South Wales Programme
Equality Impact Assessment
Stage two: post-consultation analysis
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Introduction

Section 149 of the Equality Act 2010 places a duty, referred to as the general duty, on public sector bodies. Public bodies subject to the general duty are required when designing policies or making decisions to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relations between different groups.

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

Due to the scale and complexity of the South Wales Programme the decision was taken that an iterative approach to the equality impact assessment report should be taken. A stage one equality impact assessment was produced to inform the South Wales Programme public consultation. The stage one equality impact assessment was an evidence document, which outlined the evidence behind the need for the South Wales Programme and provided a summary of available evidence from research reports and other related documents on what the anticipated impacts may be on protected characteristic groups and NHS staff.

The stage one pre-consultation evidence document was not intended to be a definitive statement on the potential impact of the South Wales Programme on protected characteristic groups. The document’s purpose was to describe our understanding at that point in the process of the likely impact. By following the EIA process it was intended that we would identify and address any gaps in our knowledge by engaging and consulting with the public and stakeholders.
This document is the stage two post-consultation analysis and presents the findings of the public consultation with our earlier analysis of the available evidence on potential impacts from the stage one document. Where relevant new research or evidence has become available we have updated our analysis from the stage one document to reflect this. The purpose is to inform those making the decision on which of the South Wales Programme options 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 health board in the South Wales Programme to demonstrate they have assessed how the South Wales Programme may impact on their service users and the wider public in the South Wales Programme area. To facilitate health boards in meeting this requirement the analysis presented in this document considers potential impact at a local authority level where data is available. A separate appendix for each health board is also provided which supplements the analysis in the body of the document. As such, it is important to emphasise that the analyses in the main report and its appendices should be read in conjunction with each other, and not in isolation.

A stage three final analysis document will be produced once the decision on the South Wales 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 South Wales Programme will be monitored and reviewed.

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.

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 Wales is a country with two official languages - Welsh and English. The importance of bilingual healthcare for all patients in Wales is fundamental and is particularly important for four key groups - people with mental health problems; those with learning disabilities; older people and young children. Research has shown these groups cannot be treated effectively except in their first language. Our consideration of equality takes account of this.
This equality impact assessment helps us 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?
Background to the South Wales Programme

The South Wales health boards have published proposals for the future of consultant-led maternity and neonatal care, inpatient children's services and emergency medicine (A&E) for people living in South Wales and South Powys – this information is available at www.wales.nhs.uk/swp and www.wales.nhs.uk/swp/hafan

Frontline clinicians – doctors, nurses, midwives, therapists and paramedics – from across South Wales and South Powys have been working together as part of the South Wales Programme to examine the issues facing these services and develop ideas for their future to improve care for all patients.

Clinicians believe we should be achieving clinical standards in each of these services and striving to match the best healthcare in the world. To do this, these services need to be concentrated in four or five hospitals in the South Wales area in the future.

This is not about reducing services or access to services – the majority of people who need hospital care will continue to receive it locally. This is about improving care for all patients, particularly for the most seriously ill and injured, who need to be seen by the most experienced clinicians and doctors as soon as they arrive at hospital.

Rationale
We cannot continue as we are – the status quo is not an option for the future. Consultant-led maternity and neonatal care; inpatient children's services and emergency medicine (A&E) for our most seriously ill and injured patients need to be provided together, in fewer hospitals as part of a wider integrated healthcare network.

The evidence is clear: doing this will improve the outcomes of care for patients even if they have to travel further for this treatment.

Each specialist team has, and is supported by, doctors-in-training – the specialists of the future. We need more of these doctors-in-training because of changes to European legislation governing working hours. And training has become much more complex, as medicine becomes more specialised.

Doctors-in-training need to see large numbers of patients to ensure they have the necessary experience and skills to specialise. So when they plan their training, not only do they choose hospitals where they will see enough patients but they also want to experience how the very best care is delivered and be well supported by
consultants as they learn.

At the moment that's not always the case in Wales. Because we are trying to run services in too many places we have frequent shortages of doctors-in-training and consultants. This means our reputation for high-quality training is not as good as it should be and we are finding it hard to attract doctors in some specialities to come to Wales to train.

Not only does this make providing safe services difficult, it makes it harder to fill consultant posts and impacts on the quality of teaching for the doctors-in-training we do have – it's a vicious cycle, which needs urgent attention. The consultants we need now and for the future are not coming to Wales and are unlikely to move to Wales from elsewhere.

If we don't take action now, there's a real risk that we'll be forced to take emergency measures when one of these services at one or our hospitals fails. We'd much rather take action in a calm and planned way, which is better for patients and staff, instead of reacting to crises.

As neighbouring health boards, we have a unique opportunity to work together in Wales to find a lasting solution for the people of South Wales and South Powys and to provide better access to hospital care. We're in the business of treating people; we want to be able to give them the best chances of surviving their illness or injury and recovering to live a full and independent life.

**Expected outcome**

To concentrate consultant-led maternity and neonatal care, inpatient children’s services and emergency medicine (A&E) in four or five hospitals; ensuring patients get the right care from the right person in the right place and at the right time.

**How it will be delivered**

Ideally, we don't want anyone to have to come to hospital unless it is absolutely necessary. To make this a reality we must strengthen our primary care services, including out of hours. We need a strong system of community services, which together with our GPs and paramedic colleagues in the Welsh Ambulance Service, will be able to better identify and treat people in the community, without the need for hospital admission.

When our sickest patients need to come to hospital we want to have senior clinicians available to see them as soon as they arrive, whatever time of day or night. This means they will get the right diagnosis, start the right treatment quicker and get better faster.
We need to offer everyone the sorts of medical advances which mean tiny premature babies have the best chance of life; people involved in serious accidents have the best chance of survival and people with life-threatening illnesses get the expert care and treatment they need to save their lives.

This kind of medicine can only be delivered by teams of doctors, nurses and therapists who have specialist skills, which they use day in and day out so they remain experts in what they do. It can’t be provided in every hospital because we don’t have enough specialists, but even if we did, they wouldn’t be able to keep up their skills because they wouldn’t be seeing enough patients.

**Who is affected?**
Everyone who uses or might need to use these services in South Wales and South Powys will be affected but some will be affected more than others.

For example:

- New parents of seriously ill newborn babies and the babies themselves.
- Relatives of the baby who want to offer support to the parents and to visit the baby in hospital.
- Older people, disabled people or people with other health conditions or impairment that might result in more frequent use of emergency medicine (A&E).
- People who might be affected by having to travel further for services or on unfamiliar roads to a different hospital site, particularly in the more rural areas of South Powys and the South Wales valleys.
- Service users who rely on public transport.
- Frequent service users including children who have forged a relationship with a particular health care team at a particular location.
- Service users in lower socioeconomic groups.

**Equality impact assessment - where we are now?**

Equality impact assessment is an ongoing process that runs throughout the course of the decision making process, from the start to implementation and review. An EIA can be broken down into a number of stages:

- **Stage one:** Define the proposal for change and the rationale behind it. Consider the expected outcomes, who will be impacted and how will it be delivered.
• Stage two: Screen for relevancy to the Equality Act. Will the proposal impact upon different groups either positively or negatively?
• Stage three: Collect evidence to identify potential impacts and any options for mitigation.
• Stage four: Consult/engage with the public.
• Stage five: Review evidence collected from stages three and four and determine whether the proposal should: continue unchanged; continue with modifications; or not proceed.
• Stage six: Publish the EIA.
• Stage seven: Monitor and review the service change.

The South Wales Programme has completed stage four and is now entering stage five - the review of evidence collected from stages three and four to help inform the decision about whether the proposal should continue unchanged; continue with modifications; or not proceed.

**Outputs from the pre-consultation engagement**

We undertook pre-consultation engagement from September to December 2012 on our original ideas. This included:

**Presentations to a range of existing groups** – including a disability reference group, older people’s forums, deaf clubs and carers’ groups.

**Working with Funky Dragon and Youth Councils** – engagement events with interactive workshops were organised for young people to hear their views on the engagement ideas.

**Making available information in other formats on request** – including Braille (in Welsh and English), Talking Book (in Welsh and English), British Sign Language, Easy Read (in Welsh and English), Large Print Version (in Welsh and English)

**Production of a British Sign Language video** – posted online.

The public told us they were concerned about a number of key issues:

• **The ambulance service** – You were very concerned about current ambulance emergency response times and whether the service could cope if changes are made to the hospital network.
• **Access to services** – You were concerned about what services would be available at what hospitals in the future and about whether patient safety would be comprised if people have to travel further for care.

• **Public transport** - You told us you were particularly concerned about whether you could travel to hospital using public transport.

• **Deprivation** - You told us you were concerned about the impact any changes would have on the most deprived communities, where levels of ill health are often higher and incomes are low.

• **Changes to our populations** - One of the questions raised in engagement was whether we would consider how changes in the population might affect what options we develop.

• **Primary and community care services** - You were concerned there was too much emphasis on hospital services.

• **Interim arrangements** - You were concerned about what would happen to services between now and when the agreed option for the final configuration of services is implemented, particularly if services become unsustainable in the meantime.

**The benefit criteria**
Public feedback, together with feedback from clinicians at the clinical conferences, was used to develop six "benefit criteria" – the most important issues against which the options for consultation would later be analysed.

These criteria were scored by public focus groups, clinicians, other NHS staff and partners at a series of events run by Opinion Research Services (ORS) in February 2013. The final weighted benefit criteria (see Table 1) were approved by individual health boards and the Welsh Ambulance Services NHS Trust at board meetings in March and April 2013. These were subsequently used to score the six options for the future locations of specialist services.
<table>
<thead>
<tr>
<th>Benefit criteria</th>
<th>Description</th>
<th>Rank</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Appropriately-trained and skilled workforce will be available to provide the service</td>
<td>1</td>
<td>22</td>
</tr>
<tr>
<td>Quality</td>
<td>Service will meet agreed clinical standards</td>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Workforce will be “fit for purpose” – meeting the European Working Time Directive and training requirements. Infrastructure requirements are deliverable in terms of feasibility</td>
<td>3=</td>
<td>20</td>
</tr>
<tr>
<td>Access</td>
<td>Access to services is optimised by providing services as close to patients’ homes as safely as possible. Appropriate and timely transfer will enable patients to be moved to higher or lower levels of care. Avoidable transfers of care will be minimised</td>
<td>3=</td>
<td>20</td>
</tr>
<tr>
<td>Equity</td>
<td>Access to services is equitable for all population groups, taking into account variation in deprivation.</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Strategic fit</td>
<td>Services will be deliverable across a network of integrated care</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

Full details about the processes we have followed, all the responses received during engagement and the work undertaken in preparation for this consultation is available on the South Wales Programme website at [www.wales.nhs.uk/swp](http://www.wales.nhs.uk/swp)
What the evidence tells us about the need for change.

In 2012, Professor Marcus Longley, from the Welsh Institute for Health and Social Care (WIHSC),\(^1\) conducted a review of the evidence about the best configuration of acute hospital services in Wales. Professor Longley’s report provided an objective analysis of the key issues facing the future of the NHS in Wales. The report answers four key questions:

- **On safety and quality:** What’s wrong with our current pattern of hospital services?
- **On the workforce:** We’ve got more staff than ever before, so what’s the problem?
- **On access:** Is poorer access inevitable to ensure good safety and quality?
- **What’s the case for change?**

**On safety and quality: What’s wrong with our current pattern of hospital services?**

The evidence from across the UK indicates that when patients are admitted affects their outcomes. Patients admitted for an emergency at the weekend have an increased risk of subsequent death (Royal College of Physicians, 2002)\(^2\). The Royal College of Physicians found that hospital admission at the weekend (Saturday or Sunday) was associated with a significant increase in hospital death over a 30 day follow-up period. The reasons for the increased mortality were likely to associated with a number of factors – patients admitted at the weekend may be more ill, availability of key staff and senior clinicians and availability of diagnostics.

An increased birth rate in the UK has coincided with increases in maternal age, obesity, multiple pregnancy, and an increase in patients with existing co-morbidity\(^3\). Additionally, women from disadvantaged backgrounds and those with complex social needs continue to experience poorer pregnancy outcomes (Lewis 2007)\(^4\).

On the basis of the available evidence Prof Longley suggests there are several health specialties which would benefit from reconfiguration:


\(^2\) Royal College of Physicians, Isolated Medical Services (2002)

\(^3\) The presence of one or more disorders (or diseases) in addition to a primary disease or disorder.

**Major trauma Services:** (multiple injuries involving different tissues and organs systems that are, or have the potential to be, life-threatening). There is evidence of significant outcome benefits for patients with major trauma when treated in a dedicated major trauma centre. In a typical year around 1,000 patients in Wales have major trauma:

- Regionalisation of care to specialist trauma centres reduces mortality by 25% and length of stay by four days.
- High volume trauma centres reduce death from major injury by up to 50%.
- Time from injury to definitive surgery is the primary determinant of outcome in major trauma (not time to arrival in the nearest emergency department).
- Major trauma patients managed initially in local hospitals are 1.5 to five times more likely to die than patients transported directly to trauma centres.
- One centre might typically serve a population of three to four million people.

**General trauma and emergency care:** Services that meet clinical standards and consistently follow recommended pathways make the most difference, whatever the size of the unit. There is increasing evidence that outcomes are better when there are more senior doctors on site 24/7 and this is becoming increasingly difficult to achieve in smaller units:

- Outcomes are better where senior doctor cover is available 24/7.
- There is some (weak) evidence that, for certain procedures (e.g. ruptured abdominal aortic aneurism), outcomes improve with unit size.
- Time to treatment can be reduced through mobile provision in some cases.

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**Royal College position (Source: Norton, Longley, and Ponton, 2012a)**

The Royal College of Physicians and the Royal College of Surgeons have stated that high-quality emergency medicine and surgery services need a critical mass of medical consultants and a minimum amount of immediately available diagnostic equipment and treatment facilities. The Royal College of Surgeons recommends that a safe major accident and emergency department should service a population of no fewer than 300,000 people (Royal College of Surgeons, 2008). This is on the basis that it would enable the provision of clinically viable accident and emergency departments with a minimum of eight to 12 consultants, working in multi-disciplinary teams with experienced nurses and therapists, to provide 24-hour cover. The Royal College states that teams should experience sufficient volume to maintain a high skill level, noting that if this is not the case then it is increasingly

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likely that people with life-threatening conditions are treated by someone who is not fully trained, particularly out of hours.

**Maternity and newborn care services:** The professional advice from the Royal College of Obstetricians and Gynaecologists states units offering obstetric care should meet minimum numbers of dedicated consultant hours on obstetric wards each week.

**Inpatient children’s services:** Professional guidance from the Royal College of Paediatrics and Child Health recommends that small paediatric units admitting fewer than 1,800 children each year should not continue to exist, unless they are geographically isolated.

**On the workforce: We’ve got more staff than ever before, so what’s the problem?**
The current service configuration and hospital network spreads medical resource very thinly, especially at middle grade. This has been exacerbated by the European Working Time Directive’s (EWTD) restrictions on working hours. In 2007, there were 2,748 junior doctors in NHS Wales with a total of 134,206 hours worked per week. In 2011 the total number of junior doctors had risen to 2,810 but as a result of the introduction of the EWTD 48-hour week the total numbers of hours worked per week had fallen to 126,651. Therefore the average junior doctor now works 2.85 hours less per week or put another way a total of 7,555 fewer hours are worked every week.⁶

Health boards are experiencing severe difficulties with recruitment. These are not the short delays which can often accompany bureaucratic appointment processes: they are persistent problems, where departments are left trying to cover gaps with temporary staff, and often experiencing acute, stressful – and sometimes risky – staff shortages.

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Table 2: Medical staff recruitment problems by specialty in Wales.

<table>
<thead>
<tr>
<th>Speciality</th>
<th>No. HBs with recruitment difficulties</th>
<th>National shortage?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>6</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>6</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Health / CAMHS</td>
<td>6</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Radiology</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Medicine / Geriatrics*</td>
<td>4</td>
<td>?</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>3</td>
<td>Yes</td>
</tr>
<tr>
<td>Microbiology</td>
<td>3</td>
<td>Yes</td>
</tr>
<tr>
<td>Obstetrics and Gynaecology</td>
<td>3</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* Sub-specialities unclear.

There is also a financial impact of these shortages. Costs for agency medical staff, for example, are high and rising in Wales.

Table 3: Agency staff analysis at month six 2011/12.

<table>
<thead>
<tr>
<th>LHB / Trust</th>
<th>2010/11 Full Year</th>
<th>2011/12 to September</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>£3.282 M</td>
<td>£2.023 M</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>£2.031 M</td>
<td>£1.027 M</td>
</tr>
<tr>
<td>Betsi Cadwaladr</td>
<td>£13.351 M</td>
<td>£7.083 M</td>
</tr>
<tr>
<td>Cardiff &amp; Vale</td>
<td>£2.67 M</td>
<td>£1.296 M</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>£3.977 M</td>
<td>£2.085 M</td>
</tr>
<tr>
<td>Hywel Dda</td>
<td>£5.275 M</td>
<td>£3.357 M</td>
</tr>
<tr>
<td>Powys</td>
<td>£0.217 M</td>
<td>£0.062 M</td>
</tr>
<tr>
<td>Public Health</td>
<td>£0.017 M</td>
<td>£0 M</td>
</tr>
<tr>
<td>Velindre</td>
<td>£0.0146 M</td>
<td>£0.003 M</td>
</tr>
<tr>
<td>Welsh Ambulance</td>
<td>£0 M</td>
<td>£0 M</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£30.966 M</strong></td>
<td><strong>£16.936 M</strong></td>
</tr>
<tr>
<td>Projected to year end</td>
<td></td>
<td><strong>£33.872 M</strong></td>
</tr>
</tbody>
</table>

Source: Longley (2012).  

In addition to the number of hours worked medical training requirements in the UK are undergoing significant change, with an anticipated decrease in medical school
numbers. The reduced numbers of training places for medical staff will lead to a redesign of service delivery.

In paediatrics, recruitment has been down for the last two to three years, with no expectation either in Wales or the UK that this situation will be resolved in the short to medium term. As a result, because there are now too many paediatric inpatient units and too many medical staff rotas NHS Wales are now unable to staff the rotas in a compliant way. The General Medical Council survey shows that the workload for paediatric trainees in Wales is amongst the highest in the UK and we are the lowest and second lowest in the UK for EWTD compliance.

The review by Prof Longley highlights that the proportion of female graduates has increased over the past two decades, with the potential that many of these will become mothers during the years of training - early 20s to late 30s. Each year in Wales, 80 to 100 doctors-in-training take maternity leave and 50% of them request less than fulltime training on return to work. At the current time there are approximately 203 (7.5%) of doctors in training working less than fulltime.

The healthcare workforce generally is ageing, and this will soon start to present challenges in particular areas. Approximately 29% of nursing and midwifery staff in Wales is over 50, and 12% over 55. An ageing workforce poses risk to supply, particularly in community nursing.

The NHS is experiencing a net outflow of nurses due to an increased migration of UK trained nurses, and a reduction in the recruitment of international nurses.

The Welsh Government’s Rural Health Plan⁹ has noted some rural areas experience difficulties in attracting and retaining appropriately-trained staff at all levels and across both health and social care.

The NHS in Wales is facing challenges in recruiting and retaining consultants. Table 4 provides a breakdown of the number of consultants across the health boards and NHS trusts in Wales.

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### Table 4: The organisational distribution of medical staff across Wales.

<table>
<thead>
<tr>
<th>Health board/trust</th>
<th>Population of the health board/trust</th>
<th>Number of medical &amp; dental staff</th>
<th>Medical &amp; dental staff per 1,000 people</th>
<th>Number of consultants</th>
<th>Consultants per 1,000 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abertawe Bro Morgannwg</td>
<td>502,929</td>
<td>1,319</td>
<td>2.62</td>
<td>497</td>
<td>0.99</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>560,409</td>
<td>1,165</td>
<td>2.08</td>
<td>383</td>
<td>0.68</td>
</tr>
<tr>
<td>Betsi Cadwaladr</td>
<td>678,750</td>
<td>1,285</td>
<td>1.89</td>
<td>456</td>
<td>0.67</td>
</tr>
<tr>
<td>Cardiff &amp; Vale</td>
<td>460,843</td>
<td>1,556</td>
<td>3.38</td>
<td>529</td>
<td>1.15</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>290,060</td>
<td>672</td>
<td>2.32</td>
<td>239</td>
<td>0.82</td>
</tr>
<tr>
<td>Hywel Dda</td>
<td>374,592</td>
<td>742</td>
<td>1.98</td>
<td>222</td>
<td>0.59</td>
</tr>
<tr>
<td>Powys</td>
<td>131,736</td>
<td>42</td>
<td>0.32</td>
<td>14</td>
<td>0.11</td>
</tr>
<tr>
<td><strong>Wales</strong></td>
<td><strong>2,999,319</strong></td>
<td><strong>6,781</strong></td>
<td><strong>2.26</strong></td>
<td><strong>2,340</strong></td>
<td><strong>0.78</strong></td>
</tr>
</tbody>
</table>

Source: Ponton, Longley and Norton, (2012b)<sup>10</sup>

The Academy of Medical Royal Colleges report *The Benefits of Consultant Delivered Care*<sup>11</sup>, examines the evidence for medical care being delivered by consultants. In summary the paper says:

- Numerous reviews by expert clinicians have concluded that patients have increased morbidity and mortality when there is a delay in Consultant involvement in their care across a wide range of fields including acute medicine and acute surgery, emergency medicine, trauma, anaesthetics and obstetrics.
- Data from the trainee doctors’ strike in New Zealand demonstrated consultant care during the strike was associated with faster patient processing and decreased hospital stay.
- The increased mortality among patients treated in hospitals at weekends has been attributed by expert clinicians to decreased consultant involvement in care.
- There is evidence across a wide range of medical fields that consultants deliver better patient outcomes and improved efficiency of care. The academy believes, therefore, that there are real evidence based benefits from moving to a system of consultant-delivered care. The academy concludes that the benefits of consultant-delivered care should be available

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<sup>10</sup> Ponton, Longley and Norton (2012b), *Op cit.*

<sup>11</sup> The Academy of Medical Royal Colleges report. *The Benefits of Consultant Delivered Care*, January 2012
to all patients throughout the week and recommends that work should be undertaken by clinicians and employers to map out the staffing requirements and service implications of implementing a consultant-delivered service throughout the week.

On access: Is poorer access inevitable to ensure good safety and quality?

Patients’ help-seeking behaviours: There is evidence of a significant mismatch between professional expectations, patients’ needs and patterns of uptake of services. This is exemplified by the low uptake of preventive services by some groups\(^\text{12}\), the delays in accessing care for serious conditions\(^\text{13,14,15}\) or over-utilisation of emergency services for what is deemed medical “trivia”\(^\text{16}\). There are particular problems in gaining access to healthcare for marginalised groups, including homeless people, new immigrant groups and institutionalised populations. There is evidence that the indirect costs of utilising healthcare may also act as a barrier to access, especially for more deprived groups and in rural areas\(^\text{17}\).

Availability of services: Problems of access in relation to the location and configuration of services have been the subject of much work, especially in rural areas. In general, the distance from a service is inversely associated with utilisation, especially for specialist services. The research suggests that travel time, costs and availability of reliable transport are often more important than physical distance per se\(^\text{18,19}\).

Organisational barriers to access: For hospital services, the main barrier has often been perceived as waiting lists and waiting times for elective hospital care. Evidence, however, suggests that for many people, being seen quickly is not always the most important consideration – being able to obtain an appointment on a day of choice and seeing a particular health professional are also important for

\(^{12}\) Cancer Research Centre 1997. Cancer Fact Sheet No. 7.5


\(^{17}\) Longley (2012), *Op cit.*


some patient groups. Commentators have concluded that, in general organisational barriers result from lack of capacity and/or inefficient use of existing capacity.

**What do patients tell us about access to healthcare?**

The Picker Institute has undertaken extensive patient surveys across the UK and reviewed the international literature. It has concluded that there are eight key aspects of healthcare that patients consider most important, and these are summarized below (Picker Institute, 2006):

![Figure 1: Eight key aspects of healthcare that patients consider most important (Picker Institute, 2006).](image)

National patient surveys undertaken by the Department of Health have found geographical convenience and transport is ranked the highest priority by far, 64% of patients ranked this as the most important factor in the 2007 survey.

A Welsh NHS Confederation survey conducted by YouGov in 2011 sought to establish the level of awareness about the management of the NHS in Wales, perceptions of quality and views on areas of policy, including the future for

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hospital services. The survey found people in Wales say they don’t mind travelling for specialist services if it means the care will be of higher quality, although there is no definition of what a specialist service is and, overall attitudes to concentrating services in fewer, larger hospitals are negative with most people opposing this, and believing their local hospital should provide every type of service.

The findings of the Picker Institute, Health Foundation and national surveys are consistent with the increasing evidence base that, when given the facts, patients and carers will prioritise excellence and quality over convenience when it comes to their healthcare treatment, particularly for major treatment interventions and life-threatening conditions, for example cancer treatment and stroke care.

Access to healthcare in rural areas
The unique nature of Wales, with significant rural areas poses specific challenges for the delivery of healthcare in Wales and this is reflected in the Rural Health Strategy (Welsh Government, 2009).

Key findings of the Institute of Rural Health review of Wales (Welsh Government, 2009)
- A minority of people in rural Wales have difficulty in accessing the following services: getting to dentists (18%), cinemas (18%), hospitals (13%), police stations (12%) and leisure centres (10%).
- The main problem lies in transport where 11% of households in rural Wales do not own or have the use of a motor vehicle. More than twice the proportion of those without a car have difficulties getting to a hospital than those with private transport.
- Access to primary health care in rural areas is complex - access is more difficult for people living in hamlets, villages and open countryside than for those living in rural towns, the longer the distance to a GP the poorer the prognosis and survival rates in certain cancers.
- Distance to specialist health services has been shown to decrease survival rates from some cancers and asthma. Travel time to specialist services can be costly in terms of time, energy, finance and emotions.
- Rural residents may not be as assertive when using out-of-hours services as their urban counterparts, thus leaving them vulnerable when urgent help is required. There is a need in rural areas for out-of-hours nursing and support

Private and public transport
While noting the availability of emergency and non-emergency patient transport services for eligible patients, the majority of people attending hospital still rely on private or public transport.

Car ownership and access to public transport in Wales – summary of current position (Source: The Poverty Site)\(^2\)

Public transport
- Among households without a car, two fifths describe the local bus service as failing to meet their needs for travel to the town centre or the shops while two thirds say it does not meet the need for travel to the hospital. Among households with a car, the proportion in each of these cases is higher still.
- Almost all households (90%) and irrespective of whether they have a car say the bus service does not meet the need either for travel at night or travel on Sundays.
- Local bus services do not meet the need for weekday travel for the majority in any part of Wales. Support for the view that local bus services do not meet weekday travel needs is highest in the South Wales valleys, at 80%. At the same time, the proportion of people with daily access to a car is lowest in the South Wales valleys, at 55%.
- The 2004 Living in Wales survey included a question about satisfaction with public transport. Although levels of satisfaction were much higher than suggested by the 2004 Welsh Consumer Council Survey, the geographic pattern was similar: high levels of dissatisfaction in rural areas (Powys, Ceredigion, Monmouthshire and Carmarthenshire) and some South Wales valleys authorities (Rhondda Cynon Taf and Blaenau Gwent).

Relating to levels of car ownership
- Levels of car ownership are closely linked with the age and number of adults in the households. Thus, fewer than a tenth of working-age couples lack a car, and only a fifth of pensioner couples. By contrast, half of lone parents lack a car and two thirds of single pensioners. The great majority of these latter two groups are women.
- The proportion of working-age households without a car varies from 26% in Merthyr Tydfil and Blaenau Gwent to 10% in Monmouthshire and Powys.
- Unlike the use of a car for work, car ownership among working-age

households is usually quite a lot higher in rural areas, although again Gwynedd is an exception. Car ownership is lowest in the major cities and in the South Wales valleys.

- Physical access to public transport is a major area of concern for older people, people with a disability and people with an illness. Many services are not viewed as having been adapted for people with mobility problems.

A review of transport for health and social care in Scotland\(^{27}\) highlighted the particular needs of older people, those with long-term health or social care needs and people who live in remote and rural areas and recognised they may need additional support to get to a hospital appointment or to access services. It concluded that, if transport is not well planned, it can result in unnecessary journeys, missed or late appointments, people staying in hospital longer than they need to and reliance on unplanned options such as taxis.

**What’s the case for change?**

Professor Longley (Longley, 2012)\(^{28}\) concludes:

“There is now a strong case for reconfiguring some hospital services, in Wales as elsewhere in the UK. This has a positive aspect – patient outcomes could be improved – and a negative aspect – some services will collapse because of shortages of key staff, if changes are not made proactively. While these problems have been developing over time, the need for change is now urgent in some key specialties, as levels of medical staffing become acute.”

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\(^{27}\) Transport for health and social care Prepared for the Auditor General for Scotland and the Accounts Commission, 2011

\(^{28}\) Longley (2012), *Op cit.*
Profile of the South Wales Programme area

The South Wales Programme area consists of five health boards: Abertawe Bro Morgannwg University Health Board (ABM); Aneurin Bevan Health Board; Cardiff and Vale University Health Board; Cwm Taf Health Board; and Powys Teaching Health Board. The five health boards deliver services to 13 local authorities, and account for 63% of the total population of Wales.

Sex

The gender split (see Table 5) for the South Wales Programme area mirrors very closely the gender split for Wales as a whole. Approximately a 50:50 split with slightly more females (50.9%) than males (49.1%).

Table 5: Sex by local authorities in Wales (Source: Table QS104EW 2011 Census, ONS).

<table>
<thead>
<tr>
<th>Region</th>
<th>Males</th>
<th>Females</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>49.3%</td>
<td>50.7%</td>
<td>100.0%</td>
<td>518,013</td>
</tr>
<tr>
<td>Swansea-</td>
<td>49.4%</td>
<td>50.6%</td>
<td>100.0%</td>
<td>239,023</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>49.0%</td>
<td>51.0%</td>
<td>100.0%</td>
<td>139,812</td>
</tr>
<tr>
<td>Bridgend</td>
<td>49.4%</td>
<td>50.6%</td>
<td>100.0%</td>
<td>139,178</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>49.0%</td>
<td>51.0%</td>
<td>100.0%</td>
<td>576,754</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>49.0%</td>
<td>51.0%</td>
<td>100.0%</td>
<td>178,806</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>49.2%</td>
<td>50.8%</td>
<td>100.0%</td>
<td>69,814</td>
</tr>
<tr>
<td>Torfaen</td>
<td>48.7%</td>
<td>51.3%</td>
<td>100.0%</td>
<td>91,075</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>49.2%</td>
<td>50.8%</td>
<td>100.0%</td>
<td>91,323</td>
</tr>
<tr>
<td>Newport</td>
<td>49.0%</td>
<td>51.0%</td>
<td>100.0%</td>
<td>145,736</td>
</tr>
<tr>
<td>Cardiff and Vale UHB</td>
<td>49.0%</td>
<td>51.0%</td>
<td>100.0%</td>
<td>472,426</td>
</tr>
<tr>
<td>Vale of Glamorgan</td>
<td>48.7%</td>
<td>51.3%</td>
<td>100.0%</td>
<td>126,336</td>
</tr>
<tr>
<td>Cardiff</td>
<td>49.1%</td>
<td>50.9%</td>
<td>100.0%</td>
<td>346,090</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>48.9%</td>
<td>51.1%</td>
<td>100.0%</td>
<td>293,212</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>48.9%</td>
<td>51.1%</td>
<td>100.0%</td>
<td>234,410</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>49.0%</td>
<td>51.0%</td>
<td>100.0%</td>
<td>58,802</td>
</tr>
<tr>
<td>Powys</td>
<td>49.4%</td>
<td>50.6%</td>
<td>100.0%</td>
<td>132,976</td>
</tr>
<tr>
<td>South Powys*</td>
<td>49.4%</td>
<td>50.6%</td>
<td>100.0%</td>
<td>66,488</td>
</tr>
<tr>
<td>South Wales Programme*</td>
<td>49.1%</td>
<td>50.9%</td>
<td>100.0%</td>
<td>1,926,893</td>
</tr>
<tr>
<td>Wales</td>
<td>49.1%</td>
<td>50.9%</td>
<td>100.0%</td>
<td>3,063,456</td>
</tr>
</tbody>
</table>

*Figures for Powys have been halved to calculate a South Powys figure.

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29 Although Powys has been included as one of the 13 local authorities, only residents of South Powys will be affected by the proposed service reconfigurations.

30 Based on 2011 Census population figures.
Table 6: Age structure by local authorities in Wales (Source: Table KS102EW 2011 Census, ONS).

<table>
<thead>
<tr>
<th>Region</th>
<th>Age 0-4</th>
<th>Age 5-15</th>
<th>Age 16-24</th>
<th>Age 25-44</th>
<th>Age 45-64</th>
<th>Age 65-84</th>
<th>Age 85 plus</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>5.5%</td>
<td>12.1%</td>
<td>12.3%</td>
<td>25.5%</td>
<td>26.4%</td>
<td>15.7%</td>
<td>2.4%</td>
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<td>518,013</td>
</tr>
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<td>Swansea</td>
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<td>15.5%</td>
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<td>100.0%</td>
<td>239,023</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>5.4%</td>
<td>12.2%</td>
<td>10.7%</td>
<td>25.3%</td>
<td>27.8%</td>
<td>16.2%</td>
<td>2.5%</td>
<td>100.0%</td>
<td>139,812</td>
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<td>Blaenau Gwent</td>
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<td>15.6%</td>
<td>2.4%</td>
<td>100.0%</td>
<td>91,075</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>5.1%</td>
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<td>21.7%</td>
<td>30.0%</td>
<td>18.0%</td>
<td>2.8%</td>
<td>100.0%</td>
<td>91,323</td>
</tr>
<tr>
<td>Newport</td>
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</tr>
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</tr>
<tr>
<td>Cardiff</td>
<td>6.5%</td>
<td>11.7%</td>
<td>17.5%</td>
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<td>11.2%</td>
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<tr>
<td>Cwm Taf</td>
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<td>14.9%</td>
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<td>100.0%</td>
<td>293,212</td>
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<tr>
<td>Rhondda Cynon Taf</td>
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<td>12.0%</td>
<td>25.8%</td>
<td>26.2%</td>
<td>14.9%</td>
<td>2.2%</td>
<td>100.0%</td>
<td>234,410</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>6.2%</td>
<td>12.5%</td>
<td>12.0%</td>
<td>26.0%</td>
<td>26.7%</td>
<td>14.6%</td>
<td>2.0%</td>
<td>100.0%</td>
<td>58,802</td>
</tr>
<tr>
<td>Powys</td>
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<td>20.8%</td>
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<td>19.7%</td>
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<td>9.6%</td>
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<td>19.7%</td>
<td>3.1%</td>
<td>100.0%</td>
<td>66,488</td>
</tr>
<tr>
<td>South Wales Programme*</td>
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<td>12.5%</td>
<td>12.7%</td>
<td>25.5%</td>
<td>25.9%</td>
<td>14.8%</td>
<td>2.3%</td>
<td>100.0%</td>
<td>1,926,893</td>
</tr>
<tr>
<td>Wales</td>
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<td>12.3%</td>
<td>12.2%</td>
<td>24.7%</td>
<td>26.6%</td>
<td>15.9%</td>
<td>2.4%</td>
<td>100.0%</td>
<td>3,063,456</td>
</tr>
</tbody>
</table>

*Figures for Powys have been halved to calculate a South Powys figure.
Age
In terms of age profile (see Table 6) there are some slight variations in the South Wales Programme area compared to Wales as a whole.

Overall for the South Wales Programme health boards the younger age bands (0-4 years, 5-16 years, 16-24 years, and 25-44 years) as a proportion of the South Wales Programme area population are slightly higher than the proportions for Wales as a whole. Conversely the older age band proportions (45-64 years, 65-84 years, and 85 years plus) are smaller than in Wales as a whole.

Powys and ABM are the exceptions among the South Wales Programme health boards. Powys and ABM have a lower proportion of their populations aged 0-44 years, and a higher proportion in the older age bands (45-64 years, 65-84 years, and 85 years plus) than Wales as a whole.

If we look at individual local authorities covered by the South Wales Programme area Cardiff has significantly higher population proportions than Wales among the 16-24 years (17.5% compared to 12.5%) and 25-44 years age bands (29.0% compared to 24.7%). Cardiff also has significantly lower population proportions than Wales among the 45-64 years (22.1% compared to 26.6%) and 65-plus years age bands (13.2% compared to 18.4%). Among the South Wales Programme local authorities Powys and Monmouthshire have the largest population proportions aged 85-plus, 22.7% for Powys and 20.9% for Monmouthshire.

Disability
The proportion of people identifying themselves as disabled in the South Wales Programme area is slightly higher than the proportion in Wales as a whole, 23% compared to 22.7% (see Table 7). There is a great deal of variation on disability among the South Wales Programme health boards. Cardiff and Vale UHB has the lowest proportion of its population reporting disability at 18.6%, while Cwm Taf at 26.1% has the highest proportion of its population reporting disability.

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31 Disabled is defined as individuals whose day-to-day activities are either limited a lot, or limited a little.
Table 7: Long-term health problem or disability by local authorities in Wales (Source: Table QS303EW 2011 Census, ONS).

<table>
<thead>
<tr>
<th>Region</th>
<th>Day-to-day activities limited a lot</th>
<th>Day-to-day activities limited a little</th>
<th>Day-to-day activities not limited</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>13.8%</td>
<td>11.2%</td>
<td>75.1%</td>
<td>100.0%</td>
<td>518,013</td>
</tr>
<tr>
<td>Swansea</td>
<td>12.6%</td>
<td>10.8%</td>
<td>76.7%</td>
<td>100.0%</td>
<td>239,023</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>16.1%</td>
<td>11.9%</td>
<td>72.0%</td>
<td>100.0%</td>
<td>139,812</td>
</tr>
<tr>
<td>Bridgend</td>
<td>13.5%</td>
<td>11.2%</td>
<td>75.3%</td>
<td>100.0%</td>
<td>139,178</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>12.5%</td>
<td>10.9%</td>
<td>76.6%</td>
<td>100.0%</td>
<td>576,754</td>
</tr>
<tr>
<td>Caerphilly</td>
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<td>11.4%</td>
<td>74.6%</td>
<td>100.0%</td>
<td>178806</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
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<td>11.5%</td>
<td>72.8%</td>
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<td>69814</td>
</tr>
<tr>
<td>Torfaen</td>
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<td>75.9%</td>
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<td>Monmouthshire</td>
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<td>10.5%</td>
<td>79.9%</td>
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</tr>
<tr>
<td>Newport</td>
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<td>10.2%</td>
<td>79.2%</td>
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<td>145736</td>
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<tr>
<td>Cardiff and Vale UHB</td>
<td>9.4%</td>
<td>9.2%</td>
<td>81.4%</td>
<td>100.0%</td>
<td>472,426</td>
</tr>
<tr>
<td>Vale of Glamorgan</td>
<td>9.9%</td>
<td>10.4%</td>
<td>79.7%</td>
<td>100.0%</td>
<td>126,336</td>
</tr>
<tr>
<td>Cardiff</td>
<td>9.2%</td>
<td>8.8%</td>
<td>82.0%</td>
<td>100.0%</td>
<td>346,090</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>14.7%</td>
<td>11.3%</td>
<td>73.9%</td>
<td>100.0%</td>
<td>293,212</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>14.5%</td>
<td>11.4%</td>
<td>74.2%</td>
<td>100.0%</td>
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</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>15.8%</td>
<td>11.1%</td>
<td>73.1%</td>
<td>100.0%</td>
<td>58,802</td>
</tr>
<tr>
<td>Powys</td>
<td>10.2%</td>
<td>11.2%</td>
<td>78.6%</td>
<td>100.0%</td>
<td>132,976</td>
</tr>
<tr>
<td>South Powys*</td>
<td>10.2%</td>
<td>11.2%</td>
<td>78.6%</td>
<td>100.0%</td>
<td>66,488</td>
</tr>
<tr>
<td>South Wales Programme*</td>
<td>12.3%</td>
<td>10.6%</td>
<td>77.0%</td>
<td>100.0%</td>
<td>1,926,893</td>
</tr>
<tr>
<td>Wales</td>
<td>11.9%</td>
<td>10.8%</td>
<td>77.3%</td>
<td>100.0%</td>
<td>3,063,456</td>
</tr>
</tbody>
</table>

*Figures for Powys have been halved to calculate a South Powys figure.

At a local authority level Cardiff (18.0%), Monmouthshire (20.1%), the Vale of Glamorgan (20.3%) and Newport (20.8%) stand out with the lowest population proportions reporting a disability.
Table 8: Ethnic group by unitary authorities in Wales (Source: Table KS201EW Census 2011, ONS).

<table>
<thead>
<tr>
<th>Region</th>
<th>White (%)</th>
<th>Mixed / Multiple ethnic group (%)</th>
<th>Asian / British (%)</th>
<th>Black / African / Caribbean / Black British (%)</th>
<th>Other ethnic group (%)</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>96.1%</td>
<td>0.8%</td>
<td>2.1%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>100.0%</td>
<td>518,013</td>
</tr>
<tr>
<td>Swansea</td>
<td>94.0%</td>
<td>0.9%</td>
<td>3.3%</td>
<td>0.8%</td>
<td>1.0%</td>
<td>100.0%</td>
<td>239,023</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>98.1%</td>
<td>0.7%</td>
<td>1.0%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>100.0%</td>
<td>139,812</td>
</tr>
<tr>
<td>Bridgend</td>
<td>97.8%</td>
<td>0.7%</td>
<td>1.1%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>100.0%</td>
<td>139,178</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>96.1%</td>
<td>1.0%</td>
<td>2.0%</td>
<td>0.6%</td>
<td>0.3%</td>
<td>100.0%</td>
<td>576,754</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>98.3%</td>
<td>0.7%</td>
<td>0.8%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>100.0%</td>
<td>178,806</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>98.5%</td>
<td>0.6%</td>
<td>0.7%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>100.0%</td>
<td>69,814</td>
</tr>
<tr>
<td>Torfaen</td>
<td>98.0%</td>
<td>0.7%</td>
<td>1.1%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>100.0%</td>
<td>91,075</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>98.0%</td>
<td>0.7%</td>
<td>1.0%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>100.0%</td>
<td>91,323</td>
</tr>
<tr>
<td>Newport</td>
<td>89.9%</td>
<td>1.9%</td>
<td>5.5%</td>
<td>1.7%</td>
<td>1.0%</td>
<td>100.0%</td>
<td>145,736</td>
</tr>
<tr>
<td>Cardiff and Vale UHB</td>
<td>87.8%</td>
<td>2.5%</td>
<td>6.3%</td>
<td>1.8%</td>
<td>1.5%</td>
<td>100.0%</td>
<td>472,426</td>
</tr>
<tr>
<td>Vale of Glamorgan</td>
<td>96.4%</td>
<td>1.3%</td>
<td>1.6%</td>
<td>0.4%</td>
<td>0.3%</td>
<td>100.0%</td>
<td>126,336</td>
</tr>
<tr>
<td>Cardiff</td>
<td>84.7%</td>
<td>2.9%</td>
<td>8.1%</td>
<td>2.4%</td>
<td>2.0%</td>
<td>100.0%</td>
<td>346,090</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>97.4%</td>
<td>0.7%</td>
<td>1.3%</td>
<td>0.5%</td>
<td>0.1%</td>
<td>100.0%</td>
<td>293,212</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>97.4%</td>
<td>0.6%</td>
<td>1.3%</td>
<td>0.6%</td>
<td>0.1%</td>
<td>100.0%</td>
<td>234,410</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>97.6%</td>
<td>0.8%</td>
<td>1.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>100.0%</td>
<td>58,802</td>
</tr>
<tr>
<td>Powys</td>
<td>98.4%</td>
<td>0.6%</td>
<td>0.9%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>100.0%</td>
<td>132,976</td>
</tr>
<tr>
<td>South Powys*</td>
<td>98.4%</td>
<td>0.6%</td>
<td>0.9%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>100.0%</td>
<td>66,488</td>
</tr>
<tr>
<td>South Wales Programme*</td>
<td>94.4%</td>
<td>1.2%</td>
<td>2.9%</td>
<td>0.8%</td>
<td>0.6%</td>
<td>100.0%</td>
<td>1,926,893</td>
</tr>
<tr>
<td>Wales</td>
<td>95.6%</td>
<td>1.0%</td>
<td>2.3%</td>
<td>0.6%</td>
<td>0.5%</td>
<td>100.0%</td>
<td>3,063,456</td>
</tr>
</tbody>
</table>

*Figures for Powys have been halved to calculate a South Powys figure.
Race
Overall the South Wales Programme area is slightly more ethnically diverse than Wales as a whole, with 5.6% black and minority ethnic (BME)\(^{32}\) population compared to 4.4% BME population nationally (see Table 8).

The South Wales Programme area contains three of the four Welsh asylum seekers dispersal areas (Cardiff, Newport, Swansea), and this is reflected in the higher BME populations in these areas compared to the other local authorities. Cardiff has the highest BME population at 15.3%, Newport the second highest BME population at 10.1% and Swansea the third highest at 6.0%. BME populations outside these local authorities in the South Wales Programme area are in the range of 1.5% to 2%.

Due to the presence of Cardiff and Newport within the South Wales Programme area, and the small BME populations in Wales outside these cities, the South Wales Programme area contains 80.4% of the total Welsh BME population. Cardiff accounts for 39.2% of the total Welsh BME population, and Newport 10.9%.

Marriage and civil partnership
The 2011 Census data shows that the overall South Wales Programme population proportions for marriage and civil partnership closely mirrors the population proportions for Wales as a whole (see Table 9).

Single (never married or never registered a same-sex civil partnership) and Married make up the bulk of all marital/civil partnerships statuses, accounting for 34.9% and 45.4% respectively in the South Wales Programme area, and 33.5% and 46.6% in Wales.

It is notable that the number of registered same-sex civil partnerships accounts for only 0.2% of all marital/civil partnerships statuses across Wales, and this pattern is repeated across nearly all South Wales Programme health boards.\(^{33}\)

There is some variation among the health boards in terms of marriage and civil partnership, with Cardiff and Vale UHB and Powys health board showing the largest variation from the overall South Wales Programme and Wales population proportions, especially in the categories of single (never married or never registered a same-sex civil partnership and married). For all other categories, the South Wales Programme health boards mirror the values for Wales as a whole.

\(^{32}\) Black and minority population is classed here as any ethnicity not included under the white categories.

\(^{33}\) Newport is the exception here, same-sex civil partnerships are 0.4%.
Table 9: Marital and civil partnership status by local authorities in Wales (Source: Table KS103EW 2011 Census, ONS).

