JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Date:	**Monday, 17 December 2018**	Time	**10.00am**
Venue	**Meeting Point House, Southwater Square, Telford, TF3 4HS**		

Enquiries Regarding this Agenda:		
Democratic and Scrutiny Services	Stacey Worthington	01952 382061
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Committee Membership:	**Telford & Wrekin**	**Shropshire**
	Councillor Andy Burford (TWC Health Scrutiny Chair)	Councillor Karen Calder (SC Health Scrutiny Chair)
	Councillor Stephen Burrell	Councillor Heather Kidd
	Councillor Rob Sloan	Councillor Madge Shineton
	Mrs Hilary Knight (Co-optee)	Mr David Beechey (Co-optee)
	Ms Carolyn Henniker (Co-optee)	Mr Ian Hulme (Co-optee)
	Mr Dag Saunders (Co-optee)	Mr Paul Cronin (Co-optee)

AGENDA

1. **Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes** — Appendix **A1** and **A2** To Follow
   To confirm the minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on 26 November and 3 December 2018.

4. **Future Fit** — Appendix **B**
   To receive the updated papers on the formal Future Fit Consultation and for Joint HOSC to outline its headline points prior to written formal feedback on the consultation process

5. **Proposed Next Steps for Joint Health Overview and Scrutiny Committee**

6. **Co- Chairs' Update**

A1

SHROPSHIRE COUNCIL,TELFORD & WREKIN COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on Monday 26 November 2018 10.00am at Meeting Point House, Southwater Square, Telford

Members Present:

Shropshire Councillors: Karen Calder (Co-Chair), Heather Kidd, Madge Shineton
Telford and Wrekin Councillors: Andy Burford, Stephen Burrell, Rob Sloan
Telford and Wrekin Co-optees: Carolyn Henniker, Hilary Knight, Dag Saunders
Shropshire Co-optees: David Beechey, Paul Cronin

Ohers Present:

David Evans, Chief Officer Telford & Wrekin CCG; Joint Senior Responsible Officer, Future Fit
Stacey Worthington, Senior Democratic and Scrutiny Services Officer, Telford & Wrekin Council
Amanda Holyoak, Committee Officer, Shropshire Council
Rod Thomson, Director of Public Health, Shropshire Council
Nigel Lee, Chief Operating Officer, Shrewsbury and Telford Hospital Trust
Deidre Fowler, Director of Nursing, Midwifery and Quality
Claire Old, Urgent Care Director, Shrewsbury and Telford Hospital Trust
Sarah Jamieson, Head of Midwifery, Shrewsbury and Telford Hospital Trust
Julia Clarke, Director of Corporate Governance, Shrewsbury and Telford Hospital Trust

1. Apologies for Absence

Apologies were received from Shropshire Co-optee Ian Hulme

2. Disposable Pecuniary Interests

Members were reminded that they must not participate in the discussion or voting on any matters in which they have a disclosable pecuniary interest and should leave the room prior to the commencement of the debate.

3. Minutes of the last Meeting

It was noted that the minutes of the meetings held on 19 September 2018 were approved.

4. Overnight Closure of the Emergency Department at the Princess Royal Hospital

The Co-Chair advised that following the previous weeks' announcement that the overnight closure of the Emergency Department at the Princess Royal Hospital had been avoided and the closure would not go ahead, the committee would still scrutinise the decision making process.

Ms Fowler stated the CQC had announced that the Trust had been placed in Special Measures. SaTH advised that they had been placed on the Challenged Provider list six months previously which recognised the fragility of the workforce. Prior to the CQC inspection, SaTH had acknowledged the challenges they had faced and had requested additional support.

Special Measures did attract some additional funding, as well as increased supervision and support from regulators. It was noted that it was not the CQC who put Trusts in Special Measures, this was done by NHS Improvement. In response to a question, Ms Fowler advised that the funding was not prescribed and decisions on how this was used was in conjunction with NHSI. The exact amount of funding the Trust would receive was still to be confirmed, but it was noted that other trusts had experienced some cost pressures with Special Measures previously. It was expected that the resources would be used as an 'invest to save' measure.

Members asked the following questions:

Had there been an impact on recruitment following the Special Measures announcement.

Ms Fowler advised that this was a concern but the way this was managed was very important. The number of leaks and the media attention around August had been more damaging to recruitment. Ms Clarke stated that measures had been put in place to ensure recruitment was sustainable and the trust were working closely with Health Education England.

Has Special Measures changed the recruitment plan?

Mr Lee stated that changes were already been in place. A number of ACPs were in training.

Where there any determining factors in the amount of funding that was granted?

Ms Fowler stated the additional funding had not yet been agreed. The Co-Chairs reported that they would be meeting the Improvement Director later in the week and would ask her about this.

The Members discussed the impact of the announcement of the overnight closure of the Emergency Department of the Princess Royal Hospital which had been called off.

The Co-Chair advised that the members of the JHOSC were disappointed they had not been consulted before, as the potential overnight closure had been discussed by SaTH for approximately 18 months.

How stable was the plan? What was the threshold for reinstating the plan? How sustainable was the situation in regards to senior and middle grade doctors?

Mr Lee advised that the Trust were delighted that the A&E was able to remain open. The new Urgent Care Centre had opened at the Princess Royal Hospital and a rota of regularly employed locums were in place until February. Additional pay had been offered for the locum doctors, and they had been offered longer contracts, of several months. The work that had been completed in regards to pathways was very useful, especially in regards to

direct access. Four substantive doctors would join the Trust in March. There would be a project review, and Members asked to have sight of this. Advice had been sought from the West Midlands Clinical Senate.

There had been criticism by other Hospitals regarding SaTH not accepting some opportunities for support.

Ms Clarke advised that the Trust had met with Wolverhampton University in respect of developing their own fellowship, however, it was noted that fellowships did not generally generate a significant amount of additional doctors for Trusts.

It was noted that recruitment of junior doctors was a national issue.

Mr Lee advised that there had been significant dialogue with Health Education England, however, the Trust were not only relying on this to increase recruitment. CQC had highlighted SaTH's medical education programme as a strength.

5. Proposals to Mitigate the Effect of Winter Pressures on NHS Services

The Co-Chair advised this was an annual process and highlighted that the NHS remained under pressure year round. Members discussed the aspirational nature of the plan.

Ms Old stated that it had been acknowledged that the 2017/18 winter had been particularly harsh. The Winter Plan looked to build on improvements and changes made. The Summary Winter Capacity Plan Bed Impact was discussed, there had been good work undertaken between the trust and the Local Authorities. Community Hospitals could be used for higher level of dependency if needed. It was noted that weekend discharges needed to be improved.

The number of stranded patients had reduced and a discussion was held regarding the impact of hospital stays on over 80s.

A discussion was held and members asked the following questions:

Where there concerns regarding the viability of the independent care sector?

The A&E Delivery Group included members from health and social care, the system was able to identify if any concerns were arising in this area. SaTH2Home were able to be flexible in the event of service need, for example, increasing the number of days support could be offered.

Handover nurses were now in place across both sites and a HALO in place at RSH. Work was being undertaken with the ambulance services in respect of preventing admissions.

What time was the latest a patient would be discharged?

Mr Lee advised that this would depend on circumstances and would be in liaison with the community teams and care homes. What time of day a patient would be discharged would depend on various factors, however, patient safety was the priority.

Was the Trust confident that there would not be boarding over the winter period?

Ms Old advised the Trust were confident, however, surges could never be avoided.

Additional beds would require additional staffing, were the staff available?

Ms Fowler advised that staffing remained a risk, however, this could be mitigated by using locum staff or deploying staff from other areas. It was important to note this would also include therapy and other support staff.

A discussion was held regarding the discharges from Powys.

Mr Lee advised that the Welsh health system did not have the same target as the English system, however, the Health Board were keen to meet the same targets. The Trust were in regular conversation with Powys Council and the Health Board.

What was the major risk of the plan?

Ms Old advised that the workforce was the major risk.

Was there support for people with long term conditions? For example, it was known there was a dedicated helpline for people with COPD, was this available for people with other long term conditions?

Ms Old advised there were a number of direct lines available, for example a Macmillan line.

It was noted that an Urgent Care Centre was due to open at PRH in November. Has this been opened?

Mr Lee confirmed this was now open. It had taken 9 months to build, however it was now fully operational. The Urgent Care Centre at RSH had already been established.

There had been previous issues in respect of the discharge lounge, what was the appropriate length of time for a patient to be in the lounge?

Ms Fowler advised that the discharge lounge at PRH had been in use for some time and had been successful in creating patient flow. It had recently been moved to a larger space. Currently, at RSH the discharge lounge was in Ward 27, however, it was possible the lounge could move to the new ward. It was noted that the ward was staffed by nurses, and ideally patients should not be in the lounge for more than 4 hours, although it was acknowledged some patients were there for significantly longer than this.

A question was asked in respect of the fragility front door.

Ms Old advised that the fragility front door was in place at RSH. At PRH, the paramedics worked to prevent people unnecessarily reaching the front door. It was noted that the paramedic in a car had prevented 60 hospital admissions in 2 weeks.

Were readmissions monitored?

Ms Old confirmed they were and that the Trust's readmission rate was relatively low.

6. Shrewsbury and Telford Hospital NHS Trust – Enforcement Action Taken by CQC and response taken by SaTH – Maternity Services

The Co-Chair stated that the members of the JHOSC had been disappointed that they had not been fully informed of the situation at previous meetings. It was confirmed that the final CQC Report was due to be published between 27 and 29 November.

A discussion took place and members asked the following questions:

Was there anything in the final CQC report which had not already been noted by the JHOSC?

Ms Fowler advised that the key themes had been discussed.

The maternity dashboard was showing a very positive figure, however, this was hard to square with the current level of scrutiny the trust was under. Were the trust measuring the right things?

Ms Jamieson advised that the dashboard was a snapshot of data and that the full dashboard had been based on the national directive. There had been a move away from RAG ratings.

Was the data presented the favourable data?

Ms Jamieson advised that no data had been hidden. A report had been taken to a recent Trust Board which had explained this more clearly.

What specifically had the CQC raised concerns about, in respect of maternity services.

Ms Jamieson advised that the details of what was included in the S.31 notice had been included in the agenda papers. In respect of Cardiotocography (CTGs) at the rural MLUs, concerns had been raised that these were monitored remotely and if low risk were signed off by a midwife. In respect of multi-disciplinary handovers of care, these had been taking place but could not be evidenced.

Had there been an improvement over the last 12 months.

Ms Jamieson stated that there had been. In respect of stillbirths, this had seen a reduction and there had been improvements in other areas, such as term admissions to the neonatal unit. Ms Fowler advised the Trust were committed to being transparent, and they had commissioned external investigators to offer a stronger level of assurance.

Members noted that service users confidence had been shaken. Had there been an increase in mothers wanting to deliver elsewhere?

Ms Jamieson advised that there have been concerns about this, however, these concerns had not been laid out with the results of the maternity survey. The team received good news stories on a daily basis and friends and families test results were positive. A maternity voices partnership was being developed.

Ms Clarke advised that the Trust had received support from a Senior Regional Communications Director, who was surprised by the level of inaccurate media coverage. The local response had been hugely supportive.

Ms Fowler stated that there had also been an impact on the staff, who were often residents of Shropshire themselves. The impact had been unrelenting and often very personal. It was noted that NHSI had ‘buddied’ the Trust with the Princess Alexandria Hospital in Harlow, which was an outstanding trust.

7. Shrewsbury and Telford Hospital NHS Trust – Enforcement Action Taken by CQC and response taken by SaTH – A&E

A discussion was held and members asked the following questions.

What concerns did the CQC have in respect of A&E?

Ms Fowler advised that concerns were raised in respect of:

- Fragility of the workforce and the impact of locums
- End of Life Care
- 7 day working
- Training and Education
- Mental Health
- 7 day working in the intensive care environment
- Cohesion of the Senior Leadership Team

What issues remained?

Ms Fowler stated that the Trust had asked if NHSI had felt assured with the progress made, which they confirmed they were. Boarding was not taking place in the ward environment. Due to Special Measures, there would be a re-inspection within a year.

The media had reported the concerns around Mental Health being illegal detention.

Ms Fowler advised that in the letter of intent, concern had been raised in respect of deprivation of liberty, however, once the Trust had responded, this had been removed from the S.31 notice.

The data provided indicated that some measures had deteriorated.

Ms Fowler stated that in respect of the 10pm checks, these were causing challenges, as 10pm was a particularly busy time.

A discussion was held in respect of the Baseline Exemplar.

Ms Fowler advised that this was used to identify challenged wards and to put in additional support for them. It was noted that it was important to differentiate between the care not being delivered and the care not being documented. Members requested sight of levels of locum staff for worse performing wards.

Why did it take the CQC to raise their concerns and the Special Measures to be put in place for there to be a focus on these areas?

Ms Fowler stated that processes were in place before the CQC inspection. A lot of the risks the CQC reported were known and included on the Trust's Risk Register.

It was noted that boarding stopped following the CQC inspection.

It was acknowledged that this took place, however, plans were already in place and it was coincidental that the remedial fire safety works were completed to allow the additional capacity. It was noted that boarding had become normalised and it was vital that this did not happen again.

The Co-Chair announced that questions would be taken from the floor.

Councillor Arnold England, Cabinet Member for Health and Wellbeing, Telford & Wrekin Council, expressed his thanks to everyone who worked to save the accident and emergency from closure overnight. He discussed the relationship between the Trust and the Local Authority, and the need for there to be a good working relationship between the Mental Health Trust and SaTH.

Mr Lee noted that the Local Authorities were part of the A&E Delivery Board.

Ms Sylvia Jones, Clunbury Parish Council, asked who the providers were for the Urgent Care Centres.

Mr Lee advised the provider for the UCC at RSH was IMH (Part of Malling Health), who were contracted by Shropshire CCG. The provider for the UCC at PRH was Shropdoc and they were directly contracted by SaTH. It was hoped to align the two contracts the following year.

Gill George, Shropshire Defend Our NHS, asked if it was wise to reduce beds given the increased pressure on services. Ms George stated that she believed that Shropdoc had only one doctor on duty after midnight for Shropshire, Telford and Wrekin.

Mr Evans stated that the contract for Shropdoc was to provide out of hours care and he did not believe that only one doctor was on duty, but also that Advanced Nurse Practioners (ANPs) were on duty as well as GPs. Ms Old stated that it was important to focus on people spending less time in bed and to reduce the length of stays.

Another question was asked in respect of palliative care and a reason why a palliative care plan could not be carried out.

Ms Fowler said that the plan should be complied with.

8. Proposed Next Steps for Joint Health Overview and Scrutiny Committee

The Co-Chair advised that the Chairs would be meeting with the Improvement Director.

The following information had been requested by the Committee:

Question	Who to Answer	Deadline
Viability of EED In February	SaTH	As soon as available
Review of Winter Plan	SaTH CCGs	February JHOSC Meeting (date to be arranged)
111 Capacity Report	SaTH	As soon as available
Neonatal Report to be presented to JHOSC	SaTH	January JHOSC Meeting (date to be arranged)
GP Cover level for Shropdoc	CCG Shropdoc	As soon as available

A Member also said that with the necessary recent focus of attention on acute services, mental health was an area that the Committee had not considered for some time. He suggested that this be added to the work programme for the coming year.

9. Co- Chairs' Update

The Chair advised that the next meeting of the JHOSC would be held on 3rd December 2018, where the Committee would receive the Future Fit Consultation Report, as well as an update in respect of the midwife led service and learning disability service.

The meeting concluded at 1.03pm.

Chair: _____

Date: _____

FUTURE FIT Report to Joint Health Overview and Scrutiny Committee

Meeting Date:	17th December 2018
Report Title:	Responding to Matters Raised on 3rd December Meeting of the JHOSC
Presented by:	Dr Simon Freeman , Dave Evans Joint SROs Future Fit
Report for	For Information
Purpose of Report:	The purpose of the report is to support the JHOSC in preparing its written formal feedback on the consultation process to the CCG Governing Bodies, through responding to a number of issues raised at the meeting on 3rd December 2018. Specifically: To provide the full Equalities Impact Assessment (EIA) To provide the updated mitigation plans for the EIA To provide the updated Travel and Transport Mitigation Plan To provide the public facing narrative for the Shropshire Care Closer to Home Strategy To address a number of other key point through a short presentation: • Centralisation of Stroke Services • Eligibility Criteria for Non-emergency Passenger Transport • Mechanisms for claiming back travel costs • Some early points on lessons learnt from consultation process A number of clinicians (subject to availability) will be present at the meeting on 17th to provide an opportunity for answering any clinical questions raised by the JHOSC.
Summary	<u>EQIA and Mitigation Plan</u> The full Equality Impact Assessment (EIA) is presented to the JHOSC; note the Executive Summary was received at the meeting on 3rd December 2018. It has drawn upon a wide range of existing information, intelligence, previous engagement work and the findings from the public consultation. It examines if particular protected characteristic groups or other vulnerable groups are likely to experience any disproportionate impact from the proposals – either negatively or positively. Our assessment work pays particular attention to equality legislation and to showing how the Programme is considering the needs and views representative of the nine protected characteristics under

	the Equality Act 2010 and Public Sector Equality Duty 2011. Four additional groups that we have made particular efforts to engage with during the consultation have also been identified: • People living in rural areas • People living in areas of deprivation • Carers • Welsh speakers, as a first language The draft EIA mitigation plan develops the necessary actions from the EIA recommendations and who is responsible for overseeing their delivery. The mitigation plan will continue to be developed and monitored through the appropriate Implementation Oversight Group (IOG) post final decision making. <u>Travel and Transport Mitigation Plan</u> The Travel and Transport Mitigation Plan is presented for information and has now been updated following additional feedback from: • Joint CCG Board on 14th November • Future Fit Programme Board on 22nd November • Joint HOSC on 26th November and 3rd December • Travel and Transport Group held on 7th December 2018. This will continue to be updated as the work of the Travel and Transport Group continues. The draft EIA and mitigation plan and travel and transport mitigation plan will form a key part of the decision making process in early 2019. <u>Shropshire Care Closer to Home</u> A public facing narrative on the Shropshire Care Closer to Home Programme is available on the CCG web site. The link is provided below: https://www.shropshireccg.nhs.uk/media/1730/shropshire-care-close-to-home-overview-document-final.pdf
Recommendation:	The Joint HOSC is asked to: • Receive the Future Fit Equalities Impact Assessment and Mitigation Plan • Receive the Travel and Transport Mitigation Plan • Note the link to the Shropshire Care Closer to Home public facing narrative on the NHS Shropshire CCG Web site. • Receive the presentation that addresses a number of other lines of enquiry raised at the meeting on 3rd December 2018.

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Joint HOSC

17 December 2018

Debbie Vogler
Associate Director

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- Independent Chair of Shropshire, Telford & Wrekin STP
- Future Fit is ‘mission critical’ for sustainability of hospital services in Shropshire, Telford and Wrekin and a crucial part of improving the wider health and care within region
- The issues we face are the same being faced across the country
- We have the advantage in that we are further ahead than other regions - we have the ambition, the plan for delivery and a large amount of capital to support it
- We cannot afford any further delays – this is the opportunity to ensure long term, sustainable hospital care

Sir Neil McKay

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Addressing points from last JHOSC

Issue	Response
Equality Impact Assessment (EIA)	Full EIA and mitigation plan circulated to members
Travel and transport mitigation plan	Circulated to members
Update on stroke services	Included in slides
Various travel and transport queries	Included in slides
Review of consultation process	Included in slides
Clinician's view	Andrew Tapp and Louise Jones from SaTH to take questions

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- Stroke services consolidated in 2013 due to workforce challenges
- PRH chosen as offered best facilities and staffing model at the time
- Dedicated hyper-acute stroke unit proven to deliver better outcomes for patients

Stroke services

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Challenges for Stroke services

- Interdependencies with other departments
- A&E: Increased admissions via A&E and workforce challenges can at times impact upon the delivery of admission to a specialist stroke unit within four hours of arrival
- Capacity within hyper-acute Stroke unit: Site and system wide challenges with patient flow, due to workforce, impacts on capacity in specialist areas
- Workforce: vacancies within Therapies impacts on delivery of the Stroke pathway
- Access to CT: PRH currently operates a single CT scanner, which has shown increasing fragility over the last year

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Response to challenges

- Work is currently underway in partnership with the Transformation Institute to address some of the issues the service faces
- However, the full benefits will not be realised until the Trust-wide challenge of managing the current configuration of services are addressed
- In the future: single stroke service could be provided on Emergency Care site alongside the ED with the required facilities and workforce to support the Stroke pathway

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- The service user has seriously impaired vision
- The service user is medically unfit to travel by any other means
- The service user is being transferred to a community hospital or step down facility - could be nursing or residential home
- The service user can only get around in a wheelchair
- The service user has psychiatric or learning difficulties and is therefore unable to use public transport
- The service user has a medical condition that would compromise their dignity or cause a public concern
- The service user is unable to walk without the continual support of another person or walking aid e.g. zimmer frame
- The service user will experience a side effect sufficient to require transport as a result of the treatment they will receive
- Escorts take up seating space and should only be authorised for genuine medical reasons, where their particular skills and/or support are needed

Patient Transport

Non-Emergency

Eligibility criteria

The eligibility criteria is currently being reviewed. The intention is for commissioners to take the revised criteria to joint HOSC in January 19.

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Claiming back travel costs

Healthcare Travel Costs Schemes

- Must be receiving one of the qualifying benefits or allowances, or meet the eligibility criteria of the NHS Low Income Scheme
- **By Car:** Fixed rates of reimbursement within a certain radius and then by mileage
- **By Public Transport:** Costs of fares associated with travelling to hospital will be refunded. In instances where a child is the patient, we will pay for the fares of the child and one adult to accompany them
- **By Taxi:** Taxi fares are only claimable provided that the patient holds a GP letter stating that they are medically unable to travel by public transport. Without such a letter, reimbursement will be made at the car allowance rate

Claim forms available at RSH and PRH Cashier's office

SaTH website has additional information and criteria

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Review of consultation process

A review of the consultation process has looked at NHS legal and policy context for significant service change in relation to public consultation and engagement, and the strategies, governance and activities that were undertaken in order to ensure a robust process for the 15 week consultation period.

Key learning has included:

- Involvement of the Stakeholder Reference Group
- Mid-point review – informed by Joint HOSC and Powys CHC
- Additional events and extension to the consultation
- Expert input for travel and transport at events
- Local Joint Committees co-presented with clinicians
- Working with the voluntary sector to assist in reaching seldom heard groups
- Adherence to Welsh and English law and guidance

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Conscientious consideration - next steps

Date	Meeting
17 December	JHOSC meeting Future Fit Programme Board
8 January	Telford & Wrekin CCG Board Montgomeryshire Local Committee of Powys Community Health Council
9 January	Shropshire CCG Board
January 2019 (TBC)	Joint HOSC meeting
January 2019 (TBC)	Joint Committee of Shropshire and Telford & Wrekin CCGs

Future Fit Programme
Equality Impact Assessment

November 2018

Table of Contents

1.0 Executive Summary

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

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

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

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

Four additional groups that we have made particular efforts to engage with during the consultation have been identified, although there is no statutory duty for the CCGs to consult with these groups:

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

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

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

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

1.1 Summary of local demographic data

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

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

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

For more detail, please go to section 8.

1.2 Summary of health profile by protected characteristic

Protected characteristic	Health profile/risk factors
Age	Certain age groups access A&E more: adults aged 80+, young children up to age 4, 20-24 year olds and 25-44 year old men and are more likely to be impacted on by changes to A&E services. Local hospital data shows that the age groups with the highest A&E attendances are 0-4, 15-19, 20-24 and 25-29 (except in Powys where the number of 0-4 year olds is lower than expected.) Women of child-bearing age most likely to be impacted on due to changes to women's and children's services and the main age groups who would be impacted on are: 20-24, 25-29, 30-34 with more Shropshire women in older age groups accessing maternity services. Local hospital data shows that children aged 0-4 are most likely to need inpatient paediatric services. Long term conditions more likely in older people. Higher risk of stroke in over 55 year olds and higher usage of planned care by older patients e.g. hip and knee surgery. Travel impacts greatest for younger and older people.
Sex	Higher impact on women due to women's and children's services, particularly BAME women (see Race section below) although men may be impacted on as visitors. Local hospital data shows that a similar number of men and women attend

	A&E, except for women aged 80+ who attend more. Young men may have a greater need to access A&E and acute services, in particular, many more men in Powys aged 25-29 use A&E services than women. Older women are more likely to require joint surgery. Older women and younger men have a higher risk of stroke. Fewer women drive than men and more women therefore tend to use public transport.
Sexual orientation	LGBT people have poorer mental and physical health e.g. higher rate of self harm and suicide. LGBT people are more likely to smoke and drink heavily and less likely to have had a smear test, increasing the risk of some cancers and stroke. Lesbian and bisexual women are at higher risk of complications during pregnancy. LGBT people may not be confident that healthcare services understand or meet their needs, which may discourage service usage and lead to late interventions. Higher rates of asthma, arthritis and obesity in lesbian and bisexual women. Some LGBT people may feel unsafe on public transport.
Disability	People with a disability more likely to use health services. Low screening uptake, excluded from sex education and less likely to have weight checks. Possible premature ageing. Higher rates of risky behaviours. Lower life expectancy for people with mental health problems and intellectual impairments. People with a learning disability (LD) have worse physical and mental health. Some ethnic groups have higher disability rates. Women with a LD more likely to access services late in pregnancy. Higher risk of worse outcomes for pregnant disabled women. People who have already had a stroke are at increased risk of another stroke, with a higher risk of disability and death. Barriers include not only transport but also accessing information and communication.
Race	BAME women have a higher risk of still birth, low weight babies, pre-term birth, congenital abnormalities, severe maternal morbidity and maternal death. Higher emergency hospital admission to intensive care for South Asian children. Local hospital data shows that a far higher number of non-white children from Telford and Wrekin access inpatient paediatric services. There is also a far higher number of non-white women from Telford and Wrekin accessing maternity services and also non-white adults accessing planned care services. Higher prevalence of certain conditions in Black and South Asian people including diabetes and stroke. Higher number of emergency admissions for gypsies and travellers. Black men and Asian women have higher risk of some cancers.
Religion	Amish/Mennonite communities more likely to have genetic disorders, birth defects and increased infant mortality rate. However, overall, they tend to have better health than the general population due to their healthy lifestyle. They are less likely to seek medical attention for non-urgent conditions and often prefer to use natural or homeopathic remedies.
Pregnancy/maternity	Older mothers more likely to have complications during and after pregnancy. Higher risks for pregnant teenagers and their babies, especially if they live in a deprived area. BAME women have higher rates of maternal mortality and still births. Disabled women are more likely to have a caesarean section and stay in hospital longer. Mental ill health may cause women to miss health checks, which could lead to pregnancy complications. Mental ill health can occur for the

	first time during pregnancy and women who have severe mental health problems before are at higher risk. Appendicitis, gallbladder disease and ectopic pregnancies can necessitate emergency surgery on pregnant women. Some cancer and stroke risks can be related to pregnancy. Travel impacts greatest for pregnant women without a local support network and young women particularly if they live in a deprived or rural area. Women of child-bearing age and their families most likely to be impacted on due to changes to women's and children's services.
Gender reassignment	No particular risk factors identified except lack of understanding of healthcare staff.
Marriage/civil partnership	No particular risk factors identified.

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

For more detail, please go to section 9.

1.3 Summary of impacts by protected characteristic

Overall, the proposed changes would have a positive impact for the whole population including those from the nine protected characteristics due to improved quality of care, waiting times, facilities and staffing. The impacts on the different protected characteristic groups may be lower or

higher depending on where people live and also if they belong to multiple protected characteristic groups. Where there is no evidence found to show a different impact on one particular protected characteristic group compared to other groups, this is included as “none identified.”

	Age	**Sex**	**Sexual orientation**	**Disability**	**Race**	**Religion**	**Pregnancy/ maternity**	**Gender reassignment**	**Marriage /civil partnership**
Consultant - led maternity services	Women of child-bearing age and neonates	Women of child-bearing age	Pregnant lesbian and bisexual women	Pregnant women with a disability, partic. learning	Pregnant BAME women BAME babies	*None identified*	Pregnant women - aged 35+ - teenagers, e.g. in deprived areas - BAME women - disabled women e.g. mental illness	*None identified*	*None identified*
Paediatric services	Children and young people (0-16), partic. 0-4 year olds	*None identified*	*None identified*	Children and young people (0-16) with a disability	BAME children, partic. South Asian	Amish/ Mennonite children	BAME babies Babies born to older and teenage mothers Babies living in an area of deprivation	*None identified*	*None identified*
Emergency care	People aged 80+ Children aged 0-4	Older women aged 80+	LGBT people aged 55+ Lesbian and	People with a disability	Black and South Asian people	*None identified*	Pregnant women with - a mental illness	*None identified*	*None identified*

	Young people aged 15-19, 20-24 and 25-29	Young men, particularly under age 30	bisexual women Gay men	e.g. mental illness	with sickle cell disease, thalasse-mia, diabetes, stroke Gypsies and travellers		- appendicitis or gallbladder disease - an ectopic pregnancy		
Planned care	People over 65 People with a long term condition	Women over the age of 50	LGBT adults Lesbian and bisexual women Male to female transgender patients	People with a disability	Black people Asian women	Amish/ Mennonite people	Older pregnant women	*None identified*	*None identified*
Stroke services	People aged 50+ (also children and working age)	Older women, women of child-bearing age, younger men	Gay and bisexual men Lesbian women	People who've already had a stroke	Older BAME people (also children and working age)	*None identified*	Pregnant women with gestational diabetes or hypertension and increased bleeding after birth Pregnant BAME women	*None identified*	*None identified*
Travel	Young people	Women, particularly	Young LGBT people	People with a	Young people	*None identified*	Pregnant women,	*None identified*	*None identified*

	and older people	younger and older women		disability e.g. learning, children, wheelchair users and people living in rural and/ or deprived areas	and older people		mothers and their families e.g. living in rural and deprived areas Pregnant women without family/friends nearby Pregnant BAME women		

For more detail, please go to section 9.

1.4 Summary of consultation participant profile

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

1.4.1 Consultation survey

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

1.4.2 Focus groups and meetings for seldom heard groups

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

1.5 Summary of themes from consultation feedback – meetings and events

Where it has been possible to identify themes from the feedback at meetings and events from a particular protected characteristic group, these have been highlighted below. However, generally, the feedback from our meetings and events with these groups was generally very similar to that of the general population in the areas where the participants lived.

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

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

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

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

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

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

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

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

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

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

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

1.6 Summary of considerations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.7 Conclusions

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

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

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

The Programme recognises that some protected characteristic groups may face additional difficulties in accessing the reconfigured services. These challenges will be greatest for those individuals that have more than one protected characteristic – for example, disabled children, older people on low income. However, it is also worth noting that the reconfiguration of services for some protected characteristic groups will in fact improve their access to these services as specialist sites are relocated more locally to them.

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

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

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

1.8 Recommendations

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

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

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

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

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

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

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

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

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

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

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

2.0 Introduction

The CCGs in Shropshire and Telford and Wrekin are proposing to transform acute hospital services across Shropshire, Telford and Wrekin with the aim to improve care for local people (including people from mid Wales). This applies to the services provided by the Shrewsbury and Telford Hospital NHS Trust (SaTH) and excludes those provided by the separate hospital in Oswestry, managed by the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust.

The proposed model of hospital care has been designed by members of the public and clinicians, GPs and social care professionals. It will see one hospital provide emergency care services (including women and children's inpatient services) and the other hospital provide planned care services. Both hospitals would have an Urgent Care Centre that is open 24 hours a day, seven days a week.

