GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Meeting Date	**26th July 2018**	**Agenda Item**
Report Title	**Outcome of Engagement on Proposed Changes to NHS Services – "Your NHS – Help us Change for the Better"**	
Report Author	Joanne Abbott-Davies, Asst Director of Strategy & Partnerships; Nicola Johnson, Head of IMTP Development	
Report Sponsor	Siân Harrop-Griffiths, Director of Strategy	
Presented by	Siân Harrop-Griffiths, Director of Strategy	
Freedom of Information	Open	
Purpose of the Report	The Health Board has been working on a range of service change plans to transform our models of care over the next year – 18 months. These service change plans were then used as the basis of public engagement which took place from 3rd May to 27th June 2018. This paper outlines the responses received to the engagement and how it is suggested that the proposals should be taken forward.	
Key Issues	Transforming our services is a key component of the Recovery and Sustainability programme of ABMU Health Board. This paper outlines the service changes; engagement carried out (in conjunction with the ABM Community Health Council); the responses received in relation to the engagement and the proposed way forward.	

Specific Action Required *(please ✓ one only)*	**Information**	**Discussion**	**Assurance**	**Approval**
				√

Recommendations

Members are asked to:

- **NOTE** the service change proposals outlined in the engagement
- **NOTE** the engagement process carried out
- **NOTE** the responses received to the engagement
- **CONSIDER** the proposed way forward in relation to service changes outlined in the document

- **NOTE** the Community Health Council's views on the outcome of the engagement
- **NOTE** the financial implications
- **AGREE** to the service changes proposed as a result of taking account of the responses received to the engagement process

OUTCOME OF ENGAGEMENT ON PROPOSED CHANGES TO NHS SERVICES – "YOUR NHS – HELP US CHANGE FOR THE BETTER"

1. INTRODUCTION

The Health Board needs to transform services and models of care in order to become sustainable. These changes need to be engaged upon and this paper outlines the proposed service changes; engagement carried out (in conjunction with the ABM Community Health Council), the responses received in relation to the engagement and the proposed way forward.

2. BACKGROUND

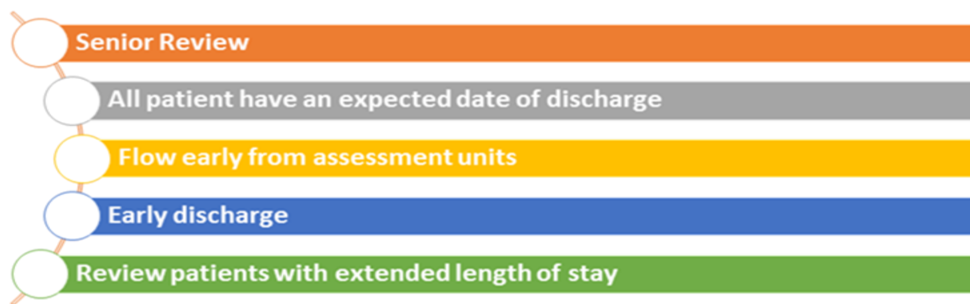
As reported to the Board in May 2018, a package of service changes have been developed as part of the Service Remodelling workstream, focusing on two main areas:

- Increasing patients' independence through reducing the amount of time that needs to be spent in hospital, and reducing the numbers of patients that need to be admitted to hospital, so allowing us to reduce beds
- Developing more community based services to support older people with mental health problems, again allowing us to reduce beds

The changes in our general hospitals revolve around the introduction of a number of new services and approaches which have had a significant impact on lengths of stay, particularly the following:

- Pilot of a new model for acute frail older people's care at Singleton to deliver high-quality integrated person centred care through the iCOP (Integrated Care of Older People) team. This pilot increased the number of patients aged 75 and over discharged home from Singleton Assessment Unit by 10% and reduced length of stay for those admitted by an average of 9.55 days compared to a similar cohort of patients (from 25.25 days to 15.7 days).
- In 2018-19 the iCOP team will be established on a permanent basis with investment of £340,000 per annum. The team will provide services to additional patient groups at Singleton.
- At Neath Port Talbot Hospital (NPTH) a Transfer of Care and Liaison Service (TOCALS) has been established to identify patients at other ABMU acute hospitals and support their care. The evaluation of TOCALS shows that 26 patients have been discharged from Morriston and Singleton Hospitals after assessment because of the Team rather than having to be admitted, saving approximately 200+ bed days. The Team have also supported 375 patients to go home directly from Morriston, Singleton and Princess of Wales Hospitals who would otherwise have been sent to NPTH before being discharged home. The average length of stay in the care of the elderly wards at NPTH has reduced from 40 days to around 29 days.

- With Neath Port Talbot County Borough Council and the housing association Pobl, a pilot has been established with a housing officer being based at NPTH and actively identifying people suitable for placement in the 12 assessment beds at Plas Bryn Rhosyn for short-term assessment and recovery prior to moving onto their long-term placement. In 2018-19 the Health Board plans to make this pilot permanent to further improve this flow of patients.
- At Neath Port Talbot and Singleton Hospitals our stroke and ortho-geriatric rehabilitation services are being targeted to ensure the patients referred are those most likely to benefit from these specialist inputs and to provide more intensive therapy per patient. This has been found to reduce how long these patients have to stay in hospital.
- At all our hospitals the use of the SAFER flow bundle is being embedded, where there is evidence this can reduce length of stay:



- Ensuring our existing expanded community services (some from Integrated Care Funding), developed in partnership with our Local Authorities are used to maximum effect and monitoring performance against the discharge standards agreed by Western Bay in 2017-18.

The changes in our Older People's Mental Health Services revolve around the investment of £1.5 million into community services and the external review of our services which urged us to develop a better balance of inpatient vs community services. The report highlighted that we have the highest number of admissions to older people's mental health beds for our population in the whole of the UK and one of the highest proportion of beds. Our bed usage has been declining because of changes in clinical practice and this additional investment has enabled us to introduce a number of new services and approaches, by physiotherapists, psychologies, occupational therapists and in-reach to care homes which have further reduced our reliance on beds in order to provide support for older people with mental health problems.

In preparation for this public engagement Delivery Units prepared service change proformas in line with the Joint Health Board and ABM Community Health Council framework for engagement and consultation. These service change proformas for each of the schemes involved, were discussed in detail with the CHC prior to the engagement starting and used as the basis of the engagement documentation. A timeline for the engagement on service changes, based on the Welsh Government

guidance on engagement and consultation and our Framework for engagement and consultation was prepared and is attached as **Appendix A**.

An engagement plan was developed which involved attendance at key stakeholder meetings, including those with members who had protected characteristics under the Equality Act 2010. This plan is attached as **Appendix B**. In addition information was distributed to a wide range of organisations, as outlined in **Appendix C**.

A Stage 1 Equality Impact Assessment was produced for the engagement, outlining the main areas where people with protected characteristics would be impacted by the proposed changes. This document has now been updated to include those issues which were raised during the engagement in this regard, and the Stage 2 Equality Impact Assessment is attached as **Appendix D**.

The engagement included a range of service changes focused on two main areas:

- Patients spending less time in hospital, through a combination of improved efficiencies in the way in which we care for people and new service models, so allowing us to reduce beds
- Developing more community based services to support older people with mental health problems, again allowing us to reduce beds

The specific proposals within the engagement document outlined new ways of providing care for people aimed at preventing problems before they occur, intervening sooner when things do go wrong, ensuring people don't have to be admitted to hospital unless there is no other way of providing care appropriate for their needs and reducing how long patients stay in hospital.

We have been developing new services and ways of ensuring that we use our hospital beds, in particular, as fully and appropriately as possible. This means we have put in new services to allow us to assess patients without admitting them to hospital, so allowing them to go home more quickly, and ensuring that where patients are receiving treatment in Morriston Hospital from other areas, they can go home direct from there rather than transfer to another hospital first, as we know that each time a patient transfers from one hospital to another they spend longer in hospital.

Ultimately, improving the way we care for patients, especially frail elderly people, will also cut ambulance queues during peak periods outside our Emergency Departments (A&E). That's because when this happens there are patients already in the Emergency Departments (A&E) – often elderly - waiting to be admitted to a ward, and until they are admitted, the ambulances can't offload the next patients.

By managing the care of frail elderly people better in the first place, and by reducing overall lengths of stay, beds become available more quickly. In addition, fewer patients come to hospital as emergency cases in the first place because their community-based care has improved.

Based on these service improvements and efficiencies the following changes in services were proposed in the engagement document:

Patients spending less time in hospital, so allowing us to reduce beds
In 2017 the Health Board temporarily closed 79 beds at its main hospitals through improvements in efficiencies at the sites, largely focused on reducing the length of stay for older frail patients, and initiatives to assess patients without admitting them and more focused rehabilitation. The spread of these beds is outlined overleaf:

Delivery Unit	Site	Specialty & Wards	No of beds
Singleton	Singleton	Care of the Elderly / Oncology (wards 10 & 12)	34
	Singleton	Gynaecology / surgical specialties (wards 2 +20)	14
NPTH	NPTH	Care of the Elderly (wards C, D, E)	20
POWH	POWH	Care of the Elderly (ward 20)	3

Although some of these beds were reopened as “surge” capacity during the winter months, they have all been closed again now. The engagement proposed closing these beds permanently (with the exception of the **14 beds** on Ward 20 at Singleton, which it was proposed would **continue to be temporarily closed** while building work is carried out on a new Transitional Care Unit for new-borns) – amounting to a **proposed permanent closure of 65 beds** across the relevant hospitals.

In addition the engagement document proposed **closing an additional 26 beds at Singleton Hospital and 20 beds at Neath Port Talbot Hospital permanently**, although with the ability to use these as “surge” capacity if required during times of winter pressures.

8 beds at Gorseinon Hospital have also been temporarily closed and the engagement document proposed permanently closing these.

Developing more community based services to support older people with mental health problems, again allowing us to reduce beds
A total of **£1.5m additional funding** has been invested into additional community services to support older people with mental health problems, through investment in physiotherapy, occupational therapy and psychology services as well as teams to support care homes in each Local Authority area.

The engagement document proposed **reducing the number of Older People’s Mental Health beds by 52**, as follows: 20 beds at Tonna Hospital for Neath Port Talbot residents; 14 beds at Princess of Wales Hospital for Bridgend residents; and 18 beds at Tonna Hospital for Swansea residents.

3. RESPONSES TO PUBLIC ENGAGEMENT

The engagement ran from 3rd May to 27th June 2018 and a total of 84 responses were received. 12 of these were declared as from NHS staff, 18 from the public but the remaining respondents did not specify / preferred not to say. Of these responses 10 were from organisations and 2 replying on behalf of both an organisation and

themselves. The details of all these responses have been shared in full with the ABM Community Health Council.

Of the 79 responses, 50 respondents answered the questions in the response form (although not necessarily all questions) but the comments / issues raised in all responses have been taken into account in the consideration of the feedback received and the actions to be taken by the Health Board as a result.

In addition, there was discussion on the Health Board's Intranet page with a total of 89 comments, which reflect those received via the response forms.

Social media was used to spread details of the engagement and the proposals being engaged upon. Facebook had a reach of over 17,000 people with 83 reactions including: 75 "likes", 4 "angry faces", 2 "wows" and 1 "laughter". There were 125 shares and 34 comments. Again the comments have been incorporated into the analysis of themes from the engagement responses.

In the response form for the engagement 3 questions were asked. These are detailed below with the views expressed through the engagement:

Q1. Why our NHS needs to change – To what extent do you agree that we need to make changes to respond to these challenges? – 50 responses

Strongly Disagree or Tend to Disagree = 13 responses (26%)
Strongly Agree or Tend to Agree = 34 responses (68%)

Q2. To what extent do you disagree or agree with the proposals around patients spending less time in hospital, so allowing us to reduce beds? – 47 responses

Strongly Disagree or Tend to Disagree = 24 responses (51%)
Strongly Agree or Tend to Agree = 21 responses (44%)

Q3. To what extent do you disagree or agree with the proposals to develop more community based services to support older people with mental health problems, so allowing us to reduce beds? – 48 responses

Strongly Disagree or Tend to Disagree = 20 response (42%)
Strongly Agree or Tend to Agree = 23 responses (48%)

Key Issues raised by respondents to the engagement:

- Funding
- Already a shortage of beds how is reducing further going to help
- Questionnaire leading and is being used to justify bed closures
- What additional community services are expected to meet the additional demand
- Lack of beds in community hospitals and nursing homes
- Bring back community/rehabilitation hospitals
- Communication poor between health and social services

- Social Services input required earlier
- Unrealistic expectations of proposals working
- Capita – using an external company to undertake bed review inappropriate
- Work should be put into resolving other problems such as waiting times
- This proposal could lead to an increase of readmissions via SAU
- Proposal of reducing time spent in hospital should not be used to close beds
- Issues with General Practice need to be resolved before services are moved into the community
- More physiotherapy, occupational therapy and mental health therapy required for inpatients

Conclusions from Responses to Engagement
As can be seen from the analysis above, 68% of people strongly agreed or tended to agree with the need for the Health Board to make changes in services in order to cope better with the challenges we face due to demographic and related changes, as outlined in the document. 26% of people strongly disagreeing or tending to disagree. Therefore it would seem that the case for change is understood and most people understand the need for changes to services.

However it is clear from the responses that when it comes to what these changes should be there is not the same level of agreement across respondents.

Proposals around patients spending less time in hospital, so allowing us to reduce beds
On these proposals 52% of people strongly disagreed or tended to disagree with these changes, and 44% of people strongly agreed or tended to agree with them. The proposed service changes and resultant reduction in beds within the engagement document were clearly predicated on improving patient flow within hospitals, so reducing how long patients stay in hospital and changing models of care to reduce the number of people admitted unnecessarily for assessment, and not the establishment of additional community services to support them. However, the detailed comments received showed general concern about the need to develop more and better community services in order to support these changes, and to do so before the changes were implemented. The importance of working more closely with Social Services Departments of Local Authorities in particular and Primary Care in planning and implementing these service changes was stressed consistently. Concern was also raised that the efficiencies were resulting in closure of beds rather than using these beds to reduce waiting lists.

Proposals to develop more community based services to support older people with mental health problems, so allowing us to reduce beds
On these proposals 42% of people strongly disagreed or tended to disagree with these changes, and 48% of people strongly agreed or tended to agree with them. In this case the service changes and reductions in beds were predicated on investing an additional £1.5m into community services. Detailed comments showed that people were pleased about the investment in community services, but felt it was not enough, and in particular more support should be targeted at Carers. Concern was also raised about reducing beds and whether these should be retained as well as community services invested in. The need to work closely with Social Services

Departments of Local Authorities and Primary care in planning and implementing these service changes was also raised.

Responses from Local Authorities and Welsh Ambulance Services NHS Trust
Responses to the engagement were received collectively from Bridgend County Borough Council, Neath Port Talbot County Borough Council and Swansea Council raising some questions regarding the proposed service changes. Their response is included as **Appendix E**. The Health Board took the opportunity to respond extensively to their queries, and this letter is included as **Appendix F.**

A response was also received from the Welsh Ambulance Services Trust which is included as **Appendix G.** Again the Health Board took the opportunity to respond extensively to their queries, and this letter is included as **Appendix H.**

In view of the comments made, and the further work undertaken within the Health Board to analyse the impact and readiness for change, it is felt that some changes to the proposals contained in the engagement document should be made and some additional actions taken by way of mitigating their impacts and the concerns raised.

Therefore it is proposed that the Health Board should:

- Note the overall support for the need to do things differently and ensure that this work continues to develop other service changes which will help the Health Board and its partners to cope better with the increasing demands it faces.

- As a result of the concerns raised about reducing beds in the acute hospitals, the Health Board should implement its plans to close the 65 temporarily closed beds on a permanent basis, but revise its plans to close the further 26 beds at Singleton and 20 beds at Neath Port Talbot Hospitals at this point in time. Instead it is proposed that 16 beds should be closed at Singleton on a phased basis during August and September 2018. At Neath Port Talbot Hospital it is proposed that 7 beds should close in August 2018. This would result in a reduced number of beds being closed from the 46 proposed in the engagement document to 23 at this point in time, however there would be a further phasing of the changes which have been engaged upon, once there is assurance on the new service models and or service efficiencies in place to support these changes.

- Although concerns were raised about the reduction in Older People's Mental Health beds, there was more support for these, and the investment in community services has been made to ensure that patients have access to alternative services to support them. Therefore it is proposed that the 52 beds proposed for closure should be implemented in full.

- As part of this revised implementation plan for both reductions in general hospital and Older People's Mental Health beds it is proposed that a joint group be established between the Health Board's Delivery Units, the ABM Community Health Council, Local Authorities and Welsh Ambulance Services

NHS Trust (WAST) to monitor the impact of these changes and ensure that no negative consequences to patient care result.

- Further discussions have been held with local authorities on jointly planning service changes going forward, and these will continue to ensure that any further service changes (to either health or social care services) are developed and implemented jointly with a clear understanding of the potential implications for different organisations.

4. GOVERNANCE AND RISK ISSUES

Engagement on service change is carried out in partnership with the ABM Community Health Council and the relevant information was circulated widely as outlined in the appendices. As outlined above a draft Equality Impact Assessment was prepared and subsequently amended with the views expressed in the engagement.

