

VASCULAR HUB AND SPOKE NETWORK FOR SOUTH EAST WALES

EQUALITY IMPACT ASSESSMENT EVIDENCE DOCUMENT

Introduction

This document presents the evidence collected to date in support of the equality impact assessment (EIA) process for the development of a Hub and Spoke Vascular Network service to serve South East Wales.

The Equality Act 2010 places a positive duty on public authorities to promote equality for the nine protected characteristics¹ and requires Welsh public bodies to demonstrate how they pay 'due regard' when carrying out their functions and activities. Equality is about making sure people are treated fairly. It is not about treating 'everyone the same', but recognising that everyone's needs are met in different ways. In the context of this work we are required to assess the impact of policies and services on equality. The purpose of this is to ensure that, as far as is practicably possible, the opportunities for promoting equality and human rights for people with protected characteristics are maximised and any actual or potential negative impact is eliminated or minimised.

The Human Rights Act 1998 also places a positive duty to promote and protect rights. We clearly recognise the importance of putting human rights at the heart of the way our services are designed and delivered. We believe this makes better services for everyone, with patient and staff experiences reflecting the core values of fairness, respect, equality, dignity and autonomy.

In addition we recognise that Wales is a country with two official languages: Welsh and English. We have a responsibility to comply with the new Welsh Language (Wales) Measure (2011). This will create

¹ Race; Sex; Gender Reassignment; Disability; Religion; belief/non belief; Sexual orientation; Age; Pregnancy and Maternity; and Marriage and Civil Partnerships: Equality Act 2010

standards regarding Welsh which will result in rights being established that will ensure Welsh speakers can receive services in Welsh. The importance of bilingual healthcare for all patients in Wales is fundamental and is particularly important for four key groups - people with mental health problems; those with learning disabilities; older people and young children. Research has shown these groups cannot be treated safely and effectively except in their first language (Welsh Language Services in Health, Social Services and Social Care, 2012)². Our consideration of equality takes account of this.

EIA requires us to consider how the development of a centralised Vascular service, including an arterial centre (Hub), supporting non arterial units (spokes) and a comprehensive rehabilitation pathway, operating within a network structure for South East Wales, may affect a range of people in different ways. The EIA will help us answer the following questions:

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

This document is not intended to be a definitive statement on the potential impact of the vascular centralisation on protected characteristic groups. The document's purpose is to describe our understanding at this point in the EIA process of the likely impact.

Background

A collaboration between Cardiff and Vale, Cwm Taf Morgannwg and Aneurin Bevan University Health Boards, has been coordinating the development of proposals for a centralised vascular service for South

² More than just words: Strategic Framework for Welsh Language Services in Health, Social Services and Social care (2012)

East Wales. Emergency Vascular services have already been centralised at the University Hospital of Wales (UHW).

The project is being led through the SE Wales Vascular steering committee, which is overseeing the work, and is supported by a clinical advisory group, operational group and a number of workstreams. The work will lead on the development of a clinical model and pathways including a comprehensive rehabilitation pathway, operating within a network structure for the region.

Through the steering committee, clinical reference group, clinicians and stakeholders have been working together to examine national guidance and to develop service models to improve care, treatment, rehabilitation and outcomes for vascular patients.

Rationale

Vascular disease accounts for 40% of deaths in the UK, many of which are preventable.

The report 'The provision of services for patients with Vascular Disease (Vascular Society, 2014)³ compiles key recommendations to deliver standards for the care of vascular patients. The evidence is consistent that the best outcomes following elective and emergency interventions are achieved by concentrating inpatient care into arterial centres, this ensures the most efficient use of staff, specialist equipment and facilities.