No decisions have been made, but under either option the model ensures that a wide range of hospital services will still be available at both hospital sites and, importantly, stay within the county. This includes outpatients, urgent care services, tests and patient wards. We believe that by changing our hospital services in this way, we will make sure patients receive safe, high quality NHS care now and in the future

The Future Fit Programme acknowledges that the proposals may impact people differently depending on a range of factors. These include the actual service patients need, the distance they will need to travel and changes within other parts of the health service which may affect patient behaviour of how they use services. The proposals have been developed in line with other models of care which includes 'Home is normal', integrated care and use of technology.

The CCGs welcome the duty placed on them to ensure they make decisions that meet the health and social care needs of communities. The work done to develop the consultation has involved adherence to the Equality Act 2010 and the need to identify the impact of changes on the nine protected characteristics: age, disability, faith or belief, gender, race, sexual orientation, being married or in a civil partnership, being transgender or being pregnant.. In addition, the Future Fit Programme Board has recognised four additional local characteristics to be taken into account: carers, rurality, deprivation and non-English first language speakers, in particular Welsh language speakers.

Our approach to developing a final Equality Impact Assessment is to create and update a 'living' process. An EIA was first developed at the pre-consultation stage and informed the consultation communications and engagement strategy and plan. It has therefore also been informed by the collation of data held in documentation produced prior to the start of consultation, including Integrated Impact Assessments and Equality Impact Assessments. These have in turn been informed by workshops with clinicians, members of the public, patients and those representing our identified 'health inclusion groups'. The EIA was refreshed at the mid point review.

3.0 Equality and impact

3.1 What is meant by equality?

Equality is about making sure people are treated fairly. It is not about treating 'everyone the same', but recognising that everyone's needs are met in different ways. Our age, disability, faith or belief, gender, race, sexual orientation, being married or in a civil partnership, being transgender or being pregnant should not disadvantage us. These different characteristics are protected under the Equality Act 2010. In addition, the Future Fit Programme Board has recognised four additional characteristics: carers, rurality, deprivation and non-English first language speakers, in particular Welsh language.

We also recognise the importance of putting human rights at the heart of the way our services are designed and delivered. We believe this makes better services for everyone, with patient and staff experiences reflecting the core values of fairness, respect, equality, dignity and autonomy.

In addition we recognise that a portion of the population which accesses services included in the consultation is based in mid Wales. Wales is a country with two official languages - Welsh and English. The importance of individuals and organisations understanding the consultation has led to all key documents being made available in Welsh to ensure sufficient access to information and to fulfil the requirements of Welsh legislation and guidance.

3.2 Legislation and guidance

Public sector organisations have a duty to adhere to legislation that relates to decision making by public bodies to ensure they make decisions that meet the health and social care needs of communities. The key legislation is:

- The Public Sector Equality Act – Section 149 of the Equality Act 2010
- The Health and Social Care Act (2012) 14T Duties as to reducing inequalities
- The NHS Constitution
- Brown Principles
- Additional duties to consult in Wales are set out in the 'The Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to:

a. eliminate discrimination, harassment and victimisation,
b. advance ‘Equality of Opportunity’, and
c. foster good relations.

The Health and Social Care Act (2012) 14T introduced a new duty on the Secretary of State, NHS England and clinical commissioning groups to ‘have regard to the need to reduce inequalities’ between patients with respect to:

- their ability to access health services and
- the outcomes achieved for them by the provision of health services.

The Brown Principles have been detailed in case law to help support organisations to meet these duties:

- The organisation must be aware of their duty.
- Due regard is fulfilled before and at the time any change is considered as well as at the time a decision is taken.
- Due regard involves a conscious approach and state of mind.
- The duty cannot be satisfied by justifying a decision after it has been taken.
- The duty must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.
- The duty is a non-delegable one.
- The duty is a continuing one.
- This formal consultation will fulfil part of our consideration of our legal duty

The equality impact assessment needs to be cognisant of the European Convention on Human Rights incorporated into domestic law through the Human Rights Act 1998 as well as international treaties.

The Welsh Language Measure (Wales) 2011 establishes a legal framework to impose a duty for certain organisations to comply with the standards of conduct for the Welsh language. This applies to organisations in Wales only but is also relevant to organisations who have a close relationship with Welsh people.

Full information on legislative requirements can be found in Appendix 2.

3.3 Equality Impact Assessments

In order to demonstrate that a public sector body has given due regard to the general duty, public sector bodies are required to conduct an equality impact assessment (EIA) of their policies and decisions, which are likely to have an impact upon people with protected characteristics.

The purpose of a consultation EIA is to answer the following questions:

- Do different groups have different needs, experiences, issues and priorities in relation to the proposed service changes?
- Is there potential, or evidence that the proposed changes will promote equality?
- Is there potential for, or evidence that the proposed changes will affect different groups differently? Is there evidence of negative impact on any groups of people?
- If there is evidence of negative impact, what alternatives are available? What changes are possible?

4.0 The approach to the Future Fit EIA

Due to the scale and complexity of the Future Fit consultation, an iterative approach to producing a final EIA post decision making is being taken. The following documents the stages of previous and planned development:

Stage one allows us to define the proposal for change and the rationale behind it, consider the expected outcomes, who would be impacted and how it would be delivered. The purpose was to describe our understanding at an early point in the process of any likely impact, rather than being a definitive statement of the impact of the proposed changes. It was developed through two Integrated Impact Assessments and further work with a Stakeholder Reference Group comprised of the voluntary sector, patient representatives, Healthwatch and engagement leads from partner organisations. It was intended that we would identify and address any gaps in our knowledge by engaging and consulting with the public and stakeholders.

Stage two allows us to undertake consultation activity with the public, stakeholders and seldom heard groups through to a mid-point review. Activity was analysed, initial themes from feedback and discussion were assessed to identify any gaps from earlier pre-consultation activity. It gathered additional knowledge and comments from a range of groups representing the nine protected characteristics and additional four characteristics identified by the Future Fit Programme Board: Carers, Rurality, Deprivation and Non English first language speakers, in particular Welsh language. This stage informed the activity for reaching seldom heard groups in the second half of the consultation.

Stage three encompasses the post consultation analysis and will present the findings of the public consultation alongside the impact analysis. The purpose will be to inform those making the decision on which option should be adopted and what potential mitigations may be required to address any impacts on protected characteristic groups that have been identified. The general duty cannot be delegated, so it is incumbent upon each CCG to demonstrate they have assessed how the Future Fit Programme may impact on their service users and the wider public in the area.

A Stage four final analysis document is produced once the decision on the Future Fit Programme has been made. This document will present the final decision, the reasons behind the decision, outline any proposed mitigations, and describe how the implementation of the Future Fit Programme will be monitored and reviewed.

4.1 Developing the EIA

This EIA builds on, a range of existing information, including but not limited to:

- Previous integrated and equalities assessment work including travel analysis reporting
- Previous integrated and equalities work relating to the impact of changes to the women and children's services
- Pre-Consultation Engagement Report summarising engagement from the Call to Action in 2013 through to the start of consultation
- Protected characteristics engagement report
- Future Fit Engagement with seldom heard groups
- Stakeholder feedback, including voluntary sector partners, Healthwatch and local authorities
- Health data and demographic profiles
- Local intelligence and information gathering as part of the face to face public and seldom heard group consultation activity
- Additional information and outputs from activity running alongside the formal consultation, including travel and transport impacts and the development of community activity

The Future Fit approach also includes an additional four groups who were identified by the Future Fit Programme Board as groups we particularly wanted to engage with:

  - People living in a rural area
  - People living in an area of deprivation
  - Carers
  - People whose first language isn't English, in particular Welsh speakers

During the course of the consultation we have also tried to identify which groups of people may:

  - access the services under consideration to a larger degree
  - have particular needs and therefore the impacts need to be considered

For instance, with four bases across the area, we have a large number of military personnel and their families. They are potentially larger users of acute services with specific additional needs identified. They have therefore been taken into consideration as part of the Future Fit approach.

Detailed stakeholder mapping was undertaken to ensure that as many groups belonging to the nine protected characteristics across Shropshire, Telford and Wrekin and Powys were engaged with during the consultation. Groups were asked what their preferred method of engagement is and wherever possible, the Future Fit team adapted its approach to meet the needs of particular groups. This included attending meetings at different times, on different days and in a variety of locations and adopting various approaches to interactions. Patients were offered consultation materials in different languages and formats on request to maximise the response rates from seldom heard groups and support was available to patients on request to understand and to respond to the consultation proposals, for example via an interpreter.

A mid point of the consultation review of engagement with people belonging to the nine protected characteristic groups was undertaken in order to identify uptake and check where groups have had low representation. This enabled groups with low response rates to be identified and informed engagement work for the remainder of the consultation. In light of previous work, representation was actively sought with:

- People under the age of 55 across the area
- Further BAME populations
- Gypsy roma traveller communities
- New migrants and asylum seekers

Equalities monitoring data was gathered as part of the consultation survey and themes from the consultation feedback of different groups will be included in the consultation report, which will inform the decision-makers. This analysis work will help identify groups which may be disproportionally negatively impacted compared to others. This impact can then be discussed with decision makers in order to fully assess any equality risks posed and mitigation actions required.

At the analysis stage, some responses may fall into more than one of the protected characteristics. This may mean that the level of impact may be higher for these individuals or groups of people. We will make every effort to fully understand the implications of this, for example, an older person who is disabled with complex health needs and finds it difficult accessing public transport due to cost and rural location is likely to be more impacted on than an older person without any other protected characteristics.

5.0 The proposed model of care

The proposed model of hospital care has been designed by members of the public and over 300 clinicians, GPs and social care professionals. Under either option it ensures that a wide range of hospital services will still be available at both hospital sites and, importantly, stay within the county. This includes outpatients, urgent care services, tests and patient wards. We believe that by changing our hospital services in this way, we will make sure patients receive safe, high quality NHS care now and in the future

From 40 potential clinical models, the process allowed the clinical commissioning groups to reach two options for consultation.

5.1 Rationale for developing a new model of care

The main reason we need to change our hospital services is to make sure our hospitals provide high quality, safe services for all patients for the long term. We want to make sure that, wherever possible, patients are seen by the right person at the right time in the right place.

It is becoming more difficult to make sure that we have enough doctors, nurses and other healthcare staff to provide a 24 hours a day, seven days a week service at both our hospitals. Although a similar picture can be seen across the country, this problem has a greater impact in Shropshire and Telford and Wrekin as we have two hospital sites that are less than 20 miles from each other that currently provide many of the same services.

We are finding it harder to recruit and keep the doctors and nurses that we need to care for patients at our two hospitals, particularly within our Accident and Emergency (A&E) departments and critical care services. Staff shortages have meant that our doctors have had to be on-call more often or work extra hours across two hospital sites in order to keep patients safe. We have also had to recruit temporary staff that are not as familiar with our hospitals and have therefore needed additional support.

All this has placed increasing pressure on our doctors and nurses who feel they cannot continue to work the number of hours a week that they do now. It has led to some doctors leaving to take up jobs at other hospitals where they can enjoy a better balance between their work and their personal lives.

The key reasons we cannot stay as we are and need to change include:

- workforce issues and problems in recruitment across a range of specialities, particularly A&E, critical care and Emergency Medicine
- poor workforce experience due to duplication of services across both hospitals
- workforce issues resulting in high levels of agency / locum cover which is costly
- staffing levels below recommended levels for A&E, critical care and emergency medicine
- issues related to quality of care and clinical standards due to staffing levels
- change in population profiles – change in demand with increasing demand due to increasingly older population with longer term and complex conditions – highest users of urgent and emergency care are frail older people
- estates surveys highlighting that investment is needed to improve the current standard of facilities and buildings across both hospital sites
- requirement for health providers to find most efficient way of delivering health care – current finances in deficit.

5.2 Developing the model of care

From the beginning, Future Fit has been led by doctors, nurses and other healthcare staff – the people who deliver our services day in, day out. Many members of public across the county took part in our ‘Call to Action’ survey and events and accepted that there was a need to make big

changes. They have since taken an active part in the design and development of the model of hospital care and been involved in the process we have gone through up to this point.

Over more than four years, we listened to and involved thousands of local people including NHS staff, patients and community groups. We held a series of public roadshows, focus groups, conducted surveys and delivered presentations to a wide range of audiences, from parish councils to young people's forums and senior citizen forums. We have conducted two Integrated Impact Assessments (IIAs) which assess the potential impact and equality effects of the changes we are proposing. These were taken into account as part of the CCGs' decision-making process in considering their preferred option.

The Pre-Consultation Business Case outlines that these proposals will result in overall improved outcomes for patients with improvements in:

- clinical effectiveness due to patients accessing most appropriate clinician
- ambulatory emergency care and reducing unnecessary admissions
- patient experience of their care
- delays and cancellations for planned care operations
- support for people with long term conditions due to earlier access to consultants
- waiting times to A&E and planned operations
- physical environment
- consistency in meeting NHS constitutional standards and quality indicators.

Factors leading to the model of care and the options on which we are consulting are fully documented within the Pre-Consultation Business Case November 2017. This is published on the Future Fit website www.nhsfuturefit.org.

5.3 Who will the proposals affect?

The Future Fit Programme acknowledges that the proposals may impact people differently depending on a range of factors. These include the actual service patients need, the distance they will need to travel and changes within other parts of the health service which may affect patient behaviour of how they use services. The proposals have been developed in line with other models of care which includes 'Home is normal', integrated care and use of technology.

The proposals affect all patients living across the areas of Shropshire, Telford and Wrekin and mid Wales who access hospital services at both Royal Shrewsbury Hospital and Princess Royal Hospital.

We understand that there may be higher impacts on certain groups due to the type of services being considered for change and these impacts are described in relation to each of the nine protected characteristics, and our other four identified characteristics, later in the document.

The map below shows the location of the two hospitals and the geography of the population we serve:

Demographic information highlights that communities living in these areas are diverse in terms of:

- Urban and rural communities
- Deprivation and associated health inequalities
- Demographic backgrounds – including age profiles, ethnicity, languages spoken

Appendix 1 has further information on the demographic profile of the population served by the two hospitals.

The figures below represent the access to hospital services and are based on data from 2016/17:

- Almost 120,000 people attended A&E of which 45,000 needed Emergency Care
- 75,000 patients currently using A&E could be treated within new 24-hour Urgent Care Centres at RSH and PRH
- There were over 50,000 planned operations at the two hospital sites
- There were over 400,000 consultant-led outpatient appointments at the two hospital sites
- 4,000 children had an overnight stay at PRH Women's and Children's Unit
- 170 children received care at Telford Children's Cancer Unit
- Over 4,000 women had a consultant-led birth at PRH Women's and Children's Centre
- Over 20,500 women had a maternity scan at one of the midwife-led units and 650 women gave birth in a midwife-led unit

Source: Future Fit shaping healthcare together – Case for Change; Future Fit shaping healthcare together – Pre-Consultation Business Case (November 2017)

5.4 Impact on patient choice

Patients who currently receive their hospital care in Shropshire and Telford and Wrekin would continue to do so under our proposed model of hospital care. Many services would remain at both hospital sites, for example urgent care services, adult and children's outpatients, tests, midwife-led units, antenatal and postnatal care and some gynaecology procedures. Some services are currently only available at one of the two hospital sites, for example acute surgery, acute stroke and children's inpatients and some patients already travel outside of our county to receive specialist care, for example major trauma and some cancer care. In total across our two hospitals, almost 80% of patients would continue to go to same hospital as they do now for emergency and urgent care. The out-of-hospital care strategies that are being developed will offer patients more care closer to home and greater choice. Any change to hospital services would mean that some patients have to travel further. However, our priority has to be around delivering safe, high quality and sustainable hospital services.

5.5 Services and their locations under the options

The main services that may change location post decision-making are:

- Emergency Care and Critical Care Unit
- Women's and Children's Unit
- Children's Cancer Unit
- Some Planned Care services particularly day case surgery
- Hyper Acute Stroke Unit

Option 1 (CCGs' preferred option) • **Emergency Care site is Royal Shrewsbury Hospital, Shrewsbury** • **Planned Care site is Princess Royal Hospital, Telford.**		
At the Royal Shrewsbury Hospital: • **24-hour Emergency Department (ED)** • **Critical Care Unit** • **Ambulatory Emergency Care Unit (AEC)** • **Emergency surgery and medicine** • **Complex planned surgery** • **Women and children's consultant-led inpatient services.**	At the Princess Royal Hospital: • Planned inpatient surgery • Day case surgery • Endoscopy • Breast inpatient services • Medical wards.	At both sites: • 24-hour Urgent Care Centre (By opening 24 hours a day, the new centres would be able to treat most patients who currently attend one of our existing A&E departments) • Adult and children's outpatient services • Day Case Renal Unit • Tests (diagnostics) • Midwife-led unit • Antenatal Day Assessment Unit • Early Pregnancy Assessment Service (EPAS) • Maternity outpatients and scanning.

Option 2 • **Emergency Care site is Princess Royal Hospital, Telford** • **Planned Care site is Royal Shrewsbury Hospital, Shrewsbury.**		
At the Princess Royal Hospital: • **24-hour Emergency Department (ED)** • **Critical Care Unit** • **Ambulatory Emergency Care Unit (AEC)** • **Emergency surgery and medicine** • **Complex planned surgery** • **Women and children's consultant-led inpatient services.**	At the Royal Shrewsbury Hospital: • Planned inpatient surgery • Day case surgery • Endoscopy • Breast inpatient services • Medical wards.	At both sites: • 24-hour Urgent Care Centre (By opening 24 hours a day, the new centres would be able to treat most patients who currently attend one of our existing A&E departments) • Adult and children's outpatient services • Day Case Renal Unit • Tests (diagnostics) • Midwife-led unit • Antenatal Day Assessment Unit • Early Pregnancy Assessment Service (EPAS) • Maternity outpatients and scanning.

Notes

- **Emergency care** is unplanned care that patients receive in a life or limb-threatening situation
- **Urgent care** is care for illnesses and injuries that are not life or limb-threatening but require urgent attention
- **Planned care** is operations, procedures and appointments that are planned in advance.

Full details on the proposals are documented in the Pre-Consultation Business Case (November 2017).

6.0 Pre-consultation engagement

6.1 Background

A range of pre-consultation engagement work was undertaken by the Future Fit Programme across Shropshire, Telford and Wrekin and mid Wales which has informed our current knowledge of patient impacts, particularly on the nine protected characteristics. It was important that work included people living in mid Wales as a proportion of these patients rely on hospital services provided by The Shrewsbury and Telford Hospital NHS Trust.

Pre-consultation engagement work followed initial engagement activity as part of the 'Call to Action.' In summary, this included:

- Public engagement to inform the Integrated Impact Assessment (IIA) and Women and Children's IIA
- Focus groups involving listening to patients, families, public and seldom heard groups
- Pop-up information stands in town centres and public places such as libraries, hospitals and shopping areas – 20 events over an 11 month period.
- Telephone and online surveys
- Responses to written requests for information
- Information through articles and adverts in newspapers
- Live radio interviews with phone-in questions from listeners
- Flyers and publications
- Social media information and feedback through twitter and Facebook
- Promotion of information and gaining feedback through the Future Fit website www.nhsfuturefit.org
- Involvement with voluntary sector supporting engagement work with black and minority ethnic groups who may not speak English as their first language

More information can be found in the pre-consultation engagement report.

6.2 Key themes emerging from pre-consultation engagement work

Pre-consultation engagement work over a few years enabled the Future Fit Programme to raise awareness of the programme ready for formal consultation on the two options. The initial engagement with seldom heard groups has also provided a good network of engagement opportunities for the formal consultation. The Pre-Consultation Engagement Report provides full details of all of this work. A summary of the key themes from protected characteristic groups can be found below:

Protected characteristic	Key themes
Age	Older people – distress of having procedure cancelled and continued pain. Services for older people living in a rural area aren't adequate; they have to travel a long way to receive care. Want shorter waiting times and appointments near to home. Young people – language barriers (Powys)

Sex	No specific themes identified.
Sexual orientation	Urgent care centre in both towns would be good but concerned if emergency centre was in other town. Concern about waiting for an ambulance/paramedic skills; people might die. Concern about getting home from emergency site for patients and visitors.
Disability	Having a local urgent care centre is a good idea. It wouldn't be an issue to travel to emergency centre as ambulance would take you. People are more likely to call an ambulance. Travel isn't a problem except it's tiring. There could be an increased risk of death due to greater travel time. Cost and availability of transport to Shrewsbury, particularly out of hours. Parking at RSH will get worse. Improved wheelchair access and transport, particularly at RSH. Want as much care as possible at local practice, close to home.
Race	Having an emergency centre nearby is good but less interested in location as would call 999. Travellers might not be registered with a GP so might access A&E more. Information needs to be in different languages.
Religion	Very keen on separation of diagnosis and treatments to reduce cancelled appointments. Like idea of urgent care centres in both towns. Less concerned about location of emergency centre, more about best hospital service.
Pregnancy and maternity	Maternity services should be next to emergency care. Concern about risk to children if longer journey time by ambulance. Some more concerned about high quality service.

	More treatments at GP surgeries would reduce need to go to A&E.
Gender reassignment	No specific themes identified.
Marriage and civil partnership	No specific themes identified.

Feedback from other groups

Homeless people – Transport difficulties; if they were taken to hospital by ambulance, how would they get back?

Carers – A separate diagnostic and treatment centre is a good idea.

People with drug and alcohol problems – Concern about time to get from Telford to Shrewsbury by ambulance.

People living in a rural area – Travel anywhere is problematical (Powys), Shrewsbury is more accessible for people living in Powys, distance is already an issue, need urgent care close to where people live.

7.0 The consultation

7.1 Reaching seldom heard groups

People across Shropshire, Telford and Wrekin and mid Wales were asked for their views on proposals to transform local acute hospital services as part of the NHS Future Fit public consultation which ran from 30 May to 11 September 2018.

Our engagement work included organising and attending meetings and circulating information aimed at the general public and specific engagement with people from one or more the nine protected characteristics and the four additional groups identified by the Future Fit Programme Board who we particularly wanted to engage with:

- People living in a rural area
- People living in an area of deprivation
- Carers
- People whose first language isn't English, in particular Welsh speakers

These areas and groups were included when planning events and a range of different tools were used to raise awareness about the consultation amongst these groups specifically, including social media. It was important to include people living in a rural area as some of these communities may have challenges relating to travel, access to public transport and accessing health provision near to home. It was also important to include

people living in an area of deprivation as they may have lower car ownership than people living in other areas and they might be more impacted on by increased travel costs. Similarly, carers and people who don't speak English as their first language might also have increased barriers to accessing health care and therefore might be more impacted on by the proposals.

In order to engage with as many people as possible from the protected characteristics, and recognising that it is not always easy to identify and engage with these groups, we took a very flexible approach. We took advice from the voluntary sector about how we could target different groups and offered different engagement opportunities depending on the different needs of the groups. This included attending their existing meetings and events at times and in locations convenient for them, speaking to individuals rather than groups where appropriate and providing consultation information in an appropriate format if attending a meeting was either not possible or not suitable during the consultation period.

We produced our consultation materials in a range of formats, including easy read, as a Word document for use by screen readers and large print and Welsh. We also gave people an opportunity to request materials in additional languages and formats. As part of the consultation survey, we asked for equalities monitoring data, which enabled us to review the response rates for the different groups at the mid point stage and to adapt our approach and targeted engagement work as appropriate.

As part of the consultation, we commissioned three voluntary and social enterprise sector organisations to provide additional activity to reach people with one or more of the nine protected characteristics and the additional four characteristics.

We used various tools to inform local people about the consultation including the Future Fit website, the local media, social media, posters and materials in public places, distribution of materials via voluntary and other local organisations and attendance at meetings and events including:

- Meetings/focus groups with seldom heard groups: 222
- Circulation of consultation materials to seldom heard groups or information for use in newsletters and social media: 49

Further details about engagement with seldom heard groups can be found in Appendix 3.

Healthwatch Telford and Wrekin, Healthwatch Shropshire and Powys Community Health Council have assisted in raising awareness of the public consultation and encouraged people to have their say. They also attended the 10 larger public exhibition events and engaged with people about Future Fit in their local areas. Their involvement in no way endorsed the clinical model or proposed changes. Their interest was in making sure the public is informed, could have their say and have their views are recorded and taken into account when final decisions are taken about service changes.

We also ensured that we engaged with groups of people who:

- access the services under consideration to a larger degree
- have particular needs and therefore the impacts need to be considered

For example, with four bases across the area, we have a large number of military personnel and their families. They are potentially more frequent users of acute services with specific additional needs identified and therefore it was important to consider their views as part of the Future Fit consultation. We also identified that homeless people may have specific health needs and some barriers to accessing health care, which might cause them to be impacted on more than other groups and therefore we made special efforts to engage with homeless people as part of the consultation.

7.2 Consultation responses

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

7.2.1 Consultation survey – demographic data

A far higher percentage of women (61%) compared to men (36%) completed the consultation survey and over 50% of respondents were over the age of 59. This imbalance was recognised at the mid point review and therefore extra efforts were made in the second half of the consultation to engage with younger, working age people, particularly men.

8 people defined their gender as intersex and 55 people said that they had had or were having gender reassignment treatment/surgery.

As we would expect from the demographic profile of Shropshire, Telford and Wrekin and Powys, the large majority of respondents (88%) told us that they were White British. We did, however, receive survey responses from 365 people of non-White backgrounds.

Again as we would expect from our local demographic profile, the majority of respondents (59%) defined their religion as Christianity, however, there was a large percentage of respondents who preferred not to tell us their religion or who said they had no religion (37%.) We also had responses from people of a number of different religions including Hinduism, Judaism, Buddhism, Islam, Sikhism and “Other” – 685 in total.

A large majority of respondents told us that they were heterosexual (89%) but we also had 342 responses from gay, lesbian and bisexual people. 80 people defined their sexuality as “Other” and 1493 preferred not to say.

20% of respondents stated that they had a child under the age of 16 and 19% told us that they had a disability. 16% of respondents also told us that they cared for friend or relative.

7.2.2 Focus groups and meetings for seldom heard groups – demographic data

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

A similar percentage of males (47%) and females (52%) took part in our focus groups and meetings. 1 person defined their gender as intersex and 2 people said that they had had or were having gender reassignment treatment/surgery.

The age profile of focus group/meeting participants is similar to survey respondents, with the majority of people aged over the age of 59 (59%.)

A lower percentage of people who took part in our focus groups/meetings told us that they were White British (56%) than respondents to the consultation survey but a higher percentage said that they were Indian (33%.)

A lower percentage of participants compared to survey respondents also told us that they were Christian (26%), and 33% of people who took part in our focus groups and meetings told us that they were Sikh.

These differences are probably because our focus groups and meetings specifically targeted seldom heard groups including people from different ethnic and religious backgrounds.

90% of participants told us that they were heterosexual. 19% of people told us that they had a child under the age of 16. This is similar to the survey respondents.

33% of participants told us that they had a disability, which is higher than the survey respondents. Again, this is probably because we specifically sought to engage with people with a physical, mental, learning or sensory disability as part of the consultation.

15% of participants told us that they were a carer.

More detailed information about the number and percentage of responses from different protected characteristic groups can be found in Appendix 4.

7.2.3 Focus groups and meetings for seldom heard groups - themes

Where it has been possible to identify themes from the consultation meetings from a particular protected characteristic group, these have been highlighted below. However, generally, the feedback from our meetings and events with these groups was generally very similar to that of the general population in the areas where the participants lived.

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

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

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

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

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

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

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

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

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

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

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

8.0 Profile of the Affected Population

This section contains summary demographic information about the three locality areas: Shropshire, Telford and Wrekin and Powys. The information provided is broken down by clinical commissioning group/health board and local authority area.

The majority of this data has been collated from Public Health England sources for Shropshire and Telford and Wrekin areas. Data on Powys is not accessed through Public Health England, however best match data has been collated through Public Health Wales Observatory – Health Needs Assessment and Powys Local Authority data for Wales.

Full details with tables can be found in Appendix 1.

8.1 Age

Data on age profiling shows that there is a higher percentage of older people (aged 50+) living in Shropshire and Powys overall compared to Telford and Wrekin but there is a higher number of middle-aged (30-44) people living in Telford and Wrekin. There is also a higher percentage of younger people living in Telford and Wrekin compared to Shropshire and Powys, with the percentage of 0-19 year olds being higher than the national rate. Interestingly, in Powys, the percentage of 5-9 year olds is higher than in Shropshire, Telford and Wrekin and the national rate. It should be noted, however, that based on the actual number of people, there is a larger number of under 19 year olds in Shropshire.

There is a slightly lower percentage of males than females living in Telford and Wrekin but for a certain age groups, for example 0-9 and 15-54, the percentage of males is higher. The percentage of women over the age of 55 is higher than for men.

In Shropshire, there is a projected decline in the age groups below 65 years of age and growth in the older age groups above 65 years. Of particular concern for service providers is the more than doubling of the elderly population, as this age group places the greatest demand upon services.

- The younger age groups in Shropshire (0-4 years and 5-15 years) are projected to decline by 6.8% and 5.7%, respectively, by 2041. By 2041, the early year's population will represent only 4.1 % of Shropshire's total population and the school age population only 10.3%.
- The older population (65 years and over) in Shropshire is projected to grow by 54.3%, from 74,300 in 2016 to 114,600 by 2041. By 2041, this population group will represent just over a third of Shropshire's population.
- The Shropshire population is predicted to grow by 3.9% in the short-term to 2026 and by 7.4% in the long-term to 2041.
- By 2041, Shropshire's population is projected to reach 337,800, from 314,400 in 2016.
- The average age in Shropshire is projected to change from 43 years in 2016 to 46 years in 2041. In comparison, nationally the average age will grow from 39 years to 41 years and regionally from 39 years to 40 years.

Source: Summary analysis 2016 sub-national population projections to 2041 for Shropshire (released by Office for National Statistics 24 May 2018)

In Telford and Wrekin, the population is growing, changing and ageing:

- The proportion of the population who are aged under 20 is decreasing (26.1% in 2010, 25.8% in 2015), as is the working age population (65.2% in 2010, 63.2% in 2015).
- The proportion of the population aged over 65 is increasing (14.3% in 2010, 15.9% in 2015), with 27,200 residents now in this age group.
- The population of the borough is projected to grow at a faster rate than the England population (T&W 13.4%, England 10.2%) and is projected to grow to 196,900 by 2031, an increase of some 23,300 people.
- Over half of the population increase will be in the over 65 age group (12,300 people), with the 85+ age group more than doubling (+117.6%) and the 65-84 age group increasing by a third (33.1%).

Source: A demographic and socio-economic profile of our communities. Organisational Delivery & Development, Telford & Wrekin Council 2017

Direct data comparison is not available for Powys however projections contained within Local Authority Population Projections for Wales document indicate that population is estimated to decrease by eight per cent by 2039. Within Powys, there is a predicted fall in young people due to moving to urban areas and an increase in older people aged 65 and above by 37 per cent and an increase in people aged over 85 by 121 per cent by 2033. *Source: Pre-Consultation Business Case section 9.4.1*

8.2 Disability

Data on rates of disability / long term conditions indicates that across all localities, rates are higher than the England rate. Rates are slightly higher for Powys and lower for people living in Telford and Wrekin. However, this data relates to long term conditions which may not include people with a learning disability or a mental health problem.

8.3 Gender Reassignment

There are no national or local government statistics available on gender reassignment. The Gender Identity Research and Education Society (GIRES) estimates that one per cent of the population is transgender.

8.4 Marriage and Civil Partnership

The percentage of married people living in Shropshire and Powys areas is above the England average but lower for Telford and Wrekin. The rate of same sex civil partnerships is generally low for England. The rate for civil partnerships is lower than the England rate for Shropshire and Telford and Wrekin but the same as the England comparator for Powys.

8.5 Pregnancy and Maternity

In 2015, there were 47,400 (30.2%) women of childbearing age (16-44) in Shropshire and 31,300 (36.3%) in Telford and Wrekin. In Shropshire, there are an average of 3400 conceptions each year and in Telford and Wrekin, 2615. It is estimated that 2700 (5.8%) women of childbearing age live in an area of deprivation in Shropshire and 8900 (28.6%) in Telford and Wrekin.