Engagement on service change inevitably evokes strong feelings from respondents and these can be seen in the responses received. It is important the Health Board takes due regard of the issues raised and those arising from the Equality Impact Assessment in making any decisions about how the service changes proposed in the engagement document should be implemented.

In view of the comments made it is proposed that the Health Board should take the actions outlined on the following pages by way of mitigating the impacts of the service changes put forward in the engagement document:

Issue / concern	Mitigation
Staffing	
• Staff levels not sufficient to provide specialist services (e.g. physiotherapy, occupational therapy or mental health therapy). • Delayed access to specialist services is increasing patient length of stay. • Understaffing contributing to rise in in-hospital infections. • Mix of staffing (e.g. management, support staff etc) is inappropriate and does not offer value for money.	As part of the Health Board's improvements the mix of staff involved in services is continually under review. Safe staffing levels are now being implemented across the Health Board on relevant wards and publicised accordingly. Additional funding has been devoted to increasing staffing levels in psychology, physiotherapy and OT services for Older People with Mental Health problems. The efficiency work of the Health Board is aiming to improve patient flow throughout our hospitals, including reducing waiting times for specialist services. Our Infection Control Committee monitors areas where in-hospital infections occur and identifying reasons for this. Environmental improvements made at Gorseinon Hospital and Princess of Wales Hospital, with further improvements planned on rolling basis at Morriston and Princess of Wales Hospitals.
Bed numbers insufficient	
• Ambulances queuing at hospital to handover patients • Ageing population will increase demand on hospital services • Closing beds will reduce ability of Health Board to react quickly to periods of high demand	It is proposed that a new Joint Monitoring and Evaluation Group is established with representation from the CHC, LAs, WAST and voluntary sector to monitor impacts of the proposed bed changes and to ensure that there aren't negative impacts of these going forward. This group will ensure that as beds are closed in

- Closing beds will have knock-on effects for other hospitals and services that may increase length of stay and ability to meet patient demand in those hospitals.

a phased way there isn't a deterioration in performance on key issues such as ambulances queueing at hospitals to handover patients.

Changing the model of care for patients is key to coping with the increase in demands for hospital services. Providing opportunities to intervene earlier when a patient's condition is deteriorating and enabling patients to be assessed without hospital admission are key ways to make this happen.

Keeping beds available that have been closed as "surge" beds means that the Health Board can respond quickly to periods of high demand.

Discharge patients too early

- Patients not provided enough time to recover fully, increases risk of readmission
- Increased risk that patients may be readmitted shortly afterwards due to complications linked to their condition, or an inability to effectively care for themselves.
- Compromised patient safety, particularly for isolated and vulnerable patients. Social isolation presents a risk to patients' mental wellbeing which may be exacerbated by their current medical condition.
- Patients discharged too early without accurate diagnosis and adequate pain management - frequently readmitted to hospital to address pain issues.

The Health Board has a duty of care to our patients and we will not be discharging patients prior to their care needs being met. The proposed changes are based on discharging patients home at the same point they would have been previously but having spent a shorter length of time in hospital. In some cases, this will mean their care needs may be lower than before, as they have lost less condition and independence while in hospital than would previously have been the case.

It is proposed that a new Joint Monitoring and Evaluation Group is established with representation from the CHC, LAs, WAST and voluntary sector to monitor impacts of the proposed bed changes and to ensure that there aren't negative impacts of these going forward. This group will ensure that as beds are closed in a phased way there isn't an increase in readmissions across any of our hospitals.

	The Health Board works closely with Local Authorities and the voluntary sector through the Western Bay Programme to develop community services jointly so that they are integrated and coordinated.
Shifting the burden of care	
• Shift to community-based care effectively shifts the burden of care from the hospital to carers, care homes and the local authority which in many cases may not be able to meet that care need due to a lack of resources. • For older people, the care provider in their own home will be their partner, another older person with their own care needs. Or they may be alone in their home, dependant on family / carer visits if available at all. • Costs of providing care may present a significant financial burden for low income households. • Local authorities are under financial strain and are struggling to meet the existing social care needs of their local populations.	The Health Board has a duty of care to our patients and we will not be discharging patients prior to their care needs being met. The proposed closure of our main hospital beds is based on improved efficiency in our hospitals and moving patients more quickly through their care experience, rather than discharging them at an earlier stage in their care which could shift the burden of care to carers or local authorities so the financial burden should not increase. It is proposed that a new Joint Monitoring and Evaluation Group is established with representation from the CHC, LAs, WAST and voluntary sector will monitor impacts of the proposed bed changes and to ensure that there isn't an increased burden of care on patients, their carers or Local Authorities, including costs. Because of patients spending a shorter time in hospital they become less dependent and have not lost as much condition so that their care needs may be reduced on discharge. The Health Board works closely with its partners, including Local Authorities to ensure that there are not knock on effects of changes in health services on their services. Investment in community services for Older People with Mental Health issues has increased the level of support available for families and care homes.

	Our proposals are based on the assumption that we will improve length of stay and flow through our existing sites through changing our service models. Although we are reducing our inpatient capacity we are not closing any sites and our admitting sites will be the same, therefore will continue to assess whether journey times to patient's homes or existing community settings will be longer than they are at present. The Health Board recognises that travel costs may increase due to patients and families having to travel further for services and ensures that reimbursement of travelling expenses are available in line with the All Wales policy on this. In addition where services do require patients to travel further, alternative travel arrangements can be made by staff where patients need to get home and do not have access to transport, such as via ambulance cars or even taxis in out of hours cases.
Integrated community-based services	
• Current community-based service provision is too fragmented to work effectively. • Community-based services are not able to meet current demand and would struggle to meet any increase in demand. (e.g. delays in getting GP appointments). • Service proposals will require a change of practice that community-based services may be unwilling, or unable to make (e.g. access to 24 hour pharmacy services). • Decision on closing beds should be delayed until community-based services are capable of	The proposed service changes are based on improved efficiency in our hospitals and moving patients more quickly through their care experience, rather than discharging them at an earlier stage in their care which could shift the burden of care to carers or local authorities. The Health Board works closely with its partners, including Local Authorities and the voluntary sector through the Western Bay Programme to develop community services jointly so that they are integrated and coordinated, to ensure that there are not knock on effects of changes in health services on their services.

meeting the new service demand, and have necessary processes in place.	It is proposed that a new Joint Monitoring and Evaluation Group is established with representation from the CHC, LAs, WAST and voluntary sector to monitor impacts of the proposed service changes and to ensure that there aren't negative impacts of these going forward. Investment in community services for Older People with Mental Health issues has increased the level of support available for families and care homes.
Access to community-based services • Shift to more community-based care provision will require patients to travel more frequently to access some health services. This will increase the logistical and financial challenges experienced by patients. For those patients without access to a car or family support, this is likely to be a significant challenge.	Our proposals are based on the assumption that we will improve length of stay and flow through our existing sites through changing our service models. Although we are reducing our inpatient capacity we are not closing any sites and our admitting sites will be the same, therefore we will continue to assess whether journey times to patient's homes or existing community settings will be longer than they are at present. The Health Board recognises this impact and ensures that reimbursement of travelling expenses are available in line with the All Wales policy on this. In addition where services do require patients to travel further, alternative travel arrangements can be made by staff where patients need to get home and do not have access to transport, such as via ambulance cars or even taxis in out of hours cases.

Staff engagement for those directly affected by these proposed changes is being carried out currently and this is planned to close on 6th August, and any amendments made based on the advice of the Community Health Council and the decision made by the Board.

5. FINANCIAL IMPLICATIONS

Implementing the reduced level of service change proposed above will have an adverse impact on the Board's Financial Plan which is being delivered via the Recovery and Sustainability Programme.

The financial plan for 2018/19 identifies savings delivery of £4.822m against the service remodelling workstream with a full year effect going into 2019/20 of £6.429m. Delivery Units have forecast partial delivery of the schemes and this is included in the Board's forecast position of a £25m deficit, after taking into account the deployment of further mitigating opportunities.

However, the proposed phasing of service changes will result in further cost pressures to the Board estimated at £314k for Neath Port Talbot and £399k for Singleton. The Neath Port Talbot Delivery Unit have identified further mitigating opportunities to offset this and this is included within their forecast year-end position, however the Singleton Delivery Unit have yet to identify mitigating actions and this has been included as a risk within their financial risk and opportunities log.

Schemes (or alternatives) need to be developed and delivered by the Units, or recurrent financial mitigation identified, to support improvement of the underlying position in 2018/9 and recurrently into 2019/20. This is being progressed through the Recovery and Sustainability Programme and the Financial Recovery meetings with the Delivery Units.

In considering any alternative service change schemes quality and safety considerations are paramount and the responses to this engagement will need to be taken into account, as well as proposals being developed jointly with partner organisations, where appropriate.

6. RECOMMENDATION

Members are asked to:

- **NOTE** the service change proposals outlined in the engagement
- **NOTE** the engagement process carried out
- **NOTE** the responses received to the engagement
- **NOTE** the Community Health Council's views on the outcome of the engagement
- **CONSIDER** the proposed way forward in relation to service changes outlined in the document
- **AGREE** to the revised service changes proposed as a result of taking account of the responses received to the engagement process

- **NOTE** that there will be an impact of agreeing the revised service changes proposed on the Recovery and Sustainability programme and related savings plans.

Governance and Assurance					
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships
	√	√	√	√	√

Link to Health and Care Standards ***(please ✓)***	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
		√	√				√

Quality, Safety and Patient Experience

Implementing these proposals will reduce lengths of stay for our patients in hospital, particularly those who are older and frail, so improving their outcomes by reducing dependency levels and maintaining their level of functioning better. For Older People with Mental Health problems it will increase their likelihood of being supported at home for longer with better support to manage their condition there.

Financial Implications

Implementing the reduced level of service change identified above will have an impact on the Recovery and Sustainability plan and related financial savings related to the Service Remodelling workstream. The implications of this will need to be further worked through and alternative areas of savings identified.

Legal Implications (including equality and diversity assessment)

The engagement process has been carried out in line with the Welsh Government's guidance on engagement and consultation on service change and in accordance with the joint framework for engagement and consultation agreed between ABMU Health Board and ABM Community Health Council. There is always a risk of challenge to the outcome of any engagement through challenge to the process via

judicial review and the mitigations outlined above are aimed to demonstrate that the Board has considered the issues raised by respondents to the engagement and via the equality impact assessment to reduce this risk.

Staffing Implications

Staff consultation for those directly affected by these proposed changes is being carried out currently and this is planned to close on 6th August, but will need to be amended to reflect the changes proposed in the schemes to be implemented, as outlined above, subject to the Board and CHC decisions.

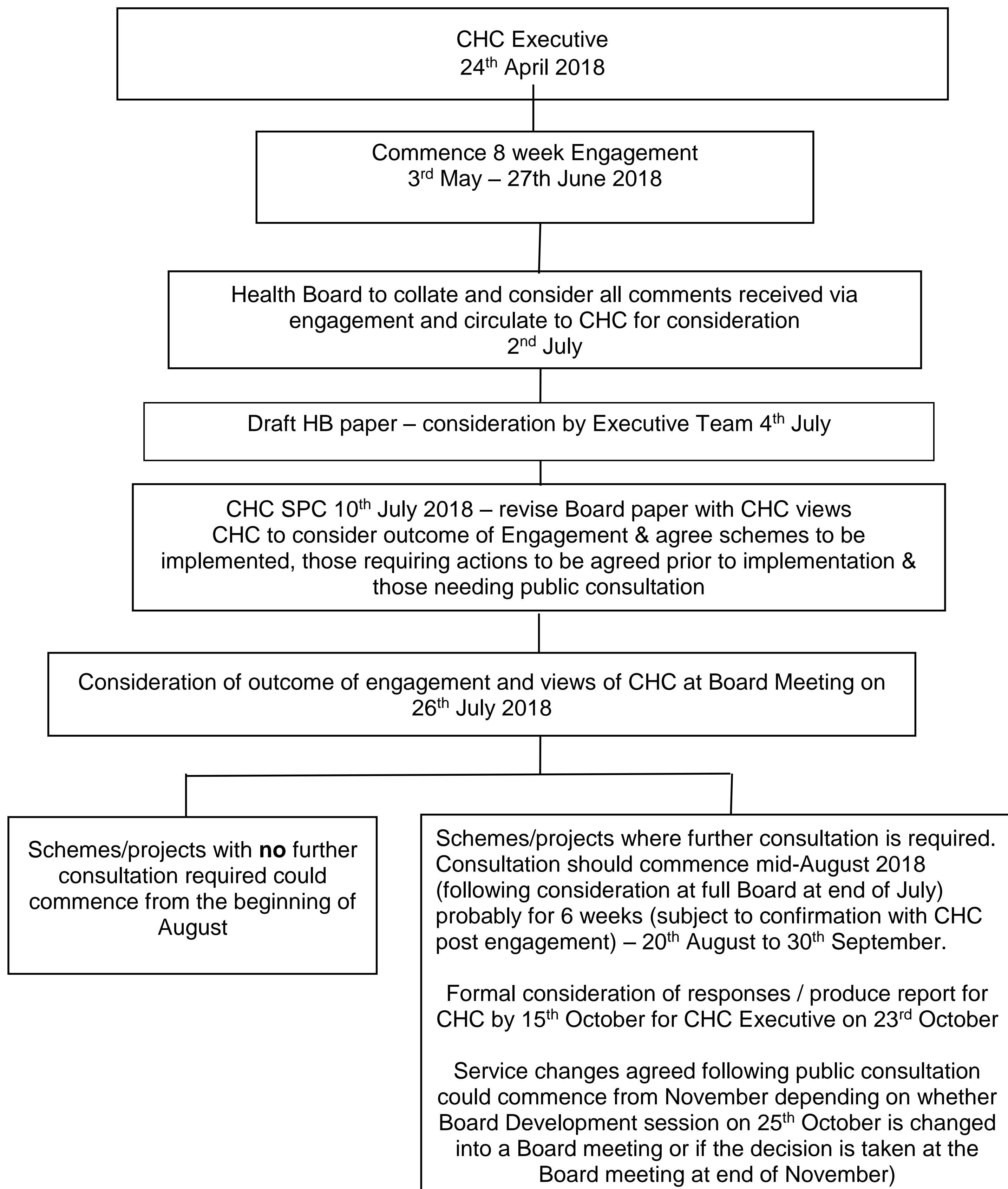
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

The five ways of working will be central to the implementation of these changes and to the development of any further plans for change going forward.

Report History	At the May meeting of the Health Board a report was presented “Public Engagement – Your NHS – Help us change for the Better” which outlined the engagement timeline and engagement plan, included the engagement documents and proposed that the outcome of the engagement would be presented to the Board at its meeting on 26th July 2018.
Appendices	Appendix A – Engagement timeline Appendix B – Service change engagement calendar of meetings Appendix C – Engagement distribution plan Appendix D – Equality Impact Assessment

Appendix A

Service Remodelling Workstream
Revised Timeline Engagement and Consultation Tranche 1 Schemes (8 weeks)



Appendix B

CALENDAR OF MEETINGS - SERVICE CHANGE ENGAGEMENT	
DATE	**MEETING**
May	
2nd	Stakeholder Reference Group
3rd	Royal National Institute for the Blind (RNIB) Have your Say Event
5th	Swansea Spring Pride
8th	Local Medical Committee (LMC)Meeting
9th	RNIB Have your Say Event
17th	Dementia Action Week Open Morning Event
17th	MH and LD Team Brief
17th	ABMYouth (cancelled)
18th	Singleton Team Brief
20th	Annual Step Out for Stroke
23rd	RNIB Have your Say Event
23rd	Health and Wellbeing Day
24th	Health Board Partnership Forum
29th	Bridgend Deaf Club
June	
1st	Morriston Hospital Out Patients Department (OPD)
6th	Neath Port Talbot Hospital Team Brief
7th	Swansea Deaf Club
11th	Joint Carers Event
11th	South West Wales Black And Minority Ethnic (BAME) Regional Meeting
13th	Princess Of Wales Team Brief
14th	Swansea Carers Centre Open Day
18th	Singleton Hospital OPD
20th	Quadrant Shopping Centre
21st	Primary and Community Services Team Brief
21st	Mental Health and Learning Disability Team Brief
25th	Singleton Team Brief

Appendix C

Distribution of Information on Service Change

Recipient	Method	Enclosures
Public on database	Email / post depending on preference	Letter 1 Engagement document Summary document Response form
ABM CHC	Executive Committee – packs distributed 22.5.18	Engagement document Summary document Additional information Engagement Plan
Third Sector organisations	Via Building Strong Bridges (BSB) Coordinators to 3rd sector network	Letter 2 Engagement document Summary document Response form Sign up sheet for database
Stakeholder Reference Group	Briefings held on 17th April as part of preparation of engagement document	Letter 3 Engagement document Summary document Response form Sign up sheet for database
Equality Groups	Bridgend Equality Forum	Letter 2 Engagement document Summary document Response form Sign up sheet for database

Recipient	Method	Enclosures
Black Minority Ethnic Communities	Send to Race Equality Group & Chinese community	Letter 2 Engagement document Summary document Response form Sign up sheet for database
Disability / Access groups	Disability Reference Group – briefings held on 17th April as part of preparation of engagement document	Letter 3 Engagement document Summary document Response form Sign up sheet for database
Local Authorities	Letter to be sent to Chief Executives, Leaders & Directors of Social Services	Letter 4 Engagement Document Summary document Additional Information Response form
Community & Town Councils	Letter to be sent to One Voice Wales	Letter 4 Engagement Document Summary document Response from
Other organisations: South Wales Police Mid & West Wales Fire & Rescue Natural Resources Wales Universities Colleges	Letter to be sent to Chief Execs	Letter 4 Engagement Document Summary document Response form

