



**National Public Health
Service for Wales**

**Gwasanaeth Iechyd Cyhoeddus
Cenedlaethol Cymru**

The Inverse Care Law in Action?

A Primary and Community Health Care Needs Assessment For Butetown and Grangetown wards Cardiff

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1. Executive Summary

1.1 Introduction

The two wards of Butetown and Grangetown in the southern arc of Cardiff are well-recognised to contain some of the most socio-economically deprived areas in Wales. However, they also contain some of the newest and most rapidly developing housing developments in the city. The Local Health Board is responsible for ensuring that the appropriate health services are available to meet the needs of the population and hence commissioned this Primary and Community Health Care Needs Assessment to inform decision-making about local health services. They also invited representatives from Cardiff and Vale NHS Trust, Cardiff Council and Cardiff Community Health Council to become a steering group for the project. There are particular opportunities in the light of:

- The Programme for Health Service Improvement in Cardiff, which is at the Strategic Outline stage in October 2006, with more detailed plans being developed after this.
- Cardiff Council plans for Loudoun Square regeneration in Butetown, including the Health Centre

1.2 Aim

To inform the planning process for meeting the needs for primary health care services in Butetown and Grangetown.

1.3 Methods

Information was drawn from many sources such as routinely collected statistics, documents, policies and previous local research. A literature search was carried out for effective health care interventions to address inequity. Key informants among local stakeholders were interviewed. The two new sources of information were a Rapid Participatory Appraisal and a postal survey of the new properties in Cardiff Bay.

1.4 Results

1.4.1 Demography

The population in both wards has been growing rapidly and is predicted to continue to grow dramatically, with a greater proportion of younger people and children and smaller proportion of older people than Cardiff and Wales. There is a high proportion of residents from non-white ethnic groups in both wards, some of these groups have very long roots in Cardiff and some are more recent arrivals. The new housing is occupied predominantly by people of working age.

1.4.2 Mortality and Morbidity

Mortality rates for all causes are relatively high in both wards and life expectancies currently vary across Cardiff, so that if current circumstances remain the same, a baby born in Butetown or Grangetown today would have a life expectancy of 10 years less than a baby born in Cyncoed or Lisvane would.

Some conditions are more common than in the rest of Cardiff and Wales, particularly heart disease, respiratory disease, mental illness, diabetes and injuries

1.4.3. Wider Determinants of Health

Deprivation is closely linked to poor health and increased mortality, and is significantly higher in these two wards. Deprivation may be at risk of becoming hidden in small pockets as areas of new housing cause an influx of people with different socio-economic status.

1.4.4 Service Provision

There is little evidence of targeting increased mainstream services to areas of higher need or of an increase in local health services in response to an increasing population. The local perceptions about access to services are especially about lack of sufficient primary care and a lack of services to overcome language differences, lack of preventive services, lack of leisure facilities and lack of access to podiatry and dental services

Butetown Health Centre does not meet the needs of its local population, the building is inadequate and it is mostly disliked by service providers and users

Current organisational changes community services within Cardiff and Vale NHS Trust may increase barriers to addressing health needs in these wards

1.4.5 Effective Interventions to Reduce Inequalities in Health

Effective interventions to reduce health inequalities tend to be multi-factorial and multi-agency and are best integrated into the mainstream of service delivery, with a focus on disadvantaged areas and groups. Individual approaches can be effective, if targeted at more disadvantaged groups and if they also include personal support. User charges or financial disincentives reduce the effectiveness of health inequalities interventions

1.4.6 Conclusions

There is evidence of poorer health status among many groups in the area but there is little evidence of the targeting of mainstream local health care to address increased needs.

The population in both wards is growing significantly and local health services have not matched this increase.

There is therefore evidence of inequality in health status and inequity in health service provision.

The most pressing issues are the level of concern about services in Butetown and the current community service reorganisation

1.4.7 Recommendations

Utilise commissioning powers.

- The Programme for Health Service Improvement for Cardiff and the Vale (PHISI) should provide the overarching strategy for meeting the health care needs of the population of Cardiff, as part of the wider Health, Social Care and Well Being Strategy.
- The Local Health Board (LHB) should have a Primary Care and Community Services strategy, which is also explicitly included in the Programme for Health Service Improvement (PHISI)
- The Primary Care and Community Services strategy should be based on a formula to redistribute mainstream local health care services according to population health needs.
- Community services should be managed in a more integrated way with Primary Care services, operating within the LHB Primary and Community Care Strategy.
- There should be stronger and more explicit public and patient involvement in planning and evaluating local health services.
- The LHB should encourage partner organisations to carry out Health Impact Assessments of any programme or policy that may affect the well being of the most disadvantaged areas and groups in Cardiff.
- The LHB and Cardiff and Vale NHS Trust (the Trust) should provide Board level leadership, such as appointing a Champion, to ensure equity is a consideration in all decisions affecting health care provision.

Enhance Primary Care and Community Health Services

- The LHB and the Trust should actively develop specific strategies for supporting recruitment and retention of staff for geographical areas and for groups of high need, beginning with Butetown.
- The LHB and the Trust should explore using different and innovative models of providing primary and community care services.
- The Trust and the LHB should urgently explore solutions to address the high health care needs of the population that Butetown Health Centre should be serving.
- The Trust should urgently review its management of the services in Butetown Health Centre, including immediate consideration of the condition of the building.

- The LHB should explore options for increasing primary care capacity for the rapidly growing population in both Butetown and Grangetown electoral wards

Improve Health Care Premises

- The LHB should continue implementing its Primary Care Estates Strategy.
- The Trust and the LHB should continue with plans to replace the current Butetown Health Centre and optimise the plans for the new Health Centre to meet the needs of the future population.
- New health care premises for the growing population in Grangetown and Butetown should preferably be located within the older housing stock areas, in order to avoid widening inequity in access to health care.

Improve well being and prevention of ill health

- Cardiff Council and the LHB should consider the health and well being of the most disadvantaged groups and areas in all policies especially economic, transport, housing and social care policies.
- Cardiff Council and the LHB should increase and improve multi agency and multifactorial approaches to health improvement for the most disadvantaged groups and areas.

1.4.8 Options

- Enhance GMS service
- Enhance Community Services
- New multi-use Centre in Butetown
- Primary Care Support Team, such as salaried GP team
- New Primary Health Care Team for growing population, with various alternative models for providing this.
- Minor Injury /Walk In Centre
- Primary Care Resource Centre

2 Introduction

Cardiff is the capital city of Wales, and is a diverse and thriving city. Cardiff Local Health Board (LHB) is responsible for ensuring access to appropriate health care for its residents and visitors and in this role the Board asked for this Health Care Needs Assessment to be carried out.

The two wards of Butetown and Grangetown in the southern arc of the city are well-recognised to contain some of the most socio-economically deprived areas in Wales. However, they also contain some of the newest and most rapidly developing housing developments in the city, creating what many people feel are two separate communities which are geographically very close but in other ways have little or no connections.

The population has poorer health status than other parts of Cardiff or Wales and it is more difficult to provide appropriate primary and community health services. There are also more vulnerable groups in this area.

3 Background

The Cardiff Health, Social Care and Well Being Strategy 2004 identified key priorities and principles:

3.1 Key priorities:

- Mental Health.
- Older People.
- Children and Young People.
- Communities with Specific Needs:
 - Black and Minority Ethnic Communities,
 - Homeless people,
 - Asylum Seekers,
 - Gypsies and Travellers)
- Improving Lifestyles and Well-being (Smoking, Overweight/Obesity, Sexual Health, Accident Prevention).
- Maximising the Use of Health and Social Care Resources.

3.2 Key principles:

- The need to reduce inequalities in health – inequalities between communities in Cardiff.
- Engagement with and empowerment of individuals and communities – to enable them to contribute to improving their own health and be involved in planning of services.
- Early intervention – to prevent people becoming ill or infirm.
- Whole systems approach – to ensure all health and social care services focus on individual's needs
- Links to other services (Housing, Transport etc) – to ensure other areas of planning take into account health and well-being needs.

3.3 The actions identified are intended to:

- develop a range of modern services that respond directly to local needs.
- ensure that health and social care resources are used to best effect.
- provide clear priorities for informing how funding is spent.
- set out goals against which progress can be monitored.

As part of the delivery of this Strategy, Cardiff Local Health Board wished to look more closely at local health needs and services in some of its most needy areas. There are particular opportunities in light of:

- Cardiff Council plans for Loudoun Square regeneration in Butetown, including the Health Centre
- The Programme for Health Service Improvement in Cardiff, which is at the Strategic Outline stage in October 2006, with more detailed plans being developed after this.

3.4 Steering Group

The Steering Group first met in April to agree the Aims and Objectives and met four times until the last meeting in November to receive the final report and recommendations.

Membership of the group was:

- Diana Callaghan, Primary Care Directorate, Cardiff and Vale NHS Trust.
- Eleri Cross, Manager, Community Therapies Services, Cardiff and Vale NHS Trust
- Don Davidson, Neighbourhood Renewal, Cardiff Council
- Sian Harrup-Griffiths, Head of Strategic and Partnership Working, Cardiff and Vale NHS Trust.
- Martin Jenkins, Chief Officer, Cardiff Community Health Council
- Menna Lloyd, Manager, Community Dental Services, Cardiff and Vale NHS Trust.
- Dr Stephen Monaghan (Chair) , Public Health Director, Cardiff Local Health Board
- Craig Preece, Primary Care Lead, Cardiff Local Health Board (until September 2006)
- Kathrin Thomas, Specialist Registrar Public Health, National Public Health Service for Wales
- Sue Toner, Senior Health Promotion Specialist, Cardiff Local Public Health Team.
- Bruce Whitear, Deputy Commissioning Director, Cardiff Local Health Board.

4 Aims

To inform the planning process for meeting the needs for primary health care services in Butetown and Grangetown.

4.1 Objectives

1. To determine the health status and the wider determinants of health in the population of Grangetown and Butetown wards.
2. To identify the primary health care needs of the current and future population.
3. To determine the current health and social care services.
4. To determine the effects of new developments in the area on future needs.
5. To examine different models of meeting identified needs.
6. To make recommendations on how to meet the need for primary and community care

5 Methodology

5.1 Design

Traditional public health needs assessment uses the following approach¹, which has been the framework for this process:

Epidemiology

- Demographic profile – age / gender / ethnicity.
- Wider determinants of health and well being / socio-economic status / social capital / equity
- Health status – mortality and morbidity.
- Current service provision.
- Effectiveness of different service models of primary and community care provision.

Corporate

- Stakeholder views on needs and solutions.
- Local residents, service providers, voluntary sector, policy and decision-makers etc
 - documented information (strategies, plans, surveys, consultations)
 - Rapid participatory appraisal
 - Community mapping and focus groups
- Postal survey of new households

Comparative

- Compare models in a similar area, with a similar population and services.

5.2 Methods

5.2.1 Routine Data and existing documents

Routinely available data was accessed for health status, determinants of health and services from the following sources:

- NPHS documents to support Cardiff Health, Social Care and Well Being Strategy.
- Mortality and morbidity statistics from the ONS website and Welsh Health Survey
- Policy, strategy, needs assessment, consultations and other existing reports in Cardiff organisations
- Demographic Information from Cardiff Research Centre, Cardiff Council
- Local Health Board Information Toolkit website

5.2.2 Literature search

A literature search was carried out to look for effective interventions for reducing health inequalities in the primary and community health care setting.

The key words used were: health, primary care, inequality, inequity, variations and several alternative versions of these. The full search strategy is in Appendix 1.

5.2.3 Key Informants

I spoke to many people who were involved in providing, commissioning or using the local services in these wards. Most of the information about existing service was provided by them. A full list is in Appendix 2

5.2.4 Rapid Participatory Appraisal (RPA)

This a process developed by the World Health Organisation for a small community to assess local health needs, and is designed to be carried out in a short space of time and to give a qualitative and richer picture of local health status, well being and health needs.

The study asked for the views of people who have a strong local knowledge, through their role in the communities. The interviewees were chosen because they are in a position in the community to talk about the views of a group, or groups of people, and not just their personal views alone.

It therefore is not a grassroots survey or a consultation.

It tells what the problems are, but not how many people are affected by them. It is also specific to a particular area and cannot be generalised to other areas.

This Rapid Participatory Appraisal was carried out between June and October 2006. The team of 15 interviewers were drawn from:

- Cardiff Local Public Health Team including the core team, the 'Barefoot' Health Workers Project and Butetown/Grangetown Healthy Living Programme (National Public Health Service)
- Cardiff and Vale NHS Trust including the Multi-Cultural Health and Information Centre and Dental Health Service
- Cardiff Local Health Board (Heartlink)
- Surestart

All of the interviewers work in the area, and some also live in Butetown or Grangetown. They all therefore have extensive local knowledge and networks themselves.

The team used the following process:

1. A one day workshop with a two hour follow up was held to:
 - a. Develop a questionnaire to be used in a semi-structured interview. This contained 33 questions.
 - b. Identify the people in the area that the team felt would have a good knowledge of the community because of their role(s).
 - c. Develop a guide to arranging and carrying out the interviews

2. Interviews were conducted by two of the team, one acting as note-taker, and were not audio-recorded. Most interviews were with one person but several had two or more people contributing.
3. Three members of the team analysed the type written interview notes.
4. A draft report summarising the results was produced and sent to all the members of the team and to all the people interviewed, for comment and feedback.

A final half day workshop was held to

- a. Check the analysis and the summary of results.
- b. Add the team's own views and observations.
- c. Discuss the process of carrying out the RPA.

5.2.5 Postal Survey

It became clear early on that much information had been collected and was available for large parts of the population in Butetown and Grangetown. However, the area has seen a large increase in population in recent years and most of this is due to new housing being built. The population living in this new accommodation was not well known to any service provider. There was some anecdotal evidence that:

- Some flats and houses were unoccupied or occupied part-time
- Many people in them were trying to access local services such as GPs and failing to do so, resulting in dissatisfaction and use of alternative services.
- Many people were registered with GPs elsewhere who were not aware of their new address.

The only way to find out whether these impressions were correct was by means of a postal survey. The map below shows the areas of Cardiff Bay that have experienced significant residential expansion in the last 10 years and highlights the boundary from which the sample was selected. Alongside these areas of development the map also identifies the location of current GP surgery and dentist facilities within the area (see Figure 1).

A questionnaire was designed which was discussed in detail by the Steering Group and also piloted by a wide group of people working within the organisations involved in this process, together with academic and public health colleagues. The final questionnaire is shown in Appendix 3.

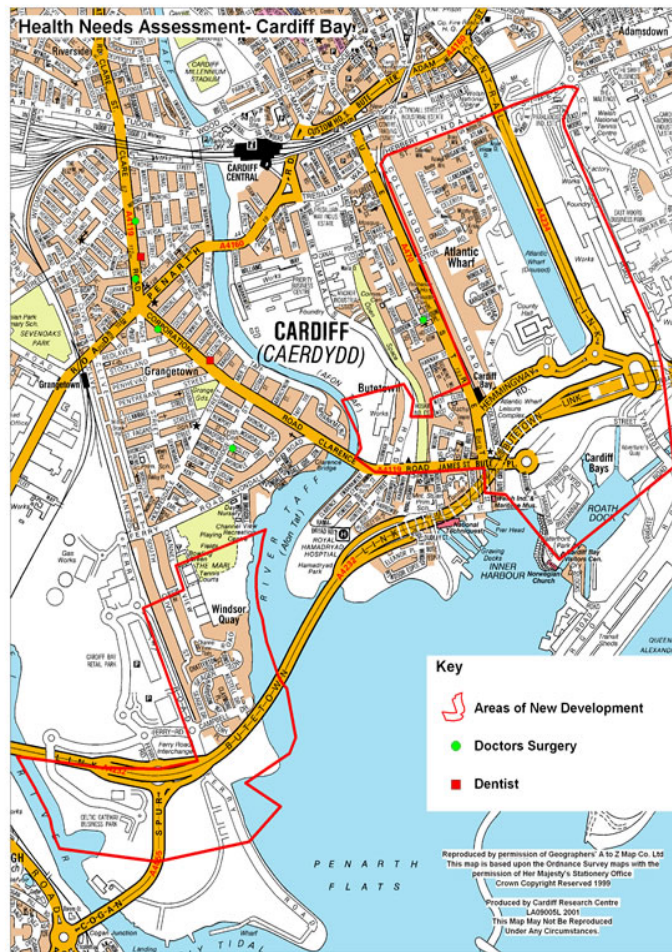
It was distributed to a total of 3,800 new build households in the Cardiff Bay, Butetown and Grangetown locality. The Cardiff Research Centre in Cardiff Council carried out and analysed the results of the survey.

Addresses were accessed directly from the Council Tax Register in order to ensure that the information with regard to new developments was as up to date as possible although it must be acknowledged that the area is continuing to experience a rapid and significant expansion.

Questionnaires were distributed to households along with a covering letter explaining the purpose of the survey and a freepost return envelope for responses

A total of 779 completed questionnaires were returned by residents of the Cardiff Bay area representing a response rate of 20.5%. This is a high response rate compared to other postal surveys carried out by Cardiff Council.