Source: Improving Outcomes for Maternity Services in Shropshire and Telford and Wrekin 2017 - 2021

SaTH Maternity Services Births 2016/17:

Maternity Unit	Shropshire patients	Telford and Wrekin patients	Powys patients	Patients from other areas
Consultant Unit	2016	1830	216	132
Shrewsbury MLU	142	0	0	0
Wrekin MLU	135	199	0	3
Bridgnorth MLU	67	2	0	8
Oswestry MLU	50	0	0	2
Ludlow MLU	31	0	0	5
Home	41	21	1	1

Born after arrival (without presence of midwife or obstetrician)	8	8	2	8
Total	2490	2060	219	159

During 2016-17, over 4,000 women had a consultant-led birth at the Women's and Children's Centre at Princess Royal Hospital and almost 650 women gave birth in one of the midwife-led units.

Source: https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

The vast majority of births were in relation to Shropshire, Telford and Wrekin patients. More women from Shropshire and Powys (2232) gave birth at the consultant-led unit than women from Telford and Wrekin (1830) in 2016/17.

In 2017, there were 697 births to women from Powys in a Welsh hospital (including Powys MLUs) and 310 in an English hospital.

Source: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Primary-and-Community-Activity/Community-Child-Health/livebirths-by-localhealthboardresidence-placebirth

8.6 Race

All areas are predominantly White British and have higher percentage of White British people than the England rate. In comparing all areas, Powys has the highest White British rate – 96.6 per cent.

There is a higher percentage of Black, Asian, Minority and Ethnic groups (BAME) in Telford and Wrekin compared to Shropshire and Powys. However, all groups have a lower percentage than the England rate apart from "Mixed/Multiple Ethnic Groups: White and Black Caribbean" which is slightly higher.

8.7 Religion and Belief

Across Shropshire, Telford and Wrekin and Powys there is some variation in religion and belief. Compared to the England rate, the number of people of Christian belief is higher than other religions in all the areas. For other religions such as Hindu, Muslim and Sikh, the rates are significantly lower than the England rates. There is a significantly higher number of people with different religions living in Telford and Wrekin than in Shropshire and Powys. There is a small Mennonite/Amish community in South Shropshire.

The percentage of people identifying themselves as having no religion varies across the different areas, with the highest rate in Powys.

8.8 Sex

Male and female populations across Shropshire, Telford and Wrekin and Powys are in line with the England population rates. There is a slightly higher female than male population across all three areas.

8.9 Sexual Orientation

Sexual orientation is not asked for by the Census, however Stonewall estimates that the LGBT population in England is between 1.5 to 5.85 per cent. The Office for National Statistics estimates that the number of LGBT people as part of the general population in England and Wales is 1.7 per cent. Additional information from Stonewall indicates that younger age groups are more likely to disclose that they are gay compared to older people. Source: https://www.stonewall.org.uk/sites/default/files/lgbt_in_britain_home_and_communities.pdf

8.10 Other key groups to consider within the Future Fit Programme

As part of our pre-consultation engagement work, the Future Fit Programme Board identified four additional groups whose views they were keen to listen to and understand, these are:

- People living in a rural area
- People living in an area of deprivation
- Carers
- Welsh speakers

8.10.1 People living in a rural area

Within the three localities impacted on by this consultation, the main rural areas are in Shropshire and Powys.

Overall Shropshire is a rural county with around 66% of the population living in what is classified as a rural area. Around 34% of the population reside in areas classed as being urban. Much of the south west of Shropshire is classified as being sparsely populated. These areas are highlighted on the map in Appendix 1.

The rural area of Telford and Wrekin covers some 20,951 hectares to the west of Telford town centre and although this is the largest area of the Borough, it has the lowest population density at 0.7 people per hectare. The population of the rural area grew by some 15.8% or 1,883 people between 1991 and 2001, some 3.9 percentage points above the Borough-wide rate of 11.9%. Conversely, the number of households grew by a lower rate, 19.4%, than the Borough-wide rate, 21.7%.

The majority of the Powys population lives in villages and small towns. The largest towns are Newtown, Ystradgynlais, Brecon, and Welshpool with populations of 12,783, 9,004, 7,901 and 6,269 respectively (2001). Powys has the lowest population density of all the principal areas of Wales. Much of Powys is upland or mountainous making north-south transport difficult. As a result of the county's large rural areas, there are high levels of rural poverty. For more detail on rural poverty in Powys, see the section on Deprivation below.

For a detailed description of how different areas are classified as rural, please follow this link: https://www.gov.uk/government/statistics/2011-rural-urban-classification

8.10.2 People living in an area of deprivation

Across the three localities under consideration as part of this consultation, Telford and Wrekin has the highest levels of deprivation. Telford and Wrekin has significant pockets of deprivation, but due to the diverse nature of the Borough, it also has areas in the least deprived areas nationally.

According to Government statistics, a total of 15 areas in the Borough are ranked in the 10% most deprived nationally, in the wards of Woodside (x4), Malinslee and Dawley Bank (x3), Madeley and Sutton Hill (x2), Brookside (x2), Hadley and Leegomery, Dawley & Aqueduct and College. The 2015 picture of the most deprived areas in Telford and Wrekin looks very similar to 2010 with new areas in Haygate, Park and Dothill and additional areas in Hadley and Leegomery and The Nedge. More than a quarter (27%) of the Borough's population lives in the 20% most deprived areas nationally, an increase on 24% in 2010.

People living in Shropshire are relatively more affluent compared with the national average. Despite this, the Pre-Consultation Business Case notes that this often masks groups of people who are living in poverty. There is also significant rural deprivation in parts of Shropshire, with access to transport and higher costs for everyday essentials being a challenge for people particularly in the far south and north of the county. In terms of average rank, Shropshire ranks 107th out of 152 local authorities in England (a rank of 1 being considered the most deprived area.)

All of the most deprived areas in Shropshire are in urban areas, with the five highest ranked being in Harlescott (Shrewsbury), Monkmoor (Shrewsbury), Ludlow East, Oswestry South and Meole/Bayston Hill, Column and Sutton. (All nine Shropshire LSOAs that fall within the 20% most deprived in England are located within urban areas of the county. Harlescott is the only area that falls within the 10% most deprived nationally.

There are different types of poverty that affect can affect people living in rural areas of Powys and Shropshire. Financial poverty in rural areas is different to that of urban areas. For example, vehicle ownership is not suitable as an indicator for poverty because people need to have a

car in order to travel to work and, or, may need a car to access public transport. Rural populations are therefore more likely to own a car than urban populations.

Populations in Powys and rural areas of Shropshire tend to be located in small towns and villages, often with poor connecting road and rail links, which poses a major challenge for access to services. In Powys, for example, 19.4% of patients have to travel over 15 minutes to access a GP, and this problem is far more acute in the north of the county (22.6% of patients) than in the south (11.9%). In total, there are 26,330 registered patients in Powys that have to travel more than 30 minutes for a round trip to the GP. If the patient does not have the time or transport access to attend an appointment, they might not seek help, and the potential benefits of identifying health issues early will not be met. These issues are compounded by an absence of District General Hospitals in Powys.

In Powys,27% of households do not have internet access. For those who do have internet, it is often low quality- with average speeds of between 0.1 and 8.5 Mbit/sec, compared to 29.8 Mbit/sec across the UK. Digital technology influences how we work, communicate, consume, learn, engage and think. Technology has enabled more personal services, cheaper goods and products, more choice, wider connections, and improved access to knowledge and communication.

For a detailed description of how different areas are classified as areas of deprivation, please follow this link:
https://www.gov.uk/government/statistics/2011-rural-urban-classification

8.10.3 Carers

There is a higher proportion of carers in all three areas than the national comparator, with Powys having the highest percentage of people providing unpaid care.

8.10.4 Welsh speakers

It is recognised that within the White British communities in Powys, there are people that speak Welsh as their first language. The greatest percentage of Welsh speakers in Powys is concentrated in the north west of the county while the south west of Powys, including Ystradgynlais, is a stronghold of the language in Brecon and Radnorshire. 21% of Powys residents speak Welsh according to the National Survey for Wales 2017/18.

8.10.5 Other groups

There is a high proportion of military families in Shropshire and Telford and Wrekin due to the number of local military bases.

According to a report by housing charity, Shelter, in 2017, the number of people recorded as homeless in Shropshire was around 462. This figure combined official rough-sleeping, temporary accommodation and social services figures. However, as government records are not definitive, the true figure of homelessness is likely to be even higher. Welsh government data from 2017/18 suggests that 63 households were identified as unintentionally homeless and in priority need. The total number of homeless applications received in Telford and Wrekin in 2016/17 was 176.

According to Government statistics for rough sleepers in England in Autumn 2017, there were 13 rough sleepers in Shropshire, all of whom were UK nationals, all but one male and all but one over the age of 25. In Telford and Wrekin, 10 UK male rough sleepers were identified, three were aged 18-25 and seven aged over 25. According to the National Rough Sleeper Count in November 2017, in Powys, it is estimated that over a 2 week period October 2016 – October 2017, 3 people were sleeping rough,

A number of refugees and asylum seekers live in the areas that are likely to be impacted on as part of this consultation. In Powys, Syrian families comprising 32 people are accommodated in Ystradgynlais, Newtown and Llandridod Wells. In Shropshire, Syrian families comprising 63 people have been resettled in four different locations throughout Shropshire – Oswestry, Shrewsbury, Wem and Much Wenlock. In Telford and Wrekin, there are seven families comprising 34 people who are all accommodated in North Telford.

9.0 Potential impacts on protected characteristics and other groups

This section provides details of the potential impacts that have been identified on each of the protected characteristics as a result of the two proposed options. Appendix 2 provides descriptions of the protected characteristics.

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

9.1 Age

9.1.1 Age profile summary

Data on age profiling shows that there is a higher percentage of older people (aged 50+) living in Shropshire and Powys overall compared to Telford and Wrekin but there are more middle-aged (30-44) people living in Telford and Wrekin. There is also a higher percentage of younger people living in Telford and Wrekin compared to Shropshire and Powys, with the percentage of 0-19 year olds being higher than the national rate. Interestingly, in Powys, the percentage of 5-9 year olds is higher than in Shropshire, Telford and Wrekin and the national rate. It should be noted, however, that based on the actual number of people, there is a larger number of under 19 year olds in Shropshire. In all areas, there is a predicted increase in the number of older people.

9.1.2 Service change impacts

The services that could change location as part of these proposals will have greater impact on certain age groups:

- Consultant led maternity services (women of child-bearing age and babies)
- Paediatric services (children and young people)
- Emergency care (children and young people – particularly young men, older people)
- Planned care (older people)
- Stroke services (older people, working age people, children)

The level of impact on the age groups may be increased if they live in rural and/or deprived areas. A change in location of services may have an impact on travel access, time and cost for some people.

Consultant led maternity services

By their nature, any changes to maternity services are most likely to impact on mothers and their babies. Women of child-bearing age would therefore be impacted on. Babies requiring neo-natal care are a group requiring specific consideration due to the intensive care they need, sometimes for a prolonged period and the impact that this can have on parents and families.

Our local hospital activity data tells us that the most likely age groups for women to use maternity services are 20-24, 25-29 and 30-34 although there are some differences in usage by age across Shropshire, Telford and Wrekin and Powys. Interestingly, there was a higher number of women using maternity services from the Shropshire CCG/local authority area in 2017/18 in the 30-34 year age group (757) than 25-29 year olds (717). There was also a relatively high number of women aged 35-39 in Shropshire who used maternity services – 413. Powys women using maternity services had a similar age profile to Telford and Wrekin maternity patients. As older women are more likely to have complicated

pregnancies and therefore are more likely to use a consultant-led maternity unit, there would be a positive impact for more older pregnant women living in Shropshire, particularly in the North and South of the county, if the Women's and Children's Centre were to be based at RSH. For more detail, please see appendix 6. *Source: Shrewsbury and Telford Hospital Trust maternity activity data 2017/18.*

There was a similar number of teenage women accessing maternity services from Shropshire/Powys (99) compared to Telford and Wrekin (111) in 2017/18. As teenage women are more likely to have complicated pregnancies and may have an increased need to access a consultant-led maternity unit, there would be a positive impact for teenage women living in Shropshire and Powys if the Women's and Children's Centre were to be based at RSH, however, the opposite would be true for pregnant teenagers living in Telford and Wrekin, particularly if they live in an area of deprivation. For more detail, please see appendix 6. *Source: Shrewsbury and Telford Hospital Trust maternity activity data 2017/18.*

Paediatric services

Paediatric services will be used by children and young people from when they are born to the age of 16, therefore these age groups and their parents/carers are most likely to be impacted on by changes to these services. Although there is a higher percentage of children and young people, as part of the overall population, living in Telford and Wrekin, the actual number of children and young people under the age of 19 is highest in Shropshire.

Our local hospital data tells us that 0-4 year olds are by far the most likely age group to use inpatient paediatric services across all three areas, with the highest number of paediatric inpatients in this age group coming from Shropshire and Powys (5500) compared to 4397 from Telford and Wrekin in 2017/18. For more detail, please see appendix 6. *Source: Shrewsbury and Telford Hospital Trust inpatient paediatrics activity data 2017/18.*

The Human Right to a family life might need to be considered where parents and families have to visit and support children who might be admitted for longer or more frequent stays in hospital.

Emergency care

There are certain age groups who tend to access A&E services more than other age groups. People aged 80+ have the highest rates of A&E attendance. In terms of raw numbers, ages 20-24 are the most common adult attendees. Young children up to the age of 4 also have high attendance rates. *Source: Briefing paper – A&E statistics – demand, performance and pressure – February 2017.*

Our local A&E data tells us that the age group with the highest attendance rate in 2017/18 was for 0-4 year olds, followed by 20-24, 25-29 and 15-19 year olds living in Shropshire and Telford and Wrekin. However, for patients from Powys, the highest attendance rates were for 15-19 year olds and 70-74 year olds followed by 20-24 year olds, 65-69 year olds and 25-29 year olds. Some studies have looked at the impact of a combination of distance, deprivation and age on A&E attendance, which may help to explain why there tend to be fewer A&E attendances for children from Powys. For example: *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0067943* found that children's attendances decreased with distance from A&E more than those of adults, with one kilometre associated with a 2.2% reduction in attendance,

and *https://injuryprevention.bmj.com/content/1/3/173.short* found a significant decrease in attendance of children with minor childhood injuries associated with distances. Potentially this indicates that the closer you live to an A&E, particularly if in deprived areas, the more likely you are to attend for non-urgent conditions that may be "better dealt with in a primary care setting." For more detail, please see appendix 6. *Source: Shrewsbury and Telford Hospital Trust A&E activity data 2017/18.*

There is a higher percentage of older people aged 50+ living in Shropshire and Powys and the actual number of older people is much higher in Shropshire than in Telford and Wrekin and Powys. This means that there would be a higher number of Shropshire patients who would be negatively impacted on if the emergency centre was based in Telford.

There are differences in suicides rate among men, particularly young men (aged 25-44), which may indicate a greater likelihood of young men requiring A&E services. *Source: Equality and Human Rights Commission (2010) How fair is Britain? Equality, Human Rights and Good Relations in 2010. The First Triennial review. Manchester: Equality and Human Rights Commission.*

Even though the percentage of young men aged 25-44 as part of the general population is higher in Telford and Wrekin (27.1%) than in the other two areas, the actual number of young men in this age group is higher in Shropshire (71, 076) as opposed to 45,137 in Telford and Wrekin. This means that there would be a negative impact for a larger number of young men if the emergency centre were to be located in Telford.

Falls are a major cause of disability and death in older people and these can often lead to increased attendance at A&E departments. Source: https://academic.oup.com/ageing/article/45/6/789/2499223

The impact on children and young people would be the same for A&E services as it would for paediatric services as it is proposed that these services would be co-located on the same site.

Planned care

Long-term conditions are more prevalent in older people (58 per cent of people over 60 compared to 14 per cent under 40). People with long-term conditions now account for about 64 per cent of all outpatient appointments and over 70 per cent of all inpatient bed days. *Source:* https://www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-long-term-conditions-multi-morbidity

Osteoarthritis (OA) is extremely common, particularly among elderly people. It represents a major cause of morbidity, disability and social isolation, especially where the hip and knee are involved. *Source:* https://www.birmingham.ac.uk/Documents/college-mds/haps/projects/HCNA/08-CHAP82.pdf

Hip and knee replacement surgery (arthroplasty) is widely performed, particularly for the treatment of severe osteoarthritis. The prevalence of arthritis increases with age, and an ageing population means that demand for these forms of surgery will continue to rise. *Source: Journal of Public Health, Vol 28, Issue 3, Sept 2006.*

Our local hospital data confirms that older people in the 65-69 and 70-74 age groups are more likely to access planned care services across all three areas. In 2017/18, over twice the number of patients in these age groups used planned care services at the Shrewsbury and Telford

Hospital Trust from the Shropshire CCG/local authority area (8320) than patients living in Telford and Wrekin (4154.) Less than one thousand patients from Powys accessed SaTH planned care services in the same year. This means that there would possibly be a negative impact on more people living in Shropshire, particularly in the North and South, if the main planned care site were to be located at PRH in Telford under option one but there would be a positive impact for older people in Shropshire who needed to access planned care services under option two. For more detail, please see appendix 6. *Source: Shrewsbury and Telford Hospital Trust A&E activity data 2017/18.*

Stroke services

People are also most likely to have a stroke over the age of 55 and In England, Wales and Northern Ireland the average age for men to have a stroke is 74 and the average age for women to have a stroke is 80. *Source: Stroke Association – State of the Nation, Stroke Statistics January 2017.*

However, while most people who have a stroke are older, younger people can have strokes too, including children. One in four strokes in the UK happens to people of working age. *Source: Stroke Association*

Travel impacts

Research for the Campaign for Better Transport (2013) explored how changes in UK government funding have impacted on young people, including increasing debts, high usage of public transport, low car usage (also for older people), and increased transport costs. This may increase the impact on these age groups if services are moved further away from where they live.

Each of the options would potentially have a disproportionate effect on men aged 30-59 who undertake high levels of road travel, depending on where they live, as research has demonstrated a link between congestion and mental health. *Source: Future Fit Integrated Impact Assessment (2 November 2016) – 5.4.6*

9.1.3 Themes from consultation feedback

Detailed themes from the consultation feedback received at focus groups and meetings from people from different age groups can be found in Appendix 5.

9.2 Disability

9.2.1 Disability profile summary

There is a higher number than the national average of patients with a longer-term condition living in all Shropshire, Telford and Wrekin and Powys. In Shropshire there are 10.2% (31,258) people who have a long-term condition/disability where activities are limited a little compared

to 9.6% (15.935) in Telford and Wrekin and 11.1% (7686) in Powys. Disabled people make up a significant percentage of the population (*ONS Census 2011data: 9.5 million people have a limiting long-term illness or impairment*) and we know that disabled people are likely to use health services more frequently than non-disabled people, although monitoring data is not as well developed as it is for race, gender and age.

The definition of disability in the Equality Act 2010 includes people with a physical or sensory impairment, people with a learning disability and people experiencing mental distress, as well as people with other long-term conditions that have a substantial and long-term effect on the ability to carry out daily activities.

According to the World Health Organisation, people with disabilities report seeking more health care than people without disabilities and have greater unmet needs. For example, a recent survey of people with serious mental disorders, showed that between 35% and 50% of people in developed countries, and between 76% and 85% in developing countries, received no treatment in the year prior to the study.

Health promotion and prevention activities seldom target people with disabilities. For example women with disabilities receive less screening for breast and cervical cancer than women without disabilities. People with intellectual impairments and diabetes are less likely to have their weight checked. Adolescents and adults with disabilities are more likely to be excluded from sex education programmes.

Co-morbid conditions occur in addition to (and are unrelated to) a primary health condition associated with disability. For example the prevalence of diabetes in people with schizophrenia is around 15% compared to a rate of 2-3% for the general population.

The ageing process for some groups of people with disabilities begins earlier than usual. For example, some people with developmental disabilities show signs of premature ageing in their 40s and 50s.

Some studies have indicated that people with disabilities have higher rates of risky behaviours such as smoking, poor diet and physical inactivity.

Mortality rates for people with disabilities vary depending on the health condition. However an investigation in the United Kingdom found that people with mental health disorders and intellectual impairments had a lower life expectancy.

Source: http://www.who.int/news-room/fact-sheets/detail/disability-and-health

People with a learning disability have worse physical and mental health than people without a learning disability. On average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population; and the life expectancy of men with a learning disability is 14 years shorter than for men in the general population *Source: NHS Digital 2017*

People who have dementia also fall within the definition of disabled people under the Equality Act. Despite some improvements, people with dementia continue to have poorer outcomes in hospital compared to those without dementia. *Source: State of Care report 2012-13*

Disabled people with other equality characteristics can face multiple disadvantages. For example, some ethnic groups have a higher proportion of the population who are disabled. 25% of people in both White Irish, and White gypsy and traveller groups are disabled.
Source: Care Quality Commission 2013 Disability and Ethnicity Equality Counts

Barriers to accessing healthcare for disabled people include transport issues, accessing information and communication can create significant barriers to accessing healthcare services for people with sensory loss or learning disability:
Research by RNIB Cymru and Action on Hearing Loss (2012) looking at issues in accessing healthcare for people with sensory loss found:

- 35% of deaf and hard of hearing people have been left unclear about their condition because of difficulties communicating with clinicians
- 70% of British Sign Language users admitted to A&E were not provided with a BSL/English interpreter

9.2.2 Service change impacts

Consultant led maternity services

General research relating to women with a learning disability (LD) has found that they can face significant barriers to accessing NHS services, which can contribute to them being less likely to use services, and more likely to access maternity care later in pregnancy. In addition, people with LD experience higher rates of co-morbidity including physical and mental health problems than those who do not have a LD and these increase their risks when pregnant, particularly as they may be unable to follow advice on prevention or self-care. *Source: Department of Health 2004*

A study reporting on the use of maternity services by women with a disability in 2010 concluded that women with a disability were at higher risk for adverse pregnancy outcomes; for example, they were more likely to deliver early and have low-birth-weight babies. However, it also concluded that some women, such as those with a physical disability, appropriately received more care. *Source: M, Malouf R, Gao H, et al Women with disability: the experience of maternity care during pregnancy, labour and birth and the postnatal period. BMC Pregnancy Childbirth 2013;13:174.doi:10.1186/1471-2393-13-174*

Disabled women are usually classified during their pregnancy as ‘high risk’ requiring more antenatal visits and more scans, however, arranging these intensive appointments can be difficult for some disabled women. *Source: Mitra M, Clements KM, Zhang J, et al. Maternal characteristics, pregnancy complications, and adverse birth outcomes among women with disabilities. Med Care 2015;53:1027–32.doi:10.1097/MLR.0000000000000427*

Paediatric services

Children with a disability may require specialist care and interventions and more frequent use of paediatric services. The impact of a change of location of paediatric services could be higher on parents of children with a disability if they regularly have to travel further (particularly if they live in a rural area and/or in an area of deprivation.) See other sections relating to access to other services for patients of all ages with a disability.

Emergency care

According to the World Health Organisation**,** people with disabilities are particularly vulnerable to deficiencies in health care services. Depending on the group and setting, people with a disability may experience greater vulnerability to secondary conditions, co-morbid conditions, age-related conditions, engaging in health risk behaviors and higher rates of premature death. This may mean that they need to access emergency care more.

Planned care

It is commonly acknowledged that people with a disability have poorer health. This puts this group at higher risk of illness and likely to have greater need of planned care and procedures. *Source: NCEPOD 2008: Elective and emergency surgery in the elderly: study protocol P.2.*

Stroke services

A third of people who have a stroke are left with long term disability, the effects of which can include aphasia, physical disability, loss of cognitive and communication skills, depression and other mental health problems. *Source: https://www.england.nhs.uk/mids-east/wp-content/uploads/sites/7/2018/03/community-stroke-rehab-specification.pdf*

Within five years of a first stroke, the risk for another stroke can increase more than 40%. Recurrent strokes often have a higher rate of death and disability because parts of the brain already injured by the original stroke may not be as resilient. This means that people who have already had a stroke and who may have been left with some form of disability are more likely to need to access stroke services again.

Travel impacts

In Great Britain, 74% of adults with impairments experienced restrictions in using transport compared with 58% of adults without impairments *Source: ONS Life Opportunities Survey 2009/10*

Research by the Office for Disability Issues (2009) found: Lack of access to a car is a significant issue for disabled people and their families and results in much greater reliance upon public transport services. Data from the Omnibus Survey (2004) suggested that disabled people were

more than twice as likely to have no access to a car in the household than non-disabled people (35.3% of those defined as having health conditions that limited activity or work compared to 14% without.)

Research by the Children's Commissioner in England (2013) highlighted that for disabled low income children transport can be a barrier to realising their right healthcare, particularly the distance some families have to travel to receive services.

People with a disability often require patient transport to be able to attend appointments. Public transport, particularly from rural areas, might represent a real challenge for someone with a disability. A carer might also need to accompany the patient to hospital appointments to offer help and support.

Sources: https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/health-and-care-of-people-with-learning-disabilities-experimental-statistics-2016-to-2017; https://www.england.nhs.uk/learning-disabilities/

Some disabled people may not feel confident in using public transport even if it is physically possible for them to do so. Challenges can include luggage blocking wheelchair access, attitudes of the public and drivers and communication for people with a learning disability.

9.2.3 Themes from consultation feedback

Detailed themes from the consultation feedback received at focus groups and meetings from people with a disability can be found in Appendix 5.

9.3 Gender reassignment

9.3.1 Gender reassignment profile summary

Care for people undergoing gender reassignment falls under Interim gender dysphoria protocols 2013/14 which is commissioned by NHS England. Previous engagement with this group has highlighted a lack of understanding by healthcare staff around gender transition and patients' preferences as to how they wished to be treated. Some gaps in services were also identified for these patients, these included:

- Tailored mental health support
- Lack of access to sexual health clinics in Powys meant some young people had to use a local GP which they found uncomfortable.

Comments collected about the proposed options in previous engagement suggested that people want tailored services: sexual health, counselling, transgender specific support. However, they emphasised that the services should be discrete 'because some people might not want to have to come out to the public'. *Source: Future Fit Protected characteristics engagement report 2015*

9.3.2 Service change impacts

For all services, the proposals do not directly impact people undergoing any core gender reassignment treatments, however this assessment acknowledges that this group is often disadvantaged within healthcare due to a general lack of understanding of transgender issues.

Previous engagement work has not highlighted any impacts from this group differing from that of the general population.

Source: http://strategyunit.co.uk/sites/default/files/2017-10/Future%20Fit%20Integrated%20Impact%20Assessment%20women%20and%20childrens.pdf

9.3.3 Themes from consultation feedback

There is no specific feedback from the consultation meetings available from people who identify themselves as undergoing or having had gender reassignment treatment. Feedback from this group is included in the general consultation feedback report.

9.4 Marriage and Civil Partnership

Marriage and Civil Partnership protection applies for employment and we have not found evidence to suggest that people who are married or are in a civil partnership are disproportionately impacted on in relation to changes to the health services we are consulting on.

9.4.1 Themes from consultation feedback

There is no specific feedback from the consultation meetings available from people who identify themselves as married or in a civil partnership. Feedback from this group is included in the general consultation feedback report.

9.5 Pregnancy and maternity

9.5.1 Pregnancy and maternity profile summary

Pregnant women and new mothers would be two of the main groups impacted on by the proposed changes to consultant-led maternity services. Although most women would receive outpatient appointments and scans where they do now, there would be an impact on women who need or choose to give birth in a consultant-led unit. This would have a higher impact on women who are classed as high risk, for example older women, women who have had complications at birth before and women who have certain long term conditions like diabetes.

Telford and Wrekin has a higher percentage of women aged 18-44, BAME women and women living in deprivation than the other two areas. However, in absolute terms Shropshire is home to the largest number of women aged 18-44 (43,670 compared to 29,206 in Telford and Wrekin and 9,163 in the impacted parts of Powys).

Telford and Wrekin has the largest number of BAME women (4,879 compared to 2,556 in Shropshire and 311 in the impacted parts of Powys) and women living in deprivation (17,185 compared to 5,408 in Shropshire and 1,354 in the affected parts of Powys). BAME women have higher than average rates of maternal mortality and stillbirths (particularly for mothers born outside the UK), which may mean that they are more likely to give birth in consultant-led units. *Source: ONS (2015)*

However, there is a higher number of women in older age groups living in the Shropshire CCG/local authority area using local maternity services, who are more likely to have complicated pregnancies and an increased need to access consultant-led services. *Source: SaTH maternity service activity data 2017/18*

9.5.2 Service change impacts

Pregnant women may need to access a number of different services being considered under these proposals in addition to maternity services:

- Consultant led maternity services
- Emergency care
- Planned care
- Stroke services

Consultant led maternity services

In 2015, 21.5% of all live births in England and Wales were to mothers aged 35 or over. Mothers in this age group are more likely on average to experience complications during pregnancy, labour and postnatal. Older age in mothers is also associated with higher rates of perinatal mortality as is the likelihood of foetuses with congenital anomalies and admissions of neonates to intensive care. Older pregnant women are therefore more likely to need specialist maternity services, including consultant-led birth and neonatal care.

Teenage pregnancy rates have decreased considerably since the late 1990s, in all areas likely to be impacted on by the proposed changes to maternity services at PRH and RSH and in 2015, only 3.4% of all live births in England and Wales were to mothers aged under 20. There are also low rates of conception among under 18s in Telford and Wrekin, Shropshire and Powys – although in Telford and Wrekin this is above the national average. The highest conception rates are in the most deprived wards.

Telford has seen a particularly pronounced decline, and in 2015 there were only 25 pregnancies per 1,000 women aged 18 and under in the borough. When records began in 1998, the rate stood at 64.2 per 1,000 women. Shropshire has a lower rate still, with 17 pregnancies per 1,000 women, but that actually reflects a slight increase on the previous year. In total, 93 under-18s in Shropshire and 79 in Telford and Wrekin got pregnant in 2015, with 63.4 per cent of those in Shropshire and 29.2 per cent of those in Telford having an abortion.
A Save the Children report in 2012 highlighted that girls under the age of 15 are five times more likely to die in pregnancy than women in their 20s, and that babies born to younger mothers are also at greater risk. Teenagers are also less likely to get pre-natal care soon enough compared to older women and are susceptible to a number of conditions including high blood pressure and pre-eclampsia. Although numbers in the UK are low, under 18s are more likely to give birth to premature babies and low birth weight babies and have complications during labour. This is likely to mean that pregnant teenage women are more likely to need access to a consultant-led maternity unit and neonatal care.

Most users of pregnancy and maternity services are in the 20-29 and 30-39 age ranges.

Source: DRAFT Future Fit Integrated Impact Assessment Additional analysis of potential changes to Women's and Children's services

BAME women have higher than average rates of maternal mortality and stillbirths (particularly for mothers born outside the UK). Black, Asian and Minority Ethnic women and children have an increased risk of some poor outcomes. See section on Race above for more details.

National evidence suggests that disabled women may use maternity services more than non-disabled women during and after pregnancy. The British Medical Journal discusses that, on average, they had more antenatal checks and scans, and were more likely to have a caesarean section and to stay in hospital for longer after birth compared to non-disabled women. This may mean that they have a higher need to use a consultant-led maternity unit.

