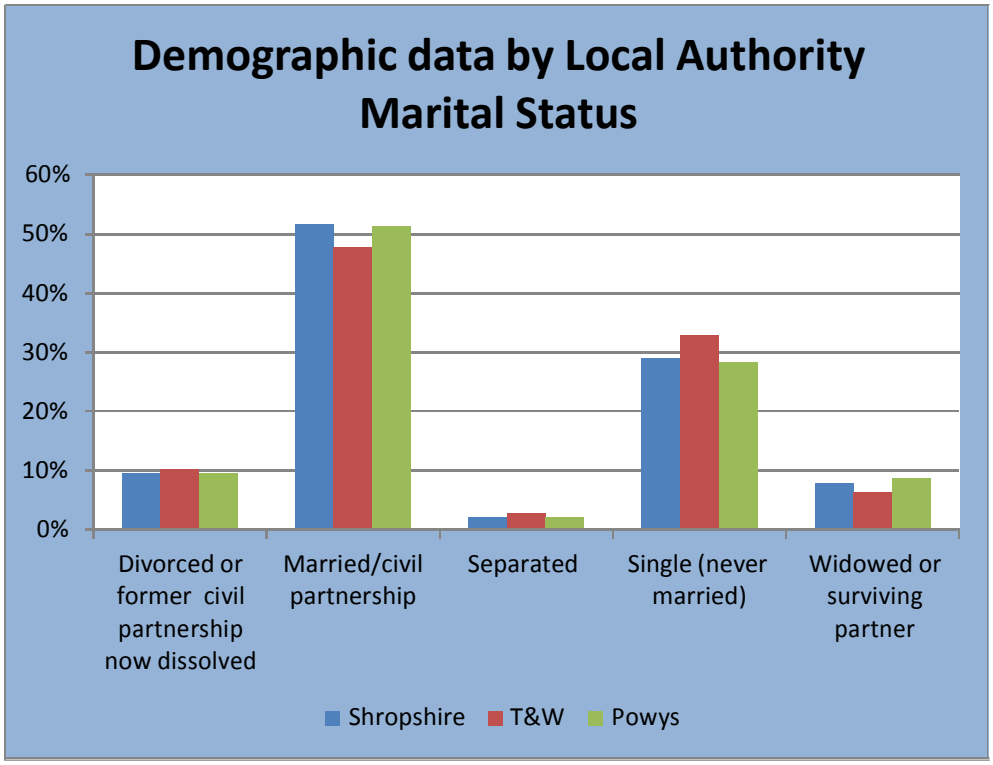


Ethnicity	Shropshire	T&W	Powys	Demographic	PRH	RSH	SaTH
White	97.85%	92.56%	98.29%	96.24%	91.75%	94.08%	93.18%
Gypsy / Traveller	0.10%	0.10%	0.10%	0.10%	3.33%	3.25%	3.28%
Mixed / Multiple Ethnicity	0.71%	1.79%	0.57%	1.02%	1.29%	0.55%	0.84%
Indian	0.25%	1.85%	0.11%	0.73%	1.28%	0.60%	0.86%
Pakistani	0.07%	1.35%	0.01%	0.47%	0.84%	0.50%	0.64%
Bangladeshi	0.07%	0.10%	0.05%	0.07%	0.04%	0.02%	0.02%
Chinese	0.33%	0.39%	0.13%	0.28%	0.13%	0.24%	0.19%
Other Asian	0.29%	0.52%	0.56%	0.46%	0.49%	0.14%	0.28%
Black / African / Caribbean	0.19%	1.07%	0.10%	0.45%	0.60%	0.41%	0.47%
Other Ethnic Group	0.14%	0.28%	0.09%	0.17%	0.25%	0.22%	0.23%