A minimum population of 800,000 is often considered the minimum population required for a centralised vascular service. This is based on the number of patients needed to provide a comprehensive emergency service; maintain competence among vascular specialists and nursing staff; ensure the most efficient use of specialist equipment, staff and facilities; and the improvement in patient outcome that is associated with increasing caseload. A minimum population of 800,000 would be appropriate but for a world class service a larger catchment area will be required. The population of SE Wales (the resident population of the Health Boards taking forward this proposal is approximately 1.6 million

³ The Provision of Services For Patients with Vascular Disease, The Vascular Society (2014)

(StatsWales 2016). The current configuration of services across separate hospital sites across South East Wales are too small to meet the quality and safety standards set out by the Vascular Society and the Royal College of Surgeons. None of the current individual units in SE Wales meet this requirement.

Benefits to the whole population will derive from an Inclusive Vascular System that provides for the needs of patients in its region by moving patients to the hospital best able to provide suitable care, freeing resources at other units.

At present, there is no vascular network or designated arterial centre operating across or within South East & Wales. Evidence demonstrates that the introduction of an arterial centre (hub) supported by non arterial units (spokes) and a comprehensive rehabilitation pathway, working in an integrated and mutually supportive way, is expected to raise the quality of services, reduce deaths, and reduce regional limitations and variations in services.

Expected outcome

The SE Wales Vascular service aims to ensure patients have appropriate, timely access to reliable, safe, high quality and sustainable services at all points along their care pathway, in line with best practice standard requirements, and evidenced through key performance indicators.

The proposal is to establish an arterial centre operating within an integrated Vascular network for South East Wales. This will provide patients with the right level of service 24 hours a day, 365 days a year. The arterial centre or 'hub' will be supported by a network of non-arterial units or 'spokes', and rehabilitation provided through specialist and local rehabilitation services.

Rehabilitation is a process of assessment, treatment and management with ongoing evaluation by which the individual, and their family and carers, are supported to achieve their maximum potential. It is a key part of the patient pathway, commencing before admission to an arterial

centre, continuing through the inpatient phase to discharge from the hub or spoke into the community and is a true enabler to achieving the best outcomes for individuals.

How it will be delivered

Based on considerations over recent years, there is good clinical consensus to proposed that if supported, the new vascular service will be based on a hub and spoke model and will have:

- Diagnosis and assessment of vascular disease (including the input of the vascular laboratory and diagnostic imaging);
- Outpatient management of patients with peripheral arterial disease;
- Inpatient spells, emergency and elective activity;
- Day case activity;
- Multidisciplinary outpatient follow up of patients receiving vascular surgery/endovascular interventions;
- Seamless repatriation of patients following rehabilitation care pathways particularly for post amputation care;
- Limb Fitting Service – the vascular service must ensure its patients have access to a local limb fitting service, which meets the standards set by The British Society of Rehabilitation Medicine.
- A dedicated vascular day case facility in both hub & spoke to allow day case surgical & interventional radiology procedure.

It is proposed that the hub and spokes have the following components:

HUB	SPOKE
➤ Emergency Vascular Service:	➤ Emergency Vascular Service:-

<ul style="list-style-type: none"> • Amputations and “<i>nibbling</i>” • Aneurysm surgery; • Patients requiring CEA within 48 hrs of index event; • Peripheral arterial reconstructions. 	<ul style="list-style-type: none"> • Angioplasty • Angiogram; • As noted above, the “front door” will remain the patient’s local hospital, defined as a Local Hospital with an Emergency Department and an Emergency General Surgery Service; • Rehabilitation.
<p>➤ Elective Vascular Service:</p> <ul style="list-style-type: none"> • Abdominal Aortic Aneurysm • Endovascular aneurysm repair • Carotid endarterectomy 	<p>➤ Elective Vascular Service:-</p> <ul style="list-style-type: none"> • Venous surgery angiography and angioplasty; • Outpatient clinics

Based on this, the main procedures that are expected to transfer from each of the current sites to any future hub are the following:

- Iliac and femoral artery procedures
- Carotid
- Open Abdominal Aortic Aneurysm
- Endovascular Abdominal Aortic Aneurysm
- Open Thoracic Aortic Aneurysm
- Thoracic endovascular aortic repair (TEVAR) ➤ Operations on vena cava ➤ Other artery.

