ANNEX B10

## THREE YEAR INTEGRATED MEDIUM TERM PLAN 2019-22

# EQUALITY IMPACT ASSESSMENT

## JANUARY 2019

## 1 INTRODUCTION

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

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

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

Due to the scale and complexity of the UHB's 3-Year Integrated Medium Term Plan (IMTP), we have taken an iterative approach to the equality impact assessment. As a high level corporate, overarching plan it is not intended to be a definitive statement on the potential impact of the IMTP on protected characteristic groups. As a pathfinder document, it is intended to describe our current understanding of the likely impact of the Plan at a high level on the communities of Rhondda, Cynon, Taf, Merthyr Tydfil and Bridgend, hereafter throughout this document known collectively as 'Cwm Taf'. It seeks to include initial observations which will require more detailed analysis. The more detailed work will be undertaken as part of the specific service changes to be delivered.

This assessment undertaken is based on Public Health Observatory and 2011 Census information. It should be read in conjunction with the Cwm Taf UHB section of the South Wales Plan Equality Impact Assessment (SWP EIA) and the Cwm Taf Health Equality Impact Assessment (CT EIA). More latterly however, this EIA also takes into consideration both the data collated and analysed, and the engagement and consultation responses received which were used to inform the development of both the Population Needs Assessment under the Social Services & Well-Being (Wales) Act 2014 and the Well-Being Assessment under the Well-Being of Future Generations (Wales) Act 2015.

The EIA has been refreshed as we update the IMTP for the period 2019-22 and further develop our delivery model, in particular our focus on an emerging Clinical Services Strategy for Cwm Taf, regional collaboration and managing strategic change through our cross cutting themes. We aim to integrate the EIA process into this programme of work from as early a stage as possible. This will include linking this work into the Engagement and Consultation Plan that underpins the IMTP.

It will also be essential to ensure the EIA process is fundamental to all directorate plans and is a key consideration in clinical/ corporate business meetings.

During this later phase of our work we will ask the following questions:

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

Engagement and consultation will continue with the public and stakeholders as part of the ongoing development and implementation of the UHB Plan. The EIA process shall be fundamental to this.

## 2 THE UHB's 3 YEAR INTEGRATED MEDIUM TERM PLAN (IMTP)

**Vision:**

Our overall vision as a University Health Board is to:

"To be recognised as a population well-being organisation that continually makes a positive contribution to improving the lives of all Cwm Taf residents."

This vision will be delivered via the UHB's new Well-Being Objectives:

- We will work with communities to prevent ill-health, protect good health and promote better health and well-being.
- We will provide high quality care as locally as possible wherever it is safe and sustainable.
- Our service delivery will be innovative, reflect the principles of prudent health care and promote better value for users.
- We will work collaboratively with our public service partners and a broader range of partners to join up health and other services where this potentially represents better value for our residents and care users.
- Through our commitment to corporate social responsibility and to improving health & social equity, we will work with our staff, partners and communities to build upon strong local relationships and solid foundations of the past.

**Key Messages in the Plan**

Our Plan makes a strong commitment to quality and safety and this commitment continues to underpin our system of integrated planning. Within the context of a community that experiences significant health challenges in terms of deprivation and the burden of ill health, the focus is on quality of delivery, improved patient experiences, ensuring optimal access to services and equity of resources. The Plan recognises that we face challenges over the coming years with growth in our population need, increased costs and significant resource constraints.

As a Health Board, our key priorities for 2019-22 are:

| Focus Theme | 2019 - 2022 Priorities |
|---|---|
| Wellbeing | 1. Embrace the prevention agenda, for example by encouraging our patients and staff to adopt 'one more healthy behaviour' and supporting the well-being of our communities with our partners, including the development of community zones. |
| Integrated Community Care | 2. Demonstrate greater integration across health and social care, particularly in the way in which services are provided to our more vulnerable client groups i.e. older people with complex needs, people with learning disabilities, children with complex needs and all age carers, with increased joint commissioning arrangements, pooled budgets and making better use of our estate in partnership |
| Care Closer to Home | 3. Implementation of our next step mental health service improvements, including the next phase of older adult mental health service redesign and new approaches to dementia care.<br><br>Implement our updated primary and community care plans including improving the sustainability of primary care; further development of our Clusters and Cluster Plans, improved demand management and evidencing the shift of service from secondary to primary care. |

