



**Transforming Midwifery Care**  
in Shropshire, Telford & Wrekin



**Equality Impact Assessment, Stage 1,**  
**June 2019**

## Version Control

Version and file name	Date	Nature of Revision	By Whom	Amended version shared with:
v.3	25.06.19		S Makin	

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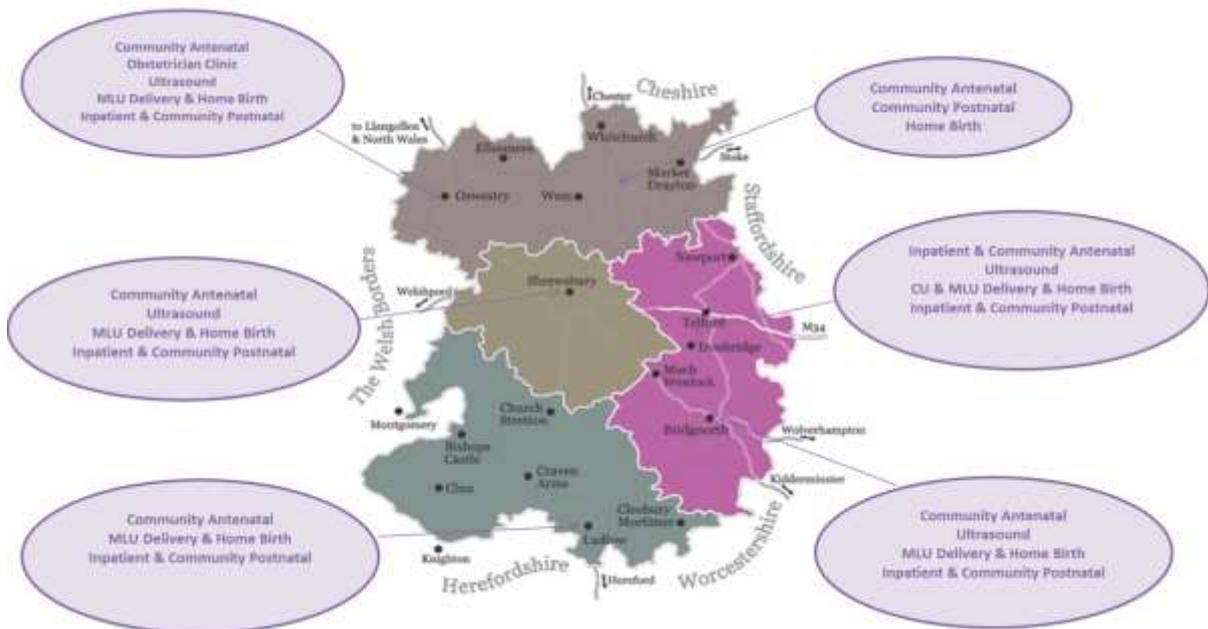
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## 1.0 Introduction

In Shropshire, Telford and Wrekin, the following services are currently available to pregnant women and mothers of newborn babies:

- 4 midwife-led units (MLU) in Bridgnorth, Oswestry, Ludlow and Shrewsbury
- 1 consultant-led unit at Princess Royal Hospital in Telford
- 1 co-located midwife-led unit at the Princess Royal Hospital
- 2 community bases in Whitchurch and Market Drayton



There is a disparity in the services available to women in different parts of the county as shown in the diagram above.

These services deliver care to women during pregnancy, at birth and after their baby is born. Around 5,500 women access maternity services in Shropshire, Telford and Wrekin each year, with around 5,000 births each year. These maternity services are delivered by The Shrewsbury and Telford Hospital NHS Trust (SaTH.) Around 80 staff work in the midwife-led units.

Maternity care is a key priority in terms of commissioning for women and children in Shropshire, Telford and Wrekin and in the broader Shropshire Telford and Wrekin Sustainability and Transformation Plan (STP). Better Births – a nationally mandated five-year local maternity system transformation programme is underway. However, local action to better meet patient needs is required.

There have been a number of high profile adverse events in the area, which has heightened public awareness and scrutiny of local maternity care. There has also been a high level of media interest, with emotive headlines in local and national newspapers and lots of feedback, including emails from the public supporting MLUs.

Following intermittent closures starting in 2016, due to staffing pressures, the Trust made the decision to withdraw births and inpatient postnatal stays at the MLUs in Bridgnorth, Ludlow and Oswestry on the grounds of safety in July 2017. These MLUs have been open for planned care only for 18 months.

In January 2019, following the Future Fit public consultation, the Shropshire and Telford & Wrekin Clinical Commissioning Groups (CCGs) made the decision to locate the women and children's consultant-led services, including maternity services, on the Royal Shrewsbury Hospital site. Both the Shrewsbury and Telford hospital sites will continue to have 24-hour midwife-led units where low risk women will be able to give birth and access antenatal and postnatal appointments and scanning. Women's, children's and neonatal outpatient appointments will also take place at both hospitals. These changes are expected to be in place by 2023-24. The new proposed model of midwifery care takes these changes into account.

In June 2019, the SaTH board took the decision to temporarily close the MLU at the Royal Shrewsbury Hospital for up to six months in order for essential building works to take place. Women booked in to give birth at this MLU were offered a birth at the MLU or the consultant-led unit at the Princess Royal Hospital in Telford. Home births were not affected. All antenatal and postnatal appointments, including scans continued to be provided at the Royal Shrewsbury Hospital.

These proposals affect all pregnant women and potentially all women of child-bearing age registered with GPs in Shropshire and Telford and Wrekin as well as a small number of women from neighbouring areas. We understand that there may be higher impacts on certain groups due to the type of service being considered for change and these impacts are described in relation to each of the nine protected characteristics later in the document.

## 1.1 Case for change

Maternity care policy has remained consistent since 2007 on the need for women to be offered choice regarding place of birth in England, to specifically include Midwife Led Units (MLUs), both alongside and freestanding as well as provision for home birth care. Since 2014, the NICE intrapartum guidelines have recommended MLUs for low risk women because they reduce labour and birth interventions, notably caesarean section rates. In 2016, the national direction for maternity services was set out in the 2016 Maternity Review Report. *Better Births: Improving outcomes of maternity services in England. A five year forward view for maternity care (Feb 2016, NHSE)* describes the way in which maternity services need to change. The seven key themes are outlined below.

- Personalised care
- Continuity of carer

- Safer care
- Better postnatal and perinatal mental health care
- Multi-professional working
- Working across boundaries
- A fair payment system

Saving Babies' Lives: A care bundle for reducing stillbirths (March 2016, NHSE) sets out the requirement to reduce stillbirths by 20% by 2020 and 50% by 2030. Saving Babies' Lives is a care bundle designed to support providers, commissioners and healthcare professionals to take action to reduce stillbirths and early neonatal death and brings together four elements of care that are recognised as evidence-based and/or best practice, these are:

- Reducing smoking in pregnancy
- Risk assessment and surveillance for fetal growth restriction
- Raising awareness of reduced fetal movement
- Effective fetal monitoring during labour

The key themes emerging from other national publications considered for this review are:

- The importance of choice and continuity of care
- The need for improvements in digital technology to support delivery of maternity services
- Outcomes-focused commissioning
- The importance of supporting and developing the workforce
- Recognition that the risks and clinical needs of women are on the increase due to mothers giving birth later in life and an increase in other risk factors such as obesity
- The need for effective joint working between professionals, including seamless transfer between services.

On a local level, there is a disparity in the current services available to women in the different parts of Shropshire, Telford and Wrekin, which means that pregnant women and mothers with newborn babies are receiving different levels of care depending on where they live. We want to make the services available to women more equitable no matter where they live in the county.

The demographic and health profile of women living within the different localities in our county is changing. There is an increasing number of women of child-bearing age in certain areas and a decrease in others. The age profile of pregnant women has also changed in recent years and there has also been an increase in certain lifestyles and conditions, which can lead to poorer outcomes, for example, obesity and diabetes.

The number of women giving birth in a midwife-led unit is declining. Over the last nine years, the births within the midwife-led units or at home on the whole have declined from approximately 1350 (26% of total activity) to 708 (14% of total activity). This is due to a steady increase in women who require a higher level of care that is available through a consultant unit birth.

A recent Birthrate Plus report in April 2017 indicated that an overall increase in the number of maternity staff, including midwives is required, but that the smaller MLUs are over-staffed for the level of activity. Sickness and absence rates within maternity services have increased so much so, that the combined factors of fewer staff and increased demand for the consultant unit has led to the provider taking action to re-distribute staff across the service. Feedback from our pre-consultation engagement work with staff working in the midwife-led units also told us that they feel that currently, we don't have the correct staffing model. Staff report that antenatal and postnatal care are now very time pressured, and whilst in the past they delivered great family centred care, they feel this is changing as a result of changes made to the service.

Families living in both rural and urban communities told us they experience continuity and that they value it highly. Families really value the support women's care assistants provide to them postnatally, particularly with breast feeding and caring for baby in the early days.

In feedback to Healthwatch in 2016/17, women and their partners reported positively in particular with regards to support provided postnatally with breastfeeding, confidence building and emotional support. Other positive feedback is in relation to the fact that services are close to home, women know the midwives and the environment in midwife-led units is welcoming and relaxing. The negative comments received included those in relation to reduced access to services at midwife-led units due to staff shortages and refurbishments.

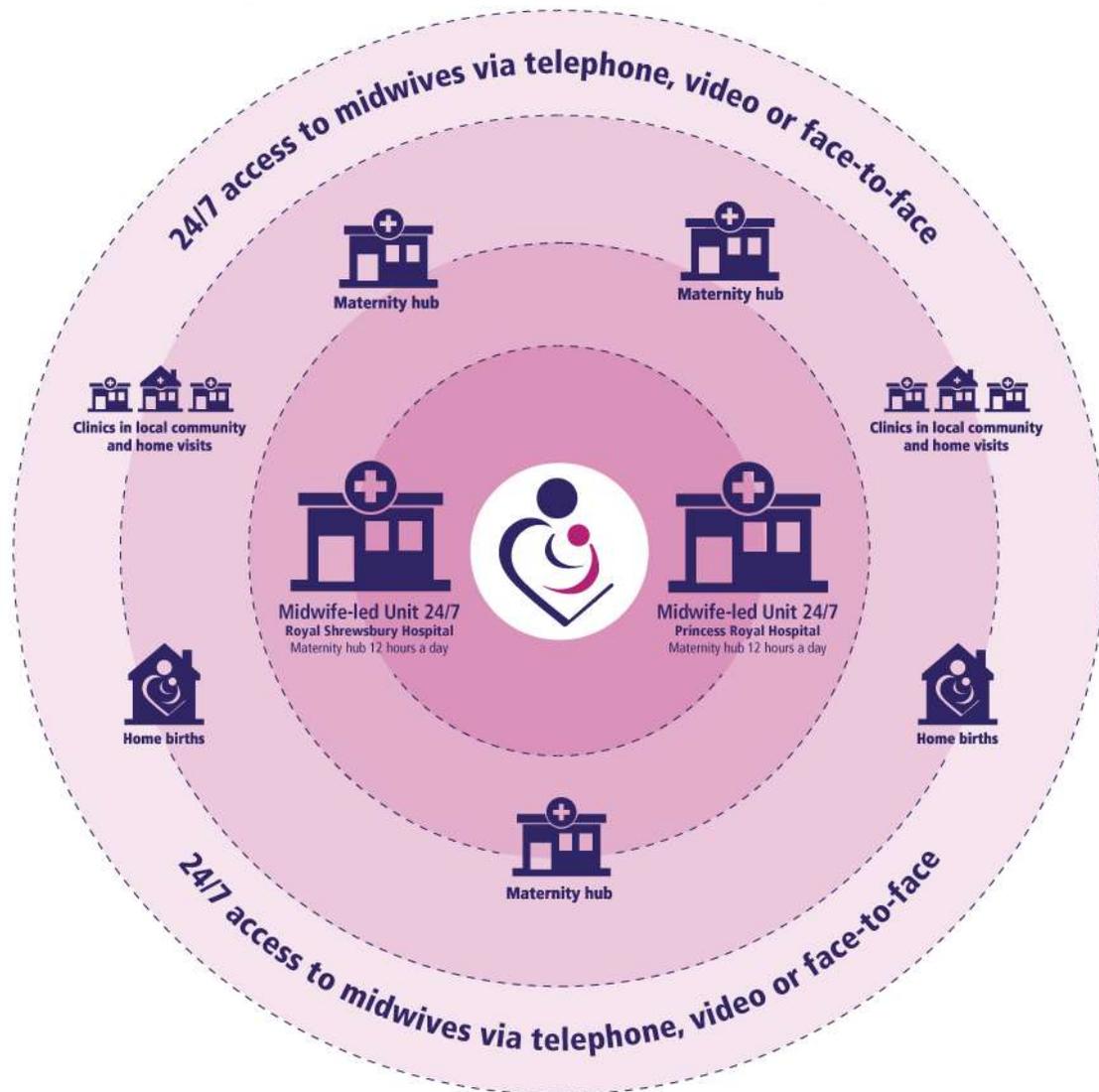
The Shropshire maternity services usage survey in 2017 identified that distance from home and continuity of carer are very important to women when choosing where to give birth. Women identified in-patient postnatal care as being very important to them.

## **1.2 Proposed model**

The CCGs are proposing to transform the way that midwifery care is currently delivered across Shropshire, Telford and Wrekin to provide all women with safe, high quality and personalised care throughout their pregnancy (antenatal care), during the birth and following the birth of their baby (postnatal care).

The CCGs propose to do this by creating a network of midwife-led units, maternity hubs and clinics delivered in the local community and at home. Midwives and maternity support workers will work flexibly across this network, providing personalised care to women throughout all stages of their pregnancy, birth and beyond.

## Proposed model of midwifery care



We are proposing to replace the existing three rural midwife-led units in Oswestry, Bridgnorth and Ludlow with **xx** new maternity hubs. These will be located in **xx** and be open 12 hours a day, every day. At every hub, women will be able to access the same full range of care. During their pregnancy women will be able to access care from a midwife and maternity support worker as well as being able to access a range of other services, including scans and obstetrician appointments. Following the birth of their baby, women and their families will be able to access care from a midwife or maternity support worker from the hub as well as getting help and advice with feeding and caring for their baby. A range of other health services will also be available to women throughout their pregnancy and beyond to help keep them and their baby healthy. This includes support with emotional and mental health as well as services to help women to be fit and healthy during pregnancy and beyond.