Source: Access and quality of maternity care for disabled women during pregnancy, birth and the postnatal period in England: data from a national survey

Sometimes, a mental health problem can also cause pregnant women to miss important health checks, which could lead to an increased risk of complications in pregnancy. *Source: www.nhs.uk*

Emergency care

It is common for women to experience mental ill health for the first time in pregnancy. Women may feel more vulnerable and anxious and some may develop depression. Women who have had severe mental ill health in the past or who have it at the time of pregnancy are more likely to become ill during pregnancy or in the year after giving birth. Severe mental ill health includes bipolar affective disorder, severe depression and psychosis. Postnatal depression can start any time in the first year after giving birth and it affects one in 10 new mothers. Women experiencing mental health problems during and/or after pregnancy may therefore be more likely to need to access emergency care. *Source: www.nhs.uk*

There are more than 8000 non-obstetrical surgical procedures performed each year, impacting up to 2% of all pregnancies. Appendicitis and gallbladder disease are the most common non-obstetric surgical emergencies during pregnancy. Approximately 1 in 635 women require non-obstetrical abdominal surgery during pregnancy. The delay in diagnosis and treatment of the surgical abdomen in the pregnant patient due to the fear of unnecessary procedures and tests contributes to a high complication rate. *Source: British Medical Journal, Emergency general surgery in pregnancy, Jeffrey J Skubic, Ali Salim*

Ectopic pregnancy is another reason a woman may need to access emergency care. In the UK, 1 in around every 80-90 pregnancies is ectopic, which equates to around 12,000 pregnancies a year. This risk of having an ectopic pregnancy is increased if women smoke or if they are older (over the age of 35.) *Source: www.nhs.uk*

Planned care

Cancer during pregnancy is rare but the risk of women being diagnosed with cancer during pregnancy is likely to increase as women are having babies when they are older and the risk of developing most cancers increases with age.

Some factors related to pregnancy may increase the risk of breast cancer: older age at birth of first child and recent childbirth. *Source: National Cancer Institute*

Under the consultation proposals, although the majority of planned care would take place on the planned care site, it is possible that some pregnant women would receive planned care on the women's and children's/emergency care site. This would depend on how many weeks pregnant they are, what their clinical condition is and what surgery is required.

Stroke services

Some of the risk factors for stroke in pregnancy are the same as for the general public – older age, obesity, smoking and heart disease, but some risk factors are specific to pregnancy. These include: gestational diabetes, gestational hypertension and increased bleeding after giving birth.

The Stroke Association's Health Of The Nation report quotes that pregnancy can increase your risk of stroke. In 100,000 pregnancies, 30 soon-to-be mothers will have a pregnancy-related stroke.

Pregnancy and the postpartum period are associated with an increased risk of ischemic stroke and intracerebral haemorrhage.

BAME women have a higher incidence of coronary heart disease and also a higher incidence of strokes so are likely to have a higher number of patients accessing this service. *Source: British Heart Foundation 2018.*

Source: https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

Travel impacts

As the current consultant-led maternity unit is based at PRH, there may be a negative impact on pregnant women living in Telford and Wrekin who choose or need to give birth in a consultant-led unit if this is moved to RSH. Conversely, there would be a positive impact on pregnant women living in Shropshire and Powys as the consultant-led unit would be nearer to their homes than it is currently. However, ante and post natal maternity care would still be available on both hospital sites.

There may be an impact for patients and carers / family visitors travelling increased distances due to location changes, particularly if regular visits are required to a baby in the neonatal unit. The negative impact is likely to be higher for younger people who are less likely to have their own transport and the means (finances) to travel and for people living in rural/and or deprived areas with limited transport options and potentially higher costs.

One notable finding from the survey in relation to women's and children's services in 2017 is that nearly a third of respondents said a friend or relative had driven them to access Women's and Children's services in the past. Women and children without such a network (including but not limited to recent BAME migrants to the area) may be disproportionately affected. *Source: IIA Women's and Children's Services: Method of Travel summary – page 34 Source; https://nhsfuturefit.org/key-documents/impact-assessment/2017*

9.5.3 Themes from consultation feedback

Detailed themes from the consultation feedback received at focus groups and meetings from pregnant women or women who have given birth recently can be found in Appendix 5.

9.6 Race

9.6.1 Race profile summary

All areas are predominantly White British and have higher rate of White British people compared to the England rate. In comparing all areas, Powys has the highest White British rate – 96.6 per cent.

There is a higher percentage of Black, Asian, Minority and Ethnic groups (BAME) in Telford and Wrekin compared to Shropshire and Powys. However, all groups have a lower percentage than the England rate apart from "Mixed/Multiple Ethnic Groups: White and Black Caribbean" which is slightly higher.

Nationally, the Afiya Trust suggests that "many minority ethnic communities have poor access to health and social care services for a variety of reasons including language barriers, lack of awareness/information, social isolation, lack of culturally sensitive services and negative attitudes about communities". *Source: Afiya Trust 2010*

The White Gypsy and Irish Traveller group, identified for the first time in the 2011 Census, has particularly poor health. Both men and women have twice the White British rates of limiting long term illness, and at each age they are the group most likely to be ill.

9.6.2 Service change impacts

- Consultant led maternity services (BAME women of child-bearing age and babies)
- Paediatric services (BAME children and young people)
- Emergency care (BAME children and young people – particularly young men, older people)
- Planned care (BAME older people)
- Stroke services (BAME older people, working age and children)

Consultant led maternity services

Black, Asian and Minority Ethnic women and children have an increased risk of some poor outcomes:

- stillbirth – babies of African -Caribbean and African mothers have more than double the risk of stillbirth, and babies of Indian, Bangladeshi and Pakistani mothers have an increased risk, compared with babies of White mothers *Source: CMACE, 2011; Gardosi, 2013*
- low birthweight – Indian, Pakistani and Bangladeshi babies are 2.5 times more likely than White babies to have a low birthweight, and Black Caribbean and Black African babies are 60% more likely to have a low birthweight *Source: Kelly, 2008*

- preterm birth – babies of African -Caribbean and African mothers are at increased risk compared to babies of mothers of other ethnic origins *Source: Aveyard et al, 2002; Office for National Statistics, 2016*
- congenital abnormalities – babies of mothers of born in India and Bangladesh are at increased risk and babies of mothers born in Pakistan are three times more likely than babies of mothers born in the UK to be born with a congenital abnormality *Source:* Blarajan et al, 1987
- severe maternal morbidity – Black and Minority Ethnic women are 50% more likely than White women to suffer severe maternal morbidity, and the risk is more than double for women of African and Afro-Caribbean origin *Source: Knight et al, 2009*
- maternal death – Black mothers are four times more likely to die in pregnancy or in the year after birth than White mothers Source: Knight et al, 2016
- late booking for antenatal care - women of South Asian origin are likely to initiate care later and have fewer antenatal visits than White women; women who are asylum seekers or refugees are disproportionately represented within unbooked births *Source: Rowe & Garcia, 2003*

Black, Asian and Minority Ethnic women are also less likely to have positive experiences of maternity care. The National Maternity Survey *(Redshaw & Henderson, 2015)* found that, compared with White women, they were:

- less likely to have the first antenatal contact by 12 weeks, less likely to be offered antenatal classes, less likely to feel they had enough information about their choices for maternity care, less likely to feel they were always involved in decisions about antenatal care, and less likely to feel their midwives were always respectful
- less likely to feel they were always involved in decisions during labour and birth, and less likely to have always had trust and confidence in staff during labour and birth
- more likely to have a postnatal stay in hospital of more than three days but less likely to feel they were always treated with respect by hospital staff.

According to our local hospital data where ethnicity has been recorded, a higher number of women from non-white backgrounds accessed maternity services from the Telford and Wrekin area in 2017/18: 192. This compared to 57 patients from Shropshire CCG/local authority area and Powys. For more detail, please see appendix 6. *Source: Shrewsbury and Telford Hospital Trust maternity activity data 2017/18.*

As women from some BAME groups are more likely to have complicated pregnancies and births and to have a greater need to access consultant-led maternity services, there could be a negative impact on a higher number of BAME women in Telford and Wrekin under option 1 if the Women's and Children's Unit were to be moved to Shrewsbury.

Paediatric services

Parslow et. al. (2009) identified that the incidence rate for emergency hospital admission from children requiring intensive care was found to be significantly higher for South Asian children.
According to our local hospital data where ethnicity has been recorded, there were a higher number of children from non-white backgrounds admitted to the Women's and Children's Unit in Telford from the Telford and Wrekin area in 2017/18: 965 children. This compared to 330 paediatric inpatients from Shropshire CCG/local authority area and 13 paediatric inpatients from Powys. For more detail, please see appendix 6. *Source: Shrewsbury and Telford Hospital Trust inpatient paediatrics activity data 2017/18.*

We are aware that there is a higher proportion of BAME communities residing in Telford and Wrekin with 2568 BAME young people residing in this area who might be disproportionately impacted under option 1 if paediatric services were to move to Shrewsbury *Source: 2014 school census, Telford and Wrekin Population Profile.*

Emergency care

There are particular conditions which affect different ethnic groups. It is important that these are recognised and taken into account. Some conditions affecting Black or South Asian people more than white people are:
• Sickle cell disease
• Thalassemia
• Higher prevalence of diabetes and high blood pressure, and associated health conditions such as kidney problems.
• Higher prevalence of stroke.
• Shortage of vitamin D.
These conditions may lead to increased A&E attendances for people from these communities.

One of the most common reasons for emergency admission amongst ethnic minority groups is for strokes and other cardiac problems such as coronary heart disease and diabetes; this highlights the need for consideration of this group in the provision of acute services. (There is a lot of evidence to suggest that rates of stroke and cardiac conditions are higher in certain ethnic minority communities, particularly South Asian communities.)

The white gypsy and traveller group is disproportionately represented with 5% of admissions. This may be due to gypsies and travellers not being registered with a GP where they are living, and therefore needing to use accident and emergency instead, rather than any increased susceptibility to accident or injury. *Source: DOH 2017*

This may mean that groups from different ethnic backgrounds living in Telford and Wrekin may be negatively impacted on if the main emergency site is in Shrewsbury.

No local activity data relating to the ethnic background of patients who attend Shrewsbury and Telford Hospital Trust's A&E departments is available.

Planned care

In comparison with white ethnic groups, black people have significantly higher rates of multiple myeloma and stomach cancer. Black men have higher rates of prostate cancer. Asian women have increases rates of cancers of the mouth. Although South Asian and Black women have lower rates of breast cancer compared to White women, they have poorer survival rates. *Source: National Cancer Intelligence Network – Cancer Incidence and Survival by Major Ethnic Group, England*

Local hospital data tells us that a far higher number of adult BAME patients in Telford and Wrekin (804), whose ethnicity was recorded, accessed planned care services at The Shrewsbury and Telford Hospital Trust in 2017/18. This was almost four times the number of adult BAME patients from the Shropshire CCG/local authority area (212) who used planned care services in the same year. Only 14 patients from Powys used the SaTH planned care services at this time.

As Telford and Wrekin has a larger BAME population than Shropshire and Powys, BAME patients living in this area would be positively impacted on under Option 1 with the planned care site at PRH but they would be negatively impacted on under Option 2 with the planned care site at RSH.

Stroke services

BAME communities have a higher incidence of coronary heart disease and also a higher incidence of strokes so are likely to have a higher number of patients accessing this service. *Source: British Heart Foundation 2018*

As Telford and Wrekin has a larger BAME population than Shropshire and Powys, BAME stroke patients living in this area may be negatively impacted on under Option 1 if the hyper acute stroke unit was moved to RSH.

Travel impacts

Research published by the RNIB has highlighted differences between ethnic populations in the risk of developing sight complications, which in turn may affect the ability of these groups to access healthcare. See the section about Disability for more information.

Otherwise there is no evidence to suggest that people from BAME communities would be disproportionately impacted on in relation to travel and transport. However, for people living in areas of deprivation, there may be a negative impact in relation to travel costs.

9.6.3 Themes from consultation feedback

Detailed themes from the consultation feedback received at focus groups and meetings from people from different races can be found in Appendix 5.

9.7 Religion and belief

9.7.1 Religion and belief profile summary

Generally, we have found no evidence to suggest that people who have different religious beliefs are at a higher or lower risk of certain conditions, which may mean they would have to access hospital services more. The only exception to this is the small Mennonite/Amish community (approx. 20 people) living in South Shropshire. This community may be more prone to genetic disorders, increased birth defects and a higher infant mortality rate than the overall population. However, in general its members are less likely to seek medical attention for non-urgent health needs, often tend to use natural or homeopathic therapies and have better health than the general population due to their healthy lifestyle.

9.7.2 Service change impacts

Although the small Mennonite/Amish community may need to access hospital services more than the general population, overall, we do not believe that a person's religious belief would mean that they would be disproportionately impacted on in relation to changes to the health services we are consulting on.

9.7.3 Themes from consultation feedback

Detailed themes from the consultation feedback received at focus groups and meetings from people from different religions and beliefs can be found in Appendix 5.

9.8 Sex

9.8.1 Sex profile summary

The percentages of men and women living in Telford and Wrekin, Shropshire and Powys are not very different, however, this does vary according to different age groups. In the older age groups, there tends to be a higher number of women than men.

There is a slightly lower number of males than females living in Telford and Wrekin but for a certain age groups, for example 0-9 and 15-54, the percentage of males is higher. The percentage of women over the age of 55 is higher than for men.

The percentage of men living in Shropshire is generally higher in younger age groups, under the age of 34.

The percentage of different male age groups in the Powys population is variable.

9.8.2 Service change impacts

Some of the health services being considered under these proposals – consultant-led maternity, neonatal care and inpatient's children's services are predominantly used by women directly or as parents/carers. The impact will therefore be greater on women, although men may be impacted on particularly as visitors and in relation to emergency care.

Consultant led maternity services

Any change to this service will have the greatest impact on women, particularly those of child-bearing age.

Black, Asian and Minority Ethnic women and children have an increased risk of some poor outcomes, including stillbirth, low birthweight, preterm birth and congenital abnormalities. There are specific impacts on BAME women and this section should be cross referenced with the Race section.

Paediatric services

There are no disproportionate impacts identified relating to gender.

Emergency care

National research indicates that men could have a disproportionate need for A&E and acute services. The supporting evidence is presented below;

- There is much evidence to suggest that young males have a higher propensity to require emergency services. For example, males are more likely to be involved in road traffic accidents than females, particularly males under the age of 30 who represent the most common group in speed-related collisions. *Source: The characteristics of speed-related collisions: Road safety research report No. 117 (2010) Department for Transport*
- Young men are at greater risk of being involved in accidents than females. In particular, men are twice as likely to be involved in (and die from) accidents at work and four times more likely to suffer major accident while practising sports. In addition, young men are most likely to experience and become victim to violent crime.

Each of the options would potentially have a disproportionate effect on men aged 30-59 who undertake high levels of road travel, depending on where they live, as research has demonstrated a link between congestion and mental health. *Source: Future Fit Integrated Impact Assessment (2 November 2016) – 5.4.6*

There is a fairly even spread of males and females using accident and emergency services nationally and locally, however slightly more males nationally and this is reflected in the use at both hospitals.

Source: HES (2013): Accident and Emergency Attendances in England (Experimental statistics),2011-12; Kings Fund (2012): 'Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions

Local activity data for 2017/18 shows us that a similar number of males and females living in Shropshire and Telford and Wrekin attended Shrewsbury and Telford Hospital A&E departments apart from in the older age groups (age 80+) when more females attended than men. Interestingly, for patients from Powys in the 25-29 age group, there is a much higher percentage of men (61%) than women (39%) attending SaTH A&E departments. For more detail, please see appendix 6. *Source: Shrewsbury and Telford Hospital Trust A&E activity data 2017/18.*

There may therefore be an increased impact on males than females if the emergency site is moved further away from where it is now, depending on where the male patients live.

Planned care

There is a different incidence of different types of cancer in men and women. More than half of new cases of cancer in males are prostate, lung and bowel cancers. More than half of new cases of cancer in females are breast, lung or bowel cancers. *Source: Cancer Research UK*

The majority of cancer surgery would be carried out on the planned care site unless there was a high level of clinical risk involved. All surgery for breast cancer would take place on the planned care site.

As there are similar numbers of males and females living in all areas, there is no evidence to suggest that either group would be disproportionately impacted on in relation to cancer services.

The prevalence of radiographic osteoarthritis is higher in women than men, especially after the age of 50 and for hand and knee osteoarthritis which may suggest that women are more likely to require joint surgery.

As there are similar numbers of males and females living in all areas, there is no evidence to suggest that either group would be disproportionately impacted on in relation to hip and knee replacement surgery.

Our local hospital data for planned care services confirms that similar numbers of men and women accessed inpatient and day case services in 2017/18. There is therefore no differential impact identified on either sex. For more detail, please see appendix 6. *Source: Shrewsbury and Telford Hospital Trust Planned Care activity data 2017/18.*

Stroke services

Women generally live longer than men, however as the risk for stroke increases with age, this means that women typically have a higher stroke risk. Some other risk factors for stroke are also specific to women:

- High levels of the female hormone oestrogen can make blood more likely to clot, so women with risk factors for stroke may not be able to use contraceptive pills containing oestrogen. Overall the risks are very low, as long as other risks are low.
- During pregnancy, health conditions like pre-eclampsia and gestational diabetes can raise the risk of a stroke.

Source: Stroke Association

Men are at higher risk of having a stroke at a younger age than women but there are a greater number of stroke-related deaths in women. This is because women live longer than men, and women tend to have their strokes when they are older.

Source: State of the Nation Stroke statistics - January 2017 – Stroke Society

Travel impacts

Women are more dependent on public transport than men and it is therefore anticipated that any additional travel to specialised units is likely to impact more on women. In 2011, 79% of men held a full driving licence compared to 65% of women and one in five men compared to one in three women do not drive. *Source: National Travel Survey, Department of Transport, 2012*

There could also possibly be an adverse impact on both men and women from deprived communities and rural communities because of issues of public transport, location and low income.

9.8.3 Themes from consultation feedback

Detailed themes from the consultation feedback received at focus groups and meetings from men and women can be found in Appendix 5.

9.9 Sexual orientation

9.9.1 Sexual orientation profile summary

The lesbian, gay, bisexual, transgender (LGBT) community has greater exposure to the wider determinants of ill health and greater health and social care needs are exhibited in relation to older people, mental health, smoking, alcohol abuse, support in motherhood and child care. LGBT people have

- poorer experiences of hospital and residential care – with poorer respect of individual rights
- poorer access to health and social care provision: gay men and women may be less likely to access primary care services than their heterosexual counterparts.
- are particularly subjected to stigmatisation, discrimination and insensitivity.

Research shows that access to health and social care for the LGBT community is problematic and that underlying causes stem from a general lack of awareness of LGBT needs and assumptions made about social and sexual practices, often leading to treatments and screenings to be negated or not deemed necessary. LGBT people have higher levels of poor mental and physical health than heterosexual counterparts.

Research leads us to assume that LGBT people are statistically as likely as the general population to use alcohol and other drugs and to misuse substances when young but are more likely to maintain that level of use in later life. There is a higher tendency (when compared to the general population) amongst the LGBT population to self-harm, attempt suicide and achieve suicide. There is also evidence that vulnerable men with learning disabilities who have sex with men have a greater exposure to HIV infection. Source: https://www.leicester.gov.uk/media/179049/the-health-and-social-care-needs-of-lesbian-gay-and-bisexual-in-leicester.pdf

When accessing general healthcare services in the last year, two in five trans people (41 per cent) said healthcare staff lacked understanding of trans health needs. *Source: LGBT in Britain Trans report 2017*

Lesbians are more likely to have smoked and to drink heavily than women in general. At various ages they are less likely to have had a smear test and more likely to have had breast cancer. Levels of self harm and suicide are significantly higher than in the wider population. Half have had negative experience of healthcare within the last year alone and a similar number feel unable to be open about their sexual orientation to their GP. *Source: Stonewall Prescription for change, Lesbian and Bisexual women's health check 2008*

9.9.2 Service change impacts

Due to certain risk factors for LGBT people, there may be an increased need for pregnant lesbian and bi-sexual women to access consultant-led maternity services and for all LGBT people to access emergency, stroke and planned care services.

Consultant led maternity services

Due to lifestyle choices, such as smoking and drinking, pregnant lesbian and bisexual women may be at increased risk of complications during pregnancy. Other impacts in relation to usage of paediatric services would be the same as for pregnant women, mothers and parents. There may, however, be an additional impact in terms of patient experience but this would not be different whether the service was based at PRH or RSH.

Paediatric services

There is no evidence that LGBT people would be disproportionately impacted on by changes to paediatric services. Any impacts in relation to usage of paediatric services would be the same as for other young people and their parents.

Emergency care

Data around sexual orientation is not collected locally for those accessing A&E, however we do have some national evidence which suggests that there may be disproportionate need for those accessing A&E within this group:

- Three in five lesbian, gay and bisexual people over 55 are not confident that healthcare and support services would be able to understand and meet their needs. Source: Stonewall Booklet -Sexual Orientation "The Equality Act Made Simple" This may discourage them from attending health services at an early stage leading to a potential increased use of emergency care.
- Half of lesbian women and bisexual women reported negative experiences in the healthcare sector between 2009/10 and a third of gay men who accessed healthcare between 2009/10 reported to have had a negative experience in relation to their sexual orientation. In a 2011 survey, 9% of lesbian and gay people, and 10% of bisexuals rated their doctor 'poor' or 'very poor' compared to 5% of heterosexuals. Source: Prescription for Change, Gay and Bisexual Men's Health Survey and GP patient survey.2011
- These experiences could mean more limited attendance for regular health check-ups which presents a higher risk of the need for emergency services to treat conditions which have worsened due to lack of earlier intervention;
- Nationally, lesbian and bisexual women are more likely to suffer from mental health problems and are more vulnerable to suicide than heterosexual women Source: National Institute for Mental Health in England (2007): 'Mental disorders, suicide and deliberate self-harm in lesbian, gay and bi-sexual people: A systematic review')
- Lesbian and bisexual women are also more vulnerable to episodes of self-harm; between 2011/12 one in five lesbian and bi-sexual women within the UK have deliberately self-harmed Source: Stonewall (2012): 'Mental health: Stonewall health briefing.'

Planned care

Multiple health-related behaviours such as smoking, lack of exercise, obesity and health conditions (including arthritis and asthma) have been found to be associated with limitations in physical functioning and disabilities. As stated above, LGBT adults are more likely to smoke than the general population and there are higher rates of asthma, arthritis and obesity in lesbian and bisexual women, which may lead to a need for planned care. *Source: American Journal of Public Health, Disability Among Lesbian, Gay and Bisexual adults: Disparities in Prevalence and Risk*

Oestrogen may increase the risk of breast cancer for male to female transgender patients. LGBT people are significantly more likely to smoke than heterosexuals. Smoking accounts for 1 in 4 cancer deaths. LGBT communities appear to consume more alcohol than the general population; drinking alcohol regularly can increase the risk of a number of cancers including breast, mouth and bowel. 18% of lesbian and

bisexual women who are eligible have never had cervical cancer screening compared with 7% of women in general. The increased risk of cancer for LGBT people as outlined above suggests that they may have an increased need to access cancer services. *Source: Macmillan.org.uk: The Emerging Picture, LGBT People with Cancer*

Stroke services

Gay and bisexual men are also more likely to smoke, drink and take illegal drugs:

- Two thirds of gay and bisexual men have smoked at some time in their life compared to half of men in general
- A quarter of gay and bisexual men currently smoke compared to 22 per cent of men in general
- More than two in five (42 per cent) gay and bisexual men drink alcohol on three or more days a week compared to 35 per cent of men in general
- Half of gay and bisexual men have taken drugs in the last year compared to just one in eight men in general

Source: Stonewall Gay and Bisexual men's health survey 2013

Lesbians are more likely to have smoked and to drink heavily than women in general. *Source: Stonewall Prescription for change Lesbian and Bisexual women's health check 2008*

From this we can conclude that LGBT communities may be more likely to have a stroke and to have the need to access stroke services than the general population due to poor health and lifestyle choices.

Travel impacts

There are a number of reports which highlight the issue of LGBT communities feeling unsafe when using public transport especially young LGBT people, The number of gay, lesbian or bisexual victims on the road and rail network trebled from 139 to 416 in 2013 *(Source: British Transport Police 2013)* and there are a number of newspaper interviews which highlight the rise of this issue but no specific research has been done.

9.9.3 Themes from consultation feedback

There is no specific feedback from the consultation meetings available from people who identify themselves as LGBT. Feedback from this group is included in the general consultation feedback report.

9.10 Staff

A review of equalities monitoring information for staff working at the Princess Royal Hospital and at the Royal Shrewsbury Hospital shows only small differences in the numbers of staff belonging to one of the protected characteristics working at each site. For more details, please see Appendix 1.

An extensive engagement programme has been undertaken with staff working at the hospitals by the Shrewsbury and Telford Hospital Trust both before and during the consultation period. SaTH reports that feedback on the consultation has generally been positive due to the clinical improvements of the reconfiguration. Therefore, the proposals will have an overall positive impact on staff experiences due to improved staffing levels, reducing duplication and improving facilities and estates.

The following were the main themes from the SaTH staff engagement work:

- Car parking and improved availability
- Will my expenses be covered if I have to travel further than I do now to get to work?
- Will I have a change of base?
- Will 7 day working be implemented, how will this affect me?
- Will it actually happen?
- Is it affordable?

Depending on which department staff work in, the proposals may have an impact on travel time. This may be either positive or negative based on individual circumstances.

Other staff groups such as ambulance staff may be impacted on by the plans. Engagement has involved West Midlands Ambulance Service and the Welsh Ambulance Service.

Ongoing travel analysis work has identified increased demand on car parking and on public transport which will be addressed within the plans.

Source: Section 8.8.4 Workforce plan within the Pre-Consultation Business Case (November 2017). Travel analysis report.

9.11 Other identified groups

9.11.1 People living in a rural area

Research carried out by the Local Government Association and Public Health England documented in Health and Wellbeing in Rural Areas (2017) notes that current national data collection on deprivation currently masks pockets of small communities that are deprived.

Although it is accepted that living in rural communities can have many positive health benefits, there are a range of issues raised within the above research. This national information is useful in understanding the needs in rural communities and in summary includes:

- Poverty – 15 per cent of households in rural areas live in poverty, compared to 22 per cent in urban areas
- Housing – Costs tend to be higher and fuel costs are also higher
- Employment – More likely for some communities to be reliant on seasonal work and lower than national average wages

- Access to transport – Travel distance to services may be longer and public transport links may be poor. Economic pressures on local authorities often results in reductions to services
- Population – Populations living in rural areas tend to be older (23.5 per cent over the age of 65 compared to urban area rate of 16.3 per cent nationally). Rural areas tend to have higher rates of White British backgrounds compared to urban areas
- Lack of national understanding of health issues relating to rural communities, however current data shows that health is generally better for people in rural areas compared to urban areas. However, there are identified issues with social isolation which can increase with age and long term conditions
- Attitudes to seeking health advice and help differs in rural areas and older people tend not to seek early help and advice from health care services
- Primary care services are important in promoting preventative and screening services to promote health.

The research also acknowledges that rural deprivation is not fully identified compared to urban deprivation and that work is underway to develop a fairer comparison of deprivation indices.

Impact

People living in rural areas may be positively or negatively impacted on by these proposals depending on where they live. From our engagement work, we have heard that people in rural communities already have challenges in relation to travel and transport. The biggest obstacle can often be getting from their home to their nearest public transport and not necessarily travelling by public transport itself, although this can often have limited availability and times are not always suitable for hospital appointment times. The situation is often exacerbated for younger people and older people who have less access to a car, although as outlined above, there is high car usage in Powys due to necessity. The impact would be greater on families on low incomes and older people without families living nearby.

As the main rural areas where patients live are in Shropshire and Powys, there would be a positive impact for people in these areas needing to access women's and children's services if they were moved to RSH as these would be nearer than where they are now. However, for people who need planned care, they would possibly have to travel further than they do now to PRH. This is likely to impact most on older people and people with a disability who are more likely to need planned care.

According to our previous Integrated Impact Assessment work: "Expert clinical advice states categorically that there will be worse outcomes for the people of Powys ……. should the trauma unit move to Telford."

Although the main rural areas relate to Shropshire and Powys, it should be noted that there are also rural areas within Telford and Wrekin that are poorly served by public transport.

Themes from consultation feedback

Detailed themes from the consultation feedback received at focus groups and meetings from people living in rural areas can be found in Appendix 5.

9.11.2 People living in an area of deprivation

People living in the most deprived areas in England have on average the lowest life expectancy. Males living in the most deprived tenth of areas can expect to live nine fewer years compared with the least deprived tenth, and females can expect to live seven fewer years.

Males and females living in the most deprived areas can also expect to spend nearly 20 fewer years in good health compared with those in the least deprived areas: they spend nearly a third of their lives in poor health. For males living in the 5 most deprived tenth of areas, and females living in the 4 most deprived, average healthy life expectancy falls below the age of 65 years.

Almost half of the gap in life expectancy between the most and least deprived areas in England is due to excess deaths from heart disease, stroke, and cancer in the most deprived areas.

There is also a higher prevalence of many behavioural risk factors among people living in the more deprived areas. For example, in more deprived areas, the prevalence of inactivity and the prevalence of smoking are both highest, while the proportion of people eating the recommended 5-a-day of fruits and vegetables is lowest. These are among the key behavioural risk factors for cardiovascular, cancer and respiratory disease deaths. People in the most deprived areas are also more likely to suffer the harms associated with alcohol consumption, one of the risk factors associated with the highest proportion of deaths in the 15 to 49 age group.

The level of risk for people living in an area of deprivation also belonging to a particular protected characteristic group could be increased. For example, men have a higher prevalence of excess weight, poor diet and smoking, but a lower prevalence of inactivity. Also, a higher proportion of those in Asian and Black ethnic groups do not eat the recommended amount of fruit and vegetables and have a higher rate of inactivity. Smoking is more common among White and Mixed ethnic groups and being overweight is higher in White and Black ethnicities.

Furthermore, the infant mortality rate is highest in the most deprived areas. The level of risk of infant mortality could be increased by a woman's ethnic background. For example, Pakistani, Black African and Black Caribbean women have an infant mortality rate higher than the England average, with Pakistani infant mortality rates the highest.

These health inequalities are underpinned by inequalities in the broad social and economic circumstances which influence health.

Source: https://www.gov.uk/government/publications/health-profile-for-england/chapter-5-inequality-in-health

This evidence suggests that as a result of the factors outlined above, people living in deprived areas can have more health needs, which may lead them to access health services more and have poorer health outcomes.

Impact

People living in areas of deprivation may be positively or negatively impacted on by these proposals depending on where they live. Although Telford and Wrekin has the most areas with high levels of deprivation, there are also areas of deprivation in Shropshire and rural deprivation, as outlined above, is a challenge for people in Powys and parts of Shropshire. The impact would be greater on pregnant women and families on low incomes and older people without families living nearby who can help with transport.

As the main areas of deprivation where patients live are in Telford and Wrekin, there would be a negative impact for women and families with young children in these areas needing to access women's and children's services if they were moved to Shrewsbury. There would also be an additional negative impact on older people, families with young children, young men and some BAME communities living in these areas who are likely to be more frequent users of emergency services as they would have additional travel time and cost if they had to travel to the emergency care site in Shrewsbury.

For people living in deprived areas of Shropshire and Powys, there would be a positive impact for pregnant women and families with young children needing to access consultant-led maternity services and paediatric services if women's and children's services were moved to Shrewsbury as they wouldn't have to travel as far as they do currently.

For people living in deprived rural areas, the impacts are described in the previous section.

Themes from consultation feedback

Detailed themes from the consultation feedback received at focus groups and meetings from people living in deprived areas can be found in Appendix 5.

9.11.3 Carers

The health needs of carers are highlighted in a report by Carers UK – State of Caring 2017. This report is important in highlighting significant disadvantages faced by carers nationally. The report highlights:

- Caring can have a significant impact on health – both physically and mentally
- GP patient surveys found that three in five carers have a long term health condition

- Health conditions in 40 per cent of young carers (aged 18-24) compared to 29 per cent of non-carers in the age group
- Back and mobility health problems are often exacerbated by lack of access to proper lifting equipment and aids
- Carers' health often compromised by lack of time to attend medical check-up for their own wellbeing
- Six out of 10 carers (61 per cent) reported that their physical health had worsened due to caring
- Seven out of 10 carers (70 per cent) reported that their mental health had worsened due to caring
- Worsening health reporting was more prevalent in carers providing more than 50 hours per week
- Carers looking after a disabled child were most likely to suffer from depression – 54 per cent
- Carers report that keeping healthy is more difficult due to the struggle to find time for exercise and maintain a healthy diet.