| Focus Theme | 2019 - 2022 Priorities |
|---|---|
| Acute Care | 4. Development of local and regional hospital service planning and delivery where appropriate in areas such as diagnostics, ophthalmology and orthopaedics, as well as vascular and ENT service redesign.<br>5. Continue to improve scheduled and unscheduled patient care, patient flow and urgent care processes including: maintaining and improving upon the target of no patients waiting for treatment over 36 weeks; maintaining and improving upon the target of no patients waiting over 8 weeks for diagnostics; continuing to work on the 95% 4 hour target (maintaining wherever possible at least 90% performance) and having no patients waiting over 12 hours.<br>6. Continue work to meet the 31 day target and work to meeting the 62 day cancer target, maintaining at least a 90% position. |
| Tertiary Services | 7. Continue our strong involvement and approach to the commissioning of specialist services working with partners such as WHSSC, EASC and Velindre NHS Trust. |
| **Enablers** | 8. Continue to improve patient experience throughout the University Health Board.<br>9. Further develop our Clinical Service Strategy.<br>10. Digitisation Plans.<br>11. Address recruitment and retention challenges with a priority on workforce planning and redesign and development of new roles such as Physician Associates.<br>12. Further developing leadership and delivery capacity across the organisation.<br>13. Engage with an increasing number of members of the public, particularly representatives from the protected groups under the Equality Act 2010, and staff in Cwm Taf through a variety of accessible platforms to involve people in the design and development of new clinically led and patient focused services, both in and out of hospital.<br>14. Improve data quality, including reporting and transparency.<br>15. Ensure compliance with legislation.<br>16. Achieve financial balance |

# 3 PROFILE OF THE PEOPLE WHO USE OUR SERVICES

## 3.1 Demographic Profile

The following analysis is based on information contained from the following sources:

- 2011 Census.
- South Wales Programme Equality Impact Assessment Evidence Document 2013.
- Welsh Index of Multiple Deprivation
- Cwm Taf Population Needs Assessment (2017).
- Cwm Taf Well-being Assessment (2017).
- Cwm Taf Public Services Board Well-Being Plan (2018-23).
- Bridgend PSB Assessment of Local Well-being (2017).
- Western Bay Population Assessment (2017).
- Bridgend Public Services Board Well-Being Plan (2018-23).

It will be important to keep this information up to date and this will remain a priority in the coming year.

The resident population of Cwm Taf (including Bridgend) was estimated to be 441,293 in 2016 accounting for just over 14% of the Welsh population. Just over 54% of the population live in Rhondda Cynon Taf Local Authority, 13.5% in Merthyr Tydfil and almost 32.5% reside in Bridgend. The Health Board's catchment population increases to approximately 530,000 when including patient flow from the Upper Rhymney Valley, South Powys, North Cardiff, Neath Port Talbot and Vale of Glamorgan.

Overall, the health of our population is improving however, we have areas of significant deprivation and far too many people still experience poor health. Many of the causes of poor health are difficult to tackle. Cwm Taf is a socio-economically deprived area, with low levels of employment and educational attainment. These factors, along with other aspects of the physical environment, impact on the lifestyles of people living in the Health Board area.

Life expectancy and healthy life expectancy in each of our Local Authority areas is lower than the Wales average, with the Bridgend population slightly higher than Rhondda Cynon Taf and Merthyr Tydfil for both males and females. The gap in life expectancy and healthy life expectancy in all our Local Authority areas is lower than Wales and there are great inequalities in outcomes for the poorest compared to the most affluent.

The population is growing in Cwm Taf. There is low employment and low levels of academic achievement in Cwm Taf. .

### 3.2 Gender

There is a very slightly higher proportion of female residents and this is broadly consistent with the rest of Wales. Women are more dependent on public transport (National Travel Survey, Department of Transport 2011) and would therefore benefit from improved local services, in both primary and community care. They are also more likely to be lone parents than men.

Pregnancy and Maternity as a protected characteristic is also relevant to the whole issue of appropriate provision of these services. Despite improvements, Cwm Taf has the highest rate of low birth weight babies in Wales. Maternal smoking and obesity are potentially the biggest modifiable risk factors for pregnant women. The Health Board is therefore taking targeted action in relation to smoking cessation and tackling obesity. See **IMTP Section 3.1** and **Book A1** for details of these interventions which are delivering very encouraging early results.

### 3.3 Age

Cwm Taf has a slightly higher proportion of younger people than the Welsh average particularly, in the 0-4 and 5-14 bands.