The Midwife-led Units (MLUs) at the Royal Shrewsbury Hospital and the Princess Royal Hospital will continue to be available 24 hours a day, 7 days a week. As well as offering the same services as the Maternity Hubs for 12 hours a day every day, women will continue to be able to give birth at an MLU, providing they don't need a higher level of care which will be available at the Consultant-led Unit.

The midwife led units will not have postnatal beds. This means that following birth, women will receive the postnatal care they need in the community, through their midwife or maternity support worker visiting them at home. In addition, they will be able to access a range of postnatal care at their local maternity hub or clinic. For the small number of women who need a higher level of care, they will receive this in the postnatal ward at the Consultant-led Unit.

Routine antenatal and postnatal appointments with midwives will continue to take place in local communities across the county in GP practices and children's centres and in a woman's home. Under our proposal, maternity support workers will be more involved in providing routine antenatal and postnatal care.

Women will continue to be able to choose from a full range of settings in which to give birth: consultant-led unit at the Princess Royal Hospital, alongside MLU at the Princess Royal Hospital, freestanding MLU at Royal Shrewsbury Hospital and home birth. Women will not be able to give birth at the maternity hubs.

Add in more on proposed option/s once confirmed

## 2.0 Equality and impact

### 2.1 What is meant by equality?

Equality is about making sure people are treated fairly. It is not about treating 'everyone the same', but recognising that everyone's needs are met in different ways. Our age, disability, faith or belief, gender, race, sexual orientation, being married or in a civil partnership, being transgender or being pregnant should not disadvantage us. These different characteristics are protected under the Equality Act 2010.

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.

### 2.2 Legislation and guidance

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

- The Public Sector Equality Act – Section 149 of the Equality Act 2010
- The Health and Social Care Act (2012) 14T Duties as to reducing inequalities
- The NHS Constitution
- Brown Principles
- Additional duties to consult in Wales are set out in the ‘The Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011

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

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

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

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

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

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

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

Full information on legislative requirements can be found in Appendix 3.

## 2.3 Equality Impact Assessments

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

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

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

## 3.0 The approach to the EIA development

An iterative approach to producing this EIA has been taken. The following shows the stages of previous and planned development:

- **Stage one** allows us to define the proposal for change and the rationale behind it, consider the expected outcomes, who would be impacted and how we would engage with people belonging to one or more of the nine protected characteristics. The purpose is to describe our understanding at an early point in the process of any likely impact, rather than being a definitive statement of the impact of the proposed changes. In this stage, we identify and address any gaps in our knowledge by engaging and consulting with the public and stakeholders.
- **Stage two** allows us to undertake consultation activity with the public, stakeholders and seldom heard groups through to a mid-point review. Activity is analysed, initial themes from feedback and discussion assessed to identify any gaps from earlier pre-consultation activity. We gather additional knowledge and comments from a range of groups representing the nine protected characteristics. This stage informs the activity for reaching seldom heard groups in the second half of the consultation.
- **Stage three** encompasses the post consultation analysis and presents the findings of the public consultation alongside the impact analysis. The purpose is to provide those making the decision with information about how people belonging to one or more of the nine protected characteristics may be disproportionately impacted on and what potential mitigations may be required to address any impacts that have been identified. The general duty cannot be delegated, so it is incumbent upon each CCG to demonstrate they have assessed how the MLU review may impact on their service users and the wider public in the area.
- A **Stage four** final analysis document is produced once the decision on the proposal 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 MLU service review will be monitored and reviewed.

A range of different data sources have been used in this document. There might be a small variation in this data but this does not make a material difference to the proposal or the recommendations.

## 4.0 Pre-consultation engagement

Extensive pre-consultation engagement work has taken place with patients and staff working in midwife-led units in Shropshire, Telford and Wrekin over the last few years.

In addition to the feedback gathered over the past year, the following sources of existing patient feedback have been used to inform the proposed new model of care:

Shropshire maternity services usage – survey by MLU campaign group (2017) (Analysis of results by campaign group and analysis of results by Healthwatch Shropshire have been used)

- Feedback from patients received by SaTH
- Feedback from patients received by Healthwatch Shropshire October 2016-May 2017
- Feedback from patients received by Healthwatch Telford & Wrekin July 2016-June 2017
- CQC survey of women's experiences of maternity services at SaTH (2015)
- The majority of feedback received from patients in relation to MLUs is positive.

In feedback to Healthwatch, women and their partners report positively in particular with regard to support provided postnatally with breastfeeding, confidence building and emotional support. Other positive feedback is in relation to the fact that services are close to home, women know the midwives and the environment in midwife-led units is welcoming and relaxing. The negative comments received included those in relation to reduced access to services at midwife-led units due to staff shortages and refurbishments.

The Shropshire maternity services usage survey identified that distance from home and continuity of carer are very important to women when choosing where to give birth. Women identified in-patient postnatal care as being very important to them in the Shropshire maternity services usage survey, with the top 3 reasons for women wanting a postnatal stay being; rest and recuperation, in order to establish breastfeeding and help and support to care for the new baby.

The results of the CQC survey about the whole of maternity services show that SaTH perform about the same or better than other trusts surveyed in relation to how positive patients reported about the service received, with most areas showing no statistically significant change in response compared to the same survey undertaken in 2013.

In 2017, a detailed engagement exercise took place to understand what people perceive is adding value and contributing to positive outcomes for both staff and families; what is working well and what is getting in the way of improved care and family outcomes as well as community priorities for change and improvement.

132 parents took part including 108 women from rural areas and 24 women who live in urban settings. 85 staff also shared their views including midwives women's care assistants, health visitors, GPs and obstetricians.

Based on participant's feedback, the characteristics that participants feel make up good maternity care in Shropshire, Telford and Wrekin are presented as fifteen design principles below:

1. The system focus is towards becoming a family, with great antenatal and postnatal care valued alongside safe births
2. Staff understanding of the impact of unexpected things on women early in pregnancy and of miscarriage should be an always event
3. Relationship centred system design including continuity of care and supporting midwives to work in small teams is a really valuable aspect of our current maternity service that this maternity system needs to preserve
4. Our maternity service needs GPs to feel interested and involved in supporting ladies who are pregnant
5. Consultants and families sharing decisions about birth and feeling able to have positive and sometimes challenging conversations about the risks and birth options is a good thing
6. A good personalised approach to care planning includes a flexible birth plan that covers antenatal, and postnatal care and recognises that unexpected things are very likely to happen to most families at some point in their journey so that families are open to discussions about different options when things change
7. Because of the rural nature of this community, having local routine care and local contingencies in place to deal with maternity emergencies safely across Shropshire, Telford and Wrekin is critical to great maternity service
8. Really responsive triage that provides quick, effective, personalised reassurance when unexpected things happen and that supports women to judge their progress in labour as accurately as possible so they get to their chosen birth place in time are vital design features of our maternity triage service – especially in rural localities
9. Having flexible antenatal appointments close to home, with time for discussion, good explanations and the chance to meet mums with a similar birth dates is key to a good antenatal experience
10. Good, safe birth experiences in Shropshire Telford and Wrekin need to be preserved
11. Good postnatal care really matters. Even though most of the benefits are realised in other parts of the NHS system, because it helps build the foundation for happy, healthy families from the start, investment in great postnatal care that delivers the following benefits is really important for community resilience:
  - Really good support with breast feeding
  - Having a safe space and support to reflect on and process the birth experience – especially when it has been traumatic for the mind and body e.g. an emergency caesarean or other difficult birth issues
  - Supporting bonding and connection with mum and the rest of the immediate family (partner and other children)

- Transitioning to parenthood with confidence
  - Meeting and connecting with other women who often become life-long friends and a source of ongoing support
  - Design needs to recognise that good postnatal care is even more important after a highly medicalised or traumatic birth – especially one that involves surgical intervention or physical injury.
12. The design of all routine antenatal and postnatal maternity care and environments, including wards, should support mums to interact, meet and make friends with others who have children of the same or similar birth date.
  13. How midwives and the maternity workforce feels really matters. The design of the maternity system needs to let midwives feel in control again, and involve staff in decisions, the planning and improvement of maternity care in Shropshire, Telford and Wrekin.
  14. We very quickly need to design services and different ways of working that restore maternity staff resilience in Shropshire, Telford and Wrekin.
  15. Maternity money flows, tariffs and outcome measures should all align better with what matters and support the creation of healthy, happy families alongside delivering babies so that other parts of the maternity journey are valued too. We need to measure different things within our maternity service in different ways, and in particular measure the things that staff and families have told us matter to them in these insights.

Themes from completed forms, feedback submitted via email/letter and feedback from seven co-design workshops are included in the ELC Programme final report “Review of Maternity Services in Shropshire Telford and Wrekin: staff, family and community perspectives.” This report can be found here: <https://www.shropshireccg.nhs.uk/media/1059/final-insight-report.pdf>

On 24 October 2018, a Midwife-Led Unit (MLU) Review stakeholder briefing took place which was attended by over 60 people. This included people involved in the MLU Review decision-making process (27), working in midwifery led services (26), those who have recently used or are using maternity services (7) and other people who didn't fit into any of these specified groups (2).

The workshop aimed to provide a reminder of the rationale for the review, what's happened so far to bring everyone up to date, what the evidence is telling us and describe what local clinicians believe is the vision for the future.

There was one main group exercise during the day where attendees were asked to feedback on the proposed new service, ideas for improvement, and if there was anything missing. There was also the opportunity to inform the consultation plan with group work on helping to inform target audiences and methods of communication.

Detailed outcomes from this workshop can be found in:

<https://www.shropshireccg.nhs.uk/media/2129/engagement-report-from-mlu-review-stakeholder-briefing-24-october-18.pdf>

Additional pre-consultation engagement work was undertaken with seldom heard groups in 2019. There was a particular focus on engaging with people who are most likely to be impacted on by the

proposed changes and those groups belonging to one or more of the nine protected characteristics as identified in this equality impact assessment. As we are discussing a proposed new service model for midwifery-led maternity services, our main target audience was women who had recently had a baby or those who were likely to have a baby in the near future. These groups were further sub-divided to include:

### **Age**

- Teenage women
- Older women (age 35+)

### **Gender**

- Women (of childbearing age)

### **Sexual orientation**

- Lesbian and bisexual women of childbearing age

### **Disability**

- Women of childbearing age with a physical disability
- Women of child-bearing age with a learning disability
- Women of child-bearing age with a mental illness
- Women of childbearing age with a sensory impairment
- Women of childbearing age with a long term condition

### **Race**

- BAME women of childbearing age (particularly those born outside the UK and African, African Caribbean, Indian, Bangladeshi and Pakistani)
- Gypsy and traveller women of childbearing age
- New migrants/asylum seekers of child-bearing age
- Non-native speakers of English e.g. Polish women of childbearing age

### **Religion**

- Amish/Mennonite women of childbearing age

Over 170 women, partners and families took part in the pre-consultation engagement exercise with seldom heard groups. We used a variety of engagement tools including a questionnaire, attending existing meetings, having a stand in a public area for example in hospital waiting rooms, one-to-one meetings and telephone conversations.

Overall, the feedback was very similar across all of the different groups, with a small number of exceptions which are highlighted below.

The key things that women told us are important to them are:

- Continuity of care/carer
- Provision of information/good support and advice/consistent messages/clear communication
- Friendly midwives who reassure and are sensitive; and who have time to talk
- More appointment availability, shorter waiting times and fewer cancellations
- Postnatal care including support with feeding and better mental health support
- Local care and available in more locations, for example consultant clinics and scans
- Choice of where to give birth
- Availability of online and telephone advice; email communication
- Home visits during pregnancy and after birth
- Antenatal care, especially in rural areas
- Peer support

However, some groups also have their own specific needs, for example, the preference of Muslim women to receive care from a female clinician and for privacy while giving birth and while breastfeeding. Halal food and prayer facilities were also important to the Muslim women we spoke to.

The Syrian refugee women we spoke to tend to prefer to see a consultant rather than a midwife and to receive care in a hospital environment as this is what they are used to in their home country.

Although some of the Syrian women don't speak English, they also told us that health services shouldn't assume that they always need an interpreter, although one would be particularly useful for the first appointment when lots of details need to be given for those who don't speak English well and at scans. It was suggested that it might be helpful if they could take a friend with them to appointments instead of using a hospital interpreter they don't know, particularly a man.

Some Syrian women we spoke to seemed keen to get back home after the birth and to be supported by other women within their community, if there were other Syrian women living nearby. Other women told us that they felt isolated when they were pregnant and had had a baby due to them being a long way away from their families and in some cases, this had led to mental health issues and postnatal depression. Postnatal care for the mother and baby, including mental health support and peer support were seen as very important. They would also appreciate advice and support on what they need to buy for the baby, on the medicines and supplements they can take and on lifestyle management and healthy eating. As hip fracture in babies is a common hereditary condition in some Syrian families, early diagnosis would be found beneficial.

For Polish women, the maternity pathway seems to be slightly different in England to what they are used to in Poland, with some women telling us that they wanted an epidural or a caesarean section but they weren't available and that they were expecting a gynaecological examination during their pregnancy as in their home country.

A female representative from the small Christian Mennonite community in South Shropshire told us that the freedom to refuse some services, such as injections or scans is important to them.

Feedback from younger women included that clinicians shouldn't always refer to "partners" as some women are single and that women's views should be respected if they don't want to have a particular treatment. It was suggested that more information targeted at teenage mums would be helpful. A few younger women would have liked their partner to have been able to stay longer after the birth and others mentioned a difficulty in getting an initial appointment because they didn't know how to book one. One woman suggested more availability of water births and another commented on a lack of support during labour.

We spoke to one teenage woman with a physical disability who told us that she felt judged and that individual views should be respected and treatment not given without approval.