<table>
<thead>
<tr>
<th>Region</th>
<th>Single (never married or never registered a same-sex civil partnership)</th>
<th>Married</th>
<th>In a registered same-sex civil partnership</th>
<th>Separated (but still legally married or still legally in a same-sex civil partnership)</th>
<th>Divorced or formerly in a same-sex civil partnership which is now legally dissolved</th>
<th>Widowed or surviving partner from a same-sex civil partnership</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>33.7%</td>
<td>46.0%</td>
<td>0.2%</td>
<td>2.2%</td>
<td>10.0%</td>
<td>7.9%</td>
<td>100.0%</td>
<td>426,692</td>
</tr>
<tr>
<td>Swansea</td>
<td>36.7%</td>
<td>43.8%</td>
<td>0.2%</td>
<td>2.3%</td>
<td>9.5%</td>
<td>7.7%</td>
<td>100.0%</td>
<td>197,627</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>31.2%</td>
<td>47.3%</td>
<td>0.2%</td>
<td>2.2%</td>
<td>10.6%</td>
<td>8.4%</td>
<td>100.0%</td>
<td>115,175</td>
</tr>
<tr>
<td>Bridgend</td>
<td>30.9%</td>
<td>48.6%</td>
<td>0.2%</td>
<td>2.2%</td>
<td>10.4%</td>
<td>7.8%</td>
<td>100.0%</td>
<td>113,890</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>31.9%</td>
<td>47.8%</td>
<td>0.2%</td>
<td>2.3%</td>
<td>9.9%</td>
<td>7.8%</td>
<td>100.0%</td>
<td>466,407</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>32.3%</td>
<td>47.9%</td>
<td>0.2%</td>
<td>2.1%</td>
<td>9.9%</td>
<td>7.6%</td>
<td>100.0%</td>
<td>143,825</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>34.2%</td>
<td>44.3%</td>
<td>0.2%</td>
<td>2.2%</td>
<td>10.6%</td>
<td>8.5%</td>
<td>100.0%</td>
<td>57,321</td>
</tr>
<tr>
<td>Torfaen</td>
<td>31.1%</td>
<td>47.7%</td>
<td>0.3%</td>
<td>2.2%</td>
<td>10.4%</td>
<td>8.3%</td>
<td>100.0%</td>
<td>73,833</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>26.3%</td>
<td>54.1%</td>
<td>0.2%</td>
<td>2.1%</td>
<td>9.4%</td>
<td>7.9%</td>
<td>100.0%</td>
<td>75,080</td>
</tr>
<tr>
<td>Newport</td>
<td>34.5%</td>
<td>45.5%</td>
<td>0.4%</td>
<td>2.6%</td>
<td>9.6%</td>
<td>7.4%</td>
<td>100.0%</td>
<td>116,348</td>
</tr>
<tr>
<td>Cardiff and Vale UHB</td>
<td>41.2%</td>
<td>41.3%</td>
<td>0.2%</td>
<td>2.2%</td>
<td>8.7%</td>
<td>6.4%</td>
<td>100.0%</td>
<td>385,619</td>
</tr>
<tr>
<td>Vale of Glamorgan</td>
<td>30.8%</td>
<td>49.1%</td>
<td>0.2%</td>
<td>2.3%</td>
<td>10.0%</td>
<td>7.6%</td>
<td>100.0%</td>
<td>102,504</td>
</tr>
<tr>
<td>Cardiff</td>
<td>45.0%</td>
<td>38.5%</td>
<td>0.2%</td>
<td>2.1%</td>
<td>8.2%</td>
<td>6.0%</td>
<td>100.0%</td>
<td>283,115</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>34.2%</td>
<td>45.7%</td>
<td>0.2%</td>
<td>2.3%</td>
<td>9.6%</td>
<td>8.1%</td>
<td>100.0%</td>
<td>237,958</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>33.9%</td>
<td>45.9%</td>
<td>0.2%</td>
<td>2.2%</td>
<td>9.6%</td>
<td>8.1%</td>
<td>100.0%</td>
<td>190,116</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>35.3%</td>
<td>44.8%</td>
<td>0.2%</td>
<td>2.5%</td>
<td>9.3%</td>
<td>7.9%</td>
<td>100.0%</td>
<td>47,842</td>
</tr>
<tr>
<td>Powys</td>
<td>28.2%</td>
<td>51.1%</td>
<td>0.2%</td>
<td>2.1%</td>
<td>9.6%</td>
<td>8.8%</td>
<td>100.0%</td>
<td>110,083</td>
</tr>
<tr>
<td>South Powys*</td>
<td>28.2%</td>
<td>51.1%</td>
<td>0.2%</td>
<td>2.1%</td>
<td>9.6%</td>
<td>8.8%</td>
<td>100.0%</td>
<td>55,042</td>
</tr>
<tr>
<td>South Wales Programme*</td>
<td>34.9%</td>
<td>45.5%</td>
<td>0.2%</td>
<td>2.2%</td>
<td>9.6%</td>
<td>7.6%</td>
<td>100.0%</td>
<td>1,571,718</td>
</tr>
<tr>
<td>Wales</td>
<td>33.5%</td>
<td>46.6%</td>
<td>0.2%</td>
<td>2.2%</td>
<td>9.7%</td>
<td>7.9%</td>
<td>100.0%</td>
<td>2,507,160</td>
</tr>
</tbody>
</table>

*Figures for Powys have been halved to calculate a South Powys figure.
Cardiff and Vale UHB has a significantly higher proportion of people categorised as single (never married or never registered a same-sex civil partnership) than the proportion for Wales as a whole (41.2% compared to 33.5%). This is due to the high numbers of residents in Cardiff within this category, compared to other local authorities. In contrast the opposite is true for Powys, which has a lower proportion than Wales under the same category (28.2% compared to 33.5%).

If we look at the married category for Cardiff and the Vale UHB and Powys, we see the converse. Here Powys has a higher proportion of its population categorised as married (51.1%), than the overall Wales proportion (46.6%), and Cardiff and the Vale UHB a lower proportion (38.5%).

**Religion**

With regards to religion, the South Wales Programme population profile closely mirrors Wales as a whole (see Table 10). In general the South Wales Programme area, and Wales, have high numbers of people who either identify as Christian (54.4%) or no religion (34.8%).

While there are variations in the South Wales Programme area on the proportion identifying as Christian (Blaenau Gwent is the lowest at 49.9%, and Powys the highest at 61.8%), most of the variation is due to differences in numbers stating they have no religion, rather than increases in the proportion of non-Christian religions.

Non-Christian religions make up only 3.4% of the overall population in the SWP area; this is higher than the figure of 2.7% for Wales as a whole. This is due to the more ethnically diverse populations in Cardiff and Newport local authorities which account for the bulk of the non-Christian religions in the South Wales Programme area, with Cardiff and Newport reporting non-Christian faith percentages of 9.7% and 5.9% respectively.

Outside Cardiff and Newport there tends to be little variation between local authorities in terms of non-Christian religions. The lowest proportion is 0.9% in Blaenau Gwent; the remaining local authorities have proportions around 1.2% and 1.3%. 
### Table 10: Religion by local authorities in Wales (Source: Table KS209EW Census 2011, ONS).

<table>
<thead>
<tr>
<th>Region</th>
<th>Christian</th>
<th>Buddhist</th>
<th>Hindu</th>
<th>Jewish</th>
<th>Muslim</th>
<th>Sikh</th>
<th>Other religion</th>
<th>No religion</th>
<th>Religion not stated</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>55.7%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>1.3%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>34.7%</td>
<td>7.3%</td>
<td>100.0%</td>
<td>518,013</td>
</tr>
<tr>
<td>Swansea</td>
<td>55.0%</td>
<td>0.4%</td>
<td>0.3%</td>
<td>0.1%</td>
<td>2.3%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>34.0%</td>
<td>7.5%</td>
<td>100.0%</td>
<td>239,023</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>57.7%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>0.4%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>33.8%</td>
<td>7.3%</td>
<td>100.0%</td>
<td>139,812</td>
</tr>
<tr>
<td>Bridgend</td>
<td>55.1%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>0.4%</td>
<td>0.0%</td>
<td>0.4%</td>
<td>36.7%</td>
<td>7.0%</td>
<td>100.0%</td>
<td>139,178</td>
</tr>
<tr>
<td>ABM</td>
<td>54.8%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>1.4%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>35.3%</td>
<td>7.6%</td>
<td>100.0%</td>
<td>576,754</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>50.7%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>40.9%</td>
<td>7.5%</td>
<td>100.0%</td>
<td>178,806</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>49.9%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>0.3%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>41.1%</td>
<td>8.1%</td>
<td>100.0%</td>
<td>91,075</td>
</tr>
<tr>
<td>Torfaen</td>
<td>55.4%</td>
<td>0.2%</td>
<td>0.3%</td>
<td>0.0%</td>
<td>0.3%</td>
<td>0.1%</td>
<td>0.3%</td>
<td>35.8%</td>
<td>7.6%</td>
<td>100.0%</td>
<td>91,323</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>62.5%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.3%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>28.5%</td>
<td>7.7%</td>
<td>100.0%</td>
<td>145,736</td>
</tr>
<tr>
<td>Newport</td>
<td>56.9%</td>
<td>0.2%</td>
<td>0.5%</td>
<td>0.1%</td>
<td>4.7%</td>
<td>0.1%</td>
<td>0.3%</td>
<td>29.7%</td>
<td>7.5%</td>
<td>100.0%</td>
<td>518,013</td>
</tr>
<tr>
<td>Cardiff and Vale UHB</td>
<td>53.2%</td>
<td>0.4%</td>
<td>1.1%</td>
<td>0.2%</td>
<td>5.2%</td>
<td>0.3%</td>
<td>0.4%</td>
<td>32.1%</td>
<td>7.2%</td>
<td>100.0%</td>
<td>472,426</td>
</tr>
<tr>
<td>Vale of Glamorgan</td>
<td>58.1%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.6%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>32.9%</td>
<td>7.4%</td>
<td>100.0%</td>
<td>126,336</td>
</tr>
<tr>
<td>Cardiff</td>
<td>51.4%</td>
<td>0.5%</td>
<td>1.4%</td>
<td>0.2%</td>
<td>6.8%</td>
<td>0.4%</td>
<td>0.4%</td>
<td>31.8%</td>
<td>7.2%</td>
<td>100.0%</td>
<td>346,090</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>51.6%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>0.4%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>39.8%</td>
<td>7.3%</td>
<td>100.0%</td>
<td>293,212</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>50.5%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>0.5%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>40.8%</td>
<td>7.4%</td>
<td>100.0%</td>
<td>234,410</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>56.0%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>0.3%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>35.8%</td>
<td>7.0%</td>
<td>100.0%</td>
<td>58,802</td>
</tr>
<tr>
<td>Powys</td>
<td>61.8%</td>
<td>0.4%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>0.6%</td>
<td>27.9%</td>
<td>8.8%</td>
<td>100.0%</td>
<td>132,976</td>
</tr>
<tr>
<td>South Powys*</td>
<td>61.8%</td>
<td>0.4%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>0.6%</td>
<td>27.9%</td>
<td>8.8%</td>
<td>100.0%</td>
<td>66,488</td>
</tr>
<tr>
<td>South Wales Programme*</td>
<td>54.4%</td>
<td>0.3%</td>
<td>0.4%</td>
<td>0.1%</td>
<td>2.1%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>34.8%</td>
<td>7.4%</td>
<td>100.0%</td>
<td>1,926,893</td>
</tr>
<tr>
<td>Wales</td>
<td>57.6%</td>
<td>0.3%</td>
<td>0.3%</td>
<td>0.1%</td>
<td>1.5%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>32.1%</td>
<td>7.6%</td>
<td>100.0%</td>
<td>3,063,456</td>
</tr>
</tbody>
</table>

*Figures for Powys have been halved to calculate a South Powys figure.
Sexual orientation
Sexual orientation is not asked for by the Census so in order to estimate the lesbian, gay and bisexual (LGB) population in Wales we need to use data from the ONS integrated household survey (see Table 11). This does not report findings by local authority, but by regional groupings. It is therefore not possible to present the data by health board, or as a total for the South Wales Programme area.

Table 11: Sexual orientation by region in Wales (Source: Integrated Household Survey 2012).

<table>
<thead>
<tr>
<th>Region</th>
<th>LGB</th>
<th>Heterosexual</th>
<th>No response</th>
<th>Other</th>
<th>Don’t know/Refusal</th>
<th>Total (%)</th>
<th>All people aged 16+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central valleys: Rhondda Cynon Taf, Merthyr Tydfil</td>
<td>1.0%</td>
<td>94.0%</td>
<td>1.0%</td>
<td>*</td>
<td>3.0%</td>
<td>100.0%</td>
<td>233,600</td>
</tr>
<tr>
<td>Gwent valleys: Torfaen, Blaenau Gwent, Caerphilly</td>
<td>1.0%</td>
<td>95.0%</td>
<td>2.0%</td>
<td>*</td>
<td>2.0%</td>
<td>100.0%</td>
<td>267,900</td>
</tr>
<tr>
<td>Bridgend and Neath Port Talbot</td>
<td>1.0%</td>
<td>95.0%</td>
<td>2.0%</td>
<td>*</td>
<td>2.0%</td>
<td>100.0%</td>
<td>221,500</td>
</tr>
<tr>
<td>Swansea</td>
<td>2.0%</td>
<td>95.0%</td>
<td>1.0%</td>
<td>*</td>
<td>1.0%</td>
<td>100.0%</td>
<td>193,200</td>
</tr>
<tr>
<td>Monmouthshire and Newport</td>
<td>1.0%</td>
<td>97.0%</td>
<td>2.0%</td>
<td>*</td>
<td>1.0%</td>
<td>100.0%</td>
<td>184,900</td>
</tr>
<tr>
<td>Cardiff and Vale of Glamorgan</td>
<td>3.0%</td>
<td>94.0%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>2.0%</td>
<td>100.0%</td>
<td>387,000</td>
</tr>
<tr>
<td>Powys</td>
<td>*</td>
<td>93.0%</td>
<td>1.0%</td>
<td>*</td>
<td>5.0%</td>
<td>100.0%</td>
<td>108,100</td>
</tr>
<tr>
<td>Wales</td>
<td>1.0%</td>
<td>94.0%</td>
<td>1.0%</td>
<td>0.0%</td>
<td>3.0%</td>
<td>100.0%</td>
<td>2,456,400</td>
</tr>
</tbody>
</table>

* The data item is too small to be disclosed or not sufficiently robust for publication.

From the results of this survey we can see that the majority of the population in Wales and the regions making up the South Wales Programme area identify as heterosexual (93% to 97%). The percentage of the population identifying as LGB is in the range of 1% to 3% in the South Wales Programme area, this is higher than the value for Wales as a whole due to the higher LGB populations in Cardiff and the Vale of Glamorgan (3.0%), and Swansea (2.0%).

Gender re-assignment
At present, there is no official estimate of the trans population. The England and Wales Census, and Scottish Census do not ask people whether they identify as transgender.

The Gender Identity Research and Education Society (GIRES) (2009), in its Home Office-funded study estimated the number of trans people in the UK to be

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between 300,000 and 500,000, defined as “…a large reservoir of transgender people who experience some degree of gender variance”. The GIRES report also notes: “There is no general correlation between a high population density and a high incidence of gender dysphoria.”

**Pregnancy and maternity**

Data from the Office for National Statistics (ONS) on live births in Wales for 2011 (see Table 12) shows there were just over 23,000 births in the South Wales Programme area. Hospital births account for the majority of all births in the South Wales Programme area and in Wales as a whole.

Low birth weight is a key health indicator for early years and is a major cause for infant mortality in developed countries, including the UK. The percentage of births that are low birth weight (below 2,500 grams) is generally consistent across four of the five health boards, in the range of 6.2% to 6.9%. At the health board level the exception is Cwm Taf, which has a low birth weight percentage of 8.2%.

At the local authority level there is much more variation within the South Wales Programme area, with Monmouthshire at 5.2% the lowest percentage, and Merthyr Tydfil the highest percentage of low birth weight births at 8.3%. Six of the 13 local authorities have low birth weight percentages higher than the percentage for Wales (6.8%).

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Table 12: Births in 2011 by location and number of live births with low birth weight by local authorities. (Source: Stats Wales).36, 37

<table>
<thead>
<tr>
<th>Region</th>
<th>All</th>
<th>NHS Hospital birth</th>
<th>At home, non NHS hospital or elsewhere</th>
<th>Number of live births with birth weight under 2,500 grams</th>
<th>Percentage of live births with birth weight under 2,500 grams</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>5,987</td>
<td>5,633</td>
<td>354</td>
<td>409</td>
<td>6.9%</td>
</tr>
<tr>
<td>Swansea</td>
<td>2,706</td>
<td>2,595</td>
<td>111</td>
<td>186</td>
<td>6.8%</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>1,584</td>
<td>1,512</td>
<td>72</td>
<td>101</td>
<td>6.5%</td>
</tr>
<tr>
<td>Bridgend</td>
<td>1,697</td>
<td>1,526</td>
<td>171</td>
<td>122</td>
<td>7.4%</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>6,613</td>
<td>6,438</td>
<td>175</td>
<td>445</td>
<td>6.7%</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>2,073</td>
<td>2,033</td>
<td>40</td>
<td>144</td>
<td>6.9%</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>784</td>
<td>773</td>
<td>11</td>
<td>58</td>
<td>7.4%</td>
</tr>
<tr>
<td>Torfaen</td>
<td>1,077</td>
<td>1,036</td>
<td>41</td>
<td>77</td>
<td>7.1%</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>780</td>
<td>750</td>
<td>30</td>
<td>41</td>
<td>5.2%</td>
</tr>
<tr>
<td>Newport</td>
<td>1,899</td>
<td>1,846</td>
<td>53</td>
<td>125</td>
<td>6.6%</td>
</tr>
<tr>
<td>Cardiff and Vale</td>
<td>6,169</td>
<td>6,026</td>
<td>143</td>
<td>381</td>
<td>6.2%</td>
</tr>
<tr>
<td>Vale of Glamorgan</td>
<td>1,438</td>
<td>1,389</td>
<td>49</td>
<td>83</td>
<td>5.8%</td>
</tr>
<tr>
<td>Cardiff</td>
<td>4,731</td>
<td>4,637</td>
<td>94</td>
<td>298</td>
<td>6.3%</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>3,729</td>
<td>3,631</td>
<td>98</td>
<td>310</td>
<td>8.2%</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>2,969</td>
<td>2,888</td>
<td>81</td>
<td>247</td>
<td>8.2%</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>760</td>
<td>743</td>
<td>17</td>
<td>63</td>
<td>8.3%</td>
</tr>
<tr>
<td>Powys</td>
<td>1,219</td>
<td>1,143</td>
<td>76</td>
<td>76</td>
<td>6.2%</td>
</tr>
<tr>
<td>South Powys*</td>
<td>610</td>
<td>572</td>
<td>38</td>
<td>38</td>
<td>6.2%</td>
</tr>
<tr>
<td>South Wales Programme</td>
<td>23,108</td>
<td>22,300</td>
<td>808</td>
<td>1,583</td>
<td>6.9%</td>
</tr>
<tr>
<td>Wales</td>
<td>35,264</td>
<td>34,072</td>
<td>1,192</td>
<td>2,403</td>
<td>6.8%</td>
</tr>
</tbody>
</table>

*Figures for Powys have been halved to calculate a South Powys figure.

Welsh language

Welsh language skills in the South Wales Programme area are lower than in Wales as a whole (see Table 13). Within the South Wales Programme area only 3.8% of the population can understand spoken Welsh. However there are significant differences between health boards and between local authorities in the South Wales Programme area.

At a health board level Welsh language skills are highest in Powys Teaching Board, and lowest in Aneurin Bevan health board area.

Table 13: Welsh language profile by local authorities in Wales (Source: Table KS208WA 2011 Census, ONS).†

<table>
<thead>
<tr>
<th>Region</th>
<th>Can understand spoken Welsh only</th>
<th>Can speak Welsh</th>
<th>Can speak, read and write Welsh</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>5.4%</td>
<td>12.0%</td>
<td>8.6%</td>
<td>500,978</td>
</tr>
<tr>
<td>Swansea</td>
<td>5.5%</td>
<td>11.4%</td>
<td>8.1%</td>
<td>231,155</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>6.4%</td>
<td>15.3%</td>
<td>10.8%</td>
<td>135,278</td>
</tr>
<tr>
<td>Bridgend</td>
<td>4.1%</td>
<td>9.7%</td>
<td>7.3%</td>
<td>134,545</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>2.5%</td>
<td>9.9%</td>
<td>7.2%</td>
<td>555,622</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>3.0%</td>
<td>11.2%</td>
<td>8.4%</td>
<td>171,972</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>2.2%</td>
<td>7.8%</td>
<td>5.5%</td>
<td>67,348</td>
</tr>
<tr>
<td>Torfaen</td>
<td>2.3%</td>
<td>9.8%</td>
<td>7.1%</td>
<td>87,844</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>2.5%</td>
<td>9.9%</td>
<td>7.2%</td>
<td>88,609</td>
</tr>
<tr>
<td>Newport</td>
<td>2.2%</td>
<td>9.3%</td>
<td>6.5%</td>
<td>139,849</td>
</tr>
<tr>
<td>Cardiff and Vale UHB</td>
<td>3.1%</td>
<td>11.0%</td>
<td>8.6%</td>
<td>454,291</td>
</tr>
<tr>
<td>Vale of Glamorgan</td>
<td>3.3%</td>
<td>10.8%</td>
<td>8.2%</td>
<td>122,018</td>
</tr>
<tr>
<td>Cardiff</td>
<td>3.1%</td>
<td>11.1%</td>
<td>8.7%</td>
<td>332,273</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>4.0%</td>
<td>11.6%</td>
<td>9.0%</td>
<td>282,178</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>4.2%</td>
<td>12.3%</td>
<td>9.7%</td>
<td>225,555</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>3.5%</td>
<td>8.9%</td>
<td>6.5%</td>
<td>56,623</td>
</tr>
<tr>
<td>Powys</td>
<td>6.7%</td>
<td>18.6%</td>
<td>13.7%</td>
<td>129,083</td>
</tr>
<tr>
<td>South Powys*</td>
<td>6.7%</td>
<td>18.6%</td>
<td>13.7%</td>
<td>64,542</td>
</tr>
<tr>
<td>South Wales Programme*</td>
<td>3.8%</td>
<td>11.3%</td>
<td>8.4%</td>
<td>1,857,611</td>
</tr>
<tr>
<td>Wales</td>
<td>5.3%</td>
<td>19.0%</td>
<td>14.6%</td>
<td>2,955,841</td>
</tr>
</tbody>
</table>

†All usual residents aged 3 years and over.
*Figures for Powys have been halved to calculate a South Powys figure.

At a local authority level Powys has the highest population proportion with Welsh language skills across the three categories, and Blaenau Gwent the lowest.

**Households and deprivation**
The dimensions of deprivation used to classify households are indicators based on the four household characteristics:

- Employment (any member of a household not a full-time student is either unemployed or long-term sick)
- Education (no person in the household has at least level two education, and no person aged 16-18 is a full-time student)
- Health and disability (any person in the household has general health bad or very bad or has a long term health problem).
- Housing (household's accommodation is ether overcrowded, with an occupancy rating -1 or less, or is in a shared dwelling, or has no central heating).
The 2011 Census data shows that the levels of deprivation for South Wales Programme area in total is very similar to the figures for Wales as a whole (see Table 14). Across the South Wales Programme area and Wales, the pattern is that the largest proportion of households are not deprived in any dimension, and this proportion decreases as the number of deprivation dimensions experienced increases.

For the South Wales Programme area as a whole approximately a third of households are deprived in one dimension, and just over a fifth deprived in two dimensions, and less than 1% are deprived in four dimensions. However, when comparing health board regions and local authorities within the South Wales Programme area there is a great deal of variation.

In terms of health boards Cardiff and Vale UHB and Powys Teaching Health Board have the highest proportion of households not deprived in any dimension, 43.2% for Cardiff and Vale UHB, and 41.6% for Powys Teaching Health Board. While Cwm Taf has the lowest proportion of households not deprived in any dimension at 33.9%.

At the local authority level Blaenau Gwent (29.8%) and Merthyr Tydfil (30.7%) have the lowest proportion of households not deprived in any dimension. While Monmouthshire (46.2%), the Vale of Glamorgan (45.0%) and Cardiff (42.5%) have the highest proportion of highest proportion of households not deprived in any dimension.

In general at the higher levels of deprivation (i.e. three or more dimensions) the South Wales Programme area local authorities are more deprived than compared to Wales as a whole. Only three of the 13 South Wales Programme area local authorities (Monmouthshire, South Powys, and Vale of Glamorgan) have lower household proportions deprived in three or more dimensions than the figure for Wales as a whole (6.9%). Blaenau Gwent (10.8%) and Merthyr Tydfil (10.8%) have the highest proportion of households deprived in three or more dimensions.
Table 14: Households by deprivation dimensions, local authorities in Wales (Source: Table QS119EW 2011 Census, ONS).

<table>
<thead>
<tr>
<th>Region</th>
<th>Household is not deprived in any dimension</th>
<th>Household is deprived in 1 dimension</th>
<th>Household is deprived in 2 dimensions</th>
<th>Household is deprived in 3 dimensions</th>
<th>Household is deprived in 4 dimensions</th>
<th>Total (%)</th>
<th>Total (Households)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>37.3%</td>
<td>31.2%</td>
<td>23.6%</td>
<td>7.5%</td>
<td>0.5%</td>
<td>100.0%</td>
<td>222,405</td>
</tr>
<tr>
<td>Swansea</td>
<td>39.1%</td>
<td>31.9%</td>
<td>21.8%</td>
<td>6.7%</td>
<td>0.5%</td>
<td>100.0%</td>
<td>103,497</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>33.6%</td>
<td>30.3%</td>
<td>26.7%</td>
<td>8.9%</td>
<td>0.5%</td>
<td>100.0%</td>
<td>60,393</td>
</tr>
<tr>
<td>Bridgend</td>
<td>38.0%</td>
<td>30.7%</td>
<td>23.5%</td>
<td>7.4%</td>
<td>0.5%</td>
<td>100.0%</td>
<td>58,515</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>37.4%</td>
<td>31.2%</td>
<td>23.9%</td>
<td>7.1%</td>
<td>0.5%</td>
<td>100.0%</td>
<td>242,824</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>35.2%</td>
<td>30.0%</td>
<td>26.0%</td>
<td>8.2%</td>
<td>0.5%</td>
<td>100.0%</td>
<td>74,479</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>29.8%</td>
<td>30.4%</td>
<td>29.0%</td>
<td>10.2%</td>
<td>0.6%</td>
<td>100.0%</td>
<td>30,416</td>
</tr>
<tr>
<td>Torfaen</td>
<td>36.7%</td>
<td>32.0%</td>
<td>24.1%</td>
<td>6.7%</td>
<td>0.5%</td>
<td>100.0%</td>
<td>38,524</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>46.2%</td>
<td>32.3%</td>
<td>17.7%</td>
<td>3.6%</td>
<td>0.3%</td>
<td>100.0%</td>
<td>38,233</td>
</tr>
<tr>
<td>Newport</td>
<td>38.8%</td>
<td>31.7%</td>
<td>22.5%</td>
<td>6.5%</td>
<td>0.6%</td>
<td>100.0%</td>
<td>61,172</td>
</tr>
<tr>
<td>Cardiff and Vale UHB</td>
<td>43.2%</td>
<td>31.4%</td>
<td>18.9%</td>
<td>5.9%</td>
<td>0.6%</td>
<td>100.0%</td>
<td>196,062</td>
</tr>
<tr>
<td>Vale of Glamorgan</td>
<td>45.0%</td>
<td>31.6%</td>
<td>18.3%</td>
<td>4.6%</td>
<td>0.4%</td>
<td>100.0%</td>
<td>53,505</td>
</tr>
<tr>
<td>Cardiff</td>
<td>42.5%</td>
<td>31.4%</td>
<td>19.2%</td>
<td>6.3%</td>
<td>0.7%</td>
<td>100.0%</td>
<td>142,557</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>33.9%</td>
<td>30.1%</td>
<td>26.3%</td>
<td>9.1%</td>
<td>0.6%</td>
<td>100.0%</td>
<td>123,927</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>34.7%</td>
<td>30.0%</td>
<td>25.8%</td>
<td>8.9%</td>
<td>0.5%</td>
<td>100.0%</td>
<td>99,663</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>30.7%</td>
<td>30.5%</td>
<td>28.0%</td>
<td>10.1%</td>
<td>0.7%</td>
<td>100.0%</td>
<td>24,264</td>
</tr>
<tr>
<td>Powys</td>
<td>41.6%</td>
<td>34.4%</td>
<td>19.8%</td>
<td>4.0%</td>
<td>0.3%</td>
<td>100.0%</td>
<td>58,345</td>
</tr>
<tr>
<td>South Powys*</td>
<td>41.6%</td>
<td>34.4%</td>
<td>19.8%</td>
<td>4.0%</td>
<td>0.3%</td>
<td>100.0%</td>
<td>29,173</td>
</tr>
<tr>
<td>South Wales Programme*</td>
<td>38.4%</td>
<td>31.2%</td>
<td>22.8%</td>
<td>7.1%</td>
<td>0.5%</td>
<td>100.0%</td>
<td>814,391</td>
</tr>
<tr>
<td>Wales</td>
<td>39.0%</td>
<td>31.9%</td>
<td>22.2%</td>
<td>6.4%</td>
<td>0.5%</td>
<td>100.0%</td>
<td>1,302,676</td>
</tr>
</tbody>
</table>

*Figures for Powys have been halved to calculate a South Powys figure.
Lone parent households
Analysis of 2011 Census data shows that across Wales and the South Wales Programme area lone parent households are predominately female, 90.4% of households in the South Wales Programme area, and 89.6% of households for Wales as a whole (see Table 15).

Employment patterns for male and female lone parent households differ with male lone parents more likely to be in full-time employment than part-time employment. Approximately the same number of male lone parent households are in full-time employment as those not in employment.

In contrast female lone parent households are more likely to be in part-time employment than full-time employment. Female lone parent households are also approximately twice as likely to not be in employment, than in full-time employment.

While the proportions for South Wales Programme area in total mirrors closely the proportions for Wales as a whole, there is noticeable variation within South Wales Programme area between health boards and between local authorities.

At a health board level Cardiff and Vale UHB has the lowest proportion of male lone parent households (8.5%), and the highest proportion of female lone parent households (91.5%). Typically the proportion of male lone parent households in the SWP area is between 8% and 10%, however Powys Teaching Health Board is a significant outlier with 16.4% of its lone parent household male. Aneurin Bevan Health Board (10.5%) has the next highest proportion of male lone parent households.

This pattern is repeated at a local authority level. Cardiff has the lowest proportion of male lone parent households (8%). Powys is again the outlier with 16.4% of its lone parent household male, this is the highest proportion in the South Wales Programme area and in Wales. Monmouthshire in Aneurin Bevan Health Board has the next highest proportion of male lone parent households in the South Wales Programme area (12.1%). The remaining Aneurin Bevan local authorities also have relatively high proportions of male lone parent households, with figures in the range of 10.0% (Blaenau Gwent) to 10.6% (Caerphilly).
Table 15: Lone parent households with dependent children by local authorities in Wales (Source: Table KS107EW 2011 Census, ONS).

<table>
<thead>
<tr>
<th>Region</th>
<th>Male lone parent: In part-time employment</th>
<th>Male lone parent: In full-time employment</th>
<th>Male lone parent: Not in employment</th>
<th>Female lone parent: In part-time employment</th>
<th>Female lone parent: In full-time employment</th>
<th>Female lone parent: Not in employment</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>1.2%</td>
<td>4.2%</td>
<td>3.9%</td>
<td>32.2%</td>
<td>18.3%</td>
<td>40.3%</td>
<td>100.0%</td>
<td>17,141</td>
</tr>
<tr>
<td>Swansea</td>
<td>1.2%</td>
<td>4.6%</td>
<td>3.7%</td>
<td>33.2%</td>
<td>18.0%</td>
<td>39.4%</td>
<td>100.0%</td>
<td>8,063</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>1.2%</td>
<td>3.9%</td>
<td>4.4%</td>
<td>30.4%</td>
<td>18.0%</td>
<td>42.1%</td>
<td>100.0%</td>
<td>4,590</td>
</tr>
<tr>
<td>Bridgend</td>
<td>1.1%</td>
<td>3.7%</td>
<td>3.7%</td>
<td>32.2%</td>
<td>19.1%</td>
<td>40.2%</td>
<td>100.0%</td>
<td>4,488</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>1.3%</td>
<td>5.1%</td>
<td>4.1%</td>
<td>30.5%</td>
<td>19.8%</td>
<td>39.2%</td>
<td>100.0%</td>
<td>19,906</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>1.3%</td>
<td>4.8%</td>
<td>4.5%</td>
<td>28.4%</td>
<td>21.3%</td>
<td>39.7%</td>
<td>100.0%</td>
<td>6,478</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>0.9%</td>
<td>4.2%</td>
<td>4.9%</td>
<td>27.2%</td>
<td>18.3%</td>
<td>44.5%</td>
<td>100.0%</td>
<td>2,759</td>
</tr>
<tr>
<td>Torfaen</td>
<td>1.4%</td>
<td>5.2%</td>
<td>3.7%</td>
<td>30.3%</td>
<td>20.9%</td>
<td>38.4%</td>
<td>100.0%</td>
<td>3,038</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>2.1%</td>
<td>7.8%</td>
<td>2.2%</td>
<td>36.2%</td>
<td>21.2%</td>
<td>30.5%</td>
<td>100.0%</td>
<td>2,057</td>
</tr>
<tr>
<td>Newport</td>
<td>1.2%</td>
<td>4.8%</td>
<td>4.1%</td>
<td>32.6%</td>
<td>17.5%</td>
<td>39.8%</td>
<td>100.0%</td>
<td>5,574</td>
</tr>
<tr>
<td>Cardiff and Vale UHB</td>
<td>1.4%</td>
<td>4.0%</td>
<td>3.2%</td>
<td>32.4%</td>
<td>18.9%</td>
<td>40.2%</td>
<td>100.0%</td>
<td>14,899</td>
</tr>
<tr>
<td>Vale of Glamorgan</td>
<td>1.7%</td>
<td>5.5%</td>
<td>2.9%</td>
<td>35.8%</td>
<td>20.7%</td>
<td>33.5%</td>
<td>100.0%</td>
<td>4,018</td>
</tr>
<tr>
<td>Cardiff</td>
<td>1.2%</td>
<td>3.4%</td>
<td>3.3%</td>
<td>31.1%</td>
<td>18.3%</td>
<td>42.7%</td>
<td>100.0%</td>
<td>10,881</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>1.0%</td>
<td>4.4%</td>
<td>3.5%</td>
<td>29.9%</td>
<td>18.7%</td>
<td>42.4%</td>
<td>100.0%</td>
<td>11,262</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>0.9%</td>
<td>4.5%</td>
<td>3.5%</td>
<td>29.3%</td>
<td>18.7%</td>
<td>43.0%</td>
<td>100.0%</td>
<td>8,907</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>1.4%</td>
<td>4.2%</td>
<td>3.4%</td>
<td>32.0%</td>
<td>18.9%</td>
<td>40.1%</td>
<td>100.0%</td>
<td>2,355</td>
</tr>
<tr>
<td>Powys</td>
<td>3.0%</td>
<td>9.8%</td>
<td>3.6%</td>
<td>33.8%</td>
<td>22.2%</td>
<td>27.7%</td>
<td>100.0%</td>
<td>3,351</td>
</tr>
<tr>
<td>South Powys*</td>
<td>3.0%</td>
<td>9.8%</td>
<td>3.6%</td>
<td>33.8%</td>
<td>22.2%</td>
<td>27.7%</td>
<td>100.0%</td>
<td>1,676</td>
</tr>
<tr>
<td>South Wales Programme *</td>
<td>1.3%</td>
<td>4.6%</td>
<td>3.7%</td>
<td>31.4%</td>
<td>19.1%</td>
<td>40.0%</td>
<td>100.0%</td>
<td>64,884</td>
</tr>
<tr>
<td>Wales</td>
<td>1.5%</td>
<td>5.2%</td>
<td>3.7%</td>
<td>32.0%</td>
<td>19.8%</td>
<td>37.8%</td>
<td>100.0%</td>
<td>97,524</td>
</tr>
</tbody>
</table>

*Figures for Powys have been halved to calculate a South Powys figure.
Unpaid care

The majority of residents in the South Wales Programme (87.8%) area and Wales (87.9%) provide no unpaid care, and this is relatively consistent across the South Wales Programme area at both health board and local authority level (see Table 16).

Table 16: Provision of unpaid care by local authorities in Wales (Source: Table KS301EW 2011 Census, ONS).

<table>
<thead>
<tr>
<th>Area name</th>
<th>Provides no unpaid care</th>
<th>Provides 1 to 19 hours unpaid care a week</th>
<th>Provides 20 to 49 hours unpaid care a week</th>
<th>Provides 50 or more hours unpaid care a week</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>86.8%</td>
<td>7.2%</td>
<td>2.0%</td>
<td>4.0%</td>
<td>100.0%</td>
<td>518,013</td>
</tr>
<tr>
<td>Swansea</td>
<td>87.3%</td>
<td>7.3%</td>
<td>1.9%</td>
<td>3.6%</td>
<td>100.0%</td>
<td>239,023</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>85.4%</td>
<td>7.4%</td>
<td>2.3%</td>
<td>4.8%</td>
<td>100.0%</td>
<td>139,812</td>
</tr>
<tr>
<td>Bridgend</td>
<td>87.1%</td>
<td>6.9%</td>
<td>2.0%</td>
<td>4.0%</td>
<td>100.0%</td>
<td>139,178</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>87.6%</td>
<td>7.0%</td>
<td>1.9%</td>
<td>3.5%</td>
<td>100.0%</td>
<td>576,754</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>87.3%</td>
<td>6.9%</td>
<td>2.0%</td>
<td>3.9%</td>
<td>100.0%</td>
<td>178,806</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>87.5%</td>
<td>6.2%</td>
<td>2.3%</td>
<td>4.0%</td>
<td>100.0%</td>
<td>69,814</td>
</tr>
<tr>
<td>Torfaen</td>
<td>86.9%</td>
<td>7.4%</td>
<td>1.9%</td>
<td>3.8%</td>
<td>100.0%</td>
<td>91,075</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>87.4%</td>
<td>8.2%</td>
<td>1.6%</td>
<td>2.8%</td>
<td>100.0%</td>
<td>91,323</td>
</tr>
<tr>
<td>Newport</td>
<td>88.6%</td>
<td>6.6%</td>
<td>1.7%</td>
<td>3.1%</td>
<td>100.0%</td>
<td>145,736</td>
</tr>
<tr>
<td>Cardiff and Vale UHB</td>
<td>89.3%</td>
<td>6.7%</td>
<td>1.4%</td>
<td>2.6%</td>
<td>100.0%</td>
<td>472,426</td>
</tr>
<tr>
<td>Vale of Glamorgan</td>
<td>87.7%</td>
<td>7.9%</td>
<td>1.6%</td>
<td>2.8%</td>
<td>100.0%</td>
<td>126,336</td>
</tr>
<tr>
<td>Cardiff</td>
<td>89.9%</td>
<td>6.3%</td>
<td>1.4%</td>
<td>2.5%</td>
<td>100.0%</td>
<td>346,090</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>87.4%</td>
<td>6.6%</td>
<td>2.0%</td>
<td>4.0%</td>
<td>100.0%</td>
<td>293,212</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>87.4%</td>
<td>6.7%</td>
<td>2.0%</td>
<td>4.0%</td>
<td>100.0%</td>
<td>234,410</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>87.4%</td>
<td>6.4%</td>
<td>2.2%</td>
<td>4.0%</td>
<td>100.0%</td>
<td>58,802</td>
</tr>
<tr>
<td>Powys</td>
<td>87.9%</td>
<td>7.7%</td>
<td>1.6%</td>
<td>2.9%</td>
<td>100.0%</td>
<td>132,976</td>
</tr>
<tr>
<td>South Powys*</td>
<td>87.9%</td>
<td>7.7%</td>
<td>1.6%</td>
<td>2.9%</td>
<td>100.0%</td>
<td>66,488</td>
</tr>
<tr>
<td>South Wales Programme</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100.0%</td>
<td>1,926,893</td>
</tr>
<tr>
<td>Wales</td>
<td>87.9%</td>
<td>6.9%</td>
<td>1.8%</td>
<td>3.4%</td>
<td>100.0%</td>
<td>3,063,456</td>
</tr>
</tbody>
</table>

*Figures for Powys have been halved to calculate a South Powys figure.

The 2011 Census data shows that the proportion of people providing unpaid care in the South Wales Programme area is around 6% to 7% for one to 19 hours of unpaid care, decreasing to 1% to 2% for 20 to 49 hours of unpaid care, but then increasing to 3% to 4% for 50 or more hours of unpaid care.

At a health board level ABM and Cwm Taf have the highest proportions of unpaid care provision, both reporting 2% for 20 to 49 hours of unpaid care, and 4% for 50 or more hours of unpaid care. Cardiff and Vale UHB has the lowest proportion, 1.4% for 20 to 49 hours of unpaid care, and 2.6% for 50 or more hours of unpaid care.
At a local authority level for 20 to 49 hours of unpaid care Neath Port Talbot and Blaenau Gwent have the highest proportion of unpaid care, both reporting 2.3%. Cardiff has the lowest proportion at 1.4%.

For 50 or more hours of unpaid care at a local authority level, Neath Port Talbot has the highest proportion (4.8%), and Cardiff the lowest (2.5%).

**Access to car or vans**
The 2011 Census data shows that the proportion of households with no car or van is higher in the South Wales Programme area than for Wales as a whole, 25.1% in the South Wales Programme area compared to 22.9% for Wales (see Table 17).

Comparing the South Wales Programme health boards, Powys has the lowest proportion of households with no car or van at 15.0%, while Cwm Taf at 27.6% has the highest proportion with no car or van.

Across the South Wales Programme area the proportion of households with access to at least one car or van is 42.9%, similar to the value for Wales as a whole (43.0%). This is proportion is also very consistent across the local authorities within the South Wales Programme area.

In terms of local authorities, Merthyr Tydfil (29.7%), Blaenau Gwent (29.0%), and Cardiff (29.0%) have the highest proportion of households with no car or van. Powys (15.0%) and Monmouthshire (15.2%) have the lowest proportion of households with no car or van.
Table 17: Car or van availability by local authorities in Wales (Source: Table KS404EW 2011 Census, ONS).

<table>
<thead>
<tr>
<th>Region</th>
<th>No cars or vans in household</th>
<th>1 car or van in household</th>
<th>2 cars or vans in household</th>
<th>3 cars or vans in household</th>
<th>4 or more cars or vans in household</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>24.7%</td>
<td>43.5%</td>
<td>24.6%</td>
<td>5.5%</td>
<td>1.7%</td>
<td>100.0%</td>
<td>222,405</td>
</tr>
<tr>
<td>Swansea</td>
<td>25.8%</td>
<td>43.3%</td>
<td>23.7%</td>
<td>5.3%</td>
<td>1.8%</td>
<td>100.0%</td>
<td>103,497</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>25.5%</td>
<td>43.3%</td>
<td>24.0%</td>
<td>5.6%</td>
<td>1.5%</td>
<td>100.0%</td>
<td>60,393</td>
</tr>
<tr>
<td>Bridgend</td>
<td>21.9%</td>
<td>43.9%</td>
<td>26.5%</td>
<td>5.8%</td>
<td>1.8%</td>
<td>100.0%</td>
<td>58,515</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>24.3%</td>
<td>42.4%</td>
<td>25.3%</td>
<td>6.0%</td>
<td>2.0%</td>
<td>100.0%</td>
<td>242,824</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>24.4%</td>
<td>43.2%</td>
<td>25.0%</td>
<td>5.7%</td>
<td>1.8%</td>
<td>100.0%</td>
<td>74,479</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>29.0%</td>
<td>43.8%</td>
<td>20.9%</td>
<td>4.9%</td>
<td>1.5%</td>
<td>100.0%</td>
<td>30,416</td>
</tr>
<tr>
<td>Torfaen</td>
<td>23.6%</td>
<td>43.5%</td>
<td>24.9%</td>
<td>6.0%</td>
<td>2.1%</td>
<td>100.0%</td>
<td>38,524</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>15.2%</td>
<td>40.2%</td>
<td>32.5%</td>
<td>8.7%</td>
<td>3.4%</td>
<td>100.0%</td>
<td>38,233</td>
</tr>
<tr>
<td>Newport</td>
<td>27.9%</td>
<td>41.4%</td>
<td>23.7%</td>
<td>5.2%</td>
<td>1.7%</td>
<td>100.0%</td>
<td>61,172</td>
</tr>
<tr>
<td>Cardiff and Vale UHB</td>
<td>26.4%</td>
<td>42.9%</td>
<td>24.1%</td>
<td>5.0%</td>
<td>1.6%</td>
<td>100.0%</td>
<td>196,062</td>
</tr>
<tr>
<td>Vale of Glamorgan</td>
<td>19.4%</td>
<td>43.0%</td>
<td>28.8%</td>
<td>6.7%</td>
<td>2.2%</td>
<td>100.0%</td>
<td>53,505</td>
</tr>
<tr>
<td>Newport</td>
<td>29.0%</td>
<td>42.9%</td>
<td>22.3%</td>
<td>4.4%</td>
<td>1.4%</td>
<td>100.0%</td>
<td>142,557</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>27.6%</td>
<td>42.7%</td>
<td>22.9%</td>
<td>5.2%</td>
<td>1.6%</td>
<td>100.0%</td>
<td>123,927</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>27.1%</td>
<td>42.6%</td>
<td>23.4%</td>
<td>5.3%</td>
<td>1.6%</td>
<td>100.0%</td>
<td>99,663</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>29.7%</td>
<td>43.2%</td>
<td>21.0%</td>
<td>4.6%</td>
<td>1.5%</td>
<td>100.0%</td>
<td>24,264</td>
</tr>
<tr>
<td>Powys</td>
<td>15.0%</td>
<td>42.8%</td>
<td>30.1%</td>
<td>8.4%</td>
<td>3.6%</td>
<td>100.0%</td>
<td>58,345</td>
</tr>
<tr>
<td>South Powys*</td>
<td>15.0%</td>
<td>42.8%</td>
<td>30.1%</td>
<td>8.4%</td>
<td>3.6%</td>
<td>100.0%</td>
<td>29,173</td>
</tr>
<tr>
<td>South Wales Programme *</td>
<td>25.1%</td>
<td>42.9%</td>
<td>24.6%</td>
<td>5.6%</td>
<td>1.8%</td>
<td>100.0%</td>
<td>814,391</td>
</tr>
<tr>
<td>Wales</td>
<td>22.9%</td>
<td>43.0%</td>
<td>25.8%</td>
<td>6.1%</td>
<td>2.2%</td>
<td>100.0%</td>
<td>1,302,676</td>
</tr>
</tbody>
</table>

*Figures for Powys have been halved to calculate a South Powys figure.
**General health**

The self-reported general health of the population in the South Wales Programme area is generally good with approximately three quarters (77.3%) stating their health was either good or very good, slightly below the 77.8% figure for Wales (see Table 18).

However, three of the five South Wales Programme health boards (Cwm Taf, ABM, and Aneurin Bevan) have population proportions below the Welsh percentage (77.8%) reporting good or very good health. The same three health boards also have population proportions higher than the Welsh percentage (7.6%) reporting bad or very bad health.

At a health board level Cardiff and Vale UHB (81.1%) has the highest proportion reporting good or very good health. Cwm Taf has the lowest proportion (74.2%) reporting good or very good health, and this is also below the figure for Wales as a whole (77.8%).