Other groups are broadly consistent, except for 25-44 group which is slightly higher than average.

Older people are also less likely to have access to a car and this is relevant where services are planned to be relocated and must therefore be a key consideration in our plans. This has also been a key consideration in the development of our Joint Commissioning Strategy for Older People's Services 2015-25.

### 3.4 Disability

Cwm Taf has a significantly higher proportion of residents who declare that their day to day activities are 'limited a lot' and a slightly higher proportion whose activities are 'limited a little' as described in Census 2011 categories - in many areas this applies to over 25% of the population and in some areas it can be up to 37% compared to the Wales average of 23%. This is consistent with the age profile as more than half of men and women over 65 years say that they have a limiting long term illness (How Fair is Wales 2011).

Disabled people are ten times more likely to report ill health and also approximately half are likely to experience mental ill health (How Fair is Britain?). The Cwm Taf population report the poorest mental health status of all Health Boards in Wales.

This could have implications in terms of service moves as disabled people are likely to have no access to a car. Disabled people are also less confident in using public transport because of physical access issues, and also because of staff attitudes.

There could also be problems for people who have sensory impairments or a learning disability accessing different sites generally and particularly if they are further away from familiar surroundings. It will be essential to ensure that consultation on changes takes account of different communication needs e.g. accessible formats for people for sensory loss and 'easy read' for people with learning disabilities. Work is underway in the Health Board to meet the All Wales Standards for Communication and Information for People with Sensory Loss and service development should meet these Standards. Likewise, the Health Board will need comply with the draft Accessible Buildings policy in relation to Sensory Loss when designing and redesigning health facilities.

A Joint Statement of Intent for Learning Disability Services has been developed in partnership by Cwm Taf UHB, Rhondda Cynon Taf County Borough Council and Merthyr Tydfil County Borough Council.

### 3.5 Ethnicity

Merthyr Tydfil and Rhondda Cynon Taf have lower representation from ethnic groups other than white than Wales as a whole. However there are significant number of Polish, Portuguese and Czech people living in the Cwm Taf community and their access issues will need to be considered.

Cwm Taf regions have taken part in a number of Home Office Schemes (i.e. the Vulnerable Person's Resettlement Programme; Vulnerable Children at Risk; and Unaccompanied Asylum Seeking Children). Although the numbers of people received into Cwm Taf and Bridgend are relatively small, we are working in collaboration with the Wales Refugee Council, local religious leaders and the families themselves to ensure their cultural and religious needs are met.

Overall, language can represent a barrier across a number of areas, for example in accessing public transport and also in terms of finding and accessing health or social services. Cultural differences may also be a factor in how people engage with health services.

We also know that certain ethnic groups are less likely to access many of our services e.g. gypsies and travellers, and it will be important to take account of strategies which address this e.g. 'Travelling to A Better Future', Welsh Government. This has been a particular consideration in the development of the UHB's Homeless and Vulnerable Groups Health Action Plan.

### 3.6 Marriage and Civil Partnership

The number of people who are married or in a same-sex civil partnership is the same as for Wales as a whole.

### 3.7 Religion

There is a lower representation in every religious group than is seen in Wales as a whole. Higher than average proportions of the population stated that they had no religion. Where there are strong community groups based on race and religion, community based care could be particularly beneficial.

### 3.8 Sexuality and transgender

This information is not currently available on either of these groups, both of whom are specifically covered by the Equality Act 2010.

Sexuality – it will be important to take account of sensitivities in relation to the needs of lesbian, gay and bisexual (LGB) people for example, in relation to, relationship status and next of kin communication when considering visiting arrangements, any kind of family therapy or support where relationships may be relevant. It is also important that services are presented as LGB friendly.

Transgender – the term trans* covers a wide spectrum of people within this group e.g. transsexual, transgender, gender neutral, gender fluid among others. Again it is important that services are regarded as trans* friendly and that particular sensitivity is given to this group who are at particular risk of discrimination throughout society and this must be taken into account in service developments.

The following groups do not constitute protected characteristics but are relevant in considering issues in relation to the groups already listed. We are aware of the need to improve access to services and patient experience particularly in relation to transgender people.

### 3.9 Car or Van Ownership

in each of our Local Authority areas there are significantly higher proportions of households who have no car than the Wales as a whole. This is particularly relevant in relation to access to or the reconfiguration of services.