Women with a learning disability told us that they wanted more postnatal support including support with feeding. One woman with a learning disability living in a rural area expressed a need for local antenatal classes.

Women who have a mental illness regularly stated a need for better mental health support, particularly for postnatal depression. We were also told that maternity and mental health services should be more co-ordinated. Women with a mental illness also value a relaxing and calm environment, with a preference for their own room in a maternity unit. One teenage woman with a mental illness commented on a lack of support during labour.

We spoke to a number of women with a long term condition at diabetes and endocrine clinics in both Telford and Shrewsbury. These women frequently mentioned issues with appointments including availability, cancellations and waiting times. They also told us that access to a diabetes nurse and good support is important to them.

The military wife we spoke to suggested that patient records should be available to clinicians working in different locations.

Feedback from the homeless woman we spoke to who had recently had a baby suggests that the system doesn't work for people with chaotic lives and that there needs to be more flexibility and more joined-up working between health and social care. The woman also felt that her emotional needs had been neglected, she felt judged and hadn't always felt supported.

Women living in certain areas also tended to have some similar views regardless of their protected characteristic(s), for example, women living in Oswestry, Bridgnorth and Ludlow liked to be able to access a midwifery-led service locally. A few women who live in a rural area said that a visit to the birth centre/delivery room before the birth and home visits during pregnancy and after the birth would be helpful. Some women living in an area of deprivation commented on feeling judged and said there's a need to listen to women and to respect their views.

Most of the feedback received during this engagement exercise was very similar to the feedback given during the general engagement work in 2017.

The feedback from the seldom heard group engagement exercise in 2019 was from a relatively small number of women and their families and should not be regarded as representative of particular protected characteristic groups although it can be useful to give an indication of potential impacts.

In addition to direct engagement with the public and particularly with people belonging to one or more of the nine protected characteristics outlined above, from the start of the midwife-led service review, our local Healthwatch and voluntary sector organisations have also been involved. We worked closely with voluntary and community organisations to enable us to contact the people they work with during our pre-consultation work with seldom heard groups. More detailed information can be found in the [pre-consultation engagement report \(add weblink.\)](#)

Significant engagement has also taken place with clinicians locally to develop the proposed clinical model. This has included GPs, midwives, women's support assistants, obstetricians, neonatal nurses and consultants and healthcare assistants. A broad mix of clinicians based in different parts of the county have also been involved in a number of stakeholder meetings and workshops, including the options appraisal workshops. Clinicians including GPs and secondary care clinicians have also been involved due to their membership of the CCG governing bodies and the Midwife-led Review Programme Board.

Non-clinical staff working in our two local clinical commissioning groups, Shropshire CCG and Telford and Wrekin CCG, and our local provider organisations, including the Shrewsbury and Telford Hospital NHS Trust, have regularly been kept up-to-date about the midwife-led unit review through their organisations' normal communications channels such as e-newsletters and face-to-face staff briefings.

Regular updates have also been given at Board meetings where directors and other members of staff have been present. Some non-clinical staff have also taken part in the engagement work that has taken place with staff working in or associated with the midwife-led units. Commissioners of maternity services, communications and engagement staff, the local maternity system programme lead, the Maternity Voices Partnership development co-ordinator and a project support officer are all involved in the Midwife-led Review Programme Board.

More detail on all of the pre-consultation engagement can be found in the [pre-consultation engagement with seldom heard groups report](#) and the [pre-consultation engagement report \(add weblinks when available.\)](#)

## 5.0 The consultation and reaching seldom heard groups

Building on the pre-consultation engagement work with seldom heard groups in May/June 2019 and working again with voluntary and community organisations, a detailed plan has been developed to obtain the views of people belonging to one or more of the nine protected characteristics on the

proposed model for midwife-led care in Shropshire, Telford and Wrekin in September and October 2019.

We used a flexible approach with a variety of engagement tools to enable as many people as possible to give us their views and this included attending existing meetings and events, one-to-one meetings and telephone conversations depending on the preferences of the people we were engaging with.

Our aims are to:

- Make sure our methods and approaches are tailored to specific audiences as required
- Identify and use the best ways of reaching the largest amount of people and providing opportunities for those within the nine protected characteristics to respond
- Work with the voluntary and community sectors to share information and to engage with groups of people who don't usually tell us their views
- Provide accessible documentation, including Easy Read, large print Word document and Word document for use with screen readers, as well as a screen reader-compatible survey
- Offer accessible formats including translated versions or interpreter facilities where required
- Have due regard for Equality and Diversity, ensuring that the consultation works to understand how people's differences, cultural expectations and social status can affect their experiences, health outcomes and quality of care.
- Monitor consultation responses to ensure the views reflect the whole population and adapt activity as required.
- Use different methods or direct activity to reach certain communities where we become aware of any under-representation.
- Arrange our meetings so they cover the local geographical areas that make up Shropshire, Telford & Wrekin.
- Arrange meetings in accessible venues and offer interpreters, translators and hearing loops where required.

Add in details of the consultation and how seldom heard groups were involved.

Add key themes by protected characteristic

## 6.0 Profile of the affected population

Due to the nature of the services that are being considered for change, the groups most likely to be impacted on are women of childbearing age and their partners and families.

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

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

SaTH Maternity Services Births 2016/17				
Maternity Unit	Shropshire patients	Telford and Wrekin patients	Powys patients	Patients from other areas
Consultant Unit	2016	1830	216	132
Shrewsbury MLU	142	0	0	0
Wrekin MLU	135	199	0	3
Bridgnorth MLU	67	2	0	8
Oswestry MLU	50	0	0	2
Ludlow MLU	31	0	0	5
Home	41	21	1	1
Born after arrival (without presence of midwife or obstetrician)	8	8	2	8
<b>Total</b>	<b>2490</b>	<b>2060</b>	<b>219</b>	<b>159</b>

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

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

Over the last nine years, the births within the midwife-led units or at home on the whole have declined from approximately 1350 (26% of total activity) to 708 (14% of total activity).

The most popular midwife-led units for giving birth were the Shrewsbury and Wrekin MLUs, with the alongside MLU at the Princess Royal Hospital having more than double the number of births than the next most popular MLU in Shrewsbury.

Between April 2016 and March 2018, compared to the county average, the percentage of pregnant women on an intermediate/intensive care pathway for antenatal care is highest in Hadley Castle, The Wrekin, Hadley South and Shrewsbury and Atcham meaning that women from these areas will have a higher need to access maternity services before they give birth. The same areas also have the highest percentage of women on an intermediate/intensive care pathway for postnatal care in addition to North Shropshire.

The antenatal pathway is based on information collected at the antenatal assessment appointment (usually undertaken at about 10 weeks' gestation) when the health and social care risk assessment is carried out. Risk factors such as obesity, smoking, diabetes, hypertension, substance misuse and domestic abuse are considered. The postnatal pathway follows the same format as the antenatal pathway based on three levels: standard, intermediate and intensive. The level is usually assigned after the woman has had her baby and is based on her health and care characteristics.

Between 2015/16 and 2017/18, the areas with the highest percentage of women who had pre-term births were South Shropshire and Lakeside South and those who had the most complicated deliveries and co-morbidities were from South Shropshire and Bridgnorth.

Over the same period, the rate of obesity in pregnancy was higher than the Shropshire average in Oswestry, Lakeside South, Hadley Castle, The Wrekin and Shrewsbury and Atcham. Rates of smoking at the time of delivery were highest in North Shropshire, Lakeside South, The Wrekin, Hadley Castle, Oswestry and Shrewsbury and Atcham.

The percentage of women living in Shrewsbury and Atcham consuming alcohol in pregnancy was higher than in other parts of the county in 2015/16 – 2017/18 and there was a higher rate of substance misuse by pregnant women living in Lakeside South and South Shropshire than in other parts of the county.

During this same period, pregnant women living in North Shropshire, Lakeside South and South Shropshire were more likely to access mental health services than women living in other parts of the county.

The proportion of women who started to breastfeed their babies was lowest in The Wrekin, Lakeside South, Hadley Castle, North Shropshire and Shrewsbury and Atcham in 2015/16-2017/18.

At this time, The Wrekin, Lakeside South, Hadley Castle, Shrewsbury and Atcham, Oswestry and North Shropshire had a higher percentage of women aged 16-44 living in the most deprived areas than the county average.

Source: Midwife Led Unit Review Stakeholder Workshop Stage 3 Data Pack 31/1/19

## 6.1 Age

In 2017/18, the locality with the largest number of women child-bearing age (16-44) was in Shrewsbury and Atcham – 15,457. The localities with the smallest number of women of child-bearing age were Oswestry (6,130) and South Shropshire (6,805.) If the total number of women in the same age range living three Telford and Wrekin localities is calculated, this equates to over double this figure – 34,024.

Female Population aged 16-44 Years Registered with a Shropshire, Telford and Wrekin GP 2017/18	
Locality	Females aged 16-44
Bridgnorth	7,840
Hadley Castle	12,307
Lakeside South	8,437
North Shropshire	10,080
Oswestry	6,130
Shrewsbury and Atcham	15,457
South Shropshire	6,805
The Wrekin	13,280

Source: GP practice data

Across all localities, the most women who accessed maternity services and who gave birth were in the 20-24, 25-29 and 30-34 age groups. A relatively small number of teenage women and older

women (age 45+) accessed maternity services and gave birth across Telford and Wrekin and Shropshire in 2016/17.

Teenage pregnancy rates have decreased considerably since the late 1990s. In 2015, only 3.4% of all live births in England and Wales were to mothers aged under 20. There are also low rates of conception among under 18s in Telford and Wrekin and Shropshire – although in Telford and Wrekin, this is above the national average. The highest conception rates are in the most deprived wards.

The areas with the most under 16 year old women who had a baby in 2016/17 were from Hadley Castle and Lakeside South (with 1 birth in each.)

The localities with the highest number of births to women in the 16-19 year age group were Lakeside South (35), Hadley Castle (31) and Shrewsbury and Atcham (30.) Only three teenagers from South Shropshire and seven from Bridgnorth gave birth during the same period.

Although the number of women giving birth in the 40-44 year age group was relatively small compared to other age groups (167 in total), the locality with the highest number of births was Shrewsbury and Atcham with 36.

The number of women over the age of 45 giving birth is even lower with the highest number of births was to women living in The Wrekin (3), followed by two women in each of the following areas: Hadley Castle, Lakeside South, Oswestry and Shrewsbury and Atcham.

There were no deliveries to women under the age of 16 or over the age of 45 living in Bridgnorth, North Shropshire or South Shropshire in 2016/17. *Source: Shrewsbury and Telford Hospital Trust maternity activity data 2016/17*

For more detail on the breakdown of deliveries by age and locality, please see Appendix 1.

## 6.2 Disability

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

According to the 2011 Census, the locality with the most women with a disability is Shrewsbury and Atcham (9139) and the locality with the lowest number of women with a disability is Oswestry with 3982.

Data relating to disability is not routinely collected by The Shrewsbury and Telford Hospital NHS Trust. We are therefore unable to make an overall assessment of if there is variation in the number of women with a disability living in different parts of the health economy who access maternity services.

### 6.3 Gender reassignment

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

Data relating to gender reassignment is not collected by The Shrewsbury and Telford Hospital NHS Trust and therefore we are unable to assess if there is variation in the number of people who have undergone or are undergoing gender reassignment treatment living in different parts of the health economy who access maternity services.

### 6.4 Marriage and civil partnership

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

Data relating to marital status is not consistently collected by The Shrewsbury and Telford Hospital NHS Trust and therefore we are unable to assess if there are different levels of marital status in different parts of the health economy and different levels of access to health services.

From the information we do have, the highest number of women who gave birth in Shropshire and Telford and Wrekin in 2016/17 were single, with Shrewsbury and Atcham (534), Hadley Castle (410) and Lakeside South (382) having the highest number of single women having a baby. The locality with the highest number of married women or those in a civil partnership who gave birth in the same year was Shrewsbury and Atcham with 304 deliveries. The total number of single women giving birth (2408) was over double the total number of married women or women in a civil partnership (1100) who gave birth in 2016/17.

However, this data should be regarded with caution as for a large number of women (1120), their marital status has not been recorded.

For more detail on deliveries by marital status and locality, please see Appendix 1.

### 6.5 Pregnancy and maternity

In Shropshire, Telford and Wrekin women have the choice whether to give birth in the consultant-led unit, in one of the midwife-led units or at home (if they are not classed as high risk.)

More women from Shropshire (2016) gave birth at the consultant-led unit than women from Telford and Wrekin (1830) in 2016/17. The vast majority of births were in relation to Shropshire, Telford and Wrekin patients although a small number of women came from neighbouring areas.

The introduction to this section and the description of the “Age” characteristic provide more information about the women of child-bearing age in our health economy.

## 6.6 Race

Both Shropshire and Telford and Wrekin are predominantly White British and have a higher percentage of White British people than the England rate. This is therefore reflected in the ethnic background of the local women giving birth, with over 80% of women saying that they were White in 2016/17.

There is a higher percentage of Black, Asian, Minority and Ethnic groups (BAME) in Telford and Wrekin compared to Shropshire, with the localities of Hadley Castle (5421) and The Wrekin (4898) having the most female BAME residents (source: 2011 Census.) However, all groups have a lower percentage than the England rate apart from “Mixed/Multiple Ethnic Groups: White and Black Caribbean” which is slightly higher.

It is therefore unsurprising that the localities with the highest number of births to BAME women are in Telford and Wrekin. The localities with the highest number of births to Asian or Asian British women in 2016/17 were Hadley Castle and the Wrekin and the highest number of births to Black women were to women from The Wrekin, Lakeside South and Hadley Castle. The home location for the number of births to Mixed/Multiple Ethnic women was slightly different with the highest number coming from Hadley Castle followed by Shrewsbury and Atcham. Overall most BAME women who gave birth in the county in 2016/17 lived in Hadley Castle and The Wrekin.

However, this data should be regarded with caution as for some women who accessed maternity services (648), their ethnicity has not been recorded.

For more detail on deliveries by race and locality, please see Appendix 1.