To achieve delivery, there will be a number of infrastructure requirements for both the hub and the spoke:

HUB	SPOKE
<ul style="list-style-type: none"> ➤ Dedicated vascular surgery ward(s). Beds will need to be staffed by an appropriate skill mix of nurses who have been trained in the care of vascular patients. Doppler investigation will need to be available on the ward; ➤ Hybrid theatre, with experienced vascular theatre staff; ➤ Scheduled elective lists (IP / DC); ➤ Anaesthesia – elective vascular services will have dedicated vascular anaesthetic input, from anaesthetists experienced in dealing with vascular patients and with a special interest in this area. This may include anaesthetists from Spoke sites given the opportunity to support elective lists in the hub; ➤ Intensive Treatment Unit (ITU) and High Dependency Unit (HDU) – Facilities with full renal support must be available onsite to support the vascular 	<ul style="list-style-type: none"> ➤ Mixed surgical wards but with ring fenced vascular beds; ➤ CEPOD theatre model; ➤ Interventional radiology; ➤ Scheduled elective DC lists; ➤ Outpatient Clinics – including access to nurses/therapists experienced in ulcer and wound dressing. Doppler ultrasound machines should be available. <p>To support this, it is also assumed that each of the spoke sites will have the following:</p> <ul style="list-style-type: none"> ➤ A consultant led Emergency Department (A&E); ➤ An Emergency General Surgery service.

<p>service. Bookable HDU/ITU with sufficient beds will need to be available for elective patients</p> <ul style="list-style-type: none"> ➤ Interventional radiology suite with access to nursing staff trained in vascular procedures. ➤ Out-patients clinics 	
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Given the range of services already in situ on the University Hospital Wales site, its position as a specialist and tertiary provider, and the codependencies between them and the vascular service, particularly major trauma, interventional cardiology and cardio-thoracic surgery, the preferred option for the hub is identified as the University Hospital of Wales, Cardiff. Given the need for consultant led A&E and a general surgery emergency service, the spokes for each of the areas are proposed as:

- **Aneurin Bevan University Health Board** – Grange University Hospital and Royal Gwent Hospital
- **Cwm Taf Morgannwg Teaching Health Board** – Royal Glamorgan Hospital, Llantrisant
- **Cardiff and Vale University Health Board** – Llandough Hospital
Vale of Glamorgan

It is important to note that as patients begin their recovery and rehabilitation journey, that this too will be provided from a hospital/community setting which is much more local to them.

Who needs these services?

The prevalence of vascular disease increases with age. Average life expectancy continues to rise especially in males. This suggests that demand for vascular services is likely to increase over time. There are

currently an estimated 200,000 people with diabetes mellitus in Wales, and prevalence is increasing.¹ Vascular disease is the major cause of morbidity in diabetes and the risks of disease progression are higher, with an epidemic of diabetic foot disease expected in the next decade.

1. Diabetes UK

Risk factors for vascular disease include:

- Being over the age of 50
- Smoking
- Being overweight
- Having abnormal cholesterol
- Having a history of cerebrovascular disease or stroke
- Having heart disease
- Having diabetes
- Having a family history of high cholesterol or high blood pressure
- Having high blood pressure
- Having kidney disease or haemodialysis

Early diagnosis is key to successfully treating vascular related disease. Patients will be admitted with a variety of both emergency and planned vascular conditions and not all patients will go on to require a complex surgical or interventional radiology procedure. Emergency care is immediate treatment to save a life or limb, urgent care is planned treatment within a limited number of days.

Patients who receive vascular services may have:

- Had a stroke and are at risk of having further strokes
- Blocked arteries in the legs causing pain which may deteriorate further and threaten the leg
- A bulge in the wall of the body's main artery which needs repair to prevent it rupturing
- Untreated or untreatable arterial blockages which mean they need a limb amputation

Not all patients admitted to a specialist service will need a complex surgical or interventional radiology intervention, however due to the nature

of their condition, these patients need specialist assessment and care provided in a specialised vascular unit.