Impact

There may be an increased travel time and cost for carers supporting relatives and friends depending on where they live and the option decided upon. This will particularly impact on parents of children with a disability and carers of adults with a disability. The impact may be higher for carers who live in rural and/or deprived areas who might have limited travel options, particularly if the person they care for needs specialist transport, for example, due to wheelchair usage.

Themes from consultation feedback

Detailed themes from the consultation feedback received at focus groups and meetings from carers can be found in Appendix 5.

9.11.4 Welsh language speakers

In the development of any proposals for changes to services affecting patients in Wales, it is important to consider the impact on people whose first language is Welsh. According to the Welsh Language Policy Unit, the ability to provide services in Welsh is one of the key elements to delivering a quality service, especially for vulnerable groups who find it easier to express themselves in their first language. The Welsh Language Strategic Framework 'More than just words...' was launched in 2012. Its focus is to provide a framework to strengthen Welsh language services within health, social services and social care. It recognises that many people can only communicate and participate effectively in their care as equal partners through the medium of Welsh.

Whilst there is no statutory requirement for NHS organisations in England to comply directly with the Welsh Language Act 1993, they would wish to ensure the best experience, safety and outcomes for patients by making reasonable adjustments, for example, by providing translation and interpreting services for any people who do not speak English as their first language and this includes Welsh speakers.

There are no identified health risk factors in relation to Welsh speakers specifically, although Welsh speakers might also fall into one or more of the protected characteristic groups, for example, older people or someone with a disability (like a learning disability or dementia.)

Impact

Anecdotal evidence from our engagement work tells us that Welsh first language speakers are more likely to feel comfortable accessing health services just across the border in Shrewsbury than they are travelling to Telford. This is because they feel that there are more likely to be Welsh speakers (both staff and patients) at RSH due to its proximity to Powys and it would be easier for family and carers to visit them and to help to translate for them. It should be noted that patient transport is frequently limited to patients only and therefore this might make it difficult and costly for relatives and carers who need to travel with patients to translate for them, particularly if they need to travel to Telford.

The main impact for Welsh first language speakers is likely to be in relation to unscheduled and emergency care, rather than planned care. This is because of the added anxiety and complexity of an emergency attendance, the reduced likelihood that planned language support can be in place (e.g. member of the family, booked translator), the increased likelihood that the admission has a direct impact on cognition (e.g. stroke, delirium) and the associated extended length of stay.

Welsh speakers are therefore more likely to be positively impacted on if women's and children's and stroke services are located at RSH, however, they are likely to be negatively impacted on if they need to access planned care services in Telford. Likewise, they are likely to be negatively impacted if the main emergency centre were to be located at PRH due to the reasons outlined above. There would be no change in the current impact under option 2 relating to women's and children's services as they are already in Telford.

The impacts are likely to be increased for first language Welsh speakers with one or more of the protected characteristics, for example someone with a disability, a learning disability or dementia.

Themes from consultation feedback

Detailed themes from the consultation feedback received at focus groups and meetings from Welsh speakers can be found in Appendix 5.

9.11.5 Other groups

This assessment acknowledges that there are other groups in existence across the three locality areas such as military families and veterans, asylum seekers/refugees and homeless people who may be impacted on by the proposed service changes. The needs of these groups are often complex and they often face barriers in accessing primary and secondary health care. We have made particular efforts to engage with these groups to ensure that we are fully informed about their needs and the potential impacts on them. While we have no statutory duty to engage with these groups, this assessment has made reference to them in relation to giving due regard to reducing health inequalities in line with The Health and Social Care Act 2012 14T.

Military

Military service members and veterans face different health issues to civilians. During their service, they are at risk of various injuries. These injuries can happen during combat, while others involve physical stress to the body. Sometimes the injuries are life-threatening or serious enough to cause disability. Others may not be as serious, but can be painful and affect daily life. There may also be a risk of health problems from exposure to environmental hazards, such as contaminated water, chemicals, infections, and burn pits. These injuries and conditions can be long lasting and military personnel can experience the effects and symptoms after they have left active service.

Being in combat and being separated from family can also be stressful. The stress can put service members and veterans at risk of mental health problems. These include anxiety, post-traumatic stress disorder, depression and substance abuse. Suicide can also be a concern.

Life for members of an armed forces family can also be stressful, which can also put family members at increased risk of mental ill health. They tend to be more mobile than families in the general population, moving every two years, with moves sometimes unplanned and at short notice. Service families experience living away from their wider family and significant periods of separation which can lead to social isolation and additional and sudden caring responsibilities, along with the worry of illness, injury and death during deployments.

Military health services for servicemen and women including primary care, specialist care (secondary and rehabilitation) and mental healthcare are delivered through a partnership between the Ministry of Defence and the NHS.

However, veterans generally access normal NHS services and they may well be at higher risk of some long term physical and mental health conditions as a result of their military service.

The military bases in Shropshire and Telford and Wrekin are in different parts of the county and so some military personnel would live nearer to Princess Royal Hospital and some nearer to the Royal Shrewsbury Hospital. However, serving personnel would be most likely to access specific military health services. The greatest impact of the proposed changes is likely to be on veterans and military families who may have an increased need to access some services like emergency or planned care. There is no specific evidence to suggest that there would be a disproportionate impact on these groups if the services being consulted on were to move location. However, the impact may be increased if a military veteran or a military family member belongs to one of the other protected groups, for example, if they have a disability.

Homeless people

The legal definition of homelessness is that a household has no home in the UK or anywhere else in the world available and reasonable to occupy. Homelessness does not just refer to people who are sleeping rough. Homelessness has been increasing since a low point between

2009 and 2010. In 2015 to 2016 local authorities reported responding to the threat of, or actual homelessness, for 327,390 households, compared to 254,320 households in 2009 to 2010.Rough sleeping has increased by 102% since 2010.

Ill health can be both a cause and consequence of homelessness, although it is not always identified as the trigger of homelessness. For example, ill health may contribute to job loss or relationship breakdown, which in turn can result in homelessness.

The health and wellbeing of people who experience homelessness is poorer than that of the general population. The longer a person experiences homelessness, particularly from young adulthood, the more likely their health and wellbeing will be at risk. Co-morbidity (two or more diseases or disorders occurring in the same person) among the longer-term homeless population is not uncommon. The average age of death of a single homeless person is 30 years lower than the general population at 47 years, and even lower for homeless women, at just 43 years.

Homeless people can have:

- poor physical health
- mental health problems including the consequences of adverse childhood experiences
- experience of violence, abuse, neglect, harassment or hate crime
- alcohol and drugs issues

Homeless people also tend to have low vaccination rates and are less likely to have health checks or to attend health screening programmes.

Source: https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health

An estimated 41% of people classified as ‘rough sleepers’ have long-term physical health problems such as heart disease, diabetes and addiction problems, compared to 28% of the general population. Another 45% have been diagnosed with mental health issues, compared to 25%.

Source: https://publichealthmatters.blog.gov.uk/2018/02/09/the-inequalities-of-homelessness-how-can-we-stop-them-dying-young/

According to the homeless charity Crisis, many homeless people face barriers when try to access health services, which means that they are more likely to suffer from poor health.

Often health services are not set up to respond to the needs of homeless people. For example, many mental health services will not treat people until they have sorted out their drug and or alcohol problem. Homeless people can often be trapped in a vicious circle of dependency.

They try to alleviate the symptoms of their mental health problems through the consumption of drugs and alcohol which means that their mental health problems go untreated.

Although many homeless people are registered with healthcare services (92% according to Homeless Link, Health Audit), many will not be using them. This could be because they have moved away from the area where they are registered with a GP. Or because they have had a bad experience of using heath care services either through treatment or how they were discharged.

A substantial number of homeless people use hospital A+E departments for treatment instead of going to see a GP.

When people are discharged following a hospital admission, many will have nowhere stable to convalesce. With no support, they return to rough sleeping or sofa surfing which won't aid their recovery.

https://www.crisis.org.uk/ending-homelessness/health-and-wellbeing/health-services/

All of these factors mean that homeless people may be more likely to need to access health services, particularly emergency services.

We have found no evidence that tells us where the majority of homeless people live although the location of homeless charities in places like Shrewsbury, Oswestry, Telford and Wellington suggests that this is where most need for support services is. This means that homeless people could be accessing hospital services either at Princess Royal or at the Royal Shrewsbury Hospital currently.

As homeless people are also likely to be impacted on by the wider determinants of health including poverty and unemployment, consideration needs to be given to the moving of services further away from where they live as a result to increased travel costs and public transport challenges. There could potentially be a disproportionate impact on homeless people living in Oswestry and Shrewsbury under option 2 if the main emergency department were to be based in Telford and similarly for homeless people living in Wellington and Telford under option 1 if the main emergency department were to be based in Shrewsbury.

The impact may be increased if a homeless person belongs to one of the other protected groups, for example, if they have a disability or they are from a BAME background.

Asylum seekers and refugees

In the UK, the number of people seeking asylum has increased in the last five years due to the new armed conflicts and widespread violation of human rights in different parts of the world. In 2001, the Home Office set up the National Dispersal Scheme under the Asylum and Immigration Act (1999). Under the scheme, asylum seekers are transferred to a number of dispersal centres around the country.

Source: https://www.gov.uk/government/publications/immigration-statistics-year-ending-march-2018/list-of-tables

Health problems associated with asylum seekers and refugees are varied and often depend upon their country of origin. Health problems may include the following:

- depression and anxiety
- post-traumatic stress disorder
- suicide
- dental problems
- physical trauma, injury and torture
- vitamin or nutritional deficiencies
- communicable diseases such as hepatitis, tuberculosis, HIV/AIDS and malaria
- chronic diseases such as chronic obstructive pulmonary disease, cardiovascular disease and diabetes
- physical disabilities
- sensory disabilities.

Some asylum seekers and refugees may have arrived from refugee camps where there is poor sanitation and poor nutrition. They may be suffering from malnutrition and injury caused by the journey. They may have experienced high levels of psychological trauma through witnessing others dying due to high risk journeys. During the journey, they may have become increasingly vulnerable to risk of sexual exploitation and human trafficking. In addition to having been victims of conflict or torture and fleeing for sanctuary, they arrive with significantly different health needs to the indigenous population.

Additional issues affecting asylum seekers and refugees may include:

- deprivation due to the inability to work and lack of access to adequate funds for essential living needs
- acculturation to the UK culture resulting in higher rates of smoking, lower breastfeeding rates and poorer diets
- social isolation
- poor housing conditions
- lack of good English language skills and formal education leading to barriers in accessing services and poor social integration.

Although the number of asylum seekers and refugees in Shropshire, Telford and Wrekin is relatively small they may have significant health needs and have little knowledge of the health and care system in England. This may cause them to access emergency services more than other groups and due to their often challenging financial situation and language barriers, this could mean that they would be negatively impacted on by any changes to hospital services. However, the level of the impact would depend on where they live.

Asylum seekers living in Newtown, for example, would be likely to experience a high negative impact if the main emergency site were to be in Telford, due to the increased travel costs and time. The impact would probably be even higher for people with physical or sensory disabilities. Conversely, asylum seekers and refugees living in Telford and Wrekin would be negatively impacted on as they would have to travel further than they do now if the main planned care site were to be located in Shrewsbury.

10.0 Considerations

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

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

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

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

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

As the women's and children's centre is currently based in Telford, there would be no change in the impact on children and young people from Shropshire and Powys if this remains at PRH under option 2, but there would be a positive impact if the centre was moved to RSH under option

1. Although there is a smaller number of children and young people living in Telford and Wrekin, there are some protected characteristic groups that are more prevalent in this area, for example BAME babies, children and young people, particularly those living in a deprived area, who may have an increased need to access paediatric services and they may be negatively impacted on if the services are moved to Shrewsbury.

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

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

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

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

The demographic profile of our local area tells us that the most rural areas are in Powys and Shropshire. There are already significant transport challenges for young people and older people, particularly those who don't drive, in these areas. The higher number of older people living in

Shropshire and Powys, who may have a greater need to access planned care, may be negatively impacted on if they have to travel further to PRH under option 1 but there would be a positive impact under option 2 as planned care would be closer to where they live. We have, however, been told that generally it's easier to organise transport for planned care and so the greatest negative impact would be likely to be if older and young people from Shropshire and Powys needed to access emergency care in Telford under option 1.

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

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

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

11.0 Conclusion

This Equality Impact Assessment evidences that although there would be overall positive impacts for the whole population as a result of the implementation of the proposed new model of care, there may be specific negative or positive impacts on particular groups belonging to one of the nine protected characteristics (and other key groups that have been identified.)

It also highlights that the level of impact may increase for members of certain groups if they belong to more than one of the protected characteristics and/or if they live in certain areas, particularly rural and/or deprived areas.

It is important that the Clinical Commissioning Groups review and consider the information contained in this assessment and the recommendations as part of their legal duties during the decision making process.

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

• Does this policy help eliminate discrimination?

• Does this policy help promote equality of opportunity?

• Does this policy help foster good relations between people possessing the protected characteristic and those that do not?

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

The Programme recognises that some protected characteristic groups may face additional difficulties in accessing the reconfigured services. These challenges will be greatest for those individuals that have more than one protected characteristic – for example, disabled children, older people on low income. However, it is also worth noting that the reconfiguration of services for some protected characteristic groups will in fact improve their access to these services as specialist sites are relocated more locally to them.

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

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

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

12.0 Recommendations

In considering this equality impact assessment on the options set out in the public consultation, the Future Fit Programme must now conscientiously take into account the views expressed by those who may be affected by proposed service changes. This is achievable because of the extensive engagement through the consultation process, in particular the engagement with those defined as having one or more protected

characteristics, but also what was already known from the original impact assessment work done in 2016 and 2017 and this EQIA. They will all contribute to this conscientious consideration phase of the programme.

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

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

The Future fit Programme has reached stage three of its equality impact assessment, the post consultation pre-decision stage. In examining this evidence and analysis and the detailed findings from the consultation response, the Future Fit Programme Board through their conscientious consideration will need to consider any necessary and relevant mitigation plans to address impacts or issues raised for protected characteristic groups and for the wider population, prior to making any final recommendations to the Joint Committee of the CCGs. The suggested initial mitigations are described below, and these will need to be worked through together with any further issues and mitigations once a decision about the way forward has been made. This will be the focus of stage four of the equality impact assessment process.

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

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

1. **Developing an effective communications and engagement strategy**, looking to address continued confusion from the public including those within protected characteristics, of the differences between emergency care, urgent care and planned care. The use of various tools such as on-line video, talking stories of services now and the proposed changes, emphasising that there will be urgent care on both sites where the majority of people will be able to go as before. Advertising and materials should be in different languages and formats where appropriate.
2. **Developing a strong public awareness campaign** about the correct service to access in the case of an urgent or emergency medical need. Consider different tools and languages/formats to reach the widest possible audience and the nine protected characteristics. Target in particular those groups most likely to access A&E services, for example, young men, parents of young children, older people and new migrants.
3. **Incorporating findings into the work of the Travel and Transport Group** the potential impacts for access and travel on protected characteristics groups as set out in this EIA into the Travel and Transport Mitigation Plans. As the impact is likely to be greatest on people living in an area of deprivation or a rural area, older people and young people, people with a disability and

homeless people particular attention should be paid to the needs of these groups. This should include a Review appointment times by the Acute Trust and how these could be adjusted to take increased travel times and costs into account, particularly for groups who are more likely to travel by public transport such as people living in deprived areas, older people and younger people and people who are likely to have to travel further, for example, people living in rural areas.

4. **Considering how the Out of Hospital Care Strategies and Neighbourhood Developments** for Shropshire, Telford& Wrekin and Mid Wales might mitigate some impacts in looking at avoiding the need for hospital admission, the need to travel to hospital for appointments and for any other opportunities for enhancing local services for some groups. Particular consideration given for groups who are more likely to travel by public transport such as people living in deprived areas, older people and younger people and people who are likely to have to travel further, for example, people living in rural areas. Example of developments under consideration would including tele-medicine.
5. **Addressing the areas of mitigation in the W&C Integrated Impact Assessment in 2017**, that were set out in three broad areas to address the anticipated impacts relating to a consolidation of women's and children's services including:
    i. **Reducing unnecessary journeys** and transfers for young children
    ii. **Safe care pathway** agreements for children
    iii. **Reducing risk factors** before, during and after pregnancy (particularly for young women, BAME women and women living in deprived areas. This will include the work within the LMS Programme
6. **Ensuring the on-going review of midwife led services** considers findings and analysis in this EIA feeds into the developing model of care for midwife led services and in particular in the design, location and scope of community hubs under consideration.
7. **Ensuring the provision of appropriate accommodation** for parents/carers whose child is an inpatient to mitigate the impact of longer journey times and increased costs.

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

8. continue to work collaboratively to build on existing and planned public health interventions and a more proactive system-wide approach to prevention, bridging deprivation and other health equalities gaps
9. continue to work collaboratively with the voluntary sector, community groups, Healthwatch and patient reference groups to carry out more detailed assessments of potential impacts in future phases of the development including the design phase and through to implementation.
10. continue to improve the volume and diversity of patient views and increase future opportunities for on-going engagement and establishing long term relationships with the protected characteristic groups as a result of the links developed through the Future Fit consultation.

11. continue to consider an inclusive approach to language barriers through fair access to information, services and premises supported by embedding equality and inclusion compliance for all sections of our local community
12. consider the translation, interpretation and other services available to people whose first language isn't English in delivering any newly configured service to ensure that it is effective and that speakers of other languages are not being negatively impacted on when they access services.
13. noting the limited activity data breakdown available, consider how the collection and analyse of data and information can be improved to better understand patient flows and experience of the protected characteristics.
14. continue to share with the groups that have been engaged with developing the EIA and particularly the voluntary sector and others representing hard to reach groups, the EIA report and the outcomes of the consultation to ensure that they are aware of how their feedback is utilised in any decision-making process.

13.0 Appendices

Appendix 1: Demographic profile

Age

Protected group of Age	Local data % Shropshire	Local data % Telford and Wrekin	Defined Lower Super Output Areas (LSOA) Powys*	Combined all defined areas	England comparative %
0 – 4	5.1% (15,698)	6.8% (11,344)	4.9% (3,529)	5.6% (30,571)	6.26%
5 – 9	5.1% (15,932)	6.0% (10,007)	7.5% (5,371)	5.7% (31,310)	5.61%
10 – 14	5.9% (17,915)	6.4% (10,594)	6.1% (4,335)	6.0% (32,844)	5.81%
15 – 19	6.2% (18,951)	6.9% (11,496)	5.8% (4,165)	6.3% (34,612)	6.30%
20 – 24	5.4% (16,619)	6.5% (10,863)	4.9% (3,479)	5.7% (30,961)	6.78%
25 – 29	5.1% (15,619)	6.5% (10,888)	4.2% (3,002)	5.4% (32,511)	6.89%
30 – 34	5.0% (15,504)	6.2% (10,334)	4.2% (3,030)	5.3% (28,868)	6.62%
35 – 39	5.8% (17,790)	6.7% (11,145)	5.2% (3,690)	6.0% (32,625)	6.69%
40 – 44	7.2% (22,163)	7.7% (12,850)	6.8% (4,826)	7.3% (39,839)	7.33%
45 – 49	7.7% (23,574)	7.6% (12,653)	7.3% (5,211)	7.6% (41,438)	7.32%
50 – 54	6.9% (21,004)	6.3% (10,502)	6.9% (4,929)	6.7% (36,435)	6.41%
55 – 59	6.6% (20,160)	5.9% (9,866)	6.9% (4,812)	6.4% (34,838)	5.65%
60 – 64	7.3% (22,300)	6.0% (10,010)	8.1% (5,649)	7.0% (37,959)	5.98%
65 – 69	6.2% (19,059)	4.8% (7,934)	7.1% (4,975)	5.9% (31,968)	4.73%
70 – 74	4.9% (15,153)	3.6% (5,994)	5.1% (3,597)	4.5% (24,744)	3.86%
75 – 79	3.8% (11,709)	2.7% (4,439)	4.0% (2,824)	3.5% (18,972)	3.15%
80 – 84	2.9% (8,971)	1.8% (3,042)	2.9% (2,103)	2.6% (14,116)	2.37%
85 – 89	1.8% (5,571)	1.1% (1,771)	1.8% (1,292)	1.5% (8,634)	1.46%

90 and over	0.9% (2,836)	0.5% (909)	0.9% (634)	0.8% (4,379)	0.76%

Source: Q5103EW NOMIS

Source Name Office for national Statistics, NOMIS table finder – official labour market statistics

Source information Source data: Census 2011, table ID QS103EW, Age by single year

Release date Latest data: 2011, last updated: 30th January 2013

*Powys LSOAs

W01000427 Beguildy W01000428 Berriew W01000429 Blaen Hafren W01000433 Caersws W01000434 Churchstoke W01000439 Dolforwyn

W01000441 Forden W01000442 Glantwymyn W01000444 Guilsfield W01000447 Kerry W01000448 Knighton 1 W01000449 Knighton 2

W01000452 Llanbrynmair & Banwy W01000453 Llandinam W01000457 Llandrinio W01000458 Llandysilio W01000460 Llanfair Caereinion

W01000461 Llanfyllin W01000464 Llangunllo W01000466 Llanidloes 1 W01000467 Llanidloes 2 W01000468 Llanrhaeadr-ym-Mochnant

W01000469 Llanrhaeadr-ym-Mochnant/Llansilin W01000470 Llansantffraid W01000473 Machynlleth W01000475 Meifod & Llanfihangel

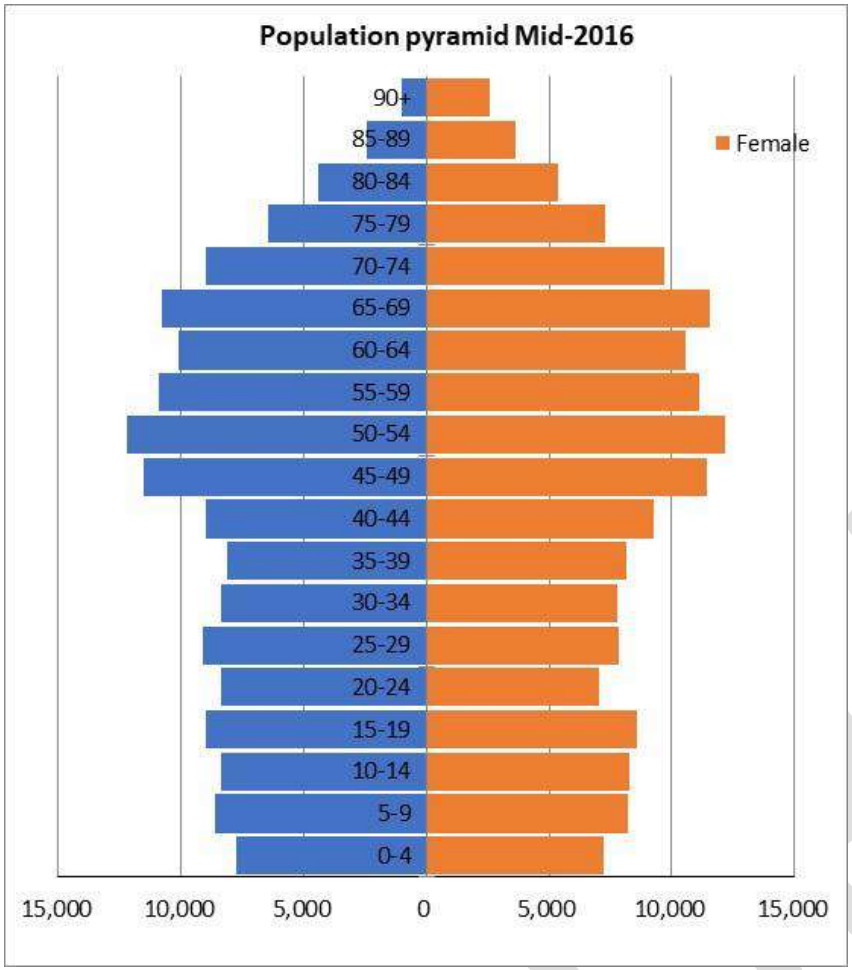
W01000476 Montgomery W01000478 Newtown Central 1 W01000479 Newtown Central 2 W01000480 Newtown East

W01000481 Newtown Llanllwchaiarn North W01000482 Newtown Llanllwchaiarn West W01000483 Newtown South

W01000488 Rhiwcynon W01000497 Trewern W01000498 Welshpool Castle W01000499 Welshpool Gungrog 1 W01000500 Welshpool Gungrog 2

W01000501 Welshpool Llanerchyddol

Age profile: Shropshire



Source and further information: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesanalysistool

Source Name *Office for National Statistics*

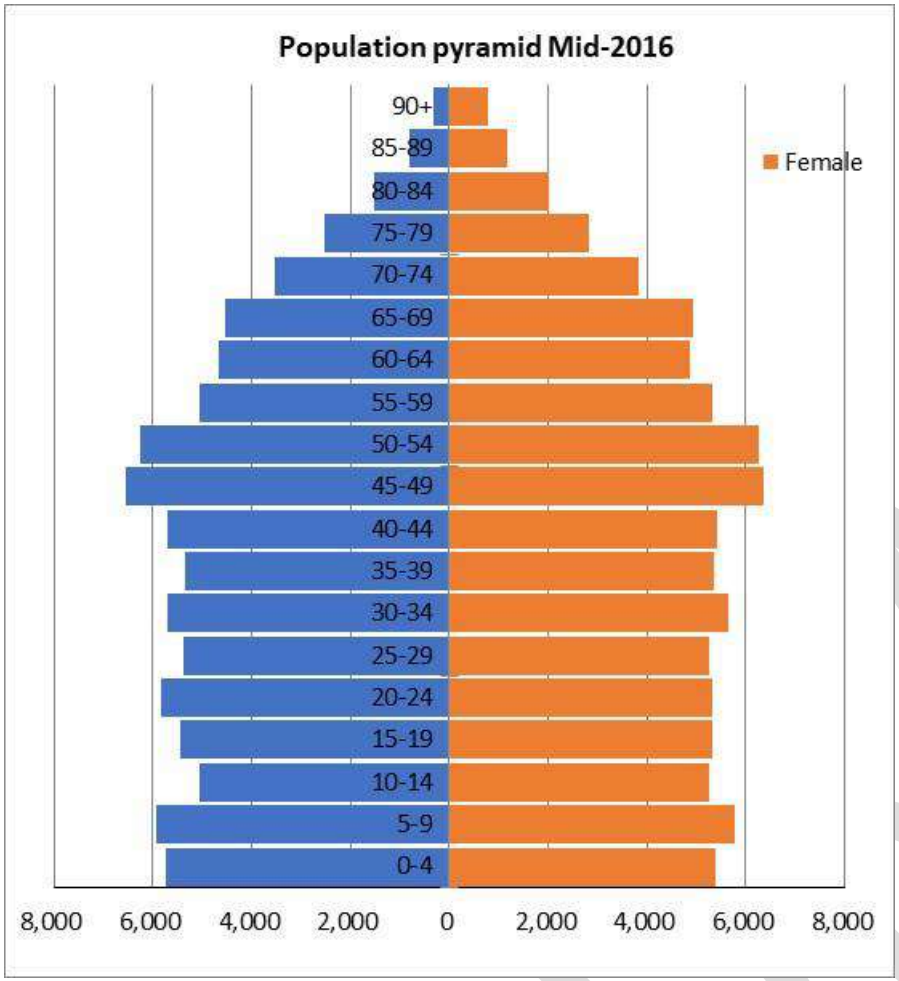
Source information *Interactive analysis of estimated UK population change, by geography, age and sex*

Release date *22 June 2017*

Age profile by gender: Shropshire

	UK		Shropshire	
Age	Female	Male	Female	Male
0-4	5.9%	6.4%	4.6%	5.0%
5-9	5.9%	6.4%	5.2%	5.5%
10-14	5.3%	5.7%	5.3%	5.4%
15-19	5.5%	6.0%	5.4%	5.8%
20-24	6.2%	6.7%	4.5%	5.4%
25-29	6.7%	7.0%	4.9%	5.9%
30-34	6.6%	6.8%	4.9%	5.4%
35-39	6.3%	6.4%	5.2%	5.2%
40-44	6.3%	6.4%	5.9%	5.8%
45-49	7.0%	7.0%	7.2%	7.4%
50-54	7.1%	7.0%	7.7%	7.9%
55-59	6.2%	6.2%	7.1%	7.0%
60-64	5.4%	5.3%	6.7%	6.5%
65-69	5.6%	5.4%	7.3%	6.9%
70-74	4.5%	4.2%	6.2%	5.8%
75-79	3.5%	3.1%	4.6%	4.1%
80-84	2.7%	2.1%	3.4%	2.9%
85-89	1.8%	1.2%	2.3%	1.6%
90+	1.2%	0.5%	1.6%	0.7%
Total	33,270,380	32,377,674	157,832	155,541

Age profile: Telford and Wrekin



Source and further information: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesanalysistool

Source name Office for National Statistics

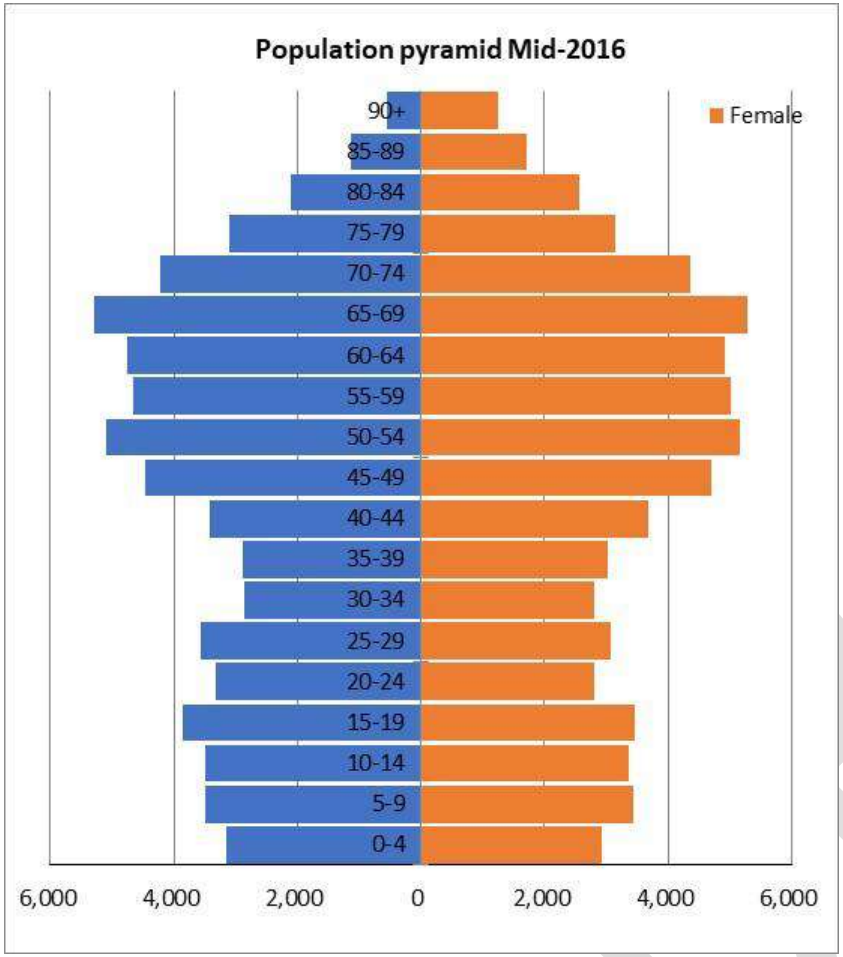
Source information Interactive analysis of estimated UK population change, by geography, age and sex