## 6.7 Religion or belief

Across Shropshire, Telford and Wrekin there is some variation in religion and belief. Compared to the England rate, the number of people of Christian belief is higher than other religions in both areas. For other religions such as Hindu, Muslim and Sikh, the rates are significantly lower than the England rates. There is a significantly higher number of people with different religions living in Telford and Wrekin than in Shropshire. The localities of Hadley Castle and The Wrekin have the highest number of non-Christian females, with 1649 and 1509 respectively (Source: 2011 Census.)

Christianity, Church of England and Catholicism are most frequently recorded as being the religion of women giving birth in our county. Islam is the most frequently recorded non-Christian religion, with the Hadley Castle and The Wrekin having the highest number of women giving birth of this faith. The Sikh religion is also most prevalent amongst women who have a baby living in Hadley Castle and The Wrekin.

However, this data should be regarded with caution as for some women who gave birth in 2016/17 (491), their religion or belief has not been recorded. 2009 women also stated that they had no religion.

For more detail on deliveries by religion or belief and locality, please see Appendix 1

## 6.8 Sex

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

## 6.9 Sexual orientation

Sexual orientation is not asked for by the Census, however Stonewall estimates that the LGBT population in England is between 1.5 to 5.85 per cent. The Office for National Statistics estimates that the number of LGBT people as part of the general population in England and Wales is 1.7 per cent.

Additional information from Stonewall indicates that younger age groups are more likely to disclose that they are gay compared to older people.

Source: [https://www.stonewall.org.uk/sites/default/files/lgbt\\_in\\_britain\\_home\\_and\\_communities.pdf](https://www.stonewall.org.uk/sites/default/files/lgbt_in_britain_home_and_communities.pdf)

Data relating to sexual orientation is not collected by The Shrewsbury and Telford Hospital NHS Trust and therefore we are unable to assess if there is variation in the number of LGBT people living in different parts of the health economy who access maternity services.

## 6.10 People living in a rural area

Overall Shropshire is a rural county with around 66% of the population living in what is classified as a rural area. Around 34% of the population resides in areas classed as being urban. Much of the south west of Shropshire is classified as being sparsely populated. Telford and Wrekin has a more urban profile. The rural area of Telford and Wrekin is to the west of Telford town centre and although this is the largest area of the Borough, it has the lowest population density at 0.7 people per hectare.

## 6.11 People living in an area of deprivation

The proportion of women aged 16-44 living in the most deprived quintile (IMD 2015) is higher in Oswestry, North Shropshire, Shrewsbury and Atcham, The Wrekin, Hadley Castle and Lakeside South than in South Shropshire and Bridgnorth localities. *Source: MLU Review options appraisal stage 3 data pack*

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

People living in Shropshire are relatively more affluent compared with the national average. However, there is also significant rural deprivation in parts of Shropshire, with access to transport and higher costs for everyday essentials being a challenge for people particularly in the far south and north of the county. All of the most deprived areas in Shropshire are in urban areas, with the five highest ranked being in Harlescott (Shrewsbury), Monkmoor (Shrewsbury), Ludlow East, Oswestry South and Meole/Bayston Hill, Column and Sutton. All nine Shropshire LSOAs that fall within the 20% most deprived in England are located within urban areas of the county. Harlescott is the only area that falls within the 10% most deprived nationally.

## 7.0 Potential impacts on the protected characteristic groups

This section provides details of the potential impacts that have been identified on each of the protected characteristics as a result of the proposed options. Appendix 3 provides descriptions of the protected characteristics.

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

Most pregnant women and mothers of newborn babies would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women. The positive benefits would be increased for particular groups of women who may need to access these services more due to increased risk factors. However, for women currently living near to a MLU where they can give birth and their families, if births are no longer possible in this location, there may be a slight negative impact if they have to travel further to a birthing unit.

### 7.1 Women

All of the people who will be directly impacted on by changes to maternity services will be women. However, there may also be an impact on partners, carers and families who could be of either gender who attend appointments with the mother-to-be/mother and/or who are present at the birth.

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

There could also possibly be an adverse impact on both men and women from deprived communities and rural communities because of issues of public transport, location and low income. However, as our most deprived communities are in Telford and Wrekin, there would be a positive impact on women if they are able to access more services from a community hub closer to their homes. There would also be a positive impact on women living in North Shropshire if more services are available to them locally.

Overall, most pregnant women would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women.

## 7.2 Women in different age groups

By their nature, any changes to maternity services are most likely to impact on pregnant women, mothers and their babies. Women of child-bearing age would therefore be most impacted on by these proposals and in particular younger and older women of child-bearing age.

In 2015, 21.5% of all live births in England and Wales were to mothers aged 35 or over. Mothers in this age group are more likely on average to experience complications during pregnancy, labour and postnatal. Older age in mothers is also associated with higher rates of perinatal mortality as is the likelihood of foetuses with congenital anomalies and admissions of neonates to intensive care. As older women are more likely to have complications during pregnancy and childbirth and are likely to need more pre- and postnatal care, they are more likely to be impacted on by any changes to maternity care.

A Save the Children report in 2012 highlighted that girls under the age of 15 are five times more likely to die in pregnancy than women in their 20s, and that babies born to younger mothers are also at greater risk. Teenagers are also less likely to get pre-natal care soon enough compared to older women and are susceptible to a number of conditions including high blood pressure and pre-eclampsia. Although numbers in the UK are low, under 18s are more likely to give birth to premature babies and low birth weight babies and have complications during labour.

The World Health Organisation adds: “the emotional, psychological and social needs of pregnant adolescent girls can be greater than those of other women.” Source: <https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy>

As teenage women are more likely to have complications during pregnancy and childbirth, they are likely to need more pre- and postnatal care and therefore, they are more likely to be impacted on by any changes to maternity care.

Most pregnant women of all ages would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women.

However, the level of impact on the different age groups may be increased if they live in rural and/or deprived areas. A change in location of services may have an impact on travel access, time and cost for some women and their families. This could represent a particular challenge for women who don't drive and who need to travel by public transport. Research for the Campaign for Better Transport (2013) explored how changes in UK government funding have impacted on young people, including increasing debts, high usage of public transport, low car usage, and increased transport costs.

As the proposed model is a community one, bringing many services closer to women's homes, there is likely to be an overall positive impact in terms of travel time and cost. However, for women currently living near to a MLU where they can give birth, if births are no longer possible in this location, there may be a slight negative impact on younger women if they have to travel further to a birthing unit. This would primarily impact on women who are classed as low risk as high risk women would already need to travel to the consultant-led unit.

### 7.3 Women with a disability

There is a higher number than the national average of patients with a longer-term condition living in all Shropshire, Telford and Wrekin. In Shropshire there are 10.2% (31,258) people who have a long-term condition/disability where activities are limited a little compared to 9.6% (15,935) in Telford and Wrekin. Disabled people make up a significant percentage of the population (*ONS Census 2011 data: 9.5 million people have a limiting long-term illness or impairment*) and we know that disabled people are likely to use health services more frequently than non-disabled people, although monitoring data is not as well developed as it is for race, gender and age.

Disabled people with other equality characteristics can face multiple disadvantages. For example, some ethnic groups have a higher proportion of the population who are disabled. 25% of people in both White Irish, and White gypsy and traveller groups are disabled.

*Source: Care Quality Commission 2013 Disability and Ethnicity Equality Counts*

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

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

Disabled women are usually classified during their pregnancy as 'high risk' requiring more antenatal visits and more scans, however, arranging these intensive appointments can be difficult for some

disabled women. Source: Mitra M, Clements KM, Zhang J, et al. Maternal characteristics, pregnancy complications, and adverse birth outcomes among women with disabilities. *Med Care* 2015;53:1027–32.doi:10.1097/MLR.0000000000000427

Barriers to accessing healthcare for disabled people include transport issues, accessing information and communication can create significant barriers to accessing healthcare services for people with sensory loss or learning disability. In Great Britain, 74% of adults with impairments experienced restrictions in using transport compared with 58% of adults without impairments Source: *ONS Life Opportunities Survey 2009/10*

Research by the Office for Disability Issues (2009) found: Lack of access to a car is a significant issue for disabled people and their families and results in much greater reliance upon public transport services. Data from the Omnibus Survey (2004) suggested that disabled people were more than twice as likely to have no access to a car in the household than non-disabled people (35.3% of those defined as having health conditions that limited activity or work compared to 14% without.)

Overall, most women would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women.

However, public transport, particularly from rural areas, might represent a real challenge for a woman with a disability if she had to travel further. A carer might also need to accompany her to maternity appointments to offer help and support.

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

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

As the proposed model is a community one, bringing many services closer to women's homes, there is likely to be an overall positive impact in terms of travel time and cost. However, for women currently living near to a MLU where they can give birth, if births are no longer possible in this location, there may be a slight negative impact on women with a disability and their partners and families if they have to travel further to a birthing unit. This would primarily impact on women who are classed as low risk as high risk women would already need to travel to the consultant-led unit.

## 7.4 Gender reassignment

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

The proposals do not directly impact people undergoing any core gender reassignment treatments, however this assessment acknowledges that this group is often disadvantaged within healthcare due to a general lack of understanding of transgender issues. Previous engagement work has not highlighted any impacts from this group differing from that of the general population.

## 7.5 Women who are married or in a civil partnership

Marriage and Civil Partnership protection applies for employment and we have found minimal evidence to suggest that people who are married or are in a civil partnership are disproportionately impacted on in relation to the proposed changes to maternity services.

Overall, most women would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women.

The only possible negative impact could be for single women who don't have a partner to help them if they needed to travel further to appointments, however, the same could apply to married women or those in a civil partnership if their partner is working or is unable to take them to appointments for another reason. This situation could be exacerbated for women who don't drive or who are more reliant on public transport due to possible increased travel times and costs to travel to appointments.

As the proposed model is a community one, bringing many services closer to women's homes, there is likely to be an overall positive impact in terms of travel time and cost. However, for women currently living near to a MLU where they can give birth, if births are no longer possible in this location, there may be a slight negative impact on single women who don't drive or who are reliant on public transport if they have to travel further to a birthing unit. This would primarily impact on women who are classed as low risk as high risk women would already need to travel to the consultant-led unit.

## 7.6 Maternal women

This protected characteristic applies to all women who access maternity services and therefore all women of child-bearing age and their partners and families would be impacted on by any changes to these services. The impacts of the proposed service changes on women with other protected characteristics are described in the other sections.

Previous engagement work has told us that accessing maternity services can be a challenge for pregnant women, particularly if they do not have family or friends nearby and during labour. This problem could be exacerbated for pregnant women living in deprived and/or rural areas due to possible increased travel costs and times.

However, overall, most women would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the

community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women. There would particularly be a positive impact on women living in North Shropshire and women living in some of the more deprived areas of Telford.

In terms of access, the impact of the proposed change on the total maternal population can be confirmed once the proposals in relation to hub sites are confirmed.

## 7.7 Women of different races

There is much evidence of different levels of risk to women from different ethnic backgrounds in relation to pregnancy and childbirth. Black, Asian and Minority Ethnic women and children, for example, have an increased risk of some poor outcomes:

- stillbirth – babies of African-Caribbean and African mothers have more than double the risk of stillbirth, and babies of Indian, Bangladeshi and Pakistani mothers have an increased risk, compared with babies of White mothers *Source: CMACE, 2011; Gardosi, 2013*
- low birthweight – Indian, Pakistani and Bangladeshi babies are 2.5 times more likely than White babies to have a low birthweight, and Black Caribbean and Black African babies are 60% more likely to have a low birthweight *Source: Kelly, 2008*
- preterm birth – babies of African -Caribbean and African mothers are at increased risk compared to babies of mothers of other ethnic origins *Source: Aveyard et al, 2002; Office for National Statistics, 2016*
- congenital abnormalities – babies of mothers of born in India and Bangladesh are at increased risk and babies of mothers born in Pakistan are three times more likely than babies of mothers born in the UK to be born with a congenital abnormality *Source: Blarajan et al, 1987*
- severe maternal morbidity – Black and Minority Ethnic women are 50% more likely than White women to suffer severe maternal morbidity, and the risk is more than double for women of African and Afro-Caribbean origin *Source: Knight et al, 2009*
- maternal death – Black mothers are four times more likely to die in pregnancy or in the year after birth than White mothers *Source: Knight et al, 2016*
- late booking for antenatal care - women of South Asian origin are likely to initiate care later and have fewer antenatal visits than white women; women who are asylum seekers or refugees are disproportionately represented within unbooked births *Source: Rowe & Garcia, 2003*

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

- less likely to have the first antenatal contact by 12 weeks, less likely to be offered antenatal classes, less likely to feel they had enough information about their choices for maternity

care, less likely to feel they were always involved in decisions about antenatal care, and less likely to feel their midwives were always respectful

- less likely to feel they were always involved in decisions during labour and birth, and less likely to have always had trust and confidence in staff during labour and birth
- more likely to have a postnatal stay in hospital of more than three days but less likely to feel they were always treated with respect by hospital staff.

All of the above factors could mean that women from the ethnic backgrounds mentioned above could have an increased need for ante- and postnatal maternity care.

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

Otherwise there is no evidence to suggest that people from BAME communities would be disproportionately impacted on in relation to travel and transport. However, for BAME people living in areas of deprivation or rural areas, there may be a negative impact in relation to access to public transport and travel costs. This would mainly be in relation to the place of giving birth which may, for some groups, be located further away than it is currently.

Some women from the Oswestry area give birth in Wales, in Wrexham. Women from Powys only access consultant-led care through SaTH and not midwife-led care. There would therefore be no impact in relation to these proposals for changes to midwife-led care on Welsh women or women who are possibly Welsh speakers.

Most pregnant BAME women would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women. As most of our local BAME communities are in Telford, there would be a positive impact on these women if there is an additional community hub closer to where they live.

## **7.8 Women of different religions or beliefs**

Generally, we have found no evidence to suggest that women who have different religious beliefs are at a higher or lower risk of certain conditions, which may mean they would have to access maternity services more. The only exception to this is the small Mennonite/Amish community (approx. 20 people) living in South Shropshire. This community may be more prone to genetic disorders, increased birth defects and a higher infant mortality rate than the overall population.