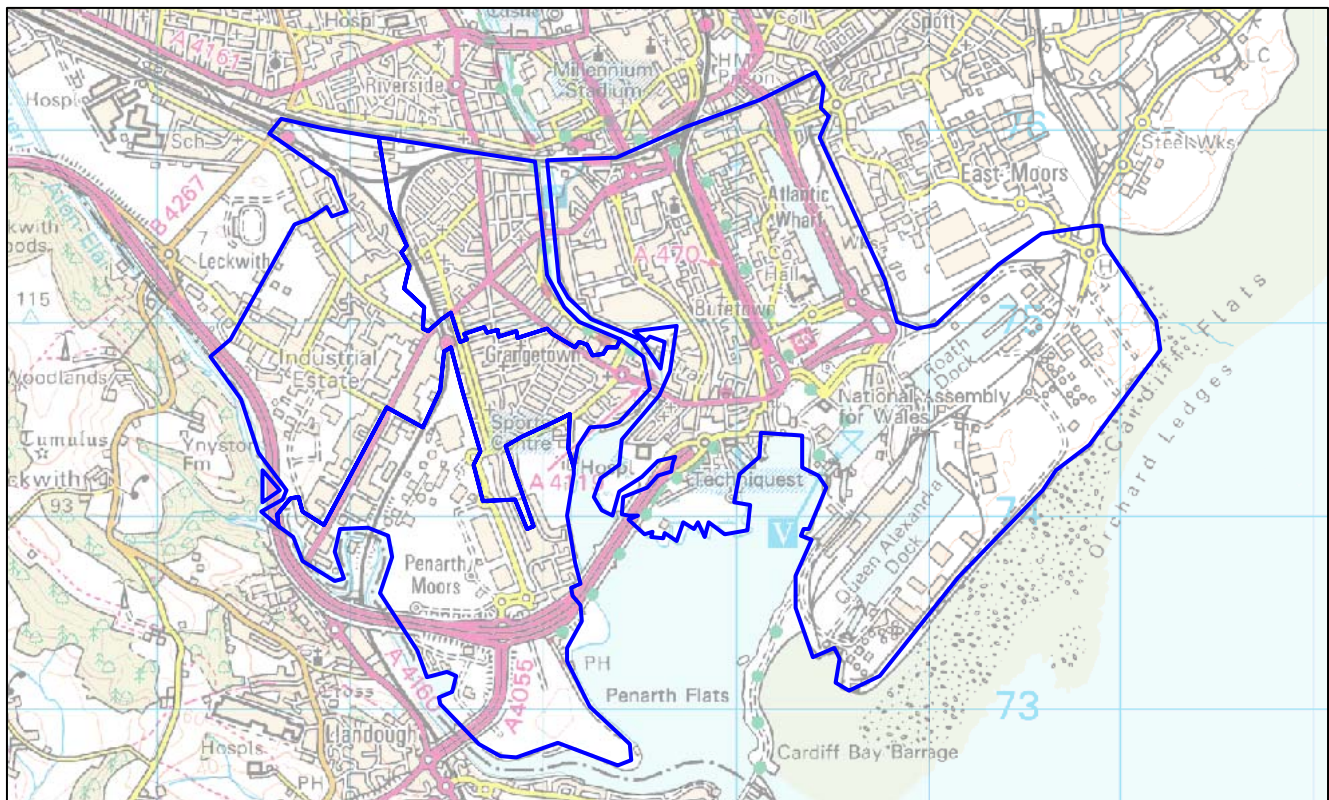
Figure 1: Map of boundaries of postal survey



6 Results

7 Geography

Figure 2: the boundaries of Grangetown and Butetown wards



Source: NPHS Health Information and Analysis Team

Information gathered about people, such as that from the ten-yearly census, is now available for small areas. The areas used in this report have been at electoral ward level mostly, or at Super Output level, which is a statistical geography. There are two Super Output levels:

- Middle Super Output areas (about 7,500 people) and there are about 400 in Wales (as shown above in Figure 2)
- Lower Super Output areas (about 1500 people) and there are about 1800 in Wales

8 Demography

8.1 Total population

There are several ways of counting people; the one most used for planning purposes is the Census. This is carried out every 10 years, the last one being in 2001.

The 2001 Census based population totals for Cardiff were significantly lower than expected, particularly in Butetown. Cardiff Council gave evidence to the Office of National Statistics (ONS) including population estimates from various other sources, but the revised numbers were little different. It is possible that the actual number of people in the city is about 5% greater than the official census figure.

The final column in Table 1 shows the Council population estimate, based on census data, previous predictions from CRC and data from the NHS Administrative Register (NHSAR). The NHSAR uses General Practitioner Registrations as it is thought over 95% of the population is registered with a doctor.

Table 1: Lower Super Output Area population estimate mid-2003

LTSOA	2001 Census Pops	Total Persons 2003	Difference 2001 Census & 2003 MYE Total Population	Cardiff Council estimate for 2004
Butetown 01	1,412	1,399	-13	
Butetown 02	1,504	1,595	91	
Butetown 03	1,576	2,101	525	
Butetown Total	4,492	5,095	603	6,700
Grangetown 01	1,445	1,433	-12	
Grangetown 02	1,319	1,460	141	
Grangetown 03	1,547	1,580	33	
Grangetown 04	1,467	1,463	-4	
Grangetown 05	1,296	1,363	67	
Grangetown 06	1,422	1,544	122	
Grangetown 07	1,513	1,575	62	
Grangetown 08	1,499	1,570	71	
Grangetown 09	1,403	1,510	107	
Grangetown 10	1,457	1,570	113	
Grangetown Total	14,368	15,068	700	15,480

Source: Cardiff Research Centre, Cardiff Council 2006.

The population is known to be growing in this area, and Cardiff Council has made some predictions for future population, which however, are very difficult to do with accuracy because there are many unknown variables influencing this. The estimate takes into account:

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- Base year housing stock and population
- Average Household Size
- Household Vacancy Rates
- Institutional (non-household population)
- Projected change in size of housing stock

Table 2: Capacity Based 15 Year Projection from 2004 Base

Population Growth Scenarios 2019	Butetown	Grangetown	Combined
2004 base year	6,700	15,480	22,180
2009 projection	9,960	20,110	30,070
Increase percentage	48.7%	29.9%	35.6%
2014 projection	11,790	20,800	32,590
2019 projection	13,610	21,500	35,110
Increase number	6,910	6,020	12,930
Increase percentage	103.1 %	38.9%	58.3%

Source: “*Projected Population Growth in the Butetown and Grangetown Electoral Divisions 2004 – 2019*” Cardiff Research Centre – Cardiff Council – 20th April 2005 ref: Siôn Ward

The Cardiff Research Centre estimated projections use a “medium growth” scenario– much depends on the economic regeneration and future land use that has not yet been planned for, such as the possible use of industrial land for residential housing. However, it is clear that the population in these two wards has been increasing dramatically and this is likely to continue to a significant degree.

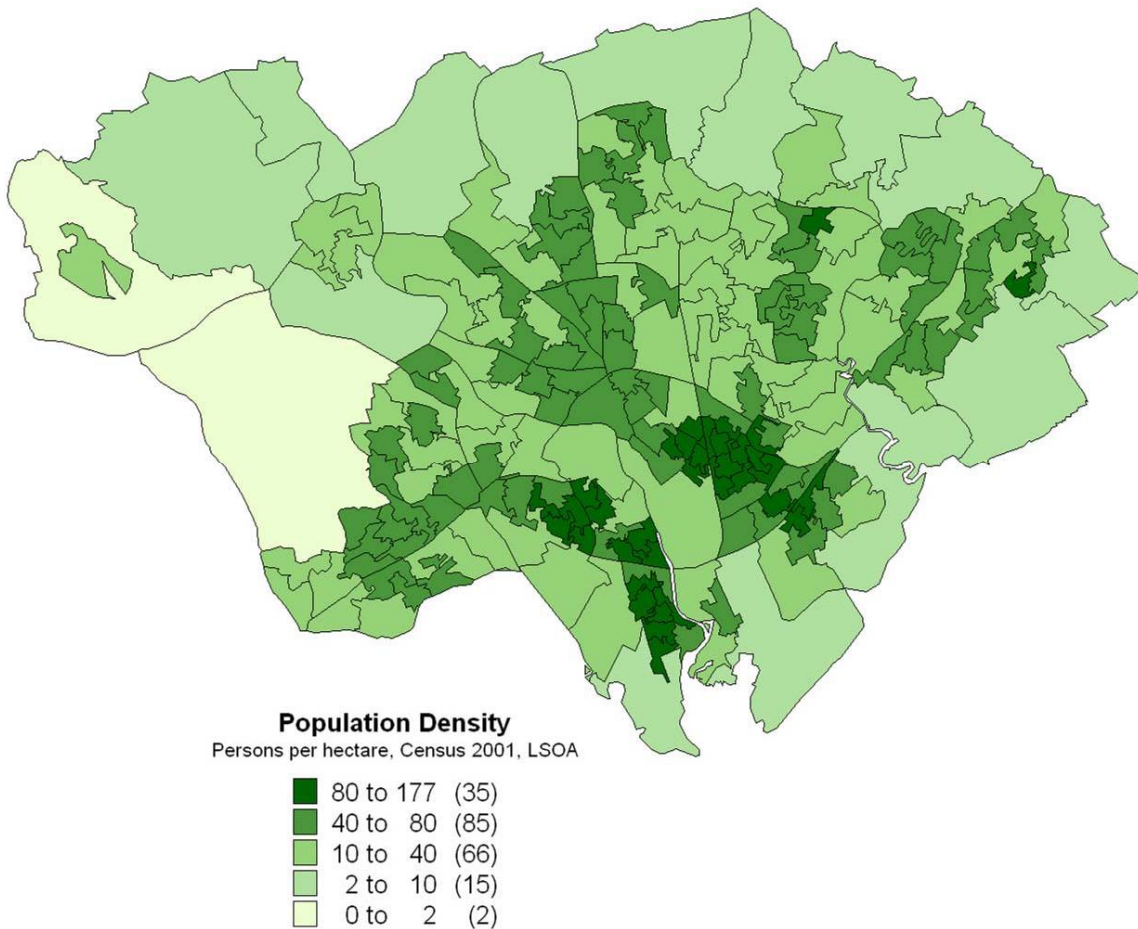
The RPA highlighted that local people had noticed the rapid increase in population, mentioning in particular an influx of students, Eastern European migrants, and family members of existing residents. They noticed more middle class people moving in. There was felt to be a change in characteristics of the population with more single-parent households, more elderly people living alone and more vulnerably housed (hostels, overcrowded homes).

There was concern over the impact on existing services, particular that of the residents of new housing:

“More housing, more people coming in. Old community moving out also. Increase in population will be more apparent over time. Butetown is an expanding community and how this impacts on services needs to be considered”

8.2 Population Density

Figure 3: Population density in Cardiff (persons per square hectare) by lower super output area (LSOA): 2001



Source: National Public Health Service for Wales, *Health Needs Assessment 2006: Cardiff LHB Specific Information*²

Note that parts of both Grangetown and Butetown are areas of high population density. This implies that there may be less open spaces, more multi-occupancy or multi-storey housing and more overcrowding.

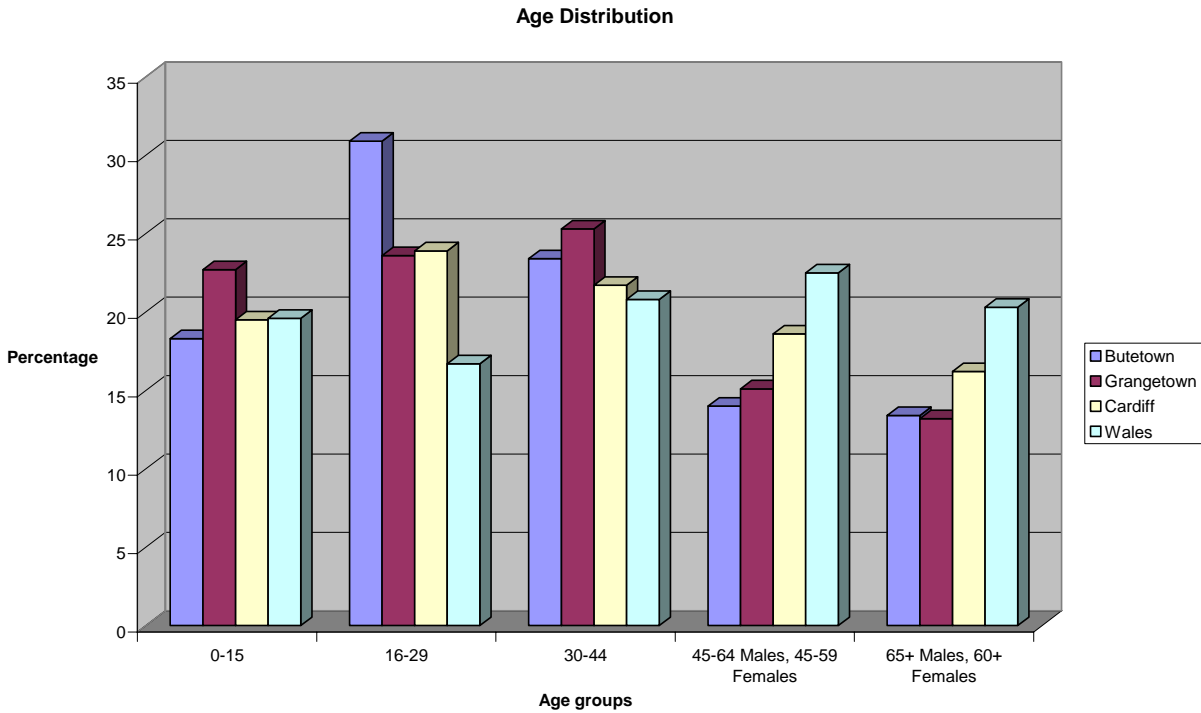
The new housing had a different profile. Of the respondents to the postal survey, only 10.3% had more than two people in the household. 39.3% were one – person households.

Also, only 80.8% said they lived at this address all the time, 9.4% lived there during the week only and 6% lived elsewhere for more than a quarter of the year.

8.3 Age

The age distributions shown in Figure 2 are based on the data from the 2001 census estimated for mid-year 2003. However, there is possibly an underestimate of the population in Cardiff, especially Butetown (see page 14) . This is likely to have an even greater effect in the younger age group (the missing young men). The true overall figure is thus likely to show an even higher proportion of children and young people and an even lower proportion of older people.

Figure 4: Age Distribution in Butetown and Grangetown, compared with Cardiff and Wales



Source: Margaret Webber, NPHS Health Information and Analysis Team: Population mid-year estimates for 2003 taken from Lower Super Output Level (experimental data)

Cardiff as a whole has a higher proportion of younger people under 29, and a lower proportion of older people over 45. This is even more marked in Butetown and Grangetown.

8.4 Ethnicity

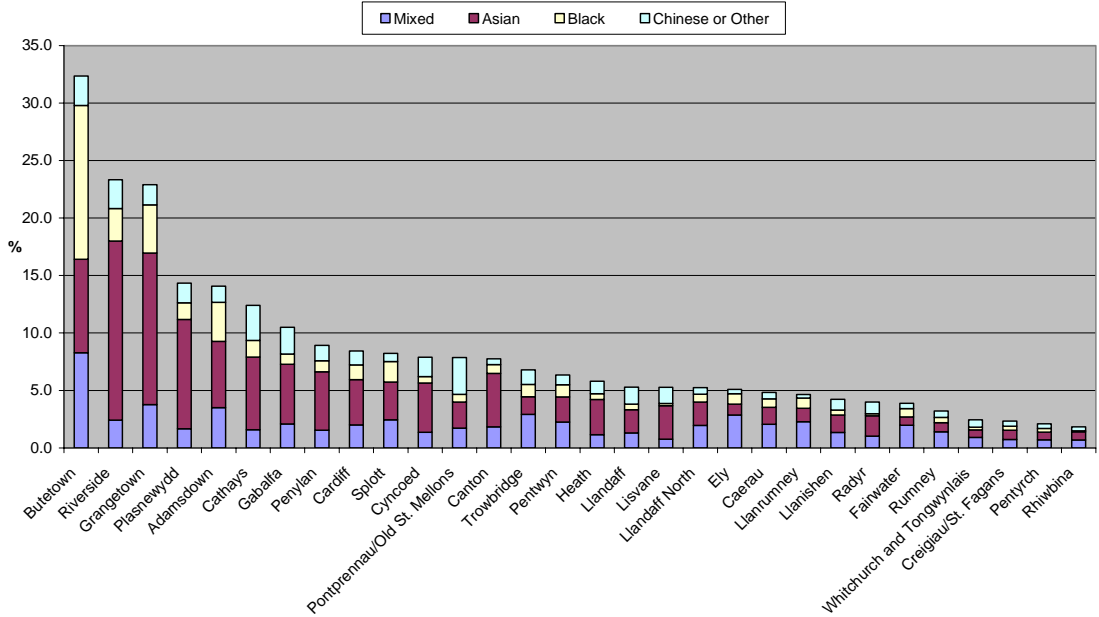
Cardiff is unusual in Wales, in that it has a relatively higher proportion of people from non-white ethnic groups. These groups are also concentrated within several wards in the city,

Ethnicity is a complex concept, and the Census asks people to self-identify many sub-categories. However, within Butetown and Grangetown there are distinct groups which are not identified separately. For instance, those from the Somali community cannot be identified separately from other Black African groups and those from the Gujarati and Pakistani communities cannot be identified separately from form Asian sub groups. This has implications as these groups have quite different needs in terms of language and culturally appropriate health services.

For example, the Somali community is the largest ethnic minority group in Butetown. The Barefoot Health Workers Project states in 2002⁵ that it has been estimated that there are between 3,500 and 4,500 individuals within the Somali community in Cardiff. Half are refugees and the other half originate from migrant worker families, such as seamen. However, not all Somali people live in these wards, and the strong community networks do not match those of wards and service planners.