Release date 22 June 2017

Age profile by gender: Telford and Wrekin

	UK		Telford & Wrekin	
Age	Female	Male	Female	Male
0-4	**5.9%**	**6.4%**	6.2%	6.7%
5-9	**5.9%**	**6.4%**	6.6%	6.9%
10-14	**5.3%**	**5.7%**	6.0%	5.9%
15-19	**5.5%**	**6.0%**	6.1%	6.3%
20-24	**6.2%**	**6.7%**	6.1%	6.8%
25-29	**6.7%**	**7.0%**	6.0%	6.3%
30-34	**6.6%**	**6.8%**	6.5%	6.6%
35-39	**6.3%**	**6.4%**	6.1%	6.2%
40-44	**6.3%**	**6.4%**	6.2%	6.6%
45-49	**7.0%**	**7.0%**	7.3%	7.6%
50-54	**7.1%**	**7.0%**	7.2%	7.3%
55-59	**6.2%**	**6.2%**	6.1%	5.9%
60-64	**5.4%**	**5.3%**	5.6%	5.4%
65-69	**5.6%**	**5.4%**	5.7%	5.3%
70-74	**4.5%**	**4.2%**	4.4%	4.1%
75-79	**3.5%**	**3.1%**	3.2%	3.0%
80-84	**2.7%**	**2.1%**	2.3%	1.8%
85-89	**1.8%**	**1.2%**	1.3%	0.9%
90+	**1.2%**	**0.5%**	0.9%	0.4%
Total	**33,270,380**	**32,377,674**	87,074	85,902

Age Profile: Powys



Source and further information:

https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesanalysistool

Source name	Office for National Statistics
Source information	Interactive analysis of estimated UK population change, by geography, age and sex
Release date	22 June 2017

Age profile by gender: Powys

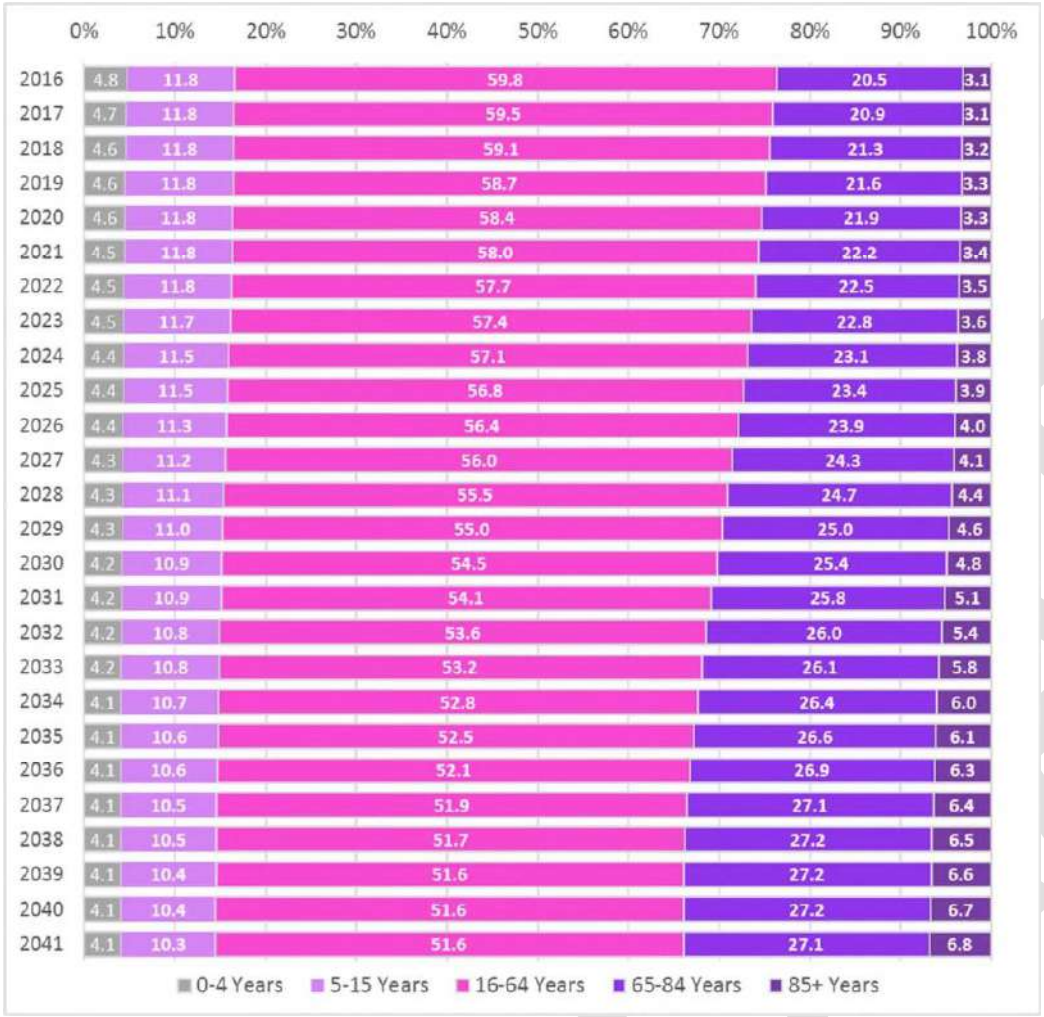
	UK		Powys	
Age	Female	Male	Female	Male
0-4	**5.9%**	**6.4%**	4.4%	4.8%
5-9	**5.9%**	**6.4%**	5.1%	5.3%
10-14	**5.3%**	**5.7%**	5.0%	5.3%
15-19	**5.5%**	**6.0%**	5.2%	5.9%
20-24	**6.2%**	**6.7%**	4.2%	5.1%
25-29	**6.7%**	**7.0%**	4.6%	5.4%
30-34	**6.6%**	**6.8%**	4.2%	4.4%
35-39	**6.3%**	**6.4%**	4.5%	4.4%
40-44	**6.3%**	**6.4%**	5.5%	5.2%
45-49	**7.0%**	**7.0%**	7.1%	6.8%
50-54	**7.1%**	**7.0%**	7.8%	7.8%
55-59	**6.2%**	**6.2%**	7.5%	7.1%
60-64	**5.4%**	**5.3%**	7.4%	7.3%
65-69	**5.6%**	**5.4%**	7.9%	8.1%
70-74	**4.5%**	**4.2%**	6.6%	6.5%
75-79	**3.5%**	**3.1%**	4.7%	4.7%
80-84	**2.7%**	**2.1%**	3.8%	3.2%
85-89	**1.8%**	**1.2%**	2.6%	1.7%
90+	**1.2%**	**0.5%**	1.9%	0.8%

Total	**33,270,380**	**32,377,674**	66,753	65,407

Projected Population Change by Broad Age Groups

Shropshire

Each of the broad population groups shown below represents a key life stage; Early Years (0-4 years); School Age (5-15 years); Working Age (16-64 years); Retirement Age (65-84 years) and Elderly (85 years and over). Individually, each of these population groups has specific needs which impact directly on the demand for public services. The table below expresses projected population change (2016-2041) by broad age group, as a proportion of the total population of Shropshire.



Source: Shropshire Council Summary Analysis – 2016 Sub-national Population Projections to 2041 for Shropshire (released by the Office for National Statistics (ONS) –24th May 2018

https://shropshire.gov.uk/information-intelligence-and-insight/facts-and-figures/population/future-projections/

Telford and Wrekin

	0-15	16-24	25-44	45-64	64-84	85+	All ages	Population change 2016-2031
Lakeside South	9,900	5,800	11,800	10,600	8,400	1,700	48,100	5,700
Hadley Castle	18,300	9,200	21,100	18,900	14,600	3,100	85,000	10,100
The Wrekin	12,100	7,000	16,100	14,900	11,400	2,200	63,700	7,500
Telford and Wrekin	**40,300**	**21,900**	**49,000**	**44,400**	**34,400**	**6,900**	**196,900**	**23,300**

Projections are only available for Telford and Wrekin as a whole, so these figures have been proportionally applied to localities based on 2015 population estimates. Counts have been independently rounded to the nearest 100.

Source: Objectively Assessed Need Report, Appendix B – Demographic Projections for Telford & Wrekin. Allocated to localities based on Office for National Statistics 2015 Output Area population Mid-Year Estimates

Note: We have been unable to obtain more up-to-date data.

Powys

Area Code	Area	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039
W92000004	Wales	3,092,036	3,099,890	3,108,054	3,116,371	3,124,784	3,133,336	3,142,024	3,150,821	3,159,716	3,168,551	3,177,158	3,185,467	3,193,400	3,200,884	3,207,927	3,214,526	3,220,698	3,226,467	3,231,833	3,236,805	3,241,390	3,245,614	3,249,512	3,253,097	3,256,412	3,259,522
W06000023	Wales	Powys	132,675	132,487	132,303	132,116	131,922	131,721	131,514	131,301	131,080	130,840	130,573	130,279	129,955	129,593	129,192	128,755	128,282	127,770	127,222	126,636	126,011	125,351	124,661	123,939	123,189	122,415

Source: https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Projections/Local-Authority/2014-based/populationprojections-by-localauthority-year

Disability

Disability	Local data % Shropshire	Local data % Telford and Wrekin	Defined Lower Super Output Areas (LSOA) Powys	Combined all defined areas	England comparative %
Long term condition / disability where day to day activities are limited a lot	8.4% (25,568)	9.0% (15,060)	9.2% (6,392)	8.7% (47,020)	8.3%
Long term condition / disability where day to day activities are limited a little	10.2% (31,258)	9.6% (15,935)	11.1% (7,686)	10.1% (54,879)	9.3%

Source: NOMIS

Marriage and civil partnership

Marital status	Local data % Shropshire	Local data % Telford and Wrekin	Defined Lower Super Output Areas (LSOA) Powys	Combined all defined areas	England comparative %
Married	48.3% (144,005)	45.9% (75,505)	51.7% (29,478)	45.9% (248,988)	46.6%
Same sex civil partnership	0.1% (319)	0.1% (217)	0.2% (107)	0.1% (643)	0.2 %

Source: Office for National Statistics (27 March 2011.) This table provides information that classifies residents aged 16 and over by marital and civil partnership status.

Race

Ethnic background	Local data % Shropshire	Local data % Telford and Wrekin	Defined Lower Super Output Areas (LSOA) Powys	Combined all defined areas	England comparative %
White British	95.4% (292,047)	89.5% (149,096)	96.6% (66,893)	93.7% (508,036)	79.8%
White Irish	0.5% (1,410)	0.4% (729)	0.3% (240)	0.4% (2,379)	1.0%
White: Gypsy or Irish Traveller	0.1% (312)	0.1% (166)	0.1% (61)	0.1% (539)	0.1%
White: Other	2.0% (6,105)	2.7% (4,424)	1.8% (1,246)	2.1% (11,775)	4.6%
Mixed/Multiple Ethnic Groups: White and Black Caribbean	0.2% (765)	0.9% (1,423)	0.2% (107)	0.4% (2,295)	0.8%
Mixed/Multiple Ethnic Groups: White and Black African	0.1% (231)	0.2% (278)	0.1% (44)	0.1% (553)	0.3%
Mixed/Multiple Ethnic Groups: White and Asian	0.2% (669)	0.5% (799)	0.2% (144)	0.2% (1,612)	0.6%
Mixed/Multiple Ethnic Groups: Other Mixed	0.2% (503)	0.3% (483)	0.1% (86)	0.1% (1,072)	0.5%
Asian/Asian British: Indian	0.2% (752)	1.8% (3,076)	0.1% (59)	0.7% (3,887)	2.6%

Asian/Asian British: Pakistani	0.1% (216)	1.3% (2,243)	0.0% (3)	0.4% (2,462)	2.1%
Asian/Asian British: Bangladeshi	0.1% (208)	0.1% (162)	0.1% (41)	0.1% (411)	0.8%
Asian/Asian British: Chinese	0.3% (1,020)	0.4% (647)	0.1% (56)	0.3% (1,723)	0.7%
Asian/Asian British: Other Asian	0.3% (893)	0.5% (863)	0.2% (138)	0.3% (1,894)	1.5%
Black/African/Caribbean/Black British: African	0.1% (302)	0.5% (863)	0.0% (21)	0.2% (1,346)	1.8%
Black/African/Caribbean/Black British: Caribbean	0.1% (164)	0.4% (607)	0.0% (33)	0.1% (804)	1.1%
Black/African/Caribbean/Black British: Other Black	0.0% (114)	0.1% (149)	0.0% (9)	0.1% (272)	0.5%
Other Ethnic Group: Arab	0.1% (179)	0.1% (86)	0.0% (12)	0.1% (277)	0.4%
Other Ethnic Group: Any Other Ethnic Group	0.1% (239)	0.2% (387)	0.1% (40)	0.1% (666)	0.6%

Source: KS201EW NOMIS Official for National Statistics, 27 March 2011

Religion

Religion	Local data % Shropshire	Local data % Telford and Wrekin	Defined Lower Super Output Areas (LSOA) Powys	Combined all defined areas	England comparative %
Christian	68.7% (210,268)	61.7% (102,892)	61.9% (39,089)	65.0% (352,249)	59.4%
Buddhist	0.3% (792)	0.2% (398)	0.3% (190)	0.3% (1,380)	0.5%
Hindu	0.1% (378)	0.5% (872)	0.1% (51)	0.2% (1,301)	1.5%
Jewish	0.04% (127)	0.04 (78)	0.1% (34)	0.04% (239)	0.5%
Muslim	0.3% (989)	1.8% (3,019)	0.2% (111)	0.8% (4,119)	5.0%

Sikh	0.1% (256)	1.3% (2,118)	0.0% (21)	0.4% (2,395)	0.8%
Other religion	0.4% (1,113)	0.4% (692)	0.6% (401)	0.4% (2,006)	0.4%
No religion	22.8% (69,725)	27.4% (45,599)	28.0% (17,690)	24.5% (133,014)	24.7%
Religion not stated	7.3% (22,481)	6.6% (10,973)	8.8% (5,575)	7.2% (39,029)	7.2%

Source: KS209EW NOMIS Office for National Statistics 27 March 2011

Sex

Protected group: Sex	Local data % Shropshire	Local data % Telford and Wrekin	Defined Lower Super Output Areas (LSOA) Powys	Combined all defined areas	England comparative %
Total	**306,129**	**166,641**	**69,233**	**542,003**	**100%**
Male population	49.5% (151,606)	49.5% (82,549)	49.7% (34,451)	49.5% (268,606)	49.2%
Female population	50.5% (154,523)	50.5% (84,092)	50.2% (34,782)	50.4% (273,397)	50.8%

Source: Office of National Statistics 4 October 2017

Sexual identity in the UK from 2012 to 2016 by region, sex, age, marital status, ethnicity and National Statistics Socio-economic Classification.

Deprivation

Deprivation	Local data % Shropshire	Local data % Telford and Wrekin	Defined Lower Super Output Areas (LSOA) Powys	Combined all defined areas	England comparative %
Economically active – unemployment rate	3.6% Oct 2016 - Sept 2017	4.6% Oct 2016 - Sept 2017	2.9% Oct 2016 - Sept 2017 Powys LA	N/A	4.3% Nov 2017 - Jan 2018
Deprivation score	16.69	24.85	-	19.57	21.67

Source of the unemployment data was from NOMIS. https://www.nomisweb.co.uk
Telford/England: https://www.nomisweb.co.uk/reports/lmp/la/1946157172/report.aspx?town=telford#tabeinact
Shropshire: https://www.nomisweb.co.uk/reports/lmp/la/1946157170/report.aspx?town=shropshire#tabeinact
Source of deprivation scores was cited in each of the fingertip PHE reports: http://fingertipsreports.phe.org.uk/health-profiles/2017/e06000051.pdf

Carers

Carers	Local data % Shropshire	Local data % Telford and Wrekin	Defined Lower Super Output Areas (LSOA) Powys	Combined all defined areas	England comparative %
Providing 1-19 hours of unpaid care	7.5% (22,835)	6.2% (10,313)	7.5% (5,159)	7.1% (38,307)	6.5%
Providing 20-49 hours of unpaid care	1.3% (4,046)	1.6% (2,653)	1.5% (1,016)	1.4% (7,715)	1.4%
Providing 50 hours or more of unpaid care	2.4% (7,379)	3.0% (4,978)	2.8% (1,908)	2.6% (14,265)	2.4%
% total of people providing unpaid care	11.2% (34,260)	10.8% (17,944)	11.6% (8,083)	11.1% (60,287)	10.3%

Source: KS301EW NOMIS Office for National Statistics 27 March 2011

Welsh speakers

Able to speak Welsh	No knowledge of Welsh	Population total	% of population able to speak Welsh	% of population with no knowledge of Welsh
24,187	108,789	132,976	18.19%	81.81%

Source: 2011 Census – Powys, Powys County Council, Statistical Research & Information Unit, Key Statistics Powys Unitary Authority, Release date: December 2013

Shrewsbury and Telford Hospital Trust Staff

The tables below identify the number of staff working at each of the two hospital sites (PRH – Princess Royal Hospital, Telford and RSH – Royal Shrewsbury Hospital) by protected characteristic. Data is not routinely collected on each of the protected characteristics but where this is collected it is included below.

Age

	Site	Total
16 - 20	PRH	25
	RSH	33
21 - 30	PRH	466
	RSH	600
31 - 40	PRH	566
	RSH	625
41 - 50	PRH	669
	RSH	805
51 - 60	PRH	703
	RSH	804
60+	PRH	159
	RSH	210

Disability

	Site	Total
No	PRH	2016
	RSH	2411
Not Declared	PRH	515
	RSH	590

Prefer Not To Answer	PRH	1
	RSH	4
Yes	PRH	56
	RSH	72

Gender

	Site	Total
Female	PRH	2159
	RSH	2396
Male	PRH	429
	RSH	681

Religion or Belief

	Site	Total
Atheism	PRH	250
	RSH	346
Buddhism	PRH	12
	RSH	10
Christianity	PRH	1349
	RSH	1564
Hinduism	PRH	53
	RSH	43
I do not wish to disclose my religion/belief	PRH	752
	RSH	935

Islam	PRH	64
	RSH	42
Judaism	RSH	2
Other	PRH	88
	RSH	122
Sikhism	PRH	20
	RSH	13

Marriage or civil partnership

	Site	Total
Civil Partnership	PRH	6
	RSH	7
Divorced	PRH	173
	RSH	192
Legally Separated	PRH	33
	RSH	38
Married	PRH	1484
	RSH	1659
Single	PRH	787
	RSH	1058
Unknown	PRH	85
	RSH	101
Widowed	PRH	20
	RSH	22

Race

	Site	Total
Asian or Asian British	PRH	183
	RSH	158
Black or Black British	PRH	56
	RSH	35
Chinese or Other Ethnic Group	PRH	63
	RSH	94
Mixed	PRH	30
	RSH	21
Undefined	PRH	25
	RSH	43
White	PRH	2231
	RSH	2726

Sexual orientation

	Site	Total
Bisexual	PRH	13
	RSH	14
Gay	PRH	9
	RSH	13
Heterosexual	PRH	1833
	RSH	2170
I do not wish to disclose my sexual orientation	PRH	729
	RSH	872
Lesbian	PRH	4

	RSH	8

Appendix 2: Equality legislation

The Equality Act 2010

The Equality Act 2010 protects people against discrimination, harassment and victimisation in relation to housing, education, clubs, the provision of services and work. It unifies and extends previous equality legislation.

The groups the Act specifically covers are called ‘protected characteristics’. These are:

- Age
- Disability
- Gender Reassignment
- Marriage and Civil Partnership (with some restrictions as protection doesn’t apply to service provision)
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual Orientation.

Information on protected characteristics

Age:

This refers to a person belonging to a particular age (e.g. 50-year-old) or range of ages (e.g. 18 to 30 year old). Age includes treating someone less favourably for reasons relating to their age (whether young or old).

Disability:

A person has a disability if s/he has a physical, mental impairment, Learning Disability or sensory impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. Disability includes sensory impairments such as sight and hearing. Also includes mental impairments such as Asperger’s syndrome, autism, dyslexia and mental illness. Within the act there is no requirement that the mental illness has to be clinically recognised. The focus of the act is the impairment rather than the cause.

Certain medical conditions are protected under disability. These include Cancer, HIV and Multiple Sclerosis.

People with genetic conditions, would be protected under disability if the effect of the condition has a substantial and long term adverse effect.

People with a past disability which falls into the definition remain protected.

Gender Reassignment:

This refers to a person proposing to undergo, is undergoing (or part of process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex. The term of transgender falls under this protected group.

Marriage and Civil Partnership:

Protection is for people that are legally married or in a legal civil partnership. It only recognises people in formally recognised unions and therefore does not include people that are not married, cohabiting couples, widows, divorcees and fiancées. Protection of this group does not extend to service provision.

Pregnancy and Maternity:

The act protects women that are discriminated due to their pregnancy or maternity – which includes breastfeeding. This protection may relate to current or previous pregnancy. Protection extends after the birth after 26 weeks from the date of the birth.

Protection includes women where baby was still born in cases where she was pregnant for at least 24 weeks prior to birth.

Race:

Race includes colour, nationality, and or ethnic or national origins. Nationality is determined by citizenship.

Religion and belief:

The Equality Act does not define religion or belief explicitly. It includes the main world religions such as Christianity, Islam, Judaism, Hinduism, Sikhism, Humanism, Secularism and Paganism. The act protects any religion, religious or philosophical belief and a lack of religion / belief.

Sex:

A man or a woman, but also includes men and women as groups. Treating a man or woman or men and women less favourably for reasons relating to their sex. People describing themselves as non-binary are not currently recognised within the act.

Sexual Orientation:

A person's sexual attraction towards their own sex, the opposite sex or more than one sex. This includes people who are Lesbian, Gay, Bisexual or Heterosexual.

Public Sector Equality Duty (2011)

PSED section 149 of the Equality Act 2010 states in the exercise of their functions must have due regard to the duty to:

- eliminate unlawful discrimination, harassment, victimisation and other prohibited conduct
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those that do not.

The Health and Social Care Act (2012) 14T Duties as to reducing inequalities

Each clinical commissioning group, must in the exercise of its functions, have due regard to the need to:

- reduce inequalities between patients with respect to their ability to access health services
- reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

These principles have been taken from the Equality and Human Rights Commission's paper on making fair financial decisions (Equality and Human Rights Commission, 2012).

Case law sets out broad principles about what public authorities need to do to have due regard to the aims set out in the general equality duties. These are sometimes referred to as the 'Brown principles' and set out how courts interpret the duties. They are not additional legal requirements, but form part of the Public Sector Equality Duty as contained in section 149 of the Equality Act 2010. Under the duty local authorities must, in the exercise of their functions have due regard to the need to:

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

In summary, the Brown principles say that:

- Decision-makers must be made aware of their duty to have 'due regard' and to the aims of the duty.
- Due regard is fulfilled before and at the time a particular policy that will or might affect people with protected characteristics is under consideration, as well as at the time a decision is taken.
- Due regard involves a conscious approach and state of mind. A body subject to the duty cannot satisfy the duty by justifying a decision after it has been taken. Attempts to justify a decision as being consistent with the exercise of the duty, when it was not considered before the decision, are not enough to discharge the duty. General regard to the issue of equality is not enough to comply with the duty.
- The duty must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.

- The duty has to be integrated within the discharge of the public functions of the body subject to the duty. It is not a question of 'ticking boxes'.
- The duty cannot be delegated and will always remain on the body subject to it.

It is good practice for those exercising public functions to keep an accurate record showing that they had actually considered the general equality duty and pondered relevant questions. If records are not kept it may make it more difficult, evidentially, for a public authority to persuade a court that it has fulfilled the duty imposed by the equality duties.

Sources: Equality and Human Rights Commission (2012). Making Fair Financial Decisions: An Assessment of HM Treasury's 2010 Spending Review conducted under Section 31 of the 2006 Equality Act. Manchester: Equality and Human Rights Commission.

The Welsh Language Measure 2011

The Welsh Language (Wales) Measure 2011 establishes a legal framework to impose a duty on some organisations to comply with standards of conduct on the Welsh Language. The Measure notes that Welsh Ministers may, by regulations, specify standards in the following areas:

- service delivery
- policy making
- operational
- promotion
- record keeping

The duties which come from the standards mean that organisations should not treat the Welsh language less favourably than the English language, together with promoting and facilitating the use of the Welsh language (making it easier for people to use in their day-to-day-life).

For the NHS in Wales, guidance on the delivery of the requirements in the Measure is set out in "More Than Just Words" which sets out a framework by which Health Boards can ensure an "active offer" of services in Welsh. This reinforces that "Many people can only communicate and participate in their care as equal partners effectively through the medium of Welsh. Service providers therefore have a responsibility to meet these care needs. People choose to receive health and social care services in Welsh because that is their preference and right. For others, however, it is more than just a matter of choice – it is a matter of need. This is especially true for the elderly, people with dementia or a stroke, or young children who may only speak Welsh." (More Than Just Words: Follow-on Strategic Framework for Welsh Language Services in Health, Social Service and Social Care, Welsh Government, 2016).

More recently the Welsh Language Standards (No. 7) Regulations 2018 have been approved by Welsh Government. These Regulations specify standards under Section 26 of the Welsh Language (Wales) Measure 2011 in relation to the conduct of the NHS. Standard 69 creates the expectation that the development of policies, including consultation on those policies, will consider the effects on (a) the opportunities for persons to use the Welsh Language and (b) treating the Welsh language no less favourably than the English Language (Standards 69 to 78).

A key step in the meeting these duties is to undertaken impact assessment in relation to Welsh Language as part of the wider equality impact assessment for substantial service changes, and Community Health Councils in Wales will expect to see evidence of this impact assessment from English NHS bodies in fulfilment of the requirements for cross-border consultation set out in Regulation 27 of the Community Health Council (Wales) Regulation 2010 and related legislation and guidance.

Appendix 3: Consultation engagement with seldom heard groups

The following groups and organisations were engaged with as part of the Future Fit consultation in Shropshire, Telford and Wrekin and Powys. This does not include more general public engagement work where some of the seldom heard groups may have been engaged with. The engagement comprises a mixture or events and meetings as well as circulation of consultation information.

Date	Location	Group name	Equalities group
30-May	Halesfield, Telford	Rheumatoid Arthritis support group	Disability
June	Shropshire, Telford & Wrekin	Enable	Disability - mental health
02-Jun	Malinslee, Telford	Malinslee Fun Day	People living in a deprived area
04-Jun	Shropshire, Telford and Wrekin	Shropshire Assn of Local Councils	All, People living in rural and/or deprived areas
05-Jun	Dawley, Telford	Information stand at Dawley Medical Practice	People living in a deprived area
06-Jun	Telford & Wrekin	Information stand at Telford Town and Parish Conference	People living in rural and/or deprived areas
06-Jun	Shropshire	Vision Technology and Training Shropshire	Disability - sensory impairment
07-Jun	Dawley, Telford	Telford Patients First Group	People living in a deprived area

07-Jun	Madeley, Telford	Information stand at TELDOC Madeley PPG	People living in a deprived area
12-Jun	Shropshire	All schools	Age - children
12-Jun	Shropshire	Learning Disability Partnership Board	Disability - learning
13-Jun	Shropshire, Telford & Wrekin	Shropshire Deaf and Hard of Hearing	Disability - sensory impairment
13-Jun	Woodside, Telford	Information stand at Woodside Medical Practice	People living in a deprived area
14-Jun	Brookside, Telford	Pop-up at Brookside community centre	People living in a deprived area
14-Jun	Dawley, Telford	Pop-up at Dawley Town Hall	People living in a deprived area
14-Jun	Shropshire, Telford and Wrekin	Shropshire Partners in Care	Carers, Age - older people, Disability
18-Jun	Shropshire, Telford and Wrekin	Age UK	Age - older people
18-Jun	Telford	Juniper House Training	Age - young people
19-Jun	Shropshire	Pan disability forum	Disability - physical, Disability - sensory impairment
19-Jun	Oakengates, Telford	Information stand at A Life Outside of Caring	Age - young people, Age - older people, Race

19-Jun	Pontesbury	Pop-up	People living in a rural area
19-Jun	Albrighton	Pop-up	People living in a rural area
20-Jun	Shropshire, Telford and Wrekin	Shropshire Chamber of Commerce	Age - working age people
21-Jun	Bridgnorth	Bridgnorth Carers group	Carers, Age - older people
21-Jun	Shropshire, Telford and Wrekin	Energize	Age - young people
22-Jun	Shrewsbury	Making it Real Board	Age - older people
22-Jun	Shropshire	Autism Network	Disability – people with autism
22-Jun	Telford and Wrekin	Walking for Health Telford	Age - older people
26-Jun	Telford	Jayne Sargent Foundation	Age - older people, people living with cancer
26-Jun	Shropshire	Maternity Voices Partnership meeting	Maternity - pregnant women, mothers
26-Jun	North Powys	Primary School Have Your Say Day	Age - children
26-Jun	Cleobury, Kinlet and Highley, Shropshire	Cleobury, Kinlet and Highley Local Joint Committee	People living in a rural area

27-Jun	Dawley, Telford	George Chetwood Court, Sheltered Living Coffee Morning	Age - older people, people living in a deprived area
27-Jun	Shrewsbury (Bicton)	Alzheimers Society meeting	Age - older people, Disability - mental health, people with dementia, carers
27-Jun	Brookside, Telford	Recharge	Age/Sex - young women, People living in a deprived area
28-Jun	Horsehay, Telford	Unit TEN	Disability - learning
28-Jun	Shrewsbury	DEEP group	Age - older people, Disability - mental health, people with dementia, Sex - men
28-Jun	Wellington, Telford	Breatheasy Support Group	Disability - physical, Age - older people
28-Jun	Church Stretton	Pop-up	People living in a rural area
28-Jun	Craven Arms	Pop-up	People living in a rural area
28-Jun	Shrewsbury	Shrewsbury College	Age - young people
29-Jun	Hadley, Telford	Over 50s Club	Age - older people

29-Jun	Telford	Maninplace	People living in a deprived area, homeless, army veterans
29-Jun	Telford	Perinatal support meeting	Sex - women, Maternity and pregnancy
30-Jun	Shropshire	Armed Forces Day, Family Event	Military personnel and families
30-Jun	Telford	Telford Priory School Festival of Culture and Diversity	Race, Religion, Age - young people
30-Jun	Shropshire, Telford and Wrekin	Royal British Legion	Military veterans
July	Shropshire	Children's centres	Sex - women, Maternity and pregnancy, Age - young women, parents
July	Shropshire	Pre-school learning alliance	Parents
01-Jul	Telford	Gurdwara	Religion - Sikh
01-Jul	Madeley, Telford	Madeley Court Fun Day	People living in a deprived area, parents
02-Jul	Shropshire	Making it Real Stakeholders	Age - older people
02-Jul	Selattyn, Gobowen, Weston Rhyn and St Martins, Shropshire	Selattyn, Gobowen, Weston Rhyn and St Martins Local Joint Committee	People living in a rural area

03-Jul	Telford and Wrekin	Fibromyalgia group	Disability
03-Jul	Telford	Job Centre / DWP	Age - working age people
03-Jul	Shropshire, Telford & Wrekin	Shropshire Partners in Care	Carers, Age - older people, Disability
04-Jul	Telford	PODs meeting	Age - young people, Disability, parents of children with a disability, carers
04-Jul	Roddington, Telford and Wrekin	Parish council meeting	People living in a rural area
04-Jul	Llanidloes, Powys	Llanidloes Patient Forum	People living in a rural area
05-Jul	Telford	Central Mosque	Religion - Muslim, Race
06-Jul	Shrewsbury	Shrewsbury College	Young people
08-Jul	Wellington, Telford	Lions Day	Parents
09-Jul	Shropshire	Armed Forces Covenant	Military and veterans
09-Jul	Shropshire	Narrow Boat community	People living in a rural area
09-Jul	Donnington, Telford	MoD Donnington	Military
09-Jul	Cosford	RAF Cosford	Military
09-Jul	Powys	Powys Older People's Partnership	Age – older people
10-Jul	Wellington, Telford	Information stand at Leisure Centre	Parents
10-Jul	Telford	Mental health forum	Disability - mental health