### 3.10 Deprivation

Higher levels of deprivation are evident in every category compared with the rest of Wales and this has implications for access to transport and health generally. Although it is noted that not all disadvantaged people live in the most deprived areas. People in deprived areas are likely to report a range of key illnesses which is relevant to many of the services under consideration in the Plan. Although deprivation is not specifically covered by the Equality Act 2010, people from protected groups are more likely to fall into this category.

Two and a half times as many working age people in Merthyr Tydfil are in receipt of out of work benefits compared to more affluent areas of Wales.

### 3.11 Health

Life expectancy and healthy life expectancy in each of our Local Authority areas is lower than the Wales average, with the Bridgend population slightly higher than Rhondda Cynon Taf and Merthyr Tydfil for both males and females. All cause mortality rates for men in the Bridgend area are significantly higher than the Wales average and their peer local authorities. The gap in life expectancy and healthy life expectancy in all our Local Authority areas is lower than Wales and there are great inequalities in outcomes for the poorest compared to the most affluent.

Lower proportions of the community declare they are in 'very good' or 'good health'. More people suffer from chronic health conditions than elsewhere in Wales, the GP Cluster Information[1] shows that whilst the population of Cwm Taf equates to 9.57% of the population of Wales, Cwm Taf residents are over represented as a higher proportion of the total numbers of people in Wales who suffer from Hypertension, Coronary Heart Disease, Chronic Obstructive Pulmonary Disease (COPD) and epilepsy live in this area. Cwm Taf has a higher death rate from respiratory disease and higher than average cancer rates than elsewhere in Wales. There is a higher than average rate of deaths from liver disease and cancer in Bridgend.

Whilst substance abuse is not as prevalent in Bridgend as Cwm Taf, in Cwm Taf substance misuse is a major issue and the death rate is increasing for alcohol related conditions. In Bridgend, the harms associated with alcohol use is significantly worse than the Wales average.

[1] Public Health Observatory 2013

### 3.12 Unpaid Carers

The 2011 census showed that there were 370,230 Carers in Wales. This had increased by 9% since the 2001 census. Carers provided 96% of all care in the community. In each of our Local Authority areas the 2011 census showed:

- 12.6% of the population in Merthyr Tydfil and 12.5% in Rhondda Cynon Taf and 12.8% in Bridgend provided care to a family member, friend or neighbour.
- In Cwm Taf, there were nearly 55,000 Carers. Broken down, this is made up of over 29,500 in RCT, nearly 7,500 in Merthyr and almost 18,000 in Bridgend.
- It is probable that the number of Carers is even higher, as the census indicated there are over double the number of people reporting a long term limiting illness compared with the number of people reporting themselves as a Carer. The 'Value of Unpaid Carers Report (2015)' estimated that there were approximately 30,000 more Carers in 2011 compared to 2001. Because there are higher levels of poor physical and mental health and disabilities in Cwm Taf there is a greater need for help from informal Carers. Many of these Carers do not recognise themselves as such in terms of the census return.
- Many Carers provide a significant amount of time caring. A total of 17,255 Carers provide over 50 hours of care per week. This has increased by 9% in Cwm Taf/Bridgend from the 2001 to the 2011 Census. This evidences that Cwm Taf Carers are providing more substantial levels of care which can often impact on the health of the Carer. There are more and more older people caring for even older people, or more than one person (perhaps caring for a partner and a parent). The issues associated with caring will vary considerably depending on the individual circumstances of the Carer and the needs of the person they care for. With an ageing population and higher demands placed on reducing budgets the number of Carers across Wales is expected to increase which will impact on the capability of services to meet the increased demand.
- There are over 3,000 young and young adult Carers under the age of 25, an increase of 19% from 2001 to 2011. However, the majority of Carers in our Local Authority areas are over fifty. The number of Carers over the age of 65 is increasing more rapidly than the general carer population.

### 3.13 Welsh Language

- In our Local Authority areas, 7.3% of adults and 27.9% of children are able to speak Welsh according to UK Census 2011. The proportion of those who are able to understand, speak and/or write Welsh varies within and the proportion of people in Bridgend whom can speak Welsh is decreasing.
- It is possible that young children, the elderly or confused may prefer to or need to communicate in Welsh. Where arrangements are already in place to accommodate these, they should be replicated elsewhere.
- It will be essential to comply with the Welsh Language Act 1993 and all supporting strategies, particularly the Bilingual Skills Strategy and the 'active offer' when planning for service change and addressing the cross cutting themes. In addition to this, the Welsh Language Commissioner has applied a new set of Standards throughout the Health Service in Wales which were issued in November 2018 and many must be met by May 2019. They cover staff and patients and we have a legal duty to meet them.