Figure 5; Ethnicity in all Cardiff Electoral divisions

Comparing the proportional size of minority community populations by electoral divisions

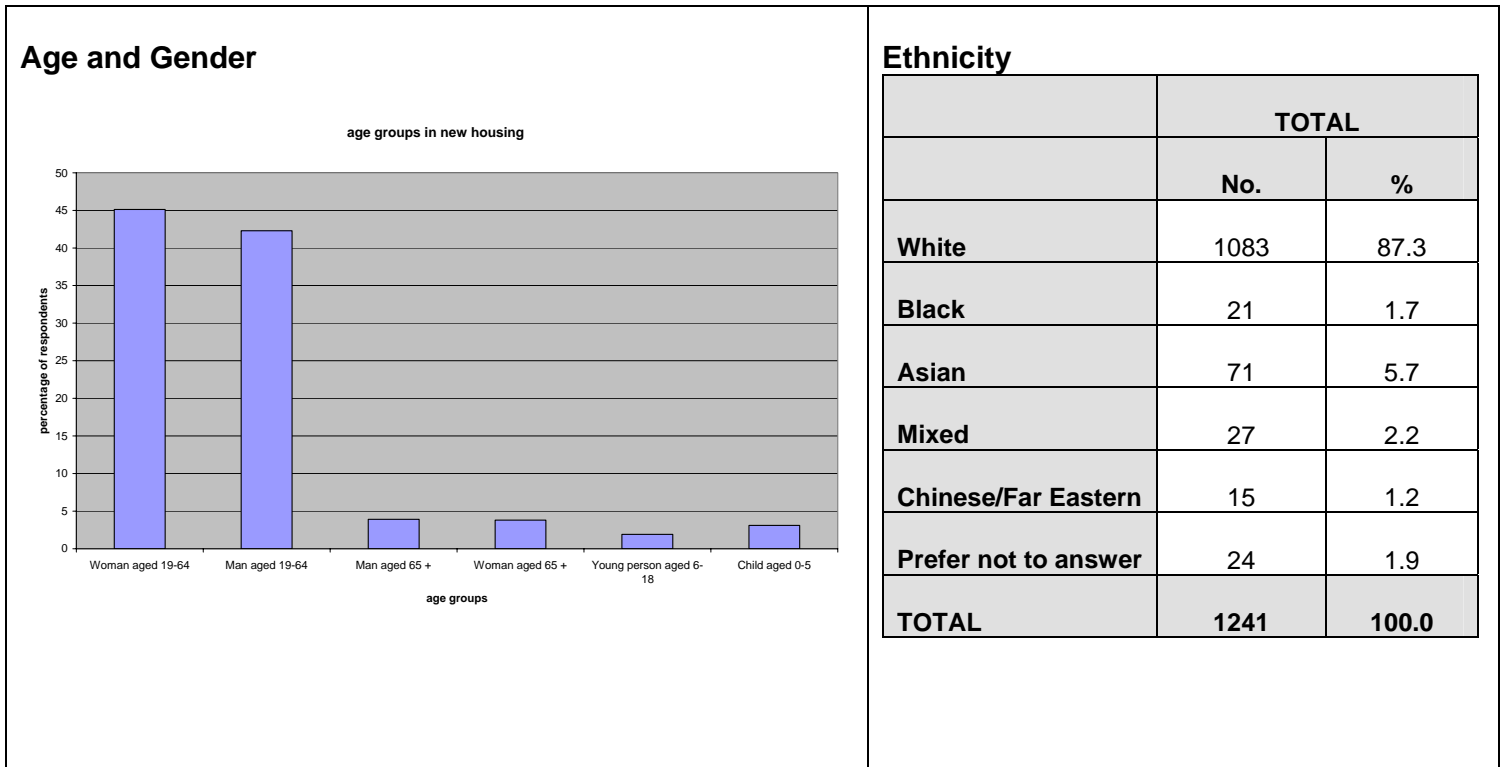


Source: Cardiff Research Centre, Cardiff Council,

8.5 New Housing Developments

Among the newer housing, the age range was thought to be narrower. The postal survey supported this, in that it showed few people under the age of 18 or over the age of 65. (See Figure 6) Although the people who did not respond to the survey may have included more of these groups, it is very unlikely as older people have in general been shown to be more likely than younger people to respond to postal surveys.

The profile of people in the new housing is not surprisingly quite different to that in the older parts of the area, with most being of working age and a low proportion of people from ethnic minority groups.

Figure 6: Age, Gender and Ethnicity in new housing.

Demography: Key Messages

1. The 2001 census is likely to have significantly underestimated the population in Butetown
2. The population in both wards has been growing rapidly and is predicted to continue to grow dramatically.
3. The population of both wards has a greater proportion of younger people and children and smaller proportion of older people than Cardiff and Wales
4. The new housing is occupied predominantly by people of working age
5. there is a high population density in Grangetown and Butetown 1
6. There is a high proportion of residents from non-white ethnic groups in both wards, some of these groups have very long roots in Cardiff and some are more recent arrivals.

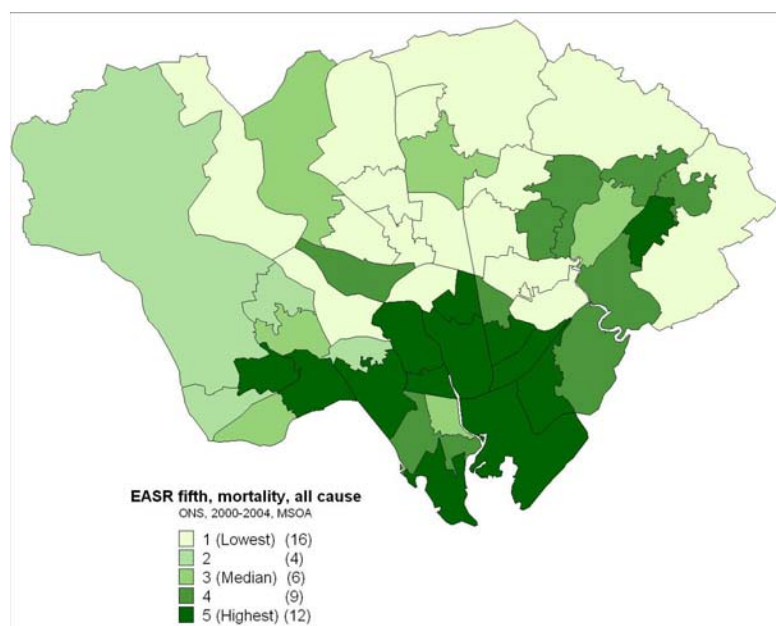
9 Mortality

The simplest measure of health status is to look at when and how people die, as this is systematically recorded for every death.

However, mortality statistics have uncertainties as they are based on the information from death certificates which can be inaccurate or incomplete, especially as fewer post mortems are now carried out to establish the cause of death. Figures in small areas are much more likely to vary, even when several years data is aggregated.

The mortality rate from all causes of death in Butetown is higher than that of a standard European population that has been adjusted for age, (see Figure 7). In Grangetown the mortality rate is average or higher.

Figure 7: European age standardised mortality rates (EASMRs) for all causes (persons, all ages) by middle super output area (MSOA): 2000-2004



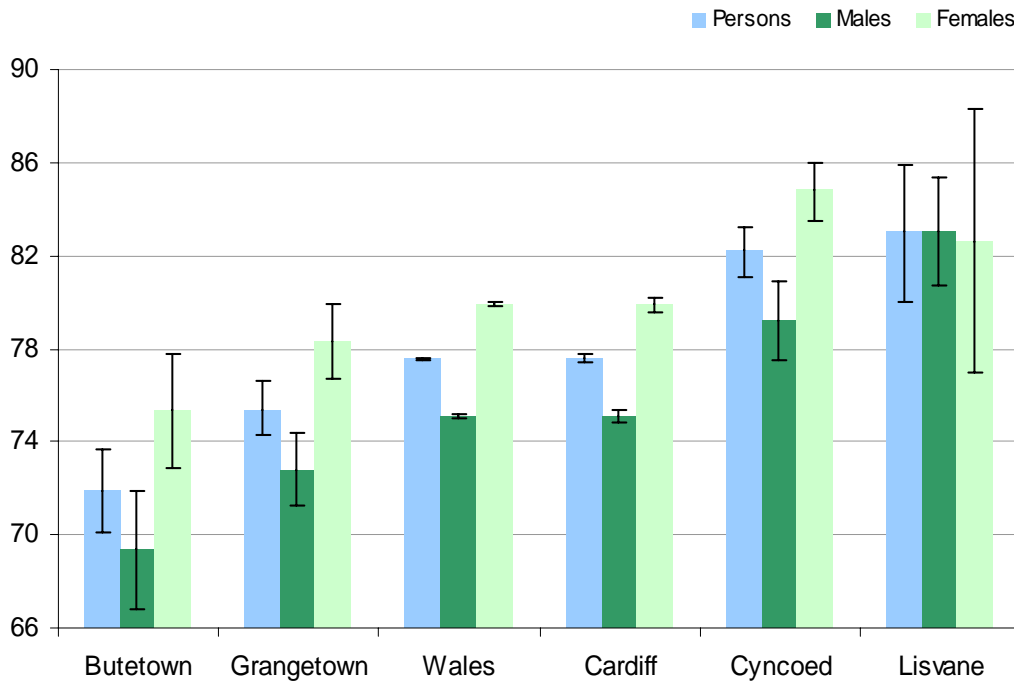
Source : Source: National Public Health Service for Wales, *Health Needs Assessment 2006: Cardiff LHB Specific Information*²

It can be seen that there is a relatively large variation in mortality across the city. As these have been standardised for age, it does not reflect the difference in age structure of the population.

There is a very similar pattern for particular causes of death, for instance circulatory diseases, respiratory diseases and even injuries.

Figure 8: Life Expectancy variations**Life expectancy at birth 1999-2003 (experimental),
selected areas (ranked), with 95% confidence limits**

Source: ONS



This figure appears to show some significant differences in life expectancy between Butetown or Grangetown wards and the rest of Cardiff and Wales, although they should be treated with caution because the data are classified as experimental by ONS and require careful interpretation:

"Life expectancy at birth for a ward in 1999-2003 is an estimate of the average number of years a newborn baby would survive if he or she experienced the particular ward's age-specific mortality rates for that time period throughout his or her life. The figure reflects mortality among those living in the ward in 1999-2003, rather than mortality among those born in each area. It is not therefore the number of years a baby born in the ward in 1999-2003 could actually expect to live, both because the death rates of the area are likely to change in the future and because many of those born in the ward will live elsewhere for at least some part of their lives." ONS (2006)

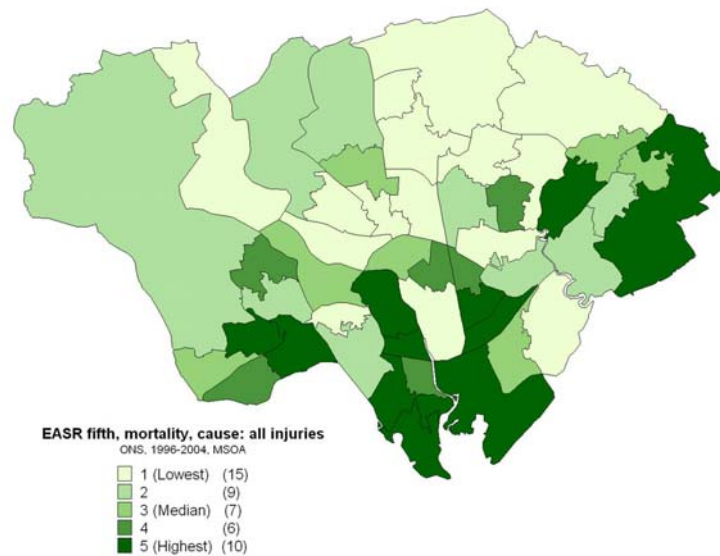
The difference between the most and least deprived wards in Cardiff appears to be about 10 years (72 and 82 years of life expectancy).

However, there is little doubt that with current circumstances applying, life expectancies show a variation – what are these circumstances and can we change them so that babies born today may have less inequality in life expectancies?

9.1 Injuries

The death rate from all injuries similarly shows a variation across wards, with higher rates in both Butetown and Grangetown. A relatively high proportion of these are younger people and this signifies a significant number of potentially avoidable deaths.

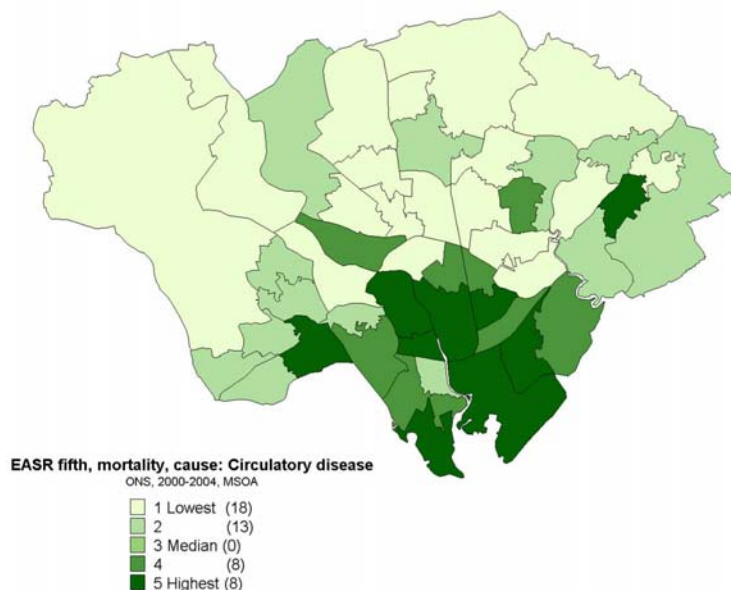
Figure 9 :European age standardised mortality rates (EASMRs) for injuries (persons, all ages) by middle super output area (MSOA): 1996-2004



Source : Source: National Public Health Service for Wales, *Health Needs Assessment 2006: Cardiff LHB Specific Information*²

9.2 Cardiovascular disease

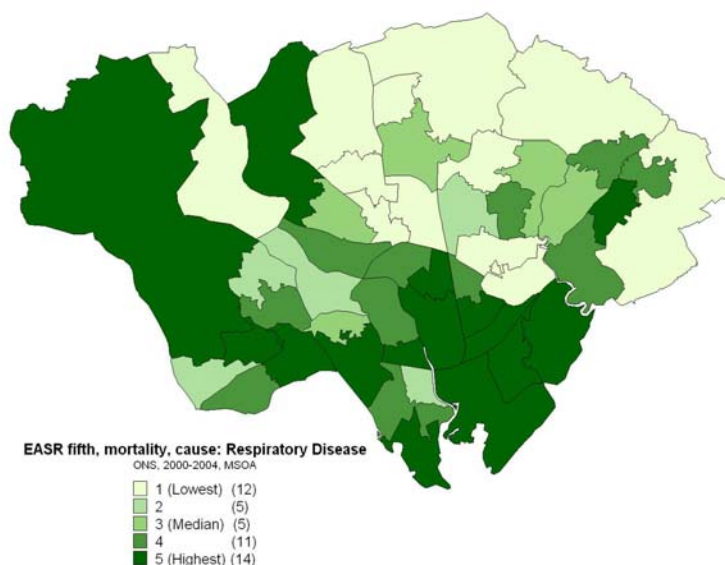
Figure 10: European age standardised mortality rates (EASMRs) for all circulatory diseases (persons, all ages) by middle super output area (MSOA): 2000-2004



Source : Source: National Public Health Service for Wales, *Health Needs Assessment 2006: Cardiff LHB Specific Information*

9.3 Respiratory Disease

Figure 11: European age standardised mortality rates (EASMRs) for respiratory disease (persons, all ages) by middle super output area (MSOA): 2000-2004



Source: National Public Health Service for Wales, *Health Needs Assessment 2006: Cardiff LHB Specific Information*

Both cardiovascular and respiratory diseases have relatively high death rates in these wards, both are linked with smoking rates.

9.3.1 Morbidity

As it is difficult to get accurate numbers for such small areas, it would be reasonable to extrapolate statistics from other areas with similar levels of deprivation in Wales. The National Public Health Service for Wales paper, *“Deprivation and Health”*⁴ stated that:

“Although these statistics are based on an analysis by fifth of deprivation for the whole of Wales, we can reasonably expect people living in areas such as Butetown, Ely, Adamsdown and Splott to have statistically significantly higher levels of ill-health and a greater exposure to the major risk factors affecting health. The following are rate ratios related to health outcomes for Wales as a whole:

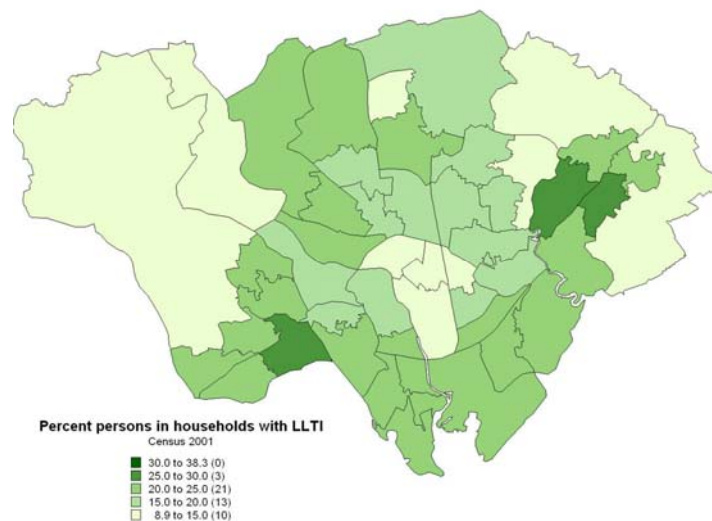
- Hearing problems (rate ratio 2.60)
- Eyesight problems (2.26)
- Pedestrian injury (2.15)
- Mental illness (1.90)
- Diabetes (1.78)
- Respiratory disease (1.52)
- Suicide (1.51)

For instance, there are almost twice as many people in the 20% most deprived wards who have a mental illness, compared to the Wales average”.