### Table 18: General health by local authorities in Wales (Source: Table KS301EW 2011 Census, ONS).

<table>
<thead>
<tr>
<th>Region</th>
<th>Very good health</th>
<th>Good health</th>
<th>Fair health</th>
<th>Bad health</th>
<th>Very bad health</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>47.0%</td>
<td>29.2%</td>
<td>14.9%</td>
<td>6.7%</td>
<td>2.2%</td>
<td>100.0%</td>
<td>518,013</td>
</tr>
<tr>
<td>Swansea</td>
<td>48.7%</td>
<td>29.3%</td>
<td>14.0%</td>
<td>6.1%</td>
<td>2.0%</td>
<td>100.0%</td>
<td>239,023</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>45.0%</td>
<td>28.4%</td>
<td>16.2%</td>
<td>7.9%</td>
<td>2.6%</td>
<td>100.0%</td>
<td>139,812</td>
</tr>
<tr>
<td>Bridgend</td>
<td>46.1%</td>
<td>29.9%</td>
<td>15.1%</td>
<td>6.8%</td>
<td>2.1%</td>
<td>100.0%</td>
<td>139,178</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>44.6%</td>
<td>31.9%</td>
<td>15.2%</td>
<td>6.4%</td>
<td>2.0%</td>
<td>100.0%</td>
<td>576,754</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>44.4%</td>
<td>30.4%</td>
<td>15.9%</td>
<td>7.2%</td>
<td>2.1%</td>
<td>100.0%</td>
<td>178,806</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>41.9%</td>
<td>30.6%</td>
<td>16.8%</td>
<td>8.2%</td>
<td>2.5%</td>
<td>100.0%</td>
<td>69,814</td>
</tr>
<tr>
<td>Torfaen</td>
<td>43.3%</td>
<td>32.5%</td>
<td>15.5%</td>
<td>6.5%</td>
<td>2.1%</td>
<td>100.0%</td>
<td>91,075</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>46.4%</td>
<td>33.7%</td>
<td>14.0%</td>
<td>4.6%</td>
<td>1.4%</td>
<td>100.0%</td>
<td>91,323</td>
</tr>
<tr>
<td>Newport</td>
<td>45.7%</td>
<td>32.8%</td>
<td>14.1%</td>
<td>5.6%</td>
<td>1.8%</td>
<td>100.0%</td>
<td>145,736</td>
</tr>
<tr>
<td>Cardiff and Vale UHB</td>
<td>49.7%</td>
<td>31.3%</td>
<td>12.5%</td>
<td>4.9%</td>
<td>1.6%</td>
<td>100.0%</td>
<td>472,426</td>
</tr>
<tr>
<td>Vale of Glamorgan</td>
<td>48.0%</td>
<td>32.0%</td>
<td>13.6%</td>
<td>4.9%</td>
<td>1.5%</td>
<td>100.0%</td>
<td>126,336</td>
</tr>
<tr>
<td>Cardiff</td>
<td>50.4%</td>
<td>31.1%</td>
<td>12.1%</td>
<td>4.8%</td>
<td>1.6%</td>
<td>100.0%</td>
<td>346,090</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>44.7%</td>
<td>29.5%</td>
<td>15.9%</td>
<td>7.6%</td>
<td>2.3%</td>
<td>100.0%</td>
<td>293,212</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>44.9%</td>
<td>29.7%</td>
<td>15.9%</td>
<td>7.4%</td>
<td>2.2%</td>
<td>100.0%</td>
<td>234,410</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>44.1%</td>
<td>28.8%</td>
<td>15.9%</td>
<td>8.3%</td>
<td>2.8%</td>
<td>100.0%</td>
<td>58,802</td>
</tr>
<tr>
<td>Powys</td>
<td>44.8%</td>
<td>34.2%</td>
<td>14.9%</td>
<td>4.8%</td>
<td>1.3%</td>
<td>100.0%</td>
<td>132,976</td>
</tr>
<tr>
<td>South Powys*</td>
<td>44.8%</td>
<td>34.2%</td>
<td>14.9%</td>
<td>4.8%</td>
<td>1.3%</td>
<td>100.0%</td>
<td>66,488</td>
</tr>
<tr>
<td>South Wales Programme*</td>
<td>46.5%</td>
<td>30.7%</td>
<td>14.5%</td>
<td>6.2%</td>
<td>2.0%</td>
<td>100.0%</td>
<td>1,926,893</td>
</tr>
<tr>
<td>Wales</td>
<td>46.6%</td>
<td>31.1%</td>
<td>14.6%</td>
<td>5.8%</td>
<td>1.8%</td>
<td>100.0%</td>
<td>3,063,456</td>
</tr>
</tbody>
</table>

*Figures for Powys have been halved to calculate a South Powys figure.
If we look at bad general health, Powys Teaching Health Board (6.1%) has the lowest population proportion reporting either bad or very bad health, and Cwm Taf (9.9%) the highest proportion.

At a local authority level Cardiff (81.1%) has the highest population proportion reporting good or very good health, and Blaenau Gwent the lowest proportion (72.6%).

At the local authority level eight of the thirteen SWP local authorities have population proportions higher than the Welsh figure (7.6%) reporting either bad or very bad health. Merthyr Tydfil (11.2%) has the highest proportion reporting bad or very bad health, followed closely by Blaenau Gwent (10.7%), and Neath Port Talbot (10.5%). Monmouthshire (5.9%) has the lowest proportion reporting bad or very bad health.

Service user data

This section presents available demographic data on people using the services being considered by the South Wales Programme.

Emergency medicine (A&E)

Information about people who use emergency medicine (A&E) services by age (see Table 19) indicates that for the majority of South Wales Programme health boards the age group which uses emergency medicine most often is the 25 to 44 age group. The population proportion is also consistent at roughly 25% for the health boards. Powys is the exception with the 65-plus age group the most frequent users of emergency medicine services. Powys also has a lower proportion of 25-44 year olds (20.7%) using emergency medicine services compared to the other four South Wales Programme health boards.

For all South Wales Programme health boards, the 16-24 age group uses emergency medicine services the least. This population group is relatively consistent across the five health boards, ranging from 13.6% (Powys) to 16.8% (Cardiff and Vale).
Table 19: Emergency medicine users by age and health board.

<table>
<thead>
<tr>
<th>Region</th>
<th>&lt;16</th>
<th>16-24</th>
<th>25-44</th>
<th>45-64</th>
<th>65+</th>
<th>Unknown</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>19.3%</td>
<td>15.6%</td>
<td>24.6%</td>
<td>19.6%</td>
<td>20.9%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>175,152</td>
</tr>
<tr>
<td>Cardiff &amp; Vale</td>
<td>22.7%</td>
<td>16.8%</td>
<td>25.4%</td>
<td>17.4%</td>
<td>17.8%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>125,837</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>20.9%</td>
<td>14.7%</td>
<td>24.7%</td>
<td>19.3%</td>
<td>20.4%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>119,959</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>22.5%</td>
<td>15.8%</td>
<td>24.9%</td>
<td>18.8%</td>
<td>18.0%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>182,535</td>
</tr>
<tr>
<td>Powys</td>
<td>15.5%</td>
<td>13.6%</td>
<td>20.7%</td>
<td>19.9%</td>
<td>30.3%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>7,003</td>
</tr>
</tbody>
</table>

Across all South Wales Programme health boards the gender split for use of emergency medicine (see Table 20) is roughly even, albeit with slightly more male than female users.

Table 20: Emergency medicine users by gender and health board.

<table>
<thead>
<tr>
<th>Region</th>
<th>Male</th>
<th>Female</th>
<th>Indeterminate or anticipated sex change</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>51.2%</td>
<td>48.8%</td>
<td>100.0%</td>
<td>175,152</td>
<td></td>
</tr>
<tr>
<td>Cardiff &amp; Vale</td>
<td>51.2%</td>
<td>48.8%</td>
<td>100.0%</td>
<td>125,837</td>
<td></td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>51.6%</td>
<td>48.4%</td>
<td>100.0%</td>
<td>119,959</td>
<td></td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>51.6%</td>
<td>48.3%</td>
<td>0.0%</td>
<td>182,535</td>
<td></td>
</tr>
<tr>
<td>Powys</td>
<td>51.6%</td>
<td>48.4%</td>
<td>100.0%</td>
<td>7,003</td>
<td></td>
</tr>
</tbody>
</table>

Data on use of emergency medicine by ethnicity is not collected consistently across the South Wales Programme health boards (see Table 21). There are significant data gaps ranging from 60% to 99% not collected. As such, it is not possible to draw any conclusions about the use of emergency medicine services by different ethnic groups.

Table 21: Emergency medicine users by ethnicity and health board.

<table>
<thead>
<tr>
<th>Region</th>
<th>White</th>
<th>Mixed / Multiple ethnic group</th>
<th>Asian / Asian British</th>
<th>Black / African / Caribbean / Black British</th>
<th>Any other ethnic group</th>
<th>Not Stated</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>38.5%</td>
<td>0.2%</td>
<td>0.4%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>60.7%</td>
<td>100.0%</td>
<td>175,123</td>
</tr>
<tr>
<td>Cardiff &amp; Vale</td>
<td>0.5%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>99.5%</td>
<td>100.0%</td>
<td>125,829</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>0.2%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>99.8%</td>
<td>100.0%</td>
<td>119,959</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>15.6%</td>
<td>0.1%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>84.0%</td>
<td>100.0%</td>
<td>182,535</td>
</tr>
<tr>
<td>Powys</td>
<td>25.4%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>74.4%</td>
<td>100.0%</td>
<td>7,003</td>
</tr>
</tbody>
</table>
Paediatrics
The paediatric service user data shows that more males than females use paediatric services, and the proportion of males to females is consistent across the South Wales Programme health boards (see Table 22).

Table 22: Paediatrics service users by gender and health board.

<table>
<thead>
<tr>
<th>Region</th>
<th>Male</th>
<th>Female</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>55.0%</td>
<td>45.0%</td>
<td>100.0%</td>
<td>9602</td>
</tr>
<tr>
<td>Cardiff &amp; Vale</td>
<td>55.4%</td>
<td>44.6%</td>
<td>100.0%</td>
<td>6674</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>54.7%</td>
<td>45.3%</td>
<td>100.0%</td>
<td>6917</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>55.1%</td>
<td>44.9%</td>
<td>100.0%</td>
<td>1,0672</td>
</tr>
<tr>
<td>Powys</td>
<td>53.1%</td>
<td>46.9%</td>
<td>100.0%</td>
<td>593</td>
</tr>
</tbody>
</table>

As already noted with emergency medicine, the ethnicity of users of paediatric services is not collected consistently across the health boards (see Table 23).

ABM has the most complete dataset with approximately 22% of user data not collected. The remaining health boards have significant data gaps, ranging from 73% (Powys) to 98% (Cardiff and Vale) not collected.

Table 23: Paediatrics service users by ethnicity and health board.

<table>
<thead>
<tr>
<th>Region</th>
<th>White</th>
<th>Mixed / Multiple ethnic group</th>
<th>Asian / Asian British</th>
<th>Black / African / Caribbean / Black British</th>
<th>Any other ethnic group</th>
<th>Not Stated</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>73.7%</td>
<td>0.7%</td>
<td>2.7%</td>
<td>0.3%</td>
<td>0.7%</td>
<td>21.9%</td>
<td>100.0%</td>
<td>9,602</td>
</tr>
<tr>
<td>Cardiff &amp; Vale</td>
<td>2.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>97.9%</td>
<td>100.0%</td>
<td>6,674</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>1.4%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>97.2%</td>
<td>100.0%</td>
<td>6,917</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>8.9%</td>
<td>0.1%</td>
<td>0.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>89.4%</td>
<td>100.0%</td>
<td>10,672</td>
</tr>
<tr>
<td>Powys</td>
<td>25.8%</td>
<td>0.0%</td>
<td>0.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>73.4%</td>
<td>100.0%</td>
<td>593</td>
</tr>
</tbody>
</table>

Due to the size of the data gaps it is not possible to draw any conclusions about the use of paediatric services by different ethnic groups.

Maternity
The data on maternity service use by the age of the mother shows that the pattern for the South Wales Programme area as a whole closely mirrors the figures for Wales (see Table 24).

At a health board level the general age pattern is the same, but there are some variations between the different health boards. The majority of mothers are between 25 and 44 years, ranging from 65.4% (Cwm Taf) to 74.7% (Powys). Only
Cwm Taf has a lower proportion of 25 to 44-year-old mothers than the figure for Wales (69.1%). Cwm Taf also has higher proportion of mothers aged 16 to 24 (33.7%), and under 16 (0.9%) than the respective figures for Wales.

Across the South Wales Programme health boards the proportion of mothers aged under 16 is low - below 1%. Cwm Taf has the highest number of mothers under 16 at 0.9%.

Similarly, the proportion of mothers aged between 45 and 64 is low, with Powys having the highest proportion at 0.3%.

At a local authority level the proportion of mothers aged 25 to 44 varies from 60.7% (Blaenau Gwent), to 79.3% (Monmouthshire). There is less variation in the 45 to 64 age range, varying from 0% (Caerphilly and Torfaen) to 0.3% (Powys).

There is greater variation between local authorities in the 16 to 24 age range. This varies from 20.1% (Monmouthshire) to 38.4% (Blaenau Gwent).

**Table 24: Births by age (years) of mother and health board.**

<table>
<thead>
<tr>
<th>Region</th>
<th>&lt;16</th>
<th>16-24</th>
<th>25-44</th>
<th>45-64</th>
<th>Not stated</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>0.7%</td>
<td>28.6%</td>
<td>70.6%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>6,126</td>
</tr>
<tr>
<td>Bridgend</td>
<td>1.1%</td>
<td>29.4%</td>
<td>69.3%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>1,715</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>0.7%</td>
<td>31.8%</td>
<td>67.4%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>1,597</td>
</tr>
<tr>
<td>Swansea</td>
<td>0.5%</td>
<td>26.2%</td>
<td>73.2%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>2,814</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>0.5%</td>
<td>30.4%</td>
<td>69.1%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>6,687</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>0.8%</td>
<td>38.4%</td>
<td>60.7%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>783</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>0.5%</td>
<td>31.1%</td>
<td>68.4%</td>
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<td>0.0%</td>
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</tr>
<tr>
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<td>66.8%</td>
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<td>0.0%</td>
<td>100.0%</td>
<td>1,097</td>
</tr>
<tr>
<td>Newport</td>
<td>0.6%</td>
<td>29.3%</td>
<td>70.1%</td>
<td>0.1%</td>
<td>0.0%</td>
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<td>1,903</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>0.4%</td>
<td>20.1%</td>
<td>79.3%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>831</td>
</tr>
<tr>
<td>Cardiff and Vale</td>
<td>0.7%</td>
<td>24.9%</td>
<td>74.2%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>6,313</td>
</tr>
<tr>
<td>Vale of Glamorgan</td>
<td>0.5%</td>
<td>24.6%</td>
<td>74.7%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>1,467</td>
</tr>
<tr>
<td>Cardiff</td>
<td>0.7%</td>
<td>25.0%</td>
<td>74.1%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>4,846</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>0.9%</td>
<td>33.7%</td>
<td>65.4%</td>
<td>0.0%</td>
<td>0.0%</td>
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</tr>
<tr>
<td>Rhondda Cynon Taff</td>
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<td>100.0%</td>
<td>2,917</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>2.1%</td>
<td>35.3%</td>
<td>62.5%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>776</td>
</tr>
<tr>
<td>Powys</td>
<td>0.5%</td>
<td>24.4%</td>
<td>74.7%</td>
<td>0.3%</td>
<td>0.1%</td>
<td>100.0%</td>
<td>1,226</td>
</tr>
<tr>
<td>South Powys*</td>
<td>0.5%</td>
<td>24.4%</td>
<td>74.7%</td>
<td>0.3%</td>
<td>0.1%</td>
<td>100.0%</td>
<td>613</td>
</tr>
<tr>
<td>South Wales Programme*</td>
<td>0.7%</td>
<td>28.8%</td>
<td>70.4%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>23,432</td>
</tr>
<tr>
<td>Wales</td>
<td>0.6%</td>
<td>28.1%</td>
<td>69.1%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>97.9%</td>
<td>28,527</td>
</tr>
</tbody>
</table>

*Figures for Powys have been halved to calculate a South Powys figure.
While the number of mothers under 16 is low, generally below 1%, two local authorities stand out with higher proportions. The proportion of mothers under 16 is highest in Merthyr Tydfil (2.1%) - more than three times the proportion for Wales as a whole - followed by Bridgend (1.1%), which is just under double the proportion for Wales (0.6%).

There are also gaps in the data on the ethnicity of mothers (see Table 25). At health board level ABM has the largest data gap (17.6% not known). While the other four health boards also have data gaps they are not as significant, with three health boards having data gaps of less than 1% and Powys 3.8%.

Table 25: Ethnicity of mother by health boards.

<table>
<thead>
<tr>
<th>Region</th>
<th>White</th>
<th>Non white</th>
<th>Not Known</th>
<th>Total (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>77.1%</td>
<td>5.3%</td>
<td>17.6%</td>
<td>100.0%</td>
<td>6,126</td>
</tr>
<tr>
<td>Bridgend</td>
<td>93.2%</td>
<td>3.4%</td>
<td>3.4%</td>
<td>100.0%</td>
<td>1,715</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>85.1%</td>
<td>3.3%</td>
<td>11.6%</td>
<td>100.0%</td>
<td>1,597</td>
</tr>
<tr>
<td>Swansea</td>
<td>62.8%</td>
<td>7.6%</td>
<td>29.7%</td>
<td>100.0%</td>
<td>2,814</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>92.5%</td>
<td>7.1%</td>
<td>0.4%</td>
<td>100.0%</td>
<td>6,687</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>96.9%</td>
<td>2.4%</td>
<td>0.6%</td>
<td>100.0%</td>
<td>783</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>97.2%</td>
<td>2.7%</td>
<td>0.1%</td>
<td>100.0%</td>
<td>2,073</td>
</tr>
<tr>
<td>Torfaen</td>
<td>96.8%</td>
<td>3.2%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>1,097</td>
</tr>
<tr>
<td>Newport</td>
<td>82.0%</td>
<td>17.8%</td>
<td>0.3%</td>
<td>100.0%</td>
<td>1,903</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>95.1%</td>
<td>3.5%</td>
<td>1.4%</td>
<td>100.0%</td>
<td>831</td>
</tr>
<tr>
<td>Cardiff and Vale</td>
<td>77.6%</td>
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<td>0.8%</td>
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<td>6,313</td>
</tr>
<tr>
<td>Vale of Glamorgan</td>
<td>92.3%</td>
<td>7.0%</td>
<td>0.7%</td>
<td>100.0%</td>
<td>1,467</td>
</tr>
<tr>
<td>Cardiff</td>
<td>73.2%</td>
<td>25.9%</td>
<td>0.8%</td>
<td>100.0%</td>
<td>4,846</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>95.7%</td>
<td>3.8%</td>
<td>0.5%</td>
<td>100.0%</td>
<td>3,693</td>
</tr>
<tr>
<td>Rhondda, Cynon, Taff</td>
<td>95.6%</td>
<td>3.8%</td>
<td>0.6%</td>
<td>100.0%</td>
<td>2,917</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>95.9%</td>
<td>4.0%</td>
<td>0.1%</td>
<td>100.0%</td>
<td>776</td>
</tr>
<tr>
<td>Powys</td>
<td>93.7%</td>
<td>2.5%</td>
<td>3.8%</td>
<td>100.0%</td>
<td>1,226</td>
</tr>
<tr>
<td>South Powys*</td>
<td>93.7%</td>
<td>2.5%</td>
<td>3.8%</td>
<td>100.0%</td>
<td>613</td>
</tr>
<tr>
<td>South Wales Programme*</td>
<td>85.2%</td>
<td>9.7%</td>
<td>5.1%</td>
<td>100.0%</td>
<td>24,045</td>
</tr>
<tr>
<td>Wales</td>
<td>82.8%</td>
<td>8.8%</td>
<td>8.4%</td>
<td>100.0%</td>
<td>27,921</td>
</tr>
</tbody>
</table>

*Figures for Powys have been halved to calculate a South Powys figure.

Due to the scale of the data gap in ABM's constituent local authority areas, in particular Swansea (29.7%) and Neath Port Talbot (11.6%), it is not possible to draw any conclusions about mothers' ethnicity in ABM or the South Wales Programme area as a whole.

The data for the other four South Wales Programme health boards indicates Cardiff and Vale (21.5%) has the highest proportion of non-white mothers, and Powys (2.5%) the lowest.
At a local authority level the proportion of non-white mothers varies from 2.4% (Blaenau Gwent) to 25.9% (Cardiff). The second highest proportion of non-white mothers is 17.8% in Newport.

While the difference between the lowest and highest proportion of non-white mothers is large, the majority of local authorities in the South Wales Programme area (excluding Swansea and Neath Port Talbot) have non-white mother proportions of around 2% to 3%. Within the South Wales Programme area only Cardiff and Newport have non-white mother proportions larger than the figure for Wales as a whole (8.8%).
What are the potential impacts on protected characteristic groups?

To inform our assessment of the potential impact of the proposed service changes on patients, families and carers, staff, members of the public and other stakeholders in the South Wales Programme area we have gathered a range of evidence. This includes:

- Geography and demography
- Findings from the engagement relevant to people with different protected characteristics
- Workforce data from the hospitals that might be affected
- Transport
- National and local evidence about relevant health inequalities.

Looking at a range of national research evidence has helped us to consider the potential impact. In particular, we are aware that many people who share certain protected characteristics, such as disability, older age, younger people and some minority ethnic groups, also face social and or economic disadvantage. Looking at socioeconomic disadvantage goes some way to showing due regard to equality considerations. There will also be other distinct areas that are not driven by socioeconomic factors but which relate directly to people with different protected characteristics.

The options under consideration by the South Wales Programme will not result in the closure of existing hospital services but the relocation of some existing services to four or five hospital sites. As such we believe the key issue for the protected characteristic groups is one of access. The health needs and potential access issues for each of the protected characteristic groups are discussed below.

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 in a local authority is a greater indicator of the impact rather than their protected characteristic.

While we can indicate generally how issues around access and health risk factors affect the protected characteristics, we are at present unable to identify where people with protected characteristics are actually resident in their local authority, other than highlight areas of economic deprivation. Additional analysis of Census data at lower super output area by protected characteristics is required once this...
data is made available if we are to understand how populations with protected characteristics are distributed across local authorities and subsequently impacted upon differentially.

**Socioeconomic status**

While socioeconomic status is not a protected characteristic under the Equality Act 2010, it is particularly relevant in relation to the protected characteristics. There is a strong correlation between the protected characteristics and low socioeconomic status, as demonstrated by the findings of numerous research studies. 38, 39, 40

In Wales, research by the Wales Institute for Social and Economic Research, Data and Methods (WISERD, 2011) 41 has demonstrated:

- Disadvantage in education, and subsequently in employment and earnings, attaches particularly to young people, those of Bangladeshi and Pakistani ethnicity, and people who are work-limiting and Disability Discrimination Act (DDA)-defined disabled. Within each of these groups, women are generally more disadvantaged;
- People who are both DDA-disabled and have a work-limiting condition are most disadvantaged in relation to employment. Seventy-four per cent are not employed. This is more than three times the overall UK proportion of 22%;
- Women are disadvantaged in employment terms; in almost all population groups women face an above-average incidence of non-employment. This is particularly the case for some ethnic minority groups in Wales, particularly women of Indian, Bangladeshi and Pakistani and Chinese ethnicity;
- Approximately a fifth of the Welsh population live in poverty (measured after housing costs). Those living on the lowest incomes are the youngest, disabled people, those of Pakistani and Bangladeshi ethnicity and those living in rented accommodation. However, lone parents are the most susceptible group, with almost half living in poverty;
- Being in work does not necessarily provide a route out of poverty, with 13% of in-work households in Wales living in poverty. In-work poverty is most

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prevalent among lone parent households, Asian households and those who are renting:
• Levels of wealth are lowest among young people, lone parents and single households, non-white households and those with a work-limiting illness or disability.

Many health researchers regard socioeconomic status as the fundamental factor affecting health. Socioeconomic status is the pivotal link in the causal chain through which social determinants connect to influence people’s health. Socioeconomic status marks the point at which social factors, such as the structure of the labour market and education system, enter and shape people’s lives, influencing the extent to which they are exposed to risk factors that directly affect their health, such as workplace hazards, damp housing and a poor diet.

The World Health Organisation (2004)\textsuperscript{42} notes:

“The social conditions in which people live powerfully influence their chances to be healthy. Indeed factors such as poverty, social exclusion and discrimination, poor housing, unhealthy early childhood conditions and low occupational status are important determinants of most diseases, deaths and health inequalities between and within countries.”

The Equality and Human Rights Commission (EHRC) Wales (2011)\textsuperscript{43} in its report \textit{How Fair is Wales?} says:

• People who are long-term unemployed or have never worked are nearly twice as likely to report that they have a limiting long-term illness as those with professional and managerial occupations (43\% compared with 23\%);\textsuperscript{44}
• People in more deprived areas were more likely than people in other areas to report a range of key illnesses, including high blood pressure, diabetes and mental health problems;\textsuperscript{45}

The Social Exclusion Unit report \textit{Transport and Social Exclusion: Making the Connections} (2003) highlighted the current challenges faced by socially-excluded groups in accessing health and other services. It found people who are socially excluded are more likely to experience a number of factors that in themselves have a negative impact on gaining access to health services. These may include

\textsuperscript{44} Welsh Government. (2010). \textit{Welsh Health Survey 2009}.
\textsuperscript{45} Welsh Government. (2010). \textit{Welsh Health Survey 2009}.
low income, disability and age coupled with poor transport provision or services sited in inaccessible locations. It also found the location of health services and the provision of transport to health services can reinforce social exclusion and disproportionately affect already excluded groups.46

Analysis by the Sustainable Development Commission (2011)47 has found:

“Existing transport patterns in the UK contribute to substantial and persistent inequalities. Some people benefit from accessing a wide range of education and employment opportunities and goods and services, whilst others are held back, unable to access the opportunities that would enable them to maximise their own wellbeing and social and economic contribution.”

In 2010, 49% of households in the lowest income quintile had no car compared with 9% in the highest income quintile. However, the gap in car availability between high and low income households is narrowing as car ownership increases among low income households (Department for Transport, 2011)48.

Premature death rates from stroke are around three times higher in the most deprived areas of the UK than in the least deprived.49

Age
Paediatrics is a medical specialty which manages medical conditions affecting babies, children and young people. As such changes to this service will have direct implications for babies, children and young people.

Findings from the EHRC (2011)50 report How Fair is Wales? show:

- Over 65 years, more than half of both men and women say they have a limiting long-term illness;51
- The combined age and area inequalities are stark. Among the over 55s, half or more in Blaenau Gwent, Merthyr Tydfil and Bridgend were disabled;

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48 Department for Transport (2011). National Travel Survey: 2010. Available at:
49 Stroke Association. (2013). Stroke statistics. Available at:
The proportion of adults reporting poor health rises with age, from 1% of 16 to 24 year olds to 13% of over 75s.\textsuperscript{52}

The Living In Wales\textsuperscript{53} survey shows that 78% of female respondents over 60 held a bus pass allowing them free travel (concessionary bus pass) compared with 70% of male respondents.

The proportion of young adults (aged 17 to 20) with a full driving licence has decreased since the early 1990s where driving licence ownership was at its highest, although the level does fluctuate year-on-year. In 1995-97, 43% of those aged 17-20 held a full licence, compared with a low of 27% in 2004 and 31% in 2011. The proportion in 2011 was the same for both males and females.\textsuperscript{54}

Research by the Campaign for Better Transport (2013)\textsuperscript{55} explored how changes in UK government funding have impacted young people. The research found:

- Two million young people are from low-income households and young people’s debts and living costs are rising due, for example, to the increase in tuition fees;
- Young and older people have the least access to cars but young people make more journeys by bus and travel a longer distance by bus than any other age group;
- Whilst bus passes for older people are protected by statute, concessionary fares for young people, which are discretionary, have seen cuts by local authorities;
- The percentage of under-20s with a driving licence is dropping steadily; one of the factors is the high cost of driving and insurance;
- Meanwhile, bus fares have risen much more than inflation since 2005.
- Younger people are travelling 21% less than they were 15 years ago but are having to travel further for essential journeys.

There are differences in rates of suicide among men, particularly young men (aged 25 to 44), which may indicate a greater likelihood of young men requiring A&E services.\textsuperscript{56}

\textsuperscript{52} Welsh Government. (2010). \textit{Welsh Health Survey 2009.}
Three-quarters of those affected by stroke are over 65, but it can happen to people of any age.\textsuperscript{57}

\textbf{Disability}

The Equality and Human Rights Commission (EHRC) Wales in its report \textit{How Fair is Wales?} (2011)\textsuperscript{58} notes:

- Disabled people are almost 10 times as likely to report poor health as non-disabled people;
- Disability and long-term illness is also associated with poor mental health: 52\% of people with limiting long-term illness/disability have a low score which indicates poor mental health, compared to 24\% of those without a limiting long-term illness/disability,\textsuperscript{59}
- Evidence from England suggests Pakistani and Bangladeshi men are significantly more likely to have poor mental health than other people.\textsuperscript{60}

In Great Britain, 74\% of adults with impairments experienced restrictions in using transport compared with 58\% of adults without impairments (ONS Life Opportunities Survey, 2009/10)\textsuperscript{61}.

Research by the Office for Disability Issues (2009)\textsuperscript{62} found:

“Lack of access to a car is a significant issue for disabled people and their families and results in a 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

\begin{bibliography}{10}
\end{bibliography}
limited activity or work’ compared to 14% without). Similarly, 40% of non-disabled people had access to two cars compared to just 23% of disabled people.”

Recent research by the Children’s Commissioner in England (2013)\(^\text{63}\) has highlighted that for disabled low-income children transport can be a barrier to realising their right to healthcare, particularly the distance some families have to travel to receive services. Families often go to great lengths to find and then keep going to good dentists or other health services where the professionals are good at understanding their child’s needs. For those on low income this means not just lengthy, but sometimes costly journeys.

Care close to a child’s home was seen as beneficial and instances where specialists came out to do clinics in rural settings meant that families did not have to undertake long, tiring and expensive journeys. Families identified that travel to and from hospital and other appointments was an additional and significant drain on their limited finances. However, because the families valued sustaining relationships with professionals they knew and trusted the physical and financial costs and sacrifices associated with travelling to appointments was seen to be worthwhile.

The gap between disabled and non-disabled people’s access to a car is greater in Wales than in other parts of the UK (Jolly et al, 2006)\(^\text{64}\). Welsh Government data (Welsh Assembly Government, 2003)\(^\text{65}\) shows six out of 10 disabled people or people with a long-term illness have the use of a car compared with eight out of 10 other people, and they are less than half as likely to have the use of more than one car.

A report by Leonard Cheshire (Campion, Greenhalgh and Knight, 2003)\(^\text{66}\) also found that 21% of disabled people surveyed felt that transport problems had limited the availability of education and training; 30% found difficulty in attending


social functions (45% for those without access to a car) and 20% found it difficult or impossible to access the healthcare they needed.

The Welsh Government’s (2012)\textsuperscript{67} consultation document \textit{Framework for Action on Independent Living} highlights a number of issues relating to public transport for disabled people. It notes that some disabled people do not feel confident in using public transport even when physical access is possible. Some report that they don’t use buses, or have stopped using them, because of problems experienced, in some cases with the attitudes of members of the public or individual drivers.

It also notes that disabled people look to drivers and other staff not only to comply with physical access requirements, but also to provide support – for example, in asking other passengers to remove luggage blocking wheelchair access – or challenge unacceptable public behaviour. In many cases, positive staff attitudes enable disabled people to travel with the same freedom and confidence as other passengers.

Where this is not the case, staff attitudes are an important barrier, and some disabled people report being made to feel unwelcome by some staff. Disabled people feel that staff training emphasises the physical aspects of, for example, wheelchair handling, but gives inadequate attention to the customer care aspects, including the diverse needs of disabled people, and the impact of different impairments. People with learning difficulties report that communication can be a barrier – some drivers and other staff lack awareness of how to communicate effectively with disabled people.

Barriers to accessing healthcare for disabled people are not limited to transport issues. Inaccessible information and communication has created significant barriers to accessing healthcare services for people with sensory loss or learning disability.

Research by RNIB Cymru and Action on Hearing Loss (2012)\textsuperscript{68} looking at issues in accessing healthcare for people with sensory loss found:

- There are 480,000 deaf and hard of hearing people in Wales; 70% of people aged 70 have hearing loss;
- 35% of deaf and hard of hearing people have been left unclear about their condition because of difficulties communicating with their GP or nurse;


\textsuperscript{68} RNIB Cymru and Action on Hearing Loss. (2012). \textit{Accessible Healthcare for People with Sensory Loss in Wales.} Cardiff: RNIB Cymru.
• 70% of British Sign Language (BSL) users admitted to A&E were not provided with a BSL/English interpreter to help them communicate;
• 59% of medical staff have not received visual impairment awareness training;
• 86% of blind and partially sighted people cannot read their appointment letters; only 17% are given information about the treatment available; one in three always or sometimes feel forgotten.

The report identified three main areas where services needed to improve:

• Communication – ensuring information (both written and face-to-face) is accessible and delivered in a way that meets the needs of people with sensory loss. Of specific note was the need to improve communication around access to appointments;
• Dignity and respect – ensuring there is appropriate customer care and assistance for people with sensory loss from staff who understand their needs and the impact that their sensory loss has. Service users felt it was essential that staff training was undertaken and that this included people with sensory loss themselves;
• Environment – ensuring the environments in which care is delivered are accessible and safe and appropriate to the needs of people with sensory loss.

In 2009, RNID Cymru69 undertook research which looked at the everyday inclusion barriers facing people who are deaf or hard of hearing in Wales. The questionnaire asked about people’s experiences of using public services and service-providing organisations and using public transport. The survey found:

• More than four fifths (84%) of questionnaire respondents believe that being deaf or hard of hearing makes it harder for them to use services;
• A lack of deaf awareness was identified as the main barrier to using services by nearly 80% of respondents, while more than a third (36%) identified the attitude of services providers as a barrier;
• About one in six (15%) said it was difficult to get information about health services. The figure rose to nearly half (45%) of respondents who use BSL and Sign Supported English (SSE) in response to this question. When discussing the health service, open forum participants raised a number of barriers to accessing services. Participants with different degrees of hearing loss noted a lack of visual information displays in waiting rooms, and shared how their hearing loss was not clearly marked on medical records. Participants who use

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BSL or SSE felt that there was still a lack of understanding regarding the need to provide interpreters for appointments, and a need to consider the interpreter preference of patients within the health service;

- 61% of respondents believe being deaf or hard of hearing makes it harder to use public transport, while 66% believe it makes it harder to use public transport when they’re on their own. A lack of deaf awareness by public transport staff was identified as the main barrier to using public transport by nearly two thirds (65%) of respondents. More than a quarter (28%) identified a lack of accessible information, while nearly a quarter (24%) identified the attitude of service providers as a barrier.

Evidence suggests that sensory loss is highly relevant to people with learning disabilities. Research by the RNIB and See Ability Learning Disabilities Observatory has found:

- People with learning disabilities are 10 times more likely to have serious sight problems than people without a learning disability;
- Six in 10 people with learning disabilities need glasses and often need support to get used to them. People with learning disabilities may not know they have a sight problem and may not tell people.

Gender
Three of the four health services being considered by the South Wales Programme - consultant-led maternity, neonatal care, and inpatient children’s services – are predominantly used by women directly or as carers. As such changes to these services will directly impact upon women more than men.

According to the 2011 Census, the geographical area covered by the South Wales Programme contains 64,884 lone parent households. This equates to 67% of all lone parent households in Wales. Within the South Wales Programme area, 90.4% of the lone parent households are female, which is slightly higher than the national figure of 89.6%.

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Lone parent households experience some of the lowest levels of wealth in Wales.⁷⁴ As such any additional travel costs incurred due to service reconfiguration will have significant impact upon service users from this group. The 2011 Census data shows that only 19.1% of female lone parent households in the South Wales Programme area in full-time employment, 31.4% are in part-time employment, and 40% are not in employment.

Research by the Department for Transport indicates that women are more dependent than men on public transport. It is anticipated that any additional cost of travelling to specialised units is likely to impact more upon women than men, due to the lower number of women either with access to a car or a full driving license. For example:

- According to the National Travel Survey (Department of Transport, 2012)⁷⁵, in 2011, more men than women hold a full driving license, 79% of men compared to 65% of women;
- While more than 80% of households have a car, one in five men and one in three women do not drive.⁷⁶

Findings from the Equalities and Human Rights Commission’s (2010)⁷⁷ Triennial Review show men are twice as likely to experience violent crime than women. Suicide rates are three times higher among men than women, and are particularly high for younger men aged 25 to 44.⁷⁸ This would suggest that men (particularly young men) may be more likely to require emergency services.

Evidence suggests that men are less likely to access healthcare than women and particularly in the context of primary healthcare.⁷⁹, ⁸⁰, ⁸¹, ⁸², ⁸³, ⁸⁴, ⁸⁵ Research also

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indicates that men are more likely to experience sensory loss, and particularly hearing loss than women\textsuperscript{86} (see Disability section regarding access problems relating to disability).

Stroke incidence is approximately 25\% higher in men than in women.\textsuperscript{87} Around one in six men and one in nine women die from heart disease.\textsuperscript{88}

**Marriage and civil partnership**
No impacts upon this protected characteristic are anticipated.

**Pregnancy and maternity**
Research by the NSPCC (2013)\textsuperscript{89} has highlighted that during pregnancy and after birth, women can be affected by a range of mental health problems, including anxiety disorders, depression and postnatal psychotic disorders.

Some women who experience mental illness in the perinatal period may have no history of mental illness and experience it for the first time in relation to their pregnancy or childbirth. Other women may have a pre-existing mental illness which persists, deteriorates or recurs during the perinatal period as the result of the intense social, psychological and physical changes occurring at this time, because of a change in medication, or as a result of the events of childbirth.

Depression is the most prevalent mental illness in the perinatal period, with research suggesting that around 10\% to 14\% of mothers are affected during

\textsuperscript{89} Hogg, S. (2013). All Babies Count: spotlight on perinatal mental health. London. NSPCC.
pregnancy or after the birth of a baby.\textsuperscript{90, 91}

Postpartum psychosis (also known as puerperal psychosis) is a severe mental illness that affects around two in 1,000 new mothers\textsuperscript{92} and causes symptoms such as confusion, delusions, paranoia, hallucinations (usually hearing voices), and mood symptoms of mania and depression. Unlike milder forms of depression and anxiety, this severe mental illness is more likely to occur after childbirth. Most cases occur during the first few weeks of a child’s life.\textsuperscript{93} Women are 20 times more likely to be admitted to a psychiatric hospital in the two weeks after delivery, than at any other time in the two years before or afterwards.\textsuperscript{94}

Factors associated with increased risk of perinatal mental illnesses: \textsuperscript{95}

- History of mental illness
- Family history of mental illness
- Psychological disturbance during pregnancy (for example anxiety or depression)
- Lone parent or poor couple relationship
- Low levels of social support
- Recent adverse or stressful life events
- Socioeconomic disadvantage
- Teenage parenthood
- Early emotional trauma/childhood abuse
- Unwanted pregnancy

Mental illness is one of the leading causes of maternal deaths in the UK. Between 2006 and 2008, 29 women were known to have committed suicide during pregnancy, or in the six months after delivery. The number of new mothers committing suicide has not fallen over the past decade. Psychiatric disorder is also associated with maternal deaths from other causes, and in the same period, 67 deaths were recorded as being the result of, or associated with, a psychiatric


disorder. Many of these deaths could have been prevented with prompt referrals to specialist services, and in particular specialist inpatient mother and baby units.96

Race
Research by the Department for Transport (2003)97 has highlighted issues around language as a barrier to accessing public transport for black and minority ethnic populations.

Black and black British people have among the lowest car ownership rates.98 The Health ASERT Programme Wales99, investigated health issues among ethnic minority groups, refugees/asylum seekers and gypsy travellers and resulted in a series of reports on these issues (Papadopoulos and Lay, 2005; Aspinall, 2005, 2006a, 2006b). These reports have highlighted the paucity of Wales-specific information in terms of research undertaken and of specific statistical Wales-based data on the groups being examined.

A review of service provision (National Assembly for Wales Equality of Opportunity Committee, 2003) found there are no centrally-collected health indicators for gypsies and travellers and although there is research about the specific health issues, much of it is limited in scope. In so far as the review could identify research (most of it not specific to Wales), it found higher levels of infant mortality, maternal death rates, lower life expectancy, higher accident rates, and higher rates of illness due to the environment, such as diarrhoea, asthma, parasites and skin conditions and rashes, than in the settled community. The report also identified a high level of unmet need in providing dental care, well-woman services and health promotion.100

In the UK and elsewhere, mean birth weight and the risk of low birth-weight vary according to ethnic group. Research looking at data from the UK Millennium

99 The acronym ASERT stands for Asylum Seekers, Ethnic minorities, Refugees and Travellers. Details of the programme are available at: http://wales.gov.uk/topics/health/research/research/programme/?lang=en
Cohort Study (Kelly et al. 2009) found Indian, Pakistani and Bangladeshi infants were 280g to 350g lighter, and two-and-a-half times more likely to be low birth weight compared with white babies. Black Caribbean babies were 150g lighter and Black African babies 70g lighter compared with white babies; Black Caribbean and Black African babies were 60% more likely to be low birth-weight compared with white babies.

Research published by the RNIB has highlighted differences between ethnic populations in the risk of developing sight complications, which in turn may affect these groups ability to access healthcare (see section on Disability and related access issues). The RNIB research reports:

- The black population has a greater risk of developing age-related macular degeneration (AMD) compared to the white population in younger age groups, whereas the white population has a greater risk of developing AMD in the latter years of life; Asians are at lower risk than whites of AMD.
- Asians have a greater risk of developing cataracts compared to the black population and white population;
- Black and Asian populations have a greater risk of developing diabetic eye disease compared to the white population.

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• The relative risk of glaucoma is much higher for the black population compared to the white population;\(^{109,110}\)
• The white population has the greater risk in developing refractive error compared to the black population.\(^{111}\)

African-Caribbean people are twice as likely to have a stroke compared with white people.\(^{112}\)

Analysis of 2011 Census data for England and Wales by the ESRC Centre on Dynamics of Ethnicity (CoDE) (2013)\(^{113}\) found:

• Persistent inequalities are seen in the health of Pakistani and Bangladeshi women. Their illness rates have both been 10% higher than White women in 1991, 2001 and 2011;
• The white gypsy or 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;
• Ethnic inequalities in health are most pronounced at older ages:
  ▪ 56% of all women aged 65 or older reported a limiting long-term illness, but over 70% of Pakistani, Bangladeshi and white gypsy or Irish traveller women at this age reported a limiting long-term illness;
  ▪ Arab and Indian older women also reported high percentages of limiting long-term illness (66% and 68% respectively);
  ▪ 50% of all men aged 65 or older reported a limiting long-term illness, but 69% of Bangladeshi and white gypsy or Irish traveller older men reported being ill.

\(^{113}\) ESRC Centre on Dynamics of Ethnicity. (2013). *Which ethnic groups have the poorest health? Ethnic health inequalities 1991 to 2011*. Manchester: ESRC Centre on Dynamics of Ethnicity.
There is evidence that maternity services frequently fail to provide satisfactory services to women, and particularly to women from ethnic minority backgrounds.\textsuperscript{114}

Poor communication is a commonly-cited problem and there are widespread inadequacies in interpretation and translation facilities, this is not merely an issue for those who cannot speak English. Poor listening, dismissiveness, rushed consultations and disrespectful attitudes are factors that have been found to undermine patient-provider communication for ethnic minority people, even where they speak English.\textsuperscript{115}

**Religion or belief (including lack of belief)**

There is some evidence from research conducted by the Department for Transport (2004)\textsuperscript{116} that women from some faith groups in the UK face restrictions on their freedom to travel. The requirement to travel to specialized service centres may present additional challenges to women from relevant faith groups.

**Sexual orientation**

Addis et al (2009)\textsuperscript{117} suggest there may be health differences because of young lesbian, gay, bisexual and transgender people’s greater use of alcohol and tobacco. Their less frequent screening may also contribute to higher incidence of certain diseases in later life and they may also experience widespread mental ill health.

More recent research on gay and bisexual men’s health (Stonewall Cymru, 2013)\textsuperscript{118} has found:

- Four in 10 gay and bisexual men drink alcohol on three or more days a week compared to three in 10 men in general;

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\textsuperscript{118} Stonewall Cymru. (2013). *Gay and Bisexual Men’s Health Survey Wales*. Cardiff: Stonewall Cymru
• Almost half of gay and bisexual men have taken drugs in the last year compared to just one in eight men in general;
• In the last year, 2% of gay men and 3% of bisexual men in Wales attempted to take their own life;
• One in 14 (7%) gay and bisexual men aged 16 to 19 have attempted to take their own life in the last year;
• One in 14 (7%) gay and bisexual men deliberately harmed themselves in the last year;
• More than one in five gay and bisexual men aged 16 to 19 have harmed themselves in the last year. It is estimated between one in 15 and one in 10 young people in general deliberately harm themselves;
• More than one in four gay and bisexual men in Wales who have accessed healthcare services in the last year have had a negative experience related to their sexual orientation.

Gay and lesbian people are more likely to say they have been treated with respect in health services only some of the time or rarely.\textsuperscript{119}

Research has suggested there may be an association between harassment and poor mental health. Some evidence suggests lesbian, gay and bisexual and transgender people, are perhaps more likely than other groups to face hostility and misunderstanding, and are more likely to experience poor mental health.\textsuperscript{120}

There is some evidence to suggest lesbian, gay and bisexual people have an increased risk of suicide\textsuperscript{121}, which could indicate a greater likelihood of requiring A&E services.

**Gender reassignment**

In the main, the literature on transgender people’s experiences of accessing healthcare focuses on gender reassignment. In relation to this the literature indicates their experience tends to be negative as they face problems receiving funding for treatments from (English) primary care trusts and experience long waiting times for assessment or treatment.


The Equality and Human Rights Commission notes in its report *How Fair is Britain?* that one in seven transgender people who responded to a survey felt they had been treated adversely by healthcare professionals because of their transgender status.\(^\text{122}\)

Research suggests transgender people are likely to experience risk of harassment when attempting to access healthcare. A survey by Press for Change (2007)\(^\text{123}\) found 36.8% (277) of transgender people (aged 18 to 75) who chose to present their acquired gender permanently, experienced negative comments while out socially because of their acquired gender. Only 27% of respondents in the survey said they had not experienced anything of the above while out in public spaces. This means that 73% of respondents experienced comments, threatening behaviour, physical abuse, verbal abuse or sexual abuse while in public spaces.

Recent research\(^\text{124}\) looking at the mental health and emotional wellbeing of transgender people has found rates of current and previously diagnosed mental ill health are high among this group. The research found:

- 88% of participants had either currently or previously experienced depression;
- 80% had experienced stress and 75% had experienced anxiety;
- 53% of participants had self-harmed at some point;
- 20% of respondents had wanted to harm themselves in relation to, or because of, involvement with a gender identity clinic or health service;
- The majority of participants (84%) considered ending their lives at some point.