If this community lives in an area of deprivation and/or a rural area, there may be slight a negative impact in relation to access to public transport and travel costs. This would mainly be in relation to the place of giving birth which may be located further away than it is currently. This would primarily impact on women who are classed as low risk as high risk women would already need to travel to the consultant-led unit.

However, most pregnant women from all religions and beliefs would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women. As most of our local women with non-Christian religions live in Telford, there would be a positive impact on these women if there is an additional community hub closer to where they live.

## 7.9 Lesbian or bisexual women

Due to lifestyle choices, such as smoking and drinking, pregnant lesbian and bisexual women may be at increased risk of complications during pregnancy. They may therefore have an increased need to access pre- and postnatal maternity services.

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

LGBT people have:

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

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

There are a number of reports which highlight the issue of LGBT communities feeling unsafe when using public transport especially young LGBT people. This could potentially make it more of a challenge for lesbian and bisexual women to access maternity services, particularly if they are unable drive or have access to a car and have to use public transport. This would mainly be in relation to the place of giving birth which may be located further away than it is currently.

However, overall, most pregnant lesbian and bisexual women would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women. In particular, lesbian and bisexual living in North Shropshire and the more deprived areas of Telford would be positively impacted on by the proposed changes.

## 7.10 Women living in a rural area

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

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

- Poverty – 15 per cent of households in rural areas live in poverty, compared to 22 per cent in urban areas
- Housing – Costs tend to be higher and fuel costs are also higher
- Employment – More likely for some communities to be reliant on seasonal work and lower than national average wages
- Access to transport – Travel distance to services may be longer and public transport links may be poor. Economic pressures on local authorities often results in reductions to services
- Population – Populations living in rural areas tend to be older and from White British backgrounds compared to urban areas
- Lack of national understanding of health issues relating to rural communities, however current data shows that health is generally better for people in rural areas compared to urban areas.
- Attitudes to seeking health advice and help differs in rural areas
- Primary care services are important in promoting preventative and screening services to promote health.

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

Most women living in rural areas would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women.

From our engagement work, we have heard that people in rural communities have challenges in relation to travel and transport. The biggest obstacle can often be getting from their home to their nearest public transport and not necessarily travelling by public transport itself, although this can often have limited availability and times are not always suitable for appointment times. The situation could be exacerbated for a small number of younger pregnant women who are less likely to have access to a car, particularly if they are on a low income and/or don't have friends and family living nearby who could give them a lift. Also, women with a disability, women from some ethnic backgrounds and lesbian or bisexual women may need to access maternity services more due to increased pregnancy risks and complications.

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

There may be slight a negative impact on women living in some rural areas in relation to access to public transport and travel costs if they have to travel further to an MLU than they do currently. This would mainly be in relation to the place of giving birth which may be located further away than it is currently and the impact would mainly be on low risk women as high risk women would already go to the consultant-led unit. However, there would be a positive impact on women living in rural areas of North Shropshire if there is an additional community hub and local services closer to where they live than exist currently.

## 7.11 Women living in an area of deprivation

There is a higher prevalence of many behavioural risk factors among women living in the more deprived areas. For example, in more deprived areas, the prevalence of inactivity and the prevalence of smoking are both highest, while the proportion of people eating the recommended 5-a-day of fruits and vegetables is lowest. People in the most deprived areas are also more likely to suffer the harms associated with alcohol consumption.

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

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

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

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

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

Women living in areas of deprivation may be positively or negatively impacted on by these proposals depending on where they live. Although Telford and Wrekin has the most areas with high levels of deprivation, there are also areas of deprivation in Shropshire and rural deprivation, as outlined above, is a challenge for people living in parts of Shropshire. The impact would be greater on pregnant women/new mothers and families on low incomes, particularly those who don't drive or

have access to a car or without family living nearby who can help with transport. This would mainly be in relation to the place of giving birth which may be located further away than it is currently.

As the main areas of deprivation where patients live are in Telford and Wrekin, there could be a potential negative impact for pregnant women and their families living in these areas if they had to travel further to access maternity services than they do now. There would also be an additional negative impact on older and younger women, women with a disability, lesbian and bisexual women and some BAME communities living in these areas who are likely to be more frequent users of maternity services. However, as the proposal would be for an additional community hub to be based in Telford and Wrekin close to these areas of deprivation, this impact is more likely to be a positive one.

Overall, most pregnant women would be positively impacted on by these proposals due to the improvement in the consistency of the services available for women across the county and the community nature of the model that is being proposed. There would also be enhanced community outreach services and ante- and postnatal care tailored to meet the needs of local women.

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

## 8.0 Conclusion/considerations

At the start of this EIA, we stated that we wanted to answer the following questions:

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

We have identified that certain groups of people do have different needs, experiences, issues and priorities in relation to maternity services, and specifically, midwife-led services. These are outlined in sections 4 and 7 above. However, overall, due to the community model that is being proposed and local services being available depending on the needs of women, there will be a positive impact on most women. The proposed model will also promote equality across the whole of the county as women will be able to generally access the same level of service, particularly ante- and postnatal care wherever they live. This isn't always the case currently. There will possibly be a negative impact on women who are currently living near to the existing rural MLUs where they can give birth, if they are no longer able to do so and therefore have to travel further. This will, however, mainly impact on women who are classed as low risk as anyone who has certain risk factors (like a long term condition, or is particularly young or old) would already have to travel to give birth in the consultant-led unit. In addition, if the hubs are not located in the same locations as the existing MLUs, some women might need to travel further to access some services.

Information to be added at the end

## 9.0 Recommendations

### Pre-consultation recommendations

- Build on the pre-consultation engagement work with seldom heard groups and ensure that the views of people belonging to one or more of the protected characteristic groups on the proposed model are obtained (the key groups likely to be impacted on are highlighted earlier in this document and in the pre-consultation engagement with seldom heard groups report.)
- Produce consultation materials in different languages and formats, including Easy Read.
- Use interpreters at meetings and events if required.
- Attend existing meetings of groups in their own area, with people they know and where they are more likely to feel comfortable to talk.
- Adapt the engagement tools used to engage with seldom heard groups depending on their availability and needs, for example, a telephone conversation might be easier for someone who finds it difficult to travel and some people might prefer a one-to-one meeting rather than giving their views in front of other people.
- Don't make assumptions about the people you are engaging with; not all women have a partner or a male partner. All women have different backgrounds and experiences and should be treated as individuals.
- Including images of women from different protected characteristic groups is also important when producing the consultation materials as women are less likely to respond if they feel the consultation isn't relevant to them.
- Use clear and consistent language that's easy for people to understand in the consultation materials.
- Investigate ways to improve cross-border and out-of-county communications between healthcare providers; ensure that maternity services in surrounding areas are engaged as part of the consultation process.

### Consultation recommendations

Information to be added at the end

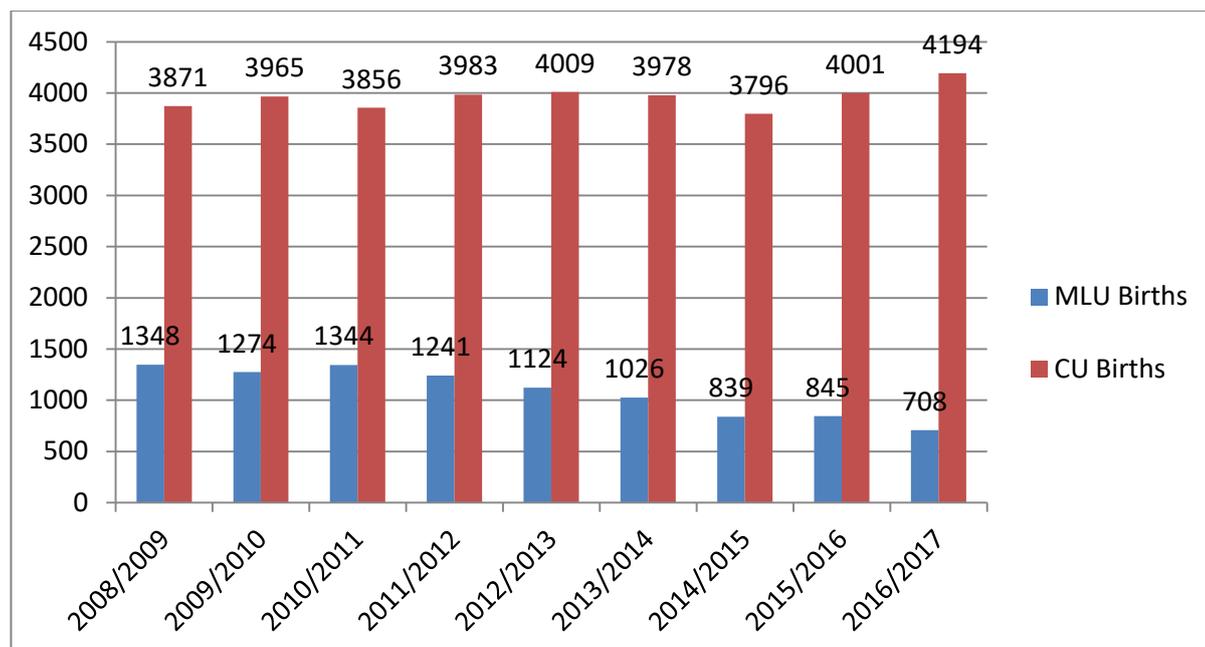
### Post-consultation recommendations

Information to be added at the end

## 10.0 Appendices

### Appendix 1: SaTH Birth Data

#### Shrewsbury and Telford Hospital NHS Trust - Summary Birth Figures 2008-2017



## Number of deliveries at Shrewsbury and Telford NHS Trust in 2016/17 by protected characteristic and locality

### 1. Age

#### Number of deliveries by age and locality

Age	Locality																			
	Total		Bridgnorth		Hadley Castle		Lakeside South		North Shropshire		Oswestry		Shrewsbury & Atcham		South Shropshire		The Wrekin		Out of area	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
<b>Below 16</b>	<10	-	<10	-	<10	-	<10	-	<10	-	0	-	<10	-	<10	-	<10	-	<10	-
<b>16-19</b>	170	4%	<10	-	31	4%	35	6%	21	4%	<10	-	30	3%	<10	-	23	4%	<10	-
<b>20-24</b>	908	19%	78	18%	172	21%	160	26%	92	19%	41	18%	165	16%	40	16%	109	18%	51	14%
<b>25-29</b>	1454	30%	119	27%	246	30%	198	32%	137	28%	73	33%	308	30%	84	34%	173	29%	116	31%
<b>30-34</b>	1390	29%	150	34%	224	27%	140	23%	145	30%	57	26%	311	30%	82	33%	176	29%	105	28%
<b>35-39</b>	736	15%	71	16%	126	15%	66	11%	73	15%	29	13%	181	18%	27	11%	95	16%	68	18%
<b>40-44</b>	167	3%	14	3%	18	2%	19	3%	22	4%	<10	-	36	3%	13	5%	17	3%	18	5%
<b>45-49</b>	11	0.2%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
<b>Age not stated</b>	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
<b>Total</b>	4849	100%	439	100%	821	100%	621	100%	490	100%	222	100%	1034	100%	250	100%	597	100%	375	100%

Source: SaTH activity data for maternity services 2016/17

## 2. Ethnicity

### Number of deliveries by ethnicity and locality

Ethnicity	Locality																			
	Total		Bridgnorth		Hadley Castle		Lakeside South		North Shropshire		Oswestry		Shrewsbury & Atcham		South Shropshire		The Wrekin		Out of area	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
White	4031	83%	354	81%	628	76%	510	82%	430	88%	192	86%	951	92%	218	87%	444	74%	304	81%
Asian/Asian British	137	3%	<10	-	41	5%	<10	-	<10	-	<10	-	18	2%	<10	-	46	8%	<10	-
Mixed/Multiple Ethnic	87	2%	<10	-	23	3%	17	3%	<10	-	<10	-	20	2%	<10	-	17	3%	<10	-
Black	49	1%	<10	-	17	2%	11	2%	<10	-	<10	-	<10	-	<10	-	14	2%	<10	-
Other	19	0.4%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Not stated	526	11%	72	16%	109	13%	72	12%	49	10%	24	11%	36	3%	30	12%	73	12%	61	16%
<b>Total</b>	<b>4849</b>	<b>100%</b>	<b>439</b>	<b>100%</b>	<b>821</b>	<b>100%</b>	<b>621</b>	<b>100%</b>	<b>490</b>	<b>100%</b>	<b>222</b>	<b>100%</b>	<b>1034</b>	<b>100%</b>	<b>250</b>	<b>100%</b>	<b>597</b>	<b>100%</b>	<b>375</b>	<b>100%</b>

Source: SaTH activity data for maternity services 2016/17

### 3. Religion or belief

#### Number of deliveries by religion or belief and locality

Religion or belief	Locality																			
	Total		Bridgnorth		Hadley Castle		Lakeside South		North Shropshire		Oswestry		Shrewsbury & Atcham		South Shropshire		The Wrekin		Out of area	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Agnostic	22	0.5%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Atheist	100	2%	33	8%	<10	-	13	2%	12	2%	<10	-	18	2%	<10	-	<10	-	<10	-
Baptist	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Buddhist	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
catholic	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Catholic (Roman)	342	7%	31	7%	95	12%	40	6%	29	6%	<10	-	70	7%	<10	-	49	8%	11	3%
Christian	780	16%	75	17%	143	17%	93	15%	105	21%	45	20%	143	14%	38	15%	98	16%	40	11%
Church of England	825	17%	127	29%	104	13%	72	12%	110	22%	53	24%	189	18%	54	22%	82	14%	34	9%
Church of Scotland	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Church of Wales	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Evangelic	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Greek Orthodox	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Hindu	14	0.3%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
humanist	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Islam	115	2%	<10	-	35	4%	<10	-	<10	-	<10	-	16	2%	<10	-	40	7%	<10	-