9.4 Long term limiting illness

There is a relatively low proportion of people who said they had a limiting long term illness in the 2001 census. These are not standardised for age so may reflect the relatively young age profiles in Cardiff, particularly in Butetown and Grangetown.

Figure 12: Percentage of persons in households with limiting long term illness by electoral division: 2001

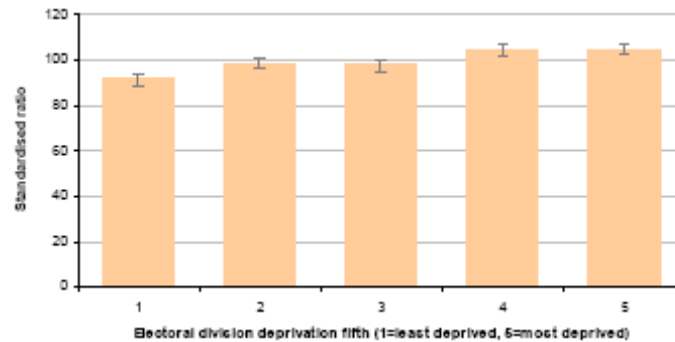


Source : Source: National Public Health Service for Wales, *Health Needs Assessment 2006: Cardiff LHB Specific Information*

9.5 Cancers

It is difficult to give accurate information about deaths from cancer in these two areas as numbers are relatively small. However, it can be extrapolated from information that we have for all Wales which shows a gradient of cancer incidence across 5 centiles of deprivation, as in Figure 13. Therefore, although we do not know for sure, it is likely that cancers are more common in Butetown and Grangetown if they reflect the general trend in Wales.

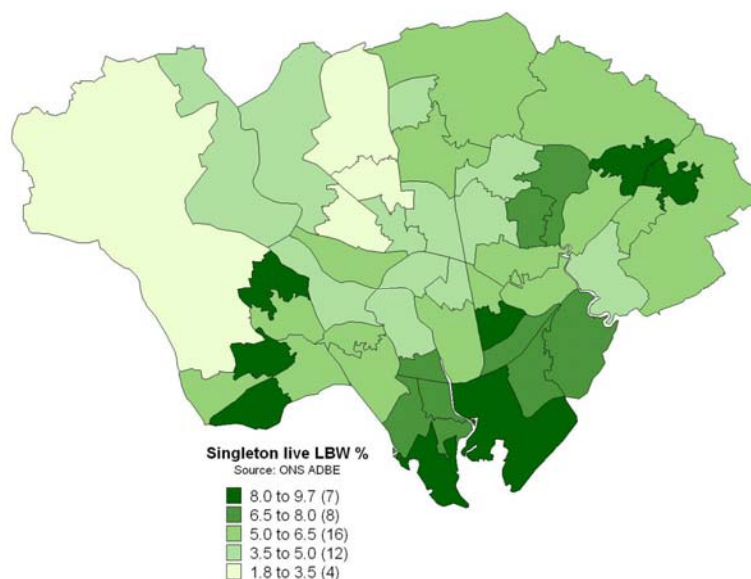
Figure 13: All cancer registrations Wales 1997-2001



9.6 Children

The health of children is difficult to assess, again due to the absence of routine data at small area level. For instance, children's weights are not routinely collected so that obesity rates cannot be determined. Birth weight is a good indicator of risk factors during pregnancy and within the family. Low birth weight has been linked to later health problems such as cardiovascular disease and hypertension.

Figure 14: Percentage of singleton live born babies with low birth weight by middle super output area (MSOA): 2002-2004



Source : Source: National Public Health Service for Wales, *Health Needs Assessment 2006: Cardiff LHB Specific Information*

This shows that more than 8% of babies in Butetown and 6.5 to 8 % of babies in Grangetown are born with a low birth weight (less than 2,500g). In wards such as Lisvane this proportion is less than 3.5 %.

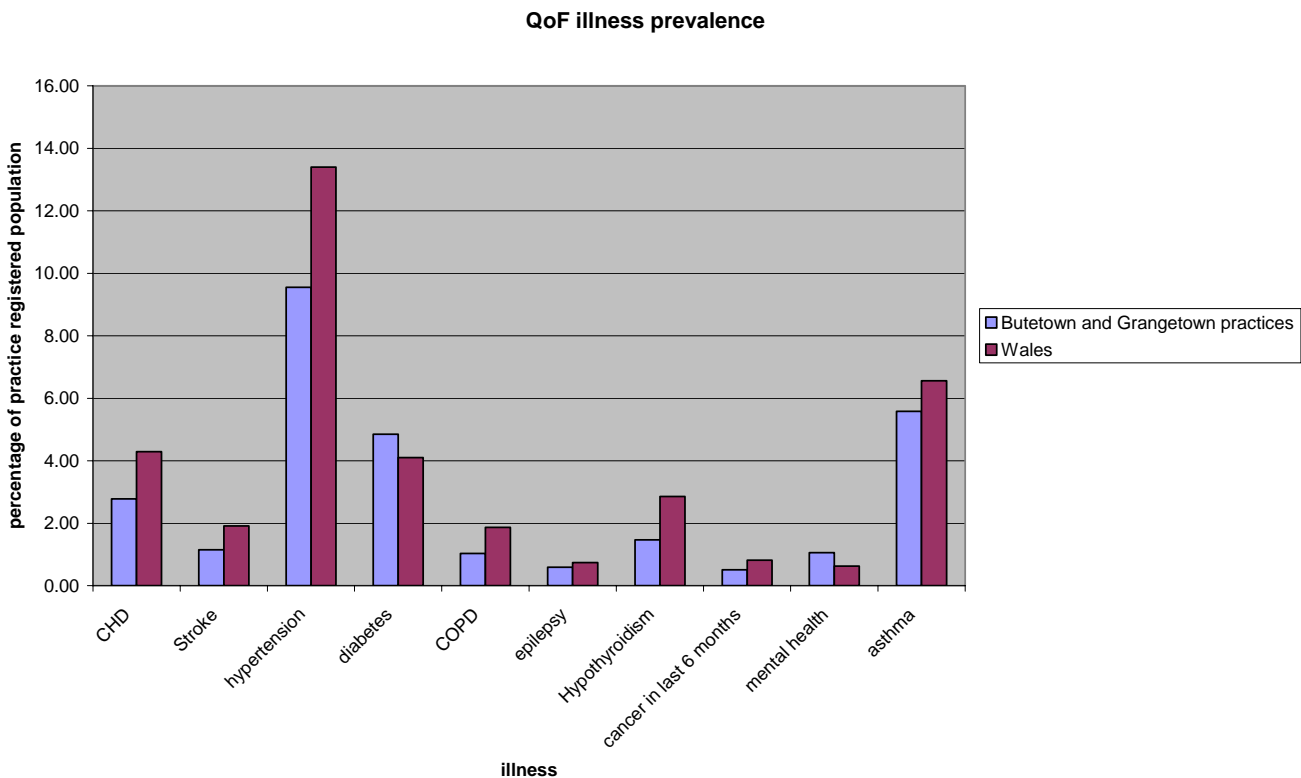
However, some ethnic minority groups have different normal ranges for birth weight so these comparisons should be taken with caution in populations with high ethnic minority births (e.g. South Asian babies are normally smaller).

9.7 Primary care information

The new GP contract in 2004 introduced the Quality and Outcomes Framework (QoF). This includes the gathering of information about common long term health conditions, such as diabetes and cardiovascular disease. This information can now be aggregated at a practice and LHB level, to provide a new and probably the most comprehensive source of information about the population’s health. However, as it is so new, there are many issues about it’s validity at the moment and it cannot be used for service planning yet. For instance, the prevalence statistics for Coronary Heart Disease do not match other sources of information; this is probably due to data collection issues and it may be that areas of higher prevalence have primary care services that are more hard pressed and hence are not able to process information as effectively.

In the Butetown and Grangetown practices, the prevalences of illness seem to be lower than expected, especially in view of the higher mortality from some of these illnesses. (see Figure 15) This is most likely due to underreporting.

Figure 15: Illness prevalence QoF data in Wales and Butetown/Grangetown



However, it can be seen that diabetes and mental health problems are higher than the Wales average – in view of the overall underreporting, it is possible that the prevalence of both of these conditions is actually much higher than the average for Cardiff

Mortality and Morbidity :Key Messages

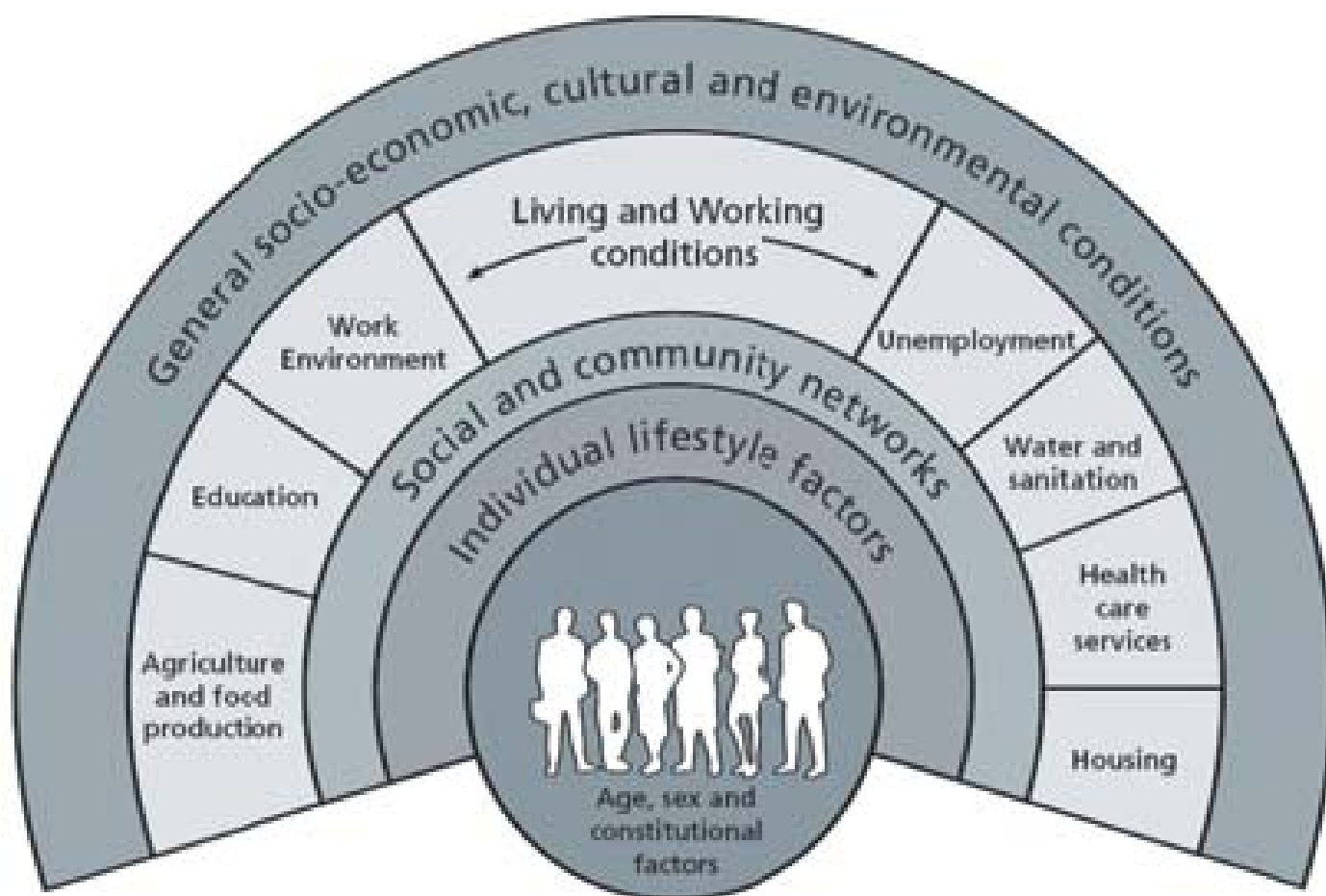
- Mortality rates for all causes are relatively high in both wards
- If current circumstances remain the same, a baby born in Butetown or Grangetown today would have a lower life expectancy than a baby born in Cyncoed or Lisvane would.
- Some conditions are more common than in the rest of Cardiff and Wales, particularly heart disease, respiratory disease, mental illness, diabetes and injuries

10 Wider Determinants of Health

A useful way of thinking about the factors which influence an individual's health is Dahlgren and Whitehead's diagram representing the multifactorial influences. (see Figure 16). For example:

- socio-economic status
- housing and living conditions
- employment
- educational achievement

Figure 16; Determinants of health

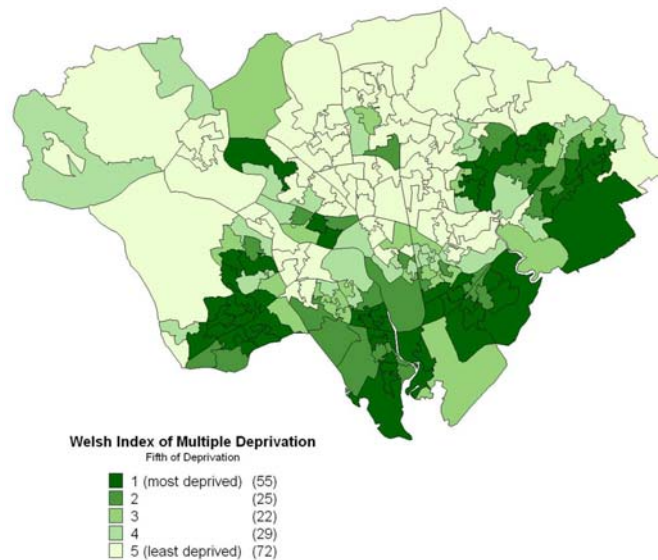


Source: Dahlgren and Whitehead, 1991

10.1 Deprivation and health

The patterns of ill health and mortality throughout the world closely match those of deprivation, whichever indicators are chosen.

Figure 17: Welsh Index of Multiple Deprivation (WIMD)* by lower super output area (LSOA): 2001



Source: National Public Health Service for Wales, *Health Needs Assessment 2006: Cardiff LHB Specific Information*
*(The Welsh Index of Multiple Deprivation uses scores derived from Income, Employment, Health, Education, Skills and Training, Geographical Access to Services, Housing, Physical Environment)

Figure 18 Difference in WIMD in Lower Super Output areas in Butetown

From the WIMD, each LSOA has a deprivation score.

Of 1896 LSOAs in Wales, the rankings are:

- Butetown 2 = number 1
- Butetown 1 = number 10
- Butetown 3 = number 909

Source: Cardiff Council website

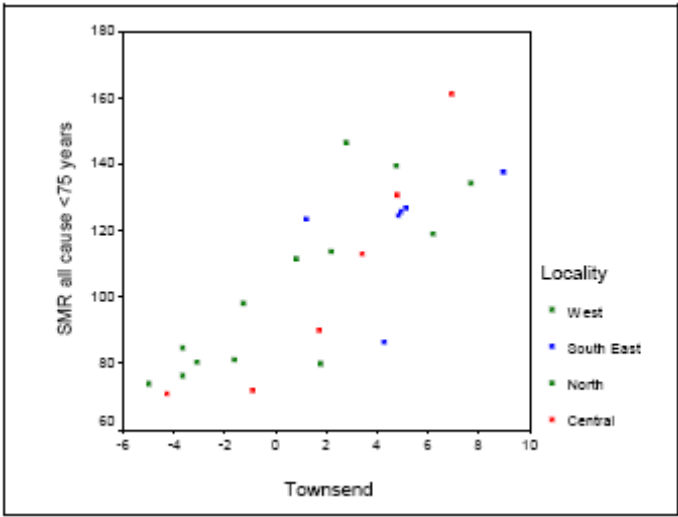


These two wards are rapidly changing and there has been marked demographic change even since the last census in 2001. For instance, even within Butetown, there is a difference in deprivation scores between the high scores of Butetown 1 and 2 which is predominantly pre- 1970s housing and with Butetown 3 which is predominantly post 1990s housing.(see Figure 18)

This may imply that in future, small pockets of high deprivation may become even more “hidden” as they are surrounded by areas of relative wealth. Small area statistics should be therefore be used routinely in these areas, preferably Lower Super Output Area level rather than Middle Super Output Area or ward level.

Another commonly used deprivation scoring method is the Townsend index. The correlation of mortality with the Townsend scores across the Cardiff localities is fairly close (see Figure 19) The correlation is similar or even greater for educational achievement, unemployment, crime figures and many other health and social indicators⁷.