### 3.14 Demographic profiles of staff

These will be considered for specific services as part of the EIAs to be undertaken by Directorates. Both service user and staff profiles should be taken into account when services are changing. When the key service changes are equality impact assessed, relevant staffing information will be analysed and every effort will be made to mitigate where issues emerge. The UHB will follow the All Wales Organisational Change Framework should any changes be made to their post or base.

# 4 WHAT ARE THE IMPLICATIONS FOR RESIDENTS OF MERTHYR TYDFIL, RHONDDA CYNON TAF AND BRIDGEND

## 4.1 Equality Perspective: Engagement & Consultation Responses

This section will be developed as part of the Engagement and Consultation Plan underpinning the development of the IMTP.

In broad terms, reference is made in the IMTP to inequalities and the focus on deprived communities and vulnerable groups, many of whom may have ‘protected characteristics’. The Plan often uses statements such as, ‘including patients from all the communities we serve’. This is particularly relevant to the high number of people in our community who have a sensory loss, hearing, sight or loss or both, who are covered by the Accessible Healthcare Standards. At present approximately 1 in 6 people within our local population are affected and our expectation is that the already high levels of sensory loss in the local community will increase as the population ages and as obesity increases given the link between diabetes and sight loss.

Furthermore, the trend towards co-production and also keeping people in their own homes as far as possible could also prove positive in terms of meeting the needs of those with ‘protected characteristics’ if managed appropriately. For example, as mentioned earlier, it would be easier to accommodate cultural needs such as those relating to religion and belief in a patient’s own home. Similarly, co-production could enable a patient to express their individual needs and ensure they are taken into account if they are allowed to influence their own health management. In Cwm Taf such considerations underpin the philosophy of our new Stay Well @Home Service.

## 4.2 Our Focus

As we travel further forward, we will continue our focus on clinically led transformation such as:

- Ensuring an over-arching focus on the reduction of health inequalities and a clear approach to adopting the principles of prudent healthcare throughout all we do;
- Delivering a strengthened primary and community care service to enable a further service shift from secondary care to primary and community care;
- Using the Intermediate Care Fund and the requirements of the Social Services & Well-Being (Wales) Act 2014 to develop a sustainable range of integrated services;
- Ensuring safe and sustainable secondary care services including implementation of the outcomes of the South Wales Programme through the UHB and South Central Acute Care Alliance;
- Developing a strengthened approach to the commissioning of services provided by others, including the Welsh Health Specialised Services Committee (WHSSC) and Welsh Ambulance Services Trust (WAST), for the benefit of our local population.

The IMTP includes proposals to significantly remodel services and continue with plans for improvements in efficiency, which will lead to improved quality of care for patients and reduced lengths of stay.

With significant additional investment from Welsh Government going into primary and community care and intermediate care in 2019/20 as a key enabler for this strategic change, there exists greater opportunity to review the way we provide services including the number and location of beds and sites required to provide the remodelled and improved services.

## 4.3 Clinical Services Strategy

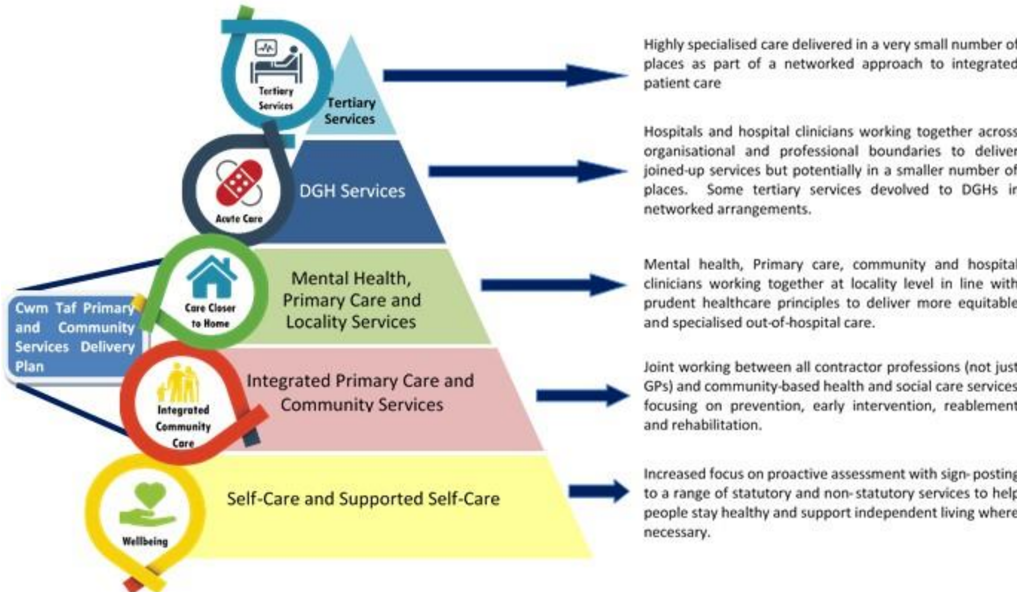
This IMTP contains detail of the Health Board’s emerging Clinical Services Strategy, which has been informed by a number of workshops, internal and external partnership discussions, supported by the Health Board’s Strategic Planning Group.