Vascular services are provided to the populations of South East Wales with the exception of Bridgend who receive care from the South West Wales vascular network. This is a population of approximately 1.6 million people.

Where are we now?

Equality impact assessment is an ongoing process that runs throughout the course of the decision making process, and through implementation and review.

This paper defines the proposal for change and the rationale, sets out the expected outcomes and who will be affected by the proposal, and considers potential impacts on different groups and any possible actions for reducing or eliminating disadvantage.

Stakeholder engagement is an important part of the development of the proposals. Stakeholders have been involved in reviewing the EIA and further opportunities will be taken to assess the impacts as the work progresses.

What the evidence tells us on the need for change

The case for change is founded on firm clinical evidence and guided by national and international good practice.

There is strong evidence that case volume influences outcomes. The 31 highest volume hospitals (which perform 57% of all elective Abdominal Aortic Aneurysm procedures in the UK) have mortality rates that are under half those seen in the 32 hospitals with the lowest volume of procedures. These data lend support to the current move towards performing major arterial surgery in larger volume units in order to further optimise outcomes. The Royal College/national professional view, is that it is no longer acceptable to provide elective or emergency vascular cover outside a fully centralised service or a formalised modern clinical network with a designated single site for all arterial interventions providing a 24/7 on-site service.

There are a number of reviews and reports that support this which include:

1. Vascular Society of Great Britain and Ireland Provision of service for patients with vascular disease (2012)
<http://www.vascularsociety.org.uk/library/quality-improvement.html>
2. https://gettingitrightfirsttime.co.uk/wpcontent/uploads/2018/02/GIRFT_Vascular_Surgery_ReportMarch_2018.pdf

What are the potential impacts on protected characteristic groups?

EIAs require analysing impacts on the basis of protected characteristics: sex; disability; race; religion or belief/non belief; age (younger people and older people); sexual orientation (lesbian; gay and bi-sexual people); gender reassignment; pregnancy and maternity; and marriage and civil partnerships. We have been gathering evidence to inform our assessment of the potential impact of the proposed establishment of a vascular hub and spoke model network on patients, families and carers, staff, and other stakeholders.

Looking at a range of national research evidence has helped us to consider the potential impact. In particular, we are aware that many people who share certain protected characteristics such as disability, older age, younger people and some minority ethnic groups also face social and or economic disadvantage. Looking at socio-economic disadvantage goes some way to showing due regard to equality considerations. There will also be other distinct areas that are not driven by socio-economic factors but which relate directly to people with different protected characteristics. The proposals under consideration for the establishment of a vascular network will result in the concentration of life-saving treatment for a relatively very small number of patients but with the most serious disease. Non arterial units and a comprehensive rehabilitation service will ensure that as a patient's condition improves responsibility for ongoing care will transfer to healthcare facilities closer to home. The key issue for the protected characteristic groups would seem to be one of access as evidence tells us that some traditionally underrepresented groups' access to health facilities is disproportionately

low when compared to the general population. The same can be said with regard to good health outcomes.

Below, from review of national evidence and research, discussion concentrates on the 'at risk groups' and the sections of the population which are likely to be most affected by the vascular proposals (those groups that are expected to experience impacts which are disproportionate to those experienced by the general population). There is also reference to health care needs in general.

The first observation to make is that vascular disease tends not to be closely associated with particular equality groups; are not simple to predict on the basis of socio-economic characteristics. Of the protected characteristics, none are particularly susceptible to vascular disease. However, a few groups are certainly key to consider in this assessment.

A literature review was carried out as a first stage of gathering evidence to inform the EIA. The results are provided below against each of the protected characteristics. There has also been engagement with stakeholders through work to develop the rehabilitation pathway.