Figure 19: Scatter plot correlation of SMR< 75 with Townsend index in Cardiff localities



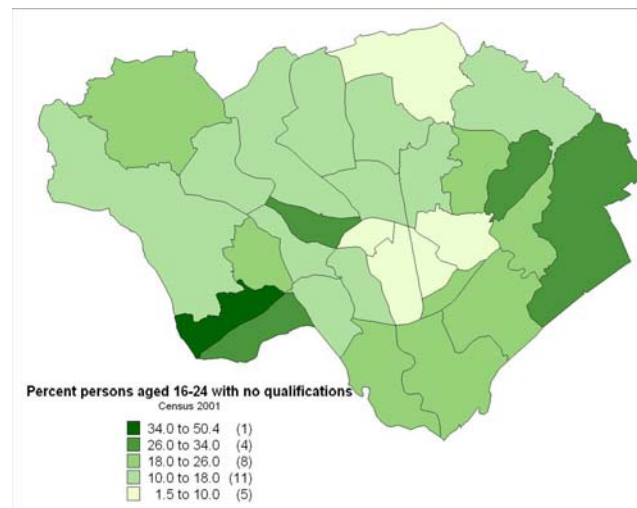
Source: Cardiff Health, Social Care and Well Being Needs Assessment 2004

It is also clear that major risk factors affecting health are significantly more prevalent in the most deprived fifth of wards across Wales⁴.The rate ratios are:

- Physical inactivity (2.08)
- Smoking (1.64)
- Obesity (1.47)
- Healthy diet (0.65; i.e. the rate of people having a healthy diet in the most deprived areas is about a third lower than the comparable rate in the least deprived areas.)

10.2 Education

Figure 20: Percentage of persons aged 16-24 with no qualifications by electoral division: 2001



Source: National Public Health Service for Wales, *Health Needs Assessment 2006: Cardiff LHB Specific Information*

There is relatively lower percentage of young people with no qualifications, which is an interesting finding as this could be linked to long term health gains for the next generation. However, it may reflect the high proportion of students who are temporarily living in city centre areas.

10.3 Income inequality gaps

Internationally, in developed Western economies, there is a strong correlation between the gaps between the richest and poorest and many health and social indicators, especially health outcomes, crime and educational achievement.

This is shown by the fact that countries with large gaps (the US and the UK) have greater health inequalities than those with small gaps (Japan and Sweden)⁸.

This cannot be assumed to be the case in small areas such as within Cardiff but it is worth bearing in mind when addressing health improvement for those in the most deprived areas.

The proximity of deprivation and wealth was a fact that was brought out in the RPA, particularly when talking about Butetown. The area is perceived as deprived with pockets of more wealthy people and this was felt to have a major impact on health and well being:

“Very split area: people in area who have great amount of money (in apartments), but there are people here who are poor. Nobody in-between. Very difficult area for those who are struggling who see the rich people. A lot of money is being pumped in, but not local people, they are not being given jobs. A few – Techniquet/ Mermaid Quay /UCI Cinema. There is poverty from what I can see. They struggle; they do their utmost to manage but find it a struggle to make ends meet. ”

“Split communities – Butetown – railway is like the Berlin Wall – on one side people are doing well – but the other side is very deprived.”

10.4 Ethnicity and health

Ethnicity has implications for health, for instance Type 2 diabetes is up to six times more common in people of South Asian descent and up to three times more common in those of African and African Caribbean descent compared to the white population (Diabetes NSF 2003).

The Barefoot Health Workers Project are involved in assessing the health needs of the Somali, Bangladeshi, Pakistani, African-Caribbean and Yemeni communities in Cardiff, using an action research approach. Several surveys, focus groups, individual interviews and other methodologies have been used to produce several reports with recommendations.

Some specific issues that have been raised are:

- Low income and other deprivation indicators are very common.
- Uptake of regular exercise is low.
- Concepts of mental health or distress/ illness are different.
- Patterns of smoking are different.
- Formal and informal community networks are strong and can be powerful influences on well being and health. Many are based around religious centres.
- People in the Somali community are concerned about some of their members who chew Qat and the effect on their health and families.
- People who have come as refugees have often had experiences which impact on their health.
- Access to health care is affected by a lack of awareness or understanding of language and cultural needs by providers and users.
- Women have specific needs, especially when considering using mixed gender services.
- there is a perception of too much research and too little appropriate action in response

Wider Determinants of Health :Key messages

- deprivation is closely linked to poor health and increased mortality
- some wider determinants of health are different in these areas, such as:
 - high proportion of ethnic minority groups with higher risk of some long term conditions.
 - higher deprivation scores in some but not all parts of both wards.
- deprivation may be at risk of becoming hidden in small pockets as areas of new housing cause an influx of people with different socioeconomic status.

11 Local Health Service Provision

11.1 Primary Care and Community Services

At the moment, all Primary Care services in Butetown and Grangetown are provided by Independent Contractor General Practitioners. There are no alternative models of provision, such as Walk In centres or Alternative Medical Providers, as there are in other parts of the UK.

There are seven practices located within Butetown and Grangetown (see Table 3). Over 80% of the population is registered with one of these practices, the remaining people being registered with other widely scattered practices.

Table 3: GP Registered population (December 2005)

Practice	Total Registered population	Butetown	Grangetown	Riverside	%of patients living within Grangetown Butetown
A	4008	385	2649	264	74.0%
B	3063	201	2203	364	76.6%
C	6383	802	4421	284	80.9%
D	1648	1274	187	46	89.5%
E	6588	1419	2745	1112	60.9%
F	3255	225	1592	477	56.1%
G	2828	1046	1003	475	71.6%
Total	27,773	5,352	14,800	3,022	72.6%

source: John Webber, Information Officer, Cardiff Local Health Board

Table 4: Where residents of Butetown and Grangetown are registered (December 2005)

Practice	Butetown		Grangetown		Total	
	number	% of all Butetown residents	number	% of all Grangetown residents	number	% of all residents
Any other GP practices	1,204	18.4%	2,314	13.5%	3,518	14.9%
Grangetown and Butetown practices	5,352	81.7%	14,800	86.5%	20,152	85.1%
Total registered	6,556	100%	17,114	100%	23,670	100%

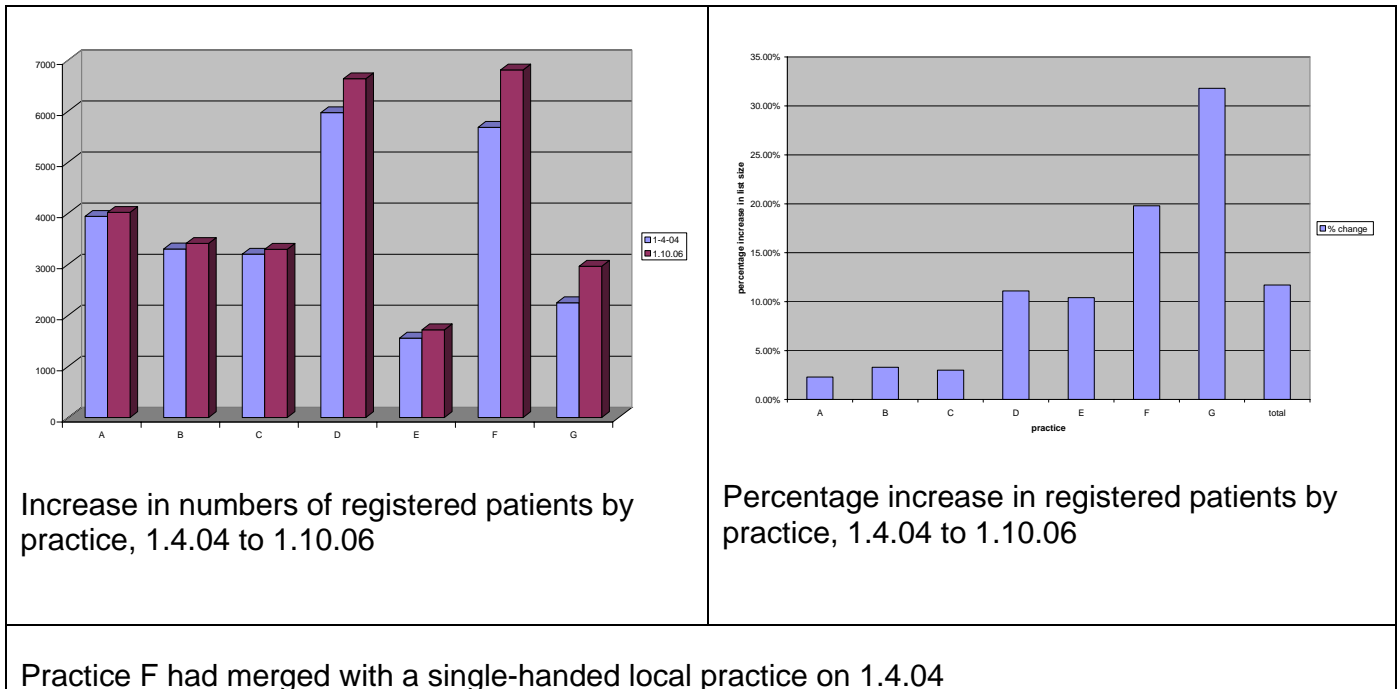
source: John Webber, Information Officer, Cardiff Local Health Board

The substantial majority (85%) of people who are registered with a GP, are registered with one of these seven local practices. Of the remainder who were registered in Wales, 467 were registered outside Cardiff, mostly in Penarth practices.

For most of these seven practices, the majority of their registered patients lived within Butetown and Grangetown (72.6%) Several of these practices also have a substantial number of patients outside Butetown and Grangetown – however, the majority of these are in neighbouring Riverside which is a similar community with high deprivation scores and a high proportion of ethnic minority groups in the population.

In view of demographic changes, it is not surprising that numbers of registered patients are increasing, putting increased pressure on the Primary Care teams. Several practices have intermittently closed their lists to new registrations and several have had difficulties in recruiting staff to meet the increased need.

The increase in the number of people registered with the seven practices was 2,943 over the last two and a half years, shown in Figure 21.

Figure 21: Increase in list sizes in Butetown and Grangetown practices

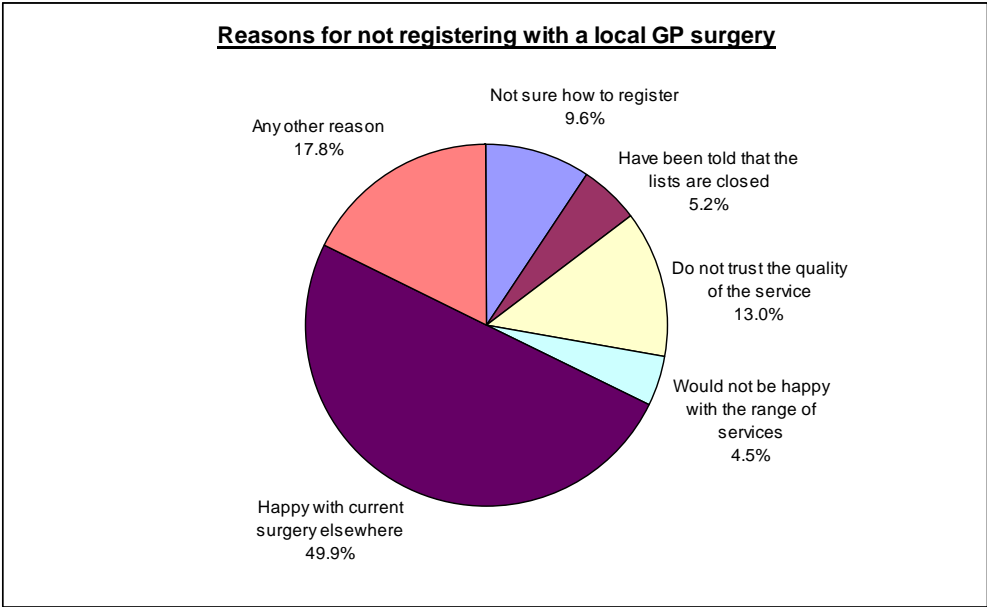
The perception among the local residents is of difficulty registering with a local practice. Among the respondents to the postal survey, many were not registered locally. (See Table 5)

Table 5: Postal Survey question - Are the people in your household registered with a GP practice?

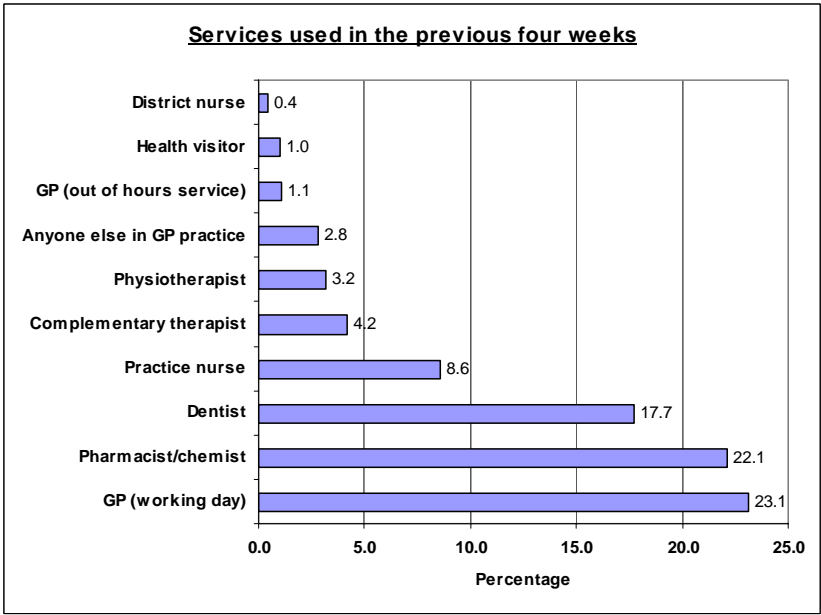
	TOTAL	
	No.	%
Yes, in Butetown Health Centre	148	11.8
Yes, in Grangetown Health Centres	350	27.9
Yes, Elsewhere in Cardiff	343	27.3
Yes, in Penarth	100	8.0
Yes, elsewhere in UK	232	18.5
No, not registered with a GP	83	6.6
TOTAL	1256	100.0

The reasons for people in the new housing not to register locally were several, see Figure 22. The people who say they are happy with their current surgery may however change to local services if they perceive them to be of an equal standard in future although people generally are very reluctant to change registration even when dissatisfied.

Figure 22: Postal survey question: For those members of your household who do not have a GP in Grangetown or Butetown, is there a reason why not?



In response to the postal survey, high proportions have used primary care service recently. This may reflect the fact that people are more likely to respond to such a survey if they have a current health problem and non-responders may possibly have a lower use.



However, 91.5% of this sample self-rated their health as good, very good or excellent.

11.2 Primary Care workforce

Primary care is based on individual General Practitioner practices. At the moment in Cardiff, the only model is that of Independent Contractors (apart from some services for specific groups such as refugees and asylum seekers). Each practice holds a contract with the Local Health Board to provide core General Medical Services. They can choose to provide additional services and enhanced services.

The only practice providing an enhanced service is Dr Kay Saunders with a contract to provide services for homeless people.

Each practice has a Primary Care Team, of whom the usual members are shown in Table 6

Table 6: typical members of a Primary Health Care Team in Cardiff

Employed by GP	Employed by Cardiff and Vale Trust	Other
General Practitioner (self-employed or salaried)	Health visitor	Citizens Advice Bureau or Welfare Rights Advice
Practice Nurse	District Nurse	
Practice Manager		Counsellor (Local Health Board)
Reception Staff		
Administrative and IT staff		

It can be seen that members of this team have different employers and therefore different lines of accountability.

11.3 Does the clinical workforce match the need?

Need is different to demand, and here I will use the term need to mean the ability to benefit from an intervention. Hence, such a intervention must exist and of course, it may not be demanded even if it is needed.

The simplest measure is to look at the number of patients per whole time health worker. However, this makes no attempt to account for the needs of the patients. For instance, if the practice has a high proportion of elderly people, they are likely to have more health problems and hence needs than younger people. They may hence place a greater demand on the time and resources of the individual health worker. A practice with 40 % of its patients aged 75 or over will have a population with higher needs than a practice with 20 % of its patients aged over 75, all else being equal.

11.4 General Practitioners

A rough estimate of the patient list size per whole time equivalent (WTE) GP (see Table 7), shows that the average list size in Butetown and Grangetown is greater than in Cardiff as a whole.

Within this, there is large variation, from 1648 to 3340 per GP. Over the last few years, and especially since the new GP contract in 2004, there has been much greater use of multi-disciplinary working. Many tasks performed by GPs are now routinely carried out by nurse and other team members. However, the number of patients per GP is a useful comparison between practices as an indicator of availability of health professionals.

Table 7: General Practitioner Workforce (July 2005)

practice	Registered population	WTE GP (retainers)	Number of patients per GP (including retainers)
A	4008	1 (0.2)	4008 (3340)
B	3063	1	3063
C	6383	3	2128
D	6588	3	2196
E	3255	1	3255
F	1648	1	1648
G	2828	1	2828
All Grangetown and Butetown practices	27773	11 (11.2)	2525 (2489)
All Cardiff practices	348583	173.87 (11.16)	2005 (1884)

sources: BSC LHB toolkit http://nww.info.bsc.wales.nhs.uk/tm1web/w2k_main_handler.asp Quarter 2 2005

11.5 Health Visitors

Health Visitors have a public health and health promotion role for all the population. At the moment, the mainstream core health visitors in Cardiff are attached to GP practices and have responsibility for the people registered with the practice, rather than a geographical population as in some other areas. Much of their focus is on supporting young families, and this role has shifted from one of equal provision to all to one of targeted support to more vulnerable groups. There are links between deprivation and increased numbers of vulnerable families (e.g. single-parent households, low educational attainment and child protection concerns).