Recipient	Method	Enclosures
Housing Associations		
DVLA		
Probation		
Police & Crime Commissioners		
Public Sector Partnerships	On agenda for Western Bay Programme Team	Presentation to be given Engagement document included in papers & response form
Carer Groups	Letters to Carers Services asking to distribute / make people aware in their Carers Groups	Letter 2 Engagement document Summary document Response form Sign up sheet for database
Children & Young People	ABM Youth	Letter 5 Engagement document Summary document Response form Sign up sheet for database
Older people	Older people's forums	Letter 5 Presentation to groups Engagement document Summary document Response form Sign up sheet for database
Faith Groups	ABMU Chaplaincy	Letter 5

Recipient	Method	Enclosures
		Engagement document Summary document Response form Sign up sheet for database
Pregnancy & Maternity	Maternity Services Liaison Group	Send information to secretariat for distribution to members of the group Letter 5 Engagement document Summary document Response form Sign up sheet for database
Sexual Orientation	Swansea LGBT Forum	Send information to secretariat for distribution to members of the group Letter 5 Engagement document Summary document Response form Sign up sheet for database
Partnership Forum	Presentation on 24th May 2018	Packs of engagement documents, summary document, additional information distributed
Medical staff committees		Letter 5 Engagement document Summary document Response form

Recipient	Method	Enclosures
LMC	Ask to distribute to all members Presentation to exec on 12th June 2018	Engagement document Summary document Response form
Local Medical Advisory Group	Ask to distribute to all members	Letter 5 Engagement document Summary document Response form
Infection Control Boards	Ask to distribute to all members	Letter 5 Engagement document Summary document Response form
Local Dental Committee	Ask to distribute to all members	Letter 5 Engagement document Summary document Response form
Local Ophthalmic Committee	Ask to distribute to all members	Letter 5 Engagement document Summary document Response form
Local Pharmaceutical Committee	Ask to distribute to all members	Letter 5 Engagement document Summary document Response form
GP Cluster Leads	Ask to distribute to all members	Letter 5 Engagement document

Recipient	Method	Enclosures
		Summary document Response form
Practice Managers' Group	Ask to distribute to all members	Letter 5
Volunteer Services	Ask to distribute to all volunteers	Letter 5
Assembly Members	Face to face briefings arranged Presentation given 18th May 2018	Packs of engagement documents, summary document, additional information distributed
MPs	All MPs	Letter 6 Engagement document Summary document Additional information Response form
Other Health Boards	Powys & Hywel Dda	Letter 4 Engagement document Summary document Additional information Response form
Other CHCs	Powys & Hywel Dda	Letter 4 Engagement document Summary document Additional information Response form
Outpatient Departments / A&E	Send copies to Service Directors for	Engagement document Summary document

Recipient	Method	Enclosures
	distribution in waiting areas	Response form Leaflets showing how to get more information

Appendix D

Abertawe Bro Morgannwg University Health Board

Your NHS – help us change for the better

Service Improvement Proposals Tranche 1: Equality Impact Assessment, Stage 2, July 2018

Proposals relating to

- **Patients spending less time in hospital, so allowing us to reduce beds**
- **Developing more community-based services to support older people with mental health problems, again allowing us to reduce beds**

This Stage 2 Equality Impact Assessment provides analysis of engagement exercise responses, an underlying evidence base, and an assessment of potential impacts. It builds upon the earlier work done in the Stage 1 Equality Impact Assessment. The Equality Impact Assessment will remain a draft throughout as changes and updates are continually made. Action is being undertaken to gather information and evidence across Protected Characteristics and to analyse the data in respect of the proposals for service change.

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Service Improvement Proposals Tranche 1: Equality Impact Assessment (EIA) Stage 2

1. Introduction

The purpose of this document is to identify and consider the equality impact of the proposed service changes as described in the public engagement document (3rd May – 27th June 2018).

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

At Abertawe Bro Morgannwg Health Board (ABMUHB) we are committed to demonstrating our core organisational values (Caring for Each Other, Working Together and Always Improving). To ensure that we "live" our values and that we make the best decisions, which are fair for all our communities, we need to go beyond the requirements of the Equality Act 2010. To achieve this, we place importance on putting human rights at the heart of the way in which our services are designed and delivered. For example, we understand that many people have caring responsibilities which can affect the way they access services and/or employment. We believe that socio-economic status is a key factor affecting healthy outcomes and we take steps to consider these areas as part of our decision making processes. In addition, we recognise that Wales is a country with two official languages, Welsh and English. The importance of bilingual healthcare for all patients in Wales is fundamental and particularly important for people with mental health problems, people with learning disabilities as well as older and younger people.

A Stage 1 Equality Impact Assessment (EIA) was produced in June 2018. The Stage 1 EIA set out ABMUHB's initial considerations of the following questions:

- Do different groups have different needs, experiences, issues and priorities in relation to the proposed service changes?
- Is there potential for or evidence that the proposed changes will promote equality?
- Is there potential for or evidence that the proposed changes will affect different groups differently (positively or negatively)?
- If potential negative impact is identified, what changes can be made to eliminate or minimise the impact?

This Stage 2 Equality Impact Assessment (EIA) builds on the Stage 1 EIA by incorporating additional data, analysis and feedback from the engagement exercise undertaken with the public and ABMUHB staff.

One of the main drivers for the changes is the difficulty the Health Board is facing (along with all other NHS organisations) in filling qualified nursing vacancies. We

have significant numbers of nursing vacancies across the Health Board (about 400 on average, primarily on medical wards) which means we are relying on agency and temporary staffing to provide enough staff to safely provide care on our wards. We continually try new approaches to appointing new staff and keeping our existing ones, including overseas recruitment, but despite these efforts we continue to have roughly the same level of vacancies. We know this level of temporary staffing is not providing the best care possible and is also costing more than we can afford. If we implement the changes outlined in this document we will not have to use as much bank or agency staff to provide care on our wards, this will mean our staff can work in teams more consistently. Existing staff employed on wards where changes are planned will be transferred into vacant posts on other wards on the same hospital site. There is no risk to the employment of any of our staff.

This report is not intended to be a definitive statement on the potential impact of the proposed changes on protected characteristic groups but to describe our understanding at this point in the process. The EIA process will help us to identify and address any gaps in our knowledge by engaging and consulting with the public and stakeholders. The EIA will be updated as further information becomes available.

2. Background and Purpose

ABMUHB covers a large geographical area and is one of the most densely populated Health Boards in Wales with 466 persons per square km. Within ABMUHB there are almost twice as many people living per square km in Swansea compared to Neath Port Talbot.

Table 1: Population density for ABMU Health Board area

Locality	Population per km^2
Swansea	603.2
Neath Port Talbot	310.6
Bridgend	534.1
ABMU Health Board	466.3

The geographical area covered by ABMUHB shows high levels of multiple deprivation as measured by the Wales Index of Multiple Deprivation (WIMD) 2014.[1] A fifth of the 382 Lower Super Output Areas (LSOAs) ranked as being the *Most Deprived* in Wales are located in the ABMUHB area. This is covered in more detail in section
Socio-economic *status* of this report.

UK NHS benchmarking and a national programme of spot checks on older people's mental health services following the serious failures of care discovered in Tawel Fan, Betsi Cadwaladr University Health Board, indicated a need to evaluate the effectiveness of our older people's mental health provision.

[1] https://gov.wales/statistics-and-research/welsh-index-multiple-deprivation/?lang=en

A review by the Welsh Government's Delivery Unit stated that despite judging the overall care on the wards to be of a good standard with some examples of excellence they were:

> *"not assured that the current service model consisting of 13 wards is sustainable in relation to the staffing establishment required. There are significant limitations in access to the full multi-disciplinary team and these limitations do not appear to form part of wider workforce planning considerations."*

To further support this the Mental Health and Learning Disability Commissioning Board agreed to commission an external clinical review which was undertaken over the summer of 2017. This identified that services need to change to help us to balance the future demands for services to meet our population's needs which are anticipated to be predominantly provided within community settings.

Failing to act or make changes to how we can best meet people's needs now is not sustainable. Doing things differently will help us to meet future demand, doing more of what we currently do, is likely to lead to an increasingly ineffective service.

The engagement document describes the background and rationale for the changes. http://abm.cymru.nhs.uk/bulletinfiles/11697/Engagement%20document%20-%20final.docx

These include the need to improve quality by supporting patients to receive care at home, to reduce the deconditioning[2] effect of staying in hospital by reducing length of stay; making sure people are as active and mobile as possible and reducing the use of temporary bank and agency staff. In addition, the proposal would help us to become sustainable by balancing our finances.

The proposed changes are in line with the Welsh Government's strategy '*A Healthier Wales: Our Plan for Health and Social Care'*.[3] The strategy proposes a shift of services from hospitals to communities and from communities to homes. The intention is that people will be supported to remain active and independent, in their own homes, for as long as possible. The Welsh Government believe that most people would prefer to be closer to home, and that hospitals should be oriented to ensuring that people who are frail or are at the end of their lives are placed in the most appropriate setting and treated with dignity and respect.

The strategy proposes that people should only go to a general hospital when that is essential. Hospital services will be designed to reduce the time spent in hospital and to speed up recovery. There should be a strong emphasis on helping people to recover their independence after treatment and on ensuring that they do not need to be re-admitted to hospital. Where specialist services need to be accessed, the system will ensure that patients return to the most appropriate local setting for their

[2] Deconditioning: the British Geriatric Society states that 'prolonged bed rest in older people can lead to substantial loss of muscle strength and physical activity'.
[3] https://gov.wales/topics/health/publications/healthier-wales/?lang=en

ongoing care, whether in a local health setting, in a step-down facility in the community or in their home.

The EIA will consider the implementation of new models of care in respect of each protected characteristic:

- Neath Port Talbot Hospital (the Transfer of Care and Liaison Service and Enabling Ethos ward)
- Singleton Hospital (the Integrated Care for Older People's team and remodelling of surgical capacity)
- Gorseinon Hospital (new clinical leadership, rehabilitation focus and improved environment)
- Tonna Hospital (investment in community services, recovery models).

There has also been an environmental change at Princess of Wales Hospital (POWH) related to the follow up of the "*Trusted to Care Report*".[4]

These new models of care have allowed us to reduce our bed capacity in the following areas:

Table 2: New Models of Care

Delivery Unit	Site	Specialty & Wards	No of beds
Singleton	Singleton	Care of the Elderly / Oncology (wards 10 & 12)	34
	Singleton	Gynaecology / surgical specialties (wards 2 +20)	14
NPTH	NPTH	Care of the Elderly (wards C, D, E)	20
POWH	POWH	Care of the Elderly (ward 20)	3
Gorseinon	Gorseinon	Primary and Community Care, Care of the Elderly	8
Tonna	Tonna	Older Peoples' Mental Health Unit	18

Table 2 illustrates that most of the changes relate to new service models for the elderly and changes to our care of the elderly and older peoples' mental health inpatient capacity. However, there are also two other groups of people affected; gynaecology patients and oncology patients. These different groups are described throughout the impact assessment.

With careful monitoring we believe we can further reduce how long patients stay in hospital and avoid more hospital admissions for assessment to provide a better balance of care, which will allow us to make further bed reductions in 2018/9. We are proposing to reduce further Care of the Elderly beds at Singleton (26) and Neath Port Talbot (20). We are also planning to further reduce our older people's mental health capacity at Tonna (20) and POWH (14) hospitals.

[4] https://gov.wales/topics/health/publications/health/reports/care/?lang=en

The fact that patients are spending shorter times in Singleton has allowed us to maintain services whilst increasing throughput and efficiency through the hospital. We have also improved the quality of care for patients by reducing the deconditioning effects on older people of a long stay in hospital.

Piloting a new model in Singleton Hospital:

During 2017/18 we piloted a new model for acute frail older people's care in the Singleton Assessment Unit (SAU) to deliver high quality, integrated person-centred care through the iCOP (Integrated Care for Older People) team. This multi-disciplinary service delivers a Consultant-led Comprehensive Geriatric Assessment service to patients on the SAU and on one of the older people's wards at Singleton. The results were as follows:

Admission avoidance

The iCOP pilot increased the number of patients aged 75 discharged home from SAU by 10%

38% of patients assessed were discharged directly from SAU

This allowed us to work out that a fully funded iCOP team assessing 40% of patients over 75 years old would avoid 128 admissions per year equivalent to 1921 bed days

Reducing how long patients stay in hospital

Early holistic assessment with a senior decision maker and multidisciplinary team reduces length of stay

The iCOP pilot assessed a frail older population (66% had a clinical frailty scale of 6 or greater)

The average number of days patients assessed by iCOP stayed in hospital was 15.7 days

A similar cohort of patients not assessed by iCOP (ward 3) stayed in hospital on average 25.25 days

There is evidence that reducing how long frail older people stay in hospital:

- Improves their outcomes
- Means we can provide care for more people because of better patient flow
- Means we are using our hospital beds as effectively as possible
- Reduces the risk and level of dependency which can result from long hospital stays
- Reduces the need for long periods of rehabilitation and / or long-term care
- Patient experience is improved through having consistent nursing and medical staff
- Helps patients not become more dependent and able retain their mobility

3. Feedback from Public and staff engagement

This section provides an overview of the feedback from the public and staff engagement exercise conducted by ABMUHB between 3rd May and 27th June 2018.

84 responses were received using a mixed range of response media (e.g. engagement exercise response forms (49 forms), e-mail, telephone, letter, and Facebook). Not all respondents provided a response to all questions used in the engagement exercise response forms.

Table 3: Question 1 – To what extent do you agree that we need to make changes to respond to these challenges?

Response	Frequency
Strongly agree	22
Tend to agree	12
Neither agree or disagree	2
Tend to disagree	0
Strongly disagree	13
Don't know	1
Total	**50**

Support for the need to make changes was high, with 34 (68%) agreeing, and 26% strongly disagreeing.

Table 4: Question 2 – To what extent do you disagree or agree with the proposal around patients spending less time in hospital, so allowing us to reduce beds?

Response	Frequency
Strongly agree	6
Tend to agree	15
Neither agree or disagree	1
Tend to disagree	8
Strongly disagree	16
Don't know	1
Total	**47**

45% of respondents agreed, and 51% disagreed with the proposal set out in Question 2.

Table 5: Question 3 – To what extent do you disagree or agree with the proposals to develop more community-based services to support older people with mental health problems, so allowing us to reduce beds?

Response	Frequency
Strongly agree	10
Tend to agree	13
Neither agree or disagree	4
Tend to disagree	4
Strongly disagree	16
Don't know	1
Total	**48**

Just under half of respondents (48%) agreed, and 42% disagreed with the proposal set out in Question 3.

It should be noted that the wording of questions 2 and 3 used on the engagement response form was raised as a concern by respondents. A number of respondents felt that by effectively including two issues or questions in one question, the question became leading. Respondents might agree with one part of the question but did not necessarily support the other part of the question, making it difficult to respond fully.

The following themes were identified from the responses:

Staffing is the issue not beds
It was suggested that "PJ Paralysis" as highlighted by the case for change documents is not inevitable and could be addressed by ensuring adequate staff levels were in place, particularly for specialist services which can directly address this (e.g. physiotherapy, occupational therapy or mental health therapy.

Access to specialist services in hospital was raised as a concern by some respondents, as delays in accessing these services can themselves prolong patient length of stay.

Understaffing was also thought to be a contributory factor to the rise in in-hospital infections.

The mix of staffing (e.g. management, support staff etc) was considered by some to be an issue, with some roles seen as not offering any value.

More beds needed not less

It was argued that in actual fact more beds, not less beds are required. To evidence this, respondents highlighted the delays patients faced in receiving care at Accident & Emergency, and the queuing of ambulances to handover patients.

It was also felt that the increased demand from an ageing population will require more beds.

With less beds some respondents felt there is a risk that patients may be discharged too early to free up space and meet hospital targets – this is discussed in more detail below.

Should the number of hospital beds be reduced, respondents were concerned that hospitals would not be able to react quickly enough to periods of high demand.

Some respondents highlighted that reducing beds in the proposed wards and hospitals will have knock-on effects for other hospitals and services that may increase length of stay and ability to meet patient demand in those hospitals.

Risk of discharging patients too early

A concern that patients may be discharged too early was raised frequently. Respondents provided examples of where their own patients or relatives had in their opinion been discharged too early, and not provided the time needed to recover fully. This is a concern as patients may become acutely unwell very rapidly (particularly for oncology patients) and require hospital care.

Too early discharge increases the risk that patients may be readmitted shortly afterwards due to complications linked to their condition, or an inability to effectively care for themselves (see ***Shifting the burden of care*** below).

As a consequence of this patient safety was felt to be compromised, particularly for isolated and vulnerable patients. Social isolation itself presents a risk to patients' mental wellbeing which may be exacerbated by their current medical condition.

In cases where patients are discharged too early without accurate diagnosis and adequate pain management they are frequently readmitted to hospital to address pain issues.

Shifting the burden of care

Many respondents were concerned that the shift to community-based care effectively shifts the burden of care from the hospital to carers, care homes and the local authority which in many cases may not be able to meet that care need due to a lack of resources.