The common themes which have arisen through initial engagement activities are a desire for the Clinical Services Strategy which:

- Improves waiting times for primary and secondary care services in general.
- Increases the access to services locally in order to overcome transport issues.
- Delivers continuity of care within primary care.
- Improves services for people with mental health conditions.
- Enables clear communication between health professionals and patients.
- Delivers integrated service provision between primary care, secondary care, Local Authorities and Third Sector partners.

In developing our Clinical Services Strategy, we are using the model of healthcare system as outlined in the figure below. In turn, this informs our priorities for each area of service provision.

Each component of the model is developing a vision. These are set out below and have been used to frame and prioritise the service change deliverables in **Chapter 5 of the IMTP**.




*A Vision for Well-being – Self Care and Supported Self-Care*

We work as 'one public service' with communities to support the development of resilient communities that are informed, connected, active and resourced and have the ability to adapt to and influence change and improve wellbeing.

We are taking a system wide approach to health and well-being, with all areas of the organisation, from primary through to secondary care, having a role to play:

- Focusing on prevention and maintaining existing health through anticipation, co-production and self-management.
- Creating opportunities to reduce health inequalities.
- Working collectively with all public service leaders and organisations.
- Using place based initiatives and focusing on adverse childhood experiences, frailty, obesity, social, economic and health inequalities and loss of well-being.

*A Vision for Integrated Community Services*

An asset based approach, building on the strengths of individuals, families and communities, taking account of their needs in relation to communication, culture etc. A comprehensive range of community services, integrated across health and social care and working with the Third Sector to provide increased support closer to home:

- Services focused on early intervention and supporting independence.
- Single point of access, available 24/7 from acute and community settings.
- Multi-disciplinary teams and care plans in place to respond in a timely way to crisis.
- Working as part of a team with primary care providers and community based health and social care professionals for a defined patient population.

### *A Vision for Mental Health, Primary Care, and Locality Services*

Build a recovery model of mental health, taking it to a logical conclusion where all but the most acute episode of illness are treated and cared for within the community, providing:

- Early diagnosis, tailored treatment programmes and on-going support for people with mental health needs, their families and carers.
- Integrated holistic care services for people (all age) mental health needs to support people to stay well at home for longer.
- A range of community based enhanced support services across local authority, social services and education.

Timely access to high quality primary care providing a comprehensive service that deals with the whole person recognising their home circumstance:

- Building on universal access to primary care.
- Focused on prevention, anticipatory care planning with early intervention.
- More care provided locally within a primary care setting, avoiding many having to access secondary care at all.
- Focus for continuity of care and co-ordination of care for patients with multiple conditions.
- Services delivered in smaller number of larger practices by wider primary care team.

Coordinated care at crisis / transition points, and for those people most at risk:

- Access to specialist advice by phone, in community settings or through rapid access to outpatients.
- Jointly agreed care plans with input from GPs, community teams, specialist nurses and consultants, with shared responsibility for implementation.
- Rapid escalation of support, on a 24/7 basis.

### *A Vision for Acute Care – Local and Regional Secondary Care*

Working together, some specialities will provide inpatient services on only one hospital site (and sometimes where appropriate regionally), driven by clear evidence of the relationship between volume and outcome, allowing each District General Hospital to develop a degree of specialisation to ensure high quality outcomes.