There is currently some ongoing work profiling the Health Visitor workload to enable better resource allocation. However, this is not based on population needs but rather on current workload which may not reflect actual need.

Although the role of health visitors is not exclusively with children, this is such a large part of the need that the number of children per WTE Health visitor has been used as a proxy (see Table 8).

Table 8: Universal Health Visitor Workforce.

practice	Registered population (1.4.06)	Registered population Under 5	WTE Health Visitor	Number of children under 5 per WTE HV
A	4059	282	1.3	217
B	3168	210	1.0	210
C	6603	438	1.5	292
D	6726	411	1.9 + 0.6	164.4
E	3187	329	???	
F	1623	81	0.4	202.5
G	2936	255	1.0	255
All Grangetown and Butetown practices	28,302	2,006	7.7	260.6
All Cardiff practices	348583	18,452	69.6	265.1

sources: BSC LHB toolkit http://www.info.bsc.wales.nhs.uk/tm1web/w2k_main_handler.asp Quarter 1 2006, and Cardiff and Vale Trust Primary Care Directorate

(This excludes any Health Visitors in specific roles, such as within Surestart schemes.)

The core workforce is not significantly greater in Butetown and Grangetown, even though the families and children will have greater needs than other parts of the city.

However, there are additional health visitors and other health workers within Surestart which is targeted at areas of greater need.

11.6 District Nurses

Similarly, district nurses in Cardiff are currently attached to one or more GP practices and although they work as teams across a geographical area, they are responsible for the patients registered with these particular practices. Although they care for people of all ages, mostly in their own homes, I

have used the number of older people as a crude proxy for need for their services. This has problems, in that their work can be very variable (from post operative acute wound care to the care of terminally ill patients at home)

Table 9: District Nurse Workforce

practice	Registered population (1.4.06)	Registered population		WTE district nurse	Number of people per WTE nurse	
		> 65	> 75		>65	>75
D	3186	301	128	5.13		
E	6730	830	334			
F	1619	164	65			
B	3140	375	169			
C	6604	839	352	2.36		
A	4059	460	176			
G	2936	422	156			
Grangetown and Butetown practices	28,724	3,391	1,380	7.49	452.7	184.2
All Cardiff practices	348583	46,371	22,996	133.98	346.1	171.6

sources: BSC LHB toolkit http://nww.info.bsc.wales.nhs.uk/tm1web/w2k_main_handler.asp Quarter 1 2006, and Cardiff and Vale NHS Trust Primary Care Directorate

The number of district nurses when standardised for age, is again no higher in these deprived wards, although the health status is worse and health needs are greater. There is currently no formal system of profiling of workload with the purpose of targeting district nursing resources.

11.7 Services for specific groups

Several specific groups have been prioritised in the Health, Social Care and Well Being Strategy. Some of these groups have a particular relevance in Butetown and Grangetown; wither because more people belong to them or because deprivation has an impact on their health.

The funding for these are often project-based and less secure than mainstream funding. Some examples are:

- **Children and families**
 - Bee Healthy Teenage Health Club
 - Surestart

- **Homeless people**
 - all Cardiff hostels for single homeless men are in Butetown
 - Nurse Practitioner for Single Homeless, Cardiff Health Access Team
 - Enhanced Service Contract with one GP practice in Butetown Health Centre

- **Refugees and Asylum Seekers**
 - Personal Medical Services practice based in Cardiff Royal Infirmary

- **Black and Minority Ethnic Groups**
 - Heartlink
 - The Multicultural Information and Resource Service in Butetown Health Centre (for Trust staff and not available to General Practices,
 - The Sickle Cell and Thalassaemia Service in Butetown Health Centre

There was sometimes an assumption among key informants that services for BME groups were therefore also addressing the needs of the residents of Butetown, Grangetown and Riverside. However:

- Ethnic minority groups are living in every ward in the city, not just in these three, and can be excluded from services targeted at BME groups if these services are geographically targeted.
- The majority of people (almost 70% even in Butetown) are white, and will not be served by these services.

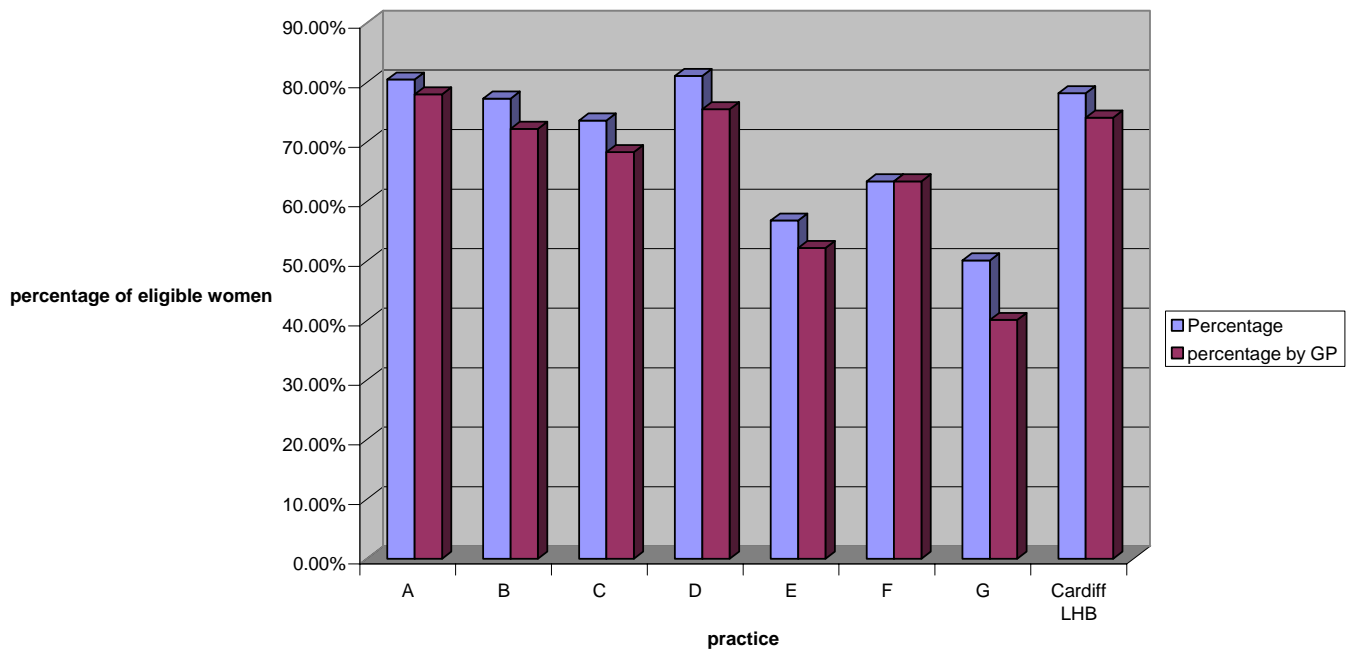
11.8 Preventive Care

Primary Care is the main deliverer of such preventive programmes as cervical screening, childhood immunisation and annual flu vaccinations.

Figure 23 shows the uptake of cervical screening across Grangetown and Butetown and can be seen to be very variable. Areas in the UK with large numbers of women from ethnic minorities tend to have a lower uptake. However, the evidence suggests that women from ethnic minorities

are equally willing to take up cervical screening if services are provided appropriately and with adequate information.

Figure 23: Cervical screening uptake in Grangetown, Butetown and Cardiff practices. Quarter 1 2006.



Source ; LHB Information Toolkit

11.9 Other Cardiff and Vale NHS Trust community services

The Trust provides many other services at sites in the local communities in Cardiff and the Vale, mostly through its own premises. It has 21 Health Centres. I have summarised the services in Table 10. This does not show all Health Centres and the information within it has been supplied by several different sources within the Trust. Any errors are my fault as it has been impossible to check this information for all centres and services.

There are also some services based in Butetown Health Centre, which provide services over a wider area:

- The Multi Cultural Health Resource and Information Centre
- The Sickle Cell and Thalassaemia Service

Other services provided in the community setting throughout Cardiff are provided at selected locations only, and include: Breastfeeding support, Counsellors, Domino, Heart Ely, Epilepsy Clinic, Learning Difficulties clinic, Contenance Clinic, Diabetic Retinopathy, Diabetic Clinic, Foot Care, Cardiac Rehab and Orthoptics.

Overall, it has been very difficult to achieve an overview of current community service provision as the management of each service is not aware of the others and there does not seem to be a key department or person who has a strategic overview of community services.

Table 10: Community services based in Cardiff and Vale NHSTrust Locations (number of sessions per week)

	CRI	Trowbridge Health Centre	Butetown Health Centre	Grangetown Health Centre	Splott Clinic	Llanrumney Clinic	Rhiwbina Clinic	St Mellons Clinic	Gabalfa Clinic	Llanishen Clinic	Llandaff North Medical Centre	St David's Hospital	Radyr Health Centre	Riverside Health Centre	Canton Health Centre	Park View Health Centre	Penarth Health Centre	Dinas Powys Health Centre
Family Planning	1	1	1	1		1						3				2	1	
Child Health	2	1		3	2	2	2	6		2	2		1	1	2	1	1	1
Enuresis				2		2												
Audiology		2		2	4	5		5		4	2			1		4	2	2
Phlebotomy			1									11	2		5			
Dieticians		3		1	1					1		5	1	2		2	6	
Speech Therapy					2	5	4				2			10		7	6	
Dental		2	6	6	6	4				10	6					10	7	
Podiatry		4		8	5	16	10		1	10		6	2			20	9	6
Citizens Advice		1	2	2	2	2												
Physiotherapy						1		1		1	1						3	
WoundClinic/Healing	1	1			1	3	2									5		
Medicals		1			2	3			5					1		2	2	
Mental health		1									1	2*		1				
Comm Nurse Clinic		3			5											9	3	9

11.10 Cardiff and vale NHS Trust Organisational Changes

Currently, the Trust has a Primary Care Directorate which includes the Health Visitors, District Nurses and Health Centre management. The latter has now moved to the Clinical Services Support Directorate from 1/11/06. There are proposals to move the district nurse workforce within the Adult Medicine Directorate and Health Visitors to the Paediatric Directorate in April 2007.

There are also currently separate management accountabilities for Therapies and Dental Services.

There are some risks in these service reorganisation changes:

- lack of a strategic overview of local and community health services
- increasing barriers for multi disciplinary working and multi-agency approaches
- increasing difficulties in resource allocation across Cardiff and the Vale
- reduced opportunities for integration of health workers, such as Health Visitors and District Nurses, within primary health care teams.
- risk of resources moving from current community services into the secondary care Directorates they will become part of, contrary to Design for Life principles and the principles of the Cardiff Programme for Health Service Improvement

11.11 Pharmacists

There are 7 pharmacists within Butetown and Grangetown, distributed with local shops and close to the GP practices. During the RPA, there were only positive and no negative comments on the service provided by pharmacists.

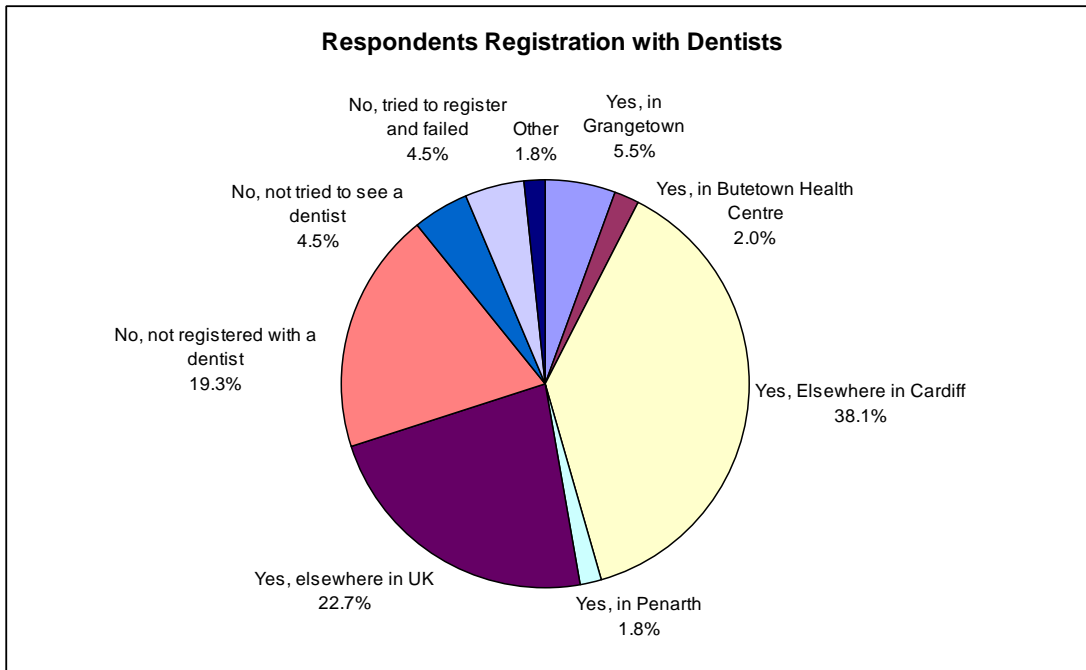
11.12 Dental services

Cardiff Local Health Board state that they are in a better position than many other Local Health Boards, in that of 64 practices in Cardiff, 57 have signed NHS contracts (including 20 PDS). This is a relatively high proportion opting to continue to provide NHS services. There are several Personal Dental Service Practices in the city, including two in Grangetown.

Out of hours dental care is provided through Primecare.

The Community Dental Service is provided by Cardiff and Vale NHS Trust. This represents the safety net provision for unregistered patients and provides a service at Butetown Health Centre and Grangetown Health Centre.

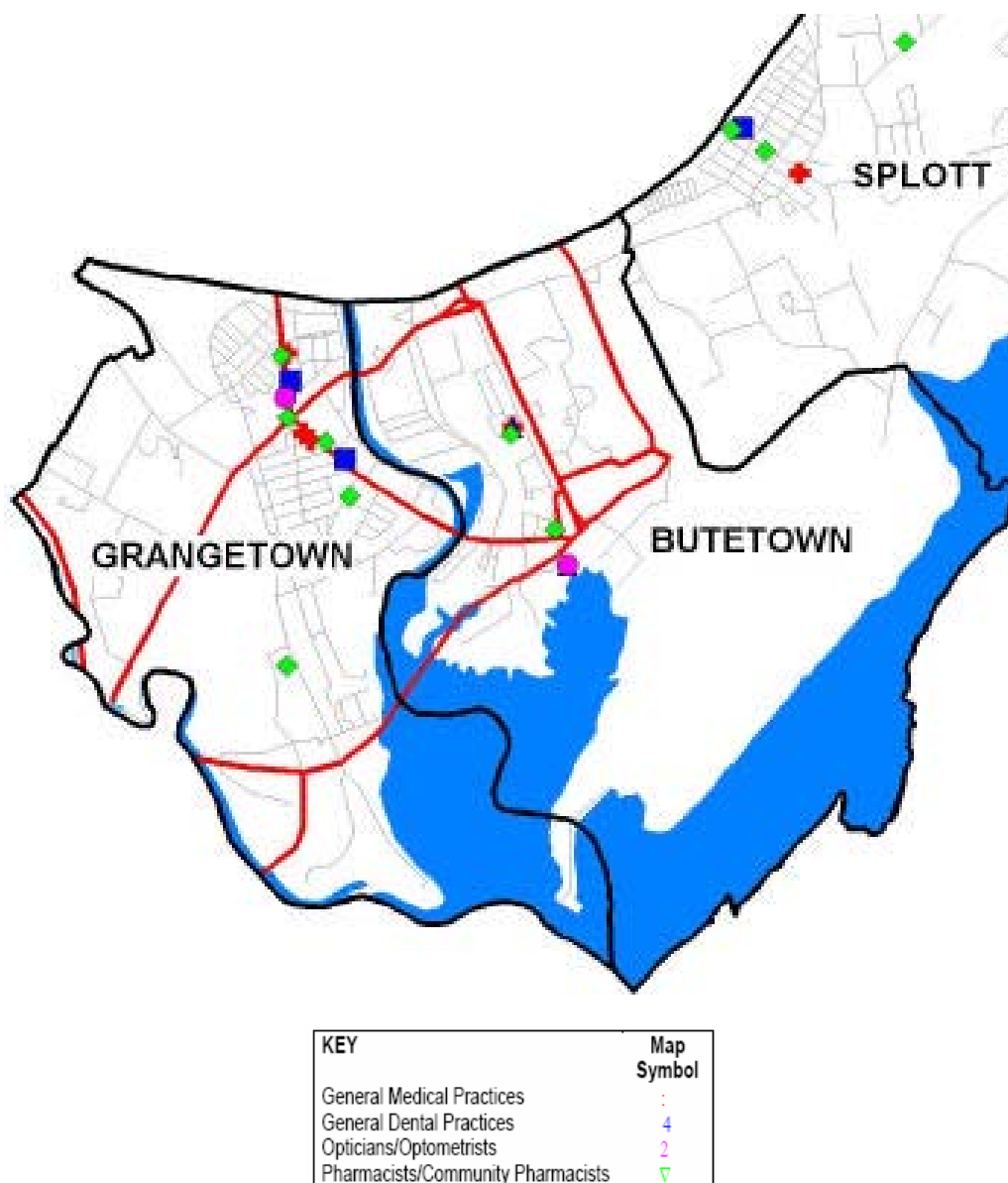
However, during the RPA, perceptions in the local community were strongly about lack of access to a dentist locally and this was also raised by respondents to the postal survey, See Figure 25

Figure 25: Postal Survey Question: is everyone in your household registered with a dentist?