Lower self-esteem and higher rates of mental health problems can have an impact on health behaviours, including higher reported rates of smoking, alcohol and drug use. These behaviours have associated long-term health risks, such as cardiovascular disease and various cancers.

Transgender people have reported experiences of inappropriate healthcare which can make them reluctant to access services. Research by Press for Change


(2007)\textsuperscript{125} identified several pieces of research which highlight transgender people being placed in inappropriate hospital wards.

The UK Department of Health briefing \textit{Trans People’s Health}\textsuperscript{126} notes that transgender men are rarely included in breast or cervical screening programmes and transgender women are rarely offered prostate screening.

The study \textit{Transgender Experiences in Scotland} (2008)\textsuperscript{127} found one of the main problems reported with accessing general health services was difficulty in getting NHS records fully updated to correctly reflect a gender change.

Engagement with transgender people has highlighted the practice of transgender people seeking gender reassignment surgery outside the UK may place them at greater risk of post-operative complications. Post-operative complications, in part due to different clinical practices, increase the risk of transgender people requiring access to A&E services.

\textbf{Welsh language}

There is a risk that the transfer of services to specialised units may impact negatively on Welsh language users. Due to service reconfiguration, people who prefer to communicate in Welsh may be required to access services at sites which do not have sufficient Welsh-speaking staff. This could affect a person’s ability to communicate with service providers in their preferred language.


What are the potential equality impacts on NHS staff?

The changes proposed by the South Wales Programme will affect NHS staff as well as the public in South Wales and South Powys. It is anticipated the main impact will be around the requirement for some to travel to new workplaces and for others to work more flexibly across health board boundaries.

There are concerns that staff rotas, while compliant with New Deal and European Working Time Directive (EWTD), will not include an appropriate work-life balance. This is particularly relevant for those staff who have existing caring commitments. This risk is further compounded by the fact that an analysis of the workforce has highlighted that it is predominantly female, as women are more likely than men to have caring responsibilities.

It is unclear to what extent affected staff are dependant on public transport for travel. Where staff do use public transport, it is worth noting the findings of the Equality and Human Rights Commission (2011) report *Hidden in Plain Sight* which highlighted public transport as a high-risk area for disability-related harassment. Public transport may also pose a greater risk of harassment for staff with other protected characteristics, such as gender, race, faith, sexual identity, and transgender.

What does this mean for staff?
The modelling work undertaken so far has included a detailed analysis of the age profiling and gender of the medical workforce. This shows we have an ageing profile of consultant staff and middle grade doctors in all four fragile services – this is most notable in emergency medicine (A&E) and paediatric services. However, as expected, the age profile is lower among doctors in training – the average age of trainee staff in emergency medicine (A&E) is between 26 and 29.

We are, of course, already aware of the predominance of female staff within the NHS but this is predicted to increase in the future, especially in medicine and particularly in maternity where there are large numbers of female doctors training. Of the 130 obstetric and gynaecology doctors-in-training across South Wales, 101 are female, representing 78% of the workforce.

This data is providing us with information so that we not only determine the impact on our future service provision but it also a heightened awareness of the opportunities this brings as we aim to blend job satisfaction, staff wellbeing, and work-life balance into our rotas and working patterns. This is something we are

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particularly aiming for in emergency medicine (A&E) as we need to be flexible in our approach to encourage the future workforce to work in Wales.

The proposed service changes will have an impact on some staff who may require relocation, although the detail of this is yet unknown. The approach we are developing is to promote the South Wales service as an integrated network with a clear vision. This means we need a workforce that is flexible enough to meet the needs of the service. The health boards are committed to working with staff to maximise work-life balance and understand individual needs. Staff will be fully involved to help minimise any unnecessary disruption and travel to individuals affected.

It is important to note that there are three fixed points in the South Wales Programme – University Hospital of Wales, in Cardiff; Morriston Hospital, in Swansea and the Specialist and Critical Care Centre, which is planned to be built in Cwmbran. This will help to minimise long distance travel for staff.

Through the development of the service models, the health boards will be looking at new ways of working and developing enhanced and extended roles – for example it is likely there will be a further development of advanced nurse practitioners (ANP), which will provide career development and opportunities for staff who are in traditional nursing roles. This positive impact will strengthen the multidisciplinary team approach and use the strengths of the ANPs, who are already acknowledged as being very valuable in providing effective care to patients.

All affected staff will be supported by the NHS Wales Organisational Change Policy (2009) in partnership with trade unions. Health boards are committed to engaging and consulting fully with staff throughout the consultation process and thereafter. Health boards recognise the workforce is predominantly female and are likely to have caring responsibilities and give consideration to the provision of different work patterns and or arrangements to facilitate employees’ personal circumstances wherever possible while ensuring efficient and effective service delivery. This will be facilitated via a range of relevant workforce policies such as flexible working. Any requirement for reasonable adjustment for staff with disabilities will be facilitated.

Where staff are relocated and this necessitates travelling further to work they are entitled under Agenda for Change terms and conditions to excess travel payments to mitigate against any additional costs involved.

Health boards will ensure a partnership approach with trade union colleagues to achieve an effective transition to the new arrangements.
What are the human rights implications of the South Wales Programme?

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.

Everyone has the right to participate in decisions which affect their human rights. The convention on the rights of people with disabilities contains protection of the right to participate in decisions and access to support for participation and access to information.

The assessment so far has indicated Article 2, the right to life; Article 8, the right to privacy and family life, home and correspondence, are both of particular relevance and have potential impact on the South Wales Programme, and will need to be considered in more detail as work progresses.

Right to Life (taking reasonable steps to protect life) It is anticipated that having more centralised hospital services will improve clinical outcomes which will have a positive impact on individuals’ right to have their life protected.

Right to respect for private and family life, home and correspondence
The improved quality of care possible due to more centralised hospital services should result in patients spending less time in hospital. However, increased travel distances could have a negative impact on the right to maintain family life. This would apply to the patient and to individual members of the family. This is not an absolute right, and any interference should be justified, lawful, necessary and proportionate.

United Nations Convention on the Rights of the Child
Children under 18 are protected by the UN Convention on the Rights of the Child (UNCRC). Healthcare providers have a duty to protect, promote and fulfil the rights of the child. The UNRC should be considered in conjunction with the Human Rights Act and the duty to promote principles of fairness, respect, equality, dignity and autonomy. Due regard must be given to the specific needs of a person of his/her age, and in particular the right to maintain contact with family members. This could apply to a child as a patient or a child/sibling of a patient. The convention recognises that children themselves, not adults, are entitled to be involved in decisions that affect them.

In order to meet the requirements of the UNCRC, the South Wales Programme has encouraged the participation of children and young people during the consultation stages. The South Wales Programme has also consulted with
stakeholders that advocate for children and young people (for example the Children’s Commissioner for Wales, and Funky Dragon).

### About the consultation

The South Wales Programme has welcomed the statutory obligation placed on it by the Public Sector Equality Duty to consider the needs of different groups when designing and delivering public services. A specific duty underpinning this is to undertake meaningful engagement as part of the equality impact assessment with people considered to be representative of one or more of the protected groups. This section describes the consultation phase of the South Wales Programme from an equality perspective.

The five community health councils – Abertawe Bro Morgannwg, Aneurin Bevan, Cardiff and Vale, Cwm Taf and Brecknock and Radnor - agreed to a formal eight-week consultation period from May 23 to July 19, 2013. This built on a broad range of engagement activity previously undertaken over a 12-week period between September and December 2012 with patients, the public, staff and other stakeholders.

The consultation was a formal exercise undertaken by Abertawe Bro Morgannwg, Aneurin Bevan, Cardiff and Vale, Cwm Taf and Powys health boards to gather views on the changes proposed to consultant-led maternity and neonatal care, inpatient children’s services and emergency medicine (A&E). The health boards, supported by Welsh Ambulance Services NHS Trust, agreed to undertake a common approach to formal consultation. This involved a range of methods which included the active participation of the following stakeholders including the following:

- service users
- third sector and equality organisations
- staff
- trade unions
- professional bodies, including the National Clinical Forum
- Assembly Members, MPs and local councillors
- the wider community.

A consultation framework setting out the consultation and communication plan was prepared which described the principles and aims of consultation, the communication tools that would be adopted and the consultation process itself.
The programme considered the needs and views of people with one or more protected characteristics. A proportionate response was taken to identify those protected groups that are more likely to be affected by the proposed changes. The programme worked in a targeted and opportunistic way to identify relevant stakeholders. Third sector colleagues played an important part by linking the programme to a range of support groups who were likely to have a particular interest in the consultation.

The South Wales Programme commissioned the services of the Consultation Institute to advise on how it could meet best practice in public, stakeholder and employee consultation. Its compliance scheme provides assurance that the South Wales Programme meets the required consultation standards in terms of the Gunning principles and the Welsh Government policy on Engagement and Consultation.

From the beginning of the South Wales Programme discussions, the importance of identifying the impact of any potential changes on individuals and groups was recognised. This would help to ensure better decision making based on the views of all relevant community members. Other benefits would include the fostering of good relationships between and within communities, the elimination of any potential unlawful discrimination and the promotion of equality.

It was important to ensure that the aim of the South Wales Programme was clear to everyone. Namely, to deliver safe and sustainable specialist services for people living in South Wales and South Powys, which match the best in the world and address the quality and staffing issues currently affecting these services.

The aim of the formal consultation was to ensure that patients, staff, stakeholders and the public had the opportunity, if they wished, to influence and inform decision making around the future delivery of the specialist services affected. To achieve this, the consultation framework aimed to ensure that there was a clear and co-ordinated approach to communication and consultation, across South Wales and South Powys, so:

- People had access to high-quality, relevant information about the South Wales Programme and the work that had been undertaken prior to consultation
- People understood the scope of the South Wales Programme and the NHS organisations involved in the process
- People understood the case for change behind the South Wales Programme and the potential solutions
- People were able to get involved in the consultation, via a range of accessible opportunities (including e-communications and social media)
People knew how their responses to the engagement process had shaped the consultation and how the consultation options were developed.

Following the close of the consultation, the South Wales Programme will ensure that people understand how their responses have informed the decision making and how they will receive feedback on the decisions that have been made. This section looks at how the South Wales Programme worked collaboratively to ensure that ‘due regard’ has been paid in meeting equality duties during the three key stages of consultation, these include:

- Stage one: planning and preparation
- Stage two: implementation and practice
- Stage three: monitoring and review

To help guide work in this area, the South Wales Programme followed good practice in engagement from an equality perspective. This reflected the following key guidance documents and principles outlined in the:

- NHS Constitution.
- National Health Services (Wales) Act 2006, Section 183.
- The Equality Act (2010).
- Doing Well, Doing Better (Welsh Government 2010).

The South Wales Programme took steps to identify and address any potential barriers to participation by equality groups. Barriers can relate to the social, cultural and financial issues, the overall approach to engagement, and the practical arrangements.

**Stage 1: Planning and Preparation**

The first stage of the consultation included planning and preparation. There was a clear commitment at the highest level across all the organisations involved in the South Wales Programme to ensure effective engagement, good practice and equality. This was lead by the South Wales Programme board (chairs and chief
executives) ensuring that clinical leadership, community engagement and professional advice have been central to the approach from the outset. A specific workstream group was established to focus on equality, engagement and editorial issues. Membership of this group included senior planners, communication leads and equality leads. Specialist advice was provided by the NHS Wales Centre for Equality and Human Rights with a member of the team also joining the work stream group.

Each health board and the Welsh Ambulance Services NHS Trust undertook a detailed stakeholder analysis to build an overall stakeholder map for the South Wales Programme. The five health boards worked collaboratively taking a proactive approach to identify and engage with the equality groups, forums and advisory bodies at local and regional level. We looked at what structures and mechanisms already existed through which engagement could take place. This enabled us to highlight where new contacts needed to be developed within our communities.

At the planning stage, it was agreed that mid-point and closing date review meetings would take place with the Consultation Institute at key stages within the compliance assessment process. The purpose of the mid point review was to check progress against key milestones and to identify if any additional activities would be required over the remaining weeks of the consultation period. This included a review of the activity undertaken with protected groups.

The closing date review considers activities for data analysis and interpretation to ensure they are still appropriate in the light of the information obtained during the consultation exercise and to be assured that high integrity and transparency have been met throughout and in responding to the consultation.

Stage 2: Implementation and Practice

Overall Approach
The South Wales Programme adopted recognised good practice by using a combination of different methods of engagement rather than a one size fits all approach. A range of approaches were required to be effective as some methods will be more appropriate for some participants than others and some will work better in some geographical areas than others.

A suite of standardised materials, which communicated the core messages and case for change, were used at formal public and staff events. The accessibility of the materials and the most effective method of engagement were considered in relation to the protected groups.
The suite of standardised materials included:

- a single consultation document with a questionnaire in Welsh and English;
- a bilingual summary consultation document with a questionnaire – this was the main document used in public meetings;
- a Braille version of the full document with a Braille questionnaire in Welsh and English;
- a BSL video version of the full document – making support available for completion of questionnaires as required;
- an audio book version of the full document with a questionnaire – making support available for completion of questionnaires as required in Welsh and English;
- an easy read version of the key messages with a questionnaire in Welsh and English;
- a standard presentation for use at meetings;
- an audio and video version of the standard presentation available to download via the South Wales Programme website;
- posters and fliers for advertising meetings;
- technical documents, available (in English only) on the South Wales Programme website and hard copies available on request;
- frequently asked questions (FAQs) in Welsh and English;
- a series of short video interviews (English-only) with the postgraduate Dean and frontline clinicians explaining the case for change.

The summary document and all versions of the questionnaire signposted people to the full consultation document for further information. Other supporting information, for example, the draft equality impact assessment was available on the South Wales Programme website. Where consultation publications were required in an alternative format or language these were distributed to relevant equality groups and made available on request. For example, in the Cwm Taf area the summary consultation document and questionnaire were translated into Polish and Portuguese.

The South Wales Programme published weekly updates to keep staff, stakeholders and the public informed. These updates were emailed directly to clinicians, managers, community health council chief officers, stakeholder groups, AMs, MPs, councillors and journalists every Friday, and were subsequently cascaded through health boards and to interested external stakeholders.

**South Wales Programme website**

A single, bilingual website for the South Wales Programme consultation was developed. The website – [www.wales.nhs.uk/swp](http://www.wales.nhs.uk/swp) and
www.wales.nhs.uk/swp/hafan - hosted all the consultation documents, video and public consultation events organised by the health boards.

Accessibility of the website was guided by government standards and the Web Content Accessibility Guidelines (WCAG). These are widely accepted as the international standard for accessibility on the web. The website offered a Browse Aloud feature. It improves web accessibility for the following group of users:

- Dyslexia
- English as a second language
- Low literacy/reading skills
- Mild visual impairments

Other web accessibility features included Adobe/Read Out Loud and the ability to adjust text size. The website enables users to access different document formats by downloading free viewers such as Adobe Acrobat Reader and Microsoft Word Viewer.

The website also directed people to a single email address if they wished to respond to the consultation (this was in addition to other means of responding).

**South Wales Programme Twitter account**
The South Wales Programme had its own Twitter account - @SouthWalesProg - throughout the consultation and used this extensively to promote consultation events and uploads to the website, including the weekly updates. It continues to be active.

**South Wales Programme Facebook page**
A Facebook page – www.facebook.com/SouthWalesProgramme - was developed for the South Wales Programme, where information, including the weekly updates and the case for change, were published and promoted in the run-up to consultation. This site was able to host video and links to external content and resources which supported the wider case for change.

**Working with the media**
It was recognised that the media would play a key role in publicising the public consultation.

Opportunities were taken to work with both the English and Welsh-language written and spoken media to promote the consultation; this included regular print articles in the daily Welsh national and regional press and weekly newspaper and news items on BBC Radio Cymru, S4C and in the magazine Golwg. The South Wales Programme was the subject of a special half-hour programme about the
South Wales Programme on Eye on Wales on BBC Radio Wales. The South Wales Programme was also the focus of an edition of The Wales Report with Huw Edwards immediately after the launch of the consultation on May 23. In addition, individual health boards worked with local media, including local radio stations, to promote the consultation locally, including publicising events in their areas, over the course of the eight-week consultation.

**Public, staff and stakeholders**

The approach to formal public meetings was agreed with community health councils, to enable appropriate focus on those communities that are most likely to be affected by change to services.

The consultation aimed to be inclusive of all; however a range of meetings were focussed on consulting with targeted groups, with particular emphasis on engaging with people with protected characteristics. Health board equality leads advised on these, based on analysis of the issues raised through engagement and other relevant evidence. This included national reports, research, best practice recommendations and advice of third sector and community colleagues.

‘Targeted’ groups included those who may be most impacted by the proposed changes but who historically may not get involved in consultation processes. We also used existing links to community groups and Third Sector partners such as the Councils for Voluntary Services to signpost people to meetings and where they could get information in a range of formats.

Each public consultation meeting was supported by a “consultation team”. Particular consideration was given to equality perspectives including:

- Accessibility of venues – for example, wheelchair access, hearing loop and communication support
- Room layout and equipment
- Parking arrangements
- Transport accessibility
- Toilet facilities
- Equality monitoring forms to collect information regarding protected characteristics

In addition to the formal public meetings, briefings and face-to-face meetings for staff, roadshows and the intranet were also used to raise awareness and encourage participation in the consultation.

**Practical arrangements**

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A key part of the planning and implementation process was consideration of the practical arrangements to ensure engagement was as accessible as possible and able to attract a wider group of participants.

**Location/venue for engagement**

Consultation was undertaken at a local level. The location and venue was chosen to ensure accessibility and suitability for all participants and was agreed with the community health councils. Community venues were mainly used for the public meetings and events. Consideration was given to the most appropriate meeting time. Meetings were held at appropriate, and a variety of, times and to increase the opportunity for people to attend.

**Other practical considerations**

Meetings and events were held and conducted in appropriate ways to encourage a wide range of participants. Additional support was provided to enable some groups to participate, including the reimbursement of travelling expenses for disabled people and young families attending events and the provision of sign language interpreters for people who are profoundly deaf. All information was made available in an accessible format on request.

The importance of ‘reasonable adjustment’ to the standardised consultation approach was important in ensuring participation of some groups. There are a number of examples that illustrate this:

Abertawe Bro Morgannwg UHB worked with Bridgend People First to ensure people with learning disabilities were able to participate. After a detailed briefing and support, they facilitated a number of consultation events to get the groups views on the proposals. In doing so important adjustments were made to the usual approach:

- Three film clips: Getting ready to go into hospital, admission onto a hospital ward and having an X-Ray and a CT scan acted as a starting point for the session and to set the scene for the consultation
- A PowerPoint presentation created by Bridgend People First on the proposed changes and background information
- A 'Going into hospital' quiz. This inclusive format was run at five meetings enabling 86 people whose voices are seldom heard to contribute their views.
- Building on work undertaken locally with deaf service users, Cwm Taf set up an event with Pontypridd Deaf Club which was also open to service users from other clubs and areas. Two British Sign Language interpreters were provided by the health board to facilitate the event.
- Powys took the opportunity to raise the South Wales Programme with a group of health visitors and school nurses and staff who work with older
looked after children and foster parents. They were encouraged to respond both individually and formally and to encourage their users/clients to do the same. The South Wales Programme was publicised at the ‘Bump to Baby’ road show in Brecon.

- Cardiff and the Vale University Health Board contacted the co-ordinator of the Barnardo’s Young Families Project who agreed to disseminate and run a discussion with the young mothers and fathers about the South Wales Programme in Roath, Cardiff. They agreed to write a response via one of the options provided.
- Aneurin Bevan Health Board hosted a meeting for the Young Persons Forum, modifying the standardised approach to include a focus group with small group discussions.

**Stage Three: Monitoring and Review**

Consultation activity was monitored closely throughout the process to ensure that it was as comprehensive and inclusive as possible. Areas for improvement from the earlier South Wales Programme engagement programme were built into the planning of the formal consultation events.

We ensured that any comments, complaints or criticisms about the process were used to inform any adjustments, improvements or additions that may be necessary in the second half of formal consultation. For example, the closing date for the consultation was extended for those completing the easy read version of the questionnaire after comments received from Learning Disability Wales and additional public meetings were held following feedback in some locations.

**Mid-Point Review**

In advance of the mid-point review, a matrix was produced setting out how the South Wales Programme consultation activity targeted different groups of people that may have one or more protected characteristics. In terms of coverage of the protected characteristics, it was identified:

- In comparison to other groups it was noted there was more participation of older people at public meetings. Presentations were given specifically at older people’s forums in recognition that proportionately the changes may have a greater impact on them.
- Participation of some disabled people needed to be strengthened and in particular for people with learning disabilities and people with a visual impairment. Plans were put in place to improve the involvement of people with learning disabilities through focus groups with appropriate support. Arrangements were made with the RNIB for a South Wales Programme representative to attend the visual impairment group in Swansea so people
could give their views. Audio CDs and Braille copies were made available for the RNIB officer to give them out at visual impairment groups.

- Young people and parents with young families needed to be targeted for further engagement. Maternity staff were raising awareness of the consultation and were highlighting it at antenatal clinics and to women supported by specialist teams. It was ensured that this was being carried out consistently across the South Wales Programme area.
- The easy read document and questionnaire was made available to Bridgend People First for this advocacy organisation to run Have your say events in July. A representative from Bridgend People First attended a South Wales Programme public meeting and a Deaf Club to be well informed to support people with learning disabilities to participate in the consultation.
- Welsh language South Wales Programme materials were distributed at the Abergavenny Eistedfodd, the Welsh Society, Mentor Iaith and Ysgol Gymraeg Y Fenni.
- Powys emailed the How Fair is Powys mailing list just before consultation end to raise awareness and encourage further response.

Feedback from the Consultation Institute at the mid-point review was positive in relation to the engagement activity undertaken to date and the plans in place for further targeted engagement with equality groups.

Closing Date Review
The schedule of South Wales Programme consultation activity with protected groups was updated for the five health boards (attached as appendices A to E). The closing date review took place in two stages, on August 1, 2013 and October 15, 2013. The Consultation Institute advisor will produce a closing report for the assessor who will consider whether the programme has met this stage of the compliance requirements.

The specific duty to undertake meaningful engagement as part of the equality impact assessment is an ongoing one which is welcomed by the five health boards of the South Wales Programme. The main consultation findings alongside other evidence will be submitted to the five health boards to ensure the feedback received is influential in the decision making process.

The South Wales Programme acknowledges that some of the areas of impact identified were outside the scope of the review. Areas of further consideration, particularly in relation to reasonable adjustments, have been highlighted and will be considered as part of ongoing work. From an equality perspective, it is recognised that there is good practice from the consultation that needs to be shared and lessons that can be learnt about ways in which to improve future engagement activity. This will be an integral part of the South Wales Programme.
Findings from the South Wales Programme consultation

As part of the South Wales Programme consultation, respondents were asked to identify any concerns they had about how the proposed changes may impact on them in relation to any of their protected characteristics.

Analysis of the responses by Opinion Research Services (ORS) has found that by far the greatest number of concerns came from residents of Rhondda Cynon Taf (RCT). Almost all responses were travel and transport related, particularly with respect to:

- Increased travel times
- Increased cost
- Patients not being seen within the so-called “golden hour”
- Mountain road closures in winter
- The lack of bus services to some hospitals (from certain areas)
- Increased ambulance usage and the resulting burden on the Welsh Ambulance Service

These concerns were found to be most prevalent in RCT where, it was argued, the burdens will be heaviest because of the disadvantaged nature of the area. Indeed, the considerable deprivation and poor health (and low levels of car ownership) in RCT led many people to object to option three – which was identified as the “best fit” – on the grounds that it will diminish health outcomes and increase health inequalities for the county’s residents.

It was also said that people from deprived areas tend not to respond to consultations such as this, and that this should be taken into consideration.

Some comments were made about the general unfairness of the proposals for South Powys residents, who argued that, as South Powys is less densely populated than South Wales and receives services from other health boards, it is always liable to lose out in the allocation of resources. The travel and transport difficulties encountered by residents there (due to poor public transport services, difficult road networks and lengthy ambulance response times) were also noted – as was the fact that access will become even more difficult for many as both Prince Charles Hospital, in Merthyr Tydfil and the proposed Specialist and Critical Care Centre (SCCC) are further than their current nearest hospital (Nevill Hall Hospital, in Abergavenny).

An analysis of the demographic profiles of the consultation respondents is presented in Appendix F.
Other equality issues highlighted during the consultation:

- Disabled people, those with mental health issues and the elderly will find it harder to access services as not all can (or can afford to) use public transport or fund additional fuel costs;
- Care provided by all services should consider mental and physical health equally;
- Removing consultant-led services from certain hospitals constitutes the removal of choice for women, especially those deemed high risk and in need of consultant-led care. Further, there is potential for increased risk to women and babies during intrapartum transfers between consultant-led and non consultant-led settings (including at home) – and such transfers will occur more frequently if the former are reduced in number;
- The parents of sick neonates must already dedicate a significant amount of time to their newborns – and are also burdened by additional transport and other costs during a child’s lengthy hospital stay. It was said that this situation will be exacerbated if the child is in a hospital some distance from home, and especially for parents with commitments to other children or work. Indeed, one respondent referenced the Human Rights Act and the “right to a family life”, suggesting that new parents who must travel or stay away for maternity care when they have other children at home are denied this right;
- The parents of sick children will experience the same issues as above if the number of inpatient paediatric units is reduced and their child is being cared for at a more distant hospital, and child health could be put at risk by families’ inability to access services;
- Continuity of care will be jeopardised by patients receiving consultant-led care at one site, but after-care (and in some cases pre-care) at another.

“Many families rely totally on public transport and do not seem to have any access to friends or family members that have access to a car either. If services were removed from the Royal Glamorgan Hospital, this would result in many families spending three-four hours on various buses trying to get to Prince Charles / University Hospital Wales whereas now there is a direct link to the Royal Glamorgan Hospital. Many parents stay in hospital with their children and pop home for essentials. Many of these families cannot afford to use the hospital canteen. If they had to use bus services this will result in sick children spending time on an acute paediatric ward without their loved one by their side.”

Ward Manager, Royal Glamorgan Hospital.
The South Wales Programme consultation invited comments from professional bodies and organisations as well as members of the public. Key equality issues raised by these groups are presented below.

The Royal College of Psychiatrists in Wales (RCP) raised concerns about the South Wales Programme’s “piecemeal” approach to reconfiguration by focusing on four specific services, which could have implications for patients with co-morbidities. Its main concern is for patients requiring additional care for their mental health needs and suggests that a liaison psychiatry review is required when assessing people with mental health issues who present to general hospital to reduce risk, highlight relevant issues, and identify a specific treatment-orientated diagnosis.

Mental health services in Wales are vital to A&E and children's services and therefore the success of the South Wales Programme. The RCP has asked the South Wales Programme to consider the importance of mental health access for patients and feels that care provided in all services must consider mental and physical health equally. Also, each health board must ensure that any strategy that impacts mental health dovetails with the South Wales Programme.

The Royal College of Nursing (RCN) is particularly concerned about the proposed changes on people in the most deprived and isolated communities, many of whom rely on public transport. This may not be an issue in an emergency situation, but is problematic for visitors and those receiving longer-term care.

Wales Probation noted the specific needs of offenders are wide ranging but among the most common are: long-term medical conditions, mental illness, drug and alcohol misuse, sexual ill-health, blood borne viruses and communicable diseases. One in four women offenders struggle with a personality disorder and many suffer from mental health problems linked to addiction and / or domestic abuse. Wales Probation notes that pre-existing health problems for offenders are often linked to social, economic and cultural factors.

Wales Probation reported the findings of a recent survey of 100 offenders across Wales. The survey found 62% of respondents said their physical or emotional health interfered with their normal activities, and 42% had attended A&E, with 15% of that figure attending A&E more than three times.

Access to services via public transport was a particular concern for Wales Probation, especially in the Rhondda valley where they are aware that some of their clients have to catch three buses to access some services. In the opinion of Wales Probation, the chaotic lifestyle of a significant proportion of offenders
exacerbates this problem. Wales Probation reported a caseload of 1,710 offenders in the Rhondda valley area.

Wales Probation highlighted that many community-based offenders have problems with accessing mainstream health services, and tend to overuse crisis services and enjoy little in the way of preventative healthcare.

Bliss is a UK charity dedicated to ensuring all premature and sick babies have the best chance of survival and have the best possible quality of life. Bliss argued that it is essential that the needs of families are met by the review. Having a baby admitted to neonatal care places a huge financial, emotional and practical strain on families. These pressures are more acute if the baby is being cared for some distance from the family home.

Neonatal services are perhaps unique in that the involvement of the patient's carers - the babies' parents - is an integral part of patient care. It is essential that parents are enabled and supported to be with their baby - especially if they are a long way from home - and involved in their direct care through services with a strong emphasis on family-centred care. Bliss suggested that arrangements should be made to help parents cover the additional cost of travelling long distances from home to see or stay with their baby. Overnight accommodation must also be available so families can stay with their baby on the unit.

RNIB Cymru noted that patients with sight loss are significant users of healthcare services. RNIB Cymru also highlighted how all options will impact on the friends and family of those in need of specialist hospital services – and it is thus imperative to consider access to transport for different groups of people. RNIB Cymru notes this is a particular issue for people with sight loss as they are largely reliant on public transport, but at the same time can face barriers in accessing it due to the lack of audio announcements, inaccessible stations and bus stops, for example.
**Themes from South Wales Programme engagement and consultation and options for mitigation.**

This table sets out the key themes to emerge from the engagement and consultation phases of the South Wales Programme. It describes the issues raised under each theme; identifies which equality protected characteristic groups the issues potentially impact upon and provides an initial response in relation to actions to mitigate against any negative impacts. These will need to be revisited at both a South Wales Programme and local level once a decision on the way forward has been made.

A - Age  
B - Disability  
C - Gender  
D - Marriage and civil partnerships  
E - Pregnancy and maternity  
F - Race  
G - Religion or belief  
H - Sexual orientation  
I – Transgender  
J – Welsh language  
K – Human rights

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<tr>
<th>Theme</th>
<th>Description</th>
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<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
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<th>I</th>
<th>J</th>
<th>K</th>
<th>Initial response/potential mitigation</th>
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<tbody>
<tr>
<td>1. Increased travel times</td>
<td>Concerns about whether patient safety would be compromised if people have to travel further for care, particularly for those requiring time critical interventions</td>
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<td>The South Wales Programme is about improving quality for all patients. We acknowledge in the future some of our patients may have to travel a little further to access a small percentage of services, but the benefits of these changes will be improved standards of care and a stronger guarantee of clinical skills and expertise being available when people need them most. The majority of care will continue to be delivered locally. In responding to concerns about whether patient safety would be compromised for those people who need to travel further for care, it is important to recognise there is a lot of evidence from around the world, which shows it is not the journey to hospital which affects...</td>
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patients’ outcomes, but the access to definitive treatment. This means the sooner the right treatment can start the better chance a patient has of recovering from their illness or injury. Getting the right treatment depends on the patient being in the right place and being seen by a doctor or clinician with the necessary skills and training to make decisions about the care the patient needs.

For this to happen, it is important patients go straight to the right hospital the first time, rather than stopping off at the first hospital they come to. The evidence also shows concentrating services for the most seriously-injured patients improves outcomes, even if the ambulance needs to travel further to get to the right hospital. Survival rates are improved by 20%, patients recover faster, with less disability, meaning they can live more independently and return to work more readily.

Ambulance crews may need additional training to increase their clinical skills, giving them the ability to diagnose and treat patients on scene. Every effort will be made to minimise long journeys and help patients to receive the right care as close to home as possible. The three air ambulances in Wales can also be used for long distance journeys.

For pregnant women, irrespective of any changes that have been proposed, community-delivered services; antenatal clinics, early pregnancy clinics and midwife-led birthing centres will continue to be available in all hospitals, as now. During the first nine months of pregnancy – and the first couple of weeks after a baby
is born – almost all women will have the majority of care delivered locally.

For most women, childbirth is thankfully a normal process which requires little or no medical intervention at all. However, we do know that some pregnancies are higher risk right from the start and others become more complicated during labour. For these people, having skilled and experienced doctors available to support the labour ward 24/7 can be critically important to mum and baby. This could mean that for some women their time in labour and in hospital after their baby is born may be a bit further from home. But it will mean that help from highly-skilled doctors is available when they need it.

Modern-day health services for children are rarely provided in a hospital bed. The majority of sick and injured children see a healthcare professional in the community, their GP surgery or their local hospital. It is only a very small percentage of children – those who are seriously ill or badly injured – who need to stay in hospital overnight. For these children there is strong evidence that having paediatric doctors available 24/7 means their outcomes are better and lives can be saved.

| 2. Public transport and non-emergency transport | Concerns the current public transport infrastructure and routes don’t match the proposed South Wales Programme service model resulting in very long and hard journeys to specialist hospitals. | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Very few people use public transport when they need emergency care but good public transport links are important when visiting loved ones in hospital and for accessing outpatient care, if this is necessary. |
| You told us in engagement you were particularly concerned about whether you could travel to hospital |
Concerns about the frequency and availability of public transport services in the evenings and at weekends, and the need for them to be better aligned to hospital services and visiting times.

Problems for patients and relatives taken to hospital by ambulance but subsequently having to make their own way home

Particular problems for people with sight loss who are largely reliant on public transport and face more complex journeys

High level of concern that an increased reliance on public transport to reach services would particularly impact on older people, disabled people and people with mental health problems and those from deprived communities (see also theme four)

We recognise there may need to be improvements to public transport and are committed to ensuring this happens as part of any implementation process. Once a decision on the way forward is agreed we will be working with local authorities and other community and public transport providers to examine the impact of any changes.

Welsh Ambulance Service non-emergency transport is not a public transport service as its use is determined by clinical need rather than distance.

Arrangements for the future of non-emergency ambulance services are currently being reviewed following the ambulance service review by Professor Siobhan McClelland. Robust non-emergency services will be required to repatriate patients from specialist centres to receive follow-up care nearer to home.

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<th>3. Difficult journeys particularly in bad weather</th>
<th>Concerns about the difficulty of travelling to the specialist hospitals given the geography of some parts of South Wales and South Powys, with particular</th>
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<td>using public transport. We commissioned Swansea University to look at the impact the options for the future of consultant-led maternity and neonatal care, inpatient children's services and emergency medicine (A&amp;E) will have on public transport (bus) travel times for patients in South Wales and South Powys. This very detailed piece of work maps the current provision of bus routes across the region and also highlights those areas where public transport provision is poor.</td>
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<td>4. Deprivation</td>
<td>Concerns about the impact on deprived communities, where levels of ill health and reliance on health services are often higher and incomes are low, as are levels of car ownership. Concerns people would face increased costs if they had to travel further and questions about the availability of financial support to help people facing increased travel costs to reach specialist services.</td>
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<td>Particular concern about the increased costs faced by older people and people with a disability</td>
<td>have to go to a hospital a little further away for part of your care, the rest of your care (for example outpatient appointments, tests and rehabilitation) will be provided in your local hospital if it is safe to do so. In addition where it is appropriate to do so, patients will be repatriated back to their local hospital when their need for specialist services ends. This is currently the pattern for services such as cardiac and neurosurgery.</td>
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<td>In the case of emergency medicine (A&amp;E), the vast majority of people who currently attend A&amp;E departments have minor injuries or an acute medicine problem— for example their long-term condition may have worsened or they may have an infection. These patients will continue to receive care in their local hospital or from standalone minor injuries units in community hospitals, which are staffed by very experienced emergency nurse practitioners.</td>
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<td>Although the South Wales Programme work focuses on four specific hospital services, the contribution of primary care, especially GPs and their teams, will be critical in providing the integrated care patients need. We fully accept that in some areas we will need to strengthen our GP services, particularly in the out-of-hours period. Many people, especially those in our most deprived communities, need more support in the community to help them lead more healthy lives and support them when they are unwell.</td>
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<td>We have already developed plans for significant investment in primary and community services in these areas. These will see an increase in the number of GPs, community nurses and other staff to redress the</td>
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balance and start to make real progress in tackling the inverse care law.

In relation to support for those on a low income, patients are able to reclaim travelling expenses for outpatient appointments and an inpatient stay if they are on certain benefits and they would also be reimbursed the cost of public transport or a mileage allowance for use of the car. The travelling expenses of someone accompanying them would only be paid if they had a letter from their GP or consultant saying that they could not travel on their own. Similarly, a taxi fare would only be reimbursed if the patient had a letter from their GP or consultant. No payments are available to cover the cost of relatives visiting.

Suggestions were made during engagement that there should be greater advertising of how people could reclaim travelling expenses, including adding details to appointment letters. These will be considered as part of any implementation process.

The majority of patients will continue to receive their hospital care locally, just as they do now. But if you do have to go to a hospital a little further away for part of your care we will try and provide the rest of your care (for example outpatient appointments, tests and rehabilitation) in your local hospital if it is safe to do so.

The expectation is that you will not have to travel significantly further for hospital services in South Wales and so there are no plans to provide accommodation for visiting relatives or families additional to those dedicated facilities already available at hospitals.
the “right to a family life” referenced, suggesting that parents who must travel or stay away for maternity care when they have other children at home are denied this right.

Also a major issue where the child in hospital has a disability or complex need and is likely to require longer inpatient stays.

High level of concern about the increased difficulty of access for visitors who are older or who have a disability or a mental health problem.

A suggestion made during engagement to introduce more flexible visiting hours to help visitors who have to travel further or who have specific needs, will be considered as part of any implementation process.

| 6. Car parking and congestion on hospital sites | Comments about the need for additional parking to deal with the increased activity going to the already congested specialist centre sites, including provision for disabled people | ✓ | ✓ | ✓ | ✓ |
| Car parking is a critical issue at many hospital sites. Any increases in demand for parking from patients, relatives and their families will need to be carefully considered by each of the health boards and mapped against future car parking requirements. |
| A suggestion made during engagement to review blue badge parking provision, including the number of spaces and distance to hospital entrances, will be considered as part of any implementation process. |

| 7. Ambulance Services | Concerns about current response times and the ability of Welsh Ambulance Service to cope with the additional demand, the importance of skilled staff in ambulances making longer journeys, and the |
| The Welsh Ambulance Services NHS Trust is a full partner in the South Wales Programme and paramedics have been working alongside other frontline clinicians to develop the service models and work on the options for consultation. |
| Specific work has been carried out as part of the South |
Wales Programme to look at the impact of any changes to the location of consultant-led maternity and neonatal care, inpatient children’s services and emergency medicine (A&E) services on the Welsh Ambulance Service and has identified the additional resources likely to be required to make sure response times are not compromised. All the options have implications for the service, this includes the potential for increased 999 activity as a result of the changes to these services, longer travel times to hospitals and additional patient transfers between hospitals in South Wales.

Ambulance crews may need additional training to increase their clinical skills, giving them additional skills to diagnose and treat patients with different types of illnesses or injuries on scene. Every effort will be made to minimise long journeys and help patients to receive the right care as close to home as possible. Sometimes, such as with serious or complex injuries or illness, it will be better for the patient to travel further and receive the best possible care available the first time. The three air ambulances in Wales can also be used for long distance journeys.

A key part of the Welsh Ambulance Service’s clinical strategy is to reduce the number of patients who are taken to hospital unnecessarily by developing specialist and advanced paramedics who can provide care closer to patients’ homes.

An emergency medical transfer and retrieval service will also need to be developed, and the existing neonatal retrieval service further developed and
extended, to ensure patients admitted to hospitals further away from their homes are able to be cared for closer to home as soon as clinically appropriate.

This may also require additional skills and training for a small number of ambulance service staff and it will need the support of doctors, nurses and midwives involved in a patient’s care.

Investment will also be needed in ambulance control room staffing, leadership teams and support services. Additional clinical support will also be needed in the ambulance service’s clinical contact centre to advise ambulance crews about patient care. Investment in ambulance service estate, vehicles, technology and equipment may also be required.

The service will also develop further in line with the McClelland review which aims for a more clinically-effective service that puts patients at the centre of improvements.

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<th>8. Patient transfers</th>
<th>Concerns about the impact on patient safety if pregnant women have to be transferred to other centres, particularly once labour has started</th>
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<td>Concern that such transfers will occur more frequently if the number of hospitals providing consultant-led services are reduced in number</td>
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All women will continue to have a choice about where they want to have their baby. All women will have the option of giving birth in a consultant-led unit, a midwife-led birth centre or a home birth, when it is safe to do so. Midwives will recommend the most appropriate and safest options for delivery based on a woman’s individual clinical history.

If a woman chooses to give birth in a consultant-led unit, it may mean she will need to travel slightly further to access that service.

If a woman chooses to have her baby at home but
Concerns arise about her or her baby’s wellbeing at any stage during labour, birth or just after, just as currently happens, an emergency ambulance will be contacted to arrange an urgent transfer to the nearest consultant-led unit.

Midwives will discuss this possibility, including the anticipated time for transfer, with women during their pregnancy so they can make an informed decision about where to have their babies.

The Welsh Ambulance Service has very clear protocols and communication pathways agreed with the maternity units to act quickly should unforeseen complications arise. This does not happen often due to appropriate care planning during the antenatal period but it is recognised that systems are required to respond should problems arise.

The Welsh Ambulance Service provides emergency transfers from the existing midwifery-led birthing centres to larger consultant-led units. This experience has ensured that the ambulance service is prepared to support any changes to service provision in a timely manner.

| 9. Neonatal services | Concern that parents of sick neonates would be burdened by additional transport and other costs during their child’s lengthy stay, and that travelling further would take more of their time away from other children or work | ✓ | ✓ | ✓ | ✓ | ✓ |

In the engagement phase, we discussed the need for either two or three neonatal intensive care (level three) units which would be based at UHW, Morriston and SCCC (this will remain at the Royal Gwent Hospital, Newport until the SCCC is completed).

Following extensive feedback about the need to ensure the region has sufficient intensive care capacity, it has been decided that three intensive care units can...
Concern about lack of capacity across South Wales and South Powys

However, we know that there is still a lot to be done to ensure the neonatal network works properly and we will continue to work to improve neonatal care across South Wales and reduce the number of babies needing to travel outside of Wales for this highly-specialised care.

High dependency (level two) neonatal care would be based alongside consultant-led maternity and inpatient children’s services.

In relation to ambulance services, the existing neonatal retrieval service will need to be further developed and extended, to ensure babies born in hospitals further away from their homes are able to be cared for closer to home as soon as clinically appropriate.

| 10. A&E services | Concerns about how current A&E services deal with patients with mental health issues and how changes would affect these service users Concerns that changes could exacerbate problems with ambulance handover times unless A&E procedures are significantly improved | √ | √ | √ | √ | The emergency medicine clinical reference group has prepared a service model which describes how the service aims to improve quality, safety, access and sustainability for patients. Health boards to review policies and procedures in relation to mental health liaison services. |
11. Primary and community services

Comments about the need to strengthen and properly resource primary and community care if the proposed model is to work, including improvements to out-of-hours provision and better integration with social care.

√ √ √

Although the South Wales Programme work focuses on four specific hospital services, the contribution of primary care, especially GPs and their teams, will be critical in providing the integrated care patients need. Health boards fully accept that in some areas we will need to strengthen GP services, particularly in the out-of-hours period. Many people, especially those in our most deprived communities, need more support in the community to help them lead more healthy lives and support them when they are unwell.

Health boards have already developed plans for significant investment in primary and community services in these areas. These will see an increase in the number of GPs, community nurses and other staff to redress the balance and start to make real progress in tackling the inverse care law.

These developments will be instrumental to the success of changes made to hospital services in the future.

√ √

12. Supporting people to be able to access services appropriately

Concerns about how people will know which hospital to go to for different services, particularly in an emergency situation

Comments about the need for services to be made more accessible for people with a disability

√ √ √

The majority of patients who require emergency specialist care will be conveyed to the nearest hospital that provides this service by the Welsh Ambulance Services NHS Trust. However it is acknowledged that some patients will access these services through private transport and therefore it will be extremely important that the public understand which services are available in their local hospital and whether these will meet their needs.

The development of a communication strategy for the public will need to form a key part of any
implementation process. This will need to take account of best practice in communicating with protected characteristic groups and should utilise partner organisation networks.

| 13. Capacity of specialist centres | Concerns about the ability of the specialist centres to cope with additional activity, and the consequent displacement of other services | ✓ ✓ ✓ | ✓ Most patients will continue to be seen at their local hospital, but having some services provided in fewer hospitals means those centres will see an increase in the number and complexity of patients they treat. We have done a lot of work to estimate how many patients will be affected and from where they will come. It is no secret that all our hospitals are already busy: we are working hard to address that. All hospitals in South Wales are very important. We want to make best use of our hospital buildings and so, as we plan to implement any agreed changes, we will look to see what services may need to be transferred to a neighbouring hospital to minimise the need for new building work needed at the specialist centres. We will discuss any such proposals with our community health councils and the public as they are developed. |

| 14. Workforce recruitment | Concern around the ability to recruit and retain sufficient doctors to provide these services given the shortages nationally, and staffing implications for hospitals which are no longer specialist centres | ✓ ✓ ✓ | ✓ Each specialist team has, and is supported by, doctors-in-training – the specialists of the future. We need more of these doctors-in-training because of changes to European legislation governing working hours. And training has become more complex, as medicine becomes more specialised. Doctors-in-training need to see large numbers of patients to ensure they have the necessary experience and skills to specialise. So when they plan their training, not only do they choose hospitals where they |
will see enough patients but they also want to experience how the very best care is delivered and be well supported by consultants as they learn.

At the moment that is not always the case in Wales. Because we are trying to run services in too many places, we have frequent shortages of doctors-in-training and consultants. This means our reputation for high-quality training is not as good as it should be and we are finding it hard to attract doctors in some specialties to come to Wales to train.

Not only does this make providing safe services difficult, it makes it harder to fill consultant posts and impacts on the quality of teaching for the doctors-in-training that we do have – it’s a vicious cycle, which needs urgent attention. The consultants we need are not coming to Wales and are unlikely to move to Wales from elsewhere.

This is a particular problem for the services being discussed in the South Wales Programme. Providing the same services in so many hospitals across South Wales means Wales’ future doctors are not getting the training they need to meet future healthcare needs. The Wales Deanery, which oversees the training of doctors in Wales, believes that concentrating these services in fewer hospitals in South Wales will help to improve training and help the NHS recruit the doctors it needs to provide services.

15. Population changes

Questions about how changing demographics have been taken into account, particularly the growing number of older people

We have looked at the predicted changes in birth rate and age profile of the South Wales and South Powys population in coming years and have applied age-standardised estimations of future demand on these
| 16. Specialist and Critical Care Centre | Concern about the lack of certainty from Welsh Government on the availability of capital to build the SCCC given that it is an integral part of all the options, how services will be provided in the interim and the consequences if it doesn’t go ahead | √ | √ | √ | √ |

An outline business case for the Specialist and Critical Care Centre (SCCC), which is planned to be built near Cwmbran, has been submitted to the Welsh Government, with a capital cost of £242m (at current prices). Funding is being requested from the all-Wales capital programme. This is being considered by Welsh Government through the normal capital process.

The SCCC will provide specialist health services which are currently based at Royal Gwent Hospital, in Newport and Nevill Hall Hospital, in Abergavenny.