10-Jul	Cleobury Mortimer	Young Health Champions	People living in a rural area, Age - young people
10-Jul	Powys	Children, Young People and Families Network	Age – children and young people, Parents
10-Jul	Llanfyllin, Powys	Llanfyllin Patient Forum Group	People living in a rural area
11-Jul	Madeley, Telford	Information stand at dry drinkers group	Disability - mental health, People living in a deprived area
11-Jul	Market Drayton	Alzheimers Society meeting	Age - older people, Disability - mental health, people with dementia, carers
12-Jul	Shrewsbury	Dementia Action Alliance	Age - older people, Disability - mental health, people with dementia
12-Jul	Tern Hill, Shropshire	1st Irish Regiment Family Health Day	Military personnel and families
12-Jul	Woodside, Telford	meeting with PPG	People living in a deprived area
12-Jul	South West Shropshire	South West Shropshire Local Joint Committee	People living in a rural area
13-Jul	Shrewsbury	Shrewsbury Access Group	Disability - physical, Disability - sensory impairment, Age - older people, parents

13-Jul	Telford	Boys Brigade	Age - young people, Sex - men
13-Jul	Shrewsbury	National Citizenship Scheme	Age - young people
14-Jul	Shrewsbury	Young Health Champions	Age - young people
14-Jul	Hadley, Telford	African and Afro Caribbean Resource Centre	Race, People living in a deprived area
15-Jul	Telford	Carnival of Giants	Age - children and young people, parents
16-Jul	Bishops Castle	Pop-up	People living in a rural area
16-Jul	Clun	Pop-up	People living in a rural area
16-Jul	Madeley, Telford	Information stand at Court St Medical Practice	People living in a deprived area
16-Jul	Whitchurch	Manor House Lane Gypsy and Traveller Site	Race - gypsies and travellers
17-Jul	Cleobury Mortimer	Young Health Champions	People living in a rural area, Age - young people
17-Jul	Telford and Wrekin	Carers Partnership Board	Carers
17-Jul	Market Drayton	Care and share group	Carers, Age - older people, Disability – mental health, people with dementia

17-Jul	Oswestry	Park Hall Gypsy and Traveller Site	Race - gypsies and travellers
18-Jul	Brookside, Telford	Meeting	Sexual orientation - LGBT
18-26 Jul	Shrewsbury and Telford	Information stands at maternity clinics x 6	Maternity - pregnant women, new parents
19-Jul	Hadley, Telford	Information stand at multi-cultural event	Race, religion, people living in a deprived area
19-Jul	Bridgnorth	Singing for the Brain	Age - older people, Disability - mental health, people with dementia, carers
19-Jul	Kynnersley, Telford and Wrekin	Parish council meeting	People living in a rural area
19-Jul	Woodside, Telford	Information stand at Community centre	People living in a deprived area
19-Jul	Tibberton & Cherrington, Telford and Wrekin	Tibberton & Cherrington Parish Council	People living in a rural area
20-Jul	Shropshire	PACC Parent and Carer Council	Disability - learning, Disability - physical, carers, parents
21-Jul	Bridgnorth	Pop-up	People living in a rural area
22-Jul	Arleston, Telford	Funday	Age - children and young people, parents, people living in a deprived area

23-Jul	Wellington, Telford	Information stand at TACT	Disability - mental health People with an addiction,
23-Jul	Shrewsbury	National citizenship programme	Age - young people, LGBT, autism, carers
23-Jul	Telford	Narcotics Anonymous	Disability - mental health, people with an addiction, people living in a deprived area,
24-Jul	Madeley, Telford	Town Council Meeting	People living in a deprived area
24-Jul	Telford	LGBT support meeting	LGBT people
24-Jul	Ludlow	Children's Centre, Family drop in	Age - women of child-bearing age, mothers, people living in a deprived area
24-Jul	Craven Arms	Children's Centre, Family drop in	Age - women of child-bearing age, mothers, people living in a rural area, Race - Indian, Pakistani, Religion - Muslim
24-Jul	Telford	Telford LGBT	Sexual orientation - LGBT
24-Jul	Sutton Hill, Telford	Information stand at Community Centre	People living in a deprived area
25-Jul	Shrewsbury	Taking Part	Disability - learning
25-Jul	Oswestry	Carers group	Age - older people, carers

25-Jul	Oswestry	Children's Centre, Stay and play	Age - women of child-bearing age, mothers, parents of children with additional needs
25-Jul	Waters Upton	Parish council meeting	People living in a rural area
25-Jul	Malinslee, Telford	Information stand at TELDOC Malinslee Surgery	People living in a deprived area
26-Jul	Near Shrewsbury	Lunch group	LGBT, People living in a rural area, Age - working age people
26-Jul	Telford	Senior Citizens Forum	Age -older people, carers
26-Jul	Telford	Wrekin Housing Trust	Age - older people
26-Jul	Wem	Pop-up	People living in a rural area
26-Jul	Wellington, Telford	Maninplace	Homeless, army veterans
26-Jul	Hadley, Telford	Sikh ladies group	Race, religion, sex, people living in a deprived area
27-Jul	Dawley, Telford	Pop-up	People living in a deprived area
27-Jul	Wellington, Telford	Information stand at Telford Mosque	Race, Religion - Muslim, Sex - male and female
29-Jul	Hadley, Telford	Sikh temple	Race, religion, sex
30-Jul	Albrighton	Children's Centre, Stay and play	Age - women of child-bearing age, mothers, military families

30-Jul	Shropshire	Longden / Ford / Rea Valley and Loton and Tern Severn Valley Local Joint Committees	People living in a rural area
31-Jul	Bridgnorth	Children's Centre, Family drop in	Age - women of child-bearing age, mothers
30-Jul	Sutton Hill, Telford	Information stand at Sutton Hill Medical Practice	People living in a deprived area
31-Jul	Oswestry	Sight loss group	Disability - sensory impairment
31-Jul	Shrewsbury	Bumps and babies	Age - women of child-bearing age, mothers
31-Jul	Wellington, Telford	Alzheimers Society support group	Disability – mental health, people with dementia, carers
01-Aug	Bishops Castle	Around the town	Age - older people, Age - working age people, people living in a rural area
02-Aug	Whitchurch	Wellbeing forum	Councillor, Voluntary sector, Statutory services, Community support
02-Aug	Telford	Visually impaired patient support group	Disability - sensory impairment
03-Aug	Albrighton	Care and share group	Carers, Age - older people, Disability – mental health, people with dementia

03-Aug	Madeley, Telford	Pop-up, leisure centre	People living in a deprived area
03-Aug	Newport	Dementia Conference	Disability - mental health, Age - older people
04-Aug	Telford town centre	Pop up at bowling alley	Age- children and young people, Parents
04-Aug	Telford town centre	Pop up at Imax cinema	Age- children and young people, Parents
06-Aug	Ludlow	Information stand at Functional fitness MOT	Age - older people, Carers
06-Aug	Newport	Bumps to breastfeeding support group	Maternity - pregnant women, Age - women of child-bearing age, mothers
06-Aug	Telford	Food bank	People living in a deprived area
07-Aug	Shropshire	Shropshire wheelchair group	Disability - physical, Carers
07-Aug	Whitchurch	Hard of Hearing Group	Age - older people, Disability - sensory impairment
07-Aug	Shrewsbury	Gay professional men	Sexual orientation - LGBT, Age - working age people
07-Aug	Newport	Alzheimer's Peer Support Group	Disability - mental health

07-Aug	Shrewsbury	Carers Trust for All	Carers, Age - older people, Disability - physical, mental health and learning
07-Aug	Wellington, Telford	Information stand at coffee morning, Belmont Centre	Age - older people, Disability
07-Aug	Newtown	Small steps	Disability -mental health, Age - young people, Sexual orientation - LGBT
08-Aug	Shropshire	Shropshire Mind	Disability -Mental health, learning, Age - older people, women of childbearing age
08-Aug	Overdale, Telford	Bumps to breastfeeding support group	Maternity - pregnant women, Age - women of child-bearing age, mothers, people living in a deprived area
08-Aug	Sutton Hill, Telford	Pop-up	People living in a deprived area
08-Aug	Sutton Hill, Telford	Sutton Hill Medical Practice PPG	People living in a deprived area
08-Aug	Hadley, Telford	Information stand at TELDOC Hadley Health Centre	People living in a deprived area
08-Aug	Wellington, Telford	Branches/TACT Service User Meeting	Disability - Mental health, People with an addiction

09-Aug	Hadley, Telford	Pop-up	People living in a deprived area
09-Aug	Shrewsbury (Harlescott)	Elim Riversway Church, Food drop in/support group	Age - older people and young families, Disability - mental health, Race - BAME, Religion, People living in a deprived area
09-Aug	Hadley, Telford	Carers group	Carers, people living in a deprived area
09-Aug	Telford	Citizens Advice Bureau	All, people living in a deprived area
09-Aug	Shropshire	Breast feeding support	Maternity
09-Aug	Shropshire, Telford and Wrekin	Maternity Voices Shropshire, Telford and Wrekin	Maternity
10-Aug	Sutton Hill, Telford	Bumps to breastfeeding support group	Maternity - pregnant women, Age - women of child-bearing age, Mothers, People living in a deprived area
10-Aug	Telford	One World UK (English Café)	Sex - female, Race - south-east Asian
13-Aug	Wellington, Telford	Inbetweeners	Carers, Age - young people
13-Aug	Aqueduct, Telford	TELDOC Aqueduct Surgery	People living in a deprived area

14-Aug	Wellington, Telford	Autism Hub	Disability - mental health
14-Aug	Hadley, Telford	Thrive	Age - young people, people living in a deprived area, homeless
14-Aug	Shropshire	Stroke Association	Age - older people, Disability, carers
14-Aug	Edgmond, Newport	Parish council meeting	People living in a rural area
14-Aug	Shrewsbury	Tinnitus group	Disability - sensory impairment
14-Aug	Telford	Breast cancer group	Sex - female
14-Aug	Newtown	Bibs Group	Sex - female, Parents of young children
14-Aug	Telford	Sex worker - agreed to talk with other workers	Sex - female
14-Aug	Clunbury, Shropshire	Clunbury Parish Council Meeting	People living in a rural area.
15-Aug	Whitchurch	Baby group	Age -women of child-bearing age, mothers
15-Aug	Shropshire and mid-Wales	Information stand at Shropshire Cancer Forum	Age - older people
15-Aug	Telford	Chinese Arts & Cultural Centre	Race - Chinese, Religion

16-Aug	Shrewsbury	Senior Citizens Forum	Age - older people
16-Aug	Shropshire	Refugee Action	Refugees, Race - BME, Religion
16-Aug	Ellesmere	ABP	Race - Polish, Romanian, Bulgarian, Religion, Age - working age people
16-Aug	Hadley, Telford	Age Uk Day Centre	Age - older people, Disability
16-Aug	Hadley, Telford	Highfield House Retirement housing	Age - older people, People living in a deprived area
17-Aug	Shropshire	Young Farmers	Age - young people, People living in a rural area
17-Aug	Dothill, Telford	Lakewood Court Care Home	Disability - learning, people living in a deprived area
17-Aug	Dothill, Telford	Lakewood Wellbeing Centre	Disability - learning, people living in a deprived area, Mental health, dementia
17-Aug	Shropshire	Rural Support Network	People living in a rural area, Age - older people, Carers
17-Aug	Welshpool	Bibs Group	Sex - female, parents of young children
20-Aug	Wem	Stay and Play	Age -women of child-bearing age, mothers
20-Aug	Shrewsbury/Shropshire	National Citizenship Scheme	Age - young people

20-Aug	Newport	Retirement Village Buttercross Court	Age - older people
21-Aug	Telford	Gypsy and traveller site	Race - gypsies and travellers, Age - women of child-bearing age, Religion, carers
21-Aug	Madeley, Telford	Chilcott Gardens Retirement Living	Age - older people, People living in a deprived area
21-Aug	Shropshire	Syrian refugee boys group	Refugees, Race - BME, Religion
21-Aug	Telford	Telford Christians Together (Churches)	Religion-Christian
22-Aug	Shropshire	Musketeers and Maidens	Disability - physical
22-Aug	Ketley, Telford	Ketley Good Companions	Age - older people
22-Aug	Shrewsbury	LGBT-friendly places	Sexual orientation - LGBT
22-Aug	Shrewsbury	Mencap	Disability - learning
22-Aug	Madeley, Telford	Pop-up	People living in a deprived area
22-Aug	Wellington, Telford	Oakwood Retirement Village	Age- older people
22-Aug	Hadley, Telford	Haybridge Hall Retirement Housing	Age- older people, people living in a deprived area

22-Aug	Telford	STABLE	Disability - epilepsy
23-Aug	Telford	Gypsy and traveller site	Race - gypsies and travellers
23-Aug	Telford	Polish shops	Race - Polish, Religion
23-Aug	Telford	Information stand at Café Kix (Fujitsu)	Age - working age people
24-Aug	Shrewsbury	Information stand at Billcar Precision Engineering Ltd.	Age - working age people
25-Aug	Telford	Pop-up at Telford Ice Rink	Age - young people, parents
25-Aug	Telford	Pop-up at Telford United Football Stadium	Age - young people, Sex – men, parents
28-Aug	Telford	Telford Mind	Disability - mental health
28-Aug	Telford	Information stand at Café Kix (Fujitsu)	Age - working age people
28-Aug	Cleobury Mortimer	Stroke support group	Carers, Age - older people, Disability
28-Aug	Oswestry	Jools Payne Partnership - Syrian Refugee Group	Race - BAME, refugees, Religion

28-Aug	Dawley, Telford	Hindu temple	Religion - Hindu, Race - BAME, People living in a deprived area
28-Aug	Lawley, Telford	Retirement Village Bournville House Oaktree Centre	Age - older people
28-Aug	Newport	Food Bank	People living in a deprived area
28-Aug	Lawley, Telford	ABC Nursery	Women of child-bearing age, mothers
29-Aug	Newtown	Befrienders lunch group	Age - older people
29-Aug	Oakengates, Telford	Pop-up	People living in a deprived area
29-Aug	Woodside, Telford	Pop-up	People living in a deprived area
29-Aug	Woodside, Telford	Age UK day centre	Age - older people, People living in a deprived area , Disability
30-Aug	Market Drayton	Bumps and babies	Women of child-bearing age, mothers
30-Aug	Dawley, Telford	Carers support group	Carers, people living in a deprived area
30-Aug	Woodside, Telford	Information stand at Challenging Perceptions	Age - young people, mental health

30-Aug	Oakengates, Telford	Salvation Army	Religion - Christian
30-Aug	Halesfield, Telford	Boxwood Café	Age - working age people, sex - men
30-Aug	Shrewsbury	Autism Hub	Disability - people with autism
30-Aug	Shrewsbury	A4U	People living in a deprived area , Disability - mental health, physical, learning, Carers
30-Aug	Shrewsbury	Louise House Community Hub	Age - older and younger people, Disability - mental health, Carers
30-Aug	Lanidloes	Bibs Group	Sex - female, parents of young children
31-Aug	Craven Arms	Mennonite (Amish) community	Religion
01-Sep	Oakengates, Telford	Information stand at ICAN2	Disability - learning, parents of children with disabilities
03-Sep	Trench, Telford	Information stand at ICAN2	Disability - learning, parents of children with disabilities
03-Sep	Muxton	Bumps and babies	Women of child-bearing age, mothers, people living in a rural area
03-Sep	Donnington, Telford	Age UK Day Centre	Age - older people, Disability

03-Sep	Lilleshall	Parish council meeting	All, people living in a rural area
04-Sep	Market Drayton	Senior Citizens Forum	Carers, Age - older people
04-Sep	Hadley, Telford	Hadley and Leegomery parish council	All, people living in a deprived area
04-Sep	Newport	Age UK	Age - older people
04-Sep	Woodside, Telford	Woodlands View and Meadowcroft Court supported living	Age - young people, people living in a deprived area, homeless or at risk of homelessness
05-Sep	Market Drayton	Stroke Club	Carers, Age- older people, Disability
05-Sep	Market Drayton	Chlidren's Centre	Age - women of childbearing age, Sex - women
05-Sep	Shrewsbury	The Ark	People living in an area of deprivation, homeless
05-Sep	Shropshire	Mental health forum	Disability - mental health
05-Sep	Minsterley	Muller	Age-working age people, Race - Eastern European
05-Sep	Telford	Information stand at Café Kix (Fujitsu)	Age - working age people

05-Sep	Donnington, Telford	Age UK day centre	Age - older people
05-Sep	Shropshire	West Mercia Police Headquarters	Age - working age people
05-Sep	Wellington, Telford	Swimming After Surgery	Sex-women, cancer survivors
05-Sep	Telford	Train Station	Age - working age people
05-Sep	Shrewsbury	Train Station	Age - working age people
06-Sep	Telford	Train Station	Age - working age people
06-Sep	Shrewsbury	Train Station	Age - working age people
06-Sep	Oswestry	"OsNosh"	Homeless, People living in a deprived area
06-Sep	Shrewsbury	Shropshire Fire and Rescue Service	Age - working age people
06-Sep	Telford	Epson Telford Ltd	Age - working age people
06-Sep	Shrewsbury	Morris Lubricants	Age - working age people
06-Sep	High Ercall	Village Hall/Shop	All, people living in a rural area
06-Sep	Ironbridge	Village Hall/shop	All, people living in a rural area

06-Sep	Preston upon the Weald Moor	Church	All, people living in a rural area
06-Sep	Bridgnorth	Rhea Estate sheltered housing scheme	Age - older people, people living in a rural area
07-Sep	Wellington	Train station	Age - working age people
07-Sep	Shrewsbury	Market hall	Age - older people, working age people
07-Sep	Market Drayton	Culina/IPS	Age - working age people
07-Sep	Whitchurch	Grocontinental	Age - working age people
09-Sep	Madeley, Telford	African faith group	Race, Religion, People living in a deprived area

Appendix 4: Profile of consultation survey respondents

Profile information	*N*	%
Gender		
Male	6569	36%
Female	11090	61%
Intersex	8	0%
Other	19	0%
Prefer not to say	350	2%
Gender reassignment?		
Yes	55	0%
No	15375	94%
Prefer not to say	929	6%
Age		
16-26	775	4%
27-37	1732	10%
38-47	2149	12%

48-58	3102	17%
59-69	4399	24%
70+	5356	30%
Prefer not to say	542	3%
Ethnicity		
White - British	15783	88%
White - Welsh	1057	6%
White - Irish	77	0%
White - Other European	113	1%
White - Other	54	0%
Asian - Indian	107	1%
Asian - Pakistani	57	0%
Asian - Bangladeshi	6	0%
Asian - Other	10	0%
Black - Caribbean	12	0%
Black - African	10	0%
Black - British	21	0%
Black - Other	3	0%

Mixed - White and Black Caribbean	32	0%
Mixed - White and Black African	8	0%
Mixed - White and Asian	22	0%
Mixed - Arab	8	0%
Mixed - Other	24	0%
Other - Chinese	13	0%
Other - Filipino	7	0%
Other - Vietnamese	1	0%
Other - Thai	2	0%
Other - Other	2	0%
Gypsy - Irish	1	0%
Gypsy - Romany	3	0%
Gypsy - Other	16	0%
Prefer not to say	484	3%
Religion		
Christianity	10375	59%
Hinduism	59	0%
Judaism	22	0%

Buddhism	63	0%
Islam	75	0%
Sikhism	44	0%
Other	422	2%
Prefer not to say	5127	8%
No religion	1400	29%
Sexual orientation		
Heterosexual (straight)	15620	89%
Gay	135	1%
Lesbian	92	1%
Bisexual	115	1%
Other	80	0%
Prefer not to say	1493	9%
Parent of a child under 16?		
Yes	3553	20%
No	13623	77%
Prefer not to say	527	3%
Disability?		

Yes	3329	19%
No	13575	76%
Prefer not to say	907	5%
Are you a carer?		
Yes	2739	16%
No	14180	81%
Prefer not to say	690	4%
Base: 16,359-18,055		

Focus Group/Meeting Profiling

Profile information	*n*	%
Gender		
Male	98	47%
Female	109	52%
Intersex	1	0%
Prefer not to say	1	0%
Gender reassignment?		
Yes	2	1%
No	162	78%
Prefer not to say	6	3%
Don't know	39	19%
Age		
16-26	9	4%
27-37	13	6%
38-47	29	14%
48-58	28	13%

59-69	58	28%
70+	65	31%
Prefer not to say	4	2%
Don't know	3	1%
Ethnicity		
White British	118	56%
Welsh	5	2%
Irish	-	-
Other European (please state)	3	1%
Other (please state)	1	0%
Indian	70	33%
Pakistani	2	1%
Bangladeshi	-	-
Other (please state)	-	-
Caribbean	-	-
African	3	1%
British	-	-
Other (please state)	-	-

White and Black Caribbean	-	-
White and Black African	2	1%
White and Asian	-	-
Arab	1	0%
Other (please state)	1	0%
Chinese	-	-
Filipino	1	0%
Vietnamese	-	-
Thai	-	-
Other (please state)	-	-
Irish	-	-
Romany	-	-
Other (please state)	-	-
Prefer not to say	-	-
Don't know	2	1%
Religion		
Christianity	55	26%
Hinduism	2	1%

Judaism	2	1%
Buddhism	-	-
Islam	5	2%
Sikhism	68	33%
Other	1	0%
No religion	25	12%
Prefer not to say	6	3%
Don't know	45	22%
Sexual orientation		
Heterosexual (straight)	189	90%
Gay	1	0%
Lesbian	1	0%
Bisexual	1	0%
Other	1	0%
Prefer not to say	7	3%
Don't know	9	4%
Parent of a child under 16?		
Yes	39	19%

No	159	76%
Prefer not to say	3	1%
Don't know	8	4%
Disability?		
Yes	69	33%
No	129	62%
Prefer not to say	8	4%
Don't know	3	1%
Are you a carer?		
Yes	32	15%
No	168	80%
Prefer not to say	4	2%
Don't know	5	2%
Base 209		

Appendix 5: Consultation feedback from seldom heard group meetings

The table below aims to give an indication of the feedback by protected characteristic but it does not reflect every comment made during the consultation by every person belonging to a protected characteristic as sometimes this is not known and sometimes people can belong to more than one protected characteristic group. It is also not reflective of the number of times similar comments have been made.

Protected characteristic: Age
Young people
it doesn't affect me
the decision has already been made
a new hospital in the middle that's easy to get to
need to spend more on treatment
need two A&Es
why can't the name "A&E" remain as people recognise it
need to explain difference between ED and UCC
cost of moving women's and children's centre
changes to ambulance service
increased travel in an emergency
ambulances need more equipment

travel time and cost (especially for carers/visitors, people on a low income and people in rural areas)
travel for non-drivers/ public transport (especially on discharge)
non-emergency patient transport in Powys
can’t travel by taxi if in labour
patients in Telford have a choice of hospitals
community hospitals should offer more services
we need more emergency care satellite units and defibrillators
emergency packs for patients on a low income without family or friends
implications for Welsh patients
treatment of Welsh patients in Wales
Welsh language support
better communication between clinicians in Wales and England
recruitment of consultants/use more foreign staff
patient choice
Working age people
why can’t we stay as we are

the decision has already been made
it’s about saving money
convenience of all services on one site
capacity of one site for extra patients
need to explain difference between ED and UCC
good idea to have a UCC on each site,
ambulance waiting times
travel time on public transport and hospital transport
inter-hospital transport and transport back home
Older people
why can’t we stay as we are
the decision has already been made
this is politically driven
length of process
cost of consultation
hospital in the middle

Northumbria model
reduction in cancelled appointments
appointment cancellations
longer waiting times
bed availability
reduction in staff and beds
need to consider growth and age of population
capacity at both hospitals
refurbishment of buildings
explain difference between ED and UCC
staffing at UCCs
need both A&Es
long A&E waits
it’s good to have emergency services on one site
planned care at PRH is a good idea
why and cost of moving women’s and children’s centre

increased travel time and risk in an emergency (especially MLUs and heart attacks)
increased pressure on and skills of paramedics
increased pressure on ambulance service
out of county ambulance staff knowledge of rural areas in Wales
lack of parking and cost
public transport challenges (especially for visitors, carers, older people, people with a learning disability, people in rural areas, on Sundays and to get home)
non-emergency transport (NEPT) time and reliability
promotion of NEPT
promotion of and investment in community transport
easier to arrange transport for planned care
appointment times for people living far away
hospital transfers
treatment of Welsh patients in Wales
national recruitment challenges
staff training
difficulty in getting a GP appointment

more GP OOHs and community services
lack of care on discharge/bed blocking
recruitment of consultants
patient choice
people need to use the right service for their illness/condition
NHS funding

Protected characteristic: Sex
Male
why can’t we stay as we are
the decision has already been made
capacity of one site for extra patients
a hospital in the middle
ambulance waiting times
travel time particularly on public transport
recruitment of consultants
Female

reduction in cancelled operations
facilities at RSH
separating ED from planned care is good
Cost of moving women’s and children’s centre
need to improve maternity unit at RSH
don’t mind women’s and children’s unit being further away if receive best care
location of neonatology service and regular travel by parents
increased travel cost and time
can’t travel by taxi if in labour
public transport particularly for elderly relatives
concern about travel while in labour
concern about travel if child has to stay in hospital overnight
promotion of community transport
delays in non-emergency patient transport
easier to arrange travel for planned care
care closer to home

more likely to have Welsh-speaking staff in Shrewsbury
paediatric clinics in Powys
mapping of defibrillators in Powys
cost of prescriptions in English hospitals for Welsh patients
need more forward planning
should have cancer services in one place
Telford and Wrekin has a young population

Protected characteristic: Sexual orientation
Little specific feedback given by this group other than that LGBT people would like to be engaged with as part of the general population and not separately
this is about saving money
the decision has already been made
cost of consultation
a hospital in the middle
Separation of planned and emergency care
need two EDs

need to explain difference between ED and UCC
seeing the right person in the right place at the right time
parking and signage
risk of increased travel in an emergency
pressure on ambulance service
hospital transfers
improved community services
bed blocking
NHS funding

Protected characteristic – disability
Managing change and movement between hospitals for people with a learning disability, autism or a mental illness
Physical
why can’t we stay as we are?
the decision has already been made
long process

medical staff should decide where patients are treated
people need to go where they can get the best treatment
capacity of one site for extra patients
RSH has no extra space
hospital in the middle
payment of loan
A&E opening hours
need to explain difference between ED and UCC
need 2 EDs
increased travel in an emergency
cost/waste of money of women’s and children’s unit at PRH
RSH maternity is not fit-for-purpose
impact on ambulance service and paramedics
ambulance handover delays
extra travel time (particularly regular visitors)
parking and access/cost

public transport availability
transport on discharge
people in Telford can go to New Cross
better access to primary care services
cottage hospitals
it makes sense for the people of Powys
impact on staff/working hours
need to consider population age and growth
consultant recruitment and pay
recruitment challenges
more forward planning
Mental health
why can’t we stay as we are?
the decision has already been made
it’s about saving money
long process

location less important than proper staffing and quality care
need good quality care in one place
a new hospital in the middle
need same services at both hospitals
some services could be in the town centre
people go to A&E because they can’t get a GP appointment
risk of increased travel in an emergency
cost/waste of money of women’s and children’s unit at PRH
increased pressure on ambulance service
inter-site transport (especially for visitors),
public transport availability and cost of taxis (particularly for people living in a deprived area)
cost of getting home
anxiety if have to travel further
travel is tiring and unfamiliar places can be a challenge
should have a shuttle bus
parking and cost

lack of GP appointments
development of community services
care close to home
expansion of cottage hospitals
emergency packs for patients on a low income without family or friends
need mental health support at both sites
health issues
improved staff understanding of mental
link to psychiatric assessments
staff understanding and training about dementia
people with autism don’t like to access GP services until something serious is wrong
hospitals should have a support team for people with autism
treatment of Welsh patients in Wales
Welsh language support
better communication between clinicians in Wales and England
lack of staff

reduction in number of nurses
Telford has the largest population
consider population growth
Learning
Best care is more important than location
Funding
RSH buildings and facilities
increased travel time (particularly for people in rural areas)
carers can’t travel with a patient on community transport
need to strengthen integrated transport service like dial-a-ride
better communication for people with a learning disability if appointments are delayed
Sensory (visual and hearing)
the decision has already been made
specialist sites are good
it makes sense
will stop people going to A&E unnecessarily

cost/waste of money
there’s more space at PRH
we need services at both sites/safety
A&E waiting times
people at A&E should be triaged to go somewhere else
people won’t mind where they go for planned care
risk of increased travel in an emergency
pressure on ambulance service
distance isn’t an issue, people will go where the ambulance takes them
increased travel time (and cost) a particular challenged for the visually impaired
availability of public transport
cost and availability of parking
more transport for the elderly
more local services
Welsh patients should have treatment in Wales
PRH is an issue for the Welsh

more staff and training
people need to use Shropdoc/111/pharmacies
educate people about the right services to use
NHS needs to be privatised
people should take responsibility for their own health
no shows for hospital appointments

Protected characteristic – race
Gypsies and travellers
happy to have access to a hospital and travel for right treatment by right person
concern about women's and children's services
Travel issue (low number of female drivers)
concern about increased travel with sick child
difficult to catch bus or read road signs due to poor literacy
African/Afro-Caribbean
Increased travel and distance

Asian and Eastern European
why can’t we stay as we are?
increased travel in an emergency
increased travel and cost for parents with a sick child
public transport costs (particularly for people on a low income)
Telford and Wrekin has a young population
Chinese
why can’t we stay as we are?
division of doctors’ time between planned and emergency care
cost/waste of money of women’s and children’s unit at PRH
increased travel time and risk in an emergency
increased travel time for planned care is fine
population size and growth

Protected characteristic – religion
Hindu

why can’t we stay as we are?
ambulance travel times in an emergency
shortage of consultants
Sikh
all services should be available at both hospitals
risk of increased travel in an emergency
travel and transport challenge for people who don’t drive and who don’t know the area (especially visitors)
possible language barrier (need to consider older Sikh ladies without family nearby and whose first language is not English),

Protected characteristic – pregnancy/maternity
separating ED from planned care is good
Cost of moving women’s and children’s centre
need to improve maternity unit at RSH
location of neonatology service and regular travel by parents
don’t mind women’s and children’s unit being further away if receive best care

increased/reduced travel cost and time
travel between sites in an emergency
can’t travel by taxi if in labour
travel for women in labour
travel for parents if child has to stay in hospital overnight
public transport particularly for elderly relatives
promotion of community transport
delays in non-emergency patient transport
care closer to home
more likely to have Welsh-speaking staff in Shrewsbury
lack of awareness of ambulance service of rural Powys
cost of prescriptions in English hospitals for Welsh patients
Telford and Wrekin has a young population

Protected characteristic – Gender reassignment
No specific feedback given by this group. Feedback is included in the general consultation feedback report

Protected characteristic – Marriage/civil partnership
No specific feedback given by this group. Feedback is included in the general consultation feedback report

Other key groups – People living in a rural area
Shropshire is a rural area – needs more beds and funding
concern about lack of beds and bed changes
a hospital in the middle
transition to new services
funding and state of RSH site,
utilisation of PRH site
Northumbria model
need to explain difference between ED and UCC
capacity at ED site
concern if a patient arrives at the wrong site
concern about additional travel for elderly for planned care

cost/waste of money of moving women’s and children’s centre
why and cost of moving women’s and children’s centre
increased travel time and risk in an emergency
ambulance waiting times
increased travel and cost
Parking
Need more local services
GP extended hours
payments for Powys patients
recruitment of A&E consultants
recruitment of consultants
consider growth and age of population
appointment waiting times
larger population and higher levels of deprivation in Telford

Other key groups – People living in a deprived area

Why can’t we stay as we are?
the decision has already been made
it’s about saving money
keep both hospitals
have a super hospital
repayment of money borrowed
hospital buildings/facilities
need a trauma unit at both hospitals
location of planned care site not important
why and cost of moving women’s and children’s centre
ambulance travel times/availability of ambulances
increased travel time and risk in an emergency
time and cost of increased travel (especially for non-drivers, visitors and with a sick child)
public transport challenges for visitors and people with a learning disability
increased pressure on parking and cost
unreliability of non-emergency transport

won’t improve health in deprived areas
emergency packs for patients on a low income without family or friends
Welsh patients should have treatment in Wales
recruitment and retention of staff
job losses
long term planning
inaccurate information in the papers

Other key groups – Carers
Why can’t we stay as we are?
the decision has already been made
it’s about saving money
need an ED at both hospitals
concern about separating planned and emergency care
concern about nursing cuts and repayment costs
need quicker process

anxiety about deciding which hospital to go to
location is less important than receiving the best care
makes sense for emergency care to be in central location
need planned care more (older people, carer of someone with dementia)
why and cost of moving women’s and children’s centre
waste of money to move women’s and children’s centre
increased travel time and risk in an emergency
increased pressure on ambulance service
skills of paramedics
increased travel and cost (especially for older people)
travel for planned care is easier to organise
Parking
transfers between hospitals
more specialist care locally
GP waiting times
improved cottage hospitals

need to consider people with mental health problems or a learning disability
staff recruitment
recruitment of consultants
recruitment challenges
mismanagement of NHS
need to consider growing and elderly population
Young carers
One ED and 2 UCCs is a good idea
Better to have the ED at RSH (easier to access including for Welsh)
Consultant-led unit should not be co-located with ED
Travel and transport issue for visitors (this could have an impact on a patient's mental health if they are unable to visit)

Other key groups – Welsh speakers
Why can't Welsh patients be treated in Welsh hospitals?
Need bi-lingual signage, Welsh TV channels and easily identifiable Welsh-speaking staff

more likely to have Welsh-speaking staff in Shrewsbury
paediatric clinics in Powys
cost of prescriptions in English hospitals for Welsh patients

Note: all of the comments above have come directly from feedback from seldom heard groups. They are the views of individuals and this does not mean that they are always factually correct, for example, comments that Telford and Wrekin has a larger population or more younger people is not accurate as in stated in other parts of this document. Please see Appendix 1 for further details.