11.13 Local Health Care Premises

Primary and community care is provided at the locations shown on the map below (figure 27). The premises either are owned by Cardiff and Vale NHS Trust (Butetown and Grangetown Health Centres) or are owned by the GPs themselves. Dentists, pharmacists and optometrists also practice from their own premises, apart from dental services provided by the Trust in their Health Centres.

Figure 27: Primary and community service locations.



11.14 Primary Care Estates Strategy

In 2004, Cardiff Local Health Board commissioned a review of existing estate and options for future development from independent consultants.

Ten options were generated, which were not all mutually exclusive, and were ranked after weighting for 6 criteria (including reducing inequalities and improving health). Participants in this process were a wide range of stakeholders. The preferred options were as shown in Table 11:

Table 11: Options for Cardiff Integrated Healthcare Estate Strategy.

Option		Ranking
Hub and Spoke	Reduce number of buildings, based around several larger Resource Centres (some may be existing bigger GP premises)	1
centralise	Rationalise to a much smaller number of properties in the form of Primary Care Resource Centres, which would co-locate multidisciplinary health and social care teams and possibly other agencies and voluntary organisations.	2
Co-locate with Local Authority		3
Do minimum	Carry out backlog maintenance and improve poor condition/performance only	4
Primary Care in patients' homes	Rely on different way of working. Invest in additional staff and technologies, rather than buildings. Premises to be focussed on more complex procedures and diagnosis.	5
decentralise	It would need a larger number of smaller properties, perhaps using other agencies properties too. It would need significant improving of existing properties and perhaps investing in new ones.	6
LHB site ownership	Purchase land in relatively inexpensive "brownfield sites", linking in with development in regeneration zones.	7
Do nothing		8
Mobile equipment	Taking service to communities e.g mobile dental services, to reduce reliance on buildings and maximise the range of services that could be "mobilised"	9
Co-locate with retail	To integrate with retail and commercial sector e.g. deliver primary care services from supermarkets, shopping centres, leisure centres etc	10

It was not possible to find the original data for Butetown and Grangetown practices. However, in Cardiff overall, the consultants found:

- significant numbers of premises over 74 years old
- the majority are fully utilised and there is little room for expansion
- most premises were not compliant with the requirements of the Disability Discrimination Act

Of the seven practices in this area:

- One is seeking to develop larger, probably new, purpose-built premises in Grangetown.
- Those using Butetown Health Centre wish it to be replaced in the same location and in the meantime to be substantially improved.
- One wishes to develop a temporary new branch surgery in Mermaid Quay.

11.15 Butetown Health Centre



Source; Cardiff Council

There was agreement between service providers and the local community (in the findings of both the RPA and the postal survey) that Butetown Health Centre evokes strong feelings. It is perceived to have an unwelcoming aspect, to be unsafe, unfit for purpose and in a location that made people who did not live in the immediate area, wary of using it.

Some comments from the RPA were:

“Butetown Health Centre is a disgrace”

“Health Centre in Butetown is run down. Toilets (are) not working. People around health centre actively chosen to go elsewhere because centre so poor.”

In the postal survey, 21 (7%) of people specifically mentioned problems with Butetown Health Centre. Comments included:

“Because I had an emergency I needed to register with Butetown. The staff are excellent but the quality/environment of the surgery leaves a lot to be desired”

“Butetown Health Centre resembles a developing country's health centre rather than a fully developed wealthy community. Attending the centre is an unpleasant experience”

“Although Dr K. Saunders does a great job, the Butetown Medical Centre is a disgrace. It is unkempt, dirty and in a rough area of town. It is distressing to visit there, I often surrounded by heroin addicts, and vagrants, plus the people can be very intimidating when alone. “

“Butetown Health Centre is terrifying”

“The health facilities in Cardiff Bay are terrible! Butetown Health Centre could not be worse - it's badly kept, badly staffed and impossible to get an appointment in, particularly for people who work full-time.”

The Community Health Council has established a Reference Group which has met several times in Butetown Community Centre. The major issue of concern is the service provision and premises in the Health Centre. The local residents are currently carrying out a questionnaire survey as a means of raising this issue with service planners (see Appendix 4).

At the time of writing this report, there had been no receptionist in the entrance foyer for 10 months, so that access to the building was uncontrolled and there is person responsible for information about the Health Centre for people arriving at the building.

Cardiff Council carried out a consultation in March this year about what local people wished to see in the Regeneration Plans for Loudoun Square. The conclusions included:

“The questionnaire revealed that local people are concerned about the poor environment at Loudoun Square, particularly the large amount of litter and dumping and poor condition of buildings.”

“The vast majority of local people (over 80%) would like to see new shops and a new health centre provided in the redevelopment of Loudoun Square.”

The Council is now working with Cardiff Community Housing Association and has recently appointed a consultancy to develop a full brief for the Project involving consultation with all stakeholders and the local community. The timescale for completion of the building work is within the next 4 to 5 years.

11.16 Rapid Participatory Appraisal results

The RPA, although not intended to be representative, gave some useful insights into local perceptions and issues of concern through talking with people who had strong networks in the area.

This report uses the written notes from 25 interviews, with the following people:

<ul style="list-style-type: none"> • 6 Primary/ Community health care workers/teams • 3 other health care • 2 councillors • 3 school/ youth 	<ul style="list-style-type: none"> • 1 police • 2 local businesses • 7 community/religious/voluntary organisations • 1 leisure service
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3 members of the team, who coded each one, read the first 6 interviews. These were then compared and themes were identified and agreed. The remaining interviews were analysed by one member of the team and every part of every interview was placed in one (and occasionally two) themes. A second member of the team then reviewed these.

The 18 themes were discussed at the final workshop and two members of the team checked the summary of each of the themes with the original interview content.

Each main issue within each theme has only been included if it had been mentioned by at least three people. All participants are assured of anonymity and should not be personally identifiable from the quotes used here.

The full Report of the Rapid Participatory Appraisal can be provided as an Appendix (19 pages) if requested.

Interpreting services were frequently mentioned, with positive regard for several interpreters and link workers but less satisfaction with LanguageLine (the telephone interpreting service provided via the Local Health Board and Cardiff Council).

We specified that we were not asking about hospital services, and few people mentioned problems. Several did bring up long waiting times and the difficulty in accessing secondary care services for vulnerable or poor people (transport, literacy, understanding the system). The perception of Social Services was generally of access being a major barrier (confusion over how to access and the difficulty of the process), although several people felt an explanation for this was that social services were overwhelmed by demand.

A large number of other services and projects were mentioned by many people, when we asked what they knew about what was available for particular groups (e.g. young people and families, the elderly etc). However, many were not mentioned at all by health workers.

11.16.1 Missing services and barriers to services

Lack of awareness by both local residents and potential referrers was frequently raised as a barrier to access.

The other major barrier was lack of services to overcome language and cultural differences, with many saying this impaired access. This extended to literacy problems, particularly with official letters, such as for hospital appointments. Many people mentioned using a family member to interpret which is not appropriate nor good practice. The health workers generally felt that someone with an advocacy role, as well as an interpreting role, was the most useful.

“Languageline – excellent and free, but not as good as having an interpreter.”

Many people mentioned the lack of access to dental and podiatry services.

Many people talked of the lack of a swimming pool in the area, and linked this to a potential beneficial impact on health.

Those felt to be best served by local health services, were those who were able to understand the system and knew how to use it. Among those considered to be least well served were people without good English language skills and those who were recent arrivals.

“Cardiff Bay residents – they can work the system, they can use appointments systems. This depends on whether they can get registered – if they do, they could swamp the system.”

“(the best served are) Better communicators. People with more understanding of the system and know where to go”

11.16.2 Access and Equity

Most people felt there was a shortage of Primary Health Care, particularly in Butetown. It was felt to be difficult to register with a GP if new to the area and also sometimes to see a GP once registered. It was perceived that the population had been increasing but there had been no increase in Primary Care services to match this. This had led to most practices refusing to take on new patients at one time or another.

“Can’t get a GP from health point of view. Lists open on and off, don’t like other practices and general provision. Not enough.”

“Lists are full within GP surgeries in Grangetown”

“Good ones are difficult to see”

Most health workers did not have an awareness of many of the voluntary or non-statutory services in the area, even when they helped people with physical or mental health problems. Non-health workers seemed to have a greater awareness of these and suggested that this could affect the access that people had to local support as their practices may be less likely to refer them.

11.16.3 Acceptability

There was a perception that local health services did not always match up to expectations, with some comments about the reasons for this being lack of time, funding or a caring attitude. Many were able to distinguish between practices in their characteristics as they seemed to be well known in the communities.

“There are good, bad and indifferent”

“They think they (GPs) are rubbish. They are tarring all GPs with the same brush..... We get flak from misperceptions.....All expect the NHS to provide, that our medicine can fix everything and then they are disappointed.”

“People don’t want to go to GP services that are poor quality.....People want more and better quality GP services.”

“I would like to devote more time to patients but not practical. In this area, staff are always stressed – communication is difficult.”

“Bad communication with Doctors, don’t take them (patients) serious. Doctors just dish out paracetamol”

The relationship with a known GP or nurse or practice was valued. There were some consistently positive comments about some of the practices, mostly in terms of their attitude being caring. The negative comments were mostly about communication.

“Surgery as a whole (and other surgeries) are at core of community – big source of support. Taking over role of church in past. Generally satisfied and loving practices.”

“Some of our clients are not listened to and were given wrong medications due to language barriers and this can be dangerous. Communication is very important to describe your illness.”

11.16.4 Female GPs

There was felt to be a lack of access to female GPs, both in Grangetown and Butetown.

“People do not have choice. Not enough women – mostly GP’s are men, especially those with an ethnic minority language.”

11.16.5 Dentists

There was a strong perception that there was a lack of access to dentists, for all age groups and in both wards. Some people believed there were no NHS dentists.

11.16.6 Premises

There were some strong feelings that Butetown Health Centre was unsuitable for many reasons, with the building felt to be unsafe and unpleasant to work in, or go to as a patient.

“Butetown Health Centre is a disgrace”

“Health Centre in Butetown is run down. Toilets not working. People around health centre actively chosen to go elsewhere because centre so poor.”

In Grangetown, the issue was more diffuse with a general comment that practices were in too small accommodation, rather than in poor quality buildings:

“Premises – old fashioned buildings that can’t respond to needs, so poorer service. Access to health centres not ideal for disabled.”

11.16.7 Summary of all RPA findings

- Butetown and Grangetown contain many communities, but particularly:
 - “old Grangetown” and “old Butetown”
 - large ethnic minority groups; Somali, Pakistani, Gujarati, Bengali, Yemeni etc
 - people in new housing who are a community only in the geographic sense
- The main health issues were felt to be about behaviour choices, long term health conditions and access to local health services.
- The area is changing rapidly, and this is seen as having both a positive and negative impact on health.
- The area is perceived as deprived with pockets of more wealthy people and this was felt to have a major impact on health and well being.
- There was felt to be strong social networks, sense of community, and community participation in all areas, except in the new developments. The latter were perceived to be a threat to social capital.
- The services that could benefit health that were perceived to be missing were:
 - dental care
 - podiatry/ chiropody
 - a swimming pool
- Barriers to services were perceived to be:
 - Lack of services to overcome language differences, and literacy difficulties.
 - Lack of knowledge in how to use the system resulting in inequities.
 - Lack of awareness of services, in residents and referrers.
 - Long waiting times, especially for substance misuse services.
- Access to primary care services was felt to be too poor, because of lack of staff and increasing demand from a growing population.

- Butetown Health Centre was disliked by all who knew it (and some who would not go there at all). Premises in Grangetown were of better quality although some were felt to be too small.
- There is a lack of awareness of the other services available locally to support people with particular problems that might affect their health.
- There was felt to be a lack of active health promotion and preventative work.
- the main suggestions for improvements were:
 - Increase and enhance current Primary and Community Care services
 - More GPs and core Primary care services.
 - Dentists.
 - Podiatry/ chiropody.
 - Better premises
 - Replace Butetown Health Centre
 - New Health centre for Grangetown and/or Butetown with room for extended services such as minor A and E service.
 - More support for the elderly, young people and families.
 - Better health promotion including leisure facilities, in particular a swimming pool

11.16.8 Summary of comments from postal survey

Of more than 700 respondents, many chose to add a short free text comment, the summary of which is as shown in Table 12

Table 12; Postal survey Summary of free text comments

Theme	Number	Percentage
Need a new NHS doctors surgery in Cardiff Bay	42	14.0
Doctors surgeries are too busy/ long wait to get an appointment	32	10.7
Difficulty registering with a GP or dentist	32	10.7
Need a new NHS dental surgery in Cardiff Bay	30	10.0
Need information on where NHS doctor and dental surgeries are located	23	7.7
Need a new Cardiff Bay Health Centre (due to increase in Cardiff Bay population)	22	7.4
Problems with Butetown Medical Centre	21	7.0
Dissatisfaction with staff	16	5.4
Personal safety issues	14	4.7
Satisfaction with staff	14	4.7
Generally poor NHS standards	11	3.7
Need longer opening hours	8	2.7
Need a greater available choice of GPs e.g. more female doctors	7	2.3
Miscellaneous	27	9.0
TOTAL	299	100.0

Local Health Service Provision :Key messages

- The large majority of the population is registered with one of seven local practices, although fewer of the new housing residents are registered locally.
- There is little evidence of targeting increased mainstream services to areas of higher need.
- There is little evidence of an increase in local health services in response to an increasing population
- the local perceptions about access to services are especially about :
 - lack of sufficient primary care.
 - Lack of services to overcome language differences, and literacy difficulties.
 - Lack of knowledge and awareness of services, in residents and referrers.
 - lack of preventive services
 - lack of leisure facilities
 - lack of access to podiatry and dental services
- Butetown Health Centre does not meet the needs of it's local population in inadequate premises and is mostly disliked by service providers and users

12 Effective interventions to reduce health inequalities

Dr Tony Jewell, The Chief Medical Officer for Wales, has stated that his four main principles for action are⁹:

- Social justice, human rights and community solidarity
- The NHS and public service ethos and values
- Public health evidence and the needs of defined populations
- The importance of the primary health care delivery system for equity, effectiveness and efficiency

He states that the Canadian Institute of Advanced Research¹⁰ estimates that health status is explained by:

- 10% physical environment
- 15% biological environment
- 25% healthcare system
- 50% social and economic environment

Health inequalities are widening across the UK as a whole, even though there has been widespread recognition and many policies and programmes to try and address the root causes of inequality¹¹. The Joseph Rowntree Foundation³ estimated that three existing UK government policies would have a major impact if fully implemented, see Table 13

Table 13 : Estimates of lives saved: results for Britain as a whole³

Table 1: Lives saved by successful implementation of three government policies (for ages less than 65)

	All of Britain		Areas with above average mortality	
	Total number of lives saved annually	Proportion of deaths <65	Total number of lives saved annually	Proportion of deaths <65
Mild redistribution of wealth	7,597	7%	3,983	37%
Full employment achieved	2,504	2%	1,702	17%
Child poverty eradicated (ages 0-14)	1,407	21%*	727	92%*
Total	11,509	10%	6,412	56%

*Note these proportions refer only to deaths of children aged 0-14.

Source : Joseph Rowntree Foundation

However, none of these are delivered by the health care sector. However, the health sector has a strong role in advocating for health with partner organisations who are able to act in these areas and who can contribute to social justice. A very helpful tool is Health Impact Assessment which has been increasingly used, particularly by Government and Local Authorities¹⁶.

All organisations are now also required to develop Equality Action Plans to comply with the Equality Act 2006. These plans bring together all equality duties, which include race and ethnicity, sex, disability, sexual orientation, age, religion and belief.

Although health care services are not the major instrument for addressing health improvement and health inequalities, this project specifically looked at the gaps and potential for change in the local health care setting.

It can be seen that there are wide inequalities in health status and that there is some evidence of inequality in access to excellent local health services in Cardiff, with the Butetown and Grangetown population being some of the most disadvantaged people.

12.1 So, what has been shown to work?

- Integrating health inequalities into the mainstream of service delivery, with a focus on disadvantaged areas and groups¹¹.
- actions likely to have the biggest impact over the longest term¹²:
 - improvement in early years support for children and families
 - improved social housing and reduced fuel poverty among vulnerable populations
 - improved educational attainment and skills development among disadvantaged populations
 - improved access to public services in disadvantaged communities in urban and rural areas
 - reduced unemployment and improved income among the poorest
- specific interventions among disadvantaged groups that are most likely to have an impact are:
 - reducing smoking in manual social groups
 - preventing and managing risks for CHD and cancer such as poor diet and obesity, physical inactivity and hypertension through effective primary care and public health interventions
 - improving housing quality by tackling cold and dampness, and reducing accidents in the home and on the road.

12.2 Health Service Interventions

The characteristics of successful interventions that are specifically aimed at reducing inequalities can be summarised as¹³:

- systematic and intensive approaches to delivering health care
- improvements in access and prompts to encourage the use of services
- strategies employing a combination of interventions and those involving a multi - disciplinary approach
- ensuring interventions addressed the expressed or identified needs of the target population
- the involvement of peers in the delivery of interventions

12.3 The Primary Care Setting

There are complexities of approaches to reducing health inequalities in primary care, with consequent difficulty in reviewing and concluding disparate interventions. However, they can usefully be divided into individual, organisational and community as suggested by the Kings Fund¹³.