The outline business case has been approved by the Welsh Government – an announcement was made by Health Minister Mark Drakeford in October 2013.

A final business case will be need to be submitted by Aneurin Bevan Health Board and approved by the Welsh Government before any work can start on site. The anticipated opening for the new hospital is 2018-19.

It is currently assumed that the SCCC will receive formal approval as it features in all the different options being considered by the South Wales Programme. If the SCCC is not approved, Aneurin Bevan Health Board will face significant challenges in delivering high-quality and sustainable services in these particular specialist areas and would therefore still require significant sums of capital investment to improve local infrastructure regardless of the outcomes from the South Wales Programme.
The SCCC was developed as part of the former Gwent Healthcare NHS Trust’s Clinical Futures Programme for modernising health services in Gwent and South Powys in 2005-06.

The Clinical Futures programme and the development of the SCCC was consulted extensively on by the former trust and involved input and support from more than 3,500 members of the public, various stakeholders and partner organisations including the community health council. Clinical Futures and the building of the SCCC also received formal support from all five of the Gwent local authority organisations. Aneurin Bevan Health Board formally agreed to the centralisation of specialist services on the SCCC in 2006-07.

The plans for the SCCC therefore remain fundamental to the delivery of the Clinical Futures Programme for the Gwent and South Powys population regardless of the outcome of the South Wales Programme.

| 17. Impact on staff | Concern around whether staff will be expected to move base, with a particular concern about the implications for ancillary staff | ✓ | ✓ | ✓ | ✓ | ✓ | The proposed service changes will have an impact on some staff who may require relocation, although the detail of this is yet unknown. The approach we are developing is to promote the South Wales services as an integrated network with a clear vision. This means that we need a workforce that is flexible enough to meet the needs of the service. However, we are committed to work with our staff to maximise work-life balance and understand individual needs as we fully involve staff on this journey and help minimise any unnecessary disruption and travel to individuals. |
affected. Any changes for staff will be considered under the NHS Wales organisational change policy.

It is important to note that there are three fixed points in the South Wales Programme – University Hospital of Wales, in Cardiff; Morriston Hospital, in Swansea and the Specialist and Critical Care Centre, which is planned to be built in Cwmbran. This will help to minimise long distance travel for staff.

Through the development of the service models, we will be looking for new ways of working and we will be developing enhanced and extended roles. We are predicting a further development of our advanced nurse practitioners (ANP) and other nurse practitioner roles and this will provide career development and opportunities for staff who are in traditional nursing roles; predominantly female. This positive impact will strengthen the multidisciplinary team approach and use the strengths of the ANPs, who are already acknowledged as being very valuable in providing effective care to our patients.

All affected staff will be supported by the NHS Wales organisational change policy (2009) in partnership with trade unions. We are committed to engaging and consulting fully with staff throughout the consultation process and thereafter. We recognise our workforce is predominantly female and who are likely to have caring responsibilities. We will give consideration to the provision of different work patterns and or arrangements to facilitate employees' personal circumstances where ever possible whilst ensuring efficient and effective service delivery. This will be
facilitated via a range of relevant workforce policies such as flexible working. Any requirement for reasonable adjustment for staff with disabilities will be facilitated.

Where staff are relocated and this necessitates travelling further to work they are entitled under Agenda for Change terms and conditions to excess travel payments to mitigate against any additional costs involved.

We will ensure a partnership approach with trade union colleagues to achieve an effective transition to the new arrangements.
Meeting the general duty of the Equality Act

To determine whether the South Wales Programme and health boards 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?

Eliminate discrimination

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 for reconfiguration. It is our belief that the potential negative impacts identified are not evidence of direct discrimination but are instead examples of potential indirect discrimination as services are not being closed but instead relocated.

In recognition of the risk of potential indirect discrimination against some protected characteristic groups the South Wales Programme has already begun the process of identifying appropriate mitigation options, and these are outlined in chapter 11 - Themes from South Wales Programme engagement and consultation and options for mitigation.

Promote equality of opportunity

The South Wales Programme is not proposing that services be closed but instead through reconfiguration; concentrate specific services - consultant-led maternity and neonatal care, inpatient children’s services and emergency medicine (A&E) – in four or five hospitals.

In doing so, the South Wales 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 explored (see chapter 11: Themes from South Wales Programme engagement and consultation and options for mitigation).

**Foster good relations between people possessing the protected characteristic and those that do not**

At this stage of the South Wales Programme opportunities to foster good relations have been limited. The public consultation process undertaken by the South Wales Programme has 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.

The consultation process has identified opportunities to promote good relations once the South Wales Programme enters the implementation phase. Advocacy groups for the protected characteristic groups engaged with during the consultation have expressed their wish to be involved in the implementation phase so they can help ensure the needs of all members of the public are given due consideration and the South Wales Programme is supported in its aim of creating centres of excellence for all users.
Appendix A: Abertawe Bro Morgannwg University
Health Board Local Assessment of Equality
Impact

Introduction

This document has been produced as an appendix to the South Wales Programme equality impact assessment (stage two) post-consultation analysis document. It provides the local context to the equality impact assessment for the areas covered by Abertawe Bro Morgannwg University Health Board - Swansea, Neath Port Talbot and Bridgend.

It supplements and should be read in conjunction with the South Wales Programme equality impact assessment (stage two) post-consultation analysis document, which provides an overview of the overall issues which may affect members of the South Wales and South Powys communities who share protected characteristics as defined by the Equality Act 2010.

It has also been considered against the Human Rights Act 1998, particularly Article 2, the right to life, Article 8, the right to privacy and family life and Article 14, Prohibition of Discrimination; and the broader context of the UN convention on the Rights of Persons with Disabilities and the UN Convention on the Rights of the Child, with particular reference to the need to provide access to healthcare.

An outline is given of the ways in which a proportionate approach was taken to consultation with different groups of people within the health board. Any local issues arising from the consultation are identified to highlight the ways in which the proposed service changes could potentially impact differently on different groups of people.

Initial consideration has been given to how the South Wales Programme would respond to the areas of potential differential impact. This analysis is contained within the equality impact assessment stage two post-consultation document. At this stage, it is too early to finalise the detailed recommendations for mitigation locally as this will depend on the option chosen by the health boards later in the year.
What are the implications for Abertawe Bro Morgannwg University Health Board?

The four options for the future of consultant-led maternity and neonatal care, inpatient children’s services and emergency medicine (A&E) are:

Option 1: University Hospital of Wales (UHW), Cardiff; Morriston Hospital, Swansea; Specialist and Critical Care Centre (SCCC), a new hospital which is planned to be built near Cwmbran, and Prince Charles Hospital, in Merthyr Tydfil

Option 2: UHW, Morriston, SCCC and Royal Glamorgan Hospital, in Llantrisant

Option 3: UHW, Morriston, SCCC, Prince Charles Hospital and Princess of Wales Hospital, in Bridgend

Option 4: UHW, Morriston, SCCC and Prince Charles and Royal Glamorgan hospitals

Each of these options has been assessed against a wide range of factors, including their impact on travel times, especially for people living in the most deprived communities; the number of doctors needed, the impact on the Welsh Ambulance Service and a high-level assessment of how much they will cost.

The option which has emerged from the process as having the least impact on all the factors the South Wales Programme has considered, and is therefore classed as the “best fit”, is option three – concentrating these services in five hospitals: UHW, Morriston, SCCC, Prince Charles and Princess of Wales hospitals.

None of our hospitals will be closing as part of this work. We will not be losing any of our A&E departments but there will be changes in exactly what is delivered in each of those departments.

Consultation with Abertawe Bro Morgannwg University Health Board equality groups

The five health boards worked collaboratively to undertake the formal consultation phase of the South Wales Programme. We took a proportionate approach to the legislative requirement to consult equality groups as described within the main equality impact assessment stage two post-consultation analysis document. As part of this collaboration, we recognised
that the nature of the consultation would vary depending on the equality forums, organisations and support groups that existed locally.

Abertawe Bro Morgannwg University Health Board undertook local consultation with equality groups. The health board worked with Swansea Council for Voluntary Service, Neath Port Talbot Council for Voluntary Service and Bridgend Association of Voluntary Organisations to raise awareness of the consultation with local voluntary organisations.

The Councils for Voluntary Services sent letters providing details of the South Wales Programme consultation, where to find information and offers of meetings to the organisations on their databases. Many of these voluntary organisations work with service users from equality groups.

As part of the planning for the consultation, it was recognised that the Bridgend and the surrounding areas were more likely to be affected by the proposed service changes than other parts of the health board. In response to increased potential impact on equality groups, there was more targeted engagement with different population groups in Bridgend than other areas.

Towards the start of the consultation, an Abertawe Bro Morgannwg representative gave a presentation on the South Wales Programme to the Bridgend Equality Forum. This forum is a group of people representing different local, voluntary and public sector organisations, which meet regularly to raise, discuss and tackle local equality-related issues. The forum is co-ordinated and supported by Bridgend County Borough Council and a health board representative is a member of the forum.

The Bridgend Equality Forum welcomed the opportunity to receive information about the consultation and identified new contacts in the local community who the health board could approach to participate in the consultation. This led to a higher level of participation from local equality groups, including Bridgend People First, the Bridgend Deaf Club and Mental Health Matters Wales.

After a detailed briefing, Bridgend People First facilitated consultation events for people with learning disabilities at five venues – Bridgend Resource Centre, Pyle Adult Support Service, Cwm Calon Day Services, Maesteg, Ty Pen y Bont Day Services, Bridgend and the Carpentry Wood Project, Tondu. Important adjustments were made to the standardised consultation approach to enable participation:
• Three film clips - Getting ready to go into hospital; Admission onto a hospital ward and Having an x-ray and a CT scan, acted as a starting point for the session and to set the scene for the consultation
• A powerpoint presentation created by Bridgend People First on the proposed changes and background information
• A ‘Going into hospital’ quiz.

These five ‘Have your Say’ events were attended by 86 people who traditionally have not participated in consultations on proposed service changes. The use of the easy read document and questionnaire also helped the participants to contribute their views.

Adjustments were also made to the consultation event held at Bridgend Deaf Club. Two British Sign Language Interpreters provided interpretation at the event, which was held on the evening that the club regularly meets.

Health board representatives visited the Bridgend wellbeing drop-in centre held at Nolton Church Hall. Mental Health Matters Wales recommended this venue as the mental health support group was well attended. The proposals were discussed on a one-to-one basis with the participants who were given support to participate in the consultation.

In addition to those referenced above, a health board representative made presentations to the following local equality groups:
• Maternity Services Liaison Committee
• Bridgend Carers Group
• ABM Stakeholder Reference Group
• SHOUT: The Voice of the Older Person
• ABM Patient Experience Forum
• Regional Equality Group
• Swansea Bay Lesbian, Gay, Bisexual and Transgender Forum
• ABM Disability Reference Group
• Swansea Disability Forum
• Gorseinon Visually Impaired Group
• Swansea Deaf Club
• Swansea Black and Minority Ethnic Forum.

Audio CDs and Braille copies were made available for the local RNIB officer to give these out at visual impairment groups.

**Open questionnaire** – Organisations responding from ABM University Health Board area with links to protected characteristics:
ABM neonatal services
ABM mental health directorate
Bridgend Association of Voluntary Organisations
Bridgend College, students’ union
Bridgend County Borough Council fostering services
Bridgend People First
Bridgend Visual Impairment Society
C.A.M.E.O. Ladies Group, Porthcawl
Cimla Over 50s Group, Neath Port Talbot Older People’s Council
Neath Port Talbot Birth Centre, midwifery team
Pencoed Women’s Institute
Porthcawl SHOUT Forum
Princess of Wales Hospital, department of mental health
Princess of Wales Hospital, A&E, children’s services and maternity departments
Princess of Wales Hospital, department of speech and language therapy
SHOUT Maesteg
SHOUT Kenfig Hill
Starfish Community Social and mental health peer support, Bridgend
Stoneleigh Court, retirement apartments, Porthcawl
Royal College of Midwives, Neath Port Talbot, Bridgend and Swansea branches
Tir Iarl Women’s Institute, Bridgend

Written submissions from Abertawe Bro Morgannwg with relevance to the protected characteristics:

Professional bodies and NHS organisations
Royal College of Midwives (Neath Port Talbot, Bridgend and Swansea)
Royal College of Nursing Wales (Bro Morgannwg)
Royal College of Nursing Wales (Swansea)

NHS staff groups
Maternity Services Liaison Committee, ABM University Health Board
Midwifery and gynaecology services, ABM University Health Board
Primary care medicines management team, ABM University Health Board
Pharmacy directorate, ABM University Health Board
Supervisors of midwives, ABM University Health Board
Acute paediatricians, Morriston Hospital
Medical Staff Advisory Committee, Princess of Wales locality
Labour ward co-ordinators, Princess of Wales Hospital
Anaesthetic department, Princess of Wales Hospital
Paediatric department, Princess of Wales Hospital
Emergency department, Princess of Wales Hospital
Obstetrics and gynaecology consultants, Princess of Wales Hospital

22 responses were received from individual ABM staff members.

Consultation activity undertaken by ABM University Health Board included meetings with a range of groups relevant to equality and protected characteristics. Data was collected on the protected characteristics of people attending public meetings and respondents to the South Wales Programme questionnaire, this included:
Equality profile of people who attended public meetings
Respondent profile from the open questionnaire and residents’ survey
Equality slides in the ORS presentation

**Service users and demographic profile**

The following analysis is based on tabular information contained in the South Wales Programme equality impact assessment stage two post-consultation analysis document.

**Gender**
The gender split for the Abertawe Bro Morgannwg area mirrors very closely the gender split for Wales as a whole. Approximately a 50:50 split with slightly more females (50.7%) than males (49.3%). Women are more dependent on public transport (National Travel Survey, Department of Transport 2011), which is relevant to their access to consultant led maternity and neonatal care and inpatient paediatric services.

**Age**
ABM has a lower proportion of its populations aged 0-44 years, and a higher proportion in the older age bands (45-64 years, 65-84 years, and 85 years plus) than Wales as a whole. This is relevant to proposed changes to emergency medicine (A&E) provision as older people are more likely to experience ill health and are less likely to have access to a car.

**Disability**
ABM has a disabled population proportion higher than the percentage figure for Wales as a whole - 25% for ABM compared to 22.3% for Wales. At a local authority level, Neath Port Talbot has the highest proportion (16.1%) of residents in the South Wales Programme area who declare that their day-to-day activities are limited a lot and the highest proportion whose activities are limited a little (11.9%). This is consistent with the age profile as more than...
half of men and women over 65 years say that they have a limiting long-term illness (How Fair is Wales? 2011).

During the South Wales Programme consultation it was said that disabled people and those with mental health problems find it harder to access services as not all can (or afford to) use public transport. Disabled people are less confident in using public transport because of physical access issues but also because of staff attitudes (Framework for Action on Independent Living 2012).

People with sensory loss and people with learning disabilities may experience some difficulties accessing services on sites further away, which are unfamiliar to them.

**Ethnicity**
Overall, the ABM area is slightly less ethnically diverse than Wales as a whole, with 3.9% black and minority ethnic (BME) population compared to 4.4% BME population nationally.

However, the overall ABM BME percentage masks the ethnically diverse population centre in Swansea. This area has a higher BME population of 6% compared to the other ABM local authorities, as it is one of the four Welsh asylum seekers dispersal areas.

It has been documented that maternity services fail to provide adequate support to women from ethnic minority backgrounds (Equality and Human Rights Commission Review 2010). There can also be issues in relation to slightly lower birth weights of babies from BME groups.

**Marriage and Civil Partnership**
The 2011 Census data shows that the overall ABM population proportions for marriage and civil partnership closely mirrors the population proportions for Wales as a whole. Single and married make up the bulk of all marital/civil partnerships statuses, accounting for 33.7% and 46% respectively in the ABM area and 33.5% and 46.6% in Wales. The number of registered same-sex civil partnerships accounts for only 0.2% of all marital/civil partnerships statuses across Wales, and this pattern is repeated across ABM.

**Religion**
With regards to religion, the ABM population profile closely mirrors Wales as a whole. ABM has high numbers of people who either identify as Christian (55.7%) or no religion (34.7%).
Non-Christian religions make up only 2.3% of the overall population in the ABM area; this is lower than the figure of 2.7% for Wales as a whole. There is variation between the local authorities in terms of non-Christian religions. The highest proportion is 3.6% in Swansea with the remaining local authorities having proportions around 1.2% (Neath Port Talbot) and 1.3% (Bridgend).

Neither marriage, civil partnership nor religion featured significantly in the consultation feedback. Sexuality and transgender information is not currently available.

The following groups do not constitute protected characteristics but are relevant when considering issues relating to the groups already listed.

**Welsh language**

Welsh language skills in the South Wales Programme area are lower than in Wales as a whole. Within the South Wales Programme area, only 3.8% of the population can understand spoken Welsh only. There are significant differences between health boards and between local authorities in this area.

At a health board level, Welsh language skills are highest in Powys Teaching Board, and lowest in Aneurin Bevan. The ABM population with Welsh language skills across the three categories is shown below.

**Table 26: Welsh language profile by local authorities for ABM (Source: Table KS208WA 2011 Census, ONS).†**

<table>
<thead>
<tr>
<th>Region</th>
<th>Can understand spoken Welsh only</th>
<th>Can speak Welsh</th>
<th>Can speak, read and write Welsh</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABM</td>
<td>5.4%</td>
<td>12.0%</td>
<td>8.6%</td>
<td>500,978</td>
</tr>
<tr>
<td>Swansea</td>
<td>5.5%</td>
<td>11.4%</td>
<td>8.1%</td>
<td>231,155</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>6.4%</td>
<td>15.3%</td>
<td>10.8%</td>
<td>135,278</td>
</tr>
<tr>
<td>Bridgend</td>
<td>4.1%</td>
<td>9.7%</td>
<td>7.3%</td>
<td>134,545</td>
</tr>
<tr>
<td>South Wales Programme*</td>
<td>3.8%</td>
<td>11.3%</td>
<td>8.4%</td>
<td>1,857,611</td>
</tr>
<tr>
<td>Wales</td>
<td>5.3%</td>
<td>19.0%</td>
<td>14.6%</td>
<td>2,955,841</td>
</tr>
</tbody>
</table>

†All usual residents aged 3 years and over.

**Car or van ownership**

The 2011 Census data shows that the proportion of households with no car or van is higher in the ABM area than for Wales as a whole, 24.7% in the ABM area compared to 22.9% for Wales.

Across the ABM area, the proportion of households with access to at least one car or van is 43.5%, similar to the value for Wales as a whole (43.0%).

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This proportion is also consistent across the local authorities within the ABM area.

**Deprivation**
The 2011 Census data shows levels of deprivation for the ABM area in total are very similar to the figures for Wales as a whole. Across the ABM area and Wales, the largest proportion of households are not deprived in any dimension and this proportion decreases as the number of deprivation dimensions experienced increases.

For the ABM area as a whole, approximately a third of households in the area are deprived in one dimension, and just under a fifth deprived in two dimensions, and less than 1% are deprived in four dimensions.

When comparing local authorities within the ABM area, there is a great deal of variation. Neath Port Talbot (33.6%) has the lowest proportion of households not deprived in any dimension of the local authorities within ABM.

Higher levels of deprivation have implications for access to transport and health generally. People in deprived areas are likely to report a range of key illnesses, which is relevant to the services under consideration.

**Health**
The self-reported general health of the population in the ABM area is generally good with approximately three quarters (76.2%) stating their health was either good or very good. However, this is slightly below the Welsh percentage (77.8%). The health board also has a population proportion (8.9%) higher than the Welsh percentage (7.6%) reporting bad or very bad health.

At the local authority level, Neath Port Talbot has a population proportion (10.5%) higher than the Welsh figure (7.6%) reporting either bad or very bad health.

**Residents who assess their general health status as bad or very bad**
All three local authorities within Abertawe Bro Morgannwg University Health Board are above the Welsh average, ranging from slightly above at 8.1% in Swansea to 10.5% in Neath Port Talbot.

There is considerable variation at the lower super output area level within the health board. However these are crude percentages only and do not take into account the age structure of the population. The proportion of residents reporting bad or very bad health ranged from one in 50 residents in the
Uplands area of Swansea (Swansea LSOA 026E) to just under one in five residents in Cymmer in Neath Port Talbot (Neath Port Talbot LSOA 011B). The areas with the highest percentages are found in the Castle areas of Swansea, the Neath North, Sandfields and Cymmer areas of Neath Port Talbot and in Caerau in Bridgend.

Figure 2: Residents who assess their general health status as bad or very bad in ABM, March 2011.

![Map of Wales showing the percentage of residents who assess their general health status as bad or very bad in March 2011.]

Residents whose daily activities were limited by a long-term health problem or disability
In Wales just over a fifth (22.7%) of residents’ day-to-day activities are limited a lot or a little by a long-term health problem. Among Welsh local authorities, Neath Port Talbot had the highest percentage of residents whose day-to-day activities are limited a lot or a little by a long-term health problem at 28%. All three local authorities in ABM were above the Welsh average, ranging from 23.3% in Swansea to 28% in Neath Port Talbot.
At the lower super output area level, the percentage of residents whose day-to-day activities are limited a lot or a little by a long-term health problem range from 7.7% in the Bryntirion, Laleston and Merthyr Mawr areas of Bridgend (Bridgend LSOA 017E) to 42% in the Neath North area of Neath Port Talbot (Neath Port Talbot LSOA 008D). These are crude percentages only and do not take into account the age structure of the population. The areas with the highest percentages are found in the Castle area of Swansea, Sandfields East, Sandfields West and Neath North areas of Neath Port Talbot and the Caerau area in Bridgend.

Residents aged 16-74 years who have never worked or are long-term unemployed
In Wales, 5.4% of the working age population have never worked or are long-term unemployed. Neath Port Talbot and Bridgend local authorities were above the Welsh average. Swansea is slightly below the Welsh average at 5.2%. At the lower super output area level, the percentage of working age residents who have never worked or are long-term unemployed range from 0.9% in the Uplands area of Swansea (Swansea LSOA 0224B) to 17.2% in the Townhill area of Swansea (Swansea LSOA 0224B). These are crude
percentages only and do not take into account the age structure of the population. The areas with the highest percentages are found in the Penderry and Townhill areas of Swansea, Sandfields West and Cymmer areas of Neath Port Talbot and in Coity in Bridgend.

**Figure 4: Residents aged 16-74 years who have never worked or are long-term unemployed in ABM, March 2011.**

Lone parents
Analysis of 2011 Census data shows that across the ABM area lone parent households are predominately female, 90.8% of households in the ABM area, and 89.6% of households for Wales as a whole.

Employment patterns for male and female lone parent households differ with male lone parents more likely to be in full-time employment than part-time employment. Approximately the same number of male lone parent households are in full-time employment as those not in employment.

In contrast, female lone parent households are more likely to be in part-time employment than full-time employment. Female lone parent households are also approximately twice as likely to not be in employment, than in full-time
employment. The proportion of male lone parent households in the ABM area is 9.3%.

The high number of female lone parent households could have a potential impact in terms of accessing all the four services, particularly when they are likely to have other children at home.

Unpaid carers
The majority of residents in the ABM (86.8%) area and Wales (87.9%) provide no unpaid care. This is relatively consistent across the health board.

The 2011 Census data shows that the proportion of people providing unpaid care in the ABM area is around 7% for one to 19 hours of unpaid care, decreasing to 2% for 20 to 49 hours of unpaid care, but then increasing to 4% to 5% for 50 or more hours of unpaid care.

At a health board level, ABM and Cwm Taf have the highest proportions of unpaid care provision, both reporting 2.0% for 20 to 49 hours of unpaid care, and 4% for 50 or more hours of unpaid care.

At a local authority level for 20 to 49 hours of unpaid care, Neath Port Talbot and Blaenau Gwent have the highest proportion of unpaid care, both reporting 2.3%. For 50 or more hours of unpaid care at a local authority level, Neath Port Talbot has the highest proportion (4.8%).

Demographic profiles of service users
Analysis of the demographic profiles of service users for emergency medicine (A&E), paediatrics and obstetrics and gynaecology is contained within the main equality impact assessment stage two post-consultation analysis document.

Staff Profile
Abertawe Bro Morgannwg University Health Board staff are 78% female and 22% male; 30% have declared they are heterosexual; 15 people have declared they are bisexual; 25 gay and 11 lesbian. Twenty-one per cent have declared they are Christian; 4% say other; 3% atheist and 31 have declared they are Hindu; 30 Islam; 11 Buddhist and 10 Sikh. There is a fairly equal split of staff between the 25-45 and 46-64 age groups and low numbers in the younger or older age groups.

Forty-seven per cent of staff have declared they are white; 2% have declared they are Asian and there is small representation in black, mixed and other groups.
Changes to travel arrangements and working arrangements (including shift patterns) are likely to be the main issues for staff. This could have a greater potential impact on those staff with family or caring commitments; staff who are older or disabled for the reasons outlined in previous sections. Individual circumstances and related issues would be addressed under the NHS Wales Organisational Change Policy. This is particularly relevant to any staff with disabilities, as some have not been declared.

**Consultation responses – equality perspective**

This section should be read in conjunction with the equality impact assessment evidence document.

The following information is relevant to this analysis:

- Equality profile of people who attended public meetings
- Comments from people who attended public meetings
- Contributors to submissions and questionnaire
- Equality codes from public meetings
- Equality codes from question five
- Equality forms from public meetings
- Respondent profile from open questions and residents survey
- Equality slides
- Equality themes from open questions
- Open questionnaire – organisations responding from Abertawe Bro Morgannwg University Health Board with links to protected characteristics.

**Summary of Key Issues**

The equality impact assessment stage two post-consultation analysis document provides a schedule of key issues, which have a potential impact on protected groups.

The Opinion Research Services consultation outcomes executive summary report covers the equality issues raised during the consultation in terms of the impact on people with protected characteristics.

Each of the highlighted issues has been reviewed from an Abertawe Bro Morgannwg perspective using information provided by respondents from this area. In terms of protected characteristics, the majority of comments specifically relate to age, disability, pregnancy and maternity. This is to be
expected given the nature of the services under consideration as part of the South Wales Programme.

**Increased travel times**
This issue relates to any impact on patient safety and outcomes if travel times are longer, particularly for time critical interventions. ABM has a higher proportion of its populations in the older age bands than Wales as a whole. These residents are more likely to require access to emergency medicine (A&E) services.

The ORS executive summary highlights one of the main reasons for respondents supporting option three – the “best fit” includes that areas such as Porthcawl have many older and frailer patients needing increasing hospitals visits.

More specifically, the ORS report highlights that comments in support of the Princess of Wales Hospital, in Bridgend includes:

- It serves some of the deprived valleys communities with above average levels of chronic conditions and communities in the Vale of Glamorgan with sizeable retired populations;
- Without full provision there, access to services from coastal Bridgend and the Llynfi, Garw and Ogmore valleys (where there are many older people and people living on low incomes with a reliance on public transport) would be poor;
- Lengthy, and sometimes costly, journeys to hospitals other than the Princess of Wales Hospital will place a burden on patients and visitors (especially those on low incomes and the elderly) and may compromise patient safety.

Specific consultation responses highlighted the following potential impacts on children, parents and women:

- The Princess of Wales Hospital serves one of the largest special needs schools (Heronsbridge School) in Wales. Should children who have seizures travel 15 or 26 miles compared to the two miles they travel currently? The Princess of Wales Hospital also has a NHS hospice on site and terminally ill patients have rapid symptom control following admission from A&E. – ABM resident;
- A single mother – an ABM resident – with two children aged seven and three questioned how people would cope in an emergency if they had to travel to Swansea and Cardiff, especially with young children;
• For women with communication issues then familiarity of the unit is important so there is a need to balance safe staffing with providing as many local units as possible - Maternity Services Liaison Committee, ABM UHB.

Public transport and non-emergency transport
As there is an increasingly ageing population across South Wales and South Powys, many older patients and visitors are accessing hospital services and rely on public transport to get there. There is a need for integrated and strengthened transport services across the South Wales Programme area (and especially in rural parts) to expedite travel times and costs for patients and visitors.

• ABM UHB’s Health Professionals Forum commented it should be ensured: “The concentration of services does not impede access and compound existing health inequalities.”

One of the main issues and themes from the public meetings was public and community transport. Access to health services was the most common issue raised across all meetings – and one of the most frequently expressed concerns was in relation to hospital access by public transport for both patients and visitors. The following comment is one of many made by participants:

“In a lot of these consultations, transport always comes up, if you live in Croeserw it’s an awful journey to get to Port Talbot let alone further away, and these difficulties are for the families. I hope you consider flexible visiting hours because buses stop at 6.30pm to Croeserw and visiting is usually in the evening.” (Aberavon).

The National Clinical Forum commented that travel distance and times have been considered, but further work is needed in relation to public transport. The challenges for people taken to A&E by ambulance, who may then be told that they are free to return home (with no transport and significant distance to travel), is not addressed. Given the relative proximity of the hospitals in South Wales, the times and distances may not be as extreme as for other parts of Wales, but the lower valleys poses some access issues.

The Third Sector in Bridgend suggested that, with fewer specialist centres across South Wales, community transport will become increasingly important.
Deprivation
The impact of the proposals on deprived communities is of relevance to areas of ABM. Comments received during the consultation included:

“We are acutely aware of the need to maintain good access to all parts of the health system, especially for older or more vulnerable people and those living in some of our most deprived communities. Without regional service in Princess of Wales Hospital, the communities in the coastal areas of Bridgend and the Llynfi Valley would be significantly disadvantaged in terms of access to services. This would be especially difficult for some of the most vulnerable people in South Wales as these are communities with many older people and people living on low incomes. They and their families will often be reliant on public transport to reach a regional centre” - Bridgend County Borough Council.

Access issues for visitors
The consultation highlighted the particular difficulties visitors may experience in accessing more distant hospitals, especially if they have to do so using public transport. It was noted this would have implications for visitors travelling to see a loved one who has a lengthy hospital stay in terms of time and transport costs. This would be exacerbated if the patient is in a hospital some distance from home and exacerbated if the journey involved traversing local authority boundaries, which public transport routes have not traditionally been planned to cross. In terms of potential impact, this would be particularly relevant to parents with a child in hospital but who also have commitments to other children or work, and for parents who stay in hospital with a sick child and pop home when needed. It was commented that support services should be developed for families whose loved ones are accessing services a long way from home or over a prolonged period of time.

There was an overall view that ready access for visitors - beneficial for patient morale and outcomes and often provide practical support - should be a priority for the South Wales Programme:

- If services are reduced at Princess of Wales Hospital, parents of sick children will be unable to pop back home to care for their families and unborn babies will be put at risk - Parent from ABM;
- Neath Port Talbot Council for Voluntary Services suggested that, as they can play a key role in a patient’s care and provide practical support, wards should be flexible and enable close relatives and carers to visit outside set hours;
- There is general understanding that visiting hours are in the evenings. Many people can’t go out in the dark (for example, a person with
glaucoma has been told not to drive at night too often) or feel uncomfortable doing so, especially the elderly. Could you ensure that people are told at the beginning of their stay that visiting can be arranged during the day for the next of kin and primary carers - Breathe Easy Neath Valley (British Lung Foundation Wales);

- The RCN branch would like to voice its concerns about transport for vulnerable groups; elderly couples; young families; isolated communities, especially at evenings and bank holidays. Felt it important that elderly frail people must be repatriated near to home. This concern was highlighted by the current planned closures of community hospitals. Concerned about investment into current community nursing teams - RCN Bro Morgannwg branch response.

**Ambulance Service**

The ambulance service was one of the main issues and themes raised in the consultation. This is particularly relevant to older people who are more likely to be accessing A&E.

Public meeting attendees were commonly concerned about the implications of the proposed changes for the ambulance service. These were particularly prevalent in the South Wales valleys and in the catchment areas for the Princess of Wales, Royal Glamorgan and Nevill Hall hospitals.

Many of the concerns were based on personal experiences of response time (and thus treatment) delays:

“There is a golden hour for saving people from accidents and this is not compatible with ambulances travelling to Cardiff at busy times of the day.” (Maesteg)

Several participants questioned how stroke and heart attack patients will receive prompt and appropriate treatment given that some will face lengthier journeys to one of the new specialist centres. The public meeting panel, and particularly the representative from the Welsh Ambulance Services NHS Trust, gave reassurance that paramedics and ambulance crews are fully trained in providing emergency intervention in such circumstances and will always take a patient to the most appropriate hospital.

The following points were raised at the public meetings in the ABM area:

- With a stroke, there is a tight timeframe for getting people to hospital. If we go with option three, will the Princess of Wales become more equitable? That is, will stroke victims going to the Princess of Wales
have access to care 24/7 at that site? Will they have access to thrombolysis? (Bridgend);

- If an individual were to have a stroke where would they go for emergency care and what would happen if they died on route to a hospital further away than their current local hospital? (Tondu).

**Patient transfers**
The Opinion Research Services analysis of the consultation responses highlights concerns expressed by respondents about the potential for increased risk to women and babies during intrapartum transfers between consultant-led and non consultant-led units (including at home). The following comment is an example of concerns expressed by ABM residents:

> “Woman gave birth to her third son. The birth was very quick and the cord snapped resulting in my son having a lack of blood. Would not have made it to Swansea or Cardiff. Losing services at the Princess of Wales Hospital would put people like [myself] and [my] son in great danger” - ABM resident.

**Neonatal services**
There are concerns that parents of sick neonates would be burdened by additional transport and other costs during their child’s lengthy stay if the hospital was some distance from home. This would be exacerbated if the parents have commitments to other children or work.

**A&E services**
Many contributors considered strengthened primary and community care services (including social care) to be essential in reducing demand on secondary care.

The consultation submissions raised specific concerns about how A&E deals with people with mental health issues. In terms of particular issues for ABM, the following was raised at a Bridgend public meeting:

> “I am representing Starfish – a mental health group from Bridgend. We are especially worried about mental health triage … people are more likely to finish their course of treatment if they are kept local … Delocalisation will mean that more people will [leave] the system and … not finish their treatment. [We] see the response to the mental health crisis at all A&Es as appalling. Out-of-hours is staffed with practitioners who lack mental health awareness and first aid for mental health issues. Will access to these services improve as a result of this consultation?”
The following comment was made in support of A&E at the Princess of Wales Hospital:

- There is an active on-site day hospital for frail older people that supports the A&E function and helps prevent A&E admissions. It can perform fast multidisciplinary frailty assessments and coordinate same-day discharge to the community where appropriate and urgent investigation and medical assessment can be done quickly as the unit is on the same site.

**Supporting people to access services appropriately**
A few respondents expressed concerns about how people will know which hospital to go to for different services, particularly in an emergency. This would be particularly relevant for certain groups who are often younger people, single parents, older people and people living in deprived areas. Access may be more difficult for those people who have a sensory loss or learning disability. Particular comments included:

- Whatever the outcome of the consultation, the changes need to be publicised widely, particularly with regards to emergency medicine. Not all young people are currently aware of the different levels of A&E care provided at different hospitals and how some hospitals have particular specialities. Some do not know about the minor injury unit at Neath Port Talbot Hospital. It is therefore crucial that information around A&E services is provided to everyone following the changes - Neath Port Talbot Youth Council.

**Workforce recruitment**
This relates to concerns expressed around the ability to recruit and retain sufficient doctors. This did not relate to any particular protected characteristic groups.

**Population changes**
Questions were asked about how changing demographics have been taken into account, particularly the growing number of older people in the population.

At the St Brides Major public meeting, it was commented:

There are issues regarding the wellbeing and welfare of, and services for, older people. There are 23,000 in the western Vale and 30,000 in Bridgend. How will the South Wales Programme address these demographic changes and the increase in older people?
Impact on staff
This relates to whether some staff will be expected to move base. From the workforce analysis, it is evident that a higher proportion of female staff could be affected than male staff.

Mitigation

As part of the equality impact assessment, the South Wales Programme is considering the views expressed by those who may be affected by proposed service changes and what is already known about how the proposals might affect different groups of people. The programme has used national evidence, Public Health Wales information, Census data, travel times and distances to hospitals, and public and staff views to identify issues. The main equality impact assessment stage two post-consultation analysis document identifies the issues common to the whole South Wales Programme.

Central to the equality impact assessment is the consideration of actions to mitigate adverse impacts. Consideration is being 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 South Wales Programme has reached stage two of its equality impact assessment, the post consultation pre-decision stage. The consultation will consider four different options including a best fit option. The issues and initial mitigations are described within the equality impact assessment document. 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 three of the equality impact assessment process. For this reason, any issues and mitigations described at this stage must be considered preliminary, not exhaustive, and untested at this stage by the clinical reference groups and stakeholders.

Summation: Meeting the general duty of the Equality Act (2010)

The public sector equality duty, referred to as the general equality duty, is set out in the Equality Act 2010. It requires Abertawe Bro Morgannwg University Health Board, in the exercise of its functions, to consciously consider the requirements set out in the general equality duty. This is described as having due regard.

The equality impact assessment document represents a real attempt to address the following questions in relation to the equality impacts of the South Wales Programme:
• Does it help eliminate discrimination?
• Does it help promote equality of opportunity?
• Does it help foster good relations between people possessing the protected characteristic and those that do not?

Where potential equality issues have been raised, these have been identified and explored in order to put forward possible mitigation, avoidance of discrimination against any particular groups of people and the promotion of equality. This has involved consultation with different groups in relation to the protected characteristics in accordance with the Equality Act (2010) through the use of appropriate media, fora and by building on existing relationships. Attendance at public meetings and completion of questionnaires has been monitored and reported.

The composition of the local population (2011 Census and Public Health information) has been analysed and the protected characteristics of staff to avoid discrimination caused by potential service changes, although this would be considered on an individual basis under the terms of the NHS Wales Organisational Change Policy once an option is agreed.

This is the second stage of the equality impact assessment process and a third stage will be undertaken once the option is agreed.
Appendix B: Aneurin Bevan University Health Board
Local Assessment of Equality Impact

Introduction

This document has been produced as an appendix to the South Wales Programme equality impact assessment (stage two). It provides the local context to the equality impact assessment for the areas covered by Aneurin Bevan University Health Board.

It supplements and should be read in conjunction with the South Wales Programme equality impact assessment evidence document stage one, which was produced in May 2013 (revisited October 2013 as stage two) and provides an overview of the overall issues which may affect members of the South Wales and South Powys communities who share protected characteristics as defined by the Equality Act 2010. It has also been considered against the Human Rights Act 1998, particularly Article 2, the right to life, Article 8, the right to privacy and family life and Article 14, Prohibition of Discrimination; and the broader context of the UN convention on the Rights of Persons with Disabilities and the UN Convention on the Rights of the Child, with particular reference to the need to provide access to healthcare.

An outline is given of the ways in which a proportionate approach was taken to consultation with different groups of people within the health board. Issues arising from the consultation are identified within the main equality impact assessment to highlight the ways in which the proposed service changes could potentially impact differently on different groups of people.

Initial consideration has been given to how the South Wales Programme would respond to the areas of potential differential impact. This analysis is contained within the equality impact assessment (stage two) document. At this stage, it is too early to finalise the detailed recommendations for mitigation locally. This will be explored further at the appropriate stage of the South Wales Programme work.

What are the implications for Aneurin Bevan University Health Board?

The four options for the future of consultant-led maternity and neonatal care, inpatient children’s services and emergency medicine (A&E) are:
Option 1: University Hospital of Wales (UHW), Cardiff; Morriston Hospital, Swansea; Specialist and Critical Care Centre (SCCC), a new hospital which is planned to be built near Cwmbran and Prince Charles Hospital, in Merthyr Tydfil

Option 2: UHW, Morriston, SCCC and Royal Glamorgan Hospital, in Llantrisant

Option 3: UHW, Morriston, SCCC, Prince Charles Hospital and Princess of Wales Hospital, in Bridgend

Option 4: UHW, Morriston, SCCC and Prince Charles and Royal Glamorgan hospitals

Each of these options has been assessed against a wide range of factors, including their impact on travel times, especially for people living in the most deprived communities; the number of doctors needed, the impact on the Welsh Ambulance Service and a high-level assessment of how much they will cost.

The option which has emerged from the process as having the least impact on all the factors the South Wales Programme has considered, and is therefore classed as the best fit, is option three – concentrating these services in five hospitals: UHW, Morriston, SCCC, Prince Charles and Princess of Wales hospitals.

None of our hospitals will be closing as part of this work. We will not be losing any of our A&E departments but there will be changes in exactly what is delivered in each of those departments.

Consultation with equality groups in Aneurin Bevan University Health Board

The five health boards worked collaboratively to undertake the formal consultation phase of the South Wales Programme. We took a proportionate approach to the legislative requirement to consult equality groups as described within the main equality impact assessment evidence document. As part of this collaboration, we recognised that the nature of the consultation would vary depending on the equality forums, organisations and support groups that existed locally.

In addition to the schedule of public meetings Aneurin Bevan University Health Board undertook local consultation across a broad range of fora. This included a number of equality groups, for example youth forums, older persons groups and Gwent Association of Voluntary Organisations. We are fortunate to have a large number of groups for older people including the 50-plus network and partnership groups across the boroughs, Newport Senior Citizen Forum and Gwent NHS Retirement Fellowship. A specific meeting was held for the Patient Panel, which reflects a number of the protected characteristics, including disability. A meeting was also held in conjunction with the other health boards with the Stakeholder
Reference Group hosted by the NHS Wales Centre for Equality and Human Rights.

Distribution of information relating to details of the South Wales Programme consultation and awareness of public meetings were widely circulated at local level. Gwent Association of Voluntary Organisations and Torfaen Voluntary Alliance were asked to distribute to their networks. Many of these groups were specifically related to protected characteristics.

Established links with other partners and organisations, such as the local authorities for Blaenau Gwent, Caerphilly, Newport, Monmouthshire and Torfaen; the South East Wales Equality Council; local service boards; community councils; Churches Together in Wales (CYTUN); Muslim Council of Wales and local mosques; the Prison Service (HMP Usk and Prescoed) and the Stakeholder Reference Group, were also used.

A written submission was received from the Royal Gwent Hospital maxillofacial consultants.

Opinion Research Services (ORS) collected data on the protected characteristics of respondents to the South Wales Programme consultation, including people who attended public meetings:

- Equality profile of people who attended equality meetings
- Contributors to submissions and questionnaire
- Respondent profile from open questions and residents survey
- Equality slides

### Aneurin Bevan University Health board population and service users

#### Demographic profile
The following analysis is based on tabular information contained in the equality impact assessment evidence document.

Aneurin Bevan University Health Board provides services for five localities - Blaenau Gwent, Caerphilly, Monmouthshire, Newport, and Torfaen, including some services for people living in South Powys.
**Gender**
Aneurin Bevan has slightly higher proportions of female residents and this is broadly consistent with the wider South Wales Programme area and Wales (see Table 5 in the *Error! Reference source not found.* equality impact assessment evidence document).

**Age**
In terms of age profile (see Table 6 in the *Error! Reference source not found.* equality impact assessment evidence document) there are some slight variations in the South Wales Programme area compared to Wales as a whole.

Powys is one of two exceptions among the South Wales Programme health boards as it has a lower proportion of the population aged 0-44 years, and a higher proportion in the older age bands (45-64 years, 65-84 years, and 85 years plus) than Wales as a whole.

Among the South Wales Programme local authorities Powys and Monmouthshire have the largest population proportions aged 85 years and older, 22.7% for Powys and 20.9% for Monmouthshire.

It is recognised that older people are less likely to have access to a car.

**Disability**
The proportion of people identifying themselves as disabled in the South Wales Programme area as a whole is slightly higher than the proportion in Wales as a whole, 23% compared to 22.7% (see Table 7 in main EIA). Monmouthshire (20.1%) and Newport (20.8%), however, stand out with the lowest population proportions reporting a disability.

In the communities where disability is higher, there could be implications in terms of transport as people who have a disability are twice as likely to have no access to a car than people without a disability (Office for Disability Issues, 2009). Disabled people are also less confident in using public transport because of physical access issues and because of staff attitudes (Framework for Action on Independent Living, 2012).

Mental health patients are more likely to present at A&E than some other groups.

**Public Health Wales data on disability**
As already noted, in Wales just over a fifth (22.7%) of residents’ day-to-day activities are limited a lot or a little by a long-term health problem. Two local authorities in Aneurin Bevan University Health Board are below the Welsh average - Monmouthshire and Newport.
Caerphilly, Blaenau Gwent and Torfaen are all above the Welsh average ranging from 24.1% to 27.2%. In Welsh local authorities, Neath Port Talbot had the highest percentage of residents whose day-to-day activities are limited a lot or a little by a long-term health problem at 28% compared to Cardiff which had the lowest proportion at 18%.

**Figure 5: Residents whose daily activities are limited a lot or a little by a long-term health problem or disability in Aneurin Bevan UHB, March 2011**

![Map showing residents whose daily activities are limited by long-term health problems in Aneurin Bevan UHB, March 2011.](image-url)
At the lower super output area level, the percentage of residents whose day-to-day activities are limited a lot or a little by a long-term health problem ranged from 7.3% in the St. Martins area of Caerphilly (Caerphilly LSOA 024F) to 36.3% in the Gaer area of Newport (Newport LSOA 017B). It is important to note that these are crude percentages only and do not take into account the age structure of the population. The areas with the highest percentages are found in the Crosskeys and Cefn Fforest areas of Caerphilly, Tredegar Central and West and Sirhowy in Blaenau Gwent and in the Gaer in Newport.

**Ethnicity**

Overall, the South Wales Programme area is slightly more ethnically diverse than Wales as a whole, with 5.6% black and minority ethnic (BME) population compared to 4.4% BME population nationally (see Table 8 in equality impact assessment document). However the overall South Wales Programme BME percentage masks two highly ethnically diverse population centres. This includes Cardiff and Newport, which is in Aneurin Bevan University Health Board area. Newport’s BME population is 10.1% of the total population in Newport.

Due to the presence of Cardiff and Newport within the South Wales Programme area, and the small BME populations in Wales outside these cities, the South Wales Programme area contains 80.4% of the total Welsh BME population. Cardiff accounts for 39.2% of the total Welsh BME population, and Newport 10.9%.

It has been documented nationally that maternity services can fail to provide adequate support to women from ethnic minority backgrounds (Equality and Human Rights Commission Review, 2010). There can also be issues in relation to slightly lower birth weights of babies from BME groups.

**Marriage and civil partnership**

The number of people who are married or in a same-sex civil partnership is the same as for the South Wales Programme health boards and Wales as a whole (see Table 9 in equality impact assessment document). It is notable that the number of registered same-sex civil partnerships accounts for only 0.2% of all marital/civil partnerships statuses across Wales, and this pattern is repeated across nearly all South Wales Programme health boards with the exception of Newport where it is 0.4%.

**Religion**

The South Wales Programme area population profile closely mirrors Wales as a whole (see Table 10 in the equality impact assessment evidence document). In general the South Wales Programme area and Wales have high numbers of people who either identify as Christian (54.4%) or no religion (34.8%).
While there are variations in the South Wales Programme area in the proportion identifying as Christian (Blaenau Gwent is the lowest at 49.9%, and Powys the highest at 61.8%), most of the variation is due to differences in numbers stating they have no religion, rather than increases in the proportion of non-Christian religions.