Jehovahs Witness	16	0.3%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Jewish	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Mennonite Christian	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Methodist	21	0.4%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Mormon	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
None	2009	41%	134	31%	358	44%	353	57%	175	36%	70	32%	506	49%	101	40%	258	43%	54	14%
None and christian	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
None and church of england	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Orthodox	22	0.5%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Other	16	0.3%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
pagan	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Protestant	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Sikh	36	1%	<10	-	15	2%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
spiritual	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Spiritualist	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Religion not stated	491	10%	22	5%	37	5%	25	4%	37	8%	27	12%	60	6%	34	14%	23	4%	226	60%
<b>Total</b>	<b>4849</b>	<b>100%</b>	<b>439</b>	<b>100%</b>	<b>821</b>	<b>100%</b>	<b>621</b>	<b>100%</b>	<b>490</b>	<b>100%</b>	<b>222</b>	<b>100%</b>	<b>1034</b>	<b>100%</b>	<b>250</b>	<b>100%</b>	<b>597</b>	<b>100%</b>	<b>375</b>	<b>100%</b>

Source: SaTH activity data for maternity services 2016/17

#### 4. Marital status

##### Number of deliveries by marital status and locality

Marital status	Locality																			
	Total		Bridgnorth		Hadley Castle		Lakeside South		North Shropshire		Oswestry		Shrewsbury & Atcham		South Shropshire		The Wrekin		Out of area	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Single	2408	50%	196	45%	410	50%	382	62%	222	45%	106	48%	534	52%	113	45%	297	50%	148	39%
Married/Civil Partner	1100	23%	100	23%	157	19%	91	15%	145	30%	48	22%	304	29%	53	21%	129	22%	73	19%
Separated	21	0.4%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Divorced/Person whose Civil Partnership has been dissolved	16	0.3%	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Widowed/Surviving Civil Partner	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Not known	181	4%	<10	-	15	2%	<10	-	15	3%	<10	-	115	11%	<10	-	<10	-	12	3%
Not applicable	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-	<10	-
Question remains unanswered	1120	23%	138	31%	230	28%	134	22%	106	22%	62	28%	70	7%	80	32%	159	27%	141	38%
<b>Total</b>	<b>4849</b>	<b>100%</b>	<b>439</b>	<b>100%</b>	<b>821</b>	<b>100%</b>	<b>621</b>	<b>100%</b>	<b>490</b>	<b>100%</b>	<b>222</b>	<b>100%</b>	<b>1034</b>	<b>100%</b>	<b>250</b>	<b>100%</b>	<b>597</b>	<b>100%</b>	<b>375</b>	<b>100%</b>

Source: SaTH activity data for maternity services 2016/17

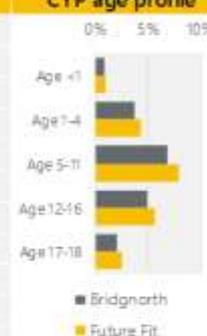
## Appendix 2: Demographic profile of the different localities

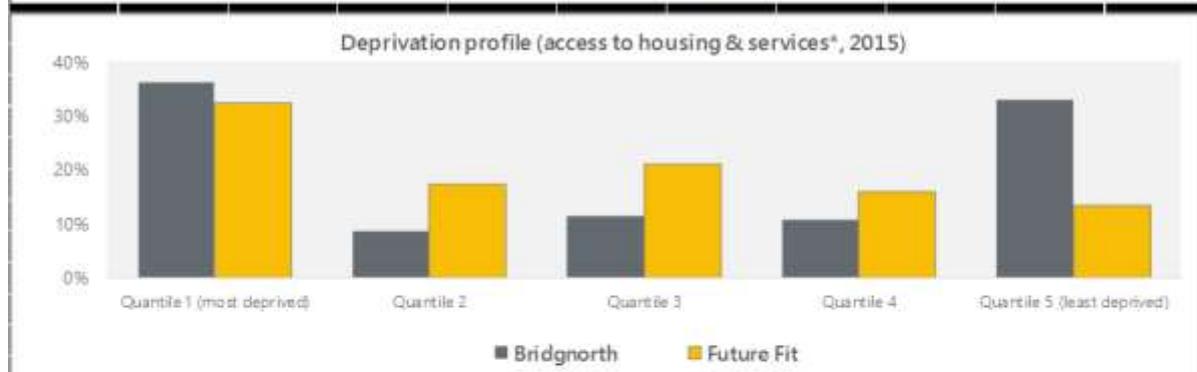
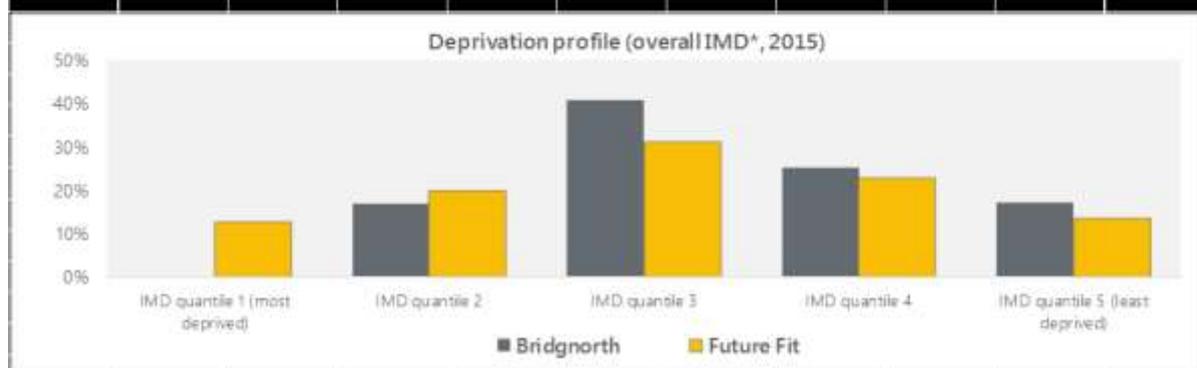
Source: *Future Fit Women's and Children's Integrated Impact Assessment* -

<https://nhsfuturefit.org/key-documents/impact-assessment/2017-4/477-appendix-15-240719-ff-ii-a-women-and-children-annexes-compressed-pdf/file>

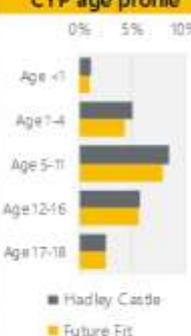
- 1) Bridgnorth
- 2) Hadley Castle
- 3) Lakeside South
- 4) North Shropshire
- 5) Oswestry
- 6) Shrewsbury and Atcham
- 7) South Shropshire
- 8) The Wrekin

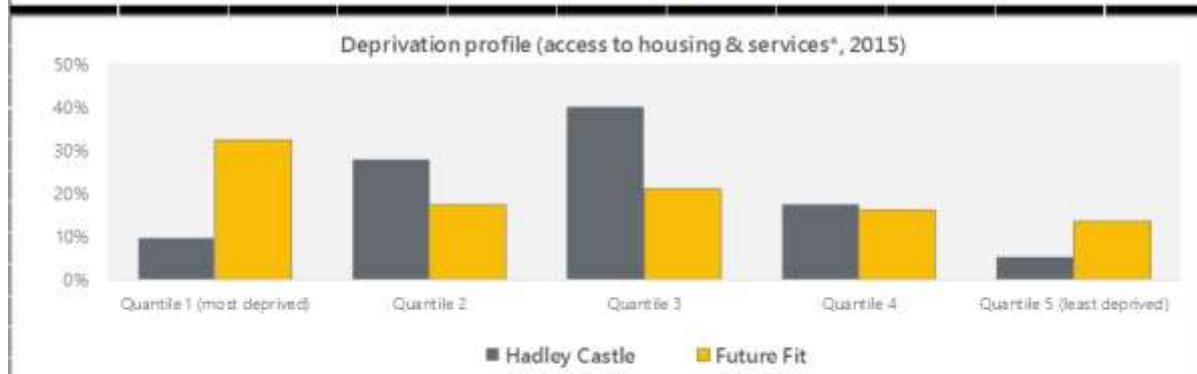
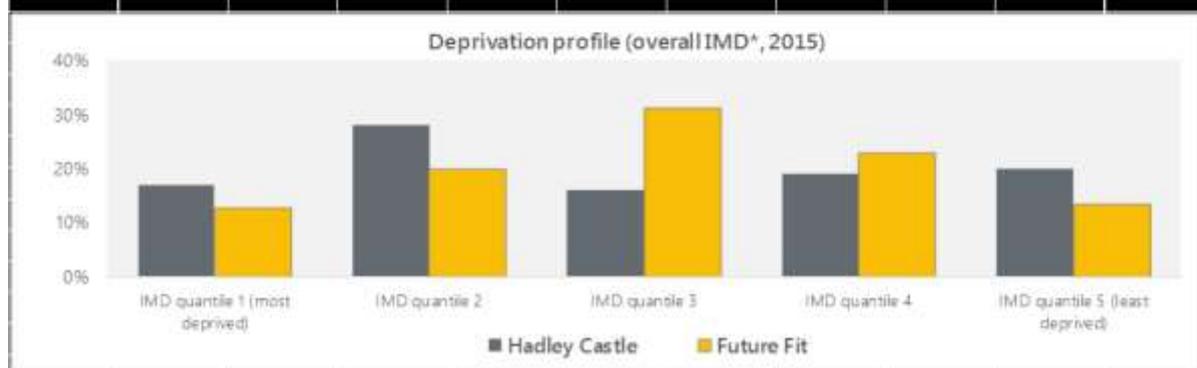
DRAFT

	Bridgnorth	Future Fit	CYP age profile
Total population, 2015 MYE	55,823	551,694	
% of Future Fit footprint	10.1%	-	
Male population, 2015 MYE	27,887	273,745	
Female population, 2015 MYE	27,936	277,949	
Male : Female ratio	50 : 50	49.6 : 50.4	
Under 18 population, 2015 MYE	9,732	111,754	
% of population	17.4%	20.3%	
Females aged 16-44, 2015 MYE	7,947	88,655	
% of population	14.2%	16.1%	
Birth inpatient spells, 2015/16	413	4,689	
Fertility rate / 1000 Females 16-44	52.0	52.9	

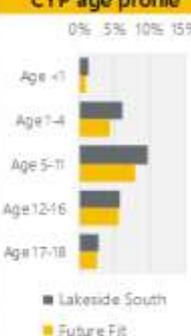


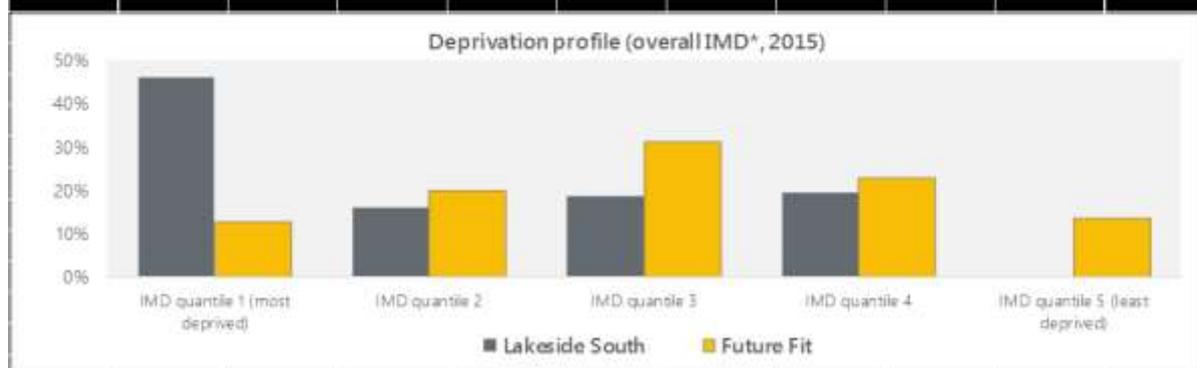
Characteristic	Source / Notes	Bridgnorth		Future Fit	
		n	%	n	%
Married or civil partnership	Census 2011	9,132	19.8%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	5,185	9.3%	52,017	9.4%
Ethnic origin: White females	Census 2011	27,078	96.9%	263,787	94.9%
Ethnic origin: BAME females	Census 2011; travellers, mixed, asian, black and other	803	3.1%	19,195	5.1%
Religion: None (females)	Census 2011	4,766	17.1%	60,200	21.7%
Religion: Christian females	Census 2011	20,561	73.6%	188,395	67.8%
Religion: Other females	Census 2011; muslim, sikh, hindu, buddhist, jewish and other	265	9.3%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other Transgender community (WAB)	Integrated Household Survey, 2014 Johnson (2001) - GRES (2008) & Wilson (1999)	712	1.5%	7,092	1.6%
		33	0.1%	329	0.1%

	Hadley Castle	Future Fit	CYP age profile
Total population, 2015 MYE	73,366	551,694	
% of Future Fit footprint	13.3%	-	
Male population, 2015 MYE	36,430	273,745	
Female population, 2015 MYE	36,936	277,949	
Male : Female ratio	49.7 : 50.3	49.6 : 50.4	
Under 18 population, 2015 MYE	16,013	111,754	
% of population	21.8%	20.3%	
Females aged 16-44, 2015 MYE	13,462	88,655	
% of population	18.3%	16.1%	
Birth inpatient spells, 2015/16	789	4,689	
Fertility rate / 1000 Females 16-44	58.6	52.9	