12.3.1 Individual approaches

Behaviour change via one-to-one encounters with health professionals can have an impact, for instance with smoking cessation and alcohol consumption.

Health education approaches which provide only information are effective in the higher socioeconomic groups but may not be effective in reducing inequalities – however, if combined alongside personal support such as that given by a health visitor, these seem to be the most effective type of intervention for all socioeconomic groups¹⁴.

However, there is a lack of evidence for lifestyle advice for diet or physical activity changes, although this is now embedded in policy. The evidence is stronger for more intensive, longer term, multidisciplinary interventions¹².

This has implications for the time and training required of health workers, and may widen inequality by being more available in less hard-pressed practices. Also, the evidence is that this is taken up preferentially by higher social classes and can hence widen inequalities initially. This has been called the “inverse prevention law”¹².

The Cardiff Health Promotion Service carried out a Health Promotion Needs Assessment with practice nurses, health visitors, district nurse and midwives in 1997⁶ which concluded that

“Although health promotion in practices was found to be largely on an individualistic approach, this way of helping people change behaviour is known to be effective as part of an overall strategy and should be encouraged with training and engagement in setting agendas locally”

For individual approaches to be effective in reducing inequalities, the mainstream primary and community services would need to be strengthened in areas where the need is higher and become responsive to delivering them in more appropriate ways, as “one size does not fit all”.

12.3.2 Organisational

These approaches are about organisation of care and access to services for disadvantaged groups. They can be from individual practice level to whole system changes. Examples are making cervical screening more accessible to minority ethnic groups by providing information and interpreting services in the right languages and in culturally sensitive locations. Another example is placing a new Primary Care Team in an area of greater need, such as a practice specifically serving homeless people.

There is good evidence that any user charge or disincentives are deterrents¹². For instance, the uptake of nicotine replacement was increased in more disadvantaged groups when it became available on prescription. Financial barriers can be hidden, such as transport for those who do have access to a car.

12.3.3 Community

Primary and Community health care services have not been central to such approaches but have often been involved with other agencies, for instance in Regeneration Projects or Neighbourhood Renewal Schemes. These may include the role of Primary Care organisations as large employers or users of land in themselves and using these opportunities to improve disadvantaged communities’ health.

The Cardiff Health Promotion Needs Assessment with practice nurses, health visitors, district nurse and midwives in 1997⁶ concluded that

“Multifactorial, multi agency health promotion interventions rather than unifactorial, single agency interventions will be more effective in the south west locality (of Cardiff) in addressing some of the population’s health promotion needs”

Effective Interventions :Key Messages		
<ul style="list-style-type: none"> • Effective interventions to reduce health inequalities tend to be multifactorial and multi-agency. • Health inequalities interventions are best integrated into the mainstream of service delivery, with a focus on disadvantaged areas and groups • Individual approaches can be effective, if targeted at more disadvantaged groups and include personal support. • user charges or financial disincentives reduce the effectiveness of health inequalities interventions 		

13 Conclusions.

The Assessment objectives were to establish the health status of these wards and the communities within them, to identify the primary health care needs of this population currently and in the future and to identify options to meet the identified needs.

It was found that although the area has fairly clear geographical boundaries, it does in fact contain many communities based around other factors, such as common ethnicity, religion or history.

The population in both wards is growing rapidly, with predictions of increased growth for many years to come.

There is evidence of higher mortality with lower life expectancy and poorer health status among many groups in the area, and high health care needs.

Local health services have not matched the increase in population.

There is little evidence of the targeting of mainstream local health care to address higher health needs.

There is therefore evidence of inequality both in health status and in health service provision.

The most pressing issues are the level of concern about services in Butetown and the current community service reorganisation

There is therefore evidence that Dr Julian Tudor Hart's statement in 1971 is still sadly true in Cardiff today:

“The availability of good medical care tends to vary inversely to the need for it in the population served.”

Tudor Hart, 1971

14 Recommendations

14.1 Utilise commissioning powers.

- 14.1.1 The Programme for Health Service Improvement for Cardiff and the Vale (PHISI) should provide the overarching strategy for meeting the health care needs of the population of Cardiff, as part of the wider Health, Social Care and Well Being Strategy.
- 14.1.2 The Local Health Board (LHB) should have a Primary Care and Community Services strategy, which is also explicitly included in the Programme for Health Service Improvement (PHISI)
- 14.1.3 The Primary Care and Community Services strategy should be based on a formula to redistribute mainstream local health care services according to population health needs.
- 14.1.4 Community services should be managed in a more integrated way with Primary Care services, operating within the Local Health Board Primary and Community Care Strategy.
- 14.1.5 There should be stronger and more explicit public and patient involvement in planning and evaluating local health services.
- 14.1.6 The LHB should encourage partner organisations to carry out Health Impact and Equality Impact Assessments of any programme or policy that may affect the well being of the most disadvantaged areas and groups in Cardiff.
- 14.1.7 The LHB and the Trust should strengthen services to overcome the language and cultural differences, with advocacy as well as interpreting roles.
- 14.1.8 The Local Health Board and Cardiff and Vale NHS Trust (the Trust) should consider appointing a Board level Champion for Inequalities, to ensure Equality and Diversity policies are implemented at the strategic level.

14.2 Enhancing Primary Care and Community Health Services

- 14.2.1 The LHB and the Trust should actively develop specific strategies for supporting recruitment and retention of staff for geographical areas and for groups of high need, beginning with Butetown.
- 14.2.2 The LHB and the Trust should explore using different and innovative models of providing primary and community care services.
- 14.2.3 The Trust and the LHB should urgently explore solutions to address the high health care needs of the population that Butetown Health Centre should be serving.
- 14.2.4 The Trust should urgently review its management of the services in Butetown Health Centre, including immediate consideration of the condition of the building.
- 14.2.5 The LHB should explore options for increasing primary care capacity for the rapidly growing population in both Butetown and Grangetown electoral wards

14.3 Improve Health Care Premises

- 14.3.1 The LHB should continue implementing its Primary Care Estates Strategy.
- 14.3.2 The Trust and the LHB should continue to work closely with Cardiff Council to replace the current Butetown Health Centre as soon as possible, and optimise the plans for the new Health Centre to meet the needs of the future population.
- 14.3.3 New health care premises for the growing population in Grangetown and Butetown should preferably be located within the older housing stock areas, in order to avoid widening inequity in access to health care.

14.4 Improve well being and prevention of ill health

14.4.1 Cardiff Council and the LHB should consider the health and well being of the most disadvantaged groups and areas in all policies especially economic, transport, housing and social care policies.

14.4.2 Cardiff Council and the LHB should increase and improve multi agency and multifactorial approaches to health improvement for the most disadvantaged groups and areas.

15 Options

Different models and approaches have been used in other areas which have tried to address inequities in Primary and Community Health Care services. They are not designed primarily to address the inequalities in health as a whole, but to provide the basis from which multi-agency and multi-disciplinary working can tackle inequalities in health. They are not mutually exclusive.

15.1 Enhancing Primary and Community services.

- Introducing Pharmacy enhanced services.
- Expanding dental provision through a Personal Dental Services practice.
- Supporting extended roles and skills mix within Primary and Community Care

15.2 Primary Care Support Team

- Directly managed by LHB or Trust
- Salaried GPs, nurses and support staff
- Placed in practices according to need and with service level agreements.

Example

Rhondda Cynon Taff LHB Primary Care Support Unit: They aim to address recruitment issues by allowing salaried GPs and nurses to experience working in RCT, support locality GPs to develop themselves and their practices, improve and increase the level of primary care services available to patients and promote and raise the profile of RCT Valley to attract high calibre GPs and nurses to the area. 122.2 WTE GPs and clinical director and manager, 8 hours nurse.

Bradford PCT: Salaried GPs are recruited and allocated to two practices to support delivering improved primary care. They have clinical audit sessions, time to pursue a special interest and attend peer review educational sessions. Currently 27 doctors supporting 15 practices

15.3 New Centre in Butetown

- Multi use
- Co-location with Social Care, Community Organisations, Voluntary sector , Leisure and Retail.
- Led by Community

Examples	
<p>A multi-agency health and community centre often initiated by local people, giving the community a sense of ownership. Can include many services such as a police office, a drugs and alcohol service, health facilities, a children's play area, education centre, benefits and work-related advice, leisure facilities, a garden, café and whatever else suits the community's needs.</p>	<p>Braunstone Health and Social Care, Leicester</p> <p>Bromley by Bow, London</p> <p>The St Matthews Health and Community Centre,</p>

15.4 New Primary Health Care Team for growing population

- Directly managed by LHB or Trust

Example
<p>The Heads of the Valleys Primary Care Project.</p> <p>This was started in 2003, by the former Gwent Health Authority, and now is in Caerphilly and Blaenau Gwent Local Health Boards. All clinical and non clinical staff are directly employed by the Local Health Boards. There is a strong link with Cardiff University Department of General Practice, with some of their clinical lecturers working in the practices and there is a commitment to teaching and professional development.</p> <p>The practices are specifically located in areas of high health care needs and primary care underprovision.</p>

- New Practice with General Practitioner holding contract

Example
New nGMS contract with provider being a General Practitioner, who recruits all required staff and acquires suitable premises with LHB support.

- Alternative Provider

Examples
<p>White Rose Medical Centre, New Tredegar</p> <p>The LHB has a contract with BKHealth who are a company led by 3 GPs and a practice manager based in Oxfordshire. The Company directly employs all clinical and non-clinical staff. This was a practice that had remained in LHB direct management for 18 months because of GP recruitment difficulties in an area of high health care needs.</p>
<p>Personal Medical Service contract</p> <p>About a third of practices in England have a PMS contract rather than a nGMS although there are none in Wales. It allows for each contract to be more flexible according to local needs and the Contract holder does not need to be a GP. There have been several led by nurses and others, particularly practices for specific groups such as Homeless people or refugees and asylum-seekers. The flexibilities have been useful for addressing primary care needs in inner-city urban areas with staff recruitment difficulties.</p>

- Expand an existing practice

Example
<p>Usually, expanding populations are absorbed by existing practices by increasing their staff and expanding their premises.</p> <p>There are local options to expand existing practices by their recruiting additional GPs and other staff and by establishing new premises or expanding exiting ones.</p> <p>The opportunity to expand existing premises is limited, apart from the future new Butetown Health Centre. One practice in Grangetown is already seeking larger purpose built premises.</p> <p>One practice in Butetown Health Centre is also seeking expanded premises in order to take on more patients.</p>

15.5 Community Participation in Butetown Health Centre Redevelopment

- There is an opportunity for a community involvement approach to developing the new primary care and community care services within the new Health Centre.

Example

Vauxhall Primary health Care, Liverpool

The Residents Association in a very deprived inner city part of Liverpool near the Docks successfully lobbied the Health Authority to set up a new practice in their underserved area. The local community set up a management board that recruited all the staff (including GPs) and managed the new practice. The GPs and practice manager were appointed in 1992, 1 year before the practice started registering patients, and worked with the community in assessing their health needs and designing an appropriate service, as well as developing an advocacy and health promotion role.

This resulted in many patients transferring to the new practice from existing practices with very high list sizes.

The practice has expanded and developed bringing in many additional services to the area. The original GPs remain and the practice retains a high level of community involvement and support.

15.6 Minor Injury /Walk In Centre

- Providing immediate care for minor illness and injury, often nurse-led supported by local GPs or GPs with a Special Interest (GPwSIs) Can also include other services, e.g. dentist, therapies.

15.7 Primary Care Resource Centre

- Model as developed within the Cardiff and Vale Programme for Health Service Improvement.
- Target location and services to areas of highest need
- Hub and spoke model

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Appendix 1

Reducing health inequalities: Search Strategy

Question:

What works to reduce health inequalities in the primary or community health care setting?

Databases	Websites
OVID Cochrane /Dare/ database	DoH website
CINAHL	WAG website
HMIC	Royal College of GPs
Psychinfo	Kings Fund
Google Scholar	

Keywords	Limits
Inequity/ inequities	In title
Inequality / inequalities	English
Variation	review
Health	Full text
Primary care/ family physician	From 1/1/1995
Reduction/ reduce/ reducing/ minimising	
Results	
57 – reviews, articles, policy documents	

Appendix 2

Acknowledgements

Rapid Participatory Appraisal Team:

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Dinah Channing	Surestart, Dental Health Service
Jasmin Chowdhury (also analysed)	'Barefoot' Health Workers Project, Cardiff Local Public Health Team
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Key Informants

	Organisation
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Sion Ward	Cardiff Council
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Gerard Williams	International Sports Village Development, Cardiff Council

Appendix 3



Cardiff Council CARDIFF BAY HEALTH SURVEY 2006

Dear Householder,

We are responsible for making sure that all Cardiff residents can get access to the right health services. We have asked the National Public Health Service to help us by undertaking a local survey looking at the health care needs of people in Butetown, Cardiff Bay, and Grangetown.

There has been a lot of new housing in this area so we want to check that the local health services continue to meet the needs of those living in the area. We are sending this survey to all the new houses and flats in the area; please help us by filling in this survey, even if this is not your main home, and then returning it to us in the pre-paid envelope provided.

Please answer for every person, including children, in your household. A household may comprise of:

- one person living alone.
- a group of people (not necessarily related) who live at the same address with a common sitting room, or share at least one meal a day.

If there are more than 5 people in your household we can send you another questionnaire. Please contact Claire Griffiths, Principal Research Officer at Cardiff Research Centre on 029 2087 3217 or email consultation@cardiff.gov.uk.

ALL RESPONSES TO THE SURVEY ARE ANONYMOUS AND WILL BE TREATED AS CONFIDENTIAL. The results will be used in the planning of health care services by:

- Cardiff and Vale NHS Trust
- Cardiff Council
- Cardiff Local Health Board

YOUR INFORMATION WILL NOT BE GIVEN TO ANYONE ELSE.

If you have any queries concerning the consultation please contact:
Dr. Kathrin Thomas at The National Public Health Service for Wales,
Temple of Peace and Health, Cardiff, CF10 3NW or telephone 029 2040 2512.



National Public Health Service for Wales
Gwasanaeth Iechyd Cyhoeddus Cenedlaethol Cymru



Cardiff Local Health Board



Cardiff Bay Health Survey

Q1 How many people live in your household? (Please tick one age group for each person)

	yourself	person 2	person 3	person 4	person 5
Women aged 19-64	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women aged 65 or older	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Man aged 19-64	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Man aged 65 or older	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child aged 0-5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Young person aged 6-18	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q2 How often are the people in your household at this address?

	yourself	person 2	person 3	person 4	person 5
All the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Week night only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weekends only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stay elsewhere for more than 13 weeks per year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q3 In general how would you describe the health of each person in your household?

	yourself	person 2	person 3	person 4	person 5
Excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Very Good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q4 Are the people in your household registered with a GP practice?

	yourself	person 2	person 3	person 4	person 5
Yes, in Butetown Health Centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes, in Grangetown (surgeries on Corporation St., Clare Road or Cambridge Street)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes, elsewhere in Cardiff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes, in Penarth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes, elsewhere in UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No, not registered with a GP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If everybody in your house is registered with a GP practice in Butetown or Grangetown, please go to Question 6 otherwise continue to Question 5.

Q5	For those members of your household who do not have a GP in Grangetown or Butetown, is there any reason why not?					
		<i>yourself</i>	<i>person 2</i>	<i>person 3</i>	<i>person 4</i>	<i>person 5</i>
	Not sure how to register	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Has been told that the lists are closed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Does not trust the quality of the service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Would not be happy with the range of services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Happy with current surgery elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Any other reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q6	Is everyone in your household registered with a dentist?					
		<i>yourself</i>	<i>person 2</i>	<i>person 3</i>	<i>person 4</i>	<i>person 5</i>
	Yes, in Grangetown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes, in Butetown Health Centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes, elsewhere in Cardiff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes, in Penarth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes, elsewhere in the UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No, not registered with a dentist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No, not tried to see a dentist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No, tried to register and failed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q7	Has anyone in your household used these services in the last 4 weeks?					
		<i>yourself</i>	<i>person 2</i>	<i>person 3</i>	<i>person 4</i>	<i>person 5</i>
	Dentist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Physiotherapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	GP (working day)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Practice nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Anyone else in the GP practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	GP out of hours service (weekend and evening)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Complementary therapist (e.g. chiropractor, homeopath, acupuncturist etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	District nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Health visitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pharmacist/chemist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q8 Which of the following best describes the ethnic identity of your household?

	yourself	person 2	person 3	person 4	person 5
White	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Black	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mixed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chinese or other Far Eastern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I prefer not to answer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other - Please specify	<input type="text"/>				

Q9 Does anyone in your household need to use an interpreter when they talk with a doctor or nurse?

	yourself	person 2	person 3	person 4	person 5
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes please specify the language used	<input type="text"/>				

Q10 What best describes what the people in your household were doing last week?

	yourself	person 2	person 3	person 4	person 5
Working full time (30+ hours per week)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working part time (less than 30 hours a week)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On a government training scheme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In full time education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unemployed - registered job seeker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unemployed - unregistered but seeking work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Permanently sick or disabled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wholly retired from work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking after home or family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring for an adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pre-school aged child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q11 Do you have any additional comments?

Thank you for taking the time to complete this questionnaire. Please now return it in the enclosed pre-paid envelope provided. Please be assured that your answers are anonymous and we can not identify you from the survey. All information will be treated as confidential and will only be used for the expressed purpose.