It was noted that in many instances for older people, the care provider in their own home will be their partner, another older person with their own care needs. Or they may be alone in their home, dependant on family / carer visits if available at all.

The ABMU Health Board area has high levels of multiple deprivation, and the costs of providing care may present a significant financial burden for some households.

Spending on social care provision by local authorities was raised as an area of concern. Respondents noted that local authorities are themselves under financial strain and are struggling to meet the social care needs of their local populations. The proposed service changes could increase the demand for these services further, which in turn could increase delays in releasing patients from hospital due to waits for care reviews / packages, and beds in care homes to become available.

Integrated community-based services

It was noted by respondents that for the proposed service changes to be effective the Health Board, local authorities, GPs, care homes etc need to work in a much more integrated manner. Current working was thought to be too fragmented, for example each of the local authorities operates different referral processes, complicating referrals for Health Board staff.

The current provision of community-based services was not thought to be adequate to meet current demand and would struggle to meet any increase in demand. In some cases, issues with current demand were thought to be contributing to issues faced by the Health Board. For example, patients frequently reported difficulty in being allocated timely GP appointments (even with the support of Health Board community support staff). This results in patients inappropriately using Accident & Emergency services to seek medical care.

Respondents were concerned that the service proposals will require a change of practice that community-based services may be unwilling, or unable to make (e.g. access to 24-hour pharmacy services).

It was felt that any decision on closing beds should therefore be delayed until community-based services are capable of meeting the new service demand, and have processes in place to facilitate it, including better communication / partnership working between the Health Board, local authorities and the third sector.

Access to community-based services

Respondents were concerned that the shift to more community-based care provision will require patients to travel more frequently to access some health services. This will increase the logistical and financial challenges experienced by patients. For those patients without access to a car or family support, this is likely to be a significant challenge.

4. Assessment of Relevance and Impact

The Equality Act 2010 (EA) places a positive duty on public authorities to promote equality for protected groups. The EA 2010 requires Welsh public bodies to

demonstrate how they pay 'due regard' to equality when carrying out their functions and activities. There is a specific duty in Wales to assess the impact of existing and new services or policies on each of the nine protected characteristics[5] in order to:

- Eliminate unlawful discrimination
- Advance equality of opportunity between people who share a relevant protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The following sections of the report consider each protected characteristic and highlight where further exploration/engagement might be necessary.

Age

Table 6 below provides 2016 population estimates for people aged 65 years plus living in the ABMUHB area.

Table 6: 2016 Population estimates for ABMU local authorities for residents aged 65 years plus (ONS Crown Copyright Reserved, from Nomis on 6 July 2018)

Region	Age	Male	Female	Total
Bridgend	Aged 65-69	4,292	4,598	**8,890**
	Aged 70-74	3,371	3,690	**7,061**
	Aged 75-79	2,445	3,038	**5,483**
	Aged 80-84	1,640	2,130	**3,770**
	Aged 85+	1,162	2,094	**3,256**
	Total	**12,910**	**15,550**	**28,460**
Neath Port Talbot	Aged 65-69	4,434	4,651	**9,085**
	Aged 70-74	3,368	3,678	**7,046**
	Aged 75-79	2,407	2,880	**5,287**
	Aged 80-84	1,623	2,151	**3,774**
	Aged 85+	1,202	2,406	**3,608**
	Total	**13,034**	**15,766**	**28,800**
Swansea	Aged 65-69	6,747	7,484	**14,231**
	Aged 70-74	5,221	6,013	**11,234**
	Aged 75-79	3,828	4,825	**8,653**
	Aged 80-84	2,883	3,872	**6,755**
	Aged 85+	2,266	4,064	**6,330**
	Total	**20,945**	**26,258**	**47,203**
ABMU	Aged 65-69	15,473	16,733	**32,206**

[5] The Protected Characteristics outlined in the Equality Act 2010 are: Age; Disability; Gender; Gender Reassignment; Marriage and Civil Partnership; Pregnancy and Maternity; Religion and Belief (including non-belief); Race and Sexual Orientation.

	Aged 70-74	11,960	13,381	**25,341**
	Aged 75-79	8,680	10,743	**19,423**
	Aged 80-84	6,146	8,153	**14,299**
	Aged 85+	4,630	8,564	**13,194**
	Total	**46,889**	**57,574**	**104,463**

Source: NOMIS

Table 6 shows that within the ABMUHB area Swansea has the largest population aged 65 years plus (47,203). In total it is estimated that there are 104,463 people aged 65 years plus, equivalent to 19.7 per cent, or approximately a fifth of the total ABMUHB population (529,548).

The demographic data in Table 6 shows that for adults aged 65 years plus, there are more women than men in each age band, and this is true for each of the local authorities in the ABMUHB area. Across ABMUHB area women account for 55 per cent of all residents aged 65 years plus.

This would suggest that proposed changes to the service will affect women slightly more than men. But this would need to be verified by patient data, as it assumes that there is no difference in the proportions of men and women presenting.

Figure 1 and Figure 2 show the population distribution by age across the 327 LSOAs in the ABMUHB area.

Figure 1: Population distribution by age (65-84 years) and LSOA in ABMU Health Board area, 2014.

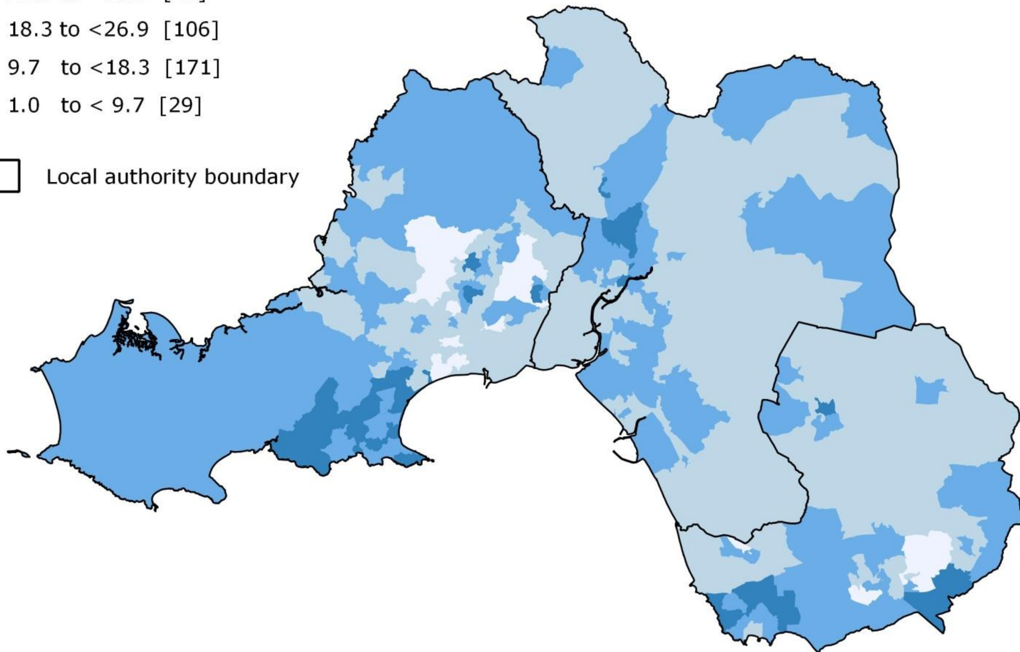

Figure 2: Population distribution by age (85 years plus) and LSOA in ABMU Health Board area, 2014.

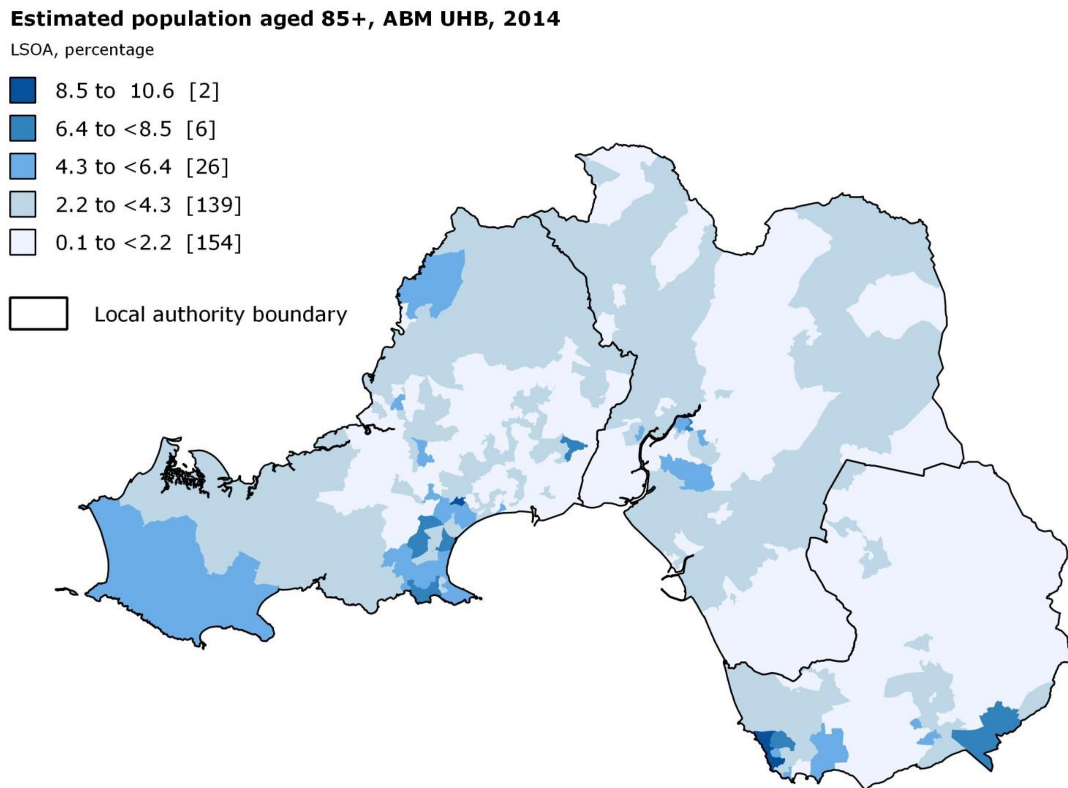

Figure 3: Population projections by age group

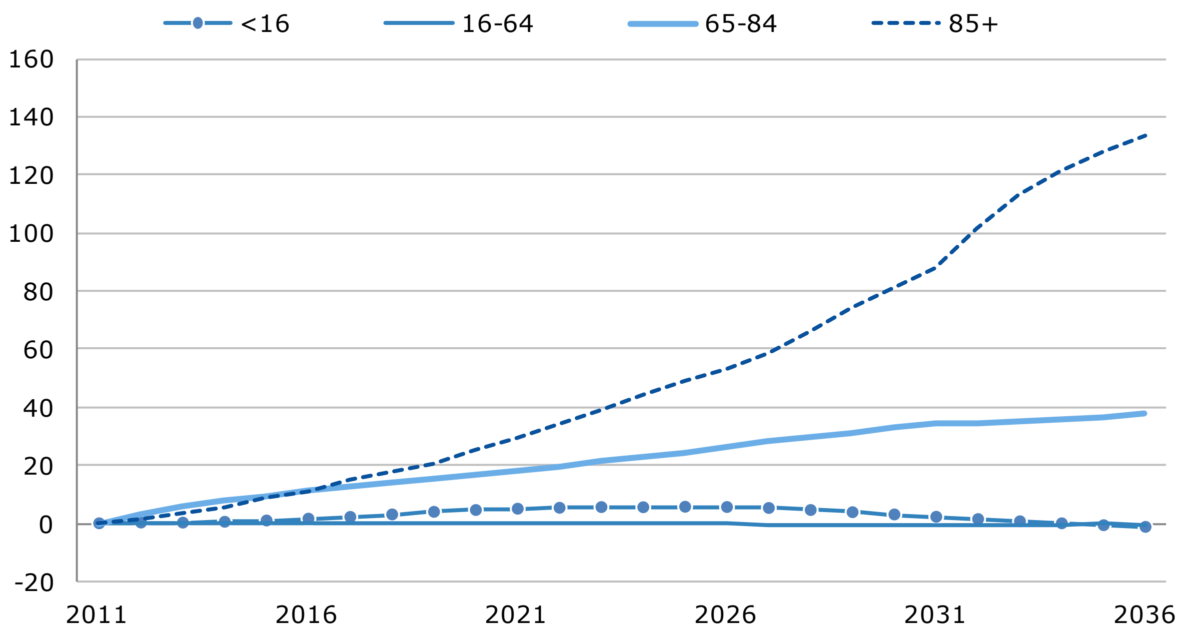

Table 6 highlighted that within ABMUHB area the 65 years plus age group accounts for a fifth of the overall population. Figure 3 above shows that this age group is projected to increase by approximately 30 percentage points between 2016 and 2036.

The 85 years plus age group (2.5 per cent of total ABMUHB area population in 2016) is projected to show a percentage change of approximately 120 percentage points between 2016 and 2036. This is the largest percentage change of all age groups.

The changes in frail elderly models affect older people and there is evidence that the need for healthcare increases disproportionately over the age of 75 years (Capita report 2016). The changes in service models are based on the evidence that longer stays in hospital have a deconditioning effect in older people (bed rest can reduce muscle mass in older people by 10-20% per week) and there is risk of harm due to healthcare acquired infection. The service model changes have been tested and found to increase the number of older people cared for locally at Singleton, Neath Port Talbot and Gorseinon hospitals by reducing length of stay (and thereby the deconditioning effects). In addition, there have been environmental improvements to increase the space around each bed, improving dignity and access for specialist equipment and reducing the risk of infection at Gorseinon and Princess of Wales hospitals.

Around half of the gynaecology inpatients at Singleton are under 40, with around three-quarters of patients being under 60 years of age. The number of patients admitted has decreased slightly (by around 3.7%) between August to April 2017/18 (i.e. since the ward changes took place) compared to the previous year, but the waiting times for surgery have stayed within the waiting times standards.

The latest statistics on cancer incidence in Wales from the Welsh Cancer Intelligence and Surveillance Unit (WCISU) website[6] show that two-thirds of cases occur in people over the age of 64 years old. Oncology patients are therefore likely to be older, and our data shows 88% of oncology inpatients at Singleton in August-April 2017/18 were over 50 years of age.

Inpatient oncology care has been provided to around 20% more patients on the site between April and August 2017/18 compared to the same period in the previous year and the service model changes have therefore had a positive impact on the access to care. The impact on this age group has been neutral with regard to changes in the oncology wards.

Older People's Mental Health Services

UK wide benchmarking indicates that mental health inpatient services for older people in ABMUHB are above average in the number of beds - 92 per 100k of over 65s compared to benchmark average of 48. There are also more admissions per 100k population with 1,019 admissions against benchmarked median of 174.

[6] http://www.wcisu.wales.nhs.uk/cancer-incidence-in-wales-1

Demographic changes and improvements in life expectancy mean that there is an expected increase in the overall number of people with dementia. In 2015, approximately 6,979 people in Western Bay had a diagnosis of dementia. By 2030, this is predicted to rise by 48% to 10,295.

The mental health inpatient services are not solely provided in relation to age but nevertheless the majority of people affected by this change are older adults.

The increased option of community-based care and reduction of inpatient care will therefore have a direct impact upon people as a consequence of their age. For many people, this might be a positive impact, however, to ensure that any disadvantage is eliminated or minimised, the characteristic "age" will need to be considered in conjunction with other protected groups, e.g. older women/men, older disabled people etc.

Disability:

The disability[7] profile in the ABMUHB area (25.0%) is higher than the figure for Wales as a whole (22.7%). The proportion of people in the ABMUHB area categorised as having their 'Day-to-day activities limited a lot' is 1.9% higher in ABMUHB than Wales.

At a local authority level there is noticeable difference between local authorities. Swansea has the lowest levels of people classed as disabled (23.4%), while Neath Port Talbot has the highest (28.0%).

Neath Port Talbot has the highest proportion of its population categorised as having their 'Day-to-day activities limited a lot' (16.1%) in Wales. Neath Port Talbot also has the second highest proportion of its population categorised as having their 'Day-to-day activities limited a little' (11.9%) in Wales. Consequently, within Wales Neath Talbot has the smallest proportion of its population categorised as not being disabled i.e. 'Day-to-day activities not limited' (72.0%).

Table 7: Long-term health problem or disability by ABMU Health Board area

Region	Day-to-day activities limited a lot	Day-to-day activities limited a little	Day-to-day activities not limited	Total (%)	Total
ABMU	13.8%	11.2%	75.1%	100.0%	518,013
Bridgend	*13.5%*	*11.2%*	*75.3%*	*100.0%*	139,178
Neath Port Talbot	*16.1%*	*11.9%*	*72.0%*	*100.0%*	139,812
Swansea	*12.6%*	*10.8%*	*76.7%*	*100.0%*	239,023
Wales	**11.9%**	**10.8%**	**77.3%**	**100.0%**	**3,063,456**

(Source: Table QS303EW 2011 Census, ONS)

[7] Disabled is defined as individuals whose day-to-day activities are either limited a lot, or limited a little.

At the LSOA level, the percentage of residents whose day-to-day activities are limited a lot or a little by a long-term health problem range from 7.7% in the Bryntirion, Laleston and Merthyr Mawr areas of Bridgend (Bridgend LSOA 017E) to 42% in the Neath North area of Neath Port Talbot (Neath Port Talbot LSOA 008D).