While non-Christian religions make up only 3.4% of the overall population in the South Wales Programme area, this is higher than the figure of 2.7% for Wales as a whole. This is due to the more ethnically diverse populations in Newport and Cardiff which accounts for the bulk of the non-Christian religions in the South Wales Programme area, with Cardiff and Newport reporting non-Christian faith percentages of 9.7% and 5.9% respectively.

Outside Newport and Cardiff there tends to be little variation between local authorities in terms of non-Christian religions. The lowest proportion is 0.9% in Blaenau Gwent; the remaining local authorities have proportions around 1.2% and 1.3%.

**Car or van ownership**
The 2011 Census data shows that the proportion of households with no car or van is higher in the South Wales Programme area than for Wales as a whole, 25.1% in the region compared to 22.9% for Wales (see Table 17 in the equality impact assessment evidence document).

Comparing the South Wales Programme health boards, Powys has the lowest proportion of households with no car or van at 15%. Blaenau Gwent (29.0%) is one of three South Wales Programme areas that have the highest proportion of households with no car or van. Powys (15.0%) and Monmouthshire (15.2%) have the lowest proportion of households with no car or van.

Transport issues have been raised consistently throughout the consultation, with concerns relating to reaching A&E and visiting arrangements with particular reference to supporting older persons and staying with children in hospital and the potential impact this could have on family life.

**Deprivation**
The dimensions of deprivation used to classify households are indicators based on the four household characteristics related to employment, education, health and disability and housing. A household can be classified as being deprived in none, or one to four of these dimensions in any combination.
The 2011 Census data shows that the levels of deprivation for South Wales Programme area in total are very similar to the figures for Wales as a whole (see Table 14 in the equality impact assessment evidence document). Within the South Wales Programme area, however, there is a great deal of variation.

Monmouthshire (46.2%) and Powys Teaching Health Board (41.6%) have one of the highest proportion of households **not** deprived in any dimension. However, Blaenau Gwent (10.8%) has the highest proportion of households deprived in three or more dimensions.

People in deprived areas are likely to report a range of illnesses and long-term conditions that are relevant to the services under consideration.

**General health**
The self-reported general health of the population in the South Wales Programme area is generally good with approximately three quarters (77.3%) stating their health was either good or very good, slightly below the figure for Wales (77.8%) (see Table 18 in the equality impact assessment evidence document).

Aneurin Bevan University Health Board is one of three South Wales Programme health boards with a population proportion below the Welsh percentage (77.8%) reporting good or very good health. We also have population proportions higher than the Welsh percentage (7.6%) reporting bad or very bad health with Blaenau Gwent reporting 10.7%.

Powys Teaching Health Board (6.1%) and Monmouthshire (5.9%) have the lowest population proportions reporting either bad or very bad health.

**Public Health Wales data on residents who assess their general health status as bad or very bad**
In Wales 7.6% of residents assessed their general health status as bad or very bad. The majority of local authorities with the highest rates of bad or very bad health are situated in the South Wales valleys. Two of the local authorities in Aneurin Bevan University Health Board were below the Welsh average - Monmouthshire and Newport. Caerphilly, Blaenau Gwent and Torfaen were above the Welsh average ranging from 8.7% to 10.7%.

Merthyr Tydfil had the highest proportion of residents who described their health status as bad or very bad at 11.2% compared to Gwynedd, which had the lowest proportion at 5.3%.

At the lower super output area level within the health board the proportion of residents reporting bad or very bad health ranged from 2.1% in the St. Martins
area of Caerphilly (Caerphilly LSOA 024F) to 18.3% in the Sirhowy area of Blaenau Gwent (Blaenau Gwent LSOA 003B). The areas with the highest percentages are found in the Pillgwenlly area of Newport, Twyn Carno and Bargoed areas of Caerphilly and in Sirhowy in Blaenau Gwent. However, these are crude percentages only and do not take into account the age structure of the population.

**Figure 6: Residents who assess their general health status as bad or very bad in Aneurin Bevan UHB, March 2011**
Lone parents
Analysis of 2011 Census data shows that across Wales and the South Wales Programme area lone parent households are predominately female, 90.4% of households in the region, and 89.6% of households for Wales as a whole (see Table 15 in the equality impact assessment evidence document).

Employment patterns for male and female lone parent households differ, with male lone parents more likely to be in full-time employment than part-time employment. Approximately the same number of male lone parent households are in full-time employment as those not in employment.

In contrast, female lone parent households are more likely to be in part-time employment than full-time employment. Female lone parent households are also approximately twice as likely to not be in employment, than in full-time employment.

While the proportions for the South Wales Programme area in total mirrors closely the proportions for Wales as a whole, there is noticeable variation within the South Wales Programme area between health boards and between local authorities. Typically, the proportion of male lone parent households in the SWP area is between 8% and 10%, however, Powys Teaching Health Board is a significant outlier with 16.4% of its lone parent household male. Aneurin Bevan (10.5%) has the next highest proportion of male lone parent households.

Being a lone parent could have implications for access to all four of the relevant services, particularly for example, if the lone parent has a child in hospital and others at home.

Unpaid carers
The majority of residents in the South Wales Programme area (87.8%) and Wales (87.9%) provide no unpaid care, and this is relatively consistent across the South Wales Programme area at both health board and local authority level (see Table 16 in the equality impact assessment evidence document).

The 2011 Census data shows that the proportion of people providing unpaid care in the South Wales Programme area is around 6% to 7% for one to 19 hours of unpaid care, decreasing to 1% to 2% for 20 to 49 hours of unpaid care, but then increasing to 3% to 4% for 50 or more hours of unpaid care. Blaenau Gwent is one of two areas that have the highest proportion of unpaid care, reporting 2.3%.
Residents aged 16-74 years who have never worked or are long-term unemployed
In Wales, 5.4% of the working age population have never worked or long-term unemployed.

Figure 7: Residents aged 16-74 years who have never worked or are long-term unemployed in Aneurin Bevan UHB, March 2011

In Aneurin Bevan University Health Board, all local authorities are above the Welsh average with the exception of Monmouthshire, which has a rate of 3.6%. In Welsh local authorities, Blaenau Gwent had the highest proportion of the
population who have never worked or are long-term unemployed at 8.7% compared to Ceredigion, which had the lowest rate of unemployment at 3.1%.

At the lower super output area level the percentage of residents who have never worked or are long-term unemployed ranges from 0.9% in the Caerleon area of Newport (Newport LSOA 001B) to 21.7% in the Pillgwenlly area of Newport (Newport LSOA 018D). It is important to note that these are crude percentages only and do not take into account the age structure of the population. The areas with the highest percentages are found in the Victoria and Pillgwenlly areas of Newport and in the St. James, Bargoed and Twyn Carno areas of Caerphilly.

Welsh language
Welsh language skills in the South Wales Programme area are lower than in Wales as a whole - only 3.8% of the population can understand spoken Welsh. However there are significant differences between health boards and between local authorities in the South Wales Programme area.

At a health board level Welsh language skills are highest in Powys Teaching Board, and lowest in Aneurin Bevan.

Table 27: Welsh language skills by local authority area.

<table>
<thead>
<tr>
<th>Region</th>
<th>Can understand spoken Welsh only</th>
<th>Can speak Welsh</th>
<th>Can speak, read and write Welsh</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aneurin Bevan</td>
<td>2.5%</td>
<td>9.9%</td>
<td>7.2%</td>
<td>555,622</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>3.0%</td>
<td>11.2%</td>
<td>8.4%</td>
<td>171,972</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>2.2%</td>
<td>7.8%</td>
<td>5.5%</td>
<td>67,348</td>
</tr>
<tr>
<td>Torfaen</td>
<td>2.3%</td>
<td>9.8%</td>
<td>7.1%</td>
<td>87,844</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>2.5%</td>
<td>9.9%</td>
<td>7.2%</td>
<td>88,609</td>
</tr>
<tr>
<td>Newport</td>
<td>2.2%</td>
<td>9.3%</td>
<td>6.5%</td>
<td>139,849</td>
</tr>
<tr>
<td>Powys</td>
<td>6.7%</td>
<td>18.6%</td>
<td>13.7%</td>
<td>129,083</td>
</tr>
<tr>
<td>South Powys*</td>
<td>6.7%</td>
<td>18.6%</td>
<td>13.7%</td>
<td>64,542</td>
</tr>
</tbody>
</table>

Demographic profiles of service users
Analysis of the demographic profiles of service users for emergency medicine (A&E), paediatrics and obstetrics and gynaecology is contained in the ‘Demographic profile of service users’ section of the equality impact assessment evidence document.
Staff profile

It is recognised that some equality data for staff is incomplete and steps are being undertaken to address this, for example data on disability and sexual orientation is very limited.

Aneurin Bevan University Health Board currently employs 12,481 people; 80% female and 20% male. Sexual orientation split shows 39% have declared they are heterosexual, 17 people are bisexual, 46 gay and 23 lesbian. It is recognised, however more than 7,000 people have either left this field blank or have declined to answer this question.

Religious belief split shows 26% Christian; 5% other; 555 declared they are atheist; 56 Hindu; 116 Islam and 21 Buddhist.

There is a fairly equal split of staff between 25-45 (46.03%) and 46-64 (48.55%) age groups and minimal numbers in the younger (586 people) and older age groups (133 people).

The ethnicity profile shows 73% of staff describe themselves as white; 2.02% as Asian and there is a small representation in black, mixed and other groups.

Changes to travel arrangements and working arrangements (shifts, etc) are likely to be the main issues for staff and this could be particularly difficult for those with family or caring commitments; staff who are older or disabled for the all the reasons outlined in previous sections. Individual circumstances and related issues would be addressed under the All-Wales Organisational Change Procedure. This is particularly relevant to disability, although, in the main, it is not currently known who may be affected.

Consultation responses – equality perspective

This section should be read in conjunction with the equality impact assessment evidence document. The following information from the Opinion Research Services consultation outcomes report is relevant to this analysis:

- Equality profile of people who attended equality meetings
- Comments from people who attended public meetings
- Contributors to submissions and questionnaire
- Equality codes from public meetings
- Equality codes from question five
- Equality forms from public meetings
- Respondent profile from open questions and residents survey
Equality presentation slides

Summary of key issues
A summary of the key themes to emerge from the engagement and consultation phases of the South Wales Programme can be found in the equality impact assessment evidence document. It describes the issues raised under each theme, identifies which equality protected characteristic groups the issues potentially impact upon and provides an initial response in relation to actions to mitigate against any negative impacts.

These will be revisited both at a South Wales Programme and local level once a decision on the way forward has been made.

The ORS consultation outcomes summary identifies that the majority of responses identify issues in relation to impacts on people with protected characteristics concerned with age, disability, pregnancy and maternity. The themes and issues are now discussed in relation to any issues identified as specific to the Aneurin Bevan University Health Board area.

Increased travel times
This issue relates to any impact on patient safety if travel times are longer. Residents of South Powys in particular expressed concerns:

- “Only Nevill Hall Hospital can be reached within the ‘golden hour’ from South and mid-Powys areas.” (Talgarth Town Council and Petitions Group)
- Some people already travel considerable distances for services at Nevill Hall. Under the South Wales Programme, the next nearest facility for specialist services will be either PCH or the SCCC - which is at least 13 miles further than Nevill Hall for South Powys residents. As such, the importance of maintaining and upgrading services at Prince Charles Hospital was noted (as was the need for Hereford Hospital, which some areas of South Powys are highly dependent on, to remain at its current operating level).

Public transport and non-emergency transport
The issue of travel and transport was raised and the need to improve public transport links. This has particular impact for older people and people who are disabled.

The National Clinical Forum identified its concerns with potential travel issues:

“Travel distance and times have been considered, but further work is needed in relation to public transport. The challenges for people taken to A&E by ambulance, who may then be told that they are free to return home (with no
transport and significant distance to travel), is not addressed. Given the relative proximity of the hospitals in South Wales, the times and distances may not be as extreme as for other parts of Wales, but the lower valleys poses some access issues. The situation for patients in South Powys is particularly important if the final option does not include Prince Charles Hospital as travel times may be significant.”

Comments were also received in relation to the poor links to the Llanfrechfa site from north Gwent and South Powys. Providing good transport links to the new hospital (from all directions) was considered imperative in ensuring equality of access to all those within its catchment area.

**Difficult journeys particularly in bad weather**
South Powys residents highlighted difficult road networks, especially over the Brecon Beacons where they are subject to harsh winter conditions. There are considerable challenges in transporting patients from this area to and from hospital – and in patients and visitors reaching hospitals themselves.

Respondents from South Powys were very concerned about the implications of losing consultant-led services from Nevill Hall Hospital.

**Access issues for visitors**
The main concerns raised under this theme relate to increased difficulty of access for visitors who are older people, or who have a disability and the impact on families who might have to travel further to visit children in hospital.

Torfaen councillors cited access and parking problems at the Royal Gwent Hospital and suggested that current A&E facilities at both the Royal Gwent and Nevill Hall hospitals are not fit for purpose.

**Ambulance services**
Concerns were expressed about the ability of the ambulance service to deal with additional demands that the proposal places on them.

**Patient transfers**
This issue primarily related to concerns about pregnant women requiring transfer from a non consultant-led unit.

**Neonatal services**
Concerns were raised that parents of sick neonates would be burdened by additional transport and other costs if a child’s stay is lengthy.
A&E services
Although there were concerns raised about the pressures already being faced by A&E services, there were few comments that related specifically to any of the protected characteristics.

Monmouthshire County Council’s adult select committee suggested public misconceptions about the closure of A&E departments must be addressed. The committee - and the Aneurin Bevan Patients Panel - felt that residents need reassurance that no hospitals are to close and that some degree of emergency services will be provided at all hospitals.

The Torfaen Youth Forum commented that having people with widely varying levels of illness or injury in A&E is unhelpful and that different types of care must be provided in different places. In Bristol, emergency services are apparently organised into emergency, not so serious and follow-up – and they felt that doing something similar in Wales would be sensible.

Paediatrics
The Police and Crime Commissioner for Dyfed Powys said Nevill Hall Hospital is used for 60% of police investigations requiring child medical examinations for Breconshire. The South Wales Programme will thus significantly impact on policing in terms of time, resources, providing police escorts or interviewing patients and casualties.

Primary and community services
Some people highlighted the need for a whole systems approach to be adopted and for the need for more investment in primary and community services for the proposals to be effective.

Supporting people to access services appropriately
Many people highlighted the need to educate and inform people about how to access services appropriately and to ensure people know where to go for what services. The need to provide information in accessible formats and ways that would be suitable for different communities was also raised.

Workforce recruitment
Concerns were expressed about the ability to recruit and retain staff did not relate to any particular protected characteristic groups.

Specialist Critical Care Centre (SCCC)
Concerns were expressed about whether the SCCC would be built and the impact on the South Wales Programme if the SCCC is not approved. Others identified that the potential impact on other services must be factored in:
The Royal College of Radiologists’ Standing Welsh Committee supports the case for the SCCC and centralising services on five sites. While identifying benefits associated with the South Wales Programme proposals, it said the proposals would increase pressures on acute radiology and that key IT and other issues will need to be addressed;

Torfaen-based respondents (and Monmouthshire County Council and Chepstow Town Council) welcomed the proposed development of the SCCC and its inclusion in all four options. They considered Cwmbran to be a wholly appropriate location for the facility as it is easy to access, making it ideal for the ambulance service and for patients and visitors from across the health board area. But they stressed the need to ensure adequate interim arrangements until the centre opens (although it was acknowledged that sustaining rotas at both Nevill Hall and Royal Gwent hospitals will be a challenge);

Others expressed concern about the lack of certainty from the Welsh Government on the availability of capital to build the SCCC given it is an integral part of all the options;

If it does receive the go-ahead, people sought reassurance about how services will be provided by Aneurin Bevan Health Board until it is operational in 2018-19.

**South Powys**

There was a general sense that, as South Powys is less densely populated than South Wales and is receiving services from other health boards such as Aneurin Bevan University Health Board; it is always liable to lose out in the allocation of resources. Indeed, several comments were made along the lines of:

“People in South Powys are already getting a poor deal in terms of medical services due to the sparsity of the population and this plan would further disadvantage them.” (Hay Health and Social Care Group)

“Care must be safe and serve the needs of the whole population. It is not clear how this is going to be achieved for the people of South Powys, as it appears to be an urban-orientated plan… it is a rural, low-wage area with a diverse, sparse population which is very different from the population of South Wales. It therefore has very different needs which need to be addressed.” (Hay Health and Social Care Group)

Travel and transport issues were frequently raised by South Powys-based respondents, particularly with respect to:
Impact on staff
This relates to whether some staff will be expected to move base. From the workforce analysis it is evident that proportionally more female staff could be affected than male staff.

Mitigation
An effective equality impact assessment takes into account the views and opinions of those who may be affected by the policy and what is already known about how the policy might affect different groups. The South Wales Programme has used national evidence, Public Health Wales information, Census data, travel times and distances to hospitals, and public views to identify issues. Issues common to the whole programme have been set out in with the main body of the equality impact assessment evidence document.

The consideration of mitigating measures and alternative ways of doing things is at the heart of the equality impact assessment process. Different options have been developed which reflect different ways of delivering the South Wales Programme aims. The consideration of mitigation of adverse impacts is intertwined with the consideration of alternative actions. Mitigation can take the form of lessening the severity of the adverse impact.

Consideration must be given to whether separate or combined actions are necessary for the South Wales Programme to be effective for any relevant group. Ways of delivering the programme’s aims, which have a less adverse effect on the relevant equality category or issue or which better promote equality of opportunity for the relevant equality category have been considered.

However, it must be emphasised that the South Wales Programme has only reached stage two of its equality impact assessment, the post consultation pre-decision stage. The consultation was to consider four options including a best fit option. The issues and initial mitigations described within the equality impact assessment reflect that. The mitigations are currently expressed at high level. These will need to be worked through together with any further issues and mitigations once a decision on a preferred option has been made. This will be the focus of stage three of the equality impact assessment process. For this reason, any issues and mitigations described in at this stage (stage two) must be considered to be preliminary, not exhaustive, and to be untested at this stage by the clinical reference groups and stakeholders.
Summation: Meeting the general duty of the Equality Act (2010)

The public sector equality duty, referred to as the general equality duty is set out in the Equality Act (2010). The general equality duty requires Aneurin Bevan University Health Board in the exercise of its functions to consciously consider the requirements set out in the general equality duty. This is described as having due regard.

The information included in this section, together with the information contained in the body of the equality impact assessment evidence document is a real attempt to address the following questions in relation to the equality impacts of the South Wales Programme:

- Does it help eliminate discrimination?
- Does it help promote equality of opportunity?
- Does it help to foster good relations between people possessing a protected characteristic and those that do not?

Where any concerns relating to equality have been raised, these have been identified and explored in order to establish possible mitigation, avoidance of discrimination against any particular groups and the promotion of equality. This has involved consultation with different groups in relation to the protected characteristics in accordance with the Equality Act (2010) through the use of appropriate media, fora and by building on existing relationships. Attendance at public meetings, completion of questionnaires etc has been monitored and reported.

The composition of the local population (2011 Census and Public Health information) has been analysed and the protected characteristics of staff to avoid discrimination caused by potential service changes, although this would be considered on an individual basis under the terms of the organisational change policy once an option is agreed.

This is the second stage of the equality impact assessment process and a third stage will be undertaken once the option is agreed.
Appendix C: Cardiff and Vale University Health Board Local Assessment of Equality Impact

Introduction

This document supplements and should be read in conjunction with the South Wales Programme equality impact assessment evidence document stage one produced in May 2013 (revisited October 2013 as stage two) which provides an overview of the overall issues which may affect members of the South Wales and South Powys communities who share protected characteristics as defined by the Equality Act 2010.

It has also been considered against the Human Rights Act 1998, particularly Article 2, the right to life, Article 8, the right to privacy and family life and Article 14, Prohibition of Discrimination; and the broader context of the UN convention on the Rights of Persons with Disabilities and the UN Convention on the Rights of the Child, with particular reference to the need to provide access to healthcare.

The intention of this document is not to repeat information contained in the evidence documents but to consider firstly, how the proposed changes could affect the local community, with particular reference to the four options where appropriate. Secondly, to consider how the staff currently employed in the specialist services could be affected by the South Wales Programme.

This assessment is based on Public Health Observatory and Census information, staffing information held by each health board on the Electronic Staff Record (ESR) system and findings collated and analysed by Opinion Research Services (ORS) from the public consultation. It is limited to data that is available at present and has been prepared without the benefit of the full ORS analysis of the public consultation.

What are the implications for Cardiff and Vale University Health Board?

The South Wales Programme consulted on four options for the future of consultant-led maternity and neonatal care, inpatient children’s services and emergency medicine (A&E). During the engagement and consultation phases of the South Wales Programme, we explained that three hospitals are considered to be fixed points because of the range of services they already provide and the size of the population they cover: University Hospital of Wales (UHW) Cardiff; Morriston Hospital, Swansea; Specialist and Critical Care Centre (SCCC) – a new
hospital to be built near Cwmbran. Three other hospitals were considered in
relation to a fourth or possibly fifth location for these specialist services.
Consultation focused on consideration of four options for the provision of these
specialist services at either four or five hospitals in the future.

The four options for the future of consultant-led maternity services, neonatal care,
inpatient children’s services and emergency medicine (A&E) are:

**Option 1**: UHW, Morriston, SCCC, and Prince Charles Hospital, in Merthyr Tydfil
**Option 2**: UHW, Morriston, SCCC and Royal Glamorgan Hospital, in Llantrisant
**Option 3**: UHW, Morriston, SCCC, Prince Charles Hospital and Princess of
Wales Hospital, in Bridgend
**Option 4**: UHW, Morriston, SCCC and Prince Charles and Royal Glamorgan
hospitals

Each of these options has been assessed against a wide range of factors,
including their safety and sustainability; impact on travel times, especially for
people living in the most deprived communities; the number of doctors needed,
the impact on the Welsh Ambulance Service, the likely cost of such change and
what we were told last year during engagement.

The option which struck the best balance between all these factors, and was
therefore identified as the best fit option, was **option three** – concentrating these
services in five hospitals: UHW, Morriston, SCCC, Prince Charles and Princess of
Wales hospitals.

Concentrating these services in fewer locations would mean some other services
in those centres would also need to move. For example, if services are
concentrated according to option three, some services – planned surgery and
some acute medicine – may need to move from Princess of Wales and UHW to
the Royal Glamorgan Hospital. In this scenario, Royal Glamorgan Hospital would
provide health services for its local population and some care for people living in
the Bridgend, Cardiff and the Vale of Glamorgan and potentially elsewhere across
South Wales depending on the future role of the hospital.

**What are the implications for residents of Cardiff and the Vale of
Glamorgan and staff working for Cardiff and Vale University Health Board?**
The majority of residents of Cardiff and the Vale of Glamorgan access consultant-
led maternity services, neonatal care, inpatient children’s services and emergency
medicine (A&E) from the University Hospital of Wales, which is one of the fixed
sites; that access will not change under any of the proposals. However, some
residents in the Vale of Glamorgan currently access these specialist services from Princess of Wales Hospital, Bridgend or the Royal Glamorgan Hospital, Llantrisant. For these residents, the location of where they would access these specialist services could change; provision of these specialist services at Princess of Wales Hospital and the Royal Glamorgan Hospital are affected differently under each of the consultation options.

In relation to staff working for Cardiff and Vale University Health Board, the only services directly affected by the consultation are those based in the University Hospital of Wales which is one of the fixed sites. While there is therefore no initial direct impact on Cardiff and Vale UHB staff this will need to be revisited once the way forward has been agreed and wider implications of service moves have been identified.

**Consultation with equality groups in Cardiff and the Vale of Glamorgan**

Each of the five health boards has contributed to a collaborative approach and this is summarised in the main equality impact assessment evidence document. As part of this collaboration, specific health boards led on consultation with particular groups – for example, Cardiff and Vale for black and other minority ethnic groups; Cwm Taf for deaf people and ABM for people with learning disabilities.

A schedule of consultation activity undertaken locally by Cardiff and Vale University Health Board is attached at the end of this appendix. This included meetings, workshops and a variety of communications with a range of groups relevant to equality and protected characteristics.

The health board worked with the two county voluntary councils (Vale Centre for Voluntary Services and Cardiff Third Sector Council) to reach third sector and community organisations working with service users with protected characteristics, providing details of the South Wales Programme consultation, where to find information and encouraging them to become involved in consultation.

Links with other partners, for example in the local authorities, were also utilised to encourage cascading of information through their networks to promote awareness of the consultation and encourage responses.

Presentations to or discussions with specific groups included the following:

- 50-plus forums in Cardiff and the Vale of Glamorgan
- Youth councils in Cardiff and the Vale of Glamorgan
- Diverse Cymru Disability Access Group
- Race Equality First
- ABCD Cymru
- Cardiff and Vale Maternity Services Liaison Committee
- Third Sector workshop facilitated by VCVS and C3SC

ORS collected data on the protected characteristics of respondents to the open questionnaire, the residents’ survey and participants in the public meetings and this is summarised in the ORS consultation outcomes documents. These include:

- Equality profile of people who attended equality meetings
- Contributors to submissions and questionnaire
- Respondent profile from open questions and residents survey

**Service users and demographic profile**

Understanding the health and demographic trends in Cardiff and the Vale of Glamorgan is important to us. Demography tells us about local people, such as their age, gender, ethnicity, where they live and other characteristics. Some of the key information and analysis is presented here and is primarily based on tabular information contained in the equality impact assessment evidence document as well as other national evidence.

**Age**

Cardiff and the Vale of Glamorgan’s population is growing quickly, especially in Cardiff. At present there are around 470,000 people who live in Cardiff and Vale. Cardiff has a higher proportion of 16-24 years, and 25-44 years than the rest of the South Wales Programme area which could be relevant to maternity provision. However in the older age range of 45-64 years, 65-84 years, and 85 years plus these proportions in Cardiff and the Vale are smaller than the rest of Wales.

Between the Census of 2001 and the latest Census in 2011, the number of people living in Cardiff rose by 13%, more than double the Welsh average of 5.5%. The make up of the population is also changing, with an even larger increase in the number of people aged over 85 as life expectancy increases and premature death falls. In Cardiff and Vale this section of the population rose by 32% in between the censuses, also outstripping the Wales average of 28%. There are currently around 10,000 people aged over 85 in Cardiff and Vale. The number of infants and young children has also risen significantly in Cardiff, with the 0-4 age group increasing by 17% compared with a rise of 6% on average across Wales, which is relevant to changes to neonatal and paediatric provision. There was no increase
in the Vale of Glamorgan. Cardiff has a younger population than a great deal of the rest of Wales which could impact on consultant obstetric services.

By 2023, it is expected that the overall population of Cardiff and Vale will increase to 550,000, a rise of 20%, more than double that forecast for the whole of Wales. The population aged 85 and over in Cardiff and Vale is estimated to have risen to nearly 15,000, an increase of around 50% and this could be relevant to emergency medicine (A&E) in terms of strokes, heart attacks, for example.

It is well recognised that older people are more likely to experience ill health and are also less likely to have access to a car and whilst some admissions to emergency medicine (A&E) would warrant ambulance transportation, this could still impact on access to this service and also for visiting if their partner, spouse or carer is admitted to one the hospitals which have emergency care provision direct from A&E.

**Disability**
Cardiff and Vale University Health Board has the lowest reported disabled population (18.6%) among the South Wales Programme health boards. It has the lowest proportion (9.4%) of residents who declare that their day-to-day activities are limited a lot and the lowest proportion (9.2%) whose activities are limited a little. This is consistent with the age profile as more than half of men and women over 65 years say that they have a limiting long term illness (How Fair is Wales? 2011).

Mental health patients are more likely to present at A&E than some other groups and concerns have been raised during the consultation process that this group tend to experience problems at this stage. Increased travel could also be problematic for these patients.

This could have implications in terms of transport as people who have a disability are twice as likely to have no access to a car as people with a disability (Office for Disability Issues 2009). Disabled people are also less confident in using public transport because of physical access issues but also because of staff attitudes (Framework for Action on Independent Living 2012).

There could also be problems for people who have sensory impairments or a learning disability accessing different sites which are further away from their familiar surroundings and travel routes to appointments.

**Ethnicity**
Cardiff and Vale University Health Board has the highest representation from ethnic groups other than white compared with the other South Wales Programme
health boards and Wales as a whole. It should be noted that Cardiff is one of four local authorities in Wales which are designated asylum dispersal areas. Asylum seekers who are dispersed to Cardiff represent approximately 57% of the total number dispersed around Wales. This potentially has an impact on all areas of service provision. Language can represent a barrier in accessing public transport (Public Transport Needs of Black and Minority Ethnic and Faith Communities, Department of Transport 2003).

**Maternity and pregnancy**
It has been documented that maternity services fail to provide adequate support to women from ethnic minority backgrounds (Equality ad Human Rights Commission Review 2010) and this should be noted even though numbers are small. There can also be issues in relation to slightly lower birth weights of babies from black and other minority ethnic groups.

However there are some gaps in the existing knowledge of maternity care. Significant gaps remain in the collection of statistics in the UK, let alone Wales or even Cardiff and Vale. This is problematic particularly in relation to women as they more likely to suffer frequently than men from chronic less easily classifiable health problems.

**Marriage and civil partnership**
The number of people who are married or in a same-sex civil partnership is broadly the same as for the South Wales Programme health boards and Wales as a whole. However for Cardiff and Vale University Health Board, it should be noted that it has the largest difference in the single and married categories.

**Religion**
The number of people who state their religion is broadly the same as for the South Wales Programme health boards and Wales as a whole. There is lower representation in every religious group than is seen in South Wales Programme and Wales as a whole. There are numerous religions, faiths and beliefs practised in Cardiff and the Vale of Glamorgan. However more research is needed to deal with the extent to which equality of opportunity concerns in relation to health are relevant to religious groups who may have specific needs which have not yet been discovered, because of a lack of research.

Ward (1998) highlighted the needs of Asian people with learning difficulties and their carers. It was noted that Asian carers had low awareness and usage of specialist services for people with learning difficulties, and that existing services were likely to neglect their religious and cultural needs and those of their relatives with learning difficulties. For those involved in the South Wales Programme it was essential that this research was taken into account and so a specific consultation
event with the ABCD project was arranged. This is a project, which is a Cardiff-based all-Wales charity, whose aim is to improve access to services for black and minority ethnic children and young people with disabilities and/or chronic illnesses.

It should be noted that neither marriage and civil partnership nor religion featured significantly in the consultation feedback.

**Sexual orientation**
Analysis of sexual orientation within the main equality impact assessment document draws upon data from the ONS integrated household survey (see table 11). This survey shows that at 3%, Cardiff and the Vale of Glamorgan has the highest proportion of people identifying as lesbian gay and bisexual among the South Wales Programme regions. The proportion of people identifying as lesbian gay and bisexual in Cardiff and Vale is three times the proportion for Wales as a whole (1%).

**Transgender**
As highlighted in the main equality impact assessment document there is no official estimate of the transgender population. The England and Wales Census, and Scottish Census do not ask people whether they identify as transgender.

**Welsh language**
Welsh language skills in the Cardiff and Vale University Health Board area are lower than in Wales as a whole. Within the area 11% can speak Welsh and 3.1% of the population can understand spoken Welsh. If more patients come to UHW as a result of the South Wales Programme, the higher proportion of Welsh spoken in other areas could impact on the request for more Welsh language provision than currently takes place.

The following groups do not constitute protected characteristics but are relevant in considering issues in relation to the groups already listed.

**Car or van ownership**
The 2011 Census shows that when comparing the South Wales Programme health boards, Cardiff has one of the highest proportions (29%) of households with no car or van. The Vale of Glamorgan has one of the lowest proportions (19.4%) of households who have no car or van. This is particularly relevant to the transport concern raised consistently in every aspect of the consultation; this would include self presentation at A&E, visiting arrangements with particular reference to supporting and staying with children in hospital. It is worth noting however that as an urban area Cardiff has good public transport links. For the majority of residents of Cardiff and the Vale of Glamorgan, access to these specialist services will remain the same so the impact would be minimal.
Households and deprivation
Cardiff and Vale University Health Board has the highest proportion of households not deprived in any dimension at 43.2% in comparison to South Wales Programme and Wales and this has implications for access to transport and health generally. People in deprived areas are likely to report a range of key illnesses which is relevant to the services under consideration.

At the local authority level the Vale of Glamorgan (45.0%) and Cardiff (42.5%) have two of the highest proportion of households not deprived in any dimension. The Vale of Glamorgan is also one of the areas that have lower household proportions deprived in three or more dimensions than the figure for Wales as a whole (6.9%).

General health
Cardiff and Vale University Health Board has the highest proportion reporting good or very good health at 81.1%. Breaking that figure down, the proportion of those reporting good or very good health in both local authority areas is higher than the Welsh average.

The type of health issues experienced by the local population is inevitably linked to the age profile of residents in Cardiff and the Vale of Glamorgan which then impacts on the type of health provision required to meet their needs. The higher proportion of younger people in Cardiff and increases in the number of infants has a particular bearing on South Wales Programme services in relation to maternity and paediatric care. In contrast, the older profile of the population in the Vale of Glamorgan has more implications for emergency medicine (A&E). The ethnically and culturally diverse nature of the Cardiff population also presents issues for the way in which services need to be tailored to meet specific needs.

There is a major variation in people’s life expectancy across Wales, which is mirrored within Cardiff and Vale. Numerous factors contribute to this type of variation in health, such as the characteristics of the local population including age and existing illnesses and other socio-economic determinants.

Lone parent
There is a higher than average number of lone parent households in Cardiff and the Vale of Glamorgan. Within those lone parent households Cardiff and Vale has the highest proportion of female lone parents (91.5%) who are more likely to work part-time or not be in employment. Conversely, it has the lowest proportion of male lone parent households (8.5%). This pattern is very similar at a local authority level. This could have implications for access to all four of the services, particularly for example, if they have a child in hospital and others are at home.
**Unpaid carers**

In the 20 to 49 hours of unpaid care and 50 or more hours of unpaid care category Cardiff and Vale UHB has the lowest proportion, 1.4% for 20 to 49 hours of unpaid care, and 2.6% for 50 or more hours of unpaid care. Cardiff has the lowest proportion (2.5%) for 50 or more hours of unpaid care at a local authority level.

It is worth noting as a very general guide, the Survey of Carers in Households - England, (Health and Social Care Information Centre 2009-10) found that carers were more likely to be women than men; 60% of carers in England were women; Carers were most likely to be aged 45-64 (42%); a quarter (25%) were aged 65 or over. Around half (46%) of carers were in paid employment, 27% were retired from paid work and 13% were looking after their home or family; 92% of carers were white, while 8% were from black and minority ethnic (BME) backgrounds.

This is relevant to issues raised in previous sections in relation to gender, age and ethnicity.

**Demographic profiles of service users**

Analysis of the demographic profiles of service users for emergency medicine (A&E), inpatient paediatrics and consultant-led maternity services and neonatal care is contained in the equality impact assessment evidence document.

**Human Rights**

The right to respect for private and family life, home and correspondence is relevant to this assessment. This human right is not an absolute right, and any interference should be justified, lawful, necessary and proportionate.

The improved quality of care possible due to more centralised hospital services should result in patients spending less time in hospital. However, potential increased travel distances for those who live in the western part of the Vale of Glamorgan could lead to a negative impact on the right to maintain family life. This would apply to the patient and to individual members of the family.

**Summary of key issues and initial responses/potential mitigations**

A summary of key themes that have emerged from the engagement and consultation phases of the South Wales Programme can be found in the equality impact assessment evidence document. It describes the issues raised under each theme, identifies which equality protected characteristic groups the issues
potentially impact upon and provides an initial response in relation to actions to mitigate against any negative impacts. These will need to be revisited both at South Wales Programme and local level once a decision on the way forward has been made.

The ORS consultation outcomes executive summary identifies that the majority of responses identifying issues in relation to impacts on people with protected characteristics concerned age, disability and pregnancy and maternity. The themes and issues identified in the main document are now discussed in relation to any issues that were identified as specific to Cardiff and the Vale of Glamorgan:

**Increased travel times**

This issue relates to any impact on patient safety and outcomes if travel times are longer. While the majority of residents of Cardiff and the Vale of Glamorgan will continue to access the affected specialist services from UHW, some residents in the Vale of Glamorgan who currently access these specialist services from either Princess of Wales Hospital or the Royal Glamorgan Hospital may have to travel a bit further under the options that affect these hospitals.

Concerns about patient safety in relation to increased travel times, particularly the impact on older people, was one of the main issues identified by Cardiff and Vale residents in the open questionnaire:

“"We have an ageing community and I am thinking about stroke care and the treatment time needed to minimise its effect. What timescale is required to treat a stroke effectively?" Rhoose public meeting participant;

“It is acknowledged within the documentation that in the future some patients may have to travel ‘a bit’ further to access a ‘small percentage’ of services ... Whilst we appreciate that at this stage these changes are unknown, we are mindful that there may be significant implications for residents across the Vale. In particular we would be concerned about the impact on the elderly, residents in rural areas and people living in more deprived areas. We are also mindful of the potential impact on social services and transport if residents have to travel further to access services.” Vale of Glamorgan Council.

**Public transport and non-emergency transport**

The issue of travel and transport was a key issue raised by respondents from the Vale of Glamorgan who highlighted the need to improve public transport links between hospitals and expressed concern about the impact particularly on those most reliant on public transport including older people and people with a disability.
Transport links are a key issue being addressed within the local development plans in both Cardiff and the Vale of Glamorgan:

“The lack of public transport in the Western Vale will have an impact on ambulance transport services as there would be additional calls on their time. At present there is anxiety with the length of time it takes for responses to emergency calls from the Western Vale; non-emergency travel will become even more difficult for the frail and elderly.” Colwinston Town Council;

“Access to public transport - what discussions have you had with local authorities? There are cutbacks and these will mean a reduction in the public transport service. This will not just affect patients but also visiting relatives. Routes between hospitals are essential to make a judgement.” Rhoose public meeting participant.

**Difficult journeys particularly in bad weather**

This was not an issue that was raised by many people in Cardiff or the Vale of Glamorgan.

**Deprivation**

Although a number of concerns were raised about the potential disproportionate impact on deprived communities, the most deprived communities in Cardiff and the Vale of Glamorgan will not be directly affected by the proposed changes as they would largely continue to access these specialist services from UHW.

**Access issues for visitors**

The major concerns raised under this theme related to increased difficulty of access for visitors who are elderly or who have a disability and the impact on families who might have to travel further to visit children in hospital. This would be an issue for Vale of Glamorgan residents visiting patients being cared for in hospitals a bit further away from where they are currently situated, particularly for those on a low income:

There were numerous comments about problems for families, carers, relatives (and patients) with transport and accommodation in cases where the patient is in a hospital some way from where they live. “This will particularly impact on people who are on low incomes/benefits and who are already being affected by welfare reforms.” Vale Centre for Voluntary Services and Cardiff Third Sector Council;
“There comes a time as you get older when you can’t drive anymore. My husband had a stroke and my mother used to take all day to see my sister. It’s a stressful time (when a family member is very ill) to be using public transport and if it’s somewhere you don’t know you could potentially be stranded in the middle of the night.” Llantwit Major public meeting participant.

**Car parking and congestion on hospital sites**

Many people commented on the problems already being faced at UHW and expressed concern about the impact of increased activity at the Heath site on parking and congestion. This was identified as a specific concern for those with mobility problems:

“I have a disabled daughter and dropping off at UHW is a nightmare. With more services coming in, and the existing problem with taxis, it’s going to get worse. Can’t you have the taxi rank away from the main entrance?” Llanedeyrn public meeting participant.

**Ambulance services**

Many concerns were expressed about ambulance response times and the ability of the ambulance service to deal with the additional demand that would be placed on them by the proposals. Particular concern came from those living in the more rural parts of the Vale of Glamorgan although they did not relate specifically to problems faced by people with protected characteristics:

“There is no doubt that there are problems with the ambulance service and they are not getting to Llantwit Major in eight minutes. We need a better first response service and more paramedics in the rural Vale.” Llantwit Major public meeting participant.

**Patient transfers**

Concerns centred on the safety of women needing to be transferred during labour. This was not an issue that was raised by many people from Cardiff and the Vale of Glamorgan, the majority of whom will continue to access services as now.

**Neonatal services**

The main focus of concern from those that raised this issue in Cardiff and the Vale of Glamorgan was on the lack of cots in South Wales. There was also concern about the burden on families for those having to travel further. Cardiff and Vale residents will continue to access neonatal services at UHW:

“There are hundreds or thousands of women being sent to England to have their babies. If units are downsized without an increase in cot capacity, I
don’t see, as a professional, how this will succeed. And UHW does not have the capacity to expand. At the Royal Glamorgan we get calls every week begging for help from UHW and you are planning to close some centres without making others bigger. How does this improve standards of care?” Barry public meeting participant.

A&E services
Many concerns were raised about the pressures already being faced by A&E services; comments specific to protected characteristic groups from Cardiff and Vale of Glamorgan residents related mainly to older people:

“What are you going to do about elderly care and particularly those who have to go to Accident and Emergency? This year I’ve been in casualty a couple of times, I spent one night on a trolley bed. On the other occasion a 90-year-old spent nine hours in casualty. It’s not very pleasant, is it?” Cowbridge public meeting participant.

Primary and community services
Many people highlighted the need for a whole systems approach to be adopted and the need for there to be investment in primary and community services for the proposals around hospital services to be effective. The importance of integrated care with social services was highlighted particularly for care of older people. Cardiff and Vale respondents also highlighted the importance of access to out-of-hours services to take the pressure off A&E services:

“There needs to be a balance between hospitals and community services. You can’t reorganise hospital services without thinking of the important need to move people out of hospitals into the community. Out-of-hours care is a nightmare here. They never know where to direct you to.” Pendoylan public meeting participant.

Supporting people to be able to access services appropriately
Many people highlighted the need to educate and inform people of how to access services appropriately and to ensure that people knew where to go for what services. The need to provide information in accessible formats and ways that would be suitable for different communities was stressed, particularly for the diverse communities living in Cardiff. Utilising the networks and expertise of the Third Sector was identified as a means of supporting this work:

“There were many comments about the need for information about health services and appropriate access and finding ways of disseminating this to diverse groups. GPs have a vital role at local level, school staff who act in loco parentis will need to know about the changes. Communities First and the third
sector can help disseminate messages. Communication is key. There will need to be joint work on this between sectors.” Vale Centre for Voluntary Services and Cardiff Third Sector Council.

**Capacity of specialist centres**
The ability of UHW to cope with additional activity was a major concern expressed by Cardiff and the Vale of Glamorgan respondents. People also wanted to know what services would have to come off the Heath site to make way for increased levels of specialist services. Comments specific to protected characteristic groups were largely related to maternity and neonatal services:

“If you go for option three and the services at Royal Glamorgan are lost, RGH has the highest Caesarean rate in Wales. If the first baby is born via Caesarean, the mother is likely to require consultant-led care subsequently. So a lot of women are going to need to be accommodated in Cardiff because those women will come in this direction.” St Andrews United Reform Church, Cardiff public meeting participant.

**Workforce recruitment**
Concerns were expressed about the ability to recruit and retain sufficient doctors did not relate to any specific protected characteristic groups.

**Population changes**
A number of comments made by Vale of Glamorgan respondents highlighted the growing numbers of older people in the Vale, seeking reassurance that these changes had been taken into account in the South Wales Programme:

“Is the general population growth for Cardiff and the Vale and the growing number of elderly patients being factored into the service remodelling?” Cardiff and Vale Medical Advisory Committee.

**Specialist and Critical Care Centre (SCCC)**
Concerns were expressed about whether the SCCC would be built and the impact on the South Wales Programme if it did not materialise, did not relate to any specific protected characteristic groups. The impact of this issue on Cardiff and Vale residents is minimal.

**Impact on staff**
Concerns were expressed about whether staff would be expected to move base do not directly affect staff employed by Cardiff and Vale UHB as none of the proposed moves being consulted upon relate to services which are provided by the UHB.
Themes and mitigations

Please see the section on ‘Themes from South Wales Programme engagement and consultation and options for mitigation’ in the main evidence document for a comprehensive list of issues and initial responses which have not been repeated here.

Mitigation

An effective equality impact assessment takes into account the views and opinions of those who may be affected by the policy and what is already known about how the policy might affect different groups. The South Wales Programme has used national evidence, Public Health Wales information, Census data, travel times and distances to hospitals, and public views to identify issues.

The consideration of mitigating measures and alternative ways of doing things is at the heart of the equality impact assessment process. Different options have been developed which reflect different ways of delivering the South Wales Programme aims. The consideration of mitigation of adverse impacts is intertwined with the consideration of alternative actions. Mitigation can take the form of lessening the severity of the adverse impact.

Consideration must be given to whether separate or combined actions are necessary for the South Wales Programme to be effective for any relevant group. Ways of delivering its aims which have a less adverse effect on the relevant equality category or issue, or which better promote equality of opportunity for the relevant equality category, have been considered.

However, it must be emphasised that the South Wales Programme has only reached stage two of its equality impact assessment, the post consultation pre-decision stage. The consultation was to consider four options, including a best fit option. The issues and initial mitigations described within the equality impact assessment reflect that. The mitigations are expressed at high level. These will need to be worked through together with any further issues and mitigations once a decision on a preferred option has been made. This will be the focus of stage three of the equality impact assessment. For this reason, any issues and mitigations described at stage two must be considered to be preliminary, not exhaustive, and to be untested at this stage by the clinical reference groups and stakeholders.
**Summation – general duty**

The public sector equality duty is here referred to as the general equality duty and is set out in the Equality Act. The general equality duty requires Cardiff and Vale University Health Board as a public sector body, in the exercise of their functions, to have due regard. To have due regard means that in making decisions and in its other day-to-day activities a body subject to the duty must consciously consider the need to do the things set out in the general equality duty.

This equality impact assessment is representative of a real attempt to address the following 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 collaborative approach taken by the five health boards include a workstream comprising the equality, planning and engagement leads and the expertise of the NHS Centre for Equality and Human Rights.

Where any concerns relating to equality have been raised, these have been identified and explored in order to establish possible mitigation (see earlier section) and to avoid discrimination against any particular groups and to promote equality of access to services. This has involved consultation with different groups in relation to the protected characteristics in accordance with the Equality Act 2010 through the use of appropriate media, fora and by building on existing relationships. Attendance at public meetings, completion of questionnaires, etc has been monitored and reported.

The composition of the local population (2011 Census and Public Health information) has been analysed and issues considered and the different groups’ current access to the four services (based on limited information) has also been considered.

The other main element of analysis involved looking at the protected characteristics shared by staff employed in each of those services to avoid discrimination caused by a potential move of the services in which they are employed although this would be considered on an individual basis under the terms of the organisational change policy once an option is agreed.
Next steps

The next stage of the equality impact assessment will be after the recommendation on a preferred way forward has been considered by the health boards. Stage three will work through identified issues and mitigations with the clinical reference groups, planners, managers and others using an equality lens.