Age

Engagement with stakeholders on the rehabilitation element of the patient pathway identified that the involvement of carers and family in rehabilitation is more difficult the further away rehabilitation is from local support mechanisms. It should be recognised that patients are not always able to return 'home', or to the setting they came from. Older patients will have different co-morbidities such as dementia or medical requirements, and it will be necessary to ensure that staff in the vascular network has all the skills required to care for these patients.

Race

There will be a need to consider requirements of those patients who may require translation or interpretation services, and access to volunteers or staff who can converse in a chosen language.

Disability

Rehabilitation services should give choice to patients with preexisting mobility issues. Specific patient needs, such as bariatric needs should be considered to ensure the ability to provide equipment across boundaries and within social care sector.

As well as physical disability, there is a need to consider learning disabilities and mental health. It is recognised that the involvement of carers/family in any programme is more difficult the further away rehabilitation is from local support mechanisms, and patients are not always able to return to the 'home/setting' they came from. Communication needs in these client groups may be more challenging and care should be adapted accordingly.

There are specific standards under the All Wales Standards for Communication and Information for People with Sensory Loss⁴ that apply directly to emergency and unscheduled care and these outline the staff training requirements, communication systems and patient needs information which should be provided by health boards.

Improved service will reduce the rates of disability and increase socioeconomic functioning.

Marriage and civil partnership

No impacts upon this protected characteristic are anticipated.

Pregnancy and maternity

No impacts upon this protected characteristic are anticipated.

Religion or belief (including lack of belief)

It will be important to note that staff consider and recognise that patients' personal beliefs may lead them to ask for a procedure for mainly religious, cultural or social reasons or refuse treatment that you judge to

be of overall benefit to them⁴. There are also many issues in relation to prayer, diet, death and dying rituals that would have to be considered.

Sexual orientation

Despite an appreciation that awareness of sexual orientation and gender identity issues in the health and social care sector has improved, Lesbian , Gay, Bisexual and Trans (LGBT) patients in Wales report significant barriers to health and social care services⁵ . Feedback provided at a Stonewall event indicated that service providers often use inappropriate language when dealing with LGBT patients, and make assumptions about patients' sexual orientation or gender identity. This makes LGBT people feel anxious about accessing health or social care and creates barriers to honest discussions about their health needs. Moreover, it can lead to serious health risks. There is a need to ensure that patients' needs and personal circumstances are taken into consideration when providing care along the patient pathway, including any implications for rehabilitation services.

Stonewall has commended work by healthcare employers around setting up LGBT staff networks, putting zero tolerance policies in place towards discrimination, and taking a more active approach to LGBT community engagement as having improved the experiences of staff and their patients. Health boards should continue to seek to make progress in this area.

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. In 'It's just Good Care: A guide for health staff caring for people who are Trans' 2015¹⁹ Trans* people must be accommodated in line with their full-time 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*

⁴ http://www.gmc-uk.org/guidance/ethical_guidance/21179.asp

⁵ <http://www.stonewallcymru.org.uk/our-work/research/have-your-say>

person and other service users. If there are no cubicles, privacy can usually be achieved with curtaining or screens. For people who are still in transition, any compromise must be temporary. 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 GRC 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. All these issues, as well as others, could be mitigated through training.

Welsh Language

Public services have a responsibility to comply with the Welsh Language (Wales) Measure. This has created standards which establish the right for Welsh language speakers to receive services in Welsh. There is a risk that the location of the arterial centre within the vascular network may impact negatively on Welsh language users. Service users who prefer to communicate in the medium of Welsh may be required to access services at sites which do not have sufficient Welsh speaking staff. This could affect the service user's ability to communicate with service providers in their preferred language. Meeting the information and communication needs of victims who speak Welsh will need to be taken into account. 'Language is the core of establishing and expressing identity. Responding sensitively to language, whilst focusing on the individual is an essential principle of maintaining dignity and respect in care within a bi-lingual setting (Welsh Language Services in Health, Social Services and Social Care, 2012)⁶.