Emergency services, including Accident and Emergency services, outpatient, diagnostic and day case services will be provided across District General Hospitals with Hospital assessment which focuses on early comprehensive assessment driving care in the right setting such as:

- Senior clinical decision makers at the front door.
- Specialist care available 24/7 where required.
- Rapid transfer to appropriate place of care, following assessment.
- In-patient stay for the acute period of care only
- Early supported discharge to home or step down care.
- Early involvement of primary, and community and social care team in planning for discharge.

Planned care which is locally accessible on an outpatient / ambulatory care basis where possible including:

- Wider range of specialist clinics in the community, working as part of a team with primary care and community services.
- Diagnostic services organised around patient needs, with investigations front-loaded to speed up pathways.
- Interventions provided as day case where possible.
- Limited hospital based follow up care, with emphasis on virtual clinics and patient led follow up.

- Rapid access as an alternative to emergency admission or to facilitate discharge

The Welsh Health Specialised Services Committee (WHSSC) is a Joint Committee of the seven Health Boards in Wales and is responsible for the planning of specialised and tertiary services on their behalf. The seven Health Boards in Wales have agreed a three year commissioning strategy in order to: *"Ensure equitable access to safe, effective, and sustainable specialised services for the people of Wales."* The aim is to use a value based health care approach across the whole patient pathway in order to ensure that investment is made in the most effective part of the care pathway, in order to achieve the greatest benefit of the patient.

### 4.4 Service Developments 2019/2020

EIAs will be undertaken for specific projects and themes where it is considered through initial analysis that they could impact on members of the community or staff. Lead managers will be responsible for ensuring they are undertaken in a timely and appropriate manner and they will be supported in this by the Equality Manager who will provide advice as appropriate.

### 4.5 Programme for Completion of EIAs

Executive Directors will need to consider which service priorities under the IMTP will require an EIA. Similarly, Directorates will also need to consider which elements of their individual Directorate Business Plans will require an EIA. An initial screening approach will be necessary to decide whether an EIA is necessary for each business plan and cross cutting theme.

Equality Impact Assessments will be taken to the Equality and Welsh Language Forum and Executive Board for approval and subsequently to the Health Board for information.

The EIA process is currently being reviewed to ensure that EIAs are undertaken at an early stage in all service developments and this will be linked closely to existing planning and business frameworks.

To date the following EIAs have been completed in relation to the IMTP:

| Service Area | Planning Lead | Status |
|---|---|---|
| Establishment of a major trauma network for South and West Wales and South Powys. | Head of Planning – Scheduled Care | Completed |
| UHB and CT Regional Partnership Children, Young People and families Statements of Intent | Head of Planning – Children, Young People & Families | Completed (due to go to EB in Jan/Feb 2019) |

Under the updated IMTP 2019-22 a commitment is given to the following programme of EIAs to be undertaken for each development listed below in an appropriate and timely manner by key individuals responsible for the service change. They will be supported in this by the Equality Manager. This list is not exhaustive and the same process will apply to other developments which emerge during the lifetime of the Plan.

| Service Area | Planning Lead | Status |
|---|---|---|
| Paediatric, Obstetric & Neonatal Services | Head of Planning – Children, Young People & Families | To be completed by April 2019 |
| Getting it Right First Time (GiRFT) Orthopaedic Service Redesign | Head of Programme Management Office | June 2019 |
| ENT Regional Services Redesign | Head of Planning - Scheduled Care | June 2019 |
| Urology Regional Services Redesign | Head of Planning - Scheduled Care | June 2019 |

**Key questions that must be answered when considering the impact of the Integrated Plan, based on advice from the Director of Equality and Human Rights, Wales.**

These can only be answered in very broad terms at this stage but will be given close attention in each of the supporting EIAs.

**Is the purpose of the policy change/decision clearly set out?**
As detailed earlier the Cwm Taf community experiences significant health challenges in terms of deprivation and the burden of ill health, the focus of the Plan is therefore on quality of delivery, improved patient experiences, ensuring optimal access to services and equity of resources. The Plan recognises that we face challenges over the coming years with growth in our population need, increased costs and significant resource constraints. The next three years will be particularly challenging with further terms real reductions in resource allocations over this period. The Plan assumes the achievement of cost reductions of around £54.5m of re-design and efficiency savings over three years, which is around 6% of the Health Board's controllable expenditure (excluding capital charges and primary care contracts) of circa £900m).

**Have those affected by the policy/decision been involved?**
The IMTP Stakeholder Engagement Plan detailed the engagement that was undertaken as part of the update of the IMTP itself. Significant engagement will also be undertaken to support the service change process. It will be important to ensure that the engagement process is as inclusive as possible and this should include reaching minority groups and ensuring that methods and resources used are accessible e.g. taking account of Welsh language, other languages and the needs of people with sensory loss who account for 20% of our population.