Number of missed hospital appointments by ethnicity

Ethnic Origin	PRH Number	PRH Percentage	RSH Number	RSH Percentage	SATH Number	SATH Percentage
White British	9493	83.13	7074	86.25	16567	84.44
Unknown	726	6.36	596	7.27	1322	6.74
Any Other White	314	2.75	221	2.69	535	2.73
Indian	145	1.27	44	0.54	189	0.96
Pakistani	142	1.24	22	0.27	164	0.84
Other mixed background	88	0.77	44	0.54	132	0.67
Other Asian background	62	0.54	34	0.41	96	0.49
White Irish	69	0.6	25	0.3	94	0.48
White and Black Caribbean	74	0.65	18	0.22	92	0.47
Any Other ethnic Group	54	0.47	34	0.41	88	0.45
White and Asian	58	0.51	28	0.34	86	0.44
African	60	0.53	20	0.24	80	0.41
White and Black African	42	0.37	11	0.13	53	0.27
Other Black background	34	0.3	13	0.16	47	0.24
Caribbean	34	0.3	7	0.09	41	0.21
Chinese	15	0.13	7	0.09	22	0.11
Bangladeshi	9	0.08	4	0.05	13	0.07
Total	**11419**	**100**	**8202**	**100**	**19621**	**100.02**

Patient Profile by Marital Status



Marital Status	Shropshire	T&W	Powys	Demographic	PRH	RSH	SaTH

Divorced or former civil partnership now dissolved	9.5%	10.2%	9.6%	9.8%	3.4%	3.4%	3.4%
Married/civil partnership	51.5%	47.8%	51.3%	50.2%	25.4%	26.5%	25.9%
Separated	2.0%	2.7%	2.1%	2.3%	0.7%	0.6%	0.6%
Single (never married)	29.1%	32.9%	28.2%	30.0%	42.4%	36.9%	39.8%
Widowed or surviving partner	7.9%	6.4%	8.8%	7.7%	4.6%	5.2%	4.9%
Unknown (SaTH data only)	0.0%	0.0%	0.0%	0.0%	23.5%	27.4%	25.4%

National In-Patient Survey Demographic

Age	Percentage	Number
16 - 35	4.91	31
36 - 50	8.56	54
51 - 65	23.61	149
66 - 80	37.08	234
80 plus	25.83	163
Total	**100**	**631**
Missing Data	0	0

Gender	Percentage	Number
Male	46.59	294
Female	53.41	337
Total	**100**	**631**
Missing Data	0	0

Ethnic Group	Percentage	Number
White	98.34	594
Mixed	0.66	4
Asian or Asian British	0.66	4
Black or Black British	0.33	2
Arab or other ethnic group	0	0
Total	**100**	**604**
Not Known	0	27

Religion	Percentage	Number
No religion	17.57	107
Buddhist	0	0
Christian	78.98	481
Hindu	0.16	1
Jewish	0	0
Muslim	0.33	2
Sikh	0.33	2
Other	1.31	8
I would prefer not to say	1.31	8
Total	**100**	**609**
Missing Data	0	22

Do you have any physical or mental health conditions, disabilities or illnesses that have

	Percentage	Number
Yes	62.84	328
No	37.16	194
Total	**100**	**522**
Missing Data	0	109

How do you think of yourself	Percentage	Number
Heterosexual / straight	93.54	550
Gay / lesbian	1.02	6
Bisexual	0	0
Other	0.85	5
I would prefer not to say	4.59	27
Total	**100**	**588**
Not Known	0	43

Age Group	Number of surveys sent	Percentage of the number of surveys sent to this age group	Number of non-returns	Percentage of non-returns
20 - 29	82	6.8	68	82.9
30 - 39	88	7.3	65	73.8
40 - 49	112	9.3	77	68.8
50 - 59	160	13.2	79	68.1
60 - 69	211	17.5	73	34.6
70 - 79	279	23	81	29
80 - 89	231	19.1	89	38.5
90 plus	46	3.8	28	60.8

Appendix 3

Interpreter Requests by Language 2017-18

Language	Total number of translation bookings
Afghani	5
Amoy	1
Arabic	183
Bengali	13
BSL	233
Bulgarian	231
Cantonese	35
Czech	18
Farsi	2
French	3
Hindi	5
Hungarian	60
Italian	15
Japanese	14
Kurdish	14
Kurdish-Southern	1
Latvian	15
Lithuanian	72
Malay	4
Mandarin	72
Mirpuri	1
Nepalese	4
Polish	963
Portuguese	13
Potwari	3
Punjabi	73
Pushto	5
Romanian	164
Russian	36
Serbian	2
Slovak	34
Spanish	20
Thai	7
Tigrinian	2
Turkish	42
Twi	13
Urdu	74
Vietnamese	3
Total	**2455**