Socio-economic status

While socio-economic status is not a protected characteristic under the Equality Act 2010, there are new legal socio-economic duties for public bodies that will come into force in March 2021 and will apply to any decision made from this date. The overall aim of the duty is to deliver better outcomes for those who experience socioeconomic disadvantage.

⁶ More than just words: Strategic Framework for welsh language services in Health, Social Services and Social Care (2012)

The report *Transport and Social Exclusion: Making the Connections* (Social Exclusion Unit, 2003) highlighted the current challenges faced by socially excluded groups in accessing health and other services. They found people who are socially excluded are more likely to experience a number of factors that in themselves have a negative impact on gaining access to health services. These may include low income, disability and age, coupled with poor transport provision or services sited in inaccessible locations. It also found that the location of health services and the provision of transport to health services can reinforce social exclusion and disproportionately affect already excluded groups.

What are the potential impacts on NHS staff?

Proposals to establish a Vascular network may affect NHS staff as the final configuration may require staff to have to travel to new workplaces and work more flexibly across health board boundaries.

There is anecdotal evidence that the establishment of a Vascular network and arterial centre within South Wales would improve recruitment and retention for those clinicians who wish to practise in such a structure. It would also ensure the arrangements for the delivery of Vascular services in South East Wales are on a par with the structures in the rest of the UK.

Staff will be engaged and consulted on the proposals and any staff affected by the final outcome will be supported by the NHS Wales Organisational Change Policy (2009). A partnership approach with trade union colleagues will be ensured to achieve an effective transition to any new arrangements.

What are the human rights implications of the Vascular development?

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

Everyone has the right to participate in decisions which affect their human rights. The convention on the rights of people with disabilities

contains protection of the right to participate in decisions and access to support for participation and access to information.

The assessment so far has indicated *Article two: the right to life*, and *Article eight: the right to respect for private and family life, home and correspondence*, are of particular relevance and potential impact to the development of the Vascular network.

Right to life (taking reasonable steps to protect life): It is anticipated that having a regionalised service, with the most complex care provided from an arterial centre, will improve clinical outcomes which will have a positive impact on individuals' right to have their life protected.

Right to respect for private and family life, home and correspondence: the improved quality of care possible through a vascular network structure should result in patients spending less time in hospital. However, increased travel distances could have a negative impact on the right to maintain family life. This would apply to the patient and individual members of the family.

This is not an absolute right and any interference should be justified, lawful, necessary and proportionate.

Initial summary conclusion

We believe that the introduction of a vascular network, including rehabilitation and the development of both an arterial centre and nonarterial units, is intended to improve patient care and outcomes for Vascular disease including timeliness of access, quality of outcome and improved equality of access and reduce inequalities.

We believe that the proposed service redesign does not introduce any additional obstacles; improving standardisation for access and specialist treatment should improve outcomes across all social groups. At this stage, this assessment indicates that there are a relatively small number of cases not currently treated at a centralised site (UHW) and, from national evidence and research, the majority of cases are male and over aged 65.

For those visiting patients whilst being cared for at an arterial centre, longer and more complex journeys are likely to be necessary for some.

Being required to travel to an unfamiliar hospital and longer distances could be particularly difficult and disorientating for people. Journey times will be increased for users of public transport, which is highly relevant in terms of equality groups. Car ownership amongst most equality groups and, particularly, socially deprived communities tends to be lower than average, requiring a high reliance on public modes. Early transfer of the patient back to a 'local' hospital would help to mitigate long periods in unfamiliar surroundings.

What happens next?

The work of the South East Wales Steering Committee, Clinical Advisory Group, Operational Group and a number of workstreams, is continuing to plan for a Vascular service, and enter a period of engagement with the arterial centre being located at UHW and a number of supporting non arterial units and a comprehensive rehabilitation pathway, operating within a network structure for South East Wales. The EIA will continue to be reviewed to further develop and refine this assessment and to ensure.