During the next stage, we will also test our assessment and the programme board’s responses and mitigations with relevant stakeholders and engage with other appropriate groups.
<table>
<thead>
<tr>
<th>DATE</th>
<th>EVENT / ACTIVITY</th>
<th>AUDIENCE</th>
<th>LOCATION</th>
<th>TIME</th>
<th>Attendance/Outcome</th>
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<tbody>
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<td>22-May</td>
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<tr>
<td>23-May</td>
<td>Signposting to consultation; full discussion at subsequent meeting</td>
<td>Local Negotiating Committee</td>
<td>Whitchurch Boardroom</td>
<td>14.30</td>
<td>Members signposted to consultation</td>
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<tr>
<td>24-May</td>
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<tr>
<td>28-May</td>
<td>Briefing/Presentation</td>
<td>Stakeholder Reference Group</td>
<td>UHL Boardroom</td>
<td>13.30-16.00</td>
<td>7 members present. Members took copies of summary to distribute within own organisations</td>
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<tr>
<td>29-May</td>
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<td>30-May</td>
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<td>31-May</td>
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<tr>
<td>03-Jun</td>
<td>Briefing/Presentation</td>
<td>All staff</td>
<td>Seminar Rm 3, Cochrane Building</td>
<td>10.00 - 11.00</td>
<td>4 members of staff attended. Further advertising of staff briefings initiated</td>
</tr>
<tr>
<td>03-Jun</td>
<td>Briefing/Presentation</td>
<td>Cardiff Children and Families Board</td>
<td>Committee Rm 3, County Hall</td>
<td>10.30</td>
<td>17 members attended; summaries distributed.</td>
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<tr>
<td>04-Jun</td>
<td>Briefing/Presentation</td>
<td>Vale Council - briefing session for all Members</td>
<td>Corporate Suite, Civic Offices, Barry</td>
<td>18.00 - 20.00</td>
<td>11 Members attended. Council response to be developed</td>
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<tr>
<td>05-Jun</td>
<td>Briefing/Presentation</td>
<td>All staff</td>
<td>Seminar Rm 5, Cochrane Building</td>
<td>12.30 - 1.30</td>
<td>25 members of staff attended.</td>
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<tr>
<td>05-Jun</td>
<td>Briefing/Presentation</td>
<td>All staff</td>
<td>Parentcraft Room, UHL</td>
<td>1.00 - 2.00</td>
<td>8 members of staff attended</td>
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<tr>
<td>06-Jun</td>
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<td>07-Jun</td>
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<tr>
<td>10-Jun</td>
<td>Briefing/Presentation</td>
<td>Diverse Cymru Disability Access Group</td>
<td>Alexandra House, Cowbridge Rd East, Cardiff</td>
<td>14.00</td>
<td>8 attendees. Additional copies of summary distributed for wider circulation</td>
</tr>
<tr>
<td>11-Jun</td>
<td>Briefing/Presentation</td>
<td>Medicine Directorate meeting</td>
<td>UHL Boardroom</td>
<td>12.30</td>
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<tr>
<td>11-Jun</td>
<td>Briefing/Presentation, UHB stand advertising public meetings and distributing summaries</td>
<td>GP Clinical Dev Session</td>
<td>Park Inn, Llanedeyrn</td>
<td>14.00-16.30</td>
<td>50 GPs attended. Summaries also circulated to Practice Nurse development session at same venue (40)</td>
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<td>Date</td>
<td>Event Type</td>
<td>Event Name</td>
<td>Location</td>
<td>Time</td>
<td>Notes</td>
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<tr>
<td>11-Jun</td>
<td>Signposting to consultation</td>
<td>Carers’ event for adult carers in Cardiff and Vale of Glamorgan to celebrate Carers’ Week</td>
<td>St Fagans</td>
<td>10.00-15.00</td>
<td>Posters displayed; summaries distributed</td>
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<tr>
<td>12-Jun</td>
<td>Briefing/Presentation</td>
<td>Community Director Meeting</td>
<td>Trenewydd</td>
<td>14.30</td>
<td>4 Primary Care Community Directors attended</td>
</tr>
<tr>
<td>12-Jun</td>
<td>Public Meeting</td>
<td>General Public</td>
<td>Llantwit Major Llantonian Hall</td>
<td>19.00-21.00</td>
<td>66 members of the public attended</td>
</tr>
<tr>
<td>13-Jun</td>
<td>Briefing/Presentation</td>
<td>C&amp;V Local LMC Constituency</td>
<td>Cowbridge Health Centre</td>
<td>14.00</td>
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<tr>
<td>13-Jun</td>
<td>Briefing/Presentation</td>
<td>Assistant Medical Director meeting</td>
<td>Clinical Research Facility, UHW</td>
<td>17.00-18.30</td>
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<tr>
<td>14-Jun</td>
<td>Briefing/Presentation</td>
<td>Cardiff Partnership Board</td>
<td>Council Room, UHW</td>
<td>10.00-12.30</td>
<td>7 members of CPB attended</td>
</tr>
<tr>
<td>14-Jun</td>
<td>Briefing/Presentation</td>
<td>C&amp;V Medical Advisory Group</td>
<td>Council Room, UHW</td>
<td>13.00-14.30</td>
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<tr>
<td>17-Jun</td>
<td>Signposting to consultation</td>
<td>C&amp;V Carers Support and Information Network</td>
<td>County Hall</td>
<td>14.00-16.00</td>
<td>12 members attended. Posters, summaries and full documents distributed</td>
</tr>
<tr>
<td>18-Jun</td>
<td>Briefing/Presentation</td>
<td>UHB Dept of Medicine Directorate meeting</td>
<td>Council Room, UHW</td>
<td>12.30</td>
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<tr>
<td>18-Jun</td>
<td>Briefing/Presentation</td>
<td>Maternity Services Liaison Committee</td>
<td>Large Obs&amp;Gynae room, Obs&amp;Gynae Directorate Offices, UHW</td>
<td>16.00-17.30</td>
<td>9 members attended</td>
</tr>
<tr>
<td>18-Jun</td>
<td>Public Meeting</td>
<td>General Public</td>
<td>St Brides Major Church Hall</td>
<td>19.00-21.00</td>
<td>87 members of the public attended</td>
</tr>
<tr>
<td>19-Jun</td>
<td>Briefing/Presentation</td>
<td>GP Clinical Dev Session</td>
<td>Future Inn, Cardiff Bay</td>
<td>14.00-16.30</td>
<td>67 GPs attended the session</td>
</tr>
<tr>
<td>19-Jun</td>
<td>Briefing/Presentation</td>
<td>UHB Senior Clinical Leaders</td>
<td>Park Inn, near Motor point Arena</td>
<td>11.30-13.00</td>
<td>19 clinicians involved</td>
</tr>
<tr>
<td>19-Jun</td>
<td>Briefing/Presentation</td>
<td>Cardiff Youth Council</td>
<td>Park Inn, near Motor point Arena</td>
<td>17.10</td>
<td>Consultation comms via 500 followers on CYC twitter feed and 167 followers on CYC Facebook</td>
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<tr>
<td>Date</td>
<td>Event Type</td>
<td>Group</td>
<td>Venue</td>
<td>Time</td>
<td>Attendees</td>
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<tr>
<td>19-Jun</td>
<td>Public Meeting</td>
<td>General Public</td>
<td>Pendoylan Church in Wales School</td>
<td>19.00 - 21.00</td>
<td>24 members of the public attended</td>
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<tr>
<td>20-Jun</td>
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<tr>
<td>21-Jun</td>
<td>Briefing/Presentation</td>
<td>Senior Medical Staff Committee</td>
<td>Lecture Hall 2</td>
<td>12.00</td>
<td>30 members attended</td>
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<tr>
<td>24-Jun</td>
<td>Public Meeting</td>
<td>General Public</td>
<td>Cowbridge Town Hall (Lesser Hall)</td>
<td>19.00 - 21.00</td>
<td>71 members of the public attended</td>
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<tr>
<td>25-Jun</td>
<td>Public Meeting</td>
<td>General Public</td>
<td>Llandebyrn Day Centre</td>
<td>19.00 - 21.00</td>
<td>42 members of the public attended</td>
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<tr>
<td>26-Jun</td>
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<tr>
<td>27-Jun</td>
<td>Briefing/Presentation</td>
<td>Vale Local Service Board</td>
<td>Civic Offices, Barry</td>
<td>10.30-12.30</td>
<td>10 members attended</td>
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<tr>
<td>27-Jun</td>
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<tr>
<td>27-Jun</td>
<td>Briefing/Presentation</td>
<td>Vale Children &amp; Young People's</td>
<td>Civic Offices, Barry</td>
<td>14.00</td>
<td>16 members attended</td>
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<td>Board</td>
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<tr>
<td>27-Jun</td>
<td>Briefing/Presentation</td>
<td>Vale Youth Forum</td>
<td>Corporate Suite, Civic Offices, Barry</td>
<td>18.00-20.00</td>
<td>11 Members attended</td>
</tr>
<tr>
<td>27-Jun</td>
<td>Public Meeting</td>
<td>General Public</td>
<td>Rhoose Community Centre</td>
<td>19.00 - 21.00</td>
<td>12 members of public attended.</td>
</tr>
<tr>
<td>28-Jun</td>
<td>Briefing/Presentation</td>
<td>Race Equality First</td>
<td>Castle land Community Centre, Café Camalot</td>
<td>13.00 - 14.30</td>
<td>10 attendees</td>
</tr>
<tr>
<td>28-Jun</td>
<td>Briefing/Presentation</td>
<td>Vale 50+ Forum</td>
<td>Committee Room 2, Civic Offices, Barry</td>
<td>14.00 - 15.30</td>
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<tr>
<td>01-Jul</td>
<td>Briefing/Presentation</td>
<td>Cardiff Council- briefing for Members</td>
<td>Committee Room 4 County Hall, Cardiff</td>
<td>17.30 - 18.30</td>
<td>11 Members attended</td>
</tr>
<tr>
<td>01-Jul</td>
<td>Public Meeting</td>
<td>General Public + CHC Cardiff Location meeting</td>
<td>Committee Room 1 County Hall, Cardiff</td>
<td>19.00 - 21.00</td>
<td>28 members of the public attended</td>
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<tr>
<td>02-Jul</td>
<td>Public Meeting</td>
<td>General Public</td>
<td>Dinas Powys Parish Hall</td>
<td>19.00 - 21.00</td>
<td>10 members of the public attended</td>
</tr>
<tr>
<td>Date</td>
<td>Type</td>
<td>Details</td>
<td>Venue</td>
<td>Time</td>
<td>Attendance</td>
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<tr>
<td>03-Jul</td>
<td>Workshop</td>
<td>Third Sector organisations in Cardiff and the Vale of Glamorgan, facilitated by C3SC and VCVS</td>
<td>Memorial Hall, Barry</td>
<td>9.30 - 12.30</td>
<td>10 attendees.</td>
</tr>
<tr>
<td>03-Jul</td>
<td>Briefing/Presentation</td>
<td>ABCD Cymru</td>
<td>Ivor House, Bridge St, Cardiff CF10 2TH</td>
<td>10.00 - 11.00</td>
<td>19 families/carers in attendance</td>
</tr>
<tr>
<td>04-Jul</td>
<td>Public Meeting</td>
<td>General Public</td>
<td>Pentyrch Rugby Club</td>
<td>19.00-21.00</td>
<td>7 members of the public attended</td>
</tr>
<tr>
<td>05-Jul</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>08-Jul</td>
<td>Public Meeting</td>
<td>General Public + CHC Vale Locality meeting</td>
<td>Corporate Suite, Civic Offices, Barry</td>
<td>19.00 - 21.00</td>
<td>21 members of the public attended</td>
</tr>
<tr>
<td>09-Jul</td>
<td>Public Meeting</td>
<td>General Public + CHC Health Watch</td>
<td>St Andrews Church Hall, Pen-Y-Lan Rd, Cardiff CF24 3PF</td>
<td>18.30 - 20.30</td>
<td>34 members of the public attended</td>
</tr>
<tr>
<td>10-Jul</td>
<td>Briefing/Presentation</td>
<td>All staff</td>
<td>Boardroom, UHL</td>
<td>12.00 - 1.00</td>
<td>25 members of staff attended.</td>
</tr>
<tr>
<td>10-Jul</td>
<td>Briefing/Presentation</td>
<td>Vale Vol Sector Jnt Liaison Committee</td>
<td>Civic Offices, Barry</td>
<td>18.00</td>
<td>12 members attended.</td>
</tr>
<tr>
<td>11-Jul</td>
<td>Briefing/Presentation</td>
<td>Healthcare Professionals' Forum</td>
<td>UHB HQ, Whitchurch</td>
<td></td>
<td>9 members attended</td>
</tr>
<tr>
<td>12-Jul</td>
<td>Briefing/Presentation</td>
<td>All staff</td>
<td>Lecture Theatre 4, UHW main hospital</td>
<td>12.00 - 1.00</td>
<td>34 members of staff attended</td>
</tr>
<tr>
<td>16-Jul</td>
<td>Briefing/Presentation</td>
<td>Local Partnership Forum</td>
<td>UHB HQ, Whitchurch</td>
<td>12.00-14.30</td>
<td>28 members attended</td>
</tr>
<tr>
<td>17-Jul</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>18-Jul</td>
<td>Briefing/Presentation</td>
<td>Local Negotiating Committee</td>
<td>0.12 Cochrane Building</td>
<td>14.30</td>
<td>12 members attended</td>
</tr>
<tr>
<td>19-Jul</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

May
Letter from Chair providing consultation docs, offering presentation & info on public events
LA leaders, chief execs, cabinet leads
Responses led to arrangement of Member briefing sessions (Vale June 4th, Cardiff July 1st)
<table>
<thead>
<tr>
<th>May</th>
<th>Letter from Chair providing consultation docs &amp; info on how to get involved</th>
<th>Key stakeholder organisations</th>
<th>Letter sent to: Assembly Members, MPs, Local Councillors, Town &amp; Community Councils, Directors of Social Services, CVCs, LSBs, Primary Care Practitioners, LMC, LDC, LOC, LPC, South Wales Police, South Wales Fire Service, Probation</th>
</tr>
</thead>
<tbody>
<tr>
<td>May/June</td>
<td>Targeted staff briefing</td>
<td>Staff in affected specialist areas</td>
<td>Teams using presentation to cascade info to staff. Summary docs distributed to key teams</td>
</tr>
<tr>
<td>June</td>
<td>Electronic communication of consultation docs and info on how to get involved</td>
<td>Communities First</td>
<td>Communication co-ordinated by CVCs including electronic and hard copies of documents</td>
</tr>
<tr>
<td>May/June</td>
<td>Communication of commencement of consultation and info on how to get involved</td>
<td>All staff including key TU &amp; Professional Body reps</td>
<td>Information on consultation, including dates of staff briefings, headlined on Intranet and via weekly bulletins. Posters advertising staff briefings posted across UHB sites</td>
</tr>
<tr>
<td>May</td>
<td>Electronic communication of consultation docs and info on how to get involved</td>
<td>UHB Volunteers</td>
<td>Volunteers contacted by UHB Patient Experience Team and signposted to where to get more information</td>
</tr>
<tr>
<td>May-July</td>
<td>Series of public meetings run in partnership with CHC, WAST and other LHBs</td>
<td>Local population including members of Town and Community Councils</td>
<td>Public meetings booked and advertised via range of social and traditional media, UHB partner websites, hard copy posters displayed in variety of venues across Cardiff and the Vale of Glamorgan. PA system hired. <strong>Total of 402 members of public attended 11 public meetings.</strong></td>
</tr>
<tr>
<td>May-July</td>
<td>Use of partner websites, networks &amp; community venues to raise awareness and advertise events</td>
<td>Stakeholder organisation staff, service users &amp; general public</td>
<td>Cardiff and Vale of Glamorgan Councils’ and County Voluntary Councils’ websites signpost to SWP website and provide info on public meetings. Councils have sent out info via staff bulletins and to Citizen Panels. CVCs have emailed out to general membership and Networks. These partners have also utilised social media to support ongoing updates</td>
</tr>
<tr>
<td>Date</td>
<td>Activity Description</td>
<td>Audience</td>
<td>Details</td>
</tr>
<tr>
<td>------------</td>
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</tr>
<tr>
<td>May-July</td>
<td>Use of online, social &amp; traditional media to provide access to information and</td>
<td>Local population</td>
<td>Consultation details including public meetings advertised via range of social and traditional media including individual Tweets for each public meeting, UHB partner websites, hard copy posters displayed in variety of venues across Cardiff and the Vale of Glamorgan</td>
</tr>
<tr>
<td></td>
<td>documentation, together with paper and e-based response mechanisms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>Distribution of hard copy posters and summary documents to variety of public venues</td>
<td>Local population</td>
<td>Posters and summaries distributed to: Cardiff and VoG Council leisure and community centres and libraries, via Council networks, Third Sector organisation networks via CVCs, local supermarkets</td>
</tr>
<tr>
<td>June</td>
<td>Distribution of hard copy posters and summary documents to primary care premises</td>
<td>Local population</td>
<td>Copies of posters, full consultation and summary documents sent to GP Practices (68) with letter from UHB chair requesting display in waiting areas</td>
</tr>
<tr>
<td>June</td>
<td>Electronic versions of public meeting posters shared with range of partners requesting that they be printed and displayed</td>
<td>Local population</td>
<td>Electronic posters sent to Third Sector Organisations via CVCs, Assembly Members, MPs, local councillors, Town &amp; Community Councils, venues of public meetings</td>
</tr>
<tr>
<td>June</td>
<td>Distribution of hard copy posters and summaries to Town and Community Councils on request</td>
<td>Local population</td>
<td>Copies delivered on request to: St Donat's Community Council, St Brides Major Community Council, Llantwit Major Town Council</td>
</tr>
<tr>
<td>June</td>
<td>Distribution of hard copy summaries to individual members of public and local politician on request, for sharing in local community</td>
<td>Local population</td>
<td>Copies delivered on request</td>
</tr>
<tr>
<td>June</td>
<td>News article on SWP in C&amp;V Primary Care Newsletter</td>
<td>Primary Care Practitioners</td>
<td>Article appeared in June edition</td>
</tr>
<tr>
<td>June</td>
<td>Following discussion, agreement for distribution of consultation resources via Age Concern Healthy, Wealthy and Wise Groups and Senior Health Shop in Barry</td>
<td>C&amp;V Age Concern Healthy, Wealthy &amp; Wise Clubs</td>
<td>Resources (summaries, posters and full documents) delivered to Age Concern Ely offices for onward distribution via Age Concern.</td>
</tr>
<tr>
<td>Date</td>
<td>Event Description</td>
<td>Relevant Groups/Unions</td>
<td>Notes</td>
</tr>
<tr>
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<tr>
<td>June</td>
<td>Following discussion, agreement to be added to Third Sector workshop invite list</td>
<td>Older Minority Ethnic Network and LGBT group - Age Cymru</td>
<td>Consultation resources circulated electronically to Group</td>
</tr>
<tr>
<td>June</td>
<td>Local Welsh medium media - SWP article in 'Pobl Caerdydd' - online Cardiff newspaper</td>
<td>Pobl Caerdydd - Welsh Language newspaper</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>Distribution of consultation summaries to Welsh Language Groups</td>
<td>Welsh Language Forum (stakeholder group for local Welsh language groups and organisations - public and third sector); Grwp Deddf (SE Wales Welsh Language Officer Group)</td>
<td>Consultation paper resources circulated to 15 members and electronically to 23 members Grwp Deddf and handed out 15</td>
</tr>
<tr>
<td>June/July</td>
<td>Distribution of consultation summaries to targeted service users</td>
<td>Midwifery distribution to antenatal clinics and women supported by specialist teams; Health Visiting distribution to families</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>Following discussion, agreement to be added to Third Sector workshop invite list</td>
<td>Stonewall</td>
<td>Consultation resources circulated electronically to Group</td>
</tr>
<tr>
<td>June</td>
<td>Following discussion, agreement that they would attend the briefing/presentation at the NHS Centre for Equality and Human Rights Stakeholders Group</td>
<td>Transgender Wales</td>
<td>NHS Centre for Equality and Human Rights Stakeholder Group meeting 21 June. In addition, Transgender Wales member attended Third Sector workshop</td>
</tr>
<tr>
<td>June</td>
<td>Following discussion, agreement that info would be circulated to the members of the group encouraging them to respond as individuals and asking them to encourage their networks to respond</td>
<td>UHB Spiritual Care Group - made up of religion, belief and non-belief representatives.</td>
<td>Consultation resources circulated electronically to Group</td>
</tr>
<tr>
<td>July</td>
<td>Distribution of consultation summaries and public meeting details</td>
<td>Cardiff Neighbourhood 50+ Forums</td>
<td>Resources distributed at inaugural meetings of groups</td>
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</tr>
<tr>
<td>July</td>
<td>Staffed stand set up in UHW concourse to distribute consultation resources and encourage people to complete questionnaires</td>
<td>UHW Patients, visitors and staff</td>
<td>Full and summary documents distributed to patients, visitors and staff; SWP explained and people encouraged to respond</td>
</tr>
<tr>
<td>July</td>
<td>Following discussion, agreement that info would be circulated and discussed with (up to 30) young people and families and asking them to provide their thoughts so that a response written on their behalf.</td>
<td>Barnardos Young People/Families Project</td>
<td>Consultation resources circulated electronically</td>
</tr>
</tbody>
</table>
Appendix D: Cwm Taf Health Board Local Assessment of Equality Impact

Introduction

This document supplements and should be read in conjunction with the South Wales Programme equality impact assessment evidence document stage one produced in May 2013 (revisited October 2013 as stage two), which provides an overview of the overall issues which may affect members of the South Wales and South Powys communities who share protected characteristics as defined by the Equality Act 2010. It has also been considered against the Human Rights Act 1998, particularly Article 2, the right to life, Article 8, the right to privacy and family life and Article 14, Prohibition of Discrimination; and the broader context of the UN convention on the Rights of Persons with Disabilities and the UN Convention on the Rights of the Child, with particular reference to the need to provide access to healthcare.

The intention of this document is not to repeat information contained in the evidence document but to consider firstly, how the proposed changes could affect the local community, with particular reference to the four options. Secondly, to consider how the four options could affect the staff currently employed in A&E, paediatrics, neonatal care and maternity.

This assessment is based on Public Health Observatory and Census information, staffing information held by each health board on the Electronic Staff Record (ESR) system and findings collated by Opinion Research Services (ORS) from the public consultation. It is limited to data that is collected and available at present.

What are the implications for Cwm Taf?

The four options for the future of consultant-led maternity and neonatal care, inpatient children's services and emergency medicine (A&E):

Option 1: University Hospital of Wales (UHW), Cardiff; Morriston Hospital, Swansea; Specialist and Critical Care Centre (SCCC), a new hospital which is planned to be built near Cwmbran and Prince Charles Hospital, in Merthyr Tydfil

Option 2: UHW, Morriston, SCCC and Royal Glamorgan Hospital, in Llantrisant

Option 3: UHW, Morriston, SCCC, Prince Charles Hospital and Princess of Wales Hospital, in Bridgend
**Option 4:** UHW, Morriston, SCCC and Prince Charles and Royal Glamorgan hospitals

Each of these options has been assessed against a wide range of factors, including their impact on travel times, especially for people living in the most deprived communities; the number of doctors needed, the impact on the Welsh Ambulance Service and a high-level assessment of how much they will cost.

The option which has emerged from the process as having the least impact on all the factors the South Wales Programme has considered, and is therefore classed as the ‘best fit’, is **option three** – concentrating these services in five hospitals: UHW, Morriston, SCCC, Prince Charles and Princess of Wales hospitals.

Options one, two and three will particularly affect Cwm Taf Health Board as at least one of its hospitals would be affected by each of these proposals. The ‘best fit’ option (option three) will particularly affect Royal Glamorgan Hospital.

**What are the implications for residents of Merthyr and Rhondda Cynon Taf?**

There are significant implications for our local community as residents of Rhondda and Taff Ely may need to travel to Princess of Wales Hospital, Bridgend, Prince Charles Hospital or to University Hospital Wales (UHW) for the particular services under review if option three, the “best fit” option is adopted. If another option is chosen which does not include Prince Charles Hospital, in Merthyr Tydfil, then residents of Merthyr Tydfil and the Cynon valley would need to travel to Royal Glamorgan Hospital or to Cardiff.

Natural travel patterns are up and down the valleys and transport links to Cardiff are more robust. In the event that the “best fit” option is chosen it is likely that residents of the Rhondda valley will travel to UHW for healthcare rather than north to Prince Charles Hospital, as they indicated in the consultation (ORS report). Option four would have little impact on Cwm Taf residents.

**Consultation with equality groups in Cwm Taf**

Each of the five health boards has contributed to a collaborative approach and this is summarised in the main equality impact assessment evidence document. As part of this collaboration, specific health boards built on existing relationships to consult with particular equality groups – for example Cwm Taf consulted with deaf people; ABM with people with a learning disability and Cardiff and Vale with black and minority ethnic (BME) groups.
A schedule of consultation activity undertaken locally by Cwm Taf Health Board is attached to this appendix. This included meetings with a range of groups relevant to equality and protected characteristics.

Cwm Taf worked with the two county voluntary councils (Interlink in RCT and VAMT in Merthyr Tydfil) to reach organisations working with service users with protected characteristics. Letters providing details about the South Wales Programme consultation; where to find information; dates of public meetings; a Third Sector workshop and offering to meet groups individually, were sent to more than 800 organisations on the councils' databases. Of these, more than 300 were groups specifically relating to protected characteristics, the majority were organisations working with older people, children and young people. However, many of the community groups on the databases work with vulnerable people of all ages who may also have other protected characteristics.

This distribution through the Third Sector was followed up by the health board’s equality manager liaising directly with protected characteristic contacts - Action on Hearing Loss; RNIB; SENSE; Wales Council for the Deaf; British Deaf Association; Diverse Cymru; Valleys Regional Equality Council; New Horizons (Mental Health); Interlink; Merthyr Tydfil Migrant Worker's Forum - accentuating the key opportunities that the consultation exercise provided for their specific issues to be highlighted (especially access issues).

Links with other partners, for example in the local authority, were also used to encourage cascading of information through their networks to promote awareness of the consultation and encourage responses. Presentations to or discussions with specific groups included the following:

**Race**
Cwm Taf sought the assistance of the Merthyr Tydfil Migrant Workers Forum and the multi-agency Diversity group to help reach Polish and Portuguese community groups. The consultation document and questionnaire were translated into both languages.

**Age**
Cwm Taf is fortunate to have a large number of groups for older people including six 50-plus forums and a range of community groups for pensioners.

Discussions were held with the youth forums in Merthyr Tydfil and Rhondda Cynon Taf (RCT) as well as Fframwraith, which is the children and young people’s partnership in RCT.
Disability
Meetings took place with Pontypridd Deaf Club which was also open to service users from other areas and British Sign Language interpreters were provided by the health board; with Rhondda Disability Forum whose members have a range of disabilities and with a mental health service user group in Cynon Valley.

Demographic profile of Cwm Taf Health Board population

The following analysis is based on tabular information contained in the equality impact assessment evidence document. It also refers to information contained in the Cwm Taf Public Health Strategic Framework 2011.

Cwm Taf includes four localities - Rhondda, Cynon, Taf and Merthyr. The first three tend to be grouped as they are covered by one local authority but it is important to note that Cynon residents are as likely to use services provided by Prince Charles Hospital, in Merthyr Tydfil, as they are to use services provided by Royal Glamorgan Hospital, in Llantrisant.

Gender
There is a very slightly higher proportion of female residents in the Cwm Taf area and this is broadly consistent with South Wales Programme and Wales. Women are more dependent on public transport (National Travel Survey, Department of Transport 2011) and this is relevant to their access to consultant-led maternity and neonatal care and inpatient children’s services. They are also more likely to be lone parents than men (2011 Census) – see lone parent section below.

Pregnancy and maternity as a protected characteristic is also relevant to the whole issue of appropriate provision of these services. For Cwm Taf, the rate of conceptions in young women aged 15-17 is higher than the average for Wales and they could have an increased reliance on consultant-led maternity services. They are also more likely to be included in the deprivation statistics - see section later.

Age
Cwm Taf Health Board has a slightly higher proportion of younger people than the South Wales Programme health boards and Wales as a whole, particularly in the 0-4 and 5-15 bands which is relevant to changes to neonatal and paediatric provision.

Other groups are broadly consistent, except for 25-44 group which could be relevant to maternity provision and 65-84 age band which is 1% higher and this could be relevant to emergency medicine (A&E) in terms of strokes, heart attacks, etc.
Older people are more likely to experience ill health and are also less likely to have access to a car and whilst some admissions to emergency medicine (A&E) would warrant ambulance transportation, this could still impact on access to this service and also for visiting if their spouse or partner is admitted to one the hospitals which have emergency care provision direct from A&E.

**Disability**
Cwm Taf has a significantly higher proportion (2.8%) of residents who declare their day-to-day activities are limited a lot and slightly higher proportion whose activities are limited a little as described in Census 2011 categories. This is consistent with the age profile as more than half of men and women over 65 years say that they have a limiting long term illness *(How Fair is Wales? 2011)*.

Disabled people are 10 times more likely to report ill health and also approximately half are likely to experience mental ill health *(How Fair is Britain?)*. The Cwm Taf population report the poorest mental health status of all health boards in Wales. Mental health patients are more likely to present at A&E than some other groups and concerns have been raised during the consultation process that this group tent to experience problems at this stage. Increased travel could also be problematic for them.

This could have implications in terms of transport as people who have a disability are twice as likely to have no access to a car than people without a disability (Office for Disability Issues 2009). Disabled people are also less confident in using public transport because of physical access issues but also because of staff attitudes (Framework for Action on Independent Living 2012).

There could also be problems for people who have sensory impairments or a learning disability accessing different sites which are further away from familiar surroundings.

**Ethnicity**
Cwm Taf Health Board has lower representation from ethnic groups other than white than the other South Wales Programme health boards and Wales as a whole.

Language can represent a barrier in accessing public transport (Public Transport Needs of Black and Minority Ethnic and Faith Communities, Department of Transport 2003).

It has been documented that maternity services fail to provide adequate support to women from ethnic minority backgrounds *(Equality and Human Rights*
Commission Review 2010) and this should be noted even though numbers are small. There can also be issues in relation to slightly lower birth weights of babies from black and minority ethnic groups.

**Marriage and civil partnership**
The number of people who are married or in a same-sex civil partnership is the same as for the South Wales Programme health boards and Wales as a whole.

**Religion**
There is a lower representation in every religious group than is seen in South Wales Programme and Wales as a whole. Higher than average proportions of the population stated that they had no religion. A similar proportion did not state their religion as other South Wales Programme health boards and Wales as a whole.

**Neither marriage and civil partnership nor religion featured significantly in the consultation feedback.**

**Sexual orientation**
Analysis of sexual orientation within the main equality impact assessment document draws upon data from the ONS integrated household survey (see Table 11). This survey shows that at 1%, Cwm Taf has the joint lowest proportion of people identifying as lesbian, gay and bisexual among the South Wales Programme regions (data on Powys is not available). The proportion of people identifying as lesbian, gay or bisexual in Cwm Taf is the same as the proportion for Wales as a whole (1%).

**Transgender**
As highlighted in the main equality impact assessment document there is no official estimate of the transgender population. The England and Wales Census, and Scottish Census do not ask people whether they identify as transgender.

The following groups do not constitute protected characteristics but are relevant in considering issues in relation to the groups already listed.

**Car or van ownership**
There are significantly higher proportions of households who have no car than the other health boards and especially compared to Wales as a whole. This is obviously relevant to the transport concern raised consistently in every aspect of the consultation; this would include self presentation at A&E, visiting arrangements with particular reference to supporting and staying with children in hospital.
Deprivation
More than 40% of residents in Merthyr Tydfil live in the most deprived quintile and within Rhondda Cynon Taf more than 30% of residents lived in the most deprived quintile in Wales. Higher levels of deprivation are evident in every category compared with the South Wales Programme health boards and Wales and this has implications for access to transport and health generally.

People living in deprived areas are likely to report a range of key illnesses which is relevant to the services under consideration – see next section.

Two-and-a-half times as many working age people in Merthyr Tydfil are in receipt of out-of-work benefits compared to more affluent areas of Wales and this is relevant to comments made about increased travel costs.

Health
Cwm Taf has the lowest life expectancy for both males and females of any of the new health boards in Wales and has the lowest healthy life expectancy (along with Blaenau Gwent).

This is consistent with the previous observation as lower proportions of the community declare they are in very good or good health. More people suffer from chronic health conditions than elsewhere in Wales and this could have implications for A&E in particular.

GP cluster information (Public Health Observatory 2013) shows that while the population of Cwm Taf equates to 9.57% of the population of Wales, Cwm Taf residents are over represented as a higher proportion of the total numbers of people in Wales who suffer from hypertension, coronary heart disease, chronic obstructive pulmonary disease and epilepsy live in this area. Cwm Taf has a higher death rate from respiratory disease and higher than average cancer rates than elsewhere in Wales. Substance misuse is a major issue for Cwm Taf and the death rate is increasing for alcohol related conditions.

Lone parents
There is a higher than average number of lone parent households and particularly female lone parent parents in the Cwm Taf area. This could have implications for access to all four of the services, particularly for example, if they have a child in hospital and others at home (see gender section above) and this is relevant to all parents in terms of the right to family life (Human Rights Act 1998).
Unpaid carers
There are slightly lower proportions of residents providing no unpaid care or one to 19 hours of unpaid care but slightly higher proportions for those providing 20 to 49 or more than 50 hours.

As a very general guide, the Survey of Carers in Households - England, (Health and Social Care Information Centre 2009-10) found that carers were more likely to be women than men; 60% of carers in England were women; carers were most likely to be aged 45-64 (42%); a quarter (25%) were aged 65 or over. Around half (46%) of carers were in paid employment, 27% were retired from paid work and 13% were looking after their home or family; 92% of carers were white, while 8% were from black and minority ethnic (BME) backgrounds. This is relevant to issues raised in previous sections in relation to gender, age and ethnicity.

Welsh language
In Cwm Taf, 12.3% of adults and 8.9% of children are able to speak Welsh. The proportion of those who are able to understand, speak and/or write Welsh varies within. It is possible that young children, the elderly or confused may need to prefer or need to communicate in Welsh. Where arrangements are already in place to accommodate these, they should be replicated elsewhere.

Demographic profiles of service users
The following analysis is based on information by the Cwm Taf Health Board workforce and education department (may be included in the equality impact assessment evidence document).

Emergency medicine (A&E)
The highest group using Cwm Taf A&E departments is the 25-44 age group (24.71%), followed by the youngest age group (20.82%) and the oldest group (20.37%). It should be noted that Cwm Taf has slightly more residents in the youngest age group and slightly less in the oldest group. Least use is made by the 16-24 group.

Slightly more use is made by males from Cwm Taf, 51.59% although there are slightly more females living in the area.

The only ethnic groups recorded as having used A&E are white and African and there is no evidence of usage by any other group although it is apparent that this data is unknown for most patients.
Paediatrics
A greater proportion of males have used this service, 54.69%. Almost equal numbers of white and Asian patients are recorded as using the service although most patients have not stated their ethnic origin.

Obstetrics and gynaecology
Ninety-six per cent of service users are white, the remainder of those known are classed generically as non-white.

Cwm Taf Health Board Staff Profile by protected characteristics
The following analysis is based on information by the Cwm Taf Health Board workforce and education department (may be included in the equality impact assessment evidence document).

Cwm Taf Health Board staff are 80% female and 20% male; 36% have declared they are heterosexual, six people have said they are bisexual, 21 gay and four are lesbian. In terms of religion: 24% are Christian; 5% other and 278 people have declared they are atheist; 35 Hindu; 25 Islam and 12 Buddhist. There is a fairly equal split of staff between the 25-45 and 46-64 age groups and minimal numbers in the younger or older age group. Eighty-six per cent of staff are white; 0.03% are Asian and there is small representation in black, mixed and other groups.

Paediatrics
There are 150 staff in paediatrics, of whom 81% are female; 33 declare themselves as heterosexual, the remainder are not known. Twenty-two declare their religion as Christian; three Hindu; two Islam; three other. The majority of staff (61%) are aged 25-45, 35% are 46-64. There are only five staff in the youngest group and one person is over 65.

Emergency medicine (A&E)
Eighty-three per cent of staff are female. More than half (57%) are aged 25-45 and 35% and 46-64. The majority of staff (88%) are white; 6% are Asian and 6% are not known. Nearly 24% are Christian; 35% declare they are heterosexual, the others are not known or numbers are too small to report.

Neonatal
There are 50 staff in total, 49 are female. Five staff have declared they are heterosexual, the others aren’t known. There is an equal split between the 25-45 and 46-64 age groups. Ethnicity is not known for any of the staff.

Obstetrics and gynaecology
There are 309 staff, 95% of whom a white. All staff are heterosexual or not known. Of those who have declared their religion, 49 are Christian; three are atheist; two
Hindu and 12 other. Five per cent of staff are Asian and there are small numbers from each of the other groups. The majority of staff (96%) are either aged 25-45 or 46-64.

Changes to travel arrangements and working arrangements (shifts, etc) are likely to be the main issues for staff and this could be particularly difficult for those with family or carer commitments, staff who are older or disabled for the all the reasons outlined in previous sections. Individual circumstances and related issues would be addressed under the All-Wales Organisational Change Procedure. This is particularly relevant to disability which is not currently known for these staff.

**Consultation responses – equality perspective**

This section should be read in conjunction with the equality impact assessment evidence document.

The following information is relevant to this analysis:
- Equality profile of people who attended equality meetings
- Comments from people who attended public meetings
- Contributors to submissions and questionnaire
- Equality codes from public meetings
- Equality codes from question five
- Equality forms from public meetings
- Respondent profile from open questions and residents survey
- Equality slides
- Equality themes from open questions
- Open questionnaire – organisations responding from Cwm Taf with links to protected characteristics

Members of the following groups within Cwm Taf attended meetings and/or submitted questionnaires:

Bedlinog Day Care centre
Taff Ely 50-plus Forum
Llantrisant 50-plus Forum
Merthyr Tydfil Old People’s Welfare Committee
Polish Community of the Valleys Association
Rhondda Hard of Hearing Group
Royal Glamorgan Hospital maternity ward
Upper Rhondda 50-plus Forum

Written submissions - contributors from Cwm Taf with links to protected characteristics
Opinion Research Services (ORS) have provided an analysis by health board and by protected characteristics group of the responses made in the text box of the open questionnaire. For Cwm Taf, the largest numbers responding related to children (2,451) and those under the age of 35 (1,773) with 1,010 relating to disability, 537 aged 75-plus, 480 maternity, 91 non-white and 920 NHS employees.

### Summary of key issues

A schedule of key issues which impact on protected groups can be found in the equality impact assessment evidence document. The ORS consultation outcomes executive summary deals with equality issues, and identified from all the possible sources of information, a number of themes.

Each of the issues highlighted has been reviewed from a Cwm Taf perspective using information and data from Cwm Taf respondents. In terms of protected characteristics, the majority of comments specifically relate to age, disability and maternity.

**Increased travel times**

This issue relates to any impact on patient safety and outcomes if travel times are longer, particularly for time critical interventions. More than 240 respondents to the open questionnaire were concerned about the impact on patient safety (including general comments about the loss of life if Royal Glamorgan Hospital is not a specialist centre); 669 (191 under 35; 267 relating to children; 54 maternity; 49 over 75; 121 disabled; four non-white and 66 NHS employees) reflected that the distance to other hospitals from the Royal Glamorgan Hospital catchment area will risk lives (generally) with a further 232 highlighting a specific risk to babies and children.

Rhondda has a substantially higher number of elderly people than the Wales average and the percentage of older people with limiting long term disabilities
across Rhondda Cynon Taf (RCT) is higher. These residents are more likely to require access to critical care services.

Options one and three which do not see Royal Glamorgan Hospital as one of the specialist centres were therefore of particular concern but similar concern in relation to option two if Prince Charles Hospital is not a centre was also voiced with reference to the strategic location of the hospital for the heads of the valleys populations:

“Two of the wards with the highest levels of patients with health limiting conditions are Treherbert and Maerdy – two wards whose travel times to hospital will arguably increase the most.” Leighton Andrews AM

“Many children with complex needs suffer from severe problems and need to receive medical treatment quickly. They have open access to the ward and can arrive in a relatively short space of time. This would not be the same if Royal Glamorgan Hospital services were transferred.” Member of staff. Royal Glamorgan Hospital

“RCT residents will have to travel considerably further to access other hospitals – an issue compounded by the fact that more than a quarter of households are reliant on public transport. This will diminish health outcomes, increase health inequalities and threaten patient safety. Valleys topography means that mountain roads are often impassable in winter and during accidents and other incidents, which restricts access to Prince Charles and Princess of Wales hospitals.” ORS report.

Increased travel time could increase risk to life, Article 2, Right to Life, Human Rights Act 1998. It is also relevant to Article 8 as it will affect family life, particularly for parents who have a child in hospital and others at home. There are also implications for people with a sensory loss who may find it more difficult to find their way around a hospital that they are not familiar with compared to a local hospital with which they are familiar and have been able to learn routes etc.

**Public transport and non-emergency transport**

This issue relates to the concerns that the current public transport infrastructure and routes do not match the proposed South Wales Programme service model and the proposed locations of specialist centres. The majority of responses from Cwm Taf were travel and transport-related with numerous examples of how difficult and expensive public transport is and the particular challenges using public transport faced by older people, people with mental health problems and disabilities.
There is a clear link to the deprivation experienced by the local community. Given an ageing population, it is likely that some hospital services will be used by older patients and visitors. More than a quarter of households in RCT are reliant on public transport. Even if service users are taken to hospital by ambulance, they often have to make their own way home.

This is borne out by the number of comments in the open questionnaire (493, of whom 104 were disabled) specifically referring to the difficulties and cost of public transport, particularly in the Royal Glamorgan Hospital catchment area and written submission responses for example:

“There are no direct bus links to Prince Charles Hospital, UHW or Princess of Wales Hospital –it would take people from the valleys three to four hours to attend either of these hospitals apart from Royal Glamorgan Hospital.” Resident from Pontyclun;

“To get from the Rhondda to Prince Charles Hospital by public transport would take at least three hours. To hire a taxi would be too costly for the majority of older people to afford. No direct bus route is available to the Princess of Wales Hospital from the Rhondda.” Rhondda 50-plusForum;

“There are many elderly residents and families on low income whose only means of access is public transport. They would find it impossible to travel to any other hospital other than the Royal Glamorgan Hospital and possibly the UHW.” Tonyrefail and District Community Council;

“The assumption that nearly all people travel to hospital by car shows total lack of understanding of how people in deprived communities exist.” Sixty-six-year-old resident from Treorchy;

“There are 12 different journey combinations from Ton Pentre to Princess of Wales Hospital. Bus journeys to Royal Glamorgan Hospital cost £5.80 but other sites cost £7.30.”

“Rushed into Royal Glamorgan Hospital by ambulance but had to come home by taxi. Don’t know how I will manage if hospital further away as on a small pension.” Older member of public;

A common theme identified in the ORS report was that “Disabled people, those with mental health issues and the elderly will find it harder to access services under the South Wales Programme as not all can (or can afford to) use public transport or fund additional fuel costs.”
Difficult journeys particularly in bad weather
This issue relates to the difficulty of travelling to proposed specialist hospitals (under option three) given the geography and topography of South Wales which can restrict access to Prince Charles and Princess of Wales hospitals. This point was made by many people (427 comments in text of open questionnaires):

“Mountain roads act like physical barriers. People do not automatically go to their nearest hospital.” Sixty-six-year-old resident from Treorchy;

“Over the last five years, all of the mountain roads out of the Rhondda - the Bwlch, the Rhigos and the Maerdy mountain roads - have been closed for a total of 52 days by the council. Adding other incidents takes to 100 days.” Councillor for Porth, Rhondda Cynon Taf.

Deprivation
This issue is about the impact of the proposals on deprived communities and is therefore of particular relevance to Cwm Taf.

Many respondents to the open questionnaire (357) commented that option three would have a disproportionate impact on deprived communities in RCT where burdens of ill health and health inequalities are greater with a higher reliance on health services. There are low levels of car ownership and lower income levels. Socioeconomic status is not a protected characteristic but there is a strong correlation between the two.

Comments were made that RCT has considerably higher levels of deprivation and poorer health than Bridgend and many of the areas that would be affected most by option three are among the most deprived in Wales:

“Removing services from Royal Glamorgan Hospital will disproportionately affect some of the most socially vulnerable and deprived members of society who are already more dependent on local health care services than neighbouring areas.” Royal Glamorgan Hospital hospital medical staff committee;

The ORS report: “Programme, travel and transport were the predominant issues raised, especially in the context of increased journey times and cost. These concerns are most prevalent in RCT where, it was argued, the burdens will fall heaviest due to disadvantaged nature of the area. Indeed, the considerable deprivation and poor health (and low levels of car ownership) in RCT led many people to object to option three on the grounds that it will diminish health outcomes and increase health inequalities for the county’s residents. It was also said that people from deprived areas tend not
to respond to consultations such as this, and that this should be taken into consideration.”

Access issues for visitors
This issue relates to visitors and increased stress for both patients and relatives in having to travel further and/or to unfamiliar centres, particularly if a relative has an inpatient stay for some time away from their local area. There are also potential cost implications. The benefits of visitors in terms of patient morale and wellbeing, outcomes and providing practical support were highlighted. Several examples were given on the impact on parents and siblings in relation to neonatal and paediatric services.

Three hundred and sixty one responses in the open questionnaire referred to difficult access for visitors/patients if services were lost at Royal Glamorgan Hospital, (73 were from respondents under 35; 122 related to children; 29 maternity; 36 over 75 and 68 were disabled). A further 73 made the same point specifically in relation to babies/children and parents. This is also relevant to Article 8:

“We live five minutes away from Royal Glamorgan Hospital. I have two other children to look after and as it was close was able to go home and back frequently. If I had to go to another hospital, it would have become a major problem.” Parent from RCT;

“On a paediatric ward, parents usually stay with their children most of the time, going home to replenish clothing and caring for other children. This would be extremely difficult if they had to travel distances to other hospitals leaving their child alone in hospital for long periods of time.” Member of staff Royal Glamorgan Hospital;

“If families have to use bus services this will result in sick children spending time on an acute paediatric ward without their loved one by their side.” Ward manager Royal Glamorgan Hospital;

“A lot of patients don’t have visitors. They are on their own as they have come a long distance. They are distressed and lonely, especially older people, as their family and close friends are unable to visit them as they are too far away or can’t visit during the day.” Member of chaplaincy team Royal Glamorgan Hospital.

Car parking and congestion on hospital sites
This issue relates to views that increasing activity on already congested sites will cause problems especially for disabled people. While some Cwm Taf respondents
raised concerns about the impact of increasing demand on centres like UHW, only
19 comments were made specifically about car parking issues in the open
questionnaire and this could be related to the lower levels of car ownership in
Cwm Taf.

Ambulance services
This issue relates to concerns about the current response times and the ability of
the Welsh Ambulance Service to cope with the proposed changes including more
and lengthened journeys. One hundred and 27 people from Cwm Taf in the open
questionnaire referred to the pressure on the ambulance service to deal with the
changes. Similarly 127 people responded that the ambulance service cannot meet
response times and must improve. Ambulance response times in RCT are the
worst in Wales and will potentially worsen under option three as ambulances will
have to travel further. Respondents’ support for option four (five hospitals
including Prince Charles and Royal Glamorgan hospitals) included reference to
the fact that the ambulance service receives twice as many calls from RCT than
Bridgend. Longer response and journey times will have a more detrimental effect
on RCT residents:

“Most people will dial 999. We are concerned about ambulance delays.”
Residents in Talbot Green;

“Concerned about ambulance responses.” Rhondda 50-plus Forum;

“Grandchild with asthma has needed admission to Royal Glamorgan
Hospital on several occasions via A&E and GP. Each time we have driven
him the short distance to hospital by our own transport. If it became
necessary to transport him to Bridgend, Cardiff or Merthyr, I would not
hesitate to call the ambulance service.” Older resident, RCT.