These are crude percentages only and do not take into account the age structure of the population. The areas with the highest percentages are found in the Castle area of Swansea, Sandfields East, Sandfields West and Neath North areas of Neath Port Talbot and the Caerau area in Bridgend.

The latest disability prevalence estimates for England and Wales (Office for Disability Issues, 2014) show that the prevalence of disability rises with age (16% working age adults and 45% adults over state pension age).

The changes in older people's services are likely to affect this group and will need to be explored further to identify any potential differential impact.

Gender

The gender split (see Table 8) for the ABMUHB area mirrors very closely the gender split for Wales as a whole. Approximately a 50:50 split with slightly more females (50.3%) than males (49.7%). The variation between local authorities within the ABMU Health Board Area is small.

Table 8: Gender by unitary authorities in ABMU Health Board area

Region	Males	Females	Total (%)	Total
ABMU	49.7%	50.3%	100.0%	531,900
Bridgend	*49.6%*	*50.4%*	*100.0%*	*144,300*
Neath Port Talbot	*49.3%*	*50.7%*	*100.0%*	*142,100*
Swansea	*49.9%*	*50.1%*	*100.0%*	*245,500*
Wales	**49.3%**	**50.7%**	**100.0%**	**3,125,200**

(Source: NOMIS Population Estimates/Projections, Local Authority based 1981 to 2017)[8]

As previously noted (see Table 6 above), for the over 65 years age group the proportion of females to males increases as the population ages. 52% of people in ABMUHB area aged 65-69 years are female, while 64.9% of the people aged 85 years plus are female.

Data from the 2011 Census shows that 89.6% of the lone parent households in Wales are female. Lone parent households experience some of the lowest levels of

[8] https://www.nomisweb.co.uk/query/construct/summary.asp?mode=construct&version=0&dataset=31

wealth in Wales.[9] As such any additional travel costs incurred due to service reconfiguration will have significant impact upon service users and staff from this group. The 2011 Census data shows that only 18.3% of female lone parent households in the ABMUHB area are in full-time employment, 32.2% are in part-time employment, and 40.3% are not in employment.

WCISU data on cancer incidence in Wales[10] shows that:

- Cancer rates are higher in older age, with older men having higher rates than older women.
- The age-adjusted cancer rate for men in Wales is consistently the highest of UK countries, but the trend is decreasing.
- Unlike for older men, women in age-groups between 35 to 54 years old continue to have higher cancer rates than men.
- Women in Wales consistently have the second highest cancer rate of all UK countries– the long-term rate is increasing in all the countries.

The most common cancers in 2015 were breast, prostate, lung, bowel, melanoma, head and neck, and non-Hodgkin lymphoma.

As in previous years, prostate cancer was by far the most common cancer in men, accounting for just over a quarter of men's cancer cases. Next most common were lung and bowel cancers each with a similar number of cases, followed by cancers of the head and neck, bladder and then melanoma.

In women, the commonest cancer by far was breast cancer, with numbers approaching a third of all cancers in women. Lung cancer was the next most common in women, making up almost 13% of cases. Cancers of the bowel and the womb (uterus), and melanoma made up a further fifth (20%) of cases in women.

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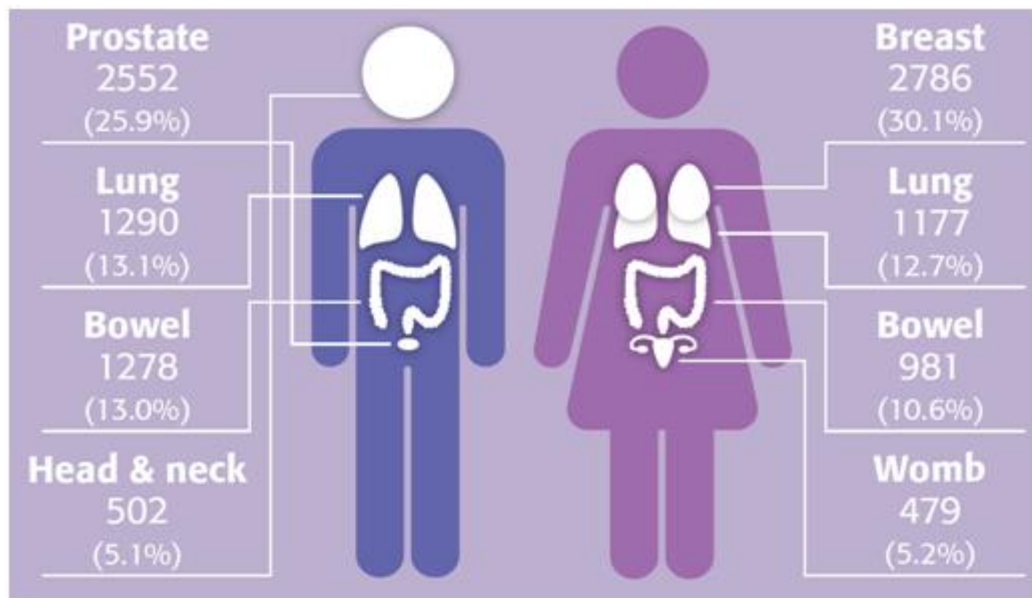
[9] Wales Institute of Social and Economic Research Data and Methods. (2011). *An anatomy of economic inequality in Wales*. Cardiff: EHRC.

[10] http://www.wcisu.wales.nhs.uk/cancer-incidence-in-wales-1

Figure 4: Most common cancers in men and women in Wales in 2015



(Source: Welsh Cancer Intelligence and Surveillance Unit's National Cancer Registry www.wcisu.wales.nhs.uk)

Gender Reassignment

Transgender

Trans is an umbrella term used to describe the whole range of people whose gender identity/or gender expression differs from the gender assumptions made at birth.

Potential Impact - In *'It's just Good Care: A guide for health staff caring for people who are Trans' 2015-19,* trans people must be accommodated in line with their gender expression. This applies to toilet facilities, wards, outpatient departments, accident and emergency or other health and social care facilities, including where these are single sex environments. Different genital or chest appearance is not a bar to this. Privacy is essential to meet the needs of the trans person and other service users. If there are no cubicles, privacy can usually be achieved with curtaining or screens. The wishes of the trans person must be taken into account rather than the convenience of nursing staff. An unconscious patient should be treated according to their gender presentation. Absolute dignity must be maintained at all times. It also states that breaching privacy about a person's Gender Recognition Certificate or gender history without their consent could amount to a criminal offence. A medical emergency where consent is not possible may provide an exception to the privacy requirements.

The EHRC note in *How fair is Britain?* that one in seven transgender people who responded to a survey felt that they had been treated adversely by healthcare professionals because of their transgender status.[11]

Research suggests transgender people are likely to experience risk of harassment when attempting to access healthcare. A survey by Press for Change (2007)[12] found 36.8% (277) of trans people (aged 18 to 75) who chose to present their acquired gender permanently, experienced negative comments while out socially, because of their acquired gender. Only 27% of respondents in the survey recorded they had not experienced anything of the above while out in public spaces. This means that 73% of respondents experienced comments, threatening behaviour, physical abuse, verbal abuse or sexual abuse while in public spaces.

Recent research[13] looking at the mental health and emotional wellbeing of trans people has found that rates of current and previously diagnosed mental ill health are high amongst trans people. The research found that:

- 88% (N=549) of participants had either currently or previously experienced depression.
- 80% (N=498) had experienced stress and 75% (N=512) had experienced anxiety.
- 53% of participants had self-harmed at some point.
- The majority of participants (84%) considered ending their lives at some point.

Access to a gynaecologist can be required by both transgender men and transgender women. The proposed service changes in relation to gynaecology therefore have the potential to impact upon transgender people.

Further work will need to be done to explore the proposals in respect of potential differential impact (positive/negative) on people who identify as trans.

Marriage and civil partnership

The increased availability of community-based care increases the longevity of partners remaining together in their own environment.

There is a possibility of an increase in the caring burden for partners as a result of community-based care. This will be mitigated through carer's assessments and provision of support and training.

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[11] Equality and Human Rights Commission. (2010). *How fair is Britain? Equality, Human Rights and Good Relations in 2010. The First Triennial Review*. Manchester: Equality and Human Rights Commission.
[12] Whittle, S., Turner, L., and Al-Alami, M. (2007). *Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination*. London: Press for Change.
[13] McNeil, J., Bailey, L., Ellis, S., Morton, J., and Regan, M. (2012). *Trans Mental Health and Wellbeing Study*. Edinburgh: Scottish Transgender Alliance.

Potential differential impact needs to be further explored in respect of this protected characteristic.

Pregnancy and Maternity

Data from the ONS on live births in Wales for 2015 (see

Table 9) shows that there were 5,462 births in the ABMUHB area. Hospital births account for the majority of all births in the ABMUHB area (96.0%) and in Wales as a whole (96.9%).

Low birth weight is a key health indicator for early years and is a major cause for infant mortality in developed countries, including the UK. The percentage of births in the ABMU Health Board area that are low birth weight (i.e. below 2,500 grams) is consistent with the figure for Wales as a whole (6.8%).

Among the Welsh Health Boards Cwm Taf Health Board has the highest proportion of low birth weight births (8.2%). ABMUHB has the second lowest proportion of low birth weight births (6.3%).

At the local authority level there is some variation within the ABMUHB area, with Bridgend (6.9%) having the highest low birth weight rate in the Health Board, and the ninth highest in Wales. Swansea (6.3%) and Neath Port Talbot (5.7%) are ranked 15th and 19th in Wales in terms of low birth weight rates (where rank 1 is the highest low birth weight rate).

Table 9: Births in 2015 by location and number of live births with low birth weight by ABMU Health Board area

	All	NHS hospital birth	At home, non-NHS hospital or elsewhere	Number of live births with birth weight under 2,500 grams	Percentage of live births with birth weight under 2,500 grams
ABMU	5,462	5,244	218	346	6.3%
Bridgend	*1,487*	*1,405*	*82*	*103*	*6.9%*
Neath Port Talbot	*1,478*	*1,434*	*44*	*85*	*5.7%*
Swansea	*2,497*	*2,405*	*92*	*158*	*6.3%*
Wales	**32,899**	**31,878**	**1,021**	**2,253**	**6.8%**

(Source: Stats Wales)[14, 15]

The changes to the wards at Singleton will support the development of the new Transitional Care Unit for new-born babies requiring specialist care and, which we believe, will have a positive impact on this population. However, further work is needed to consider the potential for differential impact relating to pregnancy and maternity in respect of accessing services/employment.

Race

The 2011 census data for the Black and Minority Ethnic (BME) population across the Health Board shows an above average BME population in Swansea at 6.0% and lower percentages in Bridgend 2.2% and Neath Port Talbot 1.9%. These proportions have all increased from the 2001 census data as there was evidence that ethnicity was under reported in 2001 and there have been increases in migrant workers within all 3 areas. In addition, Swansea University has expanded, increasing the number of foreign students and Swansea's status as a dispersal site for asylum seekers has had an impact upon all three areas.[16]

[14] https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/Births-Deaths-and-Conceptions/Births/Maternities-by-Area-PlaceOfConfinement
[15] https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/Births-Deaths-and-Conceptions/Births/LiveBirthsWithLowBirthWeight-by-Area
[16] http://www.cityofsanctuary.org/swansea

Table 10: Ethnic group by ABMU Health Board area

Region	White	Mixed / Multiple ethnic group	Asian / Asian British	Black / African / Caribbean / Black British	Other ethnic group	Total (%)	Total
ABMU	96.10%	0.80%	2.10%	0.50%	0.50%	100%	518,013
Bridgend	97.80%	0.70%	1.10%	0.20%	0.20%	100%	139,178
Neath Port Talbot	98.10%	0.70%	1.00%	0.20%	0.10%	100%	139,812
Swansea	94.00%	0.90%	3.30%	0.80%	1.00%	100%	239,023
Wales	**95.60%**	**1.00%**	**2.30%**	**0.60%**	**0.50%**	**100%**	**3,063,456**

(Source: Table KS201EW Census 2011, ONS)

Where English is not a patient's first language the ability of patients to receive and communicate about their health care provision in the language of their preference, may be affected. This is a particular issue for older patients with dementia where patients ability to communicate in English with staff may be compromised.

Further work will need to be undertaken to explore whether there is potential for differential impact with regard to race, language and culture.

Religion and Belief (including non-belief)

ABMUHB area population profile closely mirrors Wales as a whole, however there are some slight variations. The proportion of Christians in the ABMUHB area (55.7%) is slightly lower than in Wales (57.6%). The population proportion with 'No religion', in ABMU (34.7%) is higher than the figure for Wales (32.1%). In general, the ABMU Health Board area and Wales, have high numbers of people who either identify as 'Christian' (55.7%) or 'No religion' (34.7%), with very low proportions of the other religion categories.

At the local authority level Neath Port Talbot (57.7%) has the highest population proportion categorised as 'Christian' – in line with the figure for Wales (57.6%). While Swansea (55.0%) and Bridgend (55.1%) have Christian population proportions lower than Wales.

Swansea (2.3%) has the highest population proportion categorised as 'Muslim' in the ABMUHB area, this is the third highest in Wales. While the Neath Port Talbot (0.4%) and Bridgend (0.4%) 'Muslim' populations are both below the figure for Wales (1.5%)

Table 11: Religion by unitary authorities in ABMU Health Board area

Region	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other religion	No religion	Religion not stated	Total (%)	Total
ABMU	55.7%	0.3%	0.2%	0.0%	1.3%	0.1%	0.4%	34.7%	7.3%	100.0%	518,013
Bridgend	*55.1%*	*0.3%*	*0.2%*	*0.0%*	*0.4%*	*0.0%*	*0.4%*	*36.7%*	*7.0%*	*100.0%*	*139,178*
Neath Port Talbot	*57.7%*	*0.2%*	*0.1%*	*0.0%*	*0.4%*	*0.1%*	*0.4%*	*33.8%*	*7.3%*	*100.0%*	*139,812*
Swansea	*55.0%*	*0.4%*	*0.3%*	*0.1%*	*2.3%*	*0.1%*	*0.4%*	*34.0%*	*7.5%*	*100.0%*	*239,023*
Wales	**57.6%**	**0.3%**	**0.3%**	**0.1%**	**1.5%**	**0.1%**	**0.4%**	**32.1%**	**7.6%**	**100.0%**	**3,063,456**

(Source: Table KS209EW Census 2011, ONS)

Further consideration is needed to explore whether there is any potential for differential impact relating to access to services and/or employment.

Sexual Orientation

Sexual orientation is not asked for by the Census so in order to estimate the Lesbian, Gay and Bisexual (LGB) population in Wales we need to use data from the ONS's Integrated Household Survey (see Table 12). The Integrated Household Survey does not report findings by local authority, but by regional groupings, and some cells are not reported as they could either identify individuals or they are not sufficiently robust for publication.

From the Integrated Household Survey data, we can see that the majority of the population in Wales and the regions making up the ABMUHB area identify as heterosexual (c.a. 95%). The percentage of the population identifying as LGB is approximately 1.5% in the ABMUHB area, this is higher than the value for Wales as a whole (1.0%) due to the higher LGB populations in Swansea (2.0%).
LGBT people are more likely to experience mental disorder, have issues with substance misuse, deliberate self-harm and commit suicide than the general population due to long term issues of discrimination and living in an unsympathetic society.

Shifting the balance of care towards community settings and community-based care could have a positive impact for older people with a lesbian, gay, bisexual or transgender orientation who may feel more comfortable in their own environment

Table 12: Sexual orientation by ABMU Health Board area

Region	LGB	Hetero-sexual	No response	Other	Don't know /Refusal	Total (%)	All people aged 16+
Bridgend and Neath Port Talbot	1.00%	95.00%	2.00%	*	2.00%	100.00%	221,500
Swansea	2.00%	95.00%	1.00%	*	1.00%	100.00%	193,200
Wales	**1.00%**	**94.00%**	**1.00%**	**0.00**	**3.00%**	**100.00%**	**2,456,400**

(Source: Integrated Household Survey 2012)[17]
* The data item could disclose identity or not sufficiently robust for publication.

Further work is needed to explore whether there is potential differential impact in respect of sexual orientation in respect of access to services and/or employment.

[17] https://statswales.wales.gov.uk/Catalogue/Equality-and-Diversity/Sexual-Identity/SexualIdentity-by-Area-IdentityStatus

Other characteristics considered

The following characteristics described below are not Protected Characteristics under the Equality Act 2010. However, we believe they are key factors that influence healthy outcomes and underpin our organisational values. We will, therefore, endeavour to explore any potential differential impact in respect of the following:

- Welsh Language
- Human Rights
- Unpaid carers
- Socio-economic status

Welsh Language

Welsh language skills in the ABMUHB area are lower than in Wales as a whole (see Table 13). While the ABMUHB area is comparable to the Welsh figure for the proportion of the population that can understand spoken Welsh only, (5.4% vs 5.3% for Wales), it is significantly lower than Wales as a whole when considering 'Can speak Welsh' (12.0% vs 19.0%) and 'Can read and write Welsh' (8.6% compared to 14.6%).