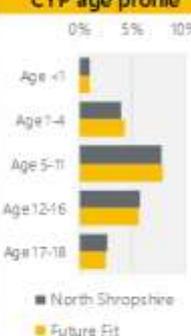


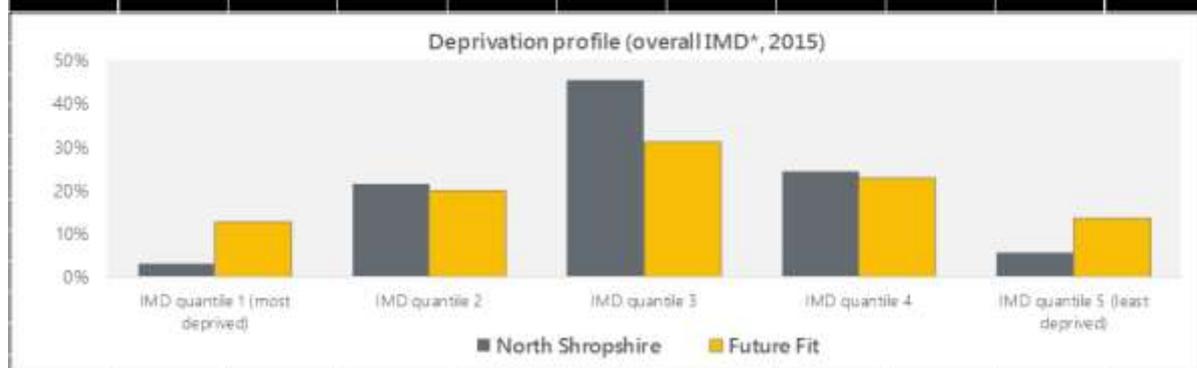
Characteristic	Source / Notes	Hadley Castle		Future Fit	
		n	%	n	%
Married or civil partnership	Census 2011	10,595	18.5%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	6,856	9.3%	52,017	9.4%
Ethnic origin: White females	Census 2011	33,483	90.7%	263,787	94.9%
Ethnic origin: BAME females	Census 2011: travellers, mixed, asian, black and other	5,421	9.3%	19,195	5.1%
Religion: None (females)	Census 2011	7,834	21.2%	60,200	21.7%
Religion: Christian females	Census 2011	24,507	66.3%	188,395	67.8%
Religion: Other females	Census 2011: muslim, sikh, hindu, buddhist, jewish and other	1,649	12.4%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other Transgender community (WAB)	Integrated Household Survey, 2014	970	1.7%	7,092	1.6%
	Johnson (2001) - GRES (2008) & Wilson (1999)	44	0.1%	329	0.1%

	Lakeside South	Future Fit	CYP age profile
Total population, 2015 MYE	42,430	551,694	
% of Future Fit footprint	7.7%	-	
Male population, 2015 MYE	20,870	273,745	
Female population, 2015 MYE	21,560	277,949	
Male : Female ratio	49.2 : 50.8	49.6 : 50.4	
Under 18 population, 2015 MYE	10,424	111,754	
% of population	24.6%	20.3%	
Females aged 16-44, 2015 MYE	7,952	88,655	
% of population	18.7%	16.1%	
Birth inpatient spells, 2015/16	578	4,689	
Fertility rate / 1000 Females 16-44	72.7	52.9	

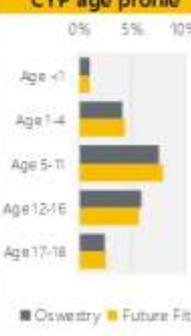


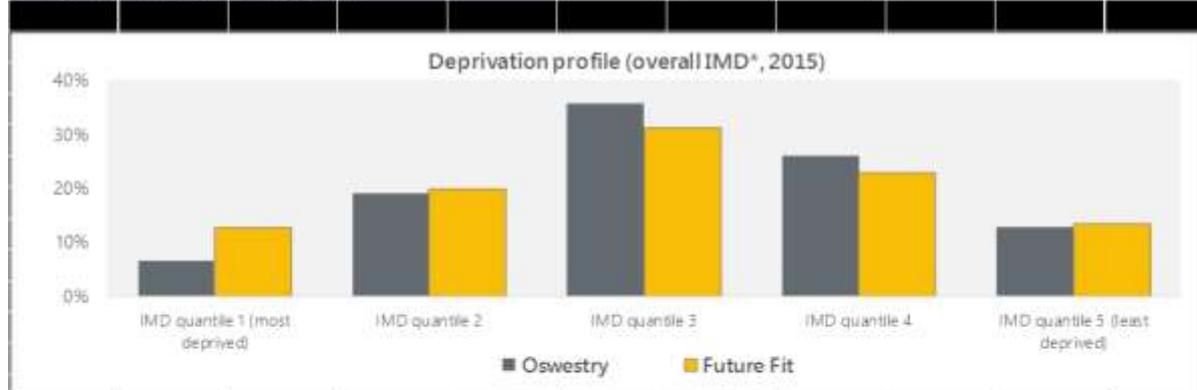
Characteristic	Source / Notes	Lakeside South		Future Fit	
		n	%	n	%
Married or civil partnership	Census 2011	5,526	17.3%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	4,161	9.8%	52,017	9.4%
Ethnic origin: White females	Census 2011	19,892	92.3%	263,787	94.9%
Ethnic origin: BAME females	Census 2011: travellers, mixed, asian, black and other	1,771	7.7%	19,195	5.1%
Religion: None (females)	Census 2011	6,620	30.7%	60,200	21.7%
Religion: Christian females	Census 2011	12,385	57.4%	188,395	67.8%
Religion: Other females	Census 2011: muslim, sikh, hindu, buddhist, jewish and other	408	11.9%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other Transgender community (WAB)	Integrated Household Survey, 2014	550	1.7%	7,092	1.6%
	Johnson (2001) - GRES (2008) & Wilson (1999)	25	0.1%	329	0.1%

	North Shropshire	Future Fit	CYP age profile
Total population, 2015 MYE	65,705	551,694	
% of Future Fit footprint	11.9%	-	
Male population, 2015 MYE	33,206	273,745	
Female population, 2015 MYE	32,499	277,949	
Male : Female ratio	50.5 : 49.5	49.6 : 50.4	
Under 18 population, 2015 MYE	12,980	111,754	
% of population	19.8%	20.3%	
Females aged 16-44, 2015 MYE	9,858	88,655	
% of population	15.0%	16.1%	
Birth inpatient spells, 2015/16	488	4,689	
Fertility rate / 1000 Females 16-44	49.5	52.9	

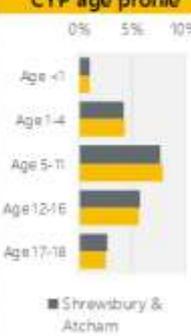


Characteristic	Source / Notes	North Shropshire		Future Fit	
		n	%	n	%
Married or civil partnership	Census 2011	10,135	19.2%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	5,811	8.8%	52,017	9.4%
Ethnic origin: White females	Census 2011	31,146	95.8%	263,787	94.9%
Ethnic origin: BAME females	Census 2011; travellers, mixed, asian, black and other	1,082	4.2%	19,195	5.1%
Religion: None (females)	Census 2011	5,446	16.8%	60,200	21.7%
Religion: Christian females	Census 2011	23,928	73.6%	188,395	67.8%
Religion: Other females	Census 2011: muslim, sikh, hindu, buddhist, jewish and other	254	9.6%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other Transgender community (WAB)	Integrated Household Survey, 2014 Johnson (2001) - GRES (2008) & Wilson (1999)	849	1.6%	7,092	1.6%
		39	0.1%	329	0.1%

	Oswestry	Future Fit	CYP age profile
Total population, 2015 MYE	41,433	551,694	
% of Future Fit footprint	7.5%	-	
Male population, 2015 MYE	20,271	273,745	
Female population, 2015 MYE	21,162	277,949	
Male : Female ratio	48.9 : 51.1	49.6 : 50.4	
Under 18 population, 2015 MYE	8,184	111,754	
% of population	19.8%	20.3%	
Females aged 16-44, 2015 MYE	6,747	88,655	
% of population	16.3%	16.1%	
Birth inpatient spells, 2015/16	292	4,689	
Fertility rate / 1000 Females 16-44	43.3	52.9	



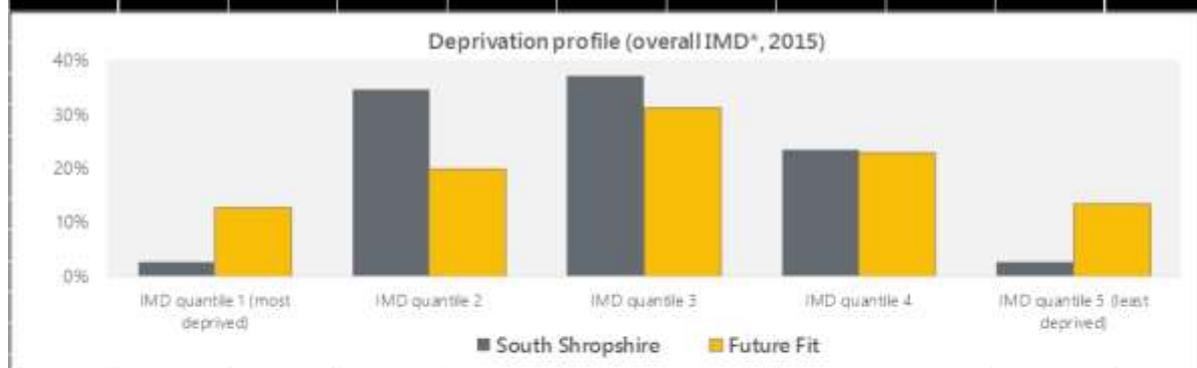
Characteristic	Source / Notes	Oswestry		Future Fit	
		n	%	n	%
Married or civil partnership	Census 2011	6,171	18.6%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	3,982	9.6%	52,017	9.4%
Ethnic origin: White females	Census 2011	20,436	96.6%	263,787	94.9%
Ethnic origin: BAME females	Census 2011; travellers, mixed, asian, black and other	823	3.4%	19,195	5.1%
Religion: None (females)	Census 2011	4,238	20.0%	60,200	21.7%
Religion: Christian females	Census 2011	14,911	70.5%	188,395	67.8%
Religion: Other females	Census 2011; muslim, sikh, hindu, buddhist, jewish and other	240	9.5%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other	Integrated Household Survey, 2014	531	1.6%	7,092	1.6%
Transgender community (WAB)	Johnson (2001) - GRES (2008) & Wilson (1999)	25	0.1%	329	0.1%

	Shrewsbury & Atcham	Future Fit	CYP age profile
Total population, 2015 MYE	103,650	551,694	
% of Future Fit footprint	18.8%	-	
Male population, 2015 MYE	50,985	273,745	
Female population, 2015 MYE	52,665	277,949	
Male : Female ratio	49.2 : 50.8	49.6 : 50.4	
Under 18 population, 2015 MYE	20,824	111,754	
% of population	20.1%	20.3%	
Females aged 16-44, 2015 MYE	17,045	88,655	
% of population	16.4%	16.1%	
Birth inpatient spells, 2015/16	1,029	4,689	
Fertility rate / 1000 Females 16-44	60.4	52.9	

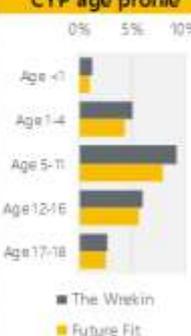


Characteristic	Source / Notes	Shrewsbury & Atcham		Future Fit	
		n	%	n	%
Married or civil partnership	Census 2011	14,881	18.0%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	9,139	8.8%	52,017	9.4%
Ethnic origin: White females	Census 2011	50,406	95.7%	263,787	94.9%
Ethnic origin: BAME females	Census 2011; travellers, mixed, asian, black and other	2,817	4.3%	19,195	5.1%
Religion: None (females)	Census 2011	11,823	22.4%	60,200	21.7%
Religion: Christian females	Census 2011	35,609	67.6%	188,395	67.8%
Religion: Other females	Census 2011; muslim, sikh, hindu, buddhist, jewish and other	705	9.9%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other	Integrated Household Survey, 2014	1,334	1.6%	7,092	1.6%
Transgender community (WAB)	Johnson (2001) - GRES (2008) & Wilson (1999)	62	0.1%	329	0.1%

	South Shropshire	Future Fit	CYP age profile
Total population, 2015 MYE	44,769	551,694	
% of Future Fit footprint	8.1%	-	
Male population, 2015 MYE	22,077	273,745	
Female population, 2015 MYE	22,692	277,949	
Male : Female ratio	49.3 : 50.7	49.6 : 50.4	
Under 18 population, 2015 MYE	7,569	111,754	
% of population	16.9%	20.3%	
Females aged 16-44, 2015 MYE	5,772	88,655	
% of population	12.9%	16.1%	
Birth inpatient spells, 2015/16	251	4,689	
Fertility rate / 1000 Females 16-44	43.5	52.9	



Characteristic	Source / Notes	South Shropshire		Future Fit	
		n	%	n	%
Married or civil partnership	Census 2011	6,877	18.5%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	4,607	10.3%	52,017	9.4%
Ethnic origin: White females	Census 2011	22,255	98.1%	263,787	94.9%
Ethnic origin: BAME females	Census 2011; travellers, mixed, asian, black and other	737	1.9%	19,195	5.1%
Religion: None (females)	Census 2011	4,454	19.6%	60,200	21.7%
Religion: Christian females	Census 2011	16,146	71.2%	188,395	67.8%
Religion: Other females	Census 2011; muslim, sikh, hindu, buddhist, jewish and other	309	9.2%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other	Integrated Household Survey, 2014	559	1.5%	7,092	1.6%
Transgender community (WAB)	Johnson (2001) - GRES (2008) & Wilson (1999)	27	0.1%	329	0.1%

	The Wrekin	Future Fit	CYP age profile
Total population, 2015 MYE	55,363	551,694	
% of Future Fit footprint	10.0%	-	
Male population, 2015 MYE	27,597	273,745	
Female population, 2015 MYE	27,766	277,949	
Male : Female ratio	49.8 : 50.2	49.6 : 50.4	
Under 18 population, 2015 MYE	12,694	111,754	
% of population	22.9%	20.3%	
Females aged 16-44, 2015 MYE	9,872	88,655	
% of population	17.8%	16.1%	
Birth inpatient spells, 2015/16	641	4,689	
Fertility rate / 1000 Females 16-44	64.9	52.9	



Characteristic	Source / Notes	The Wrekin		Future Fit	
		n	%	n	%
Married or civil partnership	Census 2011	8,090	19.0%	81,870	18.6%
Women with disability	Census 2011, day-to-day activities limited	5,085	9.2%	52,017	9.4%
Ethnic origin: White females	Census 2011	24,621	88.7%	263,787	94.9%
Ethnic origin: BAME females	Census 2011; travellers, mixed, asian, black and other	4,898	11.3%	19,195	5.1%
Religion: None (females)	Census 2011	6,353	22.9%	60,200	21.7%
Religion: Christian females	Census 2011	17,532	63.1%	188,395	67.8%
Religion: Other females	Census 2011; muslim, sikh, hindu, buddhist, jewish and other	1,509	14.0%	5,834	10.6%
Gay, Lesbian, Bi-sexual & Other	Integrated Household Survey, 2014	717	1.7%	7,092	1.6%
Transgender community (WAB)	Johnson (2001) - GRES (2008) & Wilson (1999)	33	0.1%	329	0.1%