Patient transfers
This issue primarily relates to pregnant women requiring transfer from a non
consultant-led unit, particularly during labour when unforeseen complications
arise. Other comments were around the need to strengthen discharge
arrangements and continuity of ongoing care if service users are not being cared
for locally:

“I have twice been rushed into an operating theatre at Royal Glamorgan
Hospital; once because my unborn child was in distress and once because
having given birth I needed immediate surgery. I cannot imagine the trauma
I would have suffered had it taken an hour to reach another hospital for the
procedures.” Resident from Pontyclun;
“If I had had to travel to another hospital while in labour to have this operation (emergency C-section despite being low risk labour) there may have been a very different outcome for myself and my daughter.” Resident from Blaenllechau, RCT;

“Essential for consultant-led paediatrics, obstetrics and neonatal services to be retained at Prince Charles and Royal Glamorgan hospitals because of challenges around obesity, low birth weight babies, interventions during childbirth.” Merthyr Tydfil Council;

“Standards for Caesarean sections and timings could not be met if [there was] no consultant-led service in Royal Glamorgan Hospital. How is it fair and equitable to pregnant women from some of the most socially deprived areas?” Councillor, RCT;

“Local staff have a good understanding of the services that could be used to support children and their families including those provided by voluntary organisations and local authorities. This will be more important for certain groups of children such as disabled children and young carers.” Fframwaith children and young people partnership in RCT.

**Neonatal services**

There are concerns that parents of sick neonates would be burdened by additional transport and other costs during their child’s lengthy stay and that travelling further would take more of their time away from other children or work. Comments were expressed that demand for neonatal care is far higher at Royal Glamorgan Hospital compared with Princess of Wales Hospital. Royal Glamorgan Hospital has an excellent, valued and well used level two-plus neonatal unit (the only one in Wales) that can deal with pregnancies and multiple births at 28 weeks-plus.

RCT has the highest percentage of low birth weight and premature babies in Wales as more than 8% have babies weighing less than 2,500g. BME mothers are also more likely to have lower birth rate babies.

493 people commented on this in relation to public transport costs and there were comments on access generally. There were high numbers of respondents from people under 15, children and disabled categories here.

Case studies were produced in relation to cost and travelling time from Ton Pentre and Maerdy based on 12 different travel times.

“Female member of staff – pregnancy: works at the neonatal unit, Royal Glamorgan Hospital. Questions how disadvantaged families from deprived
areas within RCT have been considered. Gives example of a pregnant woman from Maerdy, 28 weeks pregnant who goes into preterm labour. She has no transport and has other small children. She rings the midwife who arranges for an ambulance to take her to the nearest obstetric led maternity unit for assessment and delivery. Under the new shake up, she may go to Bridgend, Cardiff or Merthyr. Having delivered the baby she remains with her baby until she is discharged home. Her baby remains in hospital and she then travels everyday if she can, to see her baby. This continues for at least eight weeks. When the baby is discharged to Maerdy, there is no neonatal outreach in RCT. Will this be provided by Bridgend, Cardiff or Merthyr? The woman is comprised in safety, quality of care and accessibility, the very objectives of the South Wales Programme.”

Ten people expressed concern about the lack of capacity across South Wales and South Powys for neonatal care generally:

“We live within easy access of the A470 and M4 and yet were unable to access the care of foetal medicine in Cardiff due to the extraordinary pressure they were under. If the special care baby unit at Royal Glamorgan Hospital had been unable to accept our son, it would have been necessary to deliver and continue to be cared for a long way away from home and the expert team at Royal Glamorgan Hospital who know us so well and continue to care for us in these difficult times.” Mother with experience of using services in Royal Glamorgan Hospital and Bristol (baby born 1lb 15oz).

Both of these would particularly impact on children, females, economically deprived families and the right to family life.

**A&E services**
Concerns were raised about how current A&E services deal with patients with mental health issues. This would impact on older people and disabled people who are likely to experience mental health issues.

Concerns were also raised that changes could exacerbate problems with ambulance handover times unless A&E procedures are significantly improved.

See comments in earlier sections regarding ambulance aspect of this issue.

**Primary and community services**
Comments about the need to strengthen and properly resource primary and community care if the proposed model is to work, including improvements to out-of-hours provision and better integration with social care.
36 people and nine people, respectively, commented on primary/community and primary/community out of hours services. Most of these were in the children, 75-plus and NHS employee category.

**Supporting people to access services appropriately**
Sixteen respondents (three under 35; four children; one maternity; two aged 75-plus, one non-white and three NHS employees) expressed concerns about how people will know which hospital to go to for different services particularly in an emergency situation. This would be particularly relevant to difficult to reach groups who are often single parents, older people, people living in deprived areas and may also be challenging for those who have a sensory impairment or learning disability.

The other issue raised here was the need for services to be made more accessible for people with a disability - a female member of staff at Royal Glamorgan Hospital said children with severe problems who need to receive medical treatment quickly:

“…have open access to the ward and can arrive to the ward in a relatively short period of time. This would not be the same if the Royal Glamorgan Hospital services were transferred. Would the children (more than 100) still be able to have open access?”

This is relevant to the youngest population of RCT and Merthyr Tydfil depending on which option is selected but options one, two and three could all impact on this.

The same principle would apply to the other three services and it has already been noted that there are high numbers of disabled people and people experiencing significant ill health.

**Capacity of specialist centres**
Concerns were raised about the ability of specialist centres to cope with additional activity and the consequent displacement of other services.

Responses related to impact on UHW (253 respondents: 55 under 35; 86 children; 17 maternity; 25 aged over 75; 43 disabled; four non-white and 54 NHS employees) and the impact on Prince Charles Hospital (43, of which 12 are under 35; 17 children; three maternity; two aged over 75; seven disabled; one non-white and nine NHS employees).

If the specialist centres were unable to meet additional demand this would impact on the young, females, elderly and disabled who are particularly reliant on these four services.
Workforce recruitment
This relates to concern around the ability to recruit and retain sufficient doctors to provide these services given the shortages nationally and staffing implications for hospitals which are no longer specialist centres.

Two respondents (one under 35 and two NHS employees) from the Cwm Taf area saw this as positive for Princess of Wales but 17 (six under 35; eight children and four NHS employees) saw it as negative for Royal Glamorgan Hospital. Eighty-five (15 under 35; 31 children; three maternity; eight aged over 75; 15 disabled; five non-white and 10 NHS employees) said it was important to address these issues generally.

Some respondents to the consultation made comments to the effect that “the health service has been run down to such an extent that it is no longer an attractive proposition for mobile professions such as these”.

A Cwm Taf trauma and orthopaedic consultant commented: “Any hospital that has the 24-hour A&E care will have trauma and any that does not have 24-hour A&E cannot have any trauma cases. The implications of this are wide-reaching. Any move to trauma and non-trauma sites will impact on junior doctor training provision with a lack of complete training available at either hospital ... this would result in training grade doctors of all levels being removed from both of the hospitals making service provision impossible at either site.”

Options one, two and three could impact on this issue. If insufficient doctors could not be recruited and retained in the non-specialist centres, this could particularly impact on women, disabled and elderly people who are most likely to use those services.

Population changes
Questions were asked how changing demographics have been taken into account, particularly the growing number of older people in the population.

156 people commented on the large and growing population served by Royal Glamorgan Hospital - 37 of these were under 35; 61 children; nine maternity; eight aged 75 and over; 15 disabled; three non-white and 22 NHS employees.

It is recognised that there are particular issues in relation to RCT and Merthyr Tydfil; current projections see a rise in the older population (75 and over) of Cwm Taf Health Board residents from 22,000 (8% of total population) in 2006 to 39,000 (13% of total population) in 2031. The increase in the number of older people is likely to cause a rise on chronic conditions such as circulatory and respiratory
diseases and cancers, (Cwm Taf Demography Profile Summary, Public Health Wales Observatory, 2009).

Specialist and Critical Care Centre (SCCC)
Concerns were raised about the lack of certainty from Welsh Government on the availability of capital to build the SCCC given that it is an integral part of the options; how services will be provided in the interim and the consequences if it doesn’t go ahead.

This was raised within all five health boards and specifically by 23 Cwm Taf respondents, six of whom were disabled.

Impact on staff
This relates to concerns around whether staff will be expected to move base with a particular concern about the implications for ancillary staff.

Three comments were received specifically about staffing in relation to the SCCC but this would be unlikely to affect the Cwm Taf workforce. From the workforce analysis, it is evident that a high proportion of female staff are potentially affected as are some staff from older age groups.

Human Rights
Reference to Human Rights has been made throughout this assessment. The right to respect for private and family life, home and correspondence” is relevant to this assessment. This human right is not an absolute right, and any interference should be justified, lawful, necessary and proportionate.

The improved quality of care possible due to more centralised hospital services should result in patients spending less time in hospital. However, increased travel distances could have a negative impact on the right to maintain family life. This would apply to the patient and to individual members of the family.

Various comments have been raised throughout the consultation about the risk to life with greater travel times to A&E, women potentially being moved during labour when complications arise and transfer of neonates and this would relevant to the right to life which is an absolute right. Article 14, prohibition of discrimination is also relevant to all of the equality considerations raised.
Mitigation

An effective equality impact assessment takes into account the views and opinions of those who may be affected by the policy and what is already known about how the policy might affect different groups. The South Wales Programme has used national evidence, Public Health Wales information, Census data, travel times and distances to hospitals, and public views to identify issues. The schedule of key issues which impact on protected groups can be found in the equality impact assessment evidence document (click here).

The consideration of mitigating measures and alternative ways of doing things is at the heart of the equality impact assessment process. Different options have been developed which reflect different ways of delivering the South Wales Programme aims. The consideration of mitigation of adverse impacts is intertwined with the consideration of alternative actions. Mitigation can take the form of lessening the severity of the adverse impact.

Consideration must be given to whether separate or combined actions are necessary for the programme to be effective for any relevant group. Ways of delivering its aims which have a less adverse effect on the relevant equality category or issue, or which better promote equality of opportunity for the relevant equality category, have been considered.

However, it must be emphasised that the South Wales Programme has only reached stage two of its equality impact assessment, the post consultation pre-decision stage. The consultation considered four different options, including a best fit option. The issues and initial mitigations described within the equality impact assessment reflect that. The mitigations are expressed at high level. These will need to be worked through together with any further issues and mitigations once a decision on a preferred option has been made. This will be the focus of stage three of the equality impact assessment. For this reason, any issues and mitigations described in stage two must be considered to be preliminary, not exhaustive, and to be untested at this stage by the clinical reference groups and stakeholders.
This equality impact assessment is representative of a real attempt to address the following 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?

Where any concerns relating to equality have been raised, these have been identified and explored in order to establish possible mitigation and to avoid discrimination against any particular groups and to promote equality of access to services. This has involved consultation with different groups in relation to the protected characteristics in accordance with the Equality Act 2010 through the use of appropriate media, fora and by building on existing relationships. Attendance at public meetings, completion of questionnaires etc has been monitored and reported.

The composition of the local population (2011 Census and public health information) has been analysed and issues considered and the different groups’ current access to the four services (based on limited information) has also been considered.

The other main element of analysis involved looking at the protected characteristics shared by staff employed in each of those services to avoid discrimination caused by a potential move of the services in which they are employed although this would be considered on an individual basis under the terms of the organisational change policy once an option is agreed.

As mentioned earlier this is the second stage of the equality impact assessment process and a third stage will be undertaken once the option is agreed.
Appendix E: Powys Teaching Health Board Local Assessment of Equality Impact

Introduction

This document supplements and should be read in conjunction with the South Wales Programme equality impact assessment evidence document stage one produced in May 2013 (revisited October 2013 as stage two), which provides an overview of the overall issues which may affect members of the South Wales and South Powys communities who share protected characteristics as defined by the Equality Act 2010.

It has also been considered against the Human Rights Act 1998, particularly Article 2, the right to life; Article 8, the right to privacy and family life and Article 14, Prohibition of Discrimination; and the broader context of the UN convention on the Rights of Persons with Disabilities and the UN Convention on the Rights of the Child, with particular reference to the need to provide access to healthcare.

This assessment is based on Public Health Observatory and Census information, and findings collated and analysed by Opinion Research Services (ORS) from the public consultation. It is limited to data available at present.

Overview

The South Wales Programme consulted on four options for the future of consultant-led maternity and neonatal care, inpatient children’s services and emergency medicine (A&E). During the engagement and consultation phases of the programme, we explained that three hospitals are considered to be fixed points because of the range of services they already provide and the size of the population they cover: University Hospital of Wales (UHW) Cardiff; Morriston Hospital, Swansea; Specialist and Critical Care Centre (SCCC) – a new hospital to be built near Cwmbran. Three other hospitals were considered in relation to a fourth or possibly fifth location for these specialist services. Consultation focused on consideration of four options for the provision of these specialist services at either four or five hospitals in the future.

The four options for the future of consultant-led maternity services, neonatal care, inpatient children’s services and emergency medicine (A&E) are:

**Option 1**: UHW, Morriston, SCCC, and Prince Charles Hospital, in Merthyr Tydfil
**Option 2**: UHW, Morriston, SCCC and Royal Glamorgan Hospital, in Llantrisant
Option 3: UHW, Morriston, SCCC, Prince Charles Hospital and Princess of Wales Hospital, in Bridgend
Option 4: UHW, Morriston, SCCC and Prince Charles and Royal Glamorgan hospitals

Each of these options has been assessed against a wide range of factors, including their impact on travel times, especially for people living in the most deprived communities; the number of doctors needed, the impact on the Welsh Ambulance Service, the likely cost of such change and what we were told last year during engagement.

The option which struck the best balance between all these factors, and was therefore identified as the best fit option, was **option three** – concentrating these services in five hospitals: UHW, Morriston, SCCC, Prince Charles and Princess of Wales hospitals.

Concentrating these services in fewer locations would mean some other services in those centres would also need to move. For example, if services are concentrated according to option three, some services – planned surgery and some acute medicine – may need to move from Princess of Wales and UHW to the Royal Glamorgan Hospital. In this scenario, Royal Glamorgan Hospital would provide health services for its local population and some care for people living in the Bridgend, Cardiff and the Vale of Glamorgan.

**What are the implications for residents of Powys**

Powys residents will be affected by change regardless of the outcome of the South Wales Programme deliberations. The key services under consideration are consultant-led maternity and neonatal care, inpatient children’s services and emergency medicine (A&E) for the most seriously ill and injured patients.

Most people in South Powys accessing these services do so at Nevill Hall Hospital, in Abergavenny. Following a previous consultation it is proposed that these services will transfer to the new Specialist and Critical Care Centre (SCCC) in Cwmbran and work is currently underway by Aneurin Bevan University Health Board to take forward the outcome of that consultation.

But, importantly, most health care services, including minor injury, antenatal, postnatal and low-risk labour and birth services will still continue to be provided locally as they are now, either within Powys, but also in Nevill Hall Hospital. It is only those key hospital services described above that will be affected by the proposed changes.
Depending on where they live in South Powys, some residents will find it easier to access Prince Charles Hospital, in Merthyr Tydfil and others the SCCC. Until the SCCC is built, Prince Charles Hospital, for many residents in South Powys would be the nearest available hospital. With all of the options, some Powys residents would live further from specialist services than they do now.

Option two is the only option in which Prince Charles Hospital does not feature.

For Powys Teaching Health Board the judgment which will need to be made is whether there are increased travel times and whether these will be detrimental to outcomes for patients. Through an equalities lens, consideration also needs to be given to the impact on protected and disadvantaged groups and their families and carers.

### Consultation with equality groups

Each of the five health boards has contributed to a collaborative approach and this is summarised in the main equality impact assessment evidence document. As part of this collaboration, specific health boards built on existing relationships to consult with particular equality groups – for example Cwm Taf consulted with deaf people; ABM with people with learning disabilities and Cardiff and Vale with black and minority ethnic (BME) groups.

Although none of the proposed changes take place within Powys, the changes will affect the residents of South Powys who will have to travel out of county for specialist treatment. The health board was acutely aware of the need to ensure equality groups had the opportunity to voice their opinions. It therefore used a wide range of mechanisms in order to reach as many people as possible, including:

- Powys Carers
- Patient forums
- PAVO
- Powys Mental Health
- Town and community councils
- Hospital Leagues of Friends
- Young farmers clubs
- The How Fair is Powys public events and mailing list
- Powys maternity services liaison group
- Tros Gynnal Plant (Independent Advocacy for Children
- Children and young people’s partnership
- Maternity stakeholder group.
These groups in turn promoted and responded to the consultation on behalf of their members and equality groups.

ORS collected and collated data on the protected characteristics of respondents to the South Wales Programme consultation, summarizing it in several different ways. This included the equality profile of people who attended equality meetings; contributed written submissions to the questionnaire and responded to the residents’ survey. In addition, ORS also identified, wherever possible, contributions to the open questions within the questionnaire and the residents’ survey by equality characteristic.

### Powys Teaching Health Board population and service users

#### Gender
Very slightly higher proportions of female residents in the Powys health board area and this is broadly consistent with both the wider South Wales Programme area and Wales.

#### Age
Powys and has a lower proportion people aged 0-44 years, and a higher proportion in the older age bands (45-64 years, 65-84 years, and 85 years plus) than Wales as a whole. Older people are less likely to have access to a car.

#### Disability
A total of 21.4% of Powys residents identified themselves as disabled. While this is lower than the 23% South Wales Programme average, this is still significant particularly as disabled people are twice as likely to have no access to a car (Office for Disability Issues 2009) and more likely to experience other disadvantages such as low income, communication difficulties and getting ready to leave home to attend appointments.

Disabled people are also less confident in using public transport because of physical access issues but also because of staff attitudes (Framework for Action on Independent Living 2012).

Mental health patients are more likely to present at A&E than some other groups.

#### Ethnicity
Powys has lower representation from ethnic groups other than white than the other South Wales Programme health boards and Wales as a whole.
It has been documented that, in general, maternity services fail to provide adequate support to women from ethnic minority backgrounds (Equality and Human Rights Commission Review, 2010). Although there is no evidence of any specific issues in Powys, this fact should be noted even though numbers are small.

**Marriage and civil partnership**
The number of people who are married or in a same-sex civil partnership in Powys is higher (51.1%), than the overall Wales proportion (46.6%).

**Religion**
While there are variations in the South Wales Programme area in the proportion identifying as Christian (Blaenau Gwent is the lowest at 49.9%, and Powys the highest at 61.8%), most of the variation is due to differences in numbers stating they have no religion, rather than increases in the proportion of non-Christian religions.

**Car or van ownership**
Powys has the lowest proportion of households with no car or van at 15.0% compared to 22.9% for Wales.

**Deprivation**
Of the four household characteristics/dimensions to describe deprivation on p47 of the main evidence document Powys, together with Cardiff, has the highest proportion (41.6%) of residents who are not deprived in any dimension.

**Residents who assess their general health status as bad or very bad**
In Wales, 7.6% of residents assessed their general health status as bad or very bad. The majority of local authorities with the highest rates of bad or very bad health are situated in the South Wales valleys.

In Powys Teaching Health Board and local authority, the proportion of residents who described their health status as bad or very bad was below the Welsh average at 6.1%. Merthyr Tydfil had the highest proportion of residents who described their health status as bad or very bad at 11.2% compared to Gwynedd which had the lowest proportion at 5.3%.

There is considerable variation at the lower super output area level within the health board. However these are crude percentages only and do not take into account the age structure of the population. The proportion of residents reporting bad or very bad health ranged from 3.1% in the St Marys area of Powys (Powys LSOA 017E) to 13.3% in the Ystradgynlais area of Powys (Powys LSOA 021D).
The areas with the highest percentages are found in the Aber-craf, Cwm-twrch and Ystradgynlais areas of Powys.

Figure 8: Residents who assess their general health status as bad or very bad in Powys Teaching Health Board, March 2011.
Residents whose daily activities were limited by a long-term health problem or disability

In Wales about a fifth (22.7%) of residents’ day-to-day activities are limited a lot or a little by a long-term health problem.

Figure 2: Residents whose daily activities are limited a lot or a little by a long-term health problem or disability in Powys Teaching Health Board, March 2011
Among Welsh local authorities, Neath Port Talbot had the highest percentage of residents whose day-to-day activities are limited a lot or a little by a long-term health problem at 28% compared to Cardiff which had the lowest proportion at 18%.

In Powys Teaching Health Board and local authority, the proportion of residents whose day-to-day activities are limited a lot or a little by a long-term health problem was below the Welsh average.

At the lower super output area level the percentage of residents whose day-to-day activities are limited a lot or a little by a long-term health problem ranged from 15.8% in the Felin-fach area of Powys (Powys LSOA 020A) to 33.8% in the Ynyscedwyn area of Powys (Powys LSOA 021C). The areas with the highest percentages are found in the Ystradgynlais, Llandrindod East/Llandrindod West, Cwm-twrch, and Ynyscedwyn areas of Powys. It is important to note that these are crude percentages only and do not take into account the age structure of the population.

Residents aged 16-74 years who have never worked or are long-term unemployed
In Wales, 5.4% of the working age population has never worked or are long-term unemployed. In Powys Teaching Health Board and local authority the proportion of residents who have never worked or are long-term unemployed was below the Welsh average at 3.3%.

In Welsh local authorities Blaenau Gwent had the highest proportion of the population which has never worked or are long-term unemployed at 8.7% compared to Ceredigion which had the lowest percentage at 3.1%.

At the lower super output area level the percentage of residents who have never worked or are long-term unemployed range from 1% in the Llanafanfawr area of Powys (Powys LSOA 014C) to 8.5% in the Llandrindod East/Llandrindod West area of Powys (Powys LSOA 013A). It is important to note that these are crude percentages only and do not take into account the age structure of the population. The areas with the highest percentages are found in the Ystradgynlais, Newtown South and the Llandrindod East/Llandrindod West areas of Powys.
Lone parents
While the proportions for the South Wales Programme area in total mirrors closely the proportions for Wales as a whole, there is noticeable variation within the South Wales Programme area between health boards and between local authorities.
At a health board level, Cardiff and Vale UHB has the lowest proportion of male lone parent households (8.5%), and the highest proportion of female lone parent households (91.5%). Typically the proportion of male lone parent households in the SWP area is between 8% and 10%. However, Powys Teaching Health Board is a significant outlier with 16.4% of its lone parent household male.

**Welsh language**
Powys as a whole has the highest percentage of Welsh speakers (19%) among the population of the five South Wales Programme health boards. There is a risk that Welsh speakers, particularly the more vulnerable groups, will find it more difficult to receive a comparable bilingual service. A mitigation for this might be for other health boards to ensure the Powys linguistic profile is factored in to their workforce linguistic capacity-building when implementing their Welsh language framework active offer objective.

**Service users**
Analysis of the demographic profiles of service users for emergency medicine (A&E), paediatrics and obstetrics and gynaecology is referenced earlier within the main evidence document.

However, there are some issues and points specific to Powys, which are worth highlighting here for each of the key service areas.

**Emergency medicine (A&E)**
The equality monitoring data captured within the hospital systems used by NHS Wales of Powys patients accessing emergency medicine is not comprehensive. Of the 7,003 emergency medicine (A&E) attendances by Powys residents, 1,777 were recorded as white; 5,027 not stated and where ethnicity was reported the numbers were so low as to be identifiable and therefore not publishable.

The 7,003 attendances make up 1.2% of the 610,486 occurrences recorded in 2012 for all South Wales Programme health boards. Aneurin Bevan University Health Board’s recorded activity was 182,535.

This would indicate that a public transport solution for Powys residents travelling to the SCCC or Prince Charles Hospital might not be commercially viable. The proportion of people who access A&E via public transport is also very low across the whole of the programme area. The impact of the proposal for protected and disadvantaged groups reliant on public transport and ways of mitigating this will need to be explored further, perhaps in discussion with Welsh Government, enabling some Powys residents to access services differently.
Non-emergency patient transport eligibility criteria is a matter of national policy at government level. Consideration will need to be given to mitigate the disadvantage of people travelling longer distances for services. Alternatives to public transport, such as community transport schemes, may be appropriate to consider. The cost of travel for people not eligible for free transport is already significant for Powys residents. As highlighted in the equality impact assessment stage one and two documents, access to transportation and associated costs is more likely to have an even greater impact for the protected and socioeconomically disadvantaged groups.

There was no significant difference between males and females.

**Paediatrics**
The equality monitoring information available for paediatrics is similar to that of emergency medicine (A&E). Of the 593 recorded attendances, 435 did not state their ethnicity, 153 were recorded as white.

There were no significant difference between male and females.

An alternative source of information provided locally for 2012 shows paediatric 601 “spells” for Powys residents at Nevill Hall Hospital; 52 at Prince Charles Hospital and 812 at Hereford Hospital. This demonstrates the importance of Nevill Hall to South Powys; it also reinforces the need to mitigate against associated transportation, travel and ambulance issues during any implementation phase into a reconfigured South Wales health service for South Powys people.

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.

Of relevance to South Powys is the assertion within the themes and mitigations section of the main equality and impact assessment document, and the consultation document, that, in view of the relatively small distances that people will have to travel further, no additional provision will be given to family accommodation. While this may be true of the rest of the South Wales Programme area, this may adversely affect South Powys service users, especially those with protected characteristics.

**Obstetrics and gynaecology**
Powys is fortunate to have an acclaimed and highly-regarded midwife-led maternity service. During 2012, 1,226 women were recorded as receiving obstetrics services. Of these, 916 were aged between 25 and 44 and 299 between 16 and 24. Obstetric and maternity figures obtained locally for 2012 show
300 attendances at Nevill Hall Hospital; eight at Prince Charles Hospital; 260 at Hereford Hospital; 390 within Powys and a further 279 within the Abertawe Bro Morgannwg University Health Board area.

If consultant-led care was not available at Nevill Hall Hospital, the alternative for women from the Brecon area would be to travel to Prince Charles Hospital and for others from Powys to possibly either the Royal Gwent or Hereford hospitals. In future women would be guided towards Prince Charles Hospital or the SCCC. In future, to maintain choice it would be important that services are maintained at Prince Charles Hospital to ensure women have a choice between it and the SCCC.

Powys Health Board might want to factor in patient choice as mitigation, particularly for disadvantaged groups by ensuring that the option, in some cases, remains open for women to attend or to give birth in Hereford or elsewhere.

Neonatal
Numbers, but no further analysis on neonatal admissions provided from a local health board source, show 27 admissions to Nevill Hall Hospital and a further 20 to Hereford Hospital.

Although these numbers are small, with the other specialties, transportation, access and the right to family life should be mitigated not only from a programme-wide perspective but at local health board level. The themes and mitigations section of the main evidence document provides a comprehensive explanation of the issues and the official programme response.

Staff profile
Powys Teaching Health Board as an employer is not directly affected by these proposals and has not included staff profile information within this appendix.

Human Rights
The right to respect for private and family life, home and correspondence is relevant to this assessment. This human right is not an absolute right, and any interference should be justified, lawful, necessary and proportionate.

The improved quality of care possible due to more centralised hospital services should result in patients spending less time in hospital. However, increased travel times could have a negative impact on the right to maintain family life. This would apply to the patient and to individual members of the family.
**Consultation responses – equality perspective**

This section supplements the information provided earlier in this document, the main evidence document and the reports prepared by ORS from a Powys perspective.

The majority of responses to the consultation were from Cwm Taf residents. The low numbers of Powys respondents to the consultation is attributable to the smaller population.

The relevance of the issues on the protected characteristics is well presented within the main evidence document. Namely, that women, children, older people, disabled people, families, Welsh speakers and people described as being socioeconomically deprived will be more affected by the proposals than others. 283 questionnaires were completed. The equality profile disclosed by respondents was 43 disabled; 36 aged under 35; 40 aged over 75; seven maternity; 62 with responsibility for a child and only one non-white. Forty-five questionnaires were submitted by NHS employees.

Very few respondents offered a preference between the four or five-centre model. Those respondents who choose to highlight specific issues or suggestions tended to do so for option three. The top five issues identified from the questionnaires were:

<table>
<thead>
<tr>
<th></th>
<th>First</th>
<th>Impact of loss of Nevill Hall Hospital</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second</td>
<td>Other options</td>
<td>37</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Third</td>
<td>Will the SCCC be built?</td>
<td>35</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Fourth</td>
<td>The cost of SCCC</td>
<td>26</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Fifth</td>
<td>Location of the SCCC</td>
<td>22</td>
<td>7%</td>
<td></td>
</tr>
</tbody>
</table>

Looking specifically at what the main issues were for those respondents who had disclosed their equality profile by percentage of the total of that characteristic. Of most concern for people identifying with the maternity characteristic and with one or more dependent children was the impact of the loss of Nevill Hall Hospital.
<table>
<thead>
<tr>
<th>Issue</th>
<th>Disabled</th>
<th>Over 75</th>
<th>Under 35</th>
<th>Dependent children</th>
<th>Maternity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact of loss of Nevill Hall Hospital</td>
<td>37%</td>
<td>27%</td>
<td>19%</td>
<td>29%</td>
<td>14%</td>
</tr>
<tr>
<td>Will the SCCC be built</td>
<td>12%</td>
<td>5%</td>
<td>13%</td>
<td>7%</td>
<td>0</td>
</tr>
<tr>
<td>Access generally</td>
<td>9%</td>
<td>10%</td>
<td>11%</td>
<td>8%</td>
<td>0</td>
</tr>
<tr>
<td>Other proposals</td>
<td>16%</td>
<td>10%</td>
<td>8%</td>
<td>11%</td>
<td>0</td>
</tr>
</tbody>
</table>

The pattern with regards protected characteristics is repeated for the household survey and the public meetings. The exception to this is the age characteristic for older people. More older people (over 55) attended the public meetings than any other age group. People from all the protected characteristics attended the How Fair is Powys events.

Of the 193 written responses received, eight were from Powys.

Of 874 household questionnaires returned, 59 were from Powys residents.

Of the 155 people who attended public meetings in Powys, the biggest issue coded by ORS was travel and transportation issues to get to selected hospitals – impact on access, changes generally. What is significant, given that Powys has a smaller population, is that this particular issue was recorded 14 times during the Powys public meetings. Compare this with 19 times for the Cwm Taf area and 14 times for Aneurin Bevan (within whose area Nevill Hall Hospital is located).

The next most frequent issue for Powys was the impact of loss of services at Nevill Hall which was recorded three times. In other words, concerns about services moving further away were recorded 17 times.

This trend was echoed by Powys residents throughout the consultation regardless of the communication media used by respondents.

**Some comments from the consultation responses**

“Since the original document/plan, the South Wales Programme was started; Powys appears to have been added as an afterthought. Powys is a rural, low-wage area with a diverse, sparse population very different from the population of South Wales. It therefore has very different needs from
South Wales and the other areas in this document which need to be addressed. People in South Powys are already getting a poor deal in terms of medical services due to the sparcity of the population and this plan would further disadvantage them.” Hay Health and Social Care Group;

“If services at Nevill Hall are downgraded and reduced people in South Powys will have to travel much further to Prince Charles Hospital or even further to Cardiff. The new centre at Cwmbran is being based on population mass which is great news for people in that locality but really bad news for those of us living further away. Powys is an area of low wages and it doesn’t appear that this and the associated problems of rurality have been fully considered.” Another Hay group;

“While the community council recognises that Powys Health Board has to buy in services from other health boards, it deplores the fact that Nevill Hall has not been a “live” option in this consultation process. Cwmbran is not a satisfactory option for South Powys.”

“Llanfrynch Town Council was concerned about the equitable access of resources for the population of South Powys and the danger of losing out.”

“This concept of resources being diverted to South Powys to the detriment of Powys was a recurring theme. Powys Teaching Health Board might want to consider ways of reassuring people that this is not the case and reframe or describe the rationale for South Powys membership to the programme in a more Powys specific way.”

“In South Powys a lot of people go to Hereford Hospital. Has there been any consultation about the possible future of that hospital? I live in South Powys. Travel times to hospitals worry me. Getting home after treatment concerns me too having had problems myself getting home from Nevill Hall.” Powys resident;

“The town council is concerned [about] how friends and relatives will visit them in hospital and request that consideration be given to further work with other partners to better align public transport routes and timetables to hospital services.” Crickhowell Town Council.

Providing some balance to these comments is this from a Powys resident:

“Although travelling distance is a factor, if I have to be in hospital I need to be where I can receive the best treatment. This is not necessarily the
nearest hospital. In the past couple of years I have been in Hereford and Nevill Hall and received much better treatment in Hereford.”

This quote supports the aim of the programme to provide the best key services in right places at the right time and in the first place. This point was also highlighted by a member of the all-Wales Stakeholder Reference Group representing the transgender community.

**Themes and mitigations**

Please also see [chapter 11](#) in the main equality impact assessment document

**Mitigation**

An effective equality impact assessment takes into account the views and opinions of those who may be affected by the policy and what is already known about how the policy might affect different groups. The South Wales Programme has used national evidence, Public Health Wales information, Census data, travel times and distances to hospitals, and public views to identify issues. Issues common to the whole programme have been set out in the main evidence document. Issues specific to Powys Teaching Health Board are described within this appendix.

The consideration of mitigating measures and alternative ways of doing things is at the heart of the equality impact assessment process. Different options have been developed which reflect different ways of delivering the programme aims. The consideration of mitigation of adverse impacts is intertwined with the consideration of alternative actions. Mitigation can take the form of lessening the severity of the adverse impact.

Consideration must be given to whether separate or combined actions are necessary for the programme to be effective for any relevant group. Ways of delivering programme aims which have a less adverse effect on the relevant equality category or issue, or which better promote equality of opportunity for the relevant equality category, have been considered.

However, it must be emphasised the South Wales Programme has only reached stage two of its equality impact assessment, the post consultation pre-decision stage. The consultation was to consider four different options including a best fit option. The issues and initial mitigations described within the equality impact assessment reflect that. The mitigations are expressed at high level. These will need to be worked through together with any further issues and mitigations once a decision on a preferred option has been made. This will be the focus of stage
three of the process. For this reason, any issues and mitigations described in stage two must be considered to be preliminary, not exhaustive, and to be untested at this stage by the clinical reference groups and stakeholders.

Subject to the clarification provided above, please find below the preliminary issues and mitigations specific to Powys Teaching Health Board.

**Travel and transportation including ambulance services.**

To be read alongside [Chapter 11](#). Travel and transportation including ambulance services are the main issues for Powys residents irrespective of protected characteristic. The evidence in the main body of the evidence document highlights that travel and transport difficulties are compounded exponentially by disadvantaged members of the population, particularly those with a disability, caring responsibilities or living on low or fixed incomes. Therefore these issues are relevant to this equality impact assessment and the protected groups.

### Summation – general duty

The three elements of the general equality duty are:

- To eliminate discrimination
- Foster good relations
- Promote equality

The collaborative approach taken by the five health boards includes a workstream comprising the equality, planning and engagement leads and the expertise of the NHS Centre for Equality and Human Rights.

Powys officers have been full and active participants throughout the consultation process. As such, Powys Health Board has been able to access the South Wales Programme resources to build a rich evidence base and to engage with the residents of South Powys. This work has included a full and comprehensive and ever evolving equality impact assessment. It is through this equality impact assessment and its contribution to the decision making process that we can demonstrate having paid due regard to the general duty. Board members are asked to consider whether or not they are satisfied that they have paid due regard to the equality duty in their decision making in relation to the South Wales Programme.
Next steps

The next stage of the equality impact assessment will be after the recommendation on a preferred way forward has been considered by the health boards. Stage three will work through identified issues and mitigations with the clinical reference groups, planners, business managers etc using an equality lens.

During the next stage, we will also test our assumptions and the programme board’s responses and mitigations with relevant stakeholders. We will also engage further with those groups of people who for whatever reason were under represented during consultation. For example, young people, the LGBT community and BME groups.
## Appendix F: Equality profile of South Wales Programme consultation respondents

Figure 9: Socio-demographic characteristics for the open questionnaire overall and broken down for NHS employees.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>All Responses</th>
<th>By NHS employee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Responses</td>
<td>% of Valid Responses</td>
</tr>
<tr>
<td><strong>BY AGE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 25</td>
<td>1,757</td>
<td>7.7%</td>
</tr>
<tr>
<td>25-34</td>
<td>3,668</td>
<td>16.0%</td>
</tr>
<tr>
<td>35-44</td>
<td>3,969</td>
<td>17.4%</td>
</tr>
<tr>
<td>45-54</td>
<td>4,025</td>
<td>17.6%</td>
</tr>
<tr>
<td>55-64</td>
<td>3,730</td>
<td>16.3%</td>
</tr>
<tr>
<td>65-74</td>
<td>3,475</td>
<td>15.2%</td>
</tr>
<tr>
<td>75-84</td>
<td>1,821</td>
<td>8.0%</td>
</tr>
<tr>
<td>85+</td>
<td>419</td>
<td>1.8%</td>
</tr>
<tr>
<td>Not known</td>
<td>4,568</td>
<td>-</td>
</tr>
<tr>
<td><strong>BY GENDER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>8,148</td>
<td>35.6%</td>
</tr>
<tr>
<td>Female</td>
<td>14,729</td>
<td>64.4%</td>
</tr>
<tr>
<td>Not known</td>
<td>4,555</td>
<td>-</td>
</tr>
<tr>
<td><strong>BY DEPENDENT CHILDREN</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With children aged under 18</td>
<td>7,419</td>
<td>33.4%</td>
</tr>
<tr>
<td>Without children aged under 18</td>
<td>14,811</td>
<td>66.6%</td>
</tr>
<tr>
<td>Not known</td>
<td>5,202</td>
<td>-</td>
</tr>
<tr>
<td><strong>BY MATERNITY CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently pregnant or providing maternity care</td>
<td>1,364</td>
<td>6.3%</td>
</tr>
<tr>
<td>Not pregnant or providing maternity care</td>
<td>20,395</td>
<td>93.7%</td>
</tr>
<tr>
<td>Not known</td>
<td>5,673</td>
<td>-</td>
</tr>
<tr>
<td><strong>BY DISABILITY STATUS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider themselves to be disabled</td>
<td>3,320</td>
<td>15.1%</td>
</tr>
<tr>
<td>Not disabled</td>
<td>18,661</td>
<td>84.9%</td>
</tr>
<tr>
<td>Not known</td>
<td>5,451</td>
<td>-</td>
</tr>
<tr>
<td><strong>BY ETHNIC GROUP</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>21,530</td>
<td>97.0%</td>
</tr>
<tr>
<td>Mixed or multiple ethnic groups</td>
<td>198</td>
<td>0.9%</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>262</td>
<td>1.2%</td>
</tr>
<tr>
<td>Black, African, Caribbean or Black British</td>
<td>83</td>
<td>0.4%</td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>131</td>
<td>0.6%</td>
</tr>
<tr>
<td>Not known</td>
<td>5,228</td>
<td>-</td>
</tr>
<tr>
<td><strong>BY NHS EMPLOYEE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS employee</td>
<td>3,821</td>
<td>17.3%</td>
</tr>
<tr>
<td>Not an NHS employee</td>
<td>18,287</td>
<td>82.7%</td>
</tr>
<tr>
<td>Not known</td>
<td>5,324</td>
<td>-</td>
</tr>
</tbody>
</table>
Profile of public meeting attendees

Of the 2,331 people who attended the public meetings in the South Wales Programme area a total of 1,399 returned a completed equality monitoring form. This represents 60% of all attendees. The charts below show the characteristics of those who completed the monitoring form.
Appendix G: SWP Consultation Activity with Protected Groups

The table below sets out our consultation activity and indicates how we targeted different groups of people that may have one or more ‘protected characteristics’.

<table>
<thead>
<tr>
<th>Date, Time, Location and Target Group</th>
<th>Protected Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 May Llanhilleth Miners’ Institute 50 Plus Network Partnership</td>
<td>Age √</td>
</tr>
<tr>
<td>22 May 1.00 p.m. Clydach Rhondda Cynon Taf 50 Plus Planning Group</td>
<td>Disability √</td>
</tr>
<tr>
<td>23 May 10.30 a.m. Swansea Civic Centre Children and Young People Disability Strategy Steering Group</td>
<td>Gender Reassignment √</td>
</tr>
<tr>
<td>28 May 1.30 p.m. UHL Boardroom Stakeholder Reference Group</td>
<td>Marriage &amp; Civil Partnership √</td>
</tr>
<tr>
<td>29 May 10.00 a.m. Valleys Innovation Centre Cwm Taf Stakeholder Reference Group</td>
<td>Pregnancy &amp; Maternity √</td>
</tr>
<tr>
<td>29 May Rhondda Cynon Taf Older Persons Advisory Group</td>
<td>Race √</td>
</tr>
<tr>
<td></td>
<td>Religion or Belief √</td>
</tr>
<tr>
<td></td>
<td>Sex √</td>
</tr>
<tr>
<td></td>
<td>Sexual Orientation √</td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>------------</td>
<td>---------------</td>
</tr>
<tr>
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<td>Bridgend Resource Centre</td>
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<td>Bridgend Carers Group</td>
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<td>13 June 2.30 p.m. ABM Headquarters, Baglan</td>
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<td>13 June Llandrindod Wells Powys Autism Spectrum Disorder Stakeholder Group</td>
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<td>14 June Fframwaith - Children and Young People Partnership Rhondda Cynon Taf</td>
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<td>15 June Eisteddfod Y Fenni (Abergavenny Eisteddfod)</td>
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<td>16 June Abergavenny</td>
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<td>Oedfa Gymraeg (Welsh Chapel Service)</td>
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<td>Cardiff and Vale Carers Support and Information Network</td>
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<td>Cardiff and Vale Maternity Services Committee</td>
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<td>18 June</td>
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<td>Rhondda Cynon Taf 50 Plus Forum Cynon</td>
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<td>Rhondda Cynon Taf Children and Youth Partnership Forum</td>
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<td>Swansea Bay LGBT Forum</td>
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<tr>
<td>Llandrindod Wells Children and Young People’s Partnership Forum</td>
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<tr>
<td>21 June</td>
<td>10.00 a.m.</td>
<td>Innovation House, Llanharan</td>
<td>NHS Centre for Equality and Human Rights Stakeholder Reference Group</td>
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<td>21 June</td>
<td></td>
<td>Brecon</td>
<td>Bump to baby roadshow</td>
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<tr>
<td>25 June</td>
<td>10.15 a.m.</td>
<td>Aberavon Beach Hotel, Port Talbot</td>
<td>Disability Reference Group</td>
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<tr>
<td>25 June</td>
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<td></td>
<td>Joint Stakeholder Reference Group and Health Professional Forum</td>
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<td></td>
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<td>?which health board does this refer to</td>
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<td>2.00 p.m.</td>
<td>The Library Cwmbran, Torfaen</td>
<td>Fifty Plus Forum</td>
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<td>26 June</td>
<td>2.30 p.m. – 4.00 p.m.</td>
<td>Merthyr Tydfil Housing Association offices</td>
<td>Merthyr Tydfil Migrant Workers Forum</td>
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<td>Civic Offices, Barry</td>
<td>Vale Youth Forum</td>
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<tr>
<td>Date</td>
<td>Time</td>
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<td>Event Name</td>
<td>Attendance</td>
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<td>Civic Offices, Barry Vale</td>
<td>Vale Children and Young Peoples Board</td>
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<td></td>
<td></td>
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<td>27 June</td>
<td>2.00 p.m.</td>
<td>Neath Port Talbot Locality offices</td>
<td>Stroke Steering Group</td>
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<td></td>
<td></td>
<td>✓</td>
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<tr>
<td>28 June</td>
<td>1.00 pm</td>
<td>Café Camelot/Lancelot</td>
<td>Race Equality First</td>
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<td>Diabetes Planning and Delivery Group</td>
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<td>28 June</td>
<td>2.00 p.m.</td>
<td>Civic Offices, Barry</td>
<td>Vale 50 Plus Forum</td>
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<td>1 July</td>
<td>1.00 p.m.</td>
<td>Swansea Scout and Guide Hall</td>
<td>Swansea Disability Forum</td>
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<td></td>
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<td>2 July</td>
<td>12.30 p.m.</td>
<td>Nolton Church Hall, Bridgend</td>
<td>Mental Health Matters Wales</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td>2 July</td>
<td>1.00 p.m.</td>
<td>Gelli, Rhondda</td>
<td>Action towards Independence (Disability Group)</td>
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<td></td>
<td>– 4.00 p.m.</td>
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<td>Location</td>
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<td>Coychurch Road, Bridgend Bridgend Deaf Club</td>
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<tr>
<td>3 July 10.00 a.m.</td>
<td>Ivor House, Cardiff ABCD</td>
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<td>3 July 9.00 a.m.</td>
<td>Barry Memorial Hall Third Sector Meeting (incl. Equality Groups)</td>
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<td>3 July 9.30 a.m. – 12.30 p.m.</td>
<td>The Pavilion, Llandrindod Wells How fair is Powys event</td>
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<tr>
<td>3 July 10.15 a.m.</td>
<td>Gorseinon Institute, Gorseinon Visually Impaired Group</td>
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<tr>
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<td>Orbit Centre, Merthyr Cwm Taf Third Sector Workshop (ORS captured equality profile information)</td>
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<tr>
<td>4 July 7.00 p.m.</td>
<td>Hafod, Swansea Swansea Deaf Club</td>
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<td>5 July 2.00 p.m. – 4.00 p.m.</td>
<td>Llantwit Ffardre Sports Club Pontypridd and Rhondda NHS Retirement Fellowship</td>
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<td>5 July</td>
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<td>Newport Centre</td>
<td>Newport Senior Citizens Forum</td>
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<td>10.00 a.m.</td>
<td>YMH YMH</td>
<td>Stakeholder Reference Group Cwm Taf</td>
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<td>9 July</td>
<td>2.00 p.m.</td>
<td>Royal Glamorgan Hospital</td>
<td>Patient Experience Group</td>
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<td>Barnardo’s Marlborough Road</td>
<td>Barnardos Young Families Discussion Group</td>
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<td>6.00 p.m.</td>
<td>Civic Centre, Pontypool</td>
<td>Torfaen Youth Forum</td>
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<td>11 July</td>
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<td>Ystrad Sports Centre</td>
<td>Rhondda Cynon Disability Centre</td>
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<tr>
<td>12 July</td>
<td>9.30 a.m. – 12.30 p.m.</td>
<td>Theatr Bryncheiniog, Brecon</td>
<td>How fair is Powys event</td>
<td></td>
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<tr>
<td>Date</td>
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<td>Event Name</td>
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<td>Greenmeadow Golf Club, Cwmbran</td>
<td>NHS Retirement Fellowship</td>
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<td>Swansea BME Forum</td>
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<td>2.00 p.m.</td>
<td>Ystrad OAP Centre, Rhondda Cynon Taf</td>
<td>50 Plus Forum Rhondda</td>
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<td>Brecon</td>
<td>Tros Gynnal Plant (Children’s Advocacy Group)</td>
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<td>18 July</td>
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<td>Ty Penallta Tredoman</td>
<td>Caerphilly Youth Forum</td>
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