Table 13: Welsh language profile by ABMU Health Board area

Region	Can understand spoken Welsh only	Can speak Welsh	Can speak, read and write Welsh	Total
ABMU	5.4%	12.0%	8.6%	500,978
Bridgend	*4.1%*	*9.7%*	*7.3%*	*134,545*
Neath Port Talbot	*6.4%*	*15.3%*	*10.8%*	*135,278*
Swansea	*5.5%*	*11.4%*	*8.1%*	*231,155*
Wales	**5.3%**	**19.0%**	**14.6%**	**2,955,841**

(Source: Table KS208WA 2011 Census, ONS. All usual residents aged 3 years and over)

At the local authority level there are noticeable differences between the local authorities. Bridgend has the lowest rates of Welsh language proficiency of the three local authorities, across all three categories. While Neath Port Talbot has the highest rates of Welsh language proficiency.

It is anticipated that any impact the proposed service changes may have relating to the Welsh Language is upon the ability of patients to receive and communicate about their health care provision in the language of their preference, as staff may not be Welsh language speakers.

Human Rights

The EIA needs to be cognisant of the European Convention on Human Rights incorporated into domestic law through the Human Rights Act 1998[18] as well as international treaties.

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

In producing this EIA we have considered the potential of the proposed service changes to impact upon the following rights under the Human Rights Act 1998:

- Article 2: The right to life
- Article 3: The right to freedom from torture or inhuman or degrading treatment
- Article 5: The right to freedom and liberty
- Article 6: The right to a fair trial
- Article 7: The right to no punishment without law
- Article 8: The right to respect for private and family life, home and correspondence
- Article 9: The right to freedom of thought, conscience and religion
- Article 10: The right to freedom of expression
- Article 11: Freedom of assembly and association.
- Article 12: The right to marry and found a family
- Article 14: The right not to be discriminated against in relation to any of the rights contained in the European Convention

Based on the available evidence we do not anticipate that the proposed service changes will impinge upon patients' rights protected under the Act.

We believe that the proposed service changes will ensure that patients' rights under Article 8 are protected. The move to community-based services will support more patients to be discharged more quickly to, and receive care in their own home.

Unpaid Carers

The majority of residents in the ABMUHB area (86.8%) and Wales (87.9%) provide no unpaid care. This is relatively consistent across the health board. The 2011 Census data shows that the proportion of people providing unpaid care in the ABMUHB area is around 7% for one to 19 hours of unpaid care, decreasing to 2% for 20 to 49 hours of unpaid care, but then increasing to 4% to 5% for 50 or more hours of unpaid care.

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

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

[18] https://www.legislation.gov.uk/ukpga/1998/42/contents

hours of unpaid care at a local authority level, Neath Port Talbot has the highest proportion (4.8%).

Socio-economic status

There is a strong correlation between the protected characteristics and low socioeconomic status, as demonstrated by the findings of numerous research studies. In Wales, research by the Wales Institute for Social and Economic Research, Data and Methods (WISERD, 2011)[19] has demonstrated:

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

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

[19] Wales Institute of Social and Economic Research Data and Methods. (2011). *An anatomy of economic inequality in Wales*. Cardiff: EHRC.

The World Health Organisation (2004)[20] notes that:

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

The Welsh Index of Multiple Deprivation (WIMD) is the Welsh Government's official measure of relative deprivation for small areas in Wales. It is designed to identify those small areas where there are the highest concentrations of several different types of deprivation in Wales. WIMD is currently made up of eight separate domains (or types) of deprivation. Each domain (listed below) is compiled from a range of different indicators:

- Income
- Employment
- Health
- Education
- Access to Services
- Community Safety
- Physical Environment
- Housing

The WIMD rank score is constructed from a weighted sum of the deprivation score for each domain. The weights reflect the importance of the domain as an aspect of deprivation, and the quality of the indicators available for that domain.

Of the 1,909 Lower Super Output Areas (LSOA) in Wales ranked by WIMD, 382 are ranked as being the *Most Deprived* (0-20%). The ABMUHB area contains 84 LSOAs ranked as being in the *Most Deprived* (0-20%) LSOAs in Wales. The ABMUHB area therefore accounts for just over a fifth (22%) of all LSOAs in Wales ranked as being the *Most Deprived* (0-20%).

The ABMUHB area contains 327 LSOAs. The 84 LSOAs ranked as being in the *Most Deprived* (0-20%) therefore mean that 26% of all LSOAs in ABMUHB area are ranked as being the *Most Deprived* (0-20%). Only Cwm Taf University Health Board has a higher proportion of its LSOAs ranked as the *Most Deprived* in Wales (30%). ABMUHB is joint second highest with Aneurin Bevan University Health Board at 26%.[21]

In addition, 70 LSOAs in the ABMUHB area (21% of all LSOAs in the ABMU Health Board area) are ranked as being in the *Next Most Deprived* (20-40%) LSOAs in Wales.

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[20] World Health Organization. (2004). *Commission on social determinants of health*. Geneva: World Health Organization.
[21] See
Appendix A for a list of the 84 LSOAs.

Figure 5 shows the geographical distribution of the WIMD multiple deprivation fifths across the ABMUHB area.

Figure 5: Welsh Index of Multiple Deprivation, ABM UHB, 2014

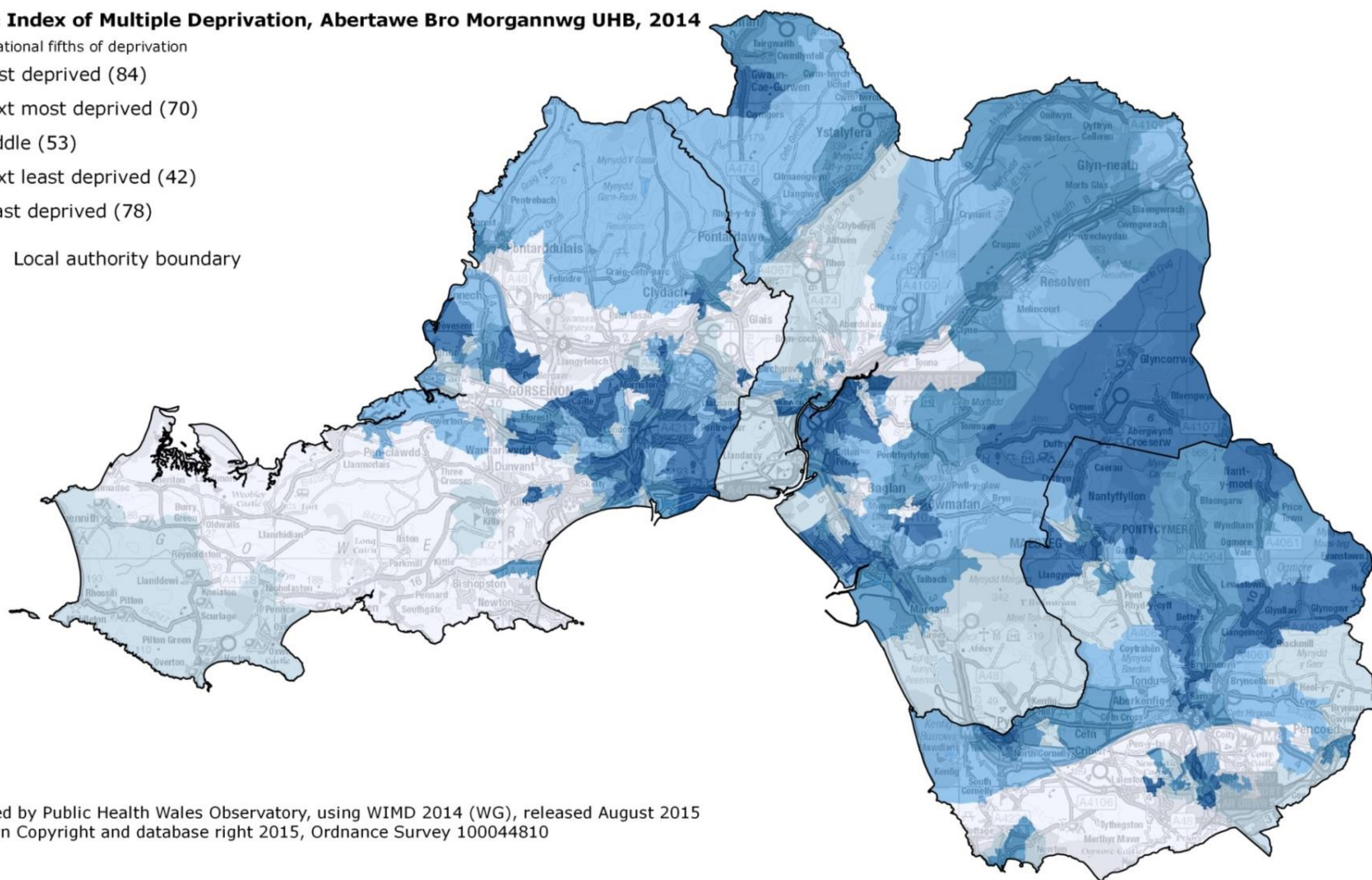

Table 14 and Table 15 show that within the ABMUHB area Neath Port Talbot has the highest levels of multiple deprivation. 60% of Neath Port Talbot's LSOAs are classed as being in the *Most Deprived* (0-20%) or *Next Most Deprived* (20-40%) LSOAs. Bridgend is close behind with 50%, while Swansea has only 38%.

Table 14: LSOAs in ABMU Health Board area ranked as Most Deprived (0-20%), WIMD 2014

Local Authority	LSOAs ranked Most Deprived (0-20%)	LSOAs as %age of all LSOAs in local authority
Bridgend	20	23%
Neath Port Talbot	27	30%
Swansea	37	25%

Table 15: LSOAs in ABMU Health Board area ranked as Next Most Deprived (20-40%), WIMD 2014

Local Authority	LSOAs ranked Most Deprived (20-40%)	LSOAs as %age of all LSOAs in local authority
Bridgend	24	27%
Neath Port Talbot	27	30%
Swansea	19	13%

5. Summing up

The patient and demographic data presented in this report has identified that the proposed service changes will have direct relevance to the following protected characteristics:

- Age
- Disability
- Gender
- Gender reassignment (in relation to older people's mental health services and gynaecology)
- Marriage and civil partnership (in relation to carers)
- Pregnancy and maternity
- Race

Based on the data currently available, we do not anticipate a direct impact on the remaining protected characteristics (e.g. religion and belief, and sexual orientation), but we will continue to monitor the proposed service changes with respect to these protected characteristics.

In addition to the above protected characteristics it is anticipated that the service changes may affect unpaid carers, the Welsh language and people with low socio-economic status.

No impact is anticipated upon patients' rights protected under the Human Rights Act 1998.

With regards to the nature of the impact (i.e. positive, neutral or negative), the work done as part of the pilot in the Singleton Assessment Unit (SAU) has demonstrated a number of potential positive impacts for patients from the proposed service changes.

However, the engagement exercise has identified a number of concerns and potential risks that may result in negative impacts on people with protected characteristics. The extent to which any positive or negative impacts occur will in large depend on the mitigations the Health Board in collaboration with its partners the local authorities and the third sector put in place. Table 16 provides a summary of the concerns and potential risks, and responses by ABMUHB to mitigate them.

In light of the identified risks it is recommended that the Health Board put in place a monitoring and review system of the proposed service changes to ensure that patients and the ability of partner organisations to meet their own statutory duties are not adversely affected. Proposals for this are set out in the next section.

Table 16: Issues raised and potential mitigations

Issue / concern	Mitigation
Staffing	
• Staff levels not sufficient to provide specialist services (e.g. physiotherapy, occupational therapy or mental health therapy). • Delayed access to specialist services is increasing patient length of stay. • Understaffing contributing to rise in in-hospital infections. • Mix of staffing (e.g. management, support staff etc) is inappropriate and does not offer value for money.	As part of the Health Board's improvements the mix of staff involved in services is continually under review. Safe staffing levels are now being implemented across the Health Board on relevant wards and publicised accordingly. Additional funding has been devoted to increasing staffing levels in psychology, physiotherapy and OT services for Older People with Mental Health problems. The efficiency work of the Health Board is aiming to improve patient flow throughout our hospitals, including reducing waiting times for specialist services. Our Infection Control Committee monitors areas where in-hospital infections occur and identifying reasons for this. Environmental improvements made at Gorseinon Hospital and Princess of Wales Hospital, with further improvements planned on rolling basis at Morriston and Princess of Wales Hospitals.
Bed numbers insufficient	
• Ambulances queuing at hospital to handover patients • Ageing population will increase demand on hospital services • Closing beds will reduce ability of Health Board to react quickly to periods of high demand	It is proposed that a new Joint Monitoring and Evaluation Group is established with representation from the CHC, LAs, WAST and voluntary sector to monitor impacts of the proposed bed changes and to ensure that there aren't negative impacts of these going forward. This group will ensure that as beds are closed in a staged way there isn't a deterioration in performance on key issues such as ambulances queueing at hospitals to handover patients.

• Closing beds will have knock-on effects for other hospitals and services that may increase length of stay and ability to meet patient demand in those hospitals.	Changing the model of care for patients is key to coping with the increase in demands for hospital services. Providing opportunities to intervene earlier when a patient's condition is deteriorating and enabling patients to be assessed without hospital admission are key ways to make this happen. Keeping beds available that have been closed as "surge" beds means that the Health Board can respond quickly to periods of high demand.
Discharge patients too early	
• Patients not provided enough time to recover fully, increases risk of readmission • Increased risk that patients may be readmitted shortly afterwards due to complications linked to their condition, or an inability to effectively care for themselves. • Compromised patient safety, particularly for isolated and vulnerable patients. Social isolation presents a risk to patients' mental wellbeing which may be exacerbated by their current medical condition. • Patients discharged too early without accurate diagnosis and adequate pain management - frequently readmitted to hospital to address pain issues.	The Health Board has a duty of care to our patients and we will not be discharging patients prior to their care needs being met. The proposed changes are based on discharging patients home at the same point they would have been previously but having spent a shorter length of time in hospital. In some cases, this will mean their care needs may be lower than before, as they have lost less condition and independence while in hospital than would previously have been the case. It is proposed that a new Joint Monitoring and Evaluation Group is established with representation from the CHC, LAs, WAST and voluntary sector to monitor impacts of the proposed bed changes and to ensure that there aren't negative impacts of these going forward. This group will ensure that as beds are closed in a staged way there isn't an increase in readmissions across any of our hospitals. The Health Board works closely with Local Authorities and the voluntary sector through the Western Bay Programme to develop community services jointly so that they are integrated and coordinated.
Shifting the burden of care	
• Shift to community-based care effectively shifts the burden of care from the hospital to carers, care homes and the local authority which in many cases may not	The Health Board has a duty of care to our patients and we will not be discharging patients prior to their care needs being met.

be able to meet that care need due to a lack of resources.
- For older people, the care provider in their own home will be their partner, another older person with their own care needs. Or they may be alone in their home, dependant on family / carer visits if available at all.
- Costs of providing care may present a significant financial burden for low income households.
- Local authorities are under financial strain and are struggling to meet the existing social care needs of their local populations.

The proposed closure of our main hospital beds is based on improved efficiency in our hospitals and moving patients more quickly through their care experience, rather than discharging them at an earlier stage in their care which could shift the burden of care to carers or local authorities so the financial burden should not increase. It is proposed that a new Joint Monitoring and Evaluation Group is established with representation from the CHC, LAs, WAST and voluntary sector will monitor impacts of the proposed bed changes and to ensure that there isn't an increased burden of care on patients, their carers or Local Authorities, including costs. Because of patients spending a shorter time in hospital they become less dependent and have not lost as much condition so that their care needs may be reduced on discharge.

The Health Board works closely with its partners, including Local Authorities to ensure that there are not knock on effects of changes in health services on their services.

Investment in community services for Older People with Mental Health issues has increased the level of support available for families and care homes.

Our proposals are based on the assumption that we will improve length of stay and flow through our existing sites through changing our service models. Although we are reducing our inpatient capacity we are not closing any sites and our admitting sites will be the same, therefore will continue to assess whether journey times to patient's homes or existing community settings will be longer than they are at present.

The Health Board recognises that travel costs may increase due to patients and families having to travel further for services and ensures that reimbursement of travelling expenses are available in line with the All Wales policy on this. In addition where services do require patients to travel further, alternative travel arrangements can be made by staff where patients need to get home and do not have access to transport, such as via ambulance cars or even taxis in out of hours cases.

Integrated community-based services • Current community-based service provision is too fragmented to work effectively. • Community-based services are not able to meet current demand and would struggle to meet any increase in demand. (e.g. delays in getting GP appointments). • Service proposals will require a change of practice that community-based services may be unwilling, or unable to make (e.g. access to 24 hour pharmacy services). • Decision on closing beds should be delayed until community-based services are capable of meeting the new service demand, and have necessary processes in place.	The proposed closure of our main hospital beds is based on improved efficiency in our hospitals and moving patients more quickly through their care experience, rather than discharging them at an earlier stage in their care which could shift the burden of care to carers or local authorities. The Health Board works closely with its partners, including Local Authorities and the voluntary sector through the Western Bay Programme to develop community services jointly so that they are integrated and coordinated, to ensure that there are not knock on effects of changes in health services on their services. It is proposed that a new Joint Monitoring and Evaluation Group is established with representation from the CHC, LAs, WAST and voluntary sector to monitor impacts of the proposed bed changes and to ensure that there aren't negative impacts of these going forward. Investment in community services for Older People with Mental Health issues has increased the level of support available for families and care homes.
Access to community-based services • Shift to more community-based care provision will require patients to travel more frequently to access some health services. This will increase the logistical and financial challenges experienced by patients. For those patients without access to a car or family support, this is likely to be a significant challenge.	Our proposals are based on the assumption that we will improve length of stay and flow through our existing sites through changing our service models. Although we are reducing our inpatient capacity we are not closing any sites and our admitting sites will be the same, therefore will continue to assess whether journey times to patient's homes or existing community settings will be longer than they are at present. The Health Board recognises this impact and ensures that reimbursement of travelling expenses are available in line with the All Wales policy on this. In addition where services do require patients to travel further, alternative travel arrangements can be made by staff where patients need to get home and

do not have access to transport, such as via ambulance cars or even taxis in out of hours cases.