## Age

Protected group of Age	Local data % Shropshire	Local data % Telford and Wrekin	England comparative %
<b>0 – 4</b>	5.1% (15,698)	6.8% (11,344)	6.26%
<b>5 – 9</b>	5.1% (15,932)	6.0% (10,007)	5.61%
<b>10 – 14</b>	5.9% (17,915)	6.4% (10,594)	5.81%
<b>15 – 19</b>	6.2% (18,951)	6.9% (11,496)	6.30%
<b>20 – 24</b>	5.4% (16,619)	6.5% (10,863)	6.78%
<b>25 – 29</b>	5.1% (15,619)	6.5% (10,888)	6.89%
<b>30 – 34</b>	5.0% (15,504)	6.2% (10,334)	6.62%
<b>35 – 39</b>	5.8% (17,790)	6.7% (11,145)	6.69%
<b>40 – 44</b>	7.2% (22,163)	7.7% (12,850)	7.33%
<b>45 – 49</b>	7.7% (23,574)	7.6% (12,653)	7.32%
<b>50 – 54</b>	6.9% (21,004)	6.3% (10,502)	6.41%
<b>55 – 59</b>	6.6% (20,160)	5.9% (9,866)	5.65%
<b>60 – 64</b>	7.3% (22,300)	6.0% (10,010)	5.98%
<b>65 – 69</b>	6.2% (19,059)	4.8% (7,934)	4.73%
<b>70 – 74</b>	4.9% (15,153)	3.6% (5,994)	3.86%
<b>75 – 79</b>	3.8% (11,709)	2.7% (4,439)	3.15%
<b>80 – 84</b>	2.9% (8,971)	1.8% (3,042)	2.37%
<b>85 – 89</b>	1.8% (5,571)	1.1% (1,771)	1.46%
<b>90 and over</b>	0.9% (2,836)	0.5% (909)	0.76%

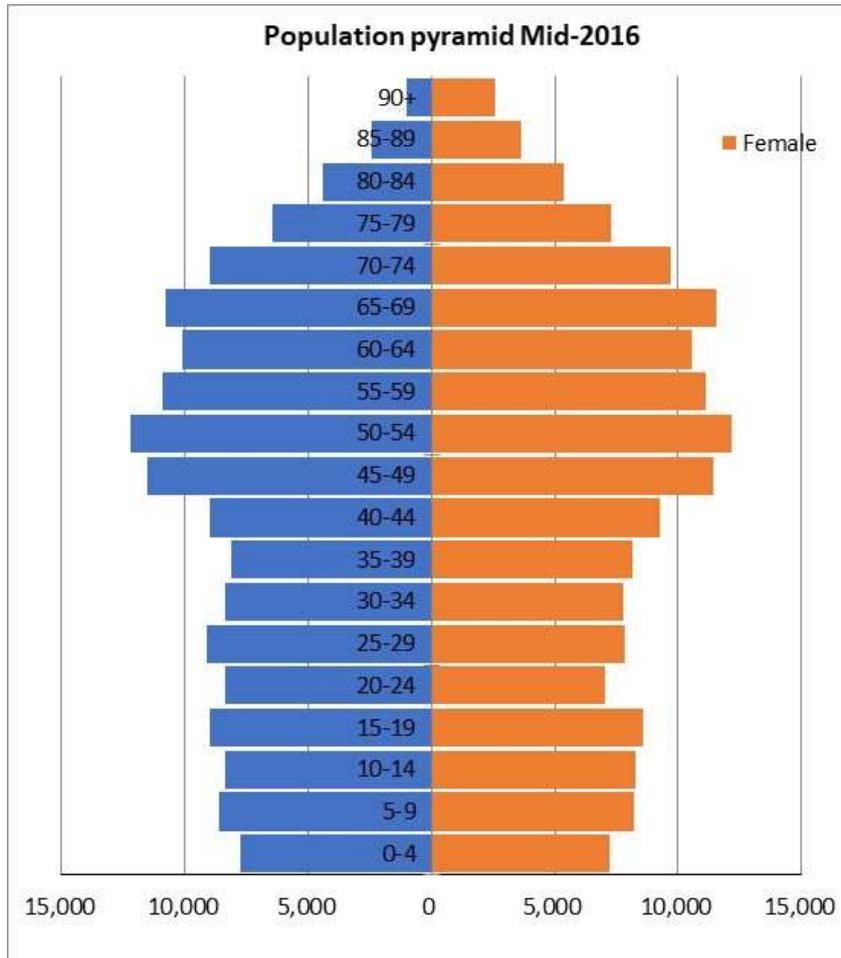
Source: Q5103EW NOMIS

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

Source information Source data: Census 2011, table ID Q5103EW, Age by single year

Release date Latest data: 2011, last updated: 30<sup>th</sup> January 2013

Age profile: Shropshire



Source and further information:

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesanalysisistool>

Source Name Office for National Statistics

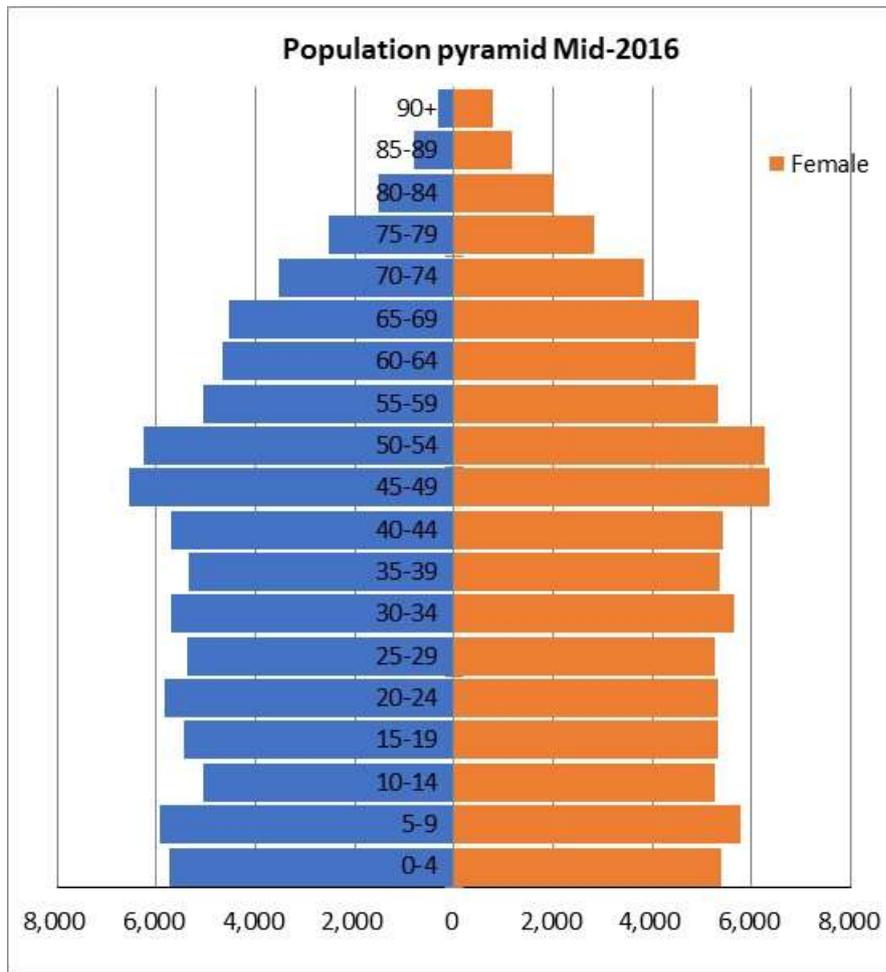
Source information Interactive analysis of estimated UK population change, by geography, age and sex

Release date 22 June 2017

Age profile by gender: Shropshire

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

Age profile: Telford and Wrekin



Source and further information:

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesanalysisistool>

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

Age profile by gender: Telford and Wrekin

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

Source and further information:

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesanalsystool>

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

## Projected Population Change by Broad Age Groups

### Shropshire

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



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

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

## Telford and Wrekin

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

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

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

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

## Disability

Disability	Local data %		England comparative %	
	Shropshire	Telford and Wrekin		
Long term condition / disability where day to day activities are limited a lot	8.4% (25,568)	9.0% (15,060)	8.3%	
Long term condition / disability where day to day activities are limited a little	10.2% (31,258)	9.6% (15,935)	9.3%	

Source: NOMIS

## Marriage and civil partnership

Marital status	Local data %		England comparative %	
	Shropshire	Telford and Wrekin		
Married	48.3% (144,005)	45.9% (75,505)	46.6%	
Same sex civil partnership	0.1% (319)	0.1% (217)	0.2 %	

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

## Race

Ethnic background	Local data %		England comparative %	
	Shropshire	Telford and Wrekin		
White British	95.4% (292,047)	89.5% (149,096)	79.8%	
White Irish	0.5% (1,410)	0.4% (729)	1.0%	
White: Gypsy or Irish Traveller	0.1% (312)	0.1% (166)	0.1%	
White: Other	2.0%	2.7%	1.8% (1,246)	2.1% 4.6%

	(6,105)	(4,424)		(11,775)	
<b>Mixed/Multiple Ethnic Groups: White and Black Caribbean</b>	0.2% (765)	0.9% (1,423)	0.2% (107)	0.4% (2,295)	0.8%
<b>Mixed/Multiple Ethnic Groups: White and Black African</b>	0.1% (231)	0.2% (278)	0.1% (44)	0.1% (553)	0.3%
<b>Mixed/Multiple Ethnic Groups: White and Asian</b>	0.2% (669)	0.5% (799)	0.2% (144)	0.2% (1,612)	0.6%
<b>Mixed/Multiple Ethnic Groups: Other Mixed</b>	0.2% (503)	0.3% (483)	0.1% (86)	0.1% (1,072)	0.5%
<b>Asian/Asian British: Indian</b>	0.2% (752)	1.8% (3,076)	0.1% (59)	0.7% (3,887)	2.6%
<b>Asian/Asian British: Pakistani</b>	0.1% (216)	1.3% (2,243)	0.0% (3)	0.4% (2,462)	2.1%
<b>Asian/Asian British: Bangladeshi</b>	0.1% (208)	0.1% (162)	0.1% (41)	0.1% (411)	0.8%
<b>Asian/Asian British: Chinese</b>	0.3% (1,020)	0.4% (647)	0.1% (56)	0.3% (1,723)	0.7%
<b>Asian/Asian British: Other Asian</b>	0.3% (893)	0.5% (863)	0.2% (138)	0.3% (1,894)	1.5%
<b>Black/African/Caribbean/Black British: African</b>	0.1% (302)	0.5% (863)	0.0% (21)	0.2% (1,346)	1.8%
<b>Black/African/Caribbean/Black British: Caribbean</b>	0.1% (164)	0.4% (607)	0.0% (33)	0.1% (804)	1.1%
<b>Black/African/Caribbean/Black British: Other Black</b>	0.0% (114)	0.1% (149)	0.0% (9)	0.1% (272)	0.5%
<b>Other Ethnic Group: Arab</b>	0.1% (179)	0.1% (86)	0.0% (12)	0.1% (277)	0.4%
<b>Other Ethnic Group: Any Other Ethnic Group</b>	0.1% (239)	0.2% (387)	0.1% (40)	0.1% (666)	0.6%

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

## Religion

Religion	Local data % Shropshire	Local data % Telford and Wrekin	England comparative %
<b>Christian</b>	68.7% (210,268)	61.7% (102,892)	59.4%
<b>Buddhist</b>	0.3% (792)	0.2% (398)	0.5%
<b>Hindu</b>	0.1% (378)	0.5% (872)	1.5%
<b>Jewish</b>	0.04% (127)	0.04 (78)	0.5%
<b>Muslim</b>	0.3% (989)	1.8% (3,019)	5.0%
<b>Sikh</b>	0.1% (256)	1.3% (2,118)	0.8%
<b>Other religion</b>	0.4% (1,113)	0.4% (692)	0.4%
<b>No religion</b>	22.8% (69,725)	27.4% (45,599)	24.7%
<b>Religion not stated</b>	7.3% (22,481)	6.6% (10,973)	7.2%

Source: KS209EW NOMIS Office for National Statistics 27 March 2011

## Sex

Protected group: Sex	Local data % Shropshire	Local data % Telford and Wrekin	England comparative %
<b>Total</b>	<b>306,129</b>	<b>166,641</b>	<b>100%</b>
<b>Male population</b>	49.5% (151,606)	49.5% (82,549)	49.2%
<b>Female population</b>	50.5% (154,523)	50.5% (84,092)	50.8%

Source: Office of National Statistics 4 October 2017 Sexual identity in the UK from 2012 to 2016 by region, sex, age, marital status, ethnicity and National Statistics Socio-economic Classification.

## Deprivation

Deprivation	Local data % Shropshire	Local data % Telford and Wrekin	England comparative %
<b>Economically active – unemployment rate</b>	3.6% Oct 2016 - Sept 2017	4.6% Oct 2016 - Sept 2017	4.3% Nov 2017 - Jan 2018
<b>Deprivation score</b>	16.69	24.85	19.57

Source of the unemployment data was from NOMIS. <https://www.nomisweb.co.uk>

Telford/England: <https://www.nomisweb.co.uk/reports/lmp/la/1946157172/report.aspx?town=telford#tabeinact>

Shropshire: <https://www.nomisweb.co.uk/reports/lmp/la/1946157170/report.aspx?town=shropshire#tabeinact>

Source of deprivation scores was cited in each of the fingertip PHE reports: <http://fingertipsreports.phe.org.uk/health-profiles/2017/e06000051.pdf>

## Appendix 3: Equality legislation

### The Equality Act 2010

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

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

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

### Information on protected characteristics

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Public Sector Equality Duty (2011)**

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

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

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

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

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

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

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

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

In summary, the Brown principles say that:

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

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

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