Appendix 6: Shrewsbury and Telford Hospital Trust activity data

1. A&E attendances in 2017/18

Table 1 Age and gender of people living in Telford & Wrekin CCG/local authority area using the A&E and UCC (from October 2017) at the Princess Royal Hospital and the A&E and UCC at the Royal Shrewsbury Hospital in 2017/18

Age	Gender						Base
	Male		Female		Not specified		
	Percentage	Number	Percentage	Number	Percentage	Number	
Total	**50%**	**23952**	**50%**	**24422**	**0.002%**	**1**	**48375**
0 – 4	57%	2320	43%	1759	0%		4079
5 – 9	52%	1304	48%	1189	0%		2493
10 – 14	54%	1628	46%	1382	0.03%	1	3011
15 – 19	48%	1646	52%	1775	0%		3421
20 – 24	47%	1778	53%	2042	0%		3820
25 – 29	49%	1838	51%	1891	0%		3729
30 – 34	47%	1465	53%	1642	0%		3107
35 – 39	51%	1446	49%	1403	0%		2849
40 – 44	51%	1289	49%	1261	0%		2550
45 – 49	51%	1428	49%	1350	0%		2778
50 – 54	50%	1298	50%	1317	0%		2615
55 – 59	50%	1129	50%	1133	0%		2262
60 – 64	49%	942	51%	999	0%		1941
65 – 69	51%	983	49%	930	0%		1913
70 – 74	48%	951	52%	1050	0%		2001
75 – 79	49%	926	51%	952	0%		1878
80 – 84	45%	720	55%	881	0%		1601
85 – 89	38%	546	62%	879	0%		1425
90 and over	35%	315	65%	587	0%		902

Table 2 Age and gender of people living in the Shropshire CCG/local authority area using the A&E and UCC (from October 2017) at the Princess Royal Hospital and the A&E and UCC at the Royal Shrewsbury Hospital in 2017/18

Age	Gender				Base
	Male		Female		
	Percentage	Number	Percentage	Number	
Total	**50%**	**32389**	**50%**	**32545**	**64934**
0 – 4	56%	2679	44%	2072	4751
5 – 9	54%	1434	46%	1210	2644
10 – 14	55%	1953	45%	1579	3532
15 – 19	49%	2052	51%	2158	4210
20 – 24	48%	2196	52%	2349	4545
25 – 29	47%	2039	53%	2291	4330
30 – 34	52%	1754	48%	1606	3360
35 – 39	52%	1609	48%	1462	3071
40 – 44	51%	1423	49%	1351	2774
45 – 49	51%	1742	49%	1687	3429
50 – 54	49%	1815	51%	1883	3698
55 – 59	51%	1727	49%	1629	3356
60 – 64	51%	1541	49%	1472	3013
65 – 69	50%	1589	50%	1609	3198
70 – 74	52%	1854	48%	1688	3542
75 – 79	50%	1607	50%	1608	3215
80 – 84	46%	1548	54%	1797	3345
85 – 89	40%	1131	60%	1665	2796
90 and over	33%	696	67%	1429	2125

Table 3 Age and gender of people living in Powys using the A&E and UCC (from October 2017) at the Princess Royal Hospital and the A&E and UCC at the Royal Shrewsbury Hospital in 2017/18

Age	Gender				Base
	Male		Female		
	Percentage	Number	Percentage	Number	
Total	**51%**	**1959**	**49%**	**1849**	**3808**
0 – 4	57%	117	43%	89	206
5 – 9	46%	46	54%	53	99
10 – 14	49%	74	51%	77	151
15 – 19	51%	137	49%	134	271
20 – 24	52%	131	48%	123	254
25 – 29	61%	144	39%	91	235
30 – 34	55%	98	45%	81	179
35 – 39	55%	85	45%	69	154
40 – 44	46%	75	54%	89	164
45 – 49	54%	102	46%	88	190
50 – 54	53%	112	47%	98	210
55 – 59	54%	104	46%	89	193
60 – 64	50%	111	50%	112	223
65 – 69	55%	133	45%	107	240
70 – 74	51%	138	49%	133	271
75 – 79	54%	120	46%	103	223
80 – 84	44%	93	56%	120	213
85 – 89	48%	99	52%	107	206
90 and over	32%	40	68%	86	126

No activity data was available for any of the other nine protected characteristic groups.

2. Paediatric inpatient service usage 2017/18

Table 4 Ethnicity of inpatient paediatric service users at The Princess Royal Hospital by CCG/local authority area

Area	Ethnicity						Base
	White	Asian	Black	Mixed	Other	Not provided/ Unknown*	
Powys	531	2	2	6	3	100	**644**
Shropshire	6779	56	12	202	60	314	**7423**
Telford & Wrekin	5100	393	158	359	55	111	**6176**
Total	**12410**	**451**	**172**	**567**	**118**	**525**	**14243**

*Note: there is a number of patients whose ethnicity is unknown.

Table 5 Age of inpatient paediatric service users at The Princess Royal Hospital by CCG/local authority area

Area	Age			Base
	0 – 4	10 – 14	15 – 16	
Powys	401	91	159	**651**
Shropshire	5099	905	1317	**7321**
Telford & Wrekin	4397	678	1019	**6094**
Total	**9897**	**1674**	**2495**	**14066**

No activity data was available for any of the other nine protected characteristic groups.

3. Maternity service usage 2017/18

Table 6 Age and ethnicity of women in the Telford & Wrekin CCG/local authority area using SaTH maternity services

Age	Ethnicity						Base
	White	Asian	Black	Mixed	Other	Not provided/ unknown*	
Total	**1701**	**99**	**46**	**36**	**11**	**306**	**2199**
15 – 19	95	1	1	3		11	111
20 – 24	379	11	3	10		67	470
25 – 29	554	25	11	7		88	685
30 – 34	423	37	13	10	8	85	576
35 – 39	213	23	14	5	3	46	304
40 – 44	33	1	2	1		9	46
45 – 49	3	1	1			0	5
50 – 54	1	99	1	36	11	0	2

*Note: there is a number of patients whose ethnicity is unknown.

Table 7 Age and ethnicity of women in the Shropshire CCG/local authority area using SaTH maternity services

Age	Ethnicity						Base
	White	Asian	Black	Mixed	Other	Not provided/ unknown*	
Total	**2211**	**16**	**5**	**19**	**14**	**235**	**2500**
15 – 19	84					10	94
20 – 24	375	1		2	1	39	418
25 – 29	633	5	2	5	3	69	717
30 – 34	672	10	2	8	2	63	757
35 – 39	364			1	6	42	413
40 – 44	78		1	3	2	11	95
45 – 49	5	16	5	19	14	1	6

*Note: there is a number of patients whose ethnicity is unknown.

Table 8 Age and ethnicity of women in Powys using SaTH maternity services

Age	Ethnicity			Base
	White	Asian	Not provided/ unknown*	
Total	**157**	**3**	**30**	**190**
15 – 19	4		1	5
20 – 24	42		15	57
25 – 29	44		6	50
30 – 34	43	1	4	48
35 – 39	19	2	4	25
40 – 44	3		0	3
45 – 49	2	3	0	2

*Note: there is a number of patients whose ethnicity is unknown.

4. No activity data was available for any of the other nine protected characteristic groups.

Planned care: Inpatient and day cases 2017/18

Table 9 Age of adult inpatient and day case service users in Telford & Wrekin and Shropshire CCG/local authority areas and Powys

	Age																Total
	17 – 19	20 – 24	25 – 29	30 – 34	35 – 39	40 – 44	45 – 49	50 – 54	55 – 59	60 – 64	65 – 69	70 – 74	75 – 79	80 – 84	85 – 89	90 and over	
Total	**458**	**897**	**1172**	**1324**	**1620**	**2046**	**3360**	**3855**	**4674**	**4780**	**6509**	**6853**	**5535**	**3738**	**1783**	**486**	**49090**
Telford & Wrekin	194	355	514	557	676	802	1299	1412	1600	1594	2107	2047	1645	1061	471	126	16460
Shropshire	235	496	581	693	882	1130	1905	2216	2822	2883	3965	4335	3533	2496	1204	329	29705

Powys	29	46	77	74	62	114	156	227	252	303	437	471	357	181	108	31	2925

Table 10 Gender of adult inpatient and day case service users across Telford & Wrekin, Shropshire CCG/local authority areas and Powys

	Gender		Total
	Male	Female	
Total	**24453**	**24637**	**49090**
Telford & Wrekin	7977	8483	**16460**
Shropshire	14985	14720	**29705**
Powys	1491	1434	**2925**

Table 11 Ethnicity of adult inpatient and day case service users across Telford & Wrekin, Shropshire CCG/local authority areas and Powys

	Ethnicity						Total
	White	Asian	Black	Mixed	Other	Unknown/ not specified*	
Total	**46181**	**565**	**165**	**182**	**118**	**1879**	**49090**
Powys	2765	2	1	10	1	146	2925
Shropshire	28241	75	19	57	61	1252	29705
Telford & Wrekin	15175	488	145	115	56	481	16460

*Note: there is a number of patients whose ethnicity is unknown.

No activity data was available for any of the other nine protected characteristic groups.

Source of Recommendation		Recommendation for Actions	Led by	Progress Status
Equality effects				
Equality Impact Assessment	**1**	**Developing an effective communications and engagement strategy:** Looking to address continued confusion from the public including those with a protected characteristic of the difference between emergency, planned and urgent care and which services are available on each site. The use of various tools such as on-line video, talking stories of services now and the proposed changes, emphasising that there will be urgent care on both sites where the majority of people will be able to go as before. Advertising and materials should be in different languages and formats where appropriate. Work with voluntary and community organisations to disseminate information to their groups.	STP Communications and Engagement Workstream	Develop a communications and engagement plan for post decision-making as part of the Implementation Oversight Group (Communications plan and associated costings in development to secure budget). Initial activity to include on-going PR, an e-newsletter (in development), social media, the Future Fit website and a newsletter for cascading through networks and potentially an insert in local newspapers.

Source of Recommendation		Recommendation for Actions	Led by	Progress Status
Equality Impact Assessment	**2**	**Developing a strong public awareness campaign:** Clear communications about the correct service to access in the case of an urgent or emergency medical need is required and which services are available on each site. Consider different tools and languages/formats to reach the widest possible audience including people with a protected characteristic. Target in particular those groups most likely to access A&E services, for example, young men, parents of young children, older people and new migrants. Also, women particularly those living in a deprived or rural area and BAME women as most frequent users of women's and children's services and therefore most likely to be impacted on by any changes.	STP Communications and Engagement Workstream	Build on the above communications and engagement plan to mirror ongoing development activity. Integrate learning from the communications and engagement plan developed for the potential overnight closure of the A&E department at PRH. Use tools and materials to promote in locations most likely to be used by people from a protected characteristic group and those more likely to access the services being considered for change.

Source of Recommendation		Recommendation for Actions	Led by	Progress Status
Equality Impact Assessment	**3**	**Travel and Transport:** Incorporate the potential impacts of access and travel on protected characteristic groups as set out in this EIA into the Travel and Transport Mitigation Plans. Mitigations include a review of appointment times by the Acute Trust and how these could be adjusted to take increased travel times and costs into account, particularly for groups who are more likely to travel by public transport such as people living in deprived areas, older people and younger people and people who are likely to have to travel further, for example, people living in rural areas, people with a disability and homeless people. Also women travelling while in labour or with a sick child.	Travel and Transport Group	A Travel and Transport Group is established and has produced a draft Action Mitigation Plan. (appendix 4 DMBC) Feedback from people with a protected characteristic in relation to travel and transport has fed into the work of the Travel and Transport Group. The mitigations for impacts on protected characteristic groups have been incorporated into the plan. The STP Communications and Engagement Lead attends the travel and transport group meetings. Public and patient representatives are also invited to these meetings.
Equality Impact Assessment	**4**	**Community Care:** Consider how the Care Closer to Home and the Neighbourhood strategies for Shropshire, Telford & Wrekin and Mid Wales might mitigate some impacts in looking at avoiding the need for hospital admission, the need to travel to hospital for appointments and for any other opportunities for enhancing local services for some groups. Particular consideration given for groups who are more likely to travel by public transport such as people living	Shropshire Care Closer to Home/Telford Neighbourhoods / Powys Health and Care Strategy Programme Boards	Community integrated care boards meet on a regular basis and plans are well developed. Public and patient representatives continue to be involved in the development and evolution of the plans. The DMBC incorporates updated plans for the Shropshire Care Closer to Home, the

Source of Recommendation		Recommendation for Actions	Led by	Progress Status
		in deprived areas, older people and younger people and people who are likely to have to travel further, for example, people living in rural areas. Example of developments under consideration include tele-medicine.		T&W Neighbourhoods work and an update on similar strategies in Powys. Appendices 11, 12 and 13 of the DMBC provide the reports. A narrative is included within the main body in Section 9.2 that describes how these strategies mitigate the impacts identified. Each plan and / or the combined plan will need to be accompanied by an Equality Impact Assessment. The impacts identified in the Future Fit EIA will be incorporated into the community integrated care EIA.

Source of Recommendation		Recommendation for Actions	Led by	Progress Status
Equality Impact Assessment	**5**	**Addressing the areas of mitigation in the Women's and Children's Integrated Impact Assessment in 2017**, that were set out in three broad areas to address the anticipated impacts relating to a consolidation of women's and children's services including: I. **Reducing unnecessary journeys** and transfers for young children II. **Safe care pathway** agreements for children III. **Reducing risk factors** before, during and after pregnancy (particularly for young women, older women, BAME women, lesbian and bisexual women and women living in deprived areas.) This will include the work within the LMS Programme.	SaTH SaTH STP PMO leads in particular LMS and Prevention Programmes working with the Health and Wellbeing Boards of all three councils.	Care pathways have been developed between SaTH and the ambulance service that set out those children who can be taken to the UCC on the planned care site. QIAs are available in appendix 17 of the DMBC. The Trust has also submitted a number of safe transfer policies for children that are already in place. Appendices 7 of the DMBC The work around reducing risk factors before, during and after pregnancy are incorporated in the project plans for the LMS and Prevention workstreams of the STP and through to the Health and Wellbeing Boards of the councils. The work to develop the clinical model for enhanced community midwifery hubs is progressing. Location of these hubs will be influenced by such factors as population data, deprivation and risk factors, number of deliveries, complexity of pathway and access .

Source of Recommendation		Recommendation for Actions	Led by	Progress Status
Equality Impact Assessment	6	**Ensuring the on-going review of midwife-led services** considers findings and analysis in the Future Fit EIA and feeds into the developing model of care for midwife-led services and in particular in the design, location and scope of community hubs under consideration.	MLU Programme Board	The Future Fit Programme team is supporting the MLU Programme Board in the development of pre-consultation activity and materials, including the MLU EIA. Pre-consultation activity has included extensive public and patient engagement and a Pre-Consultation Engagement report is in development to show how this activity has influenced options development. The work to develop the clinical model for enhanced community midwifery hubs is progressing. Options are in development to improve the model of midwifery led care that will: - Increase sustainability of service provision - Improve equity of access - Improve outcomes for women and their families. Location of these hubs will be influenced by such factors as population data, deprivation and risk factors, number of deliveries, complexity of pathway and access .

Source of Recommendation		Recommendation for Actions	Led by	Progress Status
				Further work to be done to ensure understanding by the Estates workstream of the STP in the development of multiple 'hubs' for health and care service delivery, including the community hospital sites.

Source of Recommendation		Recommendation for Actions	Led by	Progress Status
Equality Impact Assessment	7	**Ensuring the provision of appropriate accommodation** for parents/carers whose child is an inpatient to mitigate the impact of longer journey times and increased costs.	SaTH	Like for like accommodation has been assumed by SaTH and incorporated into the planning assumptions in the PCBC and referred to within the mitigation of the DMBC. To be incorporated into the work programme of the Implementation Oversight Group.

Source of Recommendation		Recommendation for Actions	Led by	Progress Status
Equality Impact Assessment	8	**Continue to work collaboratively to build on existing and planned public health interventions** and a more proactive system-wide approach to prevention, bridging deprivation and other health equalities gaps	STP Population health and Prevention workstream Future Fit programme, transport group, IIA, Neighbourhood working, MLS, and all elective care programmes	The system population health and prevention enabling workstream is working to: 1. Embed population health management and prevention through all services and workstreams, this will involve: 2. Systematically understand need and capabilities across the system 3. Systematically raise awareness and deliver lifestyle advice, signposting and referral by healthcare and other professionals, e.g. through MECC +, PHE's One You, including for a range of public health interventions 4. Improve the prevention, detection and diagnosis of CVD, specifically diabetes and hypertension 5. Radically upgrade the role of the NHS in tackling harmful alcohol consumption, through screening, identification, brief advice and referral into treatment services

Source of Recommendation		Recommendation for Actions	Led by	Progress Status
				6. Deliver prevention expectations of the national Cancer Strategy 7. To ensure the systematic delivery of mental wellbeing services, including identification of mental ill health and prioritisation of emotional support 8. Work together to make best use of resource and expertise This enabling programme needs to ensure that all transformation Programmes work to reduce health inequalities; this includes Future Fit. *programme, transport group, IIA, Neighborhood working, MLS, and all elective care Programmes.*

Source of Recommendation		Recommendation for Actions	Led by	Progress Status
Equality Impact Assessment	**9**	**Continue to work collaboratively with the voluntary sector, community groups, Healthwatch and patient reference groups** to carry out more detailed assessments of potential impacts in future phases of the development including the design phase and through to implementation.	STP Communication and Engagement Workstream Implementation Partnership Board.	Develop a communications and engagement strategy and delivery plan. Identify budget / resource requirements. Develop post decision-making EIAs aligned to future phases of development as required.
Equality Impact Assessment	**10**	**Continue to improve the volume and diversity of patient views** and increase future opportunities for on-going engagement and establishing long term relationships with the protected characteristic groups as a result of the links developed through the Future Fit consultation.	STP Communication and Engagement Workstream	Build on the above communications and engagement plan. Identify budget / resource requirements above and beyond the two CCG engagement teams.
Equality Impact Assessment	**11**	**Continue to consider an inclusive approach to language barriers** through fair access to information, services and premises supported by embedding equality and inclusion compliance for all sections of our local community.	STP Implementation Partnership Board	Build into the design and development plans for the redevelopment.

Source of Recommendation		Recommendation for Actions	Led by	Progress Status
Equality Impact Assessment	**12**	**Consider the translation, interpretation and other services available to people whose first language isn't English** in delivering any newly configured service to ensure that it is effective and that speakers of other languages are not being negatively impacted on when they access services.	STP Implementation Partnership Board	Build into the design and development plans for the redevelopment.
Equality Impact Assessment	**13**	**Noting the limited activity data breakdown available, consider how the collection and analysis of data and information can be improved** to better understand patient flows and experience of the protected characteristics.	SaTH	Review the availability of existing activity data in relation to the nine protected characteristics and investigate the possibility of enhancing this data and to monitor the level of access to different services by different groups.
Equality Impact Assessment	**14**	**Continue to share with the groups that have been engaged with:** particularly the voluntary sector and others representing seldom heard groups, the outcomes of the consultation to ensure that they are aware of how their feedback is utilised in any decision-making process.	STP Communication and Engagement Workstream / Future Fit Programme Board	Activity forms part of the post-decision-making communications and engagement plan.

DRAFT TRAVEL AND TRANSPORT MITIGATION PLAN

The draft Plan draws together travel and transport issues raised within the Integrated Impact Assessments undertaken in 2016 and 2017, the Transport Study undertaken by JMP in September 2016, key issues identified from the members of the Travel and Transport Group that was created in May 2018 and Consultation key themes from the Participate Report submitted on 8th November 2018.

The Plan also incorporates recommendations from the ORH commissioned Ambulance Modelling.

The proposed solutions are set out below with a short narrative outlining how improvements can be undertaken.

Timescales are defined as follows:-

- Short term – Less than 1 year
- Medium term – 1 – 3 years
- Long term – 3 – 5 years**+**

Category	Proposed Solution	Narrative	Lead	Short/Medium/ Long term
Ambulance Modelling	Review Operational Research for Health report with ambulance and non-emergency transport services to ensure plans are in place to commission and provide the most appropriate services for users.	To review the findings of the report and identify next steps in order to ensure the suggested plans improve the quality, capacity and and performance of services based on good practice.	CCG Commissioners	Short - Medium Term
National Drivers	Consider implications on proposed model through review of the Department of Transports Inclusive Transport Strategy: achieving equal access for disabled people	This strategy requires plans to implement improvements in travel for disabled people in particularly, whilst identifying opportunities for improvements for all Whilst many people take for granted the ability to travel easily from A to B, this is not the reality for everyone. For our ageing population, and the fifth of people who identify as having some sort of disability, access to transport can be far from straightforward. That is why this Government is determined to make sure that disabled people have the same access to transport as everyone else, and that they are able to travel easily, confidently and without extra cost https://www.gov.uk/government/publications/inclusive-transport-strategy/the-inclusive-transport-strategy-achieving-equal-access-for-disabled-people	Shropshire, Telford and Wrekin and Powys Councils and CCG Commissioners	Short - Long term

	Ensure access to national funding is available to improve transport infrastructure and services in the county	Over £2.5 billion available on mobility awards £1 billion each year on concessionary fares for older and disabled people using local bus services.	Shropshire, Telford and Wrekin and Powys Councils	Medium - Long term
	Review Shropshire Travel Plans 2011-2026 to incorporate impact of hospital reconfiguration	This Plan is currently being refreshed and sets out the Council's ambition for travel. The impact of the acute reconfiguration will need to become an integral part of the Councils future plans due to its potential impact on changes to travel across the region	Shropshire County Council	Short Term – Long Term
	Review Telford and Wrekin Travel Plan 2011-2026 to incorporate impact of hospital reconfiguration	The impact of the acute reconfiguration will need to become an integral part of the Councils future plans due to its potential impact on changes to travel across the region	Telford and Wrekin Council	Short Term
	Review Powys Local Development Plan 2011-2026 to incorporate impact of hospital reconfiguration	The impact of the acute reconfiguration will need to become an integral part of the Councils future plans due to its potential impact on changes to travel across the region	Powys County Council	Short Term
Local Drivers	Shropshire and Telford integrated care programmes to evidence plans and consideration in proposals supporting access to services closer to where people live	The provision of more locally accessible community-based services in Shropshire Telford and Wrekin travel is proposed in both CCG Programmes bring care closer to where people live	Shropshire Care Closer to Home and Neighbourhoods, Programmes	Medium - Long Term

Public Transport	To undertake baseline review of all public transport providers across Shropshire, Telford and Wrekin and Powys to identify opportunities for improvements through a collaborative and system wide partnership approach where travel stakeholders are working together to map public transport availability and identify opportunities to improve services, reduce overlap and improve spread of availability	This work has already commenced and is being led by Shropshire Council. The aim is to engage with all public transport providers to map where services are provided, identify solutions for improvements, reduce duplication of services and where possible provide improved transportation. This work will include working with local councils, bus services, non-emergency patient transport services and voluntary sector providers, including – • How do we increase capacity? • How do we keep it affordable? • Could we link some community transport with public transport routes? This baseline review will enable stakeholders to review access to transport further relating to rurality, womens and childrens and EIA considerations to ensure any improvements reduce the impact of changes on those groups who are identified as more impacted.	Shropshire, Telford and Wrekin and Powys Councils, Shropshire Community Services and all voluntary sector providers	Short - Medium Term
	Work with bus services travelling to the hospital and on site to improve the number of services available	Shropshire Council are currently working with local bus companies to improve the number of journeys to and from hospitals as well as between both Hospital sites. X5 - To explore the opportunity to decrease number of stops to reduce journey times	Shropshire, Telford and Wrekin and Powys Councils	Medium - Long Term

		(SATH have recently been able to add a further bus service which travels on site to 2. Nos. 11 and 553. 5 x buses pass close to the hospital (No.s 74, 558, X75, 70A and 12). SATH and the Council will continue to discuss more buses being able to access the site to enable wider choice to be available).	Shropshire Council and Shrewsbury and Telford NHS Trust (SaTH)	Medium - Long Term
		X4 offers 9 journeys per day between Shrewsbury and Wellington Bus Stations. It is proposed to start discussions with the bus company in order that this bus could stop at PRH.	Shropshire and Telford and Wrekin Councils	Medium - Long Term
		To commence discussions with other bus service providers such as Tanat Valley and Celtic to divert services on to PRH site.	Shropshire and Telford and Wrekin and Powys Councils	Short – Medium
	Improve awareness of the availability of concessionary travel	Whilst raising awareness of eligibility of concessionary travel, to also consider improvements to travel which will enable older people, women's and children's, homeless, people with learning difficulties, long term conditions and those within a rural area to benefit from concessionary travel opportunities that work with travelling to hospital appointments throughout the day including early mornings.	SaTH and Shropshire, Telford and Wrekin and Powys Councils	Long Term
	Development of through ticketing	To enable access to public transport across border and modes of transport, the Councils will learn from the West Midlands Combined Authority programme developing through	Shropshire, Telford and Wrekin and Powys Councils	Medium – Long Term

		ticketing and opportunity to apply the process to Shropshire, Telford and Wrekin and Powys Councils		
	Review access to train services and linkages between public transport	Local Councils and Train providers to begin to review current services and identify commercially viable opportunities to improve linkages relating to times and locations of services which will reduce long waits and delays and maximise use of services. (Need to consider franchising and powers are limited).	Shropshire, Telford and Wrekin and Powys Councils	Medium - Long Term
		To ensure all hospital, GP and community sites have access to information which enables them to publicise and awareness of the train links that work effectively across Shropshire, Telford and Wrekin and Powys.	SaTH Communications and Engagement Team	Medium Term
		To raise awareness that there is a train service that runs from Wellington Rail Station to Shrewsbury.	SaTH Communications and Engagement Team	Short Term
		Improve signage to Train and bus stations	Shropshire and Telford and Wrekin Councils	Medium Term
		Review taxi charges to ensure there is no evidence of discrimination against disabled users	Shropshire, Telford and Wrekin and Powys Councils	Short Term

Community Transport	Review provision of community transport services across Shropshire, Telford and Wrekin and Powys	To ensure all voluntary sector providers of transport are identified and services mapped within the baseline validation.	Shropshire, Telford and Wrekin and Powys Councils and Voluntary sector group representatives	Short Term
	Increase the role of community transport services	Support and incentivise voluntary sector service providers to further develop local service in areas where there is very little transport provision.	Shropshire, Telford and Wrekin and Powys Councils, SATH, Commissioners and STP Communications and Engagement	Medium – Long Term
	Widen the scope and role of community transport services	Commission the voluntary sector to identify and bid for further work and opportunity which will broaden their use and involvement.	Shropshire, Telford and Wrekin and Powys Councils	Medium to Long Term
	Raise awareness of community transport availability for those who need it	Understand the need to raise awareness of community transport availability for those who need it vs capacity of volunteers to continue to provide an efficient service	Shropshire, Telford and Wrekin and Powys Councils, Voluntary sector and STP Communications and Engagement	Medium Term
	Raise awareness and clarify eligibility of access to Non-Emergency Transport Services	To review all NEPTS services available for medical needs to ensure information relating to access and eligibility is widely available.	Commissioners and SaTH Communications and Engagement Team	Short – Medium Term

		To consider linking the NEPTS services with community transport	Commissioners	Short – Medium Term
Costs of travel	Publicise widely the Help with Travel Costs Scheme	To ensure patients and their families are aware of Help with Travel Costs for those receiving a qualifying benefit or allowance or meets the criteria of the NHS Low Income Scheme, publicise the scheme across a variety of media and focus groups as well as local hospitals, GPs and community services. Ensure patients are aware of current travel options and reimbursements available for travel	SaTH Communications and Engagement Team	Short Term
Parking at sites	To improve and reduce the need for parking facilities for patients and staff across both sites	To provide a shuttle bus service between sites that can be utilised by both patients and staff at a concessionary or free cost.	SaTH	Long Term
	Comprehensive identification of parking opportunities and review of costs	Review parking opportunities in the plans for reconfigured services and the costs of car parking across the sites	SaTH	Medium – Long Term
	Develop Park and Ride Facilities	To consider options for park and ride facilities which will maximise a reduction in car usage	SaTH	Medium Term

	Improve signage and provide information on walking access to site	To improve signage, information on Trust website and lighting to improve walking access to site	SaTH	Medium - Long Term
Modern Technology	Reduce unnecessary travel to hospitals	Ensure clinical model reduces the need to travel to hospital, particularly for routine follow-ups which may not be required.	SaTH and STP Digital Programme	Medium Term
	Use of Technology to reduce travel and travel costs	Develop the use of electronic appointment booking system to reduce the need to travel unnecessarily, along with the proposed plans to introduce an Electronic Patient Record project and new Patient Administration System. Use of telemedicine in the outpatient setting will enable consultations with patients and reduce unnecessary travelling. Similarly advice and guidance access between acute clinicians and GP's could incorporate new technology.	SaTH and STP Digital Programme	Medium - Long Term
		Ensuring that technological advances and new business models provide opportunities for all, and that people are involved from the outset in their design. The use of Phone apps have been piloted in the treatment monitoring of Prostate Cancer patients who can upload their vital signs and progress via the app, receiving clinical advice in return. There would be merit in developing	SaTH and STP Digital Programme	Medium - Long Term

		this further for other patient groups.		
	Linking sites more effectively	The link between the Emergency Site and the Planned Care Site will be enhanced through the use of technology, communication between departments and sites will be improved with the availability of telemedicine. Televisual links between the Emergency Department and Urgent Care Centres or Theatres and Critical Care for example will be used to aid the assessment and potential escalation of treatment for patients.	SaTH and STP Digital Programme	Medium to Long Term