6. Next Steps

In order to monitor the impact of the proposed service changes ABMUHB will track figures for the following Key Performance Indicators (KPIs) on a monthly basis across hospitals in ABMUHB.

- 4 hour waits – all specialities
- 12 hour waits – all specialities
- Emergency Admissions to Adult Combined Medicine
- Adult Combined Medicine Length of Stay
- Average Beds Available - includes all sites and MH but excludes paeds critical care and palliative care.
- Bed Occupancy - includes all sites and combined Medicine specialties
- Cancelled Operations
- Readmissions from Combined Medicine (to any specialty / any site) within 28 days.
- Number of cases of C. Difficile.
- Number of cases of Staph. aureus bacteraemias

The above KPIs focus on performance within ABMUHB. As such, ABMUHB should work with key partners (e.g. Wales Ambulance Service Trust, and local authorities) to develop appropriate KPIs that monitor the effect of the service changes on the performance of key partner organisations.

ABMUHB should also consider how it will gather the views of patients to ensure the impact on patients is fully captured.

As part of the EIA process it is recommended that the above data be reviewed quarterly, and an updated report be produced annually for the next two to three years.

Appendix A: List of Most deprived LSOAs in ABMUHB Area

Table 17: Most deprived (0-20%) LSOAs in ABMUHB area, WIMD 2014.

Name	Code	LHB Rank (of 327)	Wales rank (of 1909)	Deprivation
Caerau (Bridgend) 1	W01000991	1	6	0-10%
Penderry 1	W01000830	2	21	0-10%
Cymmer (Neath Port Talbot) 2	W01000921	3	22	0-10%
Castle 2 North	W01001955	4	27	0-10%
Townhill 1	W01000862	5	29	0-10%
Castle 1	W01000742	6	33	0-10%
Penderry 3	W01000832	7	34	0-10%
Townhill 2	W01000863	8	41	0-10%
Mynyddbach 1	W01000817	9	43	0-10%
Caerau (Bridgend) 2	W01000992	10	44	0-10%
Penderry 4	W01000833	11	45	0-10%
Townhill 3	W01000864	12	49	0-10%
Townhill 6	W01000867	13	50	0-10%
Townhill 5	W01000866	14	64	0-10%
Sandfields West 2	W01000962	15	72	0-10%
Aberavon 4	W01000886	16	79	0-10%
Bettws (Bridgend)	W01000975	17	90	0-10%
Sandfields East 2	W01000958	18	98	0-10%
Bonymaen 1	W01000738	19	102	0-10%
Neath North 2	W01000939	20	112	0-10%
Morriston 9	W01000814	21	116	0-10%
Brackla 3	W01000981	22	117	0-10%
Morriston 5	W01000810	23	119	0-10%
Neath East 1	W01000934	24	122	0-10%
Briton Ferry West 1	W01000896	25	123	0-10%
Sandfields West 3	W01000963	26	133	0-10%
Morfa 2	W01001022	27	136	0-10%

Morriston 7	W01000812	28	140	0-10%
Sarn 1	W01001055	29	141	0-10%
Penderry 6	W01000835	30	142	0-10%
Aberavon 3	W01000885	31	145	0-10%
Neath East 2	W01000935	32	148	0-10%
Penderry 7	W01000836	33	150	0-10%
Aberavon 2	W01000884	34	166	0-10%
Blackmill 2	W01000977	35	171	0-10%
St. Thomas 1	W01000849	36	176	0-10%
Gwynfi	W01000930	37	177	0-10%
Caerau (Bridgend) 3	W01000993	38	179	0-10%
Cornelly 4	W01001002	39	189	0-10%
Llansamlet 8	W01000801	40	207	10-20%
Sandfields West 4	W01000964	41	212	10-20%
Coedffranc Central 3	W01000914	42	216	10-20%
Cockett 8	W01000762	43	217	10-20%
Penderry 5	W01000834	44	218	10-20%
Cockett 2	W01000756	45	224	10-20%
Ynysawdre 1	W01001057	46	225	10-20%
Landore 3	W01000789	47	234	10-20%
Penderry 2	W01000831	48	246	10-20%
Pyle 2	W01001049	49	248	10-20%
Neath South 2	W01000942	50	249	10-20%
Maesteg West 3	W01001019	51	254	10-20%
Penyrheol (Swansea) 4	W01000844	52	264	10-20%
Llansamlet 6	W01000799	53	269	10-20%
Landore 4	W01000790	54	271	10-20%
Sandfields East 1	W01000957	55	278	10-20%
Glyncorrwg	W01000924	56	284	10-20%
Oldcastle 1	W01001035	57	287	10-20%
Castle 3	W01000744	58	292	10-20%
Caerau (Bridgend) 4	W01000994	59	293	10-20%

Sketty 4	W01000856	60	295	10-20%
Blackmill 1	W01000976	61	298	10-20%
Landore 2	W01000788	62	302	10-20%
Maesteg East 2	W01001015	63	303	10-20%
Bryn and Cwmavon 3	W01000900	64	310	10-20%
Port Talbot 3	W01000951	65	315	10-20%
Maesteg West 4	W01001020	66	319	10-20%
Briton Ferry East 2	W01000895	67	323	10-20%
Clydach 3	W01000752	68	325	10-20%
Neath East 3	W01000936	69	328	10-20%
Bonymaen 2	W01000739	70	331	10-20%
Mynyddbach 2	W01000818	71	332	10-20%
Neath North 3	W01000940	72	334	10-20%
Morriston 6	W01000811	73	336	10-20%
Neath East 4	W01000937	74	340	10-20%
Morfa 3	W01001023	75	342	10-20%
Nant-y-moel 1	W01001024	76	347	10-20%
Bryntirion Laleston and Merthyr Mawr 3	W01000990	77	352	10-20%
Sandfields East 4	W01000960	78	354	10-20%
Gwaun-Cae-Gurwen 2	W01000929	79	355	10-20%
Castle 4	W01000745	80	356	10-20%
Tai-bach 2	W01000967	81	361	10-20%
Penllergaer 2	W01000838	82	369	10-20%
Cymmer (Neath Port Talbot) 1	W01000920	83	372	10-20%
Bonymaen 4	W01000741	84	380	10-20%

Appendix B: Service Change Engagement Activity

Table 18: Distribution of Information on Service Change

Recipient	Method	Enclosures
Public on database	Email / post depending on preference	Letter 1 Engagement document Summary document Response form
ABM CHC	Executive Committee – packs distributed 22.5.18	Engagement document Summary document Additional information Engagement Plan
Third Sector organisations	Via BSB Coordinators to 3rd sector network	Letter 2 Engagement document Summary document Response form Sign-up sheet for database
Stakeholder Reference Group	Briefings held on 17th April as part of preparation of engagement document	Letter 3 Engagement document Summary document Response form Sign-up sheet for database
Equality Groups	Bridgend Equality Forum	Letter 2 Engagement document Summary document Response form Sign-up sheet for database
BME Communities	Send to Race Equality Group & Chinese community	Letter 2 Engagement document Summary document Response form Sign-up sheet for database

Recipient	Method	Enclosures
Disability / Access groups	Disability Reference Group – briefings held on 17th April as part of preparation of engagement document	Letter 3 Engagement document Summary document Response form Sign-up sheet for database
Local Authorities	Letter to be sent to Chief Executives, Leaders & Directors of Social Services	Letter 4 Engagement Document Summary document Additional Information Response form
Community & Town Councils	Letter to be sent to One Voice Wales	Letter 4 Engagement Document Summary document Response from
Other organisations: South Wales Police Mid & West Wales (MWW) Fire & Rescue Natural Resources Wales (NRW) Universities Colleges Housing Associations DVLA Probation Police & Crime Commissioners	Letter to be sent to Chief Execs	Letter 4 Engagement Document Summary document Response form
Public Sector Partnerships	On agenda for Western Bay Programme Team	Presentation to be given Engagement document included in papers & response form

Recipient	Method	Enclosures
Carer Groups	Letters to Carers Services asking to distribute / make people aware in their Carers Groups	Letter 2 Engagement document Summary document Response form Sign-up sheet for database
Children & Young People	ABM Youth	Letter 5 Engagement document Summary document Response form Sign-up sheet for database
Older people	Older people's forums	Letter 5 Presentation to groups Engagement document Summary document Response form Sign-up sheet for database
Faith Groups	ABMU Chaplaincy	Letter 5 Engagement document Summary document Response form Sign-up sheet for database
Pregnancy & Maternity	Maternity Services Liaison Group	Send information to secretariat for distribution to members of the group Letter 5 Engagement document Summary document Response form Sign-up sheet for database
Sexual Orientation	Swansea LGBT Forum	Send information to secretariat for distribution to members of the group

Recipient	Method	Enclosures
		Letter 5 Engagement document Summary document Response form Sign-up sheet for database
Partnership Forum	Presentation on 24th May 2018	Packs of engagement documents, summary document, additional information distributed
Medical staff committees		Letter 5 Engagement document Summary document Response form
Local Medical Committee (LMC)	Ask to distribute to all members Presentation to exec on 12th June 2018	Engagement document Summary document Response form
Local Medical Advisory Group (LMAG)	Ask to distribute to all members	Letter 5 Engagement document Summary document Response form
Infection Control Boards	Ask to distribute to all members	Letter 5 Engagement document Summary document Response form
LDC	Ask to distribute to all members	Letter 5 Engagement document Summary document Response form
LOC	Ask to distribute to all members	Letter 5 Engagement document Summary document Response form

Recipient	Method	Enclosures
Local Pharmaceutical Committee (LPC)	Ask to distribute to all members	Letter 5 Engagement document Summary document Response form
GP Cluster Leads	Ask to distribute to all members	Letter 5 Engagement document Summary document Response form
Practice Managers' Group	Ask to distribute to all members	Letter 5
Volunteer Services	Ask to distribute to all volunteers	Letter 5
AMs	Face to face briefings arranged Presentation given 18th May 2018	Packs of engagement documents, summary document, additional information distributed
MPs	All MPs	Letter 6 Engagement document Summary document Additional information Response form
Other Health Boards	Powys & Hywel Dda	Letter 4 Engagement document Summary document Additional information Response form
Other CHCs	Powys & Hywel Dda	Letter 4 Engagement document Summary document Additional information Response form

Recipient	Method	Enclosures
Outpatient Departments / A&E	Send copies to Service Directors for distribution in waiting areas	Engagement document Summary document Response form Leaflets showing how to get more information

Table 19: Calendar of Meetings - Service Change Engagement

DATE	MEETING
May	
2nd	Stakeholder Reference Group
3rd	RNIB Have your Say Event
5th	Swansea Spring Pride
8th	LMC Meeting
9th	RNIB Have your Say Event
17th	Dementia Action Week Open Morning Event
17th	MH and LD Team Brief
17th	ABMYouth (cancelled)
18th	Singleton Team Brief
20th	Annual Step Out for Stroke
23rd	RNIB Have your Say Event
23rd	Health and Wellbeing Day
24th	Health Board Partnership Forum
29th	Bridgend Deaf Club
June	
1st	Morriston Hospital OPD
6th	NPTH Team Brief
7th	Swansea Deaf Club
11th	Joint Carers Event
11th	South West Wales BAME Regional Meeting
13th	POW Team Brief
14th	Swansea Carers Centre Open Day
18th	Singleton Hospital OPD
20th	Quadrant Shopping Centre
21st	Primary and Community Services Team Brief
21st	MH and LD Team Brief
25th	Singleton Team Brief

Appendix E

Response from Bridgend CBC, Neath Port Talbot CBC and Swansea Council

Proposals around patients spending less time in hospital, so allowing us to reduce beds

To what extent do you disagree or agree with the proposals around patients spending less time in hospital, so allowing us to reduce beds?

Tend to disagree

This response is submitted on behalf of Bridgend County Borough Council, Neath Port Talbot County Borough Council and Swansea Council.

As Local Authorities we are supportive of the idea that hospital is not an appropriate setting for individuals, unless the care and intervention that they need, can only be delivered in this setting. As Local Authorities we have been partners of the University Health Board in developing and delivering alternative care models and services, to traditional hospital based care and services.

We welcome in the consultation document the commitment to the further development and investment in community based services. However at a time when budgets for community services are facing reductions, to absorb additional patients who have increased complexity and clinical status and safely keep them out of hospital, is not achievable, without a commensurate investment in community services. Without investment in community services, the reduction of beds in hospitals, could lead to cost shunting from acute to community which is currently unfunded.

Investment in the community due to these changes in policy for acute services would be required prior to any implementation in order that the necessary levels of services with appropriately skilled staff are mobilised in readiness.

The Local Authorities are supportive of the initiatives being undertaken in hospitals to prevent individual's abilities and wellbeing deteriorating, which is termed 'PJ Paralysis' in the document. We, like the University Health Board, recognise that hospitals are not safe places for individuals and staying in a hospital setting for longer than needed, is not in the interest of individuals or health and social care organisations.

The three Local Authorities do however have some concerns about what is being proposed in the consultation document. The issues of concern and questions for clarification we have are:

- There are already significant pressures within the Community Resource Teams, who although welcome the opportunity to support more people in the

community, preventing the need for hospital admissions and longer stays in hospital, do not have the resources to absorb additional demand without the creation of waiting lists. This move obviously negates the objectives of intermediate care services.

- There are substantial pressures within the domiciliary care and care home markets regionally, which will become further pressured if the proposed reduction in beds takes place, without additional resources.
- There will be an impact upon the community equipment services in meeting additional demands. Additional capacity would be required to ensure the services are able to continue to meet their contract requirements, namely the delivery, servicing and maintenance of equipment.
- There is a lack of information within the document in respect of the transfer of knowledge and skills. We respectively ask if there has been a skills and capacity analysis carried out, to deliver the replacement provision of services for the people who would currently be receiving services as inpatients, but under the proposed changes will be in the community? There is particular concern about the impact on social work, district nursing, pharmacy, therapy and psychology services.
- There is already fragile out of hours clinical coverage, which will be further impacted by the proposed changes. We question how the provision of 24 hour clinical support will be provided in the community, for individuals who would currently be in hospital?
- How will individuals who live alone and require support, have their basic needs met, such as around hydration, nutrition and personal hygiene, who would currently be in hospital? In this period of ongoing austerity, Local Authorities are not in a position to meet this additional demand without additional resources.
- Current and previous expansion in community services has come through Welsh Government Integrated Care Funding; this funding is all fully committed and we have seen no growth in this funding in recent years. This is therefore not an avenue to fund additional community support.
- We do not have consistent seven day community services across the region to meet the demand that this reduction in beds would create.
- How will the needs of individuals in the community be met, where their health needs are more than incidental and ancillary, because it is unlawful for Local Authorities to commission services to meet these needs?
- Our experience of ‘Breaking the Cycle’, was that earlier discharges took place, however the individuals were not ready for enabling and therefore the impact was felt in the “bridging” services. These services filled quickly, which required the Community Resource Team services to take them out to create “Bridging” capacity, affecting flow, which prevented people who were ready in hospital to receive an enabling service accessing the appropriate service for them.
- The consultation document states that it is planned to make the use of assessment beds at Plas Bryn Rhosyn a permanent arrangement, although Neath Port Talbot County Borough Council has made the University Health

Board aware that they are not in a position to continue with the current arrangement. The Local Authority is however happy to discuss how the University Health Board can purchase the beds at Plas Bryn Rhosyn if this is something it would like to do.

- We refer to this proposed policy change throughout our feedback, therefore we respectfully ask to have sight of the Equality Impact Assessment that would have been completed. This will then assist us to confirm/identify the impacts on the wider community services.

Proposals to develop more community based services to support older people with mental health problems, so allowing us to reduce beds

To what extent do you disagree or agree with the proposals to develop more community based services to support older people with mental health problems, so allowing us to reduce beds?

Tend to disagree

We welcome the proposal to change the balance of resources between inpatient and community settings for older people with mental health conditions. We would however be concerned if any further closure of beds occurred prior to the development and investment into community alternatives and services to hospital beds. The changes already implemented by the Health Board to Older People Mental Health services are putting unacceptable pressure on existing resources in terms of community services for older people with dementia.

In order to support this policy change by the University Health Board, the Care Homes sector will require support in development of their skills base as they will be expected to support more challenging complexity of behaviours and clinical needs. In the recent changes to Older People’s Mental Health Services, we have seen homes struggle to deal with the increased complexity, which has actually led to unnecessary hospital admissions due to the lack of outreach support available.

There is also a risk of breakdown in arrangements in the community, where informal carers and generalist providers support older people with mental health conditions, without access and support from specialist professionals.

Are there any further comments that you would like to make on our proposals for change?

We would welcome further discussion with the University Health Board about how the risks and issues outlined in this response can be mitigated.