**Have potential positive and negative impacts been identified?**
Every effort will be made to address this as the various elements of the Integrated Plan are progressed.

**Are there plans to alleviate any negative impact?**
Every effort will be made to identify and address any negative impact which is identified for the supporting plans.

**Are there plans to monitor the actual impact of the proposal?**
The actual impact will be monitored as each of the individual EIAs are undertaken. The impact of the Integrated Plan will also be considered each time it is updated on an annual basis.

**Human Rights**
Human Rights must also be considered and in general terms, the right to respect for private and family life, home and correspondence" is frequently relevant. This human right is not an absolute right, and any interference should be justified, lawful, necessary and proportionate.

The improved quality of care possible due to more centralised provision of services should result in patients spending less time in hospital and this could have a positive impact on the right to maintain family life. This would apply to the patient and to individual members of the family and could outweigh the disadvantage of patients being further from their families whilst receiving in-patient care.

It is essential that community care is appropriate and effective so that there is no risk to life, Article 1 – the right to life. One of the main concerns in relation to the South Wales Plan was that people had to travel further for treatment and sometime for life-saving care and this was also considered in the context of the right to life. Article 14, prohibition of discrimination is also relevant to all of the Equality considerations raised.

**Mitigation**
An effective EIA takes into account the views and opinions of those who may be affected by the policy and what is already known about how the policy might affect different groups. This includes national evidence, Public Health Wales information, census data and public views wherever possible in order to identify issues.

The consideration of mitigating measures and alternative ways of doing things is at the heart of the Equality Impact Assessment process. Cwm Taf UHB will endeavour to consider different options in the development of all the services covered in this plan. The consideration of mitigation of adverse impacts is intertwined with the consideration of all actions. Mitigation can take the form of lessening the severity of the adverse impact.

Ways of delivering services which have a less adverse effect on the relevant equality category or issue, or which better promote equality of opportunity for the relevant equality category, will be considered.

Mitigation is not considered in detail at this stage because, as stated earlier, this EIA only considers an overview of service developments and individual EIAs will be undertaken by each Directorate as service developments are considered. These will need to be worked through together with any further issues and mitigations once decisions are made.

In accordance with the revised arrangements for EIA, progress against mitigation actions will be monitored by the Equality Forum.

**Summation – General Duty**

**Due regard to three elements of general equality duty**
This Equality Impact Assessment is representative of a real attempt to address the following questions:

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

Where any concerns relating to equality are raised, these will be considered as a starting point for specific EIAs and these will be explored in order to establish possible mitigation (see previous section) and to avoid discrimination against any particular groups and to promote equality of access to services. This will involve consultation with different groups in relation to the protected characteristics in accordance with the Equality Act 2010 through the use of appropriate media, fora and by building on existing relationships. Attendance at public meetings, submission of comments etc will be monitored and reported as determined by the Health Board.

The composition of the local population (2011 Census and Public Health information) has been analysed and the different groups' current access to the changing services (based on information available) will also be considered.

The other main element of analysis will involve looking at the protected characteristics shared by staff employed in each of those services to avoid discrimination caused by a potential move, reconfiguration or any change to their role and/or terms and conditions. Individual issues would be addressed under the terms of the Organisational Change policy once decisions to change services are made.

**Next Steps**
The Equality Impact Assessment process is a positive and challenging process based on a **'**common-sense' approach rather than an 'exact science'. Key managers must allow time to mitigate if adverse impact against one or more protected groups is identified in the EIA process and to facilitate this the EIA should be taken early in the planning process**.** Every attempt should be made to engage and consult on planned changes and agreed changes should be implemented in partnership with stakeholders.

A programme of timetabled engagement activity, including separate meetings for agreed groups, by each individual Directorate or in partnership together is being developed as necessary to support the Health Board in meeting the requirements of the equality legislation and this will be updated should other EIAs be necessary. The engagement programme will also assist the Directorate Managers in undertaking their equality impact assessments, the outcome of which will be fed into the ongoing implementation of the Integrated Plan.

The Strategic Planning Group will oversee the development of an agreed set of Equality Impact Assessments based on a standard template to enable Directorates to consider their readiness to implement their proposals and ensure any adverse effect can be mitigated. These in turn will be considered by the Equality and Welsh Language Forum.