In particular, we would like a response to the following:

- For the proposed bed closure on each site, what additional community services are expected to meet the additional demand that the closure will create.
- How will these services be funded.
- An assurance that by closing these beds that community services will not become blocked due to increased demand, delaying discharges from hospital and increasing avoidable unscheduled care admissions.
- A copy of the analysis that was undertaken to determine that there were sufficient community services to meet the demand that the closure of these beds will create.
- A copy of the Equality Impact Assessment relating to these proposals which sets out how community services will be able to meet the adverse impact on protected groups particularly older people and people with a disability particularly mental illness.

It should be highlighted that we are supportive of any proposals to reduce the pressure on acute hospital beds, and also ensure that those beds that remain open are safely staffed. However, overall we feel that any proposed closure of beds needs to be thought through and planned with community colleagues to ensure that demand can be met and effective patient flow is maintained. There is soon to be a bed utilisation survey of acute and community provision in Swansea, and it seems premature to put forward proposals for closure of hospital beds before this piece of work is concluded.

We would therefore like our comments and the clarification we have asked for to be referenced in the final report that is considered by the Health Board and would welcome further discussions before a final decision is made.

Are there any groups protected under the Equality Act 2010 who you believe will be positively or negatively affected by our proposed changes? If so, what could we do to enhance positive or reduce negative impacts?

There is a potential negative impact on older people and people with a disability particular a mental illness, if it cannot be demonstrated how community services will meet the additional needs of the patients that will be affected by the proposed closure of the beds. Therefore, the evidence of what community services will be available to meet the need and how they will be funded needs to be clear.

Appendix F

Re: Response from Bridgend CBC, Neath Port Talbot CBC and Swansea Council to "Your NHS – Help us change for the better"

Thank you for your collective response on behalf of Bridgend CBC, Neath Port Talbot CBC and Swansea Council to our engagement document and the service changes proposed within it. I appreciate you taking the time to respond and will respond to the comments you make in relation to each section of the proposals in turn:

Case for Change:

As was clear at our joint meeting on 20th June we all share the same commitment to delivering services differently in order to fundamentally change care provision and focus on earlier intervention and prevention and diversion of people away from managed care, in whatever setting, so reducing dependency and complexity of need. The majority of people and organisations who responded to the engagement also supported the need to provide services differently going forward and this is good news for us all as we work together to transform services in line with the Parliamentary Review.

Proposals to reduce the time patients spend in hospital, so allowing us to reduce beds:

The proposals we put forward in our engagement for our main hospitals and Gorseinon Hospital, which enabled us to reduce beds, are based on the following premises:

- That patients should be assessed without needing to be admitted to hospital to achieve this
- Patients should stay in hospital for shorter periods and be mobilised more quickly, so reducing their dependency and the amount of condition they lose from being immobile in hospital beds for longer periods
- That rehabilitation should be targeted at those patients who will most benefit from it, and be delivered 7 days a week, to reduce the length of time they have to stay in hospital before they are fit for discharge
- Patients shouldn't be transferred to other hospitals if they can be discharged home directly from the hospital they are admitted to

None of the changes we proposed are based on patients being discharged prior to their care needs being met. Therefore they are not based on needing additional input in the community, as what we have been doing is improving our efficiency internally within the Health Board to speed up the interventions people need and discharge them, with at least the same level of independence, and in some cases, with lower care needs, than would have been the case previously when they would

have spent longer, sometimes significantly longer, in hospital and so lose condition and become more dependent over this time.

In relation to the specific impacts you mention in your response regarding:

- Pressures within the Community Resource Teams not having the resources to absorb additional demand without the creation of waiting lists
- Additional pressures on domiciliary care
- Additional demands for community equipment services
- Skills and knowledge transfer to deliver replacement services for the people who would currently be receiving services as inpatients who under the proposed changes will be in the community
- 24 hour clinical support in the community for individuals who would currently be in hospital
- Additional demand for basic needs support at home for patients who would currently be in hospital

We understand that these impacts would be felt if our proposals and the reduction in beds was based on the assumption that we would be discharging patients home at a point in their care where their needs would still need to be met, but at home instead of in hospital. However the changes we have and are proposing to put in place are based on discharging patients home at the same point they would previously, just having spent a shorter length of time in hospital, which in some cases will mean their care needs will be actually lower than before, as they will have lost less condition and independence than would previously been the case.

With regards to the provision at Plas Bryn Rhosyn the Health Board recognises the benefits which residents of Neath Port Talbot have derived from this facility and believes that both the Health Board and Social Services have also benefitted from using this service more effectively. We would be keen to discuss joint funding of this service with NPT CBC in order to continue the mutual benefits for all of us of this provision.

The draft Equality Impact Assessment was published alongside the engagement document and was available for consideration as part of this process and is available on our website. As part of the evaluation of the outcome from the engagement we are currently updating this to reflect the feedback we received from equality groups as part of the process.

Proposals to develop more community based services to support older people with mental health problems, so allowing us to reduce beds:

Again when we met we clearly all shared the desire to change the balance of resources between inpatient and community settings for older people with mental health conditions. The Health Board fully understands the importance of investing in additional community services for older people's mental health services prior to beds

being closed. We have already invested an additional £1.5m in community services to do exactly this, including additional psychologists, physiotherapists and OTs who are supporting people in their own homes.

You have raised the issue of the additional support required for care homes to develop their skills base to support more challenging complexity of behaviours and clinical needs. Again we completely agree with this priority and some of the £1.5m has been spent on funding a team in each local authority area to provide support and specialist input to care homes to help improve the understanding of staff there about the provision of care to their residents and reduce the need for admissions to hospitals due to behaviour changes or illnesses. These teams are already delivering services in care homes, improving the multidisciplinary mix of staff and ensuring consistency in services across all local authority areas.
A paper outlining some more details on these investments is included with this letter for your reference, which also outlines how these enhanced community services can support carers and families to ensure that their caring arrangements do not breakdown because of the additional support they are receiving, another concern you raised.

Further Comments:

You requested a specific response from the Health Board to a number of specific issues you raised, some of which I have touched on above, but I have outlined our response to each of these below:

1. **For the proposed bed closure on each site, what additional community services are expected to meet the additional demand that the closure will create?**

As outlined above we do not expect any additional demand on community services as a result of the beds we are proposing to close, this is because the bed reductions have been made possible by internal efficiency savings around reducing lengths of stay of patients significantly, targeting rehabilitation more effectively and consistently and reducing the number of patients who actually need admission by assessing these on a short stay basis with required care being provided in their homes. In developing our plans we have carefully monitored the impact of each of the internal efficiency mechanisms we have put in place on length of stay, acuity of patients on discharge, readmission rates, activity levels and therefore reductions in bed days.

2. **How will these services be funded?**

As outlined above, these proposed changes were not predicated on discharging patients at an earlier stage of their health care journey, where alternative services in the community would be required to provide care which had previously been delivered in hospital. Rather the reduction in beds has been made possible by reducing how long that same health care journey takes now. Again we have

been carefully monitoring the impact on other services of these changes to ensure that there have not been knock on effects.

3. **An assurance that by closing these beds that community services will not become blocked due to increased demand, delaying discharges from hospital and increasing avoidable unscheduled care admissions?**

The monitoring we have been carrying out as we have trialled different approaches to modernising our services, developing new models of care in our hospitals, and reducing the need for patients to be admitted for assessment means that we have been checking across all our different hospitals as well as primary and community services for any knock on impacts of these changes. However we understand the importance of all partners being able to consider this information and challenge any impacts and so we would like to invite you to join a newly constituted Joint Monitoring and Assurance Group, along with other partners such as the Community Health Council and the voluntary sector, which will look at the metrics supporting these changes and monitor the impacts of these changes as they happen so that we can jointly agree any actions we may need to take to ensure there are no negative consequences of these changes.

4. **A copy of the analysis that was undertaken to determine that there were sufficient community services to meet the demand that the closure of these beds will create**

As outlined in 1 above this was not the basis for these bed reductions and so the analysis as described was not required. However the Health Board has undertaken extensive monitoring and evaluation of each initiative which has been introduced to support the changes in practice outlined in the engagement document and we would suggest that we could outline these to you at the first meeting of the Joint Monitoring and Assurance Group (if you are happy with this proposal of course) so that you can understand the detail of how the Health Board gained assurance of the impacts of these new service models on bed occupancy, lengths of stay and therefore the number of hospital beds required.

5. **A copy of the Equality Impact Assessment relating to these proposals which sets out how community services will be able to meet the adverse impact on protected groups, particularly older people and people with a disability, particularly mental illness**

As mentioned above the Stage 1 Equality Impact Assessment was published alongside the engagement document. It has now been revised as a Stage 2 document and I have attached a copy of the Board report which will be considered at our meeting in public on 26th July 2018, and which has the EqIA included within it.

I would like to take the opportunity to thank you for your detailed consideration of the proposed service changes outlined in our engagement document. I hope the above

responses will give you some assurance that we carefully developed these new service models with clear monitoring of the impacts of these on patients and other services prior to engagement. I also hope that you see our proposal to work with us on the Joint Monitoring and Assurance Group as positive so that we can all be confident about the changes being implemented and that the impacts of these have been considered and actions taken to mitigate these where possible.

Finally I would again like to take the opportunity to confirm my personal commitment and that of the Health Board to ensure that we establish a joint mechanism going forward which allows us to discuss, develop and collectively agree service change plans for health and social care services so that we can work together more collaboratively on these for the people we serve.

Yours sincerely,

Tracy Myhill

Chief Executive

Appendix G

Response from Welsh Ambulance Services NHS Trust

6th July 2018

Dear Joanne

Re: Consultation on proposals to permanently close adult mental health beds in ABMU Health Board

I am writing in response to the proposed changes outlined in your public engagement document to permanently reduce the number of mental health beds for older people across a number of sites in ABMU.

We have reviewed the proposals and in principle support the case for change to consolidate mental health services to deliver more sustainable and efficient community-based care to patients.

We recognise the important role the ambulance service has to play in providing care for this cohort of patients and we are keen to explore further the operational implications detailed in this letter and to identify opportunities to work more closely with you to support these changes (pending approval).

Unfortunately, to-date there have been limited opportunities for us to engage with you about the proposals and would now welcome a meeting with you to discuss the proposals in more detail.

In recognition of the above point, we have discussed the proposals with key leads from within the organisation and summarised below are the key elements of feedback we would like you to consider as part of this public engagement.
For ease of reference, we have separated the response for Emergency Medical Services (EMS) and Non-Emergency Patient Transport Service (NEPTS).

EMS

- **Mental Health Clinical Pathways** – as a result of the proposed bed closures will there be any changes to the current Mental Health pathways in place for ambulance patients? If yes, what are the proposed changes and how will you engage with WAST going forward to implement these changes?

- **Delayed discharges and impact on patient flow** – do you anticipate that the reduction in community beds will impact the timely flow of patients being discharged from a hospital to a community-based setting? Our concern is that this may impact secondary care patient flow and as a result impact the timely handover of ambulance patients arriving at hospital.

- **Impact on Hospital Handover** – as above, will the proposed bed closures impact flow across the system and increase handover delays?

- **Plans to close beds** – we would like assurance that there are adequate community services in place prior to the commencement of any permanent bed closures. Also are there any plans to maintain any additional bed capacity to manage and mitigate any surge in demand or system failure?

NEPTS

- **Secondary transfers** – as a result of the bed closure will there be any implications for NEPTS with respect to undertaking secondary transfers between hospital and community based settings? Under the proposals this could mean longer journey distances to travel in comparison to the way services are currently delivered. As a result this could impact NEPTS resources and capacity.

Appendix H

Re: Response from Welsh Ambulance Services Trust to the engagement document "Your NHS – Help us change for the better"

I am writing in response to your comments on our proposals to change our service models in line with best practice to improve the way we care for older people and improve outcomes by reducing deconditioning and promoting independence. Our new ways of working will also help us to improve flow through our system and to move towards achieving the vision of providing more care closer to home as set out in 'A Healthier Wales'.

Although your letter refers to Older People's Mental Health services I have also addressed our changes in general hospitals where this appears to be in the spirit of the comments made, and I am responding to the comments you made in turn.

Case for Change

Thank you for your support for the case for change to deliver sustainable care to our older mental health patients in line with best practice. I know that we share the same commitment to delivering services differently in order to fundamentally change care provision and focus on earlier intervention and prevention and diversion of people away from managed care, in whatever setting, so reducing dependency and complexity of need. The majority of people and organisations who responded to the engagement also supported the need to provide services differently going forward and this is good news for us all as we work together to transform services in line with the Long Term Plan.

We would very much welcome a meeting with you to discuss the proposals and appreciate your offer to support the changes. We did offer a meeting in June and we would be grateful if your team could contact catrin.a.evans@wales.nhs.uk to arrange the meeting.

EMS

Mental Health Clinical Pathways: The changes affect Older People's Mental Health services only and inpatient services for older patients will continue to be provided at Tonna, Princess of Wales Hospital and Glanrhyd Hospital as at present. We have enhanced our community services to be able to rebalance our service models, promote independence and improve outcomes for older people in line with best practice. Due to these changes in the way we provide services, our bed occupancy has already dropped to a level which will allow us to maintain patient flow through the proposed reduced inpatient capacity. As our aim is to maintain more people in the community it is difficult to say what impact the changes will have, on balance, on ambulance journeys to hospital sites and we would like to discuss with you further about how we monitor the impact going forward.

Delayed discharged and patient flow / Impact on hospital handover: Due to our new ways of working, the occupancy of our inpatient provision has already decreased to the level required to support the proposed reduction in bed capacity in our Older People's Mental Health Units if this is approved. We do not anticipate an adverse impact on acute secondary care flow or consequent impact on handover of ambulance patients arriving at hospital.

With regard to general community hospitals, we have changed the service model for frail older people between Morriston and Gorseinon hospitals. This has enabled us to improve the quality of the patient experience at Gorseinon in line with Health Inspectorate Wales recommendations. The new service model is also part of our ongoing work to improve flow through Morriston hospital and improve ambulance handovers and front door waiting times. Our evaluation of the change, which we are proposing to make permanent, shows that even with reduced bed capacity we admitted c. 20% more patients to Gorseinon in 2017/18 than in 2016/17. This has had an estimated bed days reduction equivalent to 7 beds in Morriston as well as a reduction of 8 beds in Gorseinon and it is therefore unlikely to have impacted adversely on ambulance handovers.

Plans to close beds:

We have already invested an additional £1.5m in older people's mental health community services which has enabled more psychology, physiotherapy and occupational therapy services to be in place to provide support to people in the community to better manage behaviour problems, promote physical exercise, improve balance and mobility and develop activities of daily living which can reduce reliance on institutional care. We have also developed a team who provide input into care homes across each Local Authority area. Over 50% of care home residents have some form of dementia symptoms which increase the risk of hospital admission. Providing support and specialist input into care homes helps improve staff's understanding of their residents' needs and in turn improves the service provided to them and reduces hospital admissions where earlier intervention could prevent this.

The proposals we put forward in our engagement for our main hospitals and Gorseinon Hospital, which we believe enable us to reduce the beds outlined, are based on the following principles:

- That patients should be assessed without needing to be admitted to hospital to achieve this;
- Patients should stay in hospital for shorter periods and be mobilised more quickly, so reducing their dependency and the amount of condition they lose from being immobile in hospital beds for longer periods;

- That rehabilitation should be targeted at those patients who will most benefit from it, and be delivered 7 days a week, to reduce the length of time they have to stay in hospital before they are fit for discharge; and,
- Patients shouldn't be transferred to other hospitals if they can be discharged home directly from the hospital they are admitted to.

None of the changes we are proposing are based on patients being discharged prior to their care needs being met. Therefore they are not based on needing additional input in the community, as what we have been doing is improving our efficiency internally within the Health Board to speed up the interventions people need and discharge them, with at least the same level of independence, and in some cases, with lower care needs, than would have been the case previously when they would have spent longer, sometimes significantly longer, in hospital and so lose condition and become more dependent over this time.

The monitoring we have been carrying out as we have trialled different approaches to modernising our services, developing new models of care in our hospitals, and reducing the need for patients to be admitted for assessment means that we have been checking across all our different hospitals as well as primary and community services for any knock on impacts of the temporary bed reductions we have put in place, prior to engaging on making these permanent. However we understand the importance of all partners being able to consider this information and consider the impacts and so we are proposing as part of our consideration of the feedback on our service change proposals that we should establish a Joint Monitoring and Assurance Group, which we would like to invite you to join, along with other partners such as Local Authorities, the Community Health Council and the voluntary sector, which will look at the metrics supporting these changes and monitor the impacts of these changes as they happen so that we can jointly agree any actions we may need to take to ensure there are no negative consequences of these changes.

We do still plan to retain surge capacity which will be supported through our Winter Plan.

NEPTS

Secondary transfers: Our proposals are based on the assumption that we will improve length of stay and flow through our existing sites through changing our service models. Although we are reducing our inpatient capacity we are not closing any sites and our admitting sites will be the same, therefore we would like to explore with you further whether journey times to patient's homes or existing community settings will be longer than they are at present.

I would like to take the opportunity to thank you for your detailed consideration of the proposed service changes outlined in our engagement document. I hope the above

responses will give you some assurance that we carefully developed these new service models and proposals and that we are committed to continuing to evaluate the impact of the changes with partners as